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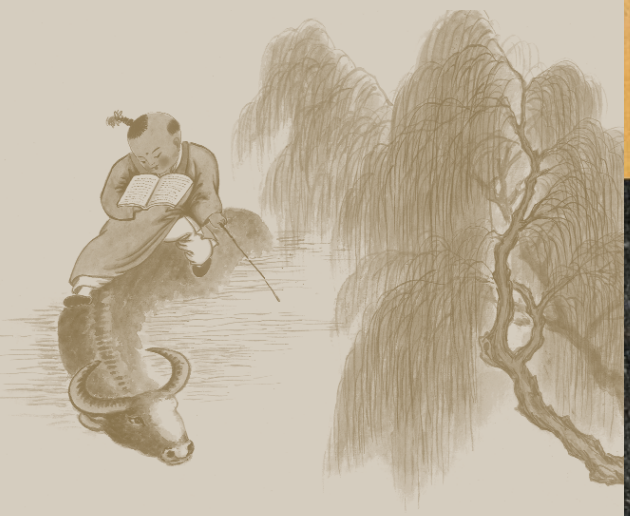

Origin – The Naming

" The buffalo is more than an animal.
It is the sun's shadow.
Our lives are bound to it.
If it lives, we live.
If it dies, we die.
It is our life and our living shield."
—Momaday

Furthering the Path of the Great Unification, the Asian Medical Nomenclature Debates expose the profession to the cultural and translational complexities that occur with the emergence of Chinese medicine in the West.

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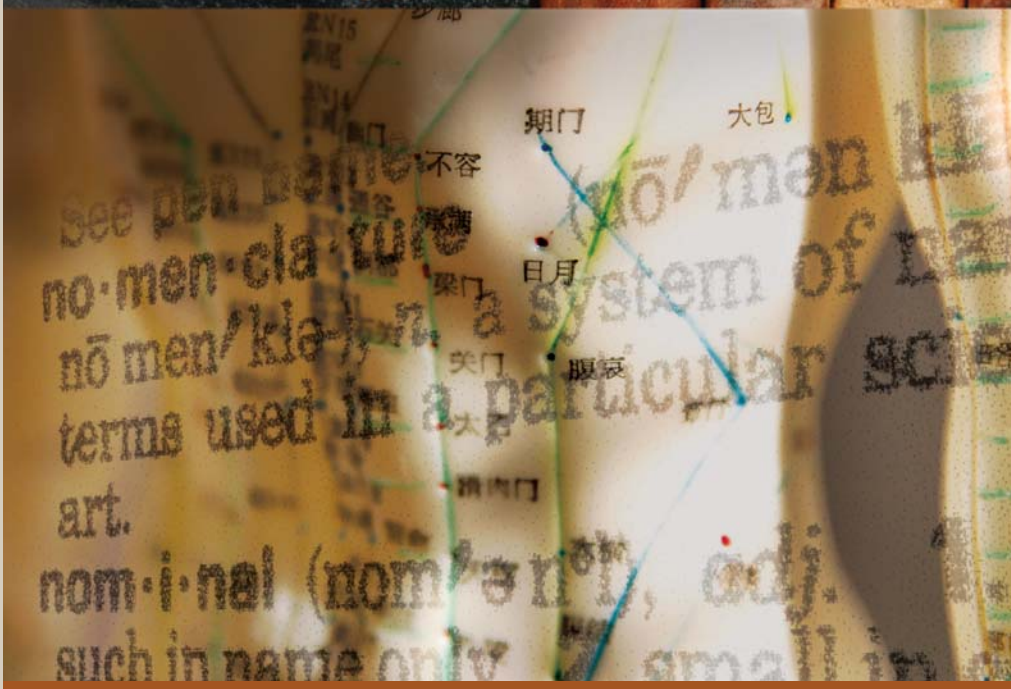

Asian Medical Nomenclature Debates

October 19, 2006

Wigwam Resort and Spa
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Origin – The Naming

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Furthering the Path of the Great Unification, the Asian Medical Nomenclature Debates expose the profession to the cultural and translational complexities that occur with the emergence of Chinese medicine in the West.

Nomenclature and the study of naming objects and ideas are at the core of the medical professional life. They dictate the procedures of medical culture. The descriptions, names and classifications of disease entities are directly tied to the beliefs of the culture within which the medical services are provided. However, there is the risk that professional language can be used politically to exclude and mystify outsiders, holding power over the public (Said, 1996). Take for instance the bombardier who uses the term 'target acquisition' instead of 'bombing a tank.' There are further risks if the goal of glossary standardization is achieved through dominance including alienation, fragmentation and conflict.

Evolutionary Perspective
Genetic and cultural drift have an impact on the development of languages via geological, oceanic and atmospheric conditions. Yet there is no direct correlation between genetic and linguistic drift even though the two often occur simultaneously in varying degrees. The spread of the English language as a standard for scientific nomenclature throughout the world provides evidence of this notion (Gianluca Bocchi, 2002).

We don't know how language evolved in human prehistory, but it is quite reasonable to suppose that the needs of communication influenced the development of these linguistic structures (Chomsky, 2001). For the original humans, definitions were simple. The early observers distinguished and classified the world by labeling objects and activities. Once the original definitions were placed, more subtle and abstract possibilities emerged as humans counted the groupings and classifications of objects and processes. The magical power of naming was transcended by the divine power of numbering (Wilber, 1979). The possibilities presented by drawing a dividing line between objects and events and then labeling them as groups or classes makes pattern differentiation possible.

Language is directly connected to socio-political activities. Recent archeological findings indicate that ever since the demise of egalitarian communities of the Neolithic period, culture has tended to be defined through domination (Eisler, 1987). Linguistic distinctions created in a climate of dominance carry technical and political power. At the same time, they create alienation, fragmentation and conflict; thus in a sense, creating the towers of Babylon. In the words of Edgar Morin, "the differences caused by the diversity of languages, myths and ethnocentric cultures have concealed our common bioanthropological identity"(Morin, 1999).

Grasping the Name

Knowledge and perception are acts of translation and reconstruction (interpretation). Reality is conceived through theories, interpretations and systems of thinking. Knowledge of politics, economics, and medicine is embedded in systems of interpretation which are in turn interdependent with respect to a system of interpretation of the nature of history (Morin, 1999).

Within the polis, conventions of medicine (East or West), humans create conventional medical descriptions that define boundaries. These are based upon actual experiences of life which has no boundaries and then confuse the two. As Korzybski and other general semanticists have pointed out, our words, symbols, signs, thoughts, and ideas are merely maps of reality, not reality itself (Wilber, 1979). This poses a dialectical problem since opposites are often isolated. But these opposites are part of a single underlying reality. This story provides an example of the relationship between words and objects:

> "One day, Korzybski was giving a lecture to a group of students, and he suddenly interrupted the lesson in order to retrieve a packet of biscuits, wrapped in white paper, from his briefcase. He muttered that he just had to eat something, and he asked the students on the seats in the front row, if they would also like a biscuit. A few students took a biscuit. 'Nice biscuit, don't you think,' said Korzybski, while he took a second one. The students were chewing vigorously. Then he tore the white paper from the biscuits, in order to reveal the original packaging. On it was a big picture of a dog's head and the words 'Dog Cookies.' The students looked at the package, and were shocked. Two of them wanted to throw up, put their hands in front of their mouths, and ran out of the lecture hall to the toilet. 'You see, ladies and gentlemen,' Korzybski remarked, 'I have just demonstrated that people don't just eat food, but also words, and that the taste of the former is often outdone by the taste of the latter.'" (Source: Wikepedia).

Korzybski's descriptions demonstrate how conceptual distortions can occur. However, these distortions and inaccuracies, while posing problems on occasion, generate inadvertent solutions. This is part of the beauty that occurs when ideas move from one culture to another. Yet, it is also where a romanticized notion of the medicine can lead one astray.

Personal Approach to Translation

Translational work for me involves a team of practitioners, including native speakers who are culturally connected and have an ability to read modern and ancient characters, as well as native English speakers. Dialogues involving the ideas and concepts continue until a consensus of meaning is achieved and this process is recorded. Then, edits and commentary are conducted with a concern for the integrity of the concepts and the experience of the readership. The value of this process comes from the use of the unconscious deep linguistic structures of each native speaker.

Closing

The current push for a standardized terminology creates clarity for learners and a reduced level of confusion for accurate translational processes. But it also poses risk. The use of political power to mandate standardized translation can create alienation, fragmentation and conflict within our profession. That said, a standardized professional language permits professionals to self-identify; this is part of what creates the boundary between who is and is not in a profession.

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[i] The Buffalo Trust is a non-profit foundation for the preservation and return of their cultural heritage to Native Americans, especially children, founded on the conviction that the loss of cultural identity–and the theft of the sacred–is the most insidious and dangerous threat to the survival of Native American culture in our time.

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Asian Medical Nomenclature Debates
Moderators, Panelists & Contributors Listing

October 19, 2006 – 8:00 AM – 5:30 PM
AAOM Expo 2006 – Wigwam Resort and Spa - (Litchfield Park) Phoenix, AZ

Moderators:

William Morris, OMD, MSEd, LAc, serves as the President of the AAOM as well as President of the Academy of Oriental Medicine at Austin. He has focused on an academic specialty in pulse diagnosis since 1980, teaching and publishing on the subject. Will serves as a site team chair for the Accreditation Commission and a member of the Commission's Doctoral Task Force. Among the many interests related to academic medicine, Dr. Morris also provides prepublication editorial review for Elsevier projects that involve Oriental Medicine.

Master Xiaotian Shen, OMD, LAc, was a physician of traditional Chinese medicine at the Teaching Hospital of Sichuan College of Medicinal C.E, a contributor to various professional journals, and a participant of several research projects. He is a frequent presenter at international conferences. His educational experiences in China and abroad and his interest in public health have furthered AOMA's clinical training collaborations in the Austin healthcare community. Xiaotian Shen is currently serving as the Dean of Clinic at the Academy of Oriental Medicine.

Panelists:

Dan Bensky, DO, is a graduate of the Macau Institute of Chinese Medicine (1975) and Michigan State University College of Osteopathic Medicine (1982), and holds a Master's degree in classical Chinese from the University of Washington (1995). He is currently a director of the Seattle Institute of Oriental Medicine and is in private practice. He is medical editor of *Eastland Press*, a well-known translator of Chinese medical works, and has lectured on Chinese medicine and osteopathy in the United States, Europe, and Japan.

Charles Chace, DiplAc, DiplCH, graduated from the New England School of Acupuncture in 1984. He is the author and translator of a wide variety of books and articles on acupuncture and Chinese medicine including, *A Qin Bowei Anthology*,; with Yang Shou Zhong, a translation of the first textbook of acupuncture from 100 C.E.: *The Yellow Emperor's Systematic Classic of Acupuncture and Moxibustion* (*Huang Di Zhen Jiu Jia Yi Jing*), and with Miki Shima, *Channel Divergences, Deeper Pathways of the Web*. He maintains a clinical practice in Boulder Colorado.

Weiyi Ding, MD(China), RN, Dipl. O.M. (NCCAOM), earned an MD from Shanghai University of TCM in 1976 and an RN degree from Indiana University of Pennsylvania in 1993. Ding was a core faculty member at Shanghai University of TCM for 10 years and is a core faculty member at Bastyr University since about 1996. She has practiced acupuncture and Chinese herbs combined with Western medicine for 30 years which include 8 years RN experience at University of Pittsburgh Medical Center and the University of Washington Medical Center. She is the co-author of several TCM books published in China and has been a member and chair of several NCCAOM examination developing committees for the last 7 years. *(Representing NCCAOM)*

Marnae C. Ergil, M.A., M.S., is a licensed acupuncturist in NY and CA. She began studying Chinese language in 1981 at Middlebury College, where she received her BA in East Asian Studies. She received her Master's degree in Anthropology in 1989 and was funded by the National Academy of Sciences to study the education of practitioners of Chinese medicine in China. She has lived and studied in Taibei, Taiwan and Tianjin, China. Marnae is the translator of Practial Diagnosis in Chinese Medicine and co-translator of Ten Lectures on Chinese Medicinals. She is currently Associate Professor at the New York Chiropractic College, School of Acupuncture and Oriental Medicine.

Robert L. Felt is a principal and partner of Redwing Book Company, Inc, and Publisher of the Paradigm Publications Imprint.

Bob Flaws, DiplAc, DiplCH, FNAAOM, RegAc [UK], is one of our profession's most prolific writers on Chinese medicine in English. Author, translator, and editor of over 100 books and scores of articles in professional journals and general magazines, Bob regularly teaches around the world. Other credits include being a founder and past president of the Acupuncture Association of Colorado, a Fellow and past Governor of the National Academy of Acupuncture & Oriental medicine and past editor of their journal, a Fellow of the Register of Chinese Herbal Medicine (UK), a founder of the Council of Oriental Medical Publishers, and editor in chief of Blue Poppy Press, Inc.

Jake Paul Fratkin, OMD, LAc, DiplAc, DiplCH, has been in practice since 1978, obtaining B.A. in Chinese language and philosophy at U. Wisconsin; Dr. Fratkin trained in Korean and Japanese acupuncture since 1975 and Chinese herbal medicine since 1982; with eleven months advanced training in Beijing at several TCM hospitals (1987-1988). Dr. Fratkin taught full time at acupuncture colleges from 1982 to 1990, and was Chairman of Herbal Medicine at Bastyr College, Seattle, and Southwest Acupuncture College, Santa Fe. He teaches regularly to graduate practitioners on herbal medicine, Japanese acupuncture and medical *qi gong*. Jake is the author of *Chinese Herbal Patent Medicines*, *The Clinical Desk Reference* (2001), and the editor-oorganizer of Wu and Fischer's *Practical Therapeutics of Traditional Chinese Medicine* (1997).

Steve Given, DAOM, LAc, is a Clinical faculty member at Bastyr Center for Natural Health, supervising acupuncture and Oriental medicine and Chinese herbal medicine appointments; department coordinator at Bastyr Center for Natural Health; faculty member at Bastyr University; private lecturer; site visit chair for the Accreditation Commission for Acupuncture and Oriental Medicine; Chair of the Core Curriculum Committee, Co-Chair of the Clean Needle Technique Committee, liason to the NCCAOM for the Council of Colleges of Acupuncture and Oriental Medicine. Steve holds a BS from Portland State University, 1987; a master's degree in traditional

Oriental medicine from Emperor's College of Traditional Oriental Medicine, Santa Monica, CA; and Doctor of Acupuncture and Oriental Medicine from Bastyr, 2006.

Miki Shima, OMD, LAc, served on the California Acupuncture Board and as President of the California Acupuncture Association (now known as CSOMA). He is the author of *The Medical I Ching – Oracle of the Healer Within*, and *Channel Divergences*. Dr. Shima is an internationally recognized Master of Oriental Medicine. Dr Shima and Charles Chase, DiplAc, DiplCH, have co-authored: *"Personal Expositions on the Eight Extraordinary Vessels" by Li Shi-zhen,* which is the definitive book on the subject, published by Eastland Press in 2006. ***AAOM is honored to have awarded Dr. Shima the Lifetime Achievement Award in 2004.***

Sub-Panelists:

Adam Burke PhD,MPH,LAc, is the senior research advisor to the American Association of Oriental Medicine Board of Directors. He is an associate professor in the department of Health Education and the co-director of the Institute for Holistic Healing Studies at San Francisco State University (SFSU). He is a published author and researcher with interest in cross-cultural studies of traditional medicine (India and China), curricular innovation in the areas of holistic health, and studies on meditation and imagery. He also serves as the co-chair of the Alternative and Complementary Health Practices Special Interest Group for the American Public Health Association (APHA), is on the APHA Governing Council.

Craig Mitchell, MSTCM, LAc, received a Master of Science degree in Traditional Chinese Medicine from the American College of Traditional Chinese Medicine in San Francisco (1993). He then studied Chinese language and medicine in Taiwan for several years. He has written numerous articles and translated several Chinese medical texts including the classic *Shäng Hán Lùn*. He is the Academic Dean at the Seattle Institute of Oriental Medicine, where he sees patients, supervises in clinic and teaches classes on herbal medicine and medical Chinese. *(Co-Author with Dan Bensky, Charles Chase, and Jason Blalack, and representative for CCAOM)*

Jeannie Kang, LAc (CA), has studied abroad at Sussex University in Brighton, England, and has received a BA from UC Riverside. She completed a Psychology Residency, Patton State Hospital, Highland, California. She received her MA from South Baylo University. Dr. Kang sat on the Board of Directors and Executive Committee of the California State Oriental Medical Association (CSOMA) from 2002-2006. She currently is the AAOM's representative (advisor) to the World Health Organization (WHO).

Z'ev Rosenberg, LAc, OMD, Chairman of the Department of Herbal Medicine at Pacific College of Oriental Medicine, San Diego, California, has been practicing Chinese medicine in the USA for 20 years. He is trained in both Chinese and Western herbal medicine, having studied Chinese medicine at Southwest Acupuncture College, Santa Fe, New Mexico, and Emperor's College of Oriental

Medicine, Santa Monica, California, and Western herbal medicine at the Institute of Traditional Medicine, Santa Fe, New Mexico.

Contributors:

Jason Blalack, LAc graduated from Pacific College of Oriental Medicine (PCOM) and has since spent time doing advanced study in Asia. He teaches the Chinese Language and Medical terminology class and is a clinic supervisor at Southwest Acupuncture School (SWAC). He has been translating Chinese Medical texts for 8 plus years. He maintains a private practice in Boulder, Colorado.

Kevin V. Ergil, M.A., M.S., is a licensed acupuncturist in NY and CA. He is past president of the American College of TCM, founding Dean of PCOM, NY and currently serves as the Director of the Graduate Program in Oriental Medicine at Touro College. Kevin has been involved in the translation of medical texts into English since the early 80's when he began translating Tibetan medical texts. He is the editor of Practical Diagnosis in Chinese Medicine and the author of numerous articles and chapters on Chinese medicine. Kevin received his BA from UC Santa Cruz in Anthropology and his Master's in Anthropology from the University of Washington.

# # # # #

Asian Medical Nomenclature Debates - Session Overviews

Language is the root of medical practice. The ability to convey medical practices from one culture to another is dependant upon the translational and linguistic assumptions in both the language of origin and the language of arrival. Is standardization necessary? If so, then how does the profession of Oriental medicine concede?

Asian Medical Nomenclature is a complex topic that will span a multi-year duration. A formidable panel was chosen to open the door to discourse and discussion for the purpose of beginning the exploration of transmission of Asian Medical texts to the West.

The Asian Medical Nomenclature Debates provides a forum for a discussion of these vital concerns by recognized experts in the field of Oriental medical education, certification and publication.

A. Part I of II - October 19, 2006 - 8:00 AM – 12 Noon: Nomenclature panelists will each present their position paper, followed by attendee questions and answers.

B. Part II of II - October 19, 2006 – 1:30 PM – 5:30 PM: The workshop will continue with a moderated open debate between all panelists. Audience members will be given an opportunity to provide their positions (limited to 5 minutes per person, based on time availability.) The day's activities will conclude with a moderated Q&A discussion among panelists and attendees. In this two-part workshop, attendees will take away a keen understanding of the depth and breadth of the divergent historical, cultural, and scientific translational complexities involved but, more importantly, its impact on the future of the day-to-day practice of OM and the future sustainability and growth of this profession.

Moderators: William Morris, OMD, MSEd, LAc; Master Xiaotian Shen, OMD, LAc
Panelists: Dan Bensky, DO; Charles Chace, DiplAc, DiplCH; Weiyi Ding, MD(China), RN, Dipl. O.M. (NCCAOM); Marnae C. Ergil, MA, MS, LAc; Robert L. Felt; Bob Flaws, DiplAc, DiplCH, FNAAOM, RegAc [UK]; Jake Paul Fratkin, OMD, LAc, DiplAc, DiplCH; Steve Given, LAc, Miki Shima, OMD, LAc
Sub-Panelists: Adam Burke PhD,MPH,LAc; Jeannie Kang, LAc (CA); Z'ev Rosenberg, LAc, OMD
Contributors: Jason Blalack, LAc, Craig Mitchell, MSTCM, LAc; Steve Ergil, MA, MS, LAc, Dipl. OM (NCCAOM)

Asian Medical Nomenclature Debates Position Paper

By Miki Shima, OMD, LAc

"Teaching Translation requires several areas of discipline for one to become a skilled, professional translator. Moreover, in "specialized translation" one needs not only training in the language of that particular profession but also in-depth knowledge of the field."

General Background

Asian medicine began to take root in the United States after President Nixon visited China in 1970 and observed an appendectomy being performed using acupuncture anesthesia. This news shocked the American people. (Veterinarians were the first to utilize acupuncture as a method of analgesia.) Quickly after Nixon's visit to China, the State of Nevada and the State of California both began to license acupuncturists in the mid-1970's, and a few state-approved acupuncture schools were established. Due to scarcity of English acupuncture literature; schools were forced to use English textbooks from China which were insufficient. However, since then, an increasing number of books on Asian medicine have been written in English and some translations of medical classics have been also published.

About 15 years ago, Bob Flaws and Honora Wolfe of Blue Poppy Press hosted a small, private brainstorming workshop in Colorado where this "terminology and translation debate" began, and the Consortium for Oriental Medical Publishers (COMP) was formed. Hitherto, our profession at the national level has failed to discuss this important issue. After calling this to the attention of the AAOM, its leadership agreed to sponsor a panel discussion on the subject and asked six experts to be panelists. Each of the six panelists was to write a position paper on the "terminology and translation" prior to the debate.

Definition and Concept of Translation

The most classic definition of *translation* in modern applied linguistics states that translation is "the reproduction of the closest natural equivalent of the source language message (Newmark 34)." It further states that, "Teaching such a necessary but tricky subject as translation which is at once a skill, a science, an art and an area of taste must to be discussed." (137). In each of these definitions, translation can be considered an oral or written transfer of a message from one language to another. For purposes of this article and the debate at large, let us consider the scope of "translation concepts" to "a written transfer of a message from a source language to a target language."

Typologies of Translation

R. Roberts categorized written translation in his article " *Towards a Typology of Translations*", Hieronymus Complutensis, *El Mondo de la Traduction*, Vol. 1, 1995, pp. 61-79) into "human translation," "machine translation" and "computer assisted translation." Again, this article is limited to "human translation" from a "source text" to a "target text." "Human translation", which shall be referred to simply as "translation" from now on, focuses on the relationship between the source text Source Text and the Target Text. Using J. Delislie's classification in his "*L'analyse du discours comme une méthode de traduction : Initiation à la traduction française de texts*

pragratiques anglais"(Ottawa, Canada; University of Ottawa Press, 1980, pp. 29-34), we can further subdivide the Source Text-Target Text translation processes into a) "pragmatic translation", b) "general translation", and c) "specialized translation". "Pragmatic translation" is usually used in literature translation like that of novels. "General translation" requires little specific knowledge of any field and is used in translation of daily conversation, magazines, newspapers, etc. "Specialized translation" demands a great deal of expertise of a particular field and translation of Asian medical literature belongs to this category. In any of those three modalities of translation, the Target Text translator must be a native speaker of that particular language. Especially in the case of "specialized translation", the translator must have extensive knowledge of his / her Source Text language. In other words, an English translator of Chinese medical literature must be a native speaker of the English language but must also be extremely knowledgeable about the Chinese language and, in particular, Chinese medical language. To reiterate Newmark's comments in his "Textbook of Translation," translation is a) the reproduction of b) the closest, c) natural equivalent of d) the source language message and teaching such a necessary but tricky subject such as translation which is at once e) a skill, f) a science, and g) an art and h) an area of taste must be discussed". And so, our discussion of these 8 aspects of Newmarks's definition of "translation" begins.

Translation as Reproduction

On translation as a "product", Newmark states that "It is not possible to obtain any figures about the quantity and the areas of the total mass of translation" (Ibid, Ibid. p. 16). This means that a "product" of a translation cannot be precisely calculated. For example, the "product" for [H =$\Sigma[f(x)+f(y)]$ in calculus cannot be accurately translated by the Product Rule in differential equations. Translation as "RE-production" becomes even harder, because the translator as a "RE-producer" must produce a new product from a Source Text into a Target Text. Therefore, the "quantity" of translation as a "product" is not determinable in any manner, and any estimation will not be precise. It is the quality of translation that matters, and the quantity of "product of translation" is a secondary issue.

Finding the "Closest Equivalent"

Between any combinations of Source Text-Target Text translation, there always exist both matched and unmatched zones of semantics. In the case of Chinese-English semantics, there is such a small area of overlapping "semantemes" that it is virtually impossible to find a word-to-word correlation. For example, "hú shàn" in Chinese medical terms has "hú" and "shàn" as its components. "Hú" or "fox" has many translations which overlap in a large area in the Chinese cultural context, but overlap in only a small area in the English context (i.e. "fox" denotes an animal). Likewise, "shàn", a name for certain types of lower abdominal pain in Chinese culture, has many definitions in Chinese, whereas in English there is only one, "mounting." When those two words are put together - "hú shàn", Nigel Wiseman, for example, in his "A Practical Dictionary of Chinese Medicine" (N. Wisemen et F. Ye, Paradigm Publications, Brookline, MA, 1998, pp. 399-400: "Practical Dictionary" from now on) translates it as "foxy mounting" as the "closest equivalent" to "hú shàn". However, the Chinese language is extremely "context sensitive" due to its complete lack of verbal conjugation, article and noun conjugation by gender and number, absence of articles before presentation of nouns, and so on. Therefore, "hú shàn" must be translated in the context of its Source Text, rather than being translated, as in "A Practical Dictionary, without any context at all.

Finding Natural Equivalents

This puts emphasis on "natural equivalents" between a Source Text and a Target Text. For example, in the case of "foxy mounting," the Target Text is not "natural" because no such compound "naturally" exists in English at all. Therefore it cannot "naturally" mean anything. If a patient comes to a doctor in China, complaining of "hú shàng", the doctor would "naturally" know what the patient is talking about. However, if an American patient presents to an acupuncturist in Chicago, for example, and says that she has "foxy mounting", the practitioner would have no idea what that complaint is. This is a clear case of "literal, unnatural equivalent" based on mechanically putting the semantic associations of the two words together in Chinese culture regardless of the context and historical background. If the translator fails to find the most "natural equivalents" between a Source Text and a Target Text, he / she fails to convey the precise meanings from the Source Text to the Target Text. Therefore, the translator must find the most "natural equivalents" between a Source Text and a Target Text in order to carry out successful translation. The type of incorrect, unnatural translation described above often occurs in Asian medical translation when a) there is no pluralism in word selection and b) there is no fixed set of term that allows for flexibility to subtle nuances in semantics. Nigel Wiseman's "Practical Dictionary" contains both of those components and, although it is a glossary of Chinese medical terms, its word-to-word rigidity falls short of providing accurate Asian medical translation into English. This is not Wiseman's fault, and it is not my intent to reflect poorly on his impressive work. It is simply impossible to find "natural" equivalents at all between the two languages.

