The Transmission & Reception of Chinese Medicine: Language, the Neglected Key

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The Transmission and Reception of Chinese Medicine: Language, the Neglected Key

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 practice and the tradition of experience in which it is based. The body of English-language literature that has developed does include genuine attempts to present the East Asian tradition accurately. Nevertheless, it also includes contributions by people who have little or no linguistic access to East Asian experience in the healing contained in East Asian-language sources and who have had only brief contact with East Asian clinicians. It further includes versions of Chinese medicine that are adapted to perceived Western needs, often without substantiation in either scientific terms or in the East Asian medical tradition. We have a body of literature that is not only composed at least in part by a narrow, often overly personalized view of Chinese medicine. But what's more, this body of literature is blighted by a terminology that does not always ensure that East Asian concepts are transmitted to Westerners accurately, and that is not sufficiently unified to ensure unequivocal communication. In short, the development of Chinese medicine in the West has suffered by failure to accord due importance to gaining direct access to the East Asian tradition, and at the core of every aspect of this problem is the failure to meet the challenges posed by language.

I propose that the English-speaking East Asian medical community would benefit from facing the fact that Chinese medicine comes from East Asia, and originally from China, and that we have barely begun to access East Asia's 2,000 years of experience in treating the sick. I suggest we could vastly improve the quality of East Asian medical education and strengthen the dynamism of Chinese medicine in the West if we enhanced the mechanisms by which we gain access to medical knowledge from East Asia by encouraging people to learn Chinese or other East Asian languages, by encouraging translation of clinical information, and by encouraging term standardization.

Preliminary Remarks

Students, teachers, and practitioners of Chinese medicine most appreciate speakers who talk about clinical issues. What people want is clinical knowledge. It is true that people such as myself who do not work in a clinic everyday cannot tell you many things you may wish to know. It is equally true that in Chinese medicine an essential element of clinical knowledge has always been, and still is, transmitted not by books or lectures—in language—but by demonstration through apprenticeship. Nevertheless, neither theoretical nor clinical knowledge can possibly be transmitted without the aid of language. The clinicians of the past who continue to provide inspiration to the physicians of today do so exclusively through the words they left in the books they wrote. Knowledge and experience are passed on from one generation to the other by means of language. Furthermore, it is largely by the medium of language that East Asian medical knowledge, skill, and experience have reached the West. East Asian medical knowledge has been made available to you today by the individuals who have knowledge of both East Asian and Western languages.

At this conference, I wish to talk about the role of language in the westward transmission of Chinese medicine. Far from focusing on specific translation choices that translators have knit-picked about over the last decades, I wish to discuss the whole delivery system by which theoretical knowledge and clinical skills are acquired in the West. In my view there are many failings in the way in which the matter of language in this connection has been dealt with, and hence I think there is much that can be done to improve on the present situation.

I personally believe that this supposedly non-clinical issue is vastly more important to your patients' health than any clinical trick anyone can

teach you because it is the hook upon which your entire clinical bag of tricks hangs. It is only when we have a sound transmission mechanism that Chinese medicine can develop firm roots on Western soil that will provide a strong foundation for the healing skills you each hope to develop.

Everyone in the West who is concerned with Chinese medicine is aware that Chinese medicine comes from East Asia. Probably everyone realizes that East Asia still has much to teach the West. I suggest, however, that the community has not acted on this awareness to the full. Over recent decades more literature has appeared in English than ever before. But so far only a tiny fraction of East Asia's vast wealth of literature has become available to English speakers.

Chinese medicine is a complex body of knowledge that has evolved over two millennia. There is a huge wealth of literature available in Chinese and other East Asian languages. Since knowledge does not become obsolete in East Asian medicine as it does, say, in modern medicine, some of the earlier literature is still highly valued to this day. Much of the theory of East Asian medicine still applied now was laid down in the *Nèijīng* (内经) and the *Nànjīng* (难经). Many acupuncture therapies used today are based on those books. Many of the medicinal formulas that are commonly used in modern practice were devised by Zhāng Jī eighteen hundred years ago. Over the time during which Chinese medicine has been adopted in the West, it has undergone great development in Korea, Japan, and especially China, and as a consequence there is now a whole new body of literature reflecting efforts to validate Chinese medicine in scientific terms and integrate it with modern Western medicine.

The fullest account of Chinese medicine is that contained in East Asian languages. Although more and more of East Asia's storehouse of experience is being made available to English speakers, we are not, as a community, adequately geared up for large-scale acquisition of East Asian medical knowledge. The transmission of Chinese medicine is still, relatively speaking, in its infancy.

I speak of the 'transmission' of East Asian medicine. The word transmission is not one heard much on the lips of people in the West. It is almost as if people forget that Chinese medicine is a body of knowledge that is transmitted to us in the West from East Asia. I think people without a knowledge of East Asian languages in particular tend to overlook on the one hand the fact what we know about Chinese medicine has been transmitted from East Asia and on the other hand the fact that not all of it may have been transmitted. I think many people believe that Chinese medicine has already arrived. In reality, we have only a small fraction.

The tendency to ignore the fact that East Asian medicine is an imported body of knowledge is clearly reflected in the fact that quite a large percentage of the English-language literature has not been translated from East Asian languages. Instead of gaining a deeper and broader understanding of East Asia's 2,000-year medical heritage through acts of translation, the English-speaking community of Chinese medicine has to some extent been rehashing the same information in commercially competitive texts vying with one another for essentially the same group of readers.

Furthermore, as much attention seems to be paid to how Chinese medicine can be adapted to serve Westerner's needs as to actually finding out more about the subject. Much effort has been put into interpreting Chinese medicine for Western recipients. On the one hand, Felix Mann and, more recently, Jacqueline Filshie & Adrian White have tried to strip Chinese medicine of its speculative elements, and use acupuncture on the basis of the Western medical understanding of the body. On the other hand, Harriet Beinfield & Efrem Korngold and Mark Seem have tried to make Chinese medicine fit the mold of body-mind philosophy. Needless to say, the more radical adaptations tend to be the work of those without access to primary East Asian sources.

It is not my intention here to evaluate any of the adaptations of Chinese medicine that have been attempted. I wish only to make two points.

One is that at the present stage of transmission, Westerners have far more to gain by learning more about the East Asian traditions than by cavalierly reshaping them to their own perceived needs. A certain amount of adaptation may be appropriate in the transmission process, but we must first

understand what it is we are adapting. So far we have not reached this stage.

The other point is that East Asian healing is rooted in a tradition that has gradually evolved over centuries, and Western practice of East Asian medicine must be rooted in that tradition if it is to claim validity from it. Chinese medicine is not based, as Western medicine is, on demonstrable fact and repeatable experiment. Unlike Western medicine, it has no mechanism to ensure that new knowledge is more reliable than the ideas of the past. Although the influence of scientific principles and the findings of modern medicine are pressing Chinese medicine into a modern Western mold, the historical roots of East Asian medical knowledge are far from being ready to be severed. Whatever course the development of East Asian medicine takes in the West, it is likely that there will always be a need for access to clinical experience contained in the medical heritage of East Asia. I believe we have not paid enough attention to gaining access to that knowledge, and that greater effort could be made to do so.

If we think carefully about the transmission process, it becomes obvious that the only way that any English-speaking individual can acquire a knowledge of Chinese medicine is a) by learning East Asian languages to gain access to primary East Asian texts, b) by reading material translated and compiled from primary sources, or c) by reading literature produced by people with no access to primary texts and who base what they say on secondary English sources and their own experience.

I am sure that nobody would disagree with the idea that the individual with access to primary East Asian texts has the best means to gain the broadest and soundest understanding of Chinese medicine as practiced in East Asia. I am sure no-one would dispute that the person who can only read translated literature is at a disadvantage insofar as less literature is available in English than in Chinese or any other East Asian language, and insofar as the quality of the translation may be lacking. I am sure not a single person would disagree that anyone reading secondary literature by authors with no direct access to East Asian sources may gain the benefit of the personal insight and experience of such authors, but they may not be getting the benefit of East Asian knowledge and experience.

People can barely fail to recognize the importance of language when the matter is put in these terms. Nevertheless, gaining access to the source has been a low priority for the Western community of Chinese medicine as a whole. Right from the start of the acupuncture boom, English speakers have relied very heavily on the ability of East Asians to tell them about their medicine in English rather than learning East Asian languages. Twenty or thirty years ago, people learned Chinese medicine through halting English descriptions by East Asian doctors like Tin-Yat So. Later, the US community of Chinese medicine relied heavily on a series of textbooks produced in the People's Republic of China. You have East Asians to thank, in no small measure, for delivering knowledge of Chinese medicine, because it is as much their command of English as our command of their languages that has provided the linguistic bridge.

Westerners have been slow to realize that acquiring linguistic skills is the key to gaining greater knowledge of Chinese medicine as practiced in East Asia. This slowness can be attributed to the belief that East Asian languages are too difficult to learn. More importantly, it can also be attributed to a failure to understand just how much greater knowledge of the subject matter exists in East Asian languages. If one cannot read texts in East Asian languages, one can never know how much more knowledge is to be gained from them.

Exerting a powerful influence on people's thoughts in this realm is a notion that comes from complementary, or alternative, health care. The acceptance of Chinese medicine in the West over the last few decades has its roots in its being perceived as an alternative or complement to Western medicine. In other words, it is thought of as being what Western medicine is not. It is understood as being primarily a clinical art that is not based on very much book-learning. It is believed to be learned through practice, from people who possess the skills, rather than through books.

Although clinical skills acquired by watching and practicing may be more important than in Western medicine, most of the forms of East Asian medicine that have been adopted in the West nevertheless

constitute a body of knowledge that can only be acquired through assiduous book-learning. The mnemonic verses that constitute a distinct genre in East Asian medical literature strongly attest this. Many people appear to believe that books offer only theoretical knowledge, that is, only limited help in gaining clinical profiency. In actual fact, however, the classical literature that is studied to this day in East Asia largely comprises the experience of past physicians. One studies the *Shāng Hán Lùn*, for example, to learn about Zhāng Jī's genial formula compositions, not to learn any theory that is only indirectly related to clinical practice.

The relatively large proportion of English literature containing no references to primary East Asian sources is one sign of the absence of linguistic access to the knowledge and experience of East Asia. When we look more closely at the literature, we find another sign: the lack of a standardized terminology pegged to the Chinese.

Everyone in the English-speaking community of Chinese medicine is now aware of a terminological problem. Everyone knows that different books apply different terminologies, and that this can create confusion. Nevertheless, I think that we have not, as a community, acted on this awareness fully.

Although people are aware of a terminological issue, I suspect they are not fully aware of its complexity and implications. Getting our terminology right is not simply a matter of translators arguing about which English words they like best. It entails deciding which words represent the original concepts faithfully and which words falsify the concepts. There are a number of examples of badly chosen English equivalents that have caused confusion; we will look at some of these later.

In many cases, terminological decision-making involves deciding whether a word denotes a concept that the translator keeps intact by representing it with a specific translation that he or she uses consistently in all contexts, or whether it is used in different senses and can therefore be translated differently in different contexts, i.e., freely. There has been a great tendency for translators not to coin special terms for East Asian medical concepts that one finds, for example, in Chinese-language dictionaries of Chinese medicine. Instead they use ad hoc expressions or descriptions to refer to them, or else avoid mentioning them altogether. In this way, concepts are often lost. Again, I will give examples of this later.

This free approach to translation has the advantage of sparing students the burden of learning a welter of unusual expressions, and of course it relieves the translator of having to gloss technical terms. Nonetheless, such an approach lacks foresight because it makes it difficult to introduce advanced knowledge. Furthermore, this tendency has of course contributed to the widespread belief that Chinese medicine possesses very few technical terms.

So far, awareness of the issues I have raised has not been as great as it could be, presumably because there are simply not enough people who have knowledge of East Asian languages. In a field where much of the available literature has been written by people without linguistic access to primary sources and where instruction in schools is largely given by teachers who, again, have no access to primary sources, it is no wonder that terminological chaos reigns.

Nevertheless, if we accept that East Asians have greater experience in the healing arts they have created, it stands to reason that a method of translation that faithfully represents East Asian experience will enhance the clinical proficiency of Westerners. And there is a methodology for doing this that is recognized by translation experts and that has been applied in other fields. I will say more about this later.

When the terminological issue is pursued seriously, then translators, publishers, and readers increasingly perceive the need for all writers to apply the same English equivalents in translation. But before translators can agree on a terminology, terminological proposals have to be put forward. Over the last decades, there has been an increasing tendency among English-speaking translators to provide glossaries in their works in order to relate terms to the original Chinese terms and explain the concepts they represent. Yet so far, most of the bilingual lists that have made proposed equivalents easily accessible have been produced by the Chinese. Western translators have their own terminologies, and these have largely yet to appear in published lists.

To recap, the English-language literature of Chinese medicine includes works based on secondary Western sources, Western experience, and Western adaptations as well as works translated and compiled from primary sources. In general, the terminology used in English-language works is variable, sometimes does not represent concepts faithfully, and is often not pegged to original Chinese terms. All of these trends reflect a lack of linguistic access to the source.

I believe that we have neglected the transmission process. The English-speaking East Asian medical community has not developed any mechanism for the accurate transmission of East Asian medical knowledge. In the literature and curricula being offered, it is difficult for those without linguistic access to primary sources to tell what is of East Asian origin and what is of Western origin. They cannot tell how faithfully what they read and learn represents East Asian traditions, or which East Asian tradition it represents. In short, there is little guarantee for the quality of information received.

My Motion

What I wish to propose here is that we could vastly improve the quality of East Asian medical education and strengthen the dynamism of the development of Chinese medicine in the West by enhancing the mechanisms by which we gain access to medical knowledge from East Asia. Put simply, we need to

1. encourage people to learn Chinese or other East Asian languages,
2. encourage translation,
3. encourage term standardization.

Let me clarify why I make these recommendations.

When people make the effort to learn East Asian languages and in particular Chinese, they gain access to a whole library of information that does not exist in English. They therefore gain access to the huge tradition of Chinese medicine, and have an opportunity to enhance their clinical skills in ways that they currently lack. East Asians have the greatest experience in their own medicine, and learning East Asian languages gives people access to that experience.

People have much to gain by learning Chinese, Japanese, or Korean. Chinese is the most important of these because the Korean and Japanese traditions are dependent upon it. The *Nèijīng* (内经), *Nànjīng* (难经), and *Shānghánlùn* (伤寒论) are of great importance in the Korean and Japanese traditions and these were written long before writing was introduced into Korea and Japan. The Korean and especially Japanese terminology of Chinese medicine are largely Chinese and are written in Chinese characters, so that anyone wishing to learn Korean or Japanese medicine in those languages must have sound knowledge of Chinese.

While it is quite practical to hope for a considerable increase in the number of people learning East Asian languages, it is highly unlikely that we would ever reach the stage where East Asian languages were the principal vehicle for East Asian medical knowledge in the West. Translation will always remain of paramount importance in gaining access to the East Asian tradition. Our access to that tradition would be enhanced by translation in greater quantity and better quality than at present.

We need more translation, but we need a higher quality. The way toward higher quality lies in developing an English terminology that accurately reflects the conceptual edifice of Chinese medicine, that is available to all translators in published lists, and that is applied consistently by all translators.

How do we increase the quantity and quality of translation? Language-learning might well be the key.

Language-learning, promotion of quality translation, and term standardization are all in fact interrelated. Increased language-learning would not only give the community greater access to the original traditions of Chinese medicine; it would also greatly enhance its potential to translate. Knowledge of source language is the basic skill required for translation, and most people who take the effort to learn East Asian languages in order to gain more information about Chinese medicine are usually keen to pass on their knowledge to other people, and are usually keen to try their hand at translation. The more people know East Asian languages, the more

translation would increase. Much more information would become available and a broader variety too.

The more people there are learning Chinese and translating and compiling literature from primary sources, the more attention will be paid to transmission of traditional East Asian medical concepts. Readers who have learned Chinese will come to expect to recognize in English literature concepts that they see in East Asian literature, and hence be able to distinguish between faithful depictions of East Asian traditions and not-so-East Asian Western versions.

When by encouraging linguistic access and translation we begin to eliminate the interference of interpretations slanted toward Western preferences, people will naturally tend to want a terminology that reflects the East Asian concepts rather than some interpretation of them. As people's knowledge of Chinese increases and a more accurate picture of East Asian medicine appears in translation, the suggestion that terminology should be standardized will start to make more sense to more people. Furthermore, standardization of terminology will become easier because the choices will be narrowed.

How Do We Do It?

In its broadest form, my motion suggests that linguistic access is the most important thing for the development of Chinese medicine in the West. Increased translation and term standardization are dependent upon it. In other words, more people should learn Chinese.

I am certainly not alone in this belief. Not only have the benefits of learning Chinese been emphasized by numerous people in the field, but several writers (Paul Unschuld, Bob Flaws, Andy Ellis, and myself) have produced textbooks designed specifically for students learning Chinese for the purposes of gaining access to more East Asian medical information. Specialized language-learning material of this kind of course makes it much easier and quicker for students to obtain their objectives.

Apart from providing textbooks, what else can be done to encourage people to learn Chinese? Within schools, there are several options open:

1. Knowledge of Chinese can be made a requirement for students applying for courses and for people applying for teaching posts.
2. Chinese can be prescribed for self-study.
3. Instruction in Chinese can be given.

I am not saying that everyone needs to learn Chinese. Nor am I claiming that one needs to learn Chinese to practice Chinese medicine. I am merely suggesting that the more people learn Chinese, the better the English-speaking community of Chinese medicine will understand East Asian medicine, and the healthier the development of Chinese medicine in the West will be.

Of course, it would be very difficult for colleges of Chinese medicine to provide sufficient instruction in Chinese to enable students to read East Asian medical texts. Nevertheless, schools could perhaps offer students the possibility of studying by themselves and taking courses outside, and then set an examination for which credits could be given.

It would be difficult to make a certain level of knowledge of an East Asian language an entrance requirement for regular courses in East Asian medicine. Yet it might be quite feasible to make Chinese an entrance requirement for Master's degrees and research degrees. This would not only significantly increase the scope of research potential; it would also mean that tomorrow's teachers would be far better qualified than today's.

A major immediate and practical course action to encourage translation is, as I have said, to encourage language-learning. Of equal importance, though, is consumer awareness. Whether you are an educator planning curricula, a teacher planning a course, or a student or practitioner browsing in a bookshop, you should remember that whatever you know about Chinese medicine—I mean *East Asian* medicine as opposed to any Western rewrite of it—reaches you by the medium of translation. However many hands any item of knowledge passes through before it reaches you, it has, at one point or another, had to be translated into English.

As the end-user in the translation chain, you ideally want information that portrays Chinese medicine reliably. It therefore makes sense to choose material that has been translated or compiled from primary sources rather than material that has been

compiled from secondary English sources. But how can one tell the difference? Bibliographies usually provide some indication. Very often, however, it is difficult to determine the origin of every item of information in a book. When translators are compiling information from multiple sources, the borderline between translation and writing becomes blurred. Any translator who is a clinician may add his own experience alongside tried and tested remedies without telling his reader clearly where each item of information he is providing comes from.

Some action has already been taken to help to guide consumers in their choice of books. In May 1995 there was a meeting to discuss a 'Code for the Council of East Asian Medical Publishers' (COMP). According to the code, publications should contain a designation indicating whether they are translated or compiled from primary sources or are original works, and, in the former case, how close the translation is. You may not have heard of the COMP designations, but they are there to help you. They are intended to help consumers to know what type of information they are getting.

COMP aims to provide consumers with better information about the content of books. Implicit in this is the desire to promote a greater awareness about transmission and translation issues that will make consumers more demanding.

As I say, the successful transmission of Chinese medicine requires that translators peg their terms to the Chinese in a published terminology. Ultimately, it requires that all translators apply the same published terminology. We are still far from achieving this goal.

In my own work over the last 20 years, I have been developing an English terminology that is matched in great detail to the Chinese. In this process, I have published two bilingual lists for the benefit of translators. I am very happy that quite a few translators have adopted the terminology, and advertised their work as applying it.

Bilingual lists essentially address translators. More has to be done in order to bring home to the English reader with no knowledge of Chinese the need for careful choice and listing of terms as the only guarantee of faithful transmission of concepts. Since students and practitioners naturally tend to see terminological discussions as relating only indirectly to their own concerns, and have no way of judging translation issues, they often fail to see their relevance to clinical proficiency.

In an attempt to promote awareness of the terminological issue, my colleagues and I decided to produce a dictionary of Chinese medical concepts that provided not only definitions, but also clinical information useful to students and practitioners. We hoped that by making the book useful in this way, we would draw attention to the conceptual complexity that is all too often absent in the present body of English literature. This rather risky venture has proved far more successful than we had ever hoped. *The Practical Dictionary of Chinese Medicine* has generally been very well received.

Political Implications

My message to you has immense political implications. It is important for each and every one of you to understand these fully because they ultimately affect your own interests.

The political implications are seen in many aspects of Chinese medicine. Let me give you one example here. If the East Asian medical community were to acquire a preference for literature translated and compiled from primary sources, the writers who describe Chinese medicine working from secondary sources would suffer a loss in popularity. If writers who have gained their knowledge and built their clinical experience exclusively through the medium of English were increasingly seen to be unreliable sources of information, their present authoritative status would be threatened.

This may seem unfair, particularly to people who are viewed as having made contributions to the field. Nevertheless, I ask you to consider the fact that in all fields of modern learning, it is customary for people to be acquainted with the relevant literature before they make their own contribution. A scholar's work becomes suspect when it comes to light that he has not done his homework. For example, any person in China, Korea, or Japan doing research in Western medicine and hoping to have the fruits of his or her research published in an internationally recognized journal has to be able to access previous research on the subject, and since English is the language of international medical research, that person would

have to be able to read English if they did not wish to waste their time doing research that has already been done or exploring avenues already known to be fruitless.

In Chinese medicine, most of the literature is in Chinese (or other East Asian languages). Therefore it stands to reason that, under normal circumstances, any English-speaker wishing to write a textbook or offer authoritative clinical experience, or wishing to present the findings of scientific research in Chinese medicine, should have access to East Asian literature. I certainly would not wish to deny people the right to present their personal experience and personal understanding provided they label it as such. Nevertheless, I suggest personal experience is only of value when it is offered as an improvement on previous experience. That most of the experience is only to be found in East Asian literature makes linguistic access to East Asian literature a must for anyone who hopes to present useful insights and experience. So long as people are unaware of this, they are effectively inventing their own Chinese medicine rather than simply importing the ready-made item.

