

Chinese Medical Terminology: Answers to Buck and Maciocia

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The editor of *Journal of Chinese Medicine* is to be lauded on including in the 63rd issue of June 2000 five contributions to the debate on the English terminology of Chinese medicine. An open discussion on term issues is long overdue and the *Journal* is to be commended for generously according so much space to their discussion.

What I wish to do here is to respond to the views put forward by the two opponents of my approach to terminology, Charles Buck and Giovanni Maciocia.

Answer to Buck

Charles Buck expresses a strong preference for Pinyin terms over the largely literally translated English terminology I have proposed. I will here try to show how transcription and literal translation have been used in the translation of terms in other acts of knowledge transmission, and discuss the relative advantages of transcription and literal translation in specific context of Chinese medicine.

As I have described in considerable detail [1], there are various methods by which we can translate technical terms from one language to another, in any field. For terms that are everyday words used more or less in their everyday sense, it is customary to use everyday equivalents. No translator disputes that *tou* should be translated as head, *qi* as umbilicus or navel, *ke sou* as cough, or *niao* as urine. These are obvious choices. Problems tend to arise with strictly technical terms, i.e., with terms devised by experts to represent concepts with which laypersons are not familiar. When translators wish to preserve all the concepts contained in source-language texts, they usually borrow the original terms or translate them quite literally. Thus loans (borrowed terms such as *qi*, *yin*, and *yang*) and loan-translations (terms literally translated like *triple burner*, *sea of blood*, and *evil*) are the types of equivalents translators choose when devising new terms in the target language [2]. Because these translations have a close affinity with the original terms (as distinct from free translations), they are *source-oriented translations*.

The choice between loans and loan-translation largely depends on how normal it is for any given language to borrow words from another language. Centuries ago, when the Latin medical terms of Western medicine first started to be translated into vernacular languages, English borrowed virtually every Latin term (in slightly altered grammatical form), while German opted for loan-translations. Whereas English speakers borrowed *vagina*, *pelvis*, and *pylorus* from Latin, Germans translated them literally as *Scheide*, *Becken*, and *Pförtner*, reflecting the original meanings of the Latin terms ('sheath', 'basin', and 'gatekeeper'). English tended to borrow from

Latin because the imposition of French after the Norman Conquest had led to the adoption of much Latinate vocabulary in English, which made subsequent borrowing from Latin very easy. The German language, on the other hand, underwent no such outside interference, so it remained conservative in its lexical preference.

When Western medicine began large-scale transmission to China in the 19th century, a source-oriented approach was again adopted. Since Chinese is resistant to borrowing words from foreign languages, the loan-translation approach was chosen. Chinese is largely a monosyllabic language, and has difficulty borrowing polysyllabic foreign words such as those that characterize Western medical terminology. It is impossible for Chinese to borrow a word like *hepatosplenomegaly*; instead it renders it as *gan-pi-zhong-da* (liver-spleen-swollen-big). The resulting Chinese term is actually far more self-explanatory to Chinese speakers than the English term, composed of Greek word roots, is to English speakers.

In languages where loan-translation is preferred to direct borrowing, it tends to be used in most cases, but not all. One exception is where a term in the source-language that is poorly chosen (terminology experts describe such terms as “poorly motivated”) is dealt with by devising a new term in the language translated into (the “target language”) from scratch. An example of this in Western medicine is the way in which *ascites* was translated into German. Instead of a literal translation (*ascites* means ‘wine skin’), German speakers chose *Bauchwassersucht* (literally ‘belly water disease’). Another exception is where, owing to the absence of a suitable equivalent in the target language, a loan is chosen. A classic example of this is the German *Muskel* (English *muscle*), a borrowing from Latin that ostensibly avoids the unwanted connotation of a dead metaphor (the Latin *musculus* originally meant ‘little mouse’, which would sound somewhat childish in German). *Yin* and *yang* are classic examples in Chinese medicine. Nevertheless, in languages in which borrowing is difficult, loan-translation is the norm, and deviation from it is comparatively infrequent. The reason for this is that the source-language term provides a major precedent. Translators naturally tend to translate the term literally wherever possible, and tend to create a new term from scratch only if a literal translation is misleading. This is not just sloth on the part of translators; a literally translated equivalent has the significant advantage of allowing those who know both the source and target languages (the key people in the transmission of knowledge through translation) to associate terms instantly. While borrowed equivalents can be recognized by their spelling, literally translated equivalents are recognized by having the same literal meaning.

The concepts of *loan* and *loan-translation* should be properly understood. The term *loan* suggests that the original source-language term is adopted into the target language, while *loan-translation* suggests the original term is not adopted but translated. A loan-translation appears to be a big step removed from a loan. Actually the distance is not so great. A loan is a borrowing of the written form; it is not a full borrowing of the meaning because target-language users do not know the source-language. In English, most people know *vagina* only by its medical

application; having no knowledge of Latin, they do not realize that in Latin *vagina* meant *sheath*, and that its application in medicine was originally metaphorical. English has, as it were, an empty shell of the written form, a representation of the sound of the Latin word. German speakers, by contrast, rejected the written form and the sound of the Latin word in preference for its literal meaning. They chose their word for 'sheath' to represent the female anatomical part. Thus, we should be aware that loans, like loan-translations, are only approximations. It is very true, as Buck points out, that the meanings of words in different languages do not always correspond exactly. Because of this, loan-translation is not always possible or ideal. Yet direct borrowing, too, is never complete since it entails loss of meaning, and as I shall explain further ahead, neither is it always possible.

How meaningful a loan is depends entirely on how familiar speaker are with the language the word has been borrowed from. In English, we can borrow almost anything from French because so many English speakers have some knowledge of the French language, even if only rudimentary. *Ménage à trois*, for example, is not an obscure expression for educated English speakers who know a) what *ménage*, *à*, and *trois* mean, and b) know how compounds can be formed in French by means of *à*. We borrow less easily from German than French, because fewer people are acquainted with German. The borrowing of *Zeitgeist*, 'spirit of the time', may have been facilitated by our ability to see in *Geist* our own word *ghost*, but it will not have been helped by *Zeit*, which is obscure to English speakers (even though it is akin to our word *tide*).

When translating Chinese medical terms into English, we must decide whether terms other than the simple everyday words should be borrowed, translated literally, or translated freely. Buck proposes that we use Pinyin rather than English terms. Since Pinyin is the representation of a Chinese word in written form accessible to people who read English but not Chinese, Pinyin terms are loans. Buck favors Pinyin loans as a standard way of representing Chinese terms in English, while I favor loan-translations (he does not make it clear when Pinyin should be used in preference to English, and I will discuss this further ahead). As I said, both these methods are source-oriented, and both are theoretically acceptable in the translation of technical concepts. Where Buck and I differ is in the relative practicality of the two. Buck believes that Pinyin is more practical because it avoids the problems of inexact correspondence between Chinese and English and gives Chinese its rightful place international communication. I, on the other hand, think that most Chinese terms are literally translatable, and that although Pinyin might be acceptable if we were dealing with only a few concepts, it cannot be used on the scale required by a field as ancient, broad and complex as Chinese medicine.

