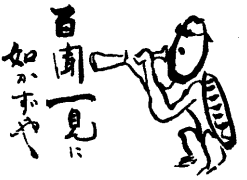

CHAPTER ONE

ACUPUNCTURE: TRADITION AND TRANSMISSION

Acupuncture and moxibustion therapies are believed to have originated in China approximately two thousand years ago. As a traditional medical practice, they encompass several treatment methods. The main method is the use of needles to puncture the skin. Secondarily, moxibustion is used to warm or cauterize points on the skin. Bloodletting, cupping, scratching needle techniques, and fire needle techniques are supplementary methods. The enormous clinical value of acupuncture and moxibustion therapies is evidenced by their continued and extensive use in modern China, their spread centuries ago to other Asian countries, such as Japan, Korea, and Vietnam, and their more recent arrival in the West, where they have weathered even the rigorous scrutiny of Western science and medicine, revealing some of their secrets to scientific method.

The tradition of acupuncture and moxibustion is rooted in, and based on, a few ancient medical texts, such as the *Huang Di Nei Jing Su Wen, Huang Di Nei Jing Ling Shu,* and *Nan Jing* (circa *300* BC to 100 **AD),** texts that have formed a rich intellectual tradition through countless commentaries, developments, extensions, and explanations in numerous subsequent texts.[1]

Throughout this long and venerable history, a complexity of theories and clinical systems have evolved. In some cases these have retained their original form, and in other cases, they have adapted to the passage of time, transforming under the scrutiny of clinicians and scholars.

TRANSMISSION

In ancient times people did not have the mechanisms for storage and transmission of knowledge that we have today. Technology was not in the hands of a few specialists, but in the hands of "doers," craftsmen and artisans. These craftsmen and artisans practiced acupuncture and moxibustion and developed high levels of expertise without the formal education that is emphasized today. They amassed experiential knowledge and the know-how of important clinical methods, passing their knowledge on in the classical texts. Using right-brain pattern recognition more than left-brain analytic methods, they constructed sophisticated methods and systems that achieved clinical success without the appearance of the scholarly and coherent methodologies that are so important to us today.

There are Western scholars who claim that no Western scientific methods were practiced in ancient China, that acupuncture and moxibustion are justified only as folk medicines with traces of shamanism. Methods such as applying simple, naturalistic philosophies, and using theories such as yin-yang and five phases to explain complex medical phenomena, are seen by such Westerners as thoroughly unscientific methodologies, inappropriate for the modern world. Yet the prevalence of this Western intellectual chauvinism is at odds with the facts. Many excellent therapeutic systems were developed in China; many excellent methodologies and technologies, among them the early use of magnets, compasses, gun powder, and astronomical instruments, had their nascence in ancient China.2 At the time of the European Middle Ages, at least twenty influential ideas and technologies had been imported from China to the West, but only two had been exported to China. Something of a paradox can be glimpsed between the historical facts and the claims of some scholars.

We would hope that such evidence might encourage us to set aside haste in judging the cultural legacies of others and in adapting them too abruptly to our own cultures. We might discover that taking the theories and language of acupuncture and moxibustion out of clinical context, and solely at face value, is not highly useful. We might discover that without a broader appreciation of the rich background and legacy of these medicines, it is all too easy to misinterpret them. We must at least acknowledge the continued survival and success of these medicines in the modern world.3 Not only has the practice of acupuncture and moxibustion gained acceptance at the professional level, but these traditional therapies have also made considerable gains in the medical delivery system.4

As acupuncture as a medical delivery system is transmitted from its ancient Eastern origins to modern Western cultures, it is essential that we recognize and understand the difficulties inherent in such transmission. For it is only by so doing that we may be able to grasp the nature of acupuncture and moxibustion and develop consistent and powerful clinical methods. By first recognizing these difficulties and then developing strategies to address them, we may find that we are not only able to clarify and verify many of the classical theories, we are – with good research methodology – able to encounter phenomena not yet described and develop new, more comprehensive theories and powerful clinical procedures that are potentially more suitable to the modern world. By raising questions in a framework broader than most other researchers use, and suggesting research methods, we may be able to point the way to a more thoughtful approach to the study of acupuncture and moxibustion.5

