

ON TERMINOLOGY & TRANSLATION

The following articles are responses to the issue of Nigel Wiseman's choice of terminology used in *A Practical Dictionary of Chinese Medicine* (reviewed in *The Journal of Chinese Medicine* 62 February 2000).

On Terminology by Charles Buck

Introduction

This article is a contribution to the emerging debate about the adoption of Wiseman's terminology (WT) which aims to guide the future development of CM in the English speaking world. Most readers will have noticed the increasing usage of WT especially by US-based publishers such as Blue Poppy Press and Paradigm. At first sight the arguments for the universal adoption of this system appear compelling but I feel it is opportune now for the CM profession as a whole to reflect on the issue before we take the final plunge by adopting WT. Feelings on this issue run high, those who hesitate to fully support WT risking censure but in the interests of provoking a wider debate on the terminology issue I welcome this chance to offer a personal view to JCM readers. After outlining some of the translator's dilemmas I will briefly look at some of the efforts of scholars who have previously recognised the problem and offered their remedies. Then I will focus on some of the shortcomings of Wiseman's terminology as I see them before presenting my own preferred solution.

Personally I feel that the key focus of our terminology should be the Chinese terms themselves, as expressed in pinyin romanisation, and that the English terms used have a supportive and slightly less crucial role than is proposed by WT. I believe there is a good case to be made for rather less translation, letting untranslatables such as qi, yin, jing, etc. stand, and extending this habit to other problematic terms.

For example terms such as hu shan ("foxy mounting" in WT) may be given in pinyin first and then explained in parentheses, footnotes, endnotes, etc. as appropriate. This recognises and respects Wiseman, Boss and Feng's important contribution in the *Glossary, Practical Dictionary*, etc. but simply shifts the emphasis from scholarly translation of every term to understanding of every term and nailing this understanding to the source term in pinyin. This is the view I presented in a discussion document to the Northern College of Acupuncture (York) some time ago, following which it was decided to phase in a gradually increasing component of CM's pinyin source terms for teaching and

handouts on the undergraduate acupuncture course¹. First it will be helpful to provide readers with more context to the issue by summarising some of the arguments that lay behind this policy.

Problems with translation

Most are agreed that the progress of CM in the west has been hindered to some extent by a legacy of varied, non-standard and often inaccurate translation. This situation has arisen in part from a relative lack of good scholarship applied to the problem of importing an extensive, professional and complete medical system across a large language and culture barrier. In addition there has been relatively poor communication and consensus between the few scholars who have applied their skills to the problem. As a result different cliques have evolved, each employing a different terminology set, sometimes lacking a clear connection to the source terms. Maciocia's translational style for example, has been very successful but some of its detail has been criticised², even though at the time of publication his earlier work was amongst the best available. The lesson is that even a slight lack of rigour can easily lead us to lose sight of what original Chinese source terms link to English words such as tonify, increase, nourish, benefit, raise, etc. and in so doing distance us from their true sense.

The problems of translation are manifold but may be fairly briefly summarised³. First we must realise there is no simple one-to-one correspondence or congruence between many words in Chinese and their translation into English. Spheres of meaning may overlap but are rarely identical. Also, ordinary words in Chinese are often adopted as technical terms in the context of Chinese medicine to convey specialist meanings. If we look up CM terms in a standard dictionary we might easily misconstrue their specialist meaning in the CM context. Furthermore, in the Chinese language a significant component of meaning is derived from context. The same Chinese character term often requires a different rendering in English in different compound terms or in different contexts - no single standardised English equivalent always fits the bill. Wiseman has also highlighted the seriously misleading errors which can arise if translators attempt to offer biomedical equivalents to CM disease categories. Exemplifying these pitfalls he points out that in relation to traditional disease labels such as 'qing mang' the term optic atrophy is an unreliable translation and its use may lead to serious misunderstandings. "Such translations are leaps of faith, not statements of fact. They

are not only inaccurate concept labels but they destroy the credibility of Chinese medicine"⁴.

Others such as Kovacs⁵ have indicated additional difficulties, pointing out that no matter how well words are chosen to translate texts, we cannot so easily bring to a western mind the wider cultural resonances inherent in CM texts that occur to a Chinese reader. This he calls "the issue of untranslatability". If we wish to gain deeper understanding of CM we must attempt to learn to understand both the Chinese language and its culture, although ultimately the cultural difficulties can be nearly insurmountable. If we are to continue to have Chinese medicine practised in the west, by westerners, some compromises must be reached, whilst keeping in mind the basic intent of avoiding Wiseman's pitfall of "entering a conceptual world of our own creation"⁶.

As a profession comprising a mix of interdependent practitioners, teachers, authors and scholars we can easily appreciate the many difficulties related to this terminological issue. We need ways of ensuring high-fidelity transmission of ideas. Much transmission to date has been relatively lo-fi. Most of us, on reflection, will realise something has to be done, but is it really best to adopt solutions derived primarily from the professional requirements incumbent upon translation scholars? Are other solutions more appropriate? The translator takes a pride in trying to find the best words to represent source terms in the target language. Teachers and practitioners have to work primarily with understanding, the actual terms used simply functioning as a convenient handle on those ideas.

Previous solutions

For a stark illustration of way in which scholarly conditions are met to the detriment of those having to work with the medicine's ideas on a daily basis we can look briefly at previous attempts at introducing more rigorous and technically correct terminology.

Porkert was well ahead of his time in recognising the translation problem. His *Theoretical Foundations* was one of the few sources I could find when researching acupuncture as a possible career in the late 70's. I certainly struggled with his Latin-based terminology and am surely not alone in feeling communication was not at all enhanced by this system. If anything it seemed to bleach out the colour and texture of the source culture, somehow squeezing it into the classics scholar's own cultural milieu. His un-Chinese approach almost scared me off the subject completely and I wondered if that was the language my chosen college would be using. For those who have not read Porkert's texts⁷, here is a sample of some of the terms he proposed:

<i>"Naturalistic term"</i>	<i>Porkert term</i>	<i>Pinyin term</i>
spleen channel	sinarteria cardinalis yin majoris pedis	zutaiyinjing
blood	individually specific structive energy	xue
yin	structive configurative force	yin
yang	active configurative force	yang

The arguments in favour of such a system were just as strong as those used for Wiseman's terminology - Porkert too was aiming for precision and standardisation. Luckily for us, and perhaps not surprisingly, virtually nobody chose to follow Dr Porkert along this painful scholarly route. Indeed it would be interesting to speculate to what extent the CM profession's development might have been helped or hindered had his system been adopted by CM publishers and the profession as a whole. We might reflect too on how our use of a specialist Latin terminology would have affected our ability to communicate with experts in China. My conclusion is that, had Porkert's terminology been adopted, it would have amounted to an almost impenetrable communication barrier between practitioners in the west and their counterparts in China. As a result practitioners, teachers and publishers in the west would have become largely dependent on the few scholars who could work this system. Communications would have had to squeeze through a terminological hiatus created and policed by an elite few who understood the root terminology. Translation scholars would, in effect, be placed in an especially privileged position guarding a high level information pass between east and west. Ordinary practitioners, by focusing on a distinctly non-Chinese word set, would be distanced from the source language and culture. What practical implications in terms of educating nascent practitioners would the adoption of Porkert's terminology have had? How many students would have lost interest faced with such an unwieldy and alienating terminological hurdle? It is fair to say that Porkert was technically correct and ahead of his time, but what he offered sacrificed clarity and accessibility on the altar of scholarship, was impractical, and was to prove unacceptable to the profession at large. Thankfully, as we muddled on through twenty five years, ignoring Porkert's counsel, we nevertheless saw a dramatic rise in the quality of materials available in English, in the standards of training available and in the quality of students entering the profession. In a few short years, Chinese medicine has blossomed in the west.