As I said, Buck does not clarify the scope of his proposed use of Pinyin. On the one hand, he says that it should be used for all untranslatable and problematic terms (terms that are impossible or difficult to translate). However, since he gives very few examples, and does not define difficulty of translation in any objective terms. He gives *qi ni* as an example of a term best left in Pinyin, while in my opinion and in that of most other translators this term is perfectly translatable (in

Wiseman terminology as *qi counterflow*). On the other hand, his claims that using Pinyin terms would help international communication suggests that Pinyin should be used for all terms, not just those that happen to be difficult or impossible to translate into one language or another. The number of term requiring standard English translations or Pinyin transcriptions is of crucial importance in deciding which method of translation to use. As I will show further ahead, Pinyin becomes the less feasible the more terms it is used to render. Buck may think that Pinyin is feasible because, like the writers who fail to offer or work to a comprehensive published glossary, he suffers from the illusion that Chinese medicine has only a small vocabulary.

First of all, I wish to question Buck's claim that Chinese medical terms are largely untranslatable. In the past, some, such as Ortega y Gasset [3], have insisted that translation is an impossible task. The more balanced view is that although it is not possible to translate every idea and nuance of meaning, translation is largely very successful. Translation theorists generally agree that the untranslatability issue has been overstated. It certainly has in Chinese medicine. In my proposed terminology, loan-translations account for 80% of terms. Adding to this the everyday equivalents of everyday words, the terminology as a whole is 98% source-oriented [4].

Loan-translation is just as feasible in Chinese-English translation of Chinese medicine as it is in the English-Chinese translation of Western medicine [5]. Although people in past have tried to introduce interpretive translations, there has usually been no need to do so.

Of course, source-oriented term translations do not always match the original terms perfectly. Buck points to problems of connotations, which I will discuss further ahead. But in general, satisfactory translation are usually possible. Buck argues that Chinese medical terms mean different things in different contexts. This is very true. However, distinct uses are finite in number, and each can be given an appropriate English translation. In my own terminology, each Chinese character appearing in Chinese medical terms has on average 2.1 English equivalents [6]. This suggests that the relationship between Chinese and English is more complex than it usually is in practice. The number of English equivalents is much lower when one considers the main uses of the chief building blocks of Chinese medical terminology. The polysemy of Chinese characters is often exaggerated. Multiple equivalents of single terms and term components are seen, for example, in the Chinese equivalents of Western medical terms (the *sub* in *subclavian*, *subacute*, *subluxation*, *subculture*, and *subinflammation* is translated in each case with different words in Chinese) [7]. The polysemy observed in Chinese medical terminology is greater than in Western medicine, but it is not of a nature as permits us to abandon all attempts to peg English terminology to the Chinese. Quite the reverse, it should encourage us, if anything, to be all the more careful so that we keep the variability of English terminology to a minimum.

The history of Chinese medical translation has not, as Buck suggests, been characterized by an endless pursuit of the right words for ideas that have no correspondence in the English language. The transmission of Chinese medicine has been bedeviled not by a lack of words in English (or other Western languages), but rather by the failure of translators to agree on an approach. Some

translators have selected non-literal translations in an attempt to make concepts clearer to Westerners, while others have insisted on literal, philological translations intended to enable Westerners to understand the concepts as they were originally conceived. The interpretative tendency is seen in the lamentably continuing practice of translating traditional Chinese medical concepts into modern medical concepts (e.g., translating *feng huo yan*, literally 'wind-fire eye', as *acute conjunctivitis*) intended to help those familiar with Western medicine to learn Chinese medicine and help to integrate Chinese medicine into the Western medical framework. It is also seen in the preference for quasi-scientific terminology whereby *qi* becomes *energy*, *bu* and *xie* arrive as *tonifying* and *sedating*, and *xie*, literally 'evil', turns into *pathogenic factor*. The opposing literal tendency, represented by myself and Unschuld, aims to present Chinese medicine as it is presented in Chinese, preserving the original metaphors as far as possible. Both of us, for example, translate *xie* as literally as *evil*, because that is what the Chinese says. It contrasts with the interpretive translation, which replaces the original metaphor with an expression that has a sterile scientific ring.

The interpretive tendency reached a conspicuous apogee in the work of Manfred Porkert. Porkert's terminology includes standard equivalents (Porkert calls them *normative equivalents*) that are in Latin (e.g., *sinarteria cardinalis yin majoris pedis*) and explanatory terms such as *individually specific structive energy (xue, blood)*, *individually specific structive energy*, *structive configurative force*, etc. The Latin terms are for the most part literal, although some of them introduce interpretations (e.g., *orbis renalis* for *shen*, *orbis cardiacus* for *xin*). The explanatory terms on the other hand recast the original concepts in such highly scientific garb as to make them completely unrecognizable. Porkert's terminology has not been adopted because few people these days learn Latin or feel they should do so to gain access to Chinese concepts and because the explanatory terms serve to obscure rather than illuminate the concepts they are intended to represent.

Nonliteral translations are not necessarily wrong. A target-language term must accord with the definition of the source-language term it renders. Since source-language terms are naturally chosen to reflect at least one essential feature of the concept, it stands to reason that a literal translation in the target-language will usually do adequately (for this reason *Sheide*, *Becken*, and *Pförtner* are acceptable German equivalents of *vagina*, *pelvis*, and *pylorus*). Nonliteral translations are acceptable provided they accord with the concept. The nonliteral rendering of *xie* as *sedate* is a classic example of where a nonliteral translation clashes with the technical concept. *Sedate* means to slow down activity and inhibit movement, whereas *xie* means to promote movement to relieve stagnation, that is, the exact opposite. The term *sedate* was chosen to represent not the Chinese concept, but its recasting in a quasi-neurological, energetic mold. It is unacceptable because, it introduces conceptual content not present in the Chinese term [8]. In most cases, the damage to the concept is not so great as this. When we translate *xue* as *point* rather than literally as *hole*, then although we have lost some of original concept (the Chinese regarded needle insertion points as

soft areas between harder structures such as bones and sinews), we do not have a translation that entirely clashes with the original term. In general, however, non-literal translations designed to express Chinese medical concepts in ways familiar to modern Westerners are much likely to be technically faultable than source-oriented literal translation. Source-oriented, i.e., essentially literal translation, is the only approach that represents the Chinese concepts faithfully. Unlike modern disciplines in which terms have explicit definitions that make the choice of term to some extent arbitrary, Chinese medicine has many terms that are poorly defined or have multiple meanings not always identifiable from context, and therefore literal translation is less likely than non-literal translation to produce an equivalent that is found to be unacceptable in any given context. Furthermore, source-oriented translation usually has the significant practical advantage of narrowing the scope of options. If translators had been aware of this thirty years ago, process of terminological standardization would have proceeded much more smoothly.