One might ask why in the field of East Asian medicine people who have no access primary sources write books and why some of them are accepted as authorities. The answer to this is, I believe, that Chinese medicine is considered to be a set of practical skills, and that most of what can be transmitted through translation is theoretical and has already been transmitted.

Just as importantly, though, is the fact that the customary practice of consulting available literature is one that has been cultivated in academia, and that because Chinese medicine largely operates outside academia it is not subject to the same rules. Chinese medicine, like many other complementary medicines, has largely been a marginal interest in the West, and escapes the normal controls that we elsewhere apply in the purveyance of knowledge.

The academic principle that scholars should have a good command of the relevant literature is the natural result of a desire to ensure the highest standards of scholarship. If the East Asian medical community in the West were to apply the same rule, it would help to raise standards immensely. If we expected writers to have a command of the literature to which they are contributing, certain authors would be reappraised and, as it were, demoted. Unfair as this might seem on them, it would ensure that the community were better served in future. We have the right, if not the duty, to ensure that we invest authority in those best qualified.

My message at this Symposium is not merely that we should have a plan of action to solve a particular problem. An important part of my message is that people should open their eyes to the political implications of their assumptions about Chinese medicine and about the people who they allow to define Chinese medicine for them.

Conclusion

I have briefly outlined a large spectrum of problems hampering the transmission of Chinese medical knowledge. In the workshop presentations I will present my evidence and arguments in greater detail, and I hope you will feel free to raise any objections you have.

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The Transmission of Chinese Medicine: Chop Suey or the Real Thing?

The transmission of Chinese medicine has been far less successful than it could be. The reasons are to be found in the nature of Chinese medicine itself, but more importantly in the motivation of those involved in the process of transmission and reception. It has suffered by the unintegratedness of its knowledge and the fuzziness of its concepts. It has suffered from the influence of Western medicine, but more importantly from Western expectations of Chinese medicine as a complementary health practice.

As I have stated, the issues I wish to talk about at this conference concern the westward transmission of Chinese medicine, that is, the whole delivery system by which the clinical knowledge of Chinese medicine gets into the hands of Westerners.

The questions I ask concern how we transmit knowledge and how much “interference” there may be in the process. How well a body of knowledge is transmitted can depend on the nature of the knowledge and the motivation of the transmitters and recipients.

Some things can be transmitted from one culture to another very easily. One might well imagine that ideas such ideas as fire-making, the stirrup, the plough, the wheel, could be easily transmitted from one culture by mere observation. Some types of knowledge, on the other hand, are more complicated, and can’t be transmitted by observation alone.

Some cultural products change in nature as they move from one culture to another. Food is a prime example. When I was a child, my mother most weeks used to serve up macaroni cheese, an adapted form of an Italian dish that came into fashion in England as early as the 18th century, I believe. Of course, what my mother cooked up did not bear much resemblance to any pasta dish with a cheese sauce that is served in Italy. Different ingredients are substituted (Cheddar instead of Italian cheeses), and the method of preparation is different.

Let me focus on this example a little. The connoisseur and professional cook wishing to learn about Italian cooking would expect to gain a detailed knowledge of the materials and methods used by Italians in the preparation of food. For an English speaker to do this, he or she would probably have to spend a good deal of time in Italy and learn Italian. It does not take too much imagination to realize that the person would have to gain a feel for what Italians appreciate in the way of food, and that would involve gaining acquaintance not only with Italian cooking but also with Italian culture in general.

For knowledge of authentic Italian cuisine to be broadly disseminated among English speakers, we need English-language Italian cookbooks written either by Italian cooks who have gained a good command of English, or else by English speakers who have spent time in Italy learning from experts. The point here is that a good Italian cookbook is written by someone who has full access to the language and culture of Italy; someone who admires Italian cooking in all its detail and Italian culture in general.

This level of transmission is quite different from merely picking up a couple of ideas from Italy. The authentic Italian cookbook is different from the cookbook for busy housewives. The recipe for quattro form`aggii is quite different from the recipe for macaroni cheese that is intended to make use of those odd moldy old bits of left-over cheese.

Not everything changes when it moves, though. Over the last century or more, a whole conglomerate of interrelated branches of Western learning have been transmitted to other language communities, notably to those of the Far East. Despite the immensity of this operation, the Western sciences look to Chinese and Japanese people very much as they look to us in the West.

The comparison with the eastward transmission of Western knowledge is useful to us in our effort to understand some of the basic issues involved in the westward transmission of Eastern knowledge. I will

show that in the westward transmission of Chinese medicine we have ended up with macaroni cheese, or rather in this case chop suey, a Western variant of Chinese food, instead of the real thing.

Eastward Transmission of Western Learning

China has had knowledge of Western healing arts for several hundred years, but it was not until the 19th century that Western medicine attracted greater interest. By this time, Western powers were making incursions into China's economic life, and Western civilization was beginning to exert great influence. Western medicine came to be adopted in China, as in many other countries throughout the world, perhaps not so much on evidence of its superior efficacy to any indigenous form of medicine as out of the prestige accorded to it by virtue of its being the medicine of the economically most advanced nations (Sivin 1987: 6).

The Chinese realized that the economic and political superiority of the West lay in its superior technology, and that they had to acquire Western scientific and technological knowledge if they were to restore their country to strength. They also realized that in order to acquire this knowledge they had to gain full linguistic access to the source culture. Thus, in the mid-19th century, they began establishing schools designed to teach foreign languages so that students could gain access to Western knowledge and translate technical information into Chinese (Wáng F-J 1945; Bì C 1996).

At the same time, plans were put in action to encourage Chinese students adequately trained in foreign languages to go abroad to study (Wáng F-J 1945). These early moves, which have continued into the present, reveal the clear recognition that language is the vehicle of knowledge, and that source languages must be learned, not necessarily by all students of the field in question, but at least by a limited number of people capable of translating information for wide dissemination.

Nowadays, students in the People's Republic of China (PRC) learn modern medicine by the medium of Chinese, in a Chinese terminology closely pegged to the terminologies of Western languages. In Hongkong and Táiwān, greater emphasis is placed on students being able to read English texts. In both cases, however, the linguistic link is important. Although in China (as in Japan) the number of people who are both fully competent in medical English and make continual use of this skill must be quite small, these people are obviously a crucially important link in the transmission of information. Furthermore, a good command of English is indispensable for any Chinese (or person of any other nationality) wishing to gain access to the findings of international research and or to gain international credit for his or her own work—in medicine, as in virtually every modern field or discipline.

The success with which Western scientific knowledge has been adopted in the Far East is partly the result of having overcome the language barrier. It is also related to some degree to the inherent transmissibility of the knowledge in question.

Scientific knowledge is very different from cookery. While Italian food may appear on the tables of English speakers in different degrees of authenticity, scientific knowledge is not so susceptible to such variability. This is quite a surprising fact because modern scientific knowledge is immensely complicated and continually growing, and because it can't be transmitted cross-culturally by observation alone, and can't be transmitted without the use of man's fuzziest tool, language.

The reason why scientific knowledge lends itself to accurate transmission lies in its own precision. Every scientific concept is clearly defined, and its relationships to all the other concepts in its conceptual system are similarly clearly defined. While in cooking one can substitute Cheddar for mozzarella and still have something edible if not tasty, in science, one could not substitute a native concept in the target culture for a concept in the knowledge system to be transmitted without grave consequences. You can't remove anything from the structure without there leaving an obvious hole, and you can't add anything without justification.

Scientific knowledge is produced in accordance with strict principles that place demonstration over human authority and allow any existing theory to be open to question. Any given phenomenon must be explained in terms of a single, comprehensive theory. When two conflicting theories are put forward, they either one or both are wrong. While scientific

principles provide no guarantees that the knowledge produced by them is one-hundred percent true, there is theoretically only one true explanation of any phenomenon.

As I said, scientific knowledge can't be transmitted from individual to individual without the use of language. Language is sometimes an ambiguous and unreliable method of communication. But the sciences are at pains to reduce the problems of communication by using language in an unequivocal way. The ideal that scientists try to achieve—and indeed do achieve to a large extent—is that each concept should be represented by a single term, and each term should represent only one concept. Very importantly, each concept must be clearly defined.

Any body of knowledge that, no matter how complex it is, admits of only one truth, and makes use of clearly defined and labelled concepts would appear to be more easily transmitted than other types of knowledge. Scientific discourse is not open to interpretation in the way that other forms of discourse are. It resists any deliberate or accidental distortion.

Westward Transmission of Chinese Medicine

Turning now to the westward transmission of Chinese medicine, we find a very different situation with regard to cultural prestige, willingness to gain linguistic access to primary sources, and the nature of the knowledge in transmission.

I will discuss the language issue first, because ultimately it is linguistic access that counts in the transmission of any complex body of knowledge that is conveyed from individual to individual by language.

If I were to ask people in this room who have some knowledge of Chinese to raise their hands, we are unlikely to have a spectacular show. If I were to ask those who can read Chinese-language literature of Chinese medicine fluently, there might be even fewer hands. Few people in the West learn Chinese. Chinese medical schools do not teach it, certainly never to a level intended to enable students to rely on Chinese literature for their intake of information.

While language was recognized as the key to the eastward transmission of Western medicine, it has not been identified as significant in the westward transmission of Chinese medicine. One might suppose, as I think many people tend to, that Chinese medicine rests on a relatively compact body of theoretical knowledge that has already been fully transmitted.

The facts speak against this, however. A huge legacy of literature is accessible in Chinese: according to different estimates, between 10,000 (Sivin 1989) and 12,000 books (Unschuld 1990). There are considerably fewer books available in the English language. According to a survey of Chinese medical literature by Birch & Tsutani (1996), fewer than 500 books were published on Chinese medicine in English between 1950 and 1993, and many of these are not translations.

A feature of traditional study of Chinese medicine is the study of classical literature. Translation of the classics has been slow to develop. Translations of a number of classics have appeared over the last 15 years or so, but good translations with adequate commentaries are few in number. Accurate book sales figures are hard to get hold of, but it is quite safe to say that translations of classics do not sell well. As Birch & Tsutani concluded from their study, Chinese medical transmission is still very much in its infancy.

For those who have linguistic access to this heritage, it is only natural to believe that Westerners would have much to benefit from if the vast amount of literature created over centuries were available in Western languages. I suggest that this thought actually rarely occurs to the monolingual English speaker, for reasons that will gradually become apparent.

Why have Western adherents of Chinese medicine not bitten the linguistic hook? One might suppose that the linguistic issue is, to some extent, a vicious circle. If people can't read Chinese, they are unlikely to realize how much more literature is available in Chinese. When they are in China, they can't even read the sign that says "library" over the door to the place where the books are kept.

Why the Chinese identified language as the key when adopting modern Western learning, I suggest, is that they could see a whole range of products of Western intelligence before their eyes—superior means of production and superior weaponry that were undermining the economy and the political power of the whole Chinese nation. The sheer force

of the impact caused the Chinese to rattle their brains to see how they could best get hold of the knowledge that made the Western powers so strong. They quite sensibly realized that knowledge is transmitted by language, and so to acquire the knowledge they had to gain linguistic access to it.

By contrast, the Chinese cultural products that Westerners have identified as being worthy of adoption are limited to acupuncture and other modalities of Chinese medicine, as well as qìgōng. Nothing from China is of any vital significance to the economic and political survival of Western nations. And even Chinese medicine is identified as desirable only by a segment of the population. The importance currently accorded to Chinese medicine is insufficient to mobilize the human and material resources necessary for the transmission of Chinese medicine on a significantly large scale.

While the transmission of Western knowledge to China has been a straightforward question of gaining linguistic access to Western knowledge, the problem for Westerners to obtain knowledge about Chinese medicine is fraught by questions of what is useful in Chinese medicine. Those with linguistic access to China's medical heritage have not agreed on what is useful in it, and have not agreed on a transmission program.

One of the main causes for this disagreement is the lack of a conspicuous cognitive structure in Chinese medicine. Chinese medical knowledge is based on different cognitive approaches, and applies diametrically opposed principles of treatment. Theory and practice are not closely interrelated.

For example, knowledge of organ functions is partly based on an analytical understanding similar to that of modern Western medicine. The lung's function of drawing in air, and the stomach's function of preliminary digestion are examples of this. But the liver's function of orderly reaching and the kidney's functions of essence storage and reproduction were the product of an inductive type of thinking that works on the principle that what is generally seen to be true in the universe must also be true of the body. The function of the liver and, in part, that of the kidney were determined on the basis of five-phase correspondences.

Over the centuries, Chinese medicine continually evolved. Successive generations of physicians made their contribution to medicine. However, nothing of the past was ever definitively discarded. For example, various systems of correspondence between the pulses and diseases of the internal organs were devised. Different schemes for the interpretation of the anomalies of the tongue and its coating were developed. The theories of the *Nèijīng* (内经) concerning febrile disease were developed into the theory of cold damage, which was centuries later to be rivaled by that of warm disease. Yet in all these developments, although earlier ideas in some cases may have been eclipsed, no ideas were ever definitively discarded.

Similarly, Chinese medicine includes different treatment modalities that have to a large extent developed separately and that are still usually practiced by different physicians. At no time did all healers join forces to decide what treatment modalities should be applied under what circumstances. Even within one modality, entirely different approaches to treatment can be taken, such as an allopathic approach of expelling evils on the one hand or a holistic approach of promoting balance on the other (Unschuld 1987, 1982; Birch 1998).

In the second millennium, the classics of the formative period (up to end of the Hàn Dynasty in the third century) were increasingly held to have authority as major works of a golden age, which scholars could only attempt to explain in depth, but would never be able to improve on.

Medicine in China is like a huge barrel from which physicians have drawn what they want. This heterogeneity of knowledge is largely alien to Westerners, and it is not surprising that we have had difficulty in identifying it and accepting it. Westerners may be apt to think that one approach is more representative of Chinese medicine than another. That's because the idea of one truth is deeply ingrained in our minds. Back in the 1970s, Manfred Porkert, for example, preached the word that Chinese medicine was based on the principle of inductivity rather than causality. This, however, does not represent the whole truth. There is clear evidence that both principles are operant.

It is precisely for these reasons that it is much

more difficult for Westerners to enter the world of Chinese medicine than it is for Chinese people to enter the world of science. It may be an exaggeration to put it like this, but it helps to make a point that is poorly understood: if one were to transfer the whole body of Western medicine to a language community that never heard anything about it, one would only have to translate, say, all the books published in English in the last year in the field of medicine and related fields for that community to gain a comprehensive grasp of the subject.

By contrast, if one were to attempt to transmit Chinese medicine to our hypothetical isolated language community, we would have to translate a whole pile of books from different centuries before the recipients could have an equally clear understanding of Chinese medicine as they would have of Western medicine.

In this respect, Chinese medicine is something like the fine arts; anything from the past can still be appreciated, and it is difficult to say if there is any such thing as progress in it.

The transmission of Chinese medicine is hampered by its knowledge structure. It is also hampered by the language it is expressed in. Chinese medicine has many "technical terms," but not quite in the sense as is meant by the expression in the modern sciences. A "technical term" is any term used in communication among specialists that the layman does not understand, or any lay term that is used in a specialized sense that the layman does not fully understand. In other words, a technical term is an unfamiliar expression or a familiar expression used in an unfamiliar sense. In this sense, Chinese medicine has many technical terms, thousands upon thousands in fact. Yet it never felt the need to sharpen the language tool to eliminate multiple meanings and ambiguities.

The transmission of Chinese medicine has been further complicated by the presence of a very vibrant medical and scientific culture in the West, and this is reflected in the fact that this knowledge has largely replaced traditional Chinese learning in the very country from which Chinese medicine comes. There are twice as many Western medical doctors as there are Chinese doctors in the PRC, and ten times as many in Táiwān (Birch & Felt 1999).

With the impact of modern knowledge in China, Western medicine relegated indigenous healing arts to a secondary role in the modern health-care system. Chinese medicine is still considered by a large section of the population to be valuable and effective. Yet, for most people in China, modern scientific methods are now the arbiter in all matters of nature, and Western medicine is considered the final judge of all medical matters.

For this reason, there is a strong belief in China that Chinese medicine must be explained in terms of scientific principles, and only that part of it that is scientifically based should be retained for posterity. It is this notion that lies behind the continuing efforts to integrate Chinese medicine with Western medicine in China.

This has been important, because the Chinese have played a major role in the transmission of Chinese medicine. A number of basic acupuncture textbooks from the PRC provided the basic texts for acupuncture training in the US for a number of years.

But the notion that therapeutic procedures need to be set on a scientific basis naturally also exists in the West. In fact, one reason why acupuncture gained in popularity in the 1970s lies in new evidence for the pain-relieving effects of acupuncture (Unschuld 1998). Experiments in the PRC in the analgesic effects of electroacupuncture in surgical operations, which were given sensationalist media coverage after they had been witnessed by Richard Nixon's personal physician during the US President's historic visit of 1972 that reopened communication between China and the West, triggered scientific experimentation by Western scientists. Initial studies suggested connections between acupuncture analgesia and the effects of endogenous opioids, which made engagement in the scientific experimentation of acupuncture respectable (Unschuld 1998: 111).

While many aspects of Chinese medicine aren't easy for Westerners to understand unless they have linguistic access to the source, there is one thing about Chinese medicine that is immediately apparent: its unscientific and speculative nature. To learn acupuncture, for example, one has to familiarize oneself with the pathways along which qì flows. Unfortunately, neither the pathways nor the qì are

detectable as individual entities by any known scientific method. And if I asked you to define qì, you"d be quite likely to each give a significantly different answer.

Some people who believe acupuncture and Chinese medicine to be valuable despite their unscientific nature have argued that empirically or scientifically based forms of Chinese medicine that to a greater or lesser degree dispense with traditional theoretical trappings are likely to be more viable in the West. In other words, trying to import Chinese medicine lock, stock, and barrel would probably be unsuccessful; rather we must adopt its treatment modalities, and ground their use in modern scientific theory. Such ideas are notably to found in Felix Mann (1992) and in Jacqueline Filshie & Adrian White (1998).

Our modern scientific view of the world has influenced the adoption of acupuncture not only by demonstrating in scientific terms the ability to suppress pain by inserting needles in the body. It has also affected our interpretation of the physiological and pathological theories on which acupuncture was traditionally practiced. Felix Mann, for example, recast the five humors (五液 *wǔ yè*), *tears, sweat, drool, nasal mucus,* and *spittle* as *tears, sweat, saliva, nasal mucus,* and *urine*. In so doing, he eliminated the rather puzzling problem of two kinds of saliva proposed in the *Nèijīng* by replacing the humor of the kidney with "urine," which of course makes a lot more sense to a modern Westerner (Mann 1962/1971). Felix Mann was probably also the person responsible for reconceptualizing the traditional principle of "draining" as "sedation," a term whose continuing use supports the equation of qì with energy. I will return to this further ahead.

The scientific respectability of research in acupuncture is undoubtedly one of the reasons for the popularity of acupuncture. Nevertheless, a more fundamental reason is to be found in the identification of acupuncture as a posible alternative or at least as a complement to Western medicine. And this makes the transmission process even more complicated.

In the 1960s, a certain segment of Western society began to lose faith in scientific medicine and turn increasingly to alternative therapies. The reasons for the complementary-health boom are generally agreed both by their proponents and by their opponents.

Biomedical treatments are often experienced as harsh and invasive, having side-effects that can sometimes create health problems as well as solve them. The great advances of Western medicine have increasingly been won through reliance on complex technology and through specialization in which personalized care is difficult to provide. The care of a single physician has given way to procedures of patient "management" involving many specialized workers, many of whom the patient never even comes in contact with. Antibiotics that create resistance, chemotherapy and nuclear medicine, abortion on demand, and maintenance of life after brain death all evoke the fear, now encountered in so many aspects of our lives other than medicine, that through the pursuit of science and technology man is, as it were, bringing to life an uncontrollable monster that will bring about his own destruction.

An increasing segment of society views Western medicine as acting forcefully against nature and failing to care for the whole patient, and has turned increasingly to complementary medicines perceived to possess the qualities of naturalness and holism felt lacking in Western medicine. Complementary medicines such as homeopathy, aromatherapy, herbalism, Bach flowers, the Alexander technique, and not least acupuncture and Chinese medicine, have in common the fact that they are deemed by their proponents to work gently through the power of nature and with minimum human intervention, and to take care of the whole patient instead of looking at an isolated laboratory report.

The insertion of Chinese medicine into the Western array of health-care options in the late 20th century was to a large extent contingent upon its ability to be perceived as a "soft" therapy, applied by practitioners who fulfill the role of holistic healer. This would, arguably, have not been possible had it not been for the Western focus on acupuncture. Ostensibly, the therapy of needles, according to traditional explanations, achieves its effect by adjusting the flow of qì. By this subtle intervention in an intangible aspect of the body's functioning, pathological imbalances can be corrected in order to bring about major beneficial effects that reach into

the deepest functional centers of the body, the internal organs. So far as we know, acupuncture introduces nothing into the body that remains in it after the treatment. It is a direct intervention in bodily function that occurs without any physical medium such as that of an ingested drug. Hence, it can be perceived as a soft therapy par excellence.

The Gospel of Complementary Health

Among the complementary-health therapies available, there are huge differences. There are very old medicines such as Chinese medicine, and relatively new ones such as Bach flower therapy. There are allopathic and homeopathic approaches to treatment. There treatments that require ingestion of substances and others that don't. Yet despite these huge differences, proponents of these therapies all espouse similar ideals.

Complementary therapies are assumed to be natural because they use simply processed animal, vegetable, and mineral products, if any at all. They are holistic in that they treat the whole patient rather than the disease, and prevent disease rather than curing it. In particular, they are felt to address spiritual, mental, and emotional needs as well as physical problems, and for this reason complementary therapies are closely related to personal growth philosophies, and practical spiritual traditions deriving from the East, such as yoga, qìgōng, and meditation.

