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ARTICLES

Smoking among Doctors: Governmentality, Embodiment, and the Diversion of Blame in Contemporary China

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How and to what effect have physicians in China become frequent cigarette smokers and blamed as engines of nationwide tobacco-induced suffering? Building on governmentality heuristics, I argue that multilevel interactions of biopolitics and male embodiment have been especially significant in shaping these phenomena. Of the effects gleaned in my fieldwork ongoing since 2003, the most important is a deflection of responsibility for tobacco-induced death away from incoherent leadership decisions—some aimed at protecting Chinese citizens from tobacco, others at facilitating trillions of cigarettes being sold annually in the PRC—made over recent years in and outside the country.

Key Words: China; cigarettes; doctors; embodiment; governmentality; masculinity

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> Medical personnel should be responsible. . . . Earlier this March 27th, however, Xinhua Online reported that, in some areas [of China], more than 55% of doctors are smokers. . . . These kinds of doctors who smoke, overall, are precisely the kinds of people who "look forward to you successfully quitting a thousand times." On the surface they tell you that "smoking is harmful to your health," and encourage you to smoke less or to quit altogether. But secretly, they are advocates of hardcore smoking. They hope you'll be hardcore smokers, contracting even more diseases, thereby allowing their business to flourish (Editorial, *City Daily*, Kunming, Yunnan, May 31, 2005).

This editorial broadside published in one of the more widely circulated papers in southwest China begs one to ask: What sociopolitical forces—longstanding and recent—have led to a situation wherein today Chinese doctors not only often smoke cigarettes but are being pilloried as furtively promoting tobacco-induced morbidity? What twists and turns in the formation of China's polity have created such a situation and to what effect? In this article, I argue that a contributive force has been a distinct type of governance and that an increasingly significant effect is the diversion of responsibility away from decades of leadership decisions, which are fostering one of the greatest human disasters of our age.

Cigarette smoking killed at least 100 million people worldwide last century, and ten times that will meet the same fate in the 21st century if present smoking rates persist (ACS 2006; Mackay, Eriksen, and Omar 2006). In China, cigarettes currently kill over a million citizens a year (40 times greater than annual deaths there from HIV/AIDS), and if present trends hold, between now and 2050, the country's annual death toll from tobacco will jump as much as 300 percent (Liu et al. 1998; National Center 2005).

In addition to corporate avarice, animating this annihilation lays a distinctive and paradoxical feature of transnational leadership. Executives of state regimes and key international organizations have been pursuing a dual track regarding tobacco during the past two decades or more: (a) continuing a longstanding strategy of using tobacco sales as a font of political economic preeminence and (b) shoring up their legitimacy by increasingly striving to regulate tobacco in light of indisputable empirical data indicating that it is highly toxic (Chaloupka et al. 2000; Reid 2005).

Participation by international leaders in this paradoxical situation can be glimpsed in two recent moves involving China. In 2001, negotiators agreed on terms allowing their long-sought prize of China's admission into the World Trade Organization. Many of those stipulations are tobacco related. Hammered out by executives of 13 countries led by the United States, the terms endorse the party-state's monopoly control of the Peoples Republic of China's cigarette industry but require Beijing to loosen financial and administrative barriers that have made it difficult for foreign companies to

peddle either their cigarettes to PRC citizens or their packaging, filters, and flavorings to Chinese cigarette factories.[1] In this very same period, however, World Health Organization (WHO) member-states were fast at work on another track—negotiating the final language of the very first global public health treaty in history (the WHO's Framework Convention on Tobacco Control). The PRC's National People's Congress ratified the treaty in 2005, joining what is today over 140 other ratifying national governments.

More purely domestic leadership decisions shaping tobacco in contemporary China over the past three decades are also worth note. After Mao's death in 1976, directors of the party-state embraced tobacco more than ever before as a cash cow for government financing. They intensified pressure on regional governments, especially in the country's poorer inland areas, to expand tobacco commerce as a development strategy.[2] In the early 1980s, party leaders created the State Tobacco Monopoly Administration (STMA) and its China National Tobacco Company to supervise industry expansion, maintain Mao-era obstacles to foreign imports, and ratchet up tax quotas placed on local leaders.[3] The results in terms of government revenue have been dizzying. From the late 1970s to the mid-1990s, the percentage contribution to state revenue of China's domestic tobacco industry nearly tripled, making it the country's top tax generator by industry for several years running at millennium's turn (Liu and Xiong 2004:169). In 2006, annual production of Chinese cigarettes hit a new all-time high of over 2 trillion sticks, spawning a record US $36 billion in yearly taxes (TobaccoChina Online 2007).

Meanwhile, since the 1980s, branches of the party-state have been promoting tobacco-control initiatives. These initiatives, to be sure, have not been aimed at eradicating tobacco from the Chinese marketplace. Instead, like elsewhere in the world recently, tobacco control has centered on *regulating* cigarettes and their harm. Efforts have included disseminating damning information about tobacco's dangers, promoting smoking cessation, establishing a tobacco-control office and association under the Ministry of Health, mandating tar-level reductions and packaging with warning labels, funding advancements in the treatment of tobacco-related diseases, and engaging proactively with international tobacco-control efforts.

To say that these paradoxical leadership moves, at once national and transnational, have been sustaining tobacco ongoing circulation in China and elsewhere is to assert the obvious. More difficult to understand, however, are attendant societal forces and their specific effects. In particular, what are the social processes entangling citizens in a polity like contemporary China such that, although they are increasingly aware of the tobacco-induced suffering ravaging their communities, they nevertheless direct scant hostility from day-to-day toward the purveyors of tobacco products?

Numerous processes are at work, some quite prevalent beyond the boarders of the PRC, others less so. I have chronicled two sets in past publications. One involves the fashioning of the risk-conscious self, a move common to our age that helps displace responsibility for tobacco exposure from regimes of production onto the individual smoker (Kohrman 2004). The second entails a distinctive style of memory-making prominent among Chinese residents today who are exposed to tobacco-related death (Kohrman 2007). I argue here in this article that a third set of processes is worth considering—the creation and problematization of conduct among doctors, specifically their consumption of cigarettes.

GOVERNMENTALITY IN AND OUTSIDE THE CLINIC

Researchers of politics from several corridors of the academy have recently been focusing on new ways of conduct, that which people do from moment to moment, from week to week. Informed by Foucault's essay "Governmentality" (1991), much of this realm of inquiry has centered around analysis at two levels. The first involves excavating long-term relationships suturing multilayered modes of authority-making to techniques for managing people and objects. In contrast to studying sovereignty's more formal concern with sustaining itself by controlling territory and its inhabitants, analyses of governmentality focus on how State and non-State political entities buttress themselves by managing "men and things" (Foucault 1991:93–94). The second level entails analyzing how the suturing of authority-making, people, and objects is contingent on conduct's problematization, the ways it gets subjected to study, critique, regulation, redirection and/or prohibition by institutions, discourses, norms, and practices of self formation (also see Dean 1999; Rose 1999).

In the pages below, a governmentality framework is tapped to help describe why cigarette smoking has become prevalent among Chinese physicians, how that conduct is being blamed as an engine of wide-scale suffering, and ways such blame-making serves cigarette manufacturers' interests. The analytical aim of this article extends further, however. I also seek to expand scholarly appreciation of *means* by which conduct is created and problematized. I do so by giving special focus to embodiment: the ways that corporality comes to be produced by and productive for social, symbolic, and political formation (Csordas 1988; Scheper-Hughes 1994; Shilling 2001). In particular, I highlight the role of *male* embodiment (Bourdieu 2001; Louie 2002). Of course, Foucault never meant that an analysis of governmentality should be gendered along the lines of simply "men and things." On the other hand, what may be discovered about sociopolitical formation,

we can ask, if we treat his literal wording as meaningful provocation and respond in kind by examining men as men?

Investigating the interplay of gendered embodiment and conduct is certainly nothing new for medical anthropologists, especially when it comes to the patient's side of the clinical encounter (e.g., Greenhalgh 2001; Lock 1998; Martin 1987). Nor is investigating blame making (e.g., Evans-Pritchard 1937; Farmer 1992; Good 1995). To date, however, few within academic circles have explored how corporeality, let alone male embodiment, can be a unique terrain through which clinicians and their relationships to things are generated and managed. Likewise, how the problematization of clinicians' bodies can serve to direct blame making away from suffering's political-economic sources has been overlooked. Consider the small literature on what has recently been called "clinical governmentality." Within that relatively congnitivist oeuvre, as Flynn outlines, the primary focus has been to glean how, inside the clinical setting, physician conduct relates to "rationalities" and "mentalities of rule" (2002:164; see also Hackett 1999; Llewellyn 2001; Walshe et al. 2000).

If these analytical issues have buoyed my interest in doctors' smoking habits, it has been no less incited by my recent fieldwork. This research began in 2003 as part of a broader study examining tobacco and the sociopolitics of disease in Kunming, capital of the southwestern province of Yunnan and a center of China's current tobacco industry. I have frequented hospital-based departments of cardiothoracic surgery for this research, choosing such departments because they are the primary medical venues where people diagnosed with lung cancer (the most widely recognized form of tobacco-related disease) are usually referred for expert care, including chemotherapy and chest surgery.

When I began visiting cardiothoracic surgery wards, I was interested in understanding how, in a city greatly invested in tobacco, some of the most iconic medical professionals involved in treating tobacco-related disease, namely lung cancer specialists, were communicating with patients about tobacco's toxicity. Shortly after I began developing this clinic-based research, I became intrigued by two other issues: that most of these surgeons are male and that they are regularly involved in a specific form of conduct. Whenever we would step away from their patients' hospital rooms and into their duty offices, these surgeons and I would be enveloped by an apparent irony. Nearly all of the surgeons, who usually labor long and exhausting days to eradicate tobacco-related disease, spend much of their time away from patients smoking cigarettes.

