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Epidemic Performance: the Qing's Manchurian Plague policy, 1910-1911

Abstract: The Third Plague Pandemic was one of the deadliest global health crises in history. Manchuria was a major epicenter with nearly 60,000 deaths. Why did the Qing government who had a long tradition of utilizing Traditional Chinese Medicine (TCM) in epidemic control, nevertheless adopt plague policy claimed as "Western measures" (*xifa*) and exclude TCM, despite recognizing strong local opposition and the government's inability to implement such policy? Furthermore, why did Qing government elites adopt *xifa* when Western medicine's efficacy had not been established and was being challenged by indigenous medicine in the other parts of the world? Challenging the prevalent explanation that the Qing's plague policy was coerced by the colonial powers (primarily Russia and Japan), I argue that the Qing initiated and persisted on Western measures because Qing elites invested in the ideological superiority of Western medicine's progressiveness (*xianjin*) and intended to utilize Western epidemic measures as a *medical agent* to build a modern state image and legitimize their sovereignty in the face of threats from neighboring empires, suggesting the Qing's internalized Orientalism. The Qing's anti-plague effort was *decoupled* from epidemic control to geopolitical interests in the contested Manchurian borderland, as transnational measures (e.g., borderland traffic control and corpse management) were prioritized, while local measures (e.g., local quarantine and medical supplies) were poorly implemented. I argue that the Qing's Manchurian plague policy stands as an instance of "*epidemic performance*", which effectively won broad recognition from competing imperial powers, including Japan and Britain, as evidenced by the presence of officials from these empires at the International Plague Conference convened by the Qing in Mukden. Therefore, the Qing's performance of Western measures was not incentivized by the material efficacy of Western medicine as World Society Theory would predict. Drawing from colonial critiques of Western medicine hegemony, Manchurian plague shows that the dominance of Western medicine was reproduced ideologically by Chinese elites.

The Manchurian Plague occurred between 1910 and 1911 in Northeast China (historically, Manchuria), which was a significant plague outbreak within the context of the Third Plague Pandemic (c.1866-c.1950), one of the deadliest global health crises in human history in terms of

mortality rate. The Third Plague Pandemic (c. 1850–1950) begun in East Asia and later spread to South Asia, Australia, and even the Americas. Approximately 60,000 people died from the plague during Manchurian Plague, whose mortality rate was more than nine times higher than the mortality rate from COVID-19 in the U.S. (JHCRC 2023; L. Wu 1922). At a time when no effective solutions for plague had yet been found (Stanley, Petrie, and Strong 1912), the Qing government, which had a long-standing tradition of utilizing traditional Chinese medicine (TCM) in epidemic control, abandoned TCM and exclusively promoted draconian disease control measures advocated by colonial powers during the Manchurian Plague (Zhou 1911).

Even the key architects of the Manchurian plague policy acknowledged that the measures constituted an "extremely cruel policy unprecedented in four thousand years" (FPEPGB [1911] 2010:8206). These measures include strict quarantines, rigid travel restrictions, crude sanitary measures, and city lockdowns. The coercive power of the police and military was deeply involved in the sanitization measures. They forcibly burned the bodies and belongings of plague victims and disinfected residential buildings with highly corrosive phenol (S. Chen 1911; Y. Chen 1911). These measures depart from contemporary biomedical epidemic control, but they were advocated by and dominant among Western medical practitioners during the Third Plague Pandemic across different regions. Hong Kong was the first city where these Western-style anti-plague measures were imposed during the Third Plague Pandemic (Echenberg 2007). Later, when the plague spread to India, the British government exclusively followed the similar Western measures before 1898, influenced by the Hong Kong anti-plague work (Lowson 1897). In this sense, I define Qing's Manchurian plague policy as "Western measures", in line with what it was called by Qing officials in the historical archives (Xifa) and Du's (2024) work, in order to indicate its differences from modern biomedicine.

It is important to note that the efficacy of Western medicine had not yet been established in plague treatment and prevention, thereby being challenged by indigenous approaches in other parts of the world. No medicine or vaccine had been proven effective yet. In fact, the first test of an antibiotic for plague treatment did not occur until 1938 (Carman 1938; Zietz and Dunkelberg 2004). Little difference was found between the efficacy of Western medicine and TCM, as supported by a comparison of the fatality rates at Western medical hospitals and TCM hospitals in Hong Kong at the turn of the twentieth century (Lowson 1897). Additionally, Western measures were not cost-effective. Quarantine, disinfection, and lockdowns required significant financial and personnel investments. These limitations of Western measures provided an opportunity for traditional and indigenous medicines around the world to changllenge the Western medicine hegemony and engage with state public health policy. For instance, the British Indian government abandoned its initial exclusive implementation of Western medicine measures and instead incorporated indigenous medicine in 1898, since the intense popular resistance against these cruel Western measures and the fatality rates remained high under them[1] (Arnold 1993; Harrison 1994).

Using the Indian anti-plague response as a shadow case, it is counterintuitive to see that the Qing proactively initiated and persisted in these ineffective Western measures during the Manchurian plague. Traditionally, the Qing provided financial support and distributed TCM for epidemic control in the affected areas (D. Wu 1893; Xu 1821). Fifteen years before the Manchurian Plague, in Canton, when the plague first broke out in a major Chinese city, the Qing followed the traditional approach to anti-plague work, relying on TCM (Echenberg 2007). However, during the Manchurian Plague, the Qing's plague policy shifted to Western measures and excluded the TCM. TCM hospitals were closed by the Qing government (Xiliang 1911). Paradoxically, the Qing was

[1] In Bombay City, India, the fatality rate reached a devastating 91.3% in 1898 (Bombay Sanitary Commissioner's Office, Bombay Sanitary Department, and Bombay Sanitary Board 1899:63).

aware of the limitations of Western measures and its incapacity to implement them. Then, why did the Qing still adopt the Western measures during Manchurian Plague?

Existing studies (Nathan 1967; Rogaski 2019; Summers 2012) viewed the Qing's Manchurian Plague policy as a reactive response to colonial powers' coercion, which was coerced to adopt Western measures due to the geopolitical pressure from Russia and Japan. While Russian and Japanese influences on the Qing's Manchurian plague policy were non-negligible, I argue that the Qing proactively initiated Western measures, which was rooted in Qing reformers' internalized Orientalism, in service of sovereignty construction in Manchuria. The Qing's Manchurian plague policy stands as an instance of "epidemic performance". This epidemic policy was performative because the Qing failed to impose Western measures in practice as they claimed while successfully producing an image of doing so to the transnational audience, as evidenced by the presence of officials from these empires at the International Plague Conference convened by the Qing in Fengtian (namely, Mukden). The Qing's anti-plague effort was decoupled from epidemic control in Manchuria, focusing instead on the sovereignty. Transnational measures (e.g., borderland traffic control and corpse management) were prioritized to demonstrate the Qing's state capacity to a transnational audience (mainly Russia and Japan), while local measures (e.g., local quarantine and medical supplies) were poorly implemented.

Literature Review

The "Development" Ideology of Western Medicine

Before the Manchurian Plague (1910-1911), many Chinese politicians and intellectuals believed in the "progressiveness" of Western medicine, advocating for its development in China. (Benedict 1996:170; Pi 2016) Xi Liang, the Viceroy of the Three Eastern Provinces (i.e., Manchuria), was

one of them. However, when the plague broke out in Manchuria, Western medicine offered few effective tools for its treatment or prevention. Despite acknowledging Western medicine's limited efficacy (e.g., Xi 1911), Qing central officials insisted on the exclusive adoption of Western measures in Manchuria. This suggests that the Qing's Western-style anti-plague measures were not driven by the epidemic utility of Western medicine, but by an ideological embrace of the "progressiveness" myth and a belief in its inherent superiority over Traditional Chinese Medicine (TCM).

World Society Theory (WST) argues that the global expansion of Western institutions around the world is driven by a world culture that celebrates the general utility of Western science and technology. Nation-states are key actors in this institutional isomorphism. Because nation-states are embedded in the external world society, many of their policies resonate more with the myths of world culture than internal local environments, a phenomenon referred to as "decoupling". (Meyer 2004; Meyer et al. 1997; Meyer and Rowan 1977) My study draws on WST in two ways: first, it emphasizes the ideological power that prompted the Qing government's isomorphic efforts to adopt Western epidemic measures; second, I employ the concept of "decoupling" to explain why the Qing's anti-plague work prioritized transnational measures over local measures, which suggests the nature of its plague measures as an epidemic performance.