Paul Unschuld too offered us a scholastically-correct take on terminology and in so doing offered his own word set. Qi, as we know, is poorly translated as energy so the more accurate term suggested was 'finest matter influences' or alternatively 'vapour influences'⁸. Doubtless 'influences' as a translation of qi can be justified pedantically, but apart from its clumsiness it is unfortunate that this was a term employed by magicians, stage hypnotists and charlatans of a century ago to explain their magical powers. All kinds of unintended and sometimes unfortunate associations can arise as a result of overly elaborate translation efforts. Sometimes these efforts take us further away from the root concepts. Surely our terminology set belongs at least as much to practitioners and teachers who should be permitted some input into its development and use? Practitioners and teachers require a practical, concise, non-polysyllabic but accurate word set - as is provided in fact by Chinese

itself. Specialist terminology sets typically evolve over time. A consequence of the input of many, they come from the 'grass roots', they are rarely invented overnight and imposed by a small clique. Can terminologies can be successfully imposed by a handful of publishers and translators? Try to introduce difficult terms or terms that are hard to say and the grassroots will soon twist them into a new set. I've noticed in teaching that we now have the term "TNT" which students have replaced for the polysyllabic "transformation and transportation" (yunhua).

Not infrequently pure scholarship takes a professional pride in cumbersome specialist terminology, but practitioners and teachers must question the wisdom and utility of unwieldy terms no matter how technically correct they may be in the minds of scholars. Few in our profession have had difficulty in getting used to saying 'qi', why replace it with Unschuld's 'finest matter influences'? We can be pretty sure that his 'vapour influences' will also never be acceptable and will hardly take us closer to understanding the concept of qi. During our training, we simply have to spend some time trying to get to grips with what the qi concept means. Just giving it a fancy English equivalent does not accomplish this for us. It seems too easy to forget that whatever language is chosen we have to be able to speak it. Few will disagree that qi is easier to say than Unschuld's 'finest matter influences' and yin less of a mouthful than Porkert's 'structive configurative force'.

Wiseman's solutions

We can now carry forward some of these broad issues to an assessment of the future place of Wiseman's terminology. I understand, incidentally, that Unschuld offers his support to WT and thereby presumably withdraws his system (thankfully I did not learn that one!). It must be said at once that the majority of the terms Wiseman has coined are welcome as relatively plain, simple and accurate representations of their Chinese equivalents, indeed many are basically the same as those that have evolved in the past 20 years. Expressions such as 'lungs govern diffusion' (fei zhu xuan san) and 'phlegm heat obstructing the lungs' (tan re zu fei) will seem familiar to most practitioners. But in striving for his stated aim of "pegging source terms to target terms" Wiseman often alienates. His intention is to signal to readers that particular terms have a special meaning in CM by choosing archaic or unusual words in English, but unfortunately these are often clumsy, obscure or even actually misleading. As Peter Deadman has pointed out⁹ many of the proposed target terms in WT are problematic not only because of their unwieldiness but because of their frequently inappropriate associations in English - associations not present in the Chinese. Deadman offers examples such as 'vacuity' which suggests mental absence not implied by the source term 'xu', and 'impediment' (bi) a word often used in English to suggest a disability such as a stammer. Impediment does not especially suggest to the English reader the blockage, pain and stiffness of bizheng (bi syn-

drome). In any case most of us say 'bi syndrome' or 'bi zheng' - why should we bother with 'impediment pattern'? In this way textbooks based on WT risk not only introducing inappropriate associations of their own, but may at the same time easily seem so forbidding to many readers that they could actually discourage further study. We can be sure this is not the intent of WT. Thankfully, though, Wiseman is prudent enough to leave 'qi' as 'qi' in his system, but why not apply this principle more widely? Is it not easier both to read and to say 'qini' than 'qi counterflow'?

We can identify further difficulties with WT. As mentioned Wiseman often chooses words that are English but their use as technical concepts is signalled by his selection of unusual or archaic words, words that risk hindering effective communication. 'Zhi yin' is a good example (a category of 'tan yin' which is itself sometimes translated elsewhere as phlegm-fluid). 'Zhi' translates literally as 'twig' or 'a prop' and yin is a pathological fluid entity. Wiseman coins the term 'propping rheum' for zhi yin but this surely carries very little meaning to most English readers. It surely leaves us no better off than if we had just stuck with the pinyin. What happens though when future graduates schooled primarily in this terminology wish to undertake further study in Chinese hospitals or with Chinese-speaking doctors? How many Chinese doctors or interpreters can be expected to understand the term 'propping rheum'? Do we not, by adopting a relatively outlandish professional terminology of our own making, cut ourselves off from colleagues in China and so reduce our capacity to draw more directly from the wellspring of this medicine. In the process we may risk rendering ourselves even more dependent on indirect transmission from scholar sinologists.

As we have touched upon before, difficulties arise because the professional imperatives incumbent upon linguistic scholars differ somewhat from the requirements of CM practitioners and educators. For Wiseman the key test of success in his work is fidelity. This is said to be achieved when an English translation can be rendered back into Chinese and the Chinese text is seen as identical to the original source. This linguists' ideal is one that may represent an unnecessarily stringent basis for developing the language of our profession as a whole, as evidenced by the clumsy language that results. There has to be some trade-off between scholarly ideals and practicalities. We may need to accept that no amount of terminological exactitude can fully overcome the obstacles of language and culture. We understand this medicine by studying it and pondering its concepts, by the effort of stretching our minds towards the rational sense detectable in the tradition. Wiseman's ideals may prove too rigorous to be practicable. I would argue that these ideals are better realised by less translation of key terms and more contact with the touchstone of the source language terms.

Paradoxically, the stated ideals of WT proponents may be seen in fact to be inhibited by its adoption. Marnae Ergil

summarises the ideals thus: If we choose to use language that is simple but inaccurate or variable, we will lose the Chinese meaning of a term and incorporate western connotations into our understandings of a Chinese philosophy/medical system¹⁰. But as we have seen, the English equivalent terms are acknowledged as imperfect. Most scholars are agreed that translation is making the best of a bad job because of the nature of the gulf between the two languages and because of Kovac's untranslatability issue¹¹. This recognises the fact that few terms translate ideally, not only because of the language incongruencies but because of cultural incongruities as well. Wiseman tacitly acknowledges that the best we can do is learn to develop new meanings for the new English terms, for example 'disinhibit' to convey the range of meanings of the character 'li'. But when fixed translations displace the Chinese terms in our minds we are inevitably taken a little further from true understanding because they do not adapt easily to the full range of contexts available in Chinese.

Inevitably words used in English to represent Chinese terms most often have associations very different from those intended in Chinese, but when we take the Chinese term as our prime reference point such problems are reduced. Wiseman's *Practical Dictionary* remains an invaluable resource, alongside the many other texts, and clearly deserves a prime position on our shelves. However, I am suggesting its greatest value is as a glossary to assist us in developing our understanding of the meaning of pinyin terms. If I have to teach the CM concept of 'qini' I might want to use Wiseman's term 'counterflow qi' and perhaps also use the earlier commonly-used term 'rebellious qi' to help describe its sense and the types of symptoms and signs that could be associated with it. I might spend some time explaining the idea but personally I would prefer in the end to hang the concept in students' minds on the pinyin 'qini'. This way we all know what we are talking about, and if these students later go to China, teachers there will know what they are talking about too. By doing this for 'qini' and other terms I am confident students have acquired the most workable keys to the tradition for their entire careers.

I feel this is an important aspect of the problem. How will westerners wishing to gain experience working in China fare when they use terms like 'unctuous strangury'? Does WT facilitate the process of communication or does it create new language and communication barriers between east and west? Graduates of the Chinese herb course at the Northern College of Acupuncture (UK) learn all the herb and prescription names in pinyin. None have dropped out due to difficulties with this terminology. Later they return from further clinical experience in China saying how empowered and delighted they felt at the ease of communication this gave with Chinese doctors and interpreters. In colleges in the US, I understand that Latin and English is often the norm for herb names and formula names. How do these practitioners get on in China? I guess they have to learn the pinyin for successful communication, or not go to

China at all. My experience is that most people learning and practising actually enjoy acquiring a repertoire of terms in Chinese. Do we need the imposition of semi-indigestible polysyllabic and contrived-sounding terminology?