UNCLEAR TERMINOLOGY

Such a diversity and wealth of literature exist in the native languages of China and Japan that sifting through the traditional ideas and clinical applications requires the skills of scholars as much as the clinical insight of practitioners. Archaic and classical Chinese create particular translational problems that require specialized philological work. The classical texts described people, health, and disease using different terms than those familiar to us today. To compound this obstacle, the general concepts described in these early texts are often rooted in clinical experience and thus do not lend themselves to interpretation by intellectual endeavor alone. Careful coordination and cooperative methods of translation are required. Even given such coordination, perhaps we can never really know what was meant by terms *two* thousand years old. Perhaps our modern languages and experiences simply do not entertain equivalent concepts.

Many use the arcane jargon of the old texts without really understanding its meaning. This is particularly true because of the predominance of left-brain thinking and cognition in the modern world, and its broad application to all things. However, we should recognize that the terms of these arcane jargons are often keys that are essential to a deep understanding of acupuncture and moxibustion. They require appropriate and reasonable methods of examination, analysis, and testing, before they can be understood accurately and coherently. One day, as when Champollion deciphered the Rosetta stone, a genius will decipher and explain these key terms. When this happens many will be surprised by the immensity and importance of this cultural legacy.

A good example of this conceptual and translational difficulty is the term *qi,* 氣, in Japanese *ki.* The *Huang Di Nei Jing Su Wen* is generally acknowledged to be the primary extant text in the field of acupuncture and moxibustion. Of the more than fifty thousand characters comprising this text, over eleven hundred (about one in fifty characters) are the term qi. It is obvious that this term has considerable significance. According to tradition, everything is composed of qi in one form or another; all movement involves qi. There have been many translations of the term by scholars and practitioners alike, all of which pose difficulties. We commonly find translations such as "vital force," "vital energy," "life force," ``energy,'' ``breath,'' "spirits," "air," ``pneuma,'' "influences," all of which represent some specific aspect of the term, or a generalization of its concept, but rarely both.

In a modern Chinese dictionary, we can see that the term qi is given quite a wide variety of meanings: "gas; air; breath; smell, odor; weather; airs, manner; spirit, morale; to make angry, to get angry; bully, insult; [in Chinese medicine] vital energy, energy of life." Obviously, the term is used in many different senses in everyday language. Characterizing all these different meanings and nuances with a single term or translation is difficult. Qi is expressed in personality and in emotional context. In Japan, we greet people by asking how is their yuan qi: "O*genki desu ka?''* As practitioners, we treat people with our qi. Certain techniques of breathing and gymnastics such as *qi gong* and *tai ji* build and master the qi. The classical literatures of China and other East Asian countries provide many examples of simple expressions of the universal and encompassing nature of qi:

Heaven and Earth have correct qi;
its form is flexible and fluid.
In the lower parts it is in the rivers and mountains on earth;
In the upper parts it is in the sun and stars in the sky;
The human being is said to be overwhelmingly
and universally soaked in it.
- The zheng qi song of the Wen Tian Xiang, before 200 BC.

Life is the follower of death and death is the predecessor of life,
but who knows their cycles?
Man's life is due to the conglomeration of the qi,
and when they are dispersed, death occurs.
- Zhuang Zhou, in Science and Civilization in China II p.76.

In everyday language and context, the term *qi* in China and Japan has multiple shades of meaning and uses, from classical to modern times. When a child inherits characteristics of his or her parents, this is traditionally said to be the *xian tian qi,* the "before heaven qi," or "prenatal qi.'' It is recognized that some form of qi passes from parents to their offspring. In the twentieth century, we understand this as details of the DNA, chromosomes, genes, etc. Likewise, when someone catches a cold or flu, it was traditionally said to be an external pathogen, a *xie qi,* such as cold, wind, damp, dryness, summerheat, or heat. Today we use theories of bacteria and viruses. In ancient times, and still in the modern literature, these

and related phenomena all come under the general heading of qi in some adverse form. It is evident that we cannot define clearly the term qi, but, as we will see, it may be possible to suggest an understanding of its nature based on numerous clinical experiences and researches. What is important in our attempts to clarify and understand such terms is the nature and consistency of the research methodology we use.