The history of Chinese medical translation has not, as Buck suggests, been a clash of scholarly precision and clinical practicality. I think it is more appropriate to characterize it as the gradual development of awareness among scholars and clinicians that the transmission of an ancient body of medical knowledge from a distant culture requires a philological approach to translation that, as the famous translation theorist Friedrich Schleiermacher would have put it [9], takes the Westerner to China rather than trying to bring Chinese medicine to the West. Since the 1970s, there has been a growing awareness among Western translators of the dangers of interpretive translation and the need for a source-oriented approach. The increasing use of the terminology I have published actually stems from the demand to know what the Chinese have to say, rather than Western writers' interpretations of it. The reason why the transmission of Chinese medicine has been slow to find its feet, as I have explained [10], is sought in the marginal position of Chinese medicine in relation to modern medicine, in unfamiliarity with the Chinese language and culture, and in the dominance of alternative health ideals over the conception of Chinese medicine.

I believe Buck not only underestimates the translatability of Chinese medical terms, but also overestimates the feasibility of using Pinyin. Admittedly, if we were to agree on the principle of direct borrowing rather than loan-translation, there would be no further quibbling over the choice of words. When we agree on the principle of loan-translation, we often have to choose from among multiple options (e.g., do we call *ming men* "life gate" or gate "of destiny?"). Nevertheless, when we look into possibilities of using Pinyin in actual practice, we see that it is problematic.

Pinyin, like any loan, offers only the form of the idea transmitted; it is a sound (and the unaccented version of Pinyin, which is almost universally used by Westerners, is an incomplete representation of even the sound). It has no meaning to the English reader. If we are to use *feng huo yan* to refer to a condition characterized by a sudden reddening of the eyes, students have to memorize a series of unfamiliar words. This requires more effort than learning the loan-translation *wind-fire eye*. Of course, if there were only a few dozen terms, this is no problem. However, if we chose Pinyin as the main form of translation, as Buck appears to suggest, then a

whole range of terms would appear in Pinyin. Body parts such as *shi er jing jin*, *zu yang ming wei jing*, *shang wan*, and *cun kou* would be chosen instead of *twelve channel sinews*, *foot yang brightness stomach channel*, *upper stomach duct*, and *inch opening*. In symptom vocabulary, transcriptions such as *de shen*, *hua tai*, and *fu man* would be much more difficult to learn and remember than my literal translations *spiritedness*, *transforming [tongue] fur*, and *abdominal fullness*. With the names of disease patterns in Pinyin too, we would speak of *xin huo shang yan*, *sui hai kong xu*, *shi re xia zhu*, and *ming men huo shuai* instead of *heart fire flaming upward*, *emptiness of the sea of marrow*, *damp-heat pouring downward*, and *debilitation of the life gate fire*. We know that students who were asked which terms they found easier to memorize preferred the literal translations. The reason is clear: the English terms are all made of familiar English words, while the Pinyin words are completely and utterly opaque.

Things would almost certainly have been otherwise had the West been under Chinese domination for centuries, and educated Westerners could all speak and write Chinese fluently. Under such circumstances, we would very likely have borrowed many Chinese words, and borrowing a few more words to meet our needs in Chinese medicine would not have been difficult. Yet as it is, we have had little contact with China, and only have a handful of Chinese words in our language (*chow-mien*, *fengshui*, *ginseng*, *kaolin*, *kow-tow*, *ketchup*, *kumquat*, *loquat*, *oolong*, *qi*, *qigong*, *sampan*, *tong*, *tea*, *yin*, *yang*). We simply do not, as a culture, have sufficient familiarity with the Chinese language to stomach the large-scale borrowing that would be necessary in Chinese if borrowing were to be used as the standard method.

Buck only gives a few examples, so it is impossible, as I have already noted, to determine the extent of his proposed Pinyinization. If he means a maximal use of Pinyin designed to assist international communication, then we would end up with text heavily laden with obscure Chinese words. As an example of the general effect on the reader, I present a paragraph *Zhongyixue Jichu* [11], translated first by liberal use of Pinyin and again by literal translation (Wiseman terminology).

Text in which terms are rendered in Pinyin: *Gan xue xu* mainly manifests not only in generalized *xue xu* signs, but also in *xue bu yang gan*, *xue bu rong mu*, *chong ren shi tiao* that are reflected in *xuan yun*, *shi mian*, *duo meng*, *mu hua*, *mu hu*, *jin mai bu li*, *zhua jia bu rong*, *jing liang jian shao*, and alternating *jing bi* and *beng lou*. In severe cases, *gan xue bu zu* can affect the kidney and give rise to *gan shen jing xue kui sun*, which is characterized by not only *gan xue xu* signs but also *yao suan*, *yi jing*, *bu yu*, *jing bi*, *xiao shou*, and *chao re*.

Text in which terms are rendered largely by literal translation: Liver blood vacuity mostly manifests in generalized blood vacuity signs, but also in blood failing to nourish the liver, blood failing to nourish the eyes, disorders to the thoroughfare (*chong mai*) and controlling vessels (*ren mai*), and in menstrual block alternating with flooding and spotting. In severe cases, insufficiency of the liver blood can affect the kidney and give rise to

depletion of the liver-kidney essence-blood, which is characterized not only by liver blood vacuity signs but also aching lumbus, seminal emission, infertility, menstrual block, emaciation, and tidal heat.

If, on the other hand, Burk means that only some terms should be rendered in Pinyin, then he would ideally have to draw some line between terms to be Pinyinized and terms to be translated. I wager he would be hard pressed to establish any objective criteria to bring the number of Pinyin terms down to within feasible limits.

But let us suppose for a moment that all technical terms were represented in Pinyin rather than translated. If students were required to memorize so much Pinyin to be able to pass their examinations, they would have to be told what the terms meant. It would be difficult to teach that *ming men huo shuai* denotes a condition characterized by a particular set of symptoms without telling them what *ming men huo shuai* means. It would be difficult to define for students the concept of *qi ni* in terms of symptoms without telling them what *qi ni* means. In both cases, the symptoms are only manifestations of a pathomechanism, they are not the pathomechanism itself. The Pinyin does not explain either pathomechanism. The simplest way to explain the pathomechanisms to students, of course, is to provide them with a literal translation. They would soon discover that rather than mechanically memorizing each Pinyin term by rote, they would learn more quickly and with greater understanding if they knew what each Pinyin word meant. In other words, they would be starting to learn Chinese. I think it would be very useful if all students learned Chinese, as I have stated publicly [12]. The practical problem with Buck's suggestion is that students would be forced to learn Chinese to be able to use Pinyin on the scale demanded by Chinese medicine. Buck's proposal therefore presupposes a familiarity with the Chinese language that the Chinese medical community unlikely to have for at least years, if ever at all.