I feel we should recognise too that not every student and practitioner using the English language to access Chinese medicine ideas has English as their native tongue? I have met Norwegians, Danes, Dutch, Germans, Portuguese, Somalians and Croatians learning from texts in English. How much more of an obstacle to understanding will the adoption of WT represent for them? All practitioners east and west belong on a continuum between novice-hood and mastery. Do we smooth the path to mastery by adopting terminology that very laudably imposes the highest scholastic ideals on all, but in effect risks alienating all but the most dedicated?

Conclusion

Flaws argues it is the seriousness of the medical endeavour that forces us to adopt the most rigorous translation standards - clearly a laudable aim if it can be achieved. As Flaws has stated³, high fidelity translation is especially crucial in medicine: "... if these technical instructions are not rendered faithfully, then the practitioner may misdiagnose and, therefore, mistreat their patients". This is true - up to a point. Experience shows that CM is quite robust and travels well. It has already travelled and survived - even benefited from - transplantation into many countries of SE Asia. It was making remarkable progress in the west even before the advent of Wiseman, Boss and Feng's *Glossary* and *Practical Dictionary*. These remain invaluable guides to translation and understanding but some more coherent ongoing peer review process should help us to evolve a terminology from the WT foundations. It must be acknowledged that many of Wiseman's terms represent a good compromise but the unilateral imposition of a new terminology incomprehensible to 90% of the world's TCM practitioners must be considered folly if it inhibits the process of our profession's acquisition of the main universal language of CM - Chinese.

As I have argued, I would prefer to see us taking a different approach to squaring the terminology circle. At some point in the development of a truly professional practice of CM in the west I believe we should acknowledge the fact that CM already has a technical language, namely Chinese, more easily accessible to us through pinyin romanisation. From a global perspective we should surely accept that the language of professional CM is Chinese. Serious TCM professionals in the west accessing the medicine using English probably number not much more than 30,000, and only a small proportion of those can be expected to be familiar with WT. China has between 1 and 2 million practitioners employing the source Chinese terminology. What then is the technical language of Chinese medicine?

I feel we should recognise Wiseman's texts as a key reference but emphasise pinyin for all those terms offering

translation difficulties. For me the ideal textbook is exemplified by Clavey's *Fluid Physiology*¹² which succeeds well in conveying the basic information using the relatively naturalistic language that evolved prior to WT. Small losses in academic rigour are easily outweighed by gains in readability and the osmotic absorption of language and culture afforded by his footnotes and asides. In this style of text, common CM terms are often given in pinyin but are explained, as appropriate, by hyphenation with an English term, by short explanation in parentheses, or by more detailed explanation in endnotes. Wiseman, Boss and Feng's works would provide a further valuable source to the reader wanting to develop more understanding of the pinyin terms. Using Clavey's more user-friendly approach, the reader can work at their own level but be guided semi-painlessly into deeper understanding. I would also suggest that perhaps the ideal acupuncture college training should employ a similar approach using ordinary words to describe the concepts but pegging them onto pinyin terms.

In the above I have attempted to summarise some of the key arguments in the terminology issue as I see them. Needless to say not every point in the issue has been examined in detail and readers are pointed to the excellent appraisal given in the *Glossary* for the definitive guide to Wiseman's case. My personal view is that practicality must be uppermost in our minds alongside the realisation that the endeavours of scholars must bring us closer to the source language and concepts and not interpose new barriers. This could be best achieved by a continuously increasing use of pinyin in our texts and teaching institutions, building on our already growing lexicon and sense of connectedness to the great historic tradition of Chinese medicine. I sincerely believe we must avoid anything that alienates us from this tradition.

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Notes

- 1 About 150 terms were selected as a base line for early stages of the course..
- 2 e.g. Flaws comments on Maciocia's *Obstetrics and Gynaecology* in Chinese Medicine on the US acupuncture.com website.
- 3 The introduction to Wiseman & Boss's *Glossary* gives a quite thorough account of these problems.

- 4 In Wiseman's *Glossary*, though the *Practical Dictionary* does offers optic atrophy as a biomedical equivalent to qing mang.
- 5 Kovacs in Unschuld 1989.
- 6 Paraphrasing Wiseman & Boss p. xxxiii.
- 7 The actual content of which is was among the best of its time - if you were prepared to wrestle with the Latin.
- 8 Unschuld 1989 p105.
- 9 JCM No 62 Feb 2000 Review of Wiseman & Feng's *Practical Dictionary*.
- 10 Marnae C. Ergil 2000 *Considerations for the translation of traditional Chinese medicine into English* Paradigm publisher's website.
- 11 Kovacs in Unschuld 1989 p89.
- 12 Clavey 1995.

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The Right Word by Ken Rose

To use words wrongly is not only a fault in itself.
 It also corrupts the soul.
Socrates

To know yet appear not to is best.
 To not know yet appear to is sickness.
Lao Zi

Nearly 2,000 years ago, a Chinese writer named Liu Xie wrote,

The Spirit of literature travels far. Contemplated in silence, congealed within a concept, this Spirit connects across a thousand years. It can change the expression on a face ten thousand miles away. What a wonderful concept! The principle is: the Spirit moves with matter, the same Spirit that dwells in the human breast. But it is the qi of the will that moves the crux of all things seen with the eyes or experienced within the body. It all hinges on the pivot of the right word.

The publication in the last issue of this journal of a review by Mr. Deadman of *A Practical Dictionary of Chinese Medicine* by Nigel Wiseman and Feng Ye has stimulated a discussion of the merits and demerits of translation standards in general and of the terminology presented in the dictionary in question. In essence this discussion is an attempt to zero in on "the right word."

I remember the day when "the terminology issue" first came to my attention. It was 1972. I was sitting in the cafeteria at the California Institute of the Arts with Marshall Ho'o. Marshall taught Taijiquan there, and a small group of us Taiji students had prevailed upon him to teach us Chinese medicine. In these days there was no law specifically covering acupuncture. The only legal liability facing those who sought to help people with Chinese medicine was the

practising of medicine without a license. I recall many a discussion aimed at framing an explanation of what we were doing that characterized it as something other than medicine. "It all has to do with spirit," one would say. "So it's not really medicine." "It's just Qi. Qi is energy. So we'll just call it working with people's energy." None of us understood much of what we were talking about.

Marshall finished reading an article by the late James Reston about his experiences with acupuncture to alleviate post-operative pain after an emergency appendectomy he had had while in China. He tossed the paper down on the table and nodded slowly.

"We need to be careful now. Lots of Americans will get interested in acupuncture." "What do we need to be careful of?" I asked. "You don't understand. And because you're Americans it will take you years to figure out that you don't understand."

The broad question of how to transmit ancient Chinese ideas to contemporary Western minds has occupied me ever since. It dawned on me early on that if I wanted to make any significant contribution to an answer to this question, I would have to devote myself to study and develop an understanding of those old notions. With this aim in mind, I took up the study of Taiji and Chinese medicine and pursue it until today. I moved to China in 1992 and spent the next six years there learning the language, the culture and customs, and the feelings of Chinese people. I was blessed with opportunities there and met thousands of students eager to learn English and dozens of teachers who shared their knowledge of Chinese language as well as medical and martial arts with me.

In 1994 I began to teach a seminar at the Chengdu University of Traditional Chinese medicine for Masters and Doctoral Degree candidates. The subject of the classes was the translation of Chinese medical terms and texts. We found a bilingual primer on Chinese medicine that had been produced in the 1970s at the Shanghai University of Traditional Chinese Medicine. It is a wonderful collection of brief essays on a range of topics from yin yang theory to differential diagnosis. The English text is not only highly readable, it very closely conveys the precise meanings of the Chinese originals. One wonders what became of that level of translation skill, as these earlier materials far exceed later efforts to produce English texts on the subject. These Shanghai texts to which I make reference are filled with Maoist political references, and this may explain why they were withdrawn from use. Perhaps the scholars who produced them similarly fell out of favor with changing political tides. Or perhaps they simply passed away, joining those numberless ranks of ancestors who have toiled over the literary legacy of Chinese medicine for more than 2,000 years.