How could it be that physicians so frequently exposed to the biological and familial devastation wrought by cigarettes have become heavy smokers? Why are these smoking habits not being curtailed by either the doctors'

exposure to disease and relevant risk data or their broader obligations to public health? Such were the questions that I mulled as my fieldwork began and, on first blush for some readers, they might seem to be a particularly apt line of inquiry for medical anthropology.

However, after stumbling on materials such as the editorial that serves as this article's epigraph, it became clear to me that it is equally necessary to consider another set of issues. What presuppositions might underlay that initial and ostensibly more anthropologically apposite line of study? Who else, animated by those very presuppositions perhaps, has been busy raising similar questions about China's medical practitioners' habits? And what broader effects might such problematization have today in terms of the human suffering that tobacco is increasingly generating?

Below, these parallel tracks of inquiry are pursued. Such parallelism helps demonstrate the value of governmentality heuristics for making sense of tobacco's ongoing prominence and illuminates more specific practicalities. It reminds us that professionals are always, to some degree, historically, institutionally, *and* somatosocially produced. It exposes that the bodies of physicians in China have been sites of contention for quite some time and have been understood as pivotal for sustaining the order of things inside and outside clinical contexts. What's more, it highlights that recent transnational tobacco-control efforts to regulate doctors' bodily conduct have, albeit inadvertently, helped to divert culpability away from cigarette producers.

My analysis unfolds as follows. Common misconceptions about doctors who smoke—particularly those who regularly treat patients with tobacco-related diseases—are initially discussed. Next, details of how some physicians currently use cigarettes in Chinese hospitals are provided. Then, a genealogy of cigarette use and male embodiment among clinicians in China is offered. The recent problematization of health care professionals' cigarette smoking is outlined next. And finally, how and to what effect that problematization is currently being experienced among some of my informants is analyzed.

DISPENSING WITH IRONY

Merriam-Webster defines irony as an "incongruity between the actual result of a sequence of events and the normal or expected result."[4] For many readers, no doubt, an expected result is that doctors—and especially those like cardiothoracic surgeons who regularly treat tobacco-related diseases—would abstain from cigarette smoking and agitate against tobacco interests. On what assumptions is that expectation grounded? At least four merit note.

First, their vocational profile makes doctors some of the most consummate of rational, risk-avoiding actors when it comes to tobacco; owing to their privileged exposure to knowledge about tobacco's danger, they will opt not to smoke. Second, doctors today are adequately outfitted with techniques to transform knowledge about risk into personal action (abstention). Third, they are encouraged to be not simply healers but public health trailblazers. And finally, cigarette smoking among doctors is a behavior minimally affected by any inducements—e.g., biochemical or somatosocial—other than knowledge (positive or negative).

Close examination of cardiothoracic surgery reveals that each of these assumptions is wanting. Let's begin with the idea that such surgeons in China are uniquely situated to acquire risk knowledge about tobacco and then seamlessly behave as rational, risk-avoiding actors when it comes to smoking. Inasmuch as these professionals must abide by highly rationalized modes of thinking and behavior to become and stay accredited, there is no reason to assume that they, more than anyone else, will always structure their personal conduct to exclude a behavior because of scientific data about its risks. After all, in many parts of the world there are significant rates of smoking among health care professionals[5] and the longstanding academic debate on rational actors—regarding the degree to which humans entirely conform to the tenets of rational choice theory—is far from settled (Feng 2005; Green and Shapiro 1994; Hastie and Dawes 2001; Hollis and Lukes 1982; Sahlins 1976; Slovic 2001; Tambiah 1990). But such comparative and theoretical practicalities notwithstanding, what we see on closer examination is that cardiothoracic surgeons are forced to manage, perhaps more than any other professionals today in China, a conceptual hurdle in the epistemology of tobacco control. Many of my informants maintain that their highly specialized job at times gives them less, rather than more, confidence in the decades of data documenting the hazards of tobacco, data that have been produced through rigorous but conceptually abstract methods.[6] Their confidence in the data is corroded, they tell me, by a form of empirical competition forced on them by their regular contact with a wide array of lung cancer cases. This is a competition that pits anecdotal knowledge and statistical information against one another. Because of surgeons' regular empirical encounters with a small but distinct segment of lung cancer patients—those who previously never smoked and who were negligibly exposed to second-hand smoke in the past—they are intermittently prompted, they explain, to feel a sense of incredulity toward the more abstract data documenting tobacco as a leading risk factor for lung disease.

Even more untenable is the assumption that cardiothoracic surgeons in China are adequately outfitted with techniques to transform epidemiological knowledge about risk into smoking abstention. One can glean this with the

briefest consideration of the tobacco-control landscape. Whereas some parts of the world are awash with tools and policies to make smoking avoidance relatively convenient, that remains far from the case across much of contemporary China. Few workplaces are entirely tobacco-free, and pressures from transnational tobacco control have not yet led to comprehensive laws (either national or local) banning smoking entirely from medical facilities. Despite recent efforts by China's domestic pharma manufacturers to seize new openings in foreign-controlled patents and to fill a marketplace long ignored by multinational companies, the vast majority of the country remains bereft of well-proven smoking-cessation medications such as nicotine-replacement therapy and bupropion. Moreover, manuals, hotlines, and consulting services that instruct people how to quit or avoid smoking uptake remain hard to find and often require complex efforts to access.

Regarding the third assumption, we are hard pressed to find many settings in the world offering extensive evidence that when it comes to promoting health local surgeons regularly stray far from a treatment-based playbook: ordering tests, weighing intervention options, carrying out procedures, prescribing medications, and directing initial postoperative recuperation. That this is how most surgeons devote much of their energy; spending little time on issues like disease prevention, no doubt stems in part from how the development of biomedicine has come transnationally to define surgery's disciplinary mission (Hæger 2000; Hurt 1996). Of the various structural forces serving to intensify that disciplinary vision among Chinese surgeons in recent years, perhaps most important has been the ways the party-state has revamped the compensation system of hospital-based physicians. Now, unlike the Maoist era, hospital-based physicians receive only a modest percentage of their monthly income from "salary" and far more from departmental "bonuses" (Liu, Liu, and Chen 2000). In the facilities where I have been conducting fieldwork recently, it is hospital accountants who set physicians' monthly bonuses, calibrated by seniority. Every 90 days, the accountants calculate the bonuses based on each department's past quarter's gross "revenue," from procedures completed, drugs dispensed, and beds occupied.

Likewise misguided is the dual supposition that when it comes to Chinese surgeons today cigarette smoking is a behavior only minimally affected by biochemical or somatosocial forces.[7] For many observers who are nonsmokers, it is all too easy to underestimate the biochemical grip that cigarettes can have over people. The fact of the matter is that irrespective of vocation and residence, with enough exposure, most anyone can develop first a tolerance for and then a dependency to the psychoactives found in tobacco, especially nicotine, one of the most addictive narcotics (Benowitz 2001).

To appreciate that cigarette smoking among Chinese surgeons is not just heavily influenced by inducements of the biochemical but also the somato-social, consider a specific bodily axis around which people's lives in China and elsewhere are heavily organized. A 2004 survey of smoking among hospital physicians in six cities carried out by China's Centers for Disease Control and Prevention indicates that the single most significant variable for predicting if doctors smoke is gender: with male physicians 35 times more likely to smoke than female doctors. The surveyors also found that within surgery, 48 percent of male clinicians smoke, whereas only 1.6 percent of female clinicians do (Jiang et al. 2005:404).

Gender's influence on smoking is, of course, not limited to medical professionals. It plays a significant and persistent role in shaping who smokes in innumerable contexts around the world. And more often than not, it predisposes men to consume cigarettes and women to avoid them.[8] That being the case, at least two questions are important to raise. How has cigarette smoking taken on an androcentric orientation in China, among doctors or others? And how do vocational specialties there—in the present case, surgery—facilitate smoking among men? I will discuss the second question first because to write a "history of the present" one must first know the here and now.

CIGARETTE SMOKING AMONG CHINESE SURGEONS TODAY

The cigarette today is far from being a random "free-floating radical" among Chinese surgeons. It is a pivotal element in a highly embodied set of organizational practices and ethics through which surgery in China is manifest. Among its many roles, cigarette smoking functions in four ways: to keep surgical departments working as units stratified by a blend of gender, accreditation, and seniority; to facilitate rites of passage for initiates; to build mentor-disciple relationships; and to nurture intra- and extra-ward alliances.

All this has been made clear as I have interacted with cardiothoracic surgeons over the past two years. These surgeons have exceptionally complex professional lives. Understanding abstract biomedical knowledge is certainly vital for the surgeons' success, but their work far exceeds intellectual competency. They must also navigate and manage multiple expectations of physical and ethical exertion from the moment they start formal surgical training to retirement. They are expected to work 60–100 hour weeks; sit for long stints at desks writing up sheaves of records; run stairs to avoid slow elevators; carry on innumerable hallway communications per day with fellow staff, patients, and their family members; and of course, participate in

challenging surgeries, wherein they stand for hours, using their upper bodies in extraordinarily delicate and strenuous ways.