Nevertheless, my study departs from WST by reflecting on the coloniality of Western medicine. While WST assumes the utility of Western science and technology is an important factor underpinning world culture, the Qing's Manchurian plague policy stands as an important counter-example, showing that Western hegemony was established in and internalized by the Qing even before the invention of truly effective medical technology. Further, WST fails to recognize the coloniality of Western science and technology, as it emphasizes their universality but ignores their

particularity situated in the Western-dominant colonial context. WST, by applying terms like "word society" and "world culture", masks the particularity of the current Western-dominant structure as universal, neutral, and predetermined, while diversity outside of the West is downplayed as "failures of world societies"(Meyer et al. 1997:175). As Foucault (1977) argued in his famous notion of the "genealogy of knowledge", Western knowledge was produced through specific historical production processes. Additionally, many political anthropological works have reflected on the spread of Western technologies and institutions, arguing that these projects conducted in the name of "development" are not politically neutral but can lead to disasters. (e.g., Ferguson 1994; Scott [1999] 2020)

Though some historical studies have noticed the inefficacy of Western medicine during plague outbreaks (e.g., Benedict 1996; Echenberg 2007), they more or less treat the Qing's Western measures as a progressive case of modernization in the shadow of geopolitics tensions (Gamsa 2006; Nathan 1967; Summers 2012). These studies assume the legitimacy of the Qing's adoption of Western measures as a predetermined development project, embrace the myth of Western medicine and, just like WST, offer no reflection on the reproduction of the Western hegemony in Manchurian anti-plague work. They failed to explain why the Qing central officials viewed Western measures as "progressive"(jinbu, Xi 1911), given that Western medicine had achieved no more practical progress than TCM in terms of efficacy. I argue that the perceived superiority of Western medicine reflects the internalized Orientalism among the Qing elites, which should be situated within the broader context of imperial geopolitics and the Qing's efforts to construct sovereignty in Manchuria.

How Western Medicine Hegemony Is Produced: Politically, Economically, and Culturally

Western medicine is a "medicine of domination"(Cunningham and Andrews 1997: 5). Numerous studies have discussed the dominat position of Western medicine and how its hegemony is produced and reproduced around the world. One of the prominent topics is how it interplays with politics. Scholars have shown how Western medicine has served as a site for colonial rule, nation-state building, and social movements. (Arnold 1993, 2000; Lo 2002; Vijayakumar 2021) In line with this body of literature, historical studies of the Manchurian Plague emphasize that the Qing's adoption of Western measures were due to the geopolitical concerns, forced by the two dominant colonial powers in Manchuria–namely, Russia and Japan. (Gamsa 2006; Nathan 1967; Summers 2012) It has also been argued that the Qing intended to leverage the epidemic crisis to expand its nation-state building in Manchuria. (Benedict 1996; Du 2024) Economic factors also play an important role in the expansion of Western medicine. Adams (2016) shows how the neoliberal economy incentivizes world health institutions to use metrics that create a new kind of "global sovereign". Since colonial powers were greatly motivated by economic interests, Iijima (2019) argues that anti-plague work was politicized because the Qing contested for economic rights (liquan) against Russia and Japan in Manchuria.

While the influence of geopolitics on the Qing's plague policy is undeniable, how it affected the Qing's plague policy needs to be examined further. First, current studies frame the colonial actors' influence as a coercive force that compelled the Qing to adopt Western anti-plague measures. The Qing is depicted as incompetent traditionalist actor whose policies were merely a reaction to the colonial powers' coercion. I argue that the Qing proactively initiated the Western measures which should be situated within the context of the New Policies (xinzheng) beginning in 1901 as part of constructing a modern Late Qing state in the medical field (Karl and Zarrow 2002).

The pressure from Russia and Japan was the Qing's primary concern of its anti-plague work, but it cannot fully explain why the Qing chose the Western measures and excluded TCM, especially considering that the state faced a severe shortage of Western medical personnel and TCM could have served as a valuable alternative backup for plague control. By comparison, the British Indian government included indigenous medicines in its anti-plague work during the Third Plague Pandemic. (Arnold 1993) Second, current studies follow the binary narrative of the Qing versus colonial powers. They overlook the historical fact that the Qing's relationships with Japan and Russia were different. While viewing Russia as a prominent threat to Qing sovereignty, the Qing considered Japan as a source of leverage for anti-plague work. Applying the transnational lens, I intend to unpack the conflation of the Qing's geopolitical relations with Russia and Japan in existing studies of the Manchurian Plague.

Third, current studies of the Manchurian Plague often ignore the cultural explanations for Western measures. I argue that the Qing's plague policy was motivated by both the geopolitical concern and the internalized Orientalism, through which the Qing intended to present itself as a modern state by embracing Western medicine as a discourse of modernity, in order to demonstrate its sovereignty legitimacy in Manchuria to colonial powers. Foucault ([1976] 2004) pioneered the idea that knowledge can be understood as a discourse of dominant power. Said (1979) applied Foucault's notion of knowledge to the West's imagination of "the Orient", arguing that Orientalism was a discourse of constructing "the Orient" ultimately to reify the Western superiority over "the Orient". Studies of colonial tropical medicine (Anderson 2006) resonates with the Orientalist discourse was imposed upon the colonized in the medical field, where the colonized were viewed as unsanitary objects of discipline. White (2023) proposes the concept of "epidemic Orientalism" to highlight the discursive power of global public health in the history of Western-

dominated infectious disease regulations, which conceives the East as the vector of diseases and the West as requiring protection from the rest of the world. Nevertheless, a subaltern perspective is lacking here. How did the others perceive the hegemony of Western medicine, and what were the roles of indigenous actors in reproducing this hegemony?

Building on these works, I argue that the Qing internalized the notion of Western superiority. By performing the Western measures, the Qing intended to shed the West' Orientalist imaginings and build a modern state image to construct its sovereignty in Manchuria through the internalization and reproduction of the Western medicine hegemony.

Who Produces the Hegemony: Transnational Perspective and Subaltern Standpoint

My study contributes to the sociology of public health by demonstrating how the Western medicine hegemony was reproduced in Manchuria from the subaltern standpoint and how colonial actors influenced the Qing's epidemic policy-making and implementation through the transnational perspective.

In the early twentieth century, Manchuria was a contested borderland where multiple nations sought to exert their influences. Among them, the Qing, Russia, and Japan were the three most prominent actors. By "contested", I mean not only that the territorial borders between these three nations were vague and in constant flux, but also that their geopolitical relations require a more nuanced understanding to transcend the dichotomous narrative of oppression versus resistance. Norman Smith (2007) highlights the dual nature of Manchurian women writers' literary careers in Manchukuo, which presented both cooperation with and colonial resistance to the Japanese government. Mitter (2000) shows that local Chinese elites fluidly adapted their political attitudes toward the Japanese over time based on their own interests. Before the Manchukuo era, local

Chinese elites built collaborative relationships with Japan to obtain economic and military support. This collaboration between the Qing and Japan can also be found in the local anti-plague efforts in Manchuria.

Then, who held the sovereignty of Manchuria? Duara (2004) argues that the sovereignty of Manchukuo was an artificial nation constructed by the Japanese, serving, de facto, the broader goal of Japanese imperial rule in Pan-Asia. Building on these transnational historical analyses of Manchuria, I argue that the Qing actively constructed its sovereignty in Manchuria during the early twentieth century, and that its plague policy should be situated within the Qing's sovereignty construction efforts amidst competition from Russia and Japan. Manchuria was a transnational frontier of imperial competition (Xie 2023), not a colony of Russia or Japan, during the Manchurian Plague. In this sense, neither colonial power possessed the unilateral ability to force the Qing to implement specific epidemic measures.

Therefore, I emphasize the transnational perspective when analyzing the Qing's plague policy, as the influence of transnational actors cannot be overlooked, and the narrative should not be limited to any single national actor (Go and Lawson 2017). Further, it is important to note that the key Russian actor (i.e., the Chinese Eastern Railway, CER) and the key Japanese actor (i.e., the South Manchuria Railway, SMR) in Manchurian plague control were transnational actors possessing their own interests and autonomy, which did not completely align with those of their national governments. Hence, when I use "Russia" and "Japan" for the sake of brevity, I refer to these transnational actors rather than their national governments.

Third, my emphasis on the influence of transnational actors on the Qing's plague policy draws on Bhabha's (2012) concepts of colonial ambivalence, mimicry, and hybridity. Bhabha criticizes the dichotomous analyses of the East versus the West in the colonial narratives, arguing that the

colonized can be attracted to colonial discourse and mimic the colonizers. The presence of such mimicry blurs the boundaries between colonizer and colonized. The Qing's adoption of Western plague policy can be interpreted as an attempt of mimicry. Due to the ambivalence, mimicry, and hybridity inherent in colonial encounters, although my historical narrative of the Manchurian plague is based on the subaltern standpoint of the Qing, by highlighting the transnational perspective, my study goes beyond constructing subaltern knowledge (Go 2016). Instead, it engaged with the global developments of Western medicine through the lens of the Manchuria case. This also resonates with Stuart Hall's ([1996] 2004) idea about the non-antithetical relationship between globalization and localization, suggesting that local knowledge can carry a global dimension.

