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East Asian Medicine: Multiple Voices of Yin-Yang

by Ted Kaptchuk on October 09, 2024

Ted J. Kaptchuk ©

Cambridge, Massachusetts

I once overheard a Cantonese-speaking colleague say something dismissive about Japanese Kampo medicine at a California meeting of acupuncturists in the 1970's. He suggested that Japanese traditional medicine is secondary, derivative and inferior. Implicitly, he was saying that all truth about Chinese medicine resided in China or the Chinese language. I had heard such remarks many times before – sometimes from Japanese or Korean or American practitioners – about the different approaches to East Asian medicine. Though I said nothing in that moment, I'm taking this opportunity to

share my views on this subject to initiate a discussion on a more generalizable question: Whose voice best represents East Asian medicine, the medicine of Yin-Yang?

A page from Wang Bing's (762 CE) version of the 黃帝內經素問 *[Huang Di Nei Jing Su Wen].* This Song Dynasty printing is the earliest existent copy of the Nei Jing was published between 1115-1234 CE.

Throughout their long histories, China, Japan, Korea, and Vietnam shared a larger East Asian macro-culture. On the literate intellectual level, each culture was connected to the root intuitions of early Chinese medical, philosophic and religious texts. The canonical medical books of the Han dynasty (202 BCE-220 CE) were widely read, albeit through distinct cultural, political, and historical lenses. Since my only formal education, outside of apprenticeships, was in Traditional Chinese Medicine (TCM), I did not remotely understand the implications of how alternative interpretations of classical texts might affect what I did as a practitioner. When I returned to the States after my training, an incident that began in a small Chinese language bookstore in Cambridge, Massachusetts, produced a dramatic revelation. While I was browsing through a Chinese medical book, an intense Japanese woman began to stare at the book with a penetrating gaze. She clearly wanted the book and I immediately gave her the only copy available. She had recently arrived in America and barely spoke English. Trying to be helpful, I wrote her a note in Chinese inviting her to my home office to look at my library. Her name was Kiiko Matsumoto. She later became the distinguished teacher of Japanese acupuncture.

On her first visit to my home, she watched me take patients for a while and then we looked at books together. After two or three visits, Kiiko accepted my invitation to treat some refractory patients who had not received adequate relief from my treatments. I watched her without understanding anything she did. I was especially taken aback when one patient, an old friend, mentioned, as he was leaving, that Kiiko was great and he did not feel anything when she inserted the needles. Later, over dinner, I wrote on a piece of paper "de qi" in Chinese and made some motions that indicated that the patient

hadn't felt qi. I wanted to know whether Kiiko obtained qi. She looked at me as if I was not too intelligent, nodded and wrote "yes." I wrote back insisting there was no "de qi" or sensation and she wrote back even more annoyed, "of course, there was de qi." We finally pulled out the *Nei* Jing and found the two places that proclaim: "needle, then de qi." We both nodded our heads and agreed that the *Nei* Jing was correct -- how could we not? -- that there needs to be de qi. We kept looking strangely at each other, puzzled, agreeing but disagreeing. Eventually it dawned on me that there was no person mentioned in the two quotes: the text does not indicate whether it is the practitioner, the patient, or both who should obtain the qi. The ambiguous text only spoke through interpretation. Much later, normative Chinese and Japanese interpretations of who should feel qi during acupuncture were codified in distinct and different ways. (Kong et al 2007). Which tradition was right?

That the text was originally written in Chinese does not necessarily mean that the Japanese interpretation is a mere shadow of the prevailing Chinese view. I began to realize that canonical texts live in *potentia* and require human interpretation to give them meaning. We may read classical texts carefully but interpretative traditions largely determine what is deemed important, what we should ignore, and how to fill in what is missing, like "who" feels the qi. Additionally, the needs of different historical epochs and distinct cultures begat processes of creative adjustment to specific circumstances. Both in theory and practice, East Asian Medicine was influenced by changing disease landscapes, feasibility issues, social and political needs, and the shifting influences of philosophy and religion. The churning of theory and practice was multi-directional.

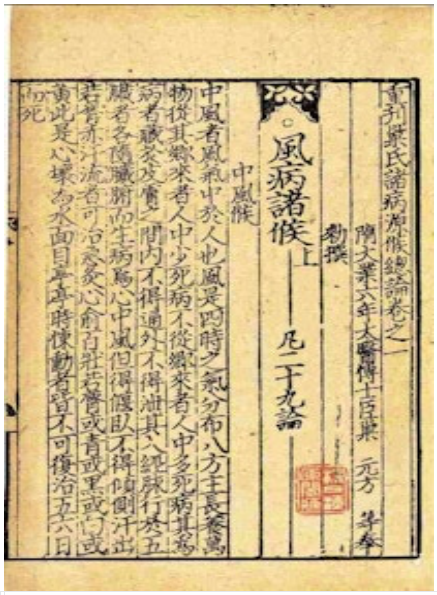
Not infrequently, new theories and treatments were transported back to China from Korea and Japan and changed Chinese interpretations. Below I look at a few examples of the historical circumstances that shaped the traditional literate medicine of China, Japan, Korea, and Vietnam and how these different traditions interacted. Toward the end, I will examine how Asian medicine is being modified through a Western lens. I hope that this review will provide insights into what East Asian medicine is, why traditions diverge, and how we should evaluate who best speaks for the "Medicine of Yin and Yang." Finally, by examining the emergent version of East Asian Medicine arising in the West, I hope to provide our profession with helpful information for self-reflection. This essay is not a standard academic essay nor a deep systematic dive into a 2000-year history. It is meant to provide an idiosyncratic pastiche of books, commentators, circumstances and data to give a sense of the multiplicity of perspectives in East Asian medicine. I hope the reader will gain a better glimpse of how each of these cultural and geographical zones, including those of the West, constantly interact and create East Asian medicine anew.

Chinese Medicine

East Asian medicine's point of origin and root intuitions derive from the Han period with the emergence of four major non-congruent canonical texts, with the earliest and most prominent being the *Inner Classic of the Yellow Emperor* (Huang-di Nei-Jing, c. 300

BCE). The *Nei Jing* is profound, difficult, opaque, contradictory, and sometimes bewildering. Much of it can only be read if a person already knows what the book supposedly says. Without scholarly interpretations any reader is easily lost. And commentators often read their own novel ideas back into the text. The three slightly later texts, *Classic of Difficulties* (Nan Jing, 2nd century CE), *Discussion on Cold-Induced Disorders* (Shang Han-lun c. 220 CE) and The *Divine Farmer's Classic of Materia Medica* (Shen-nong Ben-cao Jing, c.150 CE) arose from traditions different from the *Nei Jing* (Zhang GD 2023). It is likely that authors of the three later classics had never read what we now call the *Nei Jing*, and if they had, it was mostly ignored. All three texts were independently foundational and responded to different patient populations and classes of society. For example, the *Nei Jing* is erudite, grandiose, and global in perspective and seems to address an elite rich patient population. The diseases described sometimes seem limited to the very wealthy - for example, cases of poisoning caused by cinnabar used as an elixir. In contrast, the *Shang Hang Lun* is practical, often dealing with what we would we would now call acute infectious illness and is in touch with the down-to-earth misery of disease and actual clinical practice.