With such an exhausting schedule, it is unsurprising that the duty office is an important roost. Within the hospital, the cardiothoracic surgeon seeks refuge from patients in the duty office, has access to beverages, takes lunch (and often breakfast and dinner), and rests during both night and day. Duty offices usually have bunk beds for surgeons to enjoy after-lunch naps and longer rests for those on overnight shifts. Beyond serving as a refuge, the duty office, perhaps more significantly, is a site of constant communication and mutual surveillance. The forms of communication and surveillance that transpire are guided by a wide sweeping and shifting set of ethically infused regulatory discourses about professional conduct. Today, most of these discourses are structured around dyads broadly circulating across China such as efficient/inefficient, independent/team-oriented, masterful/incompetent, convivial/uncollegial, methodical/sloppy, modern/backward, and compassionate/insensitive. In the duty office, the ways surgeons deploy these dyads, navigate them, and interact almost always includes something else: highly mannered forms of bodily movement entailing a subtle choreography of fingers, lips, diaphragm, pockets, and surrounding space. As already mentioned, a near-constant activity in the duty office is cigarette smoking. Cigarettes are not simply consumed in the duty office but far more significantly, exchanged there, often dozens an hour. It is rare for someone to pull out a pack and light up in the duty office without first making a ''generous'' offering of the pack to others nearby.

Who joins this landscape of medical practice? What attracts and repels them? And what role does the cigarette play in their success? Along with intellectual curiosity and a strong track record through medical school, perhaps the greatest predictor for admission into a surgical training program is the very same one for smoking uptake among doctors across China today. The sexual binary of male/female—as ossified sociopolitical difference, performative script, and means of domination—has deeply marked the hierarchal environment that is the surgical ward in China (see also Evenden 1998; Morantz-Sanchez 1995). Surgeons in such a ward are expected to be male and perform as such, whereas the reputedly ''lower rung'' of employees on surgical wards, nurses, have usually been expected to be female and comport themselves in feminine ways.[9] Of the cardiothoracic surgeons I have met in China, all but one self-identifies and is recognized by colleagues as male. And in the two cardiothoracic surgery wards where I have conducted most of my fieldwork, all the nurses self-identify as female. The fact that the ''female physician'' is not more common among the staff ranks of cardiothoracic surgery departments appears to be quite complex. Most often, this has been explained to me through a highly embodied set of gender rhetorics,

a set framed less in terms of "hard and soft science" as might be expected (Oldenziel 1999; Traweek 1988) and more in terms of a highly distinctive phenomenology of physical exertion, domestic commitment, smoke, and sexual conduct. Many nurses and female medical students (while on month-long rotations through cardiothoracic surgery wards) tell me they would never want to be a ward surgeon because they feel ill-suited to work that is so physically demanding and that involves such long hours away from family and home. They also make clear that they find repellent to feminine respectability the pressure among cardiothoracic surgeons to smoke cigarettes and to spend extensive periods engaged in smoke-infused communications, camaraderie, and mutual assessment. As discussed further below, cigarette smoking for young women in China, while at times marked as modern, has been coded for many years as transgressive and as especially sexually suspect when carried out together with men. In line with these and other precepts, more than a few older cardiothoracic surgeons have told me, in self-satisfied tones, they are disinclined to admit female colleagues into their ranks because (a) "family" obligations often impede such women from committing adequate time, (b) cardiothoracic surgeons need to be especially "strong" people who, if a retractor fails, can hold open a patient's ribcage, and (c) it is far more awkward to "get along with" (*xiangchu*) female surgeons. As Dr. Zhou explains further: "Working together in the ward with men is much easier. We smoke, we talk, we eat together, we open up someone's chest, we sleep on bunks above and below. That's just men being men together. If I smoke and sleep next to a man in the duty office, there is nothing to that. If it's a woman, people can start to talk."

Medical students who approach graduation from their M.D. training and are interested in the increasingly lucrative vocation of cardiothoracic surgery must apply to one of the small numbers of senior surgeons across the country who are formally accredited to supervise graduate study. Once admitted, master students are obliged to develop friendly and docile relationships with not only their advisor, but also the rest of the surgeons in the department, which the advisor usually heads. On arrival, the young graduate student can expect senior doctors to begin frequently offering cigarettes. They do this, I have observed, out of friendliness, a sense of etiquette, and a desire to size up more fully the new trainee. They also do this to perform masculinity and produce *guanxi* (social relationships).

Offering a cigarette is *fayan* (literally, "to distribute smoke"). *Fayan* has become a basic and highly ritualized feature of male performativity and *guanxi*-making across China. In most settings, whenever men encounter each another and wish to engage in dialogue, it is expected that one or more will pull out a pack of cigarettes and offer a smoke to all men immediately present, with special attention given to participants' social status and the understood

quality/cultural coding of the cigarette pack being offered. Whereas much has been written about *guanxi* by China scholars in recent years (Kipnis 1997; Walder 1986; Yan 1996; Yang 1994) and to a lesser degree about *fayan*'s role in *guanxi*-making (Wank 2000; Yan 1996:57–61), little has been described to date about the ways that *fayan* works in academic medicine.

Today, in the context of surgical education, it is acceptable for master students to decline a *fayan* from a senior colleague by saying they do not smoke. But over time, the desire to accept and then to reciprocate such *fayan* usually grows for new trainees, especially if understood to be male. After all, their futures are heavily dependent on the relationships they build in the ward. Some students apply for and are advanced to Ph.D. programs. More often, as graduation approaches, a master student will need to find a staff position, preferably at a high-quality hospital. To succeed along either path, some of the most pivotal factors are the accrued sense of mutual respect, conviviality, and connection that these students can develop during their graduate training, with the mentor and the other senior members of the ward. Not surprisingly, this greatly amplifies the desire among male graduate students to join in and smoke.

That smoking among surgeons is so intertwined with questions of belonging, sociopolitics of comportment, professional ethics, and gender is further revealed, if not amplified, by the *fayan* directed at surgeons by people who do not work on the ward but pass through daily. The cigarettes offered by outsiders, as are those exchanged between departmental physicians, almost always are drawn from Yunnan's most touted brands, out of admiration for the region's tobacco industry and because most local smokers are unabashed in making it known that they prefer the taste of Yunnan leaf. The non-ward individuals, almost always male, that *fayan* to the surgeons are hospital administrators and representatives of drug and medical equipment companies. Surgeons are often loath to decline *fayan* from such individuals, thereby threatening a relationship, in large part because of how quickly as a discipline cardiothoracic surgery has been developing, with most departments only a decade or two old and most slated for subdivision within the next 10 years. In such a quickly changing professional environment, nurturing *guanxi* is seen as vital even by the oldest of surgeons.

Another outside source of cigarettes is the families of patients. To express appreciation, respect, or desire for exceptionally fine care, it is quite common across China for patients' relatives to proffer gifts to doctors. In public, these gifts usually come in the form of fresh fruit or packaged foods. But in the wards where I conduct research, male relatives will also regularly begin one or more of their daily communications with a physician by offering a cigarette from an expensive pack purchased especially for these interactions. All of the cardiothoracic surgeons who I have queried about this except for one, tell me

that on the average work day eight or more patients' relatives will approach them for a conversation and ritually *fayan*, which the surgeons usually feel obliged to recognize, placing the cigarette in the pocket of their white coat, lest they signal a disregard for the patient. The one exception to this pattern is Dr. Lin, the only young woman who over the last few years I have had the opportunity to observe as a graduate student and more recently as a full hospital employee. Unlike the rest of her graduate cohort and current colleagues, all of whom are male, Dr. Lin neither smokes nor is encouraged to. As is the case with female physicians that I have interviewed in other non-surgical wards, rarely if ever is a *fayan* directed at Dr. Lin.

A GENEALOGY OF CIGARETTE SMOKING AND MEDICAL CONDUCT

In addressing the question of how cigarette consumption came to develop as something so significant for Chinese men, physician and non-physician alike, it is helpful to consider first some issues of importance to recent governmentality literature. In that literature, a growing focus has been placed on spatial scale, specifically how conduct comes to be produced and regulated vís-á-vis global-local responses to overarching sociopolitical tensions (Perry and Maurer 2003). Whereas over his career Foucault frequently was attentive to the ways power is contingent on long-term interdependencies between institutions, administrative priorities, and discourses about life, he also was often eager to conceptualize power within capillary relationships minimally connected to supralocal regimes of national, transnational, and global governance. That approach was certainly productive for adding greatly needed nuance to what had previously been the social sciences' often statist and ahistorical visions of what within any community might constitute the political. More recently, governmentality scholars, much to their credit, have generally been more expansive than Foucault when it comes to the transnational: everything from nation-states, their innumerable offices, and international NGOs to multinational firms looking to invest venture capital, market products, or disseminate media (Larner and Walters 2004). These governmentality scholars recognize the need to analyze more fully interdependencies between (a) the practices of state, non-state, and multi-state entities and (b) the production and problematization of conduct. Something still waiting to be fully acknowledged in this research is that when we examine how "transnational governmentality" unfolds over time (Ferguson and Gupta 2002), it is vital to keep a close eye on particular processes of embodiment, such as how conduct's production and problematization can come to shape and be shaped by the making of masculinities (cf., Merry 2001).

When plumbing the history of what in China has bound together cigarette smoking and manhood, the questions of when to begin and what to emphasize complicate matters. Smoking of leafy plants by men in China is known to have occurred as early as 225 CE and tobacco smoking became widespread among men and to a lesser degree women after the 16th century (Brook 2004; Wang 1992). I would suggest that the most pivotal period for starting our analysis is the early 1900s (the era when China's cigarette industry first developed) and that discursive fragments pertaining to the body merit special attention from that and subsequent eras.