Teaching Translation as a Skill

It requires several areas of discipline for one to become a skilled, professional translator. Moreover, in "specialized translation" one needs not only training in the language of that particular profession but also in-depth knowledge of the field. For example, in the case of translating Asian medical literature, one needs not only linguistic, theoretical training but also clinical experience in order to translate it correctly. One without the other often produces translators who are unable to produce professional translation. Take, for example, a translation of a Chinese book on herbal medicine, which often contains herbs that are not available in the United States. A translator trained in language only would render the book clinically useless. If, however, the translator is also a current practitioner of Chinese herbal medicine, he / she can suggest substitution in the form of footnotes. Therefore, in order to teach Chinese medical translation as a professional skill, a translator needs to be not only a scholar of Chinese medical language, but also a practitioner of Chinese medicine with knowledge of current legal and clinical medical situations.

Teaching Translation as a Science

Teaching translation as a "pure" science requires Machine Translation or Computer Assisted Translation. Although this paper limits itself to HumanTranslation, it must be noted here that Machine Translation and Computer Assisted Translation also require human intervention called "programming". Based on theories of transformational-generative grammar by N. Chomsky (cf. *Knowledge of language*, New York: Praeger, 1986., *Language and problems of knowledge*: the Managua lectures., Cambridge, MA: MIT Press, 1988; *The minimalist program*, Cambridge, MA: MIT Press, 1995; etc.) and various computer language by IBM, Xerox and others, programming for Machine Translation and Computer Assisted Translation have made progress by leaps and bounds in the past 30 years. They are being tested and utilized internationally by MSN, Microsoft, Google,

Yahoo, and others on the Internet, but such translation still remains far from perfect and there are a great number of technical difficulties to be worked out. In the future, our profession may rely increasingly on Machine Translation and Computer Assisted Translation in order to obtain a "rough" transmission of semantics, which would be helpful for educational and clinical purposes. However, that "rough" transmission of semantics may be very misleading and will always need to be verified by Human Translation.

Teaching Translation as an Art

This is the highest level of training for "the reproduction of the closest natural equivalent of the source language message" (Ibid, Ibid., p.34). In order to achieve translation as an art, one requires all afore-mentioned training and experience. I must state, however, that in all honesty, there are only a handful of individuals in the United State who are capable of teaching such an art.

Teaching "Taste" in Translation

The last but certainly not least significant issue in translation is that of "taste" (or perhaps more accurately stated, "style") in translation. In Asian medical translation, this is a significant problem as every translator seems to choose his / her style of translation arbitrarily, depending on how he / she feels about the style of English in order to transfer the closest, most natural semantics and connotations of a Source Text to a Target Text. The Chinese people have had quite a historical transformation from pre-Han Chinese all the way to modern Chinese, thus it is extremely hard to choose a "style" to reflect not only diachronic changes of the language but also synchronic changes in the Chinese medical culture throughout its history. As more and more Asian medical texts are translated into English, Western scholars will accumulate their knowledge and experience which will help them choose a singular "style" to reflect the appropriate historical and medical context. This will facilitate proper translation of the Asian language Source Texts to English language Target Texts.

Serious Problems of Word-to-Word Standardization of Terminology in Asian Medical Translation

It should by now be obvious that word-to-word standardization is impossible due to the aforementioned aspects of "specialized translation" in the field of Oriental medicine. Let us return to "shàn", which is translated as "mounting" in the "Practical Dictionary" (p. 399-400). It is true that the character "疝"(shàn) has two radicals, one denoting a disease (病) and the other meaning a mountain (山). However, there is no word called "mounting" that denotes disease in the English language, according to Webster's Third New International Dictionary, G&C Merriam Company, Springfield, MA, 1981, pp. 1476-1478. Additionally, while there exists a mountain radical in the word "shan", there is no "natural equivalent" to "shàn" in the Target Text. The "Practical Dictionary" has "Seven Mountings (shàn), which consist of "FOXY MOUNTING (hú shàn); COLD MOUNTING (hán shàn); WATER MOUNTING (shui shàn); QI MOUNTING (qì shàn); BULGING MOUNTING (tuí shàn); PROMIMENT MOUNTING (kuí shàn); BLOOD MOUNTING (xuè shàn); and SINEW MOUNTING (jïn shàn). (Ibid., p. 400). There are no legitimate English words for all the disease names in modern American English. No acupuncturists will see a patient who presents with "foxy mounting" or "cold mounting", etc., which does not make the "Practical Dictionary" very practical in the modern acupuncture clinic. If this type of word-to-word, or more precisely "sematеme-to-semanteme" translation, is to ever be established as the "standard," our profession would neither be useful to the public nor accepted by the mainstream medicine.

Serious Problems of Cross-Cultural Changes in Semantics in Asian Medical Terminology

There are numerous words that have been borrowed by the Japanese language from Chinese during the last 1300 years. These have somewhat different semantics and often completely different meanings. For example, in the traditional Mai Jing (*The Pulse Classics* by Wang Shu-he), there are Shi (excess, replete, full, etc) and Xu (deficient, vacuous, empty, etc.). Those words were imported into the Japanese acupuncture as Jitsu and Kyo respectively, and are often used in very different ways from the Chinese. There is such a diagnosis as "Jin Jitsu" (Shen Shi) or "Kidney excess, Kidney repletion, Kidney fullness, etc." in Japanese acupuncture which is even not registered as a term in Wiseman's "Practical Dictionary". In fact, this concept of "Kidney excess" does not even exist in TCM. However, Japanese acupuncturists commonly use it when the Kidney pulse is full and strong. Another example can be found in a book called *"Shaku Ju Chiryo" (Treatment of Shallow and Deep Stagnation)* by S. Kobayashi (Ido-no-Nippon-Sha, Ltd., Yokosuka, Japan, 2001). "Shaku" is "ji" in Chinese, which originally means "a type of abdominal lump" ("Practical Dictionary", p. 3). "Ju" is also defined as "a kind of abdominal lump" (Ibid, Ibid, p.240). However, S. Kobayashi uses "Shaku Ju" or "Ji Ju" as deep and shallow stagnation of Qi and Blood respectively and is not referring to lumps at all – in the abdomen or anywhere else. These are good examples of cross-cultural transformation of semantics, and it cannot be solved by application of a "standardized approach" in translation. There are so many cases of such transformation of Chinese medical terms in Japanese linguistic situations that I cannot even begin to describe how impossible it is for Japanese translators to use the word-to-word translation method, because the all of the semantics have been transformed, or perhaps more accurately, transferred from Chinese to Japanese.

Possible Direction of Terminology and Translation

As briefly discussed above, "translation" and "terminology" have multi-faceted problems and issues associated with them. Asian medical translation into English in the West only seriously began 30 years ago and is still in its infancy. Therefore, it is quite premature for our profession to reach such an ideal and lofty height that translation is "the reproduction of the closest natural equivalent of the source language message" and can be carried out on a regular basis. In order to achieve that goal, I strongly urge the AAOM to be the national organization where the discussion on terminology and translation can be continued on a regular (i.e. at least annual) basis. I also urge the AAOM to establish a database of Chinese medical terminology in Chinese, Japanese, Korean and English in the spirit of pluralism in medical translation between English and the three Asian languages.

Conclusion

Due to the fact that this is the first national convention to discuss such a subject, I highly recommend that the AAOM add a "terminology-translation section" to its Website not only as a part of its membership drive but also as a place for qualified scholars and translators to post their opinions on each medical term. I also urge the AAOM to establish "criteria of qualification" for scholars and translators of those three languages and to assign a scholarly member to each of the three cohorts to facilitate communication among them.

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Relevant to this article, Dr. Shima is a professional linguist, trained to analyze syntactic structures, phonetics, phonology, semantics, semiotics, etc. of any given language and has analyzed 11 languages in the past. He has been a perpetual student of medical Japanese and Chinese for the last 40 years.

An Extra Thought about Nomenclature of Eight Extraordinary Channels

By Xiaotian Shen, LAc, MS

"As we can see from the many different meanings, a Chinese word or phrase can have an evolutionary process. If the terminology is in the Chinese language, the Chinese characters and phrases used in TCM will not change that much. Yet, after thousands of years of evolution, people's understanding and interpretation of their meanings will almost never be the same."

Translating TCM terminology from Chinese into a foreign language takes more than the direct conversion of a word or a thought. This is because the resulting translated text may lack depth, richness and readability in an alternate language. This paper provides an example of applying the original uses and cultural context to translation. The words in Chinese and their meanings have to first be translated into a current or recognizable thought and then into another language. When we look back at the ancient texts, it is important to understand the original meaning rather than immediately contrast with the contemporary usage of today's language.

When we are looking into the evolution of the TCM language, is it more important to stick to the ancient origins or is it better to keep some traditions? Can there be flexibility with the meanings of the terminologies so they are more understandable and acceptable to modern readers?

In this article it is not the purpose of the author to try to answer this question. Rather, the intent is to use the translations of the names of the eight extraordinary channels as an example of how different a translation can be when the philosophy behind the comprehension of a name is different.

The eight extraordinary channels in acupuncture are the meridians separated from the twelve regular channels. The theories of the eight extraordinary channels first appeared in the *Inner Classics* (Nei Jing), an early book of Traditional Chinese Medicine, and are scattered throughout its several chapters. *The Classic of The Difficulties* (Nan Jing) was the first book that discussed the extraordinary channels systematically and articulated them as eight extraordinary channels (Qi Jing Ba Mai). The *Systematic Classic of Acupuncture and Moxibustion* (Zheng Jiu Jia Yi Jing) detailed the locations of the points on the extra channels. *The Classic of Pulse* (Mai Jing) elaborated on the clinical applications. Finally, *The Investigation of the Eight Extraordinary Channels* (Ji Jing Ba Mai Kao) focused on the extra channels.

The eight extraordinary channels are the Du Channel, Ren channel, Chong Channel, Dai Channel, Yang Wei and Yin Wei Channels, Yang Qiao and Yin Qiao Channels. When the names of the extra channels are translated into English, often times they are perceived as verbs or words of action in their original Chinese language. Governing is for Du, conception is for Ren, penetrating is for Chong, girdling is for Dai, linking is for Wei and motility is for Qiao.

In both Chinese and English texts, the Dai Channel has always been understood as resembling a belt or a girdle around the waist, as suggested by its name Dai. In today's Chinese language, Dai is still a noun that characterizes a belt rather than a verb as in belting or girdling that can be seen in many

English translations. In this case, the Dai Channel is named after a part of a garment (a girdle or a belt), and its name is related to the location of this channel (around the waist). But the question remains as to why the names of the other extra channels are all related to certain activities (governing, conception, linking and mortality) instead of an object? Why do not the names of the other extra channels have anything to do with their locations?

Is the Dai Channel really an exception to the extra channels? Maybe not.

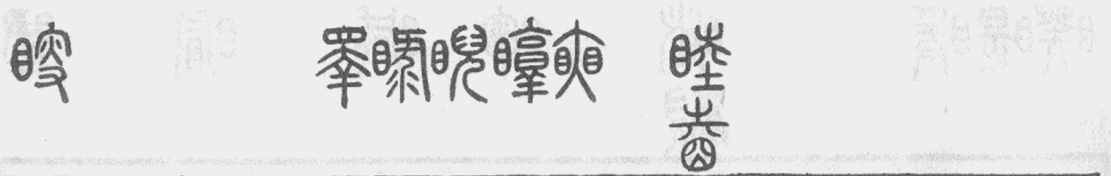
The Du Channel

Du channel is usually translated as Governing Channel in most of the English books we use today for the reason that one of the meanings of Du is to supervise, to guide or to command. However, in ancient times, the Chinese character 督 for Du also referred to the middle seam on the back of a cloth, especially when it is used as a variant (Tong Jia Zi).

The significance of Du as the middle seam on the back can be found in many classic Chinese dictionaries, including *Shuo Wen Jie Zi* (Explanation on Chinese Characters 說文解字), the first lexical work that analyzed the shape of the characters and systematically searched the source of characters in ancient China. It was written by Xu Shen in the Eastern Han Dynasty (25-220 A.D.) and completed in 121 A.D.

The similar explanation can also be found in *Jing Ji Zuan Gu* (經籍纂詁), by Ruan Yuan (1764-1849 A.D.), by Dai Tong (1200—1285 A.D.); *Kang Xi Zi Dian* (Kangxi Character Dictionary, 康熙字典, was completed in 1716 A.D.), and can be located in some modern dictionaries such as Ci Hai (辭海) and Ci Yuan（辭源）

As pointed out in *Zhuang Zi's Life Care Principles* (莊子養生主), the Du Channel runs along the posterior midline of the body, matching the back seam of a cloth. Therefore, the character Du implies the location of the channel.



督【唐書裴度傳】請身督戰 又【說文】目痛也 又【爾雅釋詁】正也【左傳僖十二年】謂督不忘【疏】謂管仲功德正而不忘也 又【增韻】責也【史記項羽紀】聞大王有意督過之【註】督責也 又考也【韓非子揚權篇】督參鞠之【註】考驗盡之也 又中也【周禮冬官考工記匠人註】督旁之脩【疏】中央爲督所以督率兩旁【莊子養生主】緣督以爲經【註】督中也謂中兩閒而立俗所謂騎縫也【六書故】人身督脈當身之中貫徹上下故衣縫當背之中達上下者亦謂之督別作裻 又【奇經攷】督者都也督脈爲陽脈之都綱 又家督長子也【史記越世家】朱公長男曰家有長子曰家督 又大將曰督【後漢郭躬傳】軍征校尉一統於督 又督郵督護都督皆官名 又地名【左傳成十六年】我師次于督揚【註】卽祝柯縣今屬濟南郡又【史記燕世家】荆軻獻督亢地圖於秦【註】督亢燕地徐廣曰涿有督亢亭 又姓望出巴郡晉有督戎 又通作篤毒竺【書微子之命】曰篤不忘【孔傳】篤厚也本又作竺【左傳】謂篤不忘林註謂督厚不可忘也【前漢張騫傳】身毒在大夏東南【李奇曰】一名天篤【師古曰】今之天竺蓋身毒聲轉爲天篤篤省文作竺又轉爲竹音【後漢杜篤論都賦】摧天督【註】卽天竺國按此是督與篤竺毒古𠀤通

睤【廣韻】匹詣切【集韻】【韻會】匹計切𠀤音媲【玉篇】左睤右睨【集韻】睤睨邪視也 又通作俾【史記信陵君傳】俾睨故久立 又通作辟【前漢息夫躬傳】辟倪兩宮閒 又通作睥【晉書列傳】睥睨漢廷 又【宋史儀衛志】睤睨如華蓋而小【唐書儀衛志】作俾倪 又【釋名】城上垣曰睤睨言其於孔中睤睨非常也一作埤堄與陴㙛𠀤通 又【集韻】普米切媲上聲義同 下从丌俗作睥非

睥【字彙】同上

睦 古文 ⿱坴囧【集韻】【韻會】𠀤莫六切音牧【說文】目順也一曰敬和也【博雅】信也【廣韻】親也【書堯典】九族既睦【禮禮運】講信修睦 又州名唐置睦州 又姓【正字通】北齊散騎常侍睦豫 又與穆通【史記司馬相如傳】旼旼睦睦【前漢書】作穆穆 又叶莫筆切音密【易林】種一得十日益有息仁政獲民四國 親睦【六書故】睦目諧也凡人喜愠必形于面目故和爲睦乖爲睽別作睿

睧【集韻】呼昆切音昏目暗也【淮南子原道訓】漢睧於勢利【註】漢睧猶鈍睧不知足也【集韻】亦省作昏

⿻大䀠【唐韻】舉朱切【集韻】恭于切𠀤音拘【說文】目邪也 又【集韻】矢長六指也 又人名彥奭見【宋史宗室表】 又【集韻】果羽切拘上聲義同 又【集韻】俱遇切拘去聲左右視也與䀠同 又【集韻】迄力切音畫邪視貌與奭同【六書統】从目在大之兩旁施目於旁不正也許氏曰斜視或視人之左或視人之右也一作⿱目大

⿰目享【唐韻】之閏切【集韻】朱閏切𠀤諄去聲【說文】謹鈍目也【廣韻】亦作盹 又【廣韻】章倫切【集韻】朱倫切𠀤音諄 又【集韻】殊倫切音純義𠀤同 又他昆切音暾視不明也 又光鑊切音郭目張貌與矌同【說文】本作瞕

睨【唐韻】【集韻】【韻會】𠀤研計切音詣【說文】袤視也【左傳哀十三年】余與褐之父睨之【史記藺相如傳】持璧睨柱【屈原離騷】忽臨睨夫舊鄉 又禽鳥斜視亦曰睨【埤雅】禽經曰雞以嗔睨【王棶補禽經】鴨以怒睨 又日斜亦曰睨【莊子天下篇】日方中方睨【衍義】日斜如人睨目 又人名睨夫見【宋史宗室表】 又與倪堄通睥睨詳睥字註 又【集韻】吾禮切詣上聲義同

睩【唐韻】【集韻】【韻會】【正韻】𠀤盧谷切音鹿【說文】目睞謹也【廣韻】視貌【宋玉招魂】蛾眉曼睩目騰光些【王逸九思】哀世兮睩睩 又【集韻】龍玉切音錄謹視貌

睪 古文 睾【唐韻】羊益切【集韻】【韻會】【正韻】夷益切𠀤音亦【說文】伺視也令吏將目捕罪人也 又【字彙】引也給也 又【玉篇】睪睪生也樂也好也 又【廣韻】引繪貌 又睪泰山名【戰國策】睪黍梁父之陰 又【六書本義】與懌釋同 又【廣韻】尼輒切【集韻】呢輒切𠀤音聶亦伺視也 又【正韻】直格切音宅與澤同【荀子正論篇】側載睪芷以養鼻【註】睪芷香草也或曰睪當爲澤澤蘭也 又【正韻】擇亦作睪 又【集韻】都故切音妒敗也與殬斁通【說文】本作睪从橫目从㚔

睫【唐韻】子葉切【集韻】卽涉切𠀤音接同䀹【說文】目旁毛也【釋名】插接也插于眼眶而相接也【禮內則】豕望視而交睫腥【註】目睫毛交也【莊子庚桑楚】向吾見若眉睫之閒吾因以得女矣【皇極經世】走之類上睫接下飛之類下睫接上類使之然也 又【集韻】七接切音妾義同 又書涉切音攝目動貌與䁝同

本 畫

睭【字彙補】知丑切音帚深也【淮南子兵略訓】深哉睭睭

睼【字彙補】丁念切音店目垂貌

⿰目⿰勿力【字彙補】故巧切嬌上聲【靑箱雜記】應徵拗⿰目⿰勿力者倔强人也

⿱厺目【字彙補】烏插切音鴨媚也

睪【說文】睪本字

㊈

增 **睬**【字彙補】此宰切音彩俶睬俗言也詞家多用此字俶音秋

睾【類篇】古文睪字註詳

瞘【集韻】訖力切音棘張目也

睮【集韻】【韻會】𠀤容朱切音俞睮睮媚貌【前漢韋賢傳】睮睮諂夫

睃【唐韻】【集韻】【韻會】𠀤蘇后切音叟【說文】無目也【玉篇】無眸子也【周語】睃賦矇誦 又通作瞍【周禮春官瞽矇註】有目無眸子謂之瞍【音

The Chinese character 任 Ren does not really have anything to do with conception but it has long been accepted as a variant (Tong Jia Zi) of 妊 which indicates pregnancy or conception. Hence the Ren Channel is usually translated as the Conception Channel.

Yet it was common in the ancient times that 任 could also be used as a variant of 衽 which still indicates the front piece of a cloth or sleeves. Even today, according to *Xinhua Dictionary with English Translation* printed in 2000, Ren (衽) indicates the "front of a garment."

Not only the scholars of Chinese language have associated the Ren to a dress but also some ancient TCM practitioners believed the name of the channel came from that of a cloth. The author of *Notes and Explanations to the Classic of Difficulties* (Nan Jing Shu Zhu, 難經疏注) stated: "任 is used as 衽。 Ren channel is ascending along the front of the abdomen, just like the front of a garment."

作衯集韻通作紟 袡 唐韻汝鹽切集韻韻會如占切𠀤音髯廣韻衣緣也 又禮喪大記婦人復不以袡註袡婦人嫁時上服也儀禮士昏禮女次純衣纁袡註袡之言任也以纁緣其衣象陰氣上任也 又類篇衣下襈也禮雜記繭衣裳與稅衣纁袡為一註裳下襈也婦人蔽膝也小爾雅蔽膝謂之袡 又集韻尼占切音粘義同 又處占切與襜裧同 直音作衻韻會別作紒 衼 唐韻集韻𠀤章移切音支類篇毛衣也 又衹枝法衣詳衹字註 衽 唐韻正韻汝鴆切集韻如鴆切𠀤音妊類篇衣襟也揚子方言褸謂之衽釋名衽襜也在傍襜襜如也禮玉藻衽當旁註衽謂裳幅所交裂也 又禮曲禮請衽何趾註衽臥席也周禮天官王府掌王之燕衣服衽席註衽席單席也 又禮檀弓棺束縮二衡三衽每束一疏小要也其形兩頭廣中央小也既不用釘棺但先鑿棺邊及兩頭合際處作坎形則以小要連之令因漢時呼衽為小要也 又屈原離騷跪敷衽以陳辭兮註衽衣前也 又博雅衽襉袾袑襣也 又集韻忍甚切音稔義同 又類篇或作䘥通作袵 衾 唐韻去金切集韻韻會袪音切𠀤音欽玉篇大被也詩召南抱衾與裯孟子謂棺槨衣衾之美也疏凡衾皆三幅鄭註衾單被也陳子昂詩旖旎光首飾葳蕤爛錦衾 類篇作衾集韻作衾 衿 唐韻集韻正韻𠀤居吟切音今說文衿謂之袊註衣小帶也 又揚子方言衿謂之交註衣交領也詩鄭風青青子衿傳青衿青領也 又類篇渠金切音琴其淹切音鈐義𠀤同 又玉篇巨禁切音妗禮內則衿纓綦屨註衿猶結也儀禮士昏禮母施衿結帨 又前漢揚雄傳衿芰茄之綠衣兮註衿帶也 又通志六書略與襟同 韻會作紟 袀 唐韻居勻切集韻規倫切𠀤音鈞玉篇戎服也後漢輿服志秦以戰國即天子位滅去禮學郊祀之服皆以袀玄左思吳都賦六軍袀服 又純也揚子太玄經陽氣袀睟清明前漢王莽傳時𢇁紺袀服帶璽韍 又綱目集覽偏裻謂之袀 篇海通作均 袧 俗袧字正字通 袁 唐韻雨元切集韻羽元切韻會于元切𠀤音園說文衣長貌从衣叀省聲 又州名篇海漢宜春縣隋置袁州 又姓通志氏族略袁氏嬀姓舜後陳胡公之後裔胡公生申公申公生請伯十八世孫莊伯生諸字伯爰陳濤塗以王父字為氏世為陳上卿亦作轅又作爰史記袁盎漢書作爰 韻會袁从口俗省作表又作袁非是 ⿰衤丑 集韻女九切音紐類篇衣耎也 袂 唐韻彌弊切集韻韻會彌蔽切𠀤音袂玉篇袖也釋名袂掣也掣開也開張之以受臂屈伸也禮曲禮以袂拘而退儀禮大射儀以袂順左右隈前漢鄒陽傳攘袂而正議者獨大王耳 又擔袂國名水經注江口有國號擔袂屬天竺遣黃門字興為擔袂王 又集韻儒稅切音汭莊子漁父篇被髮揄袂李軌云儒稅切 又倪祭切同褹詳褹字註 又類篇古穴切同橘亦袖也韻補沈炯歸魂賦矧古今之悲涼並攢心而霑袂渡狹嶺之欹危跨清津之幽咽 (增) 袃 集韻丑邁切同慸類篇慸芥刺鯁也或作袃鶡冠子世兵篇細故袃蒯 ⿱中衣 篇海類編同衷 ⿱由衣 字彙補音器袖也 ⿱衣冂 類篇同衵 ⿱衣周 五音篇海音凋棺衣也 ⿰衤牙 集韻徐嗟切音斜同衺詳衺字註 ⿰衤井 類篇普患切同襻 ⿱今衣 類篇同衾 ⿴衣凶 直音音凶孝長衣也 ⿱衣冏 字彙補與裔同見海篇註詳七畫 ⿱龶衣 字彙補漢碑表字

(五)

袈 唐韻古牙切集韻居牙切𠀤音嘉廣韻袈裟胡衣也楞嚴經會解袈裟從色得名三衣通稱通鑑武后賜僧法朗等紫袈裟 玉篇亦作䘿類篇本作髮 袉 唐韻徒何切集韻唐何切𠀤音駝類篇裾也 又韻會待可切集韻通拖說文引論語加朝服袉紳 又玉篇袉袉美也 又義同 又集韻他可切音移廣韻長舒貌 ⿱奴衣 唐韻集韻𠀤女加切音拏說文敝衣也一曰繞衸江東通言下裳曰衸 又類篇郎丁切與櫺褸同 袋 唐韻徒耐切集韻韻會待戴切正韻度耐切𠀤音代玉篇囊屬干祿字書作帒 袌 集韻薄皓切音抱六書正譌俗作抱非別詳手部 又唐韻薄報切音暴衣前襟揚子方言襌衣有袌者謂之袏衣郭註前施袌囊也 又朝服垂衣也 又集韻披敎切音炮袌囊衣緩貌 又薄褒切同袍詳袍字註 袍 唐韻薄褒切集韻韻會蒲褒切𠀤音袍長襦也釋名袍丈夫著下至跗者也袍苞也苞內衣也婦人以絳作衣裳上下連四起施緣亦曰袍義亦然也後漢輿服志袍者或曰周公抱成王宴居故施袍 又爾雅釋言襴也禮玉藻纊為襴縕為袍論語衣敝縕袍 又衣前襟公羊傳哀十四年反袂拭面涕沾袍 又禮喪大記袍必有表

The Chong Channel

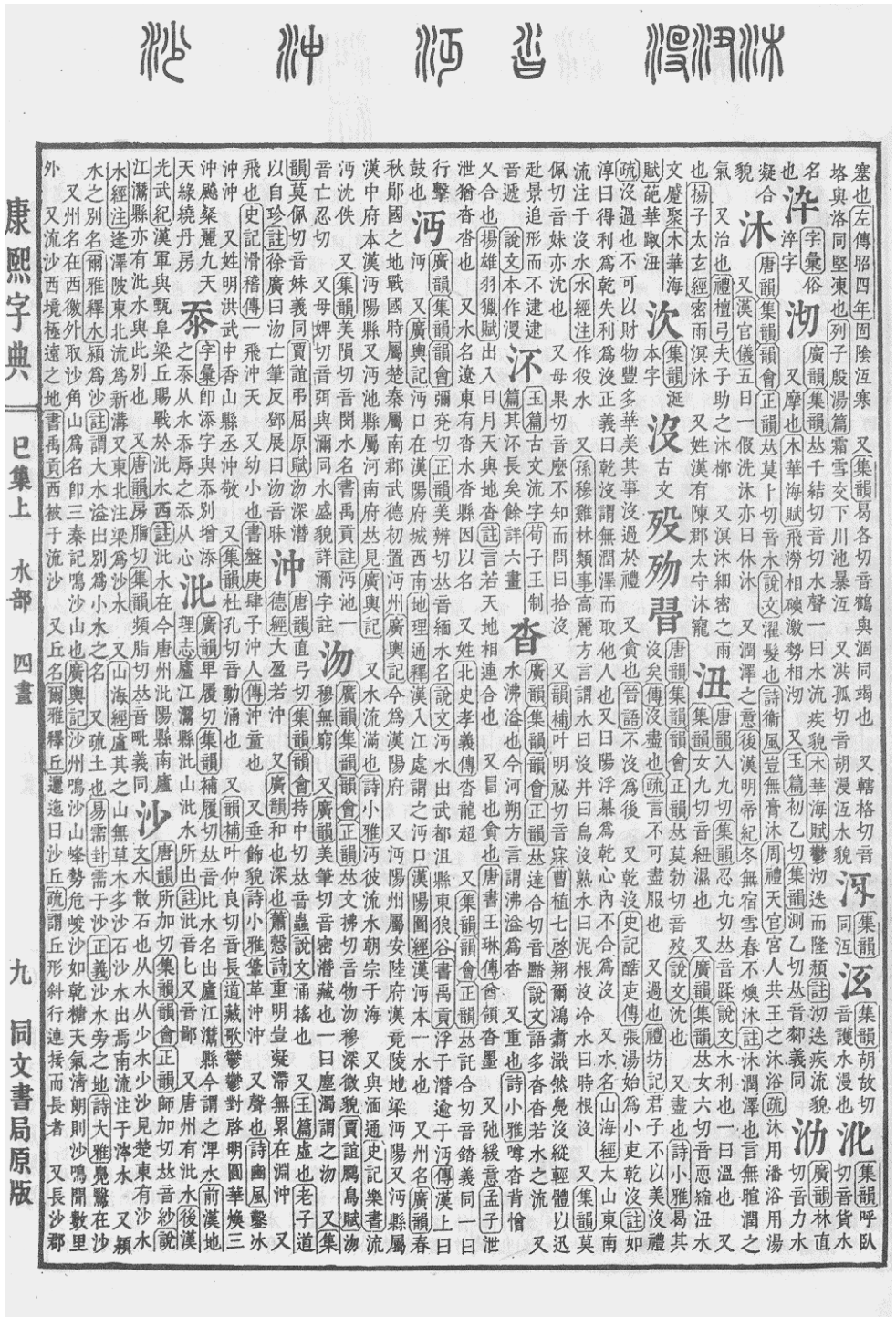
The Chong channel originates from the inside of the lower abdomen and ascends along both sides of the abdomen before it reaches the face.

