

Against Anti-Terminology

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Introduction

There is one essential requirement for successfully transmitting a complex body of knowledge from one language community to another: There must be a target-language terminology that exactly mirrors the source-language terminology and that is precisely pegged to the source-language terminology so that it can be consistently applied by all translators and universally understood by all readers. The applicability of this notion is professionally recognized for the transmission of specialist knowledge in any field. Nevertheless, its applicability to the westward transmission of Chinese medicine is a point of great disagreement among Chinese medical translators. Certain translators reject the notion that Chinese medicine has many technical terms that need fixed equivalents in English, and hence they have never provided bilingual lists of terms sufficient to enable other translators to exactly follow their translation scheme. While abundant evidence attests that Chinese medicine is a complex body of knowledge with a large terminology, no cogent evidence to the contrary has been produced by those who claim otherwise. In this paper, I describe and evaluate the few arguments that the “anti-terminology camp” has put forward in support of their position.

Those who, as I do, believe that Chinese medicine possesses a terminology that needs to be rendered with fixed English equivalents argue as follows: In any specialist field, knowledge that comprises specialist concepts must be clearly labeled. The healing skills that students of Chinese medicine hope to acquire are based on concepts. If those concepts are to be easily identifiable and communicable, they must be labeled with terms. Without terms to represent concepts, the Chinese edifice of medical knowledge and clinical skill has none of the supports required for accurate communication.

The lower the number of specialist terms in any given presentation of Chinese medicine, the lower the number of concepts it can communicate. When any translation of a high-quality Chinese medical text clearly labels fewer concepts than are present in the Chinese source, the resulting English-language text is quantitatively and qualitatively inferior to the original. Information is lost and the quality of knowledge is reduced. When translators apply procedures that consistently lead to the loss of information, users receive an inferior education.

As I explained in *Why the Fuss About Terminology?*,¹ it is difficult for members of a professional community to have a clear grasp of concepts unless those concepts are consistently labeled with terms. The three kinds of pale complexion discussed in Chinese sources, for example, can be described in sentences, but it is only when those three kinds of paleness are given names that people can clearly distinguish them and effectively talk to each other about their application. If people do not use set terms for these ideas, then the case records written by

one person will be useless or misleading for anyone else. People can increase their knowledge when they share terms because terminological rigor makes the transmission of information sure and clear, while freeing the reader from the limitations of any individual writer's skill or experience. Terms are no substitute for explanations, but explanations are no replacement for terms. We need terms to label ideas. Each time we discuss a patient's paleness we don't want to say the "pale complexion that's kinda like white as a sheet." We need terms to communicate with others and to keep medical records. In every clinical setting time is precious, and a shared set of fixed, well-defined terms could relieve clinicians of the time-consuming burden of writing complex narrative records in their own words. Concepts only stand out when they are labeled, and communication is only efficient when everyone speaks the same language.

In Chinese, there are thousands of concepts that are consistently referred to by the same Chinese terms. In English, we should have a vocabulary where each of those Chinese terms has a set English equivalent. Each concept should be referred to by one English term, wherever it occurs. This means, on the one hand, that each writer should use terms consistently and, on the other, that all writers should use the same terms. When individual writers use different terms for one and the same concept, readers have difficulty knowing that they are referencing the same phenomena or idea. It is only natural that in the initial stages of transmission the English terminology will be in a state of flux; it takes time before all translators and writers agree to use the same terms. On numerous occasions, students have asked me, "Is what you call X the same as what a certain other writer calls Y?" I am not always able to answer that question by reading the other writer's text. Usually there is insufficient information in the context to enable me to state categorically which Chinese concept is meant.

The only sure way a student can get a reliable answer to such questions is when writers relate their terms to the original Chinese terms. The most complete account of Chinese medicine is to be found only in Chinese texts. Whatever English translations of Chinese medical concepts are used in English texts, they should be related to the original Chinese terms by some means. In other words, any English text should ideally be expressed in English terms such that anyone with a mastery of English and Chinese (a bilingual) can examine the source Chinese. When English terminology is not standardized, pegging terms to the Chinese is the only means of referencing between authors.

Any serious effort to faithfully transmit the traditional medical knowledge of China to English-speaking readers should be based on an English terminology that is expressly related to the Chinese. This is particularly important in medicine, where people's health is at stake, but it still occurs too rarely. The only way of relating English terms to Chinese terms is through bilingual term lists, dictionaries, and glosses. In the past, it was difficult and expensive for English-speaking publishers to include Chinese in English-language publications. Even with the advent of Chinese desk-top publishing software that allows translators and writers to write and typeset their own work, books containing Chinese are still infrequently produced by English-speaking publishers. In the past these practical reasons may have discouraged the publication of bilingual lists or their inclusion in other works; they no longer justify this lack.

Another, to my mind much more plausible, reason why Chinese terms have not appeared in English publications is that it raises the complexity of the subject matter beyond the level presently acceptable to the most lucrative market in the field—book-buying students in

licensing-oriented education programs. Bilingual terms lists intended only for translators can be unobtrusively placed in appendices or in separate publications. Nevertheless, serious translators who accord importance to linking their English terminology to the Chinese are not usually satisfied with bilingual lists that map terminological correspondences. They usually want to include Chinese in their texts so that other bilinguals, at least, will fully understand the text. The inclusion of Chinese terms in texts allows translators to explain Chinese medical concepts in a much more meticulous way. This, of course, greatly steepens the learning curve for students. Our *Fundamentals of Chinese Medicine*,² for example, is translated from a text used by students as useful background reading before they begin studying their considerably more compendious and difficult first year texts. Despite its application for beginners in China, English-speaking students mistakenly believe it is more advanced than the text books normally used in Chinese medical schools. In a community in which very few people speak Chinese, any book that carefully relates English terms to the original Chinese terms poses a challenge that other books do not. *Fundamentals of Chinese Medicine* is unlikely to be chosen as a textbook by a teacher who has not learned Chinese because it encourages students to pose questions that cannot be answered without access to Chinese sources. The language issue presents an immense challenge to everyone in the field—writers and publishers, as well as teachers students, and practitioners. All of these groups have vested interests that are challenged by the linguistic issues.

The basic assumption with which I began the present discussion is that when people of one language community make a serious effort to acquire knowledge from another language community, they must face the challenge of developing terms in their own language and relating them to the original terms. In the transmission of Western knowledge to China, this challenge has been successfully faced. Most fields have Chinese-language specialist dictionaries that explicitly relate a highly standardized Chinese terminology to the original European language terms. Yet, adequate treatment of terminology is only part of a whole array of measures that recognize the importance of language as the vehicle of knowledge. In China, English-language training is increasingly the standard in high school curricula. In most fields, Chinese university textbooks are copiously annotated with English terms. University students who earn advanced degrees are required to have linguistic access to English-language texts. English is even a requirement for advanced degrees in Chinese medicine. The top students do their doctoral studies abroad, where foreign languages are a must. In China, as in most countries that access foreign sources, the higher the level of knowledge, the more important the foreign language skills.

In my view, the assumption of source-language primacy is applicable to Chinese medicine. If Westerners were making serious attempts to acquire Chinese medical knowledge, much greater attention would be paid to developing an English terminology pegged to Chinese. Additionally, Chinese would be far more ubiquitous in the English-speaking community of Chinese medicine than it is today. Teachers would be expected to have a comprehension of Chinese; textbooks would contain Chinese characters to help those learning Chinese medical Chinese. Furthermore, and very importantly, the whole community would realize that Chinese medicine teachers with bona fide degrees who have access to the full account of Chinese medicine know more about Chinese medicine than any English-speaker with no access to primary texts.

The reason why the English-speaking community of Chinese medicine does not accord language its rightful importance is because the community is afraid to face it. Since the importance accorded to language as a vehicle of knowledge is related to the quality of knowledge being imparted in English-speaking schools of Chinese medicine, the present discussion touches everyone's interests. Since it also relates to the quality of health-care being offered to patients, this issue is of wider interest in Western societies.

