Making Sense of *Suboptimal Health (亚健康)*: Negotiating and Embodying the Conceptual Space of ‘Neither Healthy Nor Diseased’

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Thesis submitted to the University of Sheffield for the degree of Doctor of Philosophy

The University of Sheffield

Faculty of Medicine, Dentistry and Health

The School of Clinical Dentistry

September 2022

Abstract

This thesis looks at the conceptual history and embodied narratives of a concept called suboptimal health (亚健康) and the way it is defined and utilized by different actors, including Traditional Chinese medicine (TCM), the health food industry, the Chinese government, as well as lay people in their everyday life. Subhealth was championed as 'a new concept of the 21st century' that 'troubles the majority of the world population' by TCM professionals, which was initially fuelled by the commercial development of health foods in the 1990s in China. Since then, there have been different attempts to standardize what is meant by suboptimal health, and numerous efforts to objectively, capture, define measure, and t to treat it.

Drawing on data ranging from documentary data, multi-sited ethnographic data at a TCM clinic, two TCM conferences, and on Chinese social media, as well as interviews with visitors to the TCM clinic and interviews with Chinese people, this thesis looks at the negotiations and embodied narratives of subhealth. Utilized as a vague diagnostic category that mediates between biomedical classification and traditional Chinese medicine classificatory systems, this concept is one possible way people might be granted permission to be ill (or rather to be unhealthy) in the absence of illness. It allows lay people to talk about their unhealth, opening up narratives about here and now, although this permission of being ill seems to also come with the responsibility to look for possible biological explanations and exhaust those possibilities.

Acknowledgement

I would like to sincerely thank my supervisors, Barry Gibson, and Kate Weiner for their continuous guidance and help. They are so kind and encouraging and have helped me tremendously throughout my PhD. I am also grateful to Annamaria Carusi for her kind help when I started the project and for her help me in finding Barry to take me on. I am so lucky to have great supervisors like them and have always had such helpful guidance to help me through difficult times! I am grateful to Dr Zhuang (sorry for having to use the pseudonym) for giving me access to the clinic as field site and all the participants who kindly shared with me their stories.

I am also really grateful to my parents for funding my PhD. I am grateful for my mom, Li Linling. I would have given up if it were not for her continued support, despite the many difficulties during these years. I am of course grateful for my dad, Cheng Bo, for his unspoken support (or at least the willingness to be convinced!). And of course, to my sister, Lixingzi Cheng.

I am grateful, most of all, to my two lovely cats, Melon and 小呆. Honestly, I wouldn't be able to get through the PhD if it were not for their purrs and cuddles! I think they are the reason I finished the thesis. I am also grateful for all the friends I made during my PhD, who dispelled the loneliness of this journey. I really enjoyed those pub visits after the weekly seminars in philosophy department.

This research also received various small funding from Petrie Watson exhibitions, GBCET (Great Britain-China Educational Trust), and Phil Strong Memorial Prize. That money was a lifesaver.

I am grateful for all that rainbow that appeared and disappeared.

Declaration

I, the author, confirm that the Thesis is my own work. I am aware of the University's Guidance on the Use of Unfair Means (www.sheffield.ac.uk/ssid/unfair-means). This work has not been previously presented for an award at this, or any other, university. I have written about it in a blog post on the Polyphony and a Phil Strong Memorial Prize report that is put on the BSA website.

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Chapter 1: Introduction

你若有病，中医通过'治证'而治愈了你的疾病；你若'无病'（以前认为没病就是健康），中医诊断你是某种虚证，所开的中药处方称作'调理'，其实你就是处于我们今天讲的亚健康状态。

'If you have a disease, Chinese medicine cures it by treating the pattern. If you don't have a disease (the absence of disease that used to be considered health) Chinese medicine will give you a diagnosis of some pattern of deficiency, and the medicine prescribed will be aimed to ''adjust,'' but actually you would be in the condition that we now call subhealth'.

(Yuxue Wang, *Subhealth: A New Concept of Health for the 21st Century*, 2002, p20[1])

1.1 'A New Concept of Health for the 21st Century'

Suboptimal health status (SHS, 亚健康, ya jian kang in Chinese Pinyin) is a popular concept that has enjoyed enormous popularity in China since the 1990s. It has attracted a significant amount of academic attention within China, but rarely outside of China. As can be seen in its semantic construction – 'suboptimal' but still healthy, and a status – it denotes the area in-between health and illness that usually lasts over a period of time, which is seen as being in the realm of health but also sometimes functions somewhat like a disease category. It is sometimes called suboptimal health, or 'sub-health', or 'subhealth' and it is constructed as a rather formal term, as a 'scientific' concept. This conceptual space of 'in-between health and illness' is used to describe a wide range of bodily symptoms, including general fatigue, drowsiness, low energy levels, headache, neck pain, and the list goes on. Most of the symptoms denoted by subhealth share a subjective character, and it has repeatedly been

1. The translation for this excerpt is taken from Bunkenborg (2014)

constructed in different commercial and public health narratives as the physical state in which a person may experience some health complaints that cannot warrant a concrete medical diagnosis. In other words, suboptimal health refers to (often self-reported), subjectively experienced poor health. The concept thrived both in academic discourses and popular discourses. In academic discourses, it developed almost into a 'subdiscipline' of Chinese Medicine and in popular discourse, it has become incredibly well known and taken for granted (Jing, 2019; Bunkenborg 2014). In Yang's discussion of mental health in China, widespread subhealth is seen as a result of diverse sources of anxiety in the life of Chinese citizens.

In academic and popular discourses in China, subhealth has been constructed as a concept that captures a universal condition, which requires Chinese medicine (as well as other health practices), in addition to biomedicine, as a cure. The affinities it has with the notion of 治未病（*zhiweibing*）, one of the main doctrines in traditional Chinese medicine, could be one of the main reasons why it immediately appealed to the Chinese market in its inception. Or rather, it is due to its affinity with the conception of health in the Chinese context that it was proposed in the first place. *Zhiweibing* 治未病 can be literally translated as 'curing/treating un-disease', which is an oxymoron if seen from a modern biomedical perspective; some other possible translations are 'preventing diseases from happening' or 'curing a disease before its onset'. This line of idea emphasizes the need to treat disease before it manifests itself fully drawing on a holistic understanding of health from Chinese medicine.

This can be seen in the quote at the beginning of this chapter, which is taken from a book entitled *Subhealth: A New Concept of Health for the 21st Century* written in 2002 by Wang Yuxue, who is one of the main early proponents of the concept of subhealth, and who is commonly cited as the person who first coined the term. Wang was a professor at Qingdao University Medical College researching on Chinese medicine at the time of writing this book.

As can be seen in the passage above, Wang uses the theory of Chinese medicine to explain the concept of sub-optimal health but at the same time emphasises the novelty of this concept from the perspective of Western medicine. A separate space is carved out of the conceptual space of health and put under a separate name, that is, subhealth. A sense of invention is invoked here. Indeed, this can be vividly observed in the title of Wang's book, calling subhealth a concept 'for the 21st Century'.

In its presence in the Chinese context, subhealth is operationalised as an 'audacious project of labelling the majority of the world's population with a newly discovered medical condition, lack of health', a medical condition that encompasses the worries and concerns of most of the people (Bunkenborg, 2014, p138). It is often associated with the lifestyle people have in the 21st century and the stress people experience in urban life, and it is repeatedly framed as a major public health problem for 21st century China. For example, China Daily has published some articles warning its readers 'Be aware, you might be in suboptimal health' (Huang, 2004) and urged the public to pay attention to the suboptimal health status in human beings (Ding, 2007). The first article published in 2004 with the title *Be aware, you might be in suboptimal health* was written by Huang Yongchang, who was the Vice President of the Chinese Preventive Medicine Association and this attests to the currency of the concept for the nation at that time.

In this introductory chapter I will firstly introduce the emergence of the concept in China and its contexts in some depth and introduce media coverage of the concept as well as critiques of the concept, to provide contexts for my research. After this, I will provide some background about how I started this project. I will then provide some contexts about Traditional Chinese Medicine (TCM) in China and beyond – as this concept seems to be inextricably connected with the development of TCM. Lastly, I will lay out my research objectives and research questions, before giving out a chapter-by-chapter summary.

1.2 The emergence of the concept in China: emerging as a commercial yet academic concept

Wang Yuxue, who authored the book Subhealth: A New Concept of Health for the 21st Century, admitted to proposing the concept at the same time as developing a health tonic, Caili. He was referred to as the first person to propose the concept of suboptimal health, but in his book, he commented that he was merely proposing a new concept for an objective phenomenon:

> 我的工作是把这个习以为常的普遍现象换个角度予以审视，将老的医学问题加以重新认识，把这一客观存在的医学事实重新剥离出来，命名病界定亚健康这一比较恰当的概念，赋予它合理的内涵，在理论上予以探讨，并在可能的范围内加以应用。
>
> My job is to provide a new perspective on this commonly accepted phenomenon, to re-examine an old medical project, and to separate this objective fact from health and disease and define it and coin this appropriate term (of suboptimal health status), give it reasonable meaning, conduct a theoretical discussion of it and apply it in possible contexts.
>
> (Wang, 2002, p25, my translation)

It was clear retrospectively, how this 'objective phenomenon' was carved out with the aim of marketing Caili. This took place in the context of tightened state control and more standardised regulation of health food in the middle of the 1990s in China. In 1996, in order to regulate the health products market, *Measures for the Administration of Health Food* was published, and it was the same year that the concept of subhealth was conceived and got its momentum (Wang, 2002).

In 1997, the first workshop on suboptimal health was held in Beijing, hosted by the Chinese Pharmaceutical Association (also funded by the Hai'er company, the company behind Caili). This seminar got significant publicity and was widely reported in newspapers and TV news. According to Wang (2002), all major news outlets based in Beijing reported on this seminar and reporters from Guangming Daily and Shenghuo Daily also went to Qingdao

(where Wang is based, also where Hai’er is based) to conduct detailed interviews.

Also in 1997, at a workshop called ‘Seminar on China’s Health Products Going Global Strategy’, hosted by the Chinese Ministry of Health, Wang made a speech on suboptimal health. He also highlighted in his 2002 book the comment made by Professor Li Lianda, a professor at China Academy of Chinese Medicine at the workshop, that ‘the target of Chinese health products should be people in suboptimal health’ (Wang 2002).

In 1998, the second workshop on suboptimal health took place (which was commented by Wang to be aiming to contribute to WHO’s goal of achieving health for all by the year 2000). From the beginning of the popularity of the concept, it is situated by scholars in WHO’s public health agenda.

In 2001, the third workshop on suboptimal health was held, at the same time as a committee meeting of an editorial board to publish a series of books on suboptimal health. Wang’s 2002 book *Subhealth: A New Concept of Health for the 21st Century* is part of this series. At this time, the concept of suboptimal health has already made its way from a marketing banter to an academic concept.

Even being an academic concept, it is intertwined with a commercial intention. In his 2002 book, Wang described it as such:

> 我们的工作是，第一步，确立了亚健康这一新的医学概念。第二步，提出针对亚健康应采取的措施原则是调理。第三步，调理的具体方法因人而异，并且多种多样，中药复方及其制剂不但是众多方法中比较重要的方法之一，而且是优势所在。为此，我们研制了一个中药复方制剂。
>
> Our work is, first of all, to formulate the new medical concept of sub-health. The second step is to establish that the principle of addressing sub-health should be to ‘tone your body’（调理). Next, the specific methods of toning the body vary from person to person, and there are many different methods. Compound traditional Chinese medicine preparations are not only one of the more important methods, but also the one with an advantage. To this end, we have developed a traditional Chinese medicine compound preparation.
> (Wang, 2002, p 9, my translation)

Caili is this Chinese medicine compound preparation, the health tonic. It is difficult to say whether the health tonic comes first, or the concept comes first, but it was made sure that both are conceptually wide enough to market to a very general population. ‘Caili breakthrough suboptimal health’ (采力突破亚健康, cai li tu po ya jian kang) was the promotional banter when Caili came onto the market. The literal meaning of this sentence is that Caili made a breakthrough in treating suboptimal health but in Wang’s 2002 book he explained that in its conception the banter was supposed to mean that Caili made a breakthrough in identifying the state of suboptimal health. Despite this misunderstanding, ‘Caili breakthrough suboptimal health’(采力突破亚健康’) became the slogan for Caili that appeared everywhere. Caili was imitating the marketing tactics of Sanzhu Oral Solution (三株口服液, san zhu kou fu ye), which is a very successful health product in China at the time, by adopting a mixture of pamphlets and adverts on the walls of the rural areas and its marketing did not achieve promising results. In a news article published in 1999 on China Marketing entitled ‘How come Caili is suffering from suboptimal health’ (采力何以患上亚健康, cai li he ye huan shang ya jian kang), it was commented that there is a mismatch between the marketing tactics adopted by the product and the connotation of the concept of suboptimal health.

It is worth pointing out that the phrase itself is not a very colloquial way of expressing concerns about the body, and for some may sound too formal because the word, suboptimal (亚, ya), is not a word that occurs much in everyday speech and therefore it is a concept that would only be understood or accepted by people who have a certain level of literacy. At the same time, the marketing techniques adopted by Caili were those that had been proven to be successful with the rural population, and for this reason, it did not make an appeal in either market.

Caili subsequently got the status of medicine in 2002 and continued its production while

ceasing relying on the concept of suboptimal health (Bunkenborg, 2014), but the concept seemed to have obtained a life of its own. Still, this link to the marketing scheme (and the failure of that particular marketing scheme) in the original conception has greatly shaped the meaning of the concept.

Despite Caili's turning away from the concept, the concept of suboptimal health got assimilated and reappraised in many different health products (such as Centrum, which was more successful in adopting the concept to target the urban population).

At the same time, it gradually grew as an academic concept and sparked vibrant academic knowledge production. In his book, Wang defined suboptimal health as 'a state when you do not have a disease but are not healthy – a state between health and disease' (p 193). He theorized suboptimal health as a dynamic state between health and disease, with some overlaps with health, and some overlaps with disease. In order to establish what exactly is encapsulated by the concept of suboptimal health without making it too broad, as well as to determine the prevalence of suboptimal health among the Chinese population, he led an epidemiological project which recruited 51303 respondents and concluded that 60% of the respondents are in suboptimal health, and the book *Subhealth: A New Concept of Health for the 21st Century* is a detailed report of this project while its sponsorship by Hai'er is clearly shown throughout the book.

The epidemiological study led by Wang set the ground for the later development of suboptimal health and weaved an interconnected web of Chinese medicine, the health products industry, and the public health sector in China. Although the questionnaire designed by Wang did not exclude rural population, correspondents from rural areas only occupied 6.88% percent of the whole cohort (probably because the questionnaire was published on China Youth Daily, and potential respondents need to post back their answers). In this way, in its inception, it is associated with the urban population.

Liu et al. (2004) conducted a bibliometric analysis of suboptimal health status in articles published between 1990 and 2003 and concluded that there was a rising trend in studying subhealth during that time. It is worth noting that in almost all discussions and publications on suboptimal health, it is equated to 'the third status'. In accounts of the origin and inspirations of this concept of suboptimal health, the concept of 'the third status' as proposed by the Soviet Union scholar N. Berkman in a journal called *Philosophical Issues* is named. Interestingly, 'the third status' proposed by N. Berkman is only ever mentioned to add some foreign authority to this concept, but the content of the writing of N. Berkman is rarely if ever incurred at all. In any case, it has become a received understanding for people who write about suboptimal health that the third status refers to the same phenomenon as suboptimal health. In this vein, suboptimal health is seen as a concrete status, a concrete space carved out between health and disease. In mentioning this term, a lot of articles will also claim that the WHO conducted a study which found out that more than 70 percent[2] of the world's population is sub-healthy (20 percent being diseased, and only 5 percent are perfectly healthy, accordingly), in order to elaborate on the scale of the 'suboptimal health status' of the world population, although the origin of this claim cannot be traced. This unfounded statistic of the prevalence of suboptimal health is also invoked in my observation of the conference on subhealth (discussed in detail in Chapter 4). In most cases, the discussion of subhealth would briefly mention something along the line of 'WHO conducted a study that concluded that 70%/75% of the world population is in suboptimal health… Suboptimal health was originally proposed by Soviet Union scholar N. Berkman' before they move on to their discussion. Therefore, it can be seen that when it occurs in the media or press, it is usually

2. This is a figure that is frequently invoked but no original source was ever given. Sometimes the article will give reference to another article on sub health published in China, but the original source cannot be found.

framed as a medical concept with a certain degree of authority, while also being a pressing problem for the world population.

1.3 Subhealth in the media: collective understanding of health among urban population/of urban population

Because of the connection of this concept with commercial interests and its widespread appearance in commercials and adverts, which continued after the marketing of Caili, the concept of suboptimal health became very well understood among the general public and has risen to be seen as a public health issue as well. Indeed, it gradually got inscribed in the consciousness of the general public through a combination of overwhelming advertisements and numerous articles written in the style of health education.

The popular understanding of subhealth can be concisely glimpsed in this excerpt taken from a question in the Administrative Proficiency Test as part of the National Civil Service Examination:

> The term ‘sub-health’ is passed from abroad. ‘Sub-health’ has a high occurrence rate (发生率) in the world. It is a state of discomfort caused by psychological and social stress. In recent years, the incidence of ‘sub-health’ has gradually increased at home and abroad, so it is meaningful to launch research projects on ‘sub-health’. Literally speaking, 亚（sub）means ‘second to, not good enough’. ‘Sub-health’ is a state between health and disease.
> One item that does not match the meaning of this text is ().
>
> A. ‘Sub-health’ has a high incidence （发病率） worldwide
> B. The term ‘sub-health’ came from abroad
> C. ‘Sub-health’ is an uncomfortable state of the human body caused by the pressure of the psychosocial environment
> D. ‘Sub-health’ is the state between health and disease

The text itself summarizes all common understandings of subhealth that have been circulating in popular discourses: that it is a Western concept, that there is a high occurrence rate in the world, that is bodily discomfort associated with stress, and that it is a state between health and disease. The answer to this question is A because in choice A, the sentence used

the phrase 发病率，meaning ‘disease incidence’, which is used exclusively for diseases, but the design of this question is meant to trick (and remind) the exam-takers that subhealth is not a disease.

The bodily symptoms associated with suboptimal health are increasingly characterized as pertaining to a particular set of populations in China, as can be seen in a popular advertisement marketing nutritional products made by Centrum. As already mentioned, the concept was associated with Caili, but in subsequent years, it got picked up and used in the promotion of other products. Here is a representative example, a TV advertisement for centrum aired in 2015. In the video, many young people in office attires are shown walking on very thin wires between high-rise office buildings, as can be seen in the screenshot below:

Figure 1.1 Screenshot taken from 2015 Centrum advertisement showing young people in office attires walking on very thin wires between high-rise office buildings

The star in red dress, known as 小 S in China, is in contrast shown to be walking on a much wider platform between high-rises, saying, ‘Many friends around me are in suboptimal health. Being in suboptimal health, is like wire walking, which will threaten your health’.

She then enthusiastically introduces the product and how it could contribute to a healthier body. After the product has been introduced, the wire under the feet of those who are struggling with wire-walking became widened, and they all appeared pleased with the new ease of balance. Phrases such as 'make health stable' (让健康稳稳的) and 'challenge subhealth' (挑战亚健康) also occurred in this advert.

Figure 1.2 Screenshot taken from 2015 Centrum advertisement showing the star 小 S walking on a much wider platform between high-rises

Here, the metaphor of subhealth as wire walking between high rises captures the stress in maintaining a balance between life and work for those who work in urban settings in China and the type of bodily complaints they encounter every day and frames it as a condition that needs external help from products such as health supplements. Those are the kind of bodies targeted by the concept of suboptimal health in the Chinese popular discourse. One can vividly see

> 'A white-collar worker troubled by the vicissitudes of modern life. Bothered by noise and pollution, haunted by sadness, anger, and antisocial sentiments, the person addressed here may even be worn down to the extent of exhibiting physical effects. Here, the points really add up, reminding us that subjectivities are firmly lodged in bodies that suffer from hair loss, fatigue, insomnia, impotence, and loss of appetite

> and weight.'　(Bunkenborg 2014, p130)

In the advertisement, the star in red dress also tells the audience that taking the supplement would help with '抵抗力'（the resistance to disease), which captures an understanding of how the body combats disease influenced by Traditional Chinese Medicine, a term often then conflated with the immune system in contemporary popular understanding. This points to how subhealth is often equated with 'low resistance to disease' in popular understandings.

As can be glimpsed through this advertisement, the popularity and contingency of this concept are always entangled with the marketing of nutritional and other health products or services, and sub-health was a concept that handily grouped various symptoms under one concept, for the company to target. In this way, the marketing of the concept of subhealth resembles disease mongering, except from the side of health (Chan 2006).

The popularity of the concept of suboptimal health is on the one hand, much infused by the marketing campaigns of health products of various types, and on the other hand, backed up by the official health education discourse in newspaper and entertainment and educational programs and TV shows that frequently mention the concept and educate the public about its perils.

In a popular Chinese period action comedy set in ancient times about life and stories of a few swordsmen and swordswomen called *My Own Swordsman* (武林外传) aired in China in 2006, the concept was invoked amusingly. In one scene, one swordsman was making some minor complaints about his body and his companion suddenly became serious and started (adopting the tone of a presenter):

> Then you must take care to exercise more. This is the legendary sub-health status frequently talked about in the world. Many Kungfu masters suffered from this disease and had to retire from the circle of swordsmen. Its physical manifestations are: no obvious disease, decreased vitality, decreased ability to react, dizziness, back pain…

This is then interrupted by the other swordsman who knocked on the table and said:

> You are not Yan Wenxiu, you are Tong Xiangyu; this is not *Health Express*, this is *My Own Swordsman*

In this intertextual invoking of the concept of suboptimal health, there is a parody of the concept and the context it often occurs. The character, whose name is Tong Xiangyu, a swordswoman in this show, temporarily switches to Yan Wenxiu, a medical intern in the comedy *Health Express* who is played by the same actor and starts to warn the other swordsman of the danger of this condition and lists its common manifestations. The currency of the concept at that time in China and the style of most articles or shows that mention this concept can be inferred from this scene.

In the Chinese popular discourse, the signs of suboptimal health are often infused with a sense of the fear of imminent diseases, and here it is expressed as ‘retiring from the circle of swordsmen’. Suboptimal health is constructed as a condition that troubles the vast majority of the population and would lead to devastating consequences, if not paid proper attention in good time. In extreme circumstances, it is said that it could even lead to sudden death. As commented by Bunkenborg (2014), the popular understanding of the concept of suboptimal health in the mid-2000s is often entangled with dramas of sudden death often reported in journalism.

1.4 Attacks on subhealth in the Chinese public sphere

Due to the way it is widely popularized and understood, the concept and the discourses surrounding subhealth have attracted some criticism. Tencent, a major telecommunications company in China, published a special online issue on the concept of subhealth in 2012 with several articles criticising this concept, written by scholars from academia who are also active in the public sphere. This online special issue tracked the short history of this concept in

China and criticized this concept for being pseudoscientific and in fact disease mongering and among the criticisms, Zhang Gongyao (2007), a professor at the Department of Philosophy at Central South University in China who has made his name for promoting the abolishment of Traditional Chinese Medicine, criticizes the concept for being too vague and all-encompassing and thus not very accurate. The unfounded statistics of 70 percent of the population being in suboptimal health is picked up and heavily criticized by Huang Jianshi (2010), and he highlights that it is a Chinese made-up concept and that it is the profitable side of the concept that has led to its success. Bangbang, a doctor who was actively participating in intellectual debates on the Sina blog, concludes in the 2012 article that it is a concept made up in the Chinese context to fool Chinese people, and that it is invented by Chinese medicine practitioners to give TCM a handle to fool the people (Bangbang, 2012). These attacks on the concept of suboptimal health took place at the same time as Chinese social media and blogging were gaining popularity and were part of a trend of blogging-facilitated denouncement of pseudoscience as characterized by Fang Zhouzi, who is sometimes called 'the science cop'.

In some way, it could be said that the debate on subhealth is rather polemical and part of larger activism against TCM that has arisen in China in the context of state support for TCM. The three authors cited are all highly vocal opponents of TCM. As commented by Zhu and Horst (2019), the science communication activism in China, instead of protesting against the state-science nexus as in the West, protests again TCM as 'state-authorized use of what they see as non-science', while holding a strong identification with scientific culture. This branch of activism is motivated by the state's support of TCM as part of the healthcare system, which they see as not compatible with the country's modernization. At the same time, they are highly critical of TCM's commercial expansion. Based on Qianzhan Industrial Research Institute's report (2017), TCM industry has an annual output of over 800 billion RMB in the

year of 2016, which occupies a quarter of the Chinese pharmaceutical market. Those facts motivate their protest against TCM, which features into the main criticisms of the concept of suboptimal health, deeming it as unscientific. It is interesting that whether there is any foreign literature on the concept of suboptimal health becomes a key part of the debate. Opponents of this concept highlight the fact that the concept is not heard of in the West, while supporters cite a few journal articles written in English or a few references to back up the concept's 'Westernness'. At the same time as this, there is a thriving academic production on suboptimal health, with many of the projects receiving funding from the government.

Jing (2019), an anthropologist based at Tsinghua University, comments in a recent interview that the concept of suboptimal health is a result of collective health anxiety towards the deteriorating environments, worries towards food quality, rising medical expenses, intensified by population ageing, the increase in traffic accidents and a substantial increase in health expectations. He concludes that there is no such thing as suboptimal health – you are either healthy, or you are not.

In contrast, Ning Yi (2012), a professor in the school of public health at Peking University specializing in nutrition and epidemiology, shows a more approving attitude towards the concept in his blog post. Responding to common criticisms concerning the efficacy of the concept of suboptimal health, he argues that this concept is invoked only in a particular health education context when the public has been neglecting taking care of their body, skipping health examinations and lacking proper awareness of chronic illnesses. He believes that there is merit in invoking suboptimal health in the particular context of China where the public is not paying enough attention to their health and invoking the concept can make the public realize they are 'not healthy' and need to see the doctor.

Following this line of argument, subhealth has played a certain role in public health at a particular time in China, and in some health promotion talks, subhealth is simply interpreted

as ‘not healthy’ (i.e. they could be having underlying health conditions) – to tell someone they are subhealthy is seen as more easily acceptable as compared to telling someone they are not healthy. In Ning Yi’s defence of suboptimal health, he seems to be implying the two are the same.

In such a way, the utility of the concept of subhealth for public health (or, the way it can involve Chinese medicine in public health) is recognized, but it is also constantly criticized for being a purely Chinese (which, for the critics, meant that it is pseudoscientific) concept, while at the same time deeply embedded in the everyday thinking of health in China.

At the moment, the concept of subhealth has been widely understood in China but has been invoked less and well past its peak. Although there is a lot of literature in the field of Chinese public health on this concept, it has not attracted much sociological or anthropological attention (or any investigation that is broadly situated in humanities and social sciences). Bunkenborg’s 2014 article is the only article that discusses it critically in some depth, bringing an anthropological lens to it. Zhan (2009) comments on the imaginary translational framework of subhealth. Jing (2019) sees it as a product of social anxiety and seems to believe that since it is a socially constructed concept, it warrants no further discussion. I will expand on a review of such literature in the next chapter but for now I will turn to the story of how I started the project.

1.5 Why I started this project

In 2015, when I was 23 years old, I started to feel constantly very unwell. I was doing a master’s degree at the University of Edinburgh at the time, and it was my first time to be abroad, which was an enchanting experience. Towards the mid of the second semester, I felt that my body was always swollen, and sometimes a little numb. I felt I couldn’t sleep. I felt I was trembling and that my body wasn’t steady, and that when I tried to hold something, my hands were not steady enough. And at that time my body, which had up till that point been

invisible, suddenly appeared in front of me, and became a ponderous problem to be solved.

The condition was one and off. I tried different ways to find satisfactory answers for my condition[3]. I went to the GP for a blood test and I was told I was alright. That was disappointing to me at the time as I felt it could not explain the symptoms. And when I went back to China after graduating from the programme, I had a range of thorough bodily checks. I got some different labels: polycystic ovarian syndrome, irregular thyroid level (I was told that it was hyperthyroidism but after a second check-up, it was not the case). My spine was also a little abnormal and it could be the reason for some of the problems. But I still felt that those diverse, half-fitting diagnoses do not fully explain my problem. Around this time, I went to a Chinese medicine doctor, and I was told that I was in 'sub-optimal health status(亚健康)'. It is a concept that I had been hearing in various places while growing up. And when this Chinese medicine practitioner commented that I was in 'sub-optimal health', I felt that I understood it without any further explanation and it made sense.

It felt like: Bingo. I fell into that category.

According to the doctor, like a lot of other young people who live in cities, I was having a lot of anxiety and pressure from work and urban life. And this, combined with my lifestyle (I think he meant my sleeping pattern, the fact that I go to sleep very late), led to my sub-optimal health, which is exhibited as various bodily discomforts.

Interestingly, such a vague concept, utilized as a diluted form of a disease label, helped me make sense of my body. Somehow this label felt right. It feels like an overarching answer that sounded reasonable and explanatory enough.

When I look back, I come to realize this is perhaps because the term had already been

3. It is in this process of recounting my own story of my body, I realise there are so many different possible narratives, different omissions. This part is to provide some background to the thesis, but my story is also part of my data - I will return to this later in the third chapter.

planted in my sub-consciousness. It's a term I heard about all the time from popular discourses. I remember reading many news articles which claim that a large percent of the world population is in sub-optimal health status (the figure is usually 70%/75%). And although being a vague and seemingly not so serious condition, the danger of it is pronounced too in a lot of newspaper articles – from my vague memory, at a certain point, sub-health was associated with a few cases of sudden, inexplicable death. At that moment, when given this label, it felt like I was ushered into a new kingdom, in which bodies are fragile and slightly broken. I wrap myself comfortably and fearfully, in this label.

In other words, it is my particular background and my particular story that has shaped my research pursuit.

To some extent, this whole project started because of my encounter with Chinese medicine. I encountered the concept of subhealth (as something that concerns me, although I heard of it long before that) in the context of Chinese medicine. The Chinese doctor who told me that I was in 'sub-optimal health' prescribed me some dry herbs to boil and drink, and later my mom also got me some Chinese medicine herbal cream formula (膏方) that is meant to improve my overall health. I took them on an on-and-off basis, half-heartedly before completely stopping, although I felt they had helped me to some extent. Before that point, I had rarely consulted Chinese medical practitioners, nor had I taken Chinese herbs, although there was many Chinese patent medicine that one can easily purchase from pharmacies or get prescribed even when visiting Western medicine doctors in China, and I had taken a variety of them. But those Chinese patent medicines were usually taken for different minor conditions, such as coughing, or cold, while this new encounter with Chinese medicine was part of a more overarching health crisis.

It is my encounter with this label that makes me wonder: What exactly does it mean to be 'suboptimally healthy' or 'in suboptimal health'? If this concept is pseudoscientific and

would be better discarded, why did I still find it helpful at that time? If it is a useful concept, why did I stop using that label soon after that encounter? Is it of any value at all to say there is this space between health and illness and give a name to it? What is the assumption behind saying ‘there is a space between health and illness’?

I have to admit that when I started this project I was very ignorant of the history and the construction of this concept and I felt the concept was so natural and must have always been there in history (looking at its conceptual history has now helped to de-naturalize it for me). Since I come from a background of literary criticism, in my initial PhD proposal, I ambitiously planned to look for and analyse the metaphors or narratives related to this concept in the modernist Chinese literature of the republican era. I had known that Chinese literature in that period has an overabundance of metaphors of diseases, and I took for granted that there would be metaphors of sub-health and it is just that no one has written any literary criticism about it. I spent the first year of my PhD pretending to be a philosopher and wrote the conceptual analysis of the concept of sub-health (in the style of analytical philosophy as I was trying to imitate my colleagues based at the philosophy department) while frantically looking for literary texts that contain this concept or anything approximating the concept. BUT IT WAS NOT THERE.

At the same time, before I arrived in the UK to start my PhD, when I was looking for a place to live that allows cats, which was difficult to find, I joined some WeChat (a popular, or even the dominant social networking app for Chinese people, which later becomes a part of my virtual ethnography) groups and there I encountered an advertisement looking for a receptionist at a Chinese medicine clinic. I applied and told the doctor about my project and indicated that I wanted to work there as I think it would be relevant to my research. I went for an interview on the second day of arriving in the UK and got the position, and the doctor told me she would be happy if I wanted to hand out questionnaires/surveys in the clinic to collect

data. At that time, I tried to explain to her that my primary object of study would be literature and I would not be using questionnaires or surveys, but since then my methods changed a lot. When I realized that the concept had not made its way into literature yet, it naturally occurred to me that I could collect data at the clinic. Through my observations at the initial interview for the position and my day-to-day work at the clinic, the doctor clearly knew about the concept, and in my day-to-day work, she sometimes would explain the conditions of the visitors to me while invoking the concept. Therefore, when revising my proposal, I decided to resort to ethnography to collect narratives of sub-health that I intended to find in literature. A detailed account of my research design and methods will be given in the Chapter Three.

1.6 TCM in China and beyond

I will now move on to introduce, first, the key beliefs of Chinese medicine and why it is relevant for the concept of subhealth, and I will provide some background for the development of Traditional Chinese medicine and relevant policies in and beyond China.

1.6.1 The central beliefs of Traditional Chinese Medicine: Yangsheng and Zhiweibing

The histories and philosophies of medicine in the West and in China represent two distinct civilisations. While there are some commonalities between ancient Greek medicine and Chinese medicine (especially concerning the influence of the 'wind' on body and health), the divergence between the two medical systems reflects different styles of being (Kuriyama, 1999) — in traditional Chinese medicine, for instance, the concept of muscle never occurred, while the concept of acupuncture never appeared in Western medicine. According to Elman (2009, p420), Chinese medicine is the only traditional discipline that 'survived the impact of modern science between 1850 and 1920'. Together with it survived the medical tradition that has an attentiveness to preventing disease from happening, and an emphasis on living according to nature.

The key idea behind Chinese Medicine is the complementarity of opposites, of Yin and Yang (Maciocia, 2015). This is an idea that is also key to Daoist thinking. According to Needham (2000, p67), ancient Chinese medicine is closely associated with Taoism, which is devoted to studying nature, unlike Confucianism which concerns itself with societies and relations between humans. Taoists believe that life should be lived in accordance with nature, even to the extent of believing that a certain kind of immortality is possible for one to live as an etherealised being in nature (Needham 2000, p67). Beyond the idea of Yin and Yang (阴阳), there are also ideas of Five Elements (五行)， and Qi (气), as well as complicated ideas about the relationships between those concepts and how they map onto the world and the human body. It is worth noting that Chinese medicine is a heterogeneous set of ideas and practices, with a long history and many different lineages. In the modern times, there have been efforts from China and outside of China to formulate a consistent theoretical basis for Chinese medicine. I will briefly introduce its theoretical basis here.

In Chinese medicine, Yin and Yang are opposite yet independent; they mutually consume each other but can also be intertransformed. A balance of Yin and Yang needs to be achieved for the body to be healthy. This theory of Yin and Yang is further related to the body structures - some organs are Yin organs, and some organs are Yang organs – but even Yin organs contain some Yang and vice versa. The bodily symptoms can then be seen as 'Excess of Yin', 'Excess of Yang', 'Consumption of Yang' or 'Consumption of Yin' in different organs. It is also worth noting that organs in Chinese medicine do not fully correspond to the modern western anatomical organs (Maciocia 2015). The Five Elements constitute another aspect of the main beliefs of Chinese medicine. The Five Elements refer to water, fire, metal, wood and earth – again they map onto aspects of the universe as well as human body. They are agents, activities and processes in the universe. According to a book called the 'Great Transmission of the Valued Book' which was published in Han dynasty, 'Water and Fire

provide food, Metal and Wood provide prosperity and the Earth makes provisions.' (Maciocia 2015, p 21). Last but not least, there is the idea of Qi, which is one of the key aspects of the vital substances within the body. Qi is something that is both material and immaterial, and Qi is what connects human being with the universe (Maciocia, 2015). There are many types of Qi, which includes Essence, Qi, Blood, Body Fluids, Original Qi, Nutritive Qi, and Defensive Qi. In different forms, it has different qualities, manifest as Yin or Yang. It is those central beliefs which inform the differentiation in Chinese medicine, which is the process by which the doctor reaches a diagnosis about the pattern of imbalance within the body based on observation, interrogation, palpation, hearing and smelling (Maciocia, 2015).

Therefore, sub-health evokes an idea and conceptions of health and wellbeing that are embedded in Traditional Chinese medicine, since it is fundamentally concerned not just with overt symptoms, but with the balance in the body (Wang and Yan, 2012). Chinese medicine has a long history of emphasizing preventing disease from taking place by paying attention to any early signs. Before diseases take any concrete form, an imbalance of Yin and Yang would have long taken place, in different organs. The excess or deficiency of various organs, or the stagnation of Qi, will lead to discomfort, and eventually, to diseases (Maciocia 2015). The existence of a state of being between perfect health and disease is hence quite native to the system, and there is a broad array of Chinese medical terms available to describe different types of sub-health status.

Below is an anecdote of the famous Chinese medicine master, Bian Que (扁鵲), explaining this belief in the Warring States period text《鶡冠子》(*Book of the Pheasant-Cap Master*) :

> 煖曰：「王獨不聞魏文王之問扁鵲耶？曰：『子昆弟三人其孰最善為醫？』扁鵲曰：『長兄最善，中兄次之，扁鵲最為下。』魏文侯曰：『可得聞邪？』扁鵲曰：『長兄於病視神，未有形而除之，故名不出於家。中兄治病，其在毫毛，故名不出於閭。若扁鵲者，鑱血脈，投毒藥，副肌膚，閒而名出聞於諸侯。』

> Phang Hsüan said to the king of Cho-hsiang, 'Have you not heard that Duke Wên of Wei asked the great physician, Pien Chhüeh , 'of your three brothers, which is the best physician?' Pien Chhüeh answered 'The eldest is the best, then the second, and I am the least worthy of the three.' Duke Wên said, 'Might I hear about this?' Pien Chhüeh replied, 'My eldest brother, in dealing with diseases, is attentive to the spirit (shên). Before [any symptoms] have formed, he has already got rid of it. Thus his fame has never reached beyond our own clan. My next brother treats disease when its signs are most subtle, so his name is unknown beyond our own village. As for myself, I use stone needles on the blood vessels, prescribe strong drugs, and fortify the skin and the flesh. Thus my name has become known among all the feudal lords.' [4]
>
> (Needham, 2000, p 69)

This story reiterates the idea that the doctor of the highest calibre treats disease before its onset, the mediocre doctor treats disease at its earliest stage, and the worst doctor treats diseases that are already serious. There have been some debates on whether suboptimal health should correspond to the first (treating disease before its onset, weibing 未病, as coined in later texts) or the second (the earliest stage of disease, yubing 欲病,as coined in later texts) but in most cases, a parallel seems to be drawn between suboptimal health and treating disease before its onset (zhiweibing 治未病).

It is in this context that TCM has been heavily drawn on in the development of this concept. The following sections will firstly discuss the modern construction of TCM and the way it may be a western concept, and will then discuss policies regarding TCM in China and the government's efforts to build a 'Healthy China', followed by a section on the Chinese government's efforts to promote TCM outside of China.

1.6.2 A Western concept of Traditional Chinese Medicine?

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4. This is taken from Needham's translation Science & Civilization in China, Vol. VI:6, so his translation uses romanization of names and is a little different to my own translation which uses Pingyin for names.

As mentioned by Taylor (2004), in their study of TCM in China between 1949 and 1989 when TCM gains state sanctioned statues, “Chinese medicine in modern China has been tailored to some degree by a Western concept of what Chinese medicine ‘really’ should be” (Taylor, 2004, p93). For much of this time, China was closed off to the rest of the world, and

> ‘The shroud of mystery in which China was enveloped for much of this time was to give rise to two fundamentally contradictory attitudes—one side was Chinese, pushing for a scientification of their medicine, and the other was Western, pushing for more information on a traditional healing method. (Taylor, 2004, p93).

Taylor details how a large part of Western publications on Chinese Medicine (published in 1970s and 1980s after China started to open its door, fuelled by increasing curiosity and romanticisation of Chinese medicine) were based on source materials from China; source materials that formed part of the government’s policy of ‘doctors of Western medicine study Chinese medicine’ around the 1950s and 1960s as part of the revolutionary programme (Taylor, 2004). The new slogan for the medical politics in China proposed in 1950s, that is the ‘integration of Chinese and Western medicines’ (Zhong Xi Yi Jie He 中西医结合) also impacted on the compilation of textbooks around that time in China, leading to the use of the term ‘Traditional Chinese Medicine’ (before that it was simply Chinese Medicine[5])， to frame Chinese Medicine as ‘traditional’ - to the West - but as a medicine that is scientific and of the present. Under this context, Western medical practitioners in China needed to leave their professions and study Chinese medicine full time - it is also in this context the Research Academy of TCM (Zhong Yi Yan Jiu Yuan 中医研究院) was set up in late 1955. All those moves were telling of Mao’s vision when it comes to Chinese medicine, that is, to emphasize its historical lineage and to make it capable of competing with Western medicine

5. Taylor also details how it was in 1949 when various other terms including ‘Chinese medicine’ (Zhongyi 中医), the ‘old medicine’ (Jiuyi 旧医), and ‘national medicine’ (Guoyi 国医). It was only after 1949 that the terms got standardized to that of ‘Chinese medicine’ (Zhongyi 中医).

‘on equal footing’ (Taylor, 2004).

For Taylor, the fact that Western introductions to Chinese medicine were based on such materials led to a profound misunderstanding of Chinese medicine from the West, a misunderstanding that sees it as a unified system that has a continuous history while in fact it has always been a diverse and heterogeneous tradition of practices (Taylor, 2004). Similarly, Scheid (2007) challenges the notion of TCM as an unchanging system, and uses the treatment of menopause as an example, a treatment method invented in 1964 with a strong element of Western biomedical thinking. Scheid demonstrates that, ‘like TCM itself, the TCM understanding of menopause is a direct consequence of Chinese medical modernization’ (Scheid, 2007, p54). Therefore, despite common perceptions that TCM is a longstanding, stable and homogenous tradition, it is in fact quite diverse and divergent as it is practiced, and constantly being renovated, especially as it competes with a Western medical understanding, no matter within China or outside of China. However, both Taylor and Scheid concede that there continue to be alternative sources outside of the national educational initiative, including ‘direct access to the classical medical literature, the transmission of medical knowledge through personal master- disciple networks and lineages, and the historical plurality of the Chinese medical tradition.’ (Scheid, 2007, p.55)

1.6.3 An emphasis on TCM within China as reflected in different policies

China has adopted the system of biomedicine which is now dominant in the healthcare system while also including TCM as part of the system. Developing Chinese medicine has continued to be an important part of policy making in contemporary China, although in a quite different way. There is a continued focus on proving the efficacy of TCM and making it on par with Western medicine; but at the same time, there is also a focus on the industrial development of TCM, as well as a sustained interest in spreading the knowledge of TCM to

outside of China. In 1978, the Central Committee of the Communist Party of China forwarded the Ministry of Health's *Report on Seriously Implementing the Party's Traditional Chinese Medicine Policy and Solving the Problem of Lack of Successors in the Traditional Chinese Medicine Team (*《关于认真贯彻党的中医政策，解决中医队伍后继乏人问题的报告》*)*, and detailed different kind of support it would provide to the development of Chinese medicine. It is also stated in *The Constitution of the People's Republic of China* that modern medicine and traditional medicine are both to be developed in the country in order to protect the health of the people （Xinhua News Agency, 2016）. In 1986, the State Council established a relatively independent Chinese medicine management department. Various provinces, autonomous regions, and municipalities have also established traditional Chinese medicine management institutions. In 2003, the State Council promulgated and implemented the *Regulations of the People's Republic of China on Traditional Chinese Medicine* (《中华人民共和国中医药条例》); in 2009, the State Council promulgated and implemented another document, that is, *Several Opinions on Supporting and Promoting the Development of Traditional Chinese Medicine* (《关于扶持和促进中医药事业发展的若干意见》). In such a way, a relatively comprehensive policy and administrative system to support the development of Chinese medicine has been gradually formed in China, which indicates a sustained interest in developing Chinese medicine from the Chinese government （Xinhua News Agency, 2016）.

Since the 18th National Congress of the Communist Party of China, the party and the government have raised the development of Chinese medicine to a more important position and made a series of major decisions and arrangements. The Eighteenth National Congress of the Communist Party of China and the Fifth Plenary Session of the Eighteenth Central Committee proposed to 'adhere to both Chinese and Western medicine' and 'support the

development of Chinese medicine and ethnic medicine'. In 2015, the State Council executive meeting passed the *Traditional Chinese Medicine Law (Draft)* (《中医药法（草案）》) and submitted it to the Standing Committee of the National People's Congress for deliberation, in an effort to develop legal guarantee for the development of Chinese medicine (Xinhua News Agency, 2016）. Not long after that, the State Council issued the Outline of *The Strategic Plan for the Development of Traditional Chinese Medicine (2016-2030) (《中医药发展战略规划纲要（2016－2030 年）》)*, which elevates the development of Chinese medicine to a national strategy and made many systematic arrangements for the promotion of Chinese medicine in the new era. The outline also mentions that it would systematically carry out research to formulate TCM health prevention (invoking *zhiweibing* 治未病, treating disease before taking place) standards, which indicates to some degree that the tenet of *zhiweibing* 治未病 is an area of emphasis in the development of TCM, and seen as a key characteristic of the professional development of TCM (there are even detailed policies on how TCM hospitals of certain rank must include *zhiweibing* 治未病 departments that focus on preventative treatment).

> Chinese Medicine Health Service Development Plan (2015-2020):
>
> Clarify seven key tasks: First, vigorously develop TCM health care services, support the development of TCM health care institutions, standardize TCM health care services, and carry out TCM characteristic health management; second, accelerate the development of TCM medical services and encourage social forces to provide TCM medical services. Innovate the service model of traditional Chinese medicine medical institutions; third, support the development of traditional Chinese medicine rehabilitation services; fourth, actively develop traditional Chinese medicine health care services; fifth, cultivate and develop traditional Chinese medicine culture and health tourism industry; sixth, actively promote the development of traditional Chinese medicine health services related supporting industries ; Seventh, vigorously promote the service trade of Chinese medicine to attract overseas consumption in China.

This plan mentioned 'carry out TCM characteristic health management', which is a term that is invoked in the subhealth conference as well – health management is another term, like

subhealth, that is defined by TCM practitioners as a Western term and then assimilated and made Chinese.

In 2015, Tu Youyou won the 2015 Nobel Prize in Physiology or Medicine for her discovery of artemisinin, and this to some extent can be seen as a catalyst for a renewed interest in the development of Chinese medicine by the Chinese government. For them, this indicates that Chinese medicine has made outstanding contributions to human health and proves its efficacy of Chinese medicine. And this year coincides with the surge of documents on developing Chinese medicine, as I listed above. These documents showcase a grand blueprint for 'comprehensively revitalizing Chinese medicine, accelerating the reform of the medical and health system, building a medical and health system with Chinese characteristics, and advancing the construction of a healthy China' as stated in *'Healthy China 2030' Plan Outline* in 2016.

COVID-19 to some degree coincided with the government's policymaking and sparked another wave of enthusiasm and trust in Chinese medicine. In October 2019, the State Council issued the *Opinions on Promoting the Inheritance and Innovative Development of Traditional Chinese Medicine*, which became the programmatic document for the development of the traditional Chinese medicine industry; In 2020, the State Food and Drug Administration issued a report, *Several Measures to Promote the Inheritance, Innovation and Development of Traditional Chinese Medicine 国家药监局关于促进中药传承创新发展的实施意见*, which vigorously promotes the innovative development. In the outbreak of COVID-19, Chinese medicine is conventionally called upon in the treatment and several patented medicines are developed to help with covid symptoms and are widely circulated.

1.6.4 'Healthy China'

In 2016, the Central Committee of the Communist Party of China and the State Council

issued the '*Healthy China 2030' Plan Outline (*"健康中国 2030"规划纲要）. The '*Outline'* is the first medium and long-term strategic plan in the health field proposed at the national level since the founding of the People's Republic of China. The '*Outline'* highlights three key points: first, prevention is made the priority - 'the barriers/thresholds for intervening health are moved forward', and the government shows its dedication to the promotion of a healthy lifestyle, and the reduction of the occurrence of diseases, while making wise use of resources to achieve affordable, sustainable development. The second is to adjust and optimise the health service system, strengthen early diagnosis, early treatment, and early recovery. This also involves promoting the development of the health industry to better meet the health needs of the people; the third is adhere to the government's leadership, mobilize the participation of the whole society to realize the health of the whole people. The development strategy put forward by Xi Jinping in the report of the 19th National Congress of the Communist Party of China emphasizes again that people's health is an important symbol of national prosperity, and it is necessary to improve the national health policy and provide the people with a full range of full-cycle health services. The outline led to '*Healthy China Action 2019-2030*' 健康中国行动(2019—2030 年), which listed four main shifts:

> The first is the shift from focusing on 'disease' to focusing on 'health' in terms of positioning.
> The second is to shift from focusing on 'treating pre-existing disease' to focusing on 'preventing disease' in terms of strategy.
> The third is the transformation of the main body from relying on the health system to the overall linkage of the society.
> The fourth is in the style of writing, trying to change from documents to social initiatives.

As can be seen in the documents above, a huge focus is put on health promotion on a national level and people are called on to be responsible for their health. According to an article published in Xinhuanet (2019) following the publication of the *Healthy China Action*, 'every individual is the first person responsible for their own health'.

It is worth noting that the idea of ‘moving the barrier/threshold for intervening health forward’ in the construction of a healthy China is a common theme picked up in the conference on subhealth that I observed (I participated in it as it was streamed to the public online, in 2021 - details will be provided in Methods chapter, and discussions to follow in Chapter 4), so is the idea of providing the people with a full range of full-cycle health services. The publishing of such policies and their focus on comprehensive health provision coincides with the formulation of the idea of ‘Big Health’/’Comprehensive Health’ （da jian kang 大健康） industry, an idea that appears incredibly frequently in the international TCM conference (which took place in Budapest in 2019 – details will be provided in Methods chapter) that I observed (again, further discussion in Chapter 4). As part of this action plan to promote the construction of a healthy China in the next 15 years, a series of tasks and measures to revitalize the development of Chinese medicine are proposed to serve the construction of a healthy China. This shows the way Chinese medicine is called upon in the government’s effort to promote the health of the nation, and that is why the ideas of health promotion behind *zhiweibing* 治未病 (treating disease before taking place) in Chinese medicine is also picked up and given significance.

1.6.5 Promoting the international development of Chinese medicine

The Chinese government is very keen on promoting Chinese medicine overseas, which is still quite marginal in the West and is often seen as part of alternative and complementary medicine. It has worked closely with WHO in promoting traditional medicine and has signed many TCM cooperation agreements with relevant countries and international organizations. At the same time, the Chinese government has supported the establishment of quite a few TCM centres overseas. In May 2019, the *‘Eleventh Revision of the International Classification of Diseases (ICD-11)’* was reviewed and approved by the 72nd World Health

Assembly, which included for the first time Chinese medicine. This is of great significance to promoting the internationalisation of Chinese medicine and has contributed to the rise of the international profile of Chinese medicine. This is a move that is enthusiastically celebrated at the Budapest conference that I observed, but also a move according to Jakhar (2020) condemned by some from the international medical community (more discussion to follow in Chapter 4).

The Belt and Road Initiative also contributed to the internationalisation of Chinese medicine. The Belt and Road Initiative, known also as *One Belt One Road* (一带一路) or OBOR for short, is a global infrastructure development strategy adopted by the Chinese government in 2013 to invest in nearly 70 countries and international organisations. As part of this initiative, China has co-operated internationally to establish different TCM initiatives, the so-called Health Silk Road. It promotes the diffusion of TCM knowledge along the Silk Road.

So far, I have provided contexts for my study of the concept of suboptimal health. I detailed its emergence, its popular understanding (and misunderstanding) and some of the critiques it has attracted which also corresponded with its diminishing popularity. I also gave an account of why I started the project, before giving details about the development of TCM in China and beyond. In the following section, I will now introduce my research objectives and research questions, before providing chapter-by-chapter summary.

1.7 Research objectives

The aim of this project is to explore the concept of sub-optimal health, how its meaning is negotiated in different contexts, and how it feeds into the lived experience of health in everyday life. The specific objectives include the below, which would then inform my empirical data collection:

1. To explore the historical development of the concept of sub-optimal health.

2. To examine the use of sub-optimal health in a range of different contexts (TCM conferences, a Chinese Health Clinic, digital spaces and everyday life).

3. To explore the lived experience of sub-optimal health.

In order to address those objectives, a combination of documentary analysis and multi-sited ethnography was conducted. These were conducted to understand the discursive use of this concept in different contexts and to unpack its knowledge production. As we can see from the objectives above, one of the tasks I set out to achieve was to trace the historical development of this concept and observe how sub-health is used to understand of health in multiple settings, as it happened this developed into an examination of how it complements, contradicts and meshes with biomedical ideas. I started with a range of questions. Exactly what is suboptimal health? And what criteria would put such a proportion of the world population in this space? Is it uniquely Chinese? Is it pointing to an objective phenomenon within health and illness, or is it another strand of 'culture-bound illness'? What does it mean to capture this space this way? Whose interests does it serve? And ultimately, is this concept of any relevance to sociology of health and illness at all? After conducting a thorough literature review and a careful consideration of my research methodology, I went through all those questions and formulated my central research questions.

The central research questions are:

1. How does the concept of suboptimal health travel through time and into different contexts? (Research Objectives 1 and 2 above)

2. What does it mean for ordinary people to be 'in suboptimal health'? (Research Objective 3 above).

Having addressed these questions, I go on to examine the relevance of sub-optimal health

to concepts of health and illness within the sociology of health and illness and medical humanities. This thesis is therefore situated within the sociology of health and illness and critical medical humanities. It seeks to challenge ways of conceptualizing health and disease, combining philosophical and empirical approaches in exploring how the concept of sub-optimal health is understood and utilized, while aware of the specific contexts and power in play.

1.8 Chapter breakdown

I will now give a chapter-by-chapter summary of my thesis.

This current introductory chapter provides background to the project. In the next chapter, Literature Review, I will firstly discuss philosophical ideas concerning health, disease and other related concepts and discuss how in current biomedical thought health and disease is often constructed as opposites. After the philosophical discussion I will move on to discuss empirical work conducted in the field of sociology of health and illness that attest to how health and illness often co-exist rather than exclude each other, especially in work on chronic illness. I will also briefly discuss the ways in which the space between health and illness is conceptualised and defined in the sociological literature and how this space is used to understand experiences of health and illness.

Then, in Chapter 3, the Methods Chapter, I discuss in detail my methods and materials. I start with discussing my methodological considerations, especially the way my research is fundamentally qualitative and involves multi-sited ethnography, paying attention to different contexts and subjectivities while maintaining a conceptual orientation. I then provide details on each of my methods, including the way I collected and analysed the data, as well as some precautions as well as reflections on ethics.

In Chapter 4, I explore the knowledge production of suboptimal health in the Chinese context. I look in depth at how subhealth is institutionalised, defined, diagnosed, measured

and put in practice. Based on my observations of the TCM conferences, it seems that subhealth has been articulated as a key advantage for TCM, as a way of crafting a space for TCM. But subsequently the concept became marginal. It has featured in TCM's efforts to promote itself in China and internationally, and Chinese government's policies and support have played some role in it.

In Chapter 5, I trace the conceptual history of suboptimal health. The concept, whenever it is evoked in China, is often said to be a Western concept, a WHO concept, and I try to discuss why that is the case. Following on findings from Chapter 4, this chapter discusses the occasional occurrence of this concept in the public health literature in the West, the way suboptimal health has been used by WHO, and some provocations concerning subhealth and personalised medicine.

In Chapter 6, I present an ethnography of the clinic, to look at subhealth in practices. This chapter also draws on social media data and my interviews with people brought up in China to discuss 'subhealth in medical encounters'. Admittedly, to say something of 'medical encounters of suboptimal health' is an oxymoron, and this chapter discusses the paradox in this encounter, the conceptions of health behind those encounters. In such a way, I look at how the ancient ideas of *yangsheng* are enacted in two different contexts.