Lest anyone fail to understand the importance of this stewardship of the literary traditions over the past two millennia, had just one or two generations of Chinese scholars neglected the chores of compiling and updating the medical literature, we might not have the material that

we have today. We know of several texts that have been lost to the vagaries of time and the depredations to which books, like the flesh, are heir. Just as Chinese medicine itself can be thought of as the development of wisdom and skills that can be used to counteract the vulnerabilities of the body, the medical literature constitutes a body itself, one that also requires our conscientious attention and care. There are several aspects to this work including both the custodianship of the books and the custodianship of the meanings. The first point that must be made with respect to the resolution of questions related to the terminology of Chinese medicine is its antiquity. As a result of its age, the nomenclature of Chinese medicine has taken on an enormously complex character. Even without reference to the problems facing those who seek to translate these terms into another language, the study of ancient Chinese texts is highly problematic. Chinese scholars frequently differ and debate how to render classical Chinese into modern Chinese. Furthermore, such debates have been going on throughout the long history of the subject in China. The resulting literature is complicated, to say the least.

Does this mean that every student of the subject must become a scholar of classical Chinese? Not necessarily. But does it mean that such scholarship is an indispensable and critical component in an educational system designed to transmit traditional Chinese medicine to new cultural zones? It most definitely does.

Which brings us to the issue of the *Practical Dictionary*. My wife, Zhang Yu Huan, and I have invested a considerable amount of time and money buying dictionaries. We're particularly interested in bilingual dictionaries, and bilingual dictionaries of Chinese medicine occupy several shelves in our family's flat in Chengdu. We were working on the final draft of the manuscript of our first book, *Who Can Ride the Dragon?* when we received our copy of the new *Practical Dictionary*.

Mr. Deadman suggested that writers in the field risk becoming slaves to any translation standard should one appear. Unless it has enslaved me in some dark and sinister way of which I remain ignorant, the *Practical Dictionary* has done nothing but make my work as a researcher and writer easier. How?

First of all, it compiles material from a great many references and serves as a guide for research, pointing out sources that ought not be overlooked when pursuing an understanding of the deep roots of medical thought in ancient China. Perhaps more importantly, however, is the fact that the dictionary is indeed an important step in the direction of developing a translation standard for rendering Chinese medical terms into English. Mr. Deadman raised the question, "Is such a standard desirable or even possible to attain?" It's an important question and should be thoroughly discussed.

The fact of the matter is that in every age through which traditional Chinese medicine has survived until today, scholars have had to take up the increasingly cumbersome

accumulation of materials and sort them all out thoroughly. Each age has thus collected, compiled, revised, updated, and reissued the materials that constitute the literature of the subject. This process has been going on uninterruptedly in modern China since the late 1950's. The growth in popularity of Chinese medicine around the world has meant the inclusion of translation among the duties of those who now take up the ancient mantle of responsibility for the literary transmission of the Art of Benevolence, as traditional medicine has been known in China for centuries.

Such benevolence is rooted in clear understandings. And clearly understanding the terms and concepts, the theories and methods of traditional Chinese medicine is not easily achieved. It never has been. It requires not only access to the ancient wisdom but the cultivation of personal capacities that enable an individual to make internal connections with universal ideas and potentials. The Chinese have long revered those who were able to achieve such skill and celebrated them among the immortals. We know their names, Hua Tuo, Zhong Zhong Jing, Sun Si Miao, to name a few; but how many of us know their works?

In the case of Hua Tuo's book, no one will ever read it. Why? The story goes that the Han king in Hua Tuo's time suffered from headaches. The famous surgeon was the only acupuncturist who could relieve the king's suffering. When the monarch attempted to press the physician into the Imperial household as his private doctor, Hua Tuo declined the opportunity. Instead of the financial security that such an appointment would bring to him and his entire family, Hua Tuo opted for a prison term that proved to be a life sentence. While there, he wrote his book on Chinese medicine. But his guard to whom he offered the book, refused to take it, fearing for his own neck lest he be caught in possession of the condemned physician's work.

Thus we are deprived of medical wisdom due to the shortsightedness of a very small number of people who made decisions based entirely on personal well being. Hua Tuo's silent message to all who study Chinese medicine is a powerful one indeed, one that we should contemplate in considering questions related to the ongoing transmission of traditional Chinese medical knowledge.

This kind of contemplation should inform us when we consider such seemingly simple issues as the choice of English equivalents for Chinese medical terms. Two such terms emerge from the recent discussion of the *Practical Dictionary*: xu and shi. Over the past couple of decades, the de facto translation standard for this pair of medical terms has become "deficient" and "excess." The *Practical Dictionary* corrects these poor choices in favor of two far more accurate and useful words "vacuous" and "replete."

The Chinese words are reflections of yin yang theory and the whole spectrum of Daoist cosmological concepts from which the terms emerge. Tai Xu, in Daoist cosmology is a term that refers to the state of the universe before it existed. In other words, it is highly similar to the ancient Greek notion of Chaos from which the Cosmos emerges. The

meaning of "Chaos" like the meaning of "xu" is "emptiness" or "vacuum." This is quite a different sense than that of the English, "deficient," which is a comparative term and implies inadequacy. In Daoist thinking, emptiness is the root of everything, hardly worthy of a linguistic labelling that identifies it as inadequate or deficient. The word "shi" literally means "full" or "substantial." In Taijiquan, these two words have been used for centuries in texts that clarify the function of yin and yang as the basis of a system of movement, meditation and martial skill. In English translations they are typically translated as "empty" and "full" or "insubstantial" and "substantial." Yet English translators of Chinese medical texts adopted "deficient" and "excess" several years ago and have tended to retain these inadequate choices ever since.

The simple truth is that "xu" does not mean "deficient," nor does "shi" mean "excess." Thinking that they do will not only lead people to erroneous perceptions and actions in the clinic, it will cut us off from the deep philosophical roots of these terms and of the all the complex ideas of diagnostics and therapeutics that depend upon them. Can we afford to make such mistakes, simply because we have an existing de facto standard by which we have become acquainted with these terms and ideas?

More fundamentally, can we afford to continue to conduct our education of doctors of Chinese medicine without instruction in the traditions of language and literature that have always supported the subject for the past 2,000 years? Those who seek to be vessels of this ancient transmission must accept the responsibility of knowing and using the right words in order to convey their understanding of the subject to patients and colleagues alike. The *Practical Dictionary* represents decades of combined work on the part of its authors to do just this. Is it the final word on term choices? On the contrary it is a noble beginning, a tool we can all use to advance both individual and common knowledge.

Now it is time to get down to the hard work of studying and contributing to the age old chore of understanding the legacy that we have been fortunate enough to receive. Only then can we be worthy of the trust of our teachers and the confidence of patients. The absence of standard ... and correct term choices hardly serves us in building this trust and confidence.

From Robert Felt, Paradigm Publications

In your editorial within the review of A Practical Dictionary of Chinese Medicine you suggest a link between standards and limits on writers freedoms, perhaps through economic monopoly. There are endless fields with standard terminologies and no such limitations are found. Indeed, the fact that our field lacks such standards hardly commends us to the members of these others. Publicly available standards avoid coercion or restraint. These problems are more likely when standards are unpublished or depend on individual judgments. Yet, your concern is not without sense.

You earn money from publishing, I earn money from publishing, and so does Dan Bensky, Bob Flaws, Ted Kaptchuk, Giovanni Maciocia, Nigel Wiseman, and virtually every other person who has had something to say about transmission, or who tacitly supports the status quo. Thus, I agree that the economic consequences of standards are important and should be openly discussed. Wise readers will scrutinize us all because such scrutiny is the bedrock on which public confidence is built and therefore the foundation of Chinese medicine's future in the West.

As you know, the single most lucrative arena for Chinese medicine publishers is student texts. This market is the least expensive to access, most tolerant of cost and 'captive' buying at a far higher rate than practitioners. Because the largest number of students are in U.S. acupuncture schools, the single most important market variable for English language publishers is the curriculum of those schools and the license examinations by which their students enter the career they paid tuition to achieve. Thus, the money power-point is these exams.