In most of the acupuncture books in English, Chong is translated as thorough, thoroughfare or penetrating. Almost nobody noticed that Chong also referred to a braid or a ribbon during earlier times.

A good example of Chong used as a decorative hanging on a cloth is a poem from *Shi Jing* (Classic Poetry). The earliest poetry book of China *Shi Jing* is a collection of about three hundred poems. The date of the poems ranges approximately from 1100 to 600 B.C., and the compilation was done probably around, or slightly before, the time of Confucius. *Xiaoya* (*The Minor Festal Odes*) is a part of *Si Jing*. The ancient poem in The Minor Festal Odes said: "Through the thick fog near the water, here comes the gentleman with the leather reins in his hand which looks just like the Chongs hanging there."

According to *Kang Xi Zi Dian* (*Kangxi Character Dictionary*), Chong also indicates decorative hangings on a garment. This indicates that Chong was still used as the word for braid as late as the eighteenth century.

If the Chong Channel runs on the front side of the trunk lateral to the anterior midline, does not it also look just like two silk braids hanging from the front?



康熙字典 巳集上 水部 四畫 九 同文書局原版

The Wei Channels

The Yin Wei and Yang Wei Channels are those connecting the interior and the exterior of the body. Wei could mean to link or to connect when it is used as a verb although it originally also indicated a rope. According to Xin Hua Dictionary, when the character of 維 is used as 帷， it also refers to a bed curtain or a heavy curtain, as well as a sachet worn by people in the ancient times.

Wearing a scented sachet was very popular in China. People use to put herbs in the sachet for the purposes of preventing or treating diseases, as well as for good smell and good luck. Naturally, people could also use a sachet hanging on their clothes to resemble the route of a channel.

The Qiao Channels

As far as the Qiao goes, many people believed that the name of the channels came from one of ancient implications of the Chinese character 跷， which indicates shoes. More precisely, Qiao indicates straw or wooden sandals in the ancient language. In modern Chinese, Qiao is almost no longer used as a noun, but rather as a verb. Some English acupuncture books translate Qiao as motility, which uses the verb version of this Chinese character.

When the term Qiao is used as either motility or shoes, it always has something to do with lower limbs. This also matches the clinical functions of the Qiao channels.

Summary

As we can see from the many different meanings, a Chinese word or phrase can have an evolutionary process. The best interpretation of their original meanings should and could be a big debate even for some already commonly accepted terminologies used today. It's almost inevitable that different interpretations from the original language of Chinese will be brought into existence using English translations.

If the terminology is in the Chinese language, the Chinese characters and phrases used in TCM will not change that much. Yet, after thousands of years of evolution, people's understanding and interpretation of their meanings will almost never be the same. On one hand, the debate on the meaning of the language won't affect the language itself in Chinese. On the other hand, the situation is very different in English. Once someone comes up with a different interpretation of a word, the translation will have to be changed to reflect this new understanding. In other words, how a translator understands terminology will affect how the terminology will evolve in the destined language.

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The Naming of a Medicine

By Adam Burke, PhD, MPH, LAc

We are taught the names of things from infancy, starting with aspects of self and the rudimentary names of significant others. Naming things is fundamental to human nature. A name helps us to identify something, recognize its essential attributes, and understand its relationship to other things. As such, a name is an important aspect of personal, cultural and professional identity and, ontologically speaking, a fundamental characteristic of being in the world. Because a name is used to identify or define, if the thing defined changes significantly, or if the context within which that thing is used changes, then it may become necessary for its name to change as well. One key to successful naming, however, is an agreement of usage so there can be a basis for sharing knowledge and for true understanding between individuals and groups.

A Changing Medicine

Traditional Chinese Medicine, *Zhōng Yī* (中医), is changing, as it has been for millennia. The myriad pages of its rich story have provided us with oracle bone divination, the emergence of classical medicine, significant growth in herbal knowledge, acupuncture and moxibustion during the Tang, Song and Ming dynasties, decay and the threat of abolition under Manchurian rule, revival and modernization in 20th century China, and an increasing international presence in contemporary healthcare. Indeed, the medicine has always been changing. So what is more significant now in the nomenclature debate is not that the medicine is changing, but rather that its modern contexts are changing. Consequently, to find the most suitable name for this medicine it will be essential to consider the modern context in which it now exists.

The impetus to change the name of Chinese traditional medicine, CTM, arises from a variety of forces. One of these is the increasing international recognition and acceptance of the medicine. The naming of things is one of the ways a culture takes ownership of something and creates an identity for it that is contextually meaningful such as the way a family names a child. The very fact that there is interest in this issue suggests that the medicine is a socially recognized and meaningful phenomenon. Although this signifies the health of the medicine, it also presents a challenge. That challenge is to determine the most appropriate name, one which provides patients, scholars, clinicians, and society with the requisite information on identity, essential attributes, and relevant relationships vis-à-vis other forms of healing.

Oriental Medicine

One of the current forces affecting the naming process in the US is the growing voice of Asian Americans. According to the 2000 census, there are approximately 12 millions Asians living in the United States, 4.2% of the population. Within this population the Chinese constitute the largest Asian ethnic group, about 2.7 million people. As Asian communities move into positions of greater influence there is a natural desire to improve perceptions of cultural identity. This has led to efforts to remove the term Oriental from public usage. For example, in 2001 the state of Washington passed Senate Bill 5954, which required that all state and local government documents use the word Asian when referring to individuals of Asian descent. The use of the term Oriental was prohibited.

The word Oriental comes from the Latin root *Oriens*, which means rising sun or east. It was used historically to describe things from the Far East, as compared to the West or Occident, Latin *Occidens*, to set, such as where the sun sets. Today the word Oriental is considered anachronistic by some, representing a term that is ethnocentric and representative of 19th century Western imperialism. The word, , however, is still in popular usage, for example the *Journal of the American Oriental Society* and the Oriental Institute at the University of Chicago. It is also found in wide usage in the Chinese medicine community, with numerous examples of Oriental medicine appearing in professional and organizational titles. Several of the new Chinese traditional medicine doctoral programs, for example, are using the term Doctor of Acupuncture and Oriental Medicine, DAOM. These usages may be maintained by some groups despite cultural changes, as the NAACP has done with its name. However, for new professional and organizational naming, this may become more of an issue as cultural sensitivity promotes change. So forethought at this historical juncture is warranted.

Asian Medicine

In place of the term Oriental there appears to be increasing usage and acceptance of the term Asian. Although more culturally sensitive, adoption of the term is not without its problems in relation to the naming of Chinese traditional medicine. California recently enacted legislation, Assembly Bill 1117; 2005, related to state licensure and regulation of the acupuncture profession. Among other things the bill replaced the name Oriental Medicine with Asian Medicine as the appropriate title for the profession in California. Unfortunately the term Asian Medicine violates a critical aspect of effective naming, specifically, that the name provides information on essential, distinctive attributes and relationships. If the goal is to rename Oriental Medicine, or Chinese traditional medicine, then the term Asian medicine is clearly inappropriate.

The problem lies in what Asia actually represents. Although the exact boundaries of Asia are debated, there is agreement that the Asian landmass includes a geographically, culturally, and linguistically diverse collection of countries such as Uzbekistan to the west, Mongolia and Eastern Siberia in the north, China in the east, India in the south, and Indonesia in the southeast. The US Census considers Asian ethnicity to include individuals with origins from East Asia, Southeast Asia, and the Indian subcontinent. So defined, Asian medicine would include Tibetan medicine, Ayurveda, Siddha, Arabic Unani, Indonesian Jamu, Japanese Kampo, and traditional Vietnamese or Korean medicine, for example. As several of these medicines have their own explanatory theories and clinical applications, some of them quite different from those of Chinese medicine, the descriptor "Asian"' is not useful. If the term Asian is to be used in the naming of the medicine an appropriate modifier would be needed to indicate that it is East Asian traditional medicine, which encompasses China, Taiwan, Macau, Hong Kong, Mongolia, Japan and Korea. This would distinguish it from the practices of other areas of Asia. It would also arguably be the region most geographically, culturally, linguistically and historically related to the Chinese medicine tradition.

Traditional Chinese Medicine

Given these concerns we might consider retaining the term Traditional Chinese Medicine, TCM. The trouble with TCM, however, is that it is viewed by some to represent a limited segment of the medicine and an actual movement away from the source traditions. TCM as so defined is a modernized system developed in Communist China under Mao Tse Tung in an effort to provide healthcare for the underserved, largely rural population. To meet this goal a standardized body of

ideologically acceptable traditional medicine knowledge was organized, representing a synthesis of major principles and practices. This standardization provided a useful platform from which effective large-scale formal education of healthcare providers could be launched. In the 1950's several founding TCM colleges were established and thousands of doctors, both traditional and allopathic, were trained in TCM philosophy and methods. Beginning in 1965 Barefoot Doctors were trained in basic acupuncture and herbal practice and sent out to serve rural healthcare needs. A second major aspect of Mao's modernization process was a focus on a scientific investigation of the traditional methods. This emphasis on scientific validation helped to promote the integration of traditional medicine with modern medicine. It also helped to further distance traditional medicine from its historic philosophical and cultural roots, a movement away from the "old ideas" which were antithetical to the Cultural Revolution.

This sociopolitical process ultimately produced a system TCM which does not find favor among a significant number of contemporary practitioners who seek a deeper understanding of traditional concepts and practices. Even now, due in part to health care reforms instituted by Deng Xiao Ping in the 1990's and to the relentless forces of globalization and westernization in modern China, this drive for modernization persists. Thus TCM is not likely going to change its course in the near future.

Essential Identity

So if Oriental Medicine, Asian Medicine, and TCM are problematic, what is an appropriate name? The object of an ideal naming process is to find a word, or words, that on the basis of collective agreement convey information on essential: (1) identity, (2) attributes, and (3) relationships. In terms of providing information on essential identity, the word *medicine* is crucial. The word "medicine" signifies a comprehensive body of knowledge and practices related to the etiology, diagnosis and treatment of illness and the promotion and maintenance of health. As the essential identity the word "medicine" should be considered for inclusion in any relevant usage, such as use in the titles of state boards and state licenses.

Essential Attribute

The second criterion for a useful name is that it communicates information about the essential attribute of the thing it identifies. The essential attribute of this medicine is provided in the word *traditional.* The medicine is traditional, as compared to modern or scientific. Traditional describes a body of knowledge and behaviors of a culture, or group, that are passed down continuously from one generation to the next. The written legacy of Chinese traditional medicine has been passed down since the Shang Dynasty , 1766-1122 BCE. Ancient concepts, such as the Taoist insights into the nature of opposites and the way of life persist today as a philosophical and practical foundation of the medicine. The knowledge and behaviors of countless individuals, from mountain recluses, to scholar clinicians have informed a tradition with thoughtful perspectives on life, health and existence. Maintaining that tradition is maintaining the medicine. Losing that tradition is losing the medicine.

The unique ancient and non-Western perspectives of this legacy provide one of the primary heuristic values of the medicine, and a potential source of insight to inform our own modern world view about pathways to health and well-being. It is this rich tradition which makes the medicine distinct from other medicines, such as allopathy. If the scientific study of Chinese medicine

isolates key mechanisms and explains the medicine exclusively in modern terms then we would run the risk of losing that tradition and consequently losing the deeper empirical and intuitive wisdom garnered over thousands of years. Scientific inquiry is essential for reasons of consumer safety, medical efficacy, and greater knowledge. Yet what is equally and potentially more important is the revitalization of the broader traditional roots of the medicine. These roots, rather than providing us with reductive insights into the use of a specific herb for a specific carcinoma, can provide insights into the nature of a balanced life. Such ideas may prove significantly more important in the near future for addressing the chronic illnesses of the 21st century.

Essential Relationship

Finally, as there are many forms of traditional medicine, a modifier may be necessary to specify the relationship between these systems, such as a descriptor which specifies the unique cultural and geographic context of the tradition. In that regard East Asian Traditional Medicine would make sense as an appropriate name for the medicine as "East Asian" encompasses the geographic regions most actively responsible for the birth and evolution of the medicine. It is both appropriately inclusive and specific. As such it would be a good candidate for the best descriptor of relationship.

Final Thoughts

Ultimately determining a name for which there is an agreement of usage among key constituencies is important. It should be a name which adequately and appropriately identifies and describes the key elements. There is a growing interest internationally in a variety of traditional medicines. Interest in Ayurveda, Tibetan Medicine, and other schools of thought are gaining a foothold. These medicines have not yet had to struggle with their identity in the same way as CTM, perhaps because they have not yet risen to that level of public scrutiny. At the moment these other medicines have the appeal of an accepted and recognizable brand name. Finding a similar identity for CTM would be useful. Terms like East Asian Traditional Medicine have a practical appeal for their cultural sensitivity, but may be in actual practice less ideal due to their length, for example, a Doctorate in East Asian Traditional Medicine, DEATM, seems cumbersome. TCM has a history of common usage, but its specific meaning is associated with modernization and a reductionist approach to the medicine. One could use the Chinese term *Zhong Yi*, but this was the term adopted by the PRC and associated with TCM; the older term *Yi* simply means medicine and this would convey too little information. Acupuncture and Oriental Medicine has an ease of pronunciation and a cultural appeal for some, with its association with the romanticized qualities of an exotic and mystical Far East. It also carries with it questions of cultural appropriateness and relevance in modern times. There is also a place for the unique indigenous traditions of other countries to be more recognized in name, even those heavily influenced by CTM, such as Korean medicine, or Vietnamese medicine. But in the end, having a singular recognized name as the primary referent is practical for many reasons.

Perhaps returning to the primary source of this tradition, the medicine could just be called Chinese traditional medicine, CTM, or Chinese medicine, with the tradition attribute implied, which has worked for Tibetan medicine. Indeed Chinese traditional medicine is what most students in the United States are trained in, and it is a major element of what they are tested on in state and national licensure exams. The title "Doctor of Chinese traditional medicine", DCTM, or Chinese medicine, DCM, would effectively represent that base of knowledge and historic tradition. It would succinctly provide information on essential identity (medicine), attribute (traditional), and relationship (Chinese). CTM would obviously be a more geographically and culturally narrow

description, as compared to East Asian traditional medicine which recognizes the role of countries like Korea and Japan. It would also exclude reference to the modern contributions made by western countries like France and England. But it would bring the focus back to the root culture, which ultimately is the strength of the medicine, always coming back to the source, that place where the purest medicine resides.

Ultimately people change, places change, and names change. What we hope will endure long after we are gone is the wisdom of this medicine and its power to heal. As Witter Bynner so beautifully put it in his translation of Lao Tzu's *Tao Te Ching*:

Existence is beyond the power of words
To define:
Terms may be used
But are none of them absolute…
If name be needed, wonder names them both:
From wonder into wonder
Existence opens.

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Toward a Working Methodology for Translating Chinese Medicine

By Dan Bensky, Jason Blalack, Charles Chace, and Craig Mitchell

"From our perspective, Chinese medicine is characterized by a conceptual flexibility that encourages multiple-solutions to a given problem. Just as health complaints may be approached from a variety of different models within Chinese medicine, there will always be some variability in how language is used within the medicine. Far from being a problem, this is a characteristic that translators can make use of in transmitting Chinese medicine to the West."

Over the last fifteen years or so there has been a great deal of discussion related to the proper way of transmitting Chinese medicine to the West with a specific emphasis on translation methodology. We are a group of practitioners of Chinese medicine who are native English speakers and who have varying degrees of experience translating Chinese medical texts for a variety of forums. We represent a broad spectrum of translation approaches that includes extensive direct experience with all of the major positions being advocated. Our individual views on the transmission of Chinese medical texts to the West are by no means monolithic, and in some cases they are almost diametrically opposed.

We have joined together to write this article as a positive contribution to this topic. Our aim is to present inclusive perspectives on what we believe are the key issues currently under discussion. In this paper we will define the areas where we all agree. We will present the basic operating principles in which we all work in hopes of helping to define a common ground for all approaches to Chinese medical translation. Although our individual application of these essential premises will inevitably vary among us, they are the principles that ultimately determine the course of our decision-making in specific situations. They include the following:

1. From our perspective, Chinese medicine is characterized by a conceptual flexibility that encourages multiple-solutions to a given problem. Just as health complaints may be approached from a variety of different models within Chinese medicine, there will always be some variability in how language is used within the medicine. Far from being a problem, this is a characteristic that translators can make use of in transmitting Chinese medicine to the West.

2. Glosses are a useful tool for consistently translating Chinese medical terms that are used in a consistent manner throughout the literature. That said, individual Chinese medical texts are frequently characterized by a nuanced interpretation of these terms, and that is precisely one of the things that makes them of interest to Western readers. In light of this, translators cannot rigidly adhere to any fixed term set. Moreover, there are many instances, particularly in the pre-modern literature, where Chinese medical terms clearly do not have the meanings that are often attributed to them today.

3. It is these sometimes very slight interpretive variations of Chinese medical terms that argue against rendering a term with a single English language equivalent. This finds its proper expression in the variability with which translators translate the same word. Another way of saying this is that although there is an overall agreement on the general meaning of Chinese medical terms, they

are also very sensitive to context, which may exert a significant influence on their translation into English.

4. A plurality of English terms for a given Chinese word does not necessarily obscure its meaning. On the contrary, it has the potential for promoting a more well-rounded understanding of that word. Its general meaning may remain the same, yet each well-considered English language translation sheds light on the overall scope of its use in the medicine.

5. By contrast, the rigid application of the principle of one to one correspondence in translating Chinese terms into English easily oversimplifies Chinese medical ideas and tends to obscure the very interpretive nuances that make individual texts worth reading.

6. Translating Chinese medical terms using common English words or using words requiring immediate recourse to dictionary are both valid approaches. Each methodology has its strengths and weaknesses. All translation involves loss; these different methods attempt to limit the loss in overlapping, yet different areas. In the end, we believe that these preferences have more to do with the conceptual biases and aesthetic inclinations of the translators than the effective transmission of the medicine. Chinese medical texts have been accurately transmitted into English using both methodologies. What is more important is how these methodologies are applied.

7. The question of how one defines a "term" in Chinese medicine is quite complex and the implications of that determination have far reaching consequences. If a word has an entry in a Chinese medical dictionary does that make it a term? If so, then the Chinese medical term set is truly massive, and even our current, best English-language dictionary, Wiseman's *Practical Dictionary*[1] is incomplete and, in many cases, misleading. If one defines terms as those unusual words that a non-medical reader would not recognize, or those words that have a special meaning in medicine that is very different from the common meaning, then one ends up with a much smaller and more manageable term set.[2] Furthermore, this determination is not static. When an author uses a common word in an idiosyncratic manner and that usage is worthy of note, any word may rise to the level of a term that needs to be explained. Conversely, terms that are commonly understood by the layperson, even when used in a specific medical context, may not rise to this level.

Although the authors of this paper are not in agreement as to the size of the Chinese medical term set, we believe that its size is not of critical importance because any term set is inherently flexible and changeable. The crucial issue for us is the flexibility and rigor with which these translation choices are made. In practical terms, the gloss accompanying a translated text is an expression of its presumed term set. Glosses must certainly be applied consistently, particularly within a given text, though not blindly. In every instance, it behooves translators to consider if the default term in their gloss is really the best word for the job.

8. The pluralism that we advocate is presented not so much in opposition to the concept of a fixed term set, as it is a perspective that encompasses multiple translation methodologies including a standardized approach. Our critique of fixed term sets and one-to-one translation is presented only as a means of illustrating why we prefer the methodology that we do.

9. Those who engage in Chinese medical translation must have an adequate understanding of the medicine and the language. If this is not the case then it is a virtual certainty that significant errors will be introduced in the process of translation.

As these principles are only meaningful within the context of the translation process itself, we will develop them further by discussing our rationale for translating a few Chinese medical terms.

Pluralism as a Hallmark of Chinese Medicine

Chinese medicine is marked by a few characteristics that we believe are relevant to this discussion. Primary among these is *pluralism,* as throughout the entire history of Chinese medicine multiple approaches to diagnosis, systems of underlying concepts, and principles of treatment have coexisted. Another essential aspect of Chinese medicine that it shares with Chinese culture as a whole is the importance of *context.* Context, perhaps best known in the West as the importance of connections (关系 *guān xi)*, is a concept that permeates all aspects of Chinese culture from the aesthetic of its painting to the grammar of its language. No one, no thing, no concept, no word, and no acupuncture point contains the full gamut of its meaning and importance out of context.

Pluralism and the importance of context lead to a few other important characteristics of Chinese medicine. These are flexibility, fluidity, and appropriateness. The first two (which are two aspects of the Chinese concept 灵活(*líng huó)*, literally "spirited and lively") have to do with being flexible in utilizing the style of practice or modality that best fits the patient and their condition along with a fluid use of the tools and concepts of each style or modality. This is tied up not only with their appropriate use, but also with issues such as the right intervention at the right time, as well as considerations such as dosage and amount of needle stimulation. The opposite of this approach in medicine is considered to be poor practice and is called being rigid or inflexible (死板(*sǐ bǎn),* literally being "as dead as a board"). It is not considered poor practice primarily because it violates the ethos of the medicine, but because a flexible approach gives rise to a greater understanding and is more efficacious. The Chinese medical principles of flexibility, appropriateness, and sensitivity to context run through the following discussions.

Plurality and Sensitivity to Context

Almost all translators utilize the principle of flexibility and adhere to the need for sensitivity to context in their work. For example, the Eastland Press draft glossary[3] states these principles quite clearly and gives many examples, such as glossing the word 避(*bì)* as repels or clears away depending on the context. Nigel Wiseman, arguably the most vocal advocate of one-to-one correspondences and standardization of medical terminology, clearly remains flexible in regard to context in the books that he has participated in writing. This is apparent in many of the entries appearing in his *Glossary of Chinese Medical Terms*. There are, of course, Chinese words that simply have multiple uses. For instance, tongue coats may be 滑(*huá)* glossy, but pulses are 滑(*huá)* slippery. The word is the same, but its meaning differs based on the context in which it is used.

There are also words that are translated slightly differently to better represent nuances of meaning in Chinese. For instance, Wiseman glosses 安(*ān)* as "quiet" yet depending on the context, he translates it as "tranquil," "peaceful," or "resting". Wiseman glosses the common compound 不安 (*bù ān)* as "disquieted," yet he also routinely translates the term as "agitation", "unquiet," "stirring," "fidgetiness," or "restless."[4]

Similarly, Wiseman glosses 走(*zôu)* as penetrate (v.), penetration (n.), and wandering (n.). As soon as Wiseman pairs it with 罐(*guàn:* cup) as in the phrase 走罐(*zôu guàn),* he chooses to translate the phrase as "slide-cupping" not "wandering-cupping." This latter translation would not technically be incorrect, but it fails to clearly convey the meaning. Here Wiseman opts for transparency rather than rigidly adhering to the principle of one-to-one correspondence.

Considerations such as these are the rule rather than the exception in transmitting Chinese medicine into English. The concept of one-to-one equivalence assumes that there is a single best word choice that is applicable in the vast majority of cases. This equivalence is clearly an illusion when even the staunchest proponents of this idea so often find themselves defaulting to a pluralistic approach when actually doing translation work.

Consider, for instance 忧(*yöu*). We prefer to translate this term as "worry, upset, or melancholy" and Wiseman prefers "anxiety." It is one of the seven affects and is (most commonly) related to the lung. But in the opinion of the noted modern commentator on translation, Xie Zhu-Fan, 忧(*yöu)* has at least two meanings. Depending on the context of the usage it can mean grief (忧伤 *yöu shäng)* in modern Chinese) or worry (担忧 *dän yöu)* in modern Chinese). He believes that it means worry when related to the spleen and grief when used in reference to the lung.[5] Clearly, no single word from anyone's gloss will suffice for all these situations.

Flexibility

The goal of translation must be to transmit as much as possible of the meaning of the original words into a reasonable form in the target language. We believe that, while in general, consistency is a virtue, flexibility is also important to achieve this goal. Sometimes this flexibility is built around an understanding of the pluralities of meanings of the Chinese words. One example is the character 败(*bài).* When this character appears in different words it can require a variety of translations because of different meanings of the term in question as well as differences in Chinese and English syntax. At least since the Warring States period, this word has a few different, although closely related, meanings. These include: to ruin, to corrupt, and to defeat. These different meanings show up in Chinese medical terminology where 败毒 *(bài dú)* refers to the defeat of a toxic condition (and can be translated as overcomes toxins). In other cases 败(*bài)* means corrupted or spoiled as in 败血(*bài xuè).* This term refers not to blood that has been defeated or overcome, but to blood that should have been discharged, but has not been (primarily after giving birth), and has spoiled. This can be translated as corrupted blood.