In Chapter 7, I unpack the contemporary understanding of the concept, and the narratives around it. It seems that the concept captures a liminal space in people's life, when they have some worries about their health; it is an embodied feeling of risk, with an orientation towards the future. Young people have an ambivalent attitude to the concept of and discourses surrounding suboptimal health due to its commercial orientation; some of them think there is no such thing as suboptimal health but many others have found such a conceptual space to be quite natural and occasionally make use of it. The more interesting development is when subhealth - a concept which is quite ephemeral and liminal, gets to be picked up as an identity

label on social media, or even become part of a social critique.

Chapter 2: Literature Review

2.1 Literature on the concept of suboptimal health

> Everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick. Although we all prefer to use only the good passport, sooner or later each of us is obliged, at least for a spell, to identify ourselves as citizens of that other place.
>
> Sontag, 1978

As mentioned in the introduction, there has been some limited critical work on the concept of subhealth, but they always end with arguing either with a more specific or scientific classification of subhealth or seeing subhealth as yet another case of cultural or socially bound syndrome, or a case of disease mongering (Chan, 2006). Bunkenborg's 2014 article is the only work that is dedicated to this concept where he explores contemporary medical and popular discourse on subhealth and conducts a genealogy of it based on documentary data to investigate what is behind it. He concludes that it is related to the extensive focus with the quality of the body from the state. According to Bunkenborg (2014), the discourse on sub-health reflects a concern with lack and the need to improve oneself, and this reflects the public health concern with the quality of the population (素质，suzhi). He also called for more ethnographic work beyond the framework of the state and the population. He comments that subhealth discourses and the associated clinical practices offer an example of a bio-political construction of lack that impinges upon the way bodies are imagined and upon which they are acted. But for him, the story of subhealth also tests the limit of those analytical frameworks that emphasize the population and the state. Shaped by multiple overlapping and conflicting economic and political interests, subhealth discourses suggest that medical institutions are not extensions of the state but develop their own ways of questioning the quality of bodies. Studying such practices ethnographically would provide new insight into processes of subject formation in contemporary China (Bunkenborg 2014,

p140).

In such a way, Bunkenborg (2014) convincingly situates the rise of the concept of suboptimal health in a concern with optimising the workforce of the state, but he also argues that on a more ground level in terms of how it is defined and measured in different institutions, there is still a lot to explore. For me, I started with a slightly different point compared to Bunkenborg, who took an interest in the concept as an object of anthropological interest and studied the concept as an outsider to the Chinese context. Having grown up with the context and having been labelled with the concept myself, I did not start off thinking that I was merely captured in this concept due to the Chinese government's interest to improve the quality of the nation, I was merely concerned–- what is happening to my body? What is this label 'suboptimal health'? Now what - now that I am in this space? I did not see it as a 'bio-political construction of lack'. I thought of it was a half-fitting label for my search for answers to my embodiment.

I argue this is where the gap in literature lies. I think it is necessary to study this concept not just as another culture-bound syndrome, as a concept from an *other*; instead, it might be worthwhile engaging with the concept from a more embodied perspective, to study it as an inside. It is also worth rethinking of the concept as a resource that might contribute something to sociology of health and illness and to critical medical humanities.

In the context of medical anthropology, there has been some literature on *Yangsheng*, which means 'nourishing life', an important idea behind the Chinese understanding of health which has an ancient lineage. This idea has some commonalities with subhealth, given its emphasis on the positive dimensions of health. Farquhar (2002) has written on the material practices of *Yangsheng* in urban settings, the way it gets embodied in food and sex in a post-socialist China, and the way pleasure is historically and politically constituted. This work has a focus on the diffusion of ancient ideas in people's everyday life in a new political and

historical context, and I am interested in the way such ideas continue to evolve, and the way ancient idea gets rebranded to suit modern people and even to some degree rebranded to sound Western/biomedical; it is in this context there comes about the seemingly concrete category of 'suboptimal health'. What happens when this ancient idea gets entangled with biomedical thoughts, and is infused with the ambition of not just being a Chinese idea, but a 'universal' and 'objective' existence?

In other words, this thesis aims to go beyond an anthropological account of how subhealth functions and intends to draw on the data to investigate concepts of health and illness. Since proponents of subhealth in the field of TCM and public health believe in the objective existence of such a conceptual space, this thesis would like to examine how they produce such knowledge, and what relevance this might have to philosophical and sociological understandings of health and illness. As such, the first part of this chapter will be devoted to a discussion of concepts of health and illness.

2.2 Philosophical discussions on health and disease and its logical relations

This section will give a preliminary introduction to the conventional definitions of disease, illness, health and well-being, as well as how sub-optimal health is situated in these myriads of concepts. Since the concept of suboptimal health is often defined as the space between health and disease, I will mainly focus on the concepts of health and disease and their logical relations.

Concepts of health and disease are issues that have long occupied an important place in the academic debate, not least because health and wellbeing is a very fundamental issue for human existence, and that healthcare takes up a large sum of public funding. In the field of philosophy, many philosophers have extensively explored the epistemological condition of disease – whether they can be objectively determined with empirical exploration or whether they are always human construction (Boorse, 1975; Larson, 1999; Hamilton, 2010; Leder,

1992; Nordenfelt, 1984). Among the naturalist positions, one possible claim is that disease implies the existence of concrete disease entities (Dragulinescu, 2010), and this ontological view is implicit in many biomedical discourses. In a different vein, a physiological view acknowledges disease as variations and deviations, either from a statistical norm, or from social, cultural and individual norms and expectations (Leder, 1992).

On the other hand, health has an even more enigmatic character (Gadamar, 1996). There are diverse positions on how health should be conceived, and some possible theories include: health is the ability to achieve vital goals in life (Nordenfelt, 2011), health is the ability to adapt to the environment (Canguilhem, 1989), or health is the reserve of energy and strength (Larson, 1999). In a different vein, the widely known WHO position on health is that health is 'the state of complete physical, mental and social wellbeing'. Health seems to be an all-encompassing concept that lack any objective reality, but nonetheless a working definition is essential, either for everyday life, or for the delivery of the healthcare provisions.

All those diverse positions on disease and health will be further explored in the following pages, and the discussion of existing definitions will ultimately aim to bring about some theoretical reflections on the logical relation between health and disease. The logical relation between health and disease is implicit in almost any account of either term, but it is seldom put into an explicit and extensive survey. For this reason, Hofmann's Simplified models of the relationship between health and disease (Hofmann, 2005) will be adopted as a framework to facilitate the discussion of the logical relations between this pair, because it is particularly useful in providing a starting point for delineating the various positions held for conceptualizing the logical relations between the two, and a way to move beyond square of oppositions. Ultimately, this calls for a way of defining health and disease that recognizes the fuzziness and doubleness in people's everyday experiences of bodily symptoms – just think of chronic illness as an example, where people negotiate between disease and health. With a

detailed conceptual analysis, I try to locate this conceptual space of sub-optimal health, a space that is both health and disease, or neither health nor disease among other concepts.

2.2.1 Defining disease

In an effort to define disease, there are numerous questions to sort through: Can disease be purely accounted for on objective terms, without referring to culture or value (Sulmasy, 2005; Dragulinescu, 2010; D'amico, 1995)? Is disease about the identification of faulty site in the body, the identification of statistically abnormal bodily structures or processes, the categorization and treatment of unwanted symptoms, or about the disruption to the life of the person in pain (Hofmann, 2001)? According to Hofmann, who follows Claude Bernard, there are nosological, anatomical and physiological dimensions in disease. In other words, disease can be about categorization of types, the identification of causal agents, or the maintenance of the normal functioning of the living system (Hofmann 2001). In the current bio-medical model, the drive is to pin down what exactly a certain condition is, to identify a 'thing' that accounts for the occurrences of the disease symptoms, whether it is a genetic entity, a problem with tissues, or a problem with parasites. Hence, there is the ontological view that disease is an entity, something that exists in the world, with its own histories to be traced. They are to be discovered by the ever-developing medical technologies, with scans, blood analysis, genetic tests and so on.

In this strand of thought, disease is sometimes thought of as a natural kind, pushing for a naturalist view of disease. There are many different definitions of natural kind but invoking any sense of natural kind implies that there are fundamental entities in the world that ground classifications (Kincaid and Sullivan, 2014). Nordenfelt (1984) comments on how the notion of natural kind is deeply embedded in the mainstream Western philosophical tradition as well as in the pre-Darwinian biological tradition. In a certain natural kind, some law-like relations or some sort of essence can be identified for the objects in the natural kind. By relating

diseases to natural kind, an objective reality about disease is established – either for certain forms of diseases, or for all diseases, or, for diseases as a category. For example, Dragulinescu (2010) argues that some of the disease entities in life-threatening diseases form natural kinds in the same way as exact science kinds such as 'gold', by conducting a detailed comparison between gold and Graves disease and arguing that there is not a 'ontological gap' between the two. In other words, some disease entities can be thought of as having a set of concrete properties. This was used as a move to establish the credibility of medicine, in the same way as exact science disciplines, such as physics. There are other more modest forms in this line of argument. For example, instead of arguing that diseases are natural kinds, Sulmasy (2005) emphasizes that they have to be discussed in relation to living natural kinds, such as an infected bodily part, or a certain entity that causes the disease. In a similar but less radical strain, Amico (1995) pushes for viewing the category of diseases (not each individual disease) as a natural kind. Here he adopts a slightly different definition of natural kind in which what consist of a kind depends on empirical inquiry (hence this definition diverges from essentialism). In his view, all diseases constitute one natural kind because they have certain 'property clusters' (Amico, 1995). Although in the history of medicine, there have been constant modifications about classifications of different diseases, he argues that these confusions and modifications are instances attesting to how our medical understanding and knowledge of diseases have been evolving, while the object of this understanding share some underlying features. This naturalist view aims to highlight the objective existence of disease and indicates that this alone is the foundation for scientific discovery. Values do not play a part in defining disease, on this view.

This line of argument is criticized for being too reductionist and ignores the role of social construction. For example, Reznek (1987) claims that those 'natural kinds semantics' incorrectly assumes that all diseases share a common essence, since for many conditions like

hypertension, there is not a clear boundary and the causes can vary. He further argues that the notion of disease is evaluative, and based on human likes and dislikes, and hence varies from culture to culture without a real essence. He emphasizes that ‘the crucial matter is not how the condition is caused but what effects it has’. The concept of disease, he argues, is always constructed. Therefore, ‘when we are deciding whether some condition is a disease, we are in effect deciding what sort of people we ought to be’ (Reznek, 1987, p. 166). Similarly, Jensen (1984) argues that diseases are not static entities – they will always be evolving, and as a result, they do not have essences. Societies construct them and give them different classifications.

> In this vein, disease can be seen as a way for society to manage abnormalities. Diseases are deviations from the norms, whether it is functional norms, norms in relation to the individual organisms or the social norms. Canguilhem (2007), in *The normal and the pathological*, delineated the ‘normative project’ that has shaped the biological understanding. The pathological is the negation of the normal, and they are shaped by each other. This bears important implications for our understanding of disease. Joseph Margolis (1976) also argues that diseases are constructed for the sake of the society: ‘‘since medicine in general subserves, however conservatively, the determinate ideology and ulterior goals of given societies, the actual conception of disease cannot but reflect the state of the technology, the social expectations, the division of labor, and the environmental condition of those population (1976, p. 255).

Therefore, in this vein of thought, diseases do not share an essence – they are just a social product invented to keep the society in order and make it more effective. This can be seen in the way many disease categories that have existed in medical histories turned out to be nothing but a way for the dominant power in society to govern deviance. For example, as noted by Reznek (1987), masturbation was considered to be a manifestation of a grave disease. As commented by a leading physician of the time in 1889, ‘the excitement incidents to the habitual and frequent indulgence of the unnatural practice of masturbation leads to the most serious constitutional effects and in some cases to hopeless insanity’ (Reznek, 1987). The subjective and culturally-constituted nature of disease is recognized. Other similar

instances include drapetomania (a conjectural mental illness in which the enslaved Africans seek to run away from captivity in the nineteenth century), homosexuality, menopause, and so on. Illich (2003, p.172) further observes that ‘in every society the classification of disease – the nosology – mirrors social organization.’ This is part of the opposition to the view of ontological essence or naturalism, holding that diseases are normative conceptions, and this strand of argument is sometimes named normativism. On this view, diseases are seen as value-laden and the naturalist claims for disease are severely challenged. Reznek (1987) has argued that those instances of controversial disease categories are manifestations of the way diseases are always merely states undesired by human-beings, the deviations from social norms. It is those values that constitute defining features of disease, instead of the biological underpinnings. It is impossible to have an account of disease that is free of value.

There is another important position that seems to accommodate both the objectivity of disease and the fact that there are norms and deviations. That is, the Biostatistical Theory (BST) proposed by Boorse (1977). This is in a physiological line of characterizing disease. According to this theory, diseases occur when the functions of an organ deviate from its evolutionarily assigned responsibilities. In this way, a disease is not about an essence, but about a functional norm instead, and it can still be decided upon objectively, without referring to values. In order to decide on what can be considered functionally normal, Boorse adopts the concept of reference class. For him, this reference class is ‘a natural class of organisms of uniform functional design; an age group of a sex of a species’ (1977, p. 555). The normal functions in the reference class can be decided by the ‘statistically typical contribution by it to their individual survival and reproduction’ (1977, p. 555). Therefore, for him,

> *Health* in a member of the reference class is normal functional ability: the readiness of each internal part to perform all its normal functions on typical occasions with at least typical efficiency.
> A *disease* is a type of internal state which impairs health, i.e. reduces one or more functional abilities below typical efficiency.

(Boorse, 1977, p562)

Here is an attempt to decide on health and disease with comparison to functional norms of a certain reference class. However, Kingma (2007) criticizes this position and argues that deciding on what is an appropriate reference class is already an evaluative decision. He argues that suppose there is a reference class of uncommonly heavy drinkers, then the normal functionality for this group would be different – the normal index in this group in terms of liver function may be considered a disease in another group. Therefore, a reference class cannot be constructed when the class may be considered as unhealthy in some way, but that means some prior notions of what is healthy is already established before deciding on a reference class, which makes the definition of health and disease circular (Kingma 2007). Hence, following Kingma's (2007) argument, Boorse's model is intertwined with value already. The value-laden nature of disease is highlighted, infused with human values, fears, and hopes.

As can be noted in the above debate on the nature of disease, it is difficult to separate out the biological underpinning of diseases from human cultures and values. Biological elements, subjective elements, as well as social elements all contribute to defining disease. There have been attempts to separate these dimensions and give them different names: disease, illness and sickness – disease is associated with the biological aspect, illness the subjective aspect and sickness the social aspect. To some extent, those attempts to compartmentalise them is another manifestation of the complexity of disease conceptions. Boorse (1975), for example, emphasizes the distinction between disease and illness. He contends that disease is a theoretical notion that can be applied impartially to all species and their organisms. It is biological. On the other hand, he argues that illnesses should be seen as 'merely a subclass of diseases' (p. 56) – the ones with normative characteristics. This distinction is part of his effort to narrow disease to only the physiological malfunctions, without considering any

subjective or intersubjective aspects. And then there is the concept of sickness. Parsons (1951, cited in Twaddle, 1994) is often credited for this concept due to his notion of 'sick role'. Here, disease would not only impact on the bodily functions of the person, his or her subjective feeling, but also his or her performances in society, and that is when disease is turned into sickness.

According to Twaddle, who is the first one to fully apply the triad of disease, illness and sickness in 1967, disease can be seen as 'physiological malfunction' or organic phenomenon, which can lead to reduction in terms of 'physical capacities and/or a reduced life expectancy' (Twaddle, 1994, p. 8); illness is 'a subjectively interpreted undesirable state of health' and hence it is about the subjective bodily experience. This would include subjective feelings like pain, as well as subjectively perceived bodily inadequacy and a sense of lacking in bodily competence (Twaddle, 1994, p. 10). On the one hand, Twaddle defines sickness as a social identity: 'It is the poor health or the health problem(s) of an individual defined by others with reference to the social activity of that individual'' (Twaddle, 1994, p. 11).

These three notions, disease, illness, and sickness, each gives particular emphasis to a different aspect of those undesirable bodily and mental conditions. However, the triad also reveals the way those aspects are in fact inseparable. Often, the three aspects are conjugated, and as can be seen in the previous part of defining disease, it has been put into doubts whether disease can be defined free of subjectivity or social values at all. The biological, subjective and social aspects of bodily are inseparable from each other, and to some extent, it is their subjective and intersubjective nature that lead diseases to be defined as diseases. To some extent, this triad points to the multiple dimensions in defining disease.

On the other hand, this triadic distinction is criticized by Nordenfelt (1987, cited in Hoffman, 2002) due to its inadequacy in defining 'un-health'. Nordenfelt criticizes the triad

on many grounds. Most notably, concerning the definition of disease here, conditions such as injuries, impairments and defects are not taken into account. Nordenfelt holds that those conditions are clearly instances of 'un-health', but they are not included in the picture of disease here. He further argues that these instances can only be properly accounted for if a conception of health, rather than disease, is made primary. He also criticizes the definition of illness on the grounds that it does not provide a means to tell apart the diversity of subjective feelings of 'un-health', and that, again would need an account based on health first. And finally, in criticizing the concept of sickness as proposed by Twaddle, he maintains that viewing someone as sick does not have to involve an observation of a changed activity log. He comments, 'The standard case seems to me to be the contrary. There is no particular activity at all, except the seeking of health-care, that could give any clue to the diagnosis concerning the patient.' (Nordenfelt, 1994, p. 29). In other words, being sick does not necessarily impact on the social role or social activity of an individual. Also, the seeking of medical care is the most fundamental clue to someone's bodily status – this seem to invoke Parson's 'sick role' in an interesting way. I will now turn to a discussion on conceptualizations of health.

2.2.2 Conceptualizing health

Just as Nordenfelt argues, only by making the conception of health primary can those instances such as injuries, impairments and defects be taken into account. However, the conceptions of health are just as diverse as that of disease. It is often assumed that health is the opposite of disease. When one is free from disease (no matter how it is defined), then one can be called healthy. However, this has been fiercely criticized to be an inadequate position by many (Caplan, 1993; Hamilton, 2010; Nordenfelt, 1984; Amzat and Razum, 2014). More discussion on the critique of this conception will be given in discussing the relation between disease and health, but for now, a brief summary of conceptions of health will be given first.

Below is a table illustrating main strands of thoughts on what is health (taken from Larson 1999), and as can be seen here, health is often perceived as more than the absence of disease or disability.

Model	*Definition*
1. Medical model	The absence of disease or disability.
2. World Health Organization (WHO) model	state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.
3. Wellness model	Health promotion and progress toward higher functioning, energy, comfort, and integration of mind, body, and spirit.
4. Environmental model	Adaptation to physical and social surroundings—a balance free from undue pain, discomfort, or disability.

Table 2.1: Models of Health (Larson 1999, p125)

For example, as can be seen in the WHO charter: 'health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. Health is equated with the general state of well-being. In order to be seen as healthy, a person needs to be well not only physically, but also mentally and socially. This definition has long been criticised since it gives too much power to the medical profession and entails too much power in terms of governing the deviance of citizens (Callahan, 1973). However, at the same time, it also gives more health rights to the citizens, and extends the outlets that they can get support from.

Nordenfelt (2011), on the other hand, provides his vital goals account, in which health is the ability of an individual to achieve personal vital goals, goals beyond survival but essential to a person's long-term happiness. Hence, in his definition:

> A is completely healthy, if and only if
>
> A is in a mental and bodily state which is such that

> A has a second-order ability, given accepted circumstances, to realise the states of affairs which are necessary and together sufficient for ''s minimal happiness in the long run. (Nordenfelt, 2011, p.93)

In this way, what constitutes happiness differs from person to person, and hence what constitutes health will also differ individually. It is therefore important to decide on what an individual's vital goals are and provide support for them if their bodily and mental state can be impeding the realization of those goals. The criterion is the competence for long-term happiness, which locates the definition of health beyond the lack of physiological malfunction and bears important implications for the provision of health care. Seedhouse (2001) proposed a similar model that emphasizes the role of health for personal achievement. In his model, 'the foundations conception of health', he proposes that the health system needs to provide enough resources for an individual to achieve what they think is the best for themselves, and considers social, environmental and personal factors all part of health.

On the other hand, Canguilhem follows an environmental model, which emphasizes a person's bodily adaptation to surroundings, no matter in terms of physical or social environment. For Canguilhem (1991 p116), 'health means being able to fall sick and recover, it is a biological luxury.' Here, being healthy is posed as the ability to adapt to the environment, which may involve temporally falling sick as a response to external factors but adjusting and recovering promptly. In this way, the organism's interaction with its surroundings, its own resilience and strength are given emphasis, which is seen as the key to health. A temporary physiological malfunction is allowed for one to be called healthy when the body is adapting to the environment, as long as prompt recovery is made and the relation between the individual organism and the environment is balanced and in harmony.

Another important model of health is the wellness model. Here, health is compared to a reserve, and it gives emphasis to health promotion and a constant effort from each individual

towards the higher functioning of body and mind. In this way, the subjective perception of health is highlighted. According to Marvin and Crown (1976, cited in Larson 1999), health is an internal perception, and it can be present or absent in different individuals. It can be equated to strength, or energy, or comfort, or other subjective feelings by different individuals (Larson 1999). In this way, the definition of health is separated from the definition of disease – a sense of health is much more individualised.

In all above models, a sense of well-being is implied in the definition of health, whether in terms of the ability to realize vital goals, the harmony with the environment, or a sense of strength. Health is beyond a lack of physiological malfunction, which makes it tricky for measurement. The distinction between health and well-being is therefore often made, similar to the way disease is defined against illness and sickness, or how sex is separated against gender. In distinguishing sex from gender, it was assumed that sex is neutral but gender is not (Butler 1999). However, as argued by Butler (1999), sex is in no way neutral. Similarly, when distinguishing disease, illness and sickness, it was made as if the body, the subject and the social can be neatly separated, whereas in actual fact the physical, subjective and the social cannot be readily separated from the conceptions of disease. Those kinds of distinctions point to the fact that the obvious and straightforward, or value-free concept itself is already entangled with value, and the differentiation itself always points to the entanglement. In the effort to distinguish health and well-being, health is often seen as the bodily experience while well-being is more holistic and more subjective, and this distinction is sometimes difficult to maintain. As can be seen in the previous section, in defining health, well-being is always already drawn upon. A person's energy, happiness, ability to achieve his or her goals, are all entangled in the picture.

2.2.3 Binaries of health and disease

As can be seen in the above discussion of disease and health, it is difficult to separate the

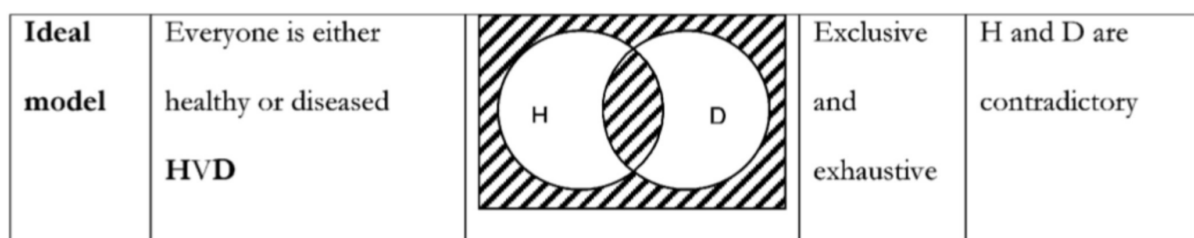
discussion of the two terms. The definition of disease often assumes that health is its opposite, and the same for health. In almost all the definitions above, a relation between disease and health is assumed. For example, in Nordenfelt's criticism of the triad of disease, illness and sickness, the main argument is the inability of the triad as proposed by Twaddle in accounting for un-health. Implicitly, the relation between disease and health is put into question. In this part, I follow the four models of health and disease characterized by Hofmann (2005) in attempting to explore the relation between the two, as well as the primacy health or disease claims at different times. Here, in his discussion, the issue of primacy involves many different aspects – it is conceived epistemologically, taxonomically, etymologically, experientially, evaluatively and practically (Hofmann 2005). The primary term of a binary opposition is often thought of as the one that is the norm, or sets the standard[6], while the secondary term is defined as a deviation or an anomaly from the norm (this is implied in Derrida's discussion of speech and writing, for example). In this way, the primary term sets the standard for both terms. In essence, the concept with primacy can be used in determining the other concept, but not vice versa, and that means there is some stricter criteria in defining the primary term, as it will then be employed to frame the definition of the whole binary. Although it might be possible to envision health as an ideal (and hence the primary term) and disease as a deviation, it is also true that disease is often given epistemological superiority in this pair, as it appears to be more knowable and discoverable, at least so in the biomedical discourse. Therefore, it is often made the primary term while health the secondary term. Four possibilities of accounting for the relations between the two are summarized by Hofmann (2005): the Ideal Model, the Holistic Model, the Medical Model, and the Disjunctive Model, which will be detailed as follows. It is worth

6. This discussion of primary here is also in accordance with Derrida's treatment of binary oppositions, see his discussion of speech and writing in Of Grammatology, 1974, for example.

noting that Hofmann's (2005) article is written from the perspective of the medical practitioners, and it is a simplified overview of a complicated issue, but it is still exemplary of the diverse philosophical views and provides one possibility of thinking through and criticizing some of the dominant models. His terminology might also be different from more commonly used terminologies, as can be seen in for example, The Ideal Model, to be discussed next.

The Ideal Model:

In Hoffmann's (2005) classification, this is the simplest model in which health is defined as the absence of disease. Hoffmann (2005) highlights how the two concepts are exclusive and exhaustive, and there is no in-between. In this model, everyone is either diseased or healthy. In this way, all the conditions can be grouped into either health or disease. The question of whether the condition or the person is being grouped will be discussed in detail later, for now bear in mind this is a simplified model. This can be seen in the model below: H refers to health and D stands for disease. There is no intersection between the two, and there is nothing beside the two (the striped areas are the areas that cannot be occupied). This is a model that treats the two as binaries and follows the rule of the excluded middle. In many of the discussions of our bodily statuses, this position is assumed. It is worth mentioning that there might be some terminological confusions, as in many other contexts, this might be seen as the biomedical model and the WHO model of health tends to be called the ideal model (See Seedhouse, 2001). In the rest of the thesis, I will be mainly drawing on Hoffmann's (2005) terminologies.



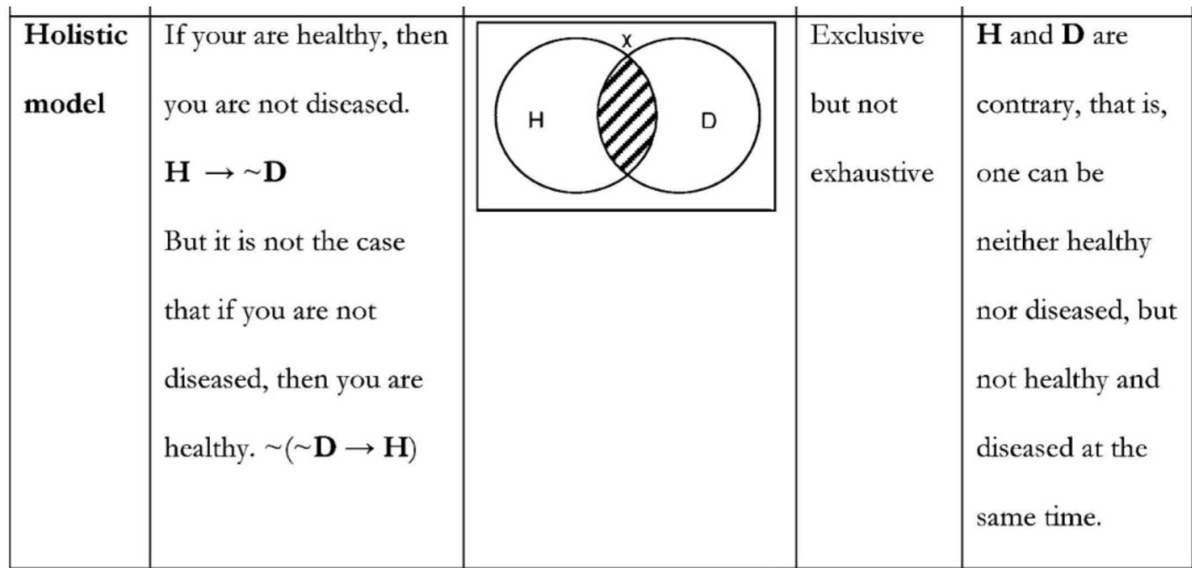
Ideal model	Everyone is either healthy or diseased **HVD**	H D	Exclusive and exhaustive	H and D are contradictory

Figure 2.1: The Ideal Model (Hoffman 2005)

The Holistic Model:

In the second model as summarized by Hoffman (2005), health is defined as more than the absence of disease. Here, health claims the primacy and has a stricter criterion than 'non-disease'. In order to be called healthy, there are other criteria, such as happiness, wellness, competency, the ability to fulfil goals, or to flourish, and so on. Hence, this model is called the holistic model because a holistic stance is taken in terms of defining health, in line with Nordenfelt or Canguilhem's notion of health as mentioned in the above section. Health can then be used to define disease, but not vice versa.

The relation between the two can be seen in the graph below. Here, the two concepts, disease and health, are exclusive but not exhaustive. They are contrary, and this is to say, it is possible that a person is neither healthy nor diseased, but it is not possible for a person to be both healthy and diseased at the same time. Also, since health takes the primacy, if a person is healthy, then he or she is not diseased, but if a person is not diseased, it is still possible that this person might not be healthy. There is the in-between space where a person is not seen as diseased (and hence disease is reduced to concrete, graspable conditions), but does not qualify for the standard of health. This can be seen in the model below.



Holistic model	If your are healthy, then you are not diseased. **H** → ~**D** But it is not the case that if you are not diseased, then you are healthy. ~(~**D** → **H**)		Exclusive but not exhaustive	**H** and **D** are contrary, that is, one can be neither healthy nor diseased, but not healthy and diseased at the same time.

Figure 2.2: The Holistic Model (Hoffman 2005)

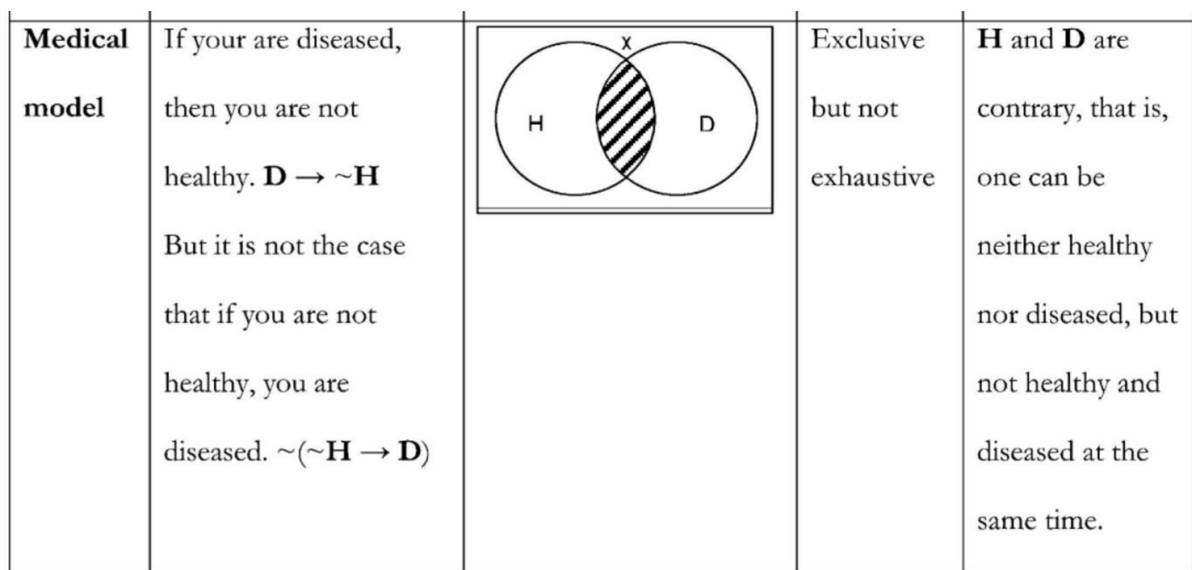
The Medical Model:

In the medical model as summarized by Hofmann (2005), disease is seen as more than the absence of health. Disease is given the primacy and hence has a stricter criterion than non-health. This is a common position for most medical practitioners, as noted by Hofmann (2005).

Diseases have to be detected by medical examinations, medical and paramedical tests, or correspondence to a set of symptom descriptions. Here, in order to be qualified as disease, there has to be an entity to be discovered, an abnormality to be identified, a diagnosis to be made – something concrete and objective. This can be seen in the model below. Here, the two concepts, disease and health, are still exclusive but not exhaustive. Disease assumes the primacy and if one is diseased, then certainly one cannot be healthy, but being unhealthy does not suffice for being called diseased. Again, a grey area emerges where a person is not seen as healthy (and hence health is conceived as an ideal state) but does not qualify for the threshold of disease.

It is worth noting that *The Holistic Model* and *The Medical Model* look the same and they both leave space for neither healthy nor diseased, the only difference being which side takes

the primacy in deciding on this space. To be more specific, ‘the medical model says that non-health is not a sufficient condition for being diseased’ (Hofmann, 2005, p359), and here disease takes primacy and requires stricter criteria, ‘whereas the holistic model emphasizes the fact that the absence of disease does not qualify for health. ’(Hofmann, 2005, p 359), and the most typical of the holistic model is the WHO model of health in which ‘health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’ infirmity (Constitution of the World Health Organization, 2005). There, health then requires stricter criteria as compared to disease.



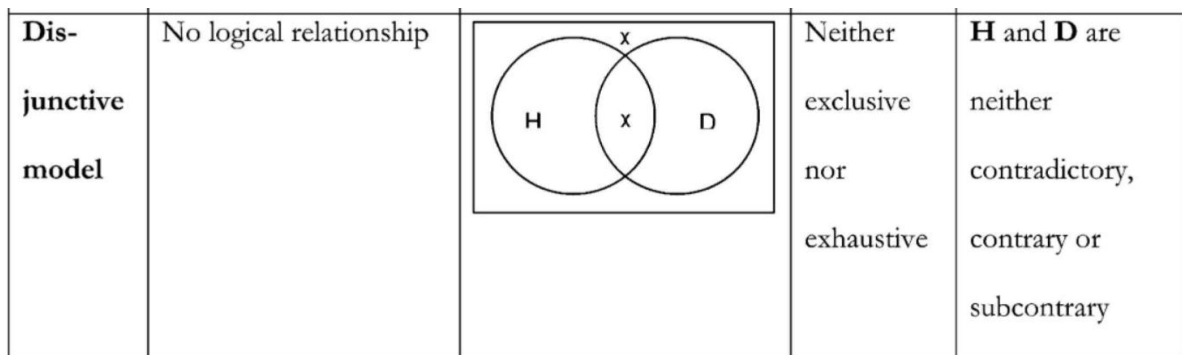
Medical model	If your are diseased, then you are not healthy. **D** → ~**H** But it is not the case that if you are not healthy, you are diseased. ~(~**H** → **D**)	X H D	Exclusive but not exhaustive	**H** and **D** are contrary, that is, one can be neither healthy nor diseased, but not healthy and diseased at the same time.

Figure 2.3: The Medical Model (Hoffman 2005)

The Disjunctive Model:

The above three models are criticized by Hofmann on the grounds that ‘they do not address situations of non-disease-and-non-health or disease-and-health which health care professionals tend to encounter quite frequently’ (2005, p361). In order to address this, he proposes the disjunctive model in which disease and health are not contradictory, contrary or sub-contrary. In fact, the two cease to be inter-definable. Moreover, one can be healthy and diseased at the same time, which means they are no longer exclusive. They are still

dependent, albeit only partly. There are no logical relations between them, at least not in the classical sense of logic.



Dis-junctive model	No logical relationship	x H x D	Neither exclusive nor exhaustive	**H** and **D** are neither contradictory, contrary or subcontrary

Figure 2.4: The Disjunctive Model (Hoffman 2005)

2.2.4 Why does the discussion of the logical relation and primacy matter?

The last section delves into a discussion of the logical relation between health and disease that is often assumed in different discourse but often remains invisible. In everyday conceptions and academic debates, disease is usually conceived as a biological entity and health as the absence of disease. This characterisation has been criticised in academic debates. There has been more critical awareness of the fact that the distinction between the two can be fuzzy and that they can co-exist (Sadegh-Zadeh 2000; Seedhouse 2005; Hofmann 2005), and there has been numerous social studies of chronic illness as a space health co-exist with illness. Still, it is very easy for the discussion of disease and health to slide into an arbitrary opposition, and the concept of disease tends to take primacy–- that is, a lack of disease is seen as indicating health. The prevalence of either *The Medical Model* (as a result of the dominance of biomedicine in society) or *The Holistic Model* (as a result of the WHO view) also mean that overtly, the intermediate space of neither healthy nor diseased is sometimes evoked, without being named.

The disjunctive model, introduced towards the end, invites reflections on the relations between health and disease, and the way the classical logic of opposition is insufficient for a

full account of health and disease. This model fits in well with the phenomenological concern with the lived experience of health and illness. On a more phenomenological approach, although there will always be biological processes when something like a disease gets detected, there might also be multiple other, non-disease related biological processes going on at the same time, which can give rise to conflicting and contradictory interpretations towards an individual's health status. The ultimate determiner of how the condition is construed and interpreted would be the lived experience of the person. In fact, it may be argued that 'there are no diseases, there are only sick people' (Armand Trousseau, 1801-1867 cited in Sadegh-Zadeh, 2015). Just as Leder (1992) noted, when someone falls sick, what is at stake is not just a faulty body-machine, but a transformation of worldly experiences: 'a disease undermines our sense of self and autonomy, our relations with others, our habitual experience of space and time' (Leder, 1992, p5).

There are acute conditions with very short time frames, and there are long-standing conditions that grow to be a part of someone's daily life, while an individual's experience of or adaptation to those conditions vary. The impact of those conditions on the person's strength level, activity pattern or realization of goals will also vary. For example, there could be 'health within illness' (Carel 2007 p96) if adaptivity and creativity are utilised, in Carel's theorization. This bears important implications for talking about health and disease, and in addressing non-disease-and-non-health or disease-and-health, as proposed in the disjunctive model.

Therefore, the disjunctive model is compatible with a phenomenological view of the body, with an awareness of the lived body, of body as a necessary part of our experience, and the impossibility of separating body and mind. It is a fundamental recognition that we are our bodies – instead of 'we have a body'.

2.3 Empirical literature on concepts of health and illness

In the above section, I engaged in an extended discussion of philosophical ideas of health, disease and illness. As can be seen, the study of concepts in analytical philosophy is useful and has its place, and that is why I felt the need to conduct conceptual analysis here at the same time as reviewing the literature; however, it is necessary to point out that in daily life things are often not so tidy and it is necessary to look at empirical work on people's experiences of health and illness. Therefore, in this following section I want to briefly introduce another important approach to the study of health and disease, that of the study of the experiences of chronic illness from the field of medical sociology/sociology of health and illness.

With modern medical developments, the death rate has significantly decreased, and chronic illness becomes a more salient problem (Bury 1991). The population with chronic illness or who report to have chronic illness have been on the rise. Among those chronic diseases, some of them can be more life-threatening, like cancer or cardiovascular diseases. On the other hand, there are some other chronic conditions that may not seem so serious but still pose considerable difficulties or discomforts for the patients and impede their realization of vital goals, such as irritable bowel syndrome (IBS) or Chronic fatigue syndrome (CFS/ME). For conditions like chronic fatigue syndrome, a concrete diagnosis is difficult to give, and it can only be diagnosed by looking at the symptoms and ruling out other possibilities. In this way, both health (since the person is living with it, and there will be a degree of adaptation, strength, the attempt to fulfil life goals, and so on) and illness (the condition, the diagnosis, the disvalue) are present - 'health within illness'.

I have discussed earlier in the chapter differentiations between disease, illness, and sickness. Since the first half of the chapter is about philosophical discussion, the concept disease is invoked a lot due to its supposed objectivity (and I have shown even such

objectivity may not be that objective after all). I have also used the concept of 'illness' a lot when discussing the disjunctive model since there the subjective experience and the whole person's embodiment in the life world is invoked. The third concept 'sickness', on the other hand, has a focus on one's role in the society. Parson's concept of 'sick role' is the most typical of this view, situated in a structural functionalist tradition. For Parsons (1972, p117) , 'Health may be defined as the state of optimum capacity of an individual for the effective performance of the roles and tasks for which he has been socialize' and therefore the most importance aspect of not being healthy is not being able to fulfil such tasks and perform those roles; the individual illness is examined in the light of a 'deviant' behaviour, a failure to execute social roles (Parsons, 1951). In this context, sick role comes with its privileges and responsibilities, being a medically sanctioned deviant behaviour. The person assuming the sick role needs to seek medical treatment and comply with it to get better, and at the same time gets temporarily exempt from the usual obligations, be it work or family or others; by being compliant with medical treatment, the person is also excused from blame.

In the 'sick role' model, being ill is about one's social responsibilities. A timely recovery is assumed in this model, making it more suitable for acute conditions, and from 1960s there have been different criticisms of it, most notably for its failure to account for much of the experiences of chronic illness. Its emphasis on patient - doctor relationship also means that the medical system takes on a rather paternalistic role and gets the centre stage (Varul, 2010), at the expense of perspectives and voices of the patients.

Research in the field of sociology of health and illness have thus, challenging Parson's model, turned to focus on patients' perspectives and meaning making, how illness interacts with self and identify, as well as health provision, from a interactionist and constructivist tradition and increasingly informed by phenomenological ideas. For example, Bury (1982) proposes the important notion of chronic illness as a biographical disruption. Based on semi-

structured interviews with a series of rheumatoid arthritis patients, Bury discusses how chronic illness is seen as a 'critical situation' that fundamentally disrupts the self and identity of the patients, as well as their relationship with others. For the young people who got the diagnosis, it can be particularly disruptive to their biographies, having been diagnosed with a condition that is usually associated with the elderly. And Bury comments that

> As such, it marked a biographical shift from a perceived normal trajectory through relatively predictable chronological steps, to one fundamentally abnormal and inwardly damaging.' (Bury, 1982, p171)

Following from this work, Charmaz (1983) further investigates the suffering of people with chronic illness and argues that 'loss of self' constitutes a fundamental form of suffering for the chronically ill, in addition to physical and psychological suffering, because living with chronic illness means they have to 'observe their former self-images crumbling away without the simultaneous development of equally valued new ones' (Charmaz, 1983, p168). Later work also discusses how biographical reconstruction and 'coping' is possible for chronic illness. Gareth Williams' (1984) work is important in this regard. Different to Bury's 1982 article that focuses on people newly diagnosed with rheumatoid arthritis (RA), Williams' interviewees are people who have been diagnosed with RA for a while and have had to live with it. Thus, Williams observes the imaginative enterprise people engage in while incorporating the illness in their biographies, in their effort to seek coherence. In his words, people with chronic illness must 'reconstitute and repair ruptures between body, self, and world by linking and interpreting different aspects of biography in order to realign present and past and self and society' (Williams, 1984, p197).

As can be seen in the literature I have sketched, there is concern for the narratives from patient perspective and thus attentiveness for the lived reality and lived experience of the patients.

And ultimately, works that try to understand the perspectives and plights of patients carry

the promise to reconceive health provision. In his book, Seedhouse (2005) proposes a foundations model of health that radically reconfigures what is health and what should be in the realm of health work. He argues that health problem is not just about issues of health and disease in the narrow sense, and hold the view that health is about autonomy, and therefore other problems in life such as access to information and education, lack of sense of community and so on should all be part of health work.

2.4 Sociological literature on the space between health and illness

The studies I have presented in the previous section showcase the tradition in the sociology of health and illness to understand the lived experiences of chronic illness, its complexities and messiness, and its impact to one's self. Those earlier studies have inspired much subsequent research that focus on different chronic conditions and seek to challenge or develop the earlier concepts. For example, see Monaghan and Gabe's (2015) article on young people's experiences of asthma as "biographical contingency", being a problem to the self 'only sometimes' and invisible in other times. Saunders et al. (2018)'s paper on biographical suspension and liminality of self for people living with severe Sciatica provide another important perspective. People living with Sciatica, which is a common form of low back pain, live in a liminal space, in biographical suspension, "whereby individuals put life on-hold in the expectation of an eventual return to their former, pain-free selves" (Saunders et al. 2018, p28). Thus, those living with Sciatica are "caught between pre- and post-sickness selves ", and thus embodying a liminal self that does not fully identify with either.

Those empirical work on health and illness attests to the multifaceted and complicated nature of health and illness, challenging binary models of health and illness while also challenging the primacy of disease in the medical model. In particular, the possibilities of coping and the instances of liminality give weight to the notion of "health and illness at the same time". In the next part that follows I will try to survey sociological literature to

examine whether there is any literature that specifically touches on “the space between health and illness” and how the space between health and illness is conceptualised and defined in the sociological literature and at how this space is used to understand experiences of health and illness.

In order to discuss the grey area between health and illness, it is important to discuss the knowledge that regulates health and illness as well as the experiences of health and illness. Over the second half of the twentieth century, sociologists have become increasingly critical of the dominance of biomedicine and the kind of linear progress biomedicine paints for itself (Nettleton, 2021). The medical gaze on the body (see Foucault, 2003) is examined and the way some spheres of life have been overly medicalized (the case of pregnancy, for example) is recognised and critiqued (Oakley, 2006).

Biomedicine has been a dominant authority on diseases and diagnosis, but its universal validity has growingly been challenged and most sociologists instead took a social constructionist position to disease and illness (Nettleton, 2021). They point out that medical knowledge is shaped by social forces and what was previously seen as natural categories such as diseases need to be examined sociologically, much in line with the debate between naturalism versus normativism that I have sketched earlier in this chapter. On the other hand, the medicalization thesis challenges the application of medical knowledge (Nettleton, 2021). Zola (1972, cited in Nettleton, 2021) sees medicine as an institution of social control, ‘nudging aside, if not incorporating, the more traditional institutions of religion and the law’. The medicalization thesis recognizes the unequal power in the construction of the knowledge of health and illness, where medical professionals hold more power in defining what counts as sickness (Nettleton, 2021). The central claim of the medicalization thesis is that nonmedical problem is being reframed as medical problems, with the ever-increasing application of medical knowledge. This can be beautifully summarised by Conrad’s (2007)

book title: *The Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders*.

Further, Conrad (2007) comments that the drivers for medicalization have changed from the medical profession to pharmaceutical and biotechnology industries. He also mentions the role of potential patients as consumers in medicalization, and the space between health and illness is undoubtedly invoked there. In this process, the interests of pharmaceutical companies play an increasing part in shaping the mundane practices and experiences of health and illness and some conditions get to be seen as “treatable disorders” because it furthers the pharmaceutical interests.

On the other hand, health is enigmatic (Gadamer, 2004). Gadamer remarks that

> Health is not a condition one introspectively feels in oneself. Rather, it is a condition of being involved, of being in the world, of being together with one’s fellow human beings, of active and rewarding engagement in one’s daily tasks. (Gadamer, 2004, p113)

Health is difficult to define and grasp and cannot be accounted for with the biomedical model alone. There is a lot of literature that discusses lay health beliefs, which according to Nettleton (2021) cannot simply be seen as diluted forms of medical knowledge. They are shaped by many different aspects including a person’s social location, cultural background, biography and so on (Nettleton 2021). There are diverse beliefs and conceptualizations people have about why they get ill and how they could get better. Also, the lay experiences of illness don't necessarily get captured in medical terms. Hanay (1980) talked about the concept of ‘illness iceberg’ which refers to the vast number of complaints that do not reach general practitioner settings.

There is also some important work that examines people’s concepts of health and illness while also considering the nature of different accounts people give about their health and illness. Cornwell (1984)’s study is an important piece of work that studied 24 people who

lived in east London focusing not only on health and illness but also on other aspects of life including housing, work, and the gendered division of labour, seeking to understand people's lives as a whole. One important finding of this book is that there is a difference between public accounts and private accounts. Often, researchers are only able to access public accounts of illness, where participants try to portray themselves in good light, and private accounts could be quite different to public accounts.

However, even ideas and practices around health have been growingly assimilated into a trend of medicalization. Crawford (1980, p368) coins the term 'healthism' to refer to a 'preoccupation with personal health as a primary', which includes holistic health movements and the attention to self-care. He sees this trend of healthism as a part of medicalization, and criticises the way such health consciousness make health a problem for the individual and de-politicises the issue of health care.

Having given an account of empirical studies on health and illness, it seems that the experiences of health and illness are highly dependent on contexts and sense-making, while also navigating between different worlds (the medical world and the lived world, for example.

In the following part I focus on two strands in sociological literature that seem to most closely relate to the grey areas of health and illness, that is the discussion of contested conditions, and the discussion of proto-disease.

Contested illnesses are conditions like chronic fatigue syndrome (CFS, also called myalgic encephalomyelitis or ME), fibromyalgia, multiple chemical sensitivities, and chronic Lyme disease. People with such contested conditions suffer from different symptoms which make a negative impact on their daily life, but the medical establishment often could not give a sufficient account or explanation. For example, persons with CFS or MCS often report having experiences of terrifying symptoms and being turned down bureaucratically in their

search for medical attention (Dumit, 2005). These conditions also fall under the label of medically unexplained symptoms (MUS), which refers to patients who suffer from symptoms that do not have identified organic basis (Nettleton, 2006). Those conditions are contested as they do not neatly fit biomedical models and there are often uncertainties about these conditions. Is it physical? Is it psychological? Interpretations of those conditions often cut across body and mind, and there are a lot of uncertainties concerning what they actually are. Those conditions occupy a more ambiguous place between health and illness and a key concern of sociological research in this area is on 'the intense interplay between diagnosis and legitimacy' (Dumit, 2005, p578). As commented by Dumit (2005, p578),

> without a diagnosis and other forms of acceptance into the medical system, sufferers are at risk of being denied social recognition of their very suffering and accused of simply faking it.

Therefore, the grey area of health and illness features in the study of diagnosis, since diagnosis serves as an important place where cultural, professional, and representational powers converge in shaping the grey area of health and illness. Often, people suffering from medically unexplained symptoms report a resistance to psychological explanations of their sufferings (Nettleton 2006). They often have to live with uncertainty and look for legitimacy, and to have their suffering explained as physical and biomedical is a source of such legitimacy. Dumit (2005) studied a large archive of internet newsgroup postings on chronic fatigue syndrome and multiple chemical sensitivity and the way sufferers try to use facts to gain legitimacy to their conditions so that their conditions can be covered by insurance, to 'fight to get' such illnesses. He concludes,

> (1) sufferers describe their experiences of being denied healthcare and legitimacy through bureaucratic categories of exclusion as dependent upon their lack of biological facts; (2) institutions manage these exclusions rhetorically through exploiting the open-endedness of science to deny efficacy to new facts; (3)collective patient action responds by archiving the systematic nature of these exclusions and developing counter-tactics.

Therefore, in the cases of contested, uncertain illnesses, the struggles, and the need to

have permission to be ill illustrate the social and institutional forces in shaping the space between health and illness. Those are cases of 'embodied' grey area, when symptoms are felt and disturb everyday life but there is also another case that is attracting growing attention: potential, future illnesses.

With the ever-expanding medical prowess, the development of different medical technologies such as health screening have made it possible to calculate the risk to develop possible diseases and have given rise to ideas such as pre-disease, which is future oriented. Armstrong (2002) sees this trend as a rise of Surveillance Medicine, a term he coined to describe the way 'normal populations' become targeted by medicine in the 20th century. For Armstrong, this new Surveillance Medicine involves 'a fundamental remapping of the spaces of illness' (p393). This new Surveillance Medicine also makes localizing illness outside the corporal space of the body a possibility (Armstrong 2002). Another related trend is the development of genetic technology, which makes it possible to interpret individuals in terms of their DNA codes. When the DNA codes reveal a predisposition to certain diseases while the person is still healthy, new understanding of disease emerged and new social dynamics are created (Timmermans and Buchbinder, 2010).

Dumit's (2012) discussed how, in this context, risk becomes equated with illness which is further equated with treatment (see also, Kreiner and Hunt, 2014). Illness becomes a line you cross, a threshold, which is defined by clinical trials, or health screening (Dumit, 2012). Such 'at risk status' is almost a pre-disease or protodisease (Rosenberg, 1997). Drugs are marketed to lower such risk. In this context, Dumit (2012, p105) coined the term 'mass health' to capture the way health and illness is put 'on a continuum', 'with the understanding that the line between them is just that, a line, but one that requires fine collective judgment by experts as to where that line can be drawn.' This is fuelled by drug industries who have shifted their logic from individual health to mass health. In this context individuals are encouraged to seek

'surplus health', defined by Dumit (2012, p17) as 'the capacity to add medications to our life through lowering the level of risk required to be at risk.'

Such future oriented focus on risk also creates new identities. 'Pre-symptomatic person' (Konrad, 2003) and 'partial patient' (Greaves, 2000) are some of the formulations. For people facing uncertainty before they could get a test results or firm diagnosis, they are subjected to a 'potential sick role' (Crawford, 1980) and a 'technoscientific illness identity' (Sulik 2009). Timmermans and Buchbinder (2010, p409) develop the concept 'patient-in-waiting' as 'an overarching concept to elucidate common experiences among people trapped between a state of sickness and health characterised by uncertainty about disease'.

Gillespie (2012) discusses how being at risk could change people's health identities and introduces the idea of measured vulnerability. Measured vulnerability is the potential for scientifically generated statistical measurements that are designed to manage risk and tame chance to instead produce uncertainty and worry in the people to whom the statistic is applied. The quest for more certainty only leads more uncertainty. Gillespie (2015) also demonstrates how being at risk could change one's social relationships.

The key concept behind all this is risk. Risk, as commented by Jauho (2019), 'adopts an ambiguous position between health and illness/disease'. Jauho (2019) also comments that most research on risk focuses on the illness/disease side of risk ambiguity, instead of the health-side of risk ambiguity. In his research on people with elevated cholesterol, it is concluded that these individuals actively attempt to not fall into the identity of patients 'through a responsible regimen of personal health care' and view themselves as 'chronically healthy individuals'. I believe this is where my research comes in too – to discuss such ambiguity between health and illness/disease from the side of health, probing such conceptions from the side of health, taking into account of the medicalization thesis but also try to go beyond a biomedical understanding of health and illness/disease.

2.5 The gap: recognised but unnamed

Sociology of health and illness recognize that health, illness, disease, and sickness are socially constructed. Although not explicitly discussing the logical relation between health and illness, in discussing cases such as chronic fatigue syndrome, or the risk experience, it is acknowledged that there is a grey area space between the two and that those are either where medical technology got too far, or where more support needs to be given. Although the space between health and illness is invoked in different places in sociological literature, and there have been different terms to capture either people in this space (such as 'partial patients' or 'patients-in-waiting') or this grey area (at risk state, protodisease), a biomedical understanding (the quest for diagnosis, clinical trials in defining mass health, genetic technology) is often assumed and biomedical language is often draw on. For example, the formulation of 'protodisease' indicates the primacy of a biomedical understanding. You first need an understanding of what is a disease before you can define what is protodisease.

Subhealth differs because it pinpoints this space but from the side of health. It cannot be fully accounted for as 'healthism' because the conceptualization of subhealth is entangled between individual health as well as social determinants of health. Naming it but from the side of health also means it is a more embodiment dimension, instead of being defined by different technologies. The way the space between health and disease is carved out and named as in the Chinese context as the third status, or suboptimal health, and oxymorons such as 'treating undisease' differs from the western contexts and is worth examining. This thesis attempts to examine this peculiar case when such an unnameable 'thing' gets named and look at what it means.

Chapter 3: Research Design and Methods

3.1 Introduction

This chapter aims to give details and rationales to my chosen methods of data collection and analysis. In this current section (3.1), I will introduce my overall strategy and I will give my methodological considerations in the next section (3.2).

