On the Value of Chinese Language Skills for Practitioners of Acupuncture and Oriental Medicine

John Aguilar, Jr

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A Note on Chinese Terms and Translation

Where technical Oriental Medical terms, titles of texts, Chinese authors, etc. are used they will be accompanied by pīnyīn, the source Chinese characters, and an English translation. The characters will be listed in traditional form first, followed by the simplified form in square brackets (the most recent style of characters used in modern China). (Note – the two styles will often be the same or very close. Both are included here to help orient the reader who is new to Chinese language to these differences.) For example, the *Huángdì Nèijīng* will appear as: *Huángdì Nèijīng* 黃帝內經 [黄帝内经] the *Yellow Emperor's Classic of Internal Medicine*. In subsequent use of the term, only the pīnyīn is used. A glossary is added at the end, listing all terms in alphabetical order by pīnyīn, to assist in cross-referencing these terms elsewhere.

English translations for terms have followed except where noted *A Practical Dictionary of Chinese Medicine* (Wiseman & Feng, 1998). An updated, 2011, version of this term list is freely available, with full search capability, online at http://www.paradigm-pubs.com/TermList. (Note - this online version does not include the definitions of the terms as *A Practical Dictionary* does).

The use of a standardized term list, such as contained in *A Practical Dictionary*, as well as including a glossary of terms used in this paper, assists in orienting the technical terms used, associating them with their original (source) meanings in Chinese. For example, such practices allow the reader to associate the English words "excess" and "replete" with the source Chinese character 實. The use of a set list of standardized English words for Chinese terms allows for consistent use of the same word for the same Chinese concept over different texts. This assists

readers in understanding which original Chinese concept is being translated. The inclusion of a glossary and appropriate footnotes allows for freedom in translation. For example, an author could choose non-standard English words, words not on the set term list, when they are not as appropriate for a specific context. A glossary and footnotes, in such cases, link the chosen English word with the original Chinese concept, again, orienting the reader to the source concept intended.

Table of Contents

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All of this, of course, revolves around – is, ultimately, secondary to – my day-to-day joy of life. So much of that happiness and peace is owed to the presence of an endlessly sweet, soulful, kind, and intelligent young woman. My girlfriend Amy is a miracle; she stands as a rare example of

why we work hard or dream big in life – so often I find myself thinking it is for accomplishment of some task or attainment of a goal. Thanks to Amy, I am reminded that it always comes down to joy – simple, pure, and perfect joy. Thank you, my love.

Preface

The following is, partly, a result of two years of research. This research involved formal and informal Chinese language studies, including:

- over one year of modern Chinese language (Mandarin) at the University of Colorado (the first year of a four-year bachelor's degree in Chinese language sequence),
- a year and a half of medical Chinese study (including classical Chinese and introductory grammar) under Chinese medical practitioner and sinologist Nicolaas Herman Oving, and
- extensive personal investigation into the language including guidance from senior practitioner/translators.

It should be stated at the outset that I do not speak or read Chinese anywhere near fluently. In this paper, I am reporting from the perspective of a novice Chinese language student (and Oriental Medical practitioner). I stand at the point of transition from not knowing to knowing Chinese, and can speak directly to the advantages of such learning. This is, in fact, a major point of this paper – for, even as little as I've learned, my awareness and knowledge of OM has increased dramatically. Importantly, everything I know of Chinese could be replicated in a year by a motivated beginning student (see the appendix "Where to Begin").

In addition to the above language studies, interviews were conducted with several published US practitioner-translators, as well as practitioners who are fluent in Chinese.

The research and this paper also reflect my personal experiences over a fourteen-year journey through the study and practice of Oriental Medicine (OM). This journey has been quite varied and extensive, beginning with personal investigation into Chinese philosophy and the Oriental Medical classics in 1993 and eventually taking me through several schools teaching Oriental Medicine, including:

- Yo San University of Traditional Chinese Medicine, CA – two trimesters of their Master's of Traditional Chinese Medicine (MSTCM) program;
- Institute of Psycho-Structural Balancing, CA – a six-month acupressure and tūiná 推拿 [推拿] program;
- Institute of Taoist Education and Acupuncture, CO – six months' training in the Classical Five-Element style of acupuncture;
- Colorado School of Traditional Chinese Medicine, CO – completed their three-and-a-half-year master's program, earning my MSTCM;
- Pacific College of Oriental Medicine, CA – one semester of their Doctorate of Acupuncture and Oriental Medicine (DAOM) program, including their first semester of Chinese language instruction; and
- Oregon College of Oriental Medicine, OR – two-year DAOM program, earning my doctorate upon completion of my capstone research (presented here).

Further, advanced studies of the Oriental Medical classics have directly aided this current research and include study of the *Huángdì Nèijīng* with Edward Neal, MD, LAc and the *Shānghán Lùn* and *Jīnguì Yàolüè* with Arnaud Versluys, PhD (China), LAc. These studies are ongoing.

Through all of this I have seen that the Oriental Medical field in the US is 1) still in its youthful stages of development and 2) changing rapidly. This research paper is intended as a constructive critique of the field based on my observations and experiences (which may not represent those of others) and is intended to help strengthen the field.

Oriental Medicine has tremendous potential, only a mere fraction of which, I believe, has actualized in the US. Progress is occurring rapidly, for instance, with the development of master's programs of 3,000+ hours and post-graduate doctoral studies, as well as greater opportunity to study with senior practitioners and experts. This paper is offered to draw attention to what I perceive as a significant deficiency in the field as it currently exists. It will also, hopefully, act as stimulus and guidance to aid in more fully developing our potential.

This paper is written, primarily, for non-Chinese-speaking, clinically active Oriental Medicine practitioners trained in the US. There is an implicit assumption of a passion for the medicine and a strong desire to improve the quality of practice. There should also be, in the ideal reader, a willingness to hear critique and be comfortable in the face of seemingly impossible tasks. A sincere seeking of truth – what is right and best – was behind the writing of this paper and will likely serve the reader best in receiving it. Though no definitive conclusions are drawn, the argument – the journey – has been followed regardless of how intimidating the potential conclusion may look. As a scientist, I have followed where the story of discovery has led, and I invite the reader to walk the path one step – one moment of sincere investigation – at a time.

As it is relevant to most US practitioners, this paper is also important for the OM field, in general. As a group, we are responsible for providing the highest possible quality of OM care. Direct access to primary sources increases both knowledge and reliability of knowledge. Oriental Medicine is, for the most part, contained within another language other than English. Quality of OM care, then, is largely dependent on our collective access to our source materials. Language skills thus become a primary factor in our field's professional responsibilities.

It follows, lastly, that this paper is also of value to the general public – those who receive our care. Just as any patient has a certain right to expect their MD to be well versed in the latest advances in cancer research or discoveries in pharmaceuticals, for example, the same patient has the right to expect their OM physician to have adequate and reliable access to the source materials of their medicine.

As with all academic endeavors, this paper – at its best – will serve as a stepping stone to the next stage of development. It is written with the intent and hope that its ideas will be consumed in the transformational destruction-growth cycle of knowledge in medical science, one set of ideas fueling the creation of new ones. Therefore, I invite comment and critique and look forward to widespread camaraderie in adding our modern voice to an ancient medical tradition.

Introduction

The study of Oriental Medicine is a journey without end. It is a limitless pursuit, an endless investigation into health and healing. It is similar to so much of ancient Chinese philosophy in that, within the professional study of OM, lies a paradox. One studies and learns, advancing and progressing with a final destination, an end point, seemingly implied. Yet, there is no terminal state, no complete mastery, of Oriental Medicine. It is a study that constantly challenges and rewards one's efforts and will forever offer greater challenge and ever more to learn. Truly a practitioner of this medicine must accept the fact that joy and peace can be found only in the journey, not in arriving at any destination.

Part of this adventure is the fact that the medicine is, by definition, the clinical application of ancient theories and accumulated experience of clinical interactions carried out over the last several millennia.[1] The base of evidence for this medicine is thus not clearly or easily defined, much less accessed and applied. The guidance and knowledge upon which practitioners base clinical decisions is obscured by time, volume, and distance. The foundations of the medicine, important developments, and reports of clinical interactions, all came about over an extensive and varied history that incorporated different cultures and are recorded in a language that itself

[1] Defining Oriental Medicine at the outset feels simultaneously essential and impossible. This paper is written based on the observation that there are practices which may look like OM practice, but are not. For example, OM interns learning the medicine may miss the point in their early stages of training, or some practitioners may take liberty with the medicine and end up straying out of authentic OM practice. This suggests that, no matter how difficult it is to come by, there is a point of demarcation between what OM is and is not. The loose definition suggested here is a medicine rooted in specific, if open for widely varied interpretation, core ideas and concepts and the collective clinical experiences of past physicians.

has been under continuous development.[2] The heart of the medicine is laid out in the field's primary source texts authored thousands of years ago. Essential secondary texts, considered near-equal to primary sources, were authored over several hundred years later, adding to the overall volume of the evidence base of the medicine. Case studies, where the actual application of foundational principles is applied, also greatly increase the amount of material available to educate modern practitioners. Finally, for the US practitioner, all of this material originated and the vast majority still exists solely in a land thousands of miles away.

The modern US practitioner is aided in many ways in crossing this gap in order to practice a medicine grounded in its evidence base. Technology makes the physical distance nearly a moot point. Ancient texts, as well as many case studies, are accessible via the Internet. For example, the *Chinese Medicine Database*, as well as the *Chinese Text Project* makes original texts available in Chinese, as well as translations and translation tools. Also, many other OM texts, in Chinese, are widely available with simple Internet searches. Similarly, the temporal and cultural disparities are potentially minimized with texts and experts making much information available. Sinology, the professional study of Chinese languages and civilization, is an entire academic field unto itself, with experts and ongoing studies and research (for example, see Gamer (2008) and Ebrey (2010) as basic introductory Chinese studies textbooks).

With such modern research and scholars we have much improved access to information on the nature and characteristics of past civilizations and cultures. This increases our ability to correctly

[2] The idea of *plurality*, or the coexistence of varying approaches to medicine over time, is discussed in relation in Chinese medical language and translation in Bensky, et al, 2006. See Unschuld (1985) for expanded discussion on OM history. See also Scheid (2002), where plurality is a major focus of his medical anthropology research.

interpret theories, concepts, and experiences, for example, of ancient Chinese culture. Even with all this assistance, however, there still remains a substantial obstacle to accessing the knowledge and accumulated experiences of generations of past physicians – Chinese language, itself.

The core texts, as well as writings of countless scholar-physicians, may be as easy to access as a click in the Internet, but they are hidden behind a wall of Chinese characters (these characters representing far more than unrecognized words – for instance, a whole different way of seeing the world and thinking about healing – as is discussed later). Discussions and research projects exploring the medicine are plentiful, but for the most part they are similarly veiled underneath a language barrier. As will be discussed in detail in the following pages, there are some solutions to this basic language-as-obstacle dilemma. However, no solution significantly reduces this basic challenge to non-Chinese-speaking practitioners. Further, none of the above solutions come close to helping the non-speaking practitioner reap the same reward as that of the one who possesses Chinese language skills. It becomes clear that knowledge of Chinese is not merely an assistant to studying and practicing the medicine, but is virtually essential to practice the medicine firmly upon its evidence base.

1. The Basic Problem – An Overview

The practice of medicine is a unique endeavor. Much like other professions, there is the execution of skill based on knowledge: one does something based on a certain understanding. The quality of one's efforts, the beauty of the outcome, is largely dependent upon the reliability of the understanding possessed, the deeper that understanding, the better the outcome.

Perhaps what makes medicine unique is the fact that it deals directly with ourselves and one of our most intimate and universally shared experiences – suffering. Across all the events and happenings of the human population, there is the common desire to be pain free so that we may carry on, uninhibited, with our endeavors. This alleviation of suffering is a primary and core desire of being human and it places medicine in a unique position as the profession that deals directly with suffering.

For the sake of comparison, we can look at the nature of other professions. For example, the skills of a carpenter are important, as are those of a lawyer, auto mechanic, or engineer. Each would, individually, be missed if absent. However, each one of those workers, themselves, has a similar need. In fact, all humans share one common need, without which we all would be at a loss. While one could continue on, albeit with not insignificant disadvantage, without mechanics or lawyers, the absence of medical professionals would result in tremendous and universal hardship. Where other professions assist in carrying out secondary activities of being human, doctors assist in the unfettered carrying out of *being human*, making it a wholly unique profession.

The too often ignored counterpart to this absence of suffering is the presence of health – not merely the lack of impediments to being healthy, but the active presence of vitality in effectively carrying on our various endeavors. With this, too, medicine – when practiced at its highest potential – deals more directly than any other profession. The carpenter, lawyer, and mechanic each carry out their individual professional duties, while common to them all is the desire to do so with joy and vigor. This is full health. A physician, a practitioner of medicine, at his or her best, not only removes obstacles, but is an active assistant to the full living of life's journey.

Perhaps it is for these reasons that the practice of medicine is unique, and perhaps this is also why practicing medicine *well* is so important. The problem leading to this current research is that the typical non-Chinese-speaking practitioner of OM simply lacks necessary access to critical materials to practice their medicine well, *reliably* and *predictably* well.

As mentioned in the introduction, Oriental Medicine is defined as being rooted in 1) a certain medical paradigm or way of thinking, the heart of which was laid down thousands of years ago, and 2) the collective clinical experience gained over billions of physician-patient interactions since then. The actual clinical practice of the medicine varies considerably (i.e. between different styles of practice and various subsystems of the medicine, such as Japanese and Korean). However, they all claim as their source the core text *Huángdì Nèijīng* 黃帝內經 [黄帝内经], the

Yellow Emperor's Classic of Internal Medicine, and the basic medical system laid out in that text.[3]

From fellow Hàn Dynasty 漢朝 [汉朝] texts, such as the *Shānghán Lùn*, through major texts written up until modern times, to include modern textbooks, authors have credited direct study of the *Nèijīng* (though not necessarily exclusively) for their expertise and clinical abilities and often, in turn, emphasize such study as a basic, core requisite for the practice of Oriental Medicine. For example, in the *Shānghán Lùn*, widely considered to be the foundational text of clinical herbal medicine, we read that modern practitioners were admonished for not studying the classics:

> In high antiquity, there were Shén-Nóng, Huáng-Dì, Qí-Bó, Bó-Gāo, Léi-Gōng, Shào-Shū, Shào-Shī, and Zhòng-Wén; in middle antiquity, there were Cháng-Sāng and Biǎn-Què; in the Hàn, there have been Gōng-Shèn, Yáng-Qìng and Cāng-Gōng. After these, we know of no [famous physicians]. *Looking at the physicians of today, [we see that they] do not ponder on the meaning of the [medical] classics to develop their knowledge, [but instead] each inherits the skills passed down in their family, constantly following traditional ways* {emphasis added}. In reflecting on illness and inquiring of patients' suffering, their efforts placed on the gift of the gab, and after a brief consultation, give a simple prescription for a decoction… (Mitchell, Ye & Wiseman, 1999, p. 30-31)

[3] There is the thought that Oriental Medicine in the US is the latest development in the long history of OM, that the Western influence on the medicine is the next step of transformation and development of the medicine. This may very well to be true, but for the West to build on OM, the West must first learn OM. Just as the other offshoots of Oriental Medicine are grounded in the *Nèijīng*, the West must learn the foundations and build from there (see "Contention and a Call for Further Research").

Further, the author of the *Zhēnjiǔ Jiǎyǐ Jīng*, *Systematic Classic of Acupuncture and Moxabustion,* credits the *Nèijīng* with "tackling all the relevant, abstruse and complicated problems [of medicine]" (Yang & Chace, 2000, p. xxiii).

This widely diverse group of OM practitioners, all basing their unique approaches to medicine on the *Nèijīng,* also has a tremendous amount of other materials upon which to rely for assistance in the clinic. These materials include:

- other primary ancient medical texts, such as:
    - *Shénnóng Běncǎo Jīng* 神農本草經 [神农本草经] *Shénnóng's Materia Medica Classic*[4,5] (unknown date of authorship),
    - *Shānghán Lùn* 傷寒論 [伤寒论] *Treatise On Cold Damage*[6] (Hàn Dynasty, 206 BCE-220 CE),
    - *Jīnguì Yàolüè* 金匱要略 [金匮要略] *Essentials from the Golden Cabinet*[7] (Hàn Dynasty, 206 BCE-220 CE), and
    - *Nán Jīng* 難經 [难经] *Classic on Difficult Issues*[8] (Hàn Dynasty, 206 BCE-220 CE),
- major philosophical texts such as:
    - *Yì Jīng* 易經 [易经] *Book of Changes* (unknown date of authorship),

[4] Shénnóng's materia medica actually belongs in the same category as the *Nèijīng*. Both are foundational texts upon which all others are based. Shénnóng's text is the locus classicus for herbal medicine (along with the *Tāngyè Jīng* 湯液經 [汤液经], which is not available in modern times), while the *Nèijīng* is the locus classicus for OM theory, in general, especially acupuncture and moxibustion.
[5] An English translation is available through Blue Poppy Press.
[6] An English translation is available through Paradigm Publications.
[7] An English translation is available through Paradigm Publications.
[8] An English translation is available through University of California Press.

  - *Huáinánzǐ* 淮南子 [淮南子] *Masters of Huainan* (second century BCE), and
  - *Dào Dé Jīng* 道德經 [道德经] *Classic of the Dao and Its Virtue* (sixth century BCE),
- traditional and modern commentaries on these texts, often considered nearly as important as the text itself, e.g., Wáng Bīng 王冰 [王冰] and Zhāng Jièbīn 張介賓 [张介宾] and their commentary on the *Huángdì Nèijīng*;
- a multitude of other major medical texts authored over the last two thousand years, such as:
  - *Zhēnjiǔ Jiǎyǐ Jīng* 針灸甲乙經 [针灸甲乙经] *Systematic Classic of Acupuncture and Moxabustion*[9] (282 CE),
  - *Zhēnjiǔ Dàchéng* 針灸大成 [针灸大成] *Grand Compendium of Acupuncture and Moxabustion*[10] (1601 CE),
  - *Pí Wèi Lùn* 脾胃論 [脾胃论] *Treatise on the Spleen and Stomach*[11] (1249 CE), (one of the texts from the "four great schools" *sì dà jiā* 四大家 [四大家], the school of supplementing earth *bǔ tǔ paì* 補土派 [补土派]);
  - Other widely read and respected texts, such as *Fù Qīngzhǔ Nǚkē* 傅青主女科 [傅青主女科] *Fù Qīngzhǔ*'s *Gynecology*[12] (1972 CE), and Sūn Sīmiǎo's 孫思邈 [孙

[9] An English translation is available through Blue Poppy Press.
[10] Certain volumes are available in English through Blue Poppy Press and the *Chinese Medicine Database*.
[11] An English translation is available through Blue Poppy Press.
[12] An English translation is available through Blue Poppy Press.

思邈] *Bèi Jí Qiān Jīn Yào Fāng* 備急千金要方 [备急千金要方] *Essential Prescriptions Worth a Thousand Gold Pieces*[13] (652 CE); and

- countless clinical case studies, modern and classic, dealing with core texts and theories, as well as modern adaptations, such as with new disease presentations and patients on pharmaceuticals.

Collectively, these materials perform three important functions. First, they spell out the essential concepts and principles of Oriental Medicine. Second, they provide guidance in practicing this unique approach to medicine. Lastly, they give a plethora of examples of such use, along with discussions of outcomes, via detailed case studies. They therefore constitute the evidence base for the medicine.[14]

Put more directly, these materials define the medicine and have provided evidence of its effectiveness through reporting outcomes via case studies and collective reporting of clinical experiences through texts such as the *Huángdì Nèijīng*.[15] As of this writing, only a small fraction of these materials are readily available to non-Chinese-speaking practitioners (details on this in chapter three).[16] Further, it is believed by some experts that, at no point, will all the material available in Chinese be translated due to the sheer volume of the information (Flaws, 1998). This means those practitioners who do not speak Chinese and, thus, do not have access to Chinese

[13] An English translation is available through the *Chinese Medicine Database*.
[14] Use of the term "evidence base" poses some challenge as it is used in a similar manner in biomedicine. Here, it has the same essential meaning, the same spirit. However, that which it actually refers to looks different than that of biomedicine. This is a direct result of the core differences of these approaches to medicine discussed later.
[15] These are both good examples of both the similarities and differences in evidence types of Oriental and Western biomedicine.
[16] Paradigm Publications (sold through Redwing Books http://www.redwingbooks.com), Blue Poppy Press (http://www.bluepoppy.com), Eastland Press (http://www.eastlandpress.com/), and the Chinese Medicine Database (http://www.cm-db.com) being primary sources for Oriental medical literature in English.

materials have extremely limited access to the evidence base of the medicine that they practice. That is, they cannot access directly the materials relaying the essential nature of their medicine, nor benefit from the tremendous library of texts and writings of past physicians. This is of concern to the practitioner, their patients, as well as the OM field, at large.[17]

What does it mean to be detached from the theory and evidence underlying medical care? Why is it so important? In general, one wishes to be successful in one's endeavors. For a professional, it becomes even more important. Where one has invested time and energy in studying a particular field, a positive outcome is expected when the acquired knowledge is applied. Additionally, those receiving the benefit of that knowledge, i.e., clients with their lawyer, customers with their mechanic, rightly expect quality service. There is not only money exchanged in such interactions, but trust. With medicine this is doubly important.

As was discussed above, the practice of medicine is unique. Medical professionals deal directly with suffering, something our entire species instinctively dislikes. This uniqueness translates to tremendous amounts of money spent and immeasurable trust placed in the medical profession. Practicing medicine well is, therefore, of paramount importance, and in order to practice it well practitioners need to be grounded in quality information and a thorough understanding of that information. They need access to information that is appropriate and fitting to their clinical needs, of sufficient depth of real world scenarios, and reliable.