While I claim that the principles governing the transmission in other fields apply to Chinese medicine, certain other translators believe that they do not. They do not think that Chinese medicine has a terminology. The community's acceptance or rejection of the notion that Chinese medicine possesses a terminology has immense implications for the development of Chinese medicine in the West. Yet the vast majority of people in the community are effectively incapable of judging the issue for themselves because they do not speak or read Chinese and because the issue is so rarely presented. Thus, to advance awareness of these issues, I will demonstrate that (1) Chinese medicine does have a terminology and (2) the few counter-arguments that have been proposed are completely groundless.

How Many Terms Does Chinese Medicine Have?

The easiest way to answer the question about whether Chinese medicine possesses a terminology is to look at dictionaries. Since we are discussing the transmission of knowledge from China to the West, the best way of determining the size of Chinese medicine's set of technical terms is to survey what the Chinese themselves consider to be the extent of Chinese medical terminology. The Chinese consider the terminology of Chinese medicine large enough to warrant the creation of dictionaries with varying degrees of specialization. In addition to general Chinese medical dictionaries, there are special dictionaries for the *Nèijīng*, *Shānghánlùn*, warm diseases, and so forth. The general terms dictionaries vary in size, but the most comprehensive ones contain over 30,000 terms. Xiè Guān's *Zhōngguó Yīxué Dàcídiǎn* (中国医学大辞典)³ of 1922 contains nearly 37,000 terms (including names of medicinals and formulas). Of course, not all of these terms are commonly used. A smaller dictionary such as *Zhōngyī Míngcí Shùyǔ Cídiǎn* (中医名词术语辞典)⁴ of 1975 contains less than 4,000 terms (excluding names of medicinals and formulas).

In the transmission of Chinese medicine to the English-speaking world, translators differ greatly about what terms need to be preserved, highlighted, explained, and presented in bilingual lists so that others can follow their translation scheme. My *English-Chinese Chinese-English Dictionary of Chinese Medicine*⁵ proposes English equivalents for over 20,000 Chinese terms. *A Practical Dictionary of Chinese Medicine*⁶ lists and explains more than 5,000 terms. These works are comparable in size to smaller Chinese dictionaries of Chinese medicine and represent a preliminary effort to deal with the main terms of Chinese medicine.

Other translators have tended to evade the problem of terminology. Giovanni Maciocia and Daniel Bensky, D.O., et al., have restricted their treatment of terminology to explaining terms in their works and including appended glossaries that contain no more than a couple of hundred terms. While Maciocia states in *Foundations of Chinese Medicine*⁷ that his terminology is complete (at least for as far as the text in hand is concerned), Bensky says in his *Chinese Herbal*

*Medicine: Materia Medica*⁸ that the glossary contains only terms with which students are likely to be unfamiliar (which of course implies that he thinks there are more terms).

Maciocia

Since Maciocia had the boldness to suggest that the list of 52 terms contained in *Foundations of Chinese Medicine* was a complete list of Chinese medical terms (at least the ones contained in the book), I publicly challenged him to give his estimate of the number of terms in Chinese medicine. He has never answered the question. Obviously, it would be a considerable task for him to explain how a basic text of nearly 500 pages requires only 52 of the 30,000 terms that the Chinese understand themselves to need. I would argue that there are far more terms in *Foundations* than the 52 found in its glossary. The expressions *stomach-qi rebelling upwards, collapse of the large intestine, phlegm-fluids, or treat the manifestation first and root later* cannot be fully understood by anyone who has not studied Chinese medicine, and hence they are specialist terms by any standard. Until Maciocia describes the criteria by which he decides what is a term and what is not a term, and thus why these expressions are not included in his Glossary, we can only presume that he is not clear as to what constitutes a term, since his estimate differs so dramatically from the findings of PRC lexicographers.

Maciocia's Glossary of Terms is simply a bilingual terms list. There are no definitions that would help a student. Therefore the only purpose his Glossary can serve is to relate his English terms to their equivalents in Chinese. This would be useful to people wishing to learn Chinese, although vastly inadequate for that purpose, but its main use could only be to enable other translators to apply the same terminology. A translator who wishes to know what Maciocia calls 谓气上逆 *wèi qì shàng nì* or 先治本后治标 *xiān zhì běn hòu zhì biāo*, for example, cannot find it in so limited a gloss. They would need to look through the entire text to find a discussion that appears to answer the description. No person with a knowledge of Chinese would bother because Chinese material is far richer in information and much more reliable. Readers dependent on English material who study Maciocia's works are sure to become aware that the same concepts may be referred to by different terms in literature other than Maciocia's (and the same terms might in fact represent different concepts!).

Among translators who believe that Chinese medicine has a complex terminology, providing a bilingual terms list is simply a courtesy that encourages scrutiny for the long term benefit of the field. In high quality translation work, the translator needs to keep a bilingual terms list to ensure term consistency within his or her own work. Chinese medicine has so many terms it is impossible for a translator to remember all the English equivalents of Chinese terms. So anyone wishing to do a good translation must have a bilingual terms list that can easily be included in works or published as a separate entity. Maciocia has provided no substantial list of terms that allows others to follow his terminology with any consistency. In the absence of a response from Maciocia, one could conclude from his practices that he does not believe Chinese medicine possesses a large set of terms that need to have set equivalents in English.

Questioned about his methodology for translating Chinese medical terms into English, Maciocia said in a statement published in *Journal of Chinese Medicine*⁹ that because English translations of Chinese medical terms usually failed to convey what the Chinese said, the Chinese terms were much more useful. He said that when lecturing on Chinese medicine he

always explains the Chinese terms, and when talking to others, he could always identify a concept by its Chinese name. If the Chinese terms are so important, one naturally wonders why he does not include Chinese terms (or at least Pīnyīn) in his texts, or provide a Chinese-English list to avoid the time lost to the inefficiency of explanations that must certainly be repeated lecture after lecture. *Foundations of Chinese Medicine* contains no Chinese except for chapter headings, where they are unaccompanied by accented Pīnyīn to help those learning the Chinese terms. If Maciocia believed that the Chinese terms were so important, he would have made an all-out effort to relate English terms to the original Chinese terms. The presence of four uncorrected characters in Maciocia's limited *Foundations* glossary through more than one printing, and the extension of three of these into the *Practice of Chinese Medicine*¹⁰ some years later, is a further indication of how little regard Maciocia has for term management.

Bensky

Like Maciocia, Daniel Bensky, D.O., who with his co-workers has produced books used in Western Chinese medical education, apparently considers only a limited gamut of terms to be worthy of explanation. In the Glossary of Technical Terms appended to *Chinese Herbal Medicine: Formulas and Strategies*,¹¹ Bensky and co-author Randall Barolet state, "Most readers with even a passing acquaintance with traditional Chinese medicine will be familiar with much of this terminology. Less common terms which appear only once or twice in the text, are explained each time they are used. The scope of this glossary is therefore limited to those terms which appear often in the text, and which are more likely to be unfamiliar to the reader." Forty terms are explained in the Glossary. The Preface of the same book mentions some of the commonly used terms (yīn, yáng, qì, deficiency, excess, cold, heat, dampness, burner, etc.). Bensky gives no estimate of the number of terms he believes Chinese medicine to have.

