

History of health - Epidemic Control in China: A Conversation with Liu Shao-hua

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‘Post-imperial’ Practices of Epidemic Control

ZJY: In the context of the outbreak of the Novel Coronavirus 2019 (COVID-19), could you please outline China's mechanisms for the control of epidemics? What new features in the reactions of government, professionals, and the general public merit attention? What kind of role does technology play in this outbreak?

LSH: What new features? It is all about Chinese characteristics, isn't it? The whole world is

following the news coming from China every day, and I believe everyone feels as if they were watching a circus. This is sadly preposterous. Wuhan has been locked down, many other places have been practically blocked, and various countries are taking action to shut down their borders. All public transport in Wuhan has been suspended. The government is so ridiculous in thinking that it will all be fine if they simply lock up the people and isolate them. For both the central government and the Hubei provincial government, epidemic control seems to mean leaving the people to take care of themselves and simply stopping the disease from expanding to other places. Thus, they are taking epidemic control actions at the superficial level. But are the patients taken care of? Is the livelihood of the people taken care of?

Then, I see a lot of volunteers in China, for example the so-called 'ferryman' (摆渡人). They take the medical staff to and from work by bike, electric bicycle, or cars since there is no public transport. From this point of view, it can be quite touching to see the public response in China. I truly think these people are amazing, as it is very difficult to be a volunteer during the outbreak of a disease. Their families may strongly oppose their choices and everyone must be under massive pressure both physically and mentally. Shouldn't these people be considered true patriots? Do you think it is also a kind of Chinese characteristic? I think so.

ZJY: In the past few years, many Chinese NGOs have been disbanded. A great number of activists—especially lawyers—were arrested, and under the new Overseas NGO Law the activities of international NGOs have been constrained, limiting the ability of domestic NGOs to access resources and opportunities for capacity building. The space for civil society has shrunk to the extreme. There has been a serious crackdown on the media, and investigative journalism has been significantly restricted. Under such circumstances, and in spite of the strict censorship, the outbreak of the disease has provoked a harsh backlash from the general public. I think that this backlash and criticism from the public is similar to what happened in the wake of the previous scandals that involved the Red Cross and government agencies after the Sichuan Earthquake. This means that the general public maintains its own critical ability. Nevertheless, these ridiculous official responses to social emergencies keep happening, and they are even getting worse.

LSH: I think we could say that the Chinese government is treating the public reaction as a kind of 'bacteria', and then desperately increasing the dose of antibiotics to fight it. But this kind of control is bound to fail as the response is going to mutate. So, this time we see a lot of things that are absurd just like before or even more. We cannot say that the reaction of the Chinese people went through a dramatic change compared to before, but can we say it did not change at all? No. Under censorship, articles published for public discussion last shorter than the virus. They are soon deleted because of censorship and then somebody else reposts them, and the cycle goes on again and again. This means that inside China there are many people who have different opinions, and they are going to express them and to take action. So, actually outsiders like us cannot stop, we need to continue to keep track and be vocal. Because even if the people inside have no way to make their own voice heard, we can take action to repost the words everywhere.

You asked about the role of technology. In the past, we would not have had any idea about what the reality of a disaster was. Now, no matter how strict the online blockade is, something always passes through. I feel technology is a bit funny this time. China always boasts of its leading role in AI, 5G, electric cars, and all kinds of technologies, and of its monetary wealth. So, why have all these technologies failed to effectively maintain the livelihood of the people during the lockdown of the cities?

ZJY: During this outbreak, it seems that technology failed to play a crucial role in supporting public management, the livelihood of the people, or the arrangement of

medical service. But perhaps the government was well-informed, but nevertheless chose not to disclose the information?

LSH: Monitoring requires technology. However, why didn't the big data technology function well in monitoring this outbreak? It would be very easy to observe the trend from the functional perspective of epidemiological big data. But those people used the data for publishing purposes, caring nothing for this trend or for public health. Everyone is criticising the Center for Disease Control (CDC) at the central level, saying that they only thought about publishing articles for themselves. What I want to ask is how big is the CDC in China? I mean, how big is their power in political decision making? Did they dare to conceal the outbreak without any command from the higher leadership?