[17] Nigel Wiseman directly states that "linguistic access is the most important thing for the development of Chinese medicine in the West" (2000, p. 36).

For practitioners of Oriental Medicine, this information needs to guide and assist them in arriving at an accurate OM diagnosis and performing individualized treatments and, importantly, with a high, predictable likelihood of achieving specific results. This is a distinctive challenge to OM practitioners, as the field is fundamentally dissimilar to the current dominant medical paradigm, that of biomedicine.[18] These differences can be seen in a few key areas. For example, biomedicine is inherently reductionist, materialistic, and mechanistic. That is, focus, both in clinical practice as well as research and development, is on constituent parts, or tangible pieces of the body and their distinct properties. Oriental Medicine, on the other hand, is fundamentally holistic and spiritual in nature ("spiritual" here is used in a technical sense, referring to a core belief in the "immateriality of the intellect and will" (Spiritualism, 2013)).

Both in its basic theories and in direct patient interaction, OM focuses on the complete person. OM professionals may identify varying aspects of a person, such as physical or psychological; however the focus and understanding is always based on the complete person. The emphasis in diagnosis and intervention is always on the whole, not an isolated part or piece.[19] Ellis, Wiseman and Boss (1991) refer to this holistic picture as a "subtle mosaic of correspondences":

> In Chinese acupuncture, parts of the body, theoretical constructs, organ functions and pathologies, psychological and physical signs, acupoint names and categories, relationships to pathology, and the indications by which treatment is selected are all

[18] Comparison of these two systems of medicine is worthy of a full book itself. What follows is a brief summary and overview.
[19] A treatment may focus on a single channel or body part, for example. However, those are always approached as aspects of a greater whole.

> linked in a subtle mosaic of correspondences that must be preserved for the full clinical picture to be understood. (p. viii)

Further, core clinical entities, such as qì 氣 [气] and shén 神 [神], are essentially non-material aspects of the human being.[20] Though their influences and actions are evident and open to manipulation, they are not tangible entities, themselves.

It takes a lot of knowledge to support effective delivery of medicine and, in the practice of Oriental Medicine, the need is for a depth and nature of understanding appropriate for its methods and approaches. These methods start with a mindset and certain perspectives on health and illness that often vary from those of contemporary times. They lead to distinct types of diagnoses, treatment approaches, and techniques that are of a different nature than that of biomedicine. The need for a solid base of theory and experience is no different than biomedicine, but the base, itself, is very different.[21] Thankfully, this evidence base exists. Unfortunately, it is inaccessible to many of the practitioners.

[20] Qì is a wholly unique term, worthy of much greater discussion. To say it is non-material must be qualified with "essentially." Maciocia, Wiseman, and Unschuld all speak about qì as if it exists at the point between material matter and pure, non-material energy (Maciocia, 2005; Wiseman, 2002a; Unschuld, 1986). Unschuld speaks directly to the fact that qì, as "finest" or "dispersed" matter, was contrasted directly with solid matter, by the ancient Chinese (1986, p 5).

[21] Here, then, is a basic similarity between the medicines – professional medical care rooted in evidence of effectiveness. A related and key difference being the specific nature of that evidence, discussed to some degree in chapter three, and the nature of this evidence is a reflection of their fundamental differences mentioned elsewhere. Thus, they both require reliable evidence upon which to base assessment and intervention, but that evidence appears different for each.

Where practitioners do not have access to these basic, core materials, they are left to rely on that which is either less reliable or perhaps inappropriate for the OM style of medicine.[22] A prime example can be found in the common curriculum in the US, where Oriental Medicine is predominantly dependent on a few authors to generate the majority of the standard texts.[23] With such a diverse and complex history, the narrowing down of a professional medical curriculum to the ideas and understanding of only a few practitioners inevitably, through no fault or failing of those authors, leads to a loss of depth and substance.[24] This may effectively stunt a practitioner's development and limit their ability to expand and deepen their clinical abilities. The medicine taught and learned in such circumstances offers far too narrow an understanding of the medicine and risks locking this narrow understanding in the minds of these practitioners, creating an obstacle to further study and education. Such training will, inevitably, reflect the opinions and experiences of those few authors, missing a larger view on two thousand years of texts and case studies. Nigel Wiseman, Chinese language scholar, states, "We have a body of literature that is partially composed of narrow, often overly personalized views of Chinese medicine" (2000, p. 29). Kovacs and Unschuld (1998), further, speak of how the texts on OM in English are "selective," intentionally omitting certain aspects or areas of the medicine, thus leaving readers dependent on these texts, i.e., non-Chinese-speaking, with a limited and slanted view of the medicine.[25,26]

[22] Unschuld (1985, 2011), Wiseman (2000), and Kovacs (1998) all discuss the problems with arguably inauthentic OM materials in English.
[23] Giovanni Maciocia (2005, 2007) for basic theory and diagnosis, Bensky, et al (2004, 2009) for herbs, Deadman (2007) for acupuncture point theory and location.
[24] A good example of mitigation of this problem through presenting a collective (four authors, here) and well researched body of information, as in Bensky, Scheid, Ellis, & Barolet, 2009.
[25] It is, of course, impossible to learn 2,000 years worth of medicine; inevitably, what is learned in a basic curriculum will be far shy of all the medicine has to teach. However, ideally, a standard curriculum would offer the foundations and essentials of medical practice as determined by a consensus of experts.
[26] As is noted throughout this paper, this problem is widely acknowledged and is actively being addressed.

Further, these authors' texts may not have become the most widely used as a result of any sort of professional vetting process.[27] That is, in the field's still youthful stage of development, there is little competition for publication, much less sufficient numbers of highly educated practitioners capable, collectively, of critically assessing the appropriateness or quality of published texts.[28,29] This leads to the situation of a new professional medical field dependent on a small selection of texts upon which to train, and eventually test for licensure, new practitioners.

Fully licensed practitioners are at a similar loss. With so few authors able to access the rich evidence base, too few texts or publications are available for non-Chinese-speaking practitioners.[30] When they meet a challenging clinical scenario, they are barred from tapping into the vast library of Oriental Medical literature for assistance. This may lead to either less than ideal OM treatment quality or, quite common in the US, inclusion of non-OM concepts, theories, principles, or techniques.[31,32] Paul Unschuld reflects on the nature of OM in the West, and its relation to the roots of Oriental Medicine in the Hàn Dynasty when foundations were laid down:

[27] A potential, future, informal vetting process could occur when more practitioners know Chinese. When more know Chinese, more could discern authentic OM information (Wiseman, 2000).
[28] Problems with English Chinese Medical texts are discussed in important detail in Nigel Wiseman's *The Transmission and Reception of Chinese Medicine*, as well as Unschuld's translation of the *Nán Jīng*.
[29] Not only has there been little competition for publication, but in fact nearly the exact opposite, where the medicine is thirsty for texts and materials.
[30] This problem has been acknowledged by many, with several authors attempting to fill the void. See, for example, Clavey (2002), the seven volume series by Sionneau & Gang (1996), Flaws & Finney (1996), Ross (1984), and Sionneau (2000). Despite these and other additions, the total OM library available in Chinese dwarfs the English counterpart, as discussed later.
[31] This is a recurring theme in the writings of the practitioners, sinologists, and medical anthropologist cited in this research. A good example can be seen in Unschuld (1986) where he discusses how authors of several OM texts do not have access to primary sources and resulting in information that reflects occidental, not Chinese, thinking.
[32] Nigel Wiseman draws a direct link between quality of translated texts and quality of care, saying it is the "hook upon which the practitioner's entire clinical bag of tricks hangs" (2009, p. 30). One clear example of limited access to information affecting clinical care is with the processing of Chinese herbs (as discussed in Sionneau, 2000).

> The creative reception of so-called TCM [Traditional Chinese Medicine] in many Western countries has led to a conceptual and clinical reality that is rather distant from its beginnings in Han-Dynasty China. (2011, p. 10)

Though not inherently bad, the resultant hybrid – of limited OM training and understanding and non-OM concepts and practices – is 1) potentially divorced from a sound base of evidence, and 2) not Oriental Medicine, as is labeled for the public and other professions. The first challenges the basic medical ethic of practicing proven reliable medicine, while the second presents the risk of false representation or misrepresentation.

Further, when a practitioner is exposed to a limited amount of materials from a select few authors, without the benefit of formal critical evaluation or consensus development, that practitioner's ability to navigate medically complex clinical scenarios is dramatically limited. As a result of the filtering process, where little information ends up available for the non-Chinese-speaking practitioner, what is available is often of a "cookbook" nature, limited to a small number of diseases, or otherwise overly simplified.[33]

This makes sense, for when limited materials make it to the physician's desk, it could be argued these are the most critical to convey initially. In fact, Nigel Wiseman states point blankly, "In the development of Chinese medicine in the West, emphasis has been placed on immediately utilizable clinical information to the detriment of an accurate representation of East Asian

[33] This is discussed further by both Bob Flaws (1994, 1996) and Philippe Sionneau (1996).

practice…" (2000, p. 1). He also presents a second argument for the plethora of simplified OM materials available in English:

> Simply put, it is very much easier to present Chinese medicine in this simplified form: The market for simplified books is always larger and simplified books are much easier and less expensive to produce. There is no need to spend a lot of time and money preparing dictionaries or glossaries to explain the terms used. (2002, p. 4)

In a cookbook approach to medicine, symptoms or diseases are presented alongside suggested treatments in a one-to-one format, i.e., "this medicine for that issue." An example may be "for frontal headache, use point X or herbal formula Y." Additionally, some of the earlier formal OM text books, such as Maciocia's *Foundations*, tended to cover the same basic diseases and a limited number of basic OM disease patterns for common diseases.[34]

To some degree, these approaches are valuable medicine. After all, they do aid in dealing with patients. They appear to have assisted modern US practitioners in providing symptom relief for countless patients and, even, in demonstrating positive outcomes in clinical research.[35,36] Very quickly, however, the shallow, limited nature of such an approach to medicine becomes obvious. Complex clinical situations arise where this style of medical care is, often dramatically, insufficient and professional practitioners seek greater capability.

[34] Hence, the reported need for the texts mentioned in the previous page, i.e., Clavey (2002), the seven volume series by Sionneau & Gang (1996), Flaws & Finney (1996), Ross (1984), and Sionneau (2000).
[35] Anecdotal evidence from peers, personal experience, and reports from OM journals and newspapers.
[36] I have, personally, collected research on acupuncture and made it available at http://www.denverchinesemedicine.com/BlogResearch.html, and the Society for Acupuncture Research also has a detailed website http://www.acupunctureresearch.org.

One lecturer/practitioner, Edward Neal, MD, LAc, labels at least part of that which is not being taught, what is missing from the modern US curriculum, and limited or "cookbook" approaches, as "physician-level" thinking (E. Neal, personal communication, 2013).[37] This level of clinical ability is based on a combination of honed critical thinking skills and a thorough understanding of the core paradigm, for example as laid out in the *Nèijīng*, to such a degree it can be applied originally and uniquely in complex clinical scenarios. A closer look at the cookbook approach (as well as any number of similarly limited or reduced treatment selection methods) reveals, for example, the fact that underlying the simple "this treatment for that disease" approach is a clinical analysis. This analysis was carried out by the originating author and lead to the suggested treatment. In other words, the author made an assessment or diagnosis of a clinical situation and decided the given treatment was appropriate.

The problem is, of course, that the original author is not present at the current situation. The physician applying such cookbook formulas is making the assumption that the patient is experiencing what the original author was assessing, and that the problem the original author saw and for which he or she suggested treatment, is exactly the same as the current situation the physician is facing. This physician is, thus, removing themselves from the core of the diagnostic process. He or she is borrowing the assessment of the original author, more or less acting as an intermediary in the assessment and treatment planning event.

[37] This concept of "physician-level thinking" is from lectures with Dr. Neal. What follows, however, is my own interpretation and understanding of the concept and its role in the practice of Oriental Medicine.

This situation reminds me of my early days in Emergency Medical Technician (EMT) training. We were trained to recognize certain types of illnesses and taught when and how to give the appropriate treatment for those conditions. Our training was limited to a certain level of medical care, simply recognizing a pre-determined set of medical problems and the corresponding interventions. However, we were technically and legally working under the direction of an MD. The nature of the illness and the best, most appropriate therapy was decided ahead of time by a physician. We were specifically told that we were not making a diagnosis (we were, in fact, legally disallowed to make a diagnosis). Our knowledge and training was not at the level where we could formally assess the condition; we merely mapped it to a pre-set list of problems and solutions. This was best exemplified in Advanced Cardiac Life Support training, where we simply ran down algorithms we had memorized (or had written down to refer to when needed) in response to serious emergencies.

As a simple example of this cookbook-type of approach in Oriental Medicine, pain is generally said to be due to the obstruction of qì and blood (bù tōng zé tòng 不通则痛 [不通则痛] when there's no movement, there's pain). A cookbook approach to treating a pain condition could involve the use of the "Four Gates" (four acupuncture points on the hands and feet), i.e., the instruction would be "when there is pain, use the Four Gates." This is based on the assumption that the pain is due solely and simply to the obstruction of qì. Though pain may always, and sometimes only, involve qì blockage, there may very likely be other OM patterns present, making the generic cookbook approach less effective.

With herbal medicine, an example of a cookbook approach could be using a premade tablet or pill version of a formula for the generic disease class for which the formula is appropriate. For example, this would be the case if a tablet version of Suānzǎorén Tāng 酸棗仁湯 [酸枣仁汤] is given for insomnia because this formula is only appropriate for certain types of insomnia.

When using such generic approaches, the assumptions underlying the assessment and suggested treatment may be more or less appropriate for the patient at hand. When a practitioner follows such approaches, he thus removes himself from the role of primary or immediate assessor of the patient before him, opting out of the bulk of the critical thinking component of care.[38]

This is a highly undesirable arrangement for all involved. The original author's treatments and books may seem ineffective because they are being applied inappropriately, for instance in the wrong clinical scenario.[39] More importantly, the patient is not receiving the highest level of medical care, as her practitioner is not assessing her directly. She is, effectively, being diagnosed from a distance, by someone not present to her and her suffering. Also, she is, in a way, being treated as a statistic. That is, the suggested treatment may often be appropriate for certain disease presentations (where the underlying pattern matches, for example). Without a complete and thorough assessment, though, the likelihood of a positive outcome is reduced. The medical provider, in these cases, is thus reduced to guessing whether a treatment will work and relying on

[38] Discussion of this type of care can get complicated. There is both pre-modern precedent, such as in the *Zhēnjiǔ Dàchéng* (see Yang and Liu, 1994, for an English translation of book eight and the treatment formulary), as well as modern examples, as in the Master Tung style of acupuncture (see Young, 2008), where relatively simple symptom-treatment pairings are seen (versus pattern differentiation). These could be quasi-cookbook styles or not, depending on the practitioner's understanding and specific rationale for use. As hopefully will be made clear, the essential point is that the nature of care reflects the depth of the practitioner's understanding in her diagnosis and treatment selection.

[39] And, thus, a potentially valuable medical reference, such as the *Zhēnjiǔ Dàchéng*, becomes under-utilized.

someone else to do the brunt of the clinical thinking. This guess work directly undermines the predictability required in professional medicine and may challenge the trust placed, by patients, in their medical provider.

Lastly, in such situations, where the treatment has limited or no effect, or where unexpected, possibly negative adverse reactions occur, the physician that effected the clinical assessment directly is unable to analyze how or why little, no, or unwanted effects occurred. He is unable to make necessary adjustments, tailoring the treatment for his patient, either increasing effect or minimizing unwanted effects.

This general argument, against cookbook-type medical practice can be extended in varying degrees to other situations in US practitioners' clinics. For instance, the common, possibly over-used, diagnosis of "qì and blood stagnation" is often vague, lacking a more complete, comprehensive understanding of the term and meaning, as well as the presentation of the patient for which the assessment was made.[40] The diagnosis is, thus, used in a cookbook manner, where deeper understanding is lacking. The practitioner relies on someone else's assessment and clinical judgment, and utilizes a simple one-to-one assessment and treatment.

There are, effectively, gradations from simple symptom/intervention pairing, such as headache and the acupuncture point Hégǔ 合谷 [合谷] LI 4, to more complex differentiated presentations or disease patterns, such as frontal headache or "liver qì stagnation" paired with more complex interventions. This continuum could be seen as a progression from reliance on someone else's

[40] Personal observation.

assessment and understanding, i.e., a technician's role, to a more direct analysis, building up from one's basic understanding, of the treating practitioner. When the practitioner applies her understanding of core principles, versus conclusions drawn from someone else's, and generates an original assessment she is acting in a manner more appropriate for physician-level care (the direct and immediate application of principles being the hallmark of such care, compared to simply applying someone else's assessment.)

To build on the previous examples, a practitioner working more from a physician role and less from that of a technician may observe that the pain is located under the ribs, occurs with acute emotional frustration, and dissipates rapidly with resolution of the frustration. Understanding the nature and channel pathway of the wood/liver phase, she could arrive at the assessment of acute liver depression, qì stagnation due to emotional constraint and use only the two of the Four Gates most directly affecting the liver organ and channel.

In the herbal example, a more thorough assessment may reveal, for instance, aching low back, seminal emission, or other kidney deficiency signs suggesting the insomnia is better treated by a heart and kidney deficiency approach, say, with Tiānwáng Bǔxīn Dān 天王補心丹 [天王补心丹] Celestial Emperor Heart-Supplementing Elixir.

In a simplified version of intervention, a mere mapping of symptom to treatment is made – pain, to the Four Gates, insomnia to Suānzǎorén Tāng. In more complex, practitioner-led, physician-type interventions, the practitioner gathers more detailed information, analyzes it according to more basic, core principles, e.g., the nature of the wood phase, liver organ and channel pathway,

or comparative organ pathology, and creates a treatment specific to that assessment. She is more directly engaged in the diagnostic process.

As practitioners of OM we should strive for this highest, physician-level thinking and care. Without direct access to source materials – the rich OM library available in Chinese – though, practitioners may find themselves in more of a technician role, following treatment algorithms, than that of physician role.[41] They are left to carry out someone else's treatment, based on the analysis and judgment of another. Ideally, as professional OM practitioners we would understand essential principles and be able to assess our patients directly. Even in a situation in which the same treatment is given as that found in a basic cookbook text, in a physician-level thinking scenario, a formal and complete assessment is made of the patient being treated.

More likely, especially in a US acupuncture clinic where complex symptom presentations are more the norm than the exception, physician-level thinking allows a practitioner to deal competently with challenging cases. Cookbook approaches are inherently limited to more easy to describe and review illnesses. Due to the very nature of having to simplify things in order to assist a practitioner with limited OM training, the covered diseases and recommended treatments are all of a simpler, straight forward nature. This is exactly the scenario, discussed previously, wherein the practitioner faces exceedingly challenging situations. Such a practitioner is forced to either do less than she truly desires or incorporate other therapies or techniques to help compensate for the lacking OM diagnosis and/or treatment skills.

[41] Access must, of course, be coupled with actual study of source materials.

This has become apparent in numerous conversations I've had with practitioners over my many years in Oriental Medicine. Often practitioners find themselves reliant on what are referred to as "shotgun" approaches, where multiple therapeutic approaches are employed (e.g. acupuncture points with overlapping actions along with the use of auricular points) with the hope that at least one of them will have positive therapeutic effect. Alternately, they may rely on overuse of certain techniques, such as electrical-stimulation of points. Further, practitioners often begin incorporating other alternative modalities in an effort to increase overall treatment effect, such as various supplements, oils, Western herbs, etc. (obviously, inclusion of any of these does not necessarily indicate insufficient OM knowledge or ability, nor does it necessarily result in lesser overall quality of care).

Physician-level thinking, rooted in the study of primary source OM materials, allows the practitioner to engage in complex situations and apply OM principles at a whole new level. When modern times bring new diseases or situations, such as patients on multiple pharmaceuticals, this type of thinking empowers practitioners to apply OM principles that lead to an OM diagnosis and treatment intervention. Such adaptability has been a cornerstone of the long running medical tradition of Oriental Medicine – applying core concepts to new situations.[42] It could be said that this situation better captures the essence of Oriental Medicine than that of applying formulaic treatments.[43]

[42] See Unschuld 2003 and 1985 for discussion on the creation of the primary-source text, the *Huángdì Nèijīng*, as well as the development of the medicine, overall. Basic concepts, essentially defining the medicine, have been applied in numerous ways, in the face of various disease presentations, in different environments, and so on.
[43] Such formulaic treatments being an outgrowth or result of the application of core principles to different situations.

Physician-level thinking, however, requires a level of understanding beyond what can be attained without direct study of primary-source materials.[44] Dr. Neal, for example, makes available training that is centered on direct study of the *Huángdì Nèijīng*.[45] Other highly knowledgeable, Chinese-speaking practitioners offer assistance in breaking through the limitations of modern texts that are forced to summarize and offer a cliff-note-type of education. For instance, it was reported to me by several of the practitioners with whom I spoke that modern texts take lines or quotations of classical texts out of their original context, leaving the reader with a superficial understanding of such concepts. In medicine, superficial understanding makes for superficial treatment. These types of texts are either expected in the beginning developmental stages of a field, where OM finds itself in the modern US, or they may be appropriate for a target audience that has already been exposed to source materials. Here, the reader would have the proper context in which to apply the information. They would, then, act as adjuncts to an otherwise robust curriculum.