The word 益 *(yì)* is another excellent example of a word requiring flexibility in translation in that it has been used in different ways throughout medical history. Wiseman glosses 益 *(yì)* as "boost," whereas Eastland Press prefers "augment" or "benefit". None of these are inherently incorrect. Some writers have argued for the use of "boost" based on its affinity for suggesting an upward lifting action, particularly in relation to the central qi. This is consistent with Li Gao's use of the word in his *Treatise on the Spleen and Stomach* (脾胃论 *Pí wèi lùn).* This is helpful information as far as it goes. However, in modern times, 益(*yì)* is most frequently equated with the common term "tonify" (补 *bû),* which does not suggest an uplifting action at all.[6] Such an interpretation is evidenced by the common use of the words 益气 *(yì qì)* in describing the actions of herbs such as Glycyrrhizae Radix *(gän câo)* and Citri reticulatae Pericarpium *(chén pí).* The latter herb is said to

have a descending action and the use of 益*(yì)* refers only to its ability to supplement (or add to) the body's qi.

益*(yì)* is appropriately translated as boost if one intends to convey the function of both tonifying and lifting. However, if the text one is translating uses the word synonymously with tonify (补*bû)*, then another word, perhaps "augment," is preferable. This example illustrates that the pre-modern usage of some terms is still prevalent in modern sources. It also illustrates that the meanings of Chinese medical terms do change over time and that there is significant variability of usage between authors. Most Chinese medical writing is characterized by classical and pre-modern quotes imbedded into the modern discussions. These quotes have words and phrases that were written by ancient authors whose word choices are not always consistent with our modern understanding. Sometimes an archaic meaning is more correct for a given context, even if it appears in a modern text.

Even terms that appear to have been used consistently and transparently throughout history merit close examination. Xie Zhu-Fan points out that the meaning and translation of even a common term like 精气(*jïng qì)* is dependent on the surrounding grammatical structure. 精(*jing)* could be an adjective meaning "essential qì." It could be two juxtaposed nouns rendering "essence and qi." 精(*jing)* could also be a possessive noun making the term "qi of essence" or even the inverse "essence of qi" as *The Chinese Textbook of Programmed TCM* course defines it.[7] Rigidly translating 精气(*jïng qì)* as essential qi is clearly a prescription for error. We also have to remember that Chinese medical works have been written by a large number of people over thousands of years without reference to a gloss or a rigidly defined term set. Idiosyncratic usages are common and translators need to be aware of this fact and then deal with different usages appropriately.

Appropriateness

The appropriateness of a translation, even more than the other characteristics that we have been discussing, is a judgment call. A particular translation or approach that may seem spot-on to one group of translators appears to be a particularly poor choice to others. To some, this may be a reason to standardize in order to remove one aspect of subjectivity. To us, this is a major reason not to standardize, both as we realize that different understandings of a word can have their own validity (and therefore can be of use to readers) and because this kind of difference convinces us that we should be a little modest in evaluating our abilities and not carve them in stone just yet. One example of this issue is the word 郁(*yù).* This is translated by Wiseman as "depression" and occurs in such compounds as depressed heat (郁热*yù rè),* exterior depression (表郁*biâo yù),* and liver qi depression (肝气郁*gän qì yù).* Wiseman has written in reference to this word "In Chinese medicine, it denotes stagnation (of qì) due to internal causes, notably in people who are angry, frustrated, depressed, etc."[8] He feels that "depression" is a particularly apt translation as its two main meanings in English are "sluggish" and "sad" and so matches very well with the Chinese medical concept a specific form of qì stagnation as well as the emotional state the word in Chinese represents.

From another perspective, depression is not an appropriate translation at all. The original meaning of the word depression means to be pressed down, a usage that is still common in English. However, the word 郁(*yù)* does not mean this but instead has a set of meanings that relate to being pent-up or stagnated. This connects to its use in Chinese medicine where, as Wiseman points

out above, 郁(*yù)* refers to a type of stagnation. We suggest the word "constraint" as a default translation for this term, although sometimes "pent-up" works better. To us this has the advantage of being accurate and appropriate across a variety of uses. For example in 表郁(*biâo yù)* (which we translate as exterior constraint) cold is compressing the exterior of the body, not slowing it down nor pressing it downwards; the same is true of 郁热(*yù rè)* (which we translate as heat from constraint).

Differences in opinion relating to appropriateness come into play even in terms of the emotional meaning of this term. To some of us, there is a nuance lost when translating 郁(*yù)* as depression as it misses some of the possible cross-cultural distinctions. To the majority of Westerners being depressed is a synonym for feeling low, in East Asia it is common for the experience to be one of being stifled and frustrated. Regardless of whether one prefers to use the word depression or constraint, the important thing is to realize that both are thoughtful translations that can be useful in illuminating this word's broader scope of meaning.

False transparency

Sometimes a literal translation may provide an immediate and succinct understanding of a word. Other times it can be overtly misleading. The compound 拒按(*jù àn)* is an example of how various translations illuminate the overall meaning of a word. 拒(*jù)* is a verb meaning to repel, to resist, or to expel. 按*(àn)* is a verb meaning to press or palpate. Translating 拒按(jù àn) as "refuses pressure" seems straightforward enough, and that is indeed the translation preferred by Wiseman. However, that is not always what the term means. To be sure, patients suffering from appendicitis or peritonitis may have an acute abdomen that is indeed so painful that it physically refuses pressure. In such cases it may well be appropriate to translate this term as "refuses pressure." It is much more common, though, for patients simply say, "ugh, that feels bad when you press there." The sensation is often one of discomfort as opposed to overt pain or tenderness. There is not necessarily any guarding or resistance on the part of the patient. Abdomens that 拒按(*jù àn)* may or may not be distended, and may be accompanied with bloating, but these are not distinguishing features of 拒按(*jù àn)*. On the contrary, it is very possible that abdomens that 拒按(*jù àn)* may be rather flaccid. In most cases, we believe it is preferable to translate 拒按(*jù àn)* simply as "discomfort upon palpation." The choice of a phrase like "discomfort upon palpation" is an example of a preference for transparency in translating medical terminology into English. Advocates of a standardized Chinese medical terminology often argue against this premise on the grounds that unusual terminology disabuses the reader of their preconceptions regarding a term and compels them to look up the meaning of the word for themselves. In this case, readers will find that the *Practical Dictionary* defines "refuses pressure" as "*jù àn* – (of pain or discomfort, especially in the chest or abdomen) to be exacerbated by pressure; a sign of interior repletion." This definition, though brief, suggests that in most cases 拒按(*jù àn)* can be rendered in an entirely accurate and arguably more transparent manner as "discomfort upon palpation." The considerations involved in translating 拒按(*jù àn)* also illustrate that sensitivity to context is essential to an effective translation strategy.

Trade-offs in Translation

We recognize that trade-offs are inherent in every facet of the translation process. For example, some of us prefer to use English translations for traditional disorders where the meaning is immediately apparent. The problem with this approach is that there can be instances when the

preferred translation does not work completely. One example is 痹(*bì),* which, when referring to a disorder, usually refers to joint or muscle pain from a combination of wind, cold, and dampness entering the channels and obstructing them. Based on this understanding, in Eastland Press books this is translated as "painful obstruction," the meaning of which is both transparent and accurate in the majority of cases. The translation used by Wiseman "impediment," emphasizes the obstruction in the channels and while being opaque to the inherent significance of physical discomfort in 痹(*bì),* has the advantage of being able to be used without any further glossing whenever the disease term 痹(*bì)* occurs.

There is one type of 痹(*bì), blood bì* (血痹, *xuè bì),* which is characterized more by numbness than pain. Translating this term as "*blood painful obstruction*" would be somewhat misleading in that it highlights the sensation of pain without acknowledging the distinguishing symptom of numbness. *Blood impediment* is arguably more accurate but it too, fails to evoke the unique quality of this disease. Both translations are approximations of the original scope of meaning.

Properly translating the term 发热(*fä rè)* involves a similar trade off. 发热(*Fä rè)* refers to a subjective sense of fever or heat in the body. Prior to the advent of the thermometer in the 1800's all fevers were subjective so it is quite reasonable to simply translate this term as "fever" when working with pre-modern Chinese medical literature. However, modern readers associate fever with an objective elevation in body temperature, possibly even in the absence of a subjective sense of warmth. One may therefore choose to translate 发热(*fä rè)* as heat effusion when it is used to refer to a subjective sense of heat and as fever when it is used in the modern biomedical sense of the word. Conversely, one may choose a single word like feverishness to convey both meanings. The word 利(*lì)* poses a similar conundrum. One may invariably translate 利(*lì)* with a single word reflecting its most general scope of meaning, or one may translate it on a case-by - case basis, to reflect its precise meaning in a given context. Both approaches are legitimate and strong arguments can be made for each. In the end, these are matters of personal preference, not scholarship.

Yet another translational difficulty arises with terms that mean different things in different contexts. An example of this is 中风*(zhòng fëng)*. In the context of the *Discussion of Cold Damage (Shäng Hán Lùn)*, it refers to a pattern of externally contracted disease characterized by feverishness, aversion to wind or cold, and mild sweating and treated with Cinnamon Twig Decoction *(guì zhï täng)*, which is reasonably translated as either "wind-strike" or "wind-attack." Of course, the exact same term is used in both classical and modern texts to refer to the sudden onset of hemiplegia, loss or distortion of speech, etc., which we recognize as stroke and translate as "wind-stroke." There is neither a difference in the characters, nor a special punctuation mark to indicate these different usages, there is only the textual context and the understanding of the translator to guide the appropriate choice.

Conclusion

As we have seen, the various approaches to translation discussed above are in practice much less polarized than they seem. Those opposed in principle to pluralism and transparency in translation are inevitably drawn in that direction simply for the sake of clarity and readability. Conversely, those opposed to one-to-one correspondences still work from glosses in the interest of consistency. The authors of this paper all differ with regard to the degree that we endorse

standardization and transparency in the translation of Chinese medical texts into English. Wherever each of us may fall along this continuum, we believe that this is nothing more than personal preference. In the end it is of secondary importance. What we do agree on is the following:

Regardless of whether one is an advocate of transparency in word choices or one favors a more technical approach that requires immediate recourse to a dictionary, words that are used in a consistent manner throughout a text should be translated as much as possible in a consistent manner throughout a given text. However, because of idiosyncratic and inconsistent word usage, there are times where this may be impossible and undesirable. If translators state their bias in the introductory notes to a translation, the reader will then know which approach is being taken and what problems may be encountered. For example, a translator who is using a fairly strict glossary approach, which is sometimes referred to as source-oriented translation, should necessarily alert the reader to any instance in which the translator chooses to veer away from the standard term set, because of the importance of maintaining the connection between the source material and the translation. However, this does not guarantee, as seen above, that the words that are pulled straight from the gloss are correct for the usage at hand, which therefore can mislead the end-reader.

However, a translator who is using a less strict, more transparent approach, which is sometimes referred to as target-oriented translation, will by design be making different word choices not specifically connected to the gloss, but to their understanding of the source text. It has been argued that source-oriented translation is truer to the original text, whereas target-oriented translation relies overly much on the translator's knowledge. We would suggest that these approaches are both valid and that each has specific limitations. Either can produce valid and valuable work, and optimally readers are told in advance which approach has been used.

Glossaries and dictionaries are useful in one way in the context of lexicography, another way in the context of translation, and yet another way in the context of reading texts. Thus, the degree of standardization and consistency required for the accurate production of a dictionary, glossary, or other reference work, is different than the flexibility required for producing a nuanced translation that accurately transmits the source text into the target language. In fact, the many examples referenced above indicate that a thorough understanding of the source text combined with a flexible approach to translation is the linchpin of effective translation.

Whatever the methodological bias of the translator, all quality translations will inevitably incorporate aspects of standardization and pluralism, accurately transmitting the meaning of a text in a manner as accessible as possible. Arguments advancing one extreme of this continuum or another are inconsistent with the realities of translation work.

In this paper we have used our areas of common agreement as a basis for defining what we consider to be the essentials of translating Chinese medical texts into English. We have suggested a template for articulating a model of Chinese medical translation that is pluralistic, inclusive, and consistent with the sensibilities of Chinese medical thinking. It is our hope that we have defined a position that will resonate with those in the Chinese medical community who are looking for a

reasonable and intellectually rigorous middle ground in the discussion of translating Chinese medical texts into English.

[1] Wiseman, N., Ye F. (1998). A Practical Dictionary of Chinese Medicine (2nd Edition). Brookline, Massachusetts: Paradigm Press

[2] An example of this would include the "Draft Glossary for Chinese Medicine" by Eastland Press. Note that in this gloss, no clear demarcation is made between technical terms and other words.

[3] Eastland Press (2006). "Draft Glossary for Chinese Medicine." Available at http://www.eastlandpress.com/upload/_pdf_20060316150625_2/draft%20Glossary%203-13-06.pdf

[4] Wiseman, N. (2005) Chinese-English Dictionary of Chinese Medicine CD Version 4.

[5] Xie Zhu-Fan (谢竹藩)(2003) Standard TCM Nomenclature: On the standard of Nomenclature of Basic Chinese Medical Terms (IV), CJIM 9(2), p. 148-151

[6] Wu Da-Zhen, Yu Chuan-Long (总编 吴大真 余传隆) (1995). Standard Dictionary of Chinese Medicine (中医辞海), 中国医药科技出版社, p. 1157

[7] Xie Zhu-Fan (谢竹藩) (2002). Standard TCM Nomenclature: On the standard of Nomenclature of Basic Chinese Medical Terms (II), CJIM 8(3), 231-234.

[8] Wiseman, N. "Against Anti-terminology" issued on the Chinese Herbal Academy Listserv, August, 2002, 12.

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Issues Surrounding the Translation of Chinese Medical Texts into English

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"Although driven by different considerations, the terminological choices made by both Chinese and non-Chinese authors and translators of Chinese medicine texts have greatly affected what students and practitioners learn and understand about Chinese medicine."

Introduction

This essay is based on a comprehensive analysis of conditions that significantly inform the translation of Chinese medical texts into English. Because of limited space this analysis is not presented in its entirety (expanded version available at www.aaom.org). However, several distinct circumstances must be considered when addressing the problems surrounding the translation of Chinese medical texts into English. These are the fact that Chinese medicine has been a text based practice since antiquity, that distinctive authorial conceits informed the production of classical Chinese texts, that the processes of engaging classical texts from the linguistic perspective of different historical periods present specific problems of their own, and that the contemporary production of marketing of texts both in China and the English speaking world are distinctively and historically determined. These topics are discussed in greater detail in the full text version.

In this essay we will examine formal translation theory and then explore the issues in Chinese medicine text translation and how formal translation theory might be applied to support the development of the field of Chinese medicine translation. We will discuss the development of the Council of Oriental Medicine Publishers (C.O.M.P.) and its role in the development of Chinese medicine text translation. Finally, we will conclude with a discussion of the debate over translation types in Chinese medical text translation and the argument for formal, denotative or functional translations.

Translation of classical and modern Chinese medical texts into English, has, in the last 20 years, set the stage for an often heated and generally lively discussion. This debate has crystallized over the question of the choice to use denotative / functional translations that use a standardized terminology freely available to readers in the form of a glossary versus the use of connotative translations where terminology is more loosely glossed, and where the text is interpreted by the author for his/her perception of the audience that is being addressed.

The Nature of the Problem & Perspectives on Translation

Systematic analysis carried out by the authors suggests that over the last 20 years, within the field of Chinese medicine, several issues concerning the translation of Chinese medical texts into English can be identified. These include:

- *For texts translated by native Chinese speakers and published in China:* Oversimplification of material; Errors and poor English; Use of biomedical terminology for Chinese medicine concepts
- *For texts translated by native English speakers:*

"Scholarly" vs. "Clinical" translations; Free or loose translations (connotative) vs. Formal (denotative) translations; Interpretive use of language depending upon context vs. standardized terminology that refers to a published glossary

- *For all texts, there exists the issue of an understanding of the audience being addressed.*

Interestingly, these are issues that have been under discussion in the more formal realm of academic translation for nearly 70 years. While the fundamentals of debate are essentially the same, the issue in Chinese medicine is complicated by the fact that translations are informing clinicians who will use the information obtained from the textbooks to treat patients. In addition to an academic or theoretical understanding of the information, there is also the patient and their wellbeing which must be considered. These texts are, without a doubt, translating technical material. However, this material is complicated by the nature of the Chinese language, especially classical Chinese and by the nature of an individual author's use of his own, personal clinical information in the form of case studies or interpretation of theory.

Formal Perspectives on Translation

Before further examining the specific issues of Chinese medical text translation, a brief discussion of the history of similar questions within the field of translation may be useful. The field of translation theory is far too large to be fully summarized; however a few notable arguments will be presented to clarify the debate that is on-going within the field of Chinese medicine translation. We will examine the work of Walter Benjamin and his discussion of translatability and the task of the translator, and the work of Eugene Nida and his discussion of the two poles of translation and the factors that inform the type of translation that a translator does as well as his definitions of the audiences that might be addressed. The work of these two authors, though not representative of the entire field of formal translation theory encompass the issues that are present in the translation of Chinese medical texts.

Since the middle of the eighteenth century, translators and translation theorists have worked to encourage a "respect for the foreign in the original source-language text"."[1] By 1923 when Walter Benjamin's "The Task of the Translator" was first published this sense of responsibility to the original was pre-eminent. Assuming this responsibility, Benjamin asks the next relevant question: is the audience for whom the translation is being done to be considered when making linguistic choices? His answer is an emphatic no. "If the original does not exist for the reader's sake, how could the translation be understood on the basis of this premise?"[2] Benjamin goes on to discuss the 'translatability' of a text as the basis for whether or not it should be translated. His view is that "translation…serves the purpose of expressing the central reciprocal relationship between languages…If the kinship of languages is to be demonstrated by translations, how else can this be done but by conveying the *form and meaning* of the original as accurately as possible. [emphasis added]"[3] and finally, "The task of the translator consists in finding that intended effect upon the language into which he is translating which produces in it the echo of the original."[4] Benjamin argues that fidelity to the original does not mean the demise of freedom in translation. Rather, freedom in translation comes when the fidelity to the pure language of the original text is such that the translator is able to "liberate the language imprisoned in a work in his re-creation of that work."[5]

Forty years later, although not writing in regard to this area specifically, Eugene Nida[6] clearly delineated some of the issues with which modern translators of Chinese medicine are currently

grappling. Nida discusses two poles of translation: "free or paraphriastic translations as contrasted with close or literal ones."[7] Within these two poles there clearly are a variety of alternatives, ranging from a strict one-to-one correspondence to a "close formal and semantic correspondence…generously supplied with notes and commentary" to a translation where the translator is "not so much concerned with giving information as with creating in the reader something of the same mood as was conveyed by the original." A formal equivalence translation is directly focused on the message of the original author, both in terms of form and content. Here "one is concerned that the message in the receptor language should match as closely as possible the different elements in the source language." This type of translation requires a significant glossary that refers to the variety of different contexts in which a specific work might appear and that "permits the reader to identify himself as fully as possible with a person in the source-language context, and to understand as much as he can of the customs, manner of thought and means of expression."[8]

In a free or paraphrasiastic translation the translator is less concerned with matching the message between the source and receptor languages than he/she is with the dynamic quality of the text. In other words, he/she is concerned that the "relationship between receptor and message should be substantially the same as that which existed between the original receptors and the message."

Nida's discussion continues with the idea that there are three primary factors that inform differences in translations. These are: the nature of the message, the purpose or purposes of the author and, by proxy, of the translator and the type of audience. Messages may be more or less focused in content or in form, or they may be equivalently focused within both. The purpose of the translator should be essentially equivalent to that of the author, but this is not always the case. Finally, in contrast to Benjamin's assertion that the audience should not be a determining factor in a translator's decision making process, Nida explains that one's audience must determine, to some degree, the type of translation to be done. He clearly outlines the 4 basic audiences that may be addressed by a translation and their 'decoding' ability. These are: "(1) the capacity of children, whose vocabulary and cultural experience are limited; (2) the double-standard capacity of new literates who can decode oral messages with facility but whose ability to decode written messages is limited; (3) the capacity of the average literate adult who can handle both oral and written messages with relative ease; and (4) the unusually high capacity of specialists (doctors, theologians, philosophers, scientists, etc.) when they are decoding messages within their own area of specialization."[9] In Chinese medicine text translation the debate over the audience being addressed is polarized between those translating for an average literal adult and those translating for a specialist in the field of Chinese medicine.

From the 1960's to the present, translation theory has continued to discuss the translatability of texts, the nature of translations and the extent of interpretation that occurs in any given translation. The field of Chinese medicine text translation must continue to work to resolve the fundamental issues of text translation and the questions of our audience, of the existence a technical vocabulary within the field of Chinese medicine and of the value of connotative vs. denotative translations.

Translation Theory as it relates to Chinese Medical Text Translation

At this point, further illustration of the Chinese medical text translation issues will help to clarify how an understanding and relationship to formal translation theory may aid translators of Chinese medical texts in their work.

Chinese publications and the problem of simplification

Texts published in China, like Chinese Acupuncture and Moxibustion or the Library of Traditional Chinese Medicine suffer from errors of inconsistency and inaccuracy as well as simplification and the liberal use of biomedical terminology. Works on Chinese medicine from China have been translated either by Chinese physicians who are not linguists but know some English or by individuals who speak English as a second language but do not know much about Chinese medicine. After the translation is 'complete' they are sent to a native English speaker for 'editing'. The skill and fluency with the learned language is rarely sufficient to have the ability to access the nuances of language in the learned language. If the translator is a physician who knows English, their English is generally limited to the technical terms of biomedicine. If the translator is more skilled at language but has no understanding of medicine, then the translator often does not understand the meaning of the word in its context in Chinese medicine.. Thus, when a word is translated, they are unaware of all of the contexts in which a character might be used. Finally, few of these individuals are trained in the techniques of translation. They do not understand the possible need for consistency of terminology nor do they understand that, in a relatively technical text, the less interpretation and the more denotative the translation, the better.

Besides the obvious problem of an insufficient and potentially inaccurate text, simplifications such as those that appear in these two sets of books point to two peculiarly Chinese viewpoints regarding Chinese medicine[10]. First, there is the concept that Chinese medicine is a scientific system that can be detached from the cultural trappings of its theory, making theory essentially meaningless. Translations of textbooks by authors who take this viewpoint work hard to make their texts appear as "scientific" as possible, using the language of biomedicine and equating Chinese medicine concepts with biomedical constructs. The idea that Chinese medicine has a scientific nature is, according to some, what permits Chinese medicine to be taught to foreigners and to be spread across the world. At the same time, there is the very commonly held feeling that, because Chinese medicine is a medical system which is so dependent on its theory and that theory is so deeply imbedded in Chinese language and culture, therefore, a non-native Chinese, a 'foreigner' can never really learn and understand the depth of Chinese medicine even if they can read and speak Chinese. These two highly disparate views may be expressed by the same person at different times or in different contexts, and have a deep impact on the translation of texts in China. If the language that is used is more "scientific" i.e. more "Western" then the medicine will make further inroads into western culture. This westernization, coupled with a simplification of the theory for the Western student, will allow the Westerner to learn the technique and have a very superficial understanding of the theory. This then reinforces the idea that a non-Asian cannot really understand Chinese medicine. The translation of the medicine into a new culture thus becomes not a translation but a simplified interpretation. This has contributed to the generally poor understanding of the complexity and depth of the clinical practice of Chinese medicine outside of Asia.

Western translation and the growing debate

Essentially, the debate surrounding translation of Chinese medicine texts, and the discussion that COMP has been having for nearly 10 years, includes two arguments. On the one hand, it is argued that if the language of a translation requires explanation then it is not a good translation. In other words, texts should be translated into language which is readily accessible and understandable to the average reader, (Nida's average literate adult). Proponents of this method argue that this simplifies the task for the student of Chinese medicine and allows the author/translator of textbooks to retain the nuance that he/she understands the source author to have intended.

The other argument is that in China, the language of Chinese medicine is highly technical and it is the job of the teacher to help the students to gain access to the nuances of the language. If an author/translator attempts to retain the nuance, based on their reading of the text, then they are adding an additional layer of interpretation. The argument continues that because the English language actually does contain vocabulary which can come extremely close to relaying the nuances of the Chinese, this more technical language should be used in translation, and glossaries of the language made readily available so that the student, the practitioner or the teacher is freed to understand the nuance in its original context.

Linguistic transparency vs. dynamic equivalence

Linguistic transparency refers to the idea that, through the use of a standard, readily available glossary or dictionary of Chinese medical terminology, the original Chinese of the text becomes essentially transparent to an individual who knows both languages or to a reader who is willing to make the effort to read and understand the definitions of unusual terms. Often the terms chosen as equivalents within this type of glossary are not words in common usage. As Hans Erich Nossack argues,[11] in doing translation, one becomes better acquainted with one's own language. "In order to find an equivalent in one's own language for a foreign metaphor or to communicate a foreign linguistic gesture with a corresponding expression, one is forced to use words that do not belong to his normal vocabulary.

Dynamic equivalency also requires that the translator have greater access to the English language than the average reader. Rather than choosing a term because it has been used before and is in common usage, or because it is more fluent than a less commonly used term, such translators strive to choose terms that will aid in the transmission of the message in a fashion that is appropriate to the receptor culture.

Within the field of Chinese medicine, the earliest work to address the concept of linguistic transparency is that of Manfred Porkert. In 1974 Porkert stated that is was necessary that "we be provided with a methodologically adequate, coherent, and comprehensible account of the Chinese theories in a Western language. Such an account in turn requires consistent use of a precise Western terminology to stand for that of the Chinese authors."[12] The equivalencies that Porkert developed were primarily based upon normative Latin equivalents and/or English equivalents. Porkert clearly stated that the message that he was attempting to relay was the depth of complexity and logical, inductive reasoning associated with Chinese medicine. His purpose was to dispel the notion that acupuncture was simply one of many techniques developed in China and to introduce the theory and premises of Chinese medical knowledge to "medical men everywhere." (his intended audience). Given Porkert's intended audience, his choice of Latin terminological equivalents makes sense (medical men everywhere were thought to share the common language of Latin). As

the type of student of Chinese medicine shifted from the medically trained to individuals with no medical or Latin background, his terminology did not remain transparent. By 1983, when Porkert's second book was published[13] other translators and writers were producing texts that were more linguistically available to the new student of Chinese medicine. By failing to substantially gloss his terminology, to make the Chinese characters available to the reader, and to use linguistically simpler language when it could be used without changing the meaning of the Chinese term, Porkert did not complete the task required to create a useful, fully transparent standardized terminology. He was never able to convince other translators and authors in the field to adopt his language style, and so the ideas that he presented and the work that he did has been essentially disregarded. Like so many new professions, this field threw out the baby with the bathwater and in declining to adopt the language preferred by Porkert, they also declined to adopt the translational precepts that he espoused, preferring to write in language that was more comfortable, more spiritual or more poetic.

The second attempt to develop a systematic glossary of Chinese medical terminology has been much more successful[14] though still extremely controversial. This second attempt refers to the extensive work of Nigel Wiseman. To date, Wiseman is the only individual to produce a systematic, thoroughly researched and readily available terminological gloss of Chinese medicine terms. Wiseman's 1990 Glossary of Chinese Medical Terms and Acupuncture Points and his later Practical Dictionary of Chinese Medicine (1998) are based upon the same linguistic and translation guidelines as Porkert's work, that a normative translation will open the availability of the interpretation of a text to the reader, rather than depending upon the translator for that interpretation.