In the source texts from which their book was compiled there are many more than 40 commonly used terms that English-speaking students would not know. For example, in our *Fundamentals of Chinese Medicine*, a more basic source, we applied a similar principle to the creation of our glossary and found eight times the number of terms as *Formulas and Strategies*. We also included more than three hundred footnotes explaining terms that only appear once or twice. Our approach is based on the principle that to uniquely express Chinese medical concepts in English, we must devise and explain terms. In our *Ten Lectures on the Use of Medicinals from the Personal Experience of Jiāo Shù Dé*,¹² a 700+ page book that introduces Prof Jiāo's use of medicinals, we included a glossary of nearly 200 hundred terms (despite the fact that virtually any term found in this book can be found in *A Practical Dictionary of Chinese Medicine*). This book is an exhaustive translation of Jiāo Shù-Dé's 用药心得十讲, which was written as a simple text for barefoot doctors. No corners were cut avoiding "difficult terms." This book is comparable in size to Bensky and Gamble's *Chinese Herbal Medicine: Materia Medica* (544 pages), whose glossary contains only 40 terms. The *Materia Medica* is compiled from primary sources, and to judge by the number of terms included in the glossary, one can only presume that a good deal of simplification occurred in the translation process.

If one does not adopt the approach of carefully noting all terms and providing their Chinese equivalents, then the only other option is to use familiar but only roughly corresponding terms. The minimalist approach to terminological management of Bensky and his colleagues suggests that this is exactly what they have chosen to do.

It is clear from statements by Bensky and colleagues that the purpose of their terminological management efforts is merely to ensure that the student understands the least familiar terms. They do not cater to translators who wish to apply their terminology. As with Maciocia, anyone wishing to apply their terminology must thoroughly read all of their literature and compile the complete bilingual list that should have been provided. Since Bensky further fails to provide a rationale for his decisions, this too must be assembled from available sources.

Statements made by Bensky on the CHA listservice¹³ help us to understand his approach to term translation. He argues that Chinese medical terms are quite easily understood by Chinese people, and hence are not really terms at all, asserting that we can talk about Chinese medicine in terms that English people understand without explanation. There is therefore no need to carefully correlate Chinese terms to fixed English equivalents, as noted in the preceding examination of his glossary. He also states that terminological standardization is not helpful to the profession or to students, and that students learn much more when they are exposed to different translation schemes. He further claims that Chinese terms each have so many different meanings that any attempt to devise a matching terminology in English is highly problematic. Though there are elements of truth in Bensky's statements, these do not justify the abandonment of the long-standing and proven practices of translation. Let us look at his arguments more closely.

Transparency

Bensky's comments on the CHA listservice contain imprecise statements that suggest Chinese medicine does not have a special terminology requiring English equivalents because Chinese medical terms are all familiar to laypersons.¹⁴ He states, "There are simply not that many words used in medical texts that are outside the realm of understanding of the average literate Chinese person." The terminology of Chinese medicine, he asserts, is largely "transparent" (i.e., self-explanatory), and the English translations should be equally transparent. He is effectively saying that because Chinese medicine is expressed in ordinary language, there are no specialist terms that need to be standardized.

It is very true that the words comprising Chinese medical terms look familiar to Chinese speakers. This is because Chinese medical terms are all created from the native word-stock of the Chinese language. This is actually true of the specialist language of any field in Chinese. In English, this is not the case. English terms in many fields are derived from obscure Greek and Latin terms (*hilum*, *cotyledon*, and *stamen* are perfect examples), so learning and remembering technical terms is often more difficult in English. Even though Chinese medical terms are largely composed of familiar words, we should recall that Chinese medicine has a long history and that it has quite a few terms that were created using words that have now become obsolete, and hence unfamiliar, to speakers of modern Chinese. Nevertheless, Chinese is an amazingly stable language, and large numbers of terms used 2,000 years ago are still used today.

Be that as it may, it is generally recognized by terminologists that familiarity with the words (or in English word-roots) has no bearing on whether an expression is a term with a specialist definition. Terminologies include everyday words (in medicine, foot, arm, nose, mouth, heart). They also include expressions that, though composed of familiar words, cannot be fully understood on the basis of a lay understanding. Large numbers of terms in Chinese medicine are

composed of everyday words, but they still must be explained to native speakers of Chinese. Bensky claims that Chinese medical terms are “transparent,” but he contradicts himself. For example, by insisting that one must capitalize the names of organs to emphasize their particular meaning in Chinese thought, he asserts that familiar words can have technical meanings.

Words appearing in Chinese terms may be familiar, but they are often used in special senses and unusual combinations. In Chinese medicine, words are often used metaphorically. The term 火 *huǒ*, fire, has many meanings that the ordinary word 火 *huǒ* in Chinese or “fire” in English does not have. Moreover, words can be combined in special ways that are obscure. For example, 水湿 *shuǐ shī*, “water-damp,” is only seen in Chinese medical literature. A highly illustrative example of a complex term is 金实不鸣 *jīn shí bù míng*, “replete metal failing to sound.” This term is composed entirely of words familiar to a modern Chinese person, but someone learning Chinese medicine has to learn that 金 *jīn*, “metal,” refers to one of the five phases and is often symbolically used to represent the organ corresponding to such phase, i.e., the lung, and that 实 *shí*, “repletion,” refers to a state in which there is an evil present and physical resistance is strong. Even if students understand those concepts, they still must learn that the whole term indicates the clinical presentation of a hoarse voice due to evil in the lung. My literal English translation “replete metal failing to sound” is also composed of familiar words, and the English-speaking student of Chinese medicine must also learn what the term as a whole means before understanding it. Familiarity with words does not really help either the Chinese or the English-speaking student to understand the entire import of the term. On the other hand, once students have learned the significance of the term, awareness of the metaphor on which it is based makes the term greatly more memorable and meaningful. The familiarity of the words appearing in terms cannot justify the notion that Chinese medicine has no terminology.

As Ken Rose has pointed out in criticism of Bensky’s transparency theory,¹⁵ “The meanings of medical terms are typically perceived by Chinese people to be arcane, abstract, and difficult.” Chinese people find many familiar words in Chinese medical literature, but they cannot make much sense of it until they study the subject systematically. Furthermore, Rose argues that it is precisely because of this problem that there are so many dictionaries produced in China to standardize and explicate the meanings of this nomenclature. Here there is obviously a huge difference of appreciation between Rose and Bensky on the matter of transparency of terminology. The only way this can be explained is by the difference in transparency between technical terms and the words that comprise them—a difference that deflates Bensky’s argument completely.

There are vast areas of Chinese medical terminology where familiarity with the words does not impart familiarity with the meanings. The four terms 恶寒 *wù hán*, 恶风 *wù fēng*, 畏寒 *wèi hán*, and 憎寒 *zēng hán*, all literally mean “dislike/fear of cold.” All are composed of very familiar words, and it is quite possible that all were everyday expressions at one time or another. In Chinese medicine, however, each has acquired a specific meaning: 恶寒 *wù hán* (aversion to cold) is a strong feeling of cold that cannot be eliminated by adding clothes or bedclothes; 恶风 *wù fēng* (aversion to wind) is a feeling of cold on exposure to wind or drafts that is relieved by covering the body and is typically observed in exterior patterns; 畏寒 *wèi hán* (fear of cold) is a feeling of cold that can be relieved by covering the body and is typically observed in yáng

vacuity; and 憎寒 *zēng hán* (external shivering) is experienced by people with interior heat. Any translator who considers these terms to be everyday terms rather than technical terms is unlikely to a) seek the meanings of the terms in a dictionary, in a reference work, or from an experienced clinician, b) convey to readers the difference in meaning between the terms, and c) translate them consistently. Since these distinctions are keys to treatment decisions such as which medicinals or acupoints to apply, failure to distinguish these concepts by using defined terms reduces the clinical options of readers. In other words, people reading an English text by such a translator will be unlikely to find four distinct concepts expressed by four distinct terms. They will only receive one concept, and they may well be discouraged from considering it important since it may have four different names, no note, and no existence in a glossary. This is of course exactly the impression that a non-initiate Chinese person has when reading these terms for the first time. The difference between the Chinese-language reader and the English-language reader, however, is that while the Chinese reader learns that look-alike terms are actually different in meaning and clinical application, the English-language reader never advances beyond an over-simplified first impression.