Let us look at the specific examples Buck gives of terms for which he thinks Pinyin serves Western students and practitioners better than my English translations. To an English speaker with no knowledge of the Chinese language, *hu shan* is an empty shell, void of any literal meaning. It offers no help to anyone who needs to remember it as the name of a condition in which the small intestine periodically enters and withdraws from the scrotum. The term *hu shan* is no more informative than a number would be. To a Chinese person, on the other hand, *hu* means fox, and *shan*, which is written with a character that contains one element meaning 'mountain' and another element meaning 'disease', denotes a disease occurring when things mount up or accumulate in the lower abdomen or scrotum. *Hu shan* means a disease characterized by a mounting of something in the scrotum that comes and goes, just as a fox slips stealthily in and out of its lair. A Chinese person may need to be given some explanation to understand this, and an English speaker may require more explanation to understand the literal translation (*shan* is familiar as a disease name to name to Chinese people even if they don't know what kind of disease, while *mounting* in the sense of a disease is a neologism in English). But once explained, the name becomes very meaningful,

far more meaningful than an empty sound.

It has been objected that my literal translation *foxy mounting* has sexual connotations. *Mounting* to some suggests not merely what one does to ride a horse, but also what, for example, animals do to gain sexual access. *Foxy* is used to characterize women of a certain kind. I would be delighted if there were an equally literal translation that did not have these associations. It might be possible to avoid the unwanted associations attached to *foxy* by using *vulpine* or *fox-like*. Personally, I would be happy to use either of these since both are as literal as *foxy*. It might be more difficult to avoid the unwanted associations attached to *mounting*, though. I tried substituting close synonyms such as *accumulation* or *amassment*, but I decided against *accumulation*, because it better translates the *ji* that refers to a particular category of abdominal lumps, and I decided against *amassment* because it is needed to translate the *xu* (in the fourth tone, not to be confused with *xu* in the first tone) that refers to a lower abdominal problem that occurs in greater yang (*tai yang*) disease. The term translator's first task is to preserve original concepts in tact. Anyone who knows why the Chinese concept is so named realizes that *foxy* (or *foxlike*) *mounting* precisely catches the imagery of the Chinese, and ignores associations that are obviously not part of the intended frame of reference.

Another example given by Buck is *zhi yin*. Again, the Pinyin *zhi yin* is a sound without meaning to a person unfamiliar with Chinese. *Yin* refers to a thin pathological fluid, while *zhi* is a branch of a tree, used here in the sense of a sawn off branch used as a prop that holds the patient upright so he cannot lie flat. Buck says that the translation *propping rheum* carries little meaning for an English speaker. More correctly, the meaning is not apparent until it is explained. But the same is equally true of the Chinese term for Chinese speakers because the obscurity is a result of the technical concept's distance from everyday use, that is, its medical application. Of course, if we did not have the faintest reason why *zhi yin* were so called in Chinese, using the Pinyin term might be a very good solution. But this is not the case.

Buck suggests that my terms alienate people from the Chinese tradition. I disagree entirely. Pinyin is only meaningful when people know what the sounds mean. Loan-translations of the type I propose tell them people what the Chinese concept means, and therefore help people to understand the Chinese terms. As I have said, I am in favor of people learning Chinese, and in fact I believe that transmission of Chinese medicine will not attain maximum success until a far greater proportion of students and practitioners gain access to primary Chinese texts by learning Chinese. Literal translations of the type I propose help to provide a bridge to the Chinese world, just as literal translations have provided a bridge to Western medical language for Chinese. This is precisely the advantage that the Chinese terminology of Western medicine has for doctors in China. They learn English to gain access to international literature, and they are greatly helped by the fact that their terminology is nearly 90% literal [13]. It would be useless for them simply to memorize words like *brachiocephalic artery*; rather they learn what *brachio*, *cephalic*, and *artery* mean, and the literal translation of the Chinese equivalents helps them greatly in their task.

As I mentioned above, borrowing is not always possible. A very difficult problem in applying Pinyin in terminology is that it is highly unsuitable for verbs and adjectives. While people can use noun forms like *san jiao* and *ming men*, it would be much more difficult for people to say that a patient's pulse is *hua* and *shuo*, or that his tongue is *guang hong*. They would not easily absorb *bu* and *xie* for the two major acupuncture stimuli. Historical linguistic research recognizes that verbs and adjectives are borrowed with far lower frequency than nouns [14]. This is because while names of things are often arbitrary, descriptions are not. Buck says that *qi ni* should be transcribed rather than translated, but *qi ni* can only be a noun representing a thing/event/process (qi counterflow); it cannot represent the active sense of 'qi flowing counterflow' (*qi [is] ni[ing]*).

Chinese medical expression makes extensive use of adjectives and verbs. The language of therapeutic actions is expressed in verb phrases, e.g., *jian pi li shi*, which in my terminology is *fortify the spleen and disinhibit dampness*. There are vast numbers of such terms, each comprising two to six characters (Pinyin words). Memorization of these would place a great burden on English-speaking student. It would be impossible to argue that such terms were not technical terms and hence could be excluded from transcription. *Hua shi*, *za o shi*, and *li shi* (*transform dampness*, *dry dampness*, and *disinhibit dampness* in my terminology) are three different terms for the elimination of dampness. They all have specific meanings in most contexts, and could not all be conflated (conceptually reduced) to "getting rid of dampness." How could we inflect Chinese verbs so that they would conform to English grammar? Do we say *hua ing shi* today and that we *zao ed* it yesterday?

The problems of using Pinyin are particularly visible in compound terms. If, for example, the six excesses, *feng*, *han*, *shu*, *shi*, *zao*, and *hu*, are translated rather than transliterated, then it has to be decided compound terms containing these terms should be fully transliterated or not. For example, should *qu feng* and *hua shi* be transliterated? Or should we say "qu wind" and "hua dampness." Most native speakers are sure to say that none of these are really satisfactory options. The fact is that anything other than translations (such as my *dispel wind* and *transform dampness*) is barely feasible in such cases. It would be impossible to argue that these compounds are in anyway not technical, so, if we followed Buck, we would be left with the tricky task of deciding what kind of technical terms should be transliterated and what kind should be translated.

A minor point is to be made about the pronunciation of Pinyin words. For people who have not learned Chinese, Pinyin sounds are not easy to guess or produce. I have had conversations with people who insisted on using the Pinyin *xu* and *shi* instead of any translation, and have sometimes been unable to follow them because their pronunciation was so far from the original as to be unintelligible to anyone trained to understand Chinese. One of the main difficulties in Chinese pronunciation is tonality. In English, we use intonation to express inquiry, doubt, emphasis, etc. In Chinese, each word has a set tone that helps to distinguish it from others (in Mandarin there are four tones as well as a so-called neutral tone). If Pinyin were to be used on

any scale, students would need to have notions of tonality. For example, a previous example, *yin3* is pronounced in the third tone. It is not the same word as the *yin* of *yin* and *yang*, which is pronounced in the first tone (*yin1*). Buck tells us that he would like to refer to *tan yin* by its Pinyin name, but he does tell us how we should refer to *yin* without its qualifier, and, if we were to use Pinyin, how we would distinguish it in writing when only a few publishers provide tone marks in their texts. Such problems are not isolated. There are two *li qi* (*li3* rectify; *li4* disinherit), and two *xu* (*xu1* vacuity; *xu4* amassment). There are also two *yuan qi* that are complete homophones distinguished only in Chinese script (*yuan2* original; *yuan2* source). There are two *zheng* distinguished only in writing (sign/pattern and right [qi]). There are two *ji mai* distinguished only in writing (urgent pulse and racing pulse).