The cigarette's turn-of-the-century appearance in China was a direct outcome of various large-scale forces, including expanding colonial incursion, state-to-state wrangling, innovations in manufacturing, and new techniques for moving finance capital. Tapping these forces, various investors began to manufacture and sell rolled tobacco products in China, the largest of them being James Duke through his British American Tobacco Company and the Nanyang Brothers through their so-named family enterprise (Cochran 1980). Seeing opportunity for massive growth and anxious about competition, these corporate players quickly fashioned nimble techniques to move

(Hong and Qiu 2001: 253, 268, 309, 347; Yi et al. 1995: 70)

FIGURE 1 Early 20th century cigarette packaging and ads.

their products into broad circulation and most importantly between people's lips. Perhaps the most visible technique they deployed was one then still novel for China and much of the world: widely distributed, graphic-rich advertising (Yi, Liu, and Gan 1995).

The ubiquity of such advertising, most of it designed in Shanghai, cannot be underestimated. Cigarette ads reached far beyond China's eastern treaty ports quite early. In 1910, for instance, one observer of the ads in the southwestern city of Kunming, which had yet to become a hub of tobacco production, noted that there is "hardly a bare wall in the town that is not brightened by the flaming posters."[10]

A priority of China's early tobacco advertising was to portray cigarette smoking as a habit salubrious to men (Figure 1). Some advertising copy tapped conventional imagery of male comportment and was designed to tie the cigarette symbolically to filial visions of manhood. A larger proportion, however, tapped a radically different symbolic palette. Crafted to pique a heteronormative audience, and blending a heady mix of ethics and erotics pertaining to vitality, health, science, modernism, and the emergent public imaginary (i.e., the Chinese nation-state), this more radical copy encouraged Chinese men through the consumption of cigarettes to "light up" and literally become the breathing spirit of the grand telos: "New China."

Something else reflected in ads of the early 20th century pertains to highly distinctive variations in the expectation of how cigarettes were to be smoked (Figure 2). For women, the smoking of cigarettes was marketed as something generally done individually and privately to display personal association with foreign-coded forms of attractiveness, independence, and wealth (cf. Barlow 2005). Those messages were also visible in some highly male-oriented ad copy. More often, however, male smoking was framed

(Hong and Qiu 2001: 222, 256, 289; Rong 2004: 121)

FIGURE 2 Early 20th century cigarette packaging.

as something men did together in public to nurture bonds of loyalty and friendship, bonds that were needed to navigate extra-kinship domains within a broader geopolitical context of upheaval.

One such extra-kinship domain was the clinic. Because of scant data from this period on smoking by specific vocation, it remains unclear the degree to which medical practitioners were receptive to early advertising or how quickly they began to use cigarettes. Nonetheless, there is no reason to assume that in clinics across China doctors did not begin to encounter increasing numbers of male patrons who were eager to solidify physician-patient respect, trust, and intimacy by proffering a cigarette. Likewise, there is little reason to assume that medicine, like other professional domains, was not becoming filled with cigarette smokers. By 1928, cigarette production in China had already reached 87 billion sticks (Cochran 1980:234), and a survey carried out in the 1930s found that the vast majority of Shanghai's workforce was smoking cigarettes (Dikötter et al. 2004:202).

The following factors suggest that physicians during the first half of the 1900s acted in step with tobacco advertisers. First, until the mid-1900s, the majority of medical practitioners in China were male.[11] Second, before the 20th century, health care experts inside and outside China regularly extolled the benefits of tobacco.[12] Third, for centuries, China's medical canon exhorted healers not only to care for others, but also to manage their own body-selves in accordance with overarching tenets of wellbeing and male respectability (Unschuld 1979:30–34). Fourth, during the early 20th century, many interconnected changes began to unfold prompting new expectations for doctors, which often dovetailed smoothly with Chinese marketing scripts then being deployed to promote cigarettes.

Among the changes of greatest significance were colonial incursion, the Qing Dynasty's collapse, nationalism's efflorescence, and the PRC's creation in 1949. But no less important were a host of other changes: opium's medicalization and eradication; the symbolic framing of Chinese "society" as an enfeebled national organic want for modernist rescue by science; the gradual rise in biomedical knowledge and services; escalating competition between biomedicine's claim to scientific legitimacy and native medicine's to cultural fidelity; and efforts by nascent state agencies to root out quackery, regulate medical accreditation, and register sundry styles of medical practitioners (Brownell 1995; Dikötter 1992; Morris 2004). In light of all these changes, medical practitioners of all stripes were increasingly being expected to conduct themselves in ways illustrating not simply their ability to heal, to understand abstract knowledge, and to comport themselves compassionately and honorably, but also to do so in ways that articulated a commitment to protecting the nation and modernizing "the people" (Lo 2002; Xu 2001; Yip 1995).

So far, this brief genealogy has not described cigarette smoking among physicians as being undesirable. There is little evidence that it was ever strongly framed as such until quite recently. Not until several decades after the founding of the PRC did smoking among doctors begin to be treated as an object of significant critique or intervention. That is not to say that tobacco use among physicians remained unchanged from 1949 onward.

During the first decades after "liberation," according to my interviewees, a modest drop in overall smoking rates among medical practitioners occurred. This drop had nothing to do with anti-tobacco efforts. Instead, it stemmed from initial post-1949 disruptions in tobacco supply and managerial moves of the young party-state to make good on promises pertaining to gender. Many women were trained and certified as doctors after 1949, thanks in part to Maoist ideals that "women hold up half the sky" and the gradual nationalization, rationalization, and state-directed expansion of China's health care delivery services and medical schools (Evans 1988). This state-engineered personnel shift contributed to a reduction in overall smoking rates among medical practitioners because new female doctors rarely smoked.[13]

The prevalence of smoking among male physicians after 1949, however, either changed little or increased, as explained to me by many older physicians from various biomedical disciplines. They said the actions of regional authorities after nationalizing China's sprawling tobacco industry in the 1950s were especially key for the upward tick of smoking among male doctors and men in other vocations across China. Not only did authorities boost overall domestic supply of inexpensively priced cigarettes, initially incrementally and then quite dramatically, but also in the 1960s and 1970s many issued monthly "cigarette coupons" to families as part of the country's larger coupon rationing system (Li 1999:43–46).[14] Owing to such ease of access and given tobacco's well established and gendered entrenchment within China, men in medicine and other vocations had little reason not to continue using cigarettes as a means for managing *guanxi* and soothing nerves agitated by enveloping sociopolitical tensions. For male doctors after 1949, such tensions pertained to everything from fostering family and career amidst a social climate riven by political campaigns, women's entry into employment structures, to new opportunities/pitfalls created by professional medicine's expansion, bureaucratization, and specialization.

Something else catalyzing male doctors' use of the cigarette and women physicians' avoidance of it was how that commodity became coded even more forcefully after 1949 as vital to male performativity, sociability, and power, as it was marked increasingly as anathema to womanhood. Two factors, it would seem, contributed heavily to this dyadic hardening of cigarette signification across China. The first was antiprostitution discourses promoted by the new Communist regime. These discourses crystallized the

perspective—one informed by the pre-Revolutionary, ad-driven conflation of female smoking with westernized sexuality—that young women who smoked were shameless and transgressive (Yang Gonghuan and Carol Benedict, personal communication). The second factor was the regularity with which people confronted a new image: groups of China's largely androcentric leadership, members of the Chinese Communist Party, with lit cigarettes in hands managing the nation's future. Whether communicated via mass media or everyday interactions, this image helped signify that male consumption of cigarettes had developed into a state-sanctioned means for embodying a strain of masculinity reputedly strong and salubrious for the well being of others.[15]

PROBLEMATIZATION

While public health interventions problematizing cigarette use among medical practitioners did not become visible across China until the new millennium, key antecedents had surfaced a decade earlier. The formal onset of PRC involvement with transnational tobacco control occurred in the spring of 1988, when branches of the central government began to "celebrate" the WHO's No Tobacco Day (NTD). Each year thereafter, the most visible feature of this annual event has been its mass media coverage. From late May to early June, the majority of China's national and regional media outlets have disseminated antismoking items, a rarity other times of the year.

To most observers, after nearly two decades of these perennial spring campaigns, the 2005 NTD would probably seem fairly uneventful. That year's NTD, as it turns out, was the most decisive turning point to date for the problematization of tobacco and masculinity among Chinese physicians.

"Health Professionals Against Tobacco, Action and Answers" was the theme of the WHO's 18th NTD. Following convention, in late May and early June 2005, China's media was studded with antitobacco items, nearly all of which referenced statistical surveys mounted in anticipation of the event. A particularly curious example of the media items circulating during the 2005 campaign is the editorial from which the epigraph for this article is drawn. That editorial was published on May 31, 2005, the day of the 18th NTD. In terms of the contempt toward Chinese physicians that it articulates, the essay is on the outer extreme of what appeared during the spring of 2005. Indeed, few other mainstream media items that I have seen go so far as the one found in the *City Daily*, which claims that physicians who smoke hope furtively that citizens across the country will do likewise, thereby making disease rates rise and doctors' profit margins increase.

However outlandish, this editorial is also quite formulaic, for it shares much with a large portion of the mass media surrounding the 2005 NTD, both in terms of what it occludes and includes. Skirting any mention of cigarette manufacturers, the editorial deploys a heady cocktail of representational tropes. That cocktail consists of more than just the misguided assumptions described at the outset of this article. The editorial cites statistical research to frame its indictment of physicians as scientifically credible. It references perhaps the most iconographic of "developed" nations, the United States, to portray the current situation in China as woefully "backward." And overlooking any other contributing factor, broader context, and/or history, it unconditionally blames doctors for their cigarette use, characterizes cigarette consumption among clinicians as a matter of, at once, failed individual thinking and breach of responsibility, and emphasizes that smoking among physicians is corrosive for broader tobacco control. Finally, it taps a highly gendered popular specter gaining visibility across post-Mao China: the notion of capitalist manhood run amok, what Zhang has termed "entrepreneurial masculinity" (2001).