Wiseman, like Porkert, has been criticized for his somewhat cumbersome and complicated language, although his language is much more readily accessible. His response, quite simply is that "the use of a less frequently used English word makes readers stop and think before they jump to unjustified conclusions based on Western ideas or notions associated with individual English words..."[15], an argument which is highly relevant when discussing the nuances and subtleties of Chinese medicine. Wiseman's linguistic choices are not set in stone, nor does he reject well supported critiques of his choices, but as he states, "failure to reflect the concepts and distinctions of the original Chinese, failure to use terms consistently, and failure to relate terminological choices to the Chinese language are entirely unacceptable because these practices violate the integrity of Chinese medicine"[16]

Proponents of the dynamic equivalence model of translation include the early work of translators such as O'Connor and Bensky and the work of authors such as Giovanni Maciocia who strive to make the material readable, even at the expense of using a linguistically more appropriate term. As Maciocia states:

> It is extremely difficult to translate Chinese medical terminology into English, and nearly every single Western acupuncture book uses different translations for the various Chinese terms. This is understandable as every writer tries to find as close an approximation as possible to the original Chinese meaning. The result is a very confusing variety of different translations for the same Chinese term…I have reviewed afresh all Chinese medical terms and tried to tread a middle way between changing established

> translations whenever I thought it was essential, and keeping certain others on account of established use.[17]

In later work, Bensky et. al. nod to the issue of technical language, but state, " Our overall approach to translation …of technical terms is to make the transmission of the concepts as transparent as possible…While there are many technical terms in Chinese medicine, the majority are more akin to those of wine tasting than of biomedicine, and are likely to be at least somewhat intelligible to the uninitiated."[18] [emphasis added] This seems to imply that it there is an emphasis on "transmission of concepts" as they are understood by the translators and for a literate, uninitiated audience, not transparency of language for an audience of professionals.

O'Connor and Bensky, Maciocia and Bensky et. al. are emphasizing the perceived needs of their audience. Unfortunately, none of these works has an extensive gloss made readily available to the reader. If there is a gloss for Acupuncture: A Comprehensive Text it is not apparent where it can be found or how it was developed. The glossary for the 1st edition of Foundations of Chinese Medicine consists of 1.5 pages, for a total of 56 terms. Admittedly, these were early works in the development of a corpus of literature in the field of Chinese medicine. However, the size of these glossaries indicates that these authors/translators do not feel that the extent of the technical language used is nearly as large as that reflected in the 26 page glossary of Wiseman's Fundamentals of Chinese Medicine or the 429 pages of Wiseman's Glossary and 719 pages of his Dictionary. The newly revised version of the Materia Medica has a 5 page glossary with 57 terms. The newly available online Eastland Press glossary is 24 pages.

The consequences of terminological choices

The result of little cohesion or interaction between translators during the 1970's and 1980's is, as Maciocia says, numerous different translations for the same Chinese characters. That a word may call to mind or signify an idea is clearly understood by linguists. Unfortunately this concept is not so clearly understood by translators of Chinese medicine texts. The ramifications of the failure to understand this are great. Over the years many different English words have been used to represent a single character from a Chinese medicine text. If the words had originally been glossed and the reader could return to the original, this would not pose as great a problem. However, when multiple terms are used and the reader has no way to determine what the original term was, he then has no way of understanding that each term represents the same idea in Chinese. Not only does the meaning of the original character get lost in the shuffle, but new ideas emerge and become a part of the corpus of information that makes up Chinese medicine for the English speaker. Anthropologically this is an extremely interesting phenomenon. From the point of view of a clinician however, it can change the nature of a clinically significant idea and create a great deal of confusion.

The language used to translate the names of the classic 28 pulses of Chinese medicine is a good example. One of these pulses, a *xì mài* is regularly translated as "thready", "thin", "small" or "fine", depending upon the translator. When students and practitioners learn that the character for all four terms is the same, it is a great relief. Students who had diligently been trying to feel the difference between a thready and a small pulse, and to understand the clinical significance of each, are suddenly relieved of a task that could not be accomplished. This becomes clear only when students and practitioners are able to return to the original character. However, because most of

the texts available do not adequately gloss their terminology, there is no point of reference for the student or the teacher. Thus, terms like *xì mai* can take on either new or multiple meanings.

Some translators have argued that one way to avoid this problem is to keep the Romanization (*pinyin*) of the term rather than use any single English translation. The Chinese language is a character based language that contains 4 tones. There may be many words that are exact homophones or that have the same sound but are a different tone. This presents the problem that there is no definitive way to return to the original character from the *pinyin* Romanization.

Detrimental to clinical clarity are the simplification, multiple translations, the use of Romanization, and linguistically inappropriate words. The best example of the occurrence of this is the translation of *bǔ* and *xiè*. The Chinese generally use either the terms "tonify" and "sedate" or "reinforce" and "reduce". While reinforce does carry the idea of adding to or supporting something and might be an appropriate choice, tonify, as it turns out, is not an English word[19] Sedate also does not include the meaning of to draw off or allow to flow, which is implied in *xiè.* "Reduce" does have this meaning and again could be appropriate. Unfortunately, in the Chinese texts, the terms have been used inconsistently and interchangeably. In China, "reinforce" and "reduce" have been used primarily to describe acupuncture techniques. When describing the functions and actions of herbs and formulas however, the Chinese will use "reinforce", "replenish" or "tonify" for *bǔ* and "sedate" or "remove" or "reduce" for *xiè.*

The inconsistency of usage, combined with the use of words which do not accurately convey the idea of the Chinese character, leads the reader to believe that several different functions or actions are possible. Tonify and sedate have become the most commonly used terms in the United States. Wiseman argues that all of the words used to date should be replaced with "supplement" and "drain", thereby relieving the reader of trying to determine what the author is talking about.

In addition to their inaccuracy as translations and the inconsistent way they have been used, the terms "tonify" and "sedate" have been used by English and Chinese speaking authors alike to cover all of the unique terms which are used to describe the various kinds of supplementation or draining.

If one examines the definition of these terms in the Practical Dictionary of Chinese Medicine, we see that there are in fact 11 terms which are used in Chinese texts to describe the different kinds of supplementation, depending upon what is being supplemented, and 10 different terms that are used to describe the various kinds of drainage.[20] Unfortunately, many authors, both Chinese and non-Chinese, have decided, for simplicity sake to use only the one term, tonify or sedate, to describe all of the different forms of supplementation and draining. This decision limits students and practitioners understanding of the subtleties of Chinese medicine and portrays Chinese medicine as much simpler and more straightforward than it is.

The impact of the use of biomedical terminology

The other terminological choice that many translators have chosen is to translate Chinese medicine signs, symptoms or patterns into biomedical signs, symptoms or diseases. For example, most of the texts coming out of China have translated the character *shàn* as hernia, *yōng* as abscess, and *lín* as dysuria. If, however, one looks at the meaning of the characters and the contexts where each can be used, these terms in fact have much more meaning than is contained in the word chosen. *Shàn*

includes the idea of hernia, but also can describe "any of various diseases characterized by pain or swelling of the abdomen or scrotum"[21] *Yōng* also has a much broader definition than just abscess. *Lín*, like *yōng* and *shàn* is broader than just dysuria and includes concepts like urinary tract infections, stones in the urine, gonorrhea and more.[22] In situations like these, there may be no single English word that can convey all of the meanings of the Chinese character in all of its contexts. However, choosing a term that will best cover all of the meanings and then glossing the term in a manner that makes clear all of the possible meanings will allow the reader to understand the breadth of the clinical conversation taking place and to decide for themselves what the author may have been discussing, based upon the context.

The application of Translation theory to Chinese medicine translation

Returning to the traditional translation theory discussed earlier, it seems appropriate to apply Nida's three criterions for determining the best type of translation to the translation of Chinese medical texts.

For Chinese medicine translation, the nature of the message is, in its most basic form, the transmission of theoretical or clinical information. In his critique of Practical Diagnosis in Chinese Traditional Chinese Medicine Deadman states: "For me, the book has two main difficulties. The first relates to the Chinese method of presenting textbook information. There is a traditional way of presenting such material that is rarely deviated from, and this can often fail to answer difficult clinical questions or reflect the true range of clinical variations."[23] Perhaps what is important to consider here is that a part of the message being relayed by the author of the original text is embodied in the form of the presentation. By presenting material in a specific and even precise manner, Chinese authors may be sending the message that by careful, precise analysis, the practitioner will be able to find his/her way to understanding more complex clinical issues. Granted, this almost formulaic manner of presentation may make for somewhat dry reading on occasion, but it is definitely a part of the message concerning Chinese medicine. The message includes the 'information' that is contained within the text, but the other part of the message is that Chinese medicine is a systematic and analytic medical system and that the practitioner must be careful to avoid leaping to clinical conclusions without going through the appropriate steps.

This message may not appeal to all practitioners of Chinese medicine, but it is the manner that those who are considered to be outstanding practitioners have gotten to that point. The knowledge and skill did not just appear, it came through hard work and careful, precise analysis according to the steps as they are outlined. Despite objections to the formulaic presentation of Chinese medicine texts, it is important, as a translator, to remain true to the form when attempting to relay the translator's message.

It is assumed that the purposes of the author/translator are primarily 1) to relay information that can be learned and that will have practical clinical application for the student of Chinese medicine and 2) to help the practitioner/student to understand historical movements and changes in the field of Chinese medicine and how these may have impacted the practice of Chinese medicine at particular periods in Chinese history. In attempting this goal, it is necessary to be as precise as possible. Oversimplification, over interpretation or over westernization can all lead to imprecise translations that leave the reader confused, and in the end may impact clinical efficacy.

Given the highly specific and theoretical nature of the material being translated, it seems most appropriate that the audience being addressed should be considered to be of Nida's last type, the specialist who is highly concerned with the accuracy and detail of the information being related. To write for multiple audiences (lay, student and clinician) leaves all constituencies unsatisfied. Simplifying a text so that it can be 'understood' by a particular audience does a disservice to both the intended audience and the original author. Chinese medicine is a highly complex medical system and should not be viewed, interpreted or translated as anything other. Just because the audience is not Chinese does not mean that the material should be altered to fit the dominant medical paradigm of the receptor culture.

A medical system is inherently a cultural system. It will be adapted to fit into the receptor culture, but that adaptation should come from a place of informed knowledge. As one learns Chinese medicine, one also learns a great deal about Chinese culture. Certain ways of thinking must simply be accepted as inherently Chinese for the student of Chinese medicine to be able to grasp the ideas of Chinese medicine. However, to assume that this is not possible for the intended audience to accomplish is a dangerous and unfortunate path to take. It forces the translator's opinion of he author's intention upon the reader and does not allow the reader the freedom to make informed clinical decisions.

COMP and the struggle over standards

In an attempt to foster a constructive conversation concerning the issues of translation and terminology in the field of Chinese medicine, a group of publishers, authors and translators came together in 1993 to form the Council of Oriental Medicine Publishers (C.O.M.P.). Historically, attempts at conversation between translators with different opinions had, for the most part resulted in yelling matches and hurt feelings. The goal of C.O.M.P. was for the trade (the publishers) to create a Code for labeling publications so the reader can have sufficient information to understand what type of material they are reading. C.O.M.P. developed the following concepts that publishers and authors might wish to apply.

- Guarantee of Validity: a claim of accuracy
- Source Documentation: "describes how an English text relates to a foreign source and how that foreign source fits in its own culture"[24]
- Freely Available Standard Glossaries: "Lists of relationships between words in a foreign language and English words that can be referenced by any reader, author or publisher."

In addition, C.O.M.P. developed the following labels for books:

- Original Document: "writings that claim no authority from any particular foreign source."
- Functional Translation: "based on a foreign source, but the map between that source and the English book is not so firmly fixed that another translator could reproduce the work."
- Denotive Translation: "The map between the original and the English edition is exact."
- Connotive Translation: The work is "grounded in a stylebook and there is a map to the sources" however, the terminology and style of the translation is such that the book is adapted to the culture of the audience.

In creating this voluntary labeling system, C.O.M.P. members are attempting to avoid labeling one type of work as better than another while simultaneously allowing the readership to make informed decisions about the type of information they want to read and to come to informed conclusions about what they have read.

While this solution does not actually address the somewhat complex state of affairs in the field of Chinese medicine translation, it does put the onus of correcting the problem on the consumer. It is not yet clear that authors and translators in the field of Chinese medicine fully understand the impact that their work has on the development of an emerging medicine in the West. This step on the part of publishers, authors and translators is a positive one. By allowing the reader to make informed decisions, C.O.M.P. is acknowledging that the readership ultimately determines the financial success of a text. This does not imply that a text that is not widely sold is not academically or clinically successful; it just may not make any money!

Conclusion

Although driven by different considerations, the terminological choices made by both Chinese and non-Chinese authors and translators of Chinese medicine texts have greatly affected what students and practitioners learn and understand about Chinese medicine. Decisions about terminology may be based upon extensive linguistic research, upon the appropriateness of a term for the specific context of a statement, upon the fact that a term has been used before and so has become the accepted norm or because it is the Western medicine translation of the concept. No matter how or why decisions are made they affect the quality and usefulness of a textbook, a matter which makes the topic of terminology and standardization one that has recently become more important to American publishers, authors and educators

Decisions about the type of translation to do are often quite personal. If, however, authors and translators in the field of Chinese medicine can begin to engage themselves with translation theory and to think carefully about the message, purpose, and audience of their translation, this will greatly assist the field in its development. As we have seen, terminological choices, interpretation and simplification can greatly impact what kind of information is available to the student and practitioner of Chinese medicine and how that information is understood. As the field develops and more complex texts like Paul Unschuld's translation of the *Nán Jīng* or Mitchell et.al's *Shāng Hán Lùn* become available, it is even more important to correctly and fully understand the ideas and the terms which are being used and to correctly label the text so that the reader is aware of the philological rational for the book and has access to the glossary that the book uses. Rather than limiting the field of Chinese medicine translation to language and texts which do not convey all of the clinical information or the actual meaning of the Chinese character, we should supply thorough and philologically precise glossaries which guarantee transparency in linguistic choices so as to widen the field of inquiry and broaden the scope of clinical understanding for the student and practitioner of Chinese medicine.

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[5] Ibid, pg. 80

[6] Nida, Eugene. "Principle of Correspondence." The Translation Studies Reader Ed. Lawrence Venuti. London: Routledge, 2000. 126-140
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[13] Porkert, Manfred. The Essentials of Chinese Diagnostics Zurich: Chinese Medicine Publications Ltd. 1983
[14] Success here is measured not only as financial success (i.e. the number of books sold) but also by the number of translators and authors who have chosen to adopt the terminology and use the available standard.
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[23] Deadman, pg. 49
[24] C.O.M.P. pg. 2

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The Role of Standards in the Transmission of Chinese Medical Information

By Robert L. Felt

"We do not need an arbitrary standard, something imposed from "on high". Neither do we need a hidden standard, something that closes primary markets to investment and development. We need an open standard that encourages competition and development."

I wish to talk about standards and their role in the transmission of information in Chinese medical regulation, education, practice and commerce. Before I do, however, I would like to discuss standards in a more generic context.

Standardization is a concept that is greatly misunderstood. People tend to think of a standard as a set of rules that everyone is forced to apply. People also tend to think that standardization of the English terminology of Chinese medicine means choosing one equivalent for each Chinese term and forcing everyone use that term. Western practitioners are resistant to the idea of standardization—of terminology or anything else—because they fear that it goes against what they consider to be the "spirit of Chinese medicine," which is individual and holistic. They see standardization is limiting their freedom of choice. Excellent ideas like the "Council of Oriental Medical Publishers" (C.O.M.P.) have been poorly received because of this misimpression.

I would like to show you that in the real world, standardization does not mean a single set of rules imposed by a single authority. The actual practice is quite different. In many cases standardization is the existence of multiple implementations that are carefully interfaced with each other. It does not limit personal preferences. In fact, an "Open Standard" gives individuals a maximum freedom of choice. The only people limited by an Open Standard are those who would impose a standard for their own benefit. Like the rule of law, standards avoid capricious and arbitrary controls. A term standard is not a list of words you must use but a method for linking your words to those of others.

The Open Source software movement (http://perens.com/OpenStandards/Definition.html) has an excellent discussion of Open Standards:

> An Open Standard is more than just a specification. The principles behind the standard, and the practice of offering and operating the standard, are what make the standard Open.

Principles

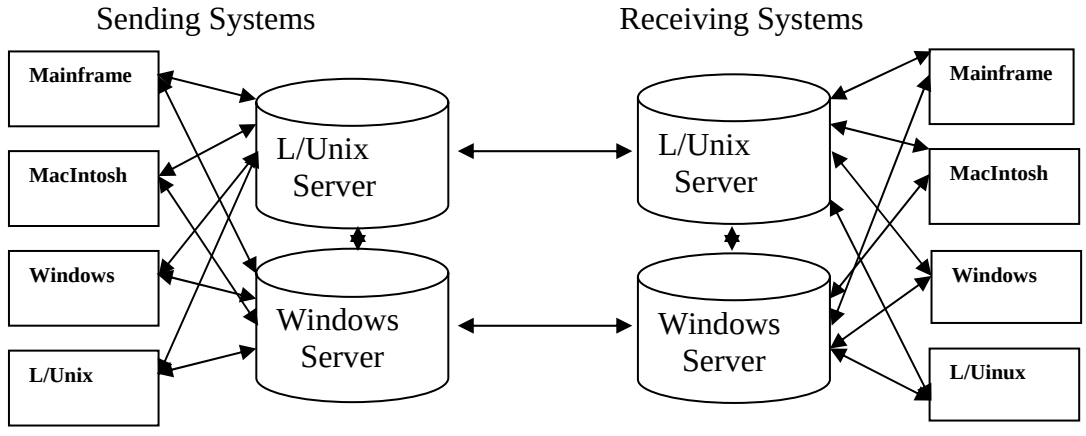
1. **Availability**
   Open Standards are available for all to read and implement.
2. **Maximize End-User Choice**
   Open Standards create a fair, competitive market for implementations of the standard. They do not lock the customer in to a particular vendor or group.
3. **No Royalty**

Open Standards are free for all to *implement,* with no royalty or fee. *Certification* of compliance by the standards organization may involve a fee.

4. **No Discrimination**
   Open Standards and the organizations that administer them do not favor one implementer over another for any reason other than the technical standards compliance of a vendor's implementation. Certification organizations must provide a path for low and zero-cost implementations to be validated, but may also provide enhanced certification services.
5. **Extension or Subset**
   Implementations of Open Standards may be extended or offered in subset form. However, certification organizations may decline to certify subset implementations, and may place requirements upon extensions (see *Predatory Practices*).
6. **Predatory Practices**
   Open Standards may employ license terms that protect against subversion of the standard by *embrace-and-extend* tactics. The licenses attached to the standard may require the publication of reference information for extensions and a license for all others to create, distribute, and sell software that is compatible with the extensions. An Open Standard may not otherwise prohibit extensions.

While the language of these principles is that of the software developer, if you change "vendor" to "publisher," and "predatory practices" to "arbitrary exclusivity," you can see that these principles are equally appropriate for information providers. Anyone who offers Chinese medical information is protected by the standard because everything they need is open and available. The user of Chinese medical information is protected because the standard insures that all information can be accurately accessed and verified.

The internet provides a familiar example that shows how open standards allow information transmission to evolve in an open and cooperative manner. Here is what the internet looks like as a generic image:



On the sending side there are many, many different operating systems and communications programs. Yet, every one of those programs can connect to any server, any service provider.

All service providers and all server systems can exchange data with all other providers and systems. The same is true on the receiving side. This is a perfectly inter-connected network. Of course, in the real world the diagram is much more complex. Not only are there many more personal and server operating systems than those shown but each of the interconnections is complex. Nonetheless, any device can be fit into the system because there are published, technically complete and shared standards for each connection. Any software writer can fit their application to the system. No manufacturer can control any user's choices. Nothing makes this clearer than the fact that to achieve control of the internet the large telecom companies (the arrows in the middle) need congressional legislation to over-ride the "net neutrality" standard, thus creating chargeable services for their own benefit. In short, it takes arbitrary action in favor of powerful insiders to break an open standard.

How Is All This Possible?

This open, perfectly interconnected network is possible because there are standards, available to anyone and controlled by standards agencies cooperatively developed and funded by commercial and academic institutions. In addition to the technical facility necessary to accurate, reliable communications, standards have allowed for contributions from many people. These contributions helped the internet grow quickly, serving vastly different societies at a relatively low cost. In Congressman John Conyers words:

> *The reason the internet has been so successful is that it may well be the most egalitarian medium ever known to man.*

The primary benefits are:

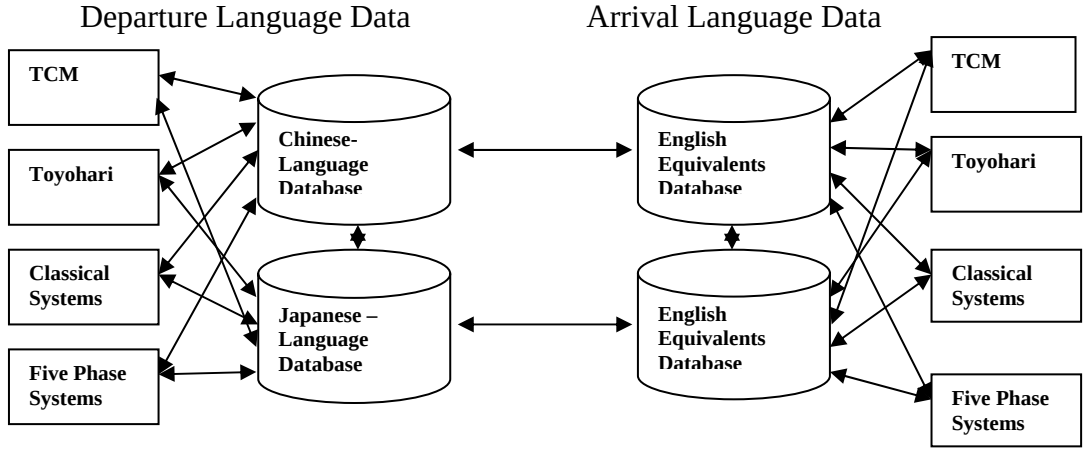
1. Equal access for all,
2. Incentives to investment in hardware and software development,
3. Elimination of monopoly control by a dominant entity,
4. Preservation of less capitalized and newer entities,
5. Preservation of minority and niche systems,
6. Greater stability for users,
7. Lowered development costs for everyone,
8. Easier "roll-out" of improvements,
9. Technical stability.

Closed systems, on the other hand, retard development and investment, restrain trade in favor of arbitrarily selected parties, and reduce the options available to individuals. As regards computing systems, Microsoft's proprietary standards are a valid example. Because the information necessary for software developers to manage aspects of the Windows operating system are available only to those whom Microsoft selects, broad areas of software development have been dominated by Microsoft. The famous court case against the integration of Internet Explorer with the Windows operating system was essentially an attempt to remedy the restraint on competition achieved through secret technical standards.

Information that cannot be traced to its sources, private methods and terms, are a closed system, just as hidden from scrutiny as a network controlled by a secret technology.

The Role of Open Standards

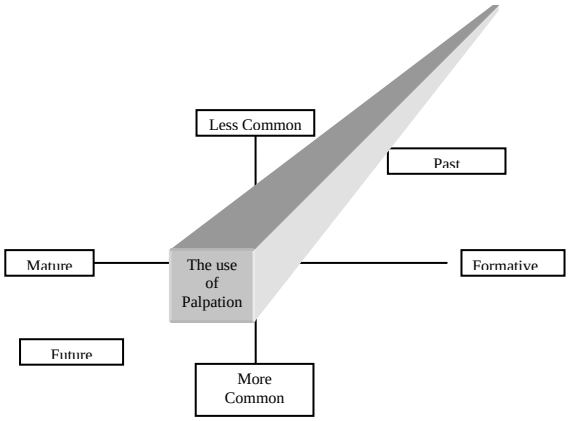
Standards play an equalizing, competition-engendering role in many aspects of computing. However, they also play this role in virtually every aspect of life that is free of dominant party control. In the context of Chinese medicine, we could modify the internet connection diagram thus:



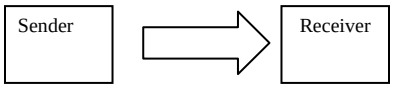
On the sending side, information in source languages like Chinese can be selected by individuals' choices. The same is true for the arrival language. Writers are free to choose what they consider important. However, if the relationship between the departure language data and the arrival language is nonexistent or obscure, only the writer knows what they have selected to transmit. It is hidden standard. You and I, the recipients of the information, are entirely dependent on the writer.

Obviously, the parallel diagram is also a considerable simplification. For the sake of the illustration, I have neglected other Asian languages such as Korean or Vietnamese. Chinese medical systems also come in many more varieties than the diagram shows, but none of those complexities exceed the model of interconnection illustrated here. When any of the relationships between the essential data become proprietary, or are simply lost by virtue of being unavailable, the interconnections break down. If the relationship between the Chinese language database and the English equivalents database is obscure, there is no way to know how the English text is related to the Chinese text. Remove the double-ended arrows in the middle of the diagram and the Chinese medical information network becomes just as arbitrary as an internet where someone else decides what you and I may say to one another.

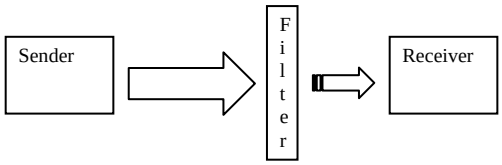
Furthermore, the systems represented by the double-ended interconnecting arrows in this model are derived from human behaviors over time, rather than through a one-time technical specification. Chinese medicine is an experiential art that has formed through practical experience in different times and places. It has not been derived from a single line of logic. Neither is it rigorously consistent or stagnant. Thus, openness is even more important



Yet, even this is not the whole story. Theoretically, data or information transmission is a relatively straightforward process:



In reality, there are "filters" that modify the transmission:



In system such as the internet, a filter might be a firewall- a program that examines arriving data for its source or destination and permits or disallows further transmission. Human exchange, whether written or oral, is filtered by subjective qualities such as audience expectations, fixed opinions, and philosophical biases. Writers may filter information based on their personal experience; publishers may filter information from economic concerns. In the term discussions that have taken place thus far, the role of filtering has been only partially recognized. The idea that one translator views the value of Chinese information differently than another has typically been discussed in terms of "clinical" as opposed to "academic" translation, or as a matter of who is right or wrong. These debates have been circular, returning to the same arguments (and even the same words) over and over again. This is because the notions of "clinical" and "academic" are inadequate for understanding how Chinese medical information is filtered in transmission and because these arguments have focused on terms as words, not as concepts.

Information Filtering

How do we shed light on this problem? If there were an open standard where writers presented their lists of English equivalents for Chinese concepts, we could compare those lists and read the decisions behind the implementers' choices. This would be very valuable to teachers because they could know whether any particular text fit their curriculum needs. This would be valuable to students for the same reason. Clinicians could easily decide what literature

was likely to have the information and the level of detail they needed. However, because there is no open standard, the problem is much more complex. Very significant filtering can go unrecognized.

First, there is filtering at the concept level. Concept filtering is the selection of what Chinese medical ideas are worth "mapping" between the source language and English (or any other arrival language). Like a sieve through which some things pass and others do not, a concept filter changes what the eventual reader receives. The decision whether or not to preserve a Chinese medical concept in translation is more or less a decision whether or not to assign it a consistent English equivalent by which it can be reliably recognized. Thus, comparing term lists is a very direct and useful way to understand what a translator, or the developer of a translation approach, considers worthwhile. It is also a practical way to understand a translator or writer's interests. A few clinically relevant examples should suffice.