Although I have always supported this process, I have also suggested that criteria other than the content of books or the statements of selected individuals should be given a significant role. For example, how does the knowledge tested compare with what Asian practitioners are required to know? Are the skills taught and tested those needed to survive as a clinician in today's marketplace, or those of the future? Do we know how many people are still in practice five years after passing their exams? In other words, do we know that we reasonably assure our students the career they paid tuition for? I don't know. Do you? And by what measure do you know it? Personally, I believe that publishing the Chinese characters and the associated English terms used in these exams would go a long way toward freeing teachers to adopt whatever texts and terms they chose.

However, regardless of what standards are chosen, it is critical that they inspire confidence and assure fairness through openness. For example, if someone made a list of every author, their years of clinical experience, their access to Asian experience, and the extent of their training (or any other reasonably objective measure), then compared it to a list of everyone who had participated in the creation of these exams, would there be a standard that reliably separated those who were included from those who were not? The fact that economic interests are effected by these standards is exactly why they should be publicly available for scrutiny and why the publication of all transmission issues, including term standards, can only help achieve this goal.

Generally, I see this in the same sense as I expressed in response to your comments on-line. I do not believe productive discussion of term standards is possible until people's assumptions about the transmission of Chinese medicine are openly discussed. For those who did not follow on-line, your latest complaints can illustrate my point. You name "standard English dictionaries" as your standard and for each of your term critiques you have selected from

among several dictionary definitions. In the Random House Unabridged Dictionary, for example, the definition you emphasize for 'vacuity' (bereft of ideas or intelligence, mindless) is the sixth of seven. The third definition for 'deficient' in the same dictionary is: "a person who is deficient, especially one who is mentally defective". The term you claim as superior fails your own standard. Therefore, if anyone wanted to use your terms, they would be dependent on you. Each time they found a term that was not in your book's gloss, they would need to ask you what term to use because there is no method by which anyone can lookup or predict your choice.

You complain that clinicians' inputs are rejected. Clinician's writings have failed to be very consistent and none have made significant glossaries available for scrutiny, or presented a methodological foundation for their choices. Thus it is difficult to say that they have meant to participate in a meaningful way. As for English-speakers preferences, those that can thus far be accommodated without sacrificing translation principles have been. There is a list of these in the Glossary Introduction. Keep in mind that a formal public terminology is fundamental to our social responsibilities. Clinical evidence must be available for scrutiny from outside the clinical fraternity, not only to protect the rights of patients and prepare for the inevitability of lawsuits, but also because the field can benefit from reliably-reported clinical evidence. The record of clinical performance belongs to the populations we serve. Therefore, the language of record, the language of education and the language by which a license to practice is awarded cannot be private, arbitrary, or require agreement with a certain group, or access to a particular writer or publisher. This is explicit in our tradition of academic freedom.

Academic freedom, like the Western ideal of freedom of expression from which it derives, is two-sided. The freedom of writers to say what they will is balanced by the freedom of readers to discover what evidence writers' have for what they say. Any writer's right to self expression is equally balanced by a responsibility to make their evidence public. These two freedoms are inseparable and to avoid repression or coercion, and to make error plain, we must be able to examine the justification for any claim. Indeed, the sine qua non of an independent profession is that its members are capable of judging information themselves without deference to an elite. Professional writing is essentially a sequence of claims and thus must be made available for scrutiny. For example, as I have noted in my response to your derision of "foxy mounting", the truly clinical issue with mounting disorders is not the words but the results of transmission decisions. Your decision not to transmit the pattern relations of mounting disorders is a claim. It is a claim that the relationships found in Chinese texts are not worthy of transmission. Since you have not published a methodology, or provided a reference to your rationale, or shown clinical evidence of irrelevance, we can only guess at the standard you applied.

Keep in mind that no person's practice experience will ever justify such a claim because none can possibly see enough patients to overwhelm the experience carried within the Chinese literature itself.

Publishing is an economic activity and will likely remain that way. Thus, we cannot eliminate economic interest, but we can eliminate barriers to scrutiny. For example, the Council of Oriental Medical Publishers guidelines are important because those labels inform us of the foundation for a publication's claims. Readers who are interested to see the logic behind the term choices for shi and xu can visit <http://www.paradigm-pubs.com/Xu1-Shi2.htm>. The reference therein to the problems with using "deficiency" in pulse literature can be followed to <http://www.paradigm-pubs.com/Maiming2.htm>

The text of my response to your earlier comments is at: <http://www.paradigm-pubs.com/JCM.htm>

Those who would like to read about claims in professional C.M. writing can see the Council of Oriental Medical Publishers and the Research Council of Oriental Medicine at <http://www.paradigm-pubs.com/html/refs.html>.

From Nigel Wiseman

Dear Editor,

I would like to thank you for your words of praise and criticism in your review of *A Practical English Dictionary of Chinese Medicine* in the last issue of this journal. I am very pleased that our work has attracted your attention.

Although you acknowledge the value of *A Practical Dictionary* and predict that it will set a standard in terminology, you lament that the English terms it proposes are not the ones that you like and that they have not been approved by clinicians. The greater part of your review of the book is devoted to this complaint. I believe that in focusing on individual term choices, you have missed the point of the endeavor. I question some of the beliefs and assumptions that underlie your criticism and present something of the wider vision with which our transmission work has been conceived

No invitation?

You state that the people who have done so much to educate the English-speaking Chinese medical community (e.g., Dan Bensky, Steve Clavey, and Giovanni Maciocia) have never been invited to discuss Chinese medical terminology. This is simply not true. Prior to any formal publication we distributed a basic list to everyone of whom we were then aware specifically inviting participation. We also arranged meetings to encourage inclusion. In 1985 *Fundamentals of Chinese Medicine* first publicly introduced, in embryonic form, the terminology that *A Practical Dictionary* presents in detail. We made clear our belief that terminology was a major issue in the transmission of Chinese medicine and that it had not been paid sufficient attention. We noted that terminology was unstandardized and that this made things difficult for students. We proposed principles for the trans-

lation of terms, and we proposed the terminology subsequently first published in *A Glossary of Chinese Medical Terms and Acupuncture Points* (1990). In each of these publications the necessity for peer review was acknowledged and, in fact, the *Glossary* contains a list of changes derived from the feedback we received.

When a body of knowledge is being transmitted from one language community to another, terminological variability must be expected in the initial stages. Glossaries and dictionaries help the process of standardization in that they present terminologies in a form that allows terms to be easily referenced by translators who either wish to apply or criticize the terminology presented. To date, we are the only group to have made our work available to scrutiny despite the fact that many have the capacity to do so.

We stated a problem and proposed a solution. We issued a clear, public invitation to discuss translation issues in the fullest sense possible. As is clear from various introductions and reviews, our invitation did not go unnoticed in the English-speaking Chinese medical and acupuncture community, and indeed, many people have responded. Nevertheless, no-one has, to my knowledge, ever articulated any argument denying the existence of the problems created by unstandardized terminology, published a detailed critique of our principles of term formation, or offered alternative principles. Nor has anyone else ever published a bilingual list of terms formally proposing a terminology for use and discussion by other translators.

Only a limited number of reasons can explain why some have chosen not to participate. One is the belief that Chinese medicine does not possess any technical terminology to speak of, so there is no need to discuss the question of English equivalents. This view appears to be quite widespread among people who have little or no access to primary Chinese texts.

People with access to Chinese texts contribute to this view through their approach to terminology. Maciocia, who is a translator, contributes to the idea that Chinese medicine possesses little technical terminology by his assertion in *Foundations of Chinese Medicine* (1989) that this general textbook can be fully glossed with only 56 terms. Given that the *Zhongyi Dacidian* (The Greater Chinese Medical Dictionary) published in 1995 by the PRC's most prestigious medical publisher, the People's Medical Publishing House, contains nearly 32,000 terms, we must conclude either that the Chinese are spinning a yarn or that Maciocia considerably underestimated what constitutes a term. If we acknowledge the Chinese as the originators of Chinese medicine, we must also acknowledge that they have a clear understanding of what is and is not a useful concept. At the very least, it is obvious that Chinese medicine has more than handful of terms and people with no knowledge of Chinese can see this for themselves in *A Practical Dictionary*.