Overall, this project employed different qualitative methods drawing on different types of data sources. The main methods were:

1. Collection of documentary data on suboptimal health/subhealth in public health literature across 20th and 21st century
2. Participant observation at three TCM conferences.
3. Ethnographic fieldwork at a TCM clinic in England.
4. Virtual ethnography by immersing myself on social media and collecting data from social media platforms including Weibo.
5. Interviews with people brought up in China

Table 3.1: Sources of Data for Each Research Question

Research Questions	Research Objectives	Relevant Data
How does the concept of suboptimal health travel through time and into different contexts?	1. To explore the historical development of the concept of sub-optimal health.	Data from method 1 as listed above
	2. To examine the use of sub-optimal health in a range of different contexts (TCM conferences, a Chinese Health Clinic, digital spaces and everyday life).	Data from method 1,2,3,4 and 5
What does it mean for ordinary people to be 'in suboptimal health'?	3. To explore the lived experience of sub-optimal health.	Data from method 3, 4 and 5

As can be seen in the listed methods, the research design is mainly ethnographic. I collected and analysed different kinds of data to explore how the concept of 'sub-health' is constructed and understood across cultural settings and whether it plays a role in the material encounters with TCM (and I have matched the data with research questions and research objectives in the table above). The TCM clinic in England was originally conceived to be the main field site, but the pandemic meant that I needed to expand my field sites and consider virtual spaces. The different elements of the research end up being complementary to each

other although some changes were contingent on the pandemic. The data from the five methods as listed above capture the travel and reach of the concept of subhealth. It is almost like a map which reveals where the concept has reached and where it hasn't. The different stands of data combined serve to map the territory of the concept of subhealth in public health discourse in China, in the west, in TCM discourses within China and in the west, and in the consciousness of the young people in China.

As can be seen in Table 3.1 above, looking at the historical documents in public health has helped me to trace the conceptual history of the concept and in particular helped me to examine the semantic construction of the term 'suboptimal health' and how it has had different meanings over history. There, I also attempted to examine the origin of subhealth, which is an important part of the puzzle, in order to understand the concept in Chinese context. This has helped me to achieve the research objective of 'To explore the historical development of the concept of sub-optimal health' and has shaped my chapter 5.

On the other hand, all different types of data combined has helped me fulfil my second research objective, which is 'To examine the use of sub-optimal health in a range of different contexts (TCM conferences, a Chinese Health Clinic, digital spaces, and everyday life).' Each type of data became part of the puzzle, helping to elucidate a deeper contextual understanding.

In such a way, the different strands of data have helped me to address my research question of 'How does the concept of suboptimal health travel through time and into different contexts?'

Finally, the combination of ethnographic fieldwork at a TCM clinic in England, virtual ethnography on Chinese social media and interviews with people brought up in China has helped me to fulfil my third research objective: 'To explore the lived experience of sub-optimal health.' It is with data from these three methods that I get to take a closer look at the day-to-

day practices and experiences of subhealth in both mundane everyday life, and in encounters with medicine and most specifically with Chinese medicine. Although the social media data and interviews with Chinese people were added because of the contingency of the pandemic, they ended up becoming an essential element of the project. They supplied the last missing piece, which is how the concept impacts on people who were exposed to the concept and how this concept impacts on their daily experiences of health. On the other hand, although subhealth is not quite featured in the Chinese medicine clinic as I anticipated, data from the clinic confirm the geographical and temporal nature of the concept of suboptimal health and capture the concept in practices.

Below is a table illustrating how different strands of the data feed into different chapters, and provide some details, for example, about how many interviews are conducted.

Table 3.2: Types of data and details on the data

Main source of data	More details on the data
Participant observation at three TCM conferences.	Observations of 3 TCM conferences, fieldnotes, documents collected from the conferences, recordings of the conferences as published by organisers where available.
Collection of documentary data on suboptimal health/subhealth in public health literature across 20th and 21st century	Documents containing mentioning of 'subhealth' or 'suboptimal health' from public health literature in the 20th Century, the most important part of which were identified using Google Ngram Viewer search, and then collected from British Library and from the WHO website.

Ethnographic fieldwork at a TCM clinic in England.	7 participants recruited from the clinic - with all of them I conducted an initial one-hour face-to-face semi structured interview, and with four of them I conducted a second one-hour interview. With three of them I observed their consultations with the doctor, but that got halted because of the pandemic. I have also conducted three formal interviews with the doctor (and around half a dozen of informal chats with the doctor) and two interviews with the other receptionist (and some occasional informal chats).
Virtual ethnography by immersing myself on social media and collecting data from social media platforms including Weibo among this.	Social media data collected mostly between November 2020 to April, 2021, in the form of screenshots on the form, which is then compiled into pdf files (around 400 pages of screenshots).
Interviews with people brought up in China	Interviews with 22 Chinese people, conducted on WeChat by voice chats that range between 15 minutes and one hour, and occasionally two hours. With 2 of the interviewees, a second one-hour interview was conducted. These semi structured interviews are all recorded and transcribed.

Below I will introduce my key methodological considerations in starting off the project and in making adaptations in response to the pandemic.

3.2 Methodological considerations

3.2.1 Qualitative Research

From the onset, it has been clear that the empirical study that has been conducted will be purely qualitative (and that has not changed despite many other changes made to the project), with the aim of establishing the cultural meaning and narratives constructed in relation to 'sub-optimal health'. My specific interest has been to examine how these link to different forces in knowledge making and different processes of sense making. The study explores the diverse professional and personal interpretations surrounding the concept, a kind of examination of the making of the concept. Therefore, it is about looking at how 'sub-optimal health' takes shape in various life worlds, how it travels between life worlds and knowledge systems. The study therefore follows an interpretivist epistemology.

There are six characteristics of Qualitative research listed by Merriam (1988): firstly, there is a focus on process instead of outcome; next, there is a sustained focus on meaning-making; thirdly, the researcher serves as the primary instrument for collecting data and for analysing data, which means data are necessarily mediated; furthermore, fieldwork is involved; it also follows that the research is descriptive, in order to establish meaning and understanding; last but not least, the research is also inductive, as a way to establish abstractions (concepts or theory) iteratively. Although, as will be clear from the following parts, there are occasionally some tensions between the conceptual orientation and a focus on lived experiences; the six qualitative characteristics will be maintained throughout, serving as the constants in the methodological explorations and tensions.

Although qualitative research can provide more in-depth accounts of a certain issue, and therefore is especially useful to investigate the use of the concept within the lifeworld, it is essential to take measures to ensure its validity and relevance (Taylor et al 2016; Hammersley 1990; Mays and Pope 2000). Hammersley (1990) notes that this drive for validity and relevance is underpinned by subtle realism. As commented by Malterud (2001, p483),

‘qualitative research methods are founded on an understanding of research as a systematic and reflective process for development of knowledge that can somehow be contested and shared, implying ambitions of transferability beyond the study setting’. In their book, Mays and Pope (2000) proposed several measures including triangulation, and clear detailing of methods of data collection and analysis and reflexivity for improved validity and using detailed reports and sampling techniques for improved relevance. On the other hand, Malterud (2001) highlights reflexivity as an equally important dimension as validity and relevance in qualitative research, instead of falling under a bracket of validity – a position that is perhaps more native to interpretivist epistemology.

All of the above have been taken into account in my research design. Firstly, triangulation is made use of to ensure the validity of my data. Different methods are combined, and different sources are sought, which include existing literature, documents at the clinic and the Chinese medicine conferences, semi structured interviews with visitors at the clinic and the doctor, observation of the everyday undertaking of the clinic, fieldnotes, and auto-ethnographic reflections. Later, because of the pandemic, this also expanded to include social media posts, semi structured interviews with Chinese people. At the same time, throughout the project, I try to be reflexive of my own role, my own positioning, my preconceptions, potential biases, and my own participation in the construction of the concept.

3.2.2 Ethnography

Gubrium and Holstein (2008) comments that the word ethnography has been given so many diverse meanings that sometimes it is seen as co-extensive with qualitative research. In essence, it is the study of culture. And due to my experience of being given the label of ‘subhealth’ when seeing a Chinese medicine practitioner I thought there must be a connection between the concept and the culture. My plan was to focus my tracing of the

concept in the culture/life worlds of Chinese medicine as practiced outside of China, with ethnography as my method and the clinic as my main field site (later it turns out to be only one of the field sites, albeit the only physical one), combined with documentary analysis tracing the conceptual history of the concept.

This clinic in the initial plan, was seen a particular cultural point to investigate the way the concept is communicated and how it shapes everyday experience. Specifically, this include looking at the way the doctor adopts the concept of sub-health in speaking with the patient, and the ways patients view and experience their own health status through the lens of sub-health, and how that shapes their life decisions. In this sense, the project has always been ultimately interested in looking at the concept in the context of the lives of the individuals, including my own. Auto-ethnography has been embedded in the ethnography, as my identity is both the researcher and a potential patient. Therefore, my own personal experience and my diaries have also been included as a source of data.

3.2.3 Combining conceptual history in the ethnography

As I just introduced in the last part, my project centres on one concept, and therefore, it is first of all essential to define what is a concept. According to Plunkett (2016), concepts are 'constituent components or ingredients of thoughts' (p.34). They help us to see the world in a particular fashion, or to connect thoughts about the world in a particular fashion. Plunkett (2016) distinguishes between 'having a concept' and 'using a concept' in the following way:

> a) an agent has a concept when she is capable of thinking thoughts involving that concept, and
>
> b) she uses that concept when she actually thinks such thoughts. (p. 34)

Having and using a concept means the thoughts of an individual are structured in some

way by the concept. Having a concept opens the space for certain thoughts to be possible instead of others. On the other hand, using a concept is a way forward; our actual thoughts are formulated under the frame of the concept (Plunkett, 2016). This is something that I will be exploring through my empirical research – whether people's subjectivities and thoughts are structured by the concept of sub-optimal health in any way.

Just as Plunkett (2016) noted, since concepts could structure our thoughts, it follows that some concepts work better for particular lines of inquiries. For matters related to health and disease (which themselves are concepts), there are a myriad of medical concepts, and a diverse web of folk concepts, being used in different discourses with different validities. For Canguilhem, when working on the history scientific concepts and theories, concepts 'interpret data', while theories 'explain data' (Canguilhem 1977, cited in Gutting, 1989). Therefore, only after having concepts that offer a preliminary understanding of a phenomenon can we then formulate (different and competing) theories to attempt to explain the phenomenon in a scientific way (Canguilhem 1977, cited in Gutting, 1989). Therefore, concepts open up space for theories and concepts are necessarily 'theoretically polyvalent' (Canguilhem 1977, cited in Gutting, 1989).

On the other hand, concepts are caught up in discourses in different ways. They do not exist in a vacuum. It is adopted by people to explain or convey different things, entangled in different thoughts and knowledge, as well as practices. The way they are utilised in different discourses, by different groups is important. It is with this awareness that I look at how the knowledge of 'sub-optimal health' has been created and sustained in different spheres and how power is deployed, and subjectivities constructed. They also have histories, and their semantic changes are tied up to historical changes, changes in the thought patterns, and so on.

In the field of philosophy, concepts are seen as the building blocks of thoughts and therefore conceptual analysis is a common methodology (Margolis and Laurence, 2019). Due

to the nature of the concept of sub-health being vague and potentially universal and all-encompassing, by this I mean, being potentially capable of describing experiences/feelings/symptoms/conditions that are not bound to any particular culture, I started off with such an attempt at a conceptual analysis to gauge the conceptual space for suboptimal health. Part of this has been included in the first part of my literature review (last chapter). I have attempted to examine the logic between philosophical understandings of health and disease, as well as the conceptual space for such a concept as 'sub-health', and that has paved the way for my understanding on the subject and my research design.

Another thing this project is interested is the conceptual history of the concept of suboptimal health. There are many different approaches to study conceptual history, each with its own philosophical, methodological implications and the definition provided by Plunkett (2016) can be a relatively neutral starting point:

> 'I take facts of conceptual history to be historical facts of the following kind: a) descriptive facts about how, when, or why a given concept (or a set of concepts) first emerged in use, and b) descriptive facts about what people have done with a given concept or set of concepts after this emergence. I will call the first set of facts ones about the emergence of a given concept (or set of concepts) and the second set of facts ones about the past use of a given concept (or set of concepts).' (Plunkett, 2016, p41)

Therefore, this project combines a genealogical approach that seeks to identify the 'discontinuities, recurrences, and unexpected backlashes as well as unexpected continuities' (Tamboukou and Ball 2003) in the construction of the concept of sub-optimal health historically, and an ethnographical approach that seeks to understand the lived experience of feeling 'sub-optimally healthy' in multiple sites, including the knowledge production surrounding such experiences. This project is interested both in the diffusion of power in the construction of the concept, as well as the potential for concept to facilitate people to make sense of their experiences, or to be subversive in one way or another.

Both approaches are open methodological frameworks that are useful for me interrogate

my notion of the grey area of health (sub-optimal health being one of the central conceptual constructs/discourses). The methodology of genealogy will assist me in understanding the shaping up and transformation of discursive formations (Anderson, 2003) of the grey area of health, while ethnography will help me engage with 'the play of power-knowledge relations in local and specific settings' (Ball, 1994, p.4).

Further, both approaches are qualitative, with the aim of establishing the cultural meaning and narratives constructed in relation to 'sub-optimal health'. It explores the diverse professional and personal interpretations surrounding the concept to establish the complicated making of the concept. Therefore, it is about looking at how 'sub-optimal health' takes shape in various life worlds, how it travels between life worlds and knowledge systems.

3.2.4 Multi-sited ethnography

Around the time of COVID-19, I had just formally started my fieldwork at the clinic and interviews with people recruited from the clinic for a couple of months, after gaining ethical approval in October 2019. The pandemic meant that I had to stop my data collection around the clinic[7], and it had also given me time to reflect on the data I collected thus far. Emerging from the data is a sense that although the doctor at the clinic is very familiar with the concept and the concept might be latent in some of the practices at the clinic, the visitors are in no way familiar with it, and thus conversations with them about the concept were not that fruitful, instead, from the interviews I got a lot of narratives about their own illnesses and their narratives of encounters with the clinic. Although those were interesting and relevant, I also realized that I would still need to collect data from sites where the concept is directly

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7. The clinic I was doing my fieldwork in was temporarily closed in April 2020 and although reopened shortly after, were open for much shorter time periods and with significantly fewer visitors, only for emergency cases, and this posed unanticipated difficulties to the data collection. For this reason, there was a need to expand the ways of collecting data.

invoked and to talk to people who actually use the concept.

In fact, around this time, my tracing the conceptual history of the concept helped to de-naturalize the concept for me and it also made me wonder whether it is my upbringing and background (growing up in China in a time when the concept was widely invoked in mass media advertisements) that made me particularly susceptible to this concept. I started to wonder whether this is true of other people from China with a similar age to me. I started to think I might recruit interviewees from China to ask them about their experiences of subhealth.

It also appeared that collecting data online became another fitting method in light of the pandemic, particularly given the fact that after an initial examination, there are frequent mentioning of and discussions of 亚健康 'subhealth' on Chinese social media platforms, which could become valuable data. Therefore, it became necessary for me to reconceive my ethnography as multi-sited and partially virtual, drawing on formulations of multi-sited ethnography (Marcus, 1995 & 2012) and virtual ethnography (Hine, 2015).

Internet based ethnography has in recent years become an emerging methodology which has attracted diverse formulations (Hine, 2011 & 2015; Kozinets, 2015; Pink, 2009), and it seems especially pertinent in the context the coronavirus crisis (Lupton, 2020). As commented by Hine (2015), studying the internet 'as an embedded, embodied, everyday phenomenon' is well in line with the multi-sited conceptualizations of the field as proposed by Marcus (1995 & 2012) and this justifies my expansion of sites and inclusion of the internet for my ethnography.

The core of my research has remained the same. It still involves the tracing of a concept, examining how it has travelled to and 'dwelled in' different cultures, and then looking at how it has got entangled into different subjectivities. It is precisely because the concept has travelled in different contexts that I have switched to travelling back and forth between

different sites (physically and virtually) instead of focusing on a pre-selected culture and immersing myself in that culture; in this way I engaged in 'a scouting for 'partial' and often ad hoc connections, neither the form nor the substance of which can be known in advance' (Atkinson et al., 2007, p51). In this way, I try to embrace ethnography 'as a textual practice and as a lived craft' (Hine, 2000) although the sense of 'being there' has been challenged.

Marcus's formulation of multi-sited ethnography highlights the need to track and follow the research object to different places in the world system, instead of being fixated in one research field site (Marcus, 1995). In fact, he argues that even in traditional ethnography, several sites are typically involved, without being explicitly pointed out (for example, the interviews could, and often do, happen outside of the designated field). This formulation implies an emphasis on the sense of space (as implicit in the notion of the field) as defining feature of ethnography, except with the broadening of the configuration of spaces, and a refashioning of the ethnographic 'subjects':

> The past habit of Malinowskian ethnography has been to take subjects as you find them in natural units of difference—cultures, communities; the habit or impulse of multi-sited research is to see subjects as differently constituted, as not products of essential unity of difference only, but to see them in development—displaced, recombined, hybrid in the once popular idiom, alternatively imagined. Such research pushes beyond the situated subject of ethnography towards the system of relations which define them. (Marcus, 2012, p19)

The 'subjects' are conceived to be displaced and hybrid entities defined by the system of relations. After all, cultures today do not seem to constitute units of difference, like it used to. They are spread out into places, constantly created, and recreated, 'fluid, inter-connected, diffusing, interpenetrating, homogenizing, diverging, hegemonizing, resisting, reformulating, creolizing, open rather than closed, partial rather than total, crossing its own boundaries, persisting where we do not expect it to, changing where we do' (Sanjek, 2014, p99). This tendency is dramatically intensified by the use of the internet, social media in particular, in everyday life. Thus, according to Hine (2011), 'Ethnography for the Internet can benefit from

being more open and more inventive about the choice of field site, enabling different kinds of connection to be pursued'. Following this, I considered my sites as 'multiple, mobile and fluid' and adapted my data collection methods accordingly.

At the same time, my focus on the concept (and the routes of travel it has taken) means I was still doing conceptual history at the same time, 'to traverse the terrain of the past as well as the terrain of the present, to include the dead among her interlocutors' (Atkinson et al 2007, p50). Therefore, in my (a little bit too zig-zag!) research journey it became necessary for me to turn from literary criticism, to conceptual analysis, to traditional ethnography, to eventually reconceive my ethnography as multi-sited and partially virtual (Marcus, 1995 & 2012; Hine, 2015).

3.2.5 Autoethnography

This thesis has gone onto a journey of tracing the concept of suboptimal health, and throughout the journey, I was the knot that ties the different parts together. At the same time as trying to give full weight to people' narratives, their stories, and the contexts they come from, "myself" is firmly part of this journey. I am part of the phenomenon I am studying too.

The ethnography conducted here thus has an element of autoethnography. According to Rashid et al. (2015), autoethnography highlights subjectivity and makes the researcher a participant at the same time. This is particularly true for this project. At the same time as conducting a study on the values and beliefs of other people, I have been reflecting on my own experiences and beliefs in relation to subhealth and indeed, my experiences and beliefs have undergone many transformations over the course of my PhD research, and this has featured in the thesis. Therefore, I have been retrospectively reflecting and analysing my own experience, seeing myself as a part of this culture with some facets of this cultural identity (Ellis et al. 2010). I have also been making use of my own personal narratives, viewing myself as "the phenomenon" to be reflected on (Ellis et al. 2010).

To some extent, this whole project started because of my encounter with Chinese medicine while I was (and still am) struggling with bodily symptoms such as trembling, and bodily swollenness, starting from the spring of 2015. After receiving no diagnosis from GP (in Edinburgh while I was doing my master's degree) and from a western medicine practitioner in China, I had two encounters with Chinese medicine, which I took half-heartedly (I took some Chinese herbs on and off and then completely stopped taking them, although I felt they helped to some extent). In this way, this research is to some degree another encounter in which I attempted to understand and treat my bodily symptoms, and I include my own stories and experiences as my qualitative data in the analysis. This also gives me a unique positionality and a somewhat enhanced reflexivity (I will expand on this in section 3.9 where I dedicate to reflexivity).

According to Ellis, Adams and Bochner (2011), there are many types of autoethnography, depending on "how much emphasis is placed on the study of others, the researcher's self and interaction with others, traditional analysis, and the interview context, as well as on power relationships" (p5). There is also the aspect of the doing of autoethnography (the process) and the writing of autoethnography (the product). The research process is explicitly autoethnographic. As I was tracing back in time the emergence and past use of the concept, it was an intriguing moment when I had the realization that a concept so natural to me which I had considered to have universal validity, was only used in certain periods and certain places, by certain groups. It is a concept that emerged and gained popularity in China as I was growing up, which is probably why it was unconsciously embedded in me. It further became a label that I unwittingly found for myself and one that seemed to make a lot of sense to me when some other labels failed me. Moments of epiphany like this has shaped my project and my thesis greatly and I am fully aware of 'myself' in the research and writing process. And indeed, it is my 'self' and my subjectivity that has shaped this whole research endeavour.

On the other hand, although I would have liked to have more space to write about my stories a bit more in the finished chapters about my changing perceptions of subhealth, my own life narrative and embodiments of subhealth, that unfortunately has not sufficiently taken place due to restraints in time. In any case, I've included quite some details about my story in the introduction of the thesis and I have tried to be aware of my positionality throughout the writing process.

3.2.6 A focus on tracing the knowledge making of the concept and a focus on lived experiences

At times, the focus on tracing the knowledge making of the concept and a focus on lived experiences seem to contradict a bit with each other. This project is interested in both theorizing about the concept in a disengaged way, and at the same time in engaging this concept in the lived world. Although I wouldn't call my methods philosophy, Jackson (2014)'s discussion of philosophy and ethnography might be relevant here. As characterized by Jackson (2014), philosophy is a result of distancing from the immediate world, but ethnography is 'a strategy for close encounters and intersubjective engagement' (p. 37). However, Jackson (2014) also emphasizes that 'this dialectic of engagement and disengagement is native to how we experience our being-in-the-world before it is consciously transformed…into the kind of disciplined and systematic reflection that characterizes the Western philosophical tradition' (pp27-28). This project follows this dialectic and will be conscious of this throughout.

My focus is on a conceptual orientation, but I constantly remind myself that I am talking about people's everyday struggles and searches for answers. It is within these that we find the concept of suboptimal health.

As I also mentioned, this project is also a process of me 'denaturalizing' the concept of suboptimal health for myself. Ultimately, I see my project as a postmodern critique.

According to Tamboukou and Ball (2003),

> 'The point of postmodernist critique is not to replace one form of''normal scienc'' with the strictures of a scientific abnormality but to introduce a constant instability into our assumptions about''doing researc'' and making theory. We must learn to research and to act without the comfort of epistemological certainties. It is about attempting to become''othe'' of what we already are. It is about disowning the ways in which we are spoken, about disidentification.' (p.104)

In what follows I will describe exactly how I gathered the different strands of data and how I analysed them.

3.3 Documentary analysis of the concept

I collected data about the emergence of this concept and its past uses. I did this through searching the concept in a variety of search engines, academic or otherwise, including my university's digital portal called Starplus, CNKI (the largest Chinese language academic database), PubMed (because I am interested in the use of the concept in medical discourse), Baidu, and Google. I collected texts with the concept in both the Chinese language (in which the concept is written as 亚健康) and the English language (with the key words of sub-optimal health, sub-health and subhealth). In particular, I used Google Ngram Viewer to collect data about its past uses. Google Ngram Viewer is a search engine that can search through a massive corpus of about 8 million books (6 percent of all books published since 1500, up until recent— the cutting point was 2008 but has been updated to 2009, and then to 2012), and it can also generate line charts of the historical changes in the frequency of the occurrence of certain words.

I used Ngram as a starting point to search 'suboptimal health' or 'subhealth' which produced snippet views of passages containing these words; I found around 70 sources throughout the 20th Century that mentioned either subhealth, sub-health, or suboptimal health (and use the terms to refer to a state of health, excluding occasions such as 'subhealth posts', or 'suboptimal healthcare'; there was also one source found in the 19th century constructing

sub-health as the opposite of super-health in a comment on magnetism).

Since I am interested in the use of the concept of subhealth in contexts and Ngram can only provide me with a cropped image of the paragraph the word occurred in, which is not enough for my line of inquiry, I used the entries found through Ngram as starting point and tried to look for those books in libraries, and the British Library has been particularly helpful. I made many visits to the British Library in London and in Boston Spa to scan the chapter/ section where the word occurred. Using Ngram has helped me to trace the concept in historical periods and places that I thought the concept did not exist in.

After this I tried to look for those books in libraries, mostly in the British Library, to gain an understanding of the contexts of the relevant texts, and I found 34 of them in the library and made scans of the pages with the term for analysis. Those texts are, without exception, all situated within a public health context. To trace the origins of the concept, it became necessary to search documents produced by the WHO, as it is commonly referred to as the organization that coined and operationalized the concept. I searched on the WHO website for all the documents published by WHO and found around 10 sources mentioning 'suboptimal health' or 'subhealth' as denoting a state of human health. I excluded occasions when the texts mention suboptimal health outcomes or suboptimal health practices or suboptimal health infrastructure.

3.4 Participant observation at the TCM conferences

Observation of three Chinese medicine conferences were conducted to have a view of the discursive use of this concept in a research context.

After an initial search online, I decided to attend the 16th World Congress of Chinese Medicine and its associated academic event 'the Belt & Road TCM Academic Communications', which took place in Budapest in November 8-9, 2019 hosted by World Traditional Chinese Medicine Pharmaceutical Association Federation (世界中医药学会联合

会). Under the guidance of State Administration of Traditional Chinese Medicine of the People's Republic of China, this is one of the largest TCM conferences in the world, and I thought it would be a useful avenue of data collection to examine the contemporary knowledge making of Chinese medicine and the role of suboptimal health in it. I attended this conference in person and conducted participant observation there (by this I mean I attended the conference and chatted to people about the concept informally, while acknowledging my identity as a PhD student collecting data about 'sub-health'). I got some opportunities to mingle with TCM practitioners at lunches and the conference dinner and ask about their views on suboptimal health. The theme of this conference is 'Disease prevention strengthens people's aspirations, health and harmony are linked to the fate' ('防病强身民心所向·健康和谐命运相连'). The title of this conference suggests a close affinity with the connotations of suboptimal health.

After the pandemic started, almost all conferences that continue to take place have switched to online mode. It is in this context many Chinese Medicine conferences started a hybrid format and started streaming the conferences to the public as well as offer recordings of the conferences online as a way to increase its influence. Therefore, I conducted additional data collection at a conference called '2021 Academic Annual Meeting and General Election Meeting of Sub-health Branch of China Association of Traditional Chinese Medicine' (I will call it 'subhealth conference' in the next chapter where I dedicate quite some space to discussing data from conferences) which took place 10-11 April 2021 in Bo'ao, Hainan in China, held by Chinese Association of Chinese Medicine (中华中医药学会) as well as the Sub-health Branch of Chinese Association of Chinese Medicine (中华中医药学会亚健康分会). This is a conference dedicated just to subhealth, and its host institution, Chinese Association of Chinese Medicine (中华中医药学会), is the largest academic organization of

Traditional Chinese Medicine in China.

Due to the affordances of the technology, I attended this online as it was live-streamed and viewed its recordings as they have since been made available to the general public. Similarly, on 4th December, 2021, The 18th World Congress of Chinese Medicine, organized by the World Federation of Chinese Medicine Societies (WFCMS), was held in Hong Kong, China, with the theme of 'Chinese Medicine for Human Health - Opportunities and Challenges for Global Chinese Medicine' ('中医药惠及人类健康 - 全球中医药机遇与挑战'). This is during the final stage of writing up my thesis, so I attended this conference to have an idea of the topics covered at the conference and to see if there are any significant differences or new developments (it seems that this conference is still largely in line with other two conferences) but did not have time to conduct detailed analysis of the talks.

The conferences have proved to be valuable sites for me to trace the concept (although it did not feature much in the first conference, and is the centre of attention in the second), to see how 'sub-optimal health' is incurred (or not incurred) in Chinese medicine discourse, how it is used in relation to a bio-medical discourse.

3.5 Ethnographic work at the clinic

3.5.1 Participant observation

According to Hammersly and Atkinson (2007, p.3), ethnography involves participating in a certain group's daily undertaking in an overt or covert manner, for an extended time frame, 'gathering whatever data are available to throw light on the issues that are the emerging focus of inquiry'. This methodology is meant to facilitate an in-depth understanding of a certain culture including the 'beliefs, values, and attitudes that shape the behaviour of a particular group of people' (Merriam 2002, p8). It is typically conducted with the means of taking notes of conversations, behaviours as well as the researcher's own experiences (Van Maanen, 1995). Jorgensen (1989) comments that participant observation is a very suitable method to

collect data on relationships, interactions, processes and organizations, as well as the social and cultural contexts, and it is suitable for my project. During my fieldwork, I have been collecting documents from the clinic, taking notes of my conversations with the doctor and the other receptionist, and reflecting on my work practice and experiences.

There are different positionalities in ethnography and for the fieldwork in the clinic I have taken on the role of participant-as-observer for my participant observation, which means that the researcher aims to integrate in the culture whilst acknowledging their research identity (Jones and Smith 2017). This is because before I officially started my ethnography, I have already integrated in the setting taking on a role already existing in the field, the receptionist, and I still needed this income even after I started my research in the clinic. This means that my time in the field would necessarily involve some participation. After I started my ethnography, I fully acknowledged my role as a researcher to the visitors. I have also left a few copies of my information sheet around in visible places in the clinic to introduce my project.

The main methods adopted during the process are participant observation at the clinic, observation of the consultations, as well as semi structured interviews outside of the clinic with the visitors (mostly in cafes, later some with the method of phone call due to pandemic). I also initially intended to invite the participants to write a body log of what they feel in seven days, and then analyse the body log as well as interview the participants based on the body log but this turned out to be an option that most of my participants were not interested in taking up, and for the one person who did the diary, the data was not deemed that relevant. The outbreak of COVID-19 significantly reduced the number of visitors to the clinic and the clinic was closed for a bit; there are also some visitors who switched from coming to the clinic for treatment to ordering herbs and asking us to post the herbs directly to them. Most of my participants either stopped visiting, or just started to order herbs online with us. This

caused some difficulty to the observation of consultations, so as it turns out, participant observation and semi structured interviews became my main methods, and I had to explore other possible field sites as well.

3.5.2 Interviews and observations with visitors to the clinic

Sampling Strategy

Initially, I consulted the doctor about the main types of syndromes people visit the clinic for and discussed which of those syndromes are classified as 'sub-healthy' by the standard of the doctor. This formed my ethnographic data to investigate the way 'sub-health' is used as a diagnostic criterion by the Chinese doctor in her medical practice. I was initially planning to invite the doctor to think of some potential candidates that match her definition of 'sub-health' and ask the receptionist to pass on the information sheet to them and ask them whether they are interested in taking part in my project. The idea was that the other receptionist would act as the gatekeeper who contact and recruit for me because this way any risk of coercion can be avoided (in case the authority of the doctor makes visitors feel pressured to take part). After starting the recruitment, I realized in order to recruit enough participants it may be better not to rely on the doctor on deciding who fit the criteria of subhealth and it may be better to just disseminate the information sheet and let whoever think they fit subhealth contact me – and this is what I ended up doing.

Therefore, I left my information sheets at a corner of the clinic. On the days when the clinic was open, either me or the other receptionist would make the visitors aware of the existence of the information sheets and whoever was interested would take a copy home. Then I waited for people to contact me and then I would arrange their participation individually with them.

Conducting the interviews and observations

In the end, I recruited 7 interviewees from the clinic. Six of them are white British, 4 females and 2 males, all in their 60s-70s. The other one is Chinese ethnicity but British citizen, female, in her 50s, having migrated to the UK decades ago. With all of them I conducted an initial one-hour face-to-face semi structured interview, and with four of them I conducted a second interview. With three of them I observed their consultations with the doctor, but that got halted because of the pandemic. Some interviews were face to face, and others were through either WhatsApp audio chat or phone chat, due to the outbreak of COVID-19. One of the three also wrote a body log and we had our second interview based on the body log. I have also conducted three formal interviews with the doctor (and around half a dozen of informal chats with the doctor) and two interviews with the other receptionist (and some occasional informal chats). I also observed consultations of three of the participants.

As Ojermark (2007) commented, the terms 'narrative inquiry' and 'life history' are quite similar, both drawing on personal narratives as research data, with the data being co-constructed by both the interviewer and the interviewee (thus different from personal stories, which refer to narratives that emerge without the input of the interviewer/researcher). Riessman (2001) sees life history research as a method that turns away from a traditional emphasis on objectivity, privileging and celebrating subjectivity and positionality and in this sense it is fitting method for me to explore the subjective encounters and experiences of health. Turning away from a positivist tradition and refraining from asking why-questions, the `life story metho" privileges an interpretivist viewpoint, studying 'how a person lives a life in a culture' (Plummer 2010, p141). This thus has implications as to how the interviews will be conducted – typically as 'open and in-depth interviews in a highly active and interactive fashion' and only a very general interview guide is needed (Plummer 2010, p140). An open-ended question can be asked in the beginning to allow the interviewee to start

talking and minimum input from the research is needed subsequently during the narration (Atkinson 1998 and Morse 1998, Plummer 2010).

The interviews with clinic visitors involved semi structured interviews with participants during several sitting and over an extended period of time. The interviews were conducted with two goals – to elicit people's experiences of their health (with an effort to establish whether they know or understand sub-health in any way at all), and to elicit personal narratives in relation to their health status and their visits to the clinic. To be more specific, I conducted my interviews with an emphasis on enquiring on the actions, events and circumstances in those particular individuals' lives that led them to come to different conclusions about their well-being, their own encounters and stories with the clinic and how these encounters influence how they view their health. I started the interviews asking them about their life history of coming to visit the clinic ('Could you tell me about how you come to visit the clinic?'), whilst also inviting them to talk about their lived experience of their body and health status at (and near) the time of the interviews ('How do you feel today?'). In this way, my interview is interested in the personal narratives of the interviewees and will loosely fall under a narrative inquiry or life history methodology.

In the beginning of my interviews, I often would invite the participants to talk about their experiences with open-ended questions and leave them the freedom to take the conversation where they wanted. During the interview process, I aimed to leave as much freedom for the participants as possible. Some open-ended and vague questions and prompts were given with the aim of inviting patients to share their stories of how they had come to visit this clinic, their encounters with Chinese medicine, their lived experience of their bodily symptoms, and their perceptions of their health statuses. I mainly took on the role of the listener, listening to them closely, and giving them as much freedom as they wanted. I would only probe occasionally, whilst sometimes asking for some clarification (or sometimes with facial

expressions) to lead them to talk more.

The pandemic caused a temporary halt to my fieldwork in the clinic and my interviews and this is parallel to when I came to realize that the most of the participants are not aware of the concept but they participate in the bodily practices that for me would involve some understanding of the concept. As soon as I mentioned the concept and provided some explanations of the concept (I only did this towards end of my interview – I started the interview asking 'how did you start to visit the clinic?'), a few of them immediately started to relate this bodily experiences to this concept and start to make sense of their past experiences within the conceptual space, which makes me aware that they may not 'have the concept' in the first place, and also that this concept, its linguistic construction, and the fact of it being quite vague, seems to have an inviting characteristic for people to implicate themselves in the concept. I also realized I need to look for other cultures in addition to the clinic, with people who already 'have the concept'. Thus, at the same time as continuing fieldwork at the clinic, I started hunting and tracing the concept again (more on that soon).

3.5.3 Diary study

Reis (1994) argues that diary methods allow data to be collected in a natural context. As a result of this, the time between the occurring of an experience and the telling of that experience is minimized as far as possible to capture real-time lived experience. It is therefore a suitable method to be incorporated in my research to explore people's introspection of health/well-being/discomfort related experiences in their natural occurring, which will then generate useful prompts for people to reminisce about their bodily experiences and talk about those in depth during the interviews. There are however some challenges for such a diary study. There can be difficulties in recruiting participants for this part, and the frequency of diary taking often has to be carefully considered to capture

experiences in full (Bolger et al 2003).

It was because of these challenges that I initially planned to include the diary study as part of the interview by combining it with the interviews. In this way, before the diary study, the participants would have talked about their lived experience of their bodily symptoms and I could communicate to them my wish to see in writing something similar, perhaps in more detail, recorded in real time. The rapport eventually build with the interviewees would enable me to work with them to write diaries. Moreover, the interviews might pave the way for the diaries and make jotting down diaries easier for them, whilst at the same time the diaries could become interview prompts to contribute to the depth of the interviews.

Due to the pandemic and its impact on my fieldwork at the clinic, including to the interviews, the diary study did not take place as expected. Only one participant wrote a diary/log to record what they feel/ what pains they have/ what health worries they have in real time and showed it to me, and we conducted the second interview based on it. And she mentioned that she already has a habit of taking a body log because of her IBS. Although this data did not get included in my final analysis in the thesis because of its lack of connection to the concept I am studying. It triggered my interest in looking at people's record of their body in natural contexts, in real time, and the ethnography I later conducted on Chinese social media to some extent, can be seen as that.

3.6 Interview people brought up in China

After the beginning of my research, I have become aware of and reflexive of the fact that I grew up in China at a time when the concept was widely invoked in mass media advertisements have shaped my current research pursuit and had previously contributed to 'naturalize' the concept for me, and the pandemic has been a turning point for me to consider to include people 'like me' 'from my culture' into my sampling, and to expand and mobilize my sites of ethnography.

3.6.1 Sampling Strategy

Since I am trapped in Sheffield and cannot make it back to China to conduct fieldwork in China, I have decided to recruit participants remotely. Since I wish to collect data about people's understanding and hopefully experiences of subhealth, which requires a level of trust between me and the interviewee, I decided that it is better for me to recruit from my existing contacts of families, friends and acquaintances who might have something to share about the concept of subhealth; after those interviews, I plan to ask the interviewees to link me up with their family, friend or acquaintance who they think might be interested in participating in the project (in other words, snowball sampling). Although it is not a very sensitive topic in Chinese culture, it is easier to elicit stories and experiences if I know the person already or if we have common connections, and snowball sampling a method suitable for scenarios where trust is needed from the side of the participants (Geddes, 2019). Geddes (2019) also comments that snowball sampling is used to access 'the everyday, mundane, and mainstream', and the topic of sub-health fall exactly into this category (in the Chinese context).

After making a modification to my ethics application, I started to chat to my friends on WeChat (the social networking app similar to WhatsApp, and it has an inbuilt function for sharing everyday life, which is called 朋友圈(Friends Circle, if literally translated, the official translation being Moments). This is the social media platform that I use on a daily basis – almost my dominant connection with my family, friends and acquaintances from back in China.

I made a post on 朋友圈(Friends Circle) in which I asked 'hey folks of my friends circle, has any of you ever had the moment of feeing sub-optimally healthy? (求问朋友圈的大家，会有觉得自己是'亚健康’的时刻吗？)’. I got 12 people replying to this post saying that

they have.

One of them said: ‘every time when I touch my fat belly (摸摸自己肚子上肥肉的时候).’

Another said, ‘Yes, I always stay up late and not exercise （有 经常熬夜 不运动）.’

Yet another said, ‘every minutes.’

And another friend commented, ‘does it count as feeling sub-healthy if I suspect I have COVID-19 everyday? （天天怀疑自己 COVID-19 算吗？）’

Another reply: ‘I can’t even open my eyes but I am going to watch another video from Tik Tok. （睁不开眼睛但是还是要再刷一条抖音）’

‘Yes, and sometimes I visibly feel on the borderline 😁. (有，有时明显感觉处于极限😁)’ .

And there are a few others.

And I decided to take this as a starting point for my participant recruitment, from which I would snowball. I also later made another WeChat posts asking ‘has any of you felt like you are in subhealth’ and asked people who replied to my post whether they are interested in taking part in my research.

Note the subjectivities under this post are textual and fragmented, but the moment I recruited them for interviews they also became subjects/subjectivities from a culture (?) who I intended to listen to and understand (with the assumption that they are coherent). Actually, among the people who replied to this post, there is my dad. He replied, ‘Yes, and sometimes I visibly feel on the borderline 😁. (有，有时明显感觉处于极限😁)’ . The moment I saw this post it immediately made me feel guilty, particularly due to the smiley face, which seemed a bit odd to be at the end of this sentence. For the young generations like me, a

smiley face is sometimes meant to convey a sense of irony, but it seems that for the older generation, smiley faces tend to be used unironically in online exchanges. When I started to ask people who replied to this post whether I could interview them, I thought of whether I should ask my dad and it seemed to me that it is something I will eventually do but I felt I was not yet ready. I feel it is something I will eventually be ready to do towards the end of my project. The sense of guilt is complicated, and the story of how that is related to the concept of sub-health will be told in detail later. But the feeling that I have to come back to my most familiar (personal) arena last reminded me acutely of my positionality. It is to some extent related to me being insider of the culture I am ending up researching on but also at the same time outsider (and I am an outsider exactly because I am away from China working on this doctoral project, and this sense of being away eventually give me a pair of 'new eyes' to look back on my own culture with, so that I could look at it with some distance). At the same time, this process brings me further away, which paradoxically means closer, to my personal dilemma (now that I think about it my educational choices since university has involved my constant and subtle effort to rebel against my dad and to make myself an outsider of my culture). This reflection reminded me of the two ethnographic strategies mentioned by Hammersley and Atkinson (2007): the 'anthropological destrangement' (to make the unknown known), and the 'anthropological estrangement' (to make the known unknown), which involves an intricate balance of being insider and outsider – to distance myself from the culture and then also to try to fit in.

Since I have turned to my culture, I have tried to be ultra-aware of myself, my positionality, my story and how it has shaped my research pursuit. My own subjectivities entangled in other subjectivities – my subjectivity interpreting other subjectivities (with an effort to do it in a way that has validity and reliability) but also look back at itself (and people who are close to the core of that self – I also remember thinking to myself that if I do decide

to interview my dad about sub-health, it might get pretty personal and any of my pretence to objectivity will crumple – I did not come around to interviewing him).

Although my plan was to maintain an inclusion of people from different backgrounds and generations, conducting short interviews with a targeted number of people (the plan is around 30 people from China, in total), while zooming in on individuals who have more to share about the concept to conduct multiple interviews. After I started interviewing it became clear that it is a concept young people have more to comment on, so I zoomed in on the younger generation.

I interviewed 24 people, 22 being in their mid to late 20s or early 30s, only 2 from the older generation, in their 50s. My data analysis focused on the 22 young people. Those 22 are all young people university level educated or beyond, living either in cities or outside of China. All 22 are from my primary contacts from WeChat. This is partly because I have quite many contacts on WeChat (around 1000), and making WeChat moment posts to invite participation has proved to be effective. I only recruited people who are from China and grow up in China in their formative years. Some of them may be temporarily studying or working overseas, but they have spent most of their life in China.

3.6.2 Conducting the interviews

The interviews were a mixture of semi-structured and unstructured interviews that were all conducted on WeChat. They are mostly in the method of Wechat audio calls, but with one person audio messages are also used as a way to conduct the interviews, since that involve significantly less time commitment and efforts from their part and can feel more spontaneous.

For those who do not relate to the concept on an embodied level, the interviews were short, around 10-15 mins on average, where I collected data on their views and opinions of the concept and where they encountered the concept.

For those who have embodied experience of subhealth (around half of the total number),

the interviews are much longer. Similar to the clinic interviews, I gave space for the interviewees to tell me about their life stories, and I mostly just listen and encourage them to speak. They are around one hour, and some of them last even two hours. With two of the interviewees, two interviews were conducted as they had a lot to share (also perhaps because we are closer friends).

3.7 Ethnographic data collection on the internet

As mentioned, the coronavirus crisis posted significant challenges to my data collection at the clinic, which has also turned out to be a good time for me to include people ‘like me’ ‘from my culture’ into my sampling, and to expand and mobilize my sites of ethnography.

An initial search on Weibo[8] has found it to be a platform where conversations and reflections about subhealth organically take place frequently. There are standard and boring promotional texts. There are personal narratives randomly thrown on the web, personal yet public. There are also some public figures (or social media influencers) on Weibo who mentioned the term ‘亚健康（suboptimal health）’, fleetingly. The concept also got caught up quite a few current affairs, notably, health in COVID-19, mental health awareness, health code（健康码）, and so on. It gives me the impression of an entanglement of voices, practices, and politics, on a vast and messy online space.

Drawing on Hine (2011 & 2015) and Kozinets (2015), I decided to conduct digital ethnography, instead of using social media methods which tends to be more quantitative.

As commented by Hine (2015), traditional ethnographical research activities still apply within the more multi-sited and multi-modal version of ethnography but some creative

8. Weibo means microblogging, but Sina Weibo has dominated the microblogging scene in China that we usually refer to it simply as Weibo.

adaptations are necessary. I firstly immersed myself for a period of time in Weibo. From November 2020 to April, 2021 I searched the keyword '亚健康(subhealth)' on the platform on a daily basis and take screenshots as well as make field notes about the posts I see. In this way, I get to encounter the concept in its natural field to see it unfold in time and in the vast backdrop of the internet, and it could also help me with 'finding out how sense is made out of the ineffable' and in turn may help me 'carve out arbitrary field sites' on Weibo (Hine, 2015). This resulted in a huge number of screenshots, which I then compiled in a pdf making it easier for analysis. The pdf file became 400 pages long. I felt data saturation at this point.

After this period, I still do the same activity but at a much less frequent basic, in order to keep an eye on whether there is any new reiteration and development.

Some other social media platforms (Douban and Zhihu) are also included to supplement the data collected from Weibo because I am an avid user of social media, I incorporate the search for subhealth into my daily browsing activities. I have always been paying attention to the concept in my own daily usage of different social media platforms.

3.8 Data analysis methods

I have mentioned data analysis in the process of describing my data collection methods, but since my methods consist different range of data and it has to some extent go (multi-sited) ethnography by combining conceptual history, narrative interviews, I will dedicate this section to a more sustained discussion of my analysis methods. According to Hammersley & Atkinson (1995), analysis is an iterative process which starts with a careful reading through of all the data and identification of patterns or puzzling aspects in the data. They also mention the process of examining whether the data match expectations, and a sensitivity to inconsistencies and contradictions. The research then reanalyse the data to either firm up some categories or to come up with new categories. This is what I did for all my data.

In this way, thematic analysis is the main analysis method. While sorting through my

diverse data, I look for themes iteratively. As Malterud (2001) reflects, qualitative research usually involves the co-existence of data collection and data analysis. Throughout the research process, I took care to organize my data, taking notes of my evolving coding schemes and reflect on the process constantly. Since my project is to some extent looking for subhealth in different places and mapping its usage, it was important for me to look for the common themes among all data as well as look for particular themes depending on different kinds of data. For all the data, I use the following questions to guide the thematic analysis: How is 'sub-health' defined? How is the concept of 'sub-health' communicated and understood? What does the concept 'do' when it is invoked?

It is worth noting that semasiological and onomasiological approaches are drawn on in my analysis. The semasiological approach consists in considering different meanings of the same word/linguistic construction, and I have looked at different meaning of the term suboptimal health. At the same time, I have also looked at other terms that may mean the same as suboptimal health and that is the onomasiological approach - analysing different words correlated with the certain object or idea (Hampsher-Monk, Tilmans and Vree, 1998).

Since my project involves different types of data, I initially tried to keep all my data in Nvivo but due to it running too slow on my laptop, I later switched to an app called Liquidtext. Where I can, I try to keep all my data as digital data and to put them into the app. For example, I compiled all the collected social media post screenshots as a several pdfs and input them in the app as well. The app allows me to draw out the common themes among all data in a separate workspace and allows me to arrange and rearrange emerging themes. Some of my data, such as physical fieldnotes and documents collected from field sites. I analysed and input the themes together with other analysis in the workspace in Liquidtext.

Just as argued by Riessman (1993), the kind of access people have towards their experiences are always mediated and narrated and narrative analysis can therefore serve as a

fitting way to analyse experiences, which is why I adopted narrative analysis to make sense of people's personal experiences of suboptimal health. To some extent, the exploration of the concept of 'suboptimal health' is inevitably entangled with the study of the culture of Chinese medicine, the storying of the individuals who seek Chinese medicine potentially mediated by the concept of 'suboptimal health'.

The analysis of the interviews and the social media data have a focus on the emerging themes and the narrative construction. Behar (1990) comments: 'A common misconception about life history texts is that they speak for themselves and can be used as a neutral tool through which to demonstrate certain phenomenon'. Therefore, in analysing the life history data, I adopted a narrative approach and remained aware of them as narratives. In my analysis, I analysed them within the cultural framework of those participants and pay attention to the way they structure their narration, avoiding the mistake of treating the data as 'a disposable commodity of information' (Behar 1990). I am also reflective of my own contribution in the narratives with the means of probing questions. After all, the story and the storying practice is hard to distinguish (Gubrium and Holstein 2008). Therefore, I conducted narrative analysis of the story structure as well as the storying practice, including the 'communicative conditions and resources surrounding how narratives are assembled' (Gubrium and Holstein 2008).

As I have mentioned before, my interviews are trying to understand experiences of their health (sub-health), and to elicit personal narratives in relation to their health status and their visits to the clinic (for the clinic interviewees) or just in the context of their everyday life (for the Chinese interviewees). This means that narratives and lived experiences of sub-health are often entangled in those interviews. Due to this, I approached the analysis with a particular approach that mesh narrative analysis with phenomenological analysis. Havi Carel (2016) proposes a particular phenomenological approach in analysing the lived experience of illness,

which will be drawn on as a guide in my narrative analysis. When writing about the reason to use phenomenology to analyse illness, she writes,

> 'Illness is a breakdown of meaning in the ill person's life. Because of the disruption of habits, expectations, and abilities, meaning structures are destabilized and in extreme cases the overall coherence of one's life is destroyed'. (p.14-15)

Therefore, she proposes to view illness as a 'deep phenomenon' that will reveal 'patterns of embodiment' and their disruption, which is fundamentally narrative as well as phenomenological (Carel 2016). Although Carel focuses on more serious health conditions in her definition of illness, I propose that her approach is also application to the conditions that may fall under 'sub-optimal health' and I have a focus on the relation of subhealth experience to the person's biography. The data will be analysed while thinking about the following questions: How is the 'doubleness' of health and sickness experienced subjectively? How do people negotiate between gray areas such as 'not healthy enough' and 'not fulfilling the disease criterion'? How is this entangled with their decision to seek help of alternative medicine, and what role does this decision play in their lives?

3.9 Reflexivity

To some extent, it is my naivety about the social and cultural context of subhealth that has given birth and shaped the project. This project is a process of me finding out more about the concept and finding out more about myself. Being an insider and being exposed to the concept from an early age and all the claims of it being a universal construct has shaped my research pursuit. It is such naivety that has made the project possible in the first place.

I am also aware that it is my encounter with the Chinese medicine clinic and the label of 'subhealth' that led to the fact that I chose a Chinese medicine clinic as the site to trace and investigate this concept. It is my identity as a person growing up in China during 1990s when the concept of subhealth was popular that got me to suspect whether the concept has in some

way shaped my experiences of health and it is in this context I started interviewing people from China and turning to social media. In this context, being a qualitative researcher, I am the 'instrument' in conducting the research, or from my perspective, a knot that ties the different elements of the research together. In this section I will reflect on my positionality in the clinic, and with my Chinese participants.

By the time I formally started my project, I was already working as a receptionist. I try to be reflexive of my position as a Chinese woman working as a receptionist in a Chinese clinic and doing a PhD at the same time. This leads to the fact that I was sometimes perceived to be an insider that has some knowledge of Chinese medicine by the visitors and some visitors assumed that I am studying Chinese medicine at university, as I'm sitting at the desk of the receptionist and picking up some mysteriously looking herbs. In fact, I have never received acupuncture nor taken any Chinese medicine consistently. I am always aware that I do not possess enough knowledge of TCM and I was not really in a position to learn about medicine or practice it in any way, and try to make that clear to the visitors. Still, an affinity is created because of such a positionality.

I think the trust visitors have of me being an insider but also the desire to help a student has shaped the recruitment and of the interviews. All of the participants I recruited from the clinic are those who visit the clinic regularly, so I had already seen them regularly in my capacity as the receptionist, and that resulted in a level of trust. Most of them have very strong beliefs in TCM. I have been very outspoken about the fact that I do not know that much about Chinese medicine, but I think the fact that I am from China and can speak Chinese, and the fact that I had worked at the clinic for a while with the doctor still make them think of me as somewhat of an insider. During the interviews, it became clear that most the visitors (all but one) have not heard of the concept and the conversation became focused

on their experiences of visiting Chinese medicine as well as other alternative health practices, their life narratives, and their understanding of health.

On the other hand, I was an employee at the clinic, so the doctor was essentially my boss. My ethics protocol required me to switch to the identity of a researcher when I collect data so during my interviews with the doctor, my relationship with her was more like a student with a teacher. Three of the interviews with the doctor are formal ones that took place in the clinic room when she was sitting by her desk and I was sitting at the seat which is usually occupied by the clinic visitors. There is also a constant struggle between medical knowledge that the doctor tries to impart on me and me trying to think through the situations and their philosophical/sociological implications. I am also aware that my presence could have led the doctor to think more about her practice through the lens of suboptimal health.

The participants from the Chinese context are all recruited from my WeChat contacts or through contact of a contact and there is already a degree of familiarity before the project started. Since I have been open in posting what I am studying on Chinese social media (in fact, I am quite active on Wechat in posting about my life as a PhD student) and have posted a few times to ask people in my WeChat contact whether they have felt subhealth, the participants would have already had some knowledge of what I am doing. I also share very similar social and cultural backgrounds with my participants. We are all 20-30 something olds from China, having received higher education. I am an insider among my interviewees from China, and we share to some extent a common understanding of subhealth. And that is why they trusted me to their reflections on subhealth. In a lot of the occasions, they refer to me as an expert in subhealth assuming that I know about it. I make sure to let them know over and over again that I do not actually know any more than they do, and I am only interested in hearing their stories. I try not to talk much during the interviews and give them the space to lead the conversations.

Since the concept of subhealth occupies a liminal space in people's lives, and in my research, I had to navigate this liminality because only a small parts of their lives are relevant to my endeavour to unpack this concept, but as a researcher, drawing the line has created an emotional burden and has led to a sense of vulnerability among nets of 'thick and thin description' (Marcus, 1995 & 2012).

3.10 Ethical issues

There are several ethical issues to consider for this study, due to the complexity of my data collection methods.

First, participant observation in the clinic requires careful consideration. It has been acknowledged that my presence as a researcher in the clinic may alter the process in the field, which is a common challenge associated with participant observation. Hammersly and Atkinson (2007) remarks that 'rather than engaging in futile attempts to eliminate the effects of the researcher completely, we should set about understanding them' (p.85). I have been trying to remain reflexive of my role and my identity, and constantly reflect on how my presence may impact on the dynamics in the field. In fact, there is one thing I constantly wonder–- did my mentioning of the concept of subhealth in my initial job interview impact on the way the doctor talk about it? If there is an influence, wouldn't this also be part of my data.? After all, what I am interested in is not to find 'the truth about the world', but to observe how people observe the world. This means my research is a second order observation.

On the other hand, it is worth noting that the nature of life history method requires effective communication to probe into particular lives while maintaining full respect of privacy and personal boundary (Abubakar, 2008). Although this is not a health care project, it does take place in a health care setting and some sensitive topics might come up in the interviews. To manage this situation, I made it clear to the patients that they can share as

much or as little about their lives and personal experiences as they wish. I do not probe about any sensitive topics but only be a listener on this occasion. I made it clear to them that they have the freedom to ask me to delete the data about those sensitive topics. I tried to an empathetic listener that fully respect other's personal boundaries. Full written consent has been obtained from all participants and I treat obtaining consent as an ongoing process.

There are also some ethical issues arising from the auto-ethnography. Ellis (2007) highlights the importance of 'relational ethics' in auto-ethnography because the researcher does not exist in void – the researcher exists in communities, connected with others. One risk of autoethnography is that when I reflect on my experience, other people in my stories may become identifiable and their privacy may be undermined. To address this, I made sure that I refrain from giving any identifiable information for people in my stories.

Last but not least, I carefully considered the ethics of collecting social media data and any potential harm this may cause to the participants. Although all the data I collected are from platforms where information is publicly available, I agree with Boyd and Crawford (2012) that 'it is problematic for researchers to justify their actions as ethical simply because the data are accessible.' Following ethical guidelines formulated in *The University of Sheffield Research Ethics Policy Note no. 14* and in *Internet Research: Ethical Guidelines 3.0* put together by AoIR (Association of Internet Researchers), I fully anonymized the social media data by not mentioning the username of the person or any personal information in the post. When directly quoting the social media posts, I will use English translations without providing Chinese original words, so that there is no possibility of searching for the person and find the person who posted it, which can eliminate any potential harm.