Related to the notion of naturalness is the idea that complementary therapies are rooted in some ancient, even timeless tradition that arose in cultures that were much simpler, earthier, and wiser than our high-tech civilization (Coward 1989; Vickers 1998; Campbell 1998). At the same time, they are supposed to respond to a postmodernist belief that the world can't be understood in terms of a single framework and that technological advance does not bring progress (Peters 1998).

It is becoming increasingly apparent to people within complementary health and outside it that the way proponents characterize their own complementary-health practices does not always fit the actual reality of those practices. There is a growing awareness that complementary health therapies are not entirely natural, that they do not have monopoly over holism, and that their claims to ancient traditions are somewhat exaggerated. Chinese medicine is a typical example. It is interesting to look into some of these points.

As to naturalness, acupuncture may be considered natural in that it appears to achieve its effect by stimulating the body to correct its own imbalances, but, as has been pointed out (Campbell 1998), there is nothing natural about sticking industrially manufactured needles into people's flesh.

The naturalness of China's materia medica is also suspect. Although vegetable products account for the vast majority, there are numerous minerals and animal products including worms such as earthworm (地龙 *dì lóng*), insects such as screwworm (五谷虫 *wǔ gǔ chóng*), spiders such as wall spider (壁钱 *bì qián*), and reptiles such as gecko (蛤蚧 *gé jiè*) and animal and human excretions such as bat's droppings (夜明砂 *yè míng shā*) and licorice in human feces (人中黄 *rén zhōng huáng*), as well as a variety of industrial waste products such as tannery tar (烟胶 *yān jiāo*) and needle filings (针砂 *zhēn shā*). It is not natural for human beings to eat animal, human, or industrial waste, and the thought of eating insects probably provokes nausea in the vast majority of humanity.

Nevertheless, proponents of Chinese medicinal therapy for the most part refer to their art quite misleadingly as "herbalism," and I suggest that they do so out of an unconscious effort to ignore in Chinese medicine what fails to conform to the notions of complementary health. Herbal remedies are closely related to vegetarianism and health food culture, as everyone knows. But Chinese drugs are not all herbal, and they are certainly not all harmless. Not only mineral products, such as cinnabar (朱砂 *zhū shā*), but also a number of the animal products such as tabanus (虻虫 *méng chóng*), and even vegetable products such as datura (曼陀罗 *màn tuó luó*) and croton (巴豆 *bā dòu*) are toxic.

The claim that Chinese medicine is holistic can be criticized on several accounts. The structure of its knowledge is not highly integrated. Chinese theories concerning the body have developed through a combination of observation and speculation, and by a combination of inductive and analytical thought. In the whole of its history, Chinese medicine has never

developed unified criteria for distinguishing facts from falsehoods and definitively rejecting the latter. To this day there are multiple explanatory models for interpreting tongue signs and pulse conditions, and for understanding febrile disease.

Even in one treatment modality such as acupuncture, there are holistic and unholistic explanatory models, since treatment can take an allopathic approach of expelling evils from the body as well as a holistic approach of promoting balance (Unschuld 1987, 1982; Birch 1998). Some treatments are purely symptomatic (Birch 1998). As Birch points out, numerous Western defenders of Chinese medicine, including Kaptchuk, Larre, Beinfield & Korngold, Cassidy, Hammer, and even the World Health Organization, have emphasized the exclusively holistic nature of Chinese medicine in spite of contrary evidence.

As Unschuld has pointed out (1994b), the battle field terminology of allopathic Western medicine so closely associated with its perceived ills in fact was predated in China by two millennia. The following expressions all appeared in the *Nēijīng*: 卫 *wèi*, "defense"; 攻邪 *gōng xié*, "attack evil"; 犯 *fàn*, "attack"; 伐 *fā*, "quell" (Zhāng D-B & Wǔ C-C 1990). The unholistic approach is much more marked in Chinese medicinal therapy, which has amongst its therapeutic arsenal the principle of "attacking toxin with toxin" and the methods of purgation and emesis.

The diagnostic process in the now most popular style of Chinese medicine relies on correlating multiple symptoms. Although many pathological conditions are attributed to causative agents such as wind or fire that have to be eliminated, just as bacteria and viruses have to be eliminated in Western medicine, these causes defy isolation and their presence is inferred from the various symptoms that the patient presents. Chinese medicine relies on the four examinations (inspection, listening/smelling, inquiry, and palpation). These naturally place the patient fully in the eye of the physician. To this extent, diagnosis is holistic. Nevertheless, the holistic diagnosis of Chinese medicine traditionally may have not been so important as is often thought. The repeated insistence in traditional literature on the performance of all four examinations rather than mere palpation of the pulse suggests that many physicians based their diagnosis on the pulse alone. This is corroborated by patient expectations in China to this day: Chinese patients often expect a skilled physician to be able to offer a diagnosis based solely on the pulse.

Chinese patients are traditionally different from the complementary health client who expects the practitioner to investigate health problems in the context of his or her life in general. Chinese people go to doctor for a solution to a specific health problem. "Feel my pulse, and don't ask me too many questions!" The Chinese medical practitioner in China addresses this specific problem very much in the way that the Western medical practitioner does, with the same minimal amount of personal contact.

The relationship that Chinese medicine establishes between psychological states and organ functions, which is much lauded in the West, is one of the dubious products of systematic applications of the five phases (obvious in the case of the liver, but less so in the case of the other organs). On paper the correspondences are simple (one reason, perhaps, why they are attractive), but less easy to see in practice, and can hardly be considered a theory of psychology in the sense of explaining thought processes and their manifestations in behavior. The significance of dreams discussed briefly in the *Nēijīng*, which did not constitute a major point of interest for subsequent generations of physicians in China, might naturally form an attraction for Westerners (Maciocia resurrects them in the *Foundations of Chinese Medicine*, 1989). Chinese medicine over its long history has accumulated many theories, some of which have lasted and some of which have fallen by the wayside. The relationship between theory and practice has always been vague.

The notion of a timeless tradition can't be applied to Chinese medicine. As Unschuld has pointed out (1992: 54), "Western proponents of Chinese medicine have depicted traditional Chinese medicine, in contrast to historical evidence, as a coherent system of thought, basically unchanged since antiquity." Stephen Birch (1998) has illustrated the point further with a description contained in the preface of a popular text (Maciocia 1989) of a fictitious peasant woman in 154 B.C., whom an

acupuncturist gave both a diagnosis and a treatment that were not to appear for centuries. Chinese medicine has never been fully integrated or static, and the unconditional reverence for ancient knowledge is a relatively recent phenomenon (Unschuld 1992).

The belief that practices of East Asian origin are rooted in ancient wisdom, in true understanding of nature, and in spiritual enlightenment makes them especially attractive to Westerners who embrace the philosophy of complementary health-care. Yet the fact that the origins of Chinese medicine lie in a distant and ancient culture by no means make the Western student of Chinese medicine particularly willing to embark on the journey through time and space to understand the roots of the art. As I have already said, classical literature so far seems to have attracted little attention.

The West's interest in Chinese medicine and other forms of complementary health is closely associated with its being perceived as being natural, holistic, timeless, and spiritual. These qualities are neither consistently observed in complementary medicines, nor are they wholly absent from modern Western medicine. Rather, they are philosophical desiderata that spring from a reaction to the ills created by modern industrialized society. Their projection onto complementary medicines is limiting and even damaging to the development of these medicines. In Chinese medicine, they foster distortion of the subject matter and divert attention away from the realities of knowledge transmission.

Criticism of complementary health therapies has not been limited to their dubious self-characterization. The main thrust of the argument presented by Campbell, Vickers, and Peters is that the lack of healthy criticism and scepticism that is characteristic of academia forecloses any progress in complementary health. The lack of criticism and scepticism, they say, fosters an almost religious attachment to complementary health practices, and discourages any research designed to prove the efficacy of treatments. Scientific demonstration of therapeutic efficacy is seen in opposition to healing skill that aims primarily to make the patient feel better.

Chinese medicine provides evidence of the lack of criticism and scepticism characteristic of complementary health practices. It has been suggested that scientific research is often used by proponents of complementary health to bolster a positive claim about their treatments, while negative evidence tends to be ignored (Vickers 1998: 2–3). It is of note that scientific research in Chinese medicine is conducted by scientists in mainstream academia; it is not considered anything worthy of promotion in Chinese medical schools. In the 1980s, in an attempt at the New England School of Acupuncture to establish a framework for clinical research in the school's teaching clinic, teachers were asked to apply a standardized vocabulary in the writing of clinical histories. Most of the teachers refused to be bound to a strict vocabulary on the grounds that, among other things, all their patients were different and could not be described in a limiting terminology. As a result, the research project failed to take off (Birch, personal communication 1990). Teachers regarded the call to research to be an unwanted act of scrutiny that encroached upon the sacred realm of the clinical competence of individual practitioners. Needless to say, such an attitude is conducive neither to clinical research nor to the much needed standardization of terminology.

Unwillingness to engage in critical self-scrutiny has been shown to be an endemic problem in complementary health. Yet, as has been pointed out (Birch & Felt 1999), Chinese medicine, unlike any other form of complementary health, not only faces the challenge of conducting research to substantiate therapeutic claims. As a form of medicine transmitted from a distant culture, it also faces the challenge of ensuring that authentic East Asian knowledge reaches Western readers.

We can proceed down different avenues at the same time. Viable approaches are a) faithful translation so that more of the corpus of Chinese medicine is made available to English speakers; b) scientific research to validate clinical efficacy. These two avenues are in fact not uninterrelated. As Stephen Birch has shown (Birch 1998), we cannot perform effective and comprehensive research in acupuncture until we have a clear picture of what acupuncture is, and that is not yet the case.

Adaptation

Although Chinese medicine does not entirely fit the tenets of complementary health, attempts have been made to make it fit them. Let us return to Beinfield & Korngold, who provide us with a startling example of the way in which Chinese medicine is remolded beyond recognition to suit complementary-health taste.

Between Heaven and Earth is divided into three parts: basic theories (including yīn-yáng and the five phases); five psychological types; and therapy. By the book's very table of contents, we see that it presents a version of Chinese medicine in which five-phase theory and the doctrine of human types are the central, if not the only features. The importance of the five phases is exaggerated to the point where the six bowels are completely subsumed to the five viscera and only five emotions are discussed, while the seven-fold classification of seven affects, 七情*qī qíng*, is not mentioned. The treatment section notably presents herbal remedies in the form of a "modular pharmacy." Formulas containing multiple ingredients are labelled "Tonify *Moisture*," "Tonify *Blood*," "Consolidate *Qi*," "Purge *Moisture*," "Supplement *Wood*," "Harmonize *Wood-Earth*," etc. What is precisely meant by all these things is not clear. The formulas have been devised by the authors and are sold by them.

This adaptation raises a number of questions. Although the authors state in their introduction that they are offering an adapted form of Chinese medicine, they do not explain in detail what parts are traditionally Chinese and what parts adapted. They do not tell us what parts have been added and what parts have been subtracted. They offer no rationale for the adaptations, and no proof of their validity.

Although Chinese medical knowledge, unlike that of Western medicine, has been not developed through repeatable experiment, it is reasonable to give it credit for its long experience in caring for human beings. Nevertheless, Beinfield & Korngold cavalierly whisk this experience away even though, without linguistic access, they can't know any more about it than has been presented by translators. Obviously, they believe that it is more useful to reinvent Chinese medicine to suit Western tastes than to take the trouble to learn an East Asian language so as to deepen their understanding of East Asia's heritage of medical experience.

What they offer in its stead is of uncertain origin. *Between Heaven and Earth* is generally recognized as belonging to what is known as the *traditional acupuncture* movement (otherwise known as the Worsely school of thought), which has a strong following in both the UK and the US. Interestingly, the founder, Englishman Jack Worsely, has not, to my knowledge, published a full description of his five-phase adaptation of Chinese medicine, any explanation of its origin, or any justification for its validity. We know that his theory of the five human types originates from a passage of not much more than a thousand characters in the *Língshū*, *Yīnyáng Èrshíwǔ Rén* (灵枢・阴阳二十五人 "Magic Pivot, Yīn-Yáng and the Twenty-Five Human Types"), but where all the detail comes from, we are not told.

Implicit in this adaptation is a belief on the part of the authors that their interpretation of Chinese medicine is adequate and reliable, and that more is to be gained by developing a Western interpretation than by acquiring linguistic access to primary texts in order to investigate in greater detail what the 2,000-year heritage of Chinese medicine has to offer. If they are unaware of the problems of transmitting a complex knowledge corpus such as Chinese medicine and unaware of the low degree of transmission that has so far been achieved, then they must have far less esteem for China's medical heritage than confidence in their own ability to improve on it.

The fact is that they do not have a clear grasp of any of the basic issues. As has been pointed out (Birch 1998), the distinct dichotomy that certain writers establish between the holistic, integrated approach of Chinese medicine on the one hand and the fractured approach of Western medicine on the other not only misrepresents the reality of Chinese medicine, but also that of Western medicine.

Furthermore, quite ironically, Beinfield & Korngold's adaptation is a simple, integrated system based on one traditional facet of Chinese medicine only, responding to what Unschuld has called a *cognitive aesthetic* (Unschuld 1989b) that is typically Western, not East Asian.

Adaptations of this kind are possible because

those of complementary-health persuasions find them attractive and are averse to applying any critical scrutiny, and do not have the linguistic access to primary sources that would enable them to apply such scrutiny to maximum benefit. Because such adaptations are often labelled as Chinese medicine, many people are unaware that they are adaptations. The fact that Chinese medicine is subject to the modifying force of political, economic, and cultural demands is rarely noted in the training of acupuncturists (Birch & Felt 1999).

The point here by the way is not that adaptation is inherently wrong. We simply need to know what is authentic and what is a adaptation. And presumably we need to know that the adaptation is justified. In my view, a modern adaptation that has been created by people who have no direct access to the East Asian tradition and that is not based on scientific evidence is likely to be far inferior than original East Asian knowledge unless it rests entirely on its placebo effect.

With a view to eliminating the problem of the dubious origin of Chinese medical information presented in current literature, three major US publishers of Chinese medical literature (Blue Poppy, Paradigm, and Eastland) met in May 1995 to discuss a "Code for the Council of East Asian Medical Publishers" (COMP) whereby publications should contain a designation indicating whether they are translated or compiled from primary sources or are original works, and, in the former case, how close the translation is. The instigator of the agreement, Blue Poppy Press, and one other participant, Paradigm Publications, accepted the code and have since applied it, and certain publications of Churchill Livingstone have included designations. The significance of the agreement in the present discussion lies in its highlighting recognition of the existence of problems in the transmission process.

I have so far only spoken of adaptations inspired by complementary health. I have not spoken of the adaptations of Western medicine. The ways in which Chinese medicine can be integrated into a Western medical framework and even Western medical practice should be fairly clear to listeners. For reasons of time, I will not go into them here.

The Consequences of Error

Unless a considerable segment of the receiving community has linguistic access to primary sources, the progress toward advanced knowledge is slow. In the United States, for example, most practitioners even today have a training based on one of a series of three basic textbooks produced in the PRC: *An Outline of Chinese Acupuncture* (1975), *Essentials of Chinese Acupuncture* (1980), and *Chinese Acupuncture and Moxibustion* (1987). They have not had to know any more than what is contained in these books to get a license to practice. Licensing hampers efforts to raise standards particularly when education is mainly provided by schools operating outside mainstream academia. However, the acupuncture literature that has been published since the above-mentioned PRC publications appeared is largely not translated, but is written by people with no access to primary sources. Books such as O"Connor & Bensky's *Acupuncture: A Comprehensive Text* (1981) and Yang & Chace's *Zhēnjiǔ Jiǎyǐjīng: The Systematic Classic of Acupuncture and Moxibustion* (针灸甲乙经) (1994) are comparatively rare highlights in the development of English-language acupuncture literature.

Unless a considerable segment of the receiving community has linguistic access to primary sources, the transmission of information is subject to a process rather like Chinese whispers, the game in which a message is whispered from person to person until it is distorted beyond recognition. I will illustrate the point with an example. Stephen Birch & Bob Felt have pointed that many English-speaking writers have expressed the belief that the eight extraordinary vessels store original qì (元气 *yuán qì*) or essence (精 *jīng*), and have counselled against their needling to prevent any loss of these substances (Birch & Felt 1999). The belief is not supported by primary Chinese sources, notably the *Huángdì Nèijīng*, and the belief has been traced to the French-speaking writers Albert Chamfrault and Nguyen Van Nghi, who are suspected of representing Vietnamese tradition.

The belief that the extraordinary vessels should not be needled is highly prevalent in the English-speaking world. It can even be seen in literature written by people such as Maciocia, whose

bibliographies deceptively suggest they work exclusively from primary Chinese sources (Maciocia 1989: 355).

It has taken decades for anyone to realize that although the contraindication against needling the extraordinary vessels is of East Asian origin, it is not an orthodox Chinese medical belief. Quite patently, people are scratching around in the English-language literature. They are not facing the burning need to learn Chinese and translate instead of picking what they like from the crumbs of past translation and piecing them together according to their own fancy.

There are quite a few people busily writing books and lecturing far and wide, as if they were authorities on traditional Chinese medicine. Nevertheless, it is simply a matter of straightforward logic that it would be possible for someone who has no knowledge of the Chinese language and hence no access to primary Chinese literature to be considered an authority on traditional Chinese medicine, only if that person and his or her readership believed either that the current body of English literature accurately represented all the essential elements of Chinese medicine or that it was not necessary to even have all the essential elements available in English since Chinese medicine can be learned not only from books but through clinical practice.

I suggest that such people are gravely mistaken. I have already pointed out how much less literature there is available in English than in Chinese. It does not take too much imagination to realize that the Chinese barrel most likely contains much useful information that has not seen the light of day in the English-speaking world. It would be naive to argue that the westward transmission of Chinese medicine had advanced past its infancy.

The notion that clinical experience confers authority is a complete myth. The contraindication against needling the extraordinary vessels is an item of theory that, if we are to judge by Chinese experience, has no substantiation in clinical reality. Yet this misinformation was not magically corrected by our clinically proficient English-speaking authorities who have all accepted it.

Some of these people have been critical of me for the emphasis I have placed on language issues. They say that Chinese medicine is a healing art, and that what counts is clinical experience, not linguistic precision. They fail to see that linguists or terminologists could have anything useful to contribute to their knowledge. Yet it is quite easy to reverse the argument and say that no amount of clinical experience is of any use unless it rests on sound knowledge of theory and a broad command of the experience of other physicians that can be made available only by negotiating between languages.

Clinicians can talk about what they have seen in the clinic in relation to what they have learned in their study of the literature. Practical experience cannot be isolated from other aspects of learning. When the literature contains faulty knowledge, then any clinical experience built on it is likely to be faulty too. If contrary to some Vietnamese tradition, Chinese acupuncturists have been needling the extraordinary vessels for centuries and have found that it has positive rather than negative effects, then it is wrong to say that the extraordinary vessels should not be needled.

Of course, it is the Vietnamese word against the Chinese since there may ultimately be no objective proof either way. The physical existence of the extraordinary vessels, of essence, and of original qì has not been proven scientifically, so that no hypothesis concerning these entities can be pursued. The fact remains, though, that to learn about the clinical experience of East Asian physicians, we need proficiency in language, not clinical skill. A paint-brush maker doesn't need to be able to paint like Picasso; he just has to understand what the artist needs.

If the Western practice of acupuncture is not to restrict itself to scientifically proven treatments, it must base itself on clinical experience. The greatest amount of experience is contained in Chinese texts. In the transmission of Chinese medicine linguistic access is actually far more important than clinical experience because it provides access to a wealth of East Asian experience.

In China, broad reading in ancient and modern literature is generally considered indispensable to the development of the individual physician's clinical proficiency. In modern medicine, such a need is minimized by the existence of an efficient mechanism

that enables objective experience to be fairly evaluated and swiftly shared. The theoretical and clinical studies published in refereed journals this year provide the raw materials for next year's textbooks. Over recent decades, Chinese medicine has tried to set itself on a similar footing, but the very nature of its knowledge makes this difficult. While in Western medicine, last year's textbooks are now being thrown away and recycled, Chinese medical doctors continue to rely on the large corpus of miscellaneous for their inspiration. Until we have access to that corpus or until an adequate proportion of it is available in reliable translation, we cannot say that we have fully acquired Chinese medicine.

Given the fact that the information-supply chain in the Western world includes people with little or no access to primary literature, the monolingual English reader can't always be guaranteed that the information he or she receives has come from a reliable origin. It is precisely these problems that the COMP agreement I mentioned earlier was meant to sort out.

Issues such as these ought to be thrashed out in formal public debate, so that everyone can arrive at a common understanding. So far, Chinese medicine in the West has not developed an adequate academic forum for dealing with such issues. Most exchanges go on behind the scenes.

Over the years, I have argued in favor of a particular approach to translation and to transmission. I have won a great deal of support, and increasing numbers of translators have adopted my proposed terminology. But the linguistic issues I have presented have elicited little or no response from the Chinese medical "establishment." Most of those who have expressed opposition to my linguistic contentions have no knowledge of Chinese. But there are those that do. However none have entered into a public dialogue about term translation, even though private, off-the-record comments are frequently heard. No others have published a glossary of terms to enable other translators to reliably follow their method of translation and create a literature that supports and develops their own. Most have declined to join the COMP agreement that is designed to orient consumers in their choice of literature. When one learns that this includes not only publishers and writers, but also those who sit on committees that decide the scope of licensing examinations, then it is easy to see how linguistic access insufficient to scrutinize published work, or to compete with it in significant markets, can hardly be considered to be without financial and personal consequence for the people in question.

I have come to realize that the full import of the linguistic problems involved in the transmission of Chinese medicine may possibly be understood only when the problem of transmission is presented in its wider social context. Unfortunately, to do that without beating around the bush entails assessing the behavior and motives of key individuals in the field. In short, it means having to turn a scholarly debate into a political one.

Conclusion

I began by comparing the transmission of Chinese medicine to the West with the transmission of Western learning to China. Let me recap.

China's acquisition of Western learning was a relatively simple process. The economic and political weakness of China made the acquisition of Western learning a necessity for survival. Language acquisition was immediately identified as the means by which the knowledge was to be acquired. The process of adoption was helped by the conceptual nature of modern scientific knowledge and its expression in language.