Translators who know there to be more than just a handful of terms can not expect any other translator to apply

their terminology consistently without making a bilingual list available. In a field with a terminology as large as that of Chinese medicine, translators can barely expect to apply their own terminology consistently without a written record. Once a translator recognizes that Chinese medicine has a substantial terminology, he or she must either apply the terms contained in an existing bilingual list, or produce a list of their own. Unless this procedure is adopted, terminological chaos reigns. If two writers refer to the same concept by different words, how can we be sure that readers trying to understand both writers' work will know that only one concept is meant when neither can be cross referenced to the other? When one translator uses the same English word for one concept that another translator uses for a different concept, how can we be sure that readers will know that two different concepts are meant?

Of course, a translator developing a terminology and realizing the need for terminological consistency is not obliged to publish their terminology. They could keep it to themselves or they could allow their list to circulate privately among selected colleagues. This is clearly their right and is entirely understandable from the commercial point of view, because publishing bilingual lists and dictionaries, especially when they must contain Chinese characters, is simply not profitable. Bilingual lists are intended for translators and other people who know Chinese and English, in other words, for a tiny fraction of the market for Chinese medical literature. Bilingual lists are produced by writers and publishers who prioritize putting the transmission of knowledge on a sound footing.

Cost is not the only reason translators might not wish to formally publish a list of terms. They might decline to publish a list believing that by so doing they would encourage other translators and publishers to produce competitive translations, thus decreasing their own access to the very markets they pursue. This makes financial sense for translators who are also publishers and is further encouraged by the fact that the examination terminology that determines what books students are required to buy is itself private. Thus, curriculum, text, and term choices are subject to greater competitive pressures than in fields which work with published dictionaries.

Whichever way you look at it, the fact that Western translators of Chinese medicine have not discussed the terminological issue and have not produced glossaries and dictionaries compels any impartial observer to the conclusion that these translators have a) ignored the facts of Chinese terminology, b) lack the will or resources to invest in the creation of tools necessary to improve the standards and the scope of Chinese medical literature, or c) chose not to contribute to this aspect of the development of Chinese medicine in the West. When you say that term makers should take into consideration the term choices of others, you must also consider that it is their right to set their own priorities.

As I said, the purpose of a glossary is to propose a

terminology that serves as a reference for translators either wishing to apply the proposed terminology or wishing to criticize it. In other words, it is the basis for discussion of terminological issues. The fact that no-one else has produced such a basic tool means that everyone else, for one reason or another, chooses to ignore the problem of terminology. Yet without a standardized terminology pegged to the Chinese and freely available to all translators, we cannot possibly expect to develop a solid corpus of English-language literature that will broaden and deepen our understanding of Chinese medicine. Furthermore, until new writers or publishers have open access to curriculum and examination terminologies, you cannot expect investment in teaching tools and publications by those who do not have personal access.

Thanks almost solely to you, a discussion of sorts has taken place, but it has been confined to informal comment, and has been almost entirely restricted to opinion about popular terms. Your review of *A Practical Dictionary* is actually a rare example of openly stated opinion on terminology. But I believe that this issue should not be tucked away in book reviews, but should be a topic for formal papers presented in the main body of journals. It is regrettable that journals are so narrowly oriented that they give little or no space for the discussion of such issues. Much would be gained by discussing, not so much individual term choices, but the principles of term translation in the context of the whole information supply system upon which every aspect of clinical ability ultimately rests.

Clinicians versus translators?

In your review of *A Practical Dictionary*, you complain that the term preferences of users and clinicians who do not speak Chinese have not been sufficiently reflected in the terminology proposed. You believe that clinicians should have a say in matters relating to the transmission of Chinese medicine. I address this question because you are certainly not the first to raise it. This is an important issue that everyone needs to look at squarely.

Let's start by getting the priorities straight. People use different equivalents for Chinese terms and some people like some terms more than others. Nevertheless, when it comes to translating Chinese terms into English, we first need to be sure that the Chinese concepts are adequately reflected. That is to say, the English terminology should reflect the concepts as they are described in Chinese texts and understood by Chinese readers. It stands to reason that at this stage of the term discussion only those who speak and read Chinese are able to contribute in this regard. This does not mean that clinicians should not be permitted to voice their preferences for certain terms. In fact, I would be very surprised if anyone's terminology has accepted more clinician feedback than that provided by the *Practical Dictionary*. However, insuring that the options available to clinicians adequately express the Chinese concepts is a matter for people with linguistic access to source texts. To

claim that a clinician is qualified to voice an opinion on matters of *translation*, that is, the act of negotiating between two languages, when he or she has no linguistic access is completely absurd.

What any monolingual speaker has to say about term choices in relation to concepts is based on the description of concepts not in Chinese texts but in English texts. For example, everything that you say in your review about *vacuity* failing to represent the concept of *xu*, is based on your understanding of the concept as represented by the term you prefer, *deficiency*.

A brief anecdote might help to illustrate this point. In the course of negotiating a contract for the translation of *A Practical Dictionary* into Italian, we asked the Italian translators to provide a list of their Italian equivalents, so that we could determine if the translation would be in the same spirit as the Chinese. For the term *lin*, the translators said that they would prefer *disfunzione urinaria dolorosa* instead of the Italian equivalent of our term *strangury*. They said they had looked up the meaning of *strangury* in the dictionary and found that it had no connotation of pain implicit in their understanding of the Chinese concept. I informed them that *lin* means dribbling or dripping, and describes the restricted flow of urine. Although pain is present in most *lin* conditions, it is not necessarily present in those *lin* related to *vacuity* patterns. Clearly, their suggestion that the Italian term should reflect the notion of pain had come not from Chinese, but from English writers who call it *painful urinary dysfunction* or *painful urinary syndrome*. They confused the original concept with the concept as presented in translation. This is neither a sin nor a crime; it is simply an oversight. It is nonetheless an oversight that denies useful information to readers.

We know that English literature is produced not only by people with access to Chinese sources, that is, by translators, but also by people without access to Chinese who use English-language literature and their own clinical experience as the sources of their ideas. But persons without linguistic access obviously cannot help in the transfer of Chinese knowledge to the West. In fact, they can hinder it. Stephen Birch & Bob Felt have demonstrated that many English-speaking writers, on a basis of a belief that the eight extraordinary vessels store original *qi* (*yuan qi*) or essence (*jing*), have counseled against their needling to prevent any loss of these substances (Birch & Felt 1999). The belief is not supported by primary Chinese sources, notably the *Huangdi Neijing* or *Nanjing*, and the belief has been traced to the French-speaking writers Albert Chamfrault and Nguyen Van Nghi, who are suspected of representing a Vietnamese school of thought. Maciocia, whose bibliographies clearly suggest that he works exclusively from primary Chinese sources, would not have found this notion in any of the Chinese sources he quotes (Maciocia 1989: 355). This view of the extraordinary vessels is an item of theory that, if we are to judge by Chinese experience, has no substantiation in clinical reality. Yet this misinformation was not magically

corrected by our clinically proficient English-speaking authorities with no knowledge of Chinese; many of them accepted it. The idea that clinical experience confers translational authority is a complete myth.

Clinical experience is important for clinical practice, but not for translating other people's clinical experience. No one's clinical experience is worth as much as everyone else's put together. No one clinician can possibly see enough patients to outweigh a whole tradition. Elimination of mistakes like the contraindication against needling the extraordinary vessels requires not clinical experience, which this error denies Western practitioners, but access to the original sources.

This is not an excessive demand in any way. In all fields of learning, it is customary for scholars wishing to contribute to the field to have a good command of the literature on the subject. In Chinese medicine, the vast majority of the literature is in Chinese. Anyone wishing to write textbooks, present new insights, or offer personal clinical experience in Chinese medicine should be broadly familiar with the Chinese literature on the subject.