3.10.1 Consent

I obtained consent from the doctor to conduct participant observation in the clinic as this

clinic is owned and managed by her. After the ethics approval, I sent my proposal for the PhD project to the doctor, as well as a briefer information sheet to her, and describe the aims and purposes of the project to her in Chinese (she is fluent in English but native in Chinese). Similarly, I attained informed consent before all my other interviews.

In the information sheet, I mentioned that my project is a social science project to make it clear that it has no medical purpose and has no relation to the treatment they receive at the clinic. I mentioned that this project aims to investigate people's understanding of health, by hearing their personal stories and their feelings of their health statuses. I made it clear that they have complete freedom to choose whether or not to take part in the research and if they decide to participate, they can choose which parts to participate in, if any. The visitors who visit the clinic are mostly literature in English, but in case some of them are not too proficient in English, I have attached a translated version of the information sheet in Chinese to help them to understand. I also made sure participants are aware that taking part is entirely voluntary and that refusing to take part will have no impact on their treatment at the clinic. They are free to withdraw at any time and that withdrawing will not affect their treatment. They were also told that any data collected from them will be anonymized. Participants can choose a pseudonym for themselves, so that they cannot be identified by anyone, but in the future, if they read my work, they can know which person is him/herself (a few of my interviewee did take this up and picked up their own pseudonyms).

After getting their informed consent I started my observation and interviewing, but I also treated consent as an ongoing process and made sure check their consent every time before I observe a consultation between the doctor and the visitor, and every time before a new interview session.

At the same time, consent for participants at the Chinese conference is a bit different in the sense that it is a public space, and it is impossible to ask for every one's consent. *The*

University Ethics Guideline (p.39) from University of Sheffield also states that ‘in certain types of research obtaining consent from every individual present is neither practical nor feasible’ and in this context, this project followed the advice of the guideline and seek the approval of relevant authorities, that is, the conference organizers. For the Budapest TCM conference, I emailed the conference organizer beforehand and checked with them when I was getting my conference badge. I also made sure whoever I talk to are informed of my research arms and give them the chance to opt-out.

3.10.2 Confidentiality

All interviews have been anonymised by removing any identifiers from it, and storing these separately in an encrypted database, or locked cabinet.

Because people visiting the Chinese medicine clinic is a small community it will be quite difficult to guarantee their anonymity. However, I will not mention the name and address of the clinic, instead I will just mention that it is in England. In this way, their anonymity will be guaranteed.

Although the doctor may not mind being not anonymized, but for the anonymity of the patients, I have given a pseudonym for the doctor.

Floyd and Arthur (2012) also note that insider anonymity is particularly tricky. They cited many examples in which the institution is easily revealed although the researcher has taken pains to protect the anonymity of the institution, and they argue that ‘internal ethical engagement should require researchers to work on the assumption that the site of their study cannot be anonymous’. In order to protect the anonymity of my site, I only mentioned in my thesis and in any presentations of my work that it is in England, but when it comes to protecting the identities of my participants, I will work on the assumption that the site is not anonymous, and I will take extra measures to protect their anonymity. I may redact the

narratives if there is a danger of someone recognizing a particular story.

3.11 Conclusion

I have presented my different data collection methods, and this table could hopefully make it clear which data the following four data chapters draw on:

Table 3.3: Chapters and corresponding data

Chapter	Main source of data
Chapter 4	Participant observation at three TCM conferences.
Chapter 5	Collection of documentary data on suboptimal health/subhealth in public health literature across 20th and 21st century
Chapter 6	Ethnographic fieldwork at a TCM clinic in England. Virtual ethnography by immersing myself on social media and collecting data from social media platforms including Weibo among this. Interviews with people brought up in China
Chapter 7	Virtual ethnography by immersing myself on social media and collecting data from social media platforms including Weibo among this. Interviews with people brought up in China

Chapter 4: The knowledge making of subhealth in contemporary China: at the intersection of Traditional Chinese Medicine and public health

This chapter seeks to unpack the knowledge production of the concept of subhealth in the contexts of Chinese medicine, public health, and consumerism. It seeks to examine efforts to standardise such a vague concept, in urging people to pay more attention to health, in promoting the usefulness and relevance of TCM, or promoting products that supposedly tackle subhealth. It is to some degree a cultivated misunderstanding among different actors, to be shaped as either Chinese or Western, or neither Chinese nor Western. The chapter begins by exploring how the term ‘sub-health’ became bound to the modern undertaking of traditional Chinese medicine, only to be discarded. The commercial origin of the concept is masked to some extent, but at the same time celebrated, thus illustrating its instability. However, this also explains, to some extent, why the concept has been so successful.

I draw on the data collected from The 16th World Congress of Chinese Medicine, which took place in Budapest in November 8-9, 2019 hosted by the World Traditional Chinese Medicine Pharmaceutical Association Federation (世界中医药学会联合会), as well as additional (online) data collected at another conference, the ‘2021 Academic Annual Meeting and General Election Meeting of the Sub-health Branch of the China Association of Traditional Chinese Medicine’ (hereafter referred to as the ‘subhealth conference’ in this chapter), 10-11 April, 2021, in Bo’ao, Hainan in China, held jointly by the Chinese Association of Chinese Medicine (中华中医药学会) and the Sub-health Branch of Chinese Association of Chinese Medicine (中华中医药学会亚健康分会). I also attended the 18th

World Congress of Chinese Medicine, organized by the World Federation of Chinese Medicine Societies (WFCMS) which featured the theme of ‘Chinese Medicine for Human Health–- Opportunities and Challenges for Global Chinese Medicine (‘中医药惠及人类健康——全球中医药机遇与挑战’) on 4th December, 2021 when it was streamed online. In addition, I also draw on documentary data including news media articles, social science academic studies discussing TCM and subhealth, academic publications of studies relating to subhealth, and policy documents.

The chapter begins with a brief introduction to the cultural and institutional context of subhealth. It then discusses the institutionalization of subhealth, and situates it in the context of this institutionalisation; it then moves on to discuss how subhealth is defined, measured and operationalized at the intersection of western medicine and Chinese medicine. For example, in Chinese medicine TCM classifications and differentiations are highlighted, but the concept has been measured alongside common Western concepts such as quality of life.

4.1The institutional context of subhealth

The prevention of diseases has been an important public health agenda in 21st century China. At the same time as highlighting the need to be prepared for contagious diseases, the government has set out to tackle burdens posed by chronic diseases and emphasize efforts to improve on the nation’s health infrastructure (Chen, 2010).

This article, posted on http://people.com/ (a major state-sanctioned online news outlet), by Wang Longde, President of the Chinese Preventive Medicine Association, and former Vice Minister of Health, serves as a good example of the key discursive elements of subhealth:

> 国内外研究表明，当前亚健康人群约占 70%，且数量正呈上升趋势。究竟什么是亚健康？亚健康会带来什么影响？亚健康是指非病非健康的一种临界状态，是界乎健康与疾病之间的次等健康状态，处于亚健康状态的人，虽然没有明确的疾病，但却已出现一些重要体征指标不正常或精神活力和适应能力的下降，

如果这种状态不能得到及时的纠正，非常容易引起身心疾病。

比如 2 型糖尿病的确诊指标是任意时间血糖超出 11.1 或者两次空腹血糖超出 7.8，但科学研究证明空腹血糖如果超出 6.1 以上到 7.8 之间已经对人体健康有比较明显的影响，但是还没有达到诊断疾病的标准。这种中间状态就是典型的亚健康状态。

引发亚健康的原因，一方面是缺乏必要的运动量，绝大多数脑力劳动者平日里运动少，导致机体调节功能和代谢能力下降；另一方面是饮食结构失衡，如今很多人饮食热量过高，营养素不全，导致重要营养素的缺乏和肥胖症增多，机体的代谢功能紊乱，从而诱发亚健康。

如何调理亚健康状态呢？建议大家’迈开腿、管住嘴’。一方面要加强身体锻炼，适当的运动是亚健康的克星，白领群体可以充分利用工作间歇或休息时间去活动身体；另一方面要做到合理膳食，以植物性食物为主和膳食多样化。植物性食物含大量纤维素，纤维素不含热能，可以增加饱腹感并帮助调解肠道功能，膳食多样化可以保证多种营养素的摄入。
[9]

Domestic and foreign research shows that the current subhealth population accounts for about 70% and the number is on the rise. What is sub-health? What are the effects of subhealth? Subhealth is a critical state of non-disease and non-health, a secondary state of health between health and disease. People in a subhealthy state do not have specific diseases, but have some important signs of abnormal indicators or reduced mental vitality and adaptability.

For example, the diagnostic index of type 2 diabetes is blood sugar exceeding 11.1 at any time or fasting blood sugar exceeding 7.8 twice, but scientific research proves that fasting blood sugar between 6.1 and 7.8 already has a relatively obvious impact on human health, but it has not yet reached the standard of a diagnosed disease. This intermediate state is a typical subhealth state.

The reason for subhealth is, on the one hand, the lack of necessary exercise, as most of the mental labourers exercise less on weekdays, resulting in the decline of the body’s regulatory function and metabolic capacity; on the other hand, the imbalance of dietary structure. Many people today have a diet with too many calories and incomplete nutrients, resulting in the lack of important nutrients and increased obesity, or metabolic function disorders, thus inducing subhealth.

How to regulate the state of sub-health? It is recommended that we ‘use our legs and keep our mouths shut’. On the one hand, we should strengthen physical exercise; appropriate exercise is the bane of sub-health, white-collar groups can make full use of work breaks or rest time to do exercises; on the other hand, we should maintain a

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9. http://health.people.com.cn/n1/2018/0523/c14739-30008280.html. 什么是亚健康？王陇德院士这样说. 人民网-人民健康网

> reasonable diet, have lots of plant-based food and maintain dietary diversity. Plant foods contain a lot of fibre – fibre does not contain calories, can increase the sense of satiety and help to mediate intestinal function; dietary diversity can ensure the intake of a variety of nutrients.

This excerpt contains all the discursive elements of subhealth – including the figure of 70 percent considered to fall into this category. The high profile of subhealth is partially because public health bodies in China recognize the relevance of the concept. This can be seen in the interview excerpt from 2007 below in which the then-Vice Minister of Health was interviewed on the Chinese government website on the current situation of public health safety in China and countermeasures, in the context of World Health Day. He answered questions about how to reduce the incidence of public health emergencies, how to effectively prevent the recurrence of SARS, and how to build the best disease control system in the world.

> 亚健康状态也属公共卫生范围 政府应该加大公共卫生的投入
> 王陇德：公共卫生安全的概念也在逐渐发展，比如最早一般是传染病控制。再加上五大卫生方面，比如食品卫生、职业卫生、学校卫生、放射卫生、环境卫生等等。现在发展到很多，比如亚健康状态、人们的行为，甚至基本医疗。为什么基本医疗也与公共卫生有关系呢？基本医疗很多是治疗传染病病例的，以往看好象是个人问题，但传染病病例如果不治好，它会危害别人。所以这样一些基本医疗也扩展到公共卫生范围里来了，所以它的范围越来越广。
>
> 亚健康状态现在很大一方面是影响慢性病发生，很主要是人的行为问题。比如现代经济社会发展了，人民生活水平提高了，不知道怎么吃。吃出超重来、吃出肥胖来、吃出高血脂来、吃出高血糖来，这些都处于亚健康状态。所以亚健康状态也是政府必须干预的方面，就是教给群众怎么建立良好的生活方式。所以亚健康状态也是公共卫生范围。那亚健康状态是谁的责任呢？应该说是政府和社会的共同责任，特别是政府应该注重公共卫生，应该加大公共卫生的投入，公共卫生工作政府不管，市场不会去管的，这方面是市场缺陷、市场失灵。所以政府应该加大这方面的投资，这就是为什么今年的口号是'投资卫生、构建卫生安全'。
>
> Wang Longde: The concept of public health security is gradually developing; for instance, the earliest stage is generally infectious disease control plus five major health aspects, such as food hygiene, occupational health, school health, radiation health, environmental health, and so on. Now it has evolved to many more, such as subhealth states, people's behaviour, and even basic medical care. Why is primary care also related to public health? In the past, it seemed to be a personal problem, but if a case of infectious disease is not cured, it will harm others. This is why some

> primary medical care has been extended to public health, as its scope is getting wider and wider.
>
> The sub-health state is now a large part of the impact of progression to chronic disease, and this has in large part to do with human behaviours. For example, the modern economy has developed and quality of life has improved, but people still do not know how to eat healthily. They become overweight, obese, have high blood lipids, and have high blood sugar. These conditions all fall under suboptimal health. Therefore, suboptimal health is one aspect that the government must intervene in. The government must teach the public how to establish a good lifestyle. This is why suboptimal health falls under the scope of public health.
>
> Whose responsibility is it? It should be the responsibility of the government and society. In particular, the government should focus on public health and increase investment in public health. If the government does not work on improving public health, the free market will not do this. This is a deficiency of the free market. This is why the government should increase investment in this area, which is why this year's slogan is "Invest in public health and build health and safety infrastructure". (Wang, 2007)

Wang in this interview identifies subhealth as the responsibility of the government to invest in health care and to educate the public on how to lead a healthy lifestyle. Interestingly, in a later interview, he says individuals should bear the responsibility:

> 谁能代替你吃饭？谁能代替你运动锻炼？个人要做自己的健康第一责任人。
> Who can eat instead of you? Who can replace your exercise and workout? Individuals must be the first person responsible for their own health.

The government's concern with preventing diseases and thus lowering the overall healthcare burden, and the context of the government's support for TCM, have underpinned the institutionalisation of subhealth. The rhetoric of responsibility permeates the knowledge making of subhealth. It can be said that the concept of suboptimal health has greatly shaped public health knowledge production in China, and it is at once a space for TCM to claim its relevance, as well as a space for public health to play a role, but also emphasizes individual responsibility.

<u>4.2 Institutionalisation of subhealth</u>

4.2.1 Two institutions of Chinese medicine: Chinese Association of Chinese Medicine (中华中医药学会) and World Federation of Chinese Medicine Societies (世界中医药学会联合会)

It is in this context that the two main institutions behind the two conferences that I attended, hosted by the Chinese Association of Chinese Medicine and The World Federation of Chinese Medicine Societies respectively, were established. The Chinese Association of Chinese Medicine is the longest-standing and largest academic group in Chinese medicine in contemporary China. It was established in 1979, has 256 affiliated institutions, 91 sub-branches, and 199,859 members. The office of the society is a public institution directly under the auspices of the State Administration of Traditional Chinese Medicine. It has many diverse branches such as the Ointment, Sports Medicine, Immunology, and Painology branches. It is worth noting that it has a *zhiweibing* 治未病 or 'Treating disease before happening/disease Prevention Branch' too, in addition to its Subhealth branch.

The World Federation of Chinese Medicine Societies was established on September 25, 2003. It is an international academic organisation approved by the State Council of the People's Republic of China, registered with the Ministry of Civil Affairs, and headquartered in Beijing, China. Currently, the deputy director is Ma Jianzhong, formerly deputy director of the State Administration of Traditional Chinese Medicine of China; and its vice chairman and secretary-general is Sang Binsheng, the former director of the Policy, Regulations and Supervision Department of the State Administration of Traditional Chinese Medicine. This institution is also closely linked with the Chinese government and its agenda to promote Chinese medicine overseas.

In fact, both institutions have subhealth branches/committees and host regular conferences on subhealth. The subhealth conferences hosted by the World Federation of Chinese Medicine Societies mainly take place in China, sponsored, supported and attended

by a similar list of actors as the subhealth conference hosted by the Chinese Association of Chinese Medicine, including the leaders of the State Administration of Traditional Chinese Medicine, the provincial sub-health branch and the prevention centre, experts and scholars at hospitals, universities and academic institutions, as well as spokespersons from TCM product companies. Governmental agenda, TCM professional projects and commercial interests are thus all present in both institutions.

It is worth noting that there are other institutions dedicated to the study of subhealth too, such as the China Association for the Advancement of Chinese Medicine Research and Treatment of Diseases and Sub-Health Branch 中国中医药研究促进会治未病与亚健康分会. Fundamentally, in both conferences, TCM, in its diverse forms, was noticeably seeking to establish itself as a space where it is useful and valid. This was either by establishing lineage, emphasizing formal education, or by showing its effectiveness in treating certain conditions, whether mild, chronic, or acute/serious. Both conferences reflected the continued efforts from TCM professionals to construct themselves as a legitimate profession and to validate their knowledge as scientific knowledge.

The subhealth branch of the Chinese association of Chinese medicine demonstrates its dedication to the development of research into subhealth. Its slogan is ‘世界、民族、中医药、亚健康’ (World, Ethnic, Chinese Medicine and Subhealth). It emphasizes that it will inherit and develop key tenets from traditional Chinese medicine - a ‘homology of medicine and food’ ‘(药食同源), and ‘holistic health preservation’(整体养生). The branch also stresses its dedication to spreading sub-health knowledge and developing sub-health practice while using modern diagnostic technology and communication methods[10]. The branch being

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10. ‘中华中医药学会亚健康分会的口号是'世界、民族、中医药、亚健康"。旨在宏扬民族文化，继承和发扬中华'药食同源"和'整体养生"的理念，结合现代检测技术，利用现代传播手段，传播亚健康知识，发展亚健康产业" .This is an introduction taken from the branch’s Sina blog page (http://blog.sina.com.cn/yajiankangfenhui).

part of the Chinese Association of Chinese Medicine also indicates the intimate relation between the two. According to this branch's official introduction:

> 中华中医药学会亚健康分会（以下简称'亚健康分会'）是亚健康领域的专业性与综合性并重的学术组织。亚健康分会作为中华中医药学会的重要组成部分，以传播中医药文化为先导，以构建亚健康学科体系为基础，以推广中医常用养生保健方法为主要手段，以预防保健专业服务人才培养为突破点，联合有志于亚健康服务的各类机构和单位，共同发展亚健康产业、服务全民健康。还在普及亚健康知识，编撰亚健康系列教材，培养亚健康专业人才，制定亚健康标准，建立各种示范基地，建立国家级亚健康重点实验室，实施世界卫生组织课题，实施国家中医药管理局课题，规范服务内容，严格行业管理与自律标准上做出了突出的业绩。

> The Sub-Health Branch of the Chinese Association of Chinese Medicine (hereinafter referred to as the 'Sub-Health Branch') is an academic organisation that pays equal attention to the professional and comprehensive aspects of the sub-health field. As an important part of the Chinese Association of Chinese Medicine, the Sub-Health branch is dedicated to the spread of Chinese medicine, and the establishment of a sub-health discipline, while also aiming to promote common health-preserving methods of traditional Chinese medicine, taking the personnel training of preventive health professional services as a breakthrough point. The branch unites various institutions and units interested in sub-health services to jointly develop the sub-health industry and serve the health of the whole nation. It has also made contributions to popularising sub-health knowledge, compiling a series of sub-health textbooks, training sub-health professionals, formulating sub-health standards, establishing various industrial demonstration bases, establishing national sub-health key laboratories, implementing World Health Organization projects, implementing projects of the State Administration of Traditional Chinese Medicine bureau, providing standardised service content, and setting up strict industry management and self-management standards.[11]

As can be seen in this introduction, the subhealth branch is a component of the Chinese Association of Chinese Medicine, and one of its tasks is to '传播中医药文化' (spread TCM culture), and it has the aim of constructing the subhealth academic discipline. It was established in 2004 and during the 17 years of its development, it experienced its peaks in its

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The branch used to have a website (http://www.chinasub.org) but it is not currently accessible.

11. This is an introduction to the subhealth branch (http://www.gynj.com.cn/index.php?m=Article&a=show&id=235) as accessed from Chinese medicine China yearbook (http://www.gynj.com.cn), a website that is managed by National Administration of Traditional Chinese Medicine.

first half-dozen years.

4.2.2 Knowledge production and training

To date, subhealth has become a well-established concept for vibrant academic pursuit in the Chinese context, almost reaching the status of a subdiscipline (亚健康学，study of sub-optimal health), although there have been ups and downs in its development. A document search on CNKI, the major Chinese academic database, for journal articles containing suboptimal health status (亚健康) in its title yielded 4,853 results, with 1070 results in core journals (as of August 2020). There are also some full-length textbooks on suboptimal health, mainly under the discipline of TCM.

As an area of study, it falls within the study of TCM. According to Sun et al. (2020), who conducted a Knowledge Map Visualization Analysis of journal articles written on suboptimal health between 2010 and 2019, a key focus of these publications is on the various TCM treatments of suboptimal health states. They also concluded that there is a key network of authors who write on suboptimal health and that there is some degree of cooperation between different teams.

Many projects on suboptimal health have been funded by central and local governments. For example, the *Study on 'Preventing Diseases and Sub-health intervention in Traditional Chinese Medicine'* comprised part of the National Science and Technology Support Plan for the eleventh Five-Year Plan period, which was from 2006 to 2010.

Within the field of traditional Chinese medicinal studies, suboptimal health has also established itself as a sub-discipline. As Tang (2014) pointed out, the study of suboptimal health as a subdiscipline of TCM is strongly supported by the National Administration of Traditional Chinese Medicine. He Qinghu, who is widely credited with establishing this sub-discipline, was also Vice President of Hunan University of Chinese Medicine. At the same

time, the Zhonghe Sub-Health Service Centre, a dedicated social service for suboptimal health under the guidance and supervision of the National Administration of Traditional Chinese Medicine, is an institution approved by the Ministry of Civil Affairs and. Its website mentions that it is ‘the only professional organisation authorized by the state to engage in sub-health research, service, and management, build sub-health service system and train sub-health professionals’. A series of textbooks on ‘subhealth’ has been published including 亚健康学基础 Fundamentals of Sub-Health （Sun, 2009）, 亚健康临床指南 Clinical Guidelines for Sub-Health （He, 2009）.

China has a healthcare system in which both Western medicine and TCM are supported and practiced, both in hospitals and primary health care services. In some ways, this can be seen as part of the drive to standardise Traditional Chinese Medicine (TCM), a process that has been carried out since the 1980s (Wang, Guo and Li, 2016). Although being seen as backward and heavily attacked at the beginning of the 20th century in China’s efforts to modernise and scientise as a nation, traditional Chinese medicine has been made ‘an ideological and practical component in China’s health care system’ since 1949 (Shi et al., 2020), and respected as a traditional Chinese asset. Throughout the 20th century, traditional Chinese medicine constantly sought to standardise and craft a professional identity for itself, and first achieved relevant levels of success in the 1930s (Xu, 2003). The reform and opening-up since the 1970s posed challenges for TCM as the use of it is sometimes seen as ‘contrary in a society committed to modernization’ (Burke, Wong and Clayson, 2003). The state has constantly explored ways to standardise TCM since the 1980s and in 2009 explicitly stated the goal of ‘promoting the standardisation of TCM’ in *Several Opinions of the State Council on Supporting and Promoting the Development of Traditional Chinese Medicine* (Shi et al., 2020).

In this context, subhealth can be seen to be at the intersection of traditional Chinese

medicine and modern Western medicine. It connects notions of health and disease, as practiced in global health contexts, to concepts of health and illness in traditional Chinese medicine.

As mentioned by Sun Guixiang in her talk at the subhealth conference, the training of people specialising in subhealth followed the trajectory from higher research level, eventually to undergraduate and professional training levels. In 2012, Hunan University of Traditional Chinese Medicine received approval from the Ministry of Education to set TCM sub-health as a secondary discipline under TCM and obtained the right to confer masters and doctorate degrees in sub-health. The recruitment started in 2013. Sun proudly commented that Hunan University of Traditional Chinese Medicine is the only institution that can offer a qualification of this type in China (which is where she is based). A set of textbooks on subhealth were edited from 2008 and became module materials for TCM undergraduates at Hunan University of Traditional Chinese Medicine in 2013. In 2014, the Zhonghe Sub-Health Service Centre launched the National Sub-health Industry College Student Employment and Entrepreneurship Project in Anhui College of Traditional Chinese Medicine. In 2018, Hunan University of Traditional Chinese Medicine received approval for the new major of Chinese Medicine Health Preservation from the Ministry of Education, the key distinguishing feature of this new major being sub-health status identification and intervention.

In 2015, the People’s Republic of China Occupation Classification Ceremony added TCM sub-health physicians as a new occupation, but, as pointed out by Sun, this occupation has not yet been formally included in the occupational evaluation system. In another talk delivered by He Qinghu, the establishment of the disciplinary system of *zhiweibing* (治未病) was mentioned in this context, the aim here being to set up a clearer career progression path for the students.

The experts in this regard are envisioned to be people with training in TCM who can

resort to the knowledge framework of TCM differentiation; they are in turn envisioned to fall under TCM professionals and progress their careers in this way.

Therefore, a key part of subhealth research focuses on the theoretical development of subhealth, which usually draws on Chinese medicine theory. According to Wang et al. (2014), who looked at journal articles on suboptimal health published up until 2008, theoretical discussion accounted for 62.81% of all TCM research on suboptimal health.

Intriguingly, no one mentioned Wang Yuxue, who first proposed this concept in China, in the subhealth conference, perhaps because any indication that the concept was born with commercial interests in mind might undermine its validity. However, the articles on subhealth and the talks I observed in the subhealth conferences all discuss, to varying extents, the commercial potential of this concept and how that might fit the current state emphasis on 'Big Health' industries (大健康产业）.

In the introduction to the thesis, I have already sketched the emergence and growth in popularity of the concept. Table 4.1 provides detail on the timeline for its emergence and development in the Chinese context.

Table 4.1 Timeline of the emergence of the concept in China

Year	Event	How the concept is defined/utilized	Who is involved?
1982	'The Third Status' is proposed		
1996	China implements the 'Health Food Management Approach' Caili goes on the market	 '采力突破亚健康' (Caili breakthrough suboptimal health)	
1997	The first seminar on suboptimal	At this seminar, scholars fully	Sponsored by

	health is held in Beijing	formulate the concept of suboptimal health	Hai'er; Hosted by Chinese Pharmaceutical Association
2002	Wang Yuxue publishes a book on suboptimal health		
2004	The subhealth branch of Chinese association of Chinese medicine is established		
2005-2010	Eleventh five-year plan, when many projects on subhealth were funded		
2012	Tencent has a special issue criticising the concept		
2012	The concept of suboptimal health appears in a medical textbook		
2000s	Publications invoking subhealth in Western journals		

To look at the list of abstracts for the subhealth conference affords a glimpse into the interests of the conference. In 2020 in its call for submissions, it asked for contributions in relation to:

> 1. TCM thoughts on treating disease preventatively (治未病) and academic research on sub-health prevention and treatment;
> 2. Research on methods and standards for health status identification, classification and evaluation;
> 3. Research on sub-health population monitoring;
> 4. Discussion on the prevention and treatment of chronic diseases in the community

service model;
5. Discussion on the digitisation of sub-health services;
6. Application of characteristic diagnoses and treatment technologies of Chinese medicine;
7. Discussion on the evaluation standard of curative effects on abnormal human functional statuses;
8. Research on key technology and product research and development of Active Health;
9. Basic research on sub-health biological mechanisms and influencing factors;
10. Chronic disease prevention and control and management research;
11. Application and evaluation of intelligent wearable technology;
12. A new health prevention model under the pandemic;
13. Discussion on applying the 'Internet+' analysis model to big data from sub-health population.

1.中医治未病思想及亚健康防治的学术研究；
2.健康状态辨识、分类与评价方法及标准的研究；
3.亚健康人群监测的研究；
4.慢病防治在社区服务模式中的探讨；
5.亚健康服务信息化建设模式探讨；
6.中医特色诊疗技术应用；
7.人体功能状态异常的疗效评价标准探讨；
8.主动健康关键技术和产品研发应用研究;
9.亚健康生物学机制及影响因素的基础研究;
10.慢病防治保障与管理研究；
11.智能化可穿戴测评技术应用与评估；
12.疫情下健康的预防新模式;
13.亚健康人群大数据的互联网+分析模式的探讨。

In this call for submissions, TCM thought on preventative treatment of disease (治未病) and academic research on sub-health prevention and treatment seemed to be considered to fall into the same category and were listed together. TCM characteristic treatments were also described. The differentiation, categorisation and measurement of subhealth were given high priority, and it was a recurring theme in the 2021 conference that I observed (in fact, the 2021 call for submissions was very similar). There was a focus on pinpointing the exact biological mechanism of subhealth and studying its influencing factors. Information, technology, internet, big data were encouraged in the study of subhealth, and those, again, were frequently invoked in the subhealth conference that I attended. Wearable technology was also

mentioned in the call for abstracts, indicating some conceptual similarities between subhealth and health tracking.

The conference gave a good summary of the field of subhealth over the years, the different players involved in this process, and the new avenue it is trying to carve out for itself. The conference was a new iteration of the academic production on subhealth, thus rehearsing many views from articles already published, but also demonstrating its commitment to integrating TCM with the new policy direction and both emphasising TCM tradition and establishing its scientificity. Throughout the conference, many presenters mentioned the need to combine research, teaching and the industrial development of subhealth.

In the presentations, the advantages of TCM in treating subhealth was a dominant theme. One of the key concerns addressed in this conference was to make the diagnosis of subhealth more concrete, reliable and visible, in line with new technologies and big data. Since this conference was also an event for nominating and celebrating new committees for this branch, most of the presenters were well-established figures in the field of subhealth, many of them having collaborated with each other on different projects. In fact, one speaker commented that all of the editors of *Clinical Guidelines of Chinese Medicine on Subhealth* were present at this conference. A few foundational textbooks on subhealth were frequently mentioned. The presenters frequently referred to each other and they seemed to have formed a closely-knit circle as experts in the field of subhealth research. Many presentations cited books and journal articles that were published around 10 years ago when there was a surge of funding for projects related to subhealth, and when many textbooks on subhealth were being published as textbooks for students of Chinese medicine; only a few new publications were mentioned. It seemed to me that for many of the speakers, the ground in diagnosing and subcategorising of subhealth had been almost set, and the concern now was to make such

diagnosis more in-tune with new technologies, more visual, more reliable, and more in-line with the approaches of biomedicine. It also had a focus on bringing their research in line with industry and with providing a service to customers/patients. Some technologies such as infrared imaging and pulse-taking machinery were mentioned and promoted, and there were also repeated mentions of big data and data management. I will flesh out a few of the noteworthy aspects of the conference in more detail in the following sections.

The international conference that I observed, the 16th World Congress of Chinese Medicine, hosted by the World Traditional Chinese Medicine Pharmaceutical Association Federation (世界中医药学会联合会) in Budapest, was co- hosted by the Central and Eastern European Society of Traditional Chinese Medicine and the Hungarian Society of Traditional Chinese Medicine. The Belt and Road Initiative was frequently mentioned during the conference. The theme for the conference was 'Prevention of Diseases and Strengthening of the People's Aspirations, Health, Harmony, and Destiny'. Although subhealth was only mentioned once in a workshop on a particular treatment method, 治未病 treating disease before occurring/disease prevention was frequently invoked; an idea that has marked prevalence in Chinese medicine.

As commented by Mei Zhan (2009), who encountered subhealth during field research on traditional Chinese medicine in Shanghai and the San Francisco Bay Area, subhealth was identified as a way for emerging Chinese medicine practitioners to find a niche for traditional Chinese medicine, and to participate in scientific knowledge production and refashion the practice for an urban middle class. It has also been noted that subhealth is also associated with a transnational frame, but it is considered to be an imaginary one, operating within China, and rarely invoked outside China. During the conference, Zoltan Csiki, Undersecretary at the Hungarian Ministry of Human Resources, said:

> 'We have a firm intention to develop further the relationship between China and Hungary in healthcare. In fact, the cooperation in medical sciences and healthcare

> between the two countries has become stronger and stronger in recent years. Hungary was the first country in the European Union that accepted Chinese medical degrees. Following this, the Semmelweis University in Budapest has been offering courses in TCM since 2011.’

This showcases China’s steady efforts in internationalising Chinese medicine and increasing its acceptance worldwide. The conference also had a session dedicated to celebrating the publication of World Traditional Chinese Medicine Professional Core Curriculum Textbooks, which comprise 14 volumes apiece in Chinese and English. They are organised and compiled by the Education Steering Committee of the World Federation of Chinese Medicine Societies and published by China Traditional Chinese Medicine Publishing House. It sets out to train TCM physicians to meet clinical demand, focusing on the prevention and treatment of diseases that are common in countries outside of China, and for which TCM has been shown to have curative effects.

4.3 Defining Subhealth and intervening subhealth

4.3.1 Defining Subhealth

According to The TCM clinical guidelines of suboptimal health status published in 2006, suboptimal health is a state in which the human body is between health and disease. People in a suboptimal state do not meet the expected standards of health, and they manifest symptoms of decreased vitality, bodily function and adaptability within a certain period of time (3 months). However they do not meet the clinical or sub-clinical diagnostic criteria of modern medicine-related diseases.

The graph below shows a procedure for deciding on whether one is in suboptimal health：

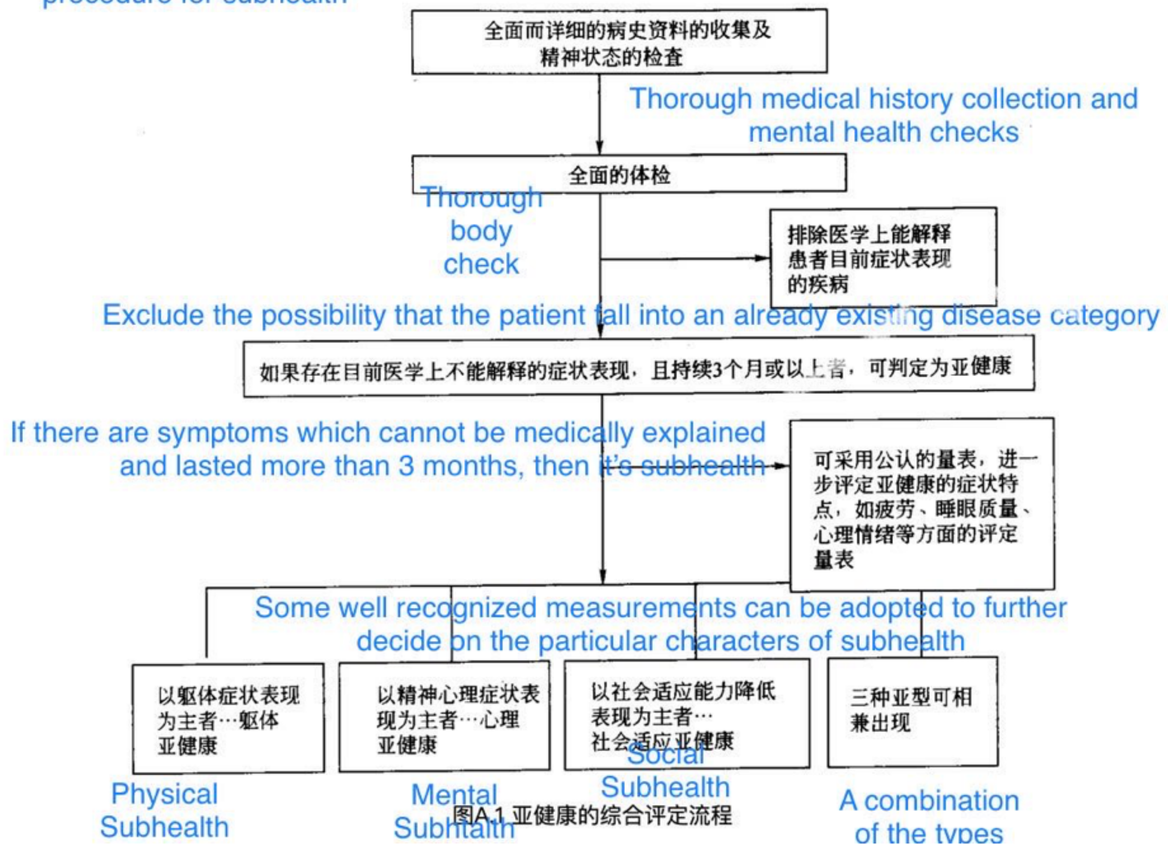

Figure 4.1 The process for diagnosing subhealth

The symptoms must persist for a duration of three months, similar to those of unexplained medical symptoms. A principle of exclusion is applied here – symptoms that can be medically explained would not be considered subhealth, in this definition (Chinese Association of Chinese Medicine, 2006). After this assessment of the chronicity of subhealth, a connection to TCM classificatory systems is provided. The differentiations offered by TCM are subsequently offered to explain and treat such conditions. In one of the textbooks on suboptimal health, *Clinical Guidelines for Sub-Health*, 27 common clinical manifestations of sub-health, 15 types of Traditional Chinese medicine differentiations of suboptimal health as well as 25 kinds of disease tendencies of suboptimal health are provided. The theory of

constitutions is also drawn upon and based on the theory of '9 types of constitution' in TCM theory, different criteria for suboptimal health are developed for each constitution and advice for toning the body is provided accordingly (Hu, 2015).

At the same time, to confirm subhealth, a diagnostic criteria and technology of modern Western medicine must be drawn upon. As commented in an article entitled Traditional Chinese medicine and suboptimal health (中医学与'亚健康 , 2017), the market in China requires that the diagnoses are made according to modern Western medicine. Or, rather, the traditional Chinese medicine practitioners give both a TCM differentiation and a Western medical diagnosis. Even for the population in suboptimal health, who cannot have a Western medicine diagnosis, drawing on at least some modern Western knowledge is inevitable. This article concludes that the identification of suboptimal health implies an integration of Chinese and Western medicine, as the language of Chinese medicine alone cannot account for suboptimal health.

Therefore, in this context, we can see that the concept of suboptimal health is present in Integrated Chinese and Western medicine in China, where there is an effort to incorporate suboptimal health as a subdiscipline.

As I have shown, there have been many TCM theoretical discussions of suboptimal health and many efforts to pin it down into different TCM differentiations and diagnoses. At the same time, the concept of suboptimal health has been refashioned into epidemiology as a concept separate to TCM, used to evaluate the population's health and associate it with risk factors.

Scholars are aware of the pitfalls of the vagueness of the concept and have spent some effort in defining and refining the scope the concept encompasses although He Liyun,, in the subhealth conference, also commented that 'the vagueness of the concept of subhealth does not have negative impact on its utility in health research' (亚健康概念的模糊性不影响其

在健康领域的应用和发展).

In the definition proposed by Wang et al. (2001), suboptimal health status is

> 'A physiological state that, although no diseases of a clinical sense can be detected, those affected can feel apparent physical and/or psychological discomfort with reduced dynamic activity and adaptability to environment.'

In this definition, optimal health is implicitly viewed as a combination of lack of physical and/or psychological comfort, optimal dynamic activity and the ability to adapt to the environment. In suboptimal health, these are disrupted. Subhealth is defined in relation to the definition of health, as less than ideal health.

In another definition provided by Zhou et al. (2002), suboptimal health status is

> 'A potential clinical stage or prior psychosomatic disease stage during which people have not been diagnosed with a disease, but they have risk factors for illness and have tendency to develop diseases' (Zhou et al., 2002)

Here, subhealth is defined in relation to the definition of diseases. It means an enhanced potentiality to develop diseases. In more medically specific terms, it is defined as a state of being in preclinical and reversible conditions. Many definitions emphasize the experience of bodily complaints without organic pathologic changes. In more medically precise terms, it is defined as a state of being preclinical and reversible without any changes in organ lesions. It is conceptualised as 'stress response', a result of the interactions between environmental, psychological, and physiological stimulations (Li et al., 2013).

Many subsequent epidemiological studies have been conducted, for public health intervention purposes. With the addition of this aspect, the content of suboptimal health has evolved too, and the population in suboptimal health also adapted.

Following the WHO classification, subhealth is often divided into physical, mental and social subhealth, as in Figure 4.1. Subhealth is sometimes also divided into single symptom subhealth, multiple symptoms subhealth, and asymptomatic subhealth (asymptomatic

subhealth paradoxically embodies the ambition and dilemma of the concept of suboptimal health because it constantly seeks to combine biomedical data). There are also different degrees of sub-health. These classifications provide a more finely crafted way to label one's health condition, but more importantly, the possibility to more finely pinpoint sections of the population for public health intervention. Sub-health is defined in this sense as 'a translational medicine instrument for health measuring in the general population' (Wang, 2012). As we shall see it is at this intersection that subhealth is further subdivided and 'measured'.

4.3.1 Subhealth diagnostic manuals

Several of the main authors of key texts in Chinese medicine were at the conference. Authors such as Sun Tao, Wang Tianfang, He Liyun and Luo Ren were speakers and the points they made indicated a considerable degree of shared knowledge at the conference. For example, one of the publications frequently referenced in this field is the *Clinical Guidelines of Chinese Medicine on Subhealth*, issued by the Chinese Association of Chinese Medicine, published by China Press of TCM Traditional Chinese Medicine in 2006. In the Guidelines, subhealth is clearly defined, its scope determined, and its main clinical manifestations explained. In these Guidelines, Subhealth is categorized into three types: physical, mental and social communication. Chinese medical differentiations are then provided, including Liver Qi Stagnation (肝气郁结症), Liver depression and spleen deficiency (肝郁脾虚证), Heart and Spleen Deficiency (心脾两虚证), Liver and kidney yin deficiency (肝肾阴虚证), Lung and Spleen Qi Deficiency (肺脾气虚证), Spleen deficiency and dampness (脾虚湿阻证), Liver depression and fire (肝郁化火症), and Phlegm-heat internal disturbance (痰热内扰证). As can be seen in the above characterisation, the tradition of Chinese medicine differentiation is drawn on here. Nonetheless, in many of the talks in the conference, a different strand of

theory is also used in characterising subhealth, that is, the TCM constitutional types.

In contrast to the TCM differentiations that aim to explain particular bodily states (which are temporary), the TCM constitutional types aim to account for the specific constitutions of different individuals, which are stable and long term. In this respect TCM divides people into 9 physical constitutions, namely, calmness, yang deficiency, yin deficiency, phlegm-dampness, damp-heat, blood stasis, qi deficiency, qi stagnation, and idiosyncratic qualities. This classification was discussed by some presenters in trying to explain how they prescribe the medicine based on different types of individuals.

In 2020, another manual on subhealth was published at an international level, issued by the World Federation of Chinese Medicine Societies, named 中医亚健康状态分类指南 *A Traditional Chinese Medicine Guide to the Classification of the Sub-health State*. It revised the 2006 Guidelines categorisation of subhealth and proposed six further types of subhealth: activity-rest type sub-health (活动-休息型态亚健康), nutrition-metabolism type sub-health （营养-代谢型态亚健康）, excretion related subhealth（排泄型态亚健康）, perception related subhealth（感知型态亚健康）, sex-reproductive subhealth（性-生殖型态亚健康）, and cognitive-coping-relationship related sub-health（认知-应对-关系型态亚健康).

The proposal to produce this manual was submitted by the Sub-Health Committee of the World Federation of Chinese Medicine Societies, in conjunction with the Zhonghe Subhealth Service Centre and the Beijing Zhonghe Subhealth Sciences Research Institute (these two institutions are very active in the knowledge production of subhealth and are also behind the organization of the subhealth conference), to the World Federation of Chinese Medicine Societies in 2017 to formulate such a guideline for classifying subhealth states. According to the committee, this project was developed and approved on the foundation of the 2010-2011 China/WHO Health Technical Cooperation Project ‘Developing Applicable Standards and Evaluation Methods for TCM Intervention in Sub-healthy Population’, and the 2012

China/WHO Health Technical Cooperation Project ‘Developing Traditional Chinese Medicine Intervention in Sub-healthy Status On the basis of ‘Service Standard Project’. The manual was published in 2020.

Sun Tao, now the Chairman of the Sub-health Committee of the World Federation of Chinese Medicine Societies (formerly head of the Chinese Association of Chinese Medicine, and participant in compiling the manual), introduced this new guideline on subhealth and discussed the process of compiling this guideline in the conference. He said that it took two years to complete and was formulated by experts from many countries around the world. It aimed at combining the basic knowledge of modern western medicine and TCM, in summarizing and characterising more than 200 common clinical sub-health symptoms. He also mentioned that this manual has an emphasis on the description and classification of functional states because, in his words, ‘In functional medicine, Chinese and Western medicine can join hands’. It is interesting that when he made this comment, he felt it unnecessary to add TCM in the title. He said, the guide could simply be called *A Guide to the Classification of Sub-health States*, but since it is issued by World Federation of Chinese Medicine Societies, TCM had to be added to the title. This comment is quite emblematic of the paradox of the concept of subhealth – the way it is perceived to be from the West, but also perceived to be useful for the professional project of Chinese medicine in highlighting Chinese medicine’s usefulness in treating such conditions. At the same time, in advancing the knowledge production around such a concept, the professionals in this field have also had to adopt the system of Western medicine, and in this manual, the classification is based, for example, on anatomy taken from Western medicine.

4.3.2 Measuring subhealth

With more epidemiological projects being carried out, the space occupied by this concept in journal articles has been fine-tuned, with the introduction of more systematic ways of

measuring subhealth. When Wang published his finding of the prevalence of suboptimal health in 2002, the prevalence rate of suboptimal health was a very alarming 60%. Such was the population carved out as a market for commercial health products. It is not surprising that those early studies often resorted to adapting self-perceived health questionnaires, quality of life instruments or self-report psychometric instruments, such as SCL-90, The World Health Organization Quality of Life (WHOQOL) and such to measure suboptimal health. It is worth noting that those studies almost exclusively looked at urban populations.

In 2009, a Suboptimal Health Questionnaire (SHSQ-25) was devised, which was widely used subsequently. It contained 25 items within 5 domains, namely fatigue, the cardiovascular system, the digestive tract, the immune system, and mental status. In this questionnaire, each interviewee rated different statements about his or her own physical health on a scale from 0 to 4. The SHS score was then calculated as the sum total of all items. A high score (≥35) represented a high level of SHS (poor health), with a score of ≥35 regarded as SHS, and the remainder were in ideal health.

The questionnaire included the following questions:

1 never or almost never	2 occasionally	3 often	4 very often	5 always

How often is it, that you (your)	1	2	3	4	5
1. were exhausted without greatly increasing your physical activity.	□	□	□	□	□
2. fatigue could not be substantially alleviated by rest.	□	□	□	□	□
3. were lethargic when working.	□	□	□	□	□
4. suffered from headaches.	□	□	□	□	□
5. suffered from dizziness.	□	□	□	□	□

How often is it, that you (your)	1	2	3	4	5
6. eyes ached or were tired.	□	□	□	□	□
7. suffered from a sore throat.	□	□	□	□	□
8. muscles or joints felt stiff.	□	□	□	□	□
9. have pain in your shoulder/neck/waist.	□	□	□	□	□
10. have a heavy feeling in your legs when walking.	□	□	□	□	□
11. feel out of breath while sitting still.	□	□	□	□	□
12. suffered from chest congestion.	□	□	□	□	□
13. were bothered by heart palpitations.	□	□	□	□	□
14. appetite is poor.	□	□	□	□	□
15. suffered from heartburn.	□	□	□	□	□
16. suffered from nausea.	□	□	□	□	□
17. could not tolerate the cold.	□	□	□	□	□
18. had difficulty falling asleep.	□	□	□	□	□
19. had trouble with waking up during night.	□	□	□	□	□
20. had trouble with your short-term memory.	□	□	□	□	□
21. could not respond quickly.	□	□	□	□	□
22. had difficulty concentrating.	□	□	□	□	□
23. were distracted for no reason.	□	□	□	□	□
24. felt nervous or jittery.	□	□	□	□	□
25. caught a cold in the past 3 months.	□	□	□	□	□

Figure 4.2 Questionnaires for self-diagnosing subhealth (Yan *et al.* 2009)

From its inception, the questionnaire was designed to assess suboptimal health among the urban population, as stated in its aims. The questions formulated in the list were designed to capture stress in the urban population and again, the symptoms listed were those that had been established as troubling certain types of demographics – for example, eye aches, pain in the shoulders, and so on. In the article *Development and evaluation of a questionnaire for measuring suboptimal health status in urban Chinese*, the discussion of suboptimal health in the introduction was situated in the urbanization of China and the stress urban dwellers face, in the same vein as Wang's (2002) construction of suboptimal health. As part of the questionnaire design, it was necessary to discriminate between groups as the authors believed that if the questionnaire could show that different groups have different subhealth problems, it was a sign of the validity of the instrument. As asserted in the discussion section of the article:

> The questionnaire instrument was also able to discriminate between groups. As

expected, there were statistically significant differences in scale scores among occupation groups, and between younger and older participants. White-collar workers had much higher SHS scores, which indicate worse health.

This instrument has been widely used in subsequent epidemiological studies. Studies have been conducted to analyse the relationship between suboptimal health status and cardiovascular risk factors using this instrument. This questionnaire is often combined with blood sample collection and clinical anthropometrics in order to establish the prevalence of suboptimal health, and the link between suboptimal health and chronic conditions such as cardiovascular events.

In a study conducted by Yan et al. in 2012, the use of the SHSQ-25 questionnaire was combined with tests in blood pressure, glucose, lipid levels, cortisol, and body mass index, in a cross-sectional study with 4,881 workers in urban Beijing. They established a correlation between suboptimal health states and 'systolic blood pressure, diastolic blood pressure, plasma glucose, total cholesterol, and HDL cholesterol among men, and correlation between SHS and systolic blood pressure, diastolic blood pressure, total cholesterol, triglyceride, and HDL cholesterol among women'.

They concluded that there is an association between suboptimal health status and cardiovascular risk factors. In another Chinese subhealth cohort study beginning in 2013, three types of data were simultaneously collected and correlated:

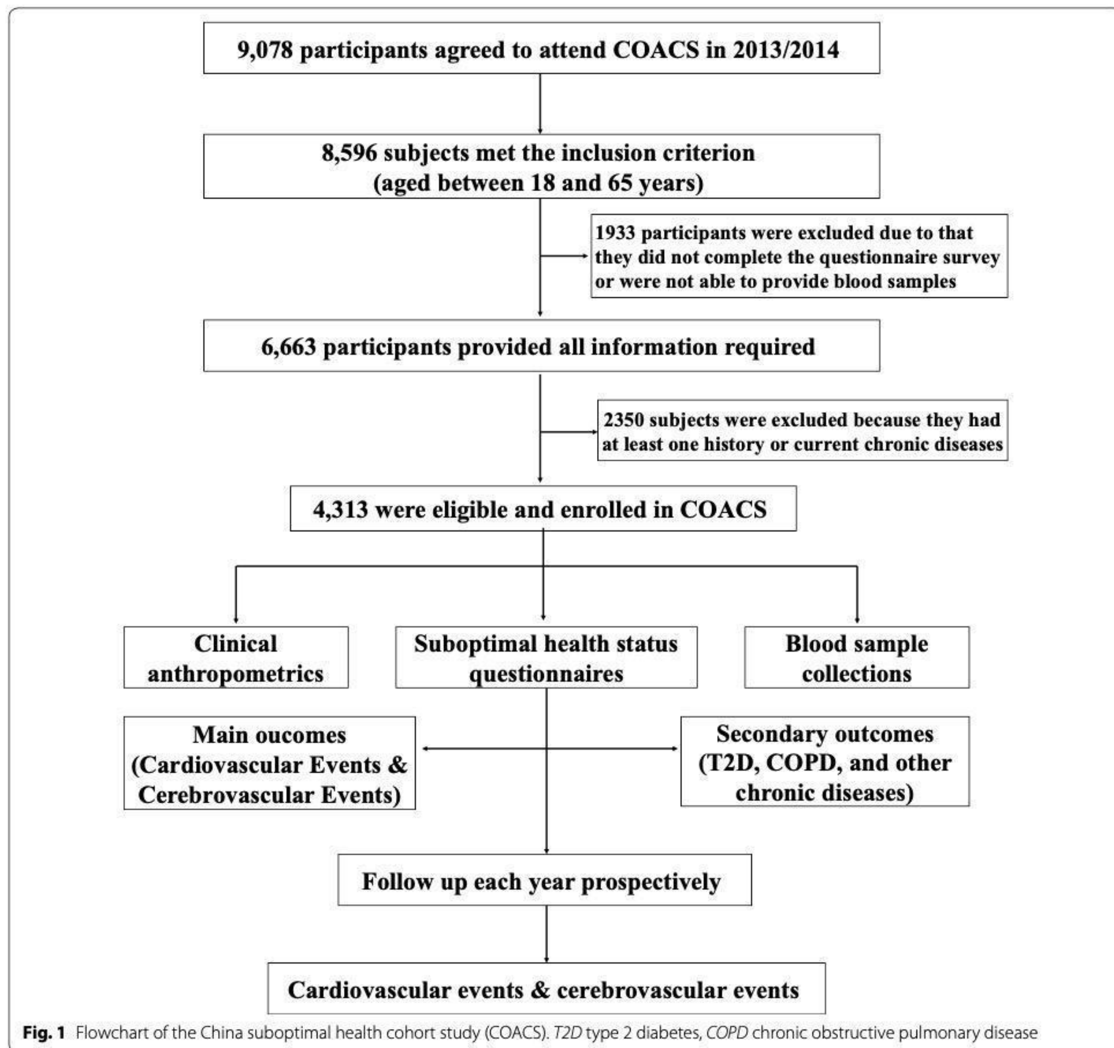

Figure 4.3 Flowchart of the China suboptimal health cohort study (Wang et al., 2016)

The prevalence rate of subhealth in this study ended up being 9.0%, a significant drop from the figure of 60% in Wang's 2012 study. The results of the study found that:

> Risk factors for chronic diseases such as socioeconomic status, marital status, highest education completed, physical activity, salt intake, blood pressure and triglycerides differed significantly between subjects of SHS (SHS score ≥35) and those of ideal health (SHS score <35).

This article also 'found that marital status (widowed, separated, divorced) is a risk factor for suboptimal health status'.. In an interesting way, scholars sought to use subhealth to

indicate disease risk factors, but at the same time, treated subhealth as some sort of a 'disease', with its own risk factors. Only urban populations were being sampled for suboptimal health, and many studies concluded that intellectuals or middle-class workers, or entrepreneurs, that is, people of higher social and economic status in general, were more likely to be in suboptimal health, which is not surprising since that is how the questionnaire was designed in the first place.

Subhealth is a concept that negotiates between the objective and subjective experiences of the body, a concept that engages with both Western medicine and Chinese medicine. It is a concept that can be said to categorize a healthy population but is also measured like a disease. It is thus a paradoxical concept that appears to be productive in serving diverse interests and shaping new subjectivities.

After these adaptations the concept made its way into medical education. In a textbook entitled *Pathophysiology* published in 2013 by People's Medical Publishing House, suboptimal health was introduced and had a short but separate section in which the suboptimal health state was defined as a state between health and illness where a person has a low physiological functioning. This book was produced as part of the National High Technology Research and Development Program of China (12th 5-Year Plan-Program). The inclusion of the concept in a medical textbook is symbolic of the ways in which it has firmly established itself as a medically relevant concept in China.

4.3.3 Putting the concept in health infrastructure

> 用现代生物学手段，用中医原始和质朴的、讲究整体、注重变化为特色的治未病和辨证施治理念来研究亚健康以及慢性复杂性疾病，是东西方两种认知力量的汇聚，是现代医学向更高境界提升和发展的一种必然性趋势
>
> Using modern biomedical methods while combined with the primitive and simple traditional Chinese medicine ideals of disease prevention and

> syndrome differentiation that focus on the overall, the changes to studying sub-health and chronic complex diseases are the way to go; it embodies the convergence of knowledge of the West and the east, and is an inevitable trend for the improvement and development of modern medicine to a higher level.
>
> (Chen, 2007)

In the above excerpt, from the Pacific Health Advanced Forum held in Beijing in 2007, Chen Zhu, China's Minister of Health, emphasized the need to break through the barriers between Chinese medicine and Western medicine and integrate the two, which is consistent with Mao's formulation of integrating Chinese and Western medicine. In this paragraph, the two terms, 治未病 (treating disease before happening/disease prevention) and 亚健康 (subhealth) both appeared. As can be seen in this paragraph, 治未病 is seen as the characteristic of TCM while sub-health and chronic complex diseases are seen as Western ideas, as problems to be addressed.