Equally interesting is that nearly this same representational cocktail underwrites the same surveys so often referenced by media items like the *City Daily* editorial. Consider the most frequently referenced survey in spring 2005, one mentioned above. This study was carried out in 2004 by China's Centers for Disease Control and Prevention (CDC), with funding from the U.S. National Institutes of Health and following protocols established by the U.S. CDC. It surveyed 600 physicians in six cities of China. The key findings of the survey articulated in its 2005 journal publication are: "The rate of smoking among Chinese doctors is extremely high, with the most important factor being gender" (Jiang et al. 2005:403).

These findings and the statistics upon which they are built are not the only messages that this publication communicates, however. The researchers proffer a set of normative narratives about cigarette smoking among male physicians. First, they express that such smoking constitutes not simply a problem for tobacco control in China, but more precisely "the *most pivotal* issue" for its advancement (407).[16] They explain this in a somewhat awkward discussion of modernist "development" teleology and synchronic smoking statistics derived from the United States.

> Developed countries with successful experience controlling tobacco have found the following to be key: first the rates of smoking among doctors are brought down and then the rates of everyone else declines. For instance, in the U.S., the general smoking rate today is at 25 percent, and the rate among doctors is 9 percent (403).

Although they are attentive to variables such as gender and education level in their analysis, the surveyors are also quick to use these variables to build a narrative of misconduct and culpability, not of sociocultural production. Rather than noting that tobacco use among male doctors is complicated by a multiplicity of forces—including entrenched homosocial strategies for career formation, tobacco company marketing, and the absence of strictly enforced legislation banning smoking in medical facilities—they instead bemoan that "the rates of smoking among China's male physicians are the highest of any country in the world" and frame this national embarrassment as being one that stems from individual failure, with a primary emphasis given to medical practitioners abrogating their professional "responsibility and duty" (403, 407).

Similar narratives are visible in yet another increasingly cited survey report, published in anticipation of NTD 2005. This study examined male doctors' "knowledge, attitudes, and behavior" about smoking, health, and quitting (Wang et al. 2004). Coincidentally conducted in Yunnan by a group of Kunming health science researchers, it collected detailed data from nearly 1,000 hospital physicians in six of the province's largest cities. The study's key findings are that among male physicians, even though knowledge about the dangers of smoking is quite high today, personal conviction about the merits of quitting is modest and actual behavioral change (quitting) is rare. The study's authors concluded with a withering critique of their research subjects' "irresponsibility" (203). In particular, they chided Chinese male medical personnel for disregarding an ostensibly established logic within the health sciences regarding cognition and individual behavior: (a) a person's acquisition of knowledge about a behavior's dangers (b) spawns his or her attitudinal hostility for that behavior which, then, (c) triggers the person to terminate it (203).[17] What's more, the authors castigate male physicians for conceptually parrying recently disseminated transnational tobacco-control discourse by privileging instead an individual right to smoke over a public right to health (even though the authors demonstrated no evidence that they researched this distinction).

FAILED QUITS AND BEYOND

In recent years, how have these and earlier moves of tobacco problematization squared with the daily lives of some of the most ardent of smokers in China's medical establishment, Chinese cardiothoracic surgeons? By what means have some of these surgeons responded to the narratives? And what broader effects might these narratives have today on tobacco control in Kunming, the city where my study has been based?

Congnitivist claims such as those just mentioned by Wang and co-authors (2004)—that doctors are purposely disregarding tobacco-control discourse and actively parrying it through an intellectual deployment of a rights-based framework—do not simply repackage some of the assumptions that I discussed at this article's outset. They are also at odds with the world of the doctors I know who smoke in China. In my hundreds of hours meeting with doctors in Kunming, I rarely have had anyone deploy "individual rights" as a rationale for why they smoke.[18] I have heard Chinese tobacco marketers in recent years invoke such a rationale for why people should be allowed to continue buying tobacco products, but rarely if ever have any of my medical informants done so.

Instead, I have heard and observed other responses, often described as much in terms of bodily experience as any logics or rationalities. As I have written about elsewhere, because of post-Mao China's growing engagement with transnational tobacco control and other biopolitical imperatives regarding modernity, several years before the WHO's 2005 NTD, Yunnan urbanites including cardiothoracic surgeons had already begun to encounter formal tobacco-control initiatives (Kohrman 2004). For example, in the mid-1990s "No Smoking" signage went up throughout areas open to patients of most Kunming hospitals. My clinical informants then restricted their on-the-job smoking to duty offices and other administrative spaces. Many also became increasingly interested in breaking their long-established smoking habit, and more than a few went so far as to quit on numerous occasions, denying their physiology the nicotine it had come to expect. In other words, in recent years these professionals, many of whom have advanced their careers through smoking, have also come to view smoking as problematic institutionally and individually, and thus worthy at times of their own self-oriented, extra-vocational bodily struggle. Yet for several reasons—not the least of which are the manifold roles that tobacco plays in the course of their workday, how nicotine dosing has become so deeply habituated into their collective corporeality, the intensification of smoking within the duty office, and the paucity of quitting tools available in China today—the vast majority of these physicians have been unable, they bemoan, to transform this institutional/individual problematization of tobacco into successful, durable quits. No less significant, because of their experiences with turnstile quitting, many clinicians on Kunming's cardiothoracic surgery wards by 2004 had come to feel a mix of contempt and fatalism about their conduct as smokers and their self-worth as men. Indeed, their repeated floundering to embody more fully tobacco-control discourse had the unintended consequence of encouraging transformations in what Foucault would likely refer to as "the relationship of self to the self,"[19] transformations understood by my informants through bodily idioms of

addiction, weakness, and male inadequacy. Dr. Ma, a surgeon in Kunming for over 20 years, had this to say in the winter of 2004:

> I have tried to quit numerous times. I know that cigarettes are dangerous and that they could be ruinous for my family if I fall seriously ill. But what am I to do? Smoking is such a big part of being a doctor here. The director of our hospital smokes. The party-secretary smokes. The chair of my department smokes. And whenever I walk into the duty office, most of my colleagues are smoking.
>
> And to tell you the truth, with such a pressure-filled job, smoking is extremely helpful, at times soothing, at times energizing, at times helping me focus my attention when preparing for a complex surgery or facing a stack of paperwork 10:30 at night. Once addicted, nicotine is a pretty useful thing.
>
> That's why my quit attempts have often begun during Spring Festival holiday or when I've been on business trips away from the hospital or out of the country for a conference. These quits have all been painful, and I've tried to cope with that discomfort as best as I can, drawing on all my willpower (*yili*). That's all one can do, depend on one's willpower. Those Chinese herbs sold to help you quit are worthless. I've heard of other techniques and medicines, but nothing like that is available here. So, I quit, and then ... aiya! ... I get back here [to the hospital] and everyone is politely proffering cigarettes (*fayan*)—colleagues, supervisors, patients' relatives. How can anyone sustain a quit under such circumstances?
>
> That's partially why, at the moment, I don't plan to quit again soon. It's too difficult. I try and then I fail. I'm just not strong enough. Others might be, but not me. Men are supposed to be strong, right? But trying to quit just makes me feel weak. And that's embarrassing and dispiriting. It leaves me disgusted with myself.

More recently, in the wake of the 2005 NTD, how have my chest-surgeon informants been responding? When I talked to them during early June 2005, most were nonplussed by the new hostility being directed at their profession. In particular, a number of them had seen the *City Daily* editorial and were deeply confused if not disturbed by the indictments communicated there. Dr. Lin, a 36-year-old surgeon, echoed many of the voices I heard on wards that summer:

> I don't understand this claim that doctors hope people will keep smoking and get sick. Why would I want that? I myself am interested in quitting once and for all. Does that *City Daily* journalist think I enjoy sitting down with people day after day and telling them they or family members have contracted a horrible disease like lung cancer? I don't. And we certainly don't need any more patients here. We've got more than we can possibly deal with. As you know, at this hospital and most of the other top hospitals in Kunming,

we frequently have to turn away patients, especially people with lung cancer, because we just don't have enough beds in cardiothoracic to treat them.

And this idea that physicians are not communicating to patients the dangers of smoking. Here, my colleagues and I regularly tell our patients that smoking has been the major cause of their disease. And we usually don't have to tell them to quit, because by the time they've gotten here to our department, they've already been told to quit by doctors earlier and they've complied.

Anyway, why all this anger about doctors smoking? Do doctors produce cigarettes? Do we sell them? Are we telling people to smoke? No. Out on the street, tobacco ads are everywhere, but in here, look around, No Smoking signs are all over this hospital. And do we smoke in front of our patients in their rooms? I've read that some doctors in China do that. But I've never seen any doctor here in this hospital do it. We hide away in our duty offices when we need to smoke. That's the rule and that's what we do.

Listening to Dr. Lin, it is hard to discern that the 2005 NTD and its attendant discourse are contributing in any normatively positive way to a redirection of the relationship of self to self, which began to unfold among male clinicians during the 1990s. Rather than emboldening a renewed sense of confidence among these men that maintaining a quit is actually plausible, what seems more salient is that the 2005 NTD (as mediated through Dr. Lin and colleagues' past failings at fully embodying tobacco-control discourse) has been triggering a different response: vocational defensiveness.

Equally disturbing is that on more than one occasion when voicing such defensiveness, my clinical informants have highlighted that the 2005 NTD may be promoting another unintended consequence: an erosion of public health. One of these informants who I first met in the fall of 2003, Dr. Liang, had this to say two years later:

All this publicity and condemnation about doctors smoking . . . instead of attacking cigarette producers, it's we doctors who are being blamed. Is this good for public health? Is this good for changing the behavior of the average person (*laobaixing*)? It's hard to get average people to quit, right? They often never try to quit, or they try to do it using nothing but their own willpower and then quickly fail.