Throughout the dynasties, China's medicine saw established theories and methods either accepted, modified, ignored, or discarded. Even a very superficial glance confirms that Chinese medicine history shows dramatic footprints of transformation. During the Han dynasty, the Heart is the "emperor." In the late Song dynasty (960-1279 CE), the Spleen becomes central. In the Ming, there is a new emphasis on the Kidneys as the "life fire gate." Much of the later Qing (1644-1911) and Republican period (1912-1949) emphasizes the Liver (Scheid 2013, Karchmer 2013). Critical details of early texts are overridden by later interpretations. If one compares the herb indications in the *Divine Farmer,* with later and modern texts, the indications can differ dramatically. For example, in the *Divine Farmer*, Angelica sinensis (dang gui) is prominently about cough and not about blood; and Panax ginseng (ren shen) is described as a calming herb and treats the hun, po, and wisdom and there is no mention of qi or the Spleen, as later texts emphasize. As part of Song dynasty's persecutions of shamanic healers (Hinrichs 2003), the indication that twelve herbs promote the "penetrating divine illumination" (tong shen-ming) found in the *Divine Farmer* were removed in favor of a more materialistic perspective on the herbs. Comparing original indications for herbal formulas shows similar transformations from earlier texts to later dynasties and modern textbooks.



Page from Chao Yuan-fang's *Discussion on the Origin of Symptoms in Illness, Zhubing Yuanhou Lun* [諸病源候論] (610 CE) in the earliest printed manuscript from the Song period.

After the Han, Chinese medical texts frequently shifted their emphasis. Through the Sui dynasty (581-618 CE), medical texts become significantly more magical. For example, Chao Yuan-fang's *Discussion on the Origin of Symptoms in Illness* (610 CE) significantly concerns demonic possession. Medical texts from the early cosmopolitan Tang dynasty (618-907 CE), including Sun Si-miao writings (581-682 CE) re-incorporated pre-Han elaborate magical-divination-supernatural elements that were discarded in the Han period. In his Thousand Duct Prescriptions (Qian-jin Yao-fang) (c. 652 CE), Sun Si-miao describes mantras, spells, and treatments and many ordinary symptoms but also for possession by various kinds of ghosts and for helping recluses move through different levels of meditative trance (samadhi). He includes an entire chapter describing Ayurvedic medical approaches to healing in early writings. As a result of the Song empire's brutal suppression of non-literate shamanic healers, literate Chinese medicine hued closer to its Han origins than to Tang medicine (Hinrichs 2003). Changes both major and minor were constantly being made. For example, the Song rejected the Tang's heavy reliance on moxibustion and, in fact, rejected the Tang notion that moxibustion is suitable for both hot and cold conditions, a practice preserved in Japan (see below). Importantly, many of the emperors of the Song were interested in Chinese medicine – some even practiced acupuncture and herbal medicine – and undertook extensive efforts to find and retrieve copies of lost canonical texts and manuscripts.

Emperor Renzong 宋仁宗坐像 *(960-1127)* Renzong personally used acupuncture for his health and may have actually treated patients in a small side-line practice of acupuncture.

Most importantly, the Song dynasty saw a major transition in Chinese medicine from what was often described as “an overreliance on symptoms” to the adoption of a sophisticated theoretical super-structure (Goldschmidt 2009). Reflecting the development of the elaborate and systematic Song Neo-Confucian schools of philosophy, the medical literati began an effort toward a unified systematic conceptual models for medicine. Theories of acupuncture and herbs were united into a single framework. For the first time, herbs were described as entering acupuncture meridians and acupuncture points might have indications that were previously exclusively used to describe herbs, e.g. “drains dampness.” (Goldschmidt 2001, 2007, 2009). Physician-philosophers such Zhang Yuan-su (ca. 1151-1234) pioneered this novel integration of acupuncture and herbal theory. These new philosophies helped reconfigure Chinese medicine. Of course, all Song changes were considered to have been already extant in the Han canonical texts.

Dosages of herbs in China responded to issues related to practicalities such as politics, availability, and feasibility. This was especially important in the Song era which accepted the idea that the imperial state had responsibilities for the health of the population (Goldschmidt 2009). Fulfilling this mandate required funding the purchase of herbs including their transportation costs. Therefore, the Tang dynasty’s reliance on large herbal dosages was radically reduced in the Song dynasty, and physicians often adopted and emphasized pills, powders and tinctures. Dosages for herb decoctions continued to seesaw through the ages. This issue is dramatically made clear by in a contemporary scholarly study comparing Tang dynasty maximal dosages to modern TCM maximal dosages: Tang dynasty dosages were much larger, sometimes by a factor of 10 (He 2013). Social circumstances necessitated changes in practice

Often new interpretations, disputes, and disagreements involved charged emotional debates. Chinese physicians continually fought for their interpretations as being correct. For example, in the Song dynasty Zhang Yuan-su (c.1151-1234) and his followers advocated the wide usage of purgatives. At the same time, Yan Young-he (c. 1206-

1268) and his faction argued that this overuse of purging could be deadly. Another example from the Qing dynasty underlines the same point. One prominent early eighteenth-century Qing dynasty physician, Ye Tian-shi (1667-1746 CE) was attacked by another famous scholar, who advocated for an earlier approach, using these words:

> Ye Tian-shi ignored Zhang Zhongjing's established principles, erroneously creating new formulas, using cloying herbs that trap the pathogen, causing innumerable harms without a single benefit. Everyone has followed in this path without reflection, adopting habits that completely mislead the people, devoting one's entire life [to this mistaken approach] without ever awakening.
> (Quoted in Karchmer 2013)

It was not uncommon for opponents to describe the Warm Febrile School as "flowing poison" (Karchmer 2013). As will be described below, all mention of this controversy and countless others are omitted in contemporary medical school education in China. Modern China and its requirement of licenses and examinations for Chinese medicine needed a harmonious story not a history of controversy and disagreement.

China's medicine changed not only through the interpretations of succeeding dynasties but also through a dynamic interaction between different vibrant Central Asian cultures. (Skaff 2012). Explicit traces of Buddhist ideas and practice can be found in late classic texts such as Ge Hong's *Emergency Prescriptions to Keep Up One's Sleeve* (Zhou-hou Bei-ji Fang, c.341 CE) (Cai 1988). Sun Si-miao (581-682 CE) wrote extensively on Ayurvedic medicine and central Asian (Persian-Sogdian) Hippocratic medicine (Sun 1982 [682 CE]) and incorporated methods and ideas from these cultures. Sun Si-miao also enumerated and discussed prescriptions he credited to the famous Indian Kucha sage and translator Kumarajiva (344-414 CE) including his recipe for treating malignant diseases (Cai 1988, cf. George 2015). Many of Sun Si-miao's mantra and talisman healing techniques are transliterated Sanskrit chants. Sun Si-miao also spoke of massage therapy borrowed from India. (Cai 1988). Later, the Song dynasty was significantly influenced by Hippocratic-Islamic medicine (Kong and Chen 1996). In fact, the introduction of many aromatic herbs from central Asia co-emerged simultaneously with the Song's increased emphasis on Spleen remedies in the formularies (Goble 2011).