Traditional Chinese medicine has a variety of patterns of swelling that are often obscured by the use of the English term "edema." Edema in Chinese medicine is actually several different traditional diseases, each of which has distinct causes, pathomechanisms, and treatments. A practitioner who is only familiar with the generic concept of edema will lack the ability to trace their patients' complaints to a specific Chinese category, thus limiting the efficacy and safety of their treatments.

While the basic Chinese medical concept of water swelling does largely correspond to edema, water swelling is further differentiated into traditional disease categories such as "skin water," and "wind water," each of which have different manifestations and require different treatments. In addition, the Western concept of edema contains pathologies that do not correspond to the general category of water swelling in Chinese medicine. For example, the biomedical condition of toxic edema is not classified as water swelling in Chinese medicine and cannot be treated as such. In clinical education, the correspondence to "edema" is probably a useful example, but losing the practical clinical distinctions also hides time-tested clinical strategies. Somewhere these practical differentiations must be learned. Otherwise, the T.C.M. learned in English will not be the T.C.M. known in Chinese. Simplifying the Chinese concept of water swelling into the Western notion of edema not only causes practitioners to lose valuable insights on potential treatments, it also has the potential to create errors in decision-making that can compromise patient safety.

Another example of a commonly simplified cluster of traditional diseases is revealed by the use of the term "spermatorrhea." Spermatorrhea is often discussed in English texts as though it represents a specific state of pathology in Chinese medicine. In fact, Chinese medicine recognizes four distinct conditions of irregular seminal discharge. Because of this widespread simplification, few Western practitioners are aware of the applicable disease categories. This lack of knowledge causes many Westerners to speculate that spermatorrhea is not a disease but is instead a polite way of discussing masturbation. Thus, their therapeutic decisions are misdirected.

The four distinct disease categories of involuntary seminal discharge have nothing to do with masturbation, and each category represents distinct pathomechanisms and gradations of

severity, requiring widely differing treatment approaches. The four traditional diseases of involuntary loss of semen that are reduced to spermatorrhea are known as: 1) dream emission, 2) seminal emission without dreaming, 3) seminal efflux, and 4) great seminal discharge. Practitioners who only learn the simplified concept of "spermatorrhea" are unaware of the differing severity of these conditions and often attribute every involuntary loss of semen to insecurity of kidney qi. In fact, seminal emission can occur because of effulgent sovereign and ministerial fire, heart vacuity and liver depression, insecurity of kidney qì, noninteraction of the heart and kidney, or spleen vacuity qì fall. Once again, we see that simplification of traditional disease concepts can only result in poor mastery of Chinese medicine. It also can result in gross clinical blunders that compromise patient care.

Examples of clinically significant simplifications abound in the English literature of Chinese medicine. For yet another example, consider the common Chinese medical concept of heart palpitations. While all students are familiar with heart palpitations, relatively few students realize that Chinese medicine differentiates two distinct types of palpitation. "Fright palpitations" are instigated by fright or an emotional stimulus. They are paroxysmal in nature. Fright palpitations are seen in both repletion and vacuity patterns. By contrast, "fearful throbbing" is a more severe and constant condition that is not triggered by emotional stimulus. Although associated with fear, fearful throbbing is not induced by fear; rather, its severity induces a sensation of fear in the patient. Unlike fright palpitations, fearful throbbing is only seen in vacuity patterns. Thus, these two distinct conditions differ in severity, causation and treatment, yet any survey of licensed practitioners will quickly reveal that this clinical distinction has largely been lost in simplified teaching materials.

What we see in these examples is filtering of information based on how well it seems to fit with western perspectives and writers' ideas of what their target audience is prepared to learn.

While issues of simplification are numerous and problematic, multiple Chinese concepts are also frequently merged as a result of biomedicalization. For example, to eliminate dampness in Chinese literature, medicinals that "disinhibit dampness" are recommended. The notion of "disinhibiting dampness" (*lì shī*) or "disinhibiting urine" (*lì niào*) refers to releasing inhibition and promoting fluency of movement and activity. However, disinhibiting medicinals are often inappropriately translated as "diuretic agents," a term that describes the specific pharmacologic action of inducing urination regardless of whether dampness or inhibited urination is present.

It is a fundamental notion in Chinese medicine that medicinals have different actions that express according to the state of the patient and the medicinals combined in a patient-centered formula. For example, *fú líng* (Poria) is considered to disinhibit urination as well as quiet the spirit. If it is prescribed in combination with spirit-quieting medicinals for a patient with insomnia, it does not disinhibit dampness. However, if Poria is combined with damp-disinhibiting medicinals for a patient suffering from water swelling, it will exert a damp-disinhibiting effect. While a diuretic agent unconditionally induces increased urine output in all subjects, this notion is not directly transferable to the Chinese medical concept of disinhibition, where the actions of a medicinal are dependent on the state of the individual and the combinations utilized in the entire formula.

As a consequence of this biomedicalization of therapeutic actions, many practitioners are unclear which dampness-disinhibiting medicinals actually exert a pharmacologically diuretic effect and which do not. At present, there is significant concern about the risk of herb-drug interactions, and diuretic herbs are considered to pose risks of additive interactions when combined with diuretic drugs. If traditional therapeutic mechanisms are passed through a filter that biases in favor of pharmacological actions, we lose the distinction between the differing approaches of Chinese and Western medicine. If we label both true diuretics and disinhibiting agents as diuretics through biomedical filtering, we lose the clarity and safety necessary for medical practice and appear pseudo-scientific in the eyes of the mainstream medical system.

These examples show the two primary filters by which clinically relevant concepts are altered in the transmission of Chinese medicine: biomedicalization and simplification. Concerned that Western readers will not be able to understand the natural metaphors and traditional theory of Chinese medicine, some authors have chosen to make traditional ideas appear more scientific. Other writers have chosen to omit various traditional concepts and disease categories because they believe that the complexity inherent in Chinese medical theory will limit the audience for their books. These decisions are theirs to make, but with an open standard everyone would be better prepared to judge the value of those decisions. It is not that there should be no simplified presentations or no correspondences to biomedicine; it is that everyone should know what they are.

Content filtering is more difficult to assess than concept filtering. If a concept filter is a sieve through which only parts of an idea will pass, then a content filter is a sieve through which only parts of a body of knowledge may pass. Although comparisons of term lists will reveal what someone believes is worthy of transmission, term lists alone will not reveal what of a given source text, or a source body of knowledge, has been included or excluded. To illustrate the problem of content filtering, I have compared two descriptions of liver depression, both of which are drawn from widely available books. One description follows the Chinese as precisely as possible (source orientation). The other was written for a student audience (target orientation).

I took the description of liver depression in **The Fundamentals of Chinese Medicine** and compared it to the equivalent description of liver qi stagnation in the new edition of **Foundations of Chinese Medicine** by breaking each description into statements of fact. There are far more differences than just the names for the same pattern. I defined a statement of fact as any claim, any sentence that said something about the subject. I matched those statements based on their agreement and quantified the differences by simple counts. (See: http://www.paradigm-pubs.com/refs/LiverComp.pdf for the details) The following table resulted:

Category of Fact	Fundamentals	Foundations
Number of fact statements	87	43
Facts not matched to the Chinese text	0	44
Number of Pathomechanism-related facts	29	15
Number of Treatment Principles	14	1
Number of Symptoms and Signs	6	10
Number of Western Medical Correspondences	4	1
Number of Pattern/Formula facts	7	2
Number of Materia Medica facts	3	0
Number of Aucpoint / Pattern facts	15	5
Number of Personal Observations	0	19

In **Foundations** only Symptoms and Signs appear more frequently than in the Chinese text, the entire difference being the inclusion of personal observations. There are no personal observations in the **Fundamentals** text, which is a significant clue as to the difference in transmission philosophy. In all other basic categories the information is richer in the Chinese sources. In other words, in the preparation of **Foundations** there have been specific decisions not to transmit elements of Chinese knowledge. In short, a content filter has been employed.

Based on simple quantification of the facts presented, it is clear that **Foundations** is a highly simplified text. A clear bias in favor of personal observations and a clear bias against Pathomechanisms, Treatment Principles and Acupoint to Pattern relationships has been used in content selection. Internal medicine in terms of Materia Medica and Formula to Pattern relationships has been deliberately excluded. While you may agree with the content filtering in **Foundations,** what counts is that everyone understands how the content has been simplified so they are able to make their own decisions.

An open standard reveals both conceptual and content filtering through making term lists and transmission philosophies freely available. Teachers, students, clinicians and educators who know what lies behind the literature they are offered are best able to choose what suits their needs.

Standardization as a Natural Process

While filtering in the development of Chinese medical information in English creates a complexity that is not present with rigorous analytic standards such as the fundamental "Transport Control Protocol / Internet Protocol" standard by which the internet functions, it does not change the essentials of Chinese medical transmission. In the simplest sense:

Chinese (人) = English (human)

There is a large database of Chinese medical data that is nearly this simple because existing standards have allowed standardization to occur naturally:

1. Acupuncture Points
2. Chinese Medicines
3. Materials and Methods

For example, I was recently at an academic conference where clinicians and scholars attended each other's presentations. At one panel that I remember particularly well Toyohari practitioners interacted with scholars of classical Chinese, Chinese medical history, anthropology and linguistics, as well as T.C.M. writers and clinicians. During a discussion of a researcher's use of particular acupoints, each person used their own nomenclature, yet there was no misunderstanding. In other words, communication was not disrupted by the different recipient filters:

K1 = Gushing Spring = *yǒng quán* = Bubbling Spring = KI-1

The first point on the kidney channel has a physical referent that is known to anyone who shares in the professional knowledge of acupuncture because it has been standardized into a relatively small number of variants. The filters that produced these variant names are not so dense as to disguise the common source. Historically, those that were not transparent, or were otherwise inconvenient, have disappeared. This is also true of the nomenclature for medicinals:

苍朮 = *Cāng Zhú* = Atractylodis Rhizoma = atractylodes root

Since there are established standards exterior to our field for the relation of Pinyin to Chinese characters, the formation of Latin pharmaceutical names and for the formation of English names for those substances that do not already have common English names (e.g. "ginger"), the transmission of information is greatly enhanced. The natural process of standardization is well advanced. Whether "Kidney" is graphically emphasized by an initial capital or "kidney" is not, we can be sure that both refer at least to the same physical viscus. Interestingly, this is also true for a small list of words that describe "ideas" more than "realities." "Meridian" and "channel," may represent different philosophical emphases but in professional discourse, there is an insignificant probability of confusion.

In sum then, through the natural processes of use and the application of ready-made standards, some classes of nomenclature in English language Chinese medicine have already become standard enough that large groups of physical entitles (e.g. flowers, seeds, stems, minerals, places on the body) have acquired standard names. While there is still more than one approach in common use, these variances have become publicly available and, in a sense, freely available because they have been used with enough consistency in a large enough body of work. Professional users have absorbed their inter-relations. As part of this process, certain names and ideas have effectively disappeared. For example, using "orbis" for the Chinese medical concept of an organ is essentially meaningless to those whose studies have commenced in recent years.

From looking at hard systems and the softer systems of Chinese medical nomenclature we can make some generalizations about significant aspects of English language term standardization:

1. They are public, meaning both that they are available and that they are not effectively the property of any one person or organization.

2. They are freely available, meaning both that you can acquire them at will and that they are not secret.

3. They have been used in a body of literature that has been found useful enough to have been absorbed into the professional knowledge base.

4. They have been reasonably consistent and used over a long period of time.

If we return to the benefits associated with open standards, we can see that all these apply. In fact, to some extent the natural process of standardization has effectively accomplished the advantages of open standards:

1. Equal access for all – anyone can acquire the rules for the formation of standardized nomenclature such as Latin names.

2. Incentives to investment – because anyone can use any of the freely-available lists, anyone can offer their own products using names that are useful in classes, examinations and other texts.

3. Elimination of monopoly control by a dominant entity – for example, although herb companies do sponsor the use of their brand names in educational and clinical materials, a freely-available standard nomenclature prevents the highly capitalized brands from achieving overwhelming name recognition. In mainstream education, the use of brand nomenclature disqualifies a text for classroom use.

4. Preservation of less capitalized and newer entities – for example, new publishing companies have been able to offer new materia medicas and study guides using the standard medicinal nomenclature used in schools.

5. Preservation of minority and niche systems – for example, Japanese transliterations are not frequently used, but anyone interested can link the Japanese to the Chinese and thus all other standards.

6. Greater stability for users – what students learn today they will be able to use tomorrow.

7. Lowered development costs for everyone – for example, anyone who writes or publishes can use the "Practical Dictionary" terminology without royalty, contract or limitation.

8. Easier "roll-out" of improvements – as can be seen with the new generation of materia medica, medicinal nomenclature is now effectively a single standard.

9. Technical Stability – Because they are open to scrutiny and available to many people, problems are more easily discovered and corrected.

Standardization is not simply one authority handing-down a terminological directive, but the natural process of a field codifying its experience; it is what we might call the

"process of generic standardization." A functional standard need not be a biblical directive (e.g. "thou shalt use deficiency"), but a criteria-based contribution to the field's intellectual tools.

C.O.M.P. as a Standards Cooperative

The process of generic standardization was greatly supported by Bob Flaws and Honora Wolfe's insightful funding of the meeting that lead to the formation of the Council of Oriental Medical Publishers (C.O.M.P.). Because the idea was not meaningful to every publisher or writer, C.O.M.P. has not progressed far beyond that first step; it is still the essential seed of a workable standards process. If participation in C.O.M.P. were extended to include professional organizations like A.A.O.M., and critically, the license testing boards such as N.C.A.A.O.M., it would become a functional standards agency. That agency would not certify one terminology over others, but would certify that the term implementations offered all met the same criteria. It would function to promulgate a standard and to make implementations of that standard freely available. The original C.O.M.P. code stated it thus:

> The Code for The Council of Oriental Medical Publishers is a way to label books, articles and other Oriental medical materials such that readers know how the information was prepared, why its producers believe it to be accurate, and how they can cross reference its information to the work of other authors. The Code establishes a set of standard labels that anyone can use, whether or not they consider themselves members of C.O.M.P. It does not exclude any approach, approve any approach, or suggest that any translator is better than any other. In other words, the C.O.M.P. code is not a regulation or ruling. It does not concern what can and cannot be sold or used for any purpose. It is a voluntary trade convention that provides useful labels that anyone may apply.
>
> C.O.M.P. has no formal membership; anyone who wishes to participate is welcome. The main product of the C.O.M.P. code is a set of labels that describe books and other information in Oriental medicine. These labels are distinguished by qualities of the writer or publisher's Stylebook. A Stylebook is a list of materials used to make intellectual works consistent. Thus, a Stylebook is not necessarily a book. For example, it may be a list of references. One publisher or writer may use more than one Stylebook. A Stylebook can be simple or it can be complex. For example, a sinologist's Stylebook could easily consist of several published books and articles that describe his or her approach to translation, the research on which that approach was based, samples of its application, and descriptions of the methods and logic behind its creation. Stylebooks can include reference books, terms lists and other tools. In sum, a Stylebook is a catalog of the resources two professionally trained translators would need to arrive at identical translations of the same text without consulting one another.

What would such a standard look like given the C.O.M.P. experience and what we have since learned? First, I think it must describe what each implementation of a term standard should provide. In my opinion, that statement should include:

1. *A statement of intent*. A detailed presentation of the implementer's notion of what their implementation accomplishes.

2. *A statement of scope.* A detailed presentation of the implementer's claim for what realm, genre, or element of the field's literature their implementation serves.

3. *A statement of procedure*. The implementer's description of how term decisions are made, the criteria for choosing one term over another. Such a statement should also describe a process for dealing with the translation of new terms.

4. *A freely available term list*. A working list of English equivalents for a set of Chinese concepts that match the intent and scope the implementer claims.

Statement of Intent

The statement of intent is key to understanding the "why" of any particular implementation of a open standard. It describes the use for which a particular implementation is designed. For an examining authority such as N.C.C.A.O.M. this might be no more than a statement that their Chinese-English term list defines the concepts they may test and the English terms used to identify those concepts on their exam. For someone writing in a particularly narrow area, such a statement might be the description of a body of texts, the names of authors, or genres to which their term list applies. What the standard requires is a public description of intent sufficient for others to make a decision whether the implementation offered fits their purpose.

As far as Paradigm Publications is concerned, we see our **Practical Dictionary** (PD) terminology as a general purpose, generic, Stylebook for the translation of a broad range of Chinese medical literature, as well as a broad range of original writing about Chinese medicine. It is intended for an intellectual environment supported by "local glosses" – term lists specific to a book or article. We offer it for use by anyone. It is a multi-author, multi-publisher standard where local glosses (new, different, historically or technically specialized terms and explanations) provide flexibility and independence while promoting readers' ability to access information accurately.

Statement of Scope

The statement of scope is of key import to understanding the who, when, or where of a Stylebook. Since Chinese medical concepts have evolved through time and have had different "slants" for different authors or different schools of thought, in some situations specialized Chinese-English glosses may be worthwhile. In many instances, a local gloss detailing term definitions specific to a particular text or author will be sufficient. While terms with multiple definitions have not proven difficult to manage in the translation of a significant sample of Chinese medical literature, the development of indigenous western ideas about Chinese medicine is accelerating. Thus, the English equivalents of Chinese terms can accrue meanings that diverge from the Chinese sources. A statement of scope can clarify these developments for readers.

The scope of the PD terminology is that of the major monolingual Chinese language Chinese medical dictionaries. The CD version we distribute to translators who adopt PD terms for their work currently covers about 30,000 terms.

Statement of Procedure

Since a relatively small part of the Chinese medical literature in Chinese has been translated, it is inevitable that term lists will need to expand. Thus, a procedure for on-going linguistic research is necessary.

As regards the PD terms, this is something that is not so formally done. Local glosses have generally handled the introduction of new terms. Currently, the group of people central to the further development of the term-set work together informally via the internet. Numerous papers and studies describe the approach well enough that multiple translators have been able to contribute terms. However, now that PD terms are used by writers who are not as well known to one another, it is likely that further growth will require a more formal peer system.

Freely Available Term List

"Freely available" does not necessarily mean "for free." It does, and must mean, that there can be no arbitrary limits on who may have access to a term list that conforms to a field-wide standard. As a specific example, while I am free to charge for the **Practical Dictionary**, I am not free to demand that no rival publisher use those terms. Access is critical to the natural process of standardization. If the term sets adopted for license testing are secret, arbitrarily available, or just unpublished, this creates a franchise for the term list owner, a block to commercial access and intellectual development.

It is important to note that none are required to offer a freely available term list. If someone feels their interests are best served by keeping their term list private, that is their right. However, it is also the field's right to say that a private list is not an acceptable foundation for educational literature. The field's interests must supersede private interests and the commercial attractiveness of the education market could be a powerful incentive to openness. In my opinion, an ideal standard would specify a list of terms for which each implementer would provide their terms. This has distinct advantages. First, it specifies a minimum scope. For example, as noted before, as a start the concepts found on license examinations provide a very practical scope. Next, because other efforts such as those of the W.H.O. or S.A.T.C.M. include lists that reflect their assessment of which are the basic terms, list comparisons will help us understand content filtering. Finally, list comparisons also reveal concept filtering by showing what Chinese terms are or are not preserved in translation.

The PD terms list has been available in a number of forms, many of which were used to gather information and suggestions from people interested in standardization of a Chinese medical term set. Presently, there are two formal publications. T**he Practical Dictionary of Chinese Medicine** is our commercial product covering 6,000 of the most used Chinese medical concepts. We also offer a CD Dictionary of 30,000 terms to translators applying the PD term set. Given

the growing scope of the PD list, and the number of current contributors, the next editions are likely to be software based.

The Current State

At present, standardization is a "hot topic." There are currently four entities addressing the standardization issue of which I am aware:

1. **The World Health Organization (WHO)**: Two of my colleagues, Drs. Wiseman and Unschuld, have participated in the the W.H.O. process since its inception. At the last meeting in Degu Korea an English terminology was voted upon, largely by persons who do not speak English. I have not seen the resulting list. I do not know if the "elected" terms were later changed by a more principled process and to my knowledge the list has not yet been published. My impression of the W.H.O. communications I have read is that the participants are primarily interested in a terminology for representing Chinese medicine in biomedical journals. The W.H.O. term set is about 4,000 terms.
2. **The World Federation of Chinese Medicine Societies (W.F.C.M.S.) acting as the agent of** The State Administration of T.C.M (S.A.T.C.M.): Recently held meetings in Beijing, P.R.C. What is important to note is that this conference was meant to forward the establishment of an English language terminology to be used by Chinese publishing companies, in particular, People's Medical Publishing House in their program to present 1,000 translations to the West. N.C.A.A.O.M. also participated in this conference. The S.A.T.C.M. term list numbers about 5,000 and has been published as **Chinese Terms in Traditional Chinese Medicine and Pharmacy** by Dr. Wang Kui and Zhu Jianping.
3. **The AAOM Annual Event**: for which I have prepared this paper.
4. **International Conferences**: There will be a large international conference in Berlin early next year. Two lists, one for biomedically integrated literature and one for traditional literature, will be circulated to experts world wide who will be invited to participate in the development of a widely distributed standard. It is implicit in the organization of this conference that those who seek the scientization of T.C.M. and those who wish to transmit the traditional practices will never agree on terms because their frames of reference are incompatible. Someone who believes that the only valuable concepts in Chinese medicine are those that can be expressed as biomedical information is not interested in retaining natural metaphors. Thus, the thrust of this conference is implicitly that of open standards.

I believe there are two significant matters to consider. First, the participants in each of these processes understand that the U.S. and Australian examination and education authorities shape the largest market for Chinese medical texts. P.R.C. authorities and publishers are neither unaware of the English language market, nor the relatively minor role P.R.C. literature plays in western education. There is no doubt that they will increase their efforts to gain what they see as a necessary influence. Second, it is clear that there will be multiple standards available by the end of 2006 and that they are likely to remain for a long time.

As regards the first observation, it is important to note that this puts the U.S. and Australian national organizations in a very powerful position. As a bookseller, I would go so far as to say that any term standard that does not recognize the need for license examinations will likely fail to inspire the production of a body of literature. This suggests that the appropriate interaction for the A.A.O.M., N.C.A.A.O.M, or a coalition of authorities is to assert a role in the

process of standardization. (I am suggesting only examples of authorities, not a participant list.) C.O.M.P. offers an established platform and a history of compliant publishers and writers. Thus it provides a nascent agency a head start. Once such an agency exists, it can invite representatives of the W.H.O. and the W.F.C.M.S. to present the principles of formation and the lists their processes derive. P.R.C. agencies are prepared to do so. The principles issued at the end of the Beijing conference are, like the forthcoming Berlin conference, are a step toward an open standard.

In other words, I suggest that the Western field assert its authority as regards its own terminological needs. I do not mean that Westerners assert authority over Chinese medicine, only that English-speaking experts should play an authoritative role in these efforts.

As regards the second observation, it is my opinion that multiple standards will exist, perhaps permanently. While the natural process of standardization will eliminate those approaches that do not attract adherents, it is far too early to make predictions of permanence. Porkert's terms have not disappeared; people simply do not use them. For the largest part it will be people who know Chinese medical language and who seek to bring Chinese medical information into English who will determine what terms are used. My suggestion, therefore, is that the appropriate authorities issue a Chinese - English list of the concepts and the English terms used to identify those concepts on U.S. (and other national) license exams. Such a list would be used as the equivalent of the W.H.O. and S.A.T.C.M. lists in an initial standards process. I believe this will have the beneficial influence on investment I have previously described while accelerating the natural process of standardization.

If we consider that there are already de facto standards created by state and national licensing exams, and that these are the foundation of a very significant investment in curriculum, commercial products and student works, I think it becomes clear that nothing will change overnight. Different approaches to transmission will be with us for a long time. Thus, a policy that supports the natural process of standardization while providing the advantages of openness, availability and scrutiny is the fairest and most advantageous policy for the field. In sum, I would like to encourage everyone who is interested in the development of our field to look at the process of standardization as a natural outcome of our need for accurate communication and learning.

We do not need an arbitrary standard, something imposed from "on high." Neither do we need a hidden standard, something that closes primary markets to investment and development. We need an open standard that encourages competition and development.

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Arguments for the Adoption of a Standard Translational Terminology in the Study & Practice of Chinese Medicine in the English-speaking World

By Bob Flaws, Lac

"The Argument: There are a number of reasons for adopting a standard English language terminology for Chinese medicine. First and foremost is to learn more technically accurate, and, therefore, more clinically effective Chinese medicine."

The Problem

Over the last 800 years, but especially during the last 30 or more years, the English language terminology of acupuncture and Chinese medicine has grown in an unplanned, haphazard way. Practitioners, teachers, students, authors, and translators have been left to their own devices to adopt or create whatever terms they like regardless of their linguistic accuracy and faithfulness to the medicine as described and expressed in Chinese. This has led to a veritable Tower of Babel within the study and practice of Chinese medicine in the West in general and in North America in particular.

My long experience in this field leads me to believe that the single greatest impediment to the learning and skillful practice of Chinese medicine in the West as it was created and is practiced in China is the lack of a linguistically accurate, standard English language translational terminology for this medicine. This problem is highlighted by the fact that such a linguistically accurate, standard English language Chinese medical terminology has existed for more than 20 years. Unfortunately, because there is no equivalent of Latin and Greek academic terms in Chinese, few Western students and practitioners of Chinese medicine have understood that this medicine does, in fact, have a standard professional terminology. Nevertheless, this is most definitely the case.

The first Westerner to recognize that Chinese medicine does have a standard technical professional terminology was Jean-Pierre Abel-Rémusat, 1788-1832. He was a practitioner of Western medicine who learned to read Chinese and Manchurian in order to study Chinese medicine. Abel- Rémusat eventually gave up the practice of medicine to become a sinologist. He became the first professor of Chinese at the Collège de France and wrote from the 1810's through the 1840's. According to Abel-Rémusat,

> "In China, as in Europe, science has a technical language – expressions and twists – of which a knowledge, albeit extensive, of the general language does not give perfect understanding."[1]

When criticizing another European translator who did not understand the technical meanings of this technical Chinese medical language, Abel-Rémusat says the following:

> "Boym, a stranger to the art of healing, has followed the literal sense of the words in translating books of medicine... he at most often translated without understanding, and I ask which of our theoretical works would not run the risk of being disfigured in passing through the hands of a similar interpreter."[2]

Unfortunately, this insight gained no practical headway in the West for another 100 years.