Qi poses particularly complex difficulties because it is essentially a qualitative rather than quantitative concept. It is thus not open to simple quantitative methodology. But what of quantitative terms? Are they more readily resolved? The term *cun* for example, loosely translated as "body division" or "body inch," is clearly a quantitative term. Yet similar problems arise with this term. According to the traditional literature, the term *cun* refers to some distance on the body surface that is different in each body area, and different according to each individual. But in the descriptions of each acupoint, the needle depths for insertion are also given in *cun*. Little or no indication is given as to which length of *cun* is meant for each point. It appears that there must be some acceptable standard length for this *cun*. For Westerners and Asians, the actual length of the *cun* will vary, because, for the most part, Westerners are taller and of larger body build. Should there be one standard for Asians and another for Westerners? Researchers who have tried to answer this and related questions come to quite different answers. The standard distance of one *cun* in Japan is now 3.3 cm, but other estimates vary from 2 cm to 3 cm.[6] In China, attempts at standardization of the *cun* have also been made. One study states, for example, that one *cun* is 22.3 +/- 0.14 mm.[7] These ranges in length are quite different. How do we resolve this problem? Perhaps the relative definition is best, because it depends on the body area and individual differences. But to the scientific mind, this is not a happy solution. A quantifiable standard is much more acceptable.

Translation of the "organs,:' the *zang fu,* is also particularly difficult. The original terms and their modern English equivalents can be seen in the following table:

Zang Organs	**Western Equivalent Organs**
xin	heart
gan	liver
pi	spleen
fei	lung
shen	kidney
xin zhu (xin bao luo)	heart governor/master (pericardium)
Fu Organs	**Western Equivalent Organs**
xiao chang	small intestine
dan	gallbladder
we	stomach
da chang	large intestine
pang guang	bladder
san jiao	triple burner (triple warmer)

We all know that the traditional Chinese terms refer only partly to the physical organs and their physiological functions, those described by Western anatomical labeling. The traditional terms also refer to functions not described by Western science. This translational problem is particularly difficult for the *xin zhu/xin bao luo,* the *san jiao,* and *pi.* It is far from clear that there is even a functional equivalent

for the *san jiao* in the Western literature. The *xin zhu/xin bao luo* is not always seen as the pericardium, as it has other functions clearly not related to the pericardium. The *pi* involves what in Western terms may be described as pancreatic functions, but it is commonly seen as the spleen, which has none of the digestive functions of the *pi*.

There are approximate functional equivalents for the other organs, but for these three, it is hard to see such near equivalence. What is the best way to translate these terms? To a Western-trained doctor, rendering the standard anatomical references can be misleading. But the terms must be translated and those seen in the preceding table, which are in common use, can be at best only approximations, carrying with them many cultural biases. Such problems must of necessity be recognized as unresolvable, at least until some creative individual invents a reasonable methodology for comprehensive understanding.

INCONSISTENT TERMINOLOGY

A particularly difficult problem with which we must contend when dealing with the literature of acupuncture, and more broadly East Asian or Oriental medicine, is the inconsistent use of the same terms by different authors, in different books, in different periods. Often the same terms are used by different authors at different times to mean different things. This has created great confusion and considerable difficulty for translators.

For example, the terms *shao yang, tai yang, yang ming, tai yin, shao yin,* and *jue yin,* when found in the classical acupuncture texts (the Su *Wen, Ling Shu, Nun Jing*), primarily referred to the pairs of arm and leg yang or yin channels, being a sixfold pairing of the twelve channels. In the herbal literature, especially in the *Shang Han Lun,* the terms referred more to the stages of progression of disease and the degree of penetration into the body of pathogens. In even earlier pre-medical texts, the terms referred to six periods of the year of sixty days each.[8] These multiple uses have created considerable difficulty and confusion.