Sun Si-miao (581 CE – 682 CE)

Interest in Islamic-Hippocratic medicine greatly expanded in the Yuan Dynasty (1279-1368 CE) where cross-cultural exchange between Central Asia, the Middle East and China dramatically expanded (Buell 2021). The juxtaposition of different cultures could be extreme. For example, the Emperor Khubilai Khan (1215-1294 CE) appointed his Nestorian Christian court physician, Isa Tarjaman (Chinese name: Zi Xu, 1227-1308), to establish the influential Islamic Medical Bureau in Beijing, the Yuan capital. (Yoeli-Tlalim 2021). It's worth mentioning that the Yuan was similar to the Tang in the presence of highly visible cultural exchanges. (Interestingly, Khubilai's mother was also a Nestorian Christian). Isa's main contact for Islamic medicine information and textbooks was Rashid al-Din (1247-1317), a Jewish physician who converted to Islam and lived in Ilkhanate, Iran (Rossabi 2009). Isa Tarjaman and his colleagues supplied the Imperial Bureau Arab-Persian-Hippocratic medical books which were exchanged for Chinese texts which were in turn translated into Persian (Buell 2007, Shinno 2017). Important conceptual ideas were adopted into Chinese medicine from these interactions. For example, aspects of the Chinese ideas on phlegm and its pathology in Chinese was likely adopted from Islamic texts (Kohle 2023). During these cultural exchanges, herbal remedies traveled back and forth across Asia (Schottenhammer 2013).

The Qing dynasty (1655-1911) had a deep interest in the Korean *Precious Mirror of Eastern Medicine*, as will be discussed below, and re-discovered lost Chinese texts from these Korean translations. Also during the Qing, the Western medical idea of blood flow influenced the development of the Warm-Febrile School (wen-re-xue) (Andrews 2015). Furthermore, Chinese medicine was dramatically influenced by medical trends migrating from Japan to China during the Republican era (1912-1949) when the famous and influential Shanghai China Medical College translated and required the study of Japanese Kohoha or "return to the Han School" texts (Karchmar 2013, Lei 2014, cf. Karchmer 2015, Daidoji and Karchmer 2016, Hsu 2009). More on this below. This Japanese influence halted during the Sino-Japanese War but has recently been revived in some places in China. The modern Chinese filiform acupuncture needle actually

originated in Japan (Andrews 2014). In fact, the revival of acupuncture during the Republican period was significantly influenced by Japanese acupuncture in general (Lei 2014, Yasu 2010). In the 1930's the influential Chinese physician Zhang Taiyuan (1868-1936) was deeply influenced by Hiroshi Watanabe's 1928 notion of "syndrome" (more often now translated as "pattern") to explain this characteristic of Kampo medicine (Lei 2014, Andrews 2014). (A more detailed discussion of 'syndrome' and 'pattern' appears below.) Another noticeable example of Chinese medical knowledge coming from outside of China is the influence of French versions of neo-Hippocratic medicine on the creation of Chinese ear acupuncture (Hsu 1996). Of course, a *Nei Jing* quote taken out of context was used to justify the practice of ear acupuncture but tracing of its actual history shows dramatic input from the West.

One of the most significant transformations of Chinese Medicine has taken place in modern times and involves the emergence of "traditional Chinese medicine" (TCM) school formulated after the establishment of the People's Republic of China in 1949. TCM represented a major adaptation of Chinese medicine to new circumstances of politics, power, education, health care, and cultural legitimacy (Taylor 2005). In 1949, very few leaders of the Chinese Communist Party were considering incorporating Chinese medicine into a new health care system (Lei 2014). Most wanted to duplicate the "scientifically tested" European medical systems. But pragmatic considerations altered deeply held preferences. In 1949, the estimated number of Chinese medical practitioners (500,000) drastically outnumbered Western medical practitioners (10,000-20,000) (Hsu 2008). Chinese society needed the human power of Chinese medicine practitioners. In 1956, Mao declared a policy of "unifying Chinese and Western medicine." One of its major thrusts was to standardize Chinese medicine so that practitioners would take national accreditation exams to obtain licenses and students could learn in teaching institutions with modern curricula that could accurately measure student proficiency. Before the revolution, apprenticeship was the main vehicle for becoming a Chinese doctor. For upper class students this was accompanied by careful reading of the classical texts and commentaries. The aggregated library of these difficult medical texts was the rice and soya sauce of training. But for a curriculum rooted in modernity, these old methods were considered less important or even dangerous. Standardization and bureaucratization were deemed critical. Earlier debates on discrepancies, and contradictions between different interpreters and schools about what is correct Chinese medicine were basically relegated to the dark archives in the new schools of TCM. Chinese medicine had to be neat and clear. No ambiguity allowed.

A critical innovation of TCM was the creation of the formal *bian-zheng lun-zhi* (pattern discrimination and treatment determination) model. Many valuable accounts of the formation and influence of *bian-zhen lun-zhi* have been written (Sheid 2007, Karchmer 2022, Lei 2014, Kim 2005, Andrews 2014) so I'll be brief.

When I was in China in the early 1970's the term *bian-zhen lun-zhi* was not yet in textbooks; rather the term was *ba-gang bian-zhen* (distinguishing the eight principal patterns) which had been created in the late 1950s. Eventually, the phrase switches

to *bian-zhen lun-zhi* When I was writing *The Web That Has No Weaver* (Kaptchuk 2000, 1983) I used the nomenclature of Eight Principals (ba-gang). Years later in the States, when I was doing footnotes for the Web book, I spent weeks unsuccessfully tracing the origins of these two phrases. Although modern textbooks in China described the Eight Principles and bian-zhen as ancient essential truths of Chinese medicine, I could not find a source for this phrase used in this sense before the late 1950s. Where did this formal model come from? I now know that both terms for the bian-zhen and Eight Principles were actually in the process of being created and adopted in the 50's and 60's and even 70's and therefore there was no information on their history. Karchmer (2022) describes a similar frustration on tracing the origin of the bian-zhen terminology. Many well-known Chinese doctors in the 1950's proposed other schema for training new practitioners of Chinese medicine (Karchmer 2022). For example, in 1953, Qin Bo-wei (1901-1970), a famous physician actively involved with the creation of TCM, proposed a synthesis of Chinese medicine with a model consisting of 56 strategies (Wu and Blalack, 2011). Later, under political pressure, Dr. Qin boiled his proposal down to 18 principles. By the late 1950's discussion of Eight Principals was becoming the dominant synthesis. Karchmer (2022) describes the creation of bian-zhen thusly:

> The editors [of Chinese medical textbooks] resolved the historical conundrum posed by bian-zheng lun-zhi by weaving the objective newness of the term into an evolutionary narrative of its development through every major period in the history of Chinese medicine, beginning with the *Yellow Emperor's Inner Canon* (ca. 100 BCE) and continuing through the works of Zhang Zhong-jing (220 CE), the four masters of the Jin and Yan dynasties (1115-1368 CE) and the Warm Disorders innovator of the Ming and Qing.