I am certainly not saying that Pinyin is totally useless as a method of translation and I am not arguing for its total disappearance. Pinyin is useful when we don't have suitable equivalents in English. *Qi*, *yin*, *yang*, and *gan* are the only Pinyin terms I have adopted for the 1000 most commonly used characters in Chinese medicine (with a few exceptions limited to specific contexts) [15]. The first three of these words were borrowed centuries ago (although, of course, *qi* is a new spelling). More importantly, Pinyin provides the means by which English terms can be linked to original Chinese terms, in many cases, even by someone who does not know Chinese. Toned Pinyin thus provides the means of referring to the Chinese term that is useful when first introducing terms in a discussion. For Westerners, it is generally the most convenient way of accessing terms in bilingual lists. Most importantly, it is a major link in the process by which any Chinese term is accessed in a bilingual list. In short, Pinyin is part of mechanism by which English terms are pegged to the Chinese originals. Using a comprehensive bilingual list such as my 1995 dictionary [16], any translator can access my proposed English equivalent of any term, and anyone reading texts that apply this terminology can also access the original Chinese terms (Pinyin and characters). Although Buck criticizes my English choices in highly emotive terms (outlandish, archaic, clumsy, cumbersome, etc.), he would have to admit that I am the only writer to use English terms whose Chinese equivalents are instantly accessible at the flip of a dictionary (and shortly also by pressing a few computer keys).

Pinyin is a necessary cross-reference, but it could not possibly be used on any large scale by English speakers who have no knowledge of Chinese. Buck's proposal that we dispense with English in favor of Pinyin would make perfect practical sense if Chinese medical terminology were composed of one or two hundred nouns. The fact is that Chinese medicine possesses thousands and thousands of terms that no individual could be expected to learn in Pinyin without also learning Chinese. On pages 130-134 of *A Practical Dictionary*, for example, there are 387 disease names. This list is by no means a complete nomenclature of disease in Chinese medicine. However, 387 Pinyin disease names is a lot of foreign sounds to memorize without a grounding in their meanings, which can only be communicated to English readers through the medium of English. If we consider the number of Chinese terms for body parts, symptoms, treatment methods, names of

medicinals, formulas and acupuncture point names, then the student embarking on the acquisition of an all-Pinyin terminology embarks upon a hopeless task. Even if one were to assert that twenty disease names and thirty symptom names were enough for what we now need to know of Chinese medicine at the present state of our knowledge, we would still need a translation methodology up to the task of open-ended transmission. Pinyin is surely not the solution. If students were to acquire so vast a Pinyin vocabulary, they would be well on the road to acquiring Chinese, in which case there, there would be no need for translation, since they would have access to a library of Chinese medical literature a thousand times larger than our current body of English-language literature.

Buck says that Pinyin names should be used for all medicinals and formulas, and points to success at the Northern College in this. Ideally students should learn medicinal and formula names in Pinyin as well as English, since these are names (which are a specific category of terms). It is for this reason that I systematically include parenthesized Pinyin for not only medicinals and formulas but also acupuncture names. There would, however, be great problems if we were to abandon any translation completely. First, particularly with the names of medicinals (I don't call them herbs because not all of them are), there are many Chinese alternative and variants. Standardizing terms for use in one school might be easier than standardizing terms over the whole of English speaking work. For anyone who reads Chinese, *gui wei* is obviously *dang gui wei* (the fine roots of *dang gui*), but for a monolingual English speaker the expression for fine roots of *dang gui* would have to be standardized to avoid confusion. Second, quite a sizeable proportion of medicinals are known to English speakers by English names. The use of Pinyin only would deprive them knowledge of the identity of those items. For example, *sheng jiang, cong bai, gan cao, hu jiao, rou gui, ju hua, ren shen, ma huang, shao yao, si gua luo, qiao mai, sang ji sheng, pu gong ying, hei zhi ma, yan sui zi, pi pa ye, mai ya, huang dou juan, lu jiao, ye ming sha, hu gu, long gu, bie jia, e jiao, chan tui, she xiang, shi gao, hua shi, nao sha, xiao shi, bai fan*, which are names that all have to be painstakingly learnt, do not have the capacity of *fresh ginger, scallion stalk, licorice, pepper, cinnamon bark, chrysanthemum, ginseng, ephedra, peony, luffa, buckwheat, mistletoe, dandelion, sesame seed, coriander seed, loquat leaf, barely sprout, bean sprouts, deerhorn, bat's droppings, tiger bone, dragon bone, turtle shell, ass hide glue, cicada molting, musk, gypsum, talcum, sal ammoniac, and alum* to help everyone to identify these items. (It might be noted in passing there is a strong argument here for using English vernacular names over Latin pharmaceutical names such as *Zingiberis Rhizoma Recens, Allii Fistulosi Bulbus, Glycyrrhizae Radix, Piperis Fructus*, etc. It is the Latin terms, which are currently used as names besides Pinyin, that should be rightly described as "semi-indigestible polysyllabic and contrived-sounding terminology;" the English syllable count is only slightly higher than that of the Pinyin. As to formulas, it may well be possible for students without a knowledge of Chinese to memorize a finite number of formula names provided they are not too long. Three hundred formula names such as *gui zhi tang, ma huang tang, liu wei di huang wan, si jun zi tang* would be feasible. However,

when we get beyond the beginner's level, we have to face the fact that the Chinese formulary is not finite. I currently have 20,000 formulas in my database, and this list is certainly by no means complete. Some of the names are long, e.g., *gui zhi qu shao yao jia shui qi mu li long gu jiu ni tang* or *gui zhi gui jia fu ling bai zhu tang*. Memorized polysyllabic Pinyin names of medicinals would become unrecognizable in the abbreviated forms in which they often appear in formula names, e.g., *qiang bang pu bo tang tang* (Notopterygium, Arctium, Dandelion, and Mint Decoction). The English name is three times the syllable that of the Pinyin, but only Notopterygium is a mouthful.

Buck's comments are confined to a few terms, namely, the ones for which he prefers Pinyin to my translation. He does not describe in detail what other methods of translation he finds acceptable. He seems to approve of what he calls "naturalist terms," but he neither explains this concept, nor tells us when we should choose between naturalistic terms and Pinyin. As far as I know, he has not published a list of terms that would provide a large enough sample to for anyone to determine his translation principles.