The westward transmission of Chinese medicine takes place under very different conditions. Chinese medicine appeals to a much more limited segment of Western society. Its transmission is hampered by the fact that the West has a powerful form of medicine that forms an integral part of a whole scientific and technological package that has spread like fire across the globe because it offers wealth and prosperity. Notably, Western knowledge, including medical knowledge, has virtually ousted all traditional knowledge in China.

The westward transmission of Chinese medicine has also been hampered by the complexity and unintegratedness of its concepts, which have laid it open to tampering by its Western (and modern Chinese) adopters.

The greatest force influencing the reception of

Chinese medicine springs, not from scientific Western, but from a reaction against it and against science and technology in general. The rise of complementary health is intimately related not merely to dissatisfaction with scientific medicine, but also to a growing awareness of the global side-effects of science and technology in general.

One would hope that no sane and intelligent person would wish to dismiss ecological problems out of hand. Nevertheless, the desiderata of complementary health have been blindly pinned by its proponents indiscriminately on a whole gamut of alternative therapies without even looking to see if they fit.

In the case of Chinese medicine, this uncritical approach has, in the most radical of adaptations, led to the removal of all contents that do not fit the complementary-health profile, and the ten-fold magnification of those elements that do fit the profile.

Westerners have projected indigenous ideas and expectations onto Chinese medicine with such an intensity that they have been virtually unaware that Chinese medicine is the product of another culture and that it is expressed in a different language.

As I have said, two avenues that we can usefully follow in the development of Chinese medicine are that of substantiating therapeutic effectiveness in scientific terms, and that of making sure we have an authentic picture of Chinese medicine complete in all the important details.

One avenue that we should not proceed down is trying to fudge Chinese medicine to make it look scientific. Another avenue that we should not proceed down is that of trying to develop a form of Chinese medicine that is completely holistic but that has neither the stamp of scientific approval nor the stamp of "made in China." We should not sift and select what conforms to complementary health tenets that are dubious anyway. We should seek to obtain as much as we can from the original source.

The fate of Chinese medicine in the West is changing all the time. In the past, training in Chinese medicine was largely provided by schools outside mainstream academia. In the United States and many other countries it has been possible to gain a license to practice acupuncture after studying at educational establishments that neither impose the academic standards nor provide the intellectual atmosphere conducive to the healthy transmission of Chinese medicine.

Over recent years, acupuncture has started to move into mainstream academia, not as some accessory to Western medicine, but as an independent field. In my eyes, this is a most propitious development. Mainstream universities differ from small-scale privately run acupuncture and Chinese medical schools in that they are responsible not only for education, but also for research. Scholars are expected to *produce* knowledge as well as pass it along to others.

In such an environment, it is difficult for voices pointing out grave deficiencies in transmission of knowledge to be ignored as they can be outside the academic system. Only as an independent field of study within academia can the energy and intellectual honesty be mustered to sort out the fiasco that has occurred in the transmission of Chinese medicine.

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Translation of Chinese Medical Terms: Not Just a Matter of Words

Highly successful acts of transcultural transmission of knowledge rest on an approach to translation that for the most part is highly literal. In the present lecture, I describe this methodology and show how it has not been applied in the westward transmission of Chinese medicine. Through practical examples, I demonstrate the conceptual problems that arise through failure to choose the methodology described.

I am going to start by describing the method used in the translation of technical terms. In parallel with my previous presentation, I will show this methodology has been used in the highly successful transmission of knowledge in Western medicine. I will then show how some translators have failed to apply this straightforward approach, and as a consequence, jeopardized the Western student's correct understanding of the subject matter. I will also show how English terminology is far less standardized than Chinese terminology, and how this has also led to loss and distortion of information.

Term Translation in Western Medicine

Since classical antiquity, the debate about translation has centered around *literal translation* versus *free translation*. Today the discussion of translation problems is more complex, but the same tendencies remain. The terms *literal* and *free* translation are not satisfactory. For reasons that will soon become apparent, I here replace them with *source-oriented* and *target-oriented* translation (Wiseman 2000a).

Translation theorists today generally agree that different translation strategies are suited to different purposes. Source-oriented translation is used for philological purposes, and is also used in the translation of technical terminology if not technical texts.

Western medicine provides illuminating examples of successful source-oriented translation. The terminology of Western medicine was originally Latin; it was only later that it was translated into the vernacular languages. More recently, it has also been translated into other languages such as Chinese.

The translation of Latin terms into German and English provide the clearest examples of terminological translation principles because even if you are not familiar with the languages in question, you will be able to see the way things work.

In medicine, as in any other technical field, we can distinguish between lay terms from the everyday language and technical terms. When the lay terms were translated from Latin into English and German, the corresponding lay terms were chosen in each case. Here are some examples.

1. Lay German and English Equivalents of Lay Latin Western Medical Terms

German ←	Latin	→ English
Ohr	*auris*	ear
Arm	*brachium*	arm
Ellbogen	*cubitum*	elbow
Finger	*digitus*	finger
Haar	*pilus*	hair

In the translation of purely technical terms, different approaches were adopted in German and English. English borrowed the Latin terms, while German rendered them by loan-translation. Let us take a closer look at a few examples to see what is happening in the translation process.

2. German Loan-Translations and English Loans in Western Medicine

German ← *loan-transl.* ←	Latin	→ *loan* → English
Becken (“basin”)	*pelvis* (“basin”)	pelvis
Vorsteherdrüse (“fore-standing gland”)	(*glandula*) *prostata* (“fore-standing gland”)	prostate (gland)
Regenbogen (“rainbow”)	*iris* (“rainbow”)	iris
Schleim (“slime”)	*mucus* (“slime”)	mucus
Scheide (“sheath”)	*vagina* (“sheath”)	vagina
Hammer (“hammer”)	*malleus* (“hammer”)	malleus
Pflugscharbein (“ploughshare bone”)	*vomer* (“ploughshare”)	vomer
Keilbein (“wedge bone”)	*os sphenoideum* (“wedge bone”)	sphenoid bone

Note: The parenthesized words indicate the literal meaning of both the Latin and the German terms.

These examples show clearly the process by which technical terms were created in English and German. The original Latin term is in the center followed by its literal meaning. All of these Latin terms have been adopted as they stand into English. Most English speakers are not aware of their literal meanings in Latin, so we tend to think of them as having only their medical meanings. In the past, though, all physicians knew Latin, and thus knew what these words meant. When the terms were translated into German, literal translations were devised. Even if you do not understand German, you will see a great similarity between the literal English translations of the Latin terms, and the literal translations in German.

Loans are often thought the purest form of source-oriented translation, because they preserve the actual terms of the source language. In reality, they really only preserve the sound (*pelvis* entered English, but not with all the meanings it had in Latin). Loan-translation preserves only the literal meaning of the terms. Despite this, loans and loan-translations are source-oriented in that they tend to respect the choice of term in the source language.

English and German took a similar approach in the translation of lay terms, but a different approach in the translation of technical terms. Why should this be?

Both English and German chose lay equivalents for lay terms because to replace vernacular words for familiar objects with unfamiliar words would go against the conventions of language. Languages often borrow the names of new things, but they replace basic vocabulary less easily. For English to have borrowed Latin words for concepts recognized by the lay would have been to obscure all that is familiar to the lay.

English differs from German because although it is a Germanic language, its vocabulary was early on influenced greatly by French. It therefore has a tradition of borrowing that German still to this day does not have. Thus English tended to borrow, while German tended to translate.

It is noteworthy that, in some cases, German created new terms instead of devising literal loan-translations. However, this was only done when the literal meaning of the Latin term could not provide the basis for a well-motivated term in German. Source-independent formations were considered only as a last resort.

arteria → *Schlagader* (lit. “beating vessel”)
scrotum → *Hodensack* (lit. “testicle sack”)
ascites → *Bauchwassersucht* (lit. “belly water sickness”)
glandula → *Drüse* (lit. “a swelling”)

When the terminology of Western medicine was translated into Chinese, we see a pattern almost identical with Latin-German translation. Lay words were translated with lay Chinese equivalents, while purely technical terms were translated by loan-translation. The Chinese as indeed not only German but also English translators saw the need to

preserve the familiarity of lay concepts by using lay terms. But since the Chinese language has even less of a tradition of borrowing from other languages than German, they chose literal translations as the next-best thing.

3. Common-Language Equivalents in Chinese and English Western Medical Terms

Chinese ←	Latin	→ English
耳 *ěr*	*auris*	ear
肘 *zhǒu*	*cubitum*	ellbow
指 *zhǐ*	*digitus*	finger
毛 *máo*	*pilus*	hair
肝 *gān*	*jecur, hepar*	liver
心 *xīn*	*cor*	heart
颈 *jǐng*	*cervix*	neck

4. Chinese Loan-Translations and English Loans in Western Medicine

Latin → *loan* →	Chinese
(*intestinum*) *duodenum* (“twelve-at-time intestine”)	十二指肠 *shí èr zǐ cháng* (“twelve-finger intestine”)
pelvis (“basin”)	骨盆 *gǔ pén* (“bone basin”)
iris (“rainbow”)	虹膜 *hóng mó* (“rainbow membrane”)
malleus (“hammer”)	鎚骨 *chuí gǔ* (“hammer bone”)
vomer (“ploughshare”)	犁骨 *lí gǔ* (“plough bone”)

The translation of Western medical terminology is slightly more complex in Chinese, since German and Japanese played an important part in the choice of terms. For poorly-motivated Latin terms, source-independent German terms (or more often literal Japanese translations of these) were sometimes taken as the model. For example, *ascites* from the Greek meaning a wineskin, was translated as 腹水 *fù shuǐ* after the German *Bauchwassersucht*.

In the translation of Western medical terminology from Latin into English and German as well as from Western languages into Chinese, source-oriented translation was used every time. While English has tended to borrow terms from Latin, Chinese and German, which do not easily borrow, have tended to prefer loan-translation.

In both German and Chinese, loan-translations are very much more numerous than source-independent creations such as the German “abdominal water disease” for *ascites*. The reason for this is practical rather than theoretical.

In Western medicine, as in all modern sciences, the concepts represented by terms are always clearly defined. When Western medical terms are translated from one language into another, any expression will do provided it represents the concept well. It is not strictly *necessary* for it to be a loan or a literal loan-translation. Literal translations are usually the first choice because for the person devising the target-language terminology, the source-language term constitutes an important precedent. Nevertheless, having terms that have the same literal meaning helps bilinguals to peg the source-language and target-language terms more easily.

Term Translation in Chinese Medicine

The above analysis of Western medical term translation suggests that a source-oriented approach can take different forms depending, essentially, on the ability of the target language to borrow from the source language.

If we presume the translation of East Asian medical terminology to be subject to the same laws, it is relatively easy to predict whether it would be likely to follow a pattern similar to that of the English translation of Latin medical terminology (borrowing)

or that of the German translation of Latin medical terminology (loan-translations). The question boils down to whether we could borrow from Chinese on the scale that English has borrowed from Latin. And the answer is quite simply no.

Although English has a tradition of borrowing, its ability to borrow from different languages varies greatly. English, as indeed most languages, finds it relatively easy to borrow words for imported objects. Borrowing the name that the object has in its source locality saves the problem of having to think of a new name. But English has only really borrowed in bulk from Latin, French, and (mostly only in fields of learning) Greek. We have borrowed words from Chinese, such as names of plants and fruits (*kumquat*, *loquat, longan*, *tea*). We also have three words for cultural realia, *yin*, *yang*, and *qi*, which in fact were introduced into our language centuries ago by sinologists. But we cannot borrow from Chinese on a scale necessary for it to become the principle method of representing technical East Asian medical concepts in English.

Chinese poses difficulties of borrowing because of a) the unfamiliarity of its sounds, and difficulties in pronunciation; b) semantic opacity of words; c) homophony that is disambiguated only in writing. Furthermore, the nature of East Asian medical terminology would pose requirements of borrowing vocabulary in word-classes which are most resistant to borrowing (adjectives and verbs).

The tendency toward borrowing in Chinese medicine, leaving aside the complex question of the names of medicinals (see Wiseman 2000a), tends to be restricted to a few key words; it is never used on a mass scale. People who have proposed the large-scale use of Pīnyīn (e.g., recently Buck 2000) tend to limit their discussion to a limited number of nouns.

Pīnyīn words are meaningless for people who have learned Chinese, and have to be explained in English anyway. In my view, it should be used only as a last resort when no suitable word can be found (and as a parenthesized reference following English names of medicinals, formulas, and acupuncture point names).

The much more appropriate form of source-oriented translation is therefore loan translation. As I have shown, my own proposed terminology is highly source-oriented. Apart from lay terms translated by lay equivalents, the vast majority of the strictly technical terms are translated with a high degree of literality (Wiseman 2000a).

Nevertheless, when we look at the current corpus of English literature, we find that the principles of translation operant in Western medical term translation and which I and my colleagues have applied in the creation of our terminology have not been applied universally in the westward transmission of Chinese medicine. In no European language has such a source-oriented approach become dominant.

This is something of a paradox, because there is in fact more reason for Chinese medical term translation to be more source-oriented than Western medical term translation. Whereas in Western medicine, source-independent formations are avoided as far as possible only for practical reasons, there is one important theoretical reason why terms should be literally translated in Chinese medicine.

In Chinese medicine, the threeway relationship between term, concept, and object is not always as clear as in Western medicine. The term 血海 *xuè hǎi* (lit. “sea of blood”) has been variously defined the thoroughfare vessel (*chōng mài*) and the liver (as well as an acupuncture point). If we were sure in each case which of these definitions an author meant, we could regularize the terminology by substituting liver or thoroughfare vessel in translation. However, we are rarely sure which of these is meant! The only accurate translation is one that allows the same degree of ambiguity in English as in Chinese, and that is a literal translation.

This problem is not isolated and occurs in 三焦 *sān jiāo*, triple burner, 命门 *mìng mén*, life gate, and 血室 *xuè shì*, blood chamber. Even basic terms such as 气 *qì*, qì, and 经络 *jīng luò*, channels and network [vessels], are problematic since their objective nature is unknown. Nevertheless, we must have English terms by which to refer to these East Asian concepts. Numerous symptom descriptions such as 喘息 *chuǎn xī*, panting respiration, 喘逆 *chuǎn nì*, panting counterflow, 上气 *shàng qì*, qì ascent, and 喘促 *chuǎn cù*, hasty panting, almost defy unequivocal circumscription. Yet without corresponding English

terms, it would be impossible to translate any detailed discussion of the subjects.

In virtually all these cases (qì being the exception here), literal translations serve admirably to represent the East Asian concepts in any discussion, and to enable those who speak Chinese to instantly identify the Chinese source term.

As my own proposed terminology shows, it is quite feasible to create a terminology of Chinese medicine that is almost a mirror image of Chinese source terminology. Despite this, most English-speaking students, teachers, and practitioners of Chinese medicine use terminologies that are far from a mirror-image reflection. Currently used terminologies are not source-oriented, and I think it is instructive to discover how they are not, why they are not, and what consequences this has for the westward transmission of Chinese medical knowledge.

Failure to Respect the Difference Between Lay and Technical Terms

The terminology of Manfred Porkert is a bit dated now, but it does highlight some points about translation. In his *Theoretical Foundations of Chinese Medicine* (Porkert 1978), he refers to blood as *hsüeh* or *individually specific structive energy*. His decision is apparently based on the idea that 血 *xuè* denotes something other than, more than, or less than the red fluid that issues from wounds, or that it is accorded functions in Chinese medicine that are not accorded it, either by the lay or by experts in modern medicine. Unfortunately neither *hsüeh* or *individually specific structive energy* preserve any relationship with the red fluid that escapes from wounds. For anyone who happens to miss the mention of *blood*, the detachment would be more or less complete. In other words, it might be possible to read the book and gain the misleading impression that Chinese doctors did not discuss the red fluid of the body.

As far as I know, Porkert was the first to start calling the organs, not by their simple English names, but orbs (or in Latin *orbis*, as *orbis cardialis*, *orbis hepaticus*, etc.). Again, the aim was to highlight the differences in understanding between Chinese medicine and Western medicine. But this translation is misleading. Chinese texts from the very beginning speak of the organs by their ordinary lay names. There is no such word in Chinese for orb.

Why Porkert should disguise the familiar in unfamiliar names is partly to be explained by the need, which he states himself, to emphasize the nature of the Chinese medical concepts in question. But especially in the case of the internal organs, there may well have been a desire to divert attention from the fact that functions posited by East Asian physicians clash, to some degree, with those recognized by modern medicine (e.g., the spleen in Chinese medicine has a digestive function not recognized in Western medicine).

Where Porkert went wrong, in my opinion, is that he failed in some cases to translate terms that are familiar to the lay in Chinese with terms that are familiar to lay in English (or his mother tongue German).

Porkert's terminology did not catch on, and his books are going out of print. But unbeknown to many, his spirit lives on in the very common practice of capitalizing the names of the internal organs, which is intended to serve the same purpose. The Heart of Chinese medicine is not the heart of Western medicine, etc.

Failure to Preserve the Integrity of Chinese Medical Concepts

In my first lecture, I said that the transmission of Chinese medicine had been influenced by both Western medicine and complementary health-care. In the translation of Chinese medical terminology, the most obvious deviation from source-oriented translation is the rendering of traditional Chinese technical terms into Western medical equivalents.

Here are some examples. On the left are my own source-oriented translations. On the right are the Westernized translations contained in a dictionary produced in the PRC.

5. English Equivalents in Wiseman and *CEMD*

Wiseman ← *Loan-transl.* ←	Chinese	Pīnyīn	→ *WM equiv.*→ CMED
impediment	痹	*bì*	arthralgia
wilting pattern	痿证	*wěi zhèng*	flaccidity syndrome
umbilical wind	脐风	*qí fēng*	tetanus neonatorum
wind lichen	风癣	*fēng xiǎn*	tinea corporis
phlegm node	痰核	*tán hé*	subcutaneous nodule
throat moth	喉蛾	*hóu é*	tonsillitis
damp-toxin vaginal discharge	湿毒带下	*shī dú dài xià*	cervicitis

When we look at contiguous entries in the *Chinese-English Medical Dictionary*, we can see how the authors have been at pains to institute a Western medical term whenever one is available. However, this is only the case in 2 out of the 5 examples you see here. In the other cases, there are no Western medical equivalents, so the authors revert to literal translation. Literal translation for all the term are quite feasible, as you can see from my own translations in the left-hand column. And a consistently literal approach preserves the integrity of the East Asian concepts, while the use of rough Western medical tends to destroy it.

While using lay terms for lay concepts such as gross body parts preserves lay familiarity (in a way that *individually specific structive energy* does not), representing non-lay concepts with Western medical terms familiar to the target language reader sacrifices the clarity of the East Asian concepts to the altar of Western medicine.

6. English Equivalents in Wiseman and *CEMD*

Wiseman ← *Loan-transl.* ←	Chinese	Pīnyīn	→ *WM equiv.*→ ZY
wind-fire	风火	*fēng huǒ*	wind fire, wind-fire pathogen
wind-fire scrofula	风火疬	*fēng huǒ lì*	acute cervical lymphadenitis
wind and fire fanning each other	风火相煽	*fēng huǒ xiāng shān*	fire and wind stirring up each other
wind-fire toothache	风火牙痛	*fēng huǒ ya tòng*	toothache due to pathogenic wind-fire
wind-fire eye (pain)	风火眼[痛]	*fēng huǒ yǎn* [*tòng*]	acute conjunctivitis

We know that terms have two levels of meaning. One is that of objects, that is, the extralinguistic phenomena, such as things, processes, and events. The other is that of the concept, that is, the mental abstraction of the object.

When 风火眼 *fēng huǒ yǎn* is translated as "acute conjunctivitis," the object may be the same—sudden redness and discomfort of the eye after a dip at the local swimming pool. On the conceptual level, the Chinese term denotes a disease of the eye caused by wind and fire. By contrast, the Western medical term "acute conjunctivitis" is a disease of a part of the eye that was never conceived in Chinese ophthalmology as being isolated from the eye as a whole.

When 痹 *bì* is translated as "arthralgia" (i.e., "joint pain"), we have an equivalent that not only does not represent the same concept, but does not even represent the same object. At the conceptual level, the Chinese term means a condition understood as "crippling" and "blockage"; at the level of objects it refers to conditions classed in Western medicine as arthritis and tendonitis (or anything popularly

referred to as rheumatism) on the one hand, and sciatica and other forms of neuralgia on the other.

Obviously the use of Western medical terms for traditional Chinese medical concepts gives the Western readership the feeling that Chinese medicine is quite similar to Western medicine. It certainly avoids the need to introduce new terms that require tedious explanation. It is interesting that scholars in the PRC prefer Western medical equivalents—even very rough ones—to creating new terms for concepts specific to Chinese medical knowledge. Their command of English limits their ability to coin new terms, but perhaps more importantly they adopt a language that is intelligible to the international medical community and will have the greatest chances of convincing it of the value of Chinese medicine. We know that the PRC aims to integrate Chinese medicine with modern medicine, and the use of Western medical terms is seen as another way of forging a communicative bridge between the two.

In English-speaking countries qì is very often called or thought of as "energy," and most confusingly, a basic acupuncture stimulus to relieve qì stagnation is called "sedation."

Since antiquity, the Chinese have understood qì as a kind of subtle substance. They never developed a concept of energy as, say, in distinction to matter. The point has been repeatedly discussed. It simply has not sunk in. Although in English-speaking countries the concept of qì is referred to as such, nevertheless it appears to be still widely conceived of as energy.

This energetic conception of qì is reflected in the continuing use of the term *sedation.* The Chinese word 泻 *xiè* literally means "to drain." *Sedate*, from the Latin *sedare*, to calm, is almost exactly the opposite in meaning to the Chinese term 泻 *xiè* it is meant to render. *Sedate* could only denote an intervention that served to strengthen the stagnation. Quite patently, the use of *sedation* in the acupuncture context makes sense only when qì is conceived as some sort of nervous energy that needs to be calmed.

Acupuncture has a therapeutic method known as 开阖补泻法 *kāi hé bǔ xiè fǎ*, "open and closed supplementation and drainage," in which supplementation is achieved by pressing the insertion point after the needle is removed, while drainage is achieved by waggling the needle as it is being extracted. The person who designed the method obviously understood qì as a substance occupying space, whose escape from the body could be enhanced by widening the hole.