ZJY: This point is closely related to how you divide time by using the term 'post-imperial' in your book on leprosy doctors. It is first and foremost a political issue, rather than a mere medical problem. So, what does 'post-imperial' mean? If the period between 1949-78 is the 'post-imperial' era, what is the period after 1978? How does it affect the epidemic-prevention work at this moment?

LSH: In my book I explained that this is not merely an issue of medical service or public health. Fundamentally, it is a problem of sociopolitical history. As I wrote in the book: 'When the world was entering into the post-colonial era, by enforcing the mandatory socialist policy, the CCP administration made the country step into a post-imperial mental state, resolutely and quickly dispelling the influence of the old and new imperial (anti-imperialism and anti-feudalism) and the influence of colonialism (church, culture).' In the context of the current outbreak of COVID-19, I think the implication is that this kind of post-imperial mentality (as a way of thinking and spiritual disposition) has never disappeared. China's 'post-imperial' has never been detached from the imperial underpinnings, but it has two layers.

When we talk about post-colonialism and post-imperialism, there is a theoretical orientation which states that it is impossible to get rid of the colonial-imperialist architecture. First, in the earlier regime, 'imperial' refers to the continuation of the legacies of the Republic of China (1912-49), which included influences from traditional China and the West, as well as the church. Second, after 1978 'imperial' needs to be read in the context of the new wave of globalisation, with the shadow of the Soviet Union cast over China's institutional settings resulting in a bipolar character. On the one hand, China is pursuing globalisation—the 'imperial' standardisation. That can explain in particular, why there is a group of people, including those from CDC, desperate to publish their research of COVID-19 in world-class journals. To some extent, this is exactly the new imperial architecture described by Michael Hardt and Antonio Negri, which I discussed in *Leprosy Doctors in China's Post-imperial Experimentation*. On the other hand, as I mentioned earlier, China is still maintaining the 'post-imperial' mentality. Especially in the public disclosure of the outbreak, it upholds such a mentality. It is a very schizophrenic bipolar manifestation, and I do not think it has changed.

ZJY: So, the 'Chinese dream' is an 'imperial dream'?

LSH: Yes, the point I am making is that China has never broken away from the imperial. It fully eliminated the influence of imperialism, especially American influence, through its adoption of socialism. But, in fact, it aimed to build up an empire on the model of the Soviet Union, another Western imperial power. It followed the model of the Soviet Union in every aspect to promote its own 'post-imperial' political and technological reform.

At the end of the 1950s, the relations between the two countries deteriorated, and in the early 1960s there was the Sino-Soviet split. Chinese scholars often deny the Soviet influence upon the Chinese system during that period. In China, not many people are interested in doing historical research on

this and instead choose to ignore it.

The full history of that period, especially regarding the influence on the formation of the healthcare system, may not easily be seen today, and it seems that nobody takes it seriously. However, that decade had a huge impact on the history of China's healthcare and epidemic-prevention primarily in two aspects. First, in the mechanism for the prevention of epidemics. China had a Soviet-style healthcare system which included many different epidemic-prevention stations (EPSs) specialised in different diseases, and it was only later that this was transformed into the American-style system of CDCs with a unified management scheme. I believe that the reactions of the government to COVID-19 and the chaos within the government agencies are related to the incomplete transformation of the system. But we still need a lot of internal data to be able to research the power, positions, arrangements, coordination mechanisms, and resource allocation within this system. The Soviet influence on the public health system was very obvious before 2000, but the degree of the transformation to the American-style system differs from place to place. Huge differences can be found between and within the central level, provincial level, city level, or even in the municipalities. I strongly agree with what Dr Zuo-Feng Zhang, the Associate Dean of the School of Public Health and Professor in Epidemiology at UCLA, said recently: that the CDC transformation in Shanghai was quite complete and that this is the reason why Shanghai could successfully curb the outbreak of SARS. Shanghai was also the first provincial municipality to declare that leprosy had been eliminated. Now, the emphasis should not be on the word 'Soviet', but on how this old system has come to develop Chinese characteristics.