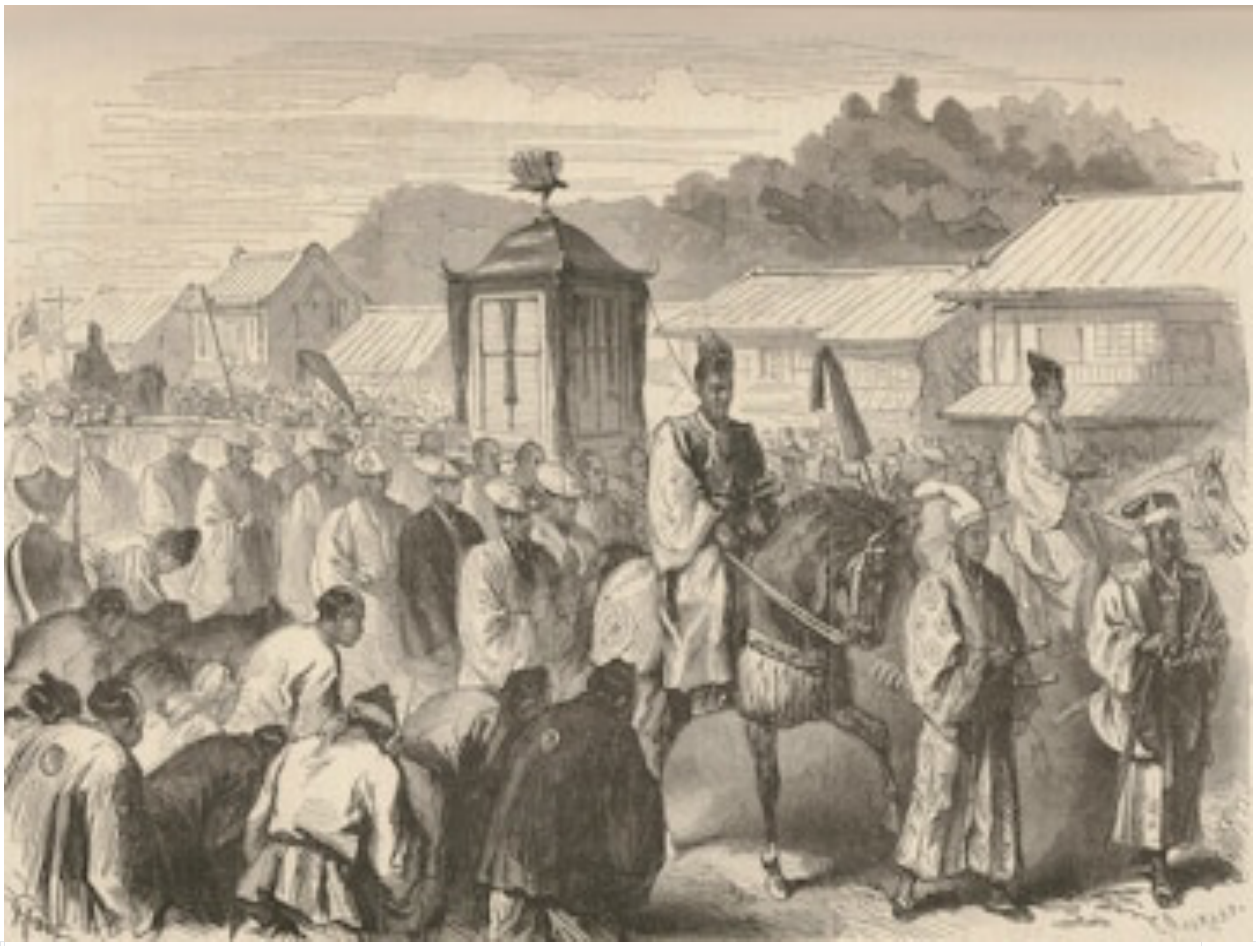
In other words, the innovators, like all creative scholastics, endowed Eight Principles with an ancient lineage. Because canonical texts can never be wrong, these modern interpreters dressed their ideas in classical garb. Please note, I am not saying that bian-zhen method is false or that creating new models or national standards is wrong. I actually think bian-zhen is profoundly insightful and is one of the key reasons that Chinese medicine survived within the Chinese national health care system and is poised to become a major component of a cosmopolitan medical system (Scheid 2007). I think bian-zhen or Eight Principles are one of the greatest syntheses of Chinese medical wisdom ever performed. But in a modern society, one needs standardization to have curricula and examinations. Standardization of a medical curriculum cannot accommodate the many debates, disagreements, and novel interpretations that existed in pre-modern China. At the same time standardization also eliminates Chinese medicine's pulsating vibrancy; its rich history of alternative interpretations in theory and practice that allowed it to grow and thrive in pre-modern times (see below). TCM standardization– and its elegance and ease of understanding – has allowed Chinese medicine to be taught in modern educational institutions. Without such clarity, Chinese medicine would not have flourished in China. Without adoption of TCM by the Chinese government, Chinese medicine would not have the legitimacy and influence that surpasses any such status bequeathed to Japanese, Korean, Ayurvedic, Unani or the

various complementary and alternative practices prevalent in the West. Without the legitimacy the Chinese government bequeaths to TCM, there would be little Chinese medicine in the West. And modern education would be difficult.

Japanese Medicine

Japan's elite literate classes eagerly adopted Sui Dynasty (581-618 CE) and Tang Dynasty (618-907 CE) Chinese medicine in a process beginning in the early 6th century and continuing through the mid-800's CE (Liu 2022). First, the transmission came directly from Korea and later from China. This period produced one of Japan's most important classical texts, Yasuyori Tamba's *Ishinpo* (Yi Xin Fang, "Formula from the Heart of Medicine," 984 CE), the 30-volume medical encyclopedia, that is the foundational text of many Kampo traditions (Tamba, 1986). The Ishinpo deals with the entire breadth of Tang medicine, from herbals and acupuncture to alchemy and magic; and quotes from hundreds of Chinese texts. The Ishinpo is a valuable window into early Chinese medicine that has been lost in the development of Chinese medicine in China. Only five percent of the quoted texts in the Ishinpo are extant and virtually none have survived in China (Goble 2011, Wilms 2013). This traditional medical knowledge only retained in Japan. Japanese medicine went through an era of further revision during the cultural exchanges that took place when new books were brought to Japan during the Song Dynasty Buddhist monks. These texts include treatments for "karma" that addressed the concerns of Song style Zen (Chan) Buddhist physician-monks (Goble 2011). Like their counterparts in China, many Japanese physicians in this period adopted a Neo-Confucian philosophical elegance in their approach to theory and strived to synthesize acupuncture and herbs into a single theory. A further major reformulation of Japanese medicine occurred between the 16th and 19th century during the period of the Gosiha School ("the school of the latter-days medicine") which expanded on Song ideas and introduced Jin-Yuan dynasty medical theories and practices (Otsuka 1976). Between the 17th and 19th centuries many Japanese physicians reacted to what they perceived as an overly theoretical Song Chinese medicine and in response developed the Kohoha (Ancient Formula) School - also called "Return to the Han" - which advocated a "return to the *Shang-han Lun*" (220 CE, Cold-Induced Disorders). This movement rejected what it considered "speculation" and only accepted the authority of Zhang Zhong-jing (150-219 CE) and used an empirical method that primarily matched symptoms to herbal formulas. Seemingly like the *Shang-han Lun*, the Kohoha School considered theory relatively unimportant. Much of contemporary Kampo medicine remains under the influence of the Kohoha School. This rejection of Song interpretations can also be found in acupuncture texts. For example, Japanese texts generally follow the shallower needle insertion depths found in such early Chinese classic as Huang-fu Mi's *Systematic Classic of Acupuncture* (282 CE). Again, Japan seems to have retained important notions that have been discarded in China. In general, one could say that modern Japanese medicine dosages of herbs are generally one-third to one-half of what one would see in modern Chinese texts. Furthermore, the Japanese tradition from the medieval period tended to rely much more on abdominal