I do not know if Bensky makes a terminological distinction between these four types of cold sensation. Because he has not provided a terms list, I would have to read all his works from beginning to end—as would any other translator who wanted to know how Bensky translates these terms. This particular case brings to light another problem with Bensky's tripartite scheme of not bothering to explain commonly used terms, explaining terms only in context, and glossing only commonly used terms unfamiliar to readers. It is quite easy to explain one of the four cold-sensation terms in running text, but to explain the relationship of one to the others can only be done in a footnote or a glossary entry. Concepts form a structure, and they are most efficiently explained through their relationship to contiguous concepts in that structure. Explanations of this kind entail too much digression to be inserted in text. The scantiness of terms in Bensky's texts and the miniscule size of his glossaries very strongly suggest that he simply translates in context. Thus he has no choice but to use familiar English words that inadequately reflect the actual conceptual complexity. Symptom terms, disease terms, and pattern terms are the major, vast areas of Chinese terminology where there are many look-alike terms similar to this example.

I am in full agreement with Bensky that familiar words should be used as far as possible in translation. But even when familiar English words are chosen to translate Chinese terms, this does not mean that the term does not require explanation. Nor does it mean that a term does not need to be related to the Chinese so that students reading authors with different translation schemes will have some means of cross-reference. The point I would insist on is that familiarity of words should not be taken to mean familiarity with their technical meanings. Terms made of familiar words are still terms: they need to be explained; they need to be translated consistently; their English equivalents need to be pegged to the Chinese so that translators who choose to can follow the same translation scheme. Because Bensky's terminological management work is confined to small glossaries appended to his works, we can see that he does not recognize these needs.

Pluralism

Let us now deal with Bensky's point that standardization is not worth the effort and that students benefit from being exposed to different styles of translation. Bensky's argument is that

Chinese medicine has always been pluralistic and that pluralism is good. Therefore, pluralism in translation schemes is a good thing. Regardless of how prevalent or good pluralism may be in Chinese medicine, it does not make any sense for a term consistently used by Chinese authors for generations and generations to be translated by different English equivalents. What is the point of being pluralistic where the Chinese are not? I agree with Bensky that there are different possible translations for terms. I agree that while transmission is in its initial phase, different translations may be helpful. Nevertheless, unless people can relate what is said by one author to what is said by another, the existence of different terminologies can only hamper the community's understanding as a whole. It certainly can do nothing to help the student because there is no way for students to know whether it is the terms or the ideas that differ. Of course, if all translators were to clearly peg all their English equivalents to the Chinese, the existence of different English terminologies would be less problematic. Yet, Bensky makes little effort to expressly relate the terms he uses to the source Chinese. Thus, his approach does nothing practical to avoid confusion or to take advantage of whatever might be learned through the comparison of different translations.

Polysemy

Another argument Bensky puts forward against the idea of standardization is that Chinese medical terms have so many different meanings that they have to be translated in different ways in English. In the introduction to the Glossary of Technical terms of the first edition of *Chinese Herbal Medicine: Materia Medica*, Bensky and Gamble say, "Our translations are the product of a search for the right word at the right time and are always subject to improvement." More recently, Bensky has said, "A certain ambiguity is inherent in the language of TCM, even in the Chinese literature there is debate about the precise meaning of certain terms, particularly in ancient texts."¹⁶ It is certainly true that ambiguity makes translation difficult. Those who have read our *Shāng Hán Lùn*¹⁷ will be aware of the ambiguities that lie in this text—terminological and grammatical. However, before leaping to the conclusion that this justifies opposing the standardization of English terminology, we must investigate the degree of ambiguity and the way in which it affects translation.

The idea that Chinese terms have too many multiple meanings to translate consistently deserves special attention because it demonstrates the degree to which arguments against the consistent translation of Chinese medical ideas are based on false assumptions. The phenomenon of words and terms having multiple meanings is called polysemy (from the Greek *poly* many + *sem* significance). The only study I know of polysemy in Chinese medical terminology¹⁸ concluded that 14% of Chinese medical terms have more than one meaning, as compared with 3% in Western medicine. Modern sciences pay considerable attention to defining terms and making sure that each term only has one meaning. Chinese medical scholars have never been quite so persnickety about terms, so polysemy does exist in Chinese medicine, and it is obviously greater than in Western medicine. Nevertheless, if we accept that 14% of Chinese medical terms are polysemous, there must be 86% that are not. This is far from an indication that Chinese medical experts have been hopelessly inconsistent in their use of terms.

Polysemy does create some problems in translation, but none so unsurmountable as to justify surrendering to confusion. To say that polysemy is so widespread that the search for English equivalents is not worthwhile is like saying that you don't want to open a bank account because

you have too much money. One should be wary of generalizations about polysemy and its significance for translation. Leafing through *A Practical Dictionary of Chinese Medicine*, one finds terms with multiple meanings. In most cases, you will find one English term as the equivalent of one Chinese term that has multiple definitions. In these cases the differences in meaning do not mean that different English terms must be found. For example, of the 128 terms beginning with *A*, only eight have more than one definition (5.5%). In none of these eight cases does the polysemy of the Chinese term create a problem in translation. For example, ancestral sinew (宗筋 *zōng jīn*) is defined as 1) the gathering point of the three yīn and three yáng channel sinews at the pubic region and 2) the penis. Multiple meanings do not usually require individual English equivalents, and to this extent the problem of polysemy in Chinese does not affect translation.

There is a much greater degree of polysemy at the level of individual characters than at the level of terms comprised of multiple characters. The character 滑 *huá* illustrates polysemy at the level of individual characters: when used as an adjective, it is translated as “slippery” in the context of the pulse and as “glossy” in the context of the tongue; when used as a verb, it is translated as “lubricate.” This Chinese character has a wide meaning that covers both tactile and visual qualities. We must use two words here. It is impossible to describe a pulse as “glossy,” and it would not be acceptable to describe a tongue as “slippery” unless we were to examine tongues by feeling them with our hands. When 滑 is used as a verb, it might be possible to translate 滑肠 *huá cháng*, as “make the intestines slippery,” but English speakers would naturally tend to say “lubricate the intestines.” One Chinese character is used in three senses each with distinct translations. But each of the senses is clearly identifiable. For translators willing to apply terminology precisely, this type of polysemy is certainly not a problem. The main point is that polysemy does not mean we should abandon the notion of having set equivalents in English. The word 滑 has a specific meaning in the context of the pulse, and it is in everyone’s interest for everyone to refer to it with the same name. The fact that 滑 has other meanings in other contexts makes not one iota of difference.

The problem of words having multiple meanings, which requires that multiple equivalents must be used in translation, is nothing new in translation theory. In Western medical terminology the English prefix *sub-* is translated into Chinese in different ways depending on the meaning: in *subcranial* and *sublingual*, it is translated as 下 (“below”); in *subculture*, it is translated as 次 (“secondary”); in *subchronic*, it is translated as 亚 (“lesser”); and in *subluxation*, it is translated as 不全 (“incomplete”). Despite this, *subcranial*, *sublingual*, *subculture*, *subchronic*, and *subluxation* all have set equivalents in Chinese. The fact that the prefix *sub-* does not have a single set equivalent is completely irrelevant.

Missing the point

Bensky’s three arguments against standardization (transparency, pluralism, and polysemy) miss the point entirely. Polysemy is not an issue, because it is a fact of language that polysemy creates problems that must be overcome in any field of translation. Transparency presents no basis for opposing standardization, because whether an everyday word appearing in a terminology is used in an everyday sense or in a special sense is irrelevant to its status as a term denoting a concept within a framework of concepts that can only be upheld by consistent use of

terms. Pluralism in translation is not intrinsically good or bad. In the initial stages of translation, variability of terms in the target language (in our case English) is an inevitable part of the decision-making process. Variability of terms is dangerous for the integrity of concepts, because when the same idea is referred to by different terms, the reader might not realize that the same concept is meant. What Bensky calls pluralism is useful to none unless all translators agree to relate their terms to the original Chinese. If Bensky pegs his terms to the Chinese so that his readers know that what he calls *constraint* and what Wiseman calls *depression* is 郁 *yù* in Chinese, then readers have a much greater chance of making a conceptual link between Bensky and Wiseman. Ultimately, when everyone understands the concept and translators agree to call it by the same name, things are easier for readers. But standardization is the end goal in a process of term management, which at any stage should involve relating target-language terms to the source-language terms.