It would be very presumptuous indeed for a person to present personal insights and experience without first acquainting him/herself with everyone else's understanding on the matter in question. Anyone wishing to write a textbook drawing together the state of the art needs to have access to the state of the art.

I think that we have to get clear about what talents are required for specific tasks. Linguistic access is the primary qualification for breaking any new ground in the transmission process. For the presentation ideas discussed in one language to a language community unfamiliar with them, linguistic access and general familiarity with the field are what is necessary. Linguistic access plus clinical experience is necessary for the evaluation of Chinese medical information (in whatever language it appears) and for contributing new ideas to the field and participating in the local and international development of Chinese medicine. People like Bob Flaws, Charles Chace, Craig Mitchell, Andy Ellis and others who combine a sound conversancy with the Chinese literature and their own clinical experience are still rare but growing in number. Our future model for purveyors and generators of Chinese medical knowledge should be people like these with full access to both the whole of tradition of Chinese medicine and clinical experience. Nevertheless, as I see it, people without linguistic access, no matter how much clinical experience they have, belong in the back seat when it comes to the transmission of knowledge. I certainly would not wish to deny such the right to publish their experience, provided it is labeled precisely as "personal experience", but as I have said, the clinical experience of people unfamiliar with the literature is likely to be far less useful to clinicians than that of people who are familiar with the literature. To put this the other way round, clinical experience without linguistic access is not likely to benefit the community as a whole, and certainly has no

place in the transmission of knowledge from China to the West.

What has been missing so far is the access to the tradition. Some translators have not recognized that Chinese medicine is a large corpus of knowledge for whose transmission we require a systematic approach to translation. By ignoring elements that they do not consider useful for Westerners, they have presented Chinese medicine as something more finite than it is. They have given the impression that the transmission of Chinese medical knowledge is basically complete, thus fostering the idea that Westerners have so complete and mature an understanding of the subject that their contributions are now as valuable as those of the Chinese.

Widening our horizons

The flaw in this attitude becomes increasingly evident with the appearance of each new text translated from primary sources that presents a new facet of Chinese medicine such as Paul Unschuld's *Nanching*, Charles Chace's *Zhenjiu Jiayi Jing*, and our *Shang Han Lun*. These works show that Chinese medicine is far more than the contents of *Chinese Acupuncture and Moxibustion*.

What *A Practical Dictionary* does is to single out Chinese medical concepts that have continually appeared in a wide variety of literature through the ages. As a dictionary it intends to inform people about concepts as well as proposing a terminological standard that enables everyone to talk about those concepts in the same language, without the confusion of speaking in tongues, without a personal or financial tie to my colleagues or myself, and regardless of whether the projects they wish to undertake will compete financially with our own (which some already do). An incidental upshot of *A Practical Dictionary* is that brings to light in glowing clarity the fact that Chinese medicine has many, many more concepts than most people currently believe. It further shows that those concepts are richer and more detailed than is common knowledge. This brings home the point in a way that no dry linguistic arguments about translation could do, that without a linguistic interface for large-scale transmission of Chinese medical knowledge, we are working with too many personally potted visions.

Your criticisms about the proposed terminology sidle right around the central issue. The primary need for the development of Chinese medicine in the West is for everyone to gain access to China's huge mine of clinical experience. That can only be achieved in one of two ways: either all Western students of Chinese medicine can learn Chinese, or dedicated people can translate enough Chinese literature for our needs. For accurate translation of China's wealth of clinical experience a rational English terminology based on solid translation principles needs to be applied by all writers and translators. Your suggestion that the authors of *A Practical Dictionary* ignored the feelings and preferences of clinicians seems to suggest that terminologists are

people who ride rough-shod over clinicians' interests. In so doing, I believe you obscure from your readers the fact that our suggestions are intended precisely and solely to set the transmission of Chinese medicine on a sound footing so that clinicians can gain greater day-to-day success.

Adaptation

You suggest in your review that term choices should take account of the Western reality of acupuncture. They should bend to the preferences of recipients of Chinese medical knowledge and take account of the natural process of adaptation to Western conditions.

I strongly disagree with this notion. First, terminologists and translation theorists who have observed the processes by which bodies of knowledge have been successfully transmitted from one culture to another agree that a close, literal style of translation is the norm in all successful acts of transmission. Translation theorists know that the target-oriented approach to translation, in which the message is often changed to please the foreign recipient, has its role in certain areas of translation, but not in areas where concepts must be kept in tact. And I would emphasize that Chinese medicine is a field that does have many concepts.

Second, although Chinese medicine will eventually adapt to Western conditions, as it is indeed adapting to changing conditions in China, any prediction of the outcome of that process of adaptation at this early stage can only narrow the possibilities open to us. The transmission of raw Chinese medical knowledge is still in its infancy, our aim at this stage should be learn more about Chinese medicine in China, not to define it narrowly as what pleases Westerners.

Appropriate adaptation cannot take place until we master what it is that we are adapting. We have not yet reached that stage.

You can't please everyone

In your review, you speak of users and clinicians as if they constituted a homogeneous group, all of whom oppose the terminology of the *A Practical Dictionary*. It surely is not beside the point that more people now own the *Practical Dictionary* than any other Chinese medical lexicographical work. We deliberately made the dictionary attractive by including vast amounts of clinical information. What people want is the clinical information, and that is far more important to them than the choice of individual words. By the fact of being a dictionary, *A Practical Dictionary* tells people that it is only by getting the terms straight that we can erect an effective delivery system. By further providing clinical information, it helps show what can be supplied when we honor the source language. The success of *A Practical Dictionary* is, I suggest, precisely because it delivers what people want, and shows them that the scheme for transmitting Chinese medicine makes sense. In other words, to draw on a previous example, clinicians would rather learn the word *strangury* than lose the clinical observations related to *lin* vacuity patterns.

We are certainly not failing to please clinicians. *A Practical Dictionary* and other works by my colleagues and I are chiefly intended for and mostly owned by clinicians. Furthermore, all of my past and present collaborators but one and, as far as I know, all the other translators using our proposed terminology are clinicians. The fact is that the terminological preferences of which you speak are by no means universal, and are increasingly confined to circles who do not possess the linguistic access required to judge the matter.

The writers who use our proposed terminology know it clearly reflects the Chinese concepts. They also use it because they know the idea of a terminology clearly pegged to the Chinese makes solid sense. Of course, it is not possible to provide a set of terms that each and every student, practitioner, translator, or scholar will like.

Our proposed terminology appeals to people who believe that there is a greater benefit for a greater number of people to be had from gaining access to two thousand years of clinical experience than from encouraging self-ordained clinical gurus who have not taken the trouble to learn Chinese. By the same token, it appeals to people who know that if the teaching of Chinese medicine is to move into mainstream educational establishments, the process of deciding terms in Chinese medicine, like everything else in academia, must be subject to open scrutiny.

We have not pleased everyone because no-one can. But what is important is that we have pleased people who have a vision for the development of Chinese medicine, people who have made the effort to learn Chinese, to gain a deeper understanding of the subject, and to help others to a deeper understanding through translation; people who are aware of the vast corpus of Chinese medical literature, and who intuit that with perseverance and cooperation we can slowly, over a period of at least several decades, assemble a body of reliably translated literature that will enable future generations of English-speakers to gain a far greater understanding of Chinese medicine than the present generation can. In other words, people with vision, tenacity, and common sense.

To conclude, any terminological standard must be based on explicit principles and set down in black and white, otherwise it cannot be subjected to scrutiny and or generally applied. My colleagues and I have taken the trouble to set our terminological principles down—my writing on the theory of Chinese medical translation alone will total about 700 pages by the end of this year. We have put these principles into practice in a bilingual list of about 25,000 terms and provided a dictionary explaining over 5,000 Chinese medical concepts. This is a basic investment in the westward transmission of Chinese medicine without which the wider interests of clinicians and the future cannot be served.