Colonial studies have long advocated for the decolonization of knowledge to examine the cultural impacts of colonial power and incorporate the local value of subaltern knowledge, rather than omitting or ignoring it. (e.g., Go 2016; Grosfoguel 2006) For instance, the revival of "Hindu Science" since the nineteen century is interpreted as a reaction to the growing influence of Western science in India, through which Hindu nationalists sought to make their own version of modern science. (Arnold 2000) Instead of simply stressing the locality of subaltern knowledge, an increasing number of studies have emerged that explore the intersection between the locality and globality. Lo (2002) characterizes the features of Japan's construction of "scientific colonialism" as "colonial ambiguities", noting that the professional identity of Japanese-manufactured Taiwanese elites which claimed to be universal was yet deeply embedded in their local ethnic identities. This phenomenon is not merely a historical one but persists in contemporary public health practices. Vijayakumar (2021) identifies the interdependency between local actors (state officials and NGO leaders) and global actors (global health institutions) in Indian HIV drop-in

centers, and Long (2024) highlights the influence of transnational actors on the Chinese CDC's HIV/AIDS control. These works suggest that the value of subaltern knowledge is not limited to local level but holds global implications. In the case of the Manchurian Plague, I seek to advocate for the global value of subaltern knowledge and bridge the subaltern standpoint in colonial studies with the transnational perspective by highlighting the transnational influences on the Qing's anti-plague work.

Data

To investigate the Qing's Manchurian plague policy (1910-1911), I collected relevant archival materials in the summers of 2024 and 2025 from four archives: (1) the Liaoning Provincial Archives (Shenyang); (2) the Heilongjiang Provincial Archives (Harbin); (3) the Archives of Modern Chinese History, Institute of Modern History, Chinese Academy of Social Sciences (Beijing); and (4) the First Historical Archives of China (Beijing). In the first two archives, I collected local government documents related to the plague. By "local government," I refer not only to the provincial, prefectural, and county administrations of the Qing, but also to local actors closely connected to the Qing government yet not formally part of it, such as chambers of commerce. In the last two archives, I examined imperial memorials concerning the Manchurian plague and the New Policies.

Because of strict catalog censorship at the Liaoning Provincial Archives and the Heilongjiang Provincial Archives, I was granted access only to "open archives" (*kaifang dangan*), while many other materials were classified as state secrets and therefore unavailable for academic research. The archivists claimed that most restricted archives dated from the Manchukuo period and that most materials from the late Qing period were open to the public. At the same time, however, I

was told that any materials involving foreign actors (*shewai dangan*) were considered politically sensitive. Even in the absence of censorship, archival collections are rarely exhaustive. While it is difficult to assess the precise extent to which these materials were affected by state censorship, I must acknowledge that such influence exists. Notably, I found no primary documents authored by Russian or Japanese actors, despite the frequent appearance of Russia and Japan in the Qing local government archives. With that said, the Qing local government archives also gives me opportunities to investigate the Qing's perception of Russia and Japan and make my transnational perspective analysis possible.

To supplement my archival materials collected in the field, I draw on a wide range of published archival collections and biographies. Sources include: (1) official government reports on the Manchurian plague, such as the *Reports on the Plague in the Three Eastern Provinces* (*Dongsansheng yishi baogaoshu*) by the Fengtian Provincial Epidemic Prevention General Bureau; (2) public reports and proceedings of the International Plague Conference; (3) Chinese and English newspaper reports from archival collections and online databases, including *the Collected Materials on Wu Lien-teh and Epidemic Prevention in the Three Eastern Provinces* (*Wu Liande ji dongsansheng fangyi ziliao jilu*) drawn from the Harbin Municipal Library's collection and the CNBKSY database; (4) relevant published archival collections, such as the Xi Liang Archives held at the Institute of Modern History; and (5) an extensive collection of local gazetteers and biographies of key characters, such as Wu Lien-teh, Alfred Sze Sao-ke, and Dugald Christien.

Empirical Findings

Initiating the Western Measures

Existing studies (Nathan 1967; Rogaski 2019; Summers 2012) often characterize the Qing's Manchurian Plague policy as a reactive response to colonial powers' coercion and downplay the Qing's agency. Such reactive geopolitical explanation argues that the Qing was coerced to adopt Western measures due to the geopolitical pressure from Russia and Japan. While Russian and Japanese influences on the Qing's Manchurian plague policy were non-negligible, I argue that the Qing's adoption of Western measures was not merely a passive reaction to the geopolitical pressure. The Qing proactively initiated Western measures, which was rooted in Qing reformers' internalized Orientalism and the construction of sovereignty.

The reactive geopolitical explanation assumes that colonial powers in Manchuria were able to dominant the Qing's epidemic policy during the plague outbreak. This explanation overlooked the fact that Qing government did not lose its policy autonomy in the anti-plague work in Manchuria. In November 1910, plague cases were reported in Harbin, a rail hub for CER in Northern Manchuria. Concerned that the plague would spread to Russia along the railway, Dmitry Horvat, the head of the CER, reached out to Yu Sixing, General Manager of the Harbin Railway Negotiations Bureau in the Qing government. Horvat's request for the railway shutdown was rejected by Yu who believed that the shutdown would harm the Qing's railway rights, which led Horvat to reach out to the Qing Ministry of Foreign Affairs (QMFA) to demand his request again. The QMFA urged Xiliang to implement railway control measures in coordination with Russia. (MFA 1910) Nevertheless, Xiliang disregarded the QMFA's request (Du 2024:127). It was not until the imperial edict (Yikuang et al. 1911) for plague control on January 13, 1911 that Xiliang started to push for the suspension of railway services (Xiliang 1911c), because at this point he

realized that the plague outbreak might spread southward to the Inner China and threaten the Qing rule. On January 14, the Qing suspended second- and third-class carriage operations on its Jingfeng Railway. At the Qing's repeated urging, the Japanese SMR and the Russian CER suspended their third- and fourth-class carriages on January 20. (FPEPGB [1911] 2010:8368) From the local official Yu Sixing to the central official Xiliang, Qing officials made and implemented their railway control policies based on their own understanding of the epidemic situation and following their own interests independent of Russia, which indicates the Qing's plague policy autonomy from colonial powers in Manchuria.

Throughout the Manchurian plague, it was also the Qing government's initiative to employ Western-trained physicians for plague control. Western-trained physicians were appointed to pivotal medical positions in the anti-plague work. For instance, the Scottish missionary Dugald Christie was hired to serve as Honorary Medical Adviser to the Government (Christie 1914:283), and the Malaysian Cambridge University graduate Wu Lien-teh was hired to serve as Chief Medical Officer (L. Wu 1959). In addition to these appointments from Beijing, provincial governors in Manchuria had actively sought to hire Western-trained physicians for local epidemic control. As soon as the Fengtian government decided to introduce quarantine inspections on the railways, it hired the British medical missionary A.F. Jackson to lead the effort (FPEPGB [1911] 2010:8418). The Qing mobilization effort of Western medical personnel was proactive and comprehensive at both the central and provincial levels, although the governments never resolved the medical personnel shortage problem. The Qing's preference for Western medicine is also reflected in its medical reward lists, as both Chinese and foreign Western-trained practitioners were rewarded after the plague outbreak (K. Chen 1911b; Z. Chen 1911b), yet no TCM practitioners were included. This consistent effort of employing and rewarding Western-trained

physicians was not merely driven by the geopolitical influence, but rather suggests the Qing's proactive advocacy of Western medicine.

Such advocacy of Western medicine was not limited to Manchuria. Outside of Manchuria, Western measures were widely adopted. In Beijing, the Qing Ministry of Civil Affairs established a temporary Epidemic Prevention Bureau at the Inner City Official Hospital, the first Western-style hospital, for plague treatment and quarantine (TEPBMCA 1911). Likewise, many provinces in Inner China, such as Shandong, Zhili, and Hubei, also established Western-style epidemic prevention institutions and adopted Western measures including quarantine and disinfection (Sun 1911; Ruicheng 1911; Chengxun 1911). After the first wave of the Manchurian plague, the Qing planned to build permanent Western medical institutions based on these anti-plague efforts both inside and outside of Manchuria (D. Wang 1911; K. Chen 1911a).