Second, the Soviet influence on China's healthcare system can also be found in the medical training system—particularly in the levels, structures, and scale of training. The professional education is designed in a general, fast, and low-level manner, which has resulted in a lot of unqualified health workers being able to obtain a medical license. The Soviet Union strongly emphasised the need to bring up mid-level professionals, and it was not the only country to do that. In the first half of the twentieth century the League of Nations also suggested that the Kuomintang Administration actively promote the medical training system in this manner. After 1949, in line with the Soviet model the PRC also started to train the people at the primary level. There are some tables in my book that describe the shifting trend in the number of leprosy doctors and leprosy-prevention entities (including the number of leper villages). We can see from these tables that after 1949 the number of high-level professionals did not increase much, whereas the number of health workers at the primary level and middle level was boosted. So, the beginning of this trend was the exact consequence of a policy based on the Soviet model.

China started to transform its epidemic-prevention system into the American-style CDC model around the year 2000. At that time, there were already a lot of clinics and EPSs, and all of them had to be consolidated under the CDC. Many people in the old systems were unaccustomed to or even worried about the central management of the CDC, including regarding decisions on resource allocation. Before the reform, each EPS was in charge of a single or several kinds of diseases, and the resources allocated to it would be distributed equally among different diseases by the EPS itself. In the new system this was centralised. So, which disease would be deemed to be most urgent at the central level? For example, AIDS was in the spotlight for a period of time, and all the money went to AIDS control. Another example is leprosy, which was thought to be eliminated in China and was thus not allocated financial support. As leprosy was an overlooked disease and the government never disclosed the places where leprosy had been eliminated but later reappeared, many leprosy doctors were reluctant to be merged. They thought: if everyone in China believed that leprosy had been eliminated in the whole country, who would care about the disease? Leprosy doctors in Sichuan province, for example, were resistant towards the merger and to this day continue to carry out their work in the dermatology institutes. From one system to another, there are a lot of internal

oscillations, and there may be a lot of institutional deficiencies as China is way too big and highly hierarchical.

ZJY: So, the initial Soviet-style epidemic-prevention system was transformed into an American-style CDC model, but the work environment and political environment in China is different from that of the United States.

LSH: Yes, transparency is the key problem. The model introduced may not be compatible with the local political and cultural environment. We have stepped into a globalisation regime led by the West, especially by the United States, and many countries and regions are inevitably involved in this process. The European countries, including France, have also adopted this American CDC model. In particular, its performance in the several major outbreaks of infectious diseases around the twentieth century made it a dominant model of disease control around the world. In addition, this kind of disease control has become increasingly reliant on big data, with a centre for data collection, monitoring, and command. If adopted by a democratic country, it would be subjected to supervision through democratic mechanisms. However, in China the centre is in charge of everything, including all resource collection, allocation, and decision-making. And there is no mechanism for monitoring, supervising, or correcting mistakes.

The central CDC concentrates all the resources and information related to the life and health of the public, but there is no mechanism to supervise it. The only institution that can supervise it is the higher political hierarchy, which the people have to believe and obey. It is a terrible thing. There has been a lot of criticism directed at the central CDC for rushing to publish their own research. Dr Zuo-Feng Zhang also indirectly criticised this phenomenon, and asked whether it is more important to publish excellent papers or to use this information for epidemic-prevention.

The Stigma and Ethics of Epidemic Prevention

ZJY: When it comes to professional ethics and the political culture in the workplace, based on my own work experience in China, it seems that things like political correctness, ‘face’, and exchanges of favours take precedence over considerations of professional development. A culture that fails to face facts with honesty and fails to show respect to professionalism has become the normal state of the authoritarian politics that is now permeating every aspect of the society. Instead of being limited to political decision making, this culture has been actively imposed on the daily life of the people.

Stigmatisation of an epidemic disease is often intertwined with lack of transparency and poor decision-making, which prioritise political considerations and echo the cultural metaphor of the disease. When it comes to the field of epidemic prevention, this sociopolitical culture further marginalises epidemic prevention work, exposes professionals to high risks, hinders collaboration in epidemic control, and brings huge damage to the public. This can also be seen in the widespread usage of the word ‘Wuhan Pneumonia’ (新冠肺炎) by media, governmental bodies, and NGOs.