The term *sedate* has obvious implications for the way in which acupuncture is understood. The basic concepts of acupuncture, qì, and the channels along which it flows, are essentially speculative. When speculative concepts are misrepresented in the translation processes, it is difficult to tell how this might affect the effect of the treatment. The energetic conception of qì is not scientifically founded, and does not help anyone to understand the concepts in their original context.

The word *sedate* appears to have been first used by Felix Mann. It is interesting to note that in his 1962 book, Mann describes Chinese theories and includes Chinese sources in his bibliography. In his 1992 book, *Reinventing Acupuncture: A New Concept of Ancient Medicine,* he basically ditches all Chinese theories, and even pokes fun at them. The term *sedate* continues to be used by people who learn traditional acupuncture not knowing that the it comes from a writer who never had very much time for what the Chinese had to say about the subject.

As far as I know, the term *sedate* is used by no writer possessing adequate linguistic access to primary texts. But many of the books circulating in English-speaking countries are the work of people without such access. One can tell by the absence of Chinese-language sources in their bibliographies.

There are of course different degrees of right and wrong in the matter of how to translate terms. In the terminology I have proposed, 虚 *xū* and 实 *shí* are rendered as "vacuity" and "repletion." But the terms have also been represented by depletion/repletion, asthenia/sthenia, emptiness/fullness, and most commonly by deficiency/excess. No equivalents chosen for 虚 *xū* and 实 *shí* are ideal, and none of the various translations that have been put forward are definitively wrong. Each pair has advantages and disadvantages that can be explained rationally.

The primary meaning of 虚 *xū* is "empty"; that of 实 *shí* is "full" or "solid." Extended meanings of the pair that follow from this in the ordinary language are "fanciful/real," "modest/honest" and

"insincere/sincere" (the intended meaning usually supported by an additional character, as in 虚伪 *xū wèi*, literally "empty-fake," i.e., insincere, hypocritical).

7. 虚 Xū and 实 Shí in the Everyday Language

虚 Xū	**实 Shí**
谦虚 *qiān xū*, modest	实在 *shí zài*, real
空虚 *kōng xū*, empty	实心 *shí xīn*, solid (of objects)
太虚 *tài xū*, Great Void	实习 *shí xí*, practice
虚幻 *xū huàn*, illusory	实干 *shí gàn*, get right on the job, do solid work
虚夸 *xū kuā*, boast(ful)	实价 *shí jià*, actual price
虚荣 *xū róng*, vanity	实权 *shí quán*, real power
虚伪 *xū wèi*, sham, false, hypocritical	实物 *shí wù*, material object
虚设 *xū shè*, nominal	实现 *shí xiàn*, realize, achieve
虚套子 *xū tào zǐ*, formalities	实用 *shí yòng*, practical

In Chinese medicine, 虚 *xū* denotes a condition created by a deficiency of wanted things, while 实 *shí* denotes a condition created by the presence of unwanted things or an excess of normal things. Nevertheless, they are slightly different in meaning from 不足 *bù zú*, "insufficiency" and 有余 *yǒu yú*, "superabundance." We often see in Chinese texts explanations such as "heart blood 虚 *xū* is the manifestation of the *bù zú* of heart blood." What is meant here is that heart blood *xū* is a condition of the whole body deficient in heart blood. If we apply the commonly used rendering of 虚 *xū*, "deficiency," in this context, we would translate the whole phrase as "heart blood deficiency is the manifestation of insufficiency of heart blood." Since *deficiency* is virtually synonymous with *insufficiency*, we logically end up in English with a sentence that means "X is the manifestation of itself." The Chinese sentence does not, however, contain a tautology, but encourages the reader to understand: "[The general condition of] lack of (or weakness in) heart blood is a manifestation of insufficiency of heart blood." For those who appreciate the holistic aspects of Chinese medicine, we could say that 心血虚 *xīn xuè xū* is the name for the condition of the whole body, while 心血不足 *xīn xuè bù zú* is its localistic cause.

Very often, 虚 *xū* is a close synonym of 不足 *bù zú*, "insufficiency," and sometimes the two are used interchangeably. Yet the primary notion of "emptiness" is present as an important connotation. A pulse that is described as 虚 *xū* is one that feels empty. If in this context we substitute the word "deficient," the description would be far less specific. A "deficient pulse" might be equated with any of several pulses small in size or lacking in strength.

"Emptiness" is the primary meaning of 虚 *xū*, and it attaches to specific senses of the term in the context of Chinese medicine. My colleagues and I rejected "emptiness/fullness" only on the grounds that another word, 满 *mǎn*, also means fullness. This word is the ordinary word for "fullness" in the everyday language of the Chinese (that is, fullness in the context of receptacles and bathtubs, etc.), and in the medical context it describes a subjective feeling of fullness in the body. This feeling, however, is often due to 虚 *xū* rather than to *shí*, and is called 虚满 *xū mǎn*. This term would be highly confusing if it were rendered as "empty fullness" or "emptiness fullness." By contrast, "vacuity fullness" is acceptable, since the different words separate the abstract concepts (vacuity/repletion) and physical meanings (fullness/emptiness) as the original Chinese terms do.

This point, incidentally, highlights another very important aspect of terminological translation: terms cannot be rendered in isolation. The set of Chinese terms has to be translated into a set of English equivalents that each represent not only the concept

in question but that also distinguishes it carefully from other concepts. A terminology is a system of words employed in the description of a conceptual system; it has to be translated systematically.

"Vacuity" and "repletion" or "fullness" and "emptiness" are not the metaphors English speakers would normally choose to describe healthy and morbid states of the body. But there is conceptual loss if we take what I call a "target-oriented approach" and replace these concepts with ones that are more familiar to readers.

Numerous other term choices can undermine the conceptual fabric of Chinese medicine. Maciocia's treatment of terms denoting parts of the chest and abdomen (Maciocia 1989; 1994) provides an example of how a whole family of concepts is obscured in the translation process.

As translations from primary texts show (Wiseman & Féng 1998a), Chinese medicine imposes divisions on this terrain that differ to some extent from traditional Western divisions. The sides of the chest are known as the *rib-side* (胁 *xié*). The abdomen is divided into the *greater abdomen* (大腹 *dà fù*), the part above the umbilicus, and the *smaller abdomen* (小腹 *xiǎo fù*), the part below the umbilicus. A small part of the greater abdomen immediately below the breastbone is variously referred to as the [*region*] *below the heart* (心下 *xīn xià*) or the *heart* [*region*] (心 *xīn*). The central part of the upper abdomen is called the *stomach duct* (胃脘 *wèi guǎn*). The *lesser abdomen* (少腹 *shào fù*) usually refers to the lateral areas of the lower abdomen, but is sometimes used to mean smaller abdomen.

In Giovanni Maciocia's *Foundations of Chinese Medicine* (1989: 156, 173), the same area is described in terms of *thorax*, *abdomen*, *chest*, *flank*, *hypochondrium*, *epigastrium*, *upper part of the abdomen*, *lower abdomen*, *lower* (*part of*) *the abdomen*, *upper part of the abdomen just below the xiphoid process*, and *hypogastrium*. Maciocia's vocabulary largely comes from Western medicine (although not used with Western medical precision), and is difficult in some places to relate to Chinese concepts.

Thorax and *chest* can be presumed to refer to one and the same thing. *Epigastrium* as an anatomical area corresponds to the *greater abdomen* of Chinese medicine, but Maciocia's diagnostic descriptions suggest that it corresponds to the *stomach duct*. In Maciocia's usage (1989: 156), *flank* obviously corresponds to the Chinese 胁 *xié* since it is said to lie under the control of the liver and gallbladder. However, this is confusing because *flank* in Western medicine refers to the side of the body between the lowest rib and the iliac crest, and Maciocia does not redefine it in the sense of 胁 *xié*. A few lines further on, however, he describes stagnation of liver qì as being reflected in a feeling of distension and stuffiness of the "hypochondrium." In *Practice of Chinese Medicine* (Maciocia, 1994), he describes *hypochondrial pain*, which is equated with the Chinese 胁痛 *xié tòng*. An illustration shows the site of the affected region to be what is called the hypochondrium in Western medicine, but this does not correspond to the region shown in a major Chinese diagnostic text (Dèng 1993) or my own work (Wiseman & Féng 1998a).

The *upper part of the abdomen just below the xiphoid process* clearly corresponds to 心下 *xīn xià*, the [*region*] *below the heart*, but the region is described without being given a name.

Maciocia is obviously at pains not to confront his readers with any new concepts. There is no English word corresponding to 胁 *xié*, and to convey the concept to the English reader (the area from the armpit to bottom rib), we must define it and attach a name to it, so that it can be referred to elsewhere without the definition having to be repeated each time. If we wish to avoid using a transcription, then we are left with the choice of redefining an existing term that does not normally mean the same thing, or making up a new expression. Maciocia takes the first option, but fails to provide the Chinese definition. In fact, he uses two different English words *flank* and *hypochondrium* for the single 胁 *xié*, leaving the intelligent reader to wonder if he means one area or two.

By rendering 心下 *xīn xià* as *upper part of the abdomen just below the xiphoid process*, Macocia offers a description, but the absence of a name means that he has to repeat his description whenever he wants to mention the area again. The reader

apparently gains clinical knowledge directly through the medium of a familiar vocabulary that he/she does not have to (and probably will not) think about. Nevertheless, this convenience is achieved at the expense of transmitting Chinese medical concepts accurately. Insistence on the use of familiar expressions as far as possible creates the impression that Chinese medicine is conceptually more familiar than it is in reality. In reality, however, the target-language reader does not receive as much information as the source-language reader.

Failure to Standardize Terms

When different translators use one and the same target-language word to render two different source-language terms, confusion can arise. The following table shows how three different translators render the terms representing the seven affects. Look how *worry* crops up in two different places in the table.

8. Comparison of Renderings of Affect Terms

	Wiseman 1994	Chéng 1987	Maciocia 1989
喜 *xǐ*	joy	joy	joy
怒 *nù*	anger	anger	anger
忧 *yōu*	anxiety	melancholy	**worry**
思 *sī*	thought	**worry**	pensiveness
悲 *bēi*	sorrow	grief	sadness
恐 *kǒng*	fear	fear	fear
惊 *jīng*	fright	fright	shock

I would like to leave aside the question of which of the terms in each case is best. Languages never match in their categories, and the names of emotions are an area where each language divides reality differently. The point I am trying to make is that anyone reading Maciocia after having read Cheng might, in some contexts, think that Maciocia was talking about the emotion associated with the spleen, when in fact he means the emotion of the lung.

The opinion appears to be quite widespread (although it almost never appears explicitly in print) that Chinese medicine only has a few terms, and that insisting on standardization of terminology goes against the spirit of Chinese medicine. I suggest the "spirit" of Chinese medicine is the one breathed into it by Westerners for whom complementary health-care defines Chinese medicine.

Chinese medical terminology differs in some respects from the terminology of modern sciences in that it has never applied any rigor to reserve one term for one concept and ensure that each concept is only represented by one term. Chinese terminology is messy in the way that our words in lay speech are. Despite this, there is far less variation in terminology in Chinese-language literature than there is in English-language literature.

The single-term pulse terms provide another example. The following table shows pulse names taken from six different sources. For each Chinese term, there are differences in the English terms used. Some translators use the same term, but there is little consistent pattern of agreement between two or more translators over the whole field. Taking the words at face value (as of course many readers do), it is possible to observe synonyms not only for different writers" equivalents of a single Chinese term, but also among different writers" equivalents for different terms. For example, *thready* in Chéng means 细 *xì*;

while *stringlike* in Unschuld and Wiseman means 弦 *xián*. The foreign student reading multiple authors might be confused by the existence of *accelerated*, *rapid*, *hurried*, and *hasty*, which in fact describe two distinct, faster-than-normal pulses (there are in fact others). Furthermore, some of the terms are untraceable in some of the sources.

It would be very difficult to argue that English speakers would have nothing to gain from a standardized English terminology of Chinese medicine pegged to the Chinese.

9. Renderings of Pulse Terms

Chinese	Porkert 1974	Sivin 1987	Chéng 1987	Maciocia 1989	Unschuld 1994a	Wiseman 1994
缓 *huǎn*	languidus	moderate	–	–	relaxed	moderate
浮 *fú*	superficialis	floating	superficial	floating	at surface	floating
沉 *chén*	mersus	sunken	deep	deep	deep	sunken
迟 *chí*	tardus	retarded	slow	slow	retarded	slow
数 *shuò*	celer	accelerated	rapid	rapid	accelerated	rapid
虚 *xū*	inanis	empty	deficiency	empty	depleted	vacuous
实 *shí*	repletus	full	excess	full	replete	replete
滑 *huá*	lubricus	smooth	rolling	slippery	smooth	slippery
涩 *sè*	asper	rough	hesitant	choppy	rough	rough
洪 *hóng*	exundans	swollen	surging	–	vast	surging
细 *xì*	minutus	small	thready	fine (thin)	fine	fine
弦 *xián*	chordalis	strung	string-taut	wiry	stringlike	stringlike
紧 *jǐn*	intentus	tense	tense	–	tense	tight
促 *cù*	agitatus	hurried	abrupt	hasty	hurried	skipping
结 *jié*	haesitans	hesitant	knotted	knotted	knotty	bound
代 *dài*	intermittens	intermittent	regularly intermittent	intermittent	intermittent	intermittent
濡 *rú*	lenis	soft	soft	weak-floating	soft	soggy
弱 *ruò*	invalidus	weak	weak	weak	weak	weak
微 *wēi*	evanescens	subtle	–	minute	feeble	faint
芤 *kōu*	cepacaulicus	hollow	–	–	scallion-stalk	scallion-stalk
大 *dà*	magnus	large	–	–	large	large

In the preceding lecture, I pointed to the problem of Chinese medical concepts being less clearly adumbrated than those of modern sciences, and less equivocally expressed in language. Efforts to standardize terms normally only spontaneously arise in disciplines that have very precise terminologies in the modern sense. It might therefore be argued that Chinese medicine does not need any standardization.

Nevertheless, when one considers the problems in areas such as the emotions and the pulses, one realizes that a lack of standardization creates even greater terminological problems than actually exist in Chinese.

Conclusion

Although time has not permitted me to go into much detail, the broad lines of a tried and tested source-oriented translation approach should now be reasonably clear. Furthermore, some of the ways in which deviation from fairly literal translation can distort concepts should now be fairly clear too.

A standardized terminology is necessary for unequivocal discourse in Chinese medicine. Until we have such a terminology, all attempts to increase the amount of information available to Western students and practitioners fail to achieve their maximum impact.

I suggest that the major reluctance to face the terminological issues posed by Chinese medicine and address the possible need for standardization of terminology stems from the fear it provokes in certain individuals.

The question of whether we translate or fabulate,

and if we translate, how we translate, is not just a matter of words. It is a matter of how we conceive Chinese medicine. It is a matter of whether or not we regard China as being a repository of useful traditional experience. It is also a matter of who we are to trust as our authorities.

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Learning Chinese: Feasibility, Desirability, and Resistance

It is generally recognized that a knowledge of Chinese is beneficial for students of Chinese medicine. Until now, however, schools have provided little or no language training, and the few students who have learned Chinese have done so on their own initiative. In this presentation, I suggest that the question of learning Chinese is one of the major issues in the transmission of Chinese medicine that, like all the linguistic issues, tends to get ignored. The question of learning Chinese deserves attention because it may be more feasible and more beneficial than has hitherto been thought. What is more, it has been in certain people's interests to ignore this fact, and to give no encouragement to the learning of Chinese.

非不能也，而不为也
It is not that people are unable to do what is right; they simply don't have the will.

Confucius

My previous presentations should have made the point that realization of the need to gain linguistic access to the primary East Asian sources has continually eluded the West. What I wish to do in this hour is to sell the idea of learning Chinese or other East Asian language.

As I have said before, Chinese is the most important because the Japanese and Korean traditions are based on the Chinese and use Chinese terminology.

People involved in the transmission of Chinese medicine, that is, translators and teachers with linguistic access to primary sources, admit that learning Chinese would benefit students of Chinese medicine. Nevertheless, it is quite clear that Chinese medical educators consider inclusion of Chinese in school curricula to be an impracticable goal, and consequently there is little discussion of the question. No school has so far developed language teaching to a level that would enable students to read Chinese medical texts with ease. People tend to regard Chinese as an incredibly difficult language to learn, and don't really see the benefits of doing so.

This view is quite misguided. I believe that learning Chinese, especially for the limited purpose of gaining access to East Asian medical literature, is easier than many people think. I also believe that not only the individual student or practitioner but the community of Chinese medicine as a whole has much more to gain from it than is commonly thought.

I propose that linguistic access is a feasible goal. Indeed, over recent years, more and more individuals have taken the initiative to learn Chinese, and I think it is time to nurture this trend.

I would like therefore to look at the proposition in detail. How feasible is it for people to learn Chinese? How desirable is it? It is only by comparing the effort needed to achieve the goal and the advantages of achieving it that we will have a clear idea of whether it would be worthwhile or not. In other words, we have to compare what we put in with what we get out.

I wager that anyone giving serious consideration to this issue is likely to come to the conclusion that it is not pie in the sky, but is a goal really worth pursuing. It has not been pursued on the one hand because the benefits have not been made clear enough, and on the other because it is perceived as a threat to vested interests.

The first question I wish to deal with is how feasible it is to learn Chinese. One thing to bear in mind is the scope of language access we need to acquire. Our aim is to put knowledge of Chinese to the benefit of the development of Chinese medicine. We need primarily a knowledge of Chinese for the purposes of studying medical Chinese. We don't need to be full-blown sinologists capable of deciphering ancient inscriptions. We don't need to be able to speak Chinese fluently enough to pass off as Chinese on the telephone or a dark night. We just need to know Chinese medical Chinese.

The Feasibility of Learning Chinese

To describe the effort anyone has to put in to learn Chinese, I must start by telling you some basic facts about the Chinese language.

China is a huge country with millions of people, constituting roughly one fifth of the world's population. There are many different dialects, many of which are so mutually unintelligible that linguists have to admit that they are really separate languages. A person from Běijīng speaking Mandarin, or Pǔtōnghuà as it is now called, will barely understand a word of the dialects spoken in Guǎngzhōu in the South, Fújiàn in the South-East, or even Shānghǎi on the Eastern seaboard. The differences in the dialects are in some cases merely differences in pronunciation of words, but there are differences in vocabulary and differences in grammar too.

These days, everyone in the People's Republic of China and in Táiwān learns Mandarin. Nowadays, it is usually only elderly people who cannot speak Mandarin.

In contrast to the dialectal differences in the spoken forms of Chinese, the written language has always been relatively unified. The modern written language is essentially based on the dialect of Běijīng. Although Chinese people may speak different dialects, they all essentially write the same language. Speakers of dialects that differ very much from Běijīng write more or less as Běijīng people because they would often find it difficult to put some elements of their own speech into writing.

Pǔtōnghuà is the modern lingua franca of the entire Chinese area. But the written language also plays a role—has always played a role—in overcoming linguistic boundaries. The Chinese script, although containing certain phonetic elements, is tied to the spoken Chinese of no geographical region of China of the present or of the past. Whatever the variations are found in the spoken language and whatever changes have taken place in spoken Chinese over the centuries, the script has remained relatively stable for at least two thousand years or more.

Since the so-called Liberation in China, the written form of many characters has been simplified. Yet the identity of the script remains essentially the same.

In our modern European languages, we are still using the same script that the Romans invented over 2,000 years ago, but our script does not give us the same access to the past, essentially because it is phonetic. The Roman alphabet represents the sounds of a language, and of course it can be used to represent different languages. We can "read" ancient Roman inscriptions in the sense that we can pronounce them after a fashion, but we have to learn Latin to make sense of them.

The Chinese script is different because it has symbols for whole words. It works more like Arabic numerals, which are written symbols that are not tied to any given language. Arabic numerals are now used by virtually all literate people across the planet, even though they are pronounced differently in each language.

Our different ways of writing are molded to the needs of our languages. English really needs a phonetic script. We could not do with a symbol to represent the verb *speak*, for example. Because our language is inflected, we need to make the difference between *speak*, *speaks*, *spoke*, etc. Chinese has no inflections, so *speak* as any other word can be represented by one invariable word symbol, or logograph.

The logographic nature of the Chinese script enables us to read much older texts than our phonetic script allows us to do in European languages. Although the pronunciation of Chinese words has changed dramatically over the centuries, the logographic script enables us to read and recognize the same word in very old texts.

The pronunciation of Chinese words is not the only thing that has changed. The Chinese language has changed in its grammar and in its lexis. So reading ancient texts is more difficult than reading a modern text.

The development of the language is broadly divided into three: Old Chinese, Middle Chinese, and Modern Chinese. Despite the differences between these three, writing for centuries followed the patterns of classical Chinese, which was the written form of Old Chinese. It was not until the 20th century that a written language remodeled on the vernacular

replaced classical Chinese as the normal way of writing for general purposes.

When one learns Chinese, one only has to learn one language in several forms: classical, literary, and modern. Nevertheless, by doing so, one gains access to over 2,000 years of culture.

It is useful to compare this with the development of our own language. Of all the major European languages, English has undergone the greatest and most rapid changes since its beginnings in the early Germanic settlements in Britain fifteen centuries ago. Yet for the modern English reader, Chaucer's 14th century Middle English is unintelligible unless we have a modern translation to compare the original texts with. And to read the earliest extant writing in Old English, *Beowulf* of the 8th century, we have to learn effectively an entirely different language and vocabulary—another language as distant from our own as modern German.

By comparison, the *Zhūbìng Yuánhòulùn* of the Suí Dynasty, almost contemporary with *Beowulf*, is as clear to a modern Chinese as Charles Dickens is to us, and the language of the much older *Huángdì Nèijīng*, though more difficult, is nevertheless approachable. The changes in the language and in the Chinese world mean that a great deal of study is necessary to gain a deep understanding of ancient texts, but the modern Chinese reader has immediate linguistic access nevertheless.