diagnosis than on pulse taking, a method derived from a meticulous Japanese reading of the *Shang Han Lun*.



The palanquin and procession of Emperor Meiji moving from Kyoto to Tokyo through the Tokaido road. Le Monde Illustré. National Library of France, Paris.

My brief synopsis of Japanese medicine emphasizes the transmission and interpretation of texts and ideas from China to Japan. The reality is more complex: books and ideas interacted with an active Japanese economic-political-commercial-social filter that constantly questioned the feasibility, relevance, adaptability, and legitimacy of these Chinese imports. Availability of herbs posed a constant challenge. For example, obtaining gallstones, ephedra, and musk were problems for Japanese physicians (Goble 2011). Even the correct identification of herbs could be a problem. (Availability and misidentification were also a constant problem within China.) Political constraints (including xenophobic attitudes toward foreigners) dramatically influenced what was acceptable or rejected [1]. Japan went through periods of rejection of “Han medicine” (Kampo) depending on the attitudes of governing and regional elites. For example, people living in Japan’s northwestern Kyushu always had more access to Chinese medicine because of its more mercantile economy. Japanese medicine was also very influenced by the circumstances of practice: Japanese Buddhist infirmaries for

the poor relied heavily on Song methods of simple, inexpensive remedies such as pills, powders or tinctures, while the Japanese aristocracy expected more elaborate Tang style treatments (Goble 2011). In more recent times, Japanese Kampo and acupuncture practitioners had to deal with active suppression as part of the emphasis on “modernity” and “science” that occurred when the Meiji restoration in 1871 adopted the German medical system as its own (Yu et al 2006, Motoo et al 2011). In 1883, Japan withdrew the licenses of traditional practitioners (Yu et al 2006). Japanese traditional medicine passed through a difficult period but the situation improved with a Kampo renaissance in the 1930s, signficantly influenced by the vibrant resurgence in Korean medicine that occurred during this time (Flowers 2020). More recently, Japanese traditional medicine has experienced another flourishing partly inspired by increased legitimacy conferred on Chinese medicine in China and the enthusiasm for acupuncture in the West.

Korean Medicine

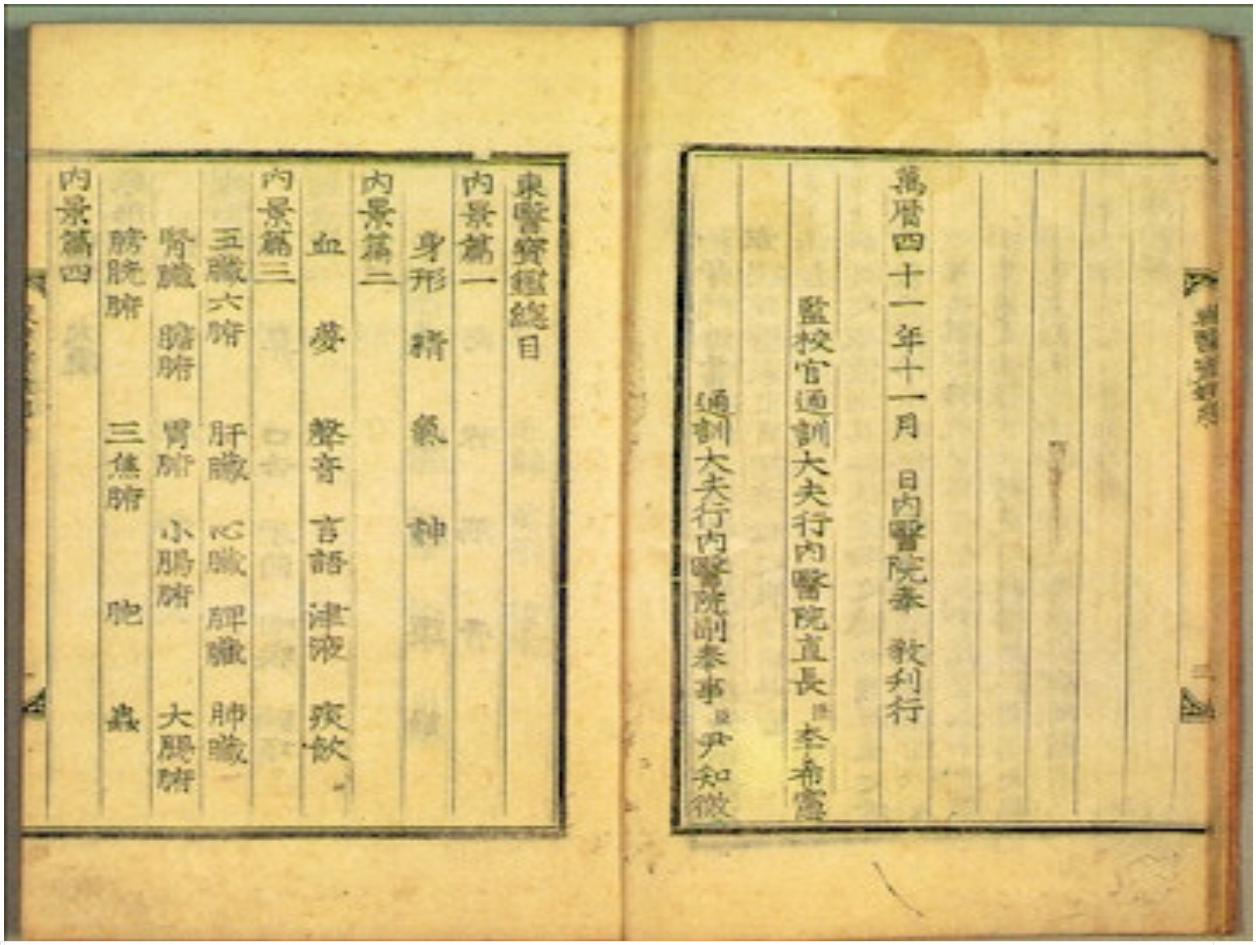
Since the Korean Silla Kingdom (57 BCE-935 CE), Korea and China have had medical contact as demonstrated by Korean ginseng being an ingredient found in the oldest layers of the Chinese materia medica. From the 6th century onward, intermittent and erratic book importations of Chinese medical texts occurred. Only during the early Choson Dynasty (1392-1910) did the importation of Chinese texts become solidified and did Hanbang (“Han medicine”) become clearly established. This “Korean traditional medicine” generally fused Chinese ideas with local traditions and often relied on local botanicals (Cho 2000). The codification of an indigenous Korean canon becomes noticeable by the 15th century with the publication of many anthologies, the most prominent being the Great Collection of Native Korean Prescriptions (Hyangyak Chipsongbang 1433 CE) which sought to fuse Chinese approaches with local methods (DiMoia 2013). The most important Korean medicine encyclopedic work is the *Precious Mirror of Eastern Medicine* (Tongguibogam, Dongyi bao jian). Sponsored by the royal court, this Korean corpus was published in 1613 CE. It was compiled from over 230 Chinese texts with priority given to Ming medical texts. Many of these Chinese texts have been lost in China and the history of translating this huge compendium back into Chinese dates from 1763, including 19 translations during the Qing Dynasty (1644-1911) and several in the Republican era. There are at least two translations into Japanese and many citations in Vietnamese medical literature (Suh 2013a, Yi 2018). The text explicitly emphasizes that Korean people have different constitutions and medical needs compared to the Chinese. Many historians claim that the *Precious Mirror* demonstrates clearly that East Asian medical knowledge does not always “spread from the center [China] to the periphery” (Yi 2018, cf. Cho 2015). Korea and Japan often communicate directly to each other with medical ideas and treatment strategies (Lee 2023).