Standardization involves having only one English term for each Chinese term (or one for each meaning of the Chinese term), so that variability in the English terminology disappears. The idea of a standardized terminology is that discourse is made much easier. Students no longer have to assemble concepts out of a jumble of different words. Standardization benefits the field as whole. Nevertheless, standardization means that some term choices have to give way to others. It means that some translators' terms are accepted, while other translators' terms are rejected. Of course, every translator tends to think the terms they have chosen are the best, and so the prospect of his/her terms being rejected is seen as a threat.

Getting everyone to use the same terms is the logical end to "term management," whose sole aim is to ensure that everyone knows what is being talked about (even if the terms are different). Whether we are in the initial stage of transmission when different terminologies are being used, or whether we are at a more advanced stage when people are agreeing to use the same terminology, all English equivalents must be explicitly linked to the Chinese terms they represent. The pegging of English terms to the Chinese helps the reader to relate different English equivalents to the same concept; it also makes it possible for any translator to follow another's translation scheme. Any translator who is committed to the idea of relieving the reader of confusion will naturally want to peg the terms they use to the original terms. Such a translator will either want to propose an English terminology of their own or use a ready-made terminology (or a mixture of both) In other words, such a translator must either create a bilingual terms list for other translators to follow or must rely on a bilingual terms list created by someone else. If there is any hope of freeing readers of the confusion created by variability in terminology, there must be a bilingual term list. Term management therefore involves relating terms in texts, in footnotes, or in appended glossaries to their Chinese equivalents for the sake of readers and in bilingual lists for the sake of translators. Term management is designed to ensure a clear relationship between target-language and source-language terms.

If you will, think of pegging English equivalents to the original Chinese terms as a mechanism that works like an electrical adapter. If you have a good multiple adaptor in your suitcase, you can plug your hair dryer, laptop computer, or travel iron into virtually any socket anywhere around the globe. Works in which the terminology is not pegged to the Chinese are like a travel iron that won't plug into a socket other than that used in the country in which it was purchased. In other words, it's no good for people—or communities—that are going places.

Although advocates of standardization are being portrayed as tyrannical, the real tyrants are translators who fail to manage their terms. Translators who fail to peg their terms to the Chinese isolate the knowledge contained in their book from the knowledge contained in other books. They are effectively saying, “Just read *my* books; you don’t need to read anyone else’s.” Term management is important to a democratic community in which people are free to choose their own interests. When works in which English terms are not adequately related to the Chinese are designated as textbooks for national examinations, it effectively creates a professional monopoly. Although the authors of such works may oppose standardization, they are in fact setting a standard—a *de facto* standard based on their own opinion. Bensky misses the point about terminology. It is about translational transparency and keeping things in the public domain, thus helping to expand professional knowledge and access.

Does Bensky really oppose standardization?

Bensky’s translation theories are hard to accept because he clearly recognizes circumstances where it is advantageous to translate terms consistently. Consider his names for medicinals and formulas. Bensky uses fixed translations for all these Chinese terms, and he sticks to these consistently. We can assume he knows, like many editors, that to refer to these items by different names would be highly confusing for his readers and not very good for the reputation of his books.

In the work of producing *Ten Lectures on the Use of Medicinals from the Personal Experience of Jiāo Shù Dé*, we found that the original author referred to many medicinals by different names in the text. Since we include the Chinese and Pīnyīn of medicinals frequently in our translations, a very exact translation would involve reproducing all the various Chinese terms for medicinals. Given that many Western students of Chinese medicinal therapy (who do not necessarily know Chinese) learn Pīnyīn names, it is very much worthwhile to eliminate the variability of Chinese (Pīnyīn) names. The idea of such standardization, I would imagine, is logically acceptable to anyone.

Yet, when it is suggested that a standardized English terminology for the entire scope of Chinese medicine would be beneficial to the community, Bensky reacts vehemently, saying: “Isn’t the co-opting and ‘standardization’ of Chinese medicine by a state that takes modern medicine as its standard one of the things that we in the West feel was a mistake made in China?”

It is true that Western notions of term management have had a strong impact on Chinese medicine. There are efforts to increase the level of standardization of Chinese terms and indeed to standardize the concept structure. The implications and consequences of PRC efforts to impose more order are worthy of discussion. Nevertheless, the degree to which this will force Chinese medicine into a scientific mold is something that requires careful assessment, not blanket judgments. First, standardization of terms is not a notion alien to Chinese medicine in the least. The welter of names of plants and plant products led to efforts centuries ago to sort out which names were acceptable and which were not.¹⁹ Second, recent efforts in China to standardize terms are motivated by a need for efficiency in providing medical education and health care to a massive population, a difficult proposition, but one in which Chinese medicine has played an important role. It seems that Bensky ignores the complexity of Chinese needs and

simply suggests that the call for “standardization” is born of a tendency fostered in the PRC to make Chinese medicine ape Western medicine in every way.

Although Bensky does not explain here what he means by the standardization of Chinese medicine in the PRC, it is clear that he implies that any standardization in Chinese medicine, terminological or otherwise, is a bug that it caught from Western medicine, and anything that comes from Western medicine is bad. He does not ask, as I think he should, whether the notion of consistent use of terminology is completely alien to Chinese medicine, and why English speakers should settle for a level of standardization in English terminology that is so much lower than that of Chinese terminology. I suggest Bensky’s thinking on this issue is imbued with the principle that “Chinese medicine must be what Western medicine is not” that I spoke of in *Westerners’ Alternative Health-Care Values Eclipsing a Wealth of Knowledge*.²⁰ His generalization is highly inaccurate and does not help us to solve problems. The fact remains that variability of English terminology causes confusion, and so translators as a group should be aiming to represent Chinese medical concepts consistently. They can only achieve this if they develop an English language of Chinese medicine that matches the Chinese language of Chinese medicine and apply it in translation.

Bensky presents us with no cogent reasons for opposing standardization of terms. In fact, his claims are consistently self-contradictory. For example, he picks one example from Wiseman terminology, namely the use of “depression” for 郁 *yù*, saying “Mr. Wiseman translates this as ‘depressed’ probably based on the term 郁证 *yù zhèng*, a primarily mental state that is often translated as depression.” Bensky fails to understand precisely why my colleagues and I chose the word ‘depression.’ The Chinese 郁 *yù* in everyday Chinese means “sad,” “melancholy,” “lugubrious.” In Chinese medicine, it denotes stagnation (of *qì*) due to internal causes, notably in people who are angry, frustrated, depressed, etc. We chose the English word “depression” to represent this Chinese medical concept on the grounds of two related meanings of the word “depression” in English. One meaning is “sluggish,” “lacking in vigor,” as in “economic depression,” which is virtually synonymous with “economic stagnation.” The English “depression” in this sense matches almost precisely the Chinese medical concept of this specific form of *qì* stagnation. The other meaning of the English “depression” is “sad” or “melancholy,” which adequately reflects the literal meaning of the Chinese word. Although, as Bensky himself notes, no translation is perfect, to translate 郁 as “depression” is about as close as one can get to perfection. Several notable clinician/translators appear to agree with connotations of 郁 and accept my translation.²¹ Furthermore, in the earlier stages of the evolution of Chinese medicine, 郁 possessed clearly psychological overtones.²² Yet far, far more importantly than this, Bensky claims that what he regards as our mistranslation of this term should warn us against standardization. He explains: “We are so far from having a good enough grasp on this material that only impatience, vanity, and hubris could push us to think that at this stage we are ready to ‘standardize’ the translations of these terms.” In other words, Bensky, who elsewhere suggests that Chinese medical terms are so clearly transparent that they are understood even by Chinese lay people, argues here that we cannot understand them. Even setting aside the fact that difficult concepts are those that most need to be pegged to a shared definition, arguments like this deny the community a clear understanding of the problem. Attacking a coherently argued case for standardization by suggesting it is motivated by “impatience, vanity, and hubris” expresses the

ire that opinions opposed to his inspire in him, but it provides no evidence or argument that can help the community understand the problems and work toward rational solutions.