In China, how does an average smoker come to quit and to do so successfully, not just for a few days, but for years and years? As you probably know . . . perhaps the most common way people today come to quit successfully . . . is that something feels strange or painful in their bodies, they go see a doctor for an exam, and together with a diagnosis they are told to stop smoking. It's amazing how powerful a physician's advice usually is under such circumstances. With healthcare so expensive in China now, people are terrified of getting sick. So, if they're even a little sick and a doctor tells them to quit, they often do.[20]

> But, you know, with all this news now saying doctors are smokers, that we're irresponsible, that we're embarrassments to medicine, and even that we secretly want people to keep smoking and get sick . . . think about it . . . how how much longer do you imagine patients are going to continue to heed our advice when we push them to quit?
>
> Hey, I don't want someone to quit a thousand times. When I encourage someone to quit, I want them to quit once and be done. But, if people no longer have respect for doctors, well, then our advice just becomes meaningless, completely meaningless. Or worse, people become even more suspicious of us, thinking our advice is just trickery.

Dr. Liang's concern—that the new and more trenchant narratives about doctors smoking that have been circulating in China since NTD 2005 might be, at least in the short run, quite harmful to a broader smoking-cessation agenda—does not seem altogether misplaced. On more than a few occasions over the past year I have heard non-clinicians who have become ill and are being told by their physicians to quit, invoke doctors' cigarette use in quite disparaging terms. For instance, a 58-year-old man whom I had lived near in Kunming noted to me:

> I've been suffering serious headaches recently. Last week, I went to the hospital for tests and treatment, and the doctor prescribed some medications for what he said was high blood pressure, and he told me to quit smoking right away. I've been taking the medicines. But, why should I listen to a doctor about my smoking? I read recently that most of them smoke. If they smoke, why should I quit? Doctors, today! I just don't have any faith in them anymore. These hospitals all over Kunming. Look at them. They all seem so greedy. It's all about making money. If you have money or good health insurance, doctors will treat you. But if you don't, and most people don't these days, forget it. I could rail on forever about how screwed up doctors are now.

Not only do these comments suggest that the recent problematization of doctors' cigarette consumption—a bodily practice performed by most men in China today—is undermining clinical credibility as a lever for smoking cessation. They also divulge something almost as troubling. They betray that that problematization, whether disseminated through newspapers or academic journals, is often conflated by community members with a broader set of embodied woes, curiously also heavily coded in terms of masculinity. People, like my 58-year-old Kunming neighbor, are coming to interpret physicians smoking as inextricably linked with their and others' expanding trepidation that everyday citizens' prospects for long-term physical well being is being devastated by China's post-Maoist "masculine market" (Rofel 1999:108), that recent medical reform (*yigai*) has resulted

in health care provision being overrun by the brutish, no-holds-barred, inflationary culture of capitalism (Blumenthal and Hsiao 2005).[21]

Tobacco manufacturers, we must assume, have to be relieved by this conflation. They must be relieved that citizens like my hypertensive neighbor, when encouraged by a doctor to at once quit smoking and confront the specter of tobacco-induced cardiovascular diseases, are instead feeling prompted to act otherwise, to intertwine their visceral discontent about the marketization of medical services with the fact that many physicians smoke. After all, the number of people who smoke cigarettes in China at present is massive; and, if these individuals continue to smoke, upwards to half will contract and die from tobacco-related diseases (Peto and Chen 1999). Rather than this situation being sociopolitically framed and embodied today such that people can easily develop firmer sentiments against both cigarettes and their producers, it is often the case that people's attention is getting redirected elsewhere, carried off at times by multilayered distress about post-Mao medical conduct.

CONCLUSION

Before ending this "history of the present," it is important to ask, in light of these patterns of problematization and blame making, wherein scorn is so easily cast at those most engaged in treating Chinese citizens sickened by tobacco, how can any meaningful movement develop among them and others against tobacco's current reign? As long as contempt gets channeled at healers, how can they and those they treat ever create meaningful alliances in opposition to the over 120 cigarette companies inside China or the scores of big tobacco firms based outside who are pedaling products?

One answer, I believe, is the production of more and better scholarship, in particular, research rigorously documenting the ethnohistorical processes by which this type of blame has come to exist and be naturalized. Once more information is available about the ways apparatus of condemnation such as the one outlined here develop; people across China and elsewhere will be far better situated to address the ultimate sources of the tobacco products that flood into their communities.

Throughout this article I have asserted that it is necessary to examine more robustly the means by which processes of governmentality work to create and problematize the conduct of physicians. More specifically, I have pressed that we interrogate closely how, through time and space, those processes become enabled not simply by logics or rationalities but by elements of embodiment.

Beyond scholarship, China's increasingly dynamic and quickly growing NGO environment may provide a glimmer of hope in what otherwise is a dark landscape; it is a possible site for foment of a more expansive public-professional biosociality in opposition to tobacco. The odds are certainly stacked against any rapid rise of a powerhouse non-governmental organization on the order of say, the American Cancer Society, especially given the degree to which the Chinese Communist Party has long been hostile to large-scale professional or public organizing. Still, the number of health-oriented NGOs in China has jumped quickly in recent years, and local anticancer associations and anticancer clubs have been popping up quietly for much of the past two decades. Today, scores of these small anti-cancer NGOs are scattered nationwide. Some provinces have several. They differ in leadership, some are run by survivors while others are directed by hospital-based physicians.

Action on behalf of "people threatened by tobacco-related diseases" has until now been negligible features for those or other NGOs active in China. That state of affairs may well change, however, assuming a number of factors: that the party-state continues to sanction small health-oriented NGOs, the country's tobacco-induced pandemic unfolds at or near its projected pace, those understanding themselves as having a vested interest in the pandemic (survivors, families of the ill, advocates, clinicians, drug companies, researchers, grantsmakers) seek out in ever greater intensity a diversity of institutions to help them manage their relationships to the pandemic. If those assumptions are indeed sound, then China's NGOs arena may be poised for modification. It may be primed to become a more productive node for antitobacco efforts in the years ahead, perhaps even to transform into a potent crucible for the development of new assemblages aligned directly against tobacco companies and their patrons.

And if that occurs, it will be intriguing to tease out how subtle internal changes among NGOs, notably shifts in everyday conduct of their members, come to shape and be shaped by embodiment.

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NOTES

1. See "China to Start WTO-Related Tariff Concessions for 2002" (Newsedge 2001); see also Zhong and Yano (2007).

2. Seventy percent of China's tobacco is now grown in its midwest and southwest provinces, where it has been responsible for 40 to 80 percent of overall government revenue in the past decade (Wang 2006:141–142).
3. Even with the smuggling of cigarettes into China, Chinese companies enjoy domestic market shares of as much as 94 percent (Lee and Collin 2006:1081).
4. Merriam-Webster Online. http://www.m-w.com/dictionary/irony (accessed December 10, 2007).
5. Recent data on smoking among health professionals are not available for all countries. Among the at least 78 countries for which data are available, 30 of those countries report that at least one in four of their health professionals are regular cigarette smokers. In Buenos Aires, Argentina, 37 percent of female and 33 percent of male third-year medical students acknowledge being cigarette smokers. Rates of smoking among physicians are especially high in Central Asia and Eastern Europe; for example, more than half of all doctors in Armenia and Bulgaria smoke (Mackay et al. 2006: 26–27, 98–105).
6. For a recent review of data on the health risks posed by cigarette smoking, see Samet (2001).
7. By somatosocial I mean the experiential realm that manifests and melds—through processes of embodiment—corporeality, personhood, and forces of sociopolitics.
8. Worldwide, nearly 1 billion men and 250 million women are daily smokers; 35 percent of men and 22 percent of women in developed countries, and 50 percent of men and 9 percent of women in developing countries smoke; and of the 150 countries for which gender-specific data are available, in at least 34 of them, 10 times as many men smoke as women (Mackay, Eriksen, and Omar 2006:22–25; 98–105; see also Mackay and Amos 2003). In China, of those 15 years old and above, 58 percent of males smoke daily whereas less than 3 percent of women do (Chinese Association of Smoking and Health 2004:7).
9. That most nurses in China are female no doubt explains the low rates of smoking within that profession, as low as 2.6 percent overall in one study (Smith, Wei, and Wang 2005).
10. O'Brien-Butler (1919); also cited in Cochran (1980).
11. In China, patriarchal hegemony long dictated that the arts of healing—because they afforded practitioners title and honor—were inequitably open to and helped to demarcate men (Hymes 1987). Spearheaded by missionaries, programmatic training of female physicians began at the dawn of the 20th century, initially in biomedicine (Lu 1999). The process, once begun, moved at a painfully slow pace. For further discussion, see Yip (1995:150–151, 230).
12. Although some began issuing warnings about the risks of tobacco as early as the Tang period (618–907), pre-1949 Chinese medical scholars more often touted tobacco on the grounds that it possessed a variety of harmonizing and disease-deterring qualities (Dikötter et al. 2004:26–28; Ma 1985:1; Wang 1992:44; see also Hughes 2003:36–94).
13. Although female doctors that I have met and interviewed in Kunming's larger biomedical facilities report rarely if ever smoking or being encouraged to smoke by anyone else, some have noted that intermittently over the years they have purchased packs and cartons of cigarettes and strategically gifted them in unopened form to colleagues and supervisors. In this way, these women have tried to participate in *guanxi*-building through cigarette exchange without actually needing to smoke themselves.
14. Data on year-to-year cigarette supply during the 1950s and 1960s is thin, but known is that from 1950 to 1979, total domestic production jumped eightfold from around 80 billion cigarettes to over 651 billion, and then more than doubled again by 1993, rising to 1.668 trillion (Yuan 1995:169). Although literally translating as "tobacco coupons" (*xiangyan piao*), these vouchers were only for the formal acquisition of cigarettes. The highly regionalized issuance of *xiangyan piao*, starting in some areas as early as the late 1950s, did not mean people were precluded from buying cigarettes or loose unrolled tobacco on the open

market. Instead, as informants have explained to me, the coupons were issued, often in greatest number before the most important national holidays, to guarantee that people of all income levels could have access to cigarettes. In addition, before holidays, special coupons were often issued that allowed citizens to acquire "higher" quality cigarettes that were often not available for sale.