The nature of the Chinese language is of great significance in the context of Chinese medicine. As everyone probably realizes, Chinese medicine, such as we know it today, has a history of over two thousand years, and the traditional study of Chinese medicine of the literate tradition involved gaining a broad knowledge not only of the contemporary state of the art, but the whole of medical thought right back to the *Huángdì Nèijīng*. As one might easily imagine, the nature of the writing system contributed to the maintenance in China of a very conservative approach to medicine.

Even though the literature of East Asian medicine spans millennia, we have only to learn one language to gain access to all of it. The effort to learn Chinese rewards us with access to the whole gamut of Chinese medical literature.

The nature of the Chinese language is such that it gives us full access to the 2,000-year heritage of Chinese medicine. Not only that, it also makes things relatively easy for the person wishing to learn Chinese exclusively for medical purposes. To explain this, I have to describe other features of the Chinese language.

Although Chinese is reputed for being extremely difficult to learn, it is less well known *in what respects* it is difficult. If we look at the different aspects of the Chinese language—its sounds, its grammar, its words, and its script—we find marked differences in the level of difficulty they create for us.

The main phonetic characteristic of Chinese that is difficult for speakers of European languages to master is its tonality. Each Chinese word has a set pitch (*lā*, *lá*, *lǎ* or *là*). A variety of pitches are observed in English to, but they serve the function of intonation, that is, the expression of emphasis, doubt, surprise, etc. It takes a little time for speakers of English to get used to the idea of tones being used to distinguish different words. In Pǔtōnghuà, for example, *mǎi* means to buy and *mài* means to sell. Nevertheless, for those learning Chinese exclusively in order to read medical texts, aural comprehension and accurate pronunciation are not a priority.

I would guess that if anyone in this room has learned a foreign language, it is probably a European language. Anyone who has learned French or Spanish knows that the most difficult thing is the grammar. Since about half of the vocabulary of English has been borrowed from French and Latin, we find that learning the vocabulary of French or Spanish is not too difficult. The hard part lies in learning the grammar.

French and Spanish have nouns that are masculine or feminine, and adjectives that have to agree with them. Much more difficult is the complicated verb system, in which each verb has about sixty different endings! Anyone who has learned German, Russian, or Latin has had to cope with not only genders of nouns but also different noun endings depending on whether the noun in question serves as the subject, object, indirect object, or has some other function in the sentence. Furthermore, German and Latin follow word-order patterns that are very different from those of English, and extremely difficult to get used to.

The student learning Spanish has quite a lot to memorize. For example, the verb "to love," *amar*, has scores of different endings depending on person, tense, mood, and voice. Here I have listed just 48 of them. In fact there are quite a few more than those listed.

The Spanish Verb Amar, To Love

Indicative

Present	Future	Conditional
amo . . . . . I love	amaré . . . . . I will love	amaría . . . . . I would love
amas . . . . . you love	amarás . . . . . you will love	amarías . . . you would love
ama . . . . . s/he loves	amará . . . . . s/he will love	amaría . . . s/he would love
amamos . . . . . we love	amaremos . . . we will love	amaríamos . we would love
amáis . . . . . you love	amaréis . . . . . you will love	amaríais . . you would love
aman . . . . . they love	amarán . . . . . they will love	amarían . . they would love

Imperfect	Preterite	Chinese
amaba . . . . . I loved	amé . . . . . I loved	
amabas . . . . . you loved	amaste . . . . . you loved	
amaba . . . . . s/he loved	amó . . . . . s/he loved	
amábamos . . . . . we loved	amamos . . . . . we loved	
amábais . . . . . you loved	amásteis . . . . . you loved	
amaban . . . . . they loved	amaron . . . . . they loved	

愛 *ài*

Subjunctive

Present	Imperfect	Imperfect
ame . . . . . I love	amase . . . . . I loved	amara . . . . . I loved
ames . . . . . you love	amases . . . . . you loved	amaras . . . . . you loved
ame . . . . . s/he love	amase . . . . . s/he loved	amara . . . . . s/he loved
amemos . . . . . we love	amásemos . . . . . we loved	amáramos . . . . . we loved
améis . . . . . you love	amáseis . . . . . you loved	amárais . . . . . you loved
amen . . . . . they love	amasen . . . . . they loved	amaran . . . . . they loved

Notice that in a spare space in my table, I have inserted the Chinese character meaning "love" together with its pronunciation. The Chinese word *ài* is completely unvariable, and to cover all of the senses in Spanish is sometimes combined with other words. The written form of the word is a complex structure, but no more complex than that of the Spanish inflections. If this is representative of the comparative degrees of difficulty of Spanish and Chinese, I leave it up to you to decide whether Chinese is actually much more difficult.

I am very sure, however, that if we were talking about the transmission of a unique body of medicine developed by Spanish speakers, then far larger numbers of people would entertain the idea of learning Spanish to get a better grasp of the subject. Whether we consider a language easy or difficult—especially before we have even attempted to learn it—is quite a subjective matter. And I think people may think, quite unfairly, that Chinese is much harder than Spanish or any other European language.

As I said, the greatest difficulty in learning European languages lies in learning the grammar. When we learn Chinese, on the other hand, we find grammar is almost a negligible problem. The patterns of the spoken language or the classical language can

be described quite briefly in a few pages, as I have done in two books (Mitchell, Féng, & Wiseman 1999; Wiseman & Féng 2000). When I began to learn Chinese over 20 years ago, I picked up Lǎo Zǐ, and started looking the words up in a dictionary. I did not even look at a grammar book. Chinese follows a basic subject-verb-object order like English, and once you understand the words, you can very often make sense of the sentence without a grammar book.

I said "once you understand the words." This is where the difficulty of Chinese lies. Memorizing Chinese vocabulary is not particularly easy. Apart from a few loans, Chinese words are completely unrelated to our own. To our ears it sounds like "wing wong ching chong," the sound of bells, rather than words to which meanings are attached. Chinese words are not easy to remember, and of course there is the added problem of the tones that I have already mentioned.

But the other snag with Chinese words lies in being able to recognize them on paper. The script is complicated to say the least. This is usually what people mean when they say Chinese is hard to learn.

Alphabetic writing, which the modern European languages inherited from Rome, is essentially phonetic. English is a bad example, because English spelling is not a reliable indicator of pronunciation as say German or Italian spelling. Many of our English words in fact reflect the pronunciation they had several hundred years ago. We just have not bothered to change the spelling.

Chinese differs greatly from alphabetic writing. Although large numbers of characters contain phonetic elements, the script is still basically logographic.

All scripts developed out of pictures, but when it came to attempts to represent human speech in pictures, lots of problems arose because language does more than to present series of images. The solution to the problem was found in using the pictures phonetically.

The Egyptian hieroglyphs include very clearly recognizable pictures of birds and animals and artifacts, as well as more stylized things. Western scholars had always assumed that these hieroglyphs were pictographic or ideographic representations. It was only after the discovery of the Rosetta stone, which allowed linguists in the early 19th century to work out from the trilingual text inscribed on the stone that the pictures were used sometimes for their picture value, and at other times for their phonetic value. In other words, it is as if a picture of an owl could be used to mean "owl" and also to represent the initial sound of the word "owl," which in Egyptian is the sound [m].

Other scripts developed in Semitic languages other than Egyptian also followed the same shift from representing images to representing sounds. And our fully phonetic Roman alphabet is actually derived from these.

Chinese too began with simple pictures. But instead of infinitely inventing new pictures for each different word, people began to borrow characters to represent words of similar sound. This could often lead to confusion, but this could be avoided by adding a new element to the character to signal some basic facet of its new application. Thus, for example, 工 *gōng*, meaning "work," was borrowed to represent a large river, and to signal the new use three sploshes of water were added on left hand side to signal a meaning that had something to do with water: 氵工. This became the most commonly used method of character creation. The vast majority of characters are composed of a phonetic element combined with a semantic agent in this way.

While scripts in the Middle East, from which our alphabet originally came, eventually broke away entirely from representing meanings and developed methods of representing sound only, Chinese has remained in a limbo half way between. It has long been not entirely pictographic, but has never become entirely phonetic either. In fact, the sound changes that have taken place over the centuries have made the phonetic elements less reliable. In modern Pǔtōnghuà, the word 工 *gōng*, meaning "work," which I just mentioned, is quite different from that of the word meaning river, 氵工 *jiāng* (although they are close in southern dialects that have developed less rapidly than the northern dialects).

Each Chinese word is represented by a separate character, but the composition of each is certainly not entirely arbitrary. The character 工 and the water signific, for example, recur as elements in hundreds

and hundreds of characters. Chinese characters are largely combined out of familiar elements, very often with one of the elements suggesting the sound.

Anyone wishing to learn Chinese to be able speak it fluently and be completely literate has a task ahead them. But today we are not talking about learning Chinese to such a level. We are only talking about learning Chinese to a level to gain access to medical texts.

And here again the nature of Chinese makes things surprisingly easy. To learn French or German, as I said, requires learning lots of grammar. Even if you only wish to read medical texts in French or German, you still have to master the grammatical complexities. In Chinese, there is very little grammar to learn. A few hours of instruction is probably enough to keep you going for quite a while.

To learn East Asian medical Chinese, you need little more than to learn the vocabulary used in Chinese medical Chinese. How much vocabulary there is to learn is difficult to say with precision. When we were working on the *Shāng Hán Lùn*, we included a language section containing a character frequency analysis. We found that the *Shāng Hán Lùn* contained only about 900 character types.

Knowledge of far fewer than 900 characters carries the beginning student a long way: quite astoundingly, the 50 characters most commonly appearing in the text account for nearly 50% of the total text; the 100 most commonly appearing characters account for nearly 70% of the text; and the 150 most commonly used characters account for almost 80% of the text.

Of course, the language of the *Shāng Hán Lùn* is not to be compared with the language of Chinese medicine as a whole. Nevertheless, on an analysis of four thousand terms constituting the main entries of a smaller dictionary of Chinese medicine, we found exactly the same pattern recurring as in the *Shāng Hán Lùn*.

In a list of 4,127 single-character and compound terms composed of 1,515 character types (individual characters) and 11,290 character tokens (occurrences of characters), the fifty character types most commonly occurring in fact account for 34% of all tokens. In other words, if our 4,127-term list is comprehensive and representative, then 50 characters account for the one third of the whole terminology.

The hundred characters most commonly occurring account for nearly 50%. This means that if you know 100 characters, you can read half the terms of Chinese medicine. Of course you need many more to read the other half. And you also need a few extra characters to read the non-technical language in which the terminology is couched in Chinese medical texts. Nevertheless, the point is that difficult though the Chinese written language may be, what you need to know to be able to start reading Chinese medical texts is not so much.

Type to Token Ratios According to Frequency

Characters 1–50 account for 34.907% of 11,290 tokens.
Characters 1–100 account for 48.175% of 11,290 tokens.
Characters 1–150 account for 57.555% of 11,290 tokens.
Characters 1–200 account for 64.216% of 11,290 tokens.
Characters 1–250 account for 69.353% of 11,290 tokens.

A little effort to master even 50 or a hundred characters is enough to give anyone the exhilarating sensation that the linguistic barrier is not a huge mountain but just a high wall. And in actual fact, a high wall with a ladder leaning against it to help them over. Considerable effort has already been put into creating literature especially to help those learning Chinese for the purposes of gaining access to Chinese medical literature.

There has been a large increase in interest in the Chinese language over recent decades, and there is now a wide selection of general Chinese-learning materials available. But for those who wish to learn

Chinese for the purposes of accessing Chinese medical texts, these general learning aids are not an efficient way of achieving the purpose.

Paul Unschuld has produced a two-volume textbook called *Learn to Read Chinese*. Bob Flaws in Boulder has produced one entitled *Teach Yourself to Read Modern Medical Chinese*. I and my colleague Féng Yè have produced a textbook that has been released in a limited edition so that it can be put to the test; a formal edition should be ready shortly. Andrew Ellis also has a book in the making.

In sum, Chinese is difficult to learn, but the difficulties have been exaggerated, at least as far as learning it for the purposes of gaining access to information in a particular field. The grammar is very easy; the real problem is with the script. Chinese medical terms are composed of a fairly limited number of characters. Students who concentrate on learning these characters gain the ability to read Chinese medical texts in no time at all.

The Advantages of Learning Chinese

I have presented the case that Chinese can be relatively easily learned. This is in fact a secondary issue. Languages may vary in difficulty, but they are all basically learnable.

The more important issue is what we have to gain by learning Chinese. In my previous presentations, I have continually emphasized the importance of language acquisition in the process of transmitting a complex body of knowledge. I have mentioned many of the advantages of learning Chinese, and here I present them more systematically.

- The more people know Chinese, the greater the Western Chinese medical community's access to vast primary sources of East Asian knowledge.

Access to a huge amount of clinical experience: Most of the traditional literature of Chinese medicine is highly practical in content. Access to primary East Asian sources means a far bigger library available, a far larger core of experience for students to refer to.

Greater linguistic access means fewer misunderstandings: Knowledge of Chinese would reduce misunderstandings about Chinese medicine. The continuing confusion that results from mistranslations and misexplanations such as I showed you in the realm of "sedate" and "qì," would slowly disappear. If more people knew Chinese than at present, it would not take twenty years for someone to realize that some non-Chinese ideas, such as the contraindication against the needling of the extraordinary vessels, had entered the pipeline.

Greater linguistic access means a clearer general conception of what Chinese medicine is: People would also have a much clearer idea about what constitutes "Chinese" medicine and what constitutes a variant of Western inspiration such as the package that Beinfield & Kornfeld are marketing.

- The more people know Chinese, the greater translation potential we have. Most people who take the effort to learn Chinese to gain more information about Chinese medicine are usually keen to pass on their knowledge to other people. And they are usually keen to test their skills at translation. Increased translation would mean a much larger amount of English literature, and a much broader array too.

- The more people know Chinese, the higher the level of scrutiny and criticism of literature placed on the market. With greater knowledge of Chinese, it would be less easy for people to publish things labelled as East Asian medicine that in fact don't represent the Chinese medical tradition. Writers would be put on their toes, and in fact we would probably see a natural decrease in writing by people with no linguistic access to primary texts.

- The more people know Chinese at the advanced level, the greater the stimulus. While it would be difficult to insert Chinese language study into the curriculum of a private Chinese medical college, it is much more feasible in the university environment. In particular, it could very easily be instituted in advanced degrees (Masters, PhD). In this framework, a basic knowledge of Chinese, I suggest, would not even have to be taught as a subject. It could simply be demanded as an entrance requirement. The learning aids for Chinese are now sufficient that students could quite easily acquire Chinese by self-study. The benefits of making Chinese compulsory at the advanced level would be twofold.

First, research would be greatly stimulated. If master's and PhD students had access to primary sources, the range of topics that could be investigated would be far greater. With the full range of Chinese medical literature available, there would be opportunities to study the historical development of Chinese, traditional theories, and a whole wealth of clinical literature.

Second, general teaching standards in Chinese medicine would rise. Learning Chinese in advanced-level Chinese medical studies would set the standard for academic accomplishment. It would mean that all the top-qualified people in the field have access to primary sources, just as all the top people in any field of international learning know English (or another major European language). Once higher degrees became a requirement for teaching posts in schools, then teaching of Chinese medicine could potentially rise to new standards of quality.

- The more people know Chinese, the easier it would be to standardize terminology. Currently, the lack of a standardized terminology constitutes a major obstacle to the development of Chinese medicine in the West. People who learn Chinese and gain access to Chinese-language literature naturally consider Chinese to be the most accurate expression of Chinese medical knowledge. Once they know Chinese, they usually become reluctant to read English literature because they do not consider it reliable. Such people are very open to the idea of a standardized English terminology of Chinese medicine. Greater linguistic access to the source would help to increase awareness of the terminological issue.

- Other advantages: Greater linguistic access to the source would give the non-MD Chinese medical community a much stronger grounding in the traditional practice of Chinese medicine that might stand them in good stead vis-à-vis the MD practitioners of Chinese medicine who claim that they alone are qualified to treat the sick.

Greater attention to learning Chinese might actually encourage sinology to take more interest in Chinese medicine. Western sinologists have traditionally not paid great attention to medicine in China by comparison with other aspects of Chinese culture. At a time when, in medical matters, a little traffic is taking place against the normal West-East flow of knowledge, one might expect more sinologists to take interest in the new page in East-West relations while it is actually in the making.

Last but not least, a solid effort to gain linguistic access to primary literature would win a great deal of respect from the Chinese. The Chinese tend to believe that Westerners are unwilling or unable to learn Chinese medicine in its original form. They have the impression that we will only be able to understand a modernized, scientized Chinese medicine that is integrated or integrable with Western medicine. As one Chinese writer said, "Even though Chinese medicine is a theoretical system based on the classics, we cannot present it abroad in the form it had two thousand years ago." (Zhāng Wéi-Huī 1994: 19–20). Actually, the Chinese confuse "Westerners" with "Western scientists." Of course, the international scientific community is unable to accept many traditional medical concepts, but this is not to say that Westerners cannot understand Chinese medicine. There have been quite a few people, including myself and colleagues, who have been busy presenting East Asian medicine in its original form.

Once the Chinese realized that increasing numbers of Westerners have a sound knowledge of Chinese, a new variety of study opportunities would open up in China. Instead of simply providing short courses in practical acupuncture as many schools in the PRC have done, a greater range of study opportunities for more advanced students with a knowledge of Chinese would be likely to appear.

In short, by increasing linguistic access, we would generate more reliable information from reliable sources, and at the same time reduce the amount of unreliable information. Making Chinese a compulsory part of, or easier still, a requirement for advanced study would at once provide greater possibilities for research and increase teaching standards.

Why Have We Failed to Identify the Need for Linguistic Access?

The English-speaking world is in many respects culturally insular. It has more speakers, more economic and political power, and more creativity

than any other single language community in Western civilization. This is why English has become the most important language in international communication.

This situation is of course very convenient for English speakers. Everyone learns our language, so we can speak our language almost everywhere we go. But it does not provide a great deal of impetus for English speakers to learn foreign languages. And it also tends to hide from us the importance of language in cross-cultural communication.

When two cultural communities wish to establish communication, they have to have a common language—the language of either one or the other of the two communities, or the language of a third community. When the choice is between the language of the one community or the other, it is really always the language of the politically, economically, and culturally dominant community that is chosen. It might be true to a certain extent to say that the strong community imposes its language on the weaker community. However, the reason why the weaker community gives in is that it is keen to learn the ways of the stronger community, and gaining access to its language provides the easiest means of access.

This is why the Romans learned Greek, and why Europe learned Latin and later French. It is also why over the last couple of hundred years, with the rise of the British empire and then the emergence of the United States as the most dominant world power, English has begun to emerge as the most important international language of the West and in the world in general.

However, dominance of the languages of the fittest is certainly not the only rule at play.

In the modern sciences, the use of any particular language is a matter of convenience, not a matter of necessity. Scientific knowledge makes use of clearly defined concepts for which expression can be found in any language. French and German speakers, and speakers of smaller language communities, have shared in the development of the sciences. With the decline of Latin, we have all tended to use our own vernacular. The German or French terminology of Western medicine, for example, is not inferior to English. Although German- and French-speaking doctors learn English to be able to communicate outside their own language communities, any text can be translated into French or German with no loss of information.

In nonscientific fields, the picture is different. In creative literature, for example, non-English-speaking people who study Shakespeare cannot do so seriously unless they can actually read Shakespeare in the original English version, because anything that can be said about a translation of Shakespeare in any language is a comment not about what Shakespeare wrote, but about what the translator wrote.

The present cultural dominance of the English-speaking world tends to make the whole world more interested in English literature than that of any other language. But that does not make English a satisfactory vehicle for studying non-English literature. Even in a rigorous field such as philosophy, it is considered useful to be able to read German or other European languages. Bible scholars learn Greek and Hebrew to gain access to original texts.

Chinese medicine is not a science in the modern, strictly defined sense of the word. Terms do not have the clearly defined relationship to objects and concepts as they do in the sciences. The scholarly study of traditional East Asian medicine (as opposed to any modernized version of it) is ultimately tied to Chinese, and will always be so.

Of course one can learn about East Asian medicine in English and practice it. Nevertheless, to gain a deeper and broader knowledge of it requires learning Chinese. As I have said, there is still much more literature on the subject in Chinese than there is in English. To argue the opposite case is to imply that Chinese medicine has arrived in the English-speaking world fully intact and complete, that is, as a precise mirror image of what it is in East Asia. This is not the case. What we have so far is only the tip of the iceberg.

For a body of knowledge to be transmitted across language frontiers, it is not necessary for everyone to have full access to primary texts. In the PRC and Japan, for example, students learn Western medicine through the medium of their own language. They can do so, because there is a reliable mechanism for translating information from abroad. Nevertheless, scholars and teachers in medical colleges all need to have the ability to read English to keep abreast of

world developments. Many of the advances in medicine come from the English-speaking world, and the fact that English is now the world language of scientific interchange means that speakers of other languages present their findings in English to gain international recognition.

In any field, scholars wishing to make their own contribution have to be familiar with the full body of extant knowledge of the subject. In many fields of learning, scholars often have to know one or more foreign languages to keep abreast of developments, especially when their native language is not English. In Chinese medicine, the bulk of the literature is in Chinese and other East Asian languages. Yet in the English-speaking community of Chinese medicine, many are considered authorities who have no access to primary East Asian sources.

In Chinese medicine, we are still quite a long way from having a basic mechanism for presenting information in English. We still have no standardized terminology pegged to the Chinese, which would provide the basis for the reliable supply of information through the medium of translation.

A standardized terminology would improve on the present situation as regards information one hundredfold, but the very achievement of the goal of standardization would require a lot more people having access to Chinese texts for the need for greater terminological rigor to be fully recognized. Given the nature of Chinese medical terminology and concepts, it would not be possible to achieve such precise terminological matches as exist between languages in the precise sciences.

Even if we were to agree on a unified terminology today, we would still be lacking the human resources needed for large-scale translation of Chinese medical literature, because there are still too few people who have adequate knowledge of English and Chinese and adequate familiarity with the subject matter. To increase translation, we need to have more people learning Chinese.

And even if we had produced large quantities of adequately translated text, a knowledge of Chinese would still be necessary for those wishing to pursue research in the traditional theory and practice of Chinese medicine.