Nigel Wiseman, Taichung, May 2000

From Giovanni Maciocia

Dear Editor,

I would like to make some comments on the debate on terminology. Firstly, I would like to confirm categorically that I was not invited to take part in any debate on terminology. I personally feel that it is simply impossible to translate Chinese medicine terms into a Western language. The best we can achieve is an approximation of meaning. Most Chinese medicine terms have more than one meaning and therefore any translation that focuses on one meaning only is necessarily an approximation. Thus, by definition, there is no "correct" translation of Chinese medicine terms. Most Chinese medicine characters are very evocative and full of meaning and no translation can do them justice: just to give one example, the character *men* (which I translate as "feeling of oppression" shows a heart squashed by a door. This clearly indicates that the feeling expressed by the word *men* has a strong emotional component. Indeed, many Chinese patients I saw in China who used this word were in a state of what we would call in the West "depression". Thus, whether one translates this term as "feeling of oppression", "feeling of tightness", "feeling of stuffiness" or whatever, none of these can ever represent the richness of meaning of the Chinese character. After all, hardly any translator translates "yin", "yang" or "qi" presumably because of the difficulty of translating words with multi-faceted meanings: this difficulty applies to most other Chinese medicine terms. Of course, this does not mean that we should not make the utmost effort to find a translation that approximates the Chinese meaning as closely as possible. The important point, however, is that insisting on a single translation of a Chinese term as the only "right" one makes Chinese terms one-faceted rather than multi-faceted and this detracts from the meaning of the term. Some people assert that if two authors use two different terms for the same concept it would lead to "chaos": this is not my experience at all, neither is it the experience of the very many heads of acupuncture colleges I have spoken to. Every acupuncture student knows that "wiry" and "bow-string" pulse are the same thing.

For these reasons, I happen to think that, when teaching Chinese medicine, it is actually better not to translate Chinese terms at all. I certainly do this and every single teacher of Chinese medicine I can think of follows the same approach. There is a difference between the printed word and lecturing. When I started writing on Chinese medicine I chose to translate all terms (except qi, yin and yang) mostly for reasons of style: I personally dislike books in English peppered with Chinese *pinyin* terms. However, when I teach I always use Chinese terms: thus I will always talk about *lin* disease rather than "painful obstruction syndrome". There are two main reasons for following this approach which, as I said, is followed by all acupuncture colleges I know of in many different countries. The first is that it is good to give acupuncture students, even if they are

not Chinese readers, a “feel” of Chinese terminology and its richness: for this reason, were I to talk about *lin* I would always introduce the character to the students, explain its meaning and its relation with the disease in question. Were we to adopt an “official” English terminology, we would gradually divorce the students from the roots of Chinese medicine. The second important reason for using Chinese terms is that Chinese terminology can then become truly international and this can happen only if we use Chinese terms. I fear that the intense debate about terminology is rather Anglo-centric. Chinese medicine is now used literally all over the world: even if we find the “correct” English terminology, what about the other countries? If we all use the Chinese terminology then practitioners from different countries can converse in a truly international terminology. For example, when I lecture in Italy, everybody knows what *lin* disease is and I do not need to use the term painful urinary syndrome. When I talk about pulse diagnosis and am not sure what Italian term doctors use for a particular pulse quality, I tell them the Chinese term and this usually clears any doubts. To give another example, a Greek doctor rang me recently to ask advice about his health problems and he told me that he suffered from *lin* disease: by using the Chinese term, we establish a truly international medium of communication among practitioners.

Furthermore, in my opinion this intense debate about terminology misses the most important issues facing practitioners today. I believe the most important issue is *diagnosis* and concentrating our attention on the “correct” terminology distracts us from the most important issue of diagnosis. The most important thing is to teach people how to master pulse diagnosis: it does not matter if the *xian* pulse is called “wiry” or “bow-string” as long as practitioners know what it feels like and what it means.

I would like to make some comments about some criticism levelled at my book *Foundations of Chinese Medicine*. Some people assert that I do not think that Chinese medicine possesses any technical terminology to speak of: this is of course a complete and gratuitous distortion of my views. They claim that this view is widespread among people who have no access to primary Chinese texts. I have in fact, an extensive library of old texts which I consult regularly when writing my books. Anybody who has read my books, would have noticed that there are very many references to the *Nei Jing*, *Nan Jing*, etc. Some remark that the *Foundations of Chinese Medicine* glossary contains 56 terms while dictionaries of Chinese Medicine contain thousands of terms. They forget some important points. Firstly, it is interesting that they always refer to the glossary in the *Foundations* and not to my more recent books which have a more extensive glossary. Secondly, they compare the *Foundations* to dictionaries of Chinese Medicine but this comparison of course does not stand, as my book is not a dictionary: I think most unbiased readers will realise that the glossary in the *Foundations* is not meant to be a complete glossary of all Chinese medicine terms but only a glossary of the terms contained in

the book: how can it therefore be compared to a dictionary? Thirdly, it is interesting how some people use my book as an example of everything that is wrong with the translation of Chinese terms by Western authors, but they never mention many other books in English which do not have a glossary at all. I wonder why.

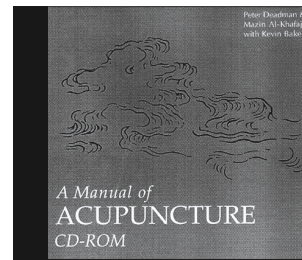
Some authors say that the idea expressed in my books that the extraordinary vessels have some relation with the yuan qi or jing is derived from French sources and cannot come from the Chinese sources I quote. I am afraid this is plainly wrong and quite an extraordinary statement. Does chapter 62 of the *Ling Shu* not say that the Chong Mai stems from the space below the Kidneys?¹ Is this space not related to the yuan qi? Does the first chapter of the *Su Wen* not relate the arrival of tian gui in girls and boys at 14 and 16 respectively to the jing of the Kidneys?² Menstrual blood and sperm are a direct manifestation of jing and chapter 1 of the *Su Wen* says that the tian gui arrives when the Ren and Chong vessels are flourishing. Does this not mean that these two vessels are related to the jing of the Kidneys? Yang Shang Ping (Sui dynasty) says: “There is Dong Qi between the Kidneys which is the source of life, the root of the 12 channels and the place where the Chong Mai arises”³. Is this dong qi” not yuan qi?

With regard to *lin* disease, some authors translate this as “strangury” rather than painful urination syndrome because this disease may occur without pain. Every single internal medicine book and dictionary I have says that *lin* is characterised by difficulty in urination, frequency and pain: quite simply, if there is no pain, it is not *lin* disease. For example, if the urine is turbid (as in *gao lin*) but without pain it would be classified as *niao zhuo*; if there is blood in the urine (as in *xue lin*) but without pain, it would be classified as *niao xue*, etc. Even the deficient types of *lin* have some dull ache. In any case, the *Oxford English Dictionary* defines strangury as “A disease of the urinary organs characterised by slow and painful emission of urine; also the condition of slow and painful urination”. Therefore this term implies pain too.

The need for a review of the Chinese medicine terminology is often justified with a reference to the ancient movement for the rectification of names called for by Confucius (Analects XIII, 3). This is a complete misunderstanding of what the ancient “rectification of names” was about. It had nothing to do with finding the “right” names for concepts, but to do with ensuring that people would behave in conformity with their names, i.e. a father behaved like a father, a son like a son, a wife like a wife, etc. In other words, it was an attempt to ensure that each person behaved according to the principles of Confucian ethics and the reference to “names” can actually be interpreted more correctly as “roles” (Analects, XII,11). I fear that the “rectification of names” advocated by some for Chinese medicine sounds more like the “rectification campaigns” unleashed by Mao Ze Dong in 1942 to purge his opponents in the Communist party with false accusations.

Notes

- 1 1981 The Yellow Emperor's Classic of Internal Medicine-Spiritual Axis (*Ling Shu Jing*), People's Health Publishing House, Beijing, p. 113.
- 2 1979 The Yellow Emperor's Classic of Internal Medicine-Simple Questions (*Huang Di Nei Jing Su Wen*), People's Health Publishing House, Beijing, p. 4.
- 3 1985 A Compilation of the Study of the Eight Extraordinary Vessels (*Qi Jing Ba Mai Kao Jiao Zhu*) by Li Shi Zhen, Shanghai Science and Technology Publishing House, p. 65.



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