Other examples abound. For instance, the use of the terms *bu* (supplementation or tonification) and *xie* (drainage or dispersion) raise many interesting questions and difficulties. The term *bu* generally is understood to mean the supplementation or replenishment of vacancies or insufficiencies, where *xie* means the ridding, draining, or breaking down of repletions or fullnesses. But there are a greater number of ideas about how these goals should be achieved, some of which are obviously unclear.

In massage therapy, massaging with the flow of the channel is said to be supplementing, while massaging against the flow of the channel is said to be draining. Yet, if KI-11 — a reflex point for the bladder channel — is sore, applying a light, stroking massage, following the directional flow of the bladder channel down the legs, will eliminate the pressure pain on this point. By stroking in the opposite direction, we can cause the pressure pain to return. Thinking in terms of supplementation or drainage in a case like this might be inappropriate. These same phenomena would occur regardless of whether the pressure pain on KI-11 is a sign of bladder repletion or vacuity. Instead, we need to redefine the terms clearly, or perhaps to not use them at all in this context.

The herbal tradition describes the use of supplementation *(bu)* and drainage *(xie),* but sometimes with opposite meaning to their use in acupuncture and moxibustion. For instance, earlier this century, the Japanese herbalist Yumoto Kyushin defined pulmonary tuberculosis as a febrile disease and prohibited the use of moxa to treat it — because of the supplementing and warming effects of moxa. Yet,

famous moxibustionists such as Takeshi Sawada and Bunshi Shiroda took great exception to this idea. They had unusually good results treating pulmonary tuberculosis using only moxa. How do we reconcile these contradictions? Consistent research methodologies might help to resolve these difficulties.

In the classical texts the following techniques were all seen to be important methods of supplementation and drainage:

1. The use of inhalations and exhalations
2. Needling against or following the flow of the channel.
3. The selection of specific points.
4. The use of finger pressure.
5. The use of slow and quick techniques.
6. The choice of moxa or needles.
7. The depth of insertion of needle.
8. Blowing or not blowing on the burning moxa.

Many contradictions and problems can be discovered when using these various techniques. For example, the classic notion of the supplementing point and draining point can be contradicted. In our research, we have found that these points can produce the same effects depending on how we stimulate or influence them. We have devised powerful clinical methods based on their simultaneous use.

Another interesting example of textual inconsistencies can be found in the numerous interpretations of radial pulse diagnosis. In the following table, while it can be seen that most texts share a general agreement over the *guan* or "bar" position and the *cun* or "inch" position, it is equally evident that the *chi* or "foot" position of the radial pulse is different in virtually all cases. This poses considerable difficulty in diagnostic consistency and is one reason why numerous other diagnostic techniques have arisen to help confirm, or deny, what is felt in the pulse.

If we study the table on the following page, we can see various interpretations of the three positions of the radial pulses on the left (L) and right (R) arms in the superficial (yang) and deep (yin) positions.[9] Many interpretations other than these eight can be found, as can different translations of the same passages, but we can clearly see differences in these samples.

There are many more examples of confusion or inconsistency in the literature. Some may have stemmed from the widespread use of simple mnemonic rhymes. When they were written, they may have served as useful learning devices for students who were almost always clinical apprentices as well. Today these rhymes are often confusing and difficult to understand, and have contributed to irregular translation.

Other unclarities may have arisen through attempts to simplify the literature, especially the introduction of simple formulary approaches. Such approaches were likely invaluable for the study of acupuncture, particularly for beginning students who could thereby obtain reasonable results quickly. However, as diminishing attention was given to the more traditional concepts of restoring balance and harmonizing the whole body (a concept, as we will see, that is essential to the practice of acupuncture), more information became lost. Further, many such formularies were given simplified explanations. Over generations, this approach lead to the creation of treatment strategies based on reduced information; understanding became more difficult.