By “impatience,” Bensky clearly implies that at a future stage, when we have a full understanding of what terms mean, it might be possible to standardize. In fact, at the COMP meeting in San Diego, 2000, Bensky proposed the creation of a public database of Chinese medicine in which people could give their opinions on Chinese medical terminology. The assumed objective for this was that we could work out a set of equivalents that everyone could agree on. I responded by saying that making a database a forum for discussion would only be useful if contributions were limited to those from people who had a knowledge of Chinese (after all it is Chinese concepts that we are seeking to transmit) and who offered a comprehensive rationale for the translation of all terms (otherwise there is no way to understand the term selections). I am not sure whether this killed the project or whether it died simply because Bensky did not follow up with an offer to finance or create a database capable of handling a large number of Chinese terms from a variety of contributors. Bensky expressed the hope that the database project could “take the politics out of terminology.” As I said in my formal answer to his proposal, I would not wish to take the politics out of terminology at all, if this meant an end to open discussion.

Bensky’s rejection of standardization of English terminology on the grounds that standardization is a modern scientific notion that has been forced on Chinese medicine by the PRC government is not unique. The idea was recently expressed by Lonny Jarrett, author of *Nourishing Destiny*,²³ in the following terms:

It is my opinion that the Wiseman method reinforces a linear analytic quality of mind more in line with a western reductionistic/mechanistic, not eastern synthetic/wholistic, quality of thought. I see this lexicon as just another emerging sign of the scientization of CM along with TCM in general (state run medicine from China), bioresearch on CM, and the move in the US for practitioners to be “Doctors” with prescriptive rights [for] milking the insurance industry. All of it has little to do with what I understand CM to be these last 22 years.

There are two problems here. One is what I talked about in considerable detail in *Westerners’ Alternative Health-Care Values Eclipsing a Wealth of Knowledge*, namely that Chinese medicine is crassly dubbed as holistic, non-reductionist, and non-mechanist while Western medicine is equally simplistically described as being unholistic, reductionistic, and mechanistic. Jarrett’s comments are the typical result of having no linguistic access to Chinese literature. When people have no access to the full account of Chinese medicine (which exists only in Chinese), they project Western ideas onto it. Those ideas that are projected onto Chinese medicine are values seen to be lacking in Western medicine.

The other problem is that Jarrett evades the central issue. If, as he says, Chinese medicine is a holistic body of knowledge, what precisely is the translation scheme he would apply? What is the kind of translation scheme that corresponds to a holistic body of knowledge such as Chinese medicine? I challenge anyone to answer this question. None of the opponents of terminological standardization have managed to put forward a case that makes any sense. The benefits with regard to the transmission of conceptual detail are easy for everyone to see; that is why term standardization is pursued in so many fields of knowledge. Of course, standardization means

that decisions about terms must be made, and that some serviceable equivalents will be eliminated. But the losses in standardization are far fewer than the gains.

It is important to understand standardization can be applied both to terms and to concepts. Term standardization occurs where one of a number of synonyms is chosen as the standard term and the use of the others equivalents is discouraged. Standardization of concepts is a deeper-level process, where not only terms but also the underlying concepts are removed. In mainland China, Chinese medical educators feel that there is a considerable need for standardization of concepts. Symptoms and patterns are two major problematic areas. When one surveys the literature, one finds a welter of terms that appear to be nearly the same but not quite the same in meaning. There are a host of descriptions of abdominal pain and patterns of the spleen, for example. Students, of course, would benefit greatly if the categories of abdominal pain and spleen patterns could be limited to a standardized set. It seems to be this is the kind of standardization that Bensky objects to most strongly.

Standardization of English terminology works only at the term level, not at the level of concepts. It means only that we have one English equivalent for each (sense of each) Chinese term. The task of the translator is to translate, not to change the information in any way. To transmit traditional Chinese medical literature, we must have an English vocabulary that matches the Chinese. In areas where there appear to be similar but not identical concepts, we must have similar but not identical terms to represent them. In a scheme that is based on loan-translation it is quite easy to reconstruct a variable terminology in English that matches the Chinese by creating equivalents in the target language through the literal translation of its components. By standardizing terms, we can convey the differences to Westerners. If terms are not standardized, all the differences are multiplied so many times by variations among translators that the differences implied in the Chinese terms are lost. The goal of translation is to reproduce, not to alter. When the community refuses standardization, the nuances are completely lost in English. This loss is responsible for the alteration of information that is prevalent throughout the whole field of Chinese medical knowledge in English.

Standardization at the level of English terms does not intrinsically have anything to do with conceptual standardization. As the future Chinese literature of Chinese medicine becomes increasingly conceptually standardized, the translation scheme I offer will be able to represent standardized concepts in English while permanently retaining a vocabulary to express the greater level of conceptual nuance found in the older literature. Future literature that conforms to new conceptual standards would, when translated into English by a standardized terminology, be instantly recognizable as such, whereas free translations of such literature would conceal the fact. Bensky's method of translation applied to conceptually standardized literature would fail to show any distinction.

Language learning

Bensky believes that language learning is an aid to learning Chinese medicine, and I thoroughly endorse that notion. He states that it is not an absolute necessity²⁴ any more than a cook needs more than one arm to be a good cook. When the West has developed a comprehensive body of English texts, presented in an English vocabulary that consistently represents Chinese terms with set English terms and a level of complexity equivalent to the

Chinese sources, I would agree that learning Chinese would not be necessary to make a good clinician. Until such a comprehensive body of literature exists, I fail to see how any Westerner can achieve the degree of proficiency that a Chinese practitioner can attain. While many people in the West appear to believe that Chinese medicine is a principally clinical skill learned in the clinic, most Chinese people practicing the orthodox literary tradition of medicine that we commonly refer to as “Chinese medicine” believe that the attainment of proficiency requires continual study of the literature combined with clinical practice. Having only one arm is a practical inconvenience for a cook. Not having access to primary Chinese texts means not having access to the full library of Chinese medicine.

I believe that the way to provide better trained clinicians rests on greater language learning and increased translation based on published terminological standards. I fail to see how Bensky on the one hand supports the idea of learning Chinese and on the other insists upon a method of translation that results—and can only result—in the simplification of Chinese medical knowledge. There are increasing numbers of people learning Chinese, and most of them naturally feel that the generally accepted terminological scheme I have promoted reflects what they see in Chinese literature better than any other approach. The more people gain access to primary texts, the more they expect English texts to duplicate Chinese medical knowledge.

Bensky seems to apply a double standard: one that satisfies the larger market (including the education market) and another designed for a Chinese-speaking elite that accepts higher standards (which I believe should be instituted as the norm). As a person with linguistic access to primary sources, Bensky knows that language-learning makes sense. His school, the Seattle Institute of Oriental Medicine, includes numerous hours of Chinese language training. As an educator in an environment where language education has yet to develop, he must support the idea that one can become a proficient clinician without learning Chinese. But from the viewpoint of the field as expressed by the treatments its patients receive, there is no cogent rationale for adopting a scheme that can only result in simplification.