With direct study of source materials (and most importantly the core classics), foundational ideas can be studied in their home context. When quotations of source texts are used to support theories, a technique common in modern texts, a mere flavor of the original is experienced. A great example can be seen with the basic five-phase chart. Here, when simply seeing and memorizing the grid-like chart, the greater context of the phases representing stages of continual development, waxing and waning of yīn and yáng, etc. can be missed. One can also miss important therapeutic information when simply memorizing chart-based correspondences. For

[44] That is, these materials must be available, accessed, and studied successfully. Access is necessary, but not sufficient in itself. Where they are not accessible, study cannot occur.
[45] See http://edwardnealmd.com for details.

instance, the water phase corresponds with the kidneys as well as the salty flavor. This is widely known and taught in any basic OM text. However, when removed from the home context and simply memorized without deeper investigation one could interpret this correspondence to mean the salty flavor strengthens or supplements the kidneys. With deeper study it is realized, however, that salty flavor and the water phase (and thus the kidneys) merely have a basic nature in common. Emphasizing one, for instance eating more salty foods, does not necessarily strengthen the other, i.e., the kidneys. Strengthening is a specific therapeutic action. To have that effect, the bitter flavor is more appropriate, for instance with herbs that drain fire to consolidate yin.[46]

One can also miss themes of authors or texts and the styles of OM they advocate, when only quotations are studied and not the entirety of the texts. Repetition of certain terms or even medicinals, as well as avoidance of certain terms, for example, in texts can help the student gain a more complete feel for the mindset underlying the system. This, in itself, is a significant limitation. Further, instead of being exposed to the original intent, the student is more likely exposed to the current, modern author's ideas, experiences, and opinions. Here, again, we see the student being removed from direct access to the evidence base, instead becoming dependent on someone else's analysis.

The basic problem seen here is that, without access to the OM source texts and other materials constituting its base of experience and evidence, all aspects of professional care suffer. Students and practitioners are left insufficiently educated and poorly equipped to wield the power of the

[46] This *consolidating* of yīn is also a good example of the process, movement orientation of OM versus the more static, state oriented nature of biomedicine, discussed later. That is, more yīn is not *added*. Instead, the dynamic nature of yīn, i.e., consolidation, the act of contracting, is assisted or emphasized therapeutically.

medicine, while their patients receive less than ideal or misrepresented care. At best, this situation is an unfortunate loss of a grand opportunity – to study, practice, and receive quality Oriental medical care. At worst, it violates basic medical ethics related to treatment and misrepresentation of skills known and practiced by licensed healthcare professionals.

2. Limitations of Translations and the Issue of a Technical Terminology

Early in my OM training, one of my professors asked if I would be getting into translation. My response was one that I have, since then, heard many times from multiple other practitioners – why does an OM practitioner need to learn Chinese, when there are already those that do, especially when those translators have so much greater expertise and experience in translation? This question is telling of several misunderstandings about the nature of language and translation. The discovery of those misunderstandings and the uncovering of some truths of translation were primary motivating factors for this current research and writing.

Put simply, there is no such thing as a perfect translation. Put another way "All translation involves loss" (Bensky, et al, 2006, p. 14). Bob Flaws, quite possibly the field's most prolific OM author and owner of one of the largest OM publishing companies, Blue Poppy Press, states clearly that "No matter how good the English language translator is, they can never fully express all the connotations nor the logic of presentation inherent in the original Chinese" (1998, p. vii). Giovanni Maciocia, arguably the most popular and widely read OM author in the US, states "… there is no such thing as a 'correct' translation of a Chinese term… in fact, Chinese medicine terms are essentially *impossible* to translate" (1998, p. xxiii). Lastly, from the main Chinese herbal medicine text used in US Oriental Medicine training, the authors speak to the extensive troubles in trying to translate Chinese materials:

> Translators are caught in a number of binds. Literal translations are often misleading, seemingly precise translations are inaccurate, and accurate translations can be so vague as

> to be almost meaningless or so long as to be minor treatises. Phrases or terms that flow well in Chinese can be extremely awkward and even silly in English. (Bensky & Gamble, 1986, p. 693)

For reasons that will be detailed shortly, the rendering of Chinese texts into English cannot be done with absolute fidelity.[47,48] To fully appreciate this fact, one would actually need an understanding of both languages. As the saying goes – for those who have had the experience, no explanation is necessary; for those who have not, none is possible. It has been in crossing that gap that I am so motivated to report to those who have not made the journey the awakening that is awaiting them.

Learning Chinese truly opens up a whole new world. When I began learning Chinese in earnest it, was literally like learning the medicine all over again, but at a much deeper, richer and more complete level. The difference was something like seeing a faded, black and white picture of a forest versus actually stepping into a rain forest with its surreal, enveloping greens and lush atmosphere. Another practitioner/translator related her initial experience in translating:

> I felt like I had opened up a treasure chest. I felt like I had seen in black and white up until then; I felt like Dorothy arriving in Oz, and suddenly everything was in color. (L. Wilcox, personal communication, October 11, 2013)

[47] This should not be misconstrued to mean there are not varying qualities of translation (discussed later in this section); simply that there is no such thing as a perfect, exact translation.
[48] It may be possible to convey, in translation from Chinese to English, all that is contained in the source text. However, to do so requires adding significant additional material in English to explain cultural and philosophical context, for example. All in all, for reasons to be detailed in this section, relying on translations is a highly undesirable situation for professional medical practice.

As the aforementioned Dr. Neal has shared, it is like standing outside a movie theater, asking those leaving, what Casablanca was about, versus going to the movie one's self. There is a dramatic difference that cannot be understood except through direct personal experience.

Somewhere in the mid-stage of my research, I realized that it may not be possible, or even needed, for all OM practitioners to be expert translators, though.[49] Just as any city has multiple types of professionals and craftsmen, a profession has places and needs for varying types of skills, abilities, and expertise. That being said, it is ideal that each citizen have some basic knowledge of other's skillsets. This would allow everyone the ability both to appreciate other roles, as well as make appropriate referrals. As all OM professionals are, ultimately, dependent on Chinese texts, every OM professional should have basic knowledge of Chinese and knowledge of the difficulties and challenges in translation.[50] Each OM professional should have direct access to primary-source materials and understand where and at what point to refer, or defer, to experts in Chinese language. Such shared and spread knowledge could be considered a key defining characteristic of a profession. A parallel could be drawn with biomedicine – MDs are not required to be professional mathematicians, biologists, or chemists, yet they are required to take courses in these topics prior to applying for medical school. These courses help them appreciate developments in, and contributions to, the field by those areas.

[49] A thought shared by the professional sinologist Nigel Wiseman. See *The Transmission of Chinese Medicine: Chop Suey or the Real Thing?*

[50] Nigel Wiseman reports translation will always be of great importance in the US, as it is highly unlikely all practitioners will learn the language themselves (2000). This makes understanding the nature of translation all that more important.

To that end, some challenges and inherent limitations of translation need be widely understood.[51] The first, and perhaps most difficult, issue is that Chinese and English languages represent different fundamental ways of perceiving the world around them.[52] For example, from the proceedings of an international symposium on translation methodologies and terminologies edited by Paul Unschuld (1989), Constantin Milsky reports, "… the spirit/matter, abstract/concrete dichotomy deeply rooted in our Western thinking is totally alien to the Chinese mentality" (p. 78). Author of the most widely-used introduction to OM text, Giovanni Maciocia, writes about the "intrinsic difference between Chinese and Western thinking and therefore the inherent inability of Western terms to convey Chinese philosophical ideas" (n.d., p. 3); while the popular Chinese expert Huang (2008) discusses the issue from the perspective of a native Chinese-born and trained practitioner seeing the difficulties of a Western-born practitioner in appreciating the culturally-unique Oriental Medicine:

> Chinese medicine is a culture, a traditional living experience and Chinese way of living. It can be very difficult for overseas students that do not belong to the Chinese culture to understand and accept it completely. (p. vi)

An exhaustive discussion of this topic is far beyond the scope of this paper. However, some basics are already widely recognized in professional circles. The first is that Chinese is a highly

[51] It need be stated that translation is its own science. What follows is a very small, focused sampling of issues directly relevant to this research. See the numerous writings of Nigel Wiseman for further reading on Oriental Medicine and translation.

[52] This is a rather larger topic in its own right worthy of much greater attention than given here. For example, Richard Nisbett (2003) authored a text diving into this topic, *The Geography of Thought: How Asians and Westerners Think Differently… and Why.* For general discussion on language and perception see Stanford psychology professor Lera Boroditsky (2010) and her article *Linguistic Relativity*, as well as Adelson (2005) writing on how language affects color perception, and in popular press, *Does Your Language Shape How You Think?* (Deutscher, 2010).

contextual language.[53] It is, to use the popular term, very holistic. Oxforddictionaries.com defines holism as:

> …the theory that parts of a whole are in intimate interconnection, such that they cannot exist independently of the whole, or cannot be understood without reference to the whole, which is thus regarded as greater than the sum of its parts. (Holism, 2013)

Merriam-Webster defines holistic as "relating to or concerned with wholes or with complete systems rather than with the analysis of, treatment of, or dissection into parts" (Holistic, 2013).This means that, within this particular worldview, the nature of any given entity is dependent upon the context within which it is observed. That is a simple and very easily under-appreciated statement (especially when it is counter to the default mindset of the Western practitioner).[54]

Another way of discussing this is to say the existence of individual objects is deemphasized in a holistic view. Instead, interactions or relationships become dominant. When the characteristics of a discrete entity are determined by the context in which it appears that entity quickly becomes secondary to its relation to the world around it. That is, when an object's nature is determined by the surrounding environment, it is, essentially, *defined by* that environment.

[53] Discussed, also, in Bensky, et al (2006) and in-depth in Nisbett (2003).
[54] Wiseman and Zmievski (Unschuld, 1989) state outright "Westerners, brought up in the modern scientific tradition, have difficulty grasping Chinese medical concepts" (p. 55).

In the West, by default, we focus on specific things, such as people, chairs, tables, cars, etc. In Western-style medicine, we isolate specific concrete aspects of the body, such as hands, feet, neurochemicals, or blood components. The starting point is a specific object, the body, and the goal is to isolate other objects, often smaller and smaller parts or pieces. Discoveries are valued when they uncover new objects to explain certain phenomena, such as new biochemicals.[55,56] This standard Western medical approach is a direct expression of English. The same mirroring is seen in Chinese.

Oriental medicine, at its roots, is about change and process. Several authors discuss this in some detail. Manfred Porkert (1983) explains the varying philosophical bases of Western and Oriental Medicine by way of causal and inductive analysis as they relate to the difference between static states versus process, function, and movement. He further discusses the loss of meaning when one system is interpreted through the ways of the other (a recurring theme in this research). Elizabeth Rochat De La Vallee, internationally recognized author and scholar in Oriental Medical classics, also states that "[Chinese character] ideograms themselves are attempts to simulate living processes more than static entities" (Unschuld, 1989, p. 68); while Paul Unschuld speaks to the dynamic processes that are the core concepts of yīn, yáng, and the wǔxíng (2003).

The Chinese, through observation as investigation, saw perpetual transition. No individual, isolated object ever persisted for long; it changed into something else. Change was seen as the constant and, thus, the reliable, basic, fundamental truth. It was pointed out by one of this author's Chinese language professors, that Chinese uses many more verbs, and English makes

[55] See Porkert (1983) for comparisons between mindsets and the medicine of the West and East.
[56] Examples can be seen where neurochemicals are sought, and used, to explain mood and emotions.

greater use of nouns (C. Xu, personal communication, March, 2013). It has also been demonstrated that Western infants learn nouns more readily than verbs, while it is the opposite in East Asia (Nisbett, 2003). That is, action is more dominant in Chinese, where, in English, static objects play a more important role. In Oriental Medicine, this is reflected in the fact that the most basic aspects of the medicine are not directly isolatable or tangible entities, but instead speak to aspects of change and process.[57] Yīn 陰 [阴], yáng 陽 [阳], and qì 氣 [气], for example, are not concrete objects that, even theoretically, could be laid out on a table and counted. Though they can be experienced directly, they are not solid entities.

Again, comprehensive discussion of these terms is far beyond the scope of this paper. However yīn and yáng are often used to describe the nature of something compared to something else or to categorize things according to their relative natures. Nigel Wiseman states they are "categories for classifying paired phenomena according to their nature and mutual relationship" (2002a, p. 73). The quality of their interaction determines their essential nature, and not any intrinsic, individual properties. For instance, xuè 血 [血] blood is described as being yīn compared to qì, categorized as being more yáng. What are yīn and yáng? They are basic ways of describing the relative nature of things (or the relation of things), the characteristics of events or entities when seen in relation, in comparison, to other things. This is very characteristic of the Chinese way.

Neither English nor Chinese, nor either associated system of medicine, is exclusively holistic or non-holistic. Biomedicine recognizes systems, such as the immune system, which could not be

[57] Again, the ancient Chinese were also interested in anatomy and did, in fact, weigh and measure internal organs, for example. However, their overall emphasis and foundation appear to have been in the intangible, e.g., the basic concepts of yīn and yáng.

laid out on a table, and the core Oriental Medical classics gave detailed descriptions of anatomical entities that exist quite objectively. The difference between the two is, instead, a matter of focus or emphasis, especially in patient analysis or development of the medicine. A good example occurs nearly daily in my clinical practice. In working with patients, I, ultimately, search for the fundamental *nature* of their pathology. There is no need for a tangible, material aspect of their body to be identified. In a biomedical assessment, I would likely need to root out that piece or part of their body that is not functioning properly. A specific tendon, hormone, gland, or tissue would need to be isolated.

In this way, then, these medicines are truly complementary to one another.

Emphasis on process versus static state is a key difference in mindset, language, and resultant medical practice. Translation between systems often blurs that distinction, even overwriting the source intent in Chinese and Oriental Medicine for the target audience, English and US practitioners. For instance:

> In modern literature, the Chinese have discarded many traditional disease categories in preference for Western medical categories. For example, modern texts will speak of tonsillitis rather than *rǔ é* [乳蛾 {乳蛾}] (throat moth), and of hysteria rather than *zàng zào* [臟躁 {脏躁}] (visceral agitation). In Chinese texts, equivalents of this type appear side-by-side with the traditional Chinese descriptions. However, most English-language publications disregard the traditional terms altogether. (Ellis, Wiseman & Boss, 1991, p. v)

Porkert (1983) also speaks to this. Wiseman and Zmievski further tell of the often negative influence of the Western mindset in translating OM texts, stating, "A large proportion of English literature, including that produced in China, omits the apparently irrational, while reformulating in inexact Western medical terminology much of what is acceptable" (Unschuld, 1989, p. 55). Wiseman (n.d.) further states that OM terms are often translated using biomedical terms to "encourage the foreign reader to understand Chinese medicine not in its own terms but in terms of its relationship to Western medicine" (p. 4). In the same paper he gives the translation of qì as "energy" as a good example of not a translation but a "transposition of the concept into an alien modern frame of reference" (p. 5).

As was discussed above, the Chinese focus on change and transition. In studying the *Nèijīng*, it becomes apparent that Oriental Medicine is based on the idea that all things experience ceaseless flux. Within that text, discussion of the fundamental contraction/expansive nature of the universe, described fundamentally with the terms yīn and yáng, then the five phases (aka the "five elements," wǔ xíng 五行 [五行]), the seasons, the human life cycle, etc., all reveal a process-oriented worldview. Compare these fundamental topics of focus in OM to the focus on discrete anatomical and biological entities in Western biomedicine.

In this OM view, movement with this universal fluctuation is called shùn 順 [顺] and leads to health. That is, where one's activities are congruent with this basic universal process, there is health. From the *Nèijīng Sùwèn*, chapter one:

> ... I have heard that the people of high antiquity, in [the sequence of] spring and autumn, all exceeded one hundred years. But in their movements and activities there was no weakening. As for the people of today, after one half of a hundred years, the movements and activities of all of them weaken. Is this because the times are different? Or is it that the people have lost this [ability]?
>
> … The people of high antiquity, those who knew the Way, they modeled [their behavior] on yin and yang. (Unschuld, 2011, p.30)

Also, in chapter two, the *Nèijīng* advises to act in a manner consistent with the seasons for better health – for instance, in spring, going to bed late and rising early; in winter, going to bed early, rising late, avoiding cold, seeking warmth, avoiding sweating, and so forth (Unschuld, 2011).

Disease, then, is where and when such movement becomes obstructed or becomes excessive (bì 痹 [痹] and kuáng 狂 [狂], respectively), for instance, when one violates the basic yīn-yáng nature of day and night by working at night and sleeping during the day, drinking excessively, etc. Following on the above *Nèijīng* excerpt, "The fact that people of today are different is because they take wine as an [ordinary] beverage, and they adopt absurd [behavior] as regular [behavior]" (Unschuld, 2011, p. 32); and from the end of chapter two:

> … the yin [qi], yang [qi], and the four seasons, they constitute end and begin of the myriad beings, they are the basis of life and death. Opposing them results in catastrophe and harms life. If one follows them, severe diseases will not emerge. This is called "to achieve the Way".

> … If one follows yin and yang, then life results; if one opposes them, then death results; if one follows them, then order results; if one opposes them, then disorder results. (Unschuld, 2011, p. 56)

Intervention, it follows, is primarily aimed at restoring proper flow, adjusting activities to align with the fundamental movement of existence, and adjusting the flow of qì and blood through the channels.

Compare this with the biomedical model, which also includes flow and process, but is more focused on the pieces, parts, or things doing the movement, not the movement, itself.[58] The easiest example of this is when illness is addressed by simply removing a piece or part, for example, an organ or a tumor. The underlying process of the tumor development or how or why the part broke down receives less emphasis than intervention targeted at the concrete object.

Pharmacotherapy is also a good example, where the receptor model has pharmaceuticals acting to physically block chemical receptors in the body (Katzung, 2001). For example, the process of discovering new receptors is a matter of looking at the interaction of *physical structure* in the body and the chemical *structure* of pharmaceuticals: "The process of defining a new receptor begins by studying the relations between structures and activities of a group of drugs on some conveniently measured response" (Katzung, 2001, p. 10). This has, in fact, become a major focus in modern pharmacotherapy research:

[58] The treating and "fixing" of parts of the body is a good example of the mechanistic underpinnings of biomedicine.

> … receptors have now become the central focus of investigation of drug effects and their mechanisms of action (pharmacodynamics). The receptor concept, extended to endocrinology, immunology, and molecular biology, has proved essential for explaining many aspects of biologic regulation. (Katzung, 2001, p. 9)

Such research serves as a good example of the fundamental mechanistic approach of modern biomedicine.

These differences between the two systems reveal the fundamental nature of Oriental Medicine, which can be altered or outright lost in translation.[59] For instance, the above-mentioned wǔxíng, five phases, has been almost exclusively referred to as the five "elements", with "xíng" translated as "element." Analysis of the character and its use, however, reveals the idea of movement, making the translation five "phases" much more appropriate versus "elements," which suggests static, concrete entities (Xing, 2012; *Far East Chinese-English Dictionary*, 2009). This difference, between element and phase, stands as a perfect example of bias for static states over process and how it affects translation.

Other examples of the Western mindset and medical system biasing translation can be seen in the use of various OM terms referring to excess or deficiency, of, for example, qì or blood, including:

- bù zú 不足 [不足] – functional insufficiency; "lack (of substance) or incompleteness (of function)" (Wiseman, 1998, p. 309);

[59] See "Contention and a Call for Further Research" for further discussion on the importance of recognizing fundamental differences between biomedicine and Oriental Medicine.

- yǒu yú 有余 [有余] – functional sufficiency; "excess (of qì, blood, or fluids) (Wiseman, 1998, p. 592);
- shèng 盛 [盛] – fullness, in reference to physical, concrete form; "vigor and abundance" (Wiseman, 1998, p. 188);
- shuāi 衰 [衰] – weak, emptiness, in reference to physical, concrete form; "a weakness, usually severe, especially of yáng" (Wiseman, 1998, p. 119);
- xū 虛 [虚] – emptiness, nothingness; "weakness, emptiness" (Wiseman, 1998, p. 645); and
- shí 實 [实] – excess, manifestation; "the opposite of vacuity" (Wiseman, 1998, p. 498), "fullness or strength" (Wiseman, 1998, p. 645).[60]

In the Western mindset, the underlying idea is, generally, too much or too little of a tangible substance, as if a glass had only a little water in it, or too much. This can be seen, for example, with the biomedical conceptualization of anemia as a low amount of red blood cells. The count is dominant and where treatment is aimed, while the functional weaknesses associated with anemia are *attributed to* the low red blood cell count.

For the Chinese, in their emphasis on change and process, these terms often indicate more of a functional insufficiency, not static states with the associated ideas of linear addition or subtraction. That is, function, itself, can be assessed and treated without a need for, or focus on,

[60] The bias of the Western medical mindset affecting the translation of specific terms is worthy of a whole volume. For example, Milsky points out that different OM diseases are often grouped under one biomedical term (Unschuld, 1989), with the distinction between them, critical in clinical care, completely lost. Ellis, Wiseman & Boss (1991) emphasize that they avoid rendering OM diseases in biomedical terms and instead seek more literal, if unusual, translations.

tangible entities that are involved in the functioning. For example, shortness of breath or weak digestion is directly attributable to insufficient lung or stomach qì. That is, the qì dynamic of those organs is hypo-functioning. Such under-functioning is directly assessable and can be where treatment is directed.

Where tangible substances, such as body fluids or blood, are deemed deficient or low, treatment focuses on restoring the function of producing those fluids (or reducing excessive consumption). For example, one of the most popular herbs to "build" blood, where it is deemed deficient, dāngguī 當歸 [当归] angelica sinensis, does so through its being sweet in flavor and thus strengthening to the digestion system, which is the system primarily responsible for making blood. By strengthening the ability to make blood, the blood production is increased to address the deficiency.