LSH: The term ‘Wuhan Virus’ or ‘China Virus’ was also used by the World Health Organisation at the initial stage. When I saw it, I sighed. I believe that it was based on technical convenience and they did not think about the implications. They did not intend to stigmatise anybody: they named the disease after the place where it first broke out and then corrected it soon afterwards. But if everybody became familiar with the old term, who would remember the new one? It may be pointless to change the name if people’s views do not change.

This is a historical lesson. From the very beginning we should not name diseases this way, and the

media, governments, NGOs, as well the general public all over the world should have restrained themselves. Even if the name is changed afterwards, the stigma is unlikely to be easily removed. For example, many Wuhan people have left the city, and people do not get sick because there are people from Wuhan around. However, the lockdown of the city associates the people from this city with the virus and disease no matter where they went, no matter where they lived, and no matter whom they had contact with in the past. We can see how the stigma is integrated into the implications of the Chinese government's lockdown measures at the grassroots, and how it devastatingly affects ordinary people's lives, especially those from the lower rungs of society. It is the same as when people used to associate people from Henan with AIDS, which was a terrible problem that made it very difficult for citizens from that province to pursue education, jobs, medical treatment, and development opportunities. Also, globally it is obvious that there are more heterosexuals than homosexuals with AIDS, but people still think that AIDS is first and foremost a gay problem. And now, in some countries the Chinese are discriminated against as if they were a synonym for the novel coronavirus. It is a matter of the people's viewpoint, not a scientific fact.

ZJY: Now many places have been taking measures to stop and check people from Hubei. What does this mean from an epidemiological perspective?

LSH: From an epidemiological perspective, this is an unprecedented quarantine in terms of scale, and it seems that historically only concentration camps reached such a size. Although there were cities in northeast China and other places that used to be locked down during outbreaks of the plague, the density of the population and the size of the city were very different in the past. When the science was not so advanced, for example, the European migrants who went to New York would be temporarily quarantined on Ellis Island. And Leprosy patients have historically been kept away from the people by being isolated on islands, in mountains, or valleys.

ZJY: What do you think Wuhan could have done differently? What can China do now?

LSH: Quarantine measures in hospitals are necessary in a reasonable public health system with open and trustworthy mechanisms. For example, visiting patients is now forbidden in the Taipei Veterans General Hospital. No more than two people are allowed to accompany each patient to the hospital and every person showing up at the hospital has to wear a mask. In Taiwan, healthy people are urged not to wear masks if they are not visiting special places or hospitals. Classification and division of work should be immediately carried out among hospitals. For example, patients with critical conditions need to be sent to the hospitals with better facilities, and special hospitals should be tasked with referrals and taking care of the needs of the patients with specific diseases. These are the ABCs of public health.

In certain cases people should be self-quarantined for a certain period of time at home and checked. Given the preciseness of China's population survey and the strict measures of control, it was surprising that they failed to visit every household to investigate and supervise at the outset. These measures are not uncommon in public epidemic control and have been applied in other places. But in China, the system just panicked. I think these people have not received any training about the proper conduct in this situation and have no idea who is at higher risk and who is not. They may not even be clear about their own information either.

So, in this case the official attitude towards the outbreak is to make sure that the residents of Wuhan cannot go out to spread the disease by locking them down. This mentality of not caring if you live or die as long as you don't come out to infect me is the worst and is not confined to the officials. The scope of the red line could be very large. But how can the government blockade a metropolis like Wuhan, with a population of ten million? In this big city, how will the government take care of the physical and psychological states of those who are not infected? What kind of aftereffects will there

be?

ZJY: The point is that in the context of China's political culture, this mentality is not confined to political decision-making—it is everyday life for the majority of people. In this blockade, we have seen a lot that is primitive, brutal, violating human rights, and threatening the basic livelihood of the people. So, in this case, is trust the most absent thing?

LSH: I don't think it is just about trust. I have mentioned in my book that the Chinese people are either actively or passively cooperating with this kind of political culture. And since it lacks ethical norms, people are not responsible for anything or anyone, including their own integrity.