Buck argues that the international nature of Chinese medicine makes Pinyin rather than English names more suitable. When the terminology of Chinese medicine in all Western languages is Chinese, then everyone will be able to communicate more easily. Yet the desirability of Pinyin in the international context does not help us over any of the previously described hurdles of incorporating Chinese words into Western languages on a vast scale. Buck points out that there are Norwegians, Danes, Dutch, Germans, Portuguese, Somalians and Croatians learning Chinese medicine from English texts and that communication would be benefited if we used Pinyin terms rather than the incomprehensible that I have proposed. But as I have said, Pinyin is incomprehensible if people don't learn Chinese. The fact that people who speak languages other than English and Chinese learn Chinese medicine through English texts is actually one of the numerous anomalies in the Westward transmission of Chinese medicine. Although there is more Chinese medical literature in English than in many other languages, its use by non-English speakers is nonetheless rooted in the fact that they are not yet prepared to learn Chinese. Because people greatly underestimate the role of literature in Chinese medicine [17], they see learning Chinese as unprofitable in the pursuit of Chinese medical knowledge, in part because few terms have been glossed in the English literature and so many people are still unaware of the conceptual complexity of Chinese medicine. Furthermore, not only are speakers of languages other than Chinese and English reading English texts, but much English literature is being translated into other languages. Quite obviously, the translation is being done by people who don't know Chinese (if they knew Chinese they would translate directly from Chinese). There are huge dangers inherent in this practice. Some of the literature being translated is not derived from primary Chinese sources. The generally poor attention played to pegging of terms means that translators have no way of accessing the original Chinese terms even in Pinyin form. Authors are translated in different ways with no method of preserving meaning between one another. German translators, for example, will translate

pattern as *Muster* and *syndrome* as *Syndrom*, despite the fact that both English terms are intended to represent the Chinese *zheng*.

To sum up, Pinyin is an indispensable means of referencing Chinese terms for English speakers. The vocabulary of Chinese medicine is too large for Pinyin to be used as the standard method of translation. Any proposal to use Pinyin should include a clear indication where Pinyin should be used and where other methods should be used and a bilingual list that demonstrates the scope of the terminology. When we look at the problems posed by Chinese medical terminology in their full scope and magnitude, and consider the evidence offered by successful acts of knowledge transmission in other fields, it becomes very obvious that Pinyin is no solution to the translation problem.

Buck's judgement of my terminology is self-contradictory. On the one hand he suggests that many of my proposed are basically the same as those evolved in the past 20 years; on the other hand he suggests that my terms are incomprehensible to 90% of practitioners (which is strange when they are all defined in a dictionary). How the Chinese medical community could be on the verge of "taking the final plunge" in adopting an "incomprehensible" terminology that is being "unilaterally imposed" is quite unclear. The development of Chinese medicine is barely aided when rational debate degenerates into generalizations and exaggerations of this nature.

Answer to Maciocia

Maciocia's contribution to the debate on terminology is largely a defensive response to criticism of his approach to terminology. He neither describes the scope of Chinese medical terminology, nor offers a plan for dealing with different types of terms.

Maciocia agrees with Buck that there is no correct translation of Chinese medical terms. He says he tends to use English when writing, but uses original terms when teaching. He suggests that his preference is for the Chinese terms, although in written texts, he does not like the clutter of Pinyin. Yet he explains neither why the written word should be different from the spoken word, nor why the best terms to use in class are not the best terms to use in books, clinical records, examinations, and inter- and intra-field communications. Maciocia's books contain little Pinyin, even less Chinese, and few explanations of Chinese terms to attest to his belief in the importance of the Chinese term. Thus I am still left with the impression that he underestimates the extent of Chinese medical terminology.

This impression is reinforced by his complaint that his critics adduce only the term list contained in *Foundations of Chinese Medicine* [18]. Indeed, *Practice of Chinese Medicine* [19] and *Obstetrics and Gynecology in Chinese Medicine* do contain more (about 76 and 162 respectively). Taking overlaps into account, his combined lists may contain a few more than 100 terms, the vast majority of which are unproblematic. Maciocia wonders why I criticize his efforts to peg his terminology to Chinese when there are many writers who include no glossaries at all. There are indeed many such writers. One finds no glossaries in other works such as Mann (1964),

Mann (1971/1992), Lewith & Lewith (1983), Pearson P (1987), Seem & Kaplan (1989), Beinfield & Korngold (1991), Mann (1992), Mole (1992), Gaeddert (1994), Stux & Pomeranz (1997) [20]. I chose Maciocia's books not only because they are familiar examples, but also because they are published by one of the most prestigious world medical publishers and are used as textbooks; in other words, Maciocia's work is highly regarded by the clinically oriented Western community of Chinese medicine. In the light of this consideration, I wonder what kind of medical discipline will result when the terminology applied as a *de facto* standard is not fully available to other translators in a published list. Maciocia's works covers theory and practice, acupuncture and drug therapy. For anyone to be able to translate or write consistently over such a broad area would have to work to a list of not 100, not 1,000, but more likely 20,000 terms. Maciocia's failure to provide a comprehensive list can only be explained by a belief on his part a) that many terms listed and defined in Chinese dictionaries are not in fact Chinese medical terms, b) that explicit pegging of all English equivalents to the original Chinese terms is not necessary, and/or c) that terminological consistency is not needed.

The fact is that Maciocia does not present all the conceptual detail present in Chinese texts. His treatment of terms denoting parts of the chest and abdomen in *Foundations of Chinese Medicine* and *Practice of Chinese Medicine* provides an example of how he obscures a whole family of concepts when he overlooks their terminological status. As can be seen from *A Practical Dictionary*, Chinese medicine imposes divisions on this bodily terrain that differ from Western divisions. The sides of the chest are known as the rib-side (*xie*). The abdomen is divided into the *greater abdomen* (*da fu*), the part above the umbilicus, and the *smaller abdomen* (*xiao fu*), the part below the umbilicus. A small part of the greater abdomen immediately below the breastbone is variously referred to as the [region] *below the heart* (*xin xia*) or the *heart* [region] (*xin*). The central part of the upper abdomen is called the *stomach duct* (*wei guan*). The *lesser abdomen* (*shao fu*) usually refers to the lateral areas of the lower abdomen, but is sometimes used to mean smaller abdomen.

In Maciocia's *Foundations of Chinese Medicine* (pp. 156, 173), the same area is described in terms of: *thorax, abdomen, chest, flank, hypochondrium, epigastrium, upper part of the abdomen, lower abdomen, lower (part of the) abdomen, upper part of the abdomen just below the xiphoid process, and hypogastrium*. Maciocia's vocabulary comes from Western medicine (although it is not used precisely according to biomedical definitions), and is difficult to relate to Chinese concepts.

Thorax and *chest* can be presumed to refer to one and the same thing. *Epigastrium* as an anatomical area corresponds to the *greater abdomen* of Chinese medicine, but Maciocia's diagnostic descriptions suggest that it corresponds to the *stomach duct*. In Maciocia's usage (*Foundations* p. 156), *flank* obviously corresponds to the Chinese *xie* since it is said to lie under the control of the liver and gallbladder. However, this usage is confusing because *flank* in Western medicine refers to a different part of the body, namely the side between the lowest rib and the iliac crest. Maciocia does not redefine *flank* to mean the Chinese definition for *xie*. A few lines further

on, however, he describes stagnation of liver qi as being reflected in a feeling of distension and stuffiness of the 'hypochondrium'. In *Practice of Chinese Medicine*, he describes *hypochondrial pain*, which is equated with the Chinese *xie tong*. An illustration shows the site of the affected region to be what is called the *hypochondrium* in Western medicine, but this does not correspond to the region shown in a major Chinese diagnostic text [21].