Comparison of radial pulse diagnoses

Text	Position	Side	Yang level	Yin level
Su Wen	*cun*	R	LU	**chest**
	cun	L	HT	CV-17
	guan	R	ST	**SP**
	guan	L	diaphragm	LR
	chi	R	KI	abdomen
	chi	L	KI	abdomen
Nan Jing	*cun*	R	LI	**LU**
	cun	L	SI	HT
	guan	R	ST	**SP**
	guan	L	GB	LR
	chi	R	TB	**PC**
	chi	L	BL	**KI**
Nan Jing Ben Yi	*cun*	R	LI	**LU**
	cun	L	SI	HT
	guan	R	ST	**SP**
	guan	L	GB	LR
	chi	R	TB	**PC**
	chi	L	*mingmen*	KI/BL
Qian Jin Yao Fang	*cun*	R	LI	LU
	cun	L	SI	HT
	guan	R	ST	**SP**
	guan	L	GB	LR
	chi	L	(?)TB	
	chi	R	KI/BL	??
Mai Jing	*cun*	R	LI	LU
	cun	L	SI	HT
	guan	R	ST	**SP**
	guan	L	GB	LR
	chi	R	child door/TB/KI/BL	
	chi	L	left **KI**	BL
Mai Jing Tu Shuo	*cun*	R	LI	LU
	cun	L	**SI**	**HT**
		R	ST	**SP**
	guan	L	GB	LR
	chi	R	TB	***mingmen***
	chi	L	BL	**KI**
Lei Jing	***cun***	R		LU
	cun	L	**PC**	HT
	guan	R	ST	**SP**
	guan	L	GB	LR
	chi	R	SI/*mingmen*	Original yang/KI/BL
	chi	L	LI/TB	Original yin
Yi Zong Jin Jian	***cun***	R	chest	LU
	cun	L	CV-17	HT
	guan	R	ST	**SP**
	guan	L	diaphragm/GB	LR
	chi	R	LI	**KI**
	chi	L	SI/BL	TB

EXPERIENTIAL ADAPTATIONS

In both historical and modern times, the practice of acupuncture has involved employment of differing treatment levels or differing treatment targets. Some focus only on the patient's symptoms and apply needles with the intention of alleviating or ameliorating those symptoms. (A common form of this therapy is shigeki ryoho or stimulation therapy.) Others focus on the state of the flow of the qi in the meridians or channels, and apply needles to correct the flow of qi. (A common form of this therapy is keiraku chiryo or channel therapy.) Still others adopt some middle ground between these two and combine both aspects in treatment.

Significant variations in approach and teaching methods are the result of these different focuses. As a result, studying acupuncture and moxibustion can be difficult and confusing for the beginner. Recognizing this, many translations, schools, and traditions within the field of acupuncture and moxibustion simplified the techniques for study and for teaching so that the student might learn more easily. (A good example of this process is the barefoot doctor training in China.) These simplifications tried to reduce and rationalize major parts of the field into a single coherent system. Though helpful at face value, over time many useful concepts were ignored or simplified to the point of inaccuracy. This is clearly seen in the T.C.M. system most popular today, the *bagang bianzheng,* where essential components of channel theory, as well as structural, five-phase, and biorhythmic concepts are ignored or simplified to mere aphorisms. It is fine to do this; within the delivery system established in China it is effective and useful. For the beginner, or those whose place in the system will be essentially paramedical, the approach is satisfactory. Yet when examined in detail this system creates basic problems. For example, the popular notion that an acupoint has specific, defined effects, a key concept in this system, disintegrates quickly when we raise the question as to how specific effects were defined and what tests determined their validity.

We must also address the fact that the functions of acupoints can vary from patient to patient. Changes occur in the points based on daily biorhythms, biological changes, changes following infection,[10] surgery, etc. If we ask what points are good for asthma we may be able to list a few that will produce a 50-60% success rate with asthmatic patients. But what of the other 40-50%? These same acupoints do not have the same characteristics. This may be an easy way for students to study acupuncture and moxibustion, but in a clinical setting it rapidly becomes limiting and overly complicated. When there are many points said to be good for a given condition, how do we select the ones to use? What parameters are used in the decision process? The more parameters, the more complex and difficult the decision becomes. Yet, the more simplistic the criteria, the lower the rate of treatment success. The clinician with many years experience can decide with ease which points to use, but how does the beginner decide?