Therefore, the Qing's adoption of Western measures during the Manchurian plague was not a reactive response to colonial powers, but rather a proactive nationwide effort throughout and beyond the outbreak. I argue that the Manchurian plague policy should be situated in the broader historical context of the late Qing "New Policies" (xinzheng), which aimed to learn from colonial powers, transition to a constitutional monarchy, and, thereby, preserve Qing rule in China. The reform also intended to integrate Western medicine into the national health system. Prior to the outbreak, the Qing had already initiated Westernizing reforms of the public health system (Benedict 1996:154). Key officials leading the anti-plague work during the Manchurian Plague were also significant reformers of New Policies, including Xiliang, Zhao Erxun, Alfred Sao-ke Sze (Xiliang 1910b), who viewed Western medicine as a progressive modern technology while dismissing TCM as backward (Andrews 2014). Besides, Qing central officials deployed thousands

of soldiers from the New Army (xinjun), the primary military army of the New Policies, in order to enforce Western measures in Manchuria(e.g., Z. Chen 1911a).

In other words, the Manchurian plague policy was one of the Late Qing New Policies, ultimately seeking to protect the Qing rule in the Inner China and construct its sovereignty in Manchuria. This ultimate goal, coupled with the Qing's insufficient capacity to fully implement Western measures, meant that the Qing's Manchurian plague policy was an epidemic performance, which was incentivized by Qing reformers' internalized Orientalism.

Disproportionate Anti-plague Efforts

Though Qing elites actively initiated Western measures in Manchuria, they were aware that the Qing lacked the capacity to fully implement Western measures. In the official report on the Manchurian plague, the four top Qing officials in Manchuria, Chen Zhaochang, Xiliang, Zhao Erxun, and Zhou Shumo[2], concluded six major difficulties in anti-plague work: "difficulty in securing qualified medical personnel, difficulty in procuring medical supplies, difficulty in allocating financial resources, difficulty in establishing hospitals and quarantine facilities, difficulty in enforcing regional cordons and inspection, and difficulty in implementing cremation, disinfection and quarantine" (Z. Chen et al. [1911] 2010). Nearly all the measures faced difficulty in implementation. For medical supplies, all local governments sought support from Fengtian, which was the seat of the Qing administration in Manchuria (FPEPGB [1911] 2010:8204), yet Fengtian faced severe shortages and was barely able to cover its own needs (Xiliang 1911e). For financial resources, the central government faced significant fiscal losses caused by the railway

[2] Xiliang (1853-1917) was the second viceroy of Manchuria, and Zhao Erxun (1844-1927) was the third viceroy of Manchuria. They successively held the highest office in Manchuria and thus occupied important positions in the Qing central government. Alfred Sao-ke Sze (1877-1958) was one of the most important diplomatists in the Modern China. During the Manchurian Plague, he was Right Vice Minister of the Ministry of Foreign Affairs.

suspension in Manchuria and was unable to provide financial support to Manchuria (Sheng 1911), while the financial burdens of anti-plague work were overwhelming for local governments (e.g., Y. Zhao 1911).

Then, how did the Qing practice these Western measures in the face of these substantial difficulties? How did the Qing government distribute its extremely limited resources for the anti-plague work in Manchuria? I argue that, instead of practicing Western measures, the Qing ended up performing the Western measures in a way that transnational measures were prioritized over local measures, which marked the Manchurian plague policy as an instance of epidemic performance. By "transnational measures" I mean measures involving transnational actions and obtaining transnational attention, which mostly were implemented in treaty port cities and borderlands; "local measures" are those only involving local people in Manchuria without transnational attention, such as quarantine, as most plague victims were Han people immigrated from Shandong province in the Inner China.

Table 1 shows that the distribution of financial resources was highly disproportionate to the epidemic severity measured by mortality rates. As Fengtian Province was the seat of the Qing administration in Manchuria, the Fengtian Provincial Epidemic Prevention General Bureau was established (FPEPGB; fengtian quansheng fangyi zongju) not only to take charge of the anti-plague work in Fengtian Province but also to support the epidemic control outside Fengtian Province (FPEPGB [1911] 2010:8322). Fengtian City was the capital of Fengtian Province, where the anti-plague work was administered by the newly established Fengtian Provincial Capital Epidemic Prevention Office (FPCEPO; fengtian shengcheng fangyi shiwusuo). Meanwhile, Fengtian City was also the epicenter of the Manchurian plague, where mortality was the highest in Fengtian Province. Because of the political significance and the epidemic significance of

Fengtian City, it received the most funds from the FPEPGB. Xinmin Prefecture was a similar case, where the plague mortality rate was high, and the city was geopolitically important for the Qing because it was a treaty port city and a traffic hub involving many foreign affairs. Similar patterns can be found in other cities where mortality rates were relatively low, yet the anti-plague measures involved transnational actors, as they were either treaty ports or had railway stations. For instance, the mortality rate of Tieling County (0.562‰) was similar to that of Yizhou (0.565‰), but the fund allocated to Tieling was nearly 171times Yizhou. Many areas, where the epidemic was rather severe, indicated by the mortality rates, yet received minimal financial support, such as Zhen'an County, Guangning County, and Yizhou. The fund distribution of the FPEPGB demonstrates that the Qing prioritized the anti-plague work in the geopolitically important areas that involved transnational affairs over other areas, regardless of epidemic severity.

Yingkou was an extreme case where no plague case was found, yet the FPEPGB delivered 171400 liang to it, which were 3-4 times the funds allocated to Changchun Circuit and Harbin Circuit, the epicenters during the Manchurian plague, as shown in Table 2. Yingkou was the first and one of the most important treaty port cities in Northeastern China since 1864, with annual cargo throughput reaching 2.46 million tons (Peng 1987). Japan, Britain, Russia, the United States, France, Sweden, the Netherlands, and Norway established consulates and administrative offices in Yingkou (Peng 1987). Though no plague case was reported in Yingkou, Yingkou was among the first cities where the Qing initiated anti-plague work. Eight quarantine stations, four isolation facilities, and one hospital were established in Yingkou with 40 medical officials, while there was only one isolation facility and one hospital in Yizhou with merely 2 medical officials (FPEPGB [1911] 2010:8331).

The Qing's plague control efforts across different areas were disproportionate to the local epidemic severity. It was not because its efforts effectively prevented the plague outbreaks, as the mortality rates among different areas were not inversely proportional to the funds they received. This disproportion suggests that the Qing's anti-plague work was decoupled from the local epidemic control to its geopolitical interests in the Manchurian borderland. The Qing's emphasis on transnational measures had few local epidemic control benefits. The anti-plague work in Hulan provides such an example.

Transnational Measures: the Hulan Case

Hulan Prefecture was just across the north of the Songhua River from the city of Harbin. Harbin was partly administered by the Qing government, i.e., Fujiadian, and partly controlled by Russia, represented through the CER company, i.e., Daoli. And the south branch of the Songhua River extended the areas under Japanese influence. Because of these geographic factors, Hulan emerged as a potential focus of Japanese and Russian attention, and, hence, as the frontier of plague geopolitics in the Qing-controlled borderland.

The decoupling of the Qing's anti-plague efforts in Hulan was presented in multiple ways. First, the timeline of the Qing's anti-plague work in Hulan was driven by transnational attention, rather than the plague progression. The plague outbreak in Human began in mid-December 1910, and the daily mortalities exceeded 100 on January 15, 1911 (Wang 1911a), but it was until January 23 that the plague outbreak in Hulan drove the Qing central government's attention, because it was at this time when Russia and Japan alerted the Qing government that hundreds of uncollected corpses accumulated along the river (Xiliang 1911j). However, the prefect of Hulan,

TABLE 1 Funds from the Fengtian Provincial Epidemic Prevention General Bureau by Areas, 1911

Area	Fund (liang)	Mortality	Population	Morality Rate(‰)	Treaty Port	Railway Station
Fengtian Provincial Capital Epidemic Prevention Office	211048	2579	657034	3.925	TRUE	TRUE
Zhen'an Xinlitun Epidemic Bureau	506	112	366980	0.305	FALSE	FALSE
Xinmin Prefecture	27363	622	333803	1.863	TRUE	TRUE
Jinzhou Prefecture	2500	33	300204	0.11	FALSE	FALSE
Changtu Prefecture	14000	619	403657	1.533	TRUE	TRUE
Liaoyang Zhou	7071	46	657910	0.07	TRUE	TRUE
Tieling County	44679	160	284522	0.562	TRUE	TRUE
Fushun County	8725	83	25719	3.202	FALSE	FALSE
Liaozhong County	400	79	339770	0.233	FALSE	FALSE
Benxi County	4000	48	221552	0.126	FALSE	TRUE
Kaiyuan County	11590	220	259178	0.849	FALSE	TRUE
Fenghua County	3450	360	330535	1.089	FALSE	FALSE
Huaide County	16986	673	221253	3.042	FALSE	TRUE
Liaoyuan Zhou	1200	26	54626	0.576	FALSE	FALSE
Zhangwu County	325	11	93732	0.117	FALSE	FALSE
Zhen'an County	650	112	366980	0.305	FALSE	FALSE
Guangning County	845	225	191316	1.176	FALSE	FALSE
Yizhou	260	173	306198	0.565	FALSE	FALSE
Ningyuan Zhou	2382	79	129886	0.608	FALSE	FALSE
Suizhong County	3270	70	121480	0.576	FALSE	TRUE
Panshan Ting	217	27	140599	0.192	FALSE	TRUE
Xifeng County	1950	83	176458	0.47	FALSE	FALSE
Xi'an County	4395	111	170796	0.65	FALSE	FALSE
Dongping County	1671	4	116017	0.034	FALSE	FALSE