The *upper part of the abdomen just below the xiphoid process* clearly corresponds to *xin xia*, the *region below the heart*, but the region is described without being given a name. Maciocia is obviously at pains not to confront his readers with new concepts. There is no English word corresponding to *xie*, and to convey the concept to the English reader (the area from the armpit to bottom rib), we must define it and attach a name to it, so that it can be referred to elsewhere without repeating the definition each time or allowing the Chinese definition to vanish in assumption. If we wish to avoid using a transcription, then we are left with the choice of redefining an existing term that does not normally mean the same thing, or making up a new expression. Maciocia takes the first option, but fails provide the Chinese definition. In fact, he uses two different English words *flank* and *hypochondrium* for the single concept *xie*, leaving the intelligent reader to wonder if he means one area or two.

By rendering *xin xia* as *upper part of the abdomen just below the xiphoid process*, Maciocia offers a description, but the absence of a name means that he has to repeat his description whenever he wants to mention the area. The assumption appears to be that prioritizing familiar words and concepts allow the direct absorption of clinical knowledge. Yet, any convenience is achieved at the expense of transmitting Chinese medical concepts accurately. Insistence on the use of familiar expressions creates the impression that Chinese medicine is conceptually more familiar than it is in reality. In reality, English readers do not receive as much information as was intended by the Chinese writers.

There are no ready-made English equivalents for all the sections of the chest and abdomen of in Chinese medicine, any more than there is a familiar equivalent for *hu shan*. We have to describe the parts, and give each an appropriate label that allows us to evoke the same concepts in future. By failing to do so, Maciocia is effectively denying that Chinese medicine has its own divisions of the chest and abdomen, and while this spares his texts the complexity of highlighting, annotating, and glossing the Chinese anatomical divisions, it does so at the expense of readers' ability to fully understand their diagnostic significance. Maciocia does not inform his readers fully about Chinese medical knowledge of this part of the body. Instead, he tells readers of his personal understanding of this knowledge, in concepts that Western readers might understand without explanation. As translation theorists observe, this loss of information is appropriate when a translated text is intended for a lay readership. It is not appropriate when technical detail is to be presented in full for an expert readership.

When concepts are regularly distinguished in Chinese by unique terms, we are obliged to choose unique terms in English to render them, and apply them consistently. Otherwise,

knowledge is lost. When a single concept is referred to by a single term in Chinese but rendered differently by translators according to context, the Chinese concept will not be preserved in translation. When different writers translate the same concept with different terms, students reading those authors will lose sight of the concept. When the same word is used by the one author or by different authors for different concepts, again the result is confusion for the reader. When there is no common practice of glossing terms and including Pinyin to alert readers to differences in English usage, the danger of confusion increases.

As Maciocia says, people are very familiar with the words *wiry* and *bowstring* as synonyms. Of course, when people are told that two words mean the same thing in the Chinese medical context, there is not much problem. Most people also know that *vacuity* and *deficiency* are different English versions of the same Chinese term. But the current variability in terminology almost certainly does give rise to confusion. Maciocia does not comment on the problem of his using *worry* for the Chinese *you*, while Cheng uses the same English word for *si* [22]. Maciocia says that it does not matter what names people call things as long as they know what the names refer to. Quite so. The problem is that people only learn what terms mean through language. This communication does not happen magically, but by careful use of language. Maciocia addresses this issue with one example only, as if to say that variability of usage is of no consequence in the case of *xian* (*wiry*, *bowstring*), therefore it is of no consequence generally. But there are numerous examples where variable translation potentially obscures conceptual distinctions. There is currently no objective data concerning the accuracy of transmission of Chinese medical concepts. I can therefore only suggest that students and practitioners read the potential areas of confusion described in the following paragraphs and judge for themselves whether the distinctions in question have reached them in tact.

When two different Chinese terms are translated by single English term, any conceptual distinction in the Chinese text is lost in translation. This often happens when two Chinese words appear to mean more or less the same thing, but in fact do not. For example, when in the context of the pulse *wu li* and *ruo* are both translated as, say, 'weak.' A pulse that described as *wu li*, literally 'having no force,' is not the same as a pulse described as *ruo*, 'weak'. *Wu li* is a descriptive term that can be applied to many pulses that, in addition to their other qualities, are lacking in strength. *Ruo* specifically denotes a pulse that apart from being forceless is also sunken, and according to some definitions fine. Although the Chinese terms appear to be synonymous, in reality they are not, since 'weak', in its sphygmological sense, has a very specific meaning. The problem that arises here results from the close synonymy in the literal meanings of the names, the everyday nature of the terms that belies their technical usage, and translators' unfamiliarity with the conceptual detail.

The challenge we face in the creation of an English terminology of Chinese medicine is to find words that can be given the same definitions as the Chinese terms, so that full meaning of the Chinese terms, and the distinctions between meanings of different terms, are carried over into English. If the translator is unaware of the distinction between *wu li* and *ruo*, or if, though aware of

it, fails to reflect it in translation and draw the reader's attention to it, then the reader will probably not grasp it. I cannot see from Maciocia's work whether he distinguishes these two; *wu li* does not appear in the term lists contained in *Foundations*, in *Practice*, or in *Obstetrics and Gynecology* [23]. It is doubtful whether students will learn of the distinction from Maciocia, and without a bilingual list with separate English equivalents for the two terms, no translator is able to reference or use his terminology accurately, even if the distinction is to be found somewhere in his texts.

Conflation of concepts can potentially arise in the translation of quite a few terms. In the context of the pulse, in addition to the above examples, *mai shuo*, *mai ji* and *mai ji* (two different characters for *ji*) could easily be rendered as 'rapid pulse', although the latter denotes a faster pulse than the former (distinguished as 'rapid pulse' and 'racing pulse'). Maciocia lists *shuo* (which he transcribes as *shu*) but only one of the *ji*. I have elsewhere written more extensively on the problems relating to the translation of pulse terms [24]. In diagnostics, *fan* and *zao* could both be represented by 'restless' or 'agitation', although the former is a subjective sensation and the latter is an objective symptom (distinguished by us as 'vexation' and 'agitation'). The two often appear together, although vexation without agitation is milder than vexation with agitation. Maciocia gives *xin fan* (as mental restlessness) [25], but he does not give *zao* in any list that I have seen. We can only presume that he either does not understand the distinction or considers it of no value to Westerners.