Many years ago I treated a patient who had a twenty-year history of asthma. I treated her asthma by burning moxa at CV-22 (at the center of the jugular fossa). This completely eliminated her symptoms. It was more than twenty years before I heard from this patient again. She was only beginning to experience a return of her asthma; apparently, that single treatment had eliminated her chronic asthma completely! Because of this experience should I conclude that burning moxa on CV-22 is effective for asthma?

Likewise, many years ago I was treating a difficult and stubborn case of trigeminal neuralgia. Various forms of therapy had so far been helpful, but only with short-lived success. Since I was researching and studying the eight extraordinary vessels at the time, I decided to try the extraordinary vessel confluence-*jiaohui*

points, SI-3 and **BL-62,** with **TB-5** and **GB-41,** using silver and gold needles shallowly inserted on the side of the body opposite to the pain. This completely eliminated the pain! Should I then have concluded that this was the treatment of choice for trigeminal neuralgia?

The interesting questions about these case studies are more to do with methodology. The problems exist at three basic levels. First, at what level of use and experience should an observed clinical effect be incorporated into the body of clinical literature? That is, at what point can we say that moxa at CV-22 is good for asthma, or that gold and silver needles at the *yang wei mai* and *yang qiao mai* effectively treat trigeminal neuralgia? Second, how are such effects differentiated within the corpus of clinical literature and when is it acceptable for such observations to submit to experiential adaptation? That is, how do we determine when and how to use these treatments? Third, who is qualified to make such decisions and what is the appropriate methodology for making them? This last question is bound to be culturally and historically dependent. The way such findings may be interpreted in modern China or modern Japan will be quite different, depending on the theoretical perspectives of the interpreter.

Let us imagine that it is nearly four hundred years ago in China and I am a good friend of Yang Ji-Zhou, the author of the *Zhen Jiu Da Cheng.* Because of this, he might have included these treatments in his text of **1601,** despite the limited experience of my two cases. Today, almost four hundred years later, practitioners and students reading his text will place enormous trust in my results because they were included in this great and revered text, and because my friend's reputation in later centuries is excellent. Is this a sufficient criteria for making general proclamations about the treatment of asthma and trigeminal neuralgia?

What if these treatments were to go through the mill of heuristic adaptation and later authors transmitted my results by saying only that **CV-22** is good for asthma, or TB-5 is good for trigeminal neuralgia, without including the method I used (moxa) or the theory of the extraordinary vessels? What if translators then simplified the terms with which **I** diagnosed these conditions? Would these points reliably produce the desired results or would there be only a statistical percentage of patients who were helped?

These are particularly difficult questions because methodology is something remarkably lacking in traditional literature. Simplifying the accretion of therapeutic effects observed over the centuries into a list of functions is useful for the beginner. But who sifted through the literature? What standards and models did they apply to interpret it? What assumptions did the compilers and translators bring to their work?

We have no simple answers to these questions, but we have at least tried to address them by devising methodologies appropriate to the ideas. Because of the great diversity of information that has developed over the centuries, we have found that generally it is better to have a more flexible model and method. Even within the lifetime of a single practitioner, many changes of theory and practice can occur. Imagine how much more complex this is with thousands of practitioners. In modern practice we often see such changes; a particular practitioner may develop a specific methodology that yields a model changing over time.

Dr. Paul Nogier, the founder of auriculotherapy, first defined very specific points and areas in the ear with specific point recipes for each disease. But now, after many years of practice, he has found that there are three overlaying maps which may be active simultaneously.[11] He has a rather complex method for using these findings, but for the beginner and general clinician he simply recommends

auriculotherapy using pressure pain points in the ears. This initial approach is easy for the student to learn because of a clear methodology and systematization. However, as the clinical findings and theories become more complex, they are more difficult for the beginning student to grasp. The second approach, the approach of auriculomedicine, is difficult for the student to learn, and is perhaps only really comprehensible to clinicians, as it is more experiential and less intellectual.