At all levels and steps of the transmission process, from developing a standardized terminology and performing translation to the highest degree of access for research purposes, Chinese cannot be dispensed with. Chinese can only be dispensed with when we decide that there is nothing more in the Chinese barrel that is of any value or interest. I suggest that too many people, out of sheer lack of linguistic access, actually assume that point to have already been reached!

Our current education system in Chinese medicine is primarily concerned only with passing on currently available knowledge. It is not concerned with increasing knowledge. In Chinese medicine, one of the main ways in which we can increase our knowledge is to increase our access to primary sources. Current East Asian medical education does not provide any mechanism for attaining this goal.

I believe that every student of East Asian medicine would benefit by learning Chinese. Of course, many students would fail to attain the ability to read medical texts fluently. Experience in Táiwān shows that even when the standard textbooks of Western medicine are English rather than Chinese, many students manage to get through their studies without being able to read English fluently, and by having to rely on the unofficial Chinese texts and student notes. Modern education works on the principle that students have to learn a whole variety of subjects that they easily forget after they leave school and never take up again. Everyone learns geometry, and I imagine that 95% forget most of it when they leave school. Even most doctors forget their anatomy. Educators work on the principle that a hundred seeds have to be cast to get just a couple of trees.

In actual fact, not everything is forgotten that is not used. We gain intangible benefits even from knowledge that we never apply. We might, as a society, have a different view of the world if geometry were taught only to those who were going to make use of it in their professional life.

The intangible benefits of language learning in the study of Chinese medicine are potentially immense. The study of Chinese, especially if combined with the study of the history of East Asian medicine and general history of China, would help to shape students" understanding of medical practices that have their root in an unfamiliar culture.

The Western community of Chinese medicine has not seen the need to learn Chinese and has not actively encouraged students to do so. People who don't know Chinese cannot really imagine the benefits. Yet those who do have linguistic access to primary literature do know the advantages. I have met no student or practitioner of Chinese medicine on the planet who has learned Chinese and thereby gained access to primary literature who has ever regretted it, or who has confessed to being more confused than ever, or who after having gained access to the East Asian world thinks that the best East Asian medical practitioners are Westerners. People who learn Chinese soon realize how much more information is available in Chinese than in English.

Why English-speakers have not realized the benefits of learning Chinese may be to some extent due to their linguistic insularity, that is, to the fact that very few of them have ever had the experience of having to learn a foreign language to gain access to anything. Only in specialist fields do English-speakers ever encounter that need. And Chinese medicine has quite wrongly not been identified as being a field with such a need.

Political Resistance

As I have suggested, promoting linguistic access would set higher standards in the field. Including language study in East Asian medical courses would be most likely to make them more expensive, and possibly even longer, than they are now.

More important are the political implications, since promoting linguistic access would mean that the creation of Chinese medical literature and the teaching of Chinese medicine would be increasingly taken over by people with a knowledge of Chinese. In other words, the élite within the field would change. There are important political implications to the learning of Chinese that we cannot simply leave to one side. We have to address them squarely. Promotion of a linguistic interface would go against the interests of individuals who have not faced the language-learning challenge.

As I already said in my opening presentation, it is a fact that in all fields of modern learning, it is customary for people to be acquainted with the relevant literature before they make their own contribution. A scholar's work becomes suspect when found to be deficient owing to inadequate familiarity with the literature. At present, there are many East Asian medical works written by people without access to primary literature. If the learning of Chinese is promoted, writers will be increasingly expected to have a knowledge of Chinese.

A highly source-oriented style of transmission that is fostered by linguistic access to primary sources has major implications for the publishing industry. The pegging of terms to Chinese requires not only bilingual terms lists, but also the inclusion of Chinese characters in almost any kind of text. With the current low level of access to Chinese, this is a problem that most publishers do not want to deal with. So far, only one Western publisher of Chinese medical literature, Paradigm Publications, has encouraged the introduction of Chinese into English texts and published bilingual dictionaries. Other publishers are beginning to introduce Chinese into their texts, but on nowhere near the same scale.

While getting Chinese script into English literature is part of the process of drawing Western recipients of Chinese medicine closer to the source, publishers are not necessarily rewarded for their efforts. As Bob Felt of Paradigm Publications has said, under the present circumstances, any book containing Chinese characters is unlikely to be chosen as a textbook by schools, because the presence of contents not understood by teachers exposes teachers to the possible embarrassment of being asked questions they cannot answer.

This comment gets right to the core of the political issue. People who are teaching and practicing now might well in their own hearts agree with the idea of linguistic access in principle. Nevertheless, a substantial increase in youngsters with full access to Chinese texts would force them to learn Chinese or else to run the risk of falling in the esteem of the new generation. Their only claim to fame would be considerable clinical experience. This brings me to a most important point.

I have been talking about the linguistic aspects of the transmission of Chinese medicine for nearly twenty years. Over this time, I have received considerable feedback from people—unfortunately very little of it through public channels.

Comparatively few people know Chinese and have any understanding of or interest in translation issues. No-one has ever put any sound arguments against what I have to say.

Nevertheless, there is a clear general reaction. People tend to see "linguistic issues" in opposition to "clinical experience." According to this view, people such as myself, who insist on linguistic issues such as term translations, are word-mongers who have no interest in the clinical practice of Chinese medicine.

People are right in thinking that I am not a clinician, but they would be quite mistaken if they thought that I had no concern for the clinical practice of Chinese medicine. My point is that anyone's experience in Chinese medicine (as opposed to some therapy of their own invention) is experience in the use of a body of theoretical knowledge and practical experience that has a history of two thousand years in China. So far, we have not paid sufficient attention to getting as much of that knowledge and experience as we can.

Clinical experience is important but no-one's clinical experience is worth as much as everyone else's put together. No one clinician can possibly see enough patients to outweigh a whole tradition. And that tradition can only be acquired by Westerners when either they all learn Chinese, or enough people learn it to translate enough literature for our needs. Whichever you choose, you cannot escape the need for a level of linguistic access that so far we have not fully achieved. Unless of course you think that we already have enough translated literature.

One can easily understand the fears of those who are not actively promoting language access, and who would resist it if there were a move to develop it. But to resist is unconscionable because it prevents Chinese medicine from developing its full potential in the West and helps to preserve the marginality of Chinese medicine in Western society.

Academia provides a framework that encourages positive, constructive thinking and fosters our understanding of the world. The freedom of expression it gives is balanced by the freedom of readers to examine writers" evidence for what they say. A clinician's right to self expression is equally balanced by the responsibility to demonstrate benefit. A clinician's claim that his or her therapy is based on a tradition should ideally be supported by the ability to demonstrate his or her access to that tradition.

These issues can be ignored and have been ignored by the non-mainstream privately run colleges of acupuncture and Chinese medicine. But they cannot be ignored in academia. In the academic environment, Chinese medicine is under pressure to scrutinize itself. The obvious areas of research are exploring the scientific bases of Chinese medical therapy, and developing the potential contained within the traditional body of literature. As I said in my first lecture, we need Chinese not only for the latter but also for the former.

Conclusion

I may be guilty of having exaggerated the ease with which one can learn Chinese. I confess my own experience of the matter is too far in the past. But people do learn Chinese, and do so quite quickly. It can take people as little as a year and half to learn Chinese to a level where they can start translating.

I have certainly not exaggerated the personal rewards to individuals who take it upon themselves to learn Chinese. For one or two years" hard work, the reward is access to a library a thousand times the size of the English-language library.

Nor have I exaggerated the benefits of a concerted effort on behalf of the community to learn Chinese. It would give many more people access to primary sources, and it would be bound to increase translation activity.

And I have definitely not overstated the silent political opposition to such an effort. I hope very much that I am not mistaken when I suggest that Chinese medicine has a much brighter future within academia than outside it.

The proposition that greater linguistic access is required for Chinese medicine in the West has not so far been seriously discussed because it is in the interests of many people not to entertain the idea. I suggest, however, that to expect the successful transmission of Chinese medical information at the present low level of linguistic access goes against common sense and experience in other fields. I suggest that as Chinese medicine assumes a position as an independent field of study in mainstream education, Chinese could be easily introduced into

the curriculum, and could with even greater ease be made a requirement for advanced-level studies. I believe the onus of proof should be placed not on those calling for greater linguistic access to explain their case, but rather on those who remain silent and refuse to explain why we need not bother to make the effort. I believe that they don't have the slightest case.

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Chinese Medical Dictionaries: A Guarantee for Better Quality Literature

The standard approach to the translation and recording of terms is as feasible in Chinese medicine as in other fields. This presentation describes my own experience in East Asian medical translation and terminography. It explains why this methodology has been slow to be applied in Chinese medicine, and how problems in dictionary compilation created by the intellectual environment of Chinese medicine can be overcome.

> . . . [N]o new dictionary would ever be undertaken if all parties knew in advance just how long it would take to do it.. . .[I]t's an awful job getting *any* dictionary written, even a bad one.
>
> Sidney Landau 1980

Introduction

I went to Táiwān nearly 20 years ago with the purpose of learning Chinese. Wishing to learn more about Chinese culture, I engaged in the study of Chinese medicine, one of the few remaining traditional bodies of Chinese knowledge still alive. The fact that this happened to be a domain in transmission to the West allowed me the opportunity to apply my skills as a translator which I had gained by studying German and Spanish translation at university.

Indeed, I was able to use these skills creatively because, as soon became apparent to me, Chinese-English translation was lacking. Looking at the transmission of Chinese medicine, many of the problems regarding the transmission of Chinese medicine that I have described in the preceding lectures became immediately apparent. Most of the literature available on Chinese medicine and acupuncture were "basic texts" containing the core theories of the subject. There was virtually no classical literature available. And every book seemed to express Chinese medical concepts in different words.

I started my translation work by picking a basic but reasonably comprehensive Chinese medical primer, (1975) *Zhōngyīxué Jīchǔ* (《中医学基础》 "Fundamentals of Chinese Medicine") by the Shànghǎi College of Chinese Medicine 上海中医学院. I began translating it as accurately as I could, with no thought of simplifying it, paraphrasing it, or biomedicizing it for the benefit of the unfamiliar English-speaking reader, but by trying simply to tell the reader what the text said.

There were of course innumerable terms for which English equivalents had to be found. In the early 1980s, there were only a couple of Chinese-English dictionaries of Chinese medicine, and these were too small to meet my needs. Existing literature in English was of little help because the equivalents they used were not pegged to the Chinese. I thus started from scratch, and I found that the best approach was usually a fairly literal translation. I was apparently instinctively applying a philological approach to translation.

A Standard Approach

As a one-time technical translator, I was aware that technical terms had to be translated consistently. In fields where target-language terminology is established, achieving terminological consistency is easy. When a comprehensive list of established equivalents—a standard dictionary—is available, terminology causes the translator few problems. But in a field where writers each apply different terms and do not work using published term lists, and where the few bilingual lists that do exist are hopelessly incomplete, a translator wishing work by rational procedures is compelled to do his own terminological work as he goes. Thus I effectively had to create a terminology in the target-language to match that of the source-language.

As I established English equivalents for Chinese terms, I had to keep a record of them so that I could use them consistently. To this end, I created a

computer database that could be indexed and easily accessed by Pīnyīn. I did not merely include in the database the terms I happened on in the translation process. Instead, I began by entering all the headwords of a small dictionary, the *Zhōngyī Míngcí Shùyǔ Cídiǎn* (《中醫名詞術語詞典》 "Dictionary of Chinese Medical Terms" *SYCD*), containing four thousand or more terms into the computer. I then systematically translated these into English in as literal a way as possible, while consulting the definitions in the dictionary. This was a useful exercise because it gave me an overall grasp of the concepts of Chinese medicine and the way they are expressed. Furthermore, by starting with a relatively comprehensive list, I had a solid basis for building a comprehensive English terminology. By taking a global approach, I would be best equipped to avoid choosing equivalents that might otherwise have to be revised if I had started with a small set of terms and gradually expanded it. As I proceeded with the translation of the text, I was able to add to the database terms I encountered that I had not previously recorded. As I went, I often had cause to revise the translation of a given term, in which case I would have to change it throughout the text, and also in the database.

The result was not only a text translated with terminological consistency, but also a bilingual list registering the choices of English equivalents that could be usefully shared by other translators. It is quite likely that no other bilingual list in the field of Chinese medicine had ever been created out of the translation process in this way. There is nothing unique about this procedure, however; I was merely following my instincts as a professional translator.

The bilingual list was first published in 1990, five years after the publication of the first book translated by it, *The Fundamentals of Chinese Medicine*.

I continued this procedure as I embarked on the translation of other texts. I have produced numerous translations and a second vastly improved edition of the bilingual list. After nearly 20 years, the database is still live, still being added to and changed. A third edition of the bilingual list is to appear shortly.

In the creation and updating of the database, I have found that I have become increasingly convinced that if any single approach to the translation of Chinese medical terms is valid, it is a literal, source-oriented approach. From our modern standpoint at least, many Chinese medical terms are speculative, poorly defined, and have been interpreted in different ways. When the relationship between terms and concepts is not clear, we first of all have to tell our readers what is being *said*; we cannot substitute what we think is *meant*. In such cases, therefore, only a literal approach is satisfactory. I have found again and again that a revision of a term usually ends up in a more literal equivalent than before.

I would stress again that the approach applied in translation is one that is, in its general lines, approved by historians and philologists, and is also applied in the translation of modern technical terminology.

A New Challenge

When it was finally published, *The Fundamentals of Chinese Medicine* contained an introduction at the front describing the translation approach applied, as well as a substantial glossary at the back explaining terms appearing in the book. What distinguished the book from other introductions to Chinese medicine available at the time was not so much differences in the choice of English terms. Terms in East Asian medical literature varied—and still do vary—considerably from book to book. What made *Fundamentals* different was the fact that it recognized far more terms than any other book. While other books tended to present Chinese medicine as having only a handful of terms, such as the names of organs, channels, and disease-causing entities, the names of one or two diseases, and the names of diagnostic categories such as *xū* and *shí* and pattern names, *Fundamentals*, by contrast, introduced a welter of terms describing symptoms, pathomechanisms, and therapeutic actions.

Fundamentals was effectively saying that Chinese medicine possessed many more technical concepts than were normally recognized by translators and writers. By implication, it was also suggesting that something had been getting lost in the transmission process.

The approach to translation it embodied posed a challenge to the community of Chinese medicine. There were different reactions.

We received little feedback from other translators about the approach. Other translators who had been applying other terminologies quite naturally had qualms about my choice of terms. Every translator becomes attached to the terms he or she uses. But no translator openly expressed approval of or opposition to the notion that English terms should be related to the Chinese. No translator openly expressed approval or opposition to the highly literal translation method.

We received considerable feedback from readers about likes and dislikes as regards terms. Whenever we received an alternative suggestion, especially when it came from more than one person, we reviewed the case of the term in question again. As a result of this process, we made numerous changes to the terminology that were incorporated in the 1990 edition of the bilingual list or in the 1995 version, as well as in the revised version of *Fundamentals*.

Another reader reaction to *Fundamentals* was that many of the terms were unexplained. In the revision, we therefore added about six hundred footnotes explaining virtually every term that meant more than its face value suggested, effectively, the equivalent of every Chinese term to be found in a Chinese medical dictionary.

Fundamentals of Chinese Medicine presents a more complex form of Chinese medicine than other English texts. *Fundamentals* is used in Táiwān as a first-year primer, but over recent years has been replaced by a book three times the size. Translated into English, the same book is considered an advanced text.

Westerners were used to a simpler version of Chinese medicine than the Chinese, a version that, beyond the basic doctrines of yīn-yáng and the five phases and of the organs and channels and patterns, avoided as far as possible the introduction of any terms and concepts that would be unfamiliar to students. This was particularly noticeable in the field of diagnostic and disease names, but it is to be seen in all parts of Chinese medical translation. I will say more about this further ahead.

The process of transmitting Chinese to the West was obviously deficient. For me, a central area of the deficiency was a failure among translators to realize the conceptual content of Chinese medical terms. In an earlier presentation, I have already given examples of how a relatively clear and detailed division of the chest and abdomen can break down in the transmission process.

Quite obviously, the overall picture East Asian medicine gained by English-speaking readers varies considerably depending on how much effort translators put into understanding Chinese terms, into representing them faithfully in English, and into explaining them so that English-speaking readers will understand them to mean the same thing as the Chinese reader understands the Chinese terms.

Dictionaries, where terms are listed and explained, potentially have an important role to play in the development of an equivalent terminology in the target-language. It is in bilingual lists that English equivalents are pegged to the Chinese, so that all translators can apply the same term choices. It is in full dictionaries that explanations of terms are given for the benefit of students and practitioners.

In the initial stages of transmission, when the target-language terminology is still in flux, normative bilingual lists offering different target-language equivalents can promote discussion about terminology and facilitate review of the various possible term choices so that a greater consensus can be reached. In Chinese medicine, exuberant efforts have been made to propose terms, but far less progress has been made as regards terminological standardization.

Over the last 20 years or more, Western translators have tended to limit their lexicographical efforts to glossaries appended to their works. Several, mostly small, bilingual dictionaries have been published in the People's Republic of China. I and my colleagues have been the only group in the West to take on the task of developing bilingual lists and full dictionaries seriously with a view to developing a comprehensive English terminology pegged to the Chinese.

Although interest in terminological issues has grown considerably, there is probably still as wide a variation in the terminology contained in lexicographical works, textbooks, and clinical literature as ever. Although the number of works applying the terminology that my colleagues and I have proposed is undergoing substantial growth following its adoption as the preferred terminology

by two of the three major US publishers of Chinese medical literature (Paradigm and Blue Poppy), there is still a large amount of literature that conforms to no discernible terminological standard.

We had hoped that there might be a full open debate on the subject of terminology. Most translators have only spoken and written about translation issues in passing. The problem of terminology has been almost totally side-stepped. Translators and writers give the impression that they recognize Chinese medicine to possess a very limited number of terms. Giovanni Maciocia, in a "Note on the Translation of Chinese Medicine Terms" contained in *Foundations of Chinese Medicine*, claims to have "reviewed afresh all Chinese medical terms," and provides what he calls a "full glossary" (pp. 485–486), which contains 56 terms. Even though he has since explained that he meant only all terms contained in the book, he still allows us to conclude that he believes that the basic theory of Chinese medicine is expressed in a small number of terms.

Are there really only 50 or so terms? The Chinese certainly would not agree. Xiè Guān's 1921 *Zhōngguó Yīxué Dàcídiǎn*, 《中國醫學大詞典》, the first comprehensive dictionary of Chinese medicine, contains nearly 37,000 terms, while the 1995 *Zhōngyī Dàcídiǎn*, 《中醫大詞典》, contains nearly 32,000. How can we explain this huge difference in appreciation of the number of terms of Chinese medicine?

Well, for a start, we might assume that any English writer is likely to possess a shallower understanding of Chinese terminology than the scholars of the *China Academy of Traditional Chinese Medicine*, China's top research body in the field. Yet the whole question of what constitutes a technical term is not such a simple matter.

Nowadays, most scholars generally agree on what a technical term is: a term used by specialists and not by the lay, or a lay term used by specialists in a special sense. Despite this broad definition, translators of Chinese medicine have tended to underestimate the conceptual significance of a great many terms. In my understanding, there are three reasons for this: the traditional absence of medical lexicography in China; the Western expectation deriving from complementary health-care that Chinese medicine cannot possess many terms; and the sheer immensity of the task. I will explain these reasons in greater detail.

First, the traditional absence of medical lexicography in China. As I have already explained, Chinese medical terms do not have quite the same strictness of usage as terms do in modern sciences, and they do not differ in their morphological form so sharply from lay expressions as, say, English medical terms, which are often marked by their Greek and Latin obscurity. This is reflected in the fact that Chinese medicine did without Chinese medical dictionaries until the twentieth century, and the development of Chinese medical lexicography was a direct prompting from Western medicine that had newly arrived on Chinese soil.

One reason for the late birth of the Chinese medical dictionary lies in the fact that although the Chinese started making general dictionaries over two thousand years ago, it was not until the 20th century that they started producing dictionaries which included compounds among their entries. (The first dictionary containing compounds was Lù Ěr-Kuí's *Cíyuán* 辞源, "Source of Words," which was published in 1915.) And this development again was a prompt from the Western world. Right up to the 20th century, the written language of China mostly followed the classical model; and the spoken language was largely neglected by scholars. The classical language was originally the written form of Old Chinese, which was more highly monosyllabic than later forms of the language. Hence in Classical Chinese, a word was essentially a single character. Characters used in the construction of medical terms were all to be found in the early dictionaries, and since the importance of compounds was not recognized, the need for a specifically medical dictionary was not recognized either.

However, as soon as the Chinese learned of the ideas of Western lexicographers, they immediately set about applying them very successfully in both general lexis and technical terminology. Chinese medicine was no exception.

Medical lexicographers of the 20th century brought to light the terminological aspect of Chinese medical literature in a way that traditional Chinese

medical scholarship never did. The huge number of terms contained in the two major dictionaries cited is partially explained by the large number of main and alternative names of medicinals and acupuncture points and by the number of names of medicinal formulas (the actual total number of formulas devised and named by Chinese physicians defies count). Nevertheless, there is an immense number of general medical terms—body parts, symptom names, disease names, etc. The general terminology contained in the 1995 *Zhōngyī Dàcídiǎn* is quite representative of the terminology appearing in modern literature and the classics that are still considered important to this day.

Despite the traditional absence of medical lexicography in East Asia, it is highly unlikely that any Chinese medical translator in the 20th century never saw a dictionary containing the fruits of Chinese medical lexicographers. Every translator must surely have at least seen Xiè Guān's 1921 dictionary, if not also the many general Chinese medical dictionaries produced since World War II, and the specialist dictionaries on the *Nèijīng*, *Shānghánlùn*, acupuncture, warm diseases, etc. Nevertheless, dictionaries traditionally do not have the place in East Asian medical education as they do, say, in modern scientific disciplines, and for this reason may have been neglected as valuable sources of information.

A second reason why East Asian medical terminography has been neglected in the West rests on the motivation for the adoption and professional practice of Chinese medicine in the West during the latter half of the 20th century. Chinese medicine owes its popularity in the West to its being perceived as one of several alternatives to Western medicine, that is to say, to its being perceived to be different from Western medicine. As I have explained in an earlier presentation, Western adherents have projected onto East Asian medicine all sorts of traits that are absent from the original East Asian form, or are at least not as pronounced. Chinese medicine is considered to be holistic, never losing sight of the picture of the suffering individual in his or her environment. In this conception, East Asian medicine could not possibly be thought to have the kind of fastidious detail that, say, Western medicine has.