In the 20th century, it was Prof. Manfred Porkert of the University of Munich who first championed the fact that Chinese medicine has a technical terminology, one which must be studied and learned on its own terms. Nathan Sivin, a Chinese medical sinologist at the University of Pennsylvania, in his Foreword to Prof. Porkert's *The Theoretical Foundations of Chinese Medicine: Systematic Correspondences*, states: "[Dr. Porkert] has earned the gratitude of every student of Chinese thought... by systematically addressing for the first time the precise meanings of the many fundamental technical terms of Chinese philosophy..."[3] By technical terms in Chinese medicine, Prof. Porkert meant "expressions that have been used consistently and unequivocally by all authorities of the science – if not at all times, at least through many centuries."[4] However, being of the "old school" of European academics, Dr. Porkert suggested Latin for the creation of a standard pan-Western Chinese medical translational terminology. "Our normative terminology thus is different from previous attempts in that it takes into full account the inductive and synthetic mode of cognition that underlies Chinese technical terminology and as a rule renders each technical term by a single Latin equivalent that can be used consistently and logically in writing about all the disciplines of Chinese medicine..."[5]

Because Latin is as much of a foreign language to most Westerners, acupuncturists and practitioners of Chinese medicine have, nevertheless, recognized that Chinese medicine does have and use professional rerminology in Chinese. Dr. Porkert's term choices were never adopted outside his own limited circle of students and admirers. Nevertheless, the fact that Chinese medicine does have and does use a technical professional terminology in Chinese continues to be an important recognition by Western scholars of this medicine. For instance, Prof. Sivin, in his *Traditional Medicine in Contemporary China*, says:

> This traditional [Chinese medical] terminology, which evolved gradually over more than two millennia, is not accommodated in English without a good deal of thought... In order to translate or even explain[,] one must therefore create a technical vocabulary in English.[6]

Within professionally practiced Chinese medicine in China, there are thousands of technical terms. Although these terms are all Chinese language words (unlike the Greek and Latinate terms of Western medicine), in China, students of Chinese medicine must be taught and learn the technical meanings of these terms when used in a Chinese medical context. The plethora of such technical professional terminology is reflected in the existence of numerous Chinese language dictionaries of the terms of Chinese medicine available in People's Republic of China and the Republic of China (Taiwan). For instance, the *Jian Ming Zhong Yi Ci Dian (A Concise Dictionary of Chinese Medicine)* published by People's Health & Hygiene Press in Beijing in 1986 is 1022 pages long and contains 1,130,000 characters discussing approximately 9700 entries covering every aspect of Chinese medicine.

The Argument

There are a number of reasons for adopting a standard English language terminology for Chinese medicine. First and foremost is to learn more technically accurate, and, therefore, more clinically effective Chinese medicine. Chinese medicine was created and refined in China over a period of not

less than 2,500 years of recorded history. Those of us who practice Chinese medicine in the West believe that this medicine has indeed been time-tested over the last two millennia. Therefore, we presume that our practice of Chinese medicine is both safe and effective. For this presumption to be correct, we need to practice this medicine as the Chinese practitioners do. If we practise differently, we can no longer say that what we are doing is safe and effective based on the long history of clinical practice.

The logic of Chinese medicine is based on the logic of the Chinese language. Chinese is the language in which this medicine was created, and Chinese is structured very differently from English and other Indo-European languages. We think in language terms, and the language we think in affects the very way we think and the way we see and interpret the world. If one really wants to understand Chinese medicine, then one must be able to read the Chinese medical literature in Chinese. Barring that, one must at least be able to read the Chinese medical literature in an English language translation which captures the logic and technical precision of that literature as closely and as accurately as possible.

Much of the *de facto* English language terminology of Chinese medicine is imprecise at best, if not simply wrong. This can either obscure the logic and technical clarity within the Chinese original or actually convey a false meaning or impression. For example, in the late 16th century, Matteo Ricci translated *wu xing* (五行) as the "five elements," thus warping the European understanding of this theory for more than 500 years. Prof. Porkert used the term "phase" instead of element. Hi interpreted the Chinese medical concept as one of phases of birth, growth, maturation, and decline, while the word "element" conveys something material and static. Yet one can hear of 21st century students and practitioners of Chinese medicine talking blithely about the five elements at every turn. Another common mistake is the traditional Chinese medical term *fa re* (发热). When used in a Western medical sense, this Chinese term is translated as fever. However, when used in a traditional Chinese medical sense, it should be translated as "emission of heat." A patient may be said to have *fa re* with or without an elevated body temperature. This Chinese medical concept is based solely on a combination of externally observed signs and internally experienced symptoms. whereas, to have a fever, body temperature must be above 98.6 F (37 C). And how many translations have we read of *shang han* (伤寒), damage [due to] cold, as "typhoid?" Such an erroneous, over-particular translation of this technical term narrows the diagnostic and prescriptive system based on this key concept to the point of uselessness in contemporary clinical practice.

While the above terms are some of the most egregious, there are many other, more subtle mistakes in the *ad hoc* English language terminology of Chinese medicine. For instance, the term *huo xue* (活血) is often translated into English as "to invigorate the blood." In English, "vigor" is a synonym for active force or strength. Therefore, "invigorate" means to strengthen. However, *xue* (血) or blood in Chinese medicine is a material substance which "nourishes and constructs." It *does not act* with force or strength. Acting with force or strength (*li*, 力 in Chinese) is an attribute of qi. Hence, to use the word "invigorate" blurs the fundamental yin-yang dichotomy between the qi and the blood, qi being active and having force or strength, blood being a material used to nourish and construct. A more technically correct translation is "to quicken the blood." In English, the word "quicken" has two meanings: 1) to make move faster, and 2) to bring to life. The treatment principle *huo xue* is the treatment principle for remedying blood stasis. A synonym of blood stasis is dead blood, *si xue* (死血). However, static blood is also blood that is not moving freely. Therefore, to quicken the blood captures both these meanings without introducing any other, erroneous meaning. Further, now we understand why the

blood must be quickened to eliminate blood stasis that hinders the engenderment of new or fresh, living blood.

Another erroneous term commonly used is "sedate" for the Chinese *xie* (泻). Sedate comes from the Latin *sedere,* "to sit." Therefore, to sedate means to make something sit in place. However, the Chinese *xie* means to drain off some evil qi that has been "sitting" in a place it should not be. The fact of its "sitting there" is what is pathological. Thus, "to sedate" is absolutely and fundamentally the wrong idea which corrupts a correct understanding of the flow of qi and blood through the channels and vessels of the body. Or take *xie*'s polar opposite, *bu* (补). In the early 20th century, Soulie De Morant coined the medicalized word "tonify." This word does not exist in standard English dictionaries, but worse that, if it did mean something in a medical sense, it would mean to make tight, as in toning a muscle. The Chinese medical terms means "to add to" or "supplement," not to make anything tight or firm.

As a teacher of Chinese medicine on the national and international level, I am frequently told that I explain Chinese medicine so clearly and so logically. However, when I teach Chinese medicine in English, I primarily translate what the Chinese themselves write and say, but I use a standard English language translational terminology that comes as close as possible to capturing the meaning and logic of the Chinese language in English. Hopefully, my clarity as a teacher isdue to my using a standard translational terminology which is as correct and accurate in English as possible and faithfully conveys the technical implications of the original Chinese. Further, I can also say that the adoption of this terminology has also significantly helped me improve the technical application of Chinese medicine in clinic, thus resulting in better therapeutic outcomes for my patients.

Another reason for adopting a standard English language translational terminology is to facilitate communication within our profession and allow cross-referencing of information. Right now, teachers and practitioners of Chinese medicine are free to use any words they like. However, how does one know that one teacher's slippery pulse is another teacher's rolling pulse is another teacher's sliding pulse is another teacher's gliding pulse? Further, how can we know the original Chinese term the teacher has in mind or is referencing, remembering that the Chinese term is our ultimate standard of reference? In order for members of this profession to accurately and easily exchange information from peer to peer, we need to all be using the same terms referenced to the same Chinese originals. Until or unless we do, our classes, meetings, and our literature will be a Tower of Babel whose information cannot be cross-referenced.

With the growing recognition and acceptance of Chinese medicine in the larger world around us, other parties rely on us to use a standard professional terminology. These other parties include:

Governmental and regulatory agencies, third party payers (insurance companies),, CAM group practices, hospital administrators and other potential employers

All these outside agencies and constituencies need to be able to compare apples to apples. If practitioners use different English terms for the same original Chinese medical concept, these outside agencies will be left comparing apples to oranges. In that case, they may decide that trying to integrate Chinese medicine into the larger health care infrastructure in the West is either impossible or not worth the effort.

A standard professional terminology is also needed to research and access information digitally. Computers (at least for now) are absolutely literal when it comes to searching a database. Google, Yahoo, and MSN will only bring up search results that contain the exact word or words included in the search parameters. That means that, if I use to term "slippery pulse," the search engine will not return any of the sites that contain the terms "sliding pulse" or "rolling pulse." This implies that I may miss a lot of useful information I may want to find about this topic. Digital information retrieval *demands* the use of a standard terminology. To fail to adopt such a standard terminology will consign this profession to the equivalent of the Dark Ages in terms of computer-aided research.

Additionally, a standard terminology is needed that is makes it easier for speakers, writers, teachers, and publishers to disseminate information on Chinese medicine. This is a small niche market, and there is not much leeway for success in this market in terms of time, energy, and money invested. Writers do not have to reinvent their own terminology and then wonder whether that terminology will agree with other books already available in the marketplace. Similarly, publishers will not have to include a glossary in the back of every book they publish, nor will they have to wonder how their books will segue with the already published literature. Adoption of a standard translational terminology would allow writers, teachers, translators, editors, and publishers to "plug and play."

Lastly, the use of a standard translational terminology pegged to the Chinese originals also makes it easier to learn to read the Chinese language literature *in Chinese.* In this case, one would only use a single dictionary or glossary to learn the meanings of the main words and compound terms. Since reading the Chinese medical literature in Chinese results in the best and most accurate understanding of the technical practice of this medicine in clinic, this final reason should not be overlooked or undervalued.

Criteria for Such a Standard

If the previous reasons for adopting a standard translational terminology are compelling, we next need to determine what criteria such a terminology should meet. Here again, there are several things that require consideration. First, the terminology *must* be pegged to the original Chinese terms as written in Chinese. It is the written Chinese that is our ultimate standard. That means the terms must reference both the so-called Chinese character(s) and its/their Romanization. In addition, since Pinyin is the standard for the Romanization of Chinese in the People's Republic of China and most of the literature on Chinese medicine comes from the People's Republic of China, Pinyin should be the standard for this Romanization.

Secondly, the English terms should be etymologically accurate *in both languages* and specifically accurate in terms of their Chinese medical usage. What do I mean by that?

English is based on three main linguistic streams:
1. Anglo-Saxon ("German")
2. French
3. Latin (some may also have Greek Antecedents)

Therefore, English language term choices should take into account the original derivations of English language words as well as emphasize the specifically Chinese medical usage of the Chinese language

original. For instance, the word *li* (利) is often erroneously translated as "benefit" in a Chinese medical context. In English, "benefit" comes from Latin and simply means "to do good." However, when this word is used as part of a treatment principle or part of a symptom description in Chinese medicine, it means something technically very specific. In this case, *li* means "uninhibited" as an adjective and "to disinhibit" as a verb. The throat, ears, or qi mechanism may be "uninhibited" or "inhibited," while we "disinhibit" the throat, urination, and the qi mechanism. In this latter case, we are not "benefiting" these things in a general, ball-park way. Some evil qi has inhibited the free flow of whatever tissue or mechanism is affected, and that tissue or mechanism needs to be disinhibited. From the point of view of treatment, this implies a species of drainage, scattering, out-thrusting, and/or dispersing, while the word "benefit" has no specific clinical implication that will lead us to a correct treatment plan.

Third, the term set must be large enough to be a meaningful standard. As we have seen above, there are approximately 10,000 terms within the professional practice of Chinese medicine. One of the great failings of the current English language literature on Chinese medicine is that most of these terms are simply missing. For instance, "stasis" (*yu*, 瘀) and "stagnation" (*zhi*, 滞) are different types of non-free flow and should not be collapsed into simply stagnation. Similarly, "depression" (*yu*, 郁) is one of the most important concepts in Chinese medicine and it likewise should not be simply collapsed into "stagnation." Without these concepts, we are not "playing with a full deck of cards." How can we, then, expect students and practitioners to understand Chinese medicine correctly when they are missing whole chunks of theory based on missing technical terms?

The term set must be freely available. Here, "freely available" means that it must be easily available in an essentially public venue to anyone who wants it. does not mean It must be freely available in the marketplace to anyone who wants to purchase it, but not free of charge. A set of terms might be excellent but is useless if it resides in a database on an individual's computer which is inaccessible to others. Even worse is a set of terms which resides primarily in a person's head.

Such a glossary, dictionary, or term set must be primarily created by native-speakers of the arrival language which, in this case, means English. Such native-speakers must be experts in their language (English), capable of reading the departure language (Chinese), experts in Chinese medicine, and familiar with professional standards and techniques for the translation of technical non-fiction.

Such native-speakers can (and should) enlist the aid of native-speakers of the departure language who are experts in that departure language, who are experts in Chinese medicine, and who may or may not read English. But the final authors and arbiters of the terminology should be native English speakers. While practitioners or scholars in China may feel proprietary about their medicine and are justified in caring about how it is transmitted in the West, anyone who has studied another language knows that it is one thing to read and understand that language and entirely another to be able to write or debate terms in that language. I feel quite sure that any Chinese person would raise an eyebrow at my suggesting Chinese words for the translation of English terms; in the same way, it is necessary that native English translators be the final authorities as to which English language words are chosen for translating Chinese medical terms with accurate technical precision.

A Practical Dictionary of Chinese Medicine

Given these requirements, I am aware of only one term set which fulfills all the above criteria: *A Practical Dictionary of Chinese Medicine* by Nigel Wiseman and Feng Ye published by Paradigm

Publications in 1998. The *Practical Dictionary* is the present incarnation of a term set first published by Nigel Wiseman in 1990 under the title *Glossary of Chinese Medical Terms and Acupuncture Points,* Paradigm Publications, 1990. The next incarnation of this term set came in 1995 under the title *English-Chinese Chinese-English Dictionary of Chinese Medicine* published by the Hunan Science & Technology Publishing Co in Changsha. This term set has been developed over the last 15 or more years by a group of people in China, Taiwan, the U.S., and Europe, including Paul Zmiewski, Andrew Ellis, Craig Mitchell, Paul Unschuld, Eric Brand, *et al.* It exists in both hard-copy and digital form and is freely available in the marketplace. The development of this term set is constantly evolving, and anyone can suggest or argue terms.

Objections to Adopting a Standard Terminology

There have been a number of objections to the adoption of this or any other standard English language term set since this terminology's first introduction to the U.S., Canada, the U.K., Europe, Australia, and New Zealand. While some of these objections are only human, they do not merit discussion in this forum. Other objections are based on the economic interests of vested persons and entities. Although these economic objections (openly voiced or otherwise) are all too real, since they are not based on rational linguistic arguments, they are also not discussed herein. However, there are several common objections to the adoption of this or any standard translational terminology profession-wide that do merit consideration and rebuttal.

Sometimes it is difficult to find a suitable English word covering a single Chinese term in all of its meanings and connotations. As anyone who has every looked in a dictionary knows, most words have more than a single meaning, be they English or Chinese. Above, we have seen that the single English word "quicken" is the only English word that covers the two medical meanings of the Chinese *huo* (活), to make move faster and to bring back to life. However, there are most definitely times when one cannot find a single English word to cover all possible medical meanings of a Chinese word. When this happens, one is forced to give two (or more) different English words depending on the Chinese word's usage and context. In that case, a single normative word or standard will not do. Nevertheless, this does not invalidate the concept of a standard. It simply means that making a standard can be complex. Take for instance the Chinese word *se* (涩). According to *A Practical Dictionary*, this word means rough when describing the pulse and the eyes but astringent when describing the action of a class of Chinese medicinals. In other words, in those cases where a single Chinese word has more than a single English meaning, one can specify two or more normative words or standards depending on the usage.

Because this is a technical terminology, some of the terms suggested by Wiseman *et al.* are unfamiliar or may sound funny to the uninitiated. However, let us remember that our schools are teaching at the master's and doctor's degree levels. Assuming this, we should be intelligent enough to be able to use and understand such words as vacuity and repletion, glomus, quicken, disinhibit, and downbearing. Even Chinese students must be taught what these words mean in a Chinese medical context. That is exactly why we have Chinese medical dictionaries. Similarly, Western medical students may also not know what a " histosalpingogram" is until they are told.

Perhaps most important, some people simply disagree with one or more terms in Wiseman *et al.*'s set. However, there is actually no problem with this. Once one has referenced the standard they are using for their public, the translator is then free to deviate from that standard. For instance, Wiseman *et al.* give "stringlike pulse" for *xian mai* (弦脉). However, a string may be loose or tight, and the string of

xian mai is the taught string of a strung bow. Therefore, I prefer to use the term "bowstring" to imply this feeling of tension. No problem! The first time I use the word "bowstring" in any given written work, I simply explain that I am using this word for Wiseman *et al.*'s "stringlike." Now the reader/listener knows what Chinese words I am translating, knows the standard suggested in *A Practical Dictionary*, and knows the term I will be using from here on. Yet someone else may prefer the word "wiry." Again, no problem (although such a translation can be debated etymologically). They simply cite the standard, explain their deviation, and everything is now transparent to everyone. By adopting a specific, freely available standard, one can have their cake and eat it too!

Conclusion

I believe that one thing every school could do today at little or no cost to improve the knowledge and education of our students would be to adopt Wiseman *et al.*'s term set as quickly as possible as the standard for all teachers and classes pertaining to Chinese medicine. That being said, this profession *as a whole* desperately needs a standard, linguistically accurate, freely available, full and complete English language term set for Chinese medical terms to become the mature profession we strive for. Since such a term set meeting the fore-going requirements already exists, it seems a waste of time and resources to start afresh. Nigel Wiseman *et al.* have done and continue to do the scholarly "heavy lifting" to create an adequate standard translational terminology. I strongly suggest we, as a profession, adopt what we already have as our working basis.

Endnotes:

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[1] Abel-Rémusat, Jean Pierre, quoted by Linda L. Barnes, *Needles, Herbs, Gods and Ghosts: China Healing and the West to 1848*, Harvard University Press, Cambridge, MA, 2005, p. 248

[2] *Ibid.*, p. 248-249

[3] Sivin, Nathan, Foreword, *The Theoretical Foundations of Chinese Medicine: Systematic Correspondences*, Manfred Porkert, The MIT Press, Cambridge, MA, 1974, p. xiii

[4] Porkert, Manfred, *op. cit.*, p. 6

[5] *Ibid.*, p. 7

[6] Sivin, Nathan, *Traditional Medicine in Contemporary China*, Center for Chinese Studies, University of Michigan, 1987, p. xxv

***Bob Flaws, DiplAc, DiplCH, FNAAOM, RegAc [UK]**, is one of our profession's most prolific writers on Chinese medicine in English. Author, translator, and editor of over 100 books and scores of articles in professional journals and general magazines, Bob regularly teaches around the world. Other credits include being a founder and past president of the Acupuncture Association of Colorado, a Fellow and past Governor of the National Academy of Acupuncture & Oriental medicine and past editor of their journal, a Fellow of the Register of Chinese Herbal Medicine (UK), a founder of the Council of Oriental Medical Publishers, and editor in chief of Blue Poppy Press, Inc.*

ASIAN MEDICAL NOMENCLATURE DEBATE - Position Paper

By: Jake Paul Fratkin, OMD, L.Ac., Dipl.Ac., Dipl.C.H.

"*The true spirit of the Chinese language is to use simple terms when explaining complex subjects.*"

Position in 2001:
From *Chinese Herbal Patent Medicines*, *The Clinical Desk Reference* (Shya Publications, 2001), p. 1159:

Appendix 10.

GLOSSARY OF CHINESE MEDICAL TERMS
155 Terms of Energetic Physiology

"There has been significant interest by the English speaking traditional Chinese medicine (TCM) community as to which English words to use for Chinese medical terms. The Chinese medical language is very precise, and will have different words for similar concepts, such as boost, assist, nourish, or tonify. These differences are quite important to the well-trained practitioner, ultimately indicating which particular herb is required for therapy. For example, various herbs may affect *qi* in the following ways: tonify, support, secure, consume, descend, rectify, absorb, break, normalize, harmonize, warm, move, increase or correct. All of these terms are represented by different Chinese characters and may indicate the need for a specific type of medicinal herb.

Early attempts by the Chinese to translate Chinese medical terms into English were remarkably successful (for example, that of Hunan Science & Technology Press in 1981, *Bibliography 5-2*), but marred by inconsistencies and a failure of the different publishing houses to adopt a uniform standard. The early American publications of Eastland Press *(Bibliography, 2-2, 3-4)* used translations by Andy Gamble and Dan Bensky which in my mind are the best for the needs of clinicians. Regrettably, Gamble and Bensky failed to follow up with an independent dictionary or glossary. This fell to the work of the scholar Nigel Wiseman, with the help of clinicians Andy Ellis and Paul Zmiewski *(Bibliography 4-3* and *5-4).*

Wiseman endeavored to apply, in the main, one English word for one Chinese word, and his work is largely successful. I have adopted his translations for the most part, due to their consistency as well as the trend of other English language publishers to adopt Wiseman's translations. I have refrained from using Wiseman's translations for 38 entries, due to awkwardness or uncommon usage in the English language. Also, for five items I have preferred to use the original *pinyin* instead of an English rendering, including *zang fu, jing,* and *shen.* "
(A PDF of the complete glossary is attached at the end).

Position, 2006:
My interest in - and concerns regarding - TCM terminology revolve around my lecturing to undergraduates and practitioners as well as writing articles and books. In the early teaching days, and in translating for *Chinese Herbal Patent Medicines, The Clinical Desk Reference*, I relied exclusively on dictionaries coming from mainland China. (See Appendix A.) I have consistently

maintained my belief that Chinese experts were competent in providing English translations for Chinese medical terms, despite some Western publishers' assertion that translations should be provided by native English speakers.

I am well aware of the efforts of Nigel Wiseman and his associates to provide comprehensive dictionaries. Not only do I applaud their Herculean efforts, but I utilize their terminology as much as possible. There are two reasons for this. First is my agreement that there should be some basic consensus on English language translations of TCM terms in the hopes of creating a solid front and foundation for students and practitioners. Second is a desire to be in step with the mainstream trends promoted by the Western TCM publishing houses.

However, since the earliest introduction of "Nigel-Speak" I have strongly resisted certain words as awkward or even incomprehensible, and I have spoken out for their replacement. I list the most egregious here. On the left are Wiseman's terms and on the right are the words I use in my own writings. (Complete comparisons are available in Appendix B.)

	Wiseman	Fratkin
huo xue	quickens the blood	invigorates blood
jiang qi	downbears *qi*	descends *qi*
li shui	disinhibits water	benefits the movement of water
li xiao bian	disinhibits the urine	benefits the movement of urine
qian xu huo	subdues frenetic vacuity fire	subdues deficiency fire
qing xu re	clears vacuity heat	clears deficiency heat
rou gan	emolliates the liver	softens the liver
san jie	dissipates binds	dissipates masses
sheng ji	engenders flesh	generates tissue
sheng jin	generates humors	generates fluid
sheng xian	raises the fallen	raises prolapse
yin xu huo wang dong	vacuity fire effulgence	yin deficiency fire flourishing (upwards)

These translations are not so offensive as irritating, basically because they are not commonly used in clinical discourse. "Emolliates" and "downbears" for example, are not found in an English language dictionary. (Nor, for that matter, is "Herbology".) The most disruptive to the ear is "vacuity" instead of "deficiency", and the most unseemly: "vacuity fire effulgence".

The attempt by some publishers to "insist" that everyone, including the Chinese, use Wiseman translations is wrong, and it emanates from intellectual snobbery. It unfortunately pits Chinese language academics against clinicians. It would be one thing if all the American scholars, teachers and publishers had a basic consensus, but when it is clear that this doesn't exist, it is almost underhanded to approach Chinese publishers as if this were so.

The true spirit of the Chinese language is to use simple terms when explaining complex subjects. When we use unusual, uncommon, or obtuse terms we go against the Asian custom of employing simple words in simple sentences. Creating an unnatural medical language in English reminds me of the Western medical model of using Latin as a foundation, and ultimately creating a glossary and

language that the common person was not meant to understand. And let us not forget the disastrous lexicon Manfred Porkert offered in his widely disseminated work of the late 1970s. This is what I mean by intellectual snobbery.

I would not like to see a Western cultural attitude applied to Oriental medicine whose cultural antecedents strived to make medical language simple. In that culture, Chinese medicine employed terms that the general population knew and used, even terms like *qi, xue, jing*, etc. Terms such as tonifying (*bu)* or draining *(xie)* are easily understood. *Xu*, commonly understood as deficiency, loses its commonness when we call it vacuity. One can make a good case why vacuity is more accurate in conceptual terms, but it is not a commonly used word in our society. Deficiency is more in keeping with the original Chinese common usage of the term, and again, in accord with the tendency of Chinese to use simple everyday words in describing medical and other scientific phenomena.

One issue at this conference is whether a standard dictionary should be imposed on writers and speakers. The different Western publishing houses (notably Eastland Press, Paradigm Publications, Blue Poppy and Churchill-Livingston) ultimately choose their own terminology, and I predict that after this conference, and perhaps because of it, they shall continue to do so. This is to say it is highly unlikely that all the publishers will adapt a standard dictionary.

Any attempt to persuade Chinese publishers, such as Foreign Language Press, etc., that English readers are expecting an allegiance to a Wiseman dictionary is wrong-headed. I hope that one result of this conference will be a clear message to the Chinese publishers that we are not in consensus on recommending the Wiseman dictionary.

Andrew Ellis, in a consultation concerning my own book's glossary, said it doesn't matter what English word is chosen as long as it is consistently used, and that Chinese characters and *pinyin* are provided so the Chinese medicine reader can identify the original term. This is the position I would also propose.

Perhaps the best or most definitive dictionary has not yet been written. Again, I still prefer the Hunan Science and Technology text (see Appendix A, 5-2), although it must certainly be out of print. More recently is the extraordinary work of Professor Xie, Zhufan in his book, "On The Standard Nomenclature of Traditional Chinese Medicine" (Foreign Language Press, Beijing). I had hoped the conference had invited Professor Xie to take part in this panel, and I would highly recommend his book to all of the panelists. Professor Xie looks at all the English language translations (including those by Wiseman, Bensky and others) and gives reasonable explanations for his preferred English word selections. I have included some of his terms in the attached PDF file comparing Wiseman terminology with alternatives. He offers a studious explanation for his English word choices, according to both the tenets of TCM as well as linguistic considerations. His English is certainly as good as the English-language scholars who are writing on the subject.

In conclusion, I would recommend that each publishing house adapt or maintain its own consistent linguistic standards but provide, as Mr. Ellis proposed, a glossary with Chinese characters, *pinyin*, and its English translation. This would apply to English translations of medical terms as well as herbal medicines, formula names, and acupuncture points. I would hope that the various publishing houses of China, printing in English, would follow these recommendations as well.

APPENDIX A.
From *Chinese Herbal Patent Medicines*, *The Clinical Desk Reference* (Shya Publications, 2001), p.:

5. BOOKS AND DICTIONARIES ON CHINESE-ENGLISH TERMINOLOGY

5-1. CHINESE-ENGLISH DICTIONARY OF TRADITIONAL CHINESE MEDICINE, Ou Ming, Editor. Guangdong Science & Technology Publishing House with Joint Publishing Co, Ltd., Hong Kong. 1988.

5-2. CHINESE-ENGLISH TERMINOLOGY OF TRADITIONAL CHINESE MEDICINE, Hunan Science & Technology Press, Hunan, 1981.