There is also the aforementioned use of certain herbs to aid kidney yīn through matching the nature of yin. Where yáng is expansive, seen for instance in heat causing expansion in a balloon, yīn is contractive in nature. Yīn tends to make things draw in, for example, in the afternoon and evening when the work day winds down and people get ready for bed. Such yīn action is also seen when things cool off and shrink or contract. When aiding kidney yin, this contracting consolidating nature is assisted through herbs that clear heat and allow yīn to consolidate. Compare this to the idea of "adding" yin, as if filling up an empty container.

Similarly, the unimpeded "flow" of thoughts and moods can be directly diagnosed, without a physical intermediary, such as hormones or neurochemicals.[61] Qì and shén were mentioned earlier as essential non-material aspects of the being in OM. Shén is one of the more difficult OM terms to translate into English, but it is considered that which "normally makes us conscious and alert during the day, what becomes inactive at night" (Wiseman, 2002, p. 19). It is that which is primarily affected during various negative emotional states such as vexation and restlessness and in the overall state of consciousness in general. Smooth, unimpeded mental activity is essential for psychological health. Impeded qì can lead to a type of depression discussed later referred to as yù 鬱 [郁], meaning "inhibition of normal emotional activity…" (Wiseman, 1998, p. 123).

In OM treatment, then, healing is seen, ultimately, as restoring flow, not adding or subtracting fluids or energies (Neal, 2013).

Even when it is acknowledged that English and Chinese represent fundamentally different perspective of the world around them and the distinct mindset of the source Chinese term is respected, often a character has multiple possible meanings. Each of these may contribute something to the intended definition in any given use before being pressed through the selective translation process. Each of the possible English translations may be similar, or the group of them may share commonality. However, a translator is forced to choose only one, sacrificing the

[61] Discussed later, the OM term yù 鬱 [郁] means stagnant or blocked and typically implies "inhibition of normal emotional activity…" (Wiseman, 1998, p. 123).

greater, global feel for the character or losing the influence of the other meanings inherent in the source Chinese term.[62,63]

Qì is a great example of this. Paul Unschuld in his translation of the *Nèijīng* says, in regards to trying to translate qì, "… the Chinese term qì has incorporated in the course of its two-millennia-long existence numerous conceptual layers that cannot be expressed by a single European word" (Unschuld, 2011, p. 19). In its original form qì depicted rising vapors (Wiseman, 2002a). It can mean "vital energy" (Qi, 2012), as in the qì and blood in the body's channels. It also often means "breath," "air," "spirit," or "attitude" (Qi, 2012), as in being used for exercise, qì gōng 氣功 [气功], and weather, tiānqì 天氣 [天气]. Even strictly within medicine, it has varied meanings incorporating the above. For instance, jīngqì 經氣 [经气], the qì flowing in the channels, is perhaps closest to "vital energy;" while qì associated directly with the internal organs ("viscera and bowels;" zàngfǔ 臟腑 [脏腑]), such as stomach qì (wèi qì 胃氣 [胃气]) or kidney qì (shèn qì 腎氣 [肾气]), incorporates the idea of vital energy, but also has to do with that organ's overall ability to perform its job, e.g., stomach qì deficiency includes the idea of reduced digestive ability.

[62] This point, as well as the translation process specifically with medical texts, is discussed in *Toward a Working Methodology for Translating Chinese Medicine*, by Bensky, Blalack, Chace, and Mitchell.

[63] It is important to mention that an essential role and thus ethical requirement for proper translation, especially of technical medical texts such as is seen in OM, is to link the chosen English word to the term in the source material. This is needed, in large part, because often there is no single English word that can act as a direct equivalent to the source Chinese. Therefore, which ever English word is chosen, it must *point to* the source term. This may be accomplished by all authors using standard terms from a widely available list. This way the reader may use that term list to link the translated term to the source terms across a wide selection of translated materials. Alternately, authors may include glossaries in their individual works.

Tīan, used previously in tīanqì, is another example of a character used frequently in OM that is included in terms with various meanings, such as:

- acupuncture point names, such as Lung 3 Tiānfǔ 天府 [天府] “Celestial Storehouse;”
- needling techniques, tiānbù 天部 [天部] “heavenly level;”
- disease names, tiānhuā 天花 [天花] smallpox;
- herbs, such as tiānhuāfěn 天花粉 [天花粉] trichosanthes root; and
- basic theoretical concepts, such as tiān rén dì 天人地 [天人地] heaven, human, and earth.

The character itself has a wide range of possible meanings depending on context, such as the specific combination with other characters, including heaven (as so often used in the medicine), season, weather, nature, natural, and something indispensable (necessities); and colloquially it is doubled, tiān tiān, to mean “every day” (Wiseman, 2002a, p. 77; Wiseman, 2003, p. 28; *Far East Chinese-English Dictionary*, 2009, p. 305).

In any given use of the term, alone or in combination, it may primarily mean one of these English words, but the original Chinese intent likely incorporates some aspect of each. Where an English reader sees only “heaven,” for example, he misses the contribution of other possible English words to the overall feel of the term, whereas the Chinese-fluent practitioner has a much broader and deeper feel for the meaning. This increased breadth and depth can assist the practitioner in challenging or unique clinical scenarios, as well as in appreciating the mindset of classical authors and physicians when they used the term.

Also adding to the complexity and potential issues in translation is the fact that, in Chinese, the grammatical function of terms is not clear. A character could be an adjective, noun, or verb, depending on the specific context. Translators must make this decision when rendering it into English, while the reader is left with the outcome of that decision. Here, again, the reader is removed from immediate access to the original. This gap leaves the reader unaware of the ambiguity existing in the original, of the other possibilities, or perhaps even of meaning implied in all the various possible English choices. For example, in the *Nèijīng* alone we have the following (Tessenow & Unschuld, 2008):

- tōng 通 [通] – to pass through, to penetrate; to communicate with; to free a passage; be passable; thoroughly; always, all (p. 426).
- bié 別 [別] – to separate; severed; to differentiate; difference; to branch out (p. 28).
- biǎo 表 [表] – exterior, outside; to manifest; to display (p. 28).
- zhōng 中 [中] – in, inside, within; center, middle; in the middle, amidst, in between (p. 592).

It is also common for a single English word to be used for several related, but different Oriental Medical terms. These are especially troublesome, as they can result directly in loss of clinical ability. One could, for instance, misdiagnose a patient because he was not aware of the distinction between various diagnostic terms. In OM, where treatments are typically associated directly with assessment, a wrong or poor diagnosis leads directly to less effective or even potentially damaging treatments.

Failure to distinguish between different OM terms that have been translated into a single English term can also directly affect treatments. For instance, the therapeutic functions and actions of both herb and acupuncture points are, themselves, technical terms with specific meanings. For example, in treating common colds, one may either "resolve" jiě 解 [解] or "course" shū 疏 [疏] the "exterior" biǎo 表 [表], each with different symptom presentations and herbal indications (Wiseman, 2002, p. 183-184). In treating various types of blood stasis xuè yū, one needs to perform one of several possible related actions, depending on the severity (Brand & Wiseman, 2008, p. 274):

- hé xuè 和血 [和血] "harmonize blood," a relatively mild action;
- huó xuè 活血 [活血] "quicken the blood," qū yū 祛瘀 [祛瘀] "dispel stasis," or sàn yū 散瘀 [散瘀] "disperse stasis," each having a stronger action; or
- in severe cases pò xuè 破血 [破血] "break blood".

In those, the proper assessment must be matched with the appropriate treatment approach in order to maximize clinical outcome.

Where these meanings are altered or muffled due to translation, treatment selection can be directly altered. In acupuncture, needle manipulation is of primary importance. Where technical OM terms are poorly translated, affecting proper acupuncture treatments can be more difficult or less effective.

One example of multiple OM terms being translated under a single English word was brought to my attention by practitioner/translator Lorraine Wilcox, LAc, PhD. Here, the following are often all rendered as "stagnation" in English:

- zhì 滞 [滞] "stagnation," as in "qì stagnation," qì zhì 氣滞 [气滞];
- yù 鬱 [郁] "depression," as in "depressed wood transforming into fire," mù yù huà huǒ 木鬱化火 [木郁化火]; and
- yū 瘀 [瘀] "stasis," as in "blood stasis," xuè yū 血瘀 [血瘀].

Clearly, these terms are related and the English word "stagnation" makes sense. However, there is critical, *clinically relevant*, distinction that is lost. For instance, qì stagnation is a distinct OM disease pattern indicating impairment of the body's internal qì dynamic (Wiseman & Ye, 2002). It has its own unique clinical symptoms, such as pain that is unfixed and temporarily relieved with belching, and requires specific therapeutic intervention. Wenlin offers "sluggish" and "stopped up" for zhì, while Wiseman (1981) gives "sluggishness of movement, particularly of qì and the food" (p. 569) (Zhī, 2012). All of this adds more to the single-word definition of "stagnation," especially when compared to the next two terms.

Consider zhī 滞 [滞] compared to yù 鬱 [郁]. It is similar to zhì stagnation, but includes changes in the mood including depression, vexation, agitation, and irascibility (Wiseman & Ye, 2002). Wenlin offers the following expanded definition, which again enriches the overall meaning: "sad, depressed; melancholy, gloomy," also "lush, verdant" (Yù, 2012). Lastly, yū 瘀 [瘀] refers to "sluggishness or cessation of movement," specifically of the blood, termed xuè yū, blood stasis

(Wiseman, 1998, p. 570). As discussed briefly above, this is its own distinct pattern with specific symptoms and unique treatment requirements. For instance, it is generally applied more where there is stagnation leading to a mass (versus mere distention and fullness, as in qì stagnation). Additionally, where herbs for blood stasis are needed, herbs for qì stagnation will likely have minimal if any effect.

There are also several different, clinically distinct OM terms that are often generically referred to as "tonification" in English, meaning strengthening or supplementing. These terms carry their own meanings, often conveyed in the structure, or "mini story," of the character. Additionally, each has more or less appropriate use in clinical application and each may be specifically paired with other OM concepts and entities. Examples include bǔ 補 [补], zhuàng 壯 [壮], yǎng 养 [养], and zī 滋 [滋] as seen in the following:

- Bǔ yīn 補陰 [补阴], "supplement yin" – Bǔ is the most common term used for supplementation or "tonifying." The radical (the core component) of the character means "cloth," and bǔ, therefore, has the primary meaning of "to patch," as in clothing. It came to be used in the general sense of "making up," "completing," or, as used here, "supplementing" (Wiseman, 2002a, p. 255).

- Zhuàng yáng 壯陽 [壮阳], "invigorate yang" – Obviously similar to bǔ supplementing, this is a technique, though, of strengthening specifically the *yáng qì* of the body with warm and supplementing herbs (Wiseman & Ye, 1998). Other uses of the character zhuàng include: big, great; strong, robust, vigorous (*Far East*

Chinese English Dictionary, p. 287). A difference between "supplementing" and "invigorating" can be seen here and though they share something in common, the distinction carries important clinical implications.

- Yǎng gān 養肝 [养肝], "nourish the liver" – Here, the liver is strengthened (tonified/supplemented), but the term yǎng is used. In this case, the use of yǎng is specific in indicating that the yīn aspect, the blood, of the liver should receive the action, i.e., nourish liver blood (Wiseman & Ye, 2002a). We can get a richer feel for what yǎng means, especially in contra-distinction to other terms, by looking at other ways it is used: to grow, to raise, to rear; to support or keep; to nourish, to cultivate (one's mind, etc.); to educate (*Far East Chinese English Dictionary*, p. 1686).

- Zī shèn 滋腎 [滋肾], "enrich the kidney" – Zī is used in a similar manner as yǎng in the above. It has several possible English translations (no exact equivalents), such as "moisten" or "nourish." It is, thus, used with yīn-natured organs and indicates that the yīn aspect should be the target, i.e., enrich kidney yīn (Wiseman & Ye, 2002a). The kidney is especially interesting when considering multiple terms because it has several aspects that need to be accurately assessed and may require therapeutic intervention – qì, yīn, and yáng.

Another example would be with the English word "excess," discussed previously. Based on my standard OM training, as well as my numerous interactions with other practitioners, students, and

teachers, when this word is used in OM it is assumed to mean a description of the nature of a disease, contrasted with deficiency, according to eight-principle pattern identification (bāgāng biànzhèng 八綱辨證 [八纲辩证]). In such use, excess is the common translation for shí 實 [实] (Wiseman translates this as "repletion" (1998, p. 498)). There are a couple of problems with this situation of always tying the word "excess," and all the implications, to the Chinese shí, however.

Oving, in his medical Chinese training program, points out that shí does not always mean something bad, as could be suggested by its strong association with describing a disease pattern (2012). The term also means "real, true, actual; honest, faithful, sincere" (*Far East Chinese-English Dictionary*, 2009, p. 368), while the character itself depicts a house full of cash (Oving, 2012). Additionally, there is another OM term that is routinely translated as "excess," for instance by Wiseman (1998, p. 181). Yín 淫 [淫], "excess" here is referring not to excess and deficiency, but to any of the Six Qì in excess (aka "Six Excesses," discussed next). Because the English word "excess" is commonly used for these two distinct OM terms, confusion can ensue.

The Six Qì (Liù Qì 六氣 [六气]) are environmental phenomena that, when in excess or arrive during improper seasonal times, are causes of disease. They are categorized as:

- fēng 風 [风] wind,
- hán 寒 [寒] cold,
- shǔ 暑 [暑] summer heat,
- shī 濕 [湿] dampness,
- zào 燥 [燥] dryness, and

- huǒ 火 [火] fire.

These are also known as the Six Excesses (Liù Yín 六淫 [六淫]). In all these instances, when the words "qì" and "excess" are used when the original source terms are not recognized, significant misunderstanding leading to poor medical care can occur. Here, as much as in any of these examples, English is simply insufficient and inappropriate for the practice of a medicine of a different language.

There is also the problem when multiple English words are used for the same Chinese term, because the reader will not only fail to receive the full meaning of the source term, but also because cross-referencing that term over several English texts will be problematic. This all, of course, will inevitably affect the quality of care in the clinic. Ellis, Wiseman and Boss (1991) spend some time with this important fact, starting with the preface to their text on Chinese acupuncture:

> At some point in their studies almost every acupuncturist tries to cross reference the acupoint indications available in different texts. The difficulty this presents is widely known. Students who wish to expand their knowledge and clinicians who hope to discover the often subtle clues that bring success in the treatment are faced with a variety of approaches and opinions concerning the meaning and value of Chinese concepts.
>
> For example, readers who see *mental restlessness* in one work, *irritability* in another, and *vexation* in our own are likely to take the words at face value, that is, attach to them

> meanings they have in common speech. While these three English expressions are by no means exact synonyms, they are all used to render one Chinese idea. They all represent *fán* [煩 {烦}]. Regardless of which English word readers prefer, this confusion of choice leaves them uncertain, unable to recognize the symptom correctly, and unable to understand its relation to other ideas. *Because Chinese acupuncture is heavily reliant on qualities and correspondences, such seemingly minor differences can cause clinicians to look for the wrong clues, or to miss clues that could be clinically useful*. [emphasis added] (p. i)

Further, a translator, perhaps unfamiliar with medical texts or texts written in a given time period, may also choose an English translation that is not appropriate for the given context (Bensky, et al, 2006). For example, rè 熱 [热] is technically "heat." However, in certain contexts it may mean "fever," for example in the *Shānghán Lùn*.[64,65] A term may even hold specific and unique meaning from that used in lay Chinese.[66] For instance, jīng 精 [精] in an OM sense may mean "essence," where a lay reading could be "sperm" (*The Contemporary Chinese English*

[64] This specific example was brought to my attention by Stephen Boyanton, an OM scholar and practitioner finishing his PhD focusing on Chinese medical history at Columbia University.
[65] The choice of "fever" is also problematic in that it chooses a biomedical term for an Oriental medical concept, where the two are not equivalent (and, again, the difference in meaning may reflect differences in the two medicines). "Fever" refers to an objectively measured temperature. In OM, the term, when used in this context refers to an objective or subjective sensation of heat, as in fā rè 發熱 [发热], "heat effusion" – (See Mitchell, Wiseman & Ye, 1999, p. 35)
[66] Chinese medicine makes use of what are called "technical" terms. These terms may be borrowed from lay Chinese, but have specialized meaning within the medicine. It is these technical terms that are so essential that a practitioner of the medicine know.

Dictionary, p. 1024).[67] Clearly, the two are related, yet different. A lay translator, then, could mistranslate terms in his own language.[68]

There is always the possibility of poor quality translation, as well. In a technical field, such as medicine, this can lead to wrong diagnosis or reduced effectiveness in the clinic. A classic example of a poor translation of an OM term is with the concept of xiè 瀉 [泻]. This term has been translated and is widely known as "sedate," as in a sedating action of herbs or of an acupuncture needling technique. The English word sedate implies calming down. As with so many of these terminology examples, there is obvious logic for the chosen English. A xiè technique in acupuncture may result in the psychological calming down of a patient. However, the implication of the word sedate is an action of actual calming, settling, or slowing down. The actual technical meaning of xiè, in Chinese, on the other hand is an action of eliminating pathogenic or "evil" qì (xié qì 邪氣 [邪气]). In acupuncture, it has to do with releasing the stagnation caused by xié qì. A therapeutic intervention based around slowing down or settling xié qì, such as "sedating" it, instead of getting rid of it would have the exact opposite clinical effect. A pathogen needs to be cleared, not calmed down.

A better, more accurate and appropriate translation for xiè would be "drain." As the *Nèijīng* states, when there is an excess, you drain it (shí zé xiè zhī 實則瀉之 [实则泻之]), not calm it or settle it down. When performing a xiè technique with acupuncture, you drain that which is

[67] An OM reading may also mean "sperm," depending on the context. However, a lay reader is highly unlikely to understand the term to mean "essence."
[68] Bob Flaws (1998) further explains how native Chinese speakers make for far less than ideal translators for rendering Chinese texts into English. Their grasp of the target language, English, is not strong enough to bring over the meaning of the terms.

causing the blockage in the river-like acupuncture channel. Lastly, the idea of "settling" or "calming" is better, more accurately conveyed with the Chinese zhèn 鎮 [镇]: "to calm; (in medicinal therapy) to calm (the spirit) with heavy settling medicinal" (Wiseman, 1998, p. 525). This is also in closer agreement with the biomedical use of the term and idea of sedation.

Another widely circulating poor translation is "conception vessel" for the Chinese term rèn mài 任脈 [任脉]. A more accurate translation is "controlling vessel."[69] The mistake is likely due to the association of rèn 任 [任] with rèn 妊 [妊], the latter meaning pregnant. Alternately, it may have arisen due to the fact that 任 [任] was sometimes used to mean pregnant, where 妊 [妊] now replaces it (Oving, 2013). The rèn in rèn mài means "to serve or appoint to a position" (Ren, 2012); duty, to bear a burden (*Far East Chinese-English Dictionary*, 2009, p. 68); endure, bear responsibility, to control (Oving, 2013).

These two English words given for rèn are significantly different. "Conception" is defined as (Conception, 2013):

1. the process of becoming pregnant involving fertilization or implantation or both.
2. the capacity, function, or process of forming or understanding ideas or abstractions or their symbols.
3. the originating of something in the mind.

[69] Unschuld prefers "Supervisor Vessel" (2011, p. 15). Notice the subtle and not so subtle differences in connotation and meaning.

As an adjective, "controlling" means (Controlling, 2013):

> Having a need to control other people's behavior; having the power to control how something is managed or done; giving someone the power to control how something is managed or done.

Where practitioners have no access to the original Chinese term, they are wholly dependent on translation and, here, the meaning conveyed by a very common translation is dramatically different. With this one example, there are, potentially, far reaching clinical implications in diagnosis and treatment.

Further, classical Chinese, the language of our foundational texts, is different in many ways than modern Chinese (and classical *medical* Chinese different enough from classical Chinese to be considered its own dialect (Rouzer, 2007)). A modern reader may recognize the characters in a classical text, yet be unable to translate them correctly (not knowing the classical meaning), fail to recognize classical grammar or sentence structure, or simply not recognize classical vocabulary. One example can be seen in the negation of *yǒu* 有 [有], "to have" or "there is". Classically, "not have" would be *wú* 無 [无]. In modern Chinese, the negation of yǒu is a two-character combination *méiyǒu* 沒有 [没有].

Similarly, yě 也 [也] in modern Chinese may mean "also," where no such meaning existed, classically. Instead, it was used as a final particle, equating or connecting the phrase it ends with a previous statement. Also, where zhè 這 [这] acts as a demonstrative pronoun for something

physically close to the speaker, e.g., *this/zhè* pencil, versus "that" pencil over there in modern Chinese, cǐ 此 [此] plays this role in classical texts (Oving, 2013).

The act of translating classical Chinese texts is also perilous for the fact that often times characters are left out if the author thought they were superfluous. Classical text was also frequently without punctuation marks of any sort. Classical grammar was also relatively simple, allowing for varied interpretation, much less differences, in translation (Oving, 2013). When a medical practitioner does not have access, her self, to these fundamental texts, but is instead removed even further by the process of translation, the risk of poor information is multiplied many times. Again, even with *good* translations much is lost. Reading a translation simply does not equate to reading the original.

Even if all the above obstacles are overcome, the non-Chinese-reading practitioner is left with English terms and concepts, not Chinese. This may seem obvious and, thus, of little importance. However, it is important to keep in mind that once one leaves the original Chinese characters, investigation into a text is investigation into English words, not Chinese concepts. Such investigation may quickly stray from the Chinese meaning, straining the tenuous connection between source Chinese and chosen English. For example, the central OM term shén 神 [神] is often translated as "God" (along with other possible terms). When the original Chinese is understood the English word God makes sense. However, if the non-Chinese-speaking reader wanted to investigate deeper into a passage or text containing shén, perhaps to hone her clinical abilities, she would rapidly run into problems. The source term here and "God" share something in common. However, they are not equivalents. Diving deeper into the meaning of God is not a

reliable way to better understand shén and will very likely result in erroneous beliefs about the meaning of shén.