Many Westerners do not realize that East Asian medicine is based largely in book-learning. As a tradition spanning 2,000 years that still reveres the earliest extant works, Chinese medicine requires students to study a whole variety of texts, ancient and modern. Even the more recent ones abound in terms that do not occur in the everyday language, many of them ostensibly archaisms. Though Chinese medicine never developed its own tradition of lexicography, commentators have traditionally paid great explanation to explaining the meanings of words.

As I showed in an earlier presentation, it is possible to discuss the chest and abdomen discarding all the traditional Chinese medical divisions, and thereby avoid the task of explaining the divisions, of establishing terms for each part, and of using these consistently in translation. The translator might well avoid this task not merely to save himself trouble, but also to make things superficially easier and more pleasant for students. Learning new physical divisions before learning the symptoms associated with each adds a new conceptual stage to the learning process that students might prefer to do without. If there is a loose vocabulary already existent in English, then it is possible to dispense with the East Asian medical technicalities. For most Westerners, Chinese medicine is a practical healing skill that involves minimal memorization. It is not like Western medicine where students are required to tediously memorize the apparently endless minutiae of anatomy, to promptly forget it afterwards! Of course, students of East Asian medicine are required to learn the channels, pathways, and points, and the therapeutic actions of medicinals. Some memorization is avoidable. But deliberate or not, there seems to be some corner cutting in other areas, and I think this is due to the widespread perception of Chinese medicine as an alternative therapy in which book-learning is not thought to figure strongly.

A third reason is that lexicography is such a big task that we have not really had sufficient resources. For translators to keep track of their term choices so that they translate terms consistently, they have a very large additional task. For translators to be able to record Chinese terms and for publishers to be able to print them, special technology is also required. When I began creating my databases on the computer 20

years ago, the first Chinese system in Táiwān had not been available for very long. For the formal printing of the terms lists, we were counting on technology that was only just starting to be available at the time. It is difficult for publishers with no knowledge of Chinese to deal with Chinese characters. (Even in the 1990s, sinologists were producing books that had few or no Chinese characters in them!) It was not until the advent of desk-top publishing, which placed typesetting in the author's own hands, that things became easier.

Incidentally, this brings us back to the question of linguistic access. Now that the means for printing Chinese are available, it remains to be seen whether writers and publishers will become sino-literate and make use of the resources available to encourage the students and practitioners to overcome the language barrier.

But to return to the main argument, while some translators have played down the importance of terminology in the westward transmission of Chinese medicine, there is no actual justification for doing so. As I have shown, the neglect of terminological issues has had a highly negative effect on the proper understanding of Chinese concepts, and has forestalled the development of a reliable body of Chinese medical literature in the English language.

Full Dictionaries

Bilingual lists are designed for translators. But students with no knowledge of the Chinese language have little use for these. The kind of lexicographical work such students need is a full dictionary with definitions that explain the concepts. Most independent disciplines these days have dictionaries of this kind. And I believed that a well-conceived dictionary of Chinese medicine could provide comprehensive documentation of Chinese medical terms and concepts that would increase awareness of terminological problems and thereby contribute to the development of a rational English terminology pegged to the source-language.

I began the task over ten years ago. It did not prove to be as easy a task as I naively expected in the beginning. I started the task by selecting a thousand or so terms collected from *Fundamentals of Chinese Medicine*. Instinctively taking modern technical dictionaries (such as Western medical dictionaries) as my model, I started to fill in the definitions of the terms. That, after all, is what Dorland's or Churchill's dictionaries contain—terms with their definitions.

As the work progressed, I started to worry that I was going to end up with something very much like the other few English dictionaries of Chinese medicine, all of which I knew to be commercial failures. Why the other dictionaries did not sell was simply, as customers had reported to Redwing Books in Brookline, that they contain nothing of clinical value. As I have said, Chinese medical students are mostly only interested in clinical information, and have never been encouraged to see Chinese medicine as a set of healing procedures supported by a complex body of knowledge whose acquisition can be made easier by such things as reference works and dictionaries.

The point of a dictionary containing terms and their definitions is to make people aware of the concepts in question. But this is not in itself enough to attract the interest of readers. To make the dictionary relevant to practicing clinicians and students learning Chinese medicine in order to practice it, we had to include a large amount of clinical information.

This was a departure from the model established by Western medical lexicography, but the idea was by no means a new one. As Chinese medical lexicography advanced in the 1980s, it started to provide clinical information in addition to definitions. In particular, it provided detailed symptoms, pattern types, and treatments for diseases.

Following this model, we began adding symptoms, pattern types, and treatments for diseases. And this brought us to another problem. By far the easiest method of creating a dictionary was to work from Chinese dictionaries. For much of the work, that is what we did. We compared the definitions and clinical information of different dictionaries, and worked out from that what we were to put in our own text. Nevertheless, in Chinese-language dictionaries treatments are virtually all medicinal rather than acupuncture treatments. As people in the West have only recently fully comprehended, "Chinese medicine" in China is principally treatment by medicinal therapy, while acupuncture has only minor status. It turned into a major task for my colleague at

China Medical College, Dr. Féng Yè, to search through a host of acupuncture books to find acupuncture treatments for all the diseases in question.

A yet greater problem lay in the absence of linguistic access and the terminological chaos among English-speakers. The whole point of the *Practical Dictionary* was to draw attention to the fact that Chinese medicine is a complex body of concepts represented by an equally if not more complex array of terms. And that need of course arose out of the fact that Westerners did not share our conception of Chinese medicine, and out of the fact that terminological chaos prevails in English expression. How were we to present the entries of the dictionary when not only many of the terms were unfamiliar to Western readers, but also many of the concepts too? There are basically two methods of ordering entries in a dictionary. One is by theme, that is, presenting related concepts together in groups. The other is some sort of linguistic order. In English that means alphabetical order; in Chinese it means stroke order.

In many areas, Chinese medical concepts do not form a neat structure, and sometimes they are not clearly defined. Sometimes, as in diagnostic terminology, it is difficult to tell how synonymous two given terms are. For this reason, the thematic ordering of terms would often be quite difficult.

By contrast, alphabetical order is straightforward because it is essentially mechanical. The problem with alphabetical order is that it can only be used where people are familiar with the terms. In conditions of terminological chaos, a student wishing to look up any given English term takes pot luck, because the concept the term represents may not be explained under the same English term in the dictionary.

Despite this problem, Chinese medical terms are to a very large extent built up out of a relatively small number of kernel concepts: yīn, yáng, qì, liver, heart, spleen, lung, kidney; wind, cold, summerheat, dampness, dryness, and fire, etc. These core terms are relatively standardized, and so grouping them together made quite a lot of sense.

Alphabetical order is not ideal, though, since there are still numerous terms that do not begin with core-words. We tried to compensate for this by including a large amount of cross-referencing between entries. Under *eye* for example, we included lists of eye symptoms and eye diseases that the reader could follow up.

Parts of the Eye

FIVE WHEELS (*wǔ lún*)
EIGHT RAMPARTS (*bā kuò*)
CANTHUS (*zì*)
EYELID (*yǎn jiǎn*)
EYELID RIM (*yǎn xián*)
EYE NEST (*mù kē*)
IRIS (*jīng lián*)
DARK OF THE EYE (*hēi jīng*)
WHITE OF THE EYE (*bái jīng*)
PUPIL SPIRIT (*tóng shén*)
SPIRIT JELLY (*shén gāo*)
EYE TIE (*yǎn xì*)

Eye Signs

CLOUDED VISION (*mù hūn*)
FLOWERY VISION (*mù huā*)
DRY EYES (*mù gān sè*)
EYE PAIN (*mù tòng*)
EYE DISCHARGE (*yǎn chī*)
ITCHY EYES (*mù yǎng*)
AVERSION TO LIGHT (*wù guāng xiū míng*)
YELLOWING OF THE EYES (*mù huáng*)
TEARING ON EXPOSURE TO WIND (*yíng fēng liú lèi*)

Eye Diseases

ULCERATION OF THE EYELID RIM (*yǎn xián chì làn*)
STY (*zhēn yǎn*)
PEPPERCORN SORE (*jiāo chuāng*)
MILLET SORES (*sù chuāng*)
PHLEGM NODE OF THE EYELID (*yǎn bāo tán hé*)
INGROWN EYELASH (*quán máo dǎo jié*)
UPPER EYELID DROOP (*shàng bāo xià chuí*)
WIND-FIRE EYE (*fēng huǒ yǎn*)

EXCRESCENCE CREEPING OVER THE EYE (*nǔ ròu pān jīng*)
FIRE GAN (*huǒ gān*)
BLOOD FLYING TO THE EYE (*mù fēi xuè*)
EYE SCREEN (*mù yì*)
EXTERNAL OBSTRUCTION (*wài zhàng*)
INTERNAL OBSTRUCTION (*nèi zhàng*)
GREEN-BLUE WIND INTERNAL OBSTRUCTION (*qīng fēng nèi zhàng*)
RED AUREOLA SURROUNDING THE DARK OF THE EYE (*wū lún chì yūn*)
RED VESSELS INVADING THE EYE (*chì mài qīn jīng*)
RED BLOOD THREADS (*hóng chì xuè sī*)
TANGLED RED THREAD-LIKE VESSELS (*chì sī qiú mài*)
CLEAR-EYE BLINDNESS (*qīng máng*)
SUDDEN BLINDNESS (*bào máng*)
NIGHT BLINDNESS (*yè máng*)
NEARSIGHTEDNESS (*néng jìn qiè yuǎn*)
FARSIGHTEDNESS (*néng yuǎn qiè jìn*)
MURKY EYE OBSTRUCTION (*hùn jīng zhàng*)
CHILD EYE GAN (*xiǎo ér gān yǎn*)

The work of cross-referencing took an immense amount of time, and had to be continually checked, especially when entries were added and in some cases deleted in the process of building the dictionary. It was worth it, though, because it helped to make the information much more accessible.

Providing clinically relevant information for as many concepts as possible turned into a mammoth task that took ten years to complete. The result was not only a dictionary, but a book that probably contains a large amount of information that has never appeared in English textbooks and clinical manuals before. The clinical information explains why it has been such an immensely successful book. Sales are far higher than that of any other Chinese medical dictionary, and far higher than we had ever thought possible.

As I said, the idea of including copious clinical information in a dictionary is to place a carrot before the donkey, a deliberate act of coaxing an unwilling readership to pay attention to the question of terminology. The wager was a large one, but I think it was won. It is testing fate to spend 10 years working on a dictionary that fills nearly a thousand pages, and expect readers who traditionally don't buy dictionaries to be interested in the product, especially when the publisher prices it at 125 US dollars. Yet it paid off, not so much in monetary terms as in being as successful as we could have ever hoped.

It is increasingly difficult for people to say that Chinese medicine only has a handful of terms. It is simply not true. As you would understand very clearly if you ever tried creating a dictionary yourselves, one fundamental and paramount reason why the terminological issue is played down is that it takes blood, sweat, and tears to address it justly.

It is quite noteworthy that most of the bilingual dictionaries are the work of PRC authors; only three have been produced in the English-speaking recipient community, all of them by one person (myself). The distribution of lexicographical effort between China and the West stands in stark contrast to the fact that the best-selling English-language literature is largely of Western authorship. It would seem that the Chinese seem to be much more aware of the importance of the role of lexicography than Westerners. The efforts of the Chinese undoubtedly springs from their greater awareness (gained through the large-scale adoption of scientific and technical knowledge from the West) of the role of language in the transmission of knowledge. Westerners, on the other hand, have, to a large extent, failed to see Chinese medicine as the product of a foreign culture whose adoption requires mastery of the linguistic key.

Nevertheless, the Chinese have failed to produce dictionaries that meet Western needs. In fact, there is evidence to suggest that their dictionaries are directed toward Chinese readers rather than English readers. Four of the English dictionaries produced in the PRC, the *Chinese-English Medical Dictionary*, the *Word-Ocean Dictionary*, the *Illustrated Dictionary of Chinese Acupuncture*, and the *Chinese-English Terminology of Traditional Chinese Medicine* adopt the "mirror-translation" format, i.e., the text for each entry is given in Chinese with an English translation. Despite their potential use for English-language readers with little or no knowledge of Chinese, this has not been fully realized by the inclusion of an

English index. The tendency to address bilinguals (or the Chinese rather than the Western reader) may reflect a belief among English-language lexicographers that, at the current state of transmission at least, dictionaries of Chinese medicine have little utility for the reader unfamiliar with Chinese. Not surprisingly, these works have not sold well in the West (Felt, personal communication 1999).

Future Prospects

Our work of dictionary-making is by no means complete. When working on the *Fundamentals of Chinese Medicine*, I not only created a database to record my chosen equivalents for general Chinese medical terms; I also began creating databases for acupuncture points, medicinals, and formulas. The contents of the acupuncture points database has been published as part of *Fundamentals of Chinese Acupuncture*. Information from the medicinals and formulas databases has been published (Wiseman 1995a, 1995b), but the databases as a whole are still awaiting completion.

These databases would probably have already been set between covers had we not been working during a time when book production is undergoing one of its greatest revolutions: the move from paper to electronic media. This is not just a change in medium. The possibilities for accessing and manipulation of electronic data are much greater than those offered by the conventional paper-format, but these can only be achieved by appropriate formatting of data.

We nevertheless hope within the next few years to be able to publish a full electronic database system including general terms, medicinals, formulas, and point names. Such a database would, in a single CD package, meet the needs of translators, students, practitioners, and researchers.

This database, we hope, will provide further impetus to the standardization of terminology. The accessing features of the electronic format will demonstrate the need for terminological management in much larger dimensions, since the accuracy of information retrieval depends on whether the user is familiar with the terminology in which the data is expressed.

Conclusion

There is no doubt that the creation of bilingual lists and dictionaries is useful to the transmission of Chinese medicine. Works dealing with terms help people to understand terms, use them correctly, and apply them consistently.

Bilingual lists are the only means by which translators propose equivalents for a comprehensive term-set to the community. They are the only means by which any translator can apply any given terminology. Hence, they are indispensable to the ultimate goal of standardization. No unpublished list can ever become a standard. The alternative to a published list is terminological chaos.

Full dictionaries enable students to be able to identify East Asian medical concepts that often tend to get partially lost in the terminological variation that characterizes the current body of literature. If a term denotes an East Asian medical concept, the concept should be traceable in a good dictionary under some name. Full dictionaries also help students to understand more about Chinese medical concepts, and hence they provide a complement to the literature. Encyclopedic dictionaries, in addition to the above advantages, also provide useful clinical information that once again complements the literature.

Because East Asian medical dictionaries deal with East Asian medical terms and concepts, and aim to relate English terms to the Chinese source-terms, the value accorded to such dictionaries and hence the success with which they can perform their function is dependent upon the recipient culture’s sensitivity to the notion that Chinese medicine is an imported product and to the notion that linguistic access is important.

Although dictionaries of East Asian medicine did not appear until the modern era, they are nevertheless useful adjuncts to study, and are virtually indispensable for any concerted transmission effort. Our experience has shown that a well-conceived dictionary can also be usefully used to attract deserved attention to the question of terminology in a way that other kinds of literature cannot.

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Appendix: Objections

Many of the ideas that I am presenting at this Symposium have been expressed before. A growing number of people are receptive to them. Some, though, are still reluctant to accept them. The most commonly heard objections, and my answers to them, run as follows.

Objection 1: *One doesn't need to read books in order to improve one's proficiency in East Asian medicine.*

Answer: East Asian medicine, at least East Asian medicine of the types being transmitted to the West, has always been very closely associated with book-learning. Close study and memorization of the classics was traditionally always important. A whole genre of mnemonic verses attests to this. I would say that the belief that East Asian medicine requires minimal book-learning derives not from understanding of East Asian medicine, but from an interpretation of it that has been molded by the desiderata of alternative health-care. Alternatives to Western medicine purportedly treat the body holistically and essentially depend on contact with the patient. I think adherents of alternative health practices tend to imagine that because students of Western medicine have to memorize lots of information they will not use to the full in their careers, their heads are so crammed with useless information that they cannot see, let alone get in contact, with their patients. Because adherents of alternative health view East Asian medicine as an alternative to Western medicine, they believe that it cannot be like Western medicine. Actually, East Asian medicine resembles Western medicine very much more with regard to book-learning than people like to think.

Objection 2: *If you don't learn Chinese, then issues such translation and standardization are irrelevant to you as a student or clinician.*

Answer: This attitude in my view is mistaken. Since writers do not always state clearly where their information comes from, it is in your interests to demand clear product descriptions. It is important for you to know whether a text is translated from primary sources or is created from secondary sources. Since you are all end-users in a chain of knowledge transmission, it is in your interests to scrutinize the mechanisms by which information reaches you. You should compare the practices observable in East Asian medicine with those of other fields, and be able to see who is doing the job right in East Asian medicine and who is cutting corners.

Objection 3: *Learning Chinese or Japanese is too much work; one does not need to be a linguist to learn Chinese medicine.*

Answer: Not everyone needs to learn Chinese for the community's knowledge of East Asian medicine to improve. Experience in other fields, however, suggests that people perceive and respond to the need to learn a foreign language that serves as the vehicle of a particular body of knowledge when they a seriously determined to gain that knowledge. In many countries of the world, great emphasis is placed on making university students being able to have full access to the English literature of their field since the English language is now the greatest repository of modern scientific and technical knowledge.

The greatest repository of East Asian medical knowledge is the Chinese language. Any serious effort to acquire East Asian medicine would be characterized by greater emphasis on the need to learn Chinese and other East Asian languages. Learning any language takes considerable effort, but this has to be weighed against the benefits in terms of access to information. The difficulties of learning Chinese are exaggerated, but a more insidious problem is the tendency to underestimate the benefits of learning Chinese. I will be devoting a section of the workshop to this.

Objection 4: *East Asian medicine does not really have a terminology, so there is nothing to standardize. Words are used in different senses, and different*

expressions are used to mean the same thing, so we cannot think of them as terms in the strict sense.

Answer: To this I would say that the *Zhōngyī Dàcídiān*, 中医大辞典, the largest dictionary of general East Asian medical terms, published by the PRC's most important medical publisher, People Medical Publishing House, contains about 32,000 terms. It is true that there is a high degree of polysemy and synonymy in Chinese medicine, but terms are still terms rather than everyday words because it requires expert knowledge to understand them. The Orient's medical community never imposed the same rigor of expression as the modern Western medical community does. That calls for extra care in translation, not gay abandon.

Objection 5: *Source-oriented translation makes texts more complicated than they need to be. To be a good East Asian medical practitioner, one does not need strange terms with specific definitions. We just need to have East Asian medicine explained to us clearly in plain, simple English.*

Answer: Of course everyone wants things to be explained clearly. Many people might like to think that Chinese medicine is a clearly circumscribed body of knowledge that can be acquired, say, in three years of night school. They might wish 2,000 years of medical experience and knowledge of physicians over a large part of the globe to be simpler than it actually is.

A translator's job is to present information present in original texts to the foreign reader. He or she may on occasion have reason to simplify matters when writing for a non-expert readership. But translators presenting technical information to professionals or students training to be professionals as a contribution to the transcultural transmission of a whole body of knowledge have a duty to present faithfully what is there. The body of Chinese medical knowledge is defined by what is available in the Chinese language. If Westerners are to acquire that body of knowledge, they must have a comprehensive and detailed view of its contents. When translators simplify things, distort them to make them readily more acceptable to readers, or omit detail, they may be inadvertently creating the false impression in the reader's mind that East Asian medicine is simpler than it is. This is not the translator's mandate.

Readers reliant for their information on English-language texts should bear in mind that translators may simplify information not only to make things easy for the student, but also for their own convenience. Having to carefully label East Asian medical concepts in English, describe them in detail, and relate the English equivalents to the original terms makes life very much harder for the translator and the publisher.

It is not difficult to imagine that to some degree it is in the interests of translators and readers to keep things simple. But it is also not difficult to imagine that keeping things simple will ultimately hamper our advancement in the acquisition of East Asian medical knowledge.

Objection 6: *East Asian medicine is a healing practice, and this should be borne in mind in all aspects of transmission. English terms should be chosen that can be applied in verbal exchanges with patients in the clinic. Terms like* vacuity, impediment, *and* foxy mounting *are not suitable for use in the clinic because they have offensive connotations.*

Answer: East Asian medicine is a practical healing art, but one which for the most part rests on a considerable body of conceptual knowledge. In the transmission of East Asian medicine, insufficient emphasis has been placed on making sure that the conceptual knowledge arrives in tact. Those who object most strongly to terms such as *vacuity*, *impediment*, and *foxy mounting* are usually people who have no linguistic access to East Asian sources and who fail to see that the English names capture precisely the literal meaning of the Chinese terms. Their objections are based on an understanding of the concepts that attaches to other, in my view, less appropriate equivalents. In deciding matters of translation, people with a sound knowledge of the source language should have a greater say.

As to the connotations of words, translation often poses the problem that it is hard to find in the target language a word that means exactly the same thing as the source-language term it is intended to represent. No translators can achieve the impossible, but good translators get as much over as they can. The most important thing is to find words that express the intended basic meaning. Connotations are of

secondary importance. Anyone seriously studying Chinese medicine knows that the sexual connotations of *foxy mounting* are completely alien to the Chinese medical context.

As to words that one can or cannot use with one's patients, again this is a secondary consideration. Essentially, one need not tell one's patient everything about his or her condition (indeed, usually one cannot, because it would take too long). Western doctors do not use the term *senile dementia* in front of a patient suffering from the illness. What one can tell one's patient can be a highly complex ethical matter. Any practitioner of East Asian medicine would probably not like to say that he was prescribing a formula containing silkworms, earthworms, screwworms, June beetles, bat's droppings, licorice in human feces, needle filings, or tannery tar. Although any other names such as Latin or Pīnyīn that conceal the nature of the entity would certainly be less unpleasant, they would actually be dishonest. However, explaining the East Asian medical view of the patient's complaint can usually be done in quite simple terms. We should not allow patient-doctor communication needs to interfere with the relaying of technical information to the student and practitioner.