Korean medicine went through a third major foundational reformulation with the publication and widespread adoption of Lee Che-ma’s (1838-1900) *Longevity and Life Preservation in Eastern Medicine* (Tongui Susebowon, 1894) that emphasized a constitutional approach to Asian medicine with a theory of four constitutional types

having different psychosomatic qualities (Suh 2013b, Cho 2000). These last two texts are still widely used in Korea and are highly influential. Koreans continue to develop new interpretations of East Asian medicine (e.g. Korean hand acupuncture.)

Interestingly, during the early twentieth century, Flowers (2020) notes that Korean traditional medicine was stronger, more self-confident and a recipient of greater popular and governmental support than its counterparts in Japan and China. If fact, in the 1920s and 1930s, during the efforts of the Republic of China government to suppress Chinese medicine, Korean practitioners tried to organize support for their Chinese colleagues.

In another study, Flowers (2021) points out that a major difference between modern Korean and Chinese traditional practices is that modern Korean medicine is a bottom-up form of health care that has autonomy and independence to develop and take charge in communities without major state interference; as opposed to China where TCM is regulated from a “top-down” central government. Such differences can be significant and awareness of this situation can provide critical knowledge for western practitioners. For example, Flowers (2021) points out that while Korean doctors at the beginning of Covid-19 adopted the “official” Chinese medicine formula advised by the Chinese government. Korean practitioners working in their communities quickly developed a more nuanced herbal approach based on individual patients’ needs. Notably, while the Chinese government reported few side- effects from the standard herbal medicine for Covid-19, independent Korean doctors were able to report many more side-effects. Another example of how such social issues differentially influence Korean and Chinese approaches to patients is a recent research study comparing clinical practice and clinical guidelines for acupuncture treatment in contemporary Korea and China (Zhao 2023). In general, Korean guidelines emphasize information concerning improvement in individual patients’ symptoms. Discussion on whether acupuncture treatment is effective for patients occupies ninety-eight percent of Korean guidelines. In China, patient-centered questions represent twenty-nine percent of discussions and the emphasis is on “population suitability” and diverse questions of implementation needed by the central government. In each country, legal structures and power relationships influence how acupuncture is performed and understood (Zhao 2023).



A page from the Precious Mirror of Eastern Medicine. Compiled under the direction of the Korean royal physician Heo Jun (1613).

Vietnamese Medicine

Since there is little information on Vietnamese traditional medicine in any language that I can read, I'm not knowledgeable concerning this voice of East Asian medicine. But I think it is important to be aware of its presence. In present day Vietnam, the two terms "Eastern medicine" (dong y) and "our medicine" (thuoc ta) are used to differentiate traditional methods from Western medicine (thouc tay) (Craig 2002, Thompson 2012). Furthermore, Vietnamese speak of Northern medicine (thuoc bac) and Southern medicine (thuoc nam) (Adorsio et al 2016). Northern medicine refers to a more literate Chinese language tradition that includes a reliance on theories derived from Chinese texts combined with indigenous botanicals. Southern medicine seems to place an even greater emphasis on local herbs and incorporates fewer identifiable Chinese theoretical ideas than Northern medicine. The more pragmatic Southern tradition relies more on oral transmission, and folk and home remedies, and displays empirical eclecticism (Craig 2002). The notion of "traditional Vietnamese medicine" an English translation of "y hoc co truyen" literally means "the study of medicine passed down from antiquity" and is a reformulation of Southern medicine compatible with the politics of the contemporary

Vietnamese government (Monnais 2013, Chau 2012). Key to any understanding of traditional Vietnamese medicine is Tue Tinh (1330-1400 CE), a Vietnamese monk-physician who was sent to China as a living form of tribute in 1385 CE. His most famous work, *Miraculous Drugs of the South* (Nam Duoc Than Hieu) was written in Chinese and was meant to explain Vietnamese practices to Chinese physicians (Thompson 2013, 2015, Monnais et al 2012). He viewed indigenous Vietnamese herbs as superior to Chinese herbs for Vietnamese people and spoke of a “Vietnamese constitution” that required lower dosages of herbs. (The issue of geographic constitutions has always been a thread in the different formulations of East Asian medicine including the *Nei Jing*.). Tue Tinh's work is the cornerstone of a literate Vietnamese traditional medicine and was incorporated into the revitalization of Vietnamese medicine after the socialist revolution. I’m unclear about the earlier history of Vietnamese traditional medicine but it is old: medical contact between China and Vietnam dates to the Han dynasty. A number of Vietnamese medical herbs are mentioned in the pre-*Nei Jing* medical manuscripts found at the Mawangdui archaeological site (168 BCE) (Harper 1998, Thompson 2012). In terms of contemporary government-sanctioned education Traditional Vietnamese Medicine is taught at medical universities in Hue, Hanoi, Tahi Bih and Ho Che Min City and also at the Traditional Medicine Academy in Hanoi (Woerdenbag 2012). These schools integrate modern biomedicine with traditional medicine and require six years of training and six years clinical practice for licensure. There are 58 public hospitals specializing in traditional medicine and 90% of all general hospitals include traditional medicine. Older practitioners who studied through apprenticeship have also been required to take an examination (Woerdenbag 2012).

Miraclous Drugs of the South *Nam dược thần hiệu*. Written by Tue Tinh in Chinese and published in 1385. Title page.