It is also around this time that the Chinese government launched projects dedicated to the prevention of diseases. Since 2007, the *Preventive Treatment of health project*（治未病健康工程）was launched, aiming to explore the establishment of a TCM preventive health care service system with Chinese characteristics. To some extent, it could be said that this marked a new type of professional project for TCM in China and specified rules for the accreditation of TCM hospitals. Since 2012, the State Administration of Traditional Chinese Medicine has clearly stated in the accreditation standards for Chinese medicine hospitals that all Chinese medicine hospitals above the second level must establish a Pre-treatment/Disease Prevention Department *(*治未病科/治未病中心) and provide related services. In 2014, the State Administration of Traditional Chinese Medicine issued the *Guidelines for the Construction and Management of the Pre-treatment/ Disease prevention Department (*治未病科/治未病中心 *of Traditional Chinese Medicine Hospitals (Revised Edition*)（中医医院"治未病"科建设与管理指南（修订版), stating that the service content of the Pre-treatment Department was

to provide health information and data management, and TCM health status identification and assessment, health consultation, Chinese medicine care and so on.

In 2017, the State Administration of Traditional Chinese Medicine issued the *Implementation Opinions on Promoting the Development of Traditional Chinese Medicine Health and Elderly Services* and emphasized again the hard indicators for the construction of the Pre-treatment/ Disease Prevention Department (治未病科/治未病中心) for Traditional Chinese Medicine Hospitals namely, 'two-level and above Chinese medicine Hospitals need to set up such a department'. It was also stated that from the perspective of management, this department needed to be a first-level department with both health management and clinical functions. It needed to be directly managed by the hospital leadership. The services provided needed to include physical examinations (both Chinese and Western medicine health assessment), health consultation and guidance, Chinese medicine nursing, follow-up management, and health education. It is interesting that the *Opinions* also stated that Acupuncture, Tuina, Rehabilitation, Physiotherapy and other clinical departments would not be included as part of this department. A particular function was given to the establishment of such departments, occupying a curious space between the medical and non-medical. On the one hand, they were established in TCM hospitals, but on the other hand, they were not meant to be treating diseases, but rather, to be used for health promotion.

It is highlighted that this department was not intended to be a clinical department. It should not be mistaken for other TCM departments such as 'famous doctor's studio (名医工作坊) '. Instead, its focus was to be on prevention. That creates a very interesting paradox: this department was meant to be established in a hospital, and at the same was not meant to serve a clinical purpose.

Zhonghe Subhealth Service Centre and the Beijing Zhonghe Subhealth Sciences Research Institute also had a spokesperson at the subhealth conference discussing its plan to develop

subhealth industrial headquarters and its ambition to set up subhealth intervention clinics. Interestingly, the spokesperson mentioned that these subhealth clinics are also non-medical, thus different to the disease prevention subhealth departments, and thus would be situated differently in the Chinese medical/commercial regulatory system. What is intriguing is the way the same conceptual space can be rendered in these two different material spaces.

4.4 Summary

The chapter began with a brief introduction to the cultural and institutional context of subhealth. It then discussed the institutionalization of subhealth, and situated it in that context, then moving on to discuss how subhealth is defined, measured and operationalized at the intersection of public health, western medicine and Chinese medicine. For example, in Chinese medicine it highlights TCM classifications and differentiations, but the concept has been measured alongside common Western concepts such as quality of life.

Based on the analysis in this chapter we can see that the conceptual space of suboptimal health has emerged at the intersection of east and west, and is shaped by different interests. We can see that this concept has a special affinity with TCM as well as the context of public health in China. TCM has a focus on individualised differentiation while public health is concerned with establishing the statistics of subhealth in the populace. The different branches of TCM theory fuel the development of subhealth as a discipline, sometimes a discipline under TCM, sometimes trying to carve out a field unconstrained by TCM; other times, it is deemed not to be part of TCM at all, favouring instead the term *zhiweibing* 治未病 (preventing disease from happening/disease prevention) - though the implication of the latter is very similar to subhealth. It has thus been defined, measured and institutionalised along different lines.

The documentary data and research into different policies, as well as attending the TCM conferences, has thus helped me unpack the contemporary understanding and knowledge

making of subhealth, and to see how such conception construction is, and is envisioned to be, materialised.

Chapter 5: The ‘making’ of subhealth

As observed by Mei Zhan (2009), subhealth operated within Traditional Chinese Medicine as part of a process of remaking itself for the urban middle class and this operates in an imagined transnational framework within China. In the introduction to the thesis, I argued that whether the concept is Chinese or Western has to some extent become an important aspect to the debate on whether it has validity, and that many critiques specifically point out that the term is a particularly Chinese construct and does not exist in the West, thus arguing that the concept should be abandoned. On the other hand, those who make use of and engage in knowledge production of the concept, as I have discussed in the previous chapter, continue to cite it as a WHO concept. This chapter constitutes an attempt at tracing the conceptual history of subhealth in the Western public health context to unpick the transformations and mutations of the concept based on documentary data from 20th century public health documents. Subhealth is a marginal concept in Western public health, an empty concept serving the purpose of evaluating the health of the population. It is however interesting to note that its role seems to have changed over the century: in the first half of the last century, subhealth was often attributed to environmental factors and facilitated a discussion of the state’s responsibility to improve public health. Since the 1980s, however, there have been cases where subhealth is attributed to individual lifestyles.

5.1 Subhealth in the transnational professional project of TCM

Although occurring somewhat sporadically, the concept has been introduced in the English language to the general public, often in association with alternative medicine and health practices. Its close association with commercial interests and its utility for selling health products is often apparent in those instances. Very similar rhetoric seems to be at work in the Chinese context. In the following introduction to subhealth in an article entitled ‘Sub-

Health Condition: A New Killer', for example:

> What is A Sub-health Condition?
> Sub-health condition is defined by the World Health Organization as a state between health and disease when all necessary physical and chemical indexes are tested negative by medical equipment, things seem normal but the person experiences all kinds of discomfiture and even pain.
>
> Most of us have the experience of driving into a repair shop and telling the mechanic that your car acts strangely and some parts do not work. After checking over, you are told that they cannot find anything wrong, and you can come back when something happens. You leave and you begin to worry that something is going to happen to the car, but you do not know when and where!
>
> It is the same thing with your health. Should you congratulate yourself and forget about it when your doctor tells you that they have found nothing wrong? Perhaps not.
>
> (Sub-Health Condition: A New Killer, n.d., https://www.taoofherbs.com/articles/55/Sub-HealthCondition.htm)

This is then followed by a list of several herbal products that are claimed to help with sub-health, targeting Western customers. Similarly, in another text introducing sub-health, after a similar introduction to subhealth, listing the World Health Organization as the organization coining the concept (and claiming that 75 percent of the world's population are in suboptimal health), several causes of subhealth are listed (air pollution, water contamination, food, medicine/drugs, household and personal care products, stress and anxiety), after which a long list of signs of suboptimal health appears, followed by a warning of the harms of suboptimal health, before a product for detox is introduced as the cure (Where Does 'Suboptimal Health' Come From? You Are In 'Suboptimal Health', 2020).

Those seem to be spin-offs from the popular understanding of subhealth in the Chinese context, slightly modified to a translational framework, in which subhealth is still constructed as a problem for urban citizens, as a state of mild health complaints before diseases are identified; and it is considered an individual responsibility. Here individuals are framed as 'consumers' who need to consume certain products or partake in certain health behaviours to combat subhealth, often involving alternative health practices.

One thing worth noting here is that in recent social media posts in the Chinese context, the text quoted above has been picked up as the origin of the concept of suboptimal health. In a video on 'suboptimal health' posted on a video-sharing platform called Bilibili, a platform mainly for young people, the presenter conducted a series of vox pop interviews to establish the popularity of the concept of suboptimal health. The presenter questioned the claim that subhealth is a WHO concept and then searched for this concept on Bing where he found this text and he concluded that subhealth was invented by Chinese medicine practitioners outside of China and that it reached China subsequently. Based on this, he criticised the validity of this concept and concluded that it is purely a bogus Chinese medicine concept (*Where Does 'Suboptimal Health' Come From? You Are In 'Suboptimal Health'!*, 2020).

This claim does not seem to be valid. First, the company (taoofherbs) seems to have been founded in 1994, which is after the concept of subhealth emerged in China, and this particular article is likely to be much more recent than that. Moreover, there are quite a few anglophone articles on subhealth with similar rhetoric, which means this text is not unique. All these articles define subhealth in very similar ways to those in the Chinese context and it is more likely that the latter were a result of the popularity of subhealth in China in relation to Chinese medicine, rather than the source of that popularity.

So, what of its true origins? Is there an origin? Should we be talking in terms of an 'origin' of this concept at all?

In the following section, I will try to trace the scattered occurrences of the concept of subhealth before it travelled to China. I do this partly because whether this concept has a Western prelude and whether it is a WHO concept seems to be a key aspect whenever debate occurs in China over the concept's validity. Yet no one appears to have attempted to trace this concept systematically or at any great length. This section therefore seeks to draw out a conceptual history of subhealth.

Table 5.1 Landmarks in the conceptual history of sub-health (its definition and measurement) and its competing concepts

Year	Use of sub-health	Year	Competing concepts
1836	Incurred in the discussion of magnetism, constructed as the opposition of 'superhealth'		
		1927	Chronic illness as a category in in Index Medicus
		1941	Positive health (health as an ideal state)
		1948	WHO definition of health
1960	Rogers proposed the ideas of 'optimum health' and 'suboptimum health',, which recognize health as a spectrum and bring attention to the grey area of health before the occurrence of disease	1951	Parson's functional theory of health Talcott Parsons in*The Social System* (1951)
		1957	Dunn's theory of health, focusing on wellness, which is later associated with positive health
1982	N Berman made note of 'the third status'		

1996	Yuxue Wang proposed 'suboptimal health' in the Chinese context		
	The concept gets picked up in TCM		Fuzzy health
2000s	Increasing use of the term in Western discourse on public health and personalized medicine		

5.2 Subhealth and WHO

For those who defend the validity of the concept and the objective existence of the concept in the polarized debate on subhealth in China, its occasional occurrence on the WHO website is often cited as an example of its validity as a WHO concept. A search of the WHO website does reveal a few scattered mentions of the term, but its meaning seems to differ from the Chinese context. The WHO never introduced nor defined the concept directly, it seems, though it appeared here and there in WHO contexts. However, the populations categorized as having subhealth are different to the ones in recent Chinese epidemiological studies. This can be seen in the following example:

> Poor social and physical infrastructure, political crises, lack of partner alignment in their health and development assistance efforts and poor regional production capacity also contribute to the suboptimal health of populations.
> （WHO, PMNCH/Africa Public Health Alliance press release: African health financing, 2011）

This excerpt is addressing health in Africa, and suboptimal health is used as an adjective categorizing the health condition of the African population. Subhealth is seen as a serious problem arising from social, economic, and political causes as well as a lack of medical provisions, and in this excerpt suboptimal health is clearly not referring to the middle-class

bodily complaints familiar from the Chinese context.

More recently, efforts have been made to 'improve health, rather than maintaining current suboptimal health, diseases and illnesses' (2018), in the address by Eugene Hamilton at the 71st World Health Assembly in 2018, as part of the aims of 'Health for all: Commit to Universal Health Coverage'. In this context, subhealth is seen as a risk factor for other eventualities, such as adverse outcomes from giving birth.

Universal health coverage (UHC) is a goal of the WHO that was initially set in motion between 1925–1952, revived and made prominent again in 2015 (Gorsky and Sirrs, 2018), and the speech cited above was made in this context. Again, subhealth, in addition to diseases and illnesses, was posed as an issue facing the population (of the world, as implied in the speech) requiring global health provision. It is unclear what exactly is meant by suboptimal health, however. Perhaps the following example can shed some light:

> Cost–utility analysis is a very well-established method for the economic evaluation of health care interventions. It relies on stated-preference methods to elicit preferences over different health states. For example, in the standard gamble method, respondents are asked about their preferences between a gamble that might result in perfect health or death versus resulting with certainty in a suboptimal health state (such as a chronic illness).
> (The Economics Of Social Determinants Of Health And Health Inequalities: a resource book, WHO, p43)

Here, subhealth is posited against perfect health, and the suboptimal health state seems to encompass anything that is not ideal health. There are a few other examples scattered throughout the WHO website that invoke the term of suboptimal health and it seems to include a wide range of health states including chronic illness, underlying disease and nutrition deficiency.

There is another dimension of suboptimal health that is revealed in the above excerpt, that is, the relation between suboptimal health and cost-utility analyses of health care interventions. Suboptimal health seems to encompass any health condition that is deemed less

than ideal, and evaluations of such suboptimal health states are elicited with a range of measures such as time trade-off or standard gamble in these instances. This partly reflects the concern to standardize the characterization of health states and to rank them based on level of severity, which has emerged since the 1960s and eventually led to the dominance of QALY in health policy and health economics (MacKillop and Sheard, 2018). MacKillop and Sheard also commented that from the late 1960s, a final key move adopted cardinal measurements to order states of illness as well as quantify their undesirability, which eventually shaped the QALY framework (2018). In this sense, suboptimal health is an arbitrary space separated from perfect health so that different kinds of trade-offs between suboptimal health and perfect health are made possible. Indeed, for this purpose, health is envisioned as a continuum, and the term suboptimal health is only very occasionally incurred as an overarching, empty construct.

As I have illustrated, the WHO has made some references to suboptimal health, although the meaning differs from the Chinese context. Next, I will look at other western public health literature occurrences and examine the common themes and look at how the space of suboptimal health was gradually carved out, and eventually aligned with the contemporary Chinese understanding of the concept.

5.3 To 'carve out' suboptimal health

In this section I will discuss the fluctuating definitions and fluctuations in thresholds when efforts are made to define suboptimal health.

In 1960, in *Human ecology and health: An introduction for administrators*, E.S. Rogers devised a conceptual framework of health, viewing it as a continuum, which included suboptimal health as one discrete stage (as seen in the figure below).[12] This is the earliest

12. Here, Rogers used suboptimum health instead of suboptimal health, but in subsequent references that

systematic definition of suboptimal health that can be found although there had been occasional uses of the word subhealth, or suboptimal health in earlier documents than this.

The scale is reproduced here:

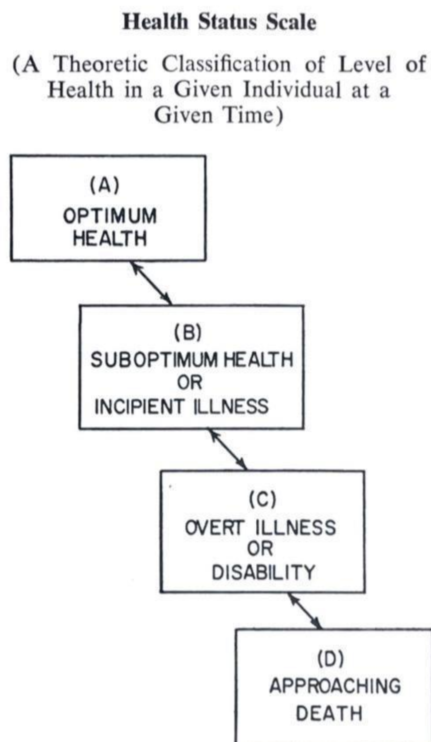

Figure 5.1: Health status scale, E.S Rogers (1960)

In this scale, health is divided into four different statuses: (A) optimum health, (B) suboptimum health or incipient illness, (C) overt illness or disability and (D) approaching death. In this way, subhealth is concretely carved out as a particular health status, differentiated from overt illness or disability, while also distinct from optimum health. It is very similar to the contemporary Chinese (or ancient Chinese) notion of subhealth, as the state between optimal health and overt illness.

The coining of the concept of suboptimal health seems to be situated in the context of a

---

quoted Rogers, the term gradually became suboptimal health.

growing interest in ranking health on a scale, turning it into numbers, deciding on its undesirability and calculating the necessity and effectiveness of healthcare input, which grew into health economics. However, this formulation by Rogers, although sharing many of the key concerns with later formulations (for example, QALY), has its focus on promotion of health and on highlighting an ecological understanding of health.

For Rogers, the aim of carving out the subhealth category is to facilitate public health services intervention. Embedded in this is a suspicion of relying exclusively on negative measurements of health and an urge to measure positive dimensions of health and to provide appropriate support at the most appropriate stage of the health status spectrum for the individual and the population, which in this context, is prior to overt illness or disability.

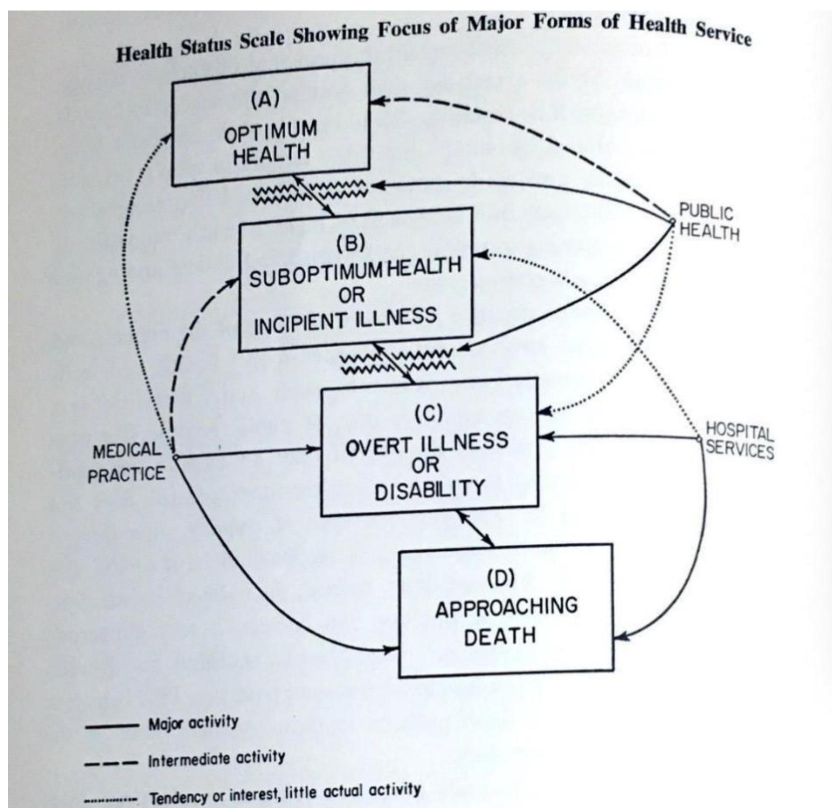

Figure 5.2: Health status scale showing focus of major forms of health service, E.S Rogers (1960)

As can be seen in the above figure, Rogers distinguished between three types of health

services: medical practice, hospital services, and public health. Hospital services are shown to serve overt illness or disability, as well as approaching death, with only tendency of interest in suboptimal health or incipient illness. On the other hand, public health is shown to have its major activity aimed at the intermediate state between optimal health and suboptimal health, as well as the intermediate state between suboptimal health and overt illness or disability. In this way, the space of suboptimal health is systematically carved out here so as to divert attention to its edges. Public health only deals with the state of suboptimal health when it is changing towards other states – whether travelling up, or travelling down. In this formulation, suboptimal health is a liminal state.

One dilemma mentioned by Rogers in devising this scale is the struggle to balance indexes that evaluate individual health (health-related quality of life) and population health indexes (usually referring to mortality), in a positive sense. A framework of health as a continuum is thus proposed for the individual, which is then conflated to the population. Rogers found it essential to devise such a scale in order to more effectively plan for the allocation of healthcare resources.

Medical practice, as the overarching practice, is shown to be a major activity for overt illness or disability, as well as the state of approaching death, but only an intermediate activity for suboptimal health or incipient illness, as well as tendency or interest in optimal health. It is here that Rogers, citing Ratner, distinguishes between preventive medicine and perfective medicine. He argues that preventive medicine is aimed at attempting to 'interpose a barrier to downward movement from optimum health to incipient illness' or 'to prevent downward movement from early illness to overt illness or disability' (Rogers, 1960, p. 177).

He then argues that this process does not produce better health and urges perfective medicine as the form that will 'promote health in the healthy' (Ratner, 1956, cited in Rogers, 1960). He equates perfective medicine with positive health, an enigmatic concept discussed

in depth by Locker and Gibson (2006). The way efforts are focused on determining the social aetiology of suboptimal health while glossing over its content is the direct opposite of what happened to positive health.

Rogers then goes on to distinguish between primary and secondary prevention, the former being 'concerned with keeping illness from occurring at all' while the latter is concerned with the earliest possible treatment. This distinction bears a striking resemblance to the Chinese context which distinguishes between 治未病 (preventing illness from taking place) and 治欲病 (treating incipient illness) where the space suboptimal health occupies is floating and unfixed between these two states.

Rogers's characterization of the goals and functions of medical practice and the space specified for public health fits perfectly well with what Deborah Lupton (1995) has called 'new' public health in *The imperative of health*, which focuses on health promotion. As can be revealed from the above analysis, subhealth has featured marginally in the 'new' notions of public health promotion – which emphasize the positive dimensions and measurements of health. In the new public health movement, Lupton discusses how dimensions of preventative medicine are identified and measures devised in order to improve overall population health. Subhealth, as featured in Rogers' model, is a carved-out area for diverting efforts of prevention, for the purpose of management of the health of the population.

In a book on *Alcohol and Nutrition* published in 1977, in one article entitled 'Marginal Nutrition and Conditioned Deficiencies', the author discussed the validity of using 'normal' populations as control groups in assessing nutritional status. Such a study is cited in the article, which I reproduce in full here because it bears some interesting resemblances to the studies on suboptimal health in China:

> … an earlier study (1967) by the U.S Public Health Service in which those interviewed were part of the 'normal' population who were not hospitalized. Respondents were asked whether they had experienced, within the past 12 months, any of 11 conditions, including asthma, stomach ulcer, hay fever. The percentages of

> those who experienced one or more chronic condition were 43 for ages 17 to 24; 59 for ages 25 to 44; 71 for ages 45 to 64; and 85 for age 65 and older. The complaints were not verified by physical examination. However, the responses indicated the incidence of suboptimal health. (pp. 26-28)

In this excerpt, the 'normal' population, defined as non-hospitalised, are found to be in suboptimal health. The figures reported here are not dissimilar to the figures for the prevalence of suboptimal health in China.

Having suboptimal health is thus framed as 'the normal' – those outside of the medical establishment of hospitals but within the surveillance of public health.

By 1980s, subhealth has been recorded as a 'rare, useful, and delightful' word in a book called *Grand panjandrum: and 1,999 other rare, useful, and delightful words and expressions*:

> A person who has no known or specific ailment but nevertheless feels tired and perhaps listless and lustless may be said to be in a state of subhealth. In ascending order, one may be in nonhealth, subhealth, or health. It is certainly easy to understand why 'To your health' or an equivalent expression is the toast most widely used around the world.
>
> (*Grand panjandrum: and 1,999 other rare, useful, and delightful words and expressions*, 1980)

The meaning denoted by the term subhealth has certainly more similarity to the contemporary Chinese context by this time. The state denoted by subhealth here – 'A person who has no known or specific ailment but nevertheless feels tired and perhaps listless and lustless' is quite similar to the subject suffering from suboptimal health in the Chinese context.

How did this definition arise? The following news article published in 1959 seems to shed some light.

Duke of Edinburgh Speaks on Fitness

Prince Philip was officially installed on June 30 as the first lay president of the Canadian Medical Association, and he took the opportunity to make an unusual Royal appeal to Canada's doctors to improve the physical fitness of the nation.

He said there was evidence that Canadians are not as fit as they might be and that the trend of medical statistics gave cause for concern. Despite the brilliant achievements of medical science in recent years and improved medical and hospital facilities, it would not be reasonable to assume that the general level of health is improving.

Canada's standard of living—almost the highest in the world—"is having the same effect upon the community as a plaster cast has on the muscles of the body." The answer, Prince Philip added, is proper physical education in schools, adequate recreational facilities for all ages and sections of the community, an extension of youth organization work, and an organization to publicize sports and recreational activities and to encourage participation.

Prince Philip enjoys many sports. Below, he is riding onto polo field at Cowdrey Park.

Urban living, increased leisure, more sedentary work, a higher standard of living and eating, and the medical assistance to children to survive have all been causes of an increase in sub-health. "It is estimated," he said, "that 34 percent of the male population of military age is unfit for military service, in which case the prospects are not good if an emergency should occur. Then there is the less vital question of national prestige in sports and games."

The Prince quoted United States figures on physical fitness "because I am led to believe that Canadian habits and manner of living are very similar." They suggested that "nearly half the younger population is already in a state of sub-health. I think the root of this problem lies in the state of the physical fitness of the young generations and therefore in the physical education of the children."

The Prince said there is a connection between emotional instability, low physical efficiency, and delinquency. "The lawless and the listless," he said, "are an equal menace. I expect you to give a lead in this matter. I believe you can do this by tackling sub-health and fitness as one of the most urgent problems confronting the medical profession.

"One thing I beg of you—don't go away from here saying, 'This has got nothing to do with me and anyhow I'm fully occupied with curing disease,' because you know it isn't true."
—David Spurgeon, Globe and Mail, *Toronto, July 1, 1959.*

(Journal of Health, Physical Education, Recreation Volume 30, 1959 - Issue 6)

This speech by Prince Philip seems to be a continuation of this concern. In his own words, as reported in the news article in 1959, addressing Canadian doctors:

> The lawless and the listless are an equal menace. I expect you to give a lead in this matter. I believe you can do this by tackling sub-health and fitness as one of the most urgent problems confronting the medical profession.

As can be seen in this report on Prince Philip's speech as the first lay president of the Canadian Medical Association appealing to Canadian doctors to improve the nation's physical fitness, subhealth is equated here with being 'listless'. This speech was delivered around the same time as Rogers was devising his health states scale, as is implied by the reference to health statistics in America. The prince quoted figures from the USA in reaching the conclusion that 'nearly half the younger population is in a state of sub-health', before urging more investment in improving children's physical education.

Here, the threshold for being in sub-health seems to have lowered and being listless has become a menace.

5.4 Subhealth as facilitating the discussion of environmental effects on health

As can be seen in the above examples, subhealth did exist outside of China, and was closely interlinked with the global public health agenda, health provision and health promotion. The term 'suboptimal health' appeared sporadically in public health discussions of childbirth, child development, nutrition, occupational medicine, rehabilitation medicine, and numerous other contexts, but it was rarely clearly defined and it has always been a marginal concern. With the modern awareness of chronic diseases and public health's role expanding beyond the control of communicable diseases, as well as the social medicine movement in Europe and in America, subhealth elusively existed there but at the margins, not being able to compete with concepts such as risk, which in 20th public health development has been made highly operationalizable. Its meaning has not always been consistent and the

scope it occupies has been in a state of flux, making it an empty construct that has been given different meanings in different contexts. At times it appears as an arbitrary concept facilitated to talk about causes of ill-health while its true meaning is never the focus in those texts.

In 1937, an article entitled ‘Mineral requirements in human nutrition’ published in *The Journal of State Medicine* discussed the effects of environment and food intake on human health:

> In hot climates and among people working in hot atmospheres an inadequate intake of sodium chloride is probably the cause of a great deal of suboptimal health. Plant foods contain much less sodium than animal foods and relatively more potassium.
> (‘Mineral requirements in human nutrition’, *The Journal of State Medicine*, 1937)

Similarly, in another article, the relationship between nutrition and suboptimal health is again picked up:

> The common occurrence of nutritional anemia in pregnancy is a cause of suboptimal health for both mother and child which could largely be avoided by attention to diet and iron intake.
> (Nestle’s Nutrition Beliefs, 1944)

The concept of ‘suboptimal’ here serves to concretize the lack of certain nutrition into bodily manifestations.

In some ways, suboptimal health and positive health, although pointing to seemingly different states of human health, share a similar agenda. Locker and Gibson (2006) discussed how in the initial stage of drafting the WHO view of health, there was an agenda to point out that health provision was not just the responsibility of the hospital, but of the whole society. This focus on environment and social provision is implicit in some reiterations of subhealth.

A recurring theme in texts mentioning suboptimal health is its relationship with work. The following text is interesting in this regard in its discussion of the environment of work and its impact on health:

> The objects of this teaching must be kept clearly in mind. The teaching should be directed to help the future doctor to interpret objectively the society in which he lives. He must learn to recognize the mental and physical responses of the individual to occupational factors, and he must appreciate, for example, something of the following.
>
> i) The part played by occupation in producing conditions of sub-health as well as frank disease, and its varying effects on both early and established disease, such as the dyspepsia of the night worker as well as the colic of the lead-worker, and the effect of various types of work on 'rheumatism';
> ii) The important part played by work in treatment and after-care, as, for example, the degrading effects of unemployment and idleness, or the prescription of work for the man with mitral stenosis.
>
> (Modern trends in public health, 1949)

Here, work is at the same time a cause of subhealth and a treatment for subhealth, and recurring discussions of subhealth on Chinese social media following the change in patterns of work after the pandemic bear resemblance to this (I will discuss this in detail in Chapter Seven).

Subhealth is posed as an issue that threatens productivity:

> Each year some 200,000 people in Great Britain cease work due to industrial accidents alone, but these account for only 20 per cent of the total accident risk to the population generally, while conditions of sub-health resulting in temporary disability constitute an even greater wastage of manpower. What, then, can industry do towards the solution of this problem and what assistance will it require in the accomplishment of this task?
>
> (*Modern Treatment Yearbook*, 1955)

Subhealth facilitates the possibility of discussing the effects of work on human health and the risk it carries. Thus, it is the responsibility of public health/health services to intervene, with the purpose of increasing productivity and avoiding wasting manpower.

It seems that, more recently, there has been a shift from social responsibility to individual responsibility for subhealth conditions. When commenting on women's health in 1988, particularly the effect of smoking on health, the authors remarked that

… Once again, although women may have an increased choice of whether or not to smoke, many appear to be making the choice which leads to suboptimal health.

(Women's Health Perspectives, 1988)

It these ways, subhealth, as a seemingly innocent construct, is shaped, first by the emergence of social medicine in the 1930s and 1940s, and then by the change of the wheel in the 1980s when individuals were assumed to hold responsibility for their health.

5.5 The entangled origin of subhealth in China

In *Subhealth: A New Concept of Health for the 21st Century*, Wang outlined his inspirations and his affiliations. He founded and was the editor-in-chief for the journal *Recuperation And Rehabilitation Medicine* (which later changed its name to *Medical Journal of Qilu*). He also mentioned that he was inspired by the sanatorium medicine from the Soviet Union and the concept of the 'Third State'. This concept of the 'Third State', attributed to N. Berkman, has since been considered the prelude of the concept of suboptimal health in China. I have tried to find the original article by Berkman, but since it is in Russian, it is quite difficult to access. I have found a Chinese translation of Berkman's article.

In his article, Berkman proposes that there is a third status between health and illness, and he further argues that 'the third status' is a social problem that will compromise the productivity of the society and thus needs to be addressed. In this way, 'the third state' only becomes a concern because it threatens productivity:

> Long before getting sick (or maybe not getting sick), most people are in a state of incomplete health to varying degrees. The range of adaptive capacity cannot be summarized by either disease or health. There are a series of intermediate states between the two. Sometimes they are close to being healthy and sometimes close to being sick, but they are neither healthy nor sick. There has not been enough research on this intermediate state, and there is no suitable name for it. Let's call it the 'third state'... Based on the survey of 1,763 workers and employees, it is inferred that the people in the 'third state' are more than half of the population. Sickness only lasts a few weeks, months, and usually not long, while the 'third state' lasts longer, years, decades, or even a lifetime. Usually, people who are sick cannot work, while people in the 'third state' still work. The 'third state' greatly reduces the labour potential of

> society. The main source of expanding the labour reserve is to reduce the number of people in the 'third state', not to cure diseases.
>
> (The philosophical aspect of human health --methodological issues, N Berkman, 1982)

It is at this point the connection between the concept and Foucault's conception of biopower becomes apparent. The minor complaints of the population have become part of 'the set of mechanisms through which the basic biological features of the human species became the object of a political strategy, of a general strategy of power' (Foucault, 2009, p1).

Berkman also attributes this problem to the opposition between human as subject and human as object.

> The main goal pursued by the optimization of the biological environment and the realization of ecological production is to protect nature. Achieving this goal will benefit people, but it will not solve all the problems of protecting health. The person as the subject is the main driving force of the scientific and technological revolution accompanied by all ecological consequences. At the same time, the person as a part of nature is the main object of these consequences. The unity of opposites between subject and object destroys human internal ecology, which is the main reason for ' 'the third state' and illness. (N Berkman, 1982, my translation from the Chinese excerpt translated by Chang, 1982)

5.6 Subhealth and predictive, preventive, and personalised medicine

Although most of the articles invoking the concept of 'sub-health' are published in Chinese journals, in recent years, the term has started to reappear in Western discourse. I provide a preliminary analysis of its occasional occurrences within debates around predictive, preventive, and personalised medicine. To some degree, this term is used because it can help to identify a sub-population in sub-optimal health as the target group for targeted preventive health measures.

To some extent, the development termed as 'surveillance medicine' has fed into the development of predictive, preventive, and personalized medicine, having emerged in the late 20th century and ongoing in the 21st century, a trend that aims to make medicine more efficient by treating disease tendencies well in advance and by being more tailored to the

individual. The conventional treatment of clinical symptoms when they start to manifest is seen as very belated, and it is proposed that providing health assistance before more severe clinical manifestations would be much more efficient and less costly. As defined in a 2016 article on predictive, preventive, and personalised medicine (PPPM) published as EMPA (European Association for Predictive, Preventive and Personalized Medicine, a key institution championing this new type of medicine) position paper of the year, PPPM is:

> a really complex all-encompassing approach … clear concepts demonstrating the highest level of maturity; the most optimal strategies considering interests of healthy individuals, subpopulations, patient cohorts, healthcare systems and society as a whole. (Golubnitschaja et al., 2016).

This is a trend that is partly fuelled by the advancement in genomics. Such hopes and expectations can be seen, for example, in a 1997 report envisioning how genomics was helping to manufacture drugs targeted at individuals instead of the 'average person' (Marshall, 1997). On the other hand, pharmacogenetics helps doctors to understand more about the interactions between drugs and the body mechanisms. For example, the ApoE ε4 genotype, a key genetic risk factor for AD, has aroused much debate concerning how it should be used in clinical practice (Hedgecoe, 2003). In this way, increases in data are deemed necessary in the treatment of patients, as well as in understanding the health levels of individuals, including genomic, protein, metabolic, epigenetic, environmental and clinical data. After all, it is the advancement in genomics, proteomics, metabolomics, and bioinformatics that has given us the ability to predict and prevent diseases. These data 'secure visualising of lesion foci that was previously unknown to clinicians' (Sadkovsky et al., 2014). They make the gaze penetrative, not only through the surface of the body towards the smallest possible segment, but also across time.

In so doing, a person's identity becomes transformed, since ultimately, the data about one's body feeds into a statistical whole. In this way, our body changes from an object under

medical gaze to a statistical body, being a part of the population data in its entirety (Stevens, 2016). Often, these measurements are not aimed at the individual, but a cohort instead. In personalised medicine, data about DNA, RNA and protein are preferred and privileged because they are more conducive to 'reading, storage and analysis on a big scale'. As can be seen, what is deemed personalised is not entirely personal. Golubnitschaja et al. distinguish between 'semi-personalised' and 'true personalised' medicine. In the former, there is a compromise between standardisation and individualisation, which involves analysing well-known characteristics in large scale groups. The latter, on the other hand, aims at true individualisation by setting up an 'individual patient profile' (Golubnitschaja et al., 2016). How is a genuinely individual patient profile possible?

Imbedded in the vision of personalized medicine is the idea that one's personal health data needs to be collected in order to predict and track one's health status, and one's health level can be decided by processing one's own data against one's bodily equilibrium. However, this is only possible when a large population of people participate and provide data. One issue arising is that the individual has become a 'data provider' in order to benefit from 'personalized' medicine, instead of a subjective being in all his or her complexity. What might be perceived as truly personal, such the personal perception of the body, his or her own health complaints, and so on, is largely missing so far. The notion of 'sub-optimal health' in this context is a small strand within personalized medicine that allows for more nuances of the subjective body, usually invoked in relation to alternative and complementary medicine, and most prominently in Chinese medicine.

To compile a genuinely individual patient profile, the subjective data from the patient should play a part too. In addition to biomedical data, there is another dimension of a person's health: his or her perceived and self-rated health – 'softer', 'first-hand' data from people who are experiencing their body in its full complexity and subjectivity.

With the development of personalized medicine, this concept has appeared in journal articles, in the fields of public health, translational medicine and personalized medicine (see Chen et al., 2014; Wang, 2016; Wang and Yan, 2012, Wang et al., 2014). As remarked by Ying Zhang and Jing Shao, in the latest use of the term 'suboptimal health', the meaning has shifted from the entirely subjective judgment to the inherent mechanisms of diseases (Zhang and Shao, 2016). Publications on 'sub-health' have also emerged in some Western journals, such as *EPMA Journal* and *Journal of Translational Medicine*. Among these publications, an interesting tendency recurs in how the subjective dimension of suboptimal health is blurred and downplayed, in order to be rendered for large-scale statistical analysis. There is visibly an intricate negotiation between subjective measurement and biomedical measurement in connecting suboptimal health with risk factors. Self-rating scales such as SHSQ-25 are combined with other standard biomedical tests in order to associate them with the progression of chronic diseases. Sub-health is thus quoted as 'a translational medicine instrument for health measuring in the general population' (Wang and Yan, 2012). This can be seen in an article titled 'Voice perturbations under the stress overload in young individuals: phenotyping and suboptimal health as predictors for cascading pathologies' published in EPMA in 2020. The abstract of this article states:

> Our current study revealed voice perturbations under the stress overload as a potentially useful biomarker to identify individuals in suboptimal health conditions who might be strongly predisposed to associated pathologies.
> …
> Further, predictive machine learning models should be developed that allow for detecting a suboptimal health condition based on voice recordings, ideally in an automated manner using derived digital biomarkers. Follow-up stratification and monitoring of individuals in suboptimal health conditions are recommended using disease-specific cell-free nucleic acids (ccfDNA, ctDNA, mtDNA, miRNA) combined with metabolic patterns detected in body fluids. Application of the cost-effective targeted prevention within the phase of reversible health damage is recommended based on the individualised patient profiling. (Kunin et al., 2020)

As can be seen in the excerpt from this abstract, the concept of 'suboptimal health' into

personalised medicine is a synonym for risk factors, while the more personal and subjective dimensions of alternative medicine subside and are transformed into the mainstream statistical vision of health.

5.7 Subhealth as an inherent problem of modernity?

As we can see, different narratives have been constructed around the prevalence of suboptimal health. On the one hand, there is the claim that there is less suboptimal health:

> Food plays an important role in one's physical well-being and emotional attitudes. To be in an optimal state of health requires interest, knowledge, faith, and persistence. In this day of food consciousness there is less cause for suboptimal health than ever before.
> (Chaney and Ahlborn, *Nutrition*, 1934)

Here suboptimal health refers to physical manifestations of lack of nutrition, and efforts made in the field of nutrition are seen as effectively addressing suboptimal health. The concept of suboptimal health is used here to tell a tale of medical advancement. However, opposite statements have also been made, framing suboptimal health as caused by 'changes in the pattern of human society', and the modern sedentary lifestyle.

> ... Sports Advisory Council, that despite the brilliant achievements of medical science and improved hospital and medical facilities, figures indicate that the general level of health is not improving. This increase in subhealth is directly related to changes in the pattern of human society…
>
> Saskatchewan. Recreation, 1953

> The conditions of modem life provide us with many excuses for avoiding the challenge of physical fitness and accepting, by default, the various grades of sub-health that await us. It is impossible to estimate accurately how much of the burden of musculoskeletal, degenerative and functional disease would be lifted if our level of fitness were to be improved over the next few decades. However, independent of the gains in physical health, the rewards in terms of genuine enjoyment of the life lived should impel us to do anything we can, as a profession and as individuals, to help the youth of the nation attain Tait MacKenzie's ideal of wholeness in so far as each is able.
>
> (*The Canadian Medical Association Journal*, 1962)

These two texts are similar to texts in the Chinese contexts where subhealth is a problem caused by urbanization and the modern lifestyle. Medical progress, decreased mortality rates and increased standard of living somehow shape a population that is in subhealth (as reflected in Prince Philip's speech earlier). This narrative seemed to become more and more frequently aired, the concept being framed in different ways, as either a modern condition, crisis of modernity, or a condition that is afforded by modernity.

5.8 Summary

The concept, whenever is evoked in China, is often said to be a Western concept, a WHO concept, and I have discussed why that is the case. Following on from the findings in Chapter 4, this chapter discusses the relation between this concept and public health in the West, the way suboptimal health has been used in WHO, and the ways in which it has been marginalized, and ultimately, been incorporated to some extent into personalised medicine.

Upon tracing the descendants of the concept, it seems that suboptimal health, although an elusive concept, was born out of a public health agenda of defining health in positive terms and paying attention to socio-environmental determinants of health. The term 'suboptimal health' was used intermittently in public health discussions of such issues as childbirth, child development, nutrition, occupational medicine, and rehabilitation medicine, but it was rarely clearly defined, and it has always been marginal. Its meaning in some cases is similar to the contemporary Chinese usage, but in some other cases its meaning is broader, encompassing everything that is neither perfect health nor death. In those appearances, the concept seems to be used as a construct that facilitates the discussion of environmental effects on health. Often, when invoking suboptimal health, the texts either tell a grand narrative of historical progress in health care, or deterioration of health due to industrialization. On the other hand, it is used in functional terms and embodies a concern with productivity.

By tracing the descendants of the concept of suboptimal health, it seems that the concept has been, throughout history, invoked in public health because it renders private feelings of health and illness public and manageable, even in economic terms. It constantly slides between denoting the health state of an individual, and the health state of a nation (or the world), negotiating between subjective experiences and biomedical manifestations.

Chapter 6: Suboptimal health as latent in the practice of *Yangsheng*

> Hence, [when it is said that]
> 'the sages did not treat those already ill, but treated those not yet ill,
> they did not put in order what was already in disorder, but put in order what was not yet in disorder,'
> then this means just the same.
> Now,
> when drugs are employed for therapy only after a disease has become fully developed,
> when [attempts at] restoring order are initiated only after disorder has fully developed,
> this is as if a well were dug when one is thirsty,
> and as if weapons were cast when the fight is on.
> Would not this be too late, too?

The Inner Canon of Huangdi[13] (Unschuld and Tessenow, 2011:58)

In this chapter I will discuss the concept of suboptimal health in relation to the practices of TCM, drawing on data from my fieldwork at the TCM clinic in England, virtual ethnography on Weibo, as well as from my interviews with people brought up in China. In this chapter, I will focus on the concept of suboptimal health in medical encounters whilst zooming in on multiple sites where it participates either manifestly or latently. The first part of the chapter focuses on the daily practices of the clinic, the doctor's understanding of TCM and suboptimal health, with most of the data collected in the form of participant observation, or from interviews with the doctor. It also probes whether the concept bears any relevance to the experiences of the visitors of the clinic, based on my interviews with the clinic visitors. As we shall see, the concept sits as a latent construct behind much of the activity at the clinic.

13. Rendered thus in the translation by Unschuld, Tessenow, and Zheng (2011)

The second part of the chapter discusses young people in contemporary China, their idea of Yangsheng (养生), which is intimately related to subhealth, and their encounters with TCM or biomedicine when they try to act on their ‘suboptimal health’, examining posts made online - short, fragmented accounts of individual encounters as well looking at my own interviews with young people from China on subhealth.

As already mentioned in the previous chapters, the concept of suboptimal health has some affinity with ideas in traditional Chinese medicine about what health is, and good practices in maintaining good health, namely, the ideas on Yangsheng (养生), and ‘治未病’ (there have been different interpretations and translations of this term, for example: ‘treat the not yet ill’; ‘treat the diseases before their external manifestations’, or ‘preventing diseases from taking place’). In this way it contrasts with much of the sociology of health and illness that, for example, focuses on narratives of chronic illness (see Bury, 1982; Cornwell, 1984, etc). There are some anthropological writings on the contemporary practices of Yangsheng (养生) but very rarely is it talked about in relation to Western medicine in a theoretical orientation. Although I focus on health practices in this chapter, I am interested in what this entanglement of knowledge, practices and materials illuminates in relation to the function of the conceptual space of ‘not ill but not healthy’.

Suboptimal health was present in the doctor’s discussion of her profession, and her understanding of the advantages of TCM. Also, it was acknowledged to be relevant to some of my interviewees recruited from the clinic when I mentioned the term, particularly for an interviewee who was suffering from ME. I have touched on the life narratives lightly to examine their reasons for visiting the clinic, their views on health and what being healthy means in general, as well as their views and experiences of navigating traditional Chinese medicine, Western medicine and other medical traditions.

6.1 Practicing TCM in the UK and where subhealth is relevant

6.1.1 The practice in the clinic (from the perspective of a receptionist)

I still remember the first time when I entered the clinic to be interviewed for the post of receptionist - I was struck by the newspaper articles displayed on the wall about this clinic, and some of the doctor's published articles displayed on a board. Over time, as the receptionist, I had more time to look at them. There were news reports introducing the clinic, and there were also some news articles on the wonders of TCM, with one article bearing the headline 'Not feeling well? Then try some medicine tailored just for you'.

Another distinctive element of the clinic (the waiting room, to be exact, as that is what people see when they first enter the clinic) is the large collection of dry herbs stored in different boxes on the shelves, directly facing the door and easily seen. The receptionist's desk is there too. I later became part of the furniture. After I started working there, I often noticed the moments when the clinic visitors first entered the waiting room and looked around the walls. Their eyes dwelled on the newspapers, but also on the herbs in the boxes and me picking different herbs and spreading them in the plates. Sometimes they asked me whether I was training to be a TCM practitioner myself, and I often needed to explain that I was doing a PhD in sociology (for the first two years I said I was doing a PhD in philosophy). Those tended to be the new visitors. There were also some familiar faces who came here regularly who would quietly pick up a magazine or play on their phone while waiting, and we did not converse much (this perhaps also had something to do with my being less than adept at small talk). Occasionally their eyes would dwell on the wall and notice a new article, and seem quite interested. Over time, some of the regular visitors figured what I was doing and what topics I was interested in because of my research. When I was not busy with preparing the medicine or other administrative tasks, sometimes the waiting room became a space for interesting conversations between myself and the visitor, or between the visitors themselves, while they waited to be seen by the doctor. The clinic tended to be quite busy and sometimes

they needed to wait before being seen. The waiting room is a space that is quite public, but since it is not that spacious, I feel it has some privateness to it as well. It is also indoors but very much connected with the outdoors. It is situated in the backyard of the doctor's house – the doctor has transformed the ground floor of the house into the clinic, and the waiting room faces the garden. It has a very wide door and when it is open it feels very much outside – it later became something of a necessity during the time of COVID-19, for ventilation purposes.

Figure 6.1 Photo of author picking the herbs, with the boxes of dry herbs prominently displayed on the wall behind.

When the visitors entered the clinic room to see the doctor, it would be more private. They would sit at a chair next to the doctor's desk. The doctor would take their pulse, sometimes ask to see their tongue, ask how they had been feeling, talk to them about their general health and wellbeing and after that they would undress so that the doctor could put in needles for acupuncture. The doctor would write a prescription and hand it to me while the

visitors were having acupuncture, and I would strive to get the medicine ready before their acupuncture was finished. There are three types of medicine: the dry herbs, herbs in powder form, and Chinese patent medicines. Usually the most time-consuming activity was picking the dry herbs. Firstly, I put the required number of plates on the table. For example, the doctor might write 6 on the note, and I would need to put six plates on the table and prepare six packets of herbs, with the content of each packet being the same. I would then follow the doctor's prescription in picking the different ingredients. There might be 20 ingredients and I would measure each ingredient one by one and spread them onto the plates. After getting all ingredients onto the plates, I put the content of each plate into a paper bag. I would usually use an old, metal, non-digital measuring scale (no idea how long it had been in the clinic) that I was taught to use when I started the job. A few digital measuring scales were purchased over the years, but I never got quite used to them. That metal, non-digital measuring scale is occasionally an item that the new visitors comment on. I guess it fits a certain imagination of an ancient medicine.

As can be seen in the picture above, there are some smaller bottles on the right side of the wall, which contain granules/powders that I mix in a similar manner to picking the herbs, following the prescriptions from the doctor. This also requires some level of labour from me. I need to find different kinds of powder from the shelves and mix them together and put them in a box container, to be taken home by the visitors. Apart from herbs and powders, there is a third possible material form for the medicine, that is, patented pills/tablets. Those take the least effort to prepare as I just need to go to the storage room and locate the right box/bottle. According to the doctor, the different material forms have different levels of effectiveness. The dry herbs are the strongest, but in addition to taking the longest time for me to prepare, they also take hours for the visitors to cook at home. The visitors need to sink the herbs in water and cook in a pot for hours, before draining the content and keeping the juice to drink.

The efficacy of the powder comes next, as mentioned by the doctor, and commented on by some visitors. The visitor will need to take the bottle of powder home and drink three teaspoons twice a day with water.

Both packets of dry herbs and bottles of powder are quite individualized. The doctor prescribes specific ingredients based on the differentiation of that person at that particular time. Due to this, not only does it differ from person to person, but it also differs from time to time for the same visitor as the doctor will potentially make adaptations for each visit. The patented pills, on the other hand, are readily manufactured following traditional and famous formulas by different companies. For example, there is a patented pill called 加味逍遥丸 (Jia Wei Xiao Yao Wan), and in the clinic we sometimes refer to it as the 'Happy Pill'. It contains Bupleurum 柴胡, Angelica 当归, White Peony 白芍, Atractylodes macrocephala 白术, Poria 茯苓, Licorice 甘草, Moutan Bark 牡丹皮, Gardenia 栀子 and Mint 薄荷. The list of the ingredients follows a classic formula and is supposed to soothe the liver and clear away heat, invigorating the spleen and nourishing blood. It will be prescribed in different scenarios as the doctor sees fit but since the formula is already made and no adjustment can be made, personalization is therefore not possible. As a result, there is less 'nuance', as Wendy (one of the participants from the clinic) would say. They are in the form of very small black pills, or sometimes larger tablets.

By the time I started working there, the doctor had been running the clinic for over twenty years, having arrived in the UK in the 1990s when alternative medicine was picking up in popularity; and therefore, the clinic had been doing quite well over the years. She treats a wide range of different conditions and has become renowned for her ability to treat infertility and thus attracts wanna-be parents who are considering or going through IVF each year. When I talked to the doctor about her practice of TCM, she told me that she graduated from a renowned TCM university in China and learned from the Chinese medicine masters at a time

when things were going back to normal and people could go to university again, after the Cultural Revolution. She mentioned this and commented that for this reason, the masters of Chinese medicine were very willing to teach students (instead of just their own disciples – since they hadn't been able to teach in universities for a long while at that point) and she learned a lot from different masters from different schools or different traditions and learnt about all schools of TCM theories. But she also emphasized that to be a good TCM doctor was not just about the training: whether you can treat the patients well is a multifaceted matter because there are people with similar qualifications who can't really communicate and treat the patients satisfactorily. There is a sense of intuitive knowledge, and different kinds of skills involved in the encounters with the visitors beyond knowledge of TCM theories. This is something I observe from the clinic as well - a sense of trust, and the attention to the visitor's embodiment are always there in the encounters. I interviewed the doctor a few times on the concept of subhealth and most of those interviews took place in the clinic, during the lunch break, or in the brief down time before a visitor's arrival.

6.1.2 Defining Subhealth in the context of the clinic

When I asked the doctor about the concept of subhealth, she framed it around the history and limitations of Western medicine:

> 怎么说呢，就说对从学中医开始中医就不是特别 pay attention for 疾病 only，他就是说中医本身他的那个就说治疗的底线就比西医低，因为上次我们说过，就说人不是说从离开健康就是疾病的，对，实际上就是说如果说健康到疾病到死亡画一个曲线的话，西医负责的是重病到死亡的这一阶段。 我上次说过就说一战二战使西医在这方面有革命性的发展，应该说对人类有很大的贡献。
>
> Well, since the beginning of studying Chinese medicine, I understood that Chinese medicine does not particularly pay attention to diseases only; what this means is that Chinese medicine itself, has a lower threshold of treatment than that of Western medicine, because as we talked about last time, people do not depart from health and suddenly end up with disease. Yes, in fact, if one draws a curve from health to disease to death, Western medicine is responsible for the stage from serious illness to death. As I said last time, during World War I and World War II Western medicine experienced a revolutionary development in this area and indeed it has made a great

contribution to mankind.

那么西医只有 100 多年历史嘛，对吧？从西医发展以后就说人很好的解决了死亡，危重疾病、传染病的这些病，抢救什么这些，如果解决了，实际上就人的寿命已经大大提高了，那么可实际上最近这个应该算二战以后，到现在七八十年了，七八十年就说整个西方国家它也就平静了，那些生命状态就是生活状态比较好的人，就开始最先对西医不满意了，为什么不满意？他们不满意有病才治。那么这时候亚健康状态的这个概念就开始越来越兴盛。

But there is only more than 100 years of history for Western medicine, right? Since the development of Western medicine, it can be said that life-threatening conditions, critical illness, infectious diseases, and acute conditions are resolved quite well. In fact, people's life span has been greatly improved. If we consider the time after World War II, it has been 70 or 80 years now. In these 70 or 80 years, on the whole Western countries have been quite peaceful. Those who are in a better state of life are the first to be dissatisfied with Western medicine. Why are they dissatisfied? They are dissatisfied that they are treated only when they are sick. Then it is in this context the concept of sub-optimal health status began to flourish at this time.

作为中医，我们自己本身就知道，因为中医是从人离开了健康就可以辨证论治，可以给予治疗，西医一定要达到足够疾病的诊断标准才开始治疗，所以就说中医的开始对健康的调护要比西医的早，要比西医早。那么关于从离开健康到疾病的过程，也就是说最近应该算有 20 年，大概就有人提出了这个概念，叫亚健康状态，pre-clinical condition。

As TCM doctors, we have always known this, because TCM can give differentiations to a person's conditions and provide treatment after a person has departed from health, while in order to be treated by Western medicine, one must meet the diagnostic criteria of disease. Therefore, TCM can provide care for health much earlier than Western medicine. So, concerning the process of leaving health and getting illness, it has been around 20 years when it got attention, and some people have proposed this concept, 亚健康状态 (suboptimal health status), or pre-clinical condition.

In the above excerpt, she started with her understanding of TCM, and how TCM has a different focus compared to biomedicine – a lower threshold to treatment. Whenever she discussed the utility of TCM, a short history of Western medicine and the sociocultural contexts in the West also tended to be mentioned. She would commend the rapid developments in Western medicine and the improvements in quality of life, but this would then lead up to her discussion of the dissatisfaction with Western medicine experienced by some people after the problems of life and death have been solved. She would then link this

to the long-standing tradition of differentiation in TCM and how TCM has always emphasized treating disease before it manifests. In the system of TCM, everyone receives a unique differentiation about their body. This is key to the practice of TCM and my work in the clinic – making herbs based on the unique differentiation and therefore the unique formula as prescribed by the doctor. In the interviews, the doctor gave me a systematic account of the different kinds of pathogenic factors as classified in Chinese medicine: wind, cold, heat, wetness, dryness and fire. She also mentioned different kinds of upright qi in the body. In chapter 4, I discussed how subhealth is utilized by TCM practitioners to connect to TCM classificatory/differentiation systems, making it accessible for lay people. Here in the clinic, I observed the related practices in treatment/toning health. In the last sentence of the interview quoted above, she commented on the short history of the concept of suboptimal health status (亚健康状态), but she gave an English translation for the term - for her, that is pre-clinical condition. Our interviews were in Chinese, so we referred to the concept of suboptimal health as 亚健康，but she often would translate this term as preclinical conditions, or preclinical state. For her, the two are the same. She mentioned that calling it 'preclinical' shows understanding of TCM while also being in line with Western medicine.