Source: Xiliang. 1911. "Xiliang Shou Fengtian Quansheng Fangyi Zongju Cheng Zi Xuantong Ernian Shier Yue Kaiban Qi Zhi Sannian Siyue Shiwu Ri Zhi Shouzhi Gekuan Qingzhe" [Memorial on the Revenues and Expenditures of the Fengtian Provincial Epidemic Prevention Headquarters, from Its Establishment in the Twelfth Month of the Second Year of Xuantong to the Fifteenth Day of the Fourth Month of the Third Year of Xuantong]. Pp. 574–599 in Jindaishi Suocang Qingdai Mingren Gaoben Chaoben, edited by Yu Heping. Zhengzhou, China: Daxiang Chubanshe; Fengtian Quansheng FaSngyi Zongju [Fengtian Provincial Capital Epidemic Prevention Office], ed. (1911) 2010. "Dong Sansheng Yishi Baogaoshu" [Report on Epidemic Affairs in the Three Eastern Provinces]. P. 8264 in Zhongguo Huangzheng Shu Jicheng. Tianjin, China: Tianjin Guji Chubanshe; Guan, Fenghe. 1909. Xinmin Fuzhi [Gazetteer of Xinmin Prefecture]. P. 14. Taipei: Chengwen Chubanshe; Liaoning Sheng Difangzhi Bianzuan Weiyuanhui Bangongshi. 2000. Liaoning Shengzhi: Tiedaozhi [Liaoning Provincial Gazetteer: Gazetteer of Railways]. Beijing: Zhongguo Tiedao Chubanshe.

TABLE 2 Funds from the Fengtian Provincial Epidemic Prevention General Bureau by Institutions, 1911

Institutions	Fund (liang)	Mortalities
Fengtian Provincial Capital Epidemic Prevention Office	211048	2579
Changchun Circuit	42250	5827
Harbin Circuit	30000	5793
Yingkou Circuit	171400	0
International Plague Conference	75000	-

Source: Xiliang. 1911. "Xiliang Shou Fengtian Quansheng Fangyi Zongju Cheng Zi Xuantong Ernian Shier Yue Kaiban Qi Zhi Sannian Siyue Shiwu Ri Zhi Shouzhi Gekuan Qingzhe" [Memorial on the Revenues and Expenditures of the Fengtian Provincial Epidemic Prevention Headquarters, from Its Establishment in the Twelfth Month of the Second Year of Xuantong to the Fifteenth Day of the Fourth Month of the Third Year of Xuantong]. Pp. 574–99 in Jindaishi Suocang Qingdai Mingren Gaoben Chaoben, edited by Yu Heping. Zhengzhou, China: Daxiang Chubanshe; Fengtian Quansheng Fangyi Zongju [Fengtian Provincial Capital Epidemic Prevention Office], ed. (1911) 2010. "Dong Sansheng Yishi Baogaoshu" [Report on Epidemic Affairs in the Three Eastern Provinces]. P. 8222, P.8264 in Zhongguo Huangzheng Shu Jicheng.

Wang Shuncun, had initiated anti-plague measures before January 17, including establishing a hospital and a quarantine station in Hulan. Concerned that Hulan had neither qualified doctors nor medical supplies, He wrote to Xiliang, the Viceroy of Manchuria, to request one or two doctors, some disinfectant, and two thousand doses of vaccines for Hulan(Wang 1911b). However, Xiliang quickly denied all these requests that day, as he could hardly secure physicians and medical supplies even for Fengtian, let alone dispatch them to other places (Xiliang 1911g). More importantly, Xiliang did not see that Hulan would drive transnational attention at this time. Once Xiliang received the complaint from Russia and Japan, the anti-plague work in Hulan became a major concern, and the city finally had the chance to receive support from Fengtian.

Second, nevertheless, the support from Fengtian to Hulan mainly focused on what Russia and Japan were concerned about, which was the body accumulation along the Hulan river, rather than other local plague control measures, like quarantine. The telegram on January 31 (Zhou 1911a) shows that Hulan had only one hospital with a capacity of 20 beds and one isolation facility capable of accommodating only several dozen people at this time, while the daily mortalities were more

than 100. However, Xiliang never pressed Wang on the quarantine issue. Instead, from Jan 25 to Feb 8, Xiliang repeatedly urged Wang to clear the backlog of bodies. Though Wang reported that 1034 bodies had been buried or cremated in the Hulan Prefectural Seat (Wang 1911c), a figure far exceeding the reported number of plague deaths in the prefectural seat, Xiliang was not satisfied with it. It turned out that Wang's efforts were focused on the wrong area. Russia and Japan were concerned not with the body accumulation across Hulan Prefecture as a whole but with the specific area of Landing Ma (Majia Chuankou), where Hulan bordered Harbin along the river, presenting a potential risk affecting Russia and Japan's controlled areas (Zhou 1911c). However, Wang focused only on the prefecture seat, which is the most densely populated part of Hulan, where Landing Ma was not included. And because the support for Hulan plague control was too late, the daily mortalities remained more than 100 during this period.

It can be seen from the Hulan case that the Qing anti-plague efforts pivoted on transnational audiences, i.e., Russia and Japan, instead of local people in Hulan. When the local people in Hulan refused to cremate plague victims' bodies as it violated the tradition that bodies should be laid to rest in the earth, and the ground was too hard to bury the bodies due to the extreme cold (Zhou 1911b), Xi approved Wang's request to allocate 30 soldiers from New Army to enforce cremation (Wang 1911d, 1911f; Xiliang 1911h). Even when multiple officials expressed their doubts about the authenticity of Russia's statement about the accumulated body issue (Wang 1911g; Y. Zhao 1911), Xi did not reply to these doubts but only put pressure on local officials. Whether the body accumulation was authentic or not did not matter to Xiliang, but what mattered was the existence of Russia's potential threats to intervene in the anti-plague work in Hulan (Xiliang 1911l, 1911i). Therefore, the priority of transnational measures over local measures was not driven by epidemic control concerns, since transnational measures were prioritized even when local officials doubted

their actual contribution to epidemic control, and they undermined local benefits by wasting limited resources on an unverified issue.