Euro-American East Asian Medicine

In North America and Europe history reveals fluctuating periods of interest in Chinese and Japanese medicine followed by subsequent disinterest (Barnes 2008, Bivins 2000). It seems that the most recent transmission of Asian medicine to the West, beginning in the 1970's, is likely to be permanent and of great consequence. Government-issued licenses, national accrediting examinations, vibrant educational institutions, ever-increasing access to European language translations of East Asian medicine texts, an infrastructure for procuring Asian herbs, and tolerance - if not acceptance - by the dominant biomedical world augers well for a continued presence of Eastern medicine in the West.

Nonetheless, like East Asian medicine in the Far East, East Asian medicine in the West has faced and continues to face many challenges that require debates, adaptation, and adjustments similar to what we've seen in China, Japan, Korea, and Vietnam. The changes are already visibl. In fact, Euro-American practitioners of Chinese (or Japanese or Korean or Vietnamese) medicine and their patients have already altered East Asian medicine such that it is virtually unrecognizable to practitioners and patients of the original traditions (Barnes 2009).[2]

I have watched dozens of newly-arriving Chinese practitioners gradually but dramatically reduce their herb dosage as they begin to treat Western patients. With respect to acupuncture dosages, who has not noticed that Eastern practitioners often treat patients for ten consecutive days with acupuncture, while the current practice in the West is likely to be once or twice weekly? (Napadow 2004). Is this a reflection of adherence considerations, tolerance questions, patients' expectations, or the need not to inconvenience patients? I don't know, but the reality of adjustment is evident and has happened organically without any formal discussion. The issue of availability of herbs has also emerged in the West as it has throughout Asian history. Important Chinese herbs (e.g., aconite, asari or ephedra) are actually illegal or becoming problematic to use in the West. These changes represent a significant adjustment to Western circumstances. The illness profile of disease is different in the East and West. New disease categories, (e.g. celiac, anorexia, autism, obesity, metabolic syndrome) and different incidence of diseases patterns (e.g., cardiovascular diseases, depression) have already refocused education and treatment priorities for practitioners in the West. Furthermore, it is clear that Western patients demand much more attention to psychological issues (Barnes 1998, Barnes 2005.) and a stronger patient-provider relationship (Kaptchuk 2011). Robust, psychologically sophisticated variants of acupuncture that have emerged in the West, such as Five Element Acupuncture, address this discrepancy (Barnes 1998, Solos 2024). Politics alone can be an enormous influence. For example, in the 1970's the Black Panther Party developed its own "revolutionary" form of authentic acupuncture (Meng 2021). Importantly, empirical evidence strongly suggests that Western patients and Asian patients prefer and even require different interactions (Ohtaki et al 2003, Pun et al 2018, Chang et al 2013, Wei 2024). A recent randomized controlled trial performed in Korea, for which I was a

collaborator, demonstrated that a personal, emotional, empathic patient-acupuncturist relationship seems to reduce the efficacy of acupuncture in the East (Ko et al 2024). The same type of research on western patients, with which I was also involved, showed that an enhanced and empathic relationship increases acupuncture's efficacy (Kaptchuk 2008).

More importantly and much less noted; the symptoms that configure diagnostic patterns have changed in the West. While Chinese patients appear in clinics with backache and a list of other symptoms that read like a list from a TCM textbooks (e.g., frequent urination, dizziness, fatigue), practitioners have noticed that in the West, accompanying symptoms are often quite different. Volker Scheid and colleagues (2010) provide an excellent case study. When they compared TCM textbook descriptions of menopausal syndrome and actual London women at midlife, they found that the symptoms did not match. They also found the herbal formula commonly used in China, Japan, and Korea to be inappropriate for their population of London women. Probably the most remarkable study of changing pattern configuration is a report by a group of Chinese traditional physician-anthropologists from China observing 141 outpatients in an American otolaryngology clinic (Kuang et al 1987). Each patient was diagnosed with a TCM pattern. Yet, many of the prominent pattern signs were not consistent with those that would be found in patients in China. Patterns of disharmony seemed to change across cultures. For example, in this otolaryngology study, American patients diagnosed with "deficient pattern" denied that they perspired easily, tired from prolonged talking or had loose stools, all of which are common characteristics of their Chinese counterparts. In fact, one third endorsed constipation as an important symptom for what the Chinese classified as "deficient pattern," which would be uncharacteristic of Asians. Furthermore, thirty-one percent of the American patients with a "cold pattern" claimed they had a persistent bitter taste, while in China this is extremely rare. Ninety percent of the American patients reported a preference for cold drinks not hot, irrespective of their constitutional pattern. The practitioner-anthropologists also describe patients with patterns that would have been accompanied by reports of "poor appetite" in China, reporting "too much appetite" in the West. It seems that "embodiment" is different in the West. Euro-American practitioners have had to adjust. Such findings seem to confirm the constant emphasis in Asian texts – including the *Nei Jing* – that patient care has to include understanding the local environment including regional differences in patient patterns. These findings are also confirmed by Margaret Lock's (2001, 2013) cross-cultural work on "local biologies" much of which was undertaken in Japan.

Text translations are also susceptible to linguistic and cultural forces . For example, translations of Chinese medical texts often describe "qi" as "life-force" echoing the Western ideas of vital energy (Kaptchuk 2006). Yet, Asian texts clearly recognize the qi of small pebbles, gigantic mountains, still ponds and whirling hurricanes. Qi constitutes everything that exists, can exist, has existed and will exist; it's not confined to "life." Qi has adopted a new meaning with Western translation. Furthermore, Western language presentations describe Chinese medicine as being "natural" (Kaptchuk 1998). While the Chinese always had a profound appreciation of nature, the Chinese language did not

have a word for “nature” (zi-ran) until the late 19th century when these characters that actually mean “what is so of itself” (and carried the meaning of “spontaneous process”) were redefined as ‘nature’ for use in translating Western scientific writings (Sivin 1995). In fact, much of Chinese medicine, still close to it its agricultural roots, is about the destructive forces of wind, dampness, fire and cold. In Asia, nature is a two-edged sword, not a virtue. In the West where the trauma of nature has been mostly forgotten, ‘nature’ is all about beneficence and nourishment (Kaptchuk and Eisenberg 1998, Kaptchuk and Eisenberg 2001).

Circumstances surrounding health care delivery can change practice across culture and history. As mentioned earlier, the medicine practiced by monk-physicians for poverty-stricken patients was not the same as that for the aristocratic court. Similarly, Euro-American Asian medicine has different and multiple approaches to delivering Chinese medicine. Community acupuncture programs, individual practitioner clinics, integrative medicine centers, and East Asian medicine in hospitals and other biomedical institutions all deliver somewhat different forms of Chinese medicine. Furthermore, TCM in China has completely integrated biomedicine into its routine practice. Graduates of modern TCM schools in China routinely diagnosis biomedical disease and even prescribe modern pharmaceuticals along with herbs and acupuncture. Herbal strategies in the context of biomedical are often different from when herbs are the primary intervention. How exactly Asian medicine will evolve in the West remains to be seen but it is predictable that context will require adaptation and transformation.