She went on to define subhealth in this way, in the context of the TCM view of the aetiology of diseases:

> 那么这样的话中医就认为疾病的产生是一个正邪相搏的结果，那么这些正邪相搏的结果就不是一定产生疾病，对吧？那么就是说邪气强，正气打不过邪气，就逐渐发展为疾病的过程。那么如果说正气强，就有可能发展为痊愈，最后就回到健康的这个过程。那么所谓亚健康从中医理论来说就是一个正邪相搏的过程。
>
> Chinese medicine believes that the occurrence of disease is the result of a fight between upright qi and pathogenic factors, so the result of these fights does not necessarily produce disease, right? If pathogenic factors are strong, and the upright qi within your body can't beat them, it gradually develops into disease. So if upright qi is strong, it is possible (for the body) to heal, and finally return to being healthy. Then the so-called sub-health is a process of fighting between upright qi and pathogenic factors from the perspective of TCM theory.

In this conception, it might be possible to say that subhealth is the liminal state where there is a fight between upright qi within the body and pathogenic factors, and it is a state where the metaphorical fight is still going on and has yet to settle. The following quote further illustrates this:

> 我个人认为亚健康应该是说偏离健康，还没有达到疾病诊断标准的过程。有一个话说的比较好，说人类健康分阶段管理，我认为是一个很有见解的观点。那么也就是说人不是说离开疾病马上就达到健康，对吧？那么随着人的生命水平的提高，也就是中医说的所谓正气，人体内的正气越足，亚健康状态就可能越长，那么这就是和中医认识疾病的产生有一定关系。
>
> I personally think that sub-health refers to a process that deviates from health and has not yet reached the criteria for disease diagnosis. There is a saying that human health should be managed by stages. I think it is a very insightful point of view. So in other words, people don't get healthy immediately after getting rid of a disease, right? Then with the improvement of people's life qualities, that means a rise in the level of upright qi from the perspective of Chinese medicine. The more upright qi there is in the human body, the longer the sub-health state may be. Then this has a certain relationship with the understanding of diseases in Chinese medicine.

What is implied in the quote above is that the doctor believes the space of subhealth has become larger because of the improvements in life quality, in more highly developed countries such as the UK, and she associates the boom in alternative medicine in the last few decades of her practice with such improvements in quality of life (and thus improvements in upright qi). The doctor used the phrase 'go into health, rather than wait for the doctors' a few times, and for her TCM is exactly situated in this space – providing support for people with relatively low life-threatening conditions, before they develop more severe conditions that need to be addressed by the NHS.

The doctor often makes conscious efforts to map TCM theory onto conceptions in Western medicine for comparison, using knowledge in Western medicine as a point of reference:

中医不像西医，西医认为疾病的产生是细菌病毒外来侵入人体而造成的病变，中医认为就说西医的这种观点认为是外来的东西，对吧？所以实际上现在对疾病的分类也分为一般分为两大类，一类是感染性疾病，一类是机体功能状态和结构紊乱的病症，就西医分这么两大类。

Traditional Chinese medicine is not like Western medicine. Western medicine believes that diseases are caused by bacteria and viruses that invade the human body. That is to say, Western medicine thinks that diseases are caused by entities foreign to the body, right? Therefore, in fact, the classification of diseases is generally divided into two categories: one is infectious diseases, and the other is diseases related to the body's functional state and structural disorders. Western medicine is divided into these two categories.

那么就是说西医生理的这些基本功能，在我们中医所谓气的过程中都被体现到了，那么从西医来说这也说得通了对吧？在没有得到疾病之前，那么一个就是说邪气很轻，那么西医也认为它可以在正邪相搏的过程中对吧？就说它的那种病毒病细菌没有足以造成一个病症。

So it means that these basic Western categories are reflected in the so-called Qi process in Chinese medicine, so it also makes sense from Western medicine, right? Before getting the disease, it could be that pathogenic factors are very mild, and you could say there is a battle between upright qi and pathogenic factors, right? It could be said that different kinds of viruses and bacteria are not strong enough to cause a disease.

那么再一个就说我们说西医说另一大块，整个结构的功能紊乱对吧？结构的功能紊乱，但是没有紊乱到脏器都 destroy 了，对吧？所以实际上现在就说我们针灸是逐渐来实现人的结构和功能的这种紊乱，因为结构和功能应该是表示一致的，那么很多疾病的产生它就是结构和功能失调了，对吧？就表现为一个亚健康状态，对吧？所以实际上就任何没有达到疾病诊断标准的，离开偏离健康的过程都可以叫做亚健康。

Then let us talk about the other category in Western medicine, the functional disorders of structures, right? The functions of the structure are dysfunctional, but not dysfunctional enough to destroy the organs, right? So in fact, acupuncture gradually adjusts this disorder of bodily structure and function, because structure and function should be consistent, and many diseases are caused by dysfunction between structure and function, right? It manifests as a sub-health state, right? So in fact, any process that does not meet the criteria for disease diagnosis and deviates from health can be called sub-health.

Subhealth for her is characterised as a 'process' – 'any process that does not meet the criteria for disease diagnosis and deviates from health', and that these 'criteria for disease diagnosis' are set up by Western medicine. The doctor's definition of subhealth always

involves two medical systems referring to each other. When I asked her about subhealth, she drew me a diagram of health (see below). As can be seen in her explanation, there is an effort to bridge Western medicine and Chinese medicine. According to her, there is a spectrum that starts from health, and then there's subhealth; after subhealth there is disease, after which comes death. In her diagram, a relationship between pathogenic factors, the upright qi, health and disease, and death is established, with Western medicine and TCM each having their roles – Western medicine for treating diseases and preventing death, TCM for when the body is still fighting:

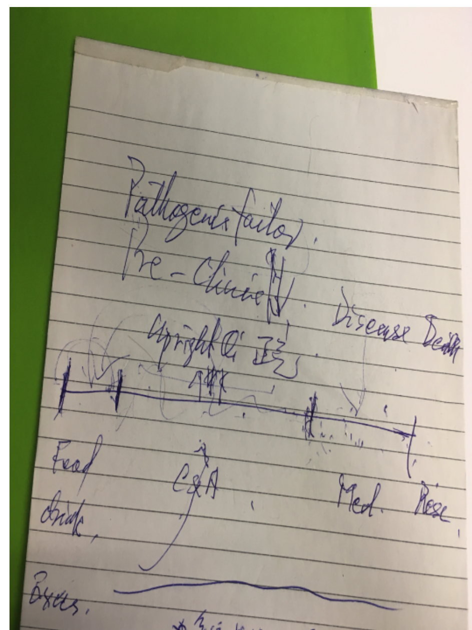

Figure 6.2 Dr Zhuang's graph illustrating subhealth

However, in addition to discussing subhealth and acknowledging that traditional Chinese medicine is quite effective for conditions that could fall under subhealth, the doctor would often emphasize that Chinese medicine can also treat more serious conditions. She acknowledged that the efficacy of treatment is often mild, particularly because of limitations in practicing Chinese medicine outside of China. She mentioned that in China, acupuncture

often takes place more frequently, sometimes even every day whereas in the clinic, people often visit weekly, or fortnightly, and the highest possible frequency is twice a week – she commented that this will limit the treatment's efficacy. There are also limitations on the availability of the right kind of herbs in the UK. She thus commented that less technically advanced Chinese doctors can only treat mild conditions, while more highly skilled TCM practitioners can also treat more serious conditions. What is implied is an acknowledgement of a natural affinity between suboptimal health states and TCM, but also an insistence on proving the efficacy of TCM in more tricky cases (this is what I observed from The 16th World Congress of Chinese Medicine at Budapest too). This can be seen in our interviews and in her published articles where she emphasises clinical trials, but also the difficulties entailed in conducting clinical trials on the relevant herbs.

6.1.3 Seeing the concept in the clinic

For the doctor, this is not just about theorizing – she uses the concept in her practice too. For example, I found this in one of her publications:

> I believe that Polycystic Ovary is the early, or the gentle stage of PCOS; it belongs to a pre-clinical condition. TCM in which Acupuncture and herbal medicine are involved will make it possible to treat, even easy to cure. But PCOS is an organic disease, it needs to be identified carefully to find a proper pattern, and make a longer comprehensive treatment to make an efficacy to it.[14]

This excerpt is one instance among a few others where she used the term 'pre-clinical condition' to categorise a certain condition. I also witnessed a moment when the doctor mentioned and introduced subhealth and used that as a diagnostic tool, while I was making the herbs. In that scenario, the doctor was saying to a new visitor that there are certain problems Western medicine will not pay attention to, but that in fact mean you are in

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14. I have not provided the citation/reference for this entry in order not to reveal the doctor's identity and the identities of other participants recruited from the clinic.

suboptimal health and you can adjust your state of health with Chinese medicine. The concept of suboptimal health only occurred briefly, to make a point about the function of TCM in helping adjust health states. The visitor was visiting to consult about her irregular periods among other health complaints, and the conversation developed into a discussion of the interconnections between thyroid problems and polycystic ovaries.

In another case, in one of her articles on the efficacy of Chinese medicine in assisting with IVF for which I did some proofreading, the concept recurred. When describing the health condition of a patient, the doctor mentioned that she was 'in preclinical state'. There was also one time when someone came to visit due to their joint pains; in her notes, the doctor wrote the diagnosis down as 风湿痛亚健康 (rheumatism subhealth). Since Bury's (1982) concept of biographical disruption is developed in the context of people diagnosed with rheumatoid arthritis, the doctor's diagnosis here of rheumatism subhealth is particularly interesting and could carry theoretical implications. Here, the suboptimal health status may involve a significant level of pain that nevertheless is not rheumatoid arthritis, or rather, not yet. This is a liminal space, a warning that something has to change to forestall the onset of disease.

In another instance, I had a friend who suffered from heavy period pains and asked me to seek help from the doctor. So, I asked the doctor whether she could prescribe some herbs and she said she would need my friend to visit the clinic because she needed to learn more to decide whether there was a concrete clinical condition or just suboptimal health.

Frequently, only those people with unidentified symptoms, symptoms seen as unimportant or untreatable by Western medicine, or chronic concerns would seek help from Chinese medicine. In a more life-threatening situation, the doctor would direct patients to the hospital. Due to the existence of the NHS in the UK and the fact that healthcare is mostly free in the UK while using alternative treatment can be costly, it can be inferred that people who

visit the clinic will be those who have some genuine concerns and discomforts that may have been dismissed by the Western medical system as unimportant, or that they have a higher standard of health and wellbeing. This is also shaped by issues of social class, health provision and so on. From my observation as a receptionist, most visitors to the clinic are from relatively affluent backgrounds. Many conditions that occasion a visit to the clinic can be seen to fall under 'sub-optimal health' (based on my chat with the doctor), such as infertility, ME, arthritis, polycystic ovaries and polycystic ovaries syndrome, and IBS, as well as some post-operation symptoms.

6.2 Is subhealth relevant to the visitors?

6.2.1 The myth of Yangsheng

> 因为在我想那个时候大概应该是在这个国家是西医一统天下，那么这样的话就会有一些病人，如果他们对西医的治疗不满意，或者说他们的病西医不能治，或者治不了，或者有毒副作用，总之是他们觉得没有很好的被健康，没有很好的被照顾到，所以他们都会去社会上有什么新的招数，他们都是就这么一群病人，知道吧？
>
> Because at that time I think that Western medicine dominated the world in this country. Then there would be some patients who were not satisfied with the treatment of Western medicine, or their disease cannot be cured by Western medicine, or the treatment had side effects, in short, they felt that they were not well taken care of, so they would check if there were any new treatments possible in the society. They are just such a group of patients, you know?
>
> (Dr Zhuang)

Above is an excerpt from the interview when Dr Zhuang described clinic visitors. In this section, I will move on to focus on the stories of the visitors who visit the TCM clinic where I worked and discuss some common themes that occurred when they talked about their visits to the clinic and their understanding of health. Participants often talked about the idea of health as a more holistic entity or a process. Often, in addition to visiting the TCM practice, the visitors might be simultaneously involved in other health and wellbeing practices. The clinic would feature as part of their belief system about health and medicine. Other practices the

participants mentioned they participated in to improve their health included: singing, the Alexander technique, the Buddhist centre, yoga, seeing a therapist, and quitting sugar.

Since the participants did not necessarily know about the concept, let alone consider themselves sub-healthy, the interviews started with asking about their reasons and experiences of visiting this clinic, and their ideas about health.

When they talked about TCM, they would mention that they visited the clinic to strengthen their immunity and improve their energy level. There is a general view of using TCM to strengthen the body. There is a lay view of immunity here, compatible with the TCM aetiology of disease. Alice mentioned that for her, cure seemed like the wrong word to use in the context of using Chinese medicine. She commented that she didn't visit the clinic to cure something. It was more about putting the body back in balance.

Just as the doctor remarked, people who visit the clinic are dissatisfied with Western medicine in one way or another. Some of them turn to alternative medicine completely. Some of them use both types to complement each other. Some of my participants had concrete organic conditions, diseases that can be detected; some others do not have any concrete conditions to be detected so there is a struggle for diagnosis. Two typical cases are irritable bowel syndrome and chronic fatigue syndrome. Alice, who was suffering from IBS at the time of being interviewed, mentioned that she had been to the GP multiple times to run different tests to try to find out the reason for the constant discomfort she was experiencing. It was a journey of looking for causes and a journey of establishing the effectiveness of different treatment plans: She was seeing the doctor at the Chinese medicine clinic and she was also trying a new diet simultaneously.

There is a certain ontology in the body of knowledge of TCM, but from what I observed in the clinic, those constancies/ontologies are enacted in different situations and have different materialities. Despite the sophistication of TCM theory about health, in actual

practice, excepting a few visitors who have become quite proficient in Chinese medicine over the years, most of the visitors may not fully understand the theory, or for example, what exactly ‘a lack in kidney qi’ actually means, but will nevertheless trust the practice. The TCM theory functions in such a way that facilitates attention to subtle discomfort in the body and provides terminologies to account for those discomforts.

Engaging in this practice takes effort, an entanglement of knowledge, practice, and materiality. Cooking the herbs at home takes time. ‘It is almost like a full-time job’, joked Wendy, when commenting on the process of cooking the dry herbs and, on another occasion, she commented that herbs are ‘disgusting’, like ‘liquidized frog’. I have already mentioned that the medicine the doctor prescribed in the clinic takes three forms: dry herb mixture, powder mixtures, and patented pills. Wendy was usually given dry herbs, which required boiling at home for an hour and a half. Wendy told me that she thought the herbs were more effective than the patented pills, because pills are based on fixed formulae, while herbs prescribed by the doctor have more subtlety and can change each time based on the differentiation of her body.

Sometimes, when she was too busy to cook the herbs, she would ask the doctor for patented pills. Knowing me and my research, she sometimes told me in detail about what she had been doing, when she visited the clinic and saw me at the reception. Sometimes she told me she had been behaving really well and had finished all the herbs prescribed by the doctor. Other times she told me she was too busy with work to cook the herbs. During the pandemic when her work was impacted, she told me she would make use of the time to work on her health, and this entailed her making a bigger commitment to the dry herbs. To some extent, the pain of going through cooking the herbs became a ritual of working on one’s health. As Wendy had, other interviewees all mentioned the ways they manage herbs in their lives and the kinds of efforts that might entail. For example, Megan mentioned that cooking herbs is

antisocial - it means she cannot invite guests over.

In what I have presented here, the materiality of taking care of one's health, so one does not fall into illness, is enacted. The meaning of health is in the action.

6.2.2 Fang's story: subhealth as a milder form of disability?

In this part I will delve a little deeper into Fang's story. Fang is a female in her 40s/50s who was originally from China but has settled in the UK. She is one of the participants recruited from the clinic. Fang migrated to Europe in the 1990s, and subsequently to the UK. Therefore, she didn't pick subhealth up from mass media but several years later when she was looking up her own bodily conditions. She said that when she started to feel various discomforts and realized that those were having an impact on her daily life, she started to search online about health (as she speaks Chinese she looks at Chinese media) and thus encountered the term subhealth (亚健康). Since that time, she also started to take a variety of health products so that she could keep up with the demands in her life circumstances. She listed many products to me: different vitamins, and some Chinese herbs. According to her this was just like some people needing to drink coffee to keep up with work. She told me that she took a handful of different health products every day. She also occasionally went to the clinic for acupuncture. Her son had a serious health condition, and she would take him to the TCM clinic for treatment as complementary to the care from the hospital, for rehabilitation. She told me she would then get an acupuncture herself since she would need to wait at the clinic anyway. Again, she commented that it was like coffee – it relaxes her for some time and improves her quality of life to a certain degree. She tried to go regularly but not too often as it can be costly. But she emphasized that those visits are necessary to maintain her daily life:

> 然后查过血，也查过什么都在正常范围内，但是你没有体育，没有精力，然后

你干不了事，怎么办？就吃这些东西。上下楼膝盖疼，别人怎么说都锻炼，建飞了多减肥飞，可是你锻炼尤其减肥，根本就不是说能马上用的到的，是你必须有体力，你才能去锻炼，才能去减肥。

所以像这种情况下最简单也觉得好像最有效的方法就吃这些营养品保健品。现在这种状况说，我们就是这些亚健康状态下，靠着补品，靠这些中医让你慢慢恢复到年龄健康状态下，你的维持生活，你得工作，要不怎么办？听得明白不？

Then I checked the blood, and everything was within the normal range, but you have no physical activity, no energy, and then you can't do anything, what should I do? Just eat these health products. I have knee pain when going up and downstairs. Others just say to me, you have to exercise! You have to lose weight, but even if you exercise, especially to lose weight, it doesn't mean that you can use it right away. You must have physical strength to exercise and lose weight.

So in this case, the easiest and most effective way is to eat these nutritional supplements. In this situation, we are in these sub-healthy states, relying on supplements and these traditional Chinese medicines to slowly restore you to a healthy state for your age. You have to maintain your life, you have to work, or what should you do? Do you understand?

She had to check health information online instead of talking to her friends or family:

因为你人和人之间朋友之间不谈这些，为什么？好像别人都很健康的感觉，你去说多了，别人会觉得你无病呻吟，你知道吗？…

就觉得对牛弹琴的感觉，为什么？当一个人完全健康，完全什么，他想不到生病以外还有这么个状态，你明白吗？包括我老公也是这么多年就一直觉得觉得好像我在这无病呻吟知道吗？老觉得你什么老跟我说你多活动你多动动多锻炼，做了就好，你明白不？

很多人都不知道这种状态，状况，而且包括一些刚得病的人的话，他觉得我最近累了，我没劲了。可是你这种状态不是一一个月是两个月两两一年两年或者是一十十几年，其实是没办法，所以我等于后来慢慢的就有就什么叫忧郁症？焦虑症的。

亚健康，他还实际上有的时候还不如生病，为什么生病？别一眼就看出来了，你明白这意思吗？别人就会知道你，照顾你所有的 treatment 片都给你，但是你在亚健康状态的时候，别人不知道就会忽略你，..反而就把你孤立起来了。

别人就会觉得你很正常，你为什么不做正常人的事儿，你为什么需要这么多 care 需要，所以有的时候我觉得所以很心里很苦

Because you and your friends don't talk about this, why? It seems that everyone else

> is feeling healthy, if you talk too much, others will think you are fussing, you know? …
>
> I just feel like playing the piano to a cow, why? When a person is completely healthy, completely healthy, he can't think of such a state other than being sick, do you understand? Including my husband, for so many years, he has always felt as if I am moaning here, you know? I always feel that you keep telling me that you need to be active, move more and exercise more. Do you understand?
>
> Many people don't know this state, situation, and even some people who just got sick, they might feel tired recently and lacking energy. But your state is not one month, two months, instead it is two years, or more than ten years. In fact, there is no way out, so I gradually developed depression and anxiety.
>
> Sub-health is actually worse sometimes than being sick. If you get sick, people know it, do you understand? Others will know about you and will give you all the treatment tablets to take care of you, but when you are in a sub-health state, others will ignore you …isolate you.
>
> Others will think that you are normal, why don't you do normal things, why do you need so much care, so sometimes I think I feel bitter.

Fang's stories invoke Parsons' sick role model, and the frustration of not being able to claim the sick role is telling. Her account of subhealth is about someone who is chronically seeking the sick role, and seeking support and being chronically denied, while at the same time she spent decades caring for her son. There, she felt her subhealth needed to be acknowledged and supported, but no one would listen to her and no one was willing to understand there is such a state between health and illness. She also mentioned that she would rather search for health information online instead of talking about health/subhealth with friends and family, which also highlights the difficulty in understanding others' embodiment, and the importance of narratives of subhealth – I will discuss in more detail about how subhealth narratives provide space to talk about unhealth in the next chapter.

6.3 Subhealth in medical encounters

In the following section, I will move on to discuss the Chinese context where young people are entangled between Western medicine and Chinese medicine. I will thus look at the

new chic 'Yangsheng' and instances where young people slip between objective and subjective subhealth in their encounters with medicine.

6.3.1 The new chic 'Yangsheng'

When the participants think of subhealth, they think of some of the health practices their parents urge them to partake in. One participant, Sherry (female, 20s), mentioned how her parents shared tips to preserve her health, such as the different temperaments of food (based on Chinese medicine theories) and how some foods cannot be eaten together with other food and that she should soak her feet in hot water and drink goji berries. Xu (female, early 30s) pointed out how the rise of subhealth was bundled with a few other ideas, such as ideas on how to 'tone your health':

> 我觉得是我觉得有几个词是一起捆绑在一起一下子兴起的，在国内，那段时间。一个就是养生，一个就是亚健康，因为因为你说养生的时候，你必定要说你亚健康是吧？养生也可以，健康的人也可以养生。但是但是他肯定会要说你特别健康，我什么都不用补，我也不用干嘛，我只要维持我的健康就行了，但是你不知道你并不知道你你到底是不是健康，也许你是亚健康呢？所以你需要养生，你需要用食谱去调。
>
> I think it was because I felt that a few words were bundled together and came up all at once, in China, during that time. One is health preservation and the other is sub-health, because when you talk about health preservation, you must say that you are sub-healthy, right? Healthy people can also do something to preserve their health. But if one is very healthy, they will definitely say that I don't need any supplement. I don't have to do anything. I just need to maintain my health. But you don't know if you are truly healthy. Maybe you are in sub-health? So you need to maintain health, you need to pay more attention to your diet.
> (Xu, female, early 30s)

However, although young people tend to distance themselves from Yangsheng practices and see those as the practices of the older generations, in recent years a new term, 'punk Yangsheng' (朋克养生), has been coined, referring to the new and often self-contradictory practices of self-care for the younger generations, such as drinking goji water but also drinking alcohol, or going to the gym while staying up very late:

> I am going to the gym everyday but also going to bed very late – not sure if I can get rid of my subhealth (Weibo post 1)

Companies thus try to market this style of Yangsheng to young people, giving it a cool image. For example, there is coffee with Yangsheng - Western and Chinese, a new chic. Young people increasingly buy health products, buy insurance, and start to worry about potential future illnesses.

They make resolutions to engage in Yangsheng when they identify themselves as in subhealth:

> I really need to Yangsheng now. Alas, my subhealth (Weibo post 2)

They also complain about how older generations urge the young to lead a healthy lifestyle but also engage in unhealthy lifestyles themselves. Conflicts between health practices between generations arise:

> I don't know why some parents ask us to go to bed early every day to maintain good health/Yangsheng. In fact, they are smoking and drinking alcohol and doing things that are most contrary to Yangsheng. It turns out that there is not only sub-health in the world, but also pseudo-health. (Weibo post 3)

Sisi, one of my interviewees, also talked about how her parents love pickled vegetables and how that is very unhealthy.

Compared to the clinic visitors, most young people on social media and whom I have interviewed are more ambivalent towards Chinese medicine. The participants from the clinic all have an already established belief in or familial ties to Chinese medicine; even if they don't, they will have a concrete complaint that they have been seeking help from the clinic for. as well as health practices, with established beliefs concerning the efficacy of those practices. What I've observed from social media is that for the young, although they have heard about sub-optimal health from different commercial and public health sources and also have some basic ideas of TCM, there is a cultivated distrust of TCM which is portrayed as

non-scientific. For others, however, subhealth marks the starting point for them to try TCM.

> Actually, the traditional Chinese medicines that I got prescribed last time worked. My diarrhoea is better, and my stomach is slightly better. I didn't get time to get more medicine this week. So, I just split one bag into two. Need to get more medicine and thank the doctor next time! People with chronic problems and sub-health conditions should go to Chinese medicine, take supplements, and treat them according to their illnesses! Because it is effective for me, I try to think of it as tonic, I don't feel too bitter when drinking the medicine anymore. (Weibo post 4)

Another common theme is the difficulty in attributing the causes of subhealth. In my interview with Zhenzhen (female, mid-30s), she recalls how she went to the hospital when she felt unwell, but the results did not show anything wrong with her body (we have just heard this narrative from Fang as well – in fact, it is with this narrative that I started my project):

> 对，因为身体但是明显的感觉的是跟以前不一样的，比如说你的胳膊酸疼，颈椎疼都属于亚健康，但是你说有没有毛病？去医院查了他是查不出来的，但是他肯定是不健康的。
> Yes, because the body obviously feels different from before. For example, your arms are sore, and your cervical spine aches, which are all sub-health, but do you think there is something wrong? Going to the hospital to check is useless because you would not find out anything, but the body is still not healthy.

Zhenzhen used the second-person pronoun. Upon checking with her in the next part of the interview, she had indeed herself been to the hospital for a health check-up which yielded no results, but she used the second-person pronoun here to denote a shared understanding, a shared narrative, perhaps because she thinks this is a common experience. She is one of the few Chinese interviewees who have a firm belief in Chinese medicine and have actively visited Chinese medicine practitioners, and she mentions that this is a shared belief among her family.

In most other cases though, there is usually some level of suspicion of TCM from the young. For example, one person talked about how the TCM practitioner said he or she was in subhealth and he or she responded: 'how sub am I?', and they subsequently went to hospital

for health checks instead of continuing to see the TCM practitioner.

But often they find, just like Zhenzhen did, that hospitals are not of any use, as this person gathered from a medical encounter:

> Doctor: I beg you to exercise well, go to bed early, improve your resistance, you have so many sub-health problems, and taking medicine is useless
> Me: ...... ok, I will. (Weibo post 5)

There are posts that mention that their body check results rendered some borderline figures, and they were asked by the doctor to visit again for further check-ups, commenting that ‘I am subhealth indeed’. The following post talked about one person’s efforts to get ready for pregnancy and the body examination revealed that her indicators were high. This comment from the doctor of her being in ‘standard subhealth’ is intriguing, with subhealth almost becoming the norm. Of course, no medicine is prescribed: subhealth is about awareness of one’s body and self-care. Medical help and the sick role are not granted yet.

> My pregnancy preparations dragged on, and I didn’t come to the examination until today. It was forced by my mother. I started the examination confidently, but it turned out that my mentality was collapsed, every indicator was high, and high blood pressure was actually found. (The doctor brought a 24-hour blood pressure tester, and I will see the final result tomorrow.) The doctor instructed me to say that my state was a standard sub-health, which looked good, but contained a crisis. No medicine is prescribed, the only suggestion is to control the diet, low-fat, and low-salt exercise to lose weight. (Weibo post 6)

6.3.2 Slipping between objective and subjective subhealth

Lan Lan was a PhD student who was in her second year of PhD based in China at the time of the interview. We were undergraduate classmates. It is intriguing how medical check-ups for some people dismantle the worry of being in subhealth - even with a result confirming a concrete problem because that means a local problem instead of an overall problem, as in Sherry’s case (female, 20s). Sherry told me how going to the hospital and finding out that there were some problems with her neck vertebrae relieved her of her general worry concerning her health status and she would no longer feel in suboptimal health. However, Lan Lan’s interpretation of subhealth (female, late 20s) was in relation to a medical

diagnosis, where subhealth is equal to the diagnosis – she saw the result from the medical examinations as medical proof of her subhealth. When I asked her whether she had moments of feeling in sub-health, she told me:

> 我觉得自己亚健康，首先我已经查出来了，有已经有桥本氏甲状腺炎了，所以其实这是一种全身性的免疫系统的疾病。你身体属于敏感性的体质，而且因为我非常在意这个事情，所以我体检的时候公司有一项服务，我还选了那项服务就是测基因，基因测序，你可以选择一部分的基因去进行测序，然后我测出来我有几个关键的基因，然后其中有一个基因就是叫什么碱基错配的一个识别的基因，就是比如说我的机体，比如说我的甲状腺在发炎的时候，然后我的免疫细胞它里面有一个基因是可以应该如果他是有基因的话，应该是可以检测出来哪一个是炎性细胞，哪一个是正常细胞，然后他会选择性的就是靶向的去攻击炎性的细胞，但是会避开那些正常的细胞。但是中国有一部分人他这个基因是缺失的，我就是缺失的。
>
> I feel that I am sub-healthy. First of all, I have found out that I have Hashimoto's thyroiditis, so it is actually a systemic immune system disease. Your body is a sensitive physique, and because I care about this very much, and also the company has a service during my physical examination, I also chose gene testing and gene sequencing. You can select some genes for sequencing. Then I tested out that I have several key genes missing, and one of them is a recognized gene. Having that gene in the body, for example, when the thyroid gland is inflamed, the immune cells should be able to detect which one is an inflammatory cell and which one is a normal cell, and then they will selectively attack the inflammatory cell, but avoid those normal cells. But there are some people in China who have that gene missing, and I am one of them.
> (Lan Lan, late 20s, female)

She also characterised her own body as a sensitive physique. She went into detail about what this can cause:

> 所以像我的身体就属于敏感性的体质，敏感性的体质的话，会有各种各样的表现，比如说新陈代谢非常的缓慢，就会倦怠，身体会容易感到倦怠，然后反应会相对而言比较迟钝。会嗜睡，然后脂肪容易堆积，就是你的肌肉含量就没有那么高，然后你的体脂率会比较高。然后这些体现都会让你整个人自己感觉是有一点亚健康的状态，感觉自己身体没有那种非常有精力充沛，然后效率非常高的那种感觉。然后执行力变弱，就是容易产生抑郁的情绪，都可以找到一些生理上的解释。所以你会发现自己很多的负面情绪，其实也可以找到一些比如说亚健康的这种生理上的解释。
>
> So my body is a sensitive physique. For sensitive physiques, there will be various manifestations. For example, the metabolism is very slow, and that means the body will feel tired easily, and then the reaction will be relatively slow. You will be lethargic, and then fat will accumulate easily, that is, your muscle content is not so high, and then your body fat rate will be higher. Then these manifestations will make

> you feel a little sub-healthy, and feel that your body is not being very energetic or efficient. So when you feel your ability to take actions becomes weak, and prone to depression, actually some physiological explanations are available. Also, if you will find yourself in a lot of negative emotions, in fact, you can also find some physiological explanations such as sub-health.
> (Lan Lan, late 20s, female)

She talks about her 'subhealth' with an interweaving of psychological experiences and physical explanations. Subhealth for her seems to take multiple forms. For one, it is the feeling that 'your body is not being very energetic nor efficient' and feelings of lethargy, which corresponds to the public narratives of subhealth in commercial and public health discourses; she used second-person pronouns to indicate a feeling that is shared by both of us. For another, it is a concrete physical condition, Hashimoto's thyroiditis, in her case, and she also talked about how through genetic sequencing she found out she was missing key genes and that became an explanation for her subhealth. In this sense, she used subhealth as both a subjective feeling and an objective biological entity, or in other words, a subjective feeling that can be rationally explained. She also situated subhealth to a threshold of age. Lan Lan talked about 25 years old being the threshold in her interview. She saw that as an arbitrary line when people started to be aware of their body:

> 医学诊断是公司体检查出来的，是偶然查出来的，某一项指标可能比正常要高出很多，但是在此之前，我都从来没有 care 过健康的问题，我是什么时候查出来的？25 岁还真的就是 25 岁，对。我是 25 岁查出来的，但是我在 25 岁之前一直都处于一种就完全不 care 自己的健康状况。比如说我在英国的一年，写论文的那段时间是完全黑夜和白天是颠倒的，然后饮食也非常的不规律，然后垃圾食品，所以那个时候其实生活状态是应该是挺差的。但是好像不知道为什么，不是很 care 觉得自己很好的，或者就像现在的一些外国人一样，就觉得自己翘了也没什么关系，反正人都是要死的。好像也没有那么惜命。

> I got the medical diagnosis at the company's physical examination, and it was found out accidentally. One index was much higher than normal. But before that, I had never cared about my health problems. When did I find out? 25 years old - it was actually when I was 25 years old, yes. I found out about it when I was 25 years old, but before I was 25, I didn't care about myself at all. For example, when I was in the UK studying for a year, I was writing my thesis with my night and day completely reversed, and then my diet was very irregular, and then I ate a lot of junk food, so at that time, the life quality would be pretty bad. But I don't know why, I just did not care. I felt good, or just like some foreigners now (in response to the pandemic), they

> don't seem to care about their life. People are going to die anyway. I didn't seem to treasure my life that much.
> (Lan Lan, late 20s, female)

It is in the middle of this passage, in her efforts to narrate her subhealth, that she realised that for her the crossing line was reached at 25 years old. She decided that it was the threshold when subhealth concretized for her and she felt various bodily complaints. It is also around that time she started to have the feeling of being willing to take good care of her body. The feeling of discomfort and the care of the self seem to be two sides of the coin for her; subhealth is related to the act of health preservation. She said that before that threshold, she

> 没有对自己的身体非常精心的照顾，非常在意，非常敏感的那种感觉，就可能你感觉到了，但是你没有很想要去精心照顾她、它的那种感觉。
>
> did not have the sense of taking care of your body very meticulously, caring very much, and very sensitively. You may feel bodily discomfort. This is very interesting because the World Health Organization, I think, dropped 'discomfort' from the ICIDH. But you can have pain and discomfort in as part of the models of health and wellbeing. Many of these individuals are developing a model of health and wellbeing, but you don't really want to take care of it.
> (Lan Lan, late 20s, female)

After the diagnosis, eventually she had more leisure to take care of her body:

> 而且那个时候其实工作方面已经可以工作量是没减，但是可以 hold 得住的，所以能够 manage 得更好，然后就能抽出来一些时间来照顾生活。比如说每天晚上跑步，尽量自己做几顿饭，会稍微注意一下，然后会开一些中药尝试一下，然后会看一些书，看看人家是怎么弄的。所以后来从从上海辞职以后回到苏州，生活就更加清闲了。生活节奏更慢了以后，就有更时间来注意这种问题。所以对于自己的身体会越来越敏感，就是会照顾得越来越精心越周到一点，但是是在你越来越有这个时间条件那个情况下。
>
> And at that time, the workload was not reduced, but it could be held, so I could manage it better, and then I could spare some time to take care of my life. For example, if you run every night, try to cook a few meals yourself, pay a little attention, then prescribe some Chinese medicines to try, and then read some books to see how others do it. So after returning to Suzhou after resigning from Shanghai, life became more leisurely. After the slower pace of life, there will be more time to pay attention to this kind of problem. Therefore, you will become more and more sensitive to your body, that is, you will take care of it more and more carefully and more thoughtfully, but only when you have more time and when the situation allows.
> (Lan Lan, late 20s, female)

She talked about two stages of this. Firstly, she was able to manage her work better after some time, and she got to spare some time to take care of her life. After quitting her job in Shanghai and starting her PhD in Suzhou, she had a slower lifestyle and more time and thus more sensitivity to changes in her body. Care of the self does not take place in a void.

As can be seen in the examples from the above section, subhealth narratives showcase an entanglement of subjective experience of the body and objective metrics for the body. Apart from the purely subjective bodily experiences that are categorized as subhealth, increasingly certain health examination results are also considered to be subhealth:

> I really need to wake up early and go to bed early now! I went for a health examination today and I think I am subhealth level 10'
> (Weibo post 7)
> I went to the gym for a personal test, and I almost cried. My cervical spine is drawn forward, the shoulders are high and low, and my hips are sagging, and the calf muscles are slanted. This is the sub-health I have as a result of four or five months lack of systematic fitness training and having to sit in the office for a long time. No one can smile doing the sub-health test.
> (Weibo post 8)
> Almost every item of my physical examination report says it needs to be followed up regularly. I really am Subhealth itself.
> (Weibo post 9)

As can be seen in the above three examples, these individuals confirmed their subhealth from various forms of health examination. This is one of the predominant narratives of subhealth for the young: to go for a health examination and conclude they are in subhealth. Sometimes subhealth occurs as a 'diagnosis' from the health examination instrument or the doctor; other times, individuals deduce their subhealth from borderline figures, from need for follow-up examinations, from needing to go to hospital often, or they might just equate various minor chronic conditions with subhealth. Those are instances when subhealth is less of an embodiment, and more of a label for one's health with the pretence of objectivity. Below is an interesting example when the person jokingly commented on how his different body parts are shown to be:

> I did a set of thermal imaging physical examinations on April 12th. My sub-healthy

> parts include cerebrovascular, cardiovascular, eyes, ears, nose, teeth, throat, trachea, thyroid, prostate, lymph, lungs, liver, stomach, and kidneys, Pelvis, ribs, knees, cervical vertebrae, thoracic vertebrae, lumbar vertebrae, tail vertebrae, shoulders, elbows...Simply put it, I am a completely broken monk. (Weibo post 10)

This post is from Kong Qingdong, who is a controversial Chinese academic from an older generation, and who is quite active on Weibo. That is why his joking reference to himself as a 'monk' is a little different to young people's phraseology. Here, he consciously invokes the sometimes-critiqued concept of subhealth and goes to great length to list all his body parts that are seemingly shown to be sub-healthy. Here, the body is no longer the lived body, but only the material and objective body.

Sometimes, the health examination confirmation of subhealth is seen in a positive light:

> I heard from my colleagues that after the medical examination, if the problem was serious, the medical examination centre would call separately to notify me. As a result, I was nervous whenever I saw a call from my mobile phone these days. Fortunately, I finally got the medical report today. I am still that subhealthy youth who has no major diseases and all the minor illness. (Weibo post 11)

The elimination of the presence of severe health conditions for this individual, and therefore, the identity as 'that subhealthy youth who has no major diseases, and all the minor illnesses' is celebrated here. Subhealth is constructed as a liminal concept that one wants to escape, but sometimes contradictorily, get into ('to recover into subhealth' also appears in some instances, which is an interesting iteration), or stay in. In another instance where subhealth is seen in a positive light, the body is seen as a machine, and a contradiction between the feeling of subhealth and the body metrics is constructed:

> I have been lying down since I came back from a business trip. Recently, I have two observations about the body. The first point is not to be afraid of sub-health or minor illnesses, or symptoms like feeling uncomfortable and having difficulty falling asleep. It is a good thing. It does not mean that the body is collapsing downwards. With these symptoms, the body machine has started to resume work and production. Various indicators are actually going up, but they have not fully recovered. The feelings of discomforts are exactly because the body's machines have started. I should enjoy and be grateful for this process. After the passing, it will be full of energy. The second observation is that if you feel uncomfortable, just lie down. The switch for the state of a person is whether you are horizontal or vertical. When you are horizontal, you actually only have a sense of consciousness. The body is already in the factory, and it

> feels like it's still connected to the brain. The matter of staying horizontal for how long depends on observation. I plan to spend two days in a row lying down and hey this saves me money for meals. (Weibo post 12)

In this intriguing example, based on the lived experience and observation of the body (seen as an object and a machine), the person shares two points of wisdom. It is thus postulated that the embodied feeling of subhealth in fact correlates with improvements in biometrics and the 'body machine restarting'. This might also reveal how the construction of subhealth in some cases is related to productivity and vitality, with a focus on the body functioning as expected. I will expand in more detail on this in the next chapter and discuss subhealth in relation to work.

6.4 Summary

In this chapter, I have presented an ethnography of the Chinese medicine clinic in England, combined with data from the Chinese context where people talk about their medical encounters of 'suboptimal health' or negotiate between objective and subjective understandings of their body. Admittedly, to say something of 'medical encounters of suboptimal health' is an oxymoron, and this chapter discusses the paradox in this encounter, and the conceptions of health behind those encounters. In essence, I have discussed practices of self-care, either in the TCM clinic, or for Chinese young people, when they choose between biomedicine and TCM in attending to their subhealth.

I looked for the concept in the clinic as it is through Chinese medicine that I encountered this concept. It is worth noting that when I interviewed the doctor and the visitors from the clinic, it became clear that the doctor has a fully developed definition of suboptimal health, which she equates with preclinical conditions, and it features in some of her practices, or her understanding of specific cases. On the other hand, the visitors have not heard of the term 'suboptimal health', and it became clear that this iteration is quite particular to the Chinese context. However, immediately after I explain what the concept means in the Chinese

context, the participants from the clinic all seem to relate to the concept in one way or another. Also, since all interviewees I recruited have been using Chinese medicine for quite some time, they also relate it to their holistic understanding of taking care of one's health and paying attention to any imbalances. The idea of *zhiweibing*(治未病) is understood, and this is in fact mentioned by two of my interviewees – although confused versions of this idea. It might be possible to say the concept of subhealth is latent in the practices of the clinic, in the differentiation Dr Zhuang applies to each individual and her aetiology for explaining subhealth.

In this chapter, I also briefly dwell on the Chinese context where young people discuss their own health worries and try to explain or treat those worries in the form of different types of 'medical encounters'. In contrast to the participants from the clinic who have an established belief in Chinese medicine and have made a habit of consulting Chinese medicine, the young Chinese have an ambivalent attitude to TCM - some of them are quite critical of it, while others embrace it under the influence of their elders. Still, TCM and its culture is quite ingrained in different aspects of life in China, and in those encounters, young Chinese people's understanding of being in-between health and illness is discussed, which is a constant negotiation between objective and subjective accounts and between self and other.

Chapter 7: Mapping the popular understanding of subhealth in China

7.1 Introduction

In this chapter I now turn to look at narratives of subhealth in the everyday life in China. The data drawn in this chapter are from my interviews with people who were brought up in China and my virtual ethnography on Chinese social media, mainly Weibo. Weibo offers a glimpse into multiple personal accounts of subhealth at a particular moment, as well as a a vast amount of diverse short narratives and discursive constructions and speculations on the health conditions of society in general, or specific sub-groups. At the same time, some narratives from the interviews echo the Weibo narratives, in greater detail and with more nuance. Many of the participants talk about subhealth, a particular concept to do with a vaguely defined area of human health, in terms of a speculative social critique. In those instances, they constantly invoke third-person and second-person pronouns to situate the discussion of subhealth in relation to modern urban life (in China in particular) and its 'assumed' shared reality. In some of the interviews, I managed to navigate from a public understanding of subhealth to the private narratives of subhealth (that is, if they ever, at any point, identified themselves with subhealth at all) - those moments when they grappled with the concept of subhealth in the context of their own lived reality. In this chapter, therefore, I will weave both Weibo narratives and interview narratives together to map the popular understanding of subhealth (after they travelled from the professional or academic discourse to the lived world) and explore the contradictions in those narratives. This chapter switches between a focus on the common themes emerging from the data and a focus on individual life stories and their nuances. In this way, I look at the different 'knots' in the ways in which this concept 'travels' through everyday life.

7.2 Subhealth as a commercial term

In one post on Weibo,

> 'You and I are both mortals, and no one can escape the current hormones, pesticides, additives, water, air pollution, and sub-health...' (Weibo post 13)

It is an accurate commentary on life in contemporary China, except this post then goes on to advertise a health product. Even after the popularity of subhealth died down, it still sometimes occurs in commercial discourses, which often present subhealth as a problem before presenting a treatment.

Jing (male, late 20s) thus criticizes subhealth as a disguise for the natural processes of aging, to turn aging into a problem - an abnormal condition that needs health products, to be addressed and framed for consumption, to elicit anxiety:

> 但是我觉得你过了 20 岁肯定就不会一直健康下去，因为你会衰老。不知道是不是这意思。这个概念是挺有蛊惑性的。 它把很多本身是自然的问题，自然会出现的问题，弄成是一个很急待解决的问题，或者一些很不正常的一个东西，真的衰老明明就是一个很正常的东西，你的精力会慢慢的下降，然后你的效率会没有以前高，让你得病，我觉得都很正常。因为本身就是衰老，其实我觉得衰老就是我也不知道，他可能想把衰老弄成一个被消费的概念，他不会说有一个防止衰老，估计大家也不会信，但是他可以弄一个亚健康的东西，你们现在都在亚健康，然后产品可以帮你解决这个问题。然后大家都信。
>
> But I think you will definitely not be healthy after 20 years old, because you will get old. This concept is quite deceptive. It turns many problems that naturally arise into a problem that needs to be solved urgently, or something that is very abnormal. Real aging is obviously a normal thing, and your energy will decrease slowly, and then your efficiency will not be as high as before, making you sick, I think it is all normal. Because it is aging itself. They may want to make aging something to profit from. They will not say that there is a way to prevent aging, since probably not many will believe it, but they can make subhealth a thing, you are all in sub-health now, and these products can help you solve this problem. Then everyone will believe this. (Jing, late 20s, Male)

We can see that Jing considers subhealth an artificial concept introduced to turn natural processes into abnormal ones. For him, this concept is deceptive and health products may find it difficult to convince people that they can address aging, but they can at least convince

people they can 'tackle subhealth'. Bing (30, male) also comments that the core of the concept of subhealth is linked to the lifestyle of the middle class and its emphasis on consumption. He compares the Chinese discourse of subhealth to the Western discourse of wanting to be 'healthier' through various health products and health practices and laughs at the common discourse that the health of the population was better in ancient times:

> 所谓亚健康那种营销概念其实也就是这样的，包括认为现代人的生活就一定是亚健康的，古代人的生活就一定是健康的，其实这也是一个问题。古代人的平均寿命是 30 岁，你活到 40 岁心梗死了，你赚了古代人有多少人是心梗死，他不知道他是心梗。
>
> The marketing concept of the so-called sub-health is actually like this, including the belief that modern people's lives must be sub-healthy, and ancient people's lives must be healthy. In fact, this is also a problem. The average life expectancy of ancient people was 30 years old. You lived to 40 years old and had a myocardial infarction，you were actually lucky. Also, many people in ancient times died from myocardial infarction and didn't know that it was myocardial infarction. (Bing, 30, male)

The case of Qu is representative in this sense. She initially considered herself in subhealth which facilitated her purchases of health products such as vitamins and primrose oil, as well as other health products for fatigue or lack of concentration. However, gradually she became suspicious of the concept and thought it was better to focus on particular symptoms instead of attaching such a label to herself.

She started to find the concept too vague, and no longer thought of herself as in suboptimal health, and no longer felt that she needed any health products. As she explained to me when interviewed, if there was a headache, it might be due to a specific reason. Instead of attributing it to a general health condition, she would try to adjust her lifestyle. There was a sense of disenchantment with the concept, a process of growing out of the concept:

> 我在使用它就觉得就像广告一样。四肢乏力，没有注意力不集中，然后非常的疲惫，如果在那个时候我就是我亚健康，
>
> When I used it, it was what was said in the advertisement. Limbs are weak, there is a lack of concentration, and I feel very tired; if so then I am sub-healthy.

…
就是逐渐的就是我好像不是亚健康，因为我可以说我不够健康，但是我对亚健康这个概念有点不太清晰，越来越不清晰，以前就是说四肢乏力，或者说精神不够集中，但是我现在发现这样的这样的一个原因，然后这些原因可能不一定是亚健康，可能是其他的原因，而且其他原因可能自己不知道。所以我也不知道，所以我说遇到这种情况，可能不会说我自己亚健康，可能说我最近的生活或者我最近不够健康。

Gradually, I feel I don't think I am sub-healthy, because I can say that I'm not healthy enough, but I feel the concept of sub-health is a bit unclear. Increasingly, I find it to be unclear. In the past, I thought subhealth is when my limbs were weak, or when I can't concentrate properly. Now I think these symptoms may not necessarily be sub-health; there may be other reasons, and we may not know about those reasons. So I don't know. I guess when I encounter those situations again, I might not say that I am in subhealth; maybe I will just say that my recent life is not healthy enough or I am not healthy enough.
(Qu, 30, female)

In the excerpt, she talks of seeing her health just like 'what was said in the advertisement' and cites symptoms that regularly occur in the advertisements: weak limbs, lack of concentration. This is also mentioned by other participants – for example, Fiona (early to mid-20s, female) also mentioned those symptoms. It might be possible to say that the symptoms mentioned by the advertisement might have led to an enhanced embodiment along those lines. Qu recalled how she no longer attributed these symptoms to subhealth. In the past, subhealth constituted a blanket explanation, paired with quick remedies (different health products) but now she would just look for specific changes she could make in her life.

7.3 Making sense of subhealth: private accounts?

7.3.1 Subtle doubt and the lived body

Interviews about subhealth are tricky because subhealth can be such a transient state. It's quite difficult to capture its full intensity in a conversation. The participants usually talk about their past instances of subhealth. At the time of the conversations, they might not feel they are in subhealth.

On the other hand, the Weibo narratives capture subhealth in its ongoing moments. There

is a sense of talking to an imaginary interlocutor on Weibo about one's health conditions, to check one's health condition with 'the other' in order to regain a sense of self. These narratives are fundamentally private yet public, detailing the most intimate embodied feelings but waiting to be seen by both friends and strangers. These more personal narratives of subhealth do not seem to be aiming to attract a large number of views; instead they initiate an avenue to talk about one's health and a way to motivate lifestyle changes, and to record these moments - an interesting form of digital diary.

A lot of the Weibo narratives start with a subtle doubt about the lived body:

> Does anyone's neck ring all the time like mine? It doesn't hurt but it has been ringing for several months. It squeaks when I move my neck. Sometimes I feel like it's blocked. If I twist my neck to make it squeak, it temporarily becomes more comfortable, and then it feels blocked again. I am actually gradually getting used to it ringing, and I asked the doctor and got told that the ringing was normal. But it is too frequent (surprised emoji) for me and I don't know if it has anything to do with my sinusitis (sub-healthy patients are too miserable!!!) (Weibo post 14)

As can be seen in this post, this Weibo user characterises themselves as 'subhealthy patients', an oxymoron in itself. This post describes in detail the feeling of neck ringing. A medical encounter is mentioned here: this person asked the doctor for reassurance that 'this is normal', but even upon receiving such confirmation, this feeling/discomfort still troubled them, leading them to conclude that this is the misery of 'subhealthy patients'. This is one representative instance of an enhanced, acute awareness of the body. This awareness triggered the user to post this question to the interlocutors on Weibo for affirmation, looking for others who share the same experience. Here are two other examples:

> For almost half a year now, my left arm has a faint pain at a certain angle. It's not very obvious. It seems that there is no impact on my daily life. It is just a kind of feeling, which is really annoying! Also, I have to carry patients every day and can't rest the left hand at all. I don't think I have reached the age of periarthritis of the shoulder yet. I guess I am just part of the fucking sub-healthy population!
> (Weibo post 15)

> List of recent sub-health states: nosebleeds, neuropathic migraine, gingival inflammation and swelling, the legs of the calves being suddenly numb and crisp,

coldness in the bones, and the bones clicking in the evening. It seems that it is time to get up early to get rid of sub-health (dog head emoji)
(Weibo post 16)

As can be seen in these two examples, a diverse range of bodily discomforts and symptoms are seen as subhealth. These bodily sensations are often characterised as annoying or troubling, often very subtly, without having a direct impact on daily life. These subhealth narratives on Weibo tend to capture those moments when there is an embodied feeling of the body being present, characterised by discomfort and a sense of the body being a mystery to make sense of, or an imperfection to be corrected.

In a more extended narrative from Sisi, another of my interviewees, a narrative of subhealth is told in relation to her aching hand:

比如说前一阶段，包括我的手，我不知道可能与我个人的比较敏感，而且总是会过度放大一些事情。我发现我敲键盘，时间长了，偶尔就会我的左手特别是大拇指的周围，就会抽住，不知道里面是经什么的抽搐，然后有时候会动不了。我就会很。就动不了，我要等一会儿，然后他慢慢的就可以舒展，然后我可以继续打字。这个事情在我之前我只会觉得我拿筷子夹馒头的时候，会觉得手特别的困，特别的累，然后我夹一会吃一会我就会放下，因为我们是北方人，就吃馒头是一整个一大个吃。然后我开始以为是我的手部力量不够还是怎么回事？后来现在慢慢演变成我的手部有时候会疼，有感觉大拇指连着的这一块里面哪根筋有在累或者是酸痛的那种感觉。然后我就联想到我以前拿馒头这种经历，我就感觉他们应该不是是处于一个毛病。后来前不多久我差点就想去医院去拍片子，就是特别想看一看我是不是有什么毛病吗？特别而且是有我看网上老是什么癌症，年轻化。然后我就自己吓自己。

For example, recently, my hands, well I don't know whether it might be because I am more sensitive, and I might exaggerate some things. I found that after I was typing on the keyboard for a long time, occasionally my left hand, especially around my thumb, would twitch. I don't know what was twitching inside my finger, and sometimes I couldn't move. I have to wait a bit, and then the hand can stretch slowly, and then I can continue typing. Before this incident, I only felt that when I held the steamed buns with chopsticks, and at that time my hand felt very sleepy and tired. Then I would put the chopsticks down periodically when I eat, because I am from the north, so we eat the buns as a whole big one. Then I began to think that my hand strength was not enough or what was going on? Later, it slowly evolved into aches in my hands like I was telling you, and I felt tired or sore in the tendons in the area where my thumb was connected. Then I thought of my previous experience of using chopsticks to get steamed buns, and I felt this might be a problem. Not too long ago, I almost wanted to go to the hospital to take an X-ray, just to see if there was

> something wrong with me. In particular, there are always some articles about how cancers are spreading to a younger population. I was scaring myself with this worry.
> (Sisi, 30, female)

She told me that after a while the hand stopped aching. She also realised that if she exercised, or if she moved around after working, then it did not happen, which lessened her worries, and made her think the symptom may not be that serious after all. Still, she felt it could be a hidden problem. She connected subhealth to some other symptoms, such as pain in the neck and, in particular, how her waist and neck hurt during her periods. The pain in her waist and neck were other symptoms she connected with subhealth. She told me this started when she was in high school, but she did not think it was a problem at the time. She thought it was normal. But at the time of the interview, she told me she was thinking maybe that pain could not be attributed to the period; it might be due to some inherent problem in her body. She also told me that if she keeps exercising, then she does not have the pain, but if she sits at the desk every day for a month and does not exercise, then there will be pain. It is interesting that even if she exercises and the body does not hurt, she still feels that she is in subhealth because

> 如果你的身体不是处于一个亚健康状态，你是完全不需要刻意的辛辛苦苦去维持这样的一个生活状态的。
> If your body is not in sub-health, you wouldn't need to work so hard to maintain such a state.
> (Sisi, 30, female)

Therefore, she concludes that subhealth is a response by her body, some sort of embodied knowledge that could potentially indicate some level of risk. This sense of risk fluctuates from day to day, so there will be moments of enhanced awareness of being in subhealth and raised levels of health anxiety, and moments when it subsides into the background. There are many floating narratives on Weibo that echo these sentiments and function as a cry in the air in those transient moments:

Uncomfortable
My current state is like half-dead
Distressed + bored
Hand weakness + shaking
And there is no strength in the hand to grasp
Had cramps in calves
Those cramps still pulling
Stomach-ache
Help
My state is completely sub-healthy
(Weibo post 17)

The narratives presented above speak to Xu's narrative. Xu is a 30-something-year-old Chinese PhD student who was studying in the UK at the time of the interview. She told me she had episodes of subhealth when she worked on some quite demanding projects at a university in China, and at those times her family and friends gave warnings about her health status. I will present Xu's account of subhealth to highlight two aspects of the embodied feeling of subhealth: the feeling that the body is somehow not functioning as well as before, and is somewhat alien; and the embodied experience of risk.