It is important to keep in mind that Chinese characters often contain much meaning enfolded within. They may contain several sections, each potentially adding something to the overall meaning in any given context. The complete "definition" of a character may be complex, sometimes conveying something like a mini story. For example, in yī 醫 [医] (meaning "medicine"), as used in yīshēng 醫生 [医生] "doctor," the traditional character 醫 is complex including, in the upper portion of the character, the idea of an arrow hitting its target, 毆, and in the bottom half a "jar for fermenting alcohol or medicinal liquids," 酉 (N. Oving, personal communication, November 2013). The latter could be interpreted as indicating medicinal liquor used in herbal medicine, while the former may refer to acupuncture or the accuracy and effectiveness of a proper medical assessment. Such complexity in characters and their combinations in sentences make for a potentially rich and deep pool of meaning (especially when put in the context of other characters, a specific text, topic, time period, etc.).

Another clinically potent example can be seen in yū 瘀 [瘀], "stasis," as in blood stasis xuè yū. This character is related in structure and composition to yū 淤, "sediment." This similarity suggests a parallel to the natural world where sediment collects and obstructs the free flow of a stream or river (Wiseman & Ye, 1998). Knowledge of this character's meaning, even visual in this case, aids in many ways subtle and not so subtle in medical assessment and intervention. For instance, in trying to assess a complex disease presentation where the patient's symptoms do not

correlate with any textbook disease patterns, one often has to go with his fundamental understanding of the medicine and stray from more standard, "textbook" disease patterns (as was discussed previously). In these situations, one's deeper understanding of the medicine – for instance, in understanding that blood stasis shares something in common with sediment collecting along a streambed interrupting the smooth flow of the river water, and is more than simply the symptom listing in books – can yield positive clinical results.

The often used term jīn 筋 [筋] "sinew" is also a great example of the composition of character lending much to its meaning (as well as how composition suggests multiple potential English meanings, depending upon the context and also some characteristic differences between Western and Oriental Medicine). The character for jīn 筋 is composed of separate parts meaning bamboo, ⺮ (the upper most section of the character, which acts as the core component, the radical), flesh, 月 (the bottom left portion), and strength, 力 (on the bottom right). The overall meaning, according to the ancient dictionary *Shuōwén Jiězì* 說文解字 [说文解字], is "the strength of flesh" (Wiseman, 2002a, p. 87), with bamboo being a suggested image and example of that strength of flesh.[70,71]

Terms for emotions also show where an English word fails to convey the richness conveyed in the source Chinese characters. For instance, in terms relating to emotion we see the following:

[70] In biomedicine, where material structure is dominant, the two – muscle and tendon – are distinct separate entities, requiring separate words. Compare this to OM, where the relation of the two, as well as the function of the entity is dominant.

[71] Jīn is also an excellent example of a single term having substantially different meanings, more than simply muscle, tendon, or sinew. *A Practical Dictionary of Chinese Medicine* (1998) gives four different translations: a tendon, a palpable muscle, the penis, and a vein visible at the surface of the body, especially one that is abnormal in size (p. 532).

- The character often translated as "joy," xǐ 喜 [喜], is a picture of a drum, 壴, and a mouth, 口, suggesting a relation between beating a drum while singing and the experience of joy.
- "Anger" is conveyed in the Chinese nù 怒 [怒]. Here, the top half of the character is "slave," 奴, while the radical is "heart," 心.
- "Anxiety" is the translation for the Chinese yōu 憂 [优], which breaks down to head, 頁, heart, 心, and walking slowly, 夂 (specifically, head over heart over the portion depicting walking slowly).
- In the character for "fear," kǒng 恐 [恐], one can speculate that "feeling a grip around the heart" may be implied in the meaning of the character, as a portion of it has the meaning of "embrace, bind, consolidate, make firm" (Oving, 2013).

In each of these, a much more rich experience is conveyed with understanding the character breakdown.

It is important to bear in mind what was stated at the outset. It is not necessarily a matter of having access to a *good* translation. The mere act of translation, itself, results in loss of information. Reading an English translation no matter the quality simply falls far shy of having direct access yourself. In medicine, this fact is of paramount importance.

It is also important to point out that the examples of terms covered here are only the tiniest fraction of technical OM terms in existence. Wiseman relates that there are over thirty *thousand* OM terms in Chinese dictionaries of Oriental Medicine (2002). Even in the more limited

terminology of modern Oriental Medicine, there are still more than a thousand characters (Wiseman, 2002a). Where the information shared in this paper hopefully deepens one's appreciation for the complexity of OM terminology, it must be stressed this is not even the tip of the iceberg compared to all that the medicine contains.

Another challenge in translating Chinese to English is that, often, it is not as easy or clear as merely different words, essentially synonyms, for the same concrete entity, such as bí 鼻 [鼻] for nose or xīn 心 [心] for heart. Often, terms are much more abstract, and in the translation process the translator is forced into choosing from a rich conceptual meaning of a character, reducing it to a specific English word or, often, phrase (as in the above). If an honorable OM practitioner wanted to deepen his understanding of the medicine and attempted to do so via translations, he would rapidly run into a dead end, becoming stuck at that English word chosen and its meaning. It would be something like trying to trace a line through a yard (from English word to source Chinese term), and the line suddenly disappears behind a wall (the limits of the English word/meaning). The English can only get you so far, as it only approximates the Chinese. There would be no way of continuing the search past that fundamental limitation. With a translation, the reader has a truncated stump of the original. It may carry some of the flavor of the original, but the connection to the original has been severed.[72]

There is, also, the obvious limitation that there may simply be no existing concept in English for a Chinese term (the aforementioned shén comes to mind).[73] Starting from such different

[72] This being the reason it is important to gloss all technical terms in professional OM publications, mapping English words to their source Chinese character so that the reader may track the writing all the way to source concepts.
[73] Unschuld discusses this matter in the *Prolegomena* section of his translation of the *Nèijīng* (2011, p. 14).

fundamental worldviews and, then, with Oriental Medicine, thousands of years of clinical exploration based on those dissimilar worldviews, the actual clinically relevant ideas and methods may be so different as to not even exist in English or Western Medicine. For example, Jürgen Kovacs speaks to this directly in addressing "the issue of untranslatability." He relates that, due to different interpretations of reality, there is decreasing translatability across cultural gaps, and says:

> … classical Chinese, in addition to the usual problems in word equivalence, harbors special difficulties due to the wide cultural gap between our current European environment and that of Chinese antiquity when the texts were written. (Unschuld, 1989, p. 91)

More here than anywhere else we face the chasm between those who have had experience and those who have not. Therefore, more here than anywhere else we run into the substantial problem of medical practitioners attempting to execute highly technical assessments and interventions without direct access and awareness of the foundational paradigm and without the guidance of generations of past medical professionals.

Lastly, it is worth mentioning that translations are, themselves, dependent on the source. For example, it is clear in OM's core and ancient secondary texts that assessments and interventions should be individualized and holistic in nature. However, in modern times, the above-mentioned

cookbook approach is common in China.[74] Translations of these texts could then suffer from all the complexities inherent in Chinese, while also being limited to a cookbook-style of medicine of the original.

Along-side the nature of source texts, the selection of texts for translation also greatly influences to what the non-Chinese-reading practitioner has access in the first place. Here, again, such an OM physician has nearly no control over choosing the material from which she learns and which she depends upon for the practice of the medicine. Speaking to the role of the Chinese in affecting the transmission of OM to the West and what, exactly, is transmitted:

> The Chinese have played a larger role in presenting Chinese medicine to the West than might have been the case if the Chinese language were easier and took less time to learn. Given this task, the books they have selected to translate into Western languages represent their new view of acupuncture, their attempt to wed traditional medicine with biomedicine, and their concern that without a strong Western orientation acupuncture would be poorly received in the West. Thus the Chinese have presented their new medicine in the way they imagine the West can best accept it, and labeled it "traditional Chinese medicine."" (Ellis, Wiseman & Boss, 1991, p. iv)

[74] For a more complete discussion of Chinese medicine in modern China, see Paul Unschuld's "Medicine in China: A History of Ideas" (1985).

3. Accessing a Medical Library One Thousand Times Larger Than Any Available in English

It is worth focusing on and detailing this single benefit of learning Chinese. With knowledge of the language, the practicing acupuncturist has access to a medical library a thousand times larger than what is available in English (Wiseman, 2003). Put another way only roughly 0.01% of OM materials in China are available in English – non-Chinese-speaking practitioners are, literally, missing 99.99% of available medical literature.[75]

This single fact was a strong motivating factor for my beginning this research project and sharing my findings with the field at large. As a new practitioner, I very quickly ran into presentations in the clinic for which I was poorly prepared. Loving the medicine and wanting to do well by my patients, I started researching other texts available to help me in the clinic. Over the first five years of practice, I nearly exhausted what was offered in English at the time, without answering the majority of my questions or significantly deepening my clinical abilities (beyond adding a few tricks to my clinical bag). I found myself at a very real dead end, with no way to take the medicine deeper. Through countless discussions with other practitioners, I realized that this appears to be more the norm than the exception.

Similarly, in discussions with translators/practitioners, one of the most common, practical benefits to knowing Chinese was having access to Chinese materials that would help in the clinic. This is one of the key differences – and a major one – between those OM practitioners who can

[75] Bob Flaws (1998) also mentions, in some detail, the tremendous amount of material, not only extant (30,000 premodern texts), but also actively being written, for example, through the thirty monthly OM journals in China, each containing 20-30 articles and the hundreds of books written annually that is out there.

read Chinese and those who cannot. All practitioners meet challenges in the clinic that require deeper investigation and research. Those who can access Chinese materials increase their potential library by a thousand-fold.[76]

In speaking with OM professionals who had both language and clinical skills, it was revealed that case studies are a huge help in the clinic. Studying detailed examples of how to apply Oriental Medicine is of tremendous value in the clinic. Bob Flaws goes as far as saying:

> I find reading these Chinese journal articles [examples of which are seen in the referenced text] a gold mine of information, and having once delved into this treasure trove, I do not know how I could go back to practicing in ignorance of them. (1994, p. vii)

This should come as no surprise when one thinks back to one's first year of Oriental Medical school. From the very beginning, odd concepts were introduced and used in alien ways. "Wind" became a disease-causing entity. "Damp" was all of a sudden suspected in numerous medical conditions. "Qi" became this ubiquitous, yet persistently vague concept that stood at the very center of an unfailingly strange world. Further, the student is expected not only to learn the medicine, but actually to be able to apply it to real people experiencing very real diseases. Clearly, much assistance is going to be needed for the entry-level practitioner (and not much less for a seasoned practitioner).

[76] Obviously, it would be impossible to access all these materials, even with knowing Chinese. The point is that the *potential* assistance to help in the clinic is dramatically increased with language skills.

Senior practitioners and my professors talk about how good it is now, with all the material that has become available over the last decade.[77] The fact remains, however, that the OM practitioner who can read Chinese is at an unbelievable advantage. Based on my discussions with practitioners who could access Chinese source materials, this point cannot be over emphasized. Case studies have been for generations, and continue to be, essential tools to practitioners trying to wield the rich store of OM concepts and techniques. There are different types of case studies. Classical case studies are key in helping interpret and apply in a real-world situation the often ambiguous theories and ideas from the medical classics.[78] The storehouse of case studies collected over the last couple millennia span a wide range of disorders, and modern cases studies stand to offer much-needed assistance with modern disease presentations and clinical scenarios never seen before (such as patients taking multiple pharmaceuticals or having undergone other modern medical intervention, such as surgery).[79,80,81]

Case studies are unique and match the medicine well in ways that much modern research, the method for investigating and applying biomedicine, is largely incapable.[82] Oriental Medicine is an immensely rich tradition that insists on being tailored to individual presentations. Compared

[77] For example, the aforementioned texts by Clavey (2002), the seven volume series by Sionneau & Gang (1996), Flaws & Finney (1996), Ross (1984), and Sionneau (2000).
[78] An example of a modern version of this, available in English, can be seen in Greta Young Jie De's *Shang Han Lun Explained*. Here she provides mini case studies in each section to help see the theory applied in real world clinical scenarios.
[79] The specific issue of patients concurrently on pharmaceuticals and Chinese herbs is a significant one in modern OM practice. Sperber and Flaws (2007) explain how there is a wealth of information in Chinese on this topic, virtually all of which is unknown to the Western OM practitioner due to lack of Chinese language skills.
[80] Both the *Journal of Chinese Medicine* and *The Lantern* are OM journals that regularly publish case studies in English.
[81] Such case studies are a great example of where and how Oriental Medicine can be brought into the twenty-first century. They can provide examples of how the medicine, rooted in its core paradigm, can be applied to "new" diseases in the modern world, as has occurred all throughout the medicine's history.
[82] Such is the case as of this writing, to the best of my knowledge. There is, however, intense effort to apply modern research methods to the unique specimen that is OM (see MacPherson, et al, 2007). Perhaps just as physics has undergone a revolution in the early 20th century, modern clinical research may undergo a similar transformation to meet new challenges (Heisenberg, 1958).

to the modern biomedical disease-based model, Oriental Medicine merely starts with the disease, and continues on to ascertain how it is presenting in the specific patient. Huang, in his text on classical herbal medicine, *Zhang Zhong-jing's Clinical Application of 50 Medicinals* (2008), states quite succinctly that "western medicine treats 'human diseases,' and traditional Chinese medicine treats 'humans with diseases'" (p. 1).

The advantage is powerful medicine with minimal side effects. However, the very same situation, OM with all of its complexity and individuality, makes for a very difficult medicine to wield properly. The aforementioned "cookbook" approach is very appealing for the very fact that it avoids dealing with the seemingly infinite variations on disease and potential treatments.

Case studies are an ideal research method and tool for this type of medicine. They offer the depth and detail needed to effect competent Oriental Medical care. Compared to the modern research gold standard of randomized, controlled clinical trials (RCTs), where limiting information is the ideal (e.g. minimizing influences on the outcome in order to draw stronger evidence of causality), case studies collect all those details and report them.[83] RCTs can distance the physician from the whole and complete reality of his patient, reducing the patient and her suffering down to, for example, individual molecules interacting with specific receptors in the body.[84,85] Case studies reflect, to a much larger degree, the reality of clinical interactions, empowering the physician to deal with real, complex disease presentations. For OM, this is not merely a nicety. To practice OM well, patients' details are needed. Oriental Medicine thrives on such complexity. It is these

[83] For discussion on modern clinical research and OM as a "complementary" system of medicine see Lewith, Jonas, & Walach (2003), also Patten (2009) for a general overview of research methods.
[84] Interestingly, anecdotally, this "distancing" is a common complaint by patients of MDs in the clinic.
[85] The reason for such reduction is to isolate the perceived cause of suffering and address it specifically with therapies that have evidence of having such specific, targeted affect.

types of situations where OM is able to flex its considerable muscle honed over billions of patient interactions.

Compared to the modern RCT, case studies lack the ability to draw a strong causal connection between any specific aspect of treatment, e.g., acupuncture point or herb or even diagnosis, and specific intervention. As they only ever report on a single patient, it is difficult to extrapolate their outcomes to the larger population.[86] That is, just because a treatment worked for one patient shows only weak evidence, in a single case study, that it will work for others. It would take an amazing amount of such case studies to start building strong, rational arguments for certain treatments for certain situations. This is exactly what Oriental Medicine brings – an immense amount of clinically relevant information. Thousands of case studies detailing clinical assessment and therapeutic intervention are available to aid OM physicians in treating their patients well. If they can read Chinese, that is.

Beyond case studies, there are, of course, the classics themselves, those texts that report, directly, the essential nature of the medicine. The Chinese-literate practitioner can access, even freely online, all of the major classics, as well as the minor classics, and the many texts authored over the last two thousand years that expand on the core classics. In the standard US curriculum where Maciocia's texts are used, students study quotes and excerpts from the classics.[87] Additionally, they may be exposed to other major texts, such as the *Jiǎyǐ Jīng* or *Zhēnjiǔ*

[86] This is precisely the trade off made between these different types of research. RCTs are much better able to draw causal connections between interventions and specific effects in the body. They, however, necessarily take out of the picture many aspects of the patient. Case studies include all those details, emphasizing the uniqueness of the patient at the expense of generalizing treatment outcome to the population at large.

[87] For example, a statement will be made, such as "qì is the commander of blood," followed by a quote from the *Nèijīng* supporting the statement. Such quotes are used in a manner similar to research in biomedicine, where a specific claim is made followed by a citation of the research studies providing evidence of such claims.

Dàchéng, and taught of the existence of various schools of thought rooted in the classics, e.g., those of the four great masters of the Jìn 晉 [晋] and Yuán 元 [元] Dynasties. However, quotes and mere exposure cannot hope to replicate or sufficiently approximate direct study of the texts, themselves.[88] Without Chinese language skills, these texts lie outside of the practitioner's reach.

A major component of the medical classics not widely mentioned in modern US Oriental Medical circles, and even less widely available, are traditional commentaries made by past OM physicians. These physicians have often gained much respect in their own right, making their thoughts on traditional texts highly respected. In several cases, traditional commentary has gained near-equal respect and acceptance as the original lines upon which they expound.

Classical passages can be vague (for all the reasons mentioned previously in this paper). Traditional commentators can help give the reader context, perhaps by way of mentioning and quoting other major texts from which the author may have borrowed ideas or terms. They can also offer guidance in gaining clinically relevant meaning from such passages, often through interpretation of passages and specific characters. They can also serve to demonstrate the wide range of potential interpretations of classical terms and passages (perhaps none definitively correct). As commentaries can span hundreds of years, reading them may also show evolution in thought in the reading of core passages.[89]

[88] Perhaps it is something like the difference between listening to a couple bars of Bach, versus investing the time and energy into listening to one of his complete works.

[89] Paul Unschuld has made available translations of the *Huángdì Nèijīng* (2011), as well as the *Nán Jīng* (1986), with traditional commentaries. Many contemporary understandings of key *Nèijīng* passages can be seen in Wáng Bīng's commentaries, while those on the *Nán Jīng* offer glimpses of contention in the opinions of various commentators.

A good example can be seen in the opening lines of the *Nèijīng*. In the following passage many comments are made (the following quote and commentary are from Unschuld, 2011, p. 29-30):

> In former times there was Huang Di. When he came to life, he had magic power like a spirit (1). While he was [still] weak, he could speak. While he was [still] young (2), he was quick (3) of apprehension.
>
> After he had grown up, he was sincere and skillful (4). After he had matured, he ascended to heaven (5).

The commentator's notes are given as follow:

1) Zhāng Jièbīn comments to clarify the statement of having "magic power like a spirit," saying "This is extreme intelligence."
2) Tanba Genkan (Chin. *Dānbō Yuánjiǎn*, 丹波元簡 [丹波元简]) adds, here, "According to the *Li Ji*, 曲禮, the age of ten years is called youth."
3) Wáng Bīng shares, "徇 stands for 疾, 'quick'; "徇 is identical with 循 in the sense of 'complete', 'comprehensive.' 齊 stands for 疾, 'quick." Tanba adds "the knowledge of the sage was comprehensive and his spirit was quick." "徇 stands for 侚."
4) Wáng Bīng: "敦 stands for 信, 'sincere'; 敏 stands for 達, intelligent." Zhāng Jièbīn: "敦 stands for 厚大, 'very sincere'."

5) Wáng Bīng: "He casted a tripod at Tripod Lake Mountain. After he had it finished (成), he rose to leave in broad daylight (as an immortal)." Paul Unschuld tells us that Zhāng Jièbīn believes this story to be a fairy tale, interpreting 登天 as "to die." Another commentator, Yu Yue, offers that if Huang Di had died, he would not have been able to ask Qi Bo the questions that comprise the text of the *Nèijīng*. Yú Yuè (俞樾 [俞樾]), then, suggests interpreting 登天 as "assuming the position of ruler," citing other ancient texts to support his line of thought.[90] Paul Unschuld reports that other commentators agree with him most likely "on the basis of an attempt to eliminate metaphysical elements from the text." Tanba then suggests that Wáng Bīng has changed this portion of the text with 登天 citing other ancient texts and asserting that Wáng Bīng had a strong Daoist background and is likely to alter the text in a way to match other ancient Daoist texts.

Lastly, there are all the teaching materials used in major OM universities in China that are not available to the average US practitioner.[91] These teaching institutions are a potential wealth of information for the US practitioner. Instead, as has been addressed previously, these practitioners must wait for translations or otherwise remain dependent on Chinese-literate practitioners to author original texts in English. This, of course, results in funneling and filtering of information.

[90] Varying interpretations of 登天 allow us a glimpse into the translation process. Compare the following possible definitions of these two characters, one set coming from a dictionary giving modern meanings and uses of the terms, the *Far East Chinese-English Dictionary*, and the other coming from a specialized dictionary of the *Huángdì Nèijīng Sùwèn*, authored by Tessenow & Unschuld, giving the meanings of the terms as used within this specific text: 登 [登] dēng – to ascend, climb, rise; to record, register, enter; to take, employ; to board; to step on; to tread (*Far East Chinese-English Dictionary*, p. 1034); to ascend; to climb; to ripen (Tessenow & Unschuld, 2008, p. 87). 天 [天] tiān – the sky, the heavens, the vault of heavens, the firmament; nature, God, heaven; nature, natural, not artificial; a day; seasons, climate, weather; father or husband; something indispensable, necessities (*Far East Chinese-English Dictionary*, p. 305); heaven; heaven [indicator]; haven [qi] (Tessenow & Unschuld, 2008, p. 422).

[91] Though this is unlikely to change, some Chinese authors are attempting to make English texts available based on national Chinese curriculum requirements (see Sung, 2008). These texts should stand as an example of the tremendous wealth of information available on the other side of the wall of Chinese language.