Scholarship Versus Clinical Experience

The language learning issue is intimately related to the issue of who is a Chinese medical authority. Those who are opposed to recognizing the linguistic aspects of making Chinese medical knowledge available in the English language have consistently stressed that the matter is the concern of academics, not the concern of clinical practitioners. This point of view cannot survive scrutiny.

It is logical to suppose that while a body of knowledge is in the process of being transmitted from one language community to another, the source community possesses more knowledge than the recipient community. Since language is the most important vehicle of human knowledge, it stands to reason that the transmission process must rely on people who have a knowledge of both languages. However, in the field today, the importance of language has been continually de-emphasized and the importance of clinical skill has been emphasized out of proportion.

The emphasis on clinical skill alone is not based on fact. It is a political defense. The fact is that were authority in Chinese medicine based on linguistic access to primary sources, the vast majority of Western teachers and practitioners of Chinese medicine would lose status. It is also

an illusion because it is unlikely that more than a handful of Western clinicians have acquired the experience of even those practitioners who today work within the PRC and ROC health-care systems, much less the vast knowledge of clinicians of the past that can only be accessed through the books they bequeathed their intellectual heirs. Many English-speaking teachers realize they must develop their teaching skills, their access to information, and their understanding of traditional medicine's applications in Asia. The problem is that insofar as people fail to fully recognize they need language access, they are helping to cement in place a system of transmission in which no one can grow.

We must face the facts of our own history. As the popularity of Chinese medicine in the West increased, it became necessary for education and practice to be professionalized. Procedures for the accreditation of schools and qualifications for practitioners were introduced. However, no provisions were introduced to ensure the quality of the knowledge transmitted. While it may have been impossible then, it is far more possible now, as forward-thinking educators already realize. In the early stages of transmission it was inevitable that what was possible at the time became what was required by schools and tests. But today there are many more resources available and there are no practical reasons why these early limits cannot be surpassed.

In an academic environment, authority is accorded to individuals by demonstrated knowledge; no one is considered authoritative who does not have a full grasp of the knowledge in their particular field. Given the present state of transmission, anyone without linguistic access to primary sources cannot possibly have as broad a clinical knowledge as someone who does. Chinese medical education receives none of the social or financial support afforded Western medical education. Thus, economic considerations create real limits. Chinese medicine is taught as a trade, not as an academic discipline. However, it is now possible for the community to establish knowledge of the Chinese language as a prerequisite for many teachers, to set the content of Chinese language texts as standards, and to make Chinese language studies a compulsory part of curricula. It will take time and it will be worth it.

Two years ago, Todd Luger²⁵ quoted an anonymous student who said:

My class was the first to be taught single herbs by a Chinese-reading instructor. I think his taking over that class vastly improved it... Another disappointment was that almost none of the American supervisors know anything about herbs (beyond major patents and some of the Seven Forests line). All of my third year, I tried to get Chinese supervisors in the clinic so they could comment on my formulas. I *never* had a non-Chinese supervisor that could have even explained what the herbs in one of my formulas did—much less make constructive suggestions.

In my view, this personal statement is credible simply because teachers who read Chinese have access to much more information than teachers who do not read Chinese. Likewise, texts based on Chinese sources can provide more information than texts based on the experience of individuals. Wisely, Western Chinese medical schools are realizing that knowledge of Chinese can raise standards and are therefore increasingly encouraging teachers to learn Chinese. Nevertheless, not all the conclusions are being drawn from the language issue that could be drawn.

Students need guidance in judging what is sound knowledge and what is not. Chinese medicine has been presented in many forms. People who have read Porkert's *Theoretical Foundations of Chinese Medicine*,²⁶ Beinfield & Korngold's *Between Heaven and Earth*,²⁷ the PRC's *Essentials of Chinese Acupuncture*, and our *Fundamentals of Chinese Medicine*²⁸ are aware that the contents of each of these books varies tremendously and would be justified in thinking that these books each describe traditions unrelated to those of the others. Students have not been trained to approach this welter of different literature critically or to apply objective criteria for what is of Chinese origin and what is not. Linguistic access to primary sources provides people with clear idea about what is Chinese medicine and what is a Western explanation or adaptation of it.

Clinicians without linguistic access to the Chinese tradition base their knowledge and decisions on their own clinical experience. On the surface, this makes sense. Nevertheless, the difference between an experienced practitioner with linguistic access to primary sources and an experienced practitioner without such access depends wholly on what is in the available English sources. At this time when few people know Chinese, there is little to inform people what Chinese sources contain, and there is an immense amount of knowledge and experience that has not yet been made available in English.

The march toward recognition of the importance of language skills is inexorable. Over the last decade, more and more students and practitioners of Chinese medicine have learned Chinese of their own accord. By continually enriching Western knowledge from Chinese sources, these pioneers provide the motivating force for the development of Chinese medicine in the West.

Progress is slow because the de-emphasis of language is rooted in a philosophical bias. As I explained in *Westerners' Alternative Health-Care Values Eclipsing a Wealth of Knowledge*,²⁹ Chinese medicine is identified as an alternative medicine and, as such, is assumed to possess the characteristics that all alternative medicines are assumed to possess. Among those characteristics are an emphasis on the value of the clinical encounter rather than on "book learning." This characterization is completely erroneous from two points of view. First, in the tradition of Chinese medicine that Westerners are trying to adopt, book learning is very important. Chinese students were expected to study the classics in detail and even to memorize them. Second, this book knowledge is not all theoretical. Most of the literature of Chinese medicine is much more closely related to clinical practice than the theoretical knowledge of Western medicine. The *Shānghánlùn*, for example, provided the theoretical basis for the development of thought on externally contracted disease for centuries. However, in the text itself, theory is very much secondary to the clinical presentations. In fact, one cannot hope to understand the theory of *Shānghánlùn* unless one reads the commentaries by later generations of medical scholars. The division between "theory" and "practice" and between "book knowledge" and "clinical experience" is not so clearly drawn.

Chinese medical literature, far from being merely theory, represents the essence of clinical experience in China. Chinese medicine is lauded by those who hold to the tenets of alternative health-care as being based on ancient wisdom.³⁰ Actually, it is more precisely a body of knowledge that has been continually evolving for 2,000 years. The body of literature that has

amassed over the centuries contains within its pages all the best experience in Chinese medicine. Bringing that information to the West is the most important thing that a translator can do.

The basic qualifications required to transmit Chinese medical knowledge are a sound knowledge of the Chinese and a sound knowledge of the subject matter. This is the same as in any other field. People who study languages and translation in college often find that most of the translation work available after graduation—technical translation—is more difficult for them than for people who have studied a technical subject and have gained language skills as an accessory. For technical translation, language and translation skills are insufficient. To be able to translate in specialist fields, a knowledge of the subject matter is necessary.

Many people hold the notion that Chinese medical clinical skills are a necessity for being able to satisfactorily translate Chinese medical literature. This is not strictly true. In Western medicine, where translation is a world-wide mainstay of knowledge transmission, translation is rarely performed by doctors with any deep clinical experience. In other fields, it is the same. People translating literature on car engines rarely have experience in automobile engine repair and maintenance. To translate, the translator needs to understand how car engines work. S/he does not need experience in engine design or engine repair. In Chinese medicine, the translator must be conversant with Chinese medical knowledge. Clinical proficiency is what patients want, but it has little to do with the process of transmitting knowledge from China. The Chinese medical translator needs a sound knowledge of Chinese language and a sound knowledge of Chinese medicine.

Knowledge of source language, knowledge of the subject matter, and clinical experience are an ideal combination. Nearly every book project I have been involved in has included someone who is primarily a clinician and who has also gained adequate linguistic access to primary texts. In my experience, their linguistic access is the qualification they most often use when translating and compiling. Rarely is there any translation issue that could not be decided without clinical experience. The two years of my life during which I spent 6 days a week in a Taipei doctor's office attending consultations, taking pulses, observing tongues, processing and dispensing medicinals, and needling patients twelve hours a day gave me an invaluable cultural as well as medical experience. It helped me to gain a well rounded knowledge of clinical Chinese medicine. But, to be honest, I cannot say that it helped very much with my translation work.