When I asked her whether she ever has the feeling that she is in subhealth, she commented:

> X: 我会。我可能就会觉得我最近身体是亚健康，就是不是那种健康的状态？因为因为比如说我以前会精力很充沛的去工作，或者是怎么样做什么事情，但我现在我的身体影响到我的任何事情，所以说我觉得我像没跟以前比是不一样了。或者是我平常比是不一样的，所以我觉得我像身体是亚健康的。我觉得可以这样说
>
> I will. I might actually feel that my body is in sub-health recently, you know, feel not very healthy. Because, for example, I used to be very energetic at work or when I do things, but now my body is in the way of my things, so I feel like I am not the same as before. Or my body is different compared to how I usually am, so I feel like my body is sub-healthy. I think it can be said that I am in subhealth.
> (Xu, early 30s, female)

In Xu's account, subhealth is an embodied feeling of when the body suddenly does not function as well as before, or as well as the body would normally. A sense of comparison is

invoked here, to an 'ordinary state', or to a past unobstructed body. She feels her body gets in the way. The body is not as energetic as before. She later complained to me how sometimes her waist hurts and she has to lie in bed. Those are the times when the body suddenly becomes present and alien. For Xu, subhealth is a state of health where her body is in the way of her daily tasks. An unpleasant presence. These experiences of subhealth constitute a reminder for changes in lifestyle while situated on the side of health but faced with the possibility of sliding into illness; they remind her to take action so that she does not cross that threshold. She characterised that feeling as 'on the way to illness':

> X: 我觉得如果那段时间真的，不过他当时说了之后我很认同的，因为我自己就觉得我是亚健康状态的，我那段时间本来一直在亚健康状态下，因为我知道我去我不知道，我现在，因为我没有去我没有一下病倒了，或者是发生一些明显的症状。我的生病了的症状。所以我不知道我现在身体状况到底是什么样子，也许它正它也就在路上，你知道吗？就在生病的路上，只是他还没有到。还没跨过那个线。也许我觉得如果我再极端一点，它可能就不健康了，所以说我也觉得我因为我起码睡不够，吃也吃不好，然后那一段时间都是很不正常了。而且精神很不充沛什么的。然后肯定是跟平常不一样，然后感觉自己特别的劳累，特别的疲惫这种。
>
> I think that at that time, after they mentioned that they think I am in subhealth, I agreed with them. Because I did feel that I was in a sub-healthy state, and I had been in a sub-healthy state throughout that period. I didn't fall ill or have some obvious symptoms. So I didn't know what my physical condition was exactly. Maybe it was on the way. Do you know? Just on the way to get sick, but it hasn't arrived yet. Haven't crossed that line yet. I felt that if I got a little more extreme, I might become unhealthy. I also think that because I didn't sleep enough, and I couldn't eat well, and it's very abnormal for a while. And I was not full of energy or something. I knew I must be different from usual. And I felt very tired, extremely tired. So I thought I must belong to a sub-healthy state, so when he said that I actually agreed. I had not been in a good state for a while.
> (Xu, early 30s, female)

From the interviews, participants see subhealth as normal and a recurring part of everyday life, or to be more specific, subhealth, when recounted in the participants' narratives, seems to revolve around an embodied sense of 'my body does not function as well as before' and to be related to various 'discomforts' and their various ways of grappling with that reality and the ways they try to come to terms with this. Here we see incipient illness as a normal part of

everyday life, as part of the conditions of the form of capitalism in which they live. They are almost mentally preparing themselves for the possibility of being ill, and calling that liminal space subhealth. This contrasts directly with the work of Bury (1982) and Charmaz (1983) where chronic illness disrupts everyday life and one's sense of self. Here, narratives of the self depict the daily grind, reflecting on everyday life and everyday health practices. The self in subhealth is a self not disrupted, but captured in a liminal, mundane space.

7.3.2 'I can't cross the threshold' : Subhealth as an embodied experience of risk and aging

Xu went on to talk of a concrete line when she is no longer in subhealth and enters unhealth; for her, that is when she seeks a concrete diagnosis and needs to take medicine. Before that, she is in the liminal space of subhealth where many different discomforts could be present and she might feel that those discomforts, if left untreated, might lead to more severe health conditions. In other words, she feels like she is in the space of risk. This embodied experience of risk is evident in many other narratives that I collected.

Risk, as observed by Jauho (2019), 'adopts an ambiguous position between health and illness/disease' and is quite similar to the Chinese construction of subhealth. In subhealth, just as in the functioning of risk, arbitrary lines are drawn, and spaces between health and illness are being mapped out. Jauho (2019) also comments that most research on risk focuses on the illness/disease side of risk ambiguity, instead of the health side of risk ambiguity. In his research on people with elevated cholesterol, it is concluded that these individuals actively attempt to not fall into the identity of patients 'through a responsible regimen of personal health care' and view themselves as 'chronically healthy individuals' (Jauho, 2019). This seems to be quite similar to the way subhealth functions in the narratives I have collected.

What is noteworthy is the way Xu's accounts invoke a shared definition of subhealth,

with repeated usage of ‘do you know’ to check whether we were on the same page although she was discussing her own health. She constructs subhealth as a warning. She situates subhealth as a reaction to a label given by others and she seems to appreciate that label and try to make sense of it, and react to it by contemplating her general state of wellbeing and making necessary adaptations. Many Weibo posts also point to this sense of health in limbo, including the few I presented at the beginning of the previous section. Those social media narratives use subhealth as a tag that can be understood by everybody, to capture their very private anxiety, in the space of ‘so-called’ ‘legendary’ subhealth. In this way, subhealth functions as a blanket concept that embodies a sense of ‘the present body’ and an experience of risk. In trying to make sense of their health privately, different states of health are ascribed to subhealth, to constitute the feeling of being ‘on the edge of subhealth’, or more simply, ‘in subhealth’.

In the narratives I collected, the concept of subhealth is constructed in relation to different thresholds and different stages of life. In many occurrences, it is related to being 25 years old. In my interview with Lan Lan, she told me the occurrence of her subhealth coincided with turning 25. In the interviews and Weibo narratives, subhealth narratives invoke very different time-points: be it 25, 30 years old, or later, and those are constructed as an objective and natural occurrence that comes with aging, or a crisis that one has to fight against because of aging. Some people also relate subhealth to getting married, commenting that there have been more bodily discomforts after marriage. In that instance, marriage is a threshold. There are various other instances where giving birth to a child is seen as a threshold. Whatever threshold people connect subhealth with, those narratives are usually followed by a resolution, such as whether to change lifestyle, or to exercise more. There are some exceptions, though. For example, one post characterises vomiting during pregnancy as subhealth, an instance when subhealth is a natural but only temporary state of health that one

can only bear with.

> If I lower my head a little longer, my cervical spine hurts. I also have dizziness, and shoulders are sore. I'm afraid I will always be in severe sub-health. When people are 25 years old, their physical health really declines significantly.
> (Weibo post 27)

> My 30-year-old body cannot bear the working state of a 23-year-old, and the intensity during the day always causes insomnia and anxiety at night. Isn't this the middle-aged sub-health crisis mentioned on TV when I was a child? Wearing eye masks and headphones while playing music half an hour, and the moment the music stopped, I became more sober? Will I have a sudden death? (Weibo post 28)

7.3.3 'Subhealth is me'（我亚了): subhealth and identity formations

In some sense, subhealth is seen as connected to young lifestyles and young identity, as can be seen in this question posted by one Weibo user:

> 'Can you even call yourself young if you are not subhealthy?'　(Weibo post 29)

There are also jokey comments like:

> Everybody, just be subhealthy and enjoy everyday. Yeah. (Weibo post 30)

Even in more serious complaints of bodily symptoms, the post ends by saying 'I am the sub-health champion' with mock-pride:

> It's annoying. I have a headache for half of a month, and I take pain killers for ten days of a month. I am the sub-health champion. (Weibo post 31)

If the concept of suboptimal health was initially invoked to capture the messy ambiguity between health and illness, it seems to be doing a good job because people are further imagining a spectrum within subhealth. In an earlier instance a poster comments 'I am sub health level 10' as if subhealth has a spectrum of levels. And here this person comments that they are the champion of subhealth as if one person's level of subhealth can be measured. People can compete against each other in subhealth. If subhealth can be seen as a spectrum, what would be at the two ends? Certainly, in this instance subhealth, even at level 10, or

being a champion, would not constitute serious health conditions in any way. Level 10 of subhealth is still the safe ambiguous space between health and illness. Subhealth is seen as (mostly) still health, with a comment in one post that:

> I am very healthy, healthy as in subhealthy (Weibo post 32)

7.3.4 Facilitating talk about health

Bing is an artist who is currently finishing up a Master's in the US while living in China, that is, remote studying. I have presented his criticism of the concept of subhealth earlier in this chapter. After giving me an extended critique of the consumerism behind the concept of subhealth, I asked him whether he ever had moments of feeling subhealthy. He said:

> 我其实是有，我觉得我就是一个严重，尤其最近就是因为阴间作息，但其实我觉得这种亚健康更多是基于心理的。对，就是你看不见太阳，对你身体产生影响，然后主要是你缺乏维生素 b 啊。你人的身体是没有办法合成维生素 b 的，是要通过有维生素 b 有一个维生素 b 的，有一种是需要通过晒太阳，就有点类似于光合作用才能合成的。
> 对，人身体是无法通过膳食合成的，有一个维生素微量的一个 b 的，因为 b 有很多种，那就吃点维生素，组合药片心情都会好很多。其实这种对身体真正直接影响是这样。包括你长时间，因为导致你的时间是混乱的时候，我就会经常会觉得操蛋累的跟狗似的，但其实往往是源于作息，其实我很理性的看这个事。
>
> Actually, I might have. I think I am quite serious, especially recently because of my underworld work and rest schedule, but in fact, I think this sub-health is more psychological. Yes, you can't see the sun, which has an impact on your body, and the main reason is that you lack vitamin B. Your body has no way to synthesize vitamin B. There is a kind of vitamin B that needs your body to be exposed to the sun, which is similar to photosynthesis. Yes, the human body cannot produce through diet a specific type of vitamin B, because there are many kinds of B. So I will just take some vitamins and combined pills and I will feel much better. In fact, this is the real direct impact on the body. Including for a long time, because when your time is chaotic, I will often feel fucking tired like a dog, but in fact, it often comes from work and rest. In fact, I look at this matter very rationally.
>
> 对，缺乏维生素 b 和以及这个造成的。
>
> Yes, lack of vitamin B and these are the causes.
> …
>
> 对最近一个特别典型，因为时间是乱的，你既要维持你在中国的生活状态，你

要维持和国外因为上学导致的，你必须要和国外产生关联性。然后从作为内心上来说，你就是处在一种两边社会游离的状态，都不是一个很，都不是一个很完整的状态生活，你的生活变成非常支离破碎，那种破碎感，然后会对你本身内心会产生一个影响。

Yes, recently is quite typical, because my time is chaotic, you have to maintain your living condition in China, and you have to maintain a relationship with the foreign country because of going to school. Then from the bottom of your heart, you are in a state of social dissociation on both sides, neither one is very, neither is a very complete state of life, your life becomes very fragmented, that kind of broken feeling, and then it will have an impact on your mind.
(Bing, 30, male)

As can be seen in the above passages, Bing considers his current messy work schedule to comprise a state of being in subhealth. He told me he had to get up every evening at 7 o'clock and then went to sleep at around 7 or 8 o'clock when he needed to teach a module last semester. His current schedule at the time of the interview was not too different. He tried to avoid using the word subhealth, because he is quite critical of all the various discourses surrounding subhealth. So, he said, 'Actually, I might have' to the question without mentioning subhealth as the object of the sentence. Also, he said, 'recently is quite typical', which, according to the context, indicates that he thinks his current state is quite typical of *that conceptual space of in-between health and illness, but he omitted the word 'subhealth'. It is as if he refuses to identify with the term, but the concept is still somewhat useful to denote his current state. He tried to rationalise his experience of these symptoms that are put into the bracket of subhealth and attribute it instead to a lack of certain kinds of vitamin B. He also attributed it to the remote study lifestyle he was going through, and his sense of being cut off from both worlds: that surrounding, mundane, 'real' word in China, and his academic 'virtual' world in the US. He talked about this feeling of brokenness. Intriguingly, in talking about such a personal experience that I did not share, he constantly used the second person pronoun. This lifestyle of some international students who study in the US or UK but live in their home countries due to the pandemic was being discussed more frequently during that

time, which constituted quite a high proportion of international students, so he may have been trying to identify with an imagined community. But at the same time, the use of second person pronoun seemed to help to frame his experience of brokenness and detachment from everyday life as an objective phenomenon. It was not really addressing me as the interlocutor but addressing imagined interlocuters who would have had exactly the same experience had they been through exactly the same thing. A subjective feeling was being framed as an objective sequence of events. He still maintained his criticism, cited earlier in the chapter, that subhealth is a vague term and people's minds are vulnerable to the suggestion of such a discourse. Still, he related his current state to the conceptual space of subhealth. He went on to recount this subjective feeling using a second person pronoun:

> 所以或者说或者就是说再晚一点 10 点早上 10 点你睡觉，但是你看着外头的朝阳，你不能出去，因为你困了，你累了你得睡觉，你不敢出去玩，因为你玩的话有可能你会晚上睡得更晚，起不来，导致你耽误了一整天的事，就陷入了一个无限的焦虑的循环里。就没生活。
>
> So sometimes you go to bed a bit later, at 10 a.m., but you look at the sunrise outside. You can't go out because you're sleepy and tired. You have to go to bed. You dare not go out to play because you if you do, it is possible that you will get up later at the evening, or can't get up in the evening, and that means you have to delay the whole day of work, and you will fall into an endless cycle of anxiety. There is no life.
> (Bing, 30, male)

What I want to highlight here, despite criticising the possible commercial undertones in discourses of subhealth, is that talking about subhealth opens spaces for Bing to reflect on his everyday life, to talk about the distress he feels. It facilitates private accounts, in Cornwell (1984)'s words.

A common element in subhealth narratives is a contemplation on the state of health for the self, almost a biographical suspension. As mentioned above, many of the Weibo narratives involve talking about their embodied and phenomenological feeling of the slightly disrupted body, when the body is no longer absent (Leder, 1990), to conclude that they are in subhealth; alternatively, people might conclude that they are in subhealth as a result of a

health examination or just as a general comment on their less than satisfactory state of well-being during a certain period; meanwhile the authors of many narratives conclude that they are in subhealth when they feel that their body fails to function as expected after playing some sports.

There often is an attempt to think about what has caused this subhealth, in the form of comments on lifestyle, or work. This is then followed by making resolutions. Usually after contemplating their state of health, these narratives will conclude with different resolutions, for example, that they need to adapt their lifestyle. Alternatively, they might try to make a point on general life attitudes or work attitudes, in the vein that work is not that important, and health is more important. The following is an example that has all three elements:

> I have always needed to work at the desk for a long time,
> I thought that a hundred poisons wouldn't invade me,
> But now feeling the panic of sub-health,
> And the crisis of middle-aged people's declining body constitution and tendency to get fat.
> It's time to keep fit and beautify (emoji)
> (I have been having back pain and pain when turning over. It may be due to too much aerobics. It may be due to the fact that when I was working[15] I stayed in one posture for a day and a half. It may also be due to sitting too straight when driving for two hours (emoji) (emoji) (emoji))
> I will present three more examples to illustrate the moves:
> Suddenly my heartbeat speeds up tonight, and my heartbeat is very fierce, flustered?? Is this sub-healthy? Go to bed early tonight! Skin care skin care skin care skin care!
> (Weibo post 18)
>
> Today is a day trip to the hospital again. In the past two years, I seem to have been in a sub-healthy state. There are a lot of minor health problems without major problems. Good health is the cornerstone to life! I will pay attention to health in the future. I will become a exercising health preserving woman!
> (Weibo post 19)
>
> Looking at my physical examination report, shedding two lines of tears. My work did not bring me wealth and happiness, but only sub-health and regular health review. Long time standing in classes, and bowing heads to prepare for lessons, even my spine physiological curvature has become straighter. For the rest of my life, everything related to work is not that important! Do your best, and health is the most

15. This person mentions more detail about their work which could be confidential, so I changed it to ‘working”.

important thing.
(Weibo post 20)

'I feel I am on the way to subhealth. Maybe I do need to swim and go to the gym now.'
(Weibo post 21)

The first post attributes subhealth to sleep patterns and skin care. The second post concludes that they are in subhealth due to visits to hospital (so chronic conditions are labelled subhealth too) and concludes that they need to engage in health preservation, while the third post draws the conclusion of subhealth from health examination results, a collection of objective metrics and attributes it to work before concluding that they will pay more attention to health instead of work in the future. This is a sense of 'colonising the future' as discussed by Lawton (2002), anticipating future health while encountering present lived reality. Lawton (2002) concludes from her research that embodiment plays a central role for people in anticipating future ill-health and taking health-related actions and that people's changes in health behaviours tend to be reactive. The movement in subhealth narratives seems to follow this trajectory, with expressions such as 'on the way to subhealth' or 'on the edge of subhealth' which invoke both present embodiment of the body and future expectation of the self, and expressions such as 'I need to conquest/tackle/address/beat subhealth', which constitute reactive actions. The conclusion of being in subhealth seems to always indicate a resolution to facilitate more care of the self. One of my interviewees, Yang, comments that:

我就觉得亚健康只是一个近几年，近十几年安在我们身上的一个标签，但是我不觉得这个标签不好，因为它会提醒我们主动去运动，去脱离这个标签，去时刻的去让自己反省一下自己的身体状况，自己的精神状态这样子。

I think that sub-health is just a label that has been attached to us in the past few years, or the past decade, but I don't think this label is bad, because it reminds us to take the initiative to exercise, to get rid of this label. It urges us to reflect on our physical condition, and our mental state.
(Yang, mid-20s, female)

But it might just be intentions with no action resulting:

> I feel sub-healthy... I want to go out for exercise tomorrow... But suddenly I remember that I am on my period... Okay, I should just lie down at home (emoji). (Weibo post 22)

This above post is one example of how people invoke a sense of embodiment and health worry, talk about some potential actions and then resolve to not take any action. Sometimes, they might jokingly comment that they are lazy themselves, but sometimes this inaction could be due to more complicated factors such as work. On the other hand, it seems that subhealth is a slippery concept; it can be a phenomenological feeling of being in-between health and illness without medical diagnosis, and it can also be a concrete form of mild illness or pre-clinical condition confirmed by physical examinations.

I need to mention that when they apply the concept of subhealth to their own lives, they, to some extent, strip subhealth of its various discourses, and treat subhealth simply as an undetermined area between health and illness (from discourse back to a concept). This assumes the understanding that from health to illness is a spectrum, and there is an area in-between that is subhealth. This is a key understanding of health and illness that is behind the conceptual construction of subhealth - its popularity, as well as a similar understanding in Traditional Chinese Medicine, has shaped such an understanding among the participants (apart from a few that insist that only biomedical diagnosis counts and there is no such area as sub-health). In this understanding, subhealth is the status in between health and illness, a chronic reality with edges. One edge borders into health, another edge borders into illness, itself being undermined by chronic reality. It is those edges people's narratives revolve around. It is this understanding that gives rise to their narratives. Again, the fuzziness of this concept makes it relevant in a new context, in everyday life.

7.4 Subhealth as the new normal: public narratives of subhealth

7.4.1 Being a 'corporate slave' in contemporary China

The term 'corporate slave' (社畜) has been increasingly used by employees in China in

self-parodic terms. Surveying the social media data has revealed that subhealth is seen as particularly related to the current stressful working patterns in big cities. Increasingly, employees in large cities, especially in technology companies, are expected to work from 9am to 9pm for six days a week, a regime called 996 work culture. According to Wang (2020), the '996' work regime in China is the result of a combination of unhinged global capitalism and a Confucian culture of hierarchy, and for her, it is a work regime 'that constitutes modern slavery'. BBC (2019) comments that it is 'the Chinese grind-it-out work culture that workers joke could land you in the ICU'. Since around 2019, 996 work culture has attracted more and more public attention.

In the interviews, some participants commented that the term subhealth was no longer suited for the current time. Quite a few mentioned the term 'corporate slave' instead. Jasper commented that:

> 我就会觉得你要让我再去形容现在大部分人职场人的情况的话，我会用社畜这两个字，因为大家我觉得真的就是工具。
>
> I feel that if you want me to describe the situation of most people in the workplace, I will use the word 'corporate slave', because I think everyone is really just a tool. (Jasper, mid-20s, female)

This led her to comment that she felt subhealth was too weak a term for the modern work condition, and being an editor, if she needed to write a new story that urged people to take care of their health, she would write about someone who suffers from more serious conditions due to work and who, eventually, with good care of the self, 'recovers back into subhealth'. She commented that she would find it unusual if anyone claimed to be completely healthy. She attributed this to the lack of time and energy to take care of oneself, both physically and mentally:

> 对在我心目中真正健康的一个人，他应该他是需要花很多的时间和精力去跟自己的身体，还有一些就是所谓什么灵魂去交流的人，但是现在我们大家没有精力做不到这一点，所以很难健康。一直不停的在消耗自己的身体，也没有办

法。

For a person who is truly healthy in my mind, they need to spend a lot of time and energy to communicate with their body, and their soul, but now we all don't have the energy to do this, so it's hard to be healthy. We all have been consuming our body continuously, and there is no way out.
(Jasper, mid 20s, female)

Most of the interviewees shared this understanding that young people in the big cities are 'consuming their body/health' too much. Yang also mentioned the term 'obesity from overwork', which is an experience Jasper also shared. Jasper thus concluded:

我是觉得亚健康–健康和钱之间呢，你好像很难真正去同时拥有。你想要钱的时候你就不那么健康，或者说你有一点点钱的时候你就亚健康，都是这种感觉。

I think that in terms of sub-health, well, health and money, it seems difficult for you to really have both. You won't be so healthy if you want money, or you are sub-healthy when you have a little money. That's how it feels for me.
(Jasper, mid 20s, female)

In both Weibo narratives and the interviews, there is an apparent tendency to treat overwork and stress-related symptoms as the new normal. In these scenarios, the functioning of the concept of subhealth seems to have changed a little. In some discursive iterations of subhealth, instead of initiating a resolution, subhealth becomes a stable identity formation, the identity of a working individual. Or, as can be seen in the following comment, subhealth is jokingly viewed as a medal for the modern individual:

Now I really feel that sub-health is the medal of modern people, and occupational diseases are the glory of corporate slaves. To die from overwork is to die in the worthy path. (Weibo post 23)

This caused those private subhealth narratives to enter the public sphere. This post attracted 10k likes and 8.9k reposts: 'The verbal tricks of capitalists: turning subhealth caused by work into subhealth caused by lack of exercise'. I am taking one particular pathway of reposts to offer a glimpse into the prevailing discussions on subhealth and work (since this is

a more public narrative, I thought it okay to provide a screenshot):

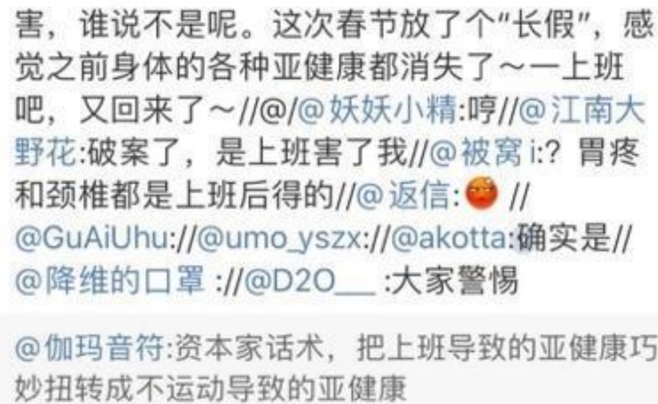

Figure 7.1 Weibo post 24, a heteroglossic discussion on how capitalism led to subhealth

This post is reposted, with a comment 'be aware everyone '; next repost and comment says 'yes indeed', followed by the next repost and comment 'my stomach ache and cervical discomfort all started after I started to work'. Another user joined this public discussion: 'mystery solved, it is work that has caused me misfortune'. And the last comment in the picture says 'That is so true. Having had a "long holiday" away from work this spring new year due to the pandemic, I felt all my subhealth symptoms disappear. And now that I am back to work again, they are all back'. There are opposing discourse constructions that say: 'The verbal tricks of the youth: turning subhealth caused by unhealthy lifestyle into subhealth caused by work', but that attract significantly fewer likes and reposts. This can to some degree reveal the contemporary sentiment towards the rising level of overwork in companies in big cities.

This following Weibo post is a good example of the sentiment:

> Why does a dust storm cause corporate slaves to react so much? It's not just that it's windy, smelly, and makes their freshly washed hair dirty.
> It is more that, even after taking in 10 days of haze, when being able to reach subhealth is a good thing, today they still have to ride a bike to the subway station, crammed into a shutting door, to reach the company two hours late, stopping at the door to tidy up a bit before roughly scanning the card to sign in, as if nothing has happened, and they have to sit at the desk waiting for the boss to hand over some

> ‘super simple’ tasks.
>
> You need this kind of weather to see that it's not the sandstorm that sucks. It's not the Monday that sucks. It's you, your life, a screw rushing about in the sand that sucks. (Weibo post 25)

There is a sense of powerlessness, of being a ‘screw’ in the machine; but even after acknowledging such a reality, there might still be some possibilities of change, although the change lies with another (hopefully better) job:

> I am most afraid of my parents’ sudden concern. Every time they call, I am working overtime. As soon as I pick up the call, not only do I have to persuade myself, but also comfort them. So difficult! I need to gain more experience from work and then hop to a different job. When most young people can’t afford to buy a house, have to work 996, and are in subhealth, the problem is probably not all with me, but I can’t always stay in the mud.
> (Weibo post 26)

This was the path Jasper took. With the awareness that the word ‘subhealth’ is becoming too weak for the new reality of ‘corporate slaves’, she quit her job and spent some time taking care of herself. After a few months, she started a new job, with the hope that this one would allow more time to relax after work, or would be more worthy of her health sacrifices in exchange.

7.4.2 Between public and private and between body and mind

When talking about subhealth with my interviewees, some recalled times when they had strong health anxieties, and others recalled difficult times in their lives and their efforts to live in peace with the stressful city life. Weibo narratives are diverse, with narratives of embodiment and health anxieties, as well as commentaries on the modern work condition; moreover, I have presented some accounts from people who take their subhealth for granted or as something to base their identity on or be proud of. One feature in common is that subhealth is apparently being gradually defined as something that is somewhere between

body and mind, and something that is both private and public.

Sky gives a detailed sketch of subhealth that emphasises its being a physical and mental issue that has lasted a long time, but usually does not get any attention:

> S:亚健康你是这个状态是持续很久。且你觉得影响到你目前的生活，但是好像也没有必要去特别的解决它，因为你已经习惯这个状态了。
>
> Sub-health is when you are in this state for a long time. And you think it affects your life, but it seems that there is no need to try to solve it specially, because you are used to this state.
>
> S:这种东西是亚健康的，比如说加班的人加班了很久，互联网公司的一直都周六上班，他觉得没什么，但是他明显颈椎有问题了，明显情绪有压力了，明显无法跟身边的人有特别深的交流，每天都被那些高强度的抖音公众号标题党去刺激，你才能够感官的感受，每人否则无法深入思考和沉淀下来的时候，你可能是亚健康，但你觉得这需要改变吗？你觉得不需要改变，没什么。我觉得这个是亚健康。
>
> This kind of thing is sub-healthy. For example, people who work overtime work overtime for a long time. Employees in internet companies always go to work on Saturdays. They feel nothing, but they may have a problem with their cervical spine. They might get obviously emotionally stressed. They may be unable to talk to people around them on a deep level. They may only be stimulated by those high-intensity TikTok videos and WeChat official account headlines every day, to feel and have senses, and they can't think deeply and calm down. They might be sub-healthy, but do you think this needs to change? You won't think it needs to be changed, it is nothing. I think that is sub-health.'
> (Sky, 29, female)

In Sky's characterisation, subhealth is when something is felt not to be right, but it does not actually need action for change. She uses third person pronouns to discuss what she appears to think to be a shared reality among people who work in cities. She defines subhealth as mild problems that people grow used to, not urgent enough to prompt changes. She told me that if someone is unhappy with their job and that they decide to quit their job, then that is not subhealth, because they are able to make changes, which is an interesting definition, one that focuses more on a general state of life and health, instead of a bodily state.

For the interviewees, bodily subhealth has almost become a certainty, and they are

commenting more markedly on sub health as a mental condition rather than a physical condition. For example, Meng comments:

> 我觉得对于现在年轻人来说，应该心理亚健康更严重一些了。体能亚健康就是普遍现象了。
> I think for young people nowadays, mental sub-health should be more of an issue. Physical sub-health is a common phenomenon. (Meng, late 20s, female)

A new development, perhaps due to increasing acceptance of mental illness and emphasis on mental health, is the spin-off of mental subhealth.

Meng also went into detail about her severe anxiety as subhealth. This new development is perhaps related to the increasing acceptance of mental illness and emphasis on mental health in contemporary China. On Weibo, there is even the iteration that 'everyone is mentally subhealthy in China' (#人均心理亚健康) in one post that aims to advise Weibo users on mental health (this post attached a screenshot of a message received from the official website of Wuhan Municipal Health Commission, with the message containing various mental health service channels for different demographic groups in the city) and there have been various hashtags urging the public to pay attention to the mental subhealth of university students, for example. If the public health promotion of 'paying attention to subhealth' has become outdated and outmoded, the public health effort of 'paying attention to mental subhealth' seems to be still ongoing. And in this, the idea of mental subhealth is playing an ongoing role. Many different professions, personalities, relation types, emotional types are placed under subhealth. Here is one example:

> I always feel that music learners (professional) who have some achievements are all somewhat mentally sub-healthy. There are too many missing things. It is not due to poor ability to withstand stress, but because they have experienced what I think is unnecessary, constant, and unnatural, stress. They internalize such pressure, turn this into a different person, a good child in the eyes of the elders, a self-disciplined and determined person, and she is her own demon. In addition, if you have emotions, you need to vent. Having said that, I found another reason to vent my little emotions. (Weibo post 33)

In this post, the author tries to make a generalization about ‘music learners (professional) who have some achievements’ being in mental subhealth. Another post contains a self-diagnosis of mental subhealth:

> My feelings for my mother are very complicated. I am very afraid when she speaks to me. As soon as there are signs of this, my scalp will tingle. Whatever she said, I thought she was attacking me. I would get nervous as soon as I heard the sound of her walking in, her putting down the key, closing and opening the drawer. I get nervous when she casts her eyes on me for scrutiny. (Emoji) mental sub-health. (Weibo post 34)

This account could be a sign of dysfunctional family relations, but this user calls this sentiment towards their mother ‘mental subhealth’. The impact of family relations on mental health seems to be a recurring theme:

> On the ‘gift’ given to me by my failed family education-eternal mental sub-health. I started to correct it in my sophomore year, and finally got better. I went home for a few months, and now I am back to the original state. (Illustrated with a picture of UPI Youth Personality Questionnaire - a result showing 32 points, psychological abnormalities, with symptoms affecting study and life) (Weibo post 35)

This reiteration of ‘mental subhealth’ and self-diagnosis of ‘mental subhealth’ seems to provide a twist to the subhealth narratives and its subjective and objective contradictions. Here is another example where an individual laments:

> ‘No matter what kind of illness I look at, it seems like I have them… Social fear, bipolar disorder...I have been in a state of mental sub-health’ when reposting a public account that posted it's me (with picture about avoidant personality disorder). (Weibo post 36)

From the interviews, it seems that the participants see subhealth as a normal part of everyday life, or, to be more specific, subhealth, when recounted in the participants’ narratives, seems to revolve around an embodied sense of ‘my body does not function as well as before’ and various discomforts and various ways of grappling with that reality and trying to come to terms with it. There, subhealth is less frequently encountered as a myriad of health

discourses perpetuated by the media, and more as a vague area between health and illness. In this private 'sense making' (Bury 2001), subhealth is always situated in relation to boundaries. It is about those moments when the participants feel various discomforts and feel that they are on the edge of becoming ill, or they feel they are in minor illness and need to make conscious efforts to maintain health. In their tales are both the sense of chronicity and urgency, and the entanglement of these two conditions.

7.4.3 The story of Sky

I will end this chapter with a detailed anecdote from Sky. Sky is a special case among my interviewees because she actively used subhealth to account for her own state of wellbeing before our interview. Sky is a friend of mine who was working in a busy financial company as an investment manager in Shanghai, and after she wrote an article on her WeChat public account talking about how she felt she had been in a constant state of physical and mental subhealth, I asked whether I could interview her, to which she agreed.

She told me at length of how she felt dissatisfied with her life currently, and started by telling me about changes in her diet and sleep. In her words, 'because the body is actually more honest than the brain'. The body will tell you what is wrong with your state of wellbeing earlier than the brain. In her words, 'you can try to convince yourself that you are in a good state. So your brain is deceptive, but your body is not good at it, so your body is a priori.' She told me she was going to sleep quite late. She used to go to sleep quite early but in the interview she told me she did not want to go to sleep until 1am every day and she constantly wanted to eat food with high calories. She told me that gradually she realised she did not want to go to sleep probably because she was too busy in the daytime.

> 其实真的是我白天那么长时间，我几乎就一从 9 点到晚 9 点，可能精神稍微轻松点的时间不超过一个小时，绝对不超过。所有的时间加起来，我中午休息可能就吃饭这件事半个小时时间比较轻松，然后工作，这工作完全没有任何摸鱼，因为摸不了，太忙了。完了之后导致我一回家，我就开始我就想稍微轻松

一点，那时候我想想吃东西，然后稍微轻松一点，开始喜欢吃那些高热量的东西。

In fact, really from 9 o'clock in the morning to 9 o'clock in the evening all the time I have to relax my mind does not exceed an hour. Adding up all the time. Maybe the half an hour at lunch break is the most relaxed time I have. There is no 'touching fish' in this work because I'm too busy. As soon as I went home after it was over, I started to want to relax a little bit, then I wanted to eat something, then relax a little bit, and started to like to eat those high-calorie stuff.

其次我没有自己的时间了，我就一定要把这个时间补回来，谁也做不到，我晚上 11:30，10:30 加班到家，我立马要睡觉，我真的做不到，我得稍微玩一会。然后玩一会，一玩就开始，因为每次都是我洗完澡都 10:30 了跟 11 点了，我就开始玩一会玩一玩至少一个多小时，就 12:00 在将近 1 点了，我睡着要 1 点。然后因为我白天所有的控制力，因为人的意志意志力是有限的，我所以意志力投入在控制工作节奏上，控制工作上，控制工作情绪上，因为工作会发生很多 shitty 的事情，你要控制它，保证自己情绪不受，不太..就对别人是要情绪稳定的在外面。

I don't have my own time. I must make it up. No one can go back home after overtime at 11:30 pm or 10:30 pm and sleep right away. I really can't. I need to play for a while. Then I started playing. Because every time after I took a shower, it was already 10:30 pm or 11 pm, and after I started to play for a while, that would be for at least an hour, and it would be 12:00 or nearly 1. It is at least 1 o'clock when I fall asleep. And because I used my control power during the day, and because people's willpower is limited, after my willpower is invested in controlling the rhythm of work, controlling work, and controlling emotions in work, you know, many shitty things happen at work, you have to control it and ensure that you are not emotionally affected. You have to be emotionally stable facing others.
(Sky, 29, female)

This passage shows her frustration with her schedule at work, which left her no personal time whatsoever. This is a touching account of the mental and physical reactions to a stressful work schedule. Sky's work seems to perfectly match the 996 work pattern and she also told me that, on several occasions, she might be asked to fly to a different city for a business trip out of the blue. Her boss might tell her to go the day before, making it difficult, or nearly impossible, for her to take control over her life. She mentioned the term 'touching fish' (摸鱼, catching fish in muddy water), which describes the act of not doing the work well and loafing on the job, which has become a strategy for 996 work schedule employees (Ren,

2021). But Sky told me she cannot do that because of the number of tasks she has to perform. She is a very diligent employee, and her boss thinks highly of her but that only results in more work for her. So, she is left with no control over her life in this context. Among all my friends, Sky used to be the one with the healthiest lifestyle – she went to sleep very early and woke up extremely early; she had an impressive control over her diet; she ran and still runs marathons in many cities. But her work leaves her with no possibility of a healthy lifestyle. Though subhealth is often attributed to unhealthy lifestyles, Sky's case reveals how so-called unhealthy lifestyles can have systematic causes. Because her work requires her to have a sense of control and willpower, this leads to a lack of control over her life, and eventually a sense that things are quite meaningless:

> 嗯，我倒不会崩溃，就感觉好像感觉我跟你说我最近陷入一种非常极强的虚无，就觉得没有什么意义。
> well, I won't break down, it feels more like I have fallen into a very strong nihilism recently, and things feel meaningless.
> (Sky, 29, female)

In Sky's definition, as I mentioned above, if someone knows what is wrong, then that is not subhealth. That would contrast with her current state, which could lead to a 'recurring subhealthy state'. She also related some of the discomforts she felt to her intestinal flora being upset, but ultimately it was not a physical problem. She told me in the interview that she could not quit her job just yet, and that appeared to be why she was trapped in this condition of subhealth. Since she couldn't change her reality yet, her solution was to attempt to construct a consistent narrative of her life. Part of this attempted solution was to see a psychological counsellor regularly, who helps to show the way she maps her 'subhealth' state into the area of the mind:

> 我开始见心理咨询师。对，因为之前我没有等于说我先是定期的去每每周跟他约一次聊一聊，大概的目的，我一定要治好我某个问题或是我这个事我不知道怎么解决，我找心理咨询师，或者发现我心理上有什么问题找他，不是这样

> 的。我觉得是要通过找心理咨询师这个方法去 review 自己每一周的状态，然后把自己情绪上不太对的地方，因为我要找到情绪不太对的地方，我才能跟他聊，我觉得这个时候我情绪的背后是什么东西，我要跟他一起把这事找出来，所以我就开始定期的见心理咨询师。我觉得这个是亚健康状态的一个处理。
>
> I started to see a counsellor. But it is not like I go there regularly to have a chat to cure a certain problem of mine. I don't have a thing that I could not solve to seek help from the counsellor. I do not have any psychological problems to approach the counsellor about. It is not like that. I think I need to find a counsellor to review my state every week, and then find out the unusual parts of my emotions. I need to find the unusual parts of my emotions before I can talk to him about what was behind those emotions. I want to find out about that together with the counsellor, so I started to see the counsellor regularly. I think this is my treatment of my sub-health status.
>
> 我觉得所以我觉得找到自己能够我觉得突破亚健康状态的特别我甚至觉得基本上对我而言是比较唯一的方法，就是活的自洽一些，就活到就活活活的方法是你觉得你可以接受的方法就可以了。这时候你就不会有所谓的特亚健康的感觉。
>
> I think the way to address subhealth and I even think it's basically the only way for me, is to be more self-consistent. To live in a way I feel acceptable and consistent. If I can do that then I will not have those so-called subhealthy feelings.
> (Sky, 29, female)

She concluded that the only way to address subhealth for her is to be self-consistent. Her effort to make sense of her subhealth is her effort to live in peace with a systematic problem, an effort to find resilience within difficult situations by looking for possible coherent narratives for her life, and underlying issues behind her moods. When she talked about her visit to the counsellor, she highlighted to me that there was no mental health problem in her per se - it was simply an effort to find the unusual parts of her emotions, to review her general state, and to find the problems behind those unusual parts of her emotions. This features as part of her efforts to make sense of her life because she feels that her state is ‘unstable and discontinuous’ and she cannot summarise what is right or what is wrong about her life because of the lack of routine. She told me that she felt her mood fluctuated and she had lost control of the rhythm of her life, and that was why she felt she was in subhealth. She felt something was wrong, but she couldn't tell what exactly was wrong with her life. And she

needed some sort of coherent account to rectify this. Coherent narratives and fluent emotions seem to be posited as the cure for her subhealth. Subhealth for her is both physical and mental; and as she could not quit work at that time, and she couldn't simply 'live more healthily' because of the stressful work pattern, there seemed to be only a choice between either accepting the 'subhealth' state and take pride in it, or seek ways to make life more coherent.

Many of these narratives fit what Bury (2002) calls 'contingent narratives' but here we are not seeing narratives of chronic ill health. Here we have narratives of chronic 'unhealth' or 'incipient disease' (Parsons, 1951). These are individuals who face a crisis of self and biographical coherence, but without any sort of diagnosis, as in Bury's (2002) study. They are in a liminal space, situated in a mundane everyday life, articulating a critique of their living conditions.

When I asked Sky why she used the particular term of subhealth to describe her condition, she said:

> S:因为其实我没有看到过别人用这个词，但我为什么用？是因为在状态这个词前面需要加一个形容词的时候，我觉得所谓的焦虑或者所谓的任何亚健康的分支，那种词都不能形容，我在这个状态，它是一个综合的状态，我就用了亚健康。所以我觉得是因为不那么健康，又不能说自己有病，说不健康我是不行的，所以我就说我勉强能控制，但需要极强的意志力，然后我也觉得现在这个状态我持续了有一段时间了，且我无法改变暂时，所以比较亚健康。
>
> S: Actually, it is not that I have seen anyone use this term, but why do I use it? It is because when an adjective needs to be added in front of the word 'state' (to describe myself), I feel that anxiety or any other concrete conditions that are subbranches of subhealth cannot fully be adequate. I am in this state and it is a comprehensive state, and I need such a word, so I used suboptimal health (亚健康). So I think it's because I'm not so healthy and I can't say I'm sick. I can't say that I'm not healthy either. I am in a state that I can barely take control, but I need a lot of willpower. Then I also feel that I have continued to be in this state for a while now, and I can't change it temporarily, so it's quite sub-healthy. I think you have something very important then in this idea of the continuum between health and illness. So this should really be part of your discussion and introduction.
>
> S:我其实用，是挺简单的想法，是因为我觉得因为我觉得肯定不算健康，但是又没到不健康那个程度，所以就用中间的那个词

> S: So my thought process is very simple. Because I think that I am definitely not healthy, but not to the level of unhealthy, so I use the word in the middle.
> (Sky, 29, female)

As can be seen in the excerpt above, Sky found it necessary to use a term like subhealth to denote her general health state as that time. Contrary to other interviewees who recounted that they found more concrete categories like neck pain, or headache more useful instead of a vague bracket like subhealth, Sky found the overarching descriptor of subhealth useful because she felt she could not call herself healthy, and she could not call herself ill, but she nevertheless felt something might be wrong and she needed a specific vocabulary to capture it, to capture this connection between body and mind, to talk about her life as a whole, so that she could start to seek coherence.

These acts of labelling the general state of body and mind as subhealth sometimes frame the condition as a crisis, and in other contexts it is framed as a normality. There is constant ambiguity in how it is defined. And, as I hope to draw out in my findings section, there are always different contradictions imbedded in the concept of suboptimal health. Is it normal? Is it pathological? Is it objective? Is it subjective? Is it private? Is it public? Subhealth is always situated in relation to boundaries. It is about those moments when the participants feel various discomforts and feel that they are on the edge of becoming ill, or they feel they are in minor illness and need to make conscious efforts to maintain health. In their tales are both the sense of chronicity and urgency, and the entanglement of the two conditions.

7.5 Summary and conclusions

In this section we can see that suboptimal health appears in multiple contexts within the daily life of young people. It is evoked in many ways, facilitating both public and private accounts. I wanted to highlight the way that talking about subhealth facilitates private accounts of health and illness in all their complexities; on the other hand, it also makes

critique of prevailing living conditions possible and is invoked in the public account of the way overwork is producing ill health in China.

I have presented moments in the narratives from Weibo and my personal interviews when participants engage with the concept of subhealth and the various discourses associated with the concept (*people are mostly in subhealth, health nowadays is worse than before, you need to buy something to tackle subhealth*). They also indicate some level of criticism towards discourses of subhealth prevalent in China for the last two decades or so. But beyond that, the participants talk about the subject of subhealth, a particular concept to do with a vaguely defined area of human health, as a sort of social critique, or a critique of a conceptual construct. They constantly invoke the use of third person and second person pronouns to situate the discussion of subhealth in relation to modern urban life (in China in particular) and its 'assumed' shared reality, thus evoking the public accounts of subhealth (Cornwell, 1984). In most of the interviews I also managed to navigate from a public understanding of subhealth to their private narratives of what suboptimal health entails (that is, if they ever, at any point, identify themselves with subhealth at all). At various points of the interviews, the participants were invited to grapple with the concept of subhealth on more private terms, making sense of the concept within their own lived reality.

Chapter 8: Discussion and Conclusion

8.1 Introduction

The thesis has jumped through various contexts in tracing the concept of sub-optimal health. In the four data chapters, I have looked at the concept in contemporary knowledge making and the different efforts to objectively, capture, define it, measure it, and then to treat it. I have also tried to look at the conceptual history of this conceptual space and its potential unwrapping in PPPM (predictive, preventive and personalized medicine). In addition, I have looked at the embodiment of this concept in the lived world of Chinese people, mainly young Chinese people who live in cities. Finally, I tried to look for the concept in a TCM clinic and tried to see if this conceptual space features in the material space and the daily functioning of the clinic.

This current chapter will try to bring all the different strands back together. After the four data chapters presented before, I will now return to my research questions and see how that might be answered. In the introduction of the thesis, I have presented these three research objectives:

1. To explore the historical development of the concept of sub-optimal health.
2. To examine the use of sub-optimal health in a range of different contexts (TCM conferences, a Chinese Health Clinic, digital spaces and everyday life).
3. To explore the lived experience of sub-optimal health .

Objective one and two are addressed in research question one: How does the concept of suboptimal health travel through time and into different contexts?

Objective three is addressed in research question two**:** What does it mean for ordinary

people to be ‘in suboptimal health’?

I will examine each of these in turn.

8.1.1 How does the concept of suboptimal health travel through time and into different contexts? (Research Objectives 1 and 2 above)

All four data chapters in one way or another looked at the travel of the concept into different contexts, either in academic, professional, or mundane everyday contexts. In chapter 4, I looked at how the concept of suboptimal health gets defined and measured in different ways, by TCM professionals in treating individuals, or by epidemiologists in large epidemiological studies. Suboptimal health, while being fundamentally subjective, is utilised in large scale studies, with concrete definitions and measurement criteria, while at the same time functioning as an intermediate category that renders the complex TCM classificatory systems relevant. It managed to be useful in some public health studies, while also became institutionalized in TCM (and ultimately made its way to some Western medicine textbook in China as a recognized category).

In chapter 5, I looked at the conceptual history of the concept of suboptimal health, especially given the paradoxical construction of its origin in the Chinese context. I uncovered how the concept has occurred in the western public health discourse and how the way it is carved out and its meanings have changed.

Chapter 6 and 7 also looked at how the concept might play a role in alternative medicine encounters, or in everyday life (I will expand on this when discussing my second research question below).

Therefore, these findings suggest that suboptimal heath, precisely due to its often-criticised vague nature, has been able to move between contexts, and that has actually become the strength of this concept. In some contexts, it has thrived and in some contexts it has become irrelevant. The vagueness of the concept enabled it to travel across national

boundaries as well the boundaries of different knowledge systems. The concept is an intermediate category for TCM professionals to work across TCM and Westernised medicine and to make TCM classificatory systems and systems of differentiation relevant to the embodiment to people not familiar with TCM. It is also this vagueness that has made it challenging to measure and operationalize, so it disappeared in the Western public health discourses while risk discourses (which focuses on the same underlying problem) grew in strength and become dominant. Its relevance to TCM has died down over the years but it might have also identified a potential site of development in PPPM for itself. As I demonstrated briefly in chapter 5, there are signs that the idea of sub-optimal health is being picked up in personalized medicine.

Chinese medicine emphasises how one should be alert to the inner balance of the body, to prevent disease from taking place. Sub-health draws on with this way of thinking to cater to the modern Chinese dwellers. To some extent, the concept of sub-health was invented to capture the grey area of health and illness and served to render them into the explanatory space of Chinese medicine.

Subhealth is a concept that negotiates between the objective and subjective experiences of the body, a concept that engages within both Western medicine and Chinese medicine. Through tracing its historical development and examining its uses in different contexts, it is possible to argue that subhealth is a cultivated misunderstanding among different actors, to be shaped as either Chinese or Western (to be inherently vague and double) and has served different interests but most notedly in furthering the professional project of TCM. It is a concept that can be said to be categorizing a healthy population but also measured like a disease. I have demonstrated how it is a paradoxical concept that has been productive in serving diverse interests and shaping new subjectivities, but ultimately, this thesis argues that the conceptions of this grey area between health and disease needs greater philosophical and

sociological attention as it not only serves the agenda of for example TCM professionals. In fact, it remains relevant to ordinary people and their embodiment as well. This relates to the second question. This thesis contributes to existing knowledge by demonstrating for the first time that the concept of sub-optimal health can and does enable discussion of ‘undisease’.

8.1.2 What does it mean for ordinary people to be ‘in suboptimal health’ ? (Research Objective 3 above)

As illustrated above when answering the first research question, this thesis, in the context of the commercialization of health, medicalization, and increasing surveillance, unpacked the different forces in shaping a contemporary understanding of subhealth and health. But it goes beyond that: ultimately, I am interested in looking at how people make use of (or do not make use of) the concepts themselves, perhaps shaped by my own autoethnographic lens. In chapter 7, it looks at the diffusion of the knowledge of Chinese medicine to the young generation of Chinese citizens, and how they negotiate the Western medical paradigm and the Chinese medicine heritage and their subjectivities and embodiments.

As I illustrated in chapter 7, suboptimal health is a vocabulary for people to start to make sense of their health conditions; it enables consideration of their bodily symptoms, embodied doubt that is both about the present and the future (and therefore it has an affinity with risk). But because of its vagueness it doesn’t disrupt their identity or day to day living. It tends to be a very liminal state that people seem to consider themselves in when they are not well enough but also not ill, when they think they need to make some changes. The paradox is that people would consider themselves to be in subhealth only when it becomes chronic (that is, last for some time, instead of a temporary ailment), when it seems to suggest there’s something wrong with one’s daily existence that needs adjusting; but only very occasionally when they concretely vocalize being in such a state because it will only be picked up when it is seen as a crisis – subhealth is somewhere between chronicity and crisis, in the day to day

life. A transient state to be in. That is when its articulation on social media becomes particularly interesting. As I have illustrated in chapter 6, subhealth has worked in social media as an identity label to enable discussion about people's health as a form of social critique. When the young jokingly or wholeheartedly talk about their subhealth and constitute it as a condition for *possibly all the young people including themselves*, it is no longer a private issue. It therefore functioned as a critique of working conditions in a neoliberal China, and the stressful work culture in China, as well as the unbearable anxiety and stress that comes with it. Articulation about one's health became a soft way of complaining about the system.

The main contributions of the thesis, emerging from the discussion of data in previous chapters is therefore the way the concept enables the discussion of 'undisease'. I am coining this term to refer to any embodied sensations, doubts, discomforts that do not fall in any disease categories[16]. Furthermore, despite the different agenda that goes in shaping the measurement and treatment of suboptimal heath, this is potentially useful for clinical prevention and occupational health in the west, when it's combined with broader conceptions of health and its interventions, most notably alternative health practices. Of course, this is not without its complications.

In the following part I will discuss more about the naming of subhealth in Section 8.2, the connection between subhealth and work (Section 8.3) the way it facilitates discussion of un-disease and suggest that it might be thought of as a 'biographical suspension' (Section 8.4), before discussing how subhealth could be seen as a pointing to an inherent doubleness in health and illness – our necessary dual citizenship in both kingdom of the well and kingdom

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16. It is important to point out that, for some people, subhealth can co-exist with some disease categories.

of the sick (Section 8.5). I will then briefly comment on the potential of subhealth for critical medical humanities (Section 8.6) and discuss limitations and challenges of this project and ideas for future research in Section 8.7.

8.2 What's in a name: suboptimal health and other related concepts

In the course of the whole thesis, I have discussed the functioning of the concept of suboptimal health but also mentioned a group of other concepts that are related to this conceptual space. Concepts of 'health', 'disease', 'illness' are obviously relevant, so are 'sickness', or 'risk'. I also mentioned the term 'pre-clinical condition/state/status', which is constructed as the same as suboptimal health by the TCM doctor at my fieldwork site. In the Chinese contexts, there are also 治未病 (treating un-disease/treating disease before taking place/treat those not yet ill), 大健康 (big health), 健康管理 (health management), 养生 (*Yangsheng*/health preservation/life cultivation).

If we look back again at the construction of the definition of suboptimal health, a concept that points to the grey area, both health and disease and neither health nor disease. In various contexts, it has been termed either as suboptimal health status (SHS), or 'sub-health', or 'the third status', or 'pre-clinical conditions'. It refers to a physical state of occupying the area between health and disease, in which a person may experience some degree of general weakness, chronic fatigue and may have low energy levels, or some level of health complaints, but it has expanded to include 'mental subhealth' and 'social subhealth'. This captures a state of being preclinical and reversible – it is defined as neither health nor disease, or both health and illness. Note that I use the word disease in the former construction because it often involves doing health check-ups and excluding other diagnosis. And I used illness in the second construction because being suboptimal often involves an embodied feeling of unwellness.

What can be observed in those constructions is the idea that there is an imagined

spectrum from health to disease/illness and that illness can be prevented if one takes good care of oneself with different methods and technologies. The construction of 'the third status' goes to the extreme of actually carving out a space between health and disease/illness, while suboptimal health does exactly the same thing, but in a more modest way. It also to some extent carves out a space between health and disease/illness, but names it in affinity with health, while functioning along the side of disease. 'Preventing disease from happening/治未病' is visibly about TCM but subhealth can be about many other things too. It is precisely this vagueness and this paradoxical nature that gives it strength to function in multiple contexts.

In TCM's contemporary development, in both China and outside of China, from the side of TCM practitioners, there was a need to establish itself in relation to Western medicine. In order to establish its space, a space for health promotion was carved out, which seemed to also have been established at a policy level. As I have mentioned in the introduction chapter when detailing the different policies, the space for *zhiweibing* (治未病) is gradually laid out in the policies in the last two decades, and subhealth is sometimes invoked too. In fact, *zhiweibing* (治未病) is laid out as a key speciality of Chinese medicine, and subhealth, although has a different tone and connotation, is welcomed in this space too, constructed as ambivalent ally of TCM. Although *zhiweibing* (治未病) is undoubtedly a TCM concept, subhealth is constructed as Western, distinguished, yet assimilated into TCM here and there.

Other related terms are comprehensive health/big health (大健康) industry and health management (健康管理). As I have discussed in Chapter 4, the subhealth conference frequently invoked talks on subhealth industry while the Budapest conference contained some discussion of comprehensive health/big health (大健康) industry. Yet in the context of these talks, those two terms seem to be talking about the same thing, albeit with different

framings. If subhealth population, and then by extension subhealth industry captures most of the people in the country, then big health, with its promise to cater to health of *all the population,* has become more catchy and more in line with the Healthy China plan.

As mentioned by Scheid (2007), TCM should be treated as a resource for thinking about illness. In this thinking is a concern for the balance of the body, a detailed conceptualization of the different imbalances of the body, and a concern to promote health. Because of such a philosophy, it has a tradition of making a differentiation concerning individual bodies with its system of yin and yang, heat and wetness, which, as commented by Bivins (2008) has many things in common with other alternative systems of healing, without needing to resort to biomedical diagnosis. Most notably, it is the resource for the recognition that the transition from health to disease is not abrupt, that health is a continuum, and that body and mind are connected. This idea is behind all the concepts I have just discussed, and the way they are formulated and so leave different space for intervention.

As we discussed earlier, the concept of suboptimal health is not just a concept, it gets in discourses and becomes materialised in practices and relationships. It is concretised in the form of health tonics, vitamins and various other health products; it was merged with some TCM practices, such as herbs or 膏方 (medicinal concoction in paste form), and is embodied in different spaces - subhealth clinics, and 治未病科. In more medical/alternative medicine settings, it involves interaction with health professionals, bodily check-ups, sitting in the clinic room, bringing back bottles and bags of medicine, going through the process of cooking the herbs for hours, among others. The participation at the TCM clinic in England is where I get the closest to the material realities of ideas of health, or rather, it was more about people's attentiveness to their bodies, and ideas of health is part of the picture. But looking at social media posts and talking to people about subhealth also revealed how our everyday lived reality is relevant in our embodiment of health and illness. In talking about subhealth,

an attention to the temporal aspects is invoked, bringing future possibilities to that of the present.

The vagueness of this concept has worked well, making it versatile to be adapted and serving the functions of different communities/social worlds. It can be used to urge the public to purchase products; it can be utilised so that the public are willing to pay more attention to health and go to hospital for health checks; it can be defined and measured in such a way that TCM became greatly useful for 'treating' such a condition. In all those diverse contexts, what exactly is suboptimal is redefined, but its central identity still holds - that arbitrary space where risk resides and where action is being called upon.

To conclude, one key concern of the thesis was to examine the naming of such a place between health and illness and my diverse data has shown not only the social and cultural forces in such naming, but also mapped the geographical and temporal terrain of this naming.