The texts and materials that make it to non-Chinese-speaking practitioners are the result of a selection process, the nature and extent of which such practitioners have very little knowledge. They do not know what they are missing, nor why what they are exposed to has been chosen. Further, there is no formal vetting process for consensus or quality.

4. Ability to Interact and Collaborate with Chinese Physicians

Another advantage of knowing Chinese, likely obvious after having attained such skills, is the ability to interact with OM physicians studying and practicing in China. This also applies to those numerous practitioners here in the US who were trained in China. These practitioners were trained by a system that has multiple levels of professional education – bachelor's, master's, as well as doctorates in the medicine. Besides much more comprehensive education than that in the US, Oriental Medicine is in mainstream medical care in China. That is, acupuncture and Chinese herbal medicine often occurs alongside biomedical care. There is also extensive research on OM occurring in China.[92] Those trained in China come from a much more extensive OM system than that in the US and have much to share.

The loss due to not knowing Chinese when around Chinese-trained physicians has likely been experienced by any US practitioner who went through the standard master's level training in the US. For most of us, many of our teachers – and often our best teachers – were trained in China (which would include all the extensive continuing education and advanced training made available by Chinese-trained physicians). Even when these teachers speak English, it is typically not fluent and there is obvious difficulty in attempting to communicate the original Chinese concepts. In my personal experience, there were many times, both at the master's and doctorate levels, when it was clear professors were settling on a poor English equivalent for the concept they had in their mind. Many times I felt sad and frustrated that better transference of knowledge

[92] See Flaws & Chace (1994) for a book collecting and reporting from the rich pool of research being conducted in China. Also see Sperber and Flaws (2007) for in-depth discussion on herbs and pharmaceuticals and drug herb interactions, specifically mentioning the wealth of information in China on the concurrent use of herbs and drugs.

and wisdom could not take place (as I'm sure was felt by these teachers, as well). There were even several times when a native Chinese speaking student would burst out in Chinese, engaging the professor to try and grasp the underlying concept more clearly.

For all the reasons listed above, as well as many others, neither the professor nor the Chinese speaking student could fully convey the meaning of the concept they were trying to share. When such concepts were finally effectively conveyed from teacher to student, it was often after a long period of discussing a whole different world. It was as if a new reality would have to be created, in our minds, and shared by the teacher in order to explain the concepts. For example, these concepts sometimes involved the holistic nature of the medicine. In studying diagnosis, for instance, students would often get stuck on the idea that a symptom would not always correspond with a certain diagnosis. Sometimes heat meant an excess condition; sometimes it indicated a case of deficiency. The eyes were associated with the liver; however, they also reflected the spirit and, thus, the heart. There were often no straight-forward one-to-one correspondences; there may even have been outright contradictions – A meant B sometimes and sometimes not B. For example, the same intervention could have opposite effects (e.g. Bǎihuì 百會 [百会] GV 20 could raise or lower the body's yáng qì).

The meaning of qì was also very difficult to convey in my OM training (as discussed earlier). It could be considered "energy," but is much more (and maybe not even "energy").[93] In Chinese, the character for qì is incorporated in many concepts, such as:

- weather (tiānqì 天氣 [天气]),

[93] Unschuld (1986) is highly critical of "energy" as a translation for qì, going as far as to say such a translation has no historical basis (Unschuld, 2011).

- air (dàqì 大氣 [大气]),
- electricity (diànqì 電氣 [电气]),
- polite or courteous (kèqi 客氣 [客气]),
- effort of physical strength (lìqi 力氣 [力气]),
- complexion (qìsè 氣色 [气色]), and
- temperament (qìxing 氣性 [气性]).

The Chinese speaker has all these meanings in mind to help understand that one character, qì, where the non-Chinese speaker has to be told of all these things in order to learn more about that one term. Many times, in my experience, this was exactly what would have to happen. In order for our Chinese teachers to convey these unique medical concepts, extensive backgrounds, contexts, would have to be given. Sometimes that was enough, sometimes not. In both cases, though, much time was spent making the effort. Where the students knew Chinese, time would be saved, and more concepts learned and, likely, learned better.

It should, further, come as no surprise that enhanced ability to speak to and engage Chinese speaking physicians would greatly enable the non-Chinese-speaking practitioner when you look at the number of OM texts authored by those who speak Chinese. In common with this, we are dependent on those who speak Chinese to teach us the medicine. If we could speak the medicine, we could learn far more directly, ourselves, and most likely learn more, because the effort we now put forth could carry us further.

Also dovetailing with this is the oft-repeated absence of a clear vetting or selection process for texts, materials, and teachers. Because we, ourselves, do not speak Chinese, we are unable to engage our Chinese-speaking professors and authors in order to investigate that which they teach us. We are left to accept the information only on a very superficial level, as we cannot engage it directly. Even when they are able to successfully convey ideas, because we do not know Chinese, we cannot take that understanding any deeper or question it to learn more. The process of learning becomes static. We simply memorize bits of information conveyed with little or no ability to dynamically engage, critically assess, it or the teacher. This is a significant stunting of the educational process and of a practitioner's ability to learn this ancient medicine. Because the training of US practitioners is so stunted, their ability to apply the medicine competently in the treatment of disease is similarly limited.

5. Improve Professional Standing of the Field

The last main area where greater language skills could benefit the US Oriental Medicine field is in our standing with other professions and academia in general. The elephant in the room is that we are a group of medical professionals very few of whom can access primary sources and our evidence base. The "why" we do what we do – both the clinical guidance of "why" to choose certain treatments and make certain diagnoses, as well as the "why" regarding our reason for believing what we do will work – lies hidden behind another whole language for the vast majority of us.

This is a problem for at least a handful of reasons. In professional medicine, the choice of treatment is based on evidence of a potential treatment's effectiveness. We do what we do in the clinic because we have strong reason to believe it will have a specific outcome. This strong reason is based on an accurate assessment and a therapeutic intervention that is backed by evidence that it will have a specific effect. In Oriental Medicine, both the assessment and intervention techniques, as well as the evidence of their effectiveness and reliability, exist within our medical tradition dating back thousands of years. This tradition is recorded in written records, texts, and case studies, as has been discussed. Without access to these materials, the reason and evidence for our assessments and medical interventions are without rooting. As non-Chinese-speaking practitioners we cannot provide, ourselves, the basis for decisions. We are left, instead, to refer to secondary sources (e.g. we are *told* that the classics say this or that, or we are left to rely on translations with inherently limited accuracy).

In the US, we are not completely without such rooting. We have an ever-expanding library of texts and papers to guide and assist us in the clinic. We now have translations of the major classics, some even with commentary. We also have a handful of physicians offering direct study of those core texts. In the US, the current problem is that the *strength and degree* of our rooting in the evidence base is weakened *to the degree that our access is limited*. That access, overall, is severely limited because so many practitioners cannot read Chinese. As a field, we are dependent on a very few people to teach us the medicine.

Most of us are without the tools necessary to effect truly "physician-level" thinking, rooted in our classics, in the clinic. That is, we cannot directly apply the medicine as spelled out in our fundamental texts because we have not had adequate access in order to thoroughly engage and study. Instead, we have been taught what others have learned and believe. We act on and apply the wisdom and experience of others instead of authentically generating our own. We are not acting on our medicine's evidence base directly, but instead simply applying what others think or know about that evidence base. We are, thus, not directly responsible for the accuracy or reliability of the information we use in the clinic.

None of this is inherently wrong or even unwanted. Studying the writings of past and present medical experts is important. Learning from the experiences of others is very valuable. The difference, however, is whether information gleaned from such interactions *supplements* one's own experiences or *stands in place* of them. Are we standing at the head of our clinical practice, assessing all information that comes in and comparing it with our own study of the evidence? Or are we simply carrying out what others have investigated and believe to be accurate and useful?

In the past, I have found myself overly-dependent on others because I had no way of knowing directly because I stood on the other side of the wall of Chinese.

As a field, our claim to practice informed evidence-backed Oriental Medicine cannot be much stronger if given practitioners are so limited in his or her ability to carry out professional level medicine. As was discussed above, not all practitioners need to be translators for the field to be strong and rooted. However, if language skills are not widely possessed, then language skill and all it confers, i.e., access to primary sources, has a net influence of near zero. When only a few practitioners possess access, while the vast majority do not, the overall value of that knowledge is greatly mitigated.

This is the case for several reasons. For example, when only a small minority have access, with the others dependent on the information gleaned from such access, there is no external or third party to vet the information gleaned.[94] There is no bar against which to compare or verify that information. If there were a book written in a language only one person knew, there would be no way to verify what that book says. This is especially relevant in OM, where our evidence base is not a listing of concrete facts to be memorized, but instead consists of basic philosophical concepts and understandings to be deeply investigated and tested in order to be grasped. No one person, or small group of people, could possess the information definitively. They merely study and come to their own understanding, which must then be studied deeply to be understood. With Oriental Medicine, teachers are ultimately guides. They can assist you in your study of the

[94] The positive impact on quality of translated materials when more practitioners know Chinese is discussed in Wiseman, 2000.

medicine, not simply pour knowledge into you. Thus, when only a very few can engage in direct study, the field, at large, remains at a minimal level of understanding.

Ideally, there would be language experts who dive deeply into texts and language. There would be clinical experts with basic access to primary sources who work at bridging the gap between written theory and clinical practice. There would be students, bringing fresh excitement and open minds to study, and there would be wise elders with depth of wisdom gained from decades of practice. All would have access to the heart of the medicine and all would be engaged in study in their own unique ways, each adding something new to the larger field.

Beyond the ethical imperative of practicing from a solid evidence base, there is also the day-to-day reality of accurately relating what we do to patients, the public at large, and other medical practitioners. When we cannot explain, at least to a minimal degree, what we do and why to others, we have little hope of earning respect and a rightful place in mainstream medical care. The ability to explain what we do and why may be assisted by a certain gift some possess more than others. However, no matter one's ability to come up with apt metaphors for alien concepts, one has to have a solid understanding themselves of what they want to convey. When we come to our understanding by simply memorizing lines from a text or quotes from a teacher, we have little hope of faithfully conveying any taste of the medicine to another.[95]

[95] It is my opinion this is partly why "energy" has become nearly synonymous with qì in US acupuncture circles. The original concept is difficult to grasp and even more so to share with a lay person. "Energy" is widely known and accepted, especially within the "alternative medicine" community.

Whether we fail to convey accurate information about the medicine or succeed in conveying information not faithful to OM concepts and theories, the field suffers. Being poorly understood or misunderstood undermines our perceived usefulness and reliability. The actual effectiveness of the medicine may get attention, but it needs to be backed by intelligent, informed explanation to be more widely accepted.

Respect also comes from self-awareness. If we practice a medicine the source of which we cannot ourselves verify or investigate, we present as fundamentally unreliable. The delineation between physician and technician becomes no clearer than when testing one's understanding of why they do what they do. Physicians, almost by definition, are entrusted with the practice of medicine based on their high level understanding of their medicine. They are trusted to act alone, not under the direct guidance of a senior precisely because they stand at the height of understanding. Imagine taking your child to a doctor and, upon asking why the doctor gave the drugs they did, you are told that is what the book says to do, or that is simply what you are supposed to do. Trust and reliability suffer when there is no direct analysis or understanding, or the ability to communicate effectively.

To be widely accepted as a genuine profession, we must also be willing and able to address issues within our field. We must be able to seek out and address our own weaknesses and short-comings because we are a medicine rooted in an ancient tradition, we must be able to access the records of that tradition in order to address challenges and discrepancies.

One specific example is how the acupuncture channel pathways and acupuncture point locations vary widely in our "bible," the *Huángdì Nèijīng* and in the main text used in US acupuncture schools, *A Manual of Acupuncture*. The lung channel is one example. The *Nèijīng* has the lung channel running on the inner, medial aspect of the biceps, near the heart channel, and modern acupuncture texts place it on the other side of the biceps. Further, Lung 5 Chǐzé 尺澤 [尺泽] was placed near Heart 3 Shàohǎi 少海 [少海], towards the medial end of the transverse cubital crease in the *Nèijīng*; whereas in modern texts, it is placed on the radial side of the biceps brachii tendon. These are significantly different anatomical locations.

Ours is an old medicine with many sub-traditions contained within, all of which have undergone constant change over its long life. Although the channel and point discrepancy is significant as it addresses the basics of clinical practice, the medicine has undergone much change over multiple generations of practitioners. Such discrepancies are to be expected. The problem is when 1) the practitioners of the medicine, the professionals of the field, are unaware of such discrepancies, and 2) most of them are unable to investigate or address the discrepancies. As the *Nèijīng* is likely not taught at many – if any – professional OM schools in the US and is not on the national board certification exams, it is highly unlikely many practitioners are even aware of the incongruity with the main text (which *is* used in schools and for board examinations).

More importantly for the topic of discussion here, in order to investigate this discrepancy, one would very likely have to study the texts and materials written between the *Nèijīng* and the modern acupuncture text. It is possible that there was a single point in OM's history where the switch to modern channel location was made. Perhaps, instead, it was a gradual change over

several hundred years, or maybe during the Cultural Revolution modern channel locations were created. The point is that our field's collective literature would have to be accessed and studied in order to investigate the problem. Without Chinese language skills this is impossible. The vast majority of the professionals in our field are not capable of addressing this discrepancy within our evidence base. Our claim to practice a medicine that has been practiced continually over thousands of years is challenged by the fact that where we locate our points is not where they were located according to our fundamental text. Yet, most of us are unable to adequately address or even begin to investigate this issue.

A similar issue can be seen when addressing the question "What, exactly, *are* acupuncture channels?" In my personal training at six different acupuncture schools, including doctoral studies at two, as well as countless interactions with students and practitioners, it appears to be widely believed that channels are invisible, undetectable lines running through the body. This runs counter to many professional opinions, such as those of Dr. Neal, Paul Unschuld (2003), Donald Kendall (2002), and others, who assert that at least several of the acupuncture channels are, in fact, major blood vessels. Here, again, a very basic tenet of our clinical practice is called into question. What we are taught, tested on, and upon which we rely for medical intervention is directly challenged. This, in and of itself, is not as important as the fact that, without the ability to access our evidence base, we have very limited ability to address it.[96]

[96] And this channel/vessel issue is a prime example of the fact that more than just a few need to know or have access to primary sources. That is, even though there are professionals who possess such knowledge, the vast majority of practitioners are still unaware. This information, even though possessed by some, is not widely recognized. If more practitioners could read Chinese, this would likely not be possible.

We are similarly limited in our ability to help bring the medicine into modern times, to help represent our field properly in the new era. Modern science has opened up whole new avenues and techniques for understanding Oriental Medicine. We can analyze herbs in new and different ways and track the effects of acupuncture in the body in a way never before possible.[97] However, without a solid rooting in the medicine, and without access to our traditional texts, what could be opportunities to learn more about the medicine or demonstrate its accuracy and reliability turns instead into instances of simply replacing traditional principles and theories with different, modern ones.[98] When we do not fully know the medicine, we cannot advance it through new information and discoveries. For example, chemical analyses replace traditional understanding of herb properties such as taste (wèi 味 [味]) and qì (temperature) instead of helping extend or further our understanding of what taste and qì mean from a biochemical perspective.[99] For example, acupuncture points are used for their effects on brain tissue instead of those effects being investigated to further the understanding of channel pathway or organ/tissue association.[100]

When we are not fully rooted in our medicine and able to actively access its rich tradition we are poor stewards for it in the new era. When our training is based on the ideas (about the medicine) of others, and not based on the direct study of the medicine ourselves, we are left with a more

[97] See, for example, Dhond, Kettner, & Napadow, 2007.
[98] For instance, basing acupuncture point selection not on a traditional OM assessment, but instead according to modern clinical research on the point's biological effects.
[99] To be sure, both of these are occurring to some degree. It is where modern methods or analysis replace, without proven superiority, traditional methods. The latter appear to be losing out without ever being fully investigated or understood. This lack of investigation, in the West, may be due to lack of awareness due to lack of access, which unfortunately may become self-perpetuating. As we are drawn more to another system due to not knowing our own, we understand our own less and less, making us more and more dependent on that other system.
[100] There is a new tendency, for instance with Dr. Neal, an MD and licensed acupuncturist, to include biomedical assessments, such as imaging studies, with OM diagnostic techniques, such as pulse diagnosis, and interpret the imaging studies for example *from within the OM paradigm*. This is an exemplary approach to knowing Oriental Medicine and combining it with biomedicine, without the subjugation of OM.

shallow appreciation of its power. In that shallow appreciation we are too easily swayed to simply adopt the ways and techniques of another, more culturally dominant system, instead of seeking equal interaction between their experiences and our own. Integration becomes doing as they do so that we will be accepted, instead of knowing and bringing to the table our collective knowledge and ideas. Without access to our medicine's rich history, we cannot practice it to its full potential and hope to be recognized for representing it in an authentic manner.

Conclusion

The practice of medicine is uniquely important and Oriental Medicine is truly unique. Perhaps this makes it all the more important in the modern medical age where a true complementary medicine seems to have a place, that integration is sorely needed. Practitioners of Oriental Medicine are simultaneously honored with the role of bringing this medicine to the world, to our patients, and at the same time burdened. Oriental Medicine is not contained within a book. It is not a list of facts, nor a series of boxes to check off in the clinic. It is a living medical tradition, one that demands investment of time, energy, and perseverant intent.

This burden is greatly increased for practitioners who do not speak or read Chinese. Access to the wisdom and experiences of not only the core texts but all the supplemental texts and papers written by past sage-physicians is woefully limited. Essential concepts, upon which medical assessment and clinical intervention are based, lie just beyond our grasp, veiled behind cultural and language differences. Moreover, we are effectively cut off from millions of peers overseas. Their training curriculum, research, writings, and experience are all inaccessible behind a wall of Chinese. Too often, without direct access ourselves, we are left with relying on the thoughts and assessments of others and often these are slightly muffled or muddled through the action of translation (an inescapable tradeoff for access here). Though we still get good effect in the clinic and are slowly accumulating modern evidence of effectiveness through clinical trials, the field is still in its infancy in terms of fully representing the beauty and power of Oriental Medicine.

The answer, the proper response is, of course, contained within the very challenge facing us. The tradition, our evidence base, is largely freely available, and the key to unlocking access is no secret, nor is it out of reach. What lies before us is merely the continuation of what we have been doing: seeking greater knowledge. As with a challenging case in the clinic, we do not simply quit or settle for good enough. We persist in knowing more. Now we advance not only a single treatment or a solo private practice, but instead advance an entire field. In doing so, we join partners with modern medicine to create a healthy human population.

Contention and a Call for Further Research

There are many questions that need to be addressed. In order to better understand the situation in the US, we need to have a clearer assessment of our overall ability to access our evidence base. How many licensed acupuncturists know Chinese? The pool began pretty small only thirty years ago. We now have multiple publishers focusing on OM texts and numerous schools supporting the translation of essential materials. Into this demand have stepped more and more people making available more texts and case studies from our intensely rich medical tradition. Knowing how many translators we have available would help clarify our current access power.

All through this research the question kept arising in my mind of how much Chinese language is enough? What is the bare minimum any given licensed practitioner should know? Should all practitioners be able to do at least basic modern translation, say from modern Chinese journals and texts? Is it more important that practitioners know classical Chinese, the language of our "bible" and source texts?

It seems that to claim to practice the medicine a practitioner should be able to access the core materials directly (would you trust an MD in the US who did not know English?) That being said, expertise in Chinese language is not necessarily required. The study of classical literature is not straight-forward. For instance, the *Nèijīng* was not simply a book written by a sage-physician two thousand years ago that we now have a copy of to read and study. It was a compilation of many sources, many different ideas, the original of which is not currently available.[101] The

[101] See Unschuld (2003) for detailed discussion.

language in which it was written is inherently ambiguous, with lots of room for interpretation. Study of the *Nèijīng* could easily be a life's focus, even without applying it to clinical practice.[102] Such is often the case in China, where there are experts in the *Shānghán Lùn* or "Fire School," and so forth.

It does not seem that to practice OM, one need be a *Nèijīng* scholar. However, he or she should be able to read and access the text in order to make use of the knowledge *Nèijīng* scholars offer. A medical professional should be informed by the opinions of such experts. Where we do not, ourselves, have our own immediate access and understanding derived from direct study, we are not capable of integrating other insights and opinions. Instead, we end up being directed by such opinions. It therefore, seems we should have basic knowledge and basic access, while some will choose to continue on to an expert level.

Some specific ideas for basic language requirements include:

- The ability to give a case history in Chinese – this would include many of OM's key terms and concepts, those most directly relevant to patient interaction.
- Knowledge of a certain set number of OM terms in Chinese. For instance, there already exists a series of workbooks, authored by a medical Chinese language expert, that cover the four hundred most common OM terms, Wiseman & Yŭhuán's *Chinese Medical Characters* series. As the curriculum is, then, almost already written, specific courses, tests, etc., would be relatively easy to create.

[102] Point of fact, Paul Unschuld, the man whose team brought us translations of the *Nèijīng* and *Nán Jīng* and several other high level texts on the history of Oriental Medicine, is not a practitioner. He is a medical anthropologist.