Like those people in the CDC who firstly published their research on COVID-19 in *The Lancet* and the *New England Journal of Medicine* in early and mid-January, for instance. Although I do not believe they were in a position of power to withhold information about the epidemic outbreak, none of them showed any conscience or stood up to reveal the truth when they published articles in those top journals. These people, from top to bottom and not just the people of the CDC—because the data was collected and sent from the bottom as well—were desperately trying to put their names on the articles. There was a list of names. So, I have no idea how many people already knew about the outbreak of the disease from the local to the central level. There might also be people who knew and whose name was not on the list.

Do those people know nothing about professional ethics or the basic morality of being human? They are intellectuals—they have the ability to communicate internationally since they can write academic English. How could they be so narrow-minded and so ignorant about the international norms? The *New England Journal of Medicine* should have withdrawn these kinds of articles later because they seriously violate research ethics. This is akin to improper acquisition of information. For example, if you are doing an experiment with a patient and know that his or her life is in danger, will you use your experimental drug to improve your professional reputation, or will you save the patient's life by immediately using an already-existing drug?

Epidemic Control: The Suppressed History in Chinese Writing

ZJY: Your 2018 work *Leprosy Doctors in China's Post-Imperial Experimentation: Metaphors of a Disease and Its Control* deals with the history of the control of epidemics in contemporary China (1949-78). You spent over ten years writing about the life of a group of leprosy doctors, as well as about epidemic-control policies and practices through the lens of politics (i.e. nation, class, religious politics), science (i.e. the development of biomedicine and education), and social culture (i.e. the stigma and emotional labour brought about by the metaphors of disease and its control practices). You wrote the book in Chinese and first published it in Taiwan. As many of the leprosy doctors you communicated with were growing old and some of them had passed away, you were hoping that they would read the manuscript and give you feedback even before it was finished. It was also a way to preserve the history of this group of individuals. However, this book is not really known in the English-speaking world, and it has not been published in mainland China as its contents failed to get passed the censors.

LSH: I think there is obviously interest in the history of epidemic-control in China in the English-speaking world, especially in academia—so why did I write it in Chinese first? Primarily this was because the historical materials and narratives I used made it difficult to render the book in English.

One of my main goals was to preserve these historical materials, and translating them directly into English would have required simplification as English readers do not need so many historical details. Besides, those English readers who engage in China Studies and who are interested in detailed historical materials are very likely to be proficient in reading Chinese.

ZJY: Is this situation common in Chinese academia? Is it a consequence of the pressure on young researchers to publish any piece of material as soon as they collect it, especially in English?

LSH: This is the situation for those of us in non-English-speaking academia: we need to try to make the book readable for the people in the English-speaking world. It is also the current trend in academia more generally that people are pushed to publish every piece of material as soon as they collect it—a situation which we can describe as ‘slight, thin, short, and small’ (简简单单). Any finding is quickly published, and it seems that it is left only to the historian to do in-depth and difficult studies. Some people question why I conduct research in Chinese, why I go into so much depth. Considering that my studies cannot be published in mainland China, they consider them ‘useless’. It is precisely because Chinese scholars cannot do that, that those of us outside the Chinese system we need to do it. Chinese scholars and the scholars within the system are more likely to have access to rich materials, as they may have different kinds of interpersonal channels and sources of data. The problem is that they would not publish these materials at all, as they neither dare to think that way nor dare to write about it. Many outstanding Chinese scholars, I believe, have plenty of materials but cannot publish them. What these scholars can do may be to collect materials or histories, but they have no way to write these things down. The few people who can write and publish probably do so outside China, so they are like us, outsiders of the Chinese system. So those of us outside the system have a duty to write.

There are some Western scholars who cooperate with China for some resource exchange and might be able to obtain some material from within the system (for instance in the medical and healthcare fields). Due to their research scope, their findings based on these materials would not be much different from those Chinese researchers.

ZJY: This is very sad.

LSH: Yes, it is sad. Moreover, being unable to analyse the political culture or politics, they can only make relatively technical descriptions. This may also be seen as a division of labour; that is, at least other researchers can cite their data. If I had written the book *Leprosy Doctors in China's Post-imperial Experimentation* in English first, my informants could not have had a chance to read it, and many materials could not have been covered. For example, when I wrote my first book *Passage to Manhood*, my informants—who were members of an ethnic minority—did not read Chinese either, so it did not make any difference to show them the Chinese or English version. However, things were different for the interviewees of *Leprosy Doctors*. These doctors were intellectuals, and they were growing old, so I had to write the Chinese version first for two reasons: first, to preserve this history; second, to give it to them and discuss.