8.3 Suboptimal health and work

Another thing that becomes apparent within the data is the link between subhealth and work. Examining historical public health literature, it's clear that the origin of subhealth has something to do with a concern with productivity. Similarly, in the Chinese context, as revealed by my interviews with people brought up in China and the social media posts, it seems that subhealth has an entangled relationship with work. Increasingly critical of the rhetoric that subhealth is a result of unhealthy lifestyles and individuals should take responsibility for their subhealth, young people joke about their subhealth, take it as part of their identity, and see it as a structural problem. Subhealth is seen as a result of overwork.

On the other hand, subtitles means that you must do some body work. This brings us to the next point, the link between subhealth and body work. One of my interviewees, Sisi, mentioned that if you have to constantly work your body to avoid pain, that is subhealth. It is an intriguing comment. Sociologists have talked about the body work in alternative medicine,

for example the kind of body talk in the intersubjective exchanges in acupuncture (Gale 2011). Subhealth seems to share some similarities with that. It requires constant work on the body, and this is an aspect worth further exploration.

8.4 Suboptimal health: biographical suspension?

As a commercial or public health buzzword, the concept has gradually lost its relevance and novelty and became heavily criticised, but it has also escaped into the vocabulary of everyday life in the Chinese language, becoming a resource people draw on to talk about their health. In chapter 6 and 7, I have hinted at the possibilities this affords for ordinary people to talk about their health. As mentioned, the main contribution of the thesis is the identification of a conceptual space that might facilitate the discussion and even treatment of 'un-disease' (treatment here is taken in a sense broader than defined by biomedicine). The idea of *Yangsheng* (养生) has been discussed in many anthropological works (see Farquhar 2002 and Dear 2012). Although this line of thoughts has been discussed in anthropology, it so far has not entered the discussion of sociology of health and illness, sometimes implicitly dismissed as a line of thought that would only concern people from some other cultures. Does it have any relevance for a world that is largely dominated by biomedicine at all? Subhealth seems to play a mediating role in making it relevant beyond TCM, and beyond Chinese culture.

As can be seen in the data from my digital ethnography on Chinese social media, in particular Weibo, and interviews with Chinese people with snowball sampling, the afterlife of this intriguing label has somehow functioned as an everyday diagnostic label. In the findings, suboptimal health is often utilized as a label for 'embodied doubt' of the lived body (Leder, 1992), entangled with embodied fear of future illness. It is often used to denote a chronic state that summarises various different bodily discomforts, a vague bracket that people engage with when they have doubts about their body and wellbeing. It is about those moments when the participants feel various discomforts and feel that they are on the edge of

becoming ill, or they feel they are in minor illness and need to make conscious efforts to maintain health. In their tales are both the sense of chronicity and urgency, the entanglement of the two. I mentioned in the last section that the understanding that from health to illness is a spectrum, and there is an area in-between that has brewed the emergence and development of subhealth and its knowledge making. This understanding can also be observed in people's outlook on health in the interview data and social media data (although there are also participants/posts that insist that only biomedical diagnosis counts and there is no area of sub-health). In this understanding, subhealth is the status in between health and illness, chronic realties with edges. One edge borders into health, another edge borders into illness, itself being an undermined chronic reality. It is at those edges people's narratives revolve around.

In the interviews, a lot of the times the young generations are circulating public narratives from the media, that is most people are in subhealth, health nowadays is worse compared to before, and certain professions are more prone to subhealth. These narratives are widely being reproduced on social media when people talk about subhealth, sometimes about embodiment, sometimes about social conditions. The discussion of subhealth seems to be right in the middle of a 'private matter' and a 'public matter' (Cornwell 1984). There is occasionally more discussion of subhealth following certain news, for example the sudden death of employee from Pinduoduo. In those instances, the occurrence of subhealth is entangled when debates about the stress and working conditions of certain professions became a public topic to be discussed. Similarly, the narratives and discursive constructions of subhealth seem to be right in the middle of different ideas of health: functional, phenomenological, Marxist and interactionist: subhealth in relation to social roles, the lived experience of subhealth, the way capitalism produces subhealth, and the various labelling and tagging of subhealth.

Utilized as a vague diagnostic category that mediate between biomedical classification

and traditional Chinese medicine classificatory systems, this concept provides a unique case study in looking at the contemporary reiteration of how people might be granted permission to be ill in the absence of disease, although this permission of being ill seems to also come with the responsibility to studiously look for possible biological explanations and exhaust those possibilities. There is still some focus on changing one's lifestyle, but there is a growing awareness that the problem may be beyond one's individual control. Replicating popular narratives of subhealth, some interviewees and social media posts consciously attribute their subhealth to their own lifestyle but lament that they do not have the time to exercise and in some way characterise themselves in a constant subhealth. One thing that gets particularly highlighted in the social media data is that subhealth is constructed by the young as a systemic problem, a thing that results from capitalism. Subhealth, a concept that was originally attributed to urban/individual lifestyle in commercial discourses, something that can be treated by health products, is gradually constructed as an inherent problem for the time. It is now constructed as caused by the unreasonable working pattern in cities, the 996 working pattern. That is perhaps why expressions like 'everybody is sub healthy' abounds on social media, and in the context of Chinese style capitalism, there are even posts that jokingly claim 'subhealth is all that I own'.

This contrasts with Bury's (2001) work and the work in the sociology of health and illness on biographical disruption in an interesting way. There are some elements of biographical disruption - people must reflect on their own subhealth not in order to look to narratives to make sense of what is happening, they mobilize resources to improve on their health. In some way, subhealth narratives can be seen as narratives of biographical suspension – the liminal state when there is fear of 'a critical situation' of serious medical condition, an unsettledness, a critique of material reality and environments, and an uncertainty as to what to do and how to make sense of daily living. There is a search for causes, but most prominently,

this has evolved into a critique of causes, and this goes beyond Bury's (2001) idea of 'contingent narratives' which only address causes in the past. What I want to argue is that subhealth narratives, those narratives of biographical suspension are going beyond individual narratives. It does not function as a disease category that might group certain narratives together due to a supposedly shared biological entity. It does not constitute disruption to lived world, not yet requiring intense sense making – but almost so. *In the shadow of that.* It is a biographical continuity that is carrying on from what is going on before, but in suspension, fearing changes. And exactly because of this nature, suboptimal health is directly related to one's living conditions in the here and now it enables a discussion of health and the conditions affecting health. This is why subhealth narratives have elements of Bury's (2001) 'contingent narratives' and the search for causes (which is visible in the data, but often in a transient way) but go beyond that and show a very direct critique of causes 'in the here and now'. Also, because those narratives go beyond current biomedical ideas of lack of disease as health (while also looming in the shadow of fearing any medical diagnosis), suboptimal health narratives can help sociologists capture more narratives on unhealth and the things people may do in the hope of preventing diseases from happening.

I would also like to also highlight the peculiarity of talking about subhealth. The Weibo narratives capture subhealth in its ongoing moments. There is a sense of talking to an imaginary interlocutor on Weibo about one's health conditions, to check one's health condition with 'the other' to regain a sense of self. Those narratives are fundamentally private yet public, written about the most intimate embodied feelings but waiting to be seen by both friends and strangers. Those more personal narratives of subhealth do not seem to be aiming at attracting a large number of views, only to initiate an avenue to talk about one's health and a way to motivate oneself to make some changes. On the other hand, those interviews I conducted about people's embodiment of subhealth are not necessarily in those moments

when they see their subhealth as a crisis. The narratives of normality and crisis, searching for meaning/making critiques are all entangled together. This is different to Bury's (2001) ideas of contingent narratives precisely because there is not really a defined event that has disrupted one's biography. That event is yet to happen, it looms on the horizon. Narratives of 'unhealth' are not searching for explanations - they happen in the here and now of 'unhealth' as it is being lived. In many respects they directly articulate a critique of current living conditions.

From both a theoretical and a sociological perspective, this in-between space between health and disease is rising in importance and warrants more analysis. The use of 'sub-health' is twofold. On the one hand, it can denote certain disease conditions, a milder form of chronic illness. On the other hand, it connects to health, and points to the never-stopping drive towards better health. This can be seen in the sub-storyline of the term, sub-health, and the way it negotiates between the objective and subjective experiences of the body.

8.5 Subhealth: Dual citizenship in kingdom of the sick and kingdom of the well

I have discussed the way the idea of suboptimal health disrupts the binary construction in some way and creates a liminal space between the two. As can be seen in the discussion of the knowledge making of suboptimal health, the medical model is still to some extent seen as a primacy. The TCM practitioners always start with saying 'although there is no diagnosed diseases' before they switch the discussion to a lack of health (the wellness model), where the sophisticated theories of TCM came into play. In this section, I would like to argue that the necessity of 'dual citizenship' (in Sontag's words), or rather, the necessity of the double (0-2 logic) in conceptualizing about health and illness.

Sickness, taken from the perspective of the inflicted, is seen as an occasion for one to encounter one's body as an alien entity, and trying to make sense of its functioning. Suboptimal health, based on the social media and interview data, seems to be this space when

one experiences this in a fleeting way. In Susan Sontag's words, 'Illness is the night-side of life, a more onerous citizenship. Everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick' (2009: 3). Since everyone possesses 'the citizenship' in 'the kingdom of the sick', and it always looms behind the daylight, it follows that the common place personal confrontation with illness – and how it shapes one's view of the world – is worth examining. Frank (1995) commented on the metaphor of the dual citizenship of being sick and healthy and talked of a 'remission society' when one has experienced illness and recovered. What about people who have experienced some discomforts and fear of serious illness and make their lives about preventing that from happening?

I will briefly discuss Sontag's contexts and her arguments, Cultural influences on the perception of illness and medicine have become increasingly noted, perhaps inexplicable from the influence of poststructuralist thinking. Scholars in medical humanities have pointed out the role culture and society plays in shaping the representation of illness – how it is always 'colored by culture or tainted by fear' (Charon, 2005: 756). According to Susan Sontag (2009), it is often clouded by metaphors that demoralizes or sentimentalizes such diseases including TB, Cancer and AIDS. The metaphors bring with them romanticised or reprehensive tones towards the diseases which impede the recognition of what they really are, the rote facts about the diseases. This type of myth often inflicts unnecessary pressure and sorrow on the patients. Thus urges Sontag:

> 'My point is that illness is not a metaphor, and that the most truthful way of regarding illness—and the healthiest way of being ill—is one most purified of, most resistant to, metaphoric thinking.' (3)

It is a forceful call for reflection on the way our cultural perception shapes the voice of illness and a caution against its negative consequences. However, in this view, the science behind these diseases is posited as the solid opposition of a metaphoric construction. If one

mission in medical humanities is to get rid of metaphors, return to the rote facts about illness, and thus provide consolation to those suffering from illness, one useful overarching question may be useful here: What exactly is the fact about illness? What is it to live one's body without metaphorical thinking? The symptoms are prone to misinterpretations and metaphors. Logically, what can account for the illness is the science behind it, and the prescriptions made by the medical practitioners. However, just as Nietzsche pointed out, science itself depends on categorical thinking (Hales and Welshon 2000), which is a close relative of metaphor. Medical science (just as all science) involves categorizing non-identical phenomena taking place in one's body under the same notion, thus creating a system of concepts that could not completely account for the senses and perception experienced by the patient. Nietzsche identifies this process of concept-making as the founding stone of Western rationality. In this sense, science and metaphor share some fundamental similarities, because they both involve equating non-identical entities (Hales and Welshon 2000).

This is more than abstract philosophical debate. These carry real implications for patients' doubts and confusions towards their body, and its situatedness between health and disease. These doubts and confusions feature heavily in the accounts reported from the Chinese Medicine Clinic in this study. For example, in evaluating possible risks towards health including smoke and pollution, or when attempting to self-diagnose certain symptoms, people encounter a situation when they need to negotiate with various notions of disease and health, and position themselves in this spectrum – it is difficult to say what exactly is the fact about their symptoms. Often, there is no concrete answer. This is the ordinary, everyday encounter with minor health problems or with potential health risks that everyone could experience, a fleeting awareness of the body on the threshold between health and illness. Before any concrete diagnosis is made by the doctor there is the growing self-awareness experienced by the patient of the alternative life behind the ordinary life (kingdom of the well). Equally

important to exploring how medical practitioners could make use of the power of narrative to console the patient is to recognize with what conception of the body a patient (or just any one, really) would encounter illness. All of this can be seen in this thesis. Participants were constantly negotiating these boundaries through the use of ideas and practices that had behind them the concept of sub optimal health. Perhaps the fact about illness is the narratives and the lived realities behind it? To get rid of metaphor is to take culture into account and take alternative formulations of health into account in a more overt manner? It is about rethinking about the hierarchy between body and soul, rethinking about the relations between self and other?

In Western science and medicine, a hierarchy between body and soul is already present. In her discussion of the metaphor surrounding TB, Sontag mentions the way TB is portrayed as a more 'soulful' disease, while Cancer is perceived to be predominantly bodily (Sontag 2009). Similarly, as Sontag pointed out, the belief that 'the happy man would not get plague' in 16th and 17th century England is an utmost illusion considering the science behind infection (Sontag 2009: 55). Trying to disengage medicine from social construction is difficult, because just as Porter (2003) points out, the history of both disease and the medicine combating it are themselves products of civilization. In this context, turning to a distinct system of medicine and the philosophy behind it has proved to be a productive attempt, with an embedded comparative lens. Chinese medicine distinctly develops from the most ancient philosophical book in China, the Book of Change, and thus contains within it both a practical system of failure and trial using different herbs, etc. in curing diseases. It is also a philosophy accounting for the connection between the human body and the universe. In this system of thoughts, the interplay and balance between Yin and Yang is considered to be the foundation of the universe, and this interplay makes up Qi, which sustains the life of human beings. Beyond the curing of symptoms, Traditional Chinese Medicine is also concerned with the

regaining of a balance between Yin and Yang, and the revitalization of Qi. As a result, the distinction between the state of wellness and the state of sickness is less distinct in Chinese medicine. In modern China, with the introduction of Western medicine, the interplay between Western Medicine and Traditional Chinese Medicine (and the so-called ‘integrated medical care’ which seeks to combine the two) has a profound impact on how people perceive their health and illness, and the tradition of TCM has meant that the treatment in TCM clinics has a personalized character.

At this point, an alternative logic, such as Kristeva ‘s ‘0-2’ logic, can be used to account for the necessity of the doubleness of health and illness. The ‘0-2’ logic was originally proposed to account for poetic language. For Kristeva, poetic language goes beyond 0-1 Boolean logic, and does not follow the law of contradiction and of the excluded middle. In Boolean logic, a statement is either 0 (false) or 1 (true) and it cannot be both. However, Kristeva argues that for poetic language, this logic does not suffice:

> the minimal unit of poetic language is at least double, not in the sense of the signifier/signified dyad, but rather, in terms of one and other .... The double would be the minimal sequence of a paragrammatic semiotics to be worked out starting from the work of Saussure (in the 'Anagrams') and Bakhtin. (Kristeva, 1980, p. 69)

Kristeva bases this ‘0-2’ logic primarily on Bakhtin’s work on dialogism and carnival. What is implied in dialogism is that words articulated are already infused with one’s interpretations, styles, and shaped by one’s particular social background, or ‘accent’ in a very broad sense (Bakhtin, 2017). Only words that are didactic are absolute, and therefore seen as 1, such as God, Law, or Definition - those are monologic (Allen, 2000). Some literary genres can be seen as monologic too. For example, in epic discourse, ‘narrative is a prohibition, a monologism, a subordination of the code to 1…’ (Kristeva, 1980, p. 70). In contrast to those monologic prohibition, Kristeva follows Bakhtin in arguing that poetic

language transgresses this monologic logic and is always double. For Bakhtin, the carnival is the full embodiment of dialogism, and polyphonic novels (such as that of Tolstoy) incorporate those carnivalesque elements. Kristeva develops this dialogism into an alternative logic of 0-2, to account for poetic language, which for her displays a sense of becoming, 'in opposition to the level of continuity and substance' (Kristeva, 1980, p. 71). For her, 'it is a logic of analogy and non-exclusive opposition, opposed to monological level of causality and identifying determination' (Kristeva, 1980, p. 72).

In this way, 0-2 logic can be seen as a fitting way to account for the issue of health and disease, exactly because it offers a possibility of non-exclusive opposition. In the same way as there are diverse tones and meanings for poetic texts, there are conflicting interpretations of bodily conditions. This in-between space located between health and disease in the above discussion does always exist in our everyday consciousness, and it is not too far-fetched to argue that we are always double in our bodily conditions. Kristeva points out that this 0-2 logic bears some resemblance to the Yin-Yang in Chinese philosophy, which is actually also the foundation for Chinese medicine, which will be drawn on a lot in the rest of the thesis as one alternative way of conceiving the health and disease opposition. In some way, this existence and balance of Yin-Yang constitute one way to bring 0-2 logic into the discussion of health and disease.

Indeed, this doubleness speaks to Susan Sontag's influential claim: 'Everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick' (Sontag, 1978). But we do not cross from one kingdom to the other at some point in life - we are always one foot in one, and one foot in the other. Hence, death, health and disease are established into a 0-2 relation. Of course, serious or life-threatening diseases will mark a crucial point in how much we belong in the kingdom of the well and in the kingdom of the sick, but before that we all already to a greater or lesser extent are familiar with the kingdom

of the sick anyway. And ‘the most truthful way of regarding illness—and the healthiest way of being ill’ is perhaps about deeply embedding in one’s own contexts and bravely talk about one’s suboptimal health, in all its materialities. This concept is thus not just as an ‘othered’ concept from another culture. It might be relevant to us all.

8.6 Links to critical medical humanities

Kristeva et al. (2018) analyzes the origins of Cura (Care) and problematizes the distinctions drawn between health and healing in the Western culture. They refute the conventional understanding that health is a ’definitive state’ situated in biology (bios) while healing is a process in the sphere of life (Zoe). Instead they gesture towards ‘the pathological and healing powers of culture, and sees the body as a complex biocultural fact.’ Following this, they argue that medical humanities should reconfigure itself and treat all medical encounters as cultural encounters, and hold the view that an approach recognizing the singular nature of evidence should be taken. This gesture expands on the possibilities of medical encounters, and the possible affordances of observing such encounters.

Viney et al. provides insights on what is ‘critical’ about critical medical humanities. In their characterisations, there are five elements: (i) exploring ‘the medical’ beyond the site of the clinical encounter; (ii) move the attention to the multiple constitution of health and illness, beyond conventional discussion of the context and experience of health and illness; (iii) engaging more with fields such as critical theory, queer theory, disability studies and so on; (iv) viewing arts and humanities, as well as social sciences not as opposite to nor complementary to the medical science; instead, viewing all the field as ‘actively entangled’ and finally (v) committed to interdisciplinary investigation in diverse forms. Throughout my thesis, I have illustrated the entangledness of the fields by focusing on the concept of suboptimal health.

Following this, I would like to situate the project in the endeavour of critical medical humanities, which is to explore 'the medical' beyond the site of the clinical encounter and to view arts and humanities, as well as social sciences not as opposite to nor complementary to medical science but focuses on the intersection instead (Viney et al., 2015). Critical medical humanities is an emerging field which sees its task as understanding the differences, relations and exchanges between, medical and humanities practices relating to the body and its treatment, instead of simply treating humanities as complementary to medicine. Critical medical humanities does not accept a sharp distinction between subjective and objective aspects of medicine. Sub-optimal health is precisely one such notion that I have unpacked, speaking to the core concern of critical medical humanities, because it is caught up in the issue of subjective and objective distinction in medicine.

According to Whitehead and Woods, in contrast to viewing arts and humanities as a supportive friend that makes medicine more 'humane' – the concern of first wave medical humanities, critical medical humanities investigate 'how models of interdisciplinarity, or even of postdisciplinarity, might be rethought in a mode that does not assume already existing territories of knowledge' (2015, p.4). Whitehead and Woods (2015) hinted at the need to push for attention to 'non-medical' notions of health, illness and wellbeing'; as well the need to investigate the way clinical knowledge is produced, and how social sciences and arts and humanities could 'play a constitutive role in shaping such knowledge' (2015, p.2). In this vein, 'Sub-optimal health' might be thought of precisely as a non-medical (or only partially medical) notion of health that participates in shaping clinical encounter and clinical knowledge.

8.7 Limitations and challenges of this project and ideas for future research

8.7.1 Limitations

Would be good to conduct fieldwork in TCM clinic in China, even better, in Subhealth clinics (治未病中心，亚健康诊所), which will provide opportunities to further observe the function of the concept, its materialities and knowledge making. Due to constraints posed by the pandemic, this thesis had to rely on discourses to untangle such materialities. In the future research, it would be useful to conduct participant observation at subhealth clinics, and 治未病科 to examine the entanglement of the concept and materialities.

This project collected narratives from social media and snowball sampling, and thus might be be representative of other possible narratives of people who are older, from different backgrounds – the samples in this project are all well-educated young people who are not representative.

8.7.2 Ideas for future research

Ideas and fear of aging perhaps play a part in the construction of the concept of suboptimal health in China. It happens also perhaps because the society places such a great emphasis on productivity, as well on fertility.

The observation of the regularity of periods plays an interesting role in the detection of suboptimal health - it is this obsession with ‘natural’ and ‘a healthy womb’, that somehow correlates with shaping subhealth in relation to age thresholds. Furthering studying subhealth in relation to aging and gender could also further the feminist lens in studying health.

This thesis briefly touched on the possible connection between subhealth and personalized medicine and it will be good to conduct a future project that examine personalized medicine and its possible affinities/differences with subhealth closer.

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Appendixes

Appendix 1: Information sheet for the doctor

Participant Information Sheet

1. Research Project Title:

Sub-optimal Health/Pre-clinical Conditions: the grey area of health and disease as embodied in a Chinese Medicine clinic in England

Researcher: Lijiaozi Cheng, University of Sheffield

2. Invitation paragraph

You are being invited to take part in a research project. Before you decide whether or not to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. You can get in touch me by email (lcheng7@sheffield.ac.uk) or by phone (07999024989). Take time to decide whether or not you wish to take part. Thank you for reading this.

3. What is the project's purpose?

The concept of 'sup-optimal health', or 'pre-clinical condition', has become closely intertwined with Chinese medicine. The aim of this study is to get a better understanding of how these ideas are drawn upon in this clinic as a unique cultural site. I am interested in how people visit this clinic make sense of this concept and what is their lived experience in relation to this concept.

4. Why have I been chosen?

You are being asked to participate in this research project because you run a Chinese medicine clinic and the concept of 'sub-optimal health' appears quite often in the clinic.

5. Do I have to take part?

It is up to you to decide whether or not to take part. You will be given this information sheet to keep, whether or not you wish to proceed. If you do decide to take part, you will be asked to sign a consent form. You can still withdraw at any time, without having to give a reason. If you wish to withdraw from the research, please contact Lijiaozi Cheng at 07999024989. Withdrawing at any time will have no impact on the running of the clinic.

6. What will happen to me if I take part? What do I have to do?

My project examines the use and understanding of the concept ‘sup-optimal health’, or ‘pre-clinical condition’ in the daily practice of your clinic, collected from you and the visitors of the clinic. I will observe the daily practice of the clinic, and the consultations you have with the patients to study the way you communicate the concept of ‘sup-optimal health’, or ‘pre-clinical condition’ to the patients. I will also consult you on which symptoms fit under ‘sup-optimal health’, or ‘pre-clinical condition’ and may need your help in recruiting visitors for interviewing. There are no risks to your health, personal safety or security associated with the research. There will be no influence on the running of the clinic.

7. What are the possible disadvantages and risks of taking part?

This project will involve observation of the consultations between you and the visitors. If you ever feel that being observed during the consultation cause you any inconvenience, you can ask me to leave the consultation at any time.

8. What are the possible benefits of taking part?

Whilst there are no immediate benefits for those people participating in the project, it is hoped that this work will make contributions to a better understanding of the concept of health and how it is fundamentally subjective.

9. Will my taking part in this project be kept confidential?

All the information that we collect about you during the course of the research will be kept strictly confidential and will only be accessible to members of the research team. You will not be able to be identified in any reports or publications unless you have given your explicit consent for this.

10. What is the legal basis for processing my personal data?

According to data protection legislation, I am required to inform you that the legal basis we are applying in order to process your personal data is that ‘processing is necessary for the performance of a task carried out in the public interest’ (Article 6(1)(e)). Further information can be found in the University’s Privacy Notice
https://www.sheffield.ac.uk/govern/data-protection/privacy/general.

11. What will happen to the data collected, and the results of the research project?

Data gathered for the project will be anonymised. No personal quotes will be shared publicly that would reveal your identity or personal information about you, but we cannot guarantee that you will not be identifiable by other members of the community. You will have the opportunity to check the accuracy of our use of data in presentations and publications prior to their use.

All anonymised interview data will be will be gathered through password protected recorders, and stored on a secure server of the University of Sheffield, separately from the identifiers.
It will be analysed by myself only, but will be shared with my supervisor, Barry Gibson (who will not have access to the signed consent forms, which means they do not have access to the personal data).

12. Who is the Data Controller?

The University of Sheffield will act as the Data Controller for this study. This means that [the University] is responsible for looking after your information and using it properly.

Raw data (interview notes and transcripts, audio) will only be shared with my supervisor, Barry Gibson, if necessary, and no one else; it will be securely stored. Fieldnotes and collected diaries will be kept in locked filing cabinets in our premises; digital copies will be stored in password-protected University of Sheffield secure file servers. Data will be retained for a period of 7 years after the end of the project, after which they will be destroyed. The research project has received ethical clearance from the University of Sheffield Research Ethics Committee.

13. What if something goes wrong and I wish to complain about the research?

If you have a concern about any aspect of this project, you can speak to the researcher's supervisor: Professor Barry J Gibson (b.j.gibson@sheffield.ac.uk).

You may also direct any complaints at any time to the Head of Dept for Philosophy, Prof Chris Bennett (c.bennett@sheffield.ac.uk), or to the secretary for the University of Sheffield Research Ethics Committee, Mrs Lindsay Unwin (https://www.shef.ac.uk/ris/other/committees/ethicscommittee) who can process your complaint or direct your complaint to the appropriate body.

14. Contact for further information

If you need more information about the project, please contact the researcher, Lijiaozi Cheng at her email address:lcheng7@sheffield.ac.uk, or at her mobile: 07999024989. You can also speak to her supervisor: Professor Barry J Gibson (b.j.gibson@sheffield.ac.uk). You will be given a copy of the information sheet and, and a signed consent form to keep.

15. Statement on GDPR

New data protection legislation comes into effect across the EU, including the UK on 25 May; this means that we need to provide you with some further information relating to how your personal information will be used and managed within this research project. This is in addition to the details provided within the information sheet that has already been given to you.

The University of Sheffield will act as the Data Controller for this study. This means that the University is responsible for looking after your information and using it properly.

In order to collect and use your personal information as part of this research project, we must have a basis in law to do so. The basis that we are using is that the research is 'a task in the public interest'. Further information, including details about how and why the University processes your personal information, how we keep your information secure, and your legal rights (including how to complain if you feel that your personal information has not been handled correctly), can be found in the University's Privacy Notice https://www.sheffield.ac.uk/govern/data-protection/privacy/general

Thanks so much for taking time to read through this time sheet and thanks for your interest in my project! If it is something you are willing to take part, please contact me and let me know.

Appendix 2: Information sheet for the clinic visitors

Participant Information Sheet

1. Research Project Title:

Sub-optimal Health/Pre-clinical Conditions: the grey area of health and disease as embodied in a Chinese Medicine clinic in England

Researcher: Lijiaozi Cheng, University of Sheffield

2. Invitation paragraph

You are being invited to take part in a research project. Before you decide whether or not to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. You can get in touch me by email (lcheng7@sheffield.ac.uk) or by phone (07999024989). Take time to decide whether or not you wish to take part. Thank you for reading this.

3. What is the project's purpose?

This project investigates the understandings of health and illness among people who use alternative medicine, Chinese medicine in this case. It is a philosophical and social investigation of people's diverse understandings of health and thus it will collect people's stories of their health and how they come to visit Chinese medicine clinic. It is also interested in collecting your own understanding of your body, in daily life, including your own experience of any issues you have with your health in your own words.

4. Why have I been chosen?

You are being invited to participate in the research for this project because you visit this clinic, which is chosen by me as a place to investigate people's alternative understandings of health.

5. Do I have to take part?

It is up to you to decide whether or not to take part. You will be given this information sheet to keep, whether or not you wish to proceed. If you do decide to take part, you will be asked to sign a consent form. Your care at the clinic will not be impacted in any way whether or not you take part in the research project.

There are no risks to your health, personal safety or security associated with the research. It will in no way affect your treatment in this clinic and this has no medical purpose whatsoever. You can still withdraw at any time, without having to give a reason should you choose to take part. If you wish to withdraw from the research, please contact Lijiaozi Cheng at 07999024989. Withdrawing at any time will also have no impact on your treatment at the clinic.

6. What will happen to me if I take part? What do I have to do?

My project is interested in your unique stories and perspectives on your health. The plan is to interview around six people who visit the clinic, and to collect their stories and experience for an extended period of time. On the other hand, I am also interested in observing people's consultations with the doctors. If you choose to take part, I would like to observe your visit and consultations with the doctor and/or you will be interviewed for a few times over the time frame of a few month or so about your stories and experiences of your health. The length and frequency of interviews will sorely depend on your convenience, so you have control over how much time you would like to put in. Typically the interviews will be at least thirty minutes and it can be as long as you like. The interview is very flexible and the schedule will be made based on your availability and preferences. The observation of the consultation will not mean any extra time for you, on the other hand, as it will take place when visit the doctor, and you can ask me to leave a consultation at any time.

If you are willing to, you will also be asked to write a diary to keep track of your experiences of health for a period of time, which will be analysed by me and also used to inform the interview. The body log is expected to take no more than 10 minutes per day.

7. What are the possible disadvantages and risks of taking part?

There are no foreseeable discomforts, disadvantages and risks that could arise from this project.

This project will involve observation of the consultations between you and the doctor, if you give me consent to do so. However, even if you have given me consent to observe, if you ever feel that being observed during the consultation cause you any inconvenience or discomfort, you can ask me to leave the consultation at any time.

Due to the nature of the research topic, some sensitive topics may come up during the interviews (if you have given me consent to take part in the interviews), and during interviews you have absolute freedom to choose what to share with me and how to share those stories and experiences, and how much to share. Your freedom will be fully respected.

8. What are the possible benefits of taking part?

Whilst there are no immediate benefits for those people participating in the project, it is hoped that this work will make contributions to a better understanding of the notion of health and how people make sense of it in different ways. You can also treat me as a person to talk to, a listener.

9. Will my taking part in this project be kept confidential?

All the information that we collect about you during the course of the research will be kept strictly confidential and will only be accessible to members of the research team. You will not be able to be identified in any reports or publications unless you have given your explicit consent for this.

10. What is the legal basis for processing my personal data?

According to data protection legislation, I am required to inform you that the legal basis we are applying in order to process your personal data is that 'processing is necessary for the performance of

a task carried out in the public interest' (Article 6(1)(e)). Further information can be found in the University's Privacy Notice
https://www.sheffield.ac.uk/govern/data-protection/privacy/general.

11. What will happen to the data collected, and the results of the research project?

Data gathered for the project will be anonymised. No personal quotes will be shared publicly that would reveal your identity or personal information about you. You will have the opportunity to check the accuracy of our use of data in presentations and publications prior to their use.

All anonymised interview data will be will be gathered through password protected recorders, and stored on a secure server of the University of Sheffield, separately from the identifiers.

It will be analysed by myself only, but will be shared with my supervisor, Barry Gibson (who will not have access to the signed consent forms, which means they do not have access to the personal data).

12. Who is the Data Controller?

The University of Sheffield will act as the Data Controller for this study. This means that [the University] is responsible for looking after your information and using it properly.

Raw data (interview notes and transcripts, audio) will only be shared with my supervisor, Barry Gibson and Annamaria Carusi, if necessary, and no one else; it will be securely stored. Fieldnotes and collected diaries will be kept in locked filing cabinets in our premises; digital copies will be stored in password-protected University of Sheffield secure file servers. Data will be retained for a period of 7 years after the end of the project, after which they will be destroyed. The research project has received ethical clearance from the University of Sheffield Research Ethics Committee.

13. What if something goes wrong and I wish to complain about the research?

If you have a concern about any aspect of this project, you can speak to the researcher's supervisor: Professor Barry J Gibson (b.j.gibson@sheffield.ac.uk). You may also direct any complaints at any time to the Head of Dept for Philosophy, Prof Chris Bennett (c.bennett@sheffield.ac.uk), or to the secretary for the University of Sheffield Research Ethics Committee, Mrs Lindsay Unwin (https://www.shef.ac.uk/ris/other/committees/ethicscommittee) who can process your complaint or direct your complaint to the appropriate body.

14. Contact for further information

If you need more information about the project, please contact the researcher, Lijiaozi Cheng at her email address:lcheng7@sheffield.ac.uk, or at her mobile: 07999024989**.** You can also speak to her supervisor: Professor Barry J Gibson (b.j.gibson@sheffield.ac.uk). You will be given a copy of the information sheet and, and a signed consent form to keep.

15. Statement on GDPR

New data protection legislation comes into effect across the EU, including the UK on 25 May; this means that we need to provide you with some further information relating to how your personal information will be used and managed within this research project. This is in addition to the details provided within the information sheet that has already been given to you.

The University of Sheffield will act as the Data Controller for this study. This means that the University is responsible for looking after your information and using it properly.

In order to collect and use your personal information as part of this research project, we must have a basis in law to do so. The basis that we are using is that the research is 'a task in the public interest'.

Further information, including details about how and why the University processes your personal information, how we keep your information secure, and your legal rights (including how to complain if you feel that your personal information has not been handled correctly), can be found in the University's Privacy Notice https://www.sheffield.ac.uk/govern/data-protection/privacy/general

Thanks so much for taking time to read through this time sheet and thanks for your interest in my project! If it is something you are willing to take part, please contact me and let me know.

Appendix 3: Information sheet for the clinic visitors

Participant Information Sheet

16. Research Project Title:

Sub-optimal Health/Pre-clinical Conditions: the grey area of health and disease

Researcher: Lijiaozi Cheng, University of Sheffield

17. Invitation paragraph

You are being invited to take part in a research project. Before you decide whether or not to participate, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information. You can get in touch me by email (lcheng7@sheffield.ac.uk) or by phone (07999024989), or WeChat (cheeroe). Take time to decide whether or not you wish to take part. Thank you for reading this.

18. What is the project's purpose?

This project investigates people's understanding and experiences of suboptimal health. It is a philosophical and social investigation of people's diverse understandings of health and thus it will interview people's understanding of the concept and collect people's stories of their health. It is also interested in collecting your own understanding of your body, in daily life, including your own experience of any issues you have with your health.

19. Why have I been chosen?

You are being invited to participate in the research for this project because you indicated that you know about the concept and showed willingness to be interviewed.

20. Do I have to take part?

It is up to you to decide whether or not to take part. You will be given this information sheet to keep, whether or not you wish to proceed. If you do decide to take part, you will be asked to sign a consent form. You can withdraw at any time, without having to give a reason. If you wish to withdraw from the research, please contact Lijiaozi Cheng at 07999024989, or at WeChat (cheeroe).

21. What will happen to me if I take part? What do I have to do?

The study consist of semi-structured interviews conducted through WeChat audio chat, (or any other ways that suit you), given the current pandemic.

22. What are the possible disadvantages and risks of taking part?

There are no foreseeable discomforts, disadvantages and risks that could arise from this project.

Due to the nature of the research topic, some sensitive topics may come up during the interviews, and during interviews you have absolute freedom to choose what to share with me and how to share those stories and experiences, and how much to share. If there are parts of interviews that you wish to be removed from the data, you can just let me know and I will promptly delete it. Your freedom will be fully respected.

23. What are the possible benefits of taking part?

Whilst there are no immediate benefits for those people participating in the project, it is hoped that this work will make contributions to a better understanding of the notion of health and how people make sense of it in different ways. You can also treat me as a person to talk to, a listener.

24. Will my taking part in this project be kept confidential?

All the information that we collect about you during the course of the research will be kept strictly confidential and will only be accessible to members of the research team. You will not be able to be identified in any reports or publications unless you have given your explicit consent for this.

25. What is the legal basis for processing my personal data?

According to data protection legislation, I am required to inform you that the legal basis we are applying in order to process your personal data is that 'processing is necessary for the performance of a task carried out in the public interest' (Article 6(1)(e)). Further information can be found in the University's Privacy Notice
https://www.sheffield.ac.uk/govern/data-protection/privacy/general.

26. What will happen to the data collected, and the results of the research project?

Data gathered for the project will be anonymised. No personal quotes will be shared publicly that would reveal your identity or personal information about you. You will have the opportunity to check the accuracy of our use of data in presentations and publications prior to their use.

All anonymised interview data will be will be gathered through password protected record devices, and stored on a secure server of the University of Sheffield, separately from the identifiers.

It will be analysed by myself only, but will be shared with my supervisor, Barry Gibson (who will not have access to the signed consent forms, which means they do not have access to the personal data).

27. Who is the Data Controller?

The University of Sheffield will act as the Data Controller for this study. This means that [the University] is responsible for looking after your information and using it properly.

Raw data (interview notes and transcripts, audio) will only be shared with my supervisor, Barry Gibson and Annamaria Carusi, if necessary, and no one else; it will be securely stored. Fieldnotes and collected diaries will be kept in locked filing cabinets in our premises; digital copies will be stored in password-protected University of Sheffield secure file servers. Data will be retained for a period of 7 years after the end of the project, after which they will be destroyed. The research project has received ethical clearance from the University of Sheffield Research Ethics Committee.

28. What if something goes wrong and I wish to complain about the research?

If you have a concern about any aspect of this project, you can speak to the researcher's supervisor: Professor Barry J Gibson (b.j.gibson@sheffield.ac.uk). You may also direct any complaints at any time

to the secretary for the University of Sheffield Research Ethics Committee, Mrs Lindsay Unwin (https://www.shef.ac.uk/ris/other/committees/ethicscommittee) who can process your complaint or direct your complaint to the appropriate body.

29. Contact for further information

If you need more information about the project, please contact the researcher, Lijiaozi Cheng at her email address:lcheng7@sheffield.ac.uk, or at her mobile: 07999024989**.** You can also speak to her supervisor: Professor Barry J Gibson (b.j.gibson@sheffield.ac.uk). You will be given a copy of the information sheet and, and a signed consent form to keep.

30. Statement on GDPR

New data protection legislation comes into effect across the EU, including the UK on 25 May; this means that we need to provide you with some further information relating to how your personal information will be used and managed within this research project. This is in addition to the details provided within the information sheet that has already been given to you.

The University of Sheffield will act as the Data Controller for this study. This means that the University is responsible for looking after your information and using it properly.

In order to collect and use your personal information as part of this research project, we must have a basis in law to do so. The basis that we are using is that the research is 'a task in the public interest'.

Further information, including details about how and why the University processes your personal information, how we keep your information secure, and your legal rights (including how to complain if you feel that your personal information has not been handled correctly), can be found in the University's Privacy Notice https://www.sheffield.ac.uk/govern/data-protection/privacy/general

Thanks so much for taking time to read through this time sheet and thanks for your interest in my project! If it is something you are willing to take part, please contact me and let me know.

Appendix 4: Information sheet for the clinic visitors –

Chinese translation

研究基本信息表

1. 研究项目标题:

亚健康/临床前病症：探索健康和疾病的灰色地带

研究人员：谢菲尔德大学，程黎娇子

2. 研究邀请

我诚挚邀请您参加我的研究项目。在决定是否参与之前，请仔细了解我的研究目的以及我的研究将涉及什么。请花些时间仔细阅读以下信息，并根据需要与他人讨论。如果还有不清楚的地方，或者您想了解更多信息，欢迎随时联系我。您可以通过电子邮件（lcheng7@sheffield.ac.uk）或通过电话（07999024989），或微信（cheeroe）与我联系。请花一些时间来决定是否要参加。谢谢您的阅读。

3. 研究目的

该项目旨在调查蕴含在亚健康这个概念里的对健康和疾病的理解。这是一项对人们关于健康的各种理解的社会调查，它旨在收集人们在日常生活中对自己身体健康情况和健康问题的理解和经验，以及种种故事。

4. 为什么邀请我？

您之所以受到邀请参加此研究，是因为您展现出了对亚健康这个概念的理解和兴趣。

5. 我必须要参加吗？

是否参加完全由您决定。无论您是否要继续进行参与，您都可以保留此信息表。如果您决定参加，您需要签署知情同意书。您可以随时退出，而不必给出选择退出的理由。如果您想退出研究，请致电 07999024989 与程黎娇子联系，或与我微信(cheeroe)联系。

6. 如果我参加的话，需要做什么？

如果您参加的话，我们会进行访谈。

7. 参加会议可能有哪些不利条件和风险？

此项目不会产生可预见的不适，不利和风险。

由于研究主题的特殊性，某些关于您健康状况的敏感主题可能会在采访过程中出现。在采访过程中，您有绝对的自由来选择与我分享什么，如何分享，分享多少。如果您后期希望从数据里删除部分访谈内容，您只需要通知我，我会把那部分访谈删除。您的自由将得到充分尊重。

8. 参加活动可能有什么好处？

对于参与该项目的人们而言，这项研究虽然没有立即的收益，但将有助于公众更好地理解健康和亚健康的概念。您也可以将我看作是一个倾听者。

9. 我参与本项目的工作会保密吗？

在研究过程中收集到的有关您的所有信息将严格保密，并且只有研究团队成员才能访问。除非您明确表示同意，否则在任何报告或出版物中，您的身份都不会被辨认出。

10.处理我的个人数据的法律依据是什么？

根据欧洲数据保护法规，我们处理您的个人数据的法律依据是’数据处理对于一个有助于公共利益的任务是有必要的’（第 6 条第 1 款）（e））。有关更多信息，请参见大学的隐私权声明
https://www.sheffield.ac.uk/govern/data-protection/privacy/general。

11.收集到的数据和研究项目的结果将如何处理？

该项目收集的所有数据将被匿名化。我不会公开共享任何会透露您的身份或有关您的个人信息的谈话内容。在发表之前，您将有机会检查我们在演示文稿和出版物中使用数据的准确性。

所有的匿名采访数据将通过受密码保护的录音设备收集，并与个人信息分开存储在谢菲尔德大学的安全服务器上。

我会对数据进行分析，数据将与我的导师 Barry Gibson 共享（他不会看到知情同意书或是您的联系方式，这意味着他将无法访问您的个人数据）。

12.谁是数据控制者？

谢菲尔德大学是这项研究的数据控制者。这意味着大学负责管理您的信息并保证它被正确使用。

原始数据（采访笔记和采访文稿，音频）仅在需要时与我的导师 Barry Gibson 共享，不会与其他人共享。它将被安全地存储。纸质数据将保存在我们办公场所的上锁的文件柜中；数字版本将存储在受密码保护的谢菲尔德大学安全文件服务器中。数据将在项目结束后保留 7 年，之后将被销毁。该研究项目已通过谢菲尔德大学研究伦理委员会的伦理审查。

13.如果出了什么问题，我想抱怨这项研究怎么办？

如果您对此项目的任何方面有疑问，都可以与研究人员的导师 Barry J Gibson 教授（b.j.gibson@sheffield.ac.uk）联系。谢菲尔德大学研究道德委员会秘书 Lindsay Unwin 女士（https （http://www.shef.ac.uk/ris/other/committees/ethicscommittee）也可以处理您的投诉，或将您的投诉反映到适当的机构。

14.如何获取更多信息

如果您需要有关该项目的更多信息，请通过电子邮件地址 lcheng7@sheffield.ac.uk 或通过手机号码 07999024989 与研究人员程黎娇子联系。您也可以与她的导师 Barry J Gibson 教授联系（b.j.gibson@sheffield.ac.uk）。您将获得一份信息表和一份知情同意书以备保留。

15.关于 GDPR 的声明

新的数据保护法规在整个欧盟（包括英国）于 2019 年 5 月 25 日生效；这意味着除了信息表中已经提供的详细信息之外，我们需要向您提供进一步的有关信息，告知您在此研究项目中我们将如何使用和管理您的个人信息。

谢菲尔德大学将担任这项研究的数据负责人。这意味着大学有责任管理您的信息并正确使用它。

为了在本研究项目中收集和使用您的个人信息，我们必须具有法律依据。我们使用的依据是这项研究是’一项符合公共利益的任务’。

更多详细信息，包括大学如何以及为什么处理您的个人信息，我们如何保护您的信息安全以及您的合法权利（包括如果您认为您的个人信息没有得到正确处理的话，如何投诉），请访问以下网站 https://www.sheffield.ac.uk/govern/data-protection/privacy/general

非常感谢您抽出宝贵的时间阅读这份信息表，并感谢您对我的项目的兴趣！如果您愿意参加，请与我联系并告知我。

Appendix 5: Consent form for the doctor

Sub-optimal Health/Pre-clinical Conditions: the grey area of health and disease as embodied in a Chinese Medicine clinic in England

Consent Form

Please tick the appropriate boxes	**Yes**	**No**
Taking Part in the Project		
I have read and understood the project information sheet dated 07/10/2019 or the project has been fully explained to me. (If you will answer No to this question please do not proceed with this consent form until you are fully aware of what your participation in the project will mean.)		
I have been given the opportunity to ask questions about the project.		
I agree to take part in the project. I understand that taking part in the project means allowing the researcher, Lijiaozi Cheng, to conduct participant observation in the clinic, which will include observation of the consultations (upon consent of the visitor involved in the consultation), as well as conducting interviews with me. I consent to being recorded (audio) during interviews.		
I understand that my taking part is voluntary and that I can withdraw from the study at any time; I do not have to give any reasons for why I no longer want to take part and there will be no adverse consequences if I choose to withdraw. I also understand that I can ask the researcher to leave any observation session if I feel the need to.		
How my information will be used during and after the project		
I understand my personal details such as name, phone number, address and email address etc. will not be revealed to people outside the project.		
I understand and agree that my words may be quoted in publications, reports, web pages, and other research outputs. I understand that I will not be named in these outputs unless I specifically request this.		
I understand and agree that other authorised researchers will have access to this data only if they agree to preserve the confidentiality of the information as requested in this form.		
I understand and agree that other authorised researchers may use my data in publications, reports, web pages, and other research outputs, only if they agree to preserve the confidentiality of the information as requested in this form.		
So that the information you provide can be used legally by the researchers		
I agree to assign the copyright I hold in any materials generated as part of this project to The University of Sheffield.		

Name of participant [printed] Signature Date

Name of Researcher [printed] Signature Date

Project contact details for further information:

If you need more information about the project, please contact the researcher, Lijiaozi Cheng at her email address:lcheng7@sheffield.ac.uk, or at her mobile: 07999024989

If you have a concern about any aspect of this project, you can also speak to her supervisor: Professor Barry J Gibson (b.j.gibson@sheffield.ac.uk). You may also direct any complaints at any time to the Head of Dept for Philosophy, Prof Chris Bennett (c.bennett@sheffield.ac.uk), or to the secretary for the University of Sheffield Research Ethics Committee, Mrs Lindsay Unwin (https://www.shef.ac.uk/ris/other/committees/ethicscommittee) who can process your complaint or direct your complaint to the appropriate body.

Appendix 6: Consent form for the visitors

Sub-optimal Health/Pre-clinical Conditions: the grey area of health and disease as embodied in a Chinese Medicine clinic in England

Consent Form

Please tick the appropriate boxes	**Yes**	**No**
Taking Part in the Project		
I have read and understood the project information sheet dated 28/07/2019 or the project has been fully explained to me. (If you will answer No to this question please do not proceed with this consent form until you are fully aware of what your participation in the project will mean.)		
I have been given the opportunity to ask questions about the project.		
I agree to take part in the project. I understand that taking part in the project will include several elements and I have absolute freedom as to which stage I want to participate.		
The stages of the project:		
I agree to allow the researcher to observe me during my consultations with the doctor during the research period		
I agree to take part of the interviews and consent to being audio recorded during interviews		
I agree to take part in the diary study (i.e. write down my feelings of my health status on a daily basis for a given period of time) as part of the interviews.		
I understand that my taking part is voluntary and that I can withdraw from the study at any time; I do not have to give any reasons for why I no longer want to take part and there will be no adverse consequences if I choose to withdraw.		
How my information will be used during and after the project		
I understand my personal details such as name, phone number, address and email address etc. will not be revealed to people outside the project.		
I understand and agree that my words may be quoted in publications, reports, web pages, and other research outputs. I understand that I will not be named in these outputs unless I specifically request this.		
I understand and agree that other authorised researchers will have access to this data only if they agree to preserve the confidentiality of the information as requested in this form.		
I understand and agree that other authorised researchers may use my data in publications, reports, web pages, and other research outputs, only if they agree to preserve the confidentiality of the information as requested in this form.		
So that the information you provide can be used legally by the researchers		
I agree to assign the copyright I hold in any materials generated as part of this project to The University of Sheffield.		

Name of participant [printed] Signature Date

Name of Researcher [printed] Signature Date

Project contact details for further information:

If you need more information about the project, please contact the researcher, Lijiaozi Cheng at her email address:lcheng7@sheffield.ac.uk, or at her mobile: 07999024989
If you have a concern about any aspect of this project, you can also speak to her supervisor: Professor Barry J Gibson (b.j.gibson@sheffield.ac.uk). You may also direct any complaints at any time to the Head of Dept for Philosophy, Prof Chris Bennett (c.bennett@sheffield.ac.uk), or to the secretary for the University of Sheffield Research Ethics Committee, Mrs Lindsay Unwin (https://www.shef.ac.uk/ris/other/committees/ethicscommittee) who can process your complaint or direct your complaint to the appropriate body.

Appendix 7: Consent form for interviews with people brought up in China

Sub-optimal Health/Pre-clinical Conditions: the grey area of health and disease
亚健康/临床前病症：探索健康和疾病的灰色地带

Consent Form 知情同意书

Please tick the appropriate boxes 请在适当的方框中打勾	**Yes 是**	**No 否**
Taking Part in the Project 参与项目		
I have read and understood the project information sheet dated 01/07/2020 or the project has been fully explained to me. (If you will answer No to this question please do not proceed with this consent form until you are fully aware of what your participation in the project will mean.) 我已阅读研究信息表/我已被详细告知研究情况（如果您的回答是否，请先联系研究员索取更多信息，然后再继续填写本表格）		
I have been given the opportunity to ask questions about the project. 我有充分机会问关于本项目的问题		
I agree to take part of the interviews and consent to being audio recorded during interviews 我同意参加采访并同意采访录音		
I understand that my taking part is voluntary and that I can withdraw from the study at any time; I do not have to give any reasons for why I no longer want to take part and there will be no adverse consequences if I choose to withdraw. 我理解我的参与是完全自愿的，我可以随时退出，并无需给出理由。退出对我不会有任何后果。		
How my information will be used during and after the project 数据使用		
I understand my personal details such as name, phone number and WeChat account etc. will not be revealed to people outside the project. 我理解我的名字，微信号等个人信息不会泄露给项目无关人员		
I understand and agree that my words may be quoted in publications, reports, web pages, and other research outputs. I understand that I will not be named in these outputs unless I specifically request this. 我理解我在采访中所有的话可能会在论文，网页文章等发表中出现，但在这些发表中我的真名不会泄露（除非我表示想要用真名）		
So that the information you provide can be used legally by the researchers 您提供的信息会被研究者合法使用		
I agree to assign the copyright I hold in any materials generated as part of this project to The University of Sheffield. 我同意将在此项目开展中被收集的数据版权授予谢菲尔德大学		

Name of participant [printed] 被采访人姓名	Signature 签名	Date 日期
Name of Researcher [printed] 研究员姓名	Signature 签名	Date 日期

Project contact details for further information:

If you need more information about the project, please contact the researcher, Lijiaozi Cheng at her email address:lcheng7@sheffield.ac.uk, or at her mobile: 07999024989， or her WeChat (cheeroe)
如果您想了解更多信息，欢迎随时联系研究者：程黎娇子。您可以通过电子邮件（lcheng7@sheffield.ac.uk）或通过电话（07999024989）,或微信（cheeroe）与我联系。
If you have a concern about any aspect of this project, you can also speak to her supervisor: Professor
Barry J Gibson (b.j.gibson@sheffield.ac.uk). You may also direct any complaints at any time to the secretary for the University of Sheffield Research Ethics Committee, Mrs Lindsay Unwin (https://www.shef.ac.uk/ris/other/committees/ethicscommittee) who can process your complaint or direct your complaint to the appropriate body.
如果您对此项目的任何方面有疑问，都可以与研究人员的导师Barry J Gibson教授（b.j.gibson@sheffield.ac.uk）联系。谢菲尔德大学研究道德委员会秘书Lindsay Unwin女士（https （http://www.shef.ac.uk/ris/other/committees/ethicscommittee）也可以处理您的投诉，或将您的投诉反映到适当的机构。

Appendix 8: Inquiry to the organizing committee of 16th World Congress of Chinese Medicine

关于参加第十六届世界中医大会的咨询

尊敬的大会组委会，

您好！

我是第十六届世界中医大会的一名参会者。我已付款报名注册了第十六届世界中医大会。我不是一名中医，而是一名研究'亚健康'这个概念的人文社科博士生。我计划在参与大会的过程中收集一些与'亚健康'相关的数据，用以推进我的相关研究，为此特写信寻求你们的同意和帮助。

我是就读于谢菲尔德大学的一名博士生，目前我的研究项目隶属于哲学系。我的研究聚焦亚健康的发展和演变。与此同时，我还致力于关注海外中医是如何理解和使用亚健康这个概念。我的博士项目主要是通过民族志的方式研究英格兰的某一个中医诊所，采访该诊所的医生和到访该诊所的病人，来聆听他们的故事，和他们对亚健康这个概念的认识和体验；我也打算参与观察中医大会上的亚健康这个概念的运用情况。我的研究设计已经通过谢菲尔德大学的伦理审查。

世界中医大学是如此规模大、参与广、层次高的一个会议，我对它非常的向往。我认为若可以参加这个会议，采集一些数据，将会大大的促进我的博士研究。我计划以一个参会者的角度，来收集一些数据，观察目前海外的中医是如何理解，使用和交流亚健康这个概念，以及这个概念是如何渗透进他们的日常诊疗中。
我也想通过参加会议，来反思我自身的健康状况。我看到你们有面对公众的健康检查环节，对此我有极大的兴趣。

为了充分尊重组委会和其他参会者，我想通过此封邮件明确表达我的目的和沟通我的计划。我的计划是在参会过程中听一些我觉得可能和亚健康相关的会场，以纸笔的形式记录下来一些我感兴趣的发言观点和片段，并且有可能在之后对这些片段进行主题分析。与此同时我会积极参加会议的种种活动，参与观察。为了尊重隐私，在采集数据时，我不会提及任何名字（除非经过交流，他们主动希望提及他们的名字）。如果在参会过程中有人表示想要接受采访，我会提供单独的研究信息表和知情同意书，在充分得到知情同意后，才会进行。当然，如果您知晓有人愿意接受采访的话，请随时联系我。

我认为我的研究某种角度上可以促进海外医学哲学领域对中医的理解，也为中医在海外的传播略尽自己的一份力量，弘扬中医文化，这与本次大会的目的是一脉相承的。因此，若是我的研究可以得到中医大会的支持，我将不胜感激。

以上是我参会的计划和打算，如有什么需要我改进和注意之处，恳请能够给我提出意见，我一定会充分尊重组委会的建议和意见。与此同时，请问您觉得是否有必要给所有参会者发一封邮件知会一下我的目的？如果有人不愿我去听他/她的该场发言，我将充分尊重，不去该场发言。

十分感谢！期待您的回复。
程黎娇子

Appendix 9: Interview guides

The initial interview guide for clinic visitors

Part 1: with a life history focus:

1. When was your first time visiting the clinic?
2. What was the reason for you to visit the clinic? Do you still remember what happened?
3. So you have visited the clinic for quite a while now, what is your view of the practice of Chinese medicine? What kind of impact did it have on your health?
4. Did visiting the clinic have any impact on your life in general?
5. Is visiting the clinic having any impact on your life in general?

Part 2: with a phenomenological focus:

1. How are you feeling today?
2. What does being healthy mean to you?
3. Could you describe a day when you feel very healthy?
4. Could you describe a day when you feel not very healthy?
5. Do you feel your feeling of being healthy is a steady feeling, or does it change day by day?

Interview guide for Chinese people

1. Have you heard of subhealth? How? Where?
2. How do you understand it? What do you think of it? Why?
3. Do you ever feel you are in subhealth? Can you tell me more?