- A Chinese language course built around the current, basic concepts already taught. For example, when studying basic concepts, such as the five phases, yīn-yáng, and zàngfǔ, students would concurrently study the terms in Chinese. This would cover the basic terms, fit into current curriculum, and there are already texts written that would fit well (see the aforementioned *Chinese Medical Characters* series). This would also serve well as an introduction to the language.
- Two years of university-level Chinese language study as a prerequisite for acceptance to OM school. It makes sense that, since there are already Chinese language courses and whole curriculum developed, to use them. Two years of Chinese would set a strong foundation for language capabilities. Students could then focus on medical Chinese or continue on with standard Chinese. This would also require the least alteration to current curriculum (discussed next). It is also consistent with graduate-level education, in general, where specific prerequisites are set that act as a foundation for advanced study. For example, biomedicine has a "pre-med" undergraduate study track, where students learn the basic sciences upon which medical science is based. Where Oriental Medicine is based on a completely different set of foundational theories, the argument for OM to have a "pre-OM" track seems even more important. Chinese language as a prerequisite for such study seems to make at least as much sense and, in fact, begins to appear as a bare minimum. This option clearly stands as the one representing the highest professional and academic standard, which would also greatly strengthen our standing within professional and academic settings.

Next, of course, comes the reality of where in current OM studies such training would be incorporated. The master's programs already place a significant burden on students, to include a large financial burden, which anecdotal (and personal) evidence suggests is extremely difficult to overcome. Perhaps we should renew our commitment to our own medicine and replace biomedical courses (making up a large portion of the three thousand hours compromising current entry-level training) with Chinese language courses. The former serves to aid directly in integration, while the latter would serve greater self (field) awareness. This awareness would not only directly increase current medical knowledge, but also the ability to know and learn more. A stronger field seems to be a better vehicle for integration than simply learning about another field.

There are, at least, two US Oriental Medicine schools that currently include language studies in their curriculum. The Seattle Institute of Oriental Medicine (SIOM), on their website, reports:

> The MAcOM [Master's of Acupuncture and Oriental Medicine] degree program includes extensive academic and clinical instruction in Chinese herbal medicine and has an integrated Chinese medical language curriculum that ensures graduates have the ability to access Chinese medical sources for additional clinical information. ("Seattle Institute of Oriental Medicine", 2009)

The Pacific College of Oriental Medicine (PCOM) includes language studies in their Doctorate of Acupuncture and Oriental Medicine (DAOM) program – "Chinese Medical Chinese Language", nine credits total:

> This track enables the doctoral fellow to understand the basic features of the literary language of Chinese medicine and its relationship to the language of various classical periods and the modern vernacular of China. The aim of this track is to develop a broader intellectual perspective in Chinese medicine through exposure to the philosophical and cultural foundations of the medicine in its source language. Excerpts from source texts of Chinese medicine are translated to expand knowledge base and enhance research abilities to continue self-directed learning and contribute to the profession by way of translation and commentary. ("Pacific College of Oriental Medicine", n.d.)

Here, then, we have examples of Chinese language studies being incorporated at both the master's and doctorate level. Any serious discussion of making language studies a requirement for training and licensure should include in-depth investigation into the programs at these two schools. How, exactly, are they including the study of Chinese language? Where in the curriculum do the studies occur? What are the stated expected outcomes from this training? What is the response from students and from practitioners after having entered the field with such training? In many ways, these schools represent the cutting edge of professional OM education and could possibly act as leaders in the next transition of improvement in OM studies in the US.

Also, as was mentioned earlier, much progress has been made since the early days of OM in the West when the main texts were *Essentials of Chinese Acupuncture* out of China, Ted Kaptchuk's *The Web That Has No Weaver*, and the "Shanghai text," *Acupuncture – A Comprehensive Text*. An extensive literature review seems appropriate to more fully assess the quality and nature of teaching materials available.

It is my belief that the need for more acupuncturists to learn Chinese has not been significantly reduced as a result of the current amount of materials available. A major point of evidence for this belief is the fact that only in 2011 did the field have access to a philologically rigorous translation of our most fundamental text, the *Háungdì Nèijīng* (Unschuld), and, then, only the *Sùwèn* 素問 [素问], no *Língshū* 靈樞 [灵枢] (the second half of the *Nèijīng* focusing on such clinically essential topics as needling techniques). As direct study of the foundational classics is a cornerstone of professional OM practice, the absence of access would seem to suggest that a professional level of practice has yet to be attained. With the first translation only recently available, OM in the West is clearly still in a youthful stage, with much greater language skills needed.

A rather big question and challenge to this paper's theme and assertions was raised in the review process and is worthy of discussion here. Several colleagues and fellow DAOM students brought up the fact that Oriental Medicine has a very diverse history and that OM in the West, which is largely defined by not having direct access to source materials, may simply be another stage in OM's development. I believe the argument being proposed is that we do not, for the most part, know Chinese in the West. Although that may be a limitation in our ability to access and apply some OM knowledge, it is effectively no different than any other phase or stage of development of Oriental Medicine. That is, not knowing Chinese may not be a problem requiring a fix, but rather a basic tenet of the new, Western style of Oriental Medicine.

For example, no one has direct access to the original *Nèijīng*. Even if they did, it is not a clear cut text on how to apply medicine. As has been discussed throughout this paper, there are significant gaps between *any* modern practitioner, Chinese speaking or not, and that which is claimed to be our ultimate source, the *Nèijīng*. There is the difference in modern and classical language, modern and ancient culture, and so forth. Thus, neither the target itself, our "bible," nor access to it is perfectly clear *for anyone*. The inability to read Chinese is simply one other way, of so many, that our ability to understand the medicine is limited. That may, then, simply be a characteristic of OM in the West. The latest transition of OM would then be into a language and culture outside of East Asia.

My main thought on this issue is that the difference, that gap of language, is a significant one, one that stretches the connection to important information too far. As was stated at the outset of this paper, there is something that is OM and is not OM. No matter how difficult it is to define, there is a difference. There is something that makes Oriental Medicine what it is. Unfortunately, it is not as clear-cut as certain overt practices or techniques, such as inserting acupuncture needles into a patient or giving them herbs. Though such things are important, nearly ubiquitous to the practice of OM, they are not sufficient, in themselves, to call what you are doing Oriental Medicine. This is clearly a tricky point and is why it is mentioned here. What is it, exactly, that defines OM? With a history seemingly as complex as the species that practices it, what exactly makes Oriental Medicine what it is?

This difference is important, essential even, to help us appreciate the need to learn something new – Oriental Medicine. What sets OM apart, especially from biomedicine, is important to

figure out so that we may better realize the need to respect it as unique and thus strive to study it in a more authentic, accurate manner. Where we understand OM as a distinct style of medicine, it is important to work harder to understand what it is exactly. In terms of translation theory, when we realize a topic of study is different from what we are used to or would expect we are more accepting of what is called a *source-oriented* approach to translation. We want information that is closer to the original, the source, and are less concerned with information that is similar to what we already know and understand. In receiving OM in the West, it is important to appreciate that it is different from biomedicine so that we make an honest attempt to understand what Oriental Medicine is. What, then, does set it apart?

One answer I have is that connection to a source. OM is the practice of a medicine rooted in the study and interaction with a certain spring source of knowledge and wisdom. Perhaps the one thing – arguably illusory as it may be – that can link all the widely varied systems of thought and styles of practice under the fantastically large umbrella of Oriental Medicine is the study of the classics and of the *Nèijīng* specifically. As mentioned earlier, though there are many styles of Oriental Medicine, with sub-styles and individualities of practitioners, they all claim the *Nèijīng* as their ultimate source. I am not a medical anthropologist or Chinese historian, but I do not believe any other version of OM has existed – that is, that there has ever been a point in OM's development, when the practitioners claiming to be professionals in the field did not make study of the *Nèijīng* a core requirement. We have a diverse medicine, but authors and founders of major varying schools of thought all state outright, to my knowledge, that the *Nèijīng* is the source of their medicine.

Now, that may be inaccurate. Maybe past practitioners and scholars only claimed to study the *Nèijīng*. Maybe politics or cultural norms demanded they pay homage to that source. Maybe there was no actual connection. Maybe OM is simply the medicine that has just happened to be practiced within a given region of the world. Maybe that is the main connection among the various practices. Maybe there is no single common root or source over all these centuries. Perhaps, then, there really is no such thing as OM, once it crosses greater land and water.

Maybe this is, or is verging on, another related argument held by colleagues for whom I hold much respect. Maybe there is, truly, only that which works in the clinic. There is no "Western" or "Eastern" medicine, i.e., there, ultimately *is no difference*. There is only reliably effective medical intervention to alleviate suffering. Whether certain paradigms or practices are OM or not is ultimately meaningless. Maybe the only thing that matters is whether the medicine works. This seems to be a wonderfully "scientific" perspective. Blind yourself to all but the bare essentials. Does what you do work? If it does, we include it in our repertoire of "World Medicine." Here, any differences are deemed insignificant and reduced to the sole criteria of *working*.

I see much value in this approach. After all, I am, ultimately, a clinician. For me, the ultimate goal, the end point of all my study and investigation, is interaction with patients. That is the ultimate "Why." That is as harsh a reality as there is. If where I pour my mental and physical focus and attention does not aid me in my working with patients and their suffering, then it gets quickly dropped. There is no theory pretty enough or pleasing enough to the ear (or mind) that can dissuade me from doing good for my patients, doing right by my practice of medicine.

Yet, here I am making an argument for learning Chinese, for increasing access to and knowledge of OM, and not validating whether it works (thus meeting that sole criteria for "World Medicine"). Why? Why not take the medicine and verify whether it works, which is to say whether it has predictably reliable results in actual practice?

The answer is as easy and obvious as it is unfulfilling – I do not know the medicine well enough. Further, I believe too many practitioners fail to appreciate the differences between OM and biomedicine, and seek to treat it, such as testing it for effectiveness, as if it was the same, and this is due, I believe, in large part to the dismal access to authentic OM materials in the West. Many would treat OM as if it were biomedicine, as if there were only medicine – no East or West, ignoring any distinction. Testing OM through clinical research in the West, at this point in time, seems inappropriate as we do not yet *know* OM (interestingly, even what we do know is proving difficult to test in a system designed for biomedicine). Thus, it comes back to the need to understand OM, and, importantly, how it is different from our standard medicine.[103]

It seems there is at least one basic tenet of OM that is clearly different and, I believe, speaks to an *essential* difference between it and Western biomedicine. This is the fact that OM is highly individualized in clinical application. That is, OM is largely dependent on the physician-patient

[103] It should be stated that this paper focuses a great deal on the differences between biomedicine and Oriental Medicine. This is largely due to the fact that I have personally witnessed tremendous effort to practice OM from a place of not yet knowing OM. This, of course, leads to a thin veneer of OM, i.e., using certain terms, doing certain physical practices, such as inserting acupuncture needles in patients, with a default Western mindset underlying those practices. Oriental Medicine, the heart of it, is lacking in this scenario. However, it should also be stated that many experts, such as Nigel Wiseman, have observed people defining OM as what biomedicine is not, essentially creating an anti-biomedicine, under the guise of OM. My focusing on the differences would seem to counter this. I would argue that a little of all the above is true. OM in the West has come to possess characteristics many feel are missing in biomedicine, while simultaneously many are failing to actually learn OM and are thus practicing from whatever mindset they had coming into study (i.e. *not* Oriental Medicine).

interaction. It exists, the reality of it seems to be borne in the interaction between physician and patient. It comes down to that practitioner's grasp of the medicine adjusting to that specific patient's needs in that moment. And both of those are in constant flux. To try to pin down OM practice, to reduce it to core components in order to investigate it, as is done with biomedicine, does not seem possible. It is not simply a collection of testable facts or statements. And I believe within that fact exists the – or perhaps at least one – answer. Here, then, is a defining aspect of the medicine, something that not only makes it unique, but different from the Western mindset: OM resists being reduced down to basic parts or actions that can be tested, where biomedicine seems to be built upon smaller pieces that can be individually tested.

In this setup, then, where exactly is the information depended upon for medical knowledge and wisdom, if it is not stored and reported as basic, isolated statements? If OM resists being reduced down to basic bits or components, where and what is the information upon which we depend to practice the medicine? I would propose it is the *investigation* into Oriental Medicine. We have key starting points, basic ideas that are taught, but a tenet of high quality OM is active investigation into source materials. That is, it is not the mechanical application of basic rules, but the constant study of our core texts and applying that understanding to unique patient presentations in the clinic. In an extension of the basic static state versus constant flux and process, Oriental Medicine is an ongoing act of research and clinical application.[104]

[104] Again, here there is a difference between OM and biomedicine. However, it is not as black and white as it may first appear. Biomedicine is also in constant development, new discoveries being constantly applied clinically. The difference is that the core foundation of OM is set, established in the *Nèijīng*, where in biomedicine no such basic foundation exists. For example, biomedicine is largely rooted in physics and physics has undergone a fundamental alteration in the last century and continues to question and develop its foundation.

What, then, is the specific evidence that it works? If there are no core statements that have been tested and proven, what then can act as evidence for effectiveness? This evidence, as well as extensive guidance on how to apply it, is contained within the vast storehouse of experiences of past physicians, their collection of investigations and reporting of experiences.

Perhaps, then, it comes down to one more key characteristic of OM that distinguishes it from biomedicine. OM has a pre-existing body of knowledge and experience – a set foundation – whereas biomedicine is still actively building. What biomedicine does in the clinic is, almost by definition, the most recently created and proven intervention. OM is not quite the same. What is done in the OM clinic is rooted in what has been done for generations. It is new in that it is unique to that patient, but it is defined by being, at its heart, hundreds or thousands of years old.

Building on that key difference of OM – the absence of a need or ability to reduce a system down to core components in order to evaluate its effectiveness – for example, is the nature of the core philosophy.[105] Again, I am neither a philosopher, historian, nor anthropologist; however, OM seems to be rooted in theories and philosophies that ultimately "point to" what is fundamental and essential, not claiming to state it outright. As with so much Chinese philosophy, the medicine, though acknowledging physical, material reality, seems to place at its core an understanding of the reality that lies beyond logic and reason, beyond what could be captured with, contained within, words.

[105] There are clinical research methods that do not require breaking down a treatment into specific causative agents and associated outcomes. They, however, hold much less respect and thus power as, say, RCTs.

In OM, there is much that can be concretely known, such as channel pathways, basic organ/phase associations, etc. However, at its core, around which all other knowledge and theories revolve, the medicine points to an understanding beyond a rational grasp, or, as seen in Gāo Shìshì's 高世栻 [高世栻] take on a line from the *Nèijīng Sùwèn*, chapter four, "Discourse on the True Words in the Golden Cabinet," "The principles are extremely subtle and they are difficult to transmit to others by means of words" (Unschuld, 2011, p. 94).[106]

Also, in the clinical practice of Oriental Medicine, the shén (spirit) is central, of utmost importance, and is discussed in the *Sùwèn*, chapter twenty-six "Discourse on the Eight Cardinal [Turning Points] and on Spirit Brilliance" (commentary notes numbered):

> The spirit, ah! The spirit!
>
> When the [physician's] eyes are clear, his heart is open and his mind goes ahead, he alone *apprehends [it as if it were] clearly perceivable (1), but the mouth cannot speak [of it]*{emphasis added}(2). Everyone looks out, [but] he alone sees [it]. If one approaches it, it seems to be obscure, [but to him] alone it is obvious [as if it were] clearly displayed (3). As if the wind had blown away the clouds. Hence one speaks of a 'spirit'. (Unschuld, 2011, p. 444-445)

Traditional commentary expounds on the above (Unschuld, 2011, p. 445):

1. Wáng Bīng: "'The ears do not hear' is to say: the activities of the spirit are subtle and undisclosed. 'The eyes are clear, the heart is open and the mind is the first' is to

[106] The rest of this chapter from the *Sùwèn* concludes: "If it is not this kind of person, do not teach him. If it is not this kind of truth, do not confer it. This called achieving the Way" (Unschuld, 2011, p. 94).

say: the penetration [of things] by the heart is comparable to the unveiling of the hid -den. The vision of the eyes is comparable to the opening of a thick screen."

2. Zhāng Jièbīn: "The miraculous cannot be transmitted by words."
3. Zhāng Zhìcōng 張志聰 [张志聪]: "…When a person is in the process of thinking, he is situated in a state of extreme clarity and lucidity. It is as if his ears did not hear anything, as if he were separated from everything in his environment and he achieves a *state beyond ordinary thinking* where he 'alone sees,' he 'alone reaches understanding,' he is 'alone in his perception'" {emphasis added}.

In chapter four of the *Zhēnjiǔ Jiǎyǐjīng*, a Hàn dynasty text organizing the information in the *Nèijīng* and another acupuncture classic now lost, we read:

> On spiritual diagnosis, it does not require the ears to listen. With eyes bright, an open mind and discernment, a clear picture presents itself. Although he is unable to express it in words, the examiner alone among all his colleagues sees clearly. The picture sees to him like the evening star, outstandingly bright, or (the sun) revealed from behind the clouds scattered by wind… (Yang & Chace, 1993, p.298)

The authors state in the commentary:

> Spiritual diagnosis is achieved through the examiner's spirit-mind which reveals the true condition of the patient. The dark of evening and the clouds refer figuratively to

> confusing or baffling symptoms. This passage implies an *intuitively based* evaluation of the patient's condition. (emphasis added) (Yang & Chace, 1993, p.298)

The practice of Oriental Medicine, ultimately, is not reducible to a set of principles that could be recited and memorized. There are, for sure, foundational theories, such as yīn and yáng, but the simple, direct, mechanical application of these is not the highest practice of the medicine. There is an understanding, a *trans*-rational grasping of key ideas, and from this understanding is born awareness of yīnyáng, wǔxíng, etc. Anything short of grasp of this basic core, anything less than direct access to this ultimate source, this knowing beyond what words can hold or convey, is still less than the height of OM. Not that one needs this highest level to practice, only that the professional practice is *defined by* the awareness and seeking of this level. If this is accurate, then this is why study of the classics is important – that lack of direct access necessarily puts you outside of the essential definition of Oriental Medicine.

To help appreciate the uniqueness of this nature of Oriental Medicine we can compare it to the current dominant medical paradigm, biomedicine. Modern medicine, to include its basic component theories, such as biology, chemistry, and physics, is different. It is a fundamentally rational practice. It is largely dependent on reason and logic. This is evident in both practice as well as research. This central place of rationality (and reductionism) in modern clinical medicine, and its important link to formal evaluation is spoken to in a basic pharmacology text:

> It was not until the concepts of rational therapeutics, especially that of the controlled clinical trial, were reintroduced into medicine – about 50 years ago – that it became

possible to *accurately evaluate therapeutic claims*. [emphasis added] (Katzung, 2001, p. 1)

I am not a biomedical professional, however, it seems that a key defining characteristic of OM, and one that clearly distinguishes it from Western medicine, is this basic rooting, reliance on logic. OM seems to incorporate logic as a skill, a tool, simultaneously recognizing its power and limitations, whereas biomedicine gives it much higher command authority.

An important consequence of this difference is that Western medicine could possibly be practiced from a predetermined set of algorithms. Maybe biomedicine could be practiced and practiced well by memorizing facts and statement such as "When X, then Y," "In this situation do this".[107] Maybe biomedicine comes down to such statements, which interestingly, but not surprisingly, lend themselves very well to direct testing in experimentation.

It is my contention that Oriental Medicine may be practiced with some effectiveness in such a manner. However, at its higher levels, an *understanding* is attained, and that understanding is applied in possibly original and creative ways in every patient interaction. No robot could master OM by simply memorizing and mechanically applying, core statements.

[107] This discussion speaks to the basic natures of the systems of medicine themselves. *In actual practice*, i.e., when an actual person puts the system into practice, an MD may not work in such a manner, just as in OM a practitioner could easily treat his training and the existent texts as black and white algorithms that need be strictly followed.

If this is true, then it may be a key piece to the essential definition of OM. It is the application of an understanding, gained by direct study of source materials, which is a more than the sum of the collective theories and statements studied.

This would also partly address why the situation is not as clear-cut as statements such as "there is no Western or Eastern medicine; there is only that which works" would make it seem. These two styles are fundamentally different for all the reasons listed throughout this paper. They both work, but they cannot be treated as the same, as if they were interchangeable.

With this distinction, a rather significant one, it is clear that Oriental Medicine needs to be studied well to be known and practiced well. Where we do not or cannot actively engage in the source materials, we cannot hope to practice a medicine close to what could be considered authentic Oriental Medicine. In order to do that, we must have access to those materials.

There is, lastly, a common challenge to this paper – the belief that whether or not learning Chinese is good or important, it simply is not going to happen. The thought is that the vast majority of Western practitioners will never learn Chinese. The question posed, then, is whether this investigation, this research, the very topic of this paper should be a priority in the field. After all, the many differences between OM and biomedicine have forced us to expend much time and energy on fighting to earn a place in mainstream medicine. This, to many it seems, appears to be a much more worthwhile focus. Since most practitioners will never learn Chinese, is it worth our time and energy to even go down this road?

To this, I assert the scientist within me, the one who demands truth. Based on the importance of linking practice to access *to,* and the reliability *of,* knowledge, the question of the need for language skills must be asked. Further, no specific possible outcome should dissuade us from investigating. The future does not exist yet. If we limit our steps taken in this moment to what we believe may be down the road, we let illusions dictate our life. We ignore our direct, immediate experience of the world – our questions and curiosity – and live instead by the "free creations" of our mind.[108]

Further, we must not confuse what could be with what has been by labeling it what *is*. This epiphany I owe to theoretical physicist and co-father of quantum mechanics David Bohm (Nichol, 2003). There is no "is." The concept of "is" is exceedingly tantalizing, but inevitably fails to deliver what was expected. Life is happening. Any moment plucked from the river of occurrences is necessarily from the past. Any time you claim "this" is the way the world is, you are actually saying this is the way the world *was*, the way things were in that moment that has now passed.