The disappearance of concepts and blurring of distinctions is not merely a theoretical problem of translation. When distinctions in language are not made, conceptual distinctions fail to be transferred. When conceptual distinctions are not transferred, the reader's understanding of the subject matter is affected, and hence certain potential for acquiring clinical skill is lost. It is of course difficult to say how much worse off readers will be for not being informed of the distinction between, say, weak (*ruo*) and (*wu li*) or between vexation (*fan*) and agitation (*zao*). Nevertheless, one can easily intuit the cumulative effect of this kind of loss in translation when it happens over and over again in all aspects of Chinese medicine. A translator might well object to this saying that readers do not have to know all the technical distinctions in Chinese texts, but in so doing he would be according himself greater authority than the text he is translating. When this kind of translation is widely practiced, Westerners be deprived of avenues to knowledge that exist for Chinese students. I suggest that this kind of practice in translation has become widespread in Chinese medicine because Western adherents of Chinese medicine view Chinese medicine as an alternative to Western medicine that is essentially a hand-on healing art that does not require large amounts of book learning to practice. Those who have no direct access to the Chinese tradition may be forgiven for not realizing that the form of Chinese medicine that is being adopted in the West is a clinical art based on a corpus of knowledge that requires close study. The continuing importance of study of the classics in China to this day attests to this.

Maciocia has very little to say about the principles of translation. Only one of his examples is concerned about how we should translate. He defends his use of *Painful*

Urination Syndrome on the grounds that pain is always present. My sources disagree with this assertion [26]. But Maciocia does not comment on the principle of the matter. The Chinese term *lin* literally means 'dribble', 'drip' or 'sprinkle'. We might assume that the Chinese named the disease after what they considered to be its principal feature, difficulty in achieving a full stream of urine. The word *dribbling* or *dripping* could be defined in the urinary sense, but both have specific applications in English (dribbling from the mouth, beef dripping). I chose *strangury* because it literally means a condition characterized by dripping urination, just like the Chinese term. I see no need to describe the condition in terms of a different feature (pain). *Strangury*, incidentally, also has the practical advantage of being a single word like the Chinese, and is easy to use in compound terms like *water-disinhibiting*, *strangury-freeing formulas* (*li shui tong lin zhi ji*). I would be even happier to use a more familiar word like *dribbling* or *dripping*, if everyone agreed on it; as I said in answer to Buck's criticisms, I am not so concerned with associations that are generally understood not to apply in the Chinese medical context.

In *Foundations*, Maciocia says that he chooses *Directing Vessel* for *ren mai*, because that is what the term means. My translation is *Controlling Vessel* (which gives the same abbreviation as that as the familiar *Conception Vessel*), but I would not quibble with his literal translation or with his desire for literality. The point is rather that he does not apply this principle consistently. He translates *chong mai*, for instance, as *Penetrating Vessel*, which does not represent the literal meaning (my literal translation is *Thoroughfare Vessel*). Similarly, he translates *bi yuan* as *nose pool*, even though *yuan* does not mean 'pool' (it means 'abyss' or 'deep source of water'). He translates *re du* as *Fire-Poison* (in one place at least), although *re* means 'heat' not 'fire'. He translates *cou li* as the space between the skin and muscles, although this is neither the literal meaning of the Chinese term or nor a reflection of its definition (the *cou li* run through the skin and flesh rather than lying between the two, and besides, Chinese medicine has no concept equivalent to the modern *muscle*). He translates *li shui* as transform water, although *li* does not mean 'transform'.

I am concerned with principles of translation. I believe that before people can accept a terminology, they must accept general principles for term translation as a whole. If no principles are agreed, there will always be reason to quibble. The principles I have outlined as fairly simple: everyday-language equivalents should be used wherever they exist (e.g., *nose* for *bi*, *heart* for *xin*, *hand* for *shou*); strictly technical terms with no ready made equivalents should be translated literally (e.g., *triple burner* for *san jiao*, *blood chamber* for *xue shi*); non-literal translations and Pinyin transcriptions should be used only when source-language terms are poorly motivated or have no lexical correspondences in English. Maciocia offers no explicit principles of term selection, and none can be deduced from his term choices. It may be that he sees no need for principles; it may be that he regards devising and testing principles of translation and working consistently to them, as through the creation of a full term list, as being academic niceties that do not bring readers any practical benefit. But without this rigor, no adequate fully documented terminology worthy

general adoption can be devised.

For the healthy transmission of Chinese medicine, an accurate vocabulary pegged to the Chinese terms is not enough; we need some guarantee of the sources of information. Maciocia's answer to criticisms I made of the supposition that the extraordinary vessels should not be needled on account of their storing essence or original qi did not address the point. He quotes Chapter 62 of one version of the *Neijing* saying that the Chong Mai originates in the space between the kidneys, and that this space is related to *yuan qi*, etc. The whole point, however, lies not in the relationship of essence and *yuan qi* to anything else, but in the notion that because of that relationship we should not needle the extraordinary vessels. After all, the kidney stores essence, but nowhere in Chinese literature is needling of all kidney channel points contraindicated on the grounds that it would drain the body of its essence. Maciocia fails to tell us what grounds there are for not needling the extraordinary vessels and what allows a speculation that is contradicted by a large literature in Chinese to become widespread in the West. Detailed bibliographic references enable people to know the origin of information and the authority on which claims are made. Like the translator's bilingual list, they are one of the guarantees of reliable transmission.

As Maciocia very rightly says, "rectifying the names" means encouraging people to adopt their proper roles (fathers should behave in fatherly fashion, etc.). In other words, rectifying the names means actually means rectifying people's behavior. In Chinese medicine, we also need to rectify people's behavior. To get people thinking about Chinese medicine in the way that Chinese physicians do, diagnosing in the way Chinese physicians do, and providing the treatment that Chinese physicians do, we need a set of terms where everything in the English is related to everything in the Chinese. In other words to transmit Chinese medical concepts faithfully, we need a standardized vocabulary pegged to Chinese. A first step toward this goal is for translators to apply a published terminology that everyone has access to, translators who, if they choose to coin new equivalents, should link them explicitly to the Chinese term. It is only when this practice develops that one translator's term choices can be adopted by others.

Conclusion

One of the main impressions I get from Buck's and Maciocia's responses is that they think that Chinese medicine has a much smaller set of technical terms than is recognized by the Chinese. My appreciation of the scope of technical terms coincides with Chinese estimates. I think that determining what is a technical term is prerequisite to deciding how to translate technical terms.

People who agree with me that Chinese medicine has a large number of terms, and that we should be moving toward a standardized English vocabulary of Chinese medicine to avoid the confusion of concepts, have welcomed the appearance of *A Practical Dictionary*. Those who agree with the extent of Chinese medical terminology, but who disagree with my approach to translation, would serve the very important terminological discussion best by stating their principles in detail for the whole gamut of terms, and by providing a bilingual list containing their

own preferences. Those who disagree with Chinese (as well as Japanese and Korean) scholars as to the conceptual scope of Chinese medicine must explain how it can be reduced without a loss of information and neither Buck nor Maciocia have addressed this major underlying issue.

Notes

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