15. There is some evidence that the efficacy of this discursive binary and other forces serving to inoculate female physicians from using cigarettes began to decline during the 1980s and 1990s when post-Maoist economic liberalization fueled a significant rise in cigarette consumption nationwide. For example, Li et al. (1999) documented that, in one sample taken in the central Chinese city of Wuhan, smoking rates among female physicians between 1987 and 1996 jumped from 4.8 to 12.2 percent. Their study also chronicled a growth in smoking rates among male physicians, with a rise from 51 to 61 percent.
16. Emphasis here is mine.
17. For critical reviews of the theoretical framework ("KAP") on which the Wang et al. (2004) study is based, see Smith (1976), Ullah (2004), and Williams and Jones (2004).
18. Based on her research in rural China, Farquhar makes an important and related argument about the pitfalls of assuming that "individuation" among medical professionals during the post-Mao epoch will follow any stereotypical Euro-American pattern (1996:251).
19. "It seems to me that the analysis of governmentality," Foucault notes, "must refer to an ethics of the subject defined by the relationship of the self to self" (2005:252).
20. This seems to be somewhat supported by China's 1996 National Prevalence Survey of Smoking which found that "illness" was the most frequent explanation (47 percent) given for quit attempts (Yang et al. 1997:47).
21. Reflecting this agonistic outlook as well as the hostilities that doctors now often face, the Ministry of Health reported in late 2005 that over 70 percent of all hospitals nationwide had been regularly experiencing patients and their families "violently beating, intimidating, and cursing" clinical staff (Beijing Morning Post 2005).

REFERENCES

ACS
2006 Tobacco Control Front and Center at International Conferences: 1 Billion Tobacco Deaths Possible if Current Trends Continue. Available at http://www.cancer.org/docroot/NWS/content/NWS_2_1x_Tobacco_Control_Front_and_Center_at_International_Conferences.asp

Barlow, T.
2005 Buying In: Shanghai and the Sexy Modern Girl Image in the 1920s and 1930s. Presented at CASA Colloquium. Stanford University.

Beijing Morning Post
2005 Weishengbu Fabu Yiyuan Diaocha Jieguo: Qicheng Yiwurenyuan Cengshouguo Weixie [Ministry of Health releases hospital study results: 70 percent of medical personnel are threatened]. 30 September, p. 1.

Benowitz, N.
2001 The Nature of Nicotine Addiction. *In* Smoking: Risk, Perception and Policy. P. Slovic, ed. Pp. 159–187. Thousand Oaks, Calif.: Sage Publications.

Blumenthal, D. and W. Hsiao
2005 Privatization and its Discontents: The Evolving Chinese Health Care System. The New England Journal of Medicine 353(11):1165–1170.

Bourdieu, P.
2001 Masculine Domination. Stanford, Calif.: Stanford University Press.
Brook, T.
2004 Smoking in Imperial China. *In* Smoke: A Global History of Smoking. S. Gilman and X. Zhou, eds. Pp. 84–91. London: Reaktion Books.
Brownell, S.
1995 Training the Body for China: Sports in the Moral Order of the People's Republic. Chicago, IL: University of Chicago Press.
Chaloupka, F., T.-W. Hu, K. Warner, R. Jacobs, and A. Yurekli
2000 The Taxation of Tobacco Products. *In* Tobacco Control in Developing Countries. P. Jha and F. Chaloupka, eds. Pp. 237–272. Oxford: Oxford University Press.
Chinese Association on Smoking and Health
2004 2002 Nian Zhongguo Renqun Xiyan Xingwei De Liuxingbingxue Diaocha [2002 epidemiological survey of China's smoking behavior]. Newsletter of Chinese Smoking and Health 62(5):7–13.
City Daily
2005 "Wuyanri Maibuguo Liyi de Kan" [The hole stopping No Tobacco Day from succeeding]. 31 May.
Cochran, S.
1980 Big Business in China: Sino-Foreign Rivalry in the Cigarette Industry 1890–1930. Cambridge, Mass.: Harvard University Press.
Csordas, T.
1988 Embodiment as a Paradigm for Anthropology. Ethos 18(1):5–47.
Dean, M.
1999 Governmentality: Power and Rule in Modern Society. London: Sage Publications.
Dikötter, F.
1992 The Discourse of Race in Modern China. London, UK: Hurst.
Dikötter, F., L. Laamann, and X. Zhou
2004 Narcotic Culture: A History of Drugs in China. London: C. Hurst.
Evans-Pritchard, E. E.
1937 Witchcraft, Oracles and Magic Among the Azande. Oxford, UK: Clarendon.
Evans, J.
1988 Medical Education in China. *In* Science and Medicine in Twentieth-Century China: Research and Education. J. Z. Bowers, J. W. Hess, and N. Sivin, eds. Pp. 239–259. Ann Arbor: Center for Chinese Studies the University of Michigan.
Evenden, D. A.
1998 Gender Differences in the Licensing and Practice of Female and Male Surgeons in Early Modern England. Medical History 42(2):194–216.
Farmer, P.
1992 AIDS and Accusation: Haiti and the Geography of Blame. Berkeley: University of California Press.
Farquhar, J.
1996 Market Magic: Getting Rich and Getting Personal in Medicine after Mao. American Ethnologist 23(2):239–257.
Feng, S.
2005 Rationality and Self-Control: The Implications for Smoking Cessation. Journal of Socio-Economics 34(2):211–222.

Ferguson, J. and A. Gupta
2002 Spatializing States: Toward an Ethnography of Neoliberal Governmentality. American Ethnologist 29(4):981–1002.
Flynn, R.
2002 Clinical Governance and Governmentality. Health, Risk and Society 4:155–173.
Foucault, M.
1991 Governmentality. *In* The Foucault Effect: Studies in Governmentality. G. Burchell, C. Gordon, and P. Miller, eds. Pp. 87–104. Chicago: University of Chicago Press.
2005 The Hermeneutics of the Subject: Lectures at the Collège de France, 1981–82. G. Burchell, trans. New York: Palgrave-Macmillan.
Good, M.-J. D.
1995 American Medicine, the Quest for Competence. Berkeley: University of California Press.
Green, D. P. and I. Shapiro
1994 Pathologies of Rational Choice Theory: A Critique of Applications in Political Science. New Haven: Yale University Press.
Greenhalgh, S.
2001 Under the Medical Gaze: Facts and Fictions of Chronic Pain. Berkeley: University of California Press.
Hackett, M. C.
1999 Implementing Clinical Governance in Trusts. International Journal of Health Care Quality Assurance 12:210–213.
Hæger, K.
2000 The Illustrated History of Surgery. Chicago: Fitzroy Dearborn Publishers.
Hastie, R. and R. M. Dawes
2001 Rational Choice in an Uncertain World: The Psychology of Judgment and Decision Making. Thousand Oaks, Calif.: Sage.
Hollis, M. and S. Lukes
1982 Introduction. *In* Rationality and Relativism. M. Hollis and S. Lukes, eds. Pp. 1–20. Oxford: Blackwell.
Hong, L. and L. Qiu
2001 Zhongguo Laoyan Biaotu Lu [A record of Chinese old cigarette package designs]. Beijing: Zhongguo Shangye Press.
Hughes, J.
2003 Learning to Smoke: Tobacco Use in the West. Chicago: University of Chicago Press.
Hurt, R.
1996 The History of Cardiothoracic Surgery from Early Times. New York: Parthenon.
Hymes, R.
1987 Not Quite Gentlemen? Doctors in Sung and Yuan. Chinese Science 8:9–76.
Jiang, Y., X. Wei, J. Tiao, G. Song, J. Wang, H. Xu, X. Wu, J. Xia, H. Xu, H. Wang, and Y. N. Yang
2005 Zhongguo Li Chengshi Yiwurenyuan Xiyan Zhuangkuang [The condition of smoking among medical personnel in six Chinese cities]. Zhongguo Jiankang Jiaoyu (China Health Education) 21(6):403–407.
Kipnis, A.
1997 Producing Guanxi: Sentiment, Self, and Subculture in a North China Village. Durham, N.C.: Duke University Press.
Kohrman, M.
2004 Should I Quit? Tobacco, Fraught Identity, and the Risks of Governmentality in Urban China. Urban Anthropology 33(2–4):211–245.

2007 Depoliticizing Tobacco's Exceptionality: Male Sociality, Death, and Memory-Making among Chinese Cigarette Smokers. The China Journal 58:85–109.

Larner, W. and W. Walters
2004 Global Governmentality: Governing International Spaces. New York: Routledge.

Lee, K. and J. Collin
2006 "Key to the Future": British American Tobacco and Cigarette Smuggling in China. PLoS Medicine 3(7):1080–1089.

Li, H. Z., D. Fish, and X. Zhou
1999 Increase in Cigarette Smoking and Decline of Anti-Smoking Counseling among Chinese Physicians: 1987–1996. Health Promotion International 14(2):123–131.