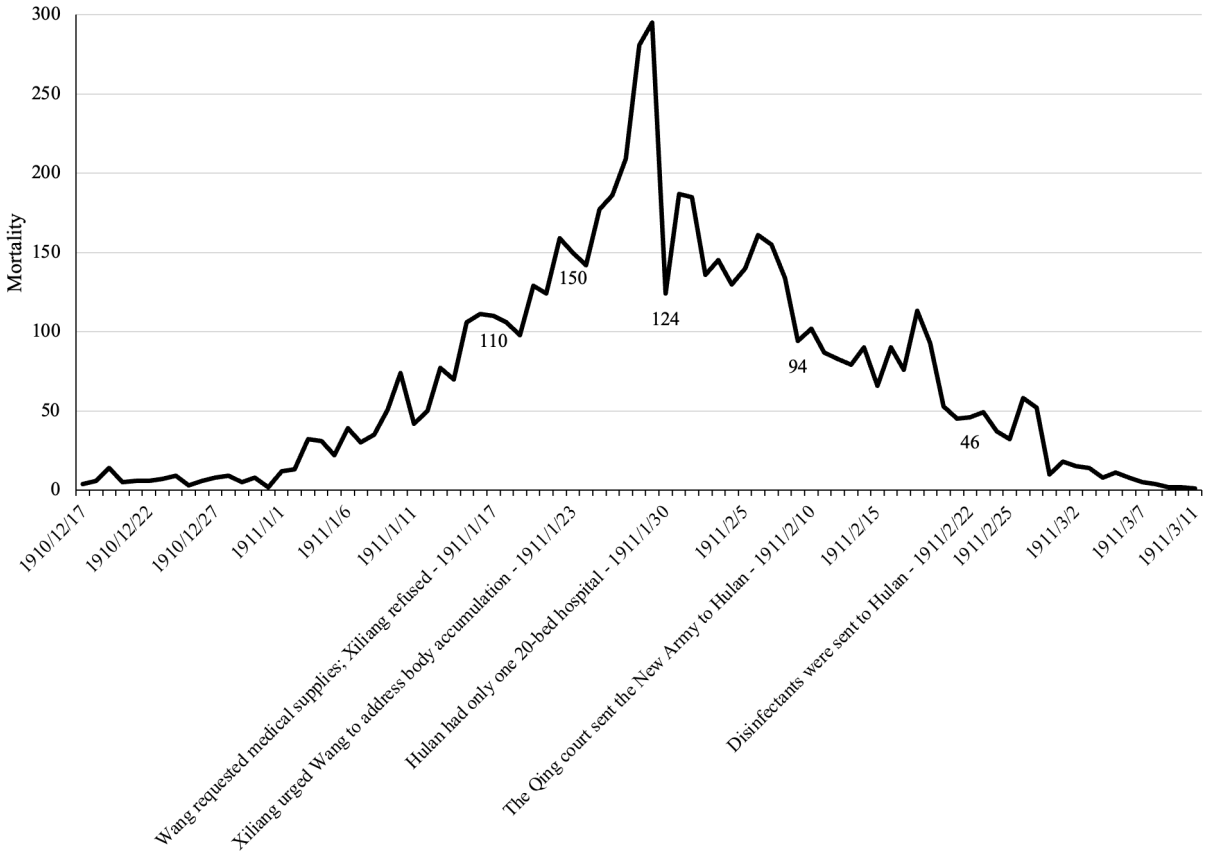

FIGURE 1 Hulan Daily Mortality Trend and Timeline of Anti-Plague Measures

Decoupling: from Plague Control to Geopolitical Interests

Figure 2 illustrates the decoupling model of the Qing Manchurian plague policy that shifted from local plague control to geopolitical interests. The Qing government's personnel and financial support for plague control in different areas in Manchuria was associated with local geopolitical importance, decoupling from the actual severity of the local plague outbreak. Local geopolitical importance can be classified into two ideal types: symbolically or materially. Both Fengtian

Prefecture and Hulan Prefecture carried symbolic importance for claiming the Qing's sovereignty in Manchuria, since Fengtian was the provincial capital of Fengtian Province and Hulan was situated in the borderland between Russia and the Qing. Both Yingkou Circuit and Tieling County were materially important for the Qing, as the former was the biggest treaty port of high commercial importance and the latter was the transit hub important for the commercial transition in Manchuria (TCLGCC 1993:385). An area can be both symbolically and materially important for the Qing. In any case, as long as the area was considered geopolitically important for the Qing, the Qing would provide more support for the local epidemic control, regardless of its epidemic severity. Conversely, in the less geopolitically important areas like Fenghua and Guanning, though there were high plague mortalities, the support for these areas was low, which was also presented in Table 1 by the low financial support from FPEPGB to Fenghua and Guanning.

Besides the varied support for different areas, the Qing's distribution of resources was inequitable for different kinds of anti-plague measures. Transnational measures were prioritized, as shown in the Hulan case, where cremation was prioritized under the pressure from Russia and Japan, yet measures for local plague control, including quarantine and disinfection, were too late and lacked support. The most salient example of transnational measures was the Qing's convening of the International Plague Conference proposed by Sao-ke Sze, who led the Qing's Foreign Affairs Department (Sze [1954] 2020:79). The Qing invested a large amount of money in this Conference. As shown in Table 2, the fund for the International Plague Conference (75,000 liang) was strikingly more than the total of the funds for the two epicenter cities in Manchuria, Changchun (42,250 liang) and Harbin (30,000 liang).

The conference claimed to investigate plague outbreaks and develop effective epidemic measures, with participation from many international medical officials from Germany, the United

States, Britain, Austria, France, Russia, and Japan (Y. Chen [1911] 2010). However, this stated purpose did not reveal the Qing's underlying intention for holding the conference. By organizing the International Plague Conference, the Qing aimed to show its ability to the transnational actors in Manchuria (Yikuang 1911) by presenting an image that it had successfully eradicated the plague (Zhao 1912). On March 5, Xiliang sent a telegram to all local governments in Manchuria urging officials to "eradicate the plague everywhere before the conference" to "avoid giving foreigners excuses for criticism" (Zhang 1911). The Qing's efforts proved successful. The costly conference received widespread praise. One British delegate attending the conference publicly commented that

> When these thirty or more delegates arrive at Mukden, we found a large school had been prepared for our use, where, for the four weeks that the Conference lasted, we all lived together like a happy family with the Imperial Commissioner Sze Sao-ke as a sort of foster-father to take care of us, which he did right well. The general opinion was that high powers of organisation were shown by the Chinese government in the way the Conference was carried through and, considering the different interests involved, in bringing it to a successful conclusion. (Stanley 1911)

These all suggest that the Qing viewed transnational actors as their primary audiences for its plague control efforts. They prioritized service to transnational actors over the local people in Manchuria. Resource distribution prioritized the transnational measures rather than local measures, even when the Qing knew that the former might not contribute to plague control. Meyer (1997) introduces the idea of "decoupling," which refers to the common phenomenon that "the claims and the policies are frequently inconsistent with practice" when states try to develop institutions isomorphic to those of other countries. This decoupling occurred in the Qing's Manchurian plague policy, which claimed to control the outbreak, yet the practice mainly focused on its geopolitical interests, which was inconsistent with its claim. Paradoxically, this decoupled Manchurian plague policy gained international recognition. According to Meyer, decoupling is an unintentional

consequence of institutional isomorphism. However, in the case of the Manchurian plague policy, the decoupling was intentional, serving Qing geopolitical interests and constructing its sovereignty in Manchuria. Therefore, I argue that the Manchurian plague policy was an epidemic performance that intentionally decoupled from the epidemic control to the geopolitical interests of the Qing government.

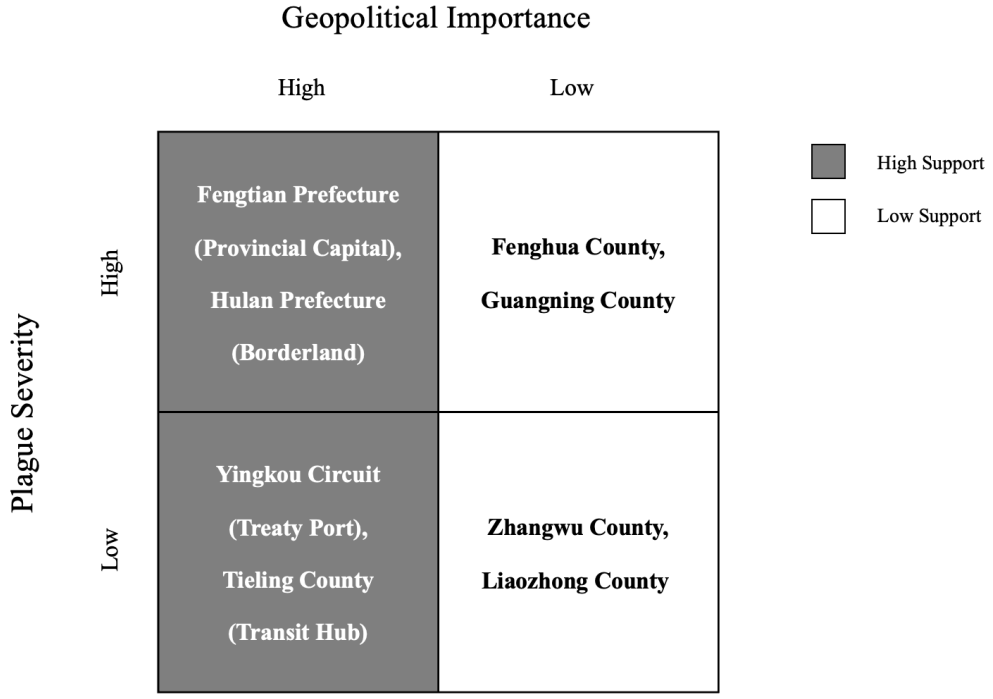

FIGURE 2 A 2×2 Matrix Model of Decoupling: From Plague Control to Geopolitical Interests

Epidemic Performance

The Qing's Manchurian plague policy stands as an epidemic performance given the paradox that the Qing failed to fully implement the Western measures as they claimed, but it successfully presented a performance of Western measures to the transnational actors.

First, the Qing gained widespread recognition from many transnational actors in Manchuria. The Qing anti-plague work was praised by many transnational actors as a successful policy implementation to stop the spread of the plague. Koike Chōzō, then Japanese Consul, wrote to Xiliang that Xiliang's "meticulous preventive measures and unremitting efforts, the epidemic was suppressed with remarkable speed" (Chōzō 1911). The British delegate, Author Stanley, said that the Qing government was unprepared at the start of the outbreak, which was "some extent excusable," but it later achieved a "success" due to the "responsible" officials and "self-sacrificed" people (Stanley 1911). This comment was ironic, as the local officials' anti-plague work was often too late, and the local people were forcibly sacrificed by the decoupled policy practice.