ZJY: Besides the impressive knowledge and depth of thought, I found your *Leprosy Doctors* book very healing. It is very human, has a power to assuage the pain. In this outbreak of COVID-19, we have seen many people, especially medical staff, who make many sacrifices and take considerable risks to keep working and providing services. In the meantime, we have also seen a lot of video clips and photos that indicate great dangers and a severe lack of crucial supplies. The doctors and nurses, including family members of my friends, have to work on the front lines, even if they themselves are running a fever or lack proper protection. So, they are taking high risks in either active or passive ways. In Hong Kong,

meanwhile, new unions have quickly organised in different industries to negotiate and struggle with the weakened government to protect the medical staff and prevent an outbreak of the epidemic in the city. This outbreak of the coronavirus has highlighted how crude and barbaric the living and working conditions are for us Chinese people. My feelings on this matter are complicated. For one thing, I deeply respect those people who are trying their best to provide professional or volunteer services in spite of the huge risks. But on the other hand, it is exactly these professionals who easily fall victim to the political culture. They are unlikely to be able to defend themselves at a time of crisis and they are suppressed when they take action.

In your book, you write about the personal life history of leprosy doctors who were carrying out their work under the pressures of stigma and a lack of resources. How did these doctors, epidemic-prevention workers, and patients develop their agency in an extremely suppressive political environment?

LSH: I would like to primarily talk about senior leprosy doctors in my book. The point that I need to stress is that these doctors were very professional. What I want to say is different from the official narratives and discourses in mainland China, and this can be called the ‘suppressed history’. Many of these senior medical staff or their teachers were trained before 1949. There was a saying around the late 1970s and early 1980s that university graduates before the Cultural Revolution had real scholarship. Even in those extremely difficult times when intellectuals were marginalised, they maintained high professional standards. Being marginalised, they had no chance to join the political battle, as they themselves were the targets of the struggle and had to go back to work after being attacked. In those circumstances, being able to work was a shelter for these intellectuals. So, they focussed on their professional work, dealing with a group of people—lepers—who were marginalised as well. They concentrated on the treatment and prevention of the disease to explore scientific questions and to gain a sense of achievement—even if these achievements were framed by the government as relief for the vast suffering of China’s rural underclass or other similar patriotic propaganda. I think it is a very critical point.

ZJY: Now, the environment in China is different, at least the degree of social openness is much different. It seems to me that people would switch to another position, if they have the chance.

LSH: The majority of the leprosy doctors who were trained after 1949 shifted to other positions. It was the group of older doctors who stuck to their posts. So, as I mentioned in the book, after the 1980s, these old doctors still worked in these positions. But as they were accustomed to maintaining a low profile, they were rarely known by the public. On the contrary, some doctors who joined later were very high profile, and were known by many and were even falsely credited for all the achievements in epidemic-prevention in China. So, I felt quite uneasy when I wrote about the story after the 1980s, because these facts are still suppressed by those in high positions.

ZJY: Is there anything else you would like to add?

LSH: Just one more thing. It would be a terrible thing if China’s medical training system included only skills but no ethics.

P.S.

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- Zeng Jinyan, writer, scholar, and documentary filmmaker, was the 2017 Oak Fellow at Colby College. She earned her PhD at the University of Hong Kong in 2017. Her book *Feminism and Genesis of the Citizen Intelligentsia in China* (City University of Hong Kong Press 2016) received a Publishing Award in the Social Science category of the 2017 Hong Kong Publishing Biennial Awards. Zeng co-directed the documentary film *Prisoners in Freedom City* with Hu Jia (2007), wrote the script for the animation short *A Poem to Liu Xia* (Trish McAdam 2015), and produced the feature documentary film *We The Workers* (2017). Currently, Zeng is a postdoctoral fellow at the University of Haifa, doing research on ethnicity, poetry, politics, and culture.

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