Li, X.
1999 Lao Piaozheng (old coupons). Shenzhen: Haitian Press.

Liu, B.-Q., R. Peto, Z.-M. Chen, J. Boreham, Y.-P. Wu, J.-Y. Li, T. C. Campbell, and J.-S. Chen
1998 Emerging Tobacco Hazards in China: 1. Retrospective Proportional Mortality Study of One Million Deaths. British Medical Journal 317(7170):1411–1422.

Liu, T. and B. Xiong
2004 Yancao Jingji Yu Yancao Kongzhi [Tobacco Economy and Tobacco Control]. Beijing: Economic Science Press.

Liu, X., Y. Liu, and N. Chen
2000 The Chinese Experience of Hospital Price Regulation. Health Policy Plan 15(2): 157–163.

Llewellyn, S.
2001 Two-Way Windows: Clinicians as Medical Managers. Organization Studies 22: 593–623.

Lo, M.-C. M.
2002 Doctors within Borders: Profession, Ethnicity, and Modernity in Colonial Taiwan. Berkeley: University of California Press.

Lock, M.
1998 Perfecting Society: Reproductive Technologies, Genetic Testing, and the Planned Family in Japan. *In* Pragmatic Women and Body Politics. M. Lock and P. Kaufert, eds. Pp. 206–239. New York: Cambridge Studies in Medical Anthropology.

Louie, K.
2002 Theorising Chinese Masculinity: Society and Gender in China. Cambridge, Oakleigh, Vic.: Cambridge University Press.

Lu, P.
1999 Modern Woman Medical Education in China after the Introduction of Western Medicine. Chinese Journal of Medical History 29(1):42–45.

Ma, W.
1985 Yan Jiu Cha Yu Jiankang [Tobacco, Alcohol, Tea and Health]. Beijing: Renmin Weisheng Press.

Mackay, J., M. Eriksen, and S. Omar
2006 The Tobacco Atlas. Atlanta: American Cancer Society.

Martin, E.
1987 The Woman in the Body: A Cultural Analysis of Reproduction. Boston, MA: Beacon Press.

Merry, S.
2001 Spatial Govemmentality and the New Urban Social Order: Controlling Gender Violence through Law. American Anthropologist 103(1):16–29.

Morantz-Sanchez, R.
1995 Making it in a Man's World: The Late-19th-century Surgical Career of Mary Amanda Dixon Jones. *In* Bulletin of the History of Medicine 69(4):542.
Morris, A.
2004 Marrow of the Nation: A History of Sport and Physical Culture in Republican China. Berkeley: University of California Press.
National Center for AIDS/STD Prevention and Control
2005 2005 Update on the HIV/AIDS Epidemic and Response in China: Ministry of Health, People's Republic of China, Joint United Nations Programme on HIV/AIDS World Health Organization. Beijing.
Newsedge
2001 "China to Start WTO-Related Tariff Concessions for 2002." 26 December, http://legacy.library.ucsf.edu/tid/ose17a00
O'Brien-Butler
1919 Records of the British Foreign Office. London: Public Records Office.
Oldenziel, R.
1999 Making Technology Masculine: Men, Women And Modern Machines In America, 1870–1945. Amsterdam: Amsterdam University Press.
Perry, R. W. and B. Maurer
2003 Introduction. *In* Globalization Under Construction: Governmentality, Law, and Identity. R. W. Perry and B. Maurer, eds. Pp. xxi, 367. Minneapolis: University of Minnesota Press.
Peto, R. and Z. Chen
1999 Tobacco: The Growing Epidemic. Nature Medicine 5:15–17.
Reid, R.
2005 Globalizing Tobacco Control: Anti-smoking Campaigns in California, France, and Japan. Bloomington, IN: Indiana University Press.
Rofel, L.
1999 Other Modernities: Gendered Yearnings in China after Socialism. Berkeley: University of California Press.
Rong, G.
2004 Yanbiao: Shoucang yu Jianshang [Tobacco Labels: Collect and Appreciate]. Shanghai: Shanghai Kexue Jishu Press.
Rose, N.
1999 Powers of Freedom: Reframing Political Thought. New York: Cambridge University Press.
Sahlins, M.
1976 Culture and Practical Reason. Chicago, IL: University of Chicago Press.
Samet, J.
2001 The Risks of Active and Passive Smoking. *In* Smoking: Risk, Perception and Policy. P. Slovic, ed. Pp. 3–28. Thousand Oaks, Calif.: Sage Publications.
Scheper-Hughes, N.
1994 Embodied Knowledge: Thinking with the Body in Critical Medical Anthropology. *In* Assessing Cultural Anthropology. R. Borofsky, ed. Pp. 229–239. New York: McGraw-Hill.
Shilling, C. C.
2001 Embodiment, Experience and Theory: In Defense of the Sociological Tradition. The Sociological Review 49(3):327–344.

Slovic, P.
2001 Cigarette Smokers: Rational Actors or Rational Fools? *In* Smoking: Risk, Perception and Policy. P. Slovic, ed. Pp. 97–124. Thousand Oaks, Calif.: Sage Publications.
Smith, D., N. Wei, and R.-S. Wang
2005 Contemporary Smoking Habits Among Nurses in Mainland China. Contemporary Nurse 20(2):258–266.
Smith, S. E. S.
1976 The KAP in Kenya: a Critical Look at KAP Survey Methodology. *In* Culture, Natality and Family Planning. J. Marshall and S. Polgar, eds. Pp. 263–288. Chapel Hill: University of North Carolina Press.
Tambiah, S.
1990 Magic, Science, Religion, and the Scope of Rationality. Cambridge, UK: Cambridge University Press.
TobaccoChina Online
2007 China's Tobacco Industry Registers Balanced Growth of Cigarette Production, Sales.
Traweek, S.
1988 Beamtimes and Lifetimes: The World of High Energy Physicists. Cambridge: Harvard University Press.
Ullah, A.
2004 A Sociocultural Analysis of Sexual Risk and Disease in a Developing Country: The Failure of KAP-Based Theories Applied to Controlling HIV/AIDS in the Bangladeshi Sex Industry. Dissertation, Australia: University of New South Wales.
Unschuld, P.
1979 Medical Ethics in Imperial China: A Study in Historical Anthropology. Berkeley: University of California Press.
Walder, A.
1986 Communist Neo-Traditionalism: Work and Authority in Chinese Industry. Berkeley, CA: University of California Press.
Walshe, K., T. Freeman, L. Latham, L. Wallance, and P. Spurgeon
2000 Clinical Governance: From Policy to Practice. Birmingham, England: Health Services Management Centre, University of Birmingham.
Wang, H.
2006 Tobacco Control in China: The Dilemma Between Economic Development and Health Improvement. Salud Publica de Mexico 48(Supplement 1):140–147.
Wang, X., J. Wu, T. Bao, and J. Zhang
2004 Investigation on KAP of Smoking and Control among Medical Personnel and Analysis of its Influencing Factors. Chinese Journal of Behavioral Medical Science 13(2):201–203.
Wang, Y.
1992 Zhiguang Yuyan: Yunnan Yuxi Zhuanyan Chang Fazhan Shi [Bright Yu Tobacco: History of the Yunnan Yuxi Tobacco Factory's Development]. Kunming: Yunnan People's Press.
Wank, D.
2000 Cigarettes and Domination in Chinese Business Networks: Institutional Change During the Market Transition. *In* The Consumer Revolution in Urban China. D. Davis, ed. Pp. 268–286. Berkeley: University of California Press.

Williams, H. A. and C. O. H. Jones
2004 A Critical Review of Behavioral Issues Related to Malaria Control in Sub-Saharan Africa: What Contributions Have Social Scientists Made? Social Science and Medicine 59(3):501–523.

Xu, X.
2001 Chinese Professionals and the Republican State: The Rise of Professional Associations in Shanghai, 1912–1937. Cambridge, U.K.: Cambridge University Press.

Xu, X.
2005 Wuyanri Maibuguo Liyidekan [The Hole from Which 'No Tobacco Day' cannot Advance]. Doushi Shibao [*City Daily*], 31 May.

Yan, Y.
1996 The Flow of Gifts: Reciprocity and Social Networks in a Chinese Village. Stanford: Stanford University Press.

Yang, G., L. Fan, J. Tan, G. Qi, Y. Zhang, J. Samet, C. Taylor, K. Becker, and J. Xu
1997 Smoking and Health in China: 1996 National Prevalence Survey of Smoking Patterns. Beijing: China Science and Technology Press.

Yang, M. M.-H.
1994 Gifts, Favors, and Banquets: The Art of Social Relationships in China. Ithaca, N.Y.: Cornell University Press.

Yi, B., Y. Liu, and Z. Gan
1995 Lao Shanghai Guang Gao [Old Advertisements of Shanghai]. Shanghai: Shanghai Huabao Chubanshe.

Yip, K.-C.
1995 Health and National Reconstruction in Nationalist China: The Development of Modern Health Services, 1928–1937. Ann Arbor, Mich.: Association for Asian Studies.

Yuan, T.
1995 Zhongguo Xiyan Shihua [Historical Narrative of Smoking in China]. Beijing: International Commercial Press.

Zhang, E.
2001 *Goudui* and the State: Constructing Entrepreneurial Masculinity in Two Cosmopolitan Areas of Post-Socialist China. *In* Gendered Modernities: Ethnographic Perspectives. D. Hodgson, ed. Pp. 235–265. New York: Palgrave.

Zhong, F. and E. Yano
2007 British American Tobacco's tactics during China's accession to the World Trade Organization. Tobacco Control 16(2):133–7.