Second, the failure of local measures was partly passively caused by objective shortages of medical supplies and personnel, but they were also actively caused by the approved loose implementation. The Qing was aware of its incapacity to fully implement Western measures (Z. Chen et al. [1911] 2010). And the Qing knew that Western measures had economic disadvantages as they were costly, and that measures including quarantine and lockdown impeded local commercial activities. Though the Qing persisted in Western measures during its anti-plague work, it made compromises by intentionally loosening some measures to alleviate economic damages caused by the plague control policy. Gongfushi was the community hit hardest by the plague in Fengtian Prefecture, where the mortality rate reached 12.95‰ (FPEPGB [1911] 2010:8268). Daximen is located in the northern part of Gongfushi, which was a commercial center in the city. Eighty-two shops in Daximen collectively submitted a petition to the FPEPGB requesting exemption from neighborhood lockdown on March 27 (FGCC 1911b; MRDF 1911), claiming that the quarantine threatened the livelihoods of local shops and the moats separated Daximen from the infected areas in Gongfushi. The petition was permitted on April 3 (Xiliang 1911a).

Such compromises of local implementation were common during the plague outbreak. Local chambers of commerce were important actors in implementing local anti-plague measures. They played the key role of mediator between the Qing government and local merchants in order to reach a practical compromise in implementation. Such compromises were reached not only through the collective petition, as in the case of Daximen, but also by individuals. For instance, the 7-day quarantine of a clerk at the Gongji Qianhao (a native bank) was exempted through a petition by the Fengtian Chamber of Commerce (fengtian shangwu zonghui), as urgent matters at the shop required him to return to work (FGCC 1911a; FPCEPO 1911). Additionally, the compromises in local implementation went beyond Fengtian Prefecture to the Manchuria. The Fushun Chamber of Commerce petitioned the county to exempt itself from the burning of the infected houses, saying that "While the plague outbreak calls for strict prevention, commercial concerns likewise need to be considered" (FIPC 1911b; FGCC 1911c; FCCC 1911b, 1911a).

While the gap between policy making and implementation commonly exists in any epidemic policy, the compromise of local measures in the Manchurian plague policy were made intentionally to alleviate the economic damage caused by the anti-plague measures. And it affected the key epidemic measures like quarantine and lockdowns even in epicenters across Manchuria. The policy compromise was especially counterintuitive, given that the Qing provided anomalous resources for transnational measures but made concession when implementing key local measures in many infected areas. The local measures were the back stage of the Qing's epidemic performance, while the transnational measures were the front stage (Goffman [1959] 2021).

Third, local measures could also be performative, serving for the transnational audiences. The rumor spread among local Chinese people that the Manchurian plague was caused by foreigners secretly putting poison into wells. Both local officials and central officials were aware that the

draconian Western measures incurred resentment against non-Chinese among local Chinese people, and they were very concerned about the rumors that would cause further tensions. To address this issue, Xiliang issued a public proclamation, stating that "foreign merchants live and eat alongside us, (so) it would be unreasonable for them to poison wells and harm others only to harm themselves as well "(Xiliang 1911b). Additionally, public educational activities on the plague were organized across Manchuria, which employed local literati to deliver public speeches to local people (FPEC 1911; M. Wang 1911; Du 1911). Same as Xiliang's proclamation, these educational activities aimed to control the rumors hostile to non-Chinese and appease popular suspicion against Western measures (L. Chen 1911).

The objects of public educational activities were the local Chinese people in Manchuria, however, the true audiences of this policy were transnational actors. The Qing Ministry of Foreign Affairs sent separate telegrams to the British and Russian legations, claiming that the rumors did not lead to any anti-foreign activities in Manchuria and that the local governments were actively organizing educational activities for the local Chinese people (L. Chen 1911). However, no evidence shows that these educational activities were proposed by Britain or Russia. Hence, these local educational activities were the Qing's local performance for the transnational audiences in Manchuria, intended to produce a progressive self-image of epidemic control.

Why Perform?: Internalized Orientalism and Sovereignty Construction

It is clear that the Qing proactively initiated an epidemic performance of adopting Western measures during the Manchuria plague. Why did the Qing stage such a performance, given that Western measures were ineffective and economically inefficient? Especially, it seemed impractical to exclusively adopt Western measures. In the other parts of the world, indigenous medicine

utilized the plague as an opportunity for its development. During the Calcutta Plague (1898-1900), Calcutta government (now Kolkata) abandoned their initial exclusive implementation of Western medicine measures and instead incorporated indigenous medicine (Arnold 1993; Harris 1994). Then, why did the Qing proactively exclude TCM in its anti-plague work? In this section, I argue that the Qing elites internalized the epidemic Orientalism (White 2023) , believing that Western medicine was superior than TCM and its dominance was the inevitable future of public health around the world. Therefore, the Qing embraced the myth of Western medicine superiority, actively adopted the Western measures, and excluded TCM from the anti-plague work, though Western medicine was ineffective for the plague and TCM could be potentially utilized as a valuable medical personnel as the Indian case demonstrates.

Paradoxically, Qing elites were aware of the limitation of Western medicine in controling the plague. They understood that Western medicine had no effective medications to treat the plague (Zhang 1911). Nevertheless, they did not perceived the inefficacy of Western medicine in the plague control as an evidence refuting the superiority of Western medicine. Rather, they viewed the limitation of Western measures as the temporary obstacles of the medical scientific development. By performing Western measures, it sought to produce the image that the Qing, together with other Western countries, was making progress of medical science. In Xiliang's welcome address in the International Plague Conference, he stated:

> We, Chinese, have for a long time believed in an ancient system of medical practice, which the experience of centuries has found to be serviceable for many ailments, but the lessons taught by this epidemic, which, until practically three or four months ago, had been unknown in China, have been great, and have compelled several of us to revise our former ideas of this valuable branch of knowledge. We feel that the progress of medical science must go hand in hand with the advancement of learning, and that if railways, telegraphs, electric light, and other modern inventions are indispensable to the material welfare of this country, we should also make use of the wonderful resources of Western medicine for the benefit of our people. (THE INTERNATIONAL PLAGUE CONFERENCE. 1911)

TCM was viewed inherently inferior to Western medicine by the Qing elites, although both medicines were ineffective in treating the plague. The Qing elites perceived their pursuit of Western medical measures as "progressive" (jinbu), while TCM was viewed as backward. Plague control "cannot be managed without Western-trained physicians" (Xiliang 1911k). Yet TCM should be excluded. The Qing closed the Chamber of Commerce Hospital which was led by TCM practitioners, because the hospital did not comply with the government's policy to employ Western physicians (FIPC 1911a; FGCC 1911d).

The Qing elites casted Orientalist gaze on the local Chinese people who resisted against the draconian Western measures and conservative local officials who supported to include TCM in the anti-plague efforts. Local people hardly cooperated with the Western measures, as they were cruel and some of the measures violated Chinese traditions like cremation. The widely used disinfectant, phenol, was high corrosive to the skin and the respiratory tract. Criticism against Western measures were also raised by a few conservative officials. A conservative official Chen Yingxi impeached to the Regent that "more people died from anti-plague measures than from the plague itself" (Y. Chen 1911). Supporters and implementers of Western measures dismissed these dissents. Troops were sent to enforce the measures if needed. From the viceroy Xiliang to the local prefects, they referred people who did not support Western measures as "obstinate" (yumei) (Zhou 1911c; Wang 1911d; Z. Chen et al. [1911] 2010), needed to be civilized by Western medicine.

While the Qing elites themselves projected Orientalist gaze on their own people, they aimed to shield the state from the Orientalist gaze of transnational actors. In embracing epidemic Orientalism, they strategically positioned the Qing government alongside the dominant colonial powers rather than as an object of their intervention. The opening address in the International Plague Conference by the Qing official Alfred Sao-ke Sze illustrates this:

> While the Chinese people have not such caste prejudices, as are present in some other oriental races, they are apt to resent what they consider undue interference with, or intrusion into their family life, and it has been a difficult duty for us to carry out such apparently cruel work—the quick separation of a plague case from his or her family relatives, removal of one member to the plague hospital and others to segregation camps and so on…Gentlemen, in asking your consideration of these questions and any other suggestions which you may, from your past experience see fit to make, I will on behalf of my Emperor and Government respectfully beg of you ever to have the practical side of the subject in view. Science comes often into conflict with daily life, just as it is ever aiding it. What may be scientifically and theoretically desirable, may, when the time comes for it to be put into actual practice, be found impossible to carry out; but we are determined to meet this enemy henceforth armed with the best knowledge we can obtain. We will thoroughly consider your recommendations and whenever possible act up to them. The day has now gone past when any Government can allow an epidemic to cause such ravages among its people unchecked, not only for economic but also for humanitarian reasons. (THE INTERNATIONAL PLAGUE CONFERENCE. 1911)

Sze shrewdly asked the foreign delegates to focus on the "practical side" and the "medical and scientific aspects" of plague prevention. By de-politicizing the plague during the conference, Sze sought to position China alongside other dominant transnational actors in a purely medical struggle against a common enemy: the plague. However, his intention was fundamentally political. By aligning the Qing on the side of Western medicine and emphasizing that this approach differed from other "Oriental" countries, Sze intended to position China among the politically dominant Western nations to avoid political interventions in the Qing's public health policy. Furthermore, by embracing modern science, he intended to project an image of the Qing as a modern state, distinct from other "Oriental" nations. In this way, Qing elites like Sze and Xiliang reproduced the dominance of Western medicine in China to assert the legitimacy of Qing rule against colonial threats in Manchuria.