Finally, politics shapes language and in turn conceptual frameworks. I learned this firsthand when I received serious criticism from Asian colleagues for my translation of the Chinese character “zheng” as “pattern”. My Chinese colleagues said the correct translation should be “syndrome”, which implies a disease that is still missing a cause. For my Asian colleagues, the agenda was to situate Chinese medicine within a western medical gaze in order to be more scientific. My political agenda was to push for a distinct identity of East Asian medicine in the West. Ideological differences will undoubtedly continue to produce language and conceptual differences.

The five inner organs as depicted in a Japanese diagram. Late 19th century.

East Asian Medicine

East Asian medicine – the Medicine of Yin-Yang -- has always been about change; embracing new ideas, discarding the old, and also reviving the old. Creative adaptation has always been a necessity. Disagreement, disputes and radical shifts can be hidden but never eliminated. Geography, history, politics, economics, governments, and patients themselves consciously and non-consciously conspire to re-shape yin and yang. Yet, a "core stability" exists. Practitioners of East Asian medicine read some of the same books, albeit often in different languages. We all try to be "authentic" but there is not one bona fide thoroughfare. As Lo and Renton (2012) have observed:

> Practitioners commonly try to align their practice with a single 'authentic' lineage. Different schools or teachers claim the right to represent a timeless tradition dating to an eminent Chinese ancestor, or even the revelations of the mythical Yellow Emperor. This quasi-religious impulse to be the latest living proponent of the 'Real Thing' obscures the complex interplay that exists between the faithful transmission of knowledge and practice across millennia and the ways in which old medicines are often interpreted for new contexts.

Underneath the different paths, perspectives and divergent therapeutic strategies of East Asian medicine is a commitment to yin-yang, five elements, qi, microcosm-macrocosm, resonance, and the other root intuitions of the early generations. Despite some fierce arguments, I think most practitioners – unlike the Chinese practitioner I describe in the first page -- have respect for the different schools and cultural traditions. Without mutual respect, the Medicine of Yin-Yang will never become a series effort in the West. Understanding the converging and diverging streams increases our self-understanding and vision. It is an opportunity to reflect and connect to how interpretations and different forms of yin-yang shape the history of our profession and

how each of us shapes our own vision of East Asian medicine. We should not aspire to uniformity; differences are a sign of robustness. What Annemarie Mol (2002) wrote concerning distinct contemporary perspectives on identical diseases in biomedicine applies also to East Asian medicine:

> Different roads do not contradict each other; they carry different traffic in different directions. And if "theories" are not taken to be statements about A that exclude non-A, but as diverging ways of handling reality, then a difference between them need not be a contradiction either.

May I suggest, a perspective that synthesizes the multiple voices of East Asian Medicine in a different manner. The medicine of yin-yang asserts that there is never only yin or only yang; sharp clarity is the opposite of yin-yang. Yin is always found within yang and yang is always present in yin. The deeper one's vision penetrates and the more one sees details, and then the more contradictions within contradictions appear and so on. When we propose a diagnosis or assert a treatment strategy, or advocate a model or even state a "fact", we are always, at least temporarily, ossifying and hardening the boundary between yin and yang to create a necessary decision for action, a push in the right direction and trying to say something meaningful. We feel better with a lucid diagnosis, a crystalline strategy, and articulate theory. But in fact, reality often eludes this certainty. Yin and yang are ever-present in everything, including our sharpest treatment plans and theoretical models. In schools, students study well-defined patterns and treatment protocols, not to learn the truth, but in order not to make mistakes; to learn to reach a reasonable approximation. Our training as students of East Asian medicine prepares us for the honor of spending a lifetime sharpening the vision of yin-yang, living in constant flux and penetrating to deeper and deeper nuance and insight. Our education points us in a direction but does not give us certainty. Our take on reality is often tentative, momentary, elusive, and contingent. The different interpretations, debates, and disagreements that exist in East Asian traditions are not errors or mistakes. They are actually precious gems of vision. Now that the profession of Yin-Yang Medicine has been standardized and involve accredited institutions of learning, we do not want to rely on these fierce debates, multiple interpretations and unique adaptions. Like all good empiricists we want the known "facts." The existence in East Asian medicine of multiple versions and multiple voices, actually preserves the wisdom, sagacity, and sensitivity of East Asian medicine. Each interpretation is a glimmer of deep reflection. In Asia, national chauvinism sometimes prevents practitioners from acknowledging and respecting the different interpretations of Yin-Yang medicine. Chinese, Japanese and Korean practitioners implicitly accept the assumption that what they currently do is best, correct and historically more accurate. Each claims their practice as the best interpretation. The "other" tradition is not as valuable. For us in the West, who have no national heritage of Asian medicine, grappling with the variant traditions of East Asia presents a unique opportunity to encounter the diverse insights that different traditions preserve. Attending to the "other" is one way to preserve the vibrancy in the entirety of East Asian medicine.

Yin-yang medicine is entirely about seeing beyond what is easily taught or seen. It is about perceiving what is always changing. Through the centuries, all the multiple perspectives, learning from "outside" traditions, obvious contradictions, fierce debates, long-standing arguments, sharp disagreements, serious confusion, and stubborn opaqueness in canonical texts, commentaries and differences in clinical practice are actually efforts to speak and touch the inexpressible. The sharp fissures and dark cavities allow for creativity and novelty. Living with this ultimate indeterminateness – the essential nature of a constantly changing Yin-Yang – has always contributed to the vibrancy of Asian medicine's growth and development. Of course, we need to live in modernity and maintain a profession, pass exams, obtain licensure, and make decisions to treat our patients.

But if I may write something we often forget, we also need to acknowledge – at least in whispers – the embedded, irreducible uncertainty and inchoate mystery expressed in Yin-Yang Medicine. Lao Zi (c. 604-531 BCE) told us this in very beginning: "the Tao that can be told is the not eternal Tao. The name that can be named is not the eternal name." Underneath the yin-yang duality, the constant flux, and the multiplicity, is the inexpressible singularity, uniqueness, indivisibility, ineffability, and ultimate reality of the unnamable One. We are an ancient tradition that seeks to engage what cannot be fully contained or completely known. Our debates remind us that we can get close, even very close, but never really capture yin and yang. Yin-yang cannot be grasped, it lives as a process.

Footnotes:

1. This situation parallels China. Early Tang medicine was expansive and adopted many central and southeast Asian herbs and strategies while in the later Tang, persecutions of Buddhism and all things foreign reversed this expansion. This narrowness even led to the deliberate destruction of Arab and Sogdian pharmacies located in China, which were critical sources of many of the new herbals introduced in the early Tang (Beckwith 2009, Lewis 2009).

2. Limitations of space and lack of solid knowledge does not allow a discussion of other vibrant non-Asian practices of Chinese medicine in places such as Africa (Hsu 2002), Cuba (Lo and Renton 2012) and Eastern Europe (Rybicka et al. 2023). Neither is there space to address Chinese medicine as practiced in the Chinese diaspora (e.g., Chew 2024) or the history of Chinese medicine practitioners providing healing to non-Chinese nationals (e.g., Flowers 2022).

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