Clinical experience helps translators understand the problems of those learning Chinese medicine and to know what information will make their task easier. However, clinical experience is also a danger. When so-called “clinician translators” select what is important and what is not important on the basis of their personal experience, they are substituting their knowledge for the knowledge of the original writer. When they present their work as a text containing what is worth learning about Chinese medicine, they substitute their personal experience for the experience of the field. When an author translating from primary sources produces a book that, whatever its title, might better be called *All You Need to Know About Chinese Medicine*, the danger is that its implicit substantiation—“all So-and-So thinks you need to know”—is lost to readers. Clinical practice in Chinese medicine rests on a huge body of knowledge contained in the literature. The process of transmission aims to make that body of knowledge available to Westerners. In an environment that exaggerates clinical skill out of

proportion to the knowledge on which clinical skill must be based, the individual approach is an unacceptable limit.

When it comes to transmitting a body of knowledge, linguistic access is indispensable whereas clinical experience is sometimes helpful. However, a Westerner with no knowledge of Chinese often confuses this matter. When people who regard themselves as having clinical experience, but who have no linguistic access to Chinese sources, write on Chinese medicine, they are offering only their personal experience and not the experience of a 2,000 year tradition. When one looks at adaptations of Chinese medicine that have been created by Westerners who claim clinical proficiency but who do not have expert linguistic access to primary Chinese sources, it is easy to see what Paul Unschuld means when he says that what makes a medicine acceptable to a community is not its efficacy, but the cultural acceptability of its underlying ideas (1992).³¹ In virtually all of these adaptations, the notions *yīn-yáng* and the five phases are exaggerated out of all proportion simply because they appeal to Westerners' desire for holism. Clinical utility is a nebulous concept, because there are no objective criteria in Chinese medicine to decide what works and what does not work. Regardless, I know of no such author who actually expresses the scope of their clinical experience in any meaningful way. While I could not say what adaptive writers such as Jarrett have been able to transmit that is useful to people, I can say that their failure to label their writings as personal adaptations helps no one distinguish Chinese knowledge from their own ideas.

The simple fact is that transmission, like clinical practice, is a job best done by people who are adequately trained and experienced to do it. The transmission of Chinese medicine is largely—though not wholly—a question of transmitting a body of knowledge contained in Chinese texts. For that purpose, we require qualified translators, i.e., people who understand the language and the subject matter. As Birch & Tsutani's bibliometric study has shown,³² the transmission of Chinese medicine is still very much in its infancy. There is a huge amount of literature in Chinese that Western students and practitioners would find useful if it were available in English. At a rough guess, the amount of literature a Chinese medical student in China has to read before graduation would probably take one translator several decades to translate. If the transmission of Chinese medicine were to rely on people with clinical proficiency (which takes years to develop), the rate of transmission would be forever inadequate. Ideally we need an army of qualified translators.

To transmit Chinese medical knowledge to the West, we can only ensure that concepts are relayed faithfully when the terms that represent concepts are translated faithfully. It is a grave mistake to think that terms are an unnecessary complication and that the concepts of Chinese medicine somehow all become clear through clinical experience. This goes against all scientific understanding of language and human thought. Every language breaks the world up in different ways. Different languages, for example, break up the color spectrum in different ways. In technical knowledge, these differences become embedded in technical concepts. So when technical terms of a discipline are translated into another language, the distinctions of the source-language have to be recreated in the target language. To do this, we have to redefine existing terms or create new terms. The Chinese 黃 *huáng* means yellow, but in actual fact it includes much more than yellow; it also includes what English speakers would call light brown. If translators say that the Chinese 黃 means different things in different contexts, they might

translate the word 黃 with different English words. But in so doing, the notion of 黃 as a correspondence to earth in the five phases might sometimes be lost. Apart from borrowing the word *huáng* into the English language, the only way to avoid this problem is to redefine the word “yellow” to mean yellow and light brown, and consistently using “yellow” in translation. People who say that words have different meanings and have to be translated in different ways according to context deny the concepts that form part of a knowledge system on which clinical proficiency is based.

To transmit Chinese medical knowledge to the West, we must translate, not reinvent. To translate specialist knowledge, we must have a systematic method that represents specialist concepts in English. When English equivalents for Chinese terms are set, translation work is made much more easy, efficient, and accurate. Translators applying a standard terminology can concentrate on translating the information. Furthermore, by having set terms, the risk of the translator misunderstanding the text is markedly reduced, and the ability to effectively cooperate with both Chinese- and English-speaking clinicians is greatly enhanced.

The notion that only clinicians should translate accords perfectly with the view that Chinese medicine does not have a terminology. Emphasis on the preeminent position of people with clinical skill in the translation process has had a damaging effect on the transmission of Chinese medicine because the inappropriate elevation of clinical skill is associated with a conception of Chinese medicine that is rooted in false Western expectations. In any instance of transmission of knowledge between languages, a standardized terminology makes the translation process much more efficient—as is shown by a very considerable foundation of human experience. In Chinese medicine, people are reluctant to accept that there is a large body of knowledge to be transmitted because they prefer to think of Chinese medical healing to rest on sublime knowledge that transcends the normal plane of human experience which can be communicated in words. The leaders of a community of Chinese medicine in which beliefs of this kind prevail have a highly privileged position. They are considered to be not just knowledgeable, but enlightened. They are gurus and demigods whose personal experience and conceptions stand in place of Chinese knowledge.

Conclusion

Chinese medicine is a large and complex body of knowledge with a large and complex terminology; it can only be transmitted faithfully when due attention is paid to providing all its concepts with English labels that correspond to the Chinese. Maciocia, Bensky, and other writers take a minimalist approach to terminological management. They do not provide full bilingual lists of terms, so other translators cannot easily use their terminology and readers cannot easily relate their terminology to that of others. Without bilingual terms lists, it is difficult to imagine how their own use of terms can be rigorously consistent. They do so little to draw readers’ attention to terms or to explain the concepts represented that they create the impression Chinese medicine does not really possess a terminology. In short, this minimalist approach to term management leads to the loss of concepts and substitutes conceptual simplification for terminological standardization.

Translation decisions are not just a technical concern of translators who have a knowledge of both languages; they are of crucial significance for the understanding of Chinese medicine in the

West. Matters that affect the interests of students and practitioners who rely on English-language literature should be discussed in public. The scant arguments that Maciocia and Bensky have put forward fail every logical test.

Members of the community have a right to question the methods adopted by translators and writers and they deserve to receive answers. Translators and writers who take responsibility for their action should explain themselves. In fact, however, the importance of language has never been fully recognized. Recognition of this fact and all the measures that flow from it (encouraging a source-pegged terminology, language acquisition, study in China) could breathe life into the development of Chinese medicine in the West by planting seeds that would continually enhance the quantity and quality of Chinese medical knowledge. Instead, the English-speaking community has continually de-emphasized the importance of language because the ideals of alternative health-care devalue the knowledge-based traditional Chinese healing system. That switching of emphasis has been encouraged by Chinese medical education's isolation from mainstream academia where critical scrutiny is the norm. It has also encouraged a profusion of adaptations of Chinese medicine so different from the original Chinese practices that their clinical effectiveness cannot rightfully claim justification by Chinese heritage.

Things are changing. Over the last decade, there has been a marked increase in the number of people learning Chinese. These people naturally discover that, however much they have learned through clinical application of their knowledge, access to the experience of Chinese clinicians adds a new dimension to their clinical abilities. As these people make their mark on the field by contributing new literature, older perceptions of Chinese medicine that are influenced by indigenous notions derived from alternative health-care will diminish. At the same time, the voices that deny the importance of terminology in the process of translation will gradually fade away. The gurus will be replaced by scholars.

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