5-3. DICTIONARY OF TRADITIONAL CHINESE MEDICINE, edited by Xie and Huang, Beijing Medical College; Commercial Press Ltd., Hong Kong, 1984.

5-4. ENGLISH-CHINESE CHINESE-ENGLISH DICTIONARY OF CHINESE MEDICINE, Nigel Wiseman, Hunan Science & Technology Press, Hunan, 1995.

5-5. GLOSSARY OF CHINESE MEDICAL TERMS AND ACUPUNCTURE POINTS, Nigel Wiseman with Ken Boss, Paradigm Publications, Brookline, 1990.

5-5. MATHEWS' CHINESE-ENGLISH DICTIONARY, Revised, American Edition, Harvard University Press, Cambridge, 1931, 1993.

5-6. THE PINYIN CHINESE-ENGLISH DICTIONARY. Commercial Press, Hong Kong. 1978, 1981, 1995.

Note: This represents the full position paper submitted by Dr. Fratkin, but an accompanying 7 page Glossary is available online.

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APPENDIX B

	Fratkin (when different)	Wiseman	Xie, Zhufan (when different)
an hui		quiets roundworms	
an shen	calms *shen*	quiets the spirit	calms the mind
an tai		quiets the fetus	
bao xin		protects the heart	
bu qi	tonifies *qi*	supplements *qi*	tonifies *qi*
bu yang	tonifies *yang*	supplements *yang*	tonifies *yang*
chu re		eliminates heat	relieves fever
chu shi		eliminates damp	
chu tan		eliminates phlegm	
dan		gallbladder	
ding chuan	stabilizes wheezing	stabilizes panting	
gu biao		secures the exterior	strengthens the exterior
gu jing	secures *jing*	secures the essence	strengthens essence
gu qi she xue		secures *qi* and contain blood	
gu shen		secures the kidney	strengthens kidney
he dan wei		harmonizes gallbladder and stomach	
he gan pi		harmonizes liver and spleen	
he gan wei		harmonizes liver and stomach	
he wei		harmonizes the stomach	
he zhong	harmonizes the middle *jiao*	harmonizes the center	

hua tan ye		transforms phlegm fluid	resolves phlegm fluid
hua tan zhuo		transforms phlegm turbidity	resolves phlegm turbidity
hua tan		transforms phlegm	resolves phlegm
huo luo	invigorates the collaterals	quickens the connections	

	Fratkin (when different)	Wiseman	Xie, Zhufan (when different)
huo xue	invigorates blood	quickens the blood	activates blood
jian pi	strengthens the spleen	fortifies the spleen	invigorates the spleen
jiang qi	descends *qi*	downbears *qi*	sends *qi* downwards
tong jing luo	opens the channels and collaterals	frees the channels and connections	unblocks the
jiao	*jiao*	burner	
jie		resolves spasms	relieves spasm
jie biao		resolves the exterior	releases the exterior
jie du		resolves toxin	relieves toxicity
jie xiong men		resolves chest oppression	relieves chest oppression
jie yu	resolves stagnation	resolves depression	relieves depression
jing	*jing*	essence	
jing	channels	channels	meridians
jing luo	channels and collaterals	channels and connections	meridians and collaterals
kai qiao		opens the orifices	
li shui	benefits the movement of water	disinhibits water	promotes urination
li xiao bian	benefits the movement of urine	disinhibits the urine	
li xue			regulates blood
li yan	benefits the throat	benefits the pharynx	relieves sore throat
liang xue		cools blood	
ming mu		brightens the eyes	improves vision
pai nong		discharges pus	

pai shi	expels stones
pi	spleen

	Fratkin (when different)	Wiseman	Xie, Zhufan (when different)
ping chuan	calms wheezing	calms panting	relieves dyspnea, asthma
ping gan		calms the liver	
po xue yu		breaks blood stasis	breaks up blood stasis
po yu		breaks stasis	breaks up stagnation
qian huo		subdues fire	
qian xu huo	subdues deficiency fire	subdues frenetic vacuity fire	subdues deficiency fire
qian yang		subdues *yang*	
qiang jin gu	strengthens tendon and bone	strengthens sinew and bone	
qing huo		clears fire	
qing re jie du		clears heat and resolves toxin	
qing re		clears heat	
qing shu		clears summer heat	
qing wei		clears the stomach	
qing xia fu jie	clears and purges the bowel	clears the bound and precipitates the bowels	
qing xu re	clears deficiency heat	clears vacuity heat	
qu feng han		disperse wind cold dispels wind cold	
qu feng xie	dispels pathogenic wind	dispels wind evil	dispels pathogenic wind
qu feng		dispels wind	
qu han		dispels cold	
qu huang		dispels jaundice	
qu shi re		dispels damp heat	

qu shi yu	dispels food stasis
qu shi	dispels damp
qu tan zhuo	dispels phlegm turbidity
qu tan	dispels phlegm

	Fratkin (when different)	Wiseman	Xie, Zhufan (when different)
qu xie	dispels pathogenic factors	dispels evil	dispels the pathogenic
qu xue yu		dispels blood stasis	
qu zhuo		dispels turbidity	dispels turbidity
rou gan	softens the liver	emolliates the liver	
ruan jian		softens hardness	
ruan san jie		softens and dissipates nodules	
run chang		moistens the intestines	
run fei		moistens the lung	
run hou		moistens the throat	
san han		dissipates cold	
san jie	dissipates masses	dissipates binds	dissipates nodulation
se jing	astringes *jing*	astringes the essence	astringes essence, semen
sha chong		kills parasites	
sheng ji	generates tissue	engenders flesh	regenerates flesh, tissue
sheng jin	generates fluid	generates humors	promotes fluid
sheng xian	raises prolapse	raises the fallen	
sheng yang		raises *yang*	
shu gan	dredges the liver	courses the liver	
shu gan		soothes the liver	
shu tong jing luo	dredges and opens the channels and collaterals		
		courses and frees the channels and connections	

shun qi	normalizes *qi*
tiao he yin yang	regulates and harmonizes *yin* and *yang*
tiao he ying wei	regulates and harmonizes *ying* and *wei*
tiao jing	regulates menses

	Fratkin (when different)	Wiseman	Xie, Zhufan (when different)
tong bi sui		opens the nasal passages	
tong bian		frees the stool	frees the bowels
tong jing		frees menstruation	promotes menstruation
tuo du		expels toxins	
wen bao		warms the uterus	
wen gan mai		warms the liver channel	
wen jing luo		warms the channels and collaterals	
wen qi		warms *qi*	
wen shen		warms the kidney	
wen wei		warms the stomach	
wen yang		warms *yang*	
wen zhong		warms the middle (*jiao*)	
xi feng zhi jing		extinguishes wind to stop convulsion	
xi feng		extinguishes wind	
xiao feng		disperses wind	
xiao yan		disperses inflammation	
xiao zhong		disperses swelling	alleviates swelling
xie fei		drains the lung	
xie huo		drains fire	purges fire
xie re		drains heat	
xing qi		moves *qi*	

	Fratkin (when different)	Wiseman	Xie, Zhufan (when different)
xing shi		moves damp	
xuan fei		diffuses the lung	disseminates lung *qi*
yang gan		nourishes liver	
yang jing	nourishes *jing*	nourishes the essence	
yang xin		nourishes the heart	
yang xue		nourishes blood	
yang yin		nourishes *yin*	
yang ying wei		nourishes *ying* and *wei qi*	
yi fei	benefits the lungs	boosts the lungs	tonifies lung
yi jing	increases *jing*	boosts the essence	replenishes essence
yi mu	benefits the eyes	boosts the eyes	
yi qi	increases *qi*	boosts *qi*	replenish *qi*
yi shen	benefits the kidneys	boosts the kidney	tonifies kidneys
yin xu huo wang dong	yin deficiency fire flourishing (upwards)	vacuity fire effulgence	
zang fu	*zang fu*	viscera and bowels	
zao shi		dries damp	
zhen gan		settles the liver	
zhen xin		settles the heart	
zheng qi	*zheng qi*	correct *qi*	
zheng		pattern, syndrome	
zhi dai		relieves vaginal discharge	stops vaginal discharge

zhi jing	relieves spasm	stops spasm
zhi ke	relieves cough	stops cough
zhi ke	relieves thirst	quenches thirst

	Fratkin (when different)	Wiseman	Xie, Zhufan (when different)
zhi li		relieves dysentery	stops dysentery
zhi ou		stops vomiting	
zhi suan		restrains acid	
zhi tong		relieves pain	stops, alleviates pain
zhi xie		relieves diarrhea	
zhi xue		stops bleeding	stop, arrests bleeding
zhi yang		relieves itching	relieves, alleviates itching
zhi jing		stops convulsion	stops convulsion
zhu yang		assists *yang*	

Council of Colleges of Acupuncture and Oriental Medicine (CCAOM) Medical Nomenclature

By: Steve Given, LAc

"Further, the AAUP states 'The common good depends upon the free search for truth and its free exposition.'"[1] In an institutional environment where academic freedom is paramount, decisions regarding the work of the academy, including translation, must be left to the individual scholar."

The Council of Colleges of Acupuncture and Oriental Medicine (CCAOM) represent fifty schools across the United States. These schools include practitioners and scholars working in diverse traditions and languages including Traditional Chinese Medicine, Five Element Acupuncture, Japanese Acupuncture and French Energetic Acupuncture among others.

It is the position of the CCAOM that the continued growth and success of this profession results in part from this diversity in practice and scholarship within academic institutions of acupuncture and Oriental Medicine. The specifics of scholarship, including the study and translation of classical and modern texts are best left to the individual scholars working in the field. It is not in the interest of academic institutions or the profession as a whole to infringe on the basic academic freedom of scholars within these institutions, especially in an area of study such as translation, where there remains significant disagreement on the transliteration of specific characters and phrases, or the process of translation itself.[234] The creation of a translation standard without broad agreement among scholars working in the field would constitute such an infringement. The ability to gain consensus at this point on such a far reaching topic is highly problematic.

Academic freedom is enshrined in the accreditation standards for schools of acupuncture and Oriental medicine. One of the goals of accreditation is to "to protect institutions against encroachment which might jeopardize educational effectiveness or academic freedom."[5] The American Association of University Professors (AAUP) endorsed a statement published in 1940 that includes the following statement. "Academic freedom is essential to these purposes and applies to both teaching and research. Freedom in research is fundamental to the advancement of truth. Academic freedom in its teaching aspect is fundamental for the protection of the rights of the teacher in teaching and of the student to freedom in learning. Further, the AAUP states "The common good depends upon the free search for truth and its free exposition."[6] In an institutional environment where academic freedom is paramount, decisions regarding the work of the academy, including translation, must be left to the individual scholar.

Translation within academic institutions of acupuncture and Oriental medicine are motivated by diverse goals. Translation is done with the goal of publication, as an aid in teaching and clinical training, and to support research and scholarship in the field. The success in achieving each of these goals depends on the skill and judgment of the translator in effectively translating the text in question with as much fidelity to the meaning of the original as is possible, and creating the most readable text in light of the original text.

Note: This is the full position paper submitted by Dr. Given on behalf of the CCAOM.

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[1] http://aaup.org/statements/Redbook/1940stat.htm
[2] On Terminology & Translation, *Journal of Chinese Medicine* Vol. 63
[3] Rosenberg Z (2000) Acupuncture Today, Vol. 1, No. 5
[4] Ergil M, http://www.sotcm.com/ATTENTIONS.htm
[5] Accreditation Commission for Acupuncture and Oriental Medicine, *Accreditation Handbook*, page 1.
[6] http://aaup.org/statements/Redbook/1940stat.htm

A Position Paper on Terminology: A Personal Perspective from a Professor of Herbal Medicine.

By Z'ev Rosenberg, LAc

Introduction

I have been teaching Chinese herbal medicine continuously as a professor at Pacific College of Oriental Medicine, San Diego, for the past 16 years, and before that at Southwest Acupuncture College in Santa Fe, N.M. for one year. During this time, I have also taught several seminars and lectured around the United States to both fellow practitioners and the general public. I was part of the first wave of practitioners in the United States, and a graduate in 1983 of one of the first acupuncture colleges to open in this country as well. This school originally was the Institute of Traditional Medicine in Santa Fe, New Mexico, now the Southwest Acupuncture College.

While I understand and support the use of "East Asian medicine" as a description of the broader expression of medicine including Japan, Korea, and other Asian countries, since I am referring mostly to specifically Chinese herbal medicine, I will use the term '"Chinese medicine," because that is the medicine I practice.

As a dedicated practitioner and proponent of Chinese medicine, envisioning it as a way of life as well as a profession, I have devoured a majority of English language texts on the subject. This started with just a relative handful of books back in the early 1980's, and has now grown to include many hundreds of texts of varying quality. In the early days of the profession, it was quite a challenge to find quality materials to study in English. Translation of Chinese medical texts was in its infancy, and the results were variable at best. There were also few ways to learn medical Chinese language without trying to master the language as a whole, a massive undertaking for a Westerner. No school at the time offered any classes on medical Chinese, and few do today. The principal texts at the time were *Essentials of Chinese Acupuncture*, *The Web That Has No Weaver*, and *Acupuncture: A Comprehensive Text*. The first text, *Essentials of Chinese Acupuncture*, was basically an acupuncture text designed in mainland China for short courses for Western MDs. "The Web" was a survey text of TCM that served as both a textbook on theory and an introductory text for the general public. "A Comprehensive Text" was the first actual translation of a Chinese textbook on acupuncture to appear in a Western language.

After eight years in full-time clinical practice, where I treated as many as one hundred patients per week in Denver, Colorado, I decided it was time for to teach as well as practice Chinese medicine. I decided to focus on teaching herbal medicine, as there were few available teachers at the time (the late 1980's). As I gained experience in teaching courses on Chinese herbal medicine, focusing on prescriptions, materia medica, and classics such as the *Shāng Hán Lùn*, it became apparent that there was much confusion in most students over much of the material being taught. The major problem was that most of the required texts each used different translation schemes without much explanation. There were few glossaries to explain term choices, and no comprehensive dictionary was available. For each textbook used, students had to learn a new nomenclature. Some books capitalized the names of the "Organs", some did not. Some called the 脏zàng "organs," other translations were 'yīn viscera', 'hollow organs', 'orbs'. And this is just one basic, simple term.

The many inaccuracies in translation led to distortions in understanding the subject, and allowed misconceptions to flourish as gaps in understanding were filled by inappropriate biomedical and alternative medical substitutions. Even though most translators aimed at "transparency," i.e., a simple, easy-to-read approach, the end result was often a poor transmission of core concepts. This contributed to poor communication between practitioners, students and teachers alike. While each person in our field has valuable perspectives and original insights that should be shared with others, several authors were not careful to differentiate between original ideas and source materials in their textbooks. Several of these textbooks became the basis of TCM college programs, and ultimately state and national board exams and certifications.

While there have been great improvements in the quality of Chinese medical texts in recent years, many essential texts remain poorly or not translated at all, including seminal texts such as the *Huáng Dì Nèi Jīng* ("Yellow Emperor's Internal Canon"). I own about ten different English translations of this text and several Chinese originals, and only one translation (Paul Unschuld's introductory text, the first of a series) begins to do justice to the original text in Chinese. The fact that a seminal, foundational text has not be accurately translated into English despite several attempts shows that there are major issues with the subject as taught.

_PD_ Terminology

In my opinion, the text that revolutionized the field in terms of deepening and broadening Chinese medical knowledge was the *Practical Dictionary of Chinese Medicine* (hereafter referred to as *PD*) compiled by Nigel Wiseman and Féng Yè. It was the first comprehensive dictionary in the English language that matched Chinese language Chinese medical dictionaries such as the *Zhōng Yī Dà Cí Diǎn* ("Great Dictionary of Chinese Medicine"), which has thousands of technical terms. While there has been some disagreement over English term choices by other authors and publishers, the scope of this text and its clear definitions are unmatched at this point. It gave me, finally, a definitive source to explain key concepts of Chinese medicine in English. It also provided me with a gateway into medical Chinese language that could be developed further with concentrated study.

Clinical proficiency rests on a body of intellectual knowledge, in which concepts are the basic building blocks. Students cannot hope to practice Chinese medicine skillfully and effectively if they do not have a grasp of the concepts. *PD* has filled an important gap. Over the last six years, I have consistently made a point of questioning my students on specific terms and concepts. Before *PD* was required reading at Pacific College, the ability of students to explain terms and concepts was very poor. In the last year or two, since *PD* was a required text, the knowledge of terms and concepts has increased exponentially.

The problems of a confusing variability in basic textbooks for beginning students can be to some extent be overcome when teachers are able to explain conflicting term choices. However, teachers are only able to do this effectively when they know Chinese. Sadly, all too few Chinese medicine teachers have a satisfactory knowledge of Chinese to be able to do this. *PD* remedies this, because it provides full explanations of over 5,000 commonly used terms for people who have no knowledge of Chinese.

More advanced study of Chinese medicine quickly becomes confusing without terminology that is more consistent. Many texts have distorted concepts. For example, a commonly used acupuncture text translates 疝气 *shàn qì* or 疝 *shàn* as "hernial disorder." In *PD* 疝气*shàn qì* or 疝*shàn* are translated as "mounting," based on the use of the mountain character (山*shàn* inside the disease radical), the image of something amassing. The term 疝 *shàn* is broad in meaning, referring to accumulations of cold in the lower abdomen, or to bulging of the scrotum due to the presence of fluid or invasion by the small intestine. The term "hernial disorder" is completely misleading because is suggests only the latter pathology. *PD* lists several kinds of mounting: cold mounting, water mounting, qi mounting, bulging mounting, blood mounting, and several others, each with a specific definition. What is so special about the relationship of English equivalents in this system is that they preserve the relationships of sensory phenomena that are the visible expressions of disease, therefore are congruent with the specific diagnostic and treatment modalities of Chinese medicine.

The English choice of "mounting" for疝 *shàn* is an example of what is called a "source-based translation approach." It aims to reflect the ideas that the ancient physicians of China had in mind when they were naming the concepts they developed. "Hernial disorder" by contrast is a "target-based" translation; it aims to be immediately intelligible to the Western reader. Numerous examples can be found to show that source-based terms reflect the original concepts much more accurately than target-based translations. Source-based translation is applied by historians such as Unschuld. No terminology applied in the clinical literature of Chinese medicine is as source-based as *PD* terminology. In discussions about standardization, the basic difference between source-based and target-based approaches should be very much on the agenda. There is no point haggling about terms when there is no agreement on a fundamental approach. We cannot begin to discuss whether 疝 *shàn* should be translated "mounting" or "hernial disorder" until we understand the fundamental difference between the two as regards translation theory.

Biomedical terminology is quite prevalent in English-language literature at the current time. *PD* is very sparing in its use of Western medicinal terms, because they often fail to represent traditional Chinese medical concepts accurately. The "easy-to-read" philosophy distorts concepts. Many English texts from mainland China translate 痹 *bì* as "arthralgia." This is misleading because *bì* takes many forms, not all of which are characterized by pain in joints. Although many instances of *bì* correspond to arthritis, there are others that correspond to sciatica or to other musculoskeletal disorders. Furthermore, not all forms of joint pain (arthralgia) fall within the scope of *bì.* This is why Chinese texts speak of 关节疼痛 *guān jié téng tòng* as a symptom, distinct from痹 *bì,* which is a disease name. Many of us in clinical practice like to refer to *bì* by its Chinese name. Nevertheless, having an English name that captures the sense of the Chinese term provides a useful aid to students in understanding the concept.

The "transparent," "easy-to-read," target-based approach that many translators and writers have adopted in the past has not only led to distortion, but also to simplification of concepts. Many English texts speak of involuntary loss of semen as "spermatorrhea." Those who read Chinese know that Chinese medicine makes an important distinction between "seminal emission" (遗精 *yí jīng*) and "seminal efflux" (滑精 *huá jīng*). This distinction is of importance in therapy, because it is usually only the latter that calls for the use of astringents. And of course, a further distinction is made between seminal emission with dreaming and

seminal emission without dreaming, the former being associated with hyperactivity of the ministerial fire due to insufficiency of liver and kidney yīn, while the latter is associated with debilitation of the life gate fire. Where such fine distinctions are made, it is important that we have terms to represent all of the concepts and also that writers try to abide by the same terms so that people don't get confused about what is what.

PD does not only help students to gain a firm grasp of the concepts of Traditional Chinese Medicine. Because it relates all the English terms to the original Chinese terms, it enables any translator to apply *PD* terminology in their own works. It is precisely because of this that over the last 20 years a vast amount of textbooks and clinical literature using *PD* terminology have appeared on our bookshelves. Both Paradigm Publications and Blue Poppy have adopted *PD* terminology as their house standards. It is so helpful when finally, after years of terminological confusion, a body of literature is developing, in which the technical language is unified. People reading these texts do not have to wonder what terms mean, because they can find most of them in *PD.* Thus, they can gradually build their knowledge of Chinese medicine, instead of wracking their brains wondering whether term X in one book is supposed to mean the same as term Y in another book. There can be no terminological standard in which

translators and scholars cannot consistently associate

English equivalents with the original Chinese terms.. No terminology can become a standard unless there is a growing body of literature that uses it. Moreover, no standard can develop unless there is agreement on basic approaches to translation (source-based versus target-based). The advent of *PD* has unleashed a process of standardization that this meeting should recognize. However, this does not necessarily mean that *PD* terminology should be forcefully imposed as a standard. Yet, as the success of *PD* has shown, all writers would do themselves and their readers good if they related the terms they use to those used by the Chinese. Recently, Eastland Press has begun to provide glossaries that relate their terminology to *PD* terminology. It is only when different English terminologies can be related to each other that readers are spared confusion.

I believe that it is probably pointless at this stage to get the major authors of Chinese medical books to sit around a table and iron out their differences. All writers have stakes in the literature they have created. All we can hope to achieve in the near future is develop awareness of the need for referencing between the various English terminologies on the one hand and the Chinese terminology on the other. This is what is meant by an Open Standard, which is recommended by Bob Felt of Paradigm Publications.

As I have heard from my colleagues Nigel Wiseman and Paul Unschuld, there has recently been much talk at meetings in the WHO and the PRC on a double nomenclature for disease name. An example of this is 风火眼 *fēng huǒ yǎn,* for which the source-based translation is "wind-fire eye," while the target-based translation is "acute conjunctivitis." East Asians are concerned about the respectability of East Asian medicine in the eyes of the international biomedical establishment. They therefore prefer target-based translations like "acute conjunctivitis." Wiseman and Unschuld favor a dual nomenclature in which风火眼 *fēng huǒ yǎn* would appear in a term list with the English equivalents as: wind-fire eye (acute conjunctivitis). This would not only enable translators to take their pick; it would also enable readers to establish an association between the source-based and target-based translations. This dual approach is one

example of an Open Standard. An Open Standard is one that satisfies everyone's needs without any tyrannical enforcement of anyone's preference over anyone else's.

An Open Standard is, in my opinion, the best choice. Attempts at an open standard in publication were an essential part of the foundation of COMP. (Council of Oriental Medical Publishers), but COMP was perhaps an idea before its time. An Open Standard doesn't require rigid conformity to specific term sets, but does encourage an accountable, source-based approach to translation. That source is primarily the Chinese language, specifically technical Chinese medical language encoded in voluminous dictionaries derived from thousands of medical texts over two thousand years of history.

General Suggestions

I have a number of specific suggestions for CM publishers and authors aimed to enable teachers of Chinese medicine to teach professional Chinese medicine properly and facilitate communication between people using different terminologies. These are as follows:

a) textbooks with ample footnotes explaining concepts, source texts, and applications of specific terms
b) glossaries of technical Chinese medical terminology, especially those unique to the text
c) regular communication between publishers and teachers on various issues and difficulties with subject matter
d) coordination of textbooks between publishers, with consistency of conceptual and linguistic materials
e) teaching materials, such as audio-visual aids, DVDs, charts, and other software tools
f) regular updates to textbooks as needed, perhaps by e-mail notification and postings at websites

As a teacher, I feel that some standardization of textbook materials is necessary, or at the very least, cross-referenced glossaries that allow teachers and students to communicate essential information. For example, in order to keep accurate charts of patients, specifically pulse data, there needs to be a list of the twenty-eight or so main pulse qualities with definitions, pinyin, and Chinese characters. Without this, it becomes very difficult, if not impossible, to teach or measure pulses, one of our essential diagnostic tools.

Key words: target based translation, source based translation, terminology.

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AAOM ADVISORY TO WORLD HEALTH ORGANIZATION (WHO) INFORMAL CONSULTATION ON DEVELOPMENT OF CLASSIFICATION OF EAST ASIAN TRADITIONAL

SUMMARY REPORT
INFORMAL CONSULTATION ON DEVELOPMENT OF CLASSIFICATION OF EAST ASIAN TRADITIONAL
6 TO 8 JUNE 2006 - SEOUL, REPUBLIC OF KOREA

An Informal Consultation on Development of Classification of East Asian Traditional Medicine was held in Seoul, Republic of Korea, from 6 to 8 June 2006.

The meeting was attended by 15 temporary advisers from Australia, China, Japan, Republic of Korea, United States of America, and Viet Nam, a World Health Organization (WHO) consultant, and one secretariat staff member each from WHO Regional Office for the Western Pacific and from WHO Headquarters. There were also eleven observers from the Republic of Korea and the United States of America. **Dr. Jeannie Kang, LAc (CA) was the Advisor selected to represent the American Association of Oriental Medicine (AAOM) at this meeting, and Marilyn Allen, AAC Public Relations and Marketing Director & Acupuncture Today Editor and Chief, participated as an Observer for Media Relations on behalf of the AAOM.** Presentations and reports covered the need for standardization of terminology and classification in traditional medicine, country efforts and options for further development.

At the plenary sessions, consensus was reached on the following issues:

(1) The classification is to be international

(2) Proposal is to be made to WHO-Family of International Organizations (FIC) for the classification to be derived from ICD and accepted as a member of the WHO-Family of International Classifications

(3) The name of the classification is to be the International Classification of Traditional Medicine (ICTM)

(4) The purpose of the classification is to promote standardization in traditional medicine terminology and data for communication, sharing of knowledge and resources, analyzing and reporting. Its aims are to avoid duplication of effort and create economies of scale, raise the standard of traditional medicine ™ in clinical practice, public health, research, clinical trials, education, policy development, resource allocation and allow exchange of health records and inclusion of TM data in health information systems

(5) The classification is to be developed to demonstrate its links to International Classification of Disease (ICD)-10 as well as to reflect the characteristics of traditional medicine. This will create a platform for inclusion of traditional medicine in ICD-11.

(6) International Standard Terminology (IST, country efforts and ICD, prepared by WHO/WPRO, are to be the main resources for ICTM development.

The meeting made the following recommendations:

(1) WHO to facilitate development and support of ICTM

(2) WHO to promote ICTM development to traditional medicine and to wider health care field

(3) WHO to ensure consistency of terminologies used in classifications of TM and other relevant health care fields such as FHH (Forum for Harmonization of Herbal Medicine)

(4) Member States to provide support (including financial) to ensure development and effective implementation of ICTM

(5) Member States to ensure that TM and Western medicine (WM) professions have access to ICTM to promote cross discipline communication

(6) Member States to recommend to WHO that ICTM be accepted as a member of WHO-FIC (WHO/WPRO to prepare draft proposal)

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