The difference from one moment to the next may be small enough that the most recent acts as a decent approximation of the next. However, between the two there is change. The more we hold onto any one event, any single occurrence, the more risk we take of missing the new and latest, and we miss that change. By taking one moment and consciously projecting it into the future, we

[108] A favorite Einstein term: "Physical concepts are free creations of the human mind, and are not, however it may seem, uniquely determined by the external world. In our endeavor to understand reality, we are somewhat like a man trying to understand the mechanism of a closed watch. He sees the face and the moving hands, even hears it ticking, but he has no way of opening the case. If he is ingenious, he may form some picture of a mechanism which could be responsible for all the things he observes, but he may never be quite sure his picture is the only one which could explain his observations. He will never be able to compare his picture with the real mechanism and he cannot even imagine the possibility of the meaning of such a comparison." Einstein & Infeld, 1938, p. 31

merely attempt to continue a pattern that *has already occurred*, which is both inaccurate, and risky because there will be a difference between your projection and reality.

For us, here, to say practitioners will not learn Chinese may be true. Maybe many current practitioners will resist, likely successfully, learning a whole new language. I say, however, 1) that should not, cannot, stop us from asking whether learning Chinese is important for the practice of Oriental Medicine, and 2) we should not let our projection (which is, itself, at this point, an assumption) blind us to other potential futures. To me, one possible future that, without a doubt, looks brilliant, is all OM practitioners having at least basic Chinese language skills. This seems, to my eyes, like it would dramatically lift the standard of care, of practice, of research and collaboration. That scenario is no more a guarantee than that of practitioners not learning Chinese, but, at least to my eyes, it is a much more beautiful and powerful possibility. It is a vision, a possible future that I would rather strive for than merely repeat the way things have been. After all, change is happening. The future will be different; in what way, exactly, is up to us. We might as well strive for the ideal.

Appendix: Where to Begin

Those who are convinced and eager to act can do so immediately. There are many ways to begin the study of Chinese, from free and easy to full-on university level studies. Chinese is such a popular language, one could simply do an Internet search for "learn to read Chinese" and numerous resources come up, many of which are immediately accessible and free.

For those wanting to focus on Chinese as it relates to the study of medicine there are both books and professional trainings readily available. Nicolaas Herman Oving, a sinologist and Oriental Medicine practitioner, offers extensive medical Chinese training online. He starts at the very beginning and takes students through both basic terms as well as grammar. He focuses on the language as it is used in the medicine, both in modern times and classically. Studying the language in such a manner immediately opens up and enlivens one's world of Oriental Medicine. Basic terms become whole individual worlds unto themselves, and lines from classical texts speak more completely and fully, guiding one in both clinical assessment and treatment. As this training is done online, primarily through self-study and email correspondence, there is little reason every licensed OM professional should not be partaking. This setup also makes it ideal to be added to master's curriculums immediately. Soon those schools that offer language training will be fully recognized for offering a more complete and higher quality education.

Nigel Wiseman has also written many texts designed for licensed OM professionals. His *Chinese Medical Characters* series goes over the most commonly occurring characters, such as qì and the five phases, in workbook fashion. You learn about the history and development of these core

characters and can practice writing them in spaces provided. There are currently four volumes available, exposing you to four hundred of the most frequently used terms. A fifth is planned for release. The texts are arranged by topic:

- *Chinese Medical Characters, Volume 1, Basic Vocabulary;*
- *Chinese Medical Characters, Volume 2, Acupoint Vocabulary;*
- *Chinese Medical Characters, Volume 3, Materia Medica Vocabulary;*
- *Chinese Medical Characters, Volume 4, Diagnostic Vocabulary;* and
- *Chinese Medical Characters, Volume 5, Treatment Vocabulary (*in progress*);*

He also has a handful of other texts to take you even further, including:

- *Introduction to English Terminology of Chinese Medicine,* and
- *Chinese Medical Chinese: Grammar and Vocabulary.*

The *Chinese Medicine Database* is also a resource worth seriously looking into. Not only does it directly support translators and make available, for the first time in English, many translations, it has a searchable database of terms and texts and translation tools anyone could make immediate use of. Included in this searchable database:

- 690 single herbs – pinyin, alternative, botanical, pharmaceutical, and common name, category, action, indication, nature, flavor, organ, tongue, pulse, and contraindication;
- 1,510 formulas – pinyin name, root formula, category, multiple herbs within a formula, company, action, indication, diagnosis, tongue, and pulses;

- single points – the 361 regular points, including – point number, pinyin name, Chinese character, English name, alternate name, point category, element, action, indication, and Western indication;
- 15,000 Western diagnoses with ICD-9 Codes;
- dictionary of over 102,271 Chinese terms – traditional Chinese, simplified Chinese, intoned pinyin, numbered pinyin, Eastland term set, WHO term set, CM-DB term set, Chinese-English Dictionary;
- translations – search by English, Dynasty, Author, Translator, and Traditional Chinese;
- timeline of Chinese medicine texts and authors;
- STORT – Game to learn to translate texts;
- videos from our Beer Hall Lecture Series; and
- translation tool – allows the user to translate their own traditional Chinese.

Current translated texts available in the *Chinese Medicine Database* include, but are not limited to:

- *Shāng Hán Lái Sū Jí* 傷寒來蘇集 [伤寒来苏集] *Renewal of Treatise on Cold Damage* (Qīng 清 [清] Dynasty, 1644-1912 CE);
- *Qí Jīng Bā Mài Kǎo* 奇經八脈考 [奇经八脉考] *Explanation of the Eight Vessels of the Marvelous Meridians* (Míng 明 [明] Dynasty, 1368-1644 CE);
- *Shāng Hán Míng Lǐ Lùn* 傷寒明理論 [伤寒明理论] *Treatise on Enlightening the Principles of Cold Damage* (Jìn 晉 [晋] Dynasty, 265-420 CE);

- *Wú Jū Tōng Yī Àn* 吳鞠通醫案 [吳鞠通医案] *Case Studies of Wú Jū-tōng* (Qīng Dynasty, 1644-1912 CE);
- *Nán Jīng;*
- *Zàng Fǔ Biāo Běn Hán Rè Xū Shí Yòng Yào Shì* 臟腑標本寒熱虛實用藥式 [脏腑标本寒热虚实用药式] *Viscera and Bowels, Tip and Root, Cold and Heat, Vacuity and Repletion Model for Using Medicinals* (Jìn Dynasty, 265-420 CE);
- *Wēn Rè Lún* 溫熱論 [温热论] *Treatise on Warm Heat Disease* (Qīng Dynasty, 1644-1912 CE);
- *Shāng Hán Shé Jiàn* 傷寒舌鑒 [伤寒舌鉴] *Tongue Mirror of Cold Damage* (Qīng Dynasty, 1644-1912 CE);
- *Xǔ Shì Yī Àn* 許氏醫案 [许氏医案] *Case Studies of Master Xǔ* (Míng Dynasty, 1368-1644 CE);
- *Fǔ Xìng Jué Zāng Fǔ Yòng Yào Fǎ Yào* 輔行決臟腑用藥法要 [辅行决脏腑用药法要] *Secret Instructions for Assisting the Body: Essential Methods for the Application of Drugs to the Viscera & Bowels* (Nán 南 [南] Dynasty, 420-599 CE);
- *Liú Juān Zǐ Guǐ Yí Fāng* 劉涓子鬼遺方 [刘涓子鬼遗方] *Liú Juānzǐ's Formulas Inherited from Ghosts* (Nán Dynasty, 420-599 CE);
- *Shèn Jí Chú Yán* 慎疾芻言 [慎疾刍言] *Precautions in Illness: My Humble Thoughts* (Qīng Dynasty, 1644-1912 CE);
- *Yào Zhèng Jì* Yí 藥症忌宜 [药症忌宜] *Medicinals & Patterns Contraindications & Appropriate [Choices]* (Qīng Dynasty, 1644-1912 CE);
- *Fù Kē Wèn Dá* 婦科問答 [妇科问答] *Questions and Answers in Gynecology;*

- *Nèi Jīng Zhī Yào* 內經知要 [内经知要] *Essential Knowledge from the Nèijīng* (Míng Dynasty, 1368-1644 CE);
- *Zhù Jiě Shāng Hán Lùn* 注解傷寒論 [注解伤寒论] *Annotated Shāng Hán Lùn* (Jìn Dynasty, 265-420 CE) (in progress); and
- *Běn Cǎo Bèi Yào* 本草備要 [本草备要] *The Essential Completion of Traditional Materia Medica* (in progress) (Qīng Dynasty, 1644-1912 CE).

The *Chinese Text Project* also offers online searchable Chinese texts, including a wide selection of philosophical texts and several medical, many of which were mentioned in this paper, such as:

- *Zhuāngzi* 莊子 [庄子],
- *Dào Dé Jīng*,
- *Huáinánzǐ*,
- *Shuōwén Jiězì*,
- *Huángdì Nèijīng*,
- *Nán Jīng*,
- *Shānghán Lùn*,
- *Jīnguì Yàolüè, and*
- *Yì Jīng*.

Bob Flaws also has published a book representing a specific approach to reading Chinese, *Teach Yourself to Read Modern Medical Chinese*. Called “dictionary translation,” this text helps you learn to read modern medical Chinese through the combination of a term list (essentially a cheat

sheet), and knowledge of how to use a Chinese-English dictionary. It is his stated contention that one could learn to read modern medical Chinese, for instance a modern OM journal, with only several months-worth of study.

Wenlin, billed as Chinese translation software, is also immensely useful. It combines multiple dictionaries, including ancient (a must for understanding our classical texts), with the ability to cut and paste electronic passages directly into the software. After pasting terms or passages, in their original Chinese, into Wenlin, one can simply hover over the terms with the mouse and dictionary entries pop up. It is possible to gain access to entire texts, such as the *Nèijīng*, through this process.[109] Wenlin also has multiple tools to help learn the language, including reading, writing, and some listening comprehension (the *Chinese Medicine Database* has much of this functionality, as well, with the bonus of having several medical texts available in its database).

Lastly, Pleco (available for android and apple devices) is an application that has several dictionaries (including Wiseman's *Practical Dictionary*), language learning tools, including handwriting reading, a document reader, and even "optical character recognition" (OCR). With OCR, one can simply point a camera phone at a character, be it in a book, newspaper, road sign, etc., and dictionary entries pop up. Obviously, not a replacement for actual translation, Pleco is an outstanding tool for OM practitioners learning Chinese.

[109] This should definitely not be misconstrued as complete, competent translation. Professional sinologists or those fluent in Chinese should be consulted for accurate and reliable translation. These tools, such as Wenlin, merely aid the novice Chinese speaker or curious OM practitioner in gaining some access to the language.

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Glossary

bāgāng biànzhèng 八綱辨證 [八纲辩证] eight-principle pattern identification

Bǎihuì 百會 [百会] Governing Vessel 20 (GV 20) “Hundred Convergences” (acupuncture point)

Bèi Jí Qiān Jīn Yào Fāng 備急千金要方 [备急千金要方] *Essential Prescriptions Worth a Thousand Gold Pieces*

Běn Cǎo Bèi Yào 本草備要 [本草备要] *The Essential Completion of Traditional Materia Medica*

bí 鼻 [鼻] nose

bì 痹 [痹] obstruction of universal fluctuations; impediment (Wiseman, 1998, p. 295)

biǎo 表 [表] exterior

bié 别 [别] to separate

bǔ tǔ paì 補土派 [补土派] school of supplementing earth

bǔ yīn 補陰 [补阴] supplement yin

bù tōng zé tòng 不通則痛 [不通则痛] when there’s no movement, there’s pain

bù zú 不足 [不足] functional insufficiency; insufficiency (Wiseman, 1998, p. 309)

Chǐzé 尺澤 [尺泽] Lung 5 (LU 5) “Cubit Marsh” (acupuncture point)

cǐ 此 [此]

dāngguī 當歸 [当归] angelica sinensis

Dào Dé Jīng 道德經 [道德经]

dàqì 大氣 [大气] air

dēng 登 [登] to ascend, climb, rise; to record, register, enter; to take, employ; to board; to step on; to tread (*Far East Chinese English Dictionary*, p. 1034); to ascend; to climb; to ripen (Tessenow & Unschuld, 2008, p. 87)

diànqì 電氣 [电气] electricity

fā rè 發熱 [发热] heat effusion

fán 煩 [烦] vexation

fēng 風 [风] wind

Fǔ Xìng Jué Zāng Fǔ Yòng Yào Fǎ Yào 輔行決臟腑用藥法要 [辅行决脏腑用药法要] *Secret Instructions for Assisting the Body: Essential Methods for the Application of Drugs to the Viscera & Bowels*

Fù Kē Wèn Dá 婦科問答 [妇科问答] *Questions and Answers in Gynecology*

Fù Qīngzhǔ Nǚkē 傅青主女科 [傅青主女科] *Fù Qīngzhǔ*'s *Gynecology*

Gāo Shìshì 高世栻 [高世栻]

hán 寒 [寒] cold

Hàn cháo 漢朝 [汉朝] Hàn Dynasty

hé xuè 和血 [和血] harmonize the blood

Hégǔ 合谷 [合谷] Large Intestine 4 (LI 4) "Union Valley" (acupuncture point)

Huáinánzǐ 淮南子 [淮南子] *Masters of Huainan*

Huángdì Nèijīng 黃帝內經 [黄帝内经] *Yellow Emperor's Classic of Internal Medicine*

huó xuè 活血 [活血] quicken the blood

huǒ 火 [火] fire

jiě 解 [解] resolve

jīn 筋 [筋] sinew

Jìn cháo 晉朝 [晋朝] Jìn Dynasty

jīng 精 [精] essence

jīngqì 經氣 [经气] channel qi

Jīnguì Yàolüè 金匱要略 [金匮要略] *Essentials from the Golden Cabinet*

kèqi 客氣 [客气] polite, courteous

kǒng 恐 [恐] fear

kuáng 狂 [狂] excessive or disordered movement of universal fluctuations; mania (Wiseman, 1998, p. 386)

Lǐ Dōng-yuán 李東垣 [李东垣]

Língshū 靈樞 [灵枢] *Magic Pivot*, as in *Huángdì Nèijīng Língshū, Yellow Emperor's Classic of Internal Medicine, Magic Pivot* (book two)

lìqi 力氣 [力气] effort of physical strength

Liú Juān Zǐ Guǐ Yí Fāng 劉涓子鬼遺方 [刘涓子鬼遗方] *Liú Juānzǐ's Formulas Inherited from Ghosts*

Liù Qì 六氣 [六气] Six Qì

Liù Yín 六淫 [六淫] Six Excesses

méi yǒu 沒有 [没有] not have, there is not

Míng 明 [明] Dynasty

mù yù huà huǒ 木鬱化火 [木郁化火] depressed wood transforming into fire

Nán Jīng 難經 [难经] *Classic on Difficult Issues*

Nèi Jīng Zhī Yào 內經知要 [内经知要] *Essential Knowledge from the Nèijīng*

nù 怒 [怒] anger

Pí Wèi Lùn 脾胃論 [脾胃论] *Treatise on the Spleen and Stomach*

pò xuè 破血 [破血] break blood

Qí Jīng Bā Mài Kǎo 奇經八脈考 [奇经八脉考] *Explanation of the Eight Vessels of the Marvelous Meridians*

qì 氣 [气]

Qīng 清 [清] Dynasty

qìsè 氣色 [气色] complexion

qìxing 氣性 [气性] temperament

qū yū 祛瘀 [祛瘀] dispel stasis

rè 熱 [热] heat

rèn mài 任脈 [任脉] controlling vessel

rèn 妊 [妊] pregnant

rǔ é 乳蛾 [乳蛾] nipple moth

sàn yū 散瘀 [散瘀] disperse stasis

Shāng Hán Lái Sū Jí 傷寒來蘇集 [伤寒来苏集] *Renewal of Treatise on Cold Damage*

Shāng Hán Míng Lǐ Lùn 傷寒明理論 [伤寒明理论] *Treatise on Enlightening the Principles of Cold Damage*

Shāng Hán Shé Jiàn 傷寒舌鑒 [伤寒舌鉴] *Tongue Mirror of Cold Damage*

Shānghán Lùn 傷寒論 [伤寒论] *On Cold Damage*

Shàohǎi 少海 [少海] Heart 3 (HT 3) "Lesser Sea" (acupuncture point)

shén 神 [神] spirit

Shèn Jí Chú Yán 慎疾芻言 [慎疾刍言] *Precautions in Illness: My Humble Thoughts*

shèn qí 腎氣 [肾气] kidney qì

shèng 盛 [盛] fullness, in reference to form; exuberance (Wiseman, 1998, p. 188)

Shénnóng Běncǎo Jīng 神農本草經 [神农本草经] *Shénnóng's Materia Medica Classic*

shī 濕 [湿] dampness

shí zé xiè zhī 實則瀉之 [实则泻之] when there is excess, drain it

shí 實 [实] excess, manifestation; repletion (Wiseman, 1998, p. 645)

shū 疏 [疏] course

shǔ 暑 [暑] summer heat

shuāi 衰 [衰] weak, emptiness, in reference to form; debilitation (Wiseman, 1998, p. 119)

shùn 順 [顺] movement with the basic universal fluctuations

Shuōwén Jiězì 說文解字 [说文解字] ancient (early 2nd century) Chinese dictionary

sì dà jiā 四大家 [四大家] four great schools (of thought)

Suānzǎorén Tāng 酸棗仁湯 [酸枣仁汤] Sour Jujube Seed Decoction

Sùwèn 素問 [素问] *Elementary Questions,* as in *Huángdì Nèijīng Sùwèn, Yellow Emperor's Classic of Internal Medicine, Elementary Questions* (book one)

Tanba Genkan (Chin. *Dānbō Yuánjiǎn*, 丹波元簡 [丹波元简])

Tāngyè Jīng 湯液經 [汤液经] *Decoction Classic*

tiān rén dì 天人地 [天人地] heaven, human, and earth

tiān 天 [天] the sky, the heavens, the vault of heavens, the firmament; nature, God, heaven; nature, natural, not artificial; a day; seasons, climate, weather; father or husband; something indispensable, necessities (*Far East Chinese English Dictionary*, p. 305); heaven; heaven [indicator]; haven [qi] (Tessenow & Unschuld, 2008, p. 422)

tiānbù 天部 [天部] heaven level

Tiānfǔ 天府 [天府] Lung 3 (LU 3) "Celestial Storehouse" (acupuncture point)

tiānhuā 天花 [天花] smallpox

tiānhuāfěn 天花粉 [天花粉] trichosanthes root

tiānqì 天氣 [天气] weather; OM: the qi of heaven

Tiānwáng Bǔxīn Dān 天王補心丹 [天王补心丹] Celestial Emperor Heart-Supplementing Elixir

tōng 通 [通] to pass through; free, restore, unstop (Wiseman, 1998, p. 226, 502, 638)

tūiná 推拿 [推拿] Chinese massage

Wáng Bīng 王冰 [王冰]

wèi 味 [味] taste; flavor (Wiseman 1998, p. 210)

Wēn Rè Lún 溫熱論 [温热论] *Treatise on Warm Heat Disease*

Wú Jū Tōng Yī Àn 吳鞠通醫案 [吳鞠通医案] *Case Studies of Wú Jū-tōng*

wǔ xíng 五行 [五行] Five Phases (aka "Elements")

wú 無 [无] not have, there is not

xǐ 喜 [喜] joy

xié qì 邪氣 [邪气] evil qì

xiè 瀉 [泻] drain

xīn 心 [心] heart

Xǔ Shì Yī Àn 許氏醫案 [许氏医案] *Case Studies of Master Xǔ*

xū 虛 [虚] emptiness, nothingness; vacuity, vacuous (Wiseman, 1998, p. 645)

xuè yū 血瘀 [血瘀] blood stasis

xuè 血 [血] blood

yáng 陽 [阳]

yǎng gān 养肝 [养肝] nourish the liver

Yào Zhèng Jì Yí 藥症忌宜 [药症忌宜] *Medicinals & Patterns Contraindications & Appropriate [Choices]*

yě 也 [也]

yī 醫 [医] medicine

Yì Jīng 易經 [易经] *Book of Changes*

yīn 陰 [阴]

yín 淫 [淫] excess

yīshēng 醫生 [医生] doctor

yōu 憂 [优] anxiety

yǒu yú 有余 [有余] functional sufficiency; superabundance (Wiseman, 1998, p. 592)

yǒu 有 [有] to have, there is

yū 淤 [淤] sediment

yū 瘀 [瘀] stasis

Yú Yuè 俞樾 [俞樾]

yù 鬱 [郁] depression

Yuán cháo 元朝 [元朝] Yuán Dynasty

Zàng Fǔ Biāo Běn Hán Rè Xū Shí Yòng Yào Shì 臟腑標本寒熱虛實用藥式 [脏腑标本 热虚实用药式] *Viscera and Bowels, Tip and Root, Cold and Heat, Vacuity and Repletion Model for Using Medicinals*

zàng zào 臟躁 [脏躁] visceral agitation

zàngfǔ 臟腑 [脏腑] bowels and viscera

zào 燥 [燥] dryness

Zhāng Jièbīn 張介賓 [张介宾]

Zhāng Zhìcōng 張志聰 [张志聪] (=Zhāng Yǐn'ān 張隱庵 [张隐庵])

zhè 這 [这]

zhèn 鎮 [镇] settle

Zhēnjiǔ Dàchéng 針灸大成 [针灸大成] *Grand Compendium of Acupuncture and*

Moxabustion

Zhēnjiǔ Jiǎyǐjīng 針灸甲乙經 [针灸甲乙经] *Systematic Classic of Acupuncture and Moxabustion*

zhì 滯 [滞] stagnation

zhōng 中 [中] in, inside; center, middle (Wiseman, p. 54, 394)

Zhù Jiě Shāng Hán Lùn 注解傷寒論 [注解伤寒论] *Annotated Shāng Hán Lùn*

zhuàng yáng 壯陽 [壮阳] invigorate yang

Zhuāngzi 莊子 [庄子]

zī shèn 滋腎 [滋肾] enrich the kidney