Sovereignty and Plague Control

The Western measures ultimately aimed at constructing and protecting Qing sovereignty in China. "Epidemic prevention concerned both national sovereignty and the lives of the people." (Zhang 1911) Sovereignty construction and protection during the plague outbreak had two dimensions: the first was to protect the Qing's anti-plague work from the interventions of transnational actors; the second was to protect Inner China from the plague outbreak. The Qing's anti-plague work started in January when the plague spread to Southern Manchuria (i.e., Fengtian), as the central government realized the plague might go southward and break out in Inner China. Before January, the Qing was aware of the plague outbreaks in Northern Manchuria, yet it did not pay much attention to them since they were far from Inner China. As the plague moved southward, an imperial edict was ordered to immediately establish a prevention bureau at Shanhai Guan to strictly guard the gateway between Manchuria and Inner China (Yikuang et al. 1911). Substantial funds were distributed for plague control in the inner provinces, such as Shandong, Rehe, and Hubei (Sun 1911; Ruicheng 1911; Chengxun 1911). The Manchurian plague policy was initiated to protect Inner China from the plague, aiming to "govern the territory" and protect "the broader national interest"(Xiliang 1911f).

As Manchuria was a contested borderland where Russia and Japan also exercised influence, anti-plague work in the region was deeply intertwined with geopolitics from the beginning. The Qing sought to utilize the plague crisis to further construct its sovereignty in Manchuria. This construction manifested in both discursive and material ways. The International Plague Conference demonstrated that the Qing intended to utilize Western medicine as a discursive force to construct political legitimacy in Manchuria against other transnational actors. This intention turned its plague policy into an "epidemic performance." The Qing performed Western measures because it was concerned that transnational actors would exploit any perceived incapacity to

implement Western measures as a pretext to intervene in anti-plague work in Manchuria, thereby threatening its sovereignty in the region. “To avoid foreign intervention” was a recurring phrase in the official documents used to legitimize these Western measures, from Viceroy Xi Liang to Governor Zhou Shumou, and even among local officials like Hulan Prefect Wang Shuncun and Xinmin Prefect Zhang Yiting. (Zhou 1910a; Zhang 1911; Wang 1911e; Xiliang 1911d).

The material intertwining of sovereignty construction and plague control was particularly evident on the frontier. The Ussuri River region was a borderland between Russia and China where no plague cases were found. Nonetheless, Russia shot a Chinese man attempting to cross the river and claimed the act was for epidemic control. The Qing government dispatched Western-trained physician Zhong Musheng to investigate the epidemic in the region. However, as the exact location of the border in the Ussuri River region remained contested, it took half a month for the Qing and Russia to negotiate where Zhong Musheng should conduct his investigation (Zhong 1911). In Zhong’s report on his investigation of the Ussuri River region, he explained that the absence of plague in the region was due to underpopulation and noted how Russia utilized plague control as a pretext to deploy military forces in local villages. However, Zhong’s observations extended beyond the epidemic. In addition to his medical report (Zhong 1911), he attached a lengthy political memorandum suggesting that the Qing encourage migration to this region and bolster military oversight along the border. Zhong, as the Chief Medical Officer of Jilin Province, performed duties far beyond the medical field, assuming his political responsibilities of a state official.

Like Zhong, Western-trained physicians constantly played the political role as medical agents handling the epidemic issues that were highly intertwined with geopolitics. Qing politicians were acutely aware of the political significance of Western medicine and strategically employed

Western-trained physicians to fulfill their political objectives. Nenjiang (known to the Russians as Mergen) also lay on the frontier between the Qing and Russia and was among the first places where the plague broke out. Russia intended to establish inspection stations in Mergen, which raised concerns for the Qing. Governor Zhou Shumou held that not only would such inspections disrupt commercial exchange on the frontier, but more concerningly, they would easily incur Russian intervention in the Qing's borderland (Zhou 1910b). Xiliang shared the similar concern with Zhou: "As we cannot entirely sever cross-border transit, and given that the Russians have no confidence in traditional Chinese medicine, if the Chinese departing the area are not inspected by Chinese Western-trained physicians according to Western protocols, the Russians will still find pretexts (for intervention)" (Xiliang 1910a). Therefore, Western-trained physicians were dispatched by the Qing to conduct Nenjiang's anti-plague work, while TCM practitioners were excluded. The Nenjiang case illustrates the material influence of Western medicine as the agent for the Qing to control the frontier.

Discussion

The Qing's Manchurian plague policy marked the first instance in which Western medicine, rather than Traditional Chinese Medicine (TCM), dominated state public health policy. The exclusive adoption of Western measures during the Manchurian plague was not merely a passive reaction coerced by colonial powers, such as Russia and Japan. Instead, the Qing proactively initiated and performed these measures, despite their high cost and the intense popular resistance they provoked. While the contemporary Chinese government commemorates the Manchurian plague policy as a progressive milestone—the foundational step in the modernization of China's public health—a more critical analysis is required.

I argue that the Manchurian plague policy was fundamentally performative, characterized by a decoupling of local epidemic control from geopolitical interests. Though the policy left some medical legacies, such as the establishment of the South Manchurian Medical School which has since developed into one of China's top medical schools (E. Zhao 1911), the policy practice was inherently symbolic and political. The ideological superiority of Western medicine was believed by the Qing reformers of "New Policies" (*xinzheng*), who were the primary architects of Western measures during the plague outbreak. They perceived their pursuit of Western epidemic measures as "progressive" (*jinbu*), while dismissing TCM as backward. These Qing reformers projected an Orientalist gaze on the populace and local officials who did not support the draconian Western measures, labeling them as "obstinate" (*yumei*). Therefore, the Qing's performance of Western measures was not incentivized by the material efficacy of Western medicine as WST would predict. Rather, it demonstrates an internalized Orientalism by the Qing, in which the elite perceived the ideological superiority of Western medicine even in the absence of proven material efficacy. Because Western medicine was viewed as inherently superior to TCM, the limitations of Western measures were viewed by the Qing as temporary obstacles in the inevitable progress of scientific development. Drawing from colonial critiques of Western medicine hegemony, Manchurian plague shows that the dominance of Western medicine was reproduced ideologically by Chinese elites, prior to and without the existence of material efficacy.

As Manchuria was a contested borderland, anti-plague work was deeply intertwined with geopolitics. By investing in the ideological value of Western medicine through the epidemic performance, the Qing sought to produce a political image of a modern state, positioning itself alongside the dominant colonial powers and in contrast to other "Oriental" nations that had not embraced Western medicine as well as the Qing. Ultimately, the epidemic performance aimed at

the interests of the Qing's sovereign. Western-trained physicians were medical agents in the geopolitical stage of three empires, Russia, Japan and the Qing. Their political roles as medical agents had both symbolic and material dimensions. Symbolically, the Qing utilized the discursive power of Western medicine to legitimize its rule, demonstrating a capacity for modern governance that sought to delegitimize foreign pretexts for intervention in Manchurian anti-plague work. Materially, physicians directly engaged in the frontier politics, as the plague recognized no border line, yet physicians themselves had clear national backgrounds. Their work was frequently supported by military force, and the geopolitical scope of their efforts was often constrained by the contested delimitation of the borderland.

To what extent did the Qing secure its geopolitical interests through these measures? Did Russia or Japan restrain their colonial ambitions because of the Qing's epidemic performance? Due to the limitations of available archives, it is difficult to construct a complete picture of Russian or Japanese perceptions of Qing policy. However, from the perspective of the Qing state, it achieved as much as could be expected under the circumstances. The International Plague Conference showcased the Qing's anti-plague efforts to the world as a significant advancement in Chinese public health, despite certain flaws. Had the Qing failed to perform these Western measures, it is likely that further tragedies like the shooting incident on the Ussuri River would have occurred, and the state would have exercised even less influence over its contested borders.

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