As clinical practitioners develop more expertise, their techniques and strategies often evolve, leading to quite different approaches. This is necessary for both individual and general growth, but is typically not within the grasp of students. Hence students are generally exposed to a systematized approach that tries to sidestep these issues. But, just as in a game of chess or in a fencing match, the players must modify their techniques based on their opponent's reaction, in medicine, the practitioner must do the same based on the response of the patient. Often the simplified systematic approaches that beginners learn are not sufficiently flexible to allow for such modifications. What is important is the need for, and utilization of, a creative and consistent research methodology and methods of assessing the effects of treatment. We can take nothing at face value because without clinical tests and confirmation, we have no real idea of what these simplifications mean.

RESEARCH DIFFICULTIES

In recent years much scientific research has been done on the nature and mechanisms of acupuncture and moxibustion. While this is laudable, it often leaves unanswered questions as to what the classical acupuncturists were doing. A major focus of this research has been the neurological effects of acupuncture, but this is really only one part of what happens during therapy. The effects of treatment are complex and entwined. Some are hidden and hard to measure. Yet as we hope to demonstrate, these minute signals and responses are probably the most important occurrences and the ones most closely allied to classical theory and practice.

Many scientific researchers in acupuncture tend to take a narrow perspective in their research, unfortunately neglecting the larger picture and losing sight of the general significance and effects of acupuncture. Such a perspective also creates poor clinical research and practice. This was evidenced in a recent symposium of the Society of Japanese Acupuncturists and Moxibustionists on the systematization of the diagnosis and treatment of lumbar problems. Instead of looking systemically at lumbar problems, it focused only on the diagnosis and treatment of the lumbar region. While this may be a good "scientific" approach, this simplistic, reductionist approach can only fail to achieve a complete understanding.

This method ignores the simple clinical reality that we are frequently able to treat lumbar problems without touching the lumbar region. Unfortunately, modern scientific researchers and acupuncturists scorn traditional theories (channel theory, five-phase theory, etc.). This may be simply the result of their inability to devise suitable tests or to develop equipment sensitive enough to research these theories. Whatever their reasons, this mental bias in their approach biases their results.

Scientific research is further hampered by its own unattainable concept of rigor. The double blind study is the supposed pinnacle of clinical research, yet in acupuncture research, it is impossible to perform a true double blind study. Some of the effects involved in acupuncture and moxibustion are so subtle that they are impossible to block or eliminate. These effects are more than the placebo effect,

which is a thorn in the side of any medical researcher. They manifest at more subtle levels, such as the simple touch of the patient by the therapist. We can show how touch can have a series of effects, two clearly demonstrable ones being the touch of the thumb versus the touch of the little finger. Both these techniques produce notably different effects depending on where the touch occurs. Even the best designed double blind studies involve touching the subject in some manner, if only to insert the needles. How are we to account for the potential effects of touching contact? Further, in certain styles of acupuncture practice, the success of treatment depends in part on the practitioner's qi for its efficacy. How can these effects be eliminated and leave a viable form of treatment to be studied?

Another related problem in the scientific analysis of acupuncture arises at a more basic level. The premises that comprise the foundations of acupuncture and East Asian medicine are quite different from the premises that support Western science and medicine. As a consequence, applying Western premises to the analysis of acupuncture and East Asian medicine may, at times, be like trying to slice a loaf of bread with a chain saw: it is possible, but very little of the bread remains. The following passage from the Tang dynasty medical sage, Sun Si-Mo, expresses some of these differences:

> *There are diseases whose interiors are the same, but whose exteriors are different, and vice versa. Therefore the repletion and vacuity of the* ***zang*** *and* ***fu,*** *the smoothness and blockages of the blood vessels,* ***ying,*** *and* ***wei*** *cannot be observed [solely] by the ears and eyes, [instead they] can be elucidated by pulse diagnosis. There are floating, sinking, wiry, and tight [categories] of pulse in the blood vessels. There are high,* ***low,*** *shallow, and deep flows in the different inductive [acu]points. There are differences in the thickness, thinness, hardness, and* soft*ness of the skin, muscles, and bones. Only a person who uses his heart [/mind] delicately can tell these* ***differences.***[12]

Western medical analysis needs objective signs and indications before diagnosis and treatment are determined. Here, traditional Chinese medicine is seen as relying primarily on subjective assessments, in particular, intuitive observations and decisions. This is a significant difference between Western methodology and Chinese or Japanese traditional medical methodology.

While scientific research is important for mapping some of the effects of therapy, it rarely addresses the important questions regarding what it was that the classical texts tried to describe. It is self-limiting in a field such as acupuncture, where it is impossible to rule out or describe the subtle effects — which are possibly the more important effects — and is thus not very helpful in achieving the goal of a consistent research methodology. This does not, however, rule out the use of scientific knowledge and technology for achieving this goal.

The current attitudes toward the research and the teaching of acupuncture and East Asian medicine in Japan arose during the Meiji era. The government was desperately and hastily trying to modernize Japan. The medical systems of that time, including acupuncture, moxibustion, anma (massage), and herbal medicine were Westernized, both in their theoretical descriptions and the manner in which they were allowed to be taught. The traditional theories were completely thrown out, and, with the exception of the blind practitioners of acupuncture, moxibustion, and anma, who were allowed to continue as part of the government's social policy towards the blind, all other practitioners were banned from practice. The Ministry of Education set the curriculum for the education of the blind. The committee that decided this curriculum submitted the following plan:

> *Since the channel is a concept not considered by Western medicine, if shall be omitted and instead of talking about the* ***jing xue,*** *channel acupoints, the term* ***kong xue,*** *acuholes, will be used.*
>
> *The* ***kong xue*** *will be taught solely by their anatomical locations and their effects [main indications].*
>
> *Treatments* for *particular diseases will be given simply by listing combinafions of* ***kong xue*** *for each disease.*

The principles in this plan still seem to be in operation in most schools of acupuncture in Japan. The scientific study of acupuncture typically takes these Meiji-era modernizations as fundamental to research protocols. As a consequence, most research ignores the basic principles and premises of acupuncture. This problem is not limited to Japan. Also in China, for example, following the political changes of the late 1940's and the cultural revolution of the 1960's, acceptable methodology for the study of acupuncture underwent enormous revision. Political, social, and cultural influences play important roles in the determination of methodology and protocol. Modern politics usually has had little patience for the ancient and traditional theories of China.

If we are truly to appreciate and understand acupuncture and moxibustion, we must take an open-minded approach. We must contend with the difficulties of transmission of knowledge posed by the differences of culture and language, and acknowledge that much of the information described has been derived from clinical experience and thus may not be amenable to a strict Western analytical, academic method. Who in the modern world, where scientists are making fundamental discoveries so rapidly that they need constantly to redefine principles, would want to state that a particular body of "scientific knowledge" and the methodologies on which it is based, represents a fixed, immutable constant of universal application? If the standards and methodologies of traditional Western science are inappropriate for modern Western medicine, how much more is this true for East Asian medicine?[13]

TOWARDS A MEDICAL EVOLUTION

The interaction and evolution of different medical systems is a phenomenon dependent on many factors. Paul Unschuld describes the integration of East Asian and Western medicines in three stages: coexistence, cooperation, and integration. These stages appear on three fronts: the methods or means, the personnel, and the systems used. The progression through these three stages is already underway, particularly in China where East Asian and Western medical systems have evolved through coexistence and cooperation toward an integrated approach. But, in general, the evolution of personnel and systems will take more time. In China, personnel coexist and are beginning to cooperate, but have not come close to an integrated approach. The systems, however, are neither cooperating nor integrating, merely coexisting. This is a complex issue; there are many methodological considerations that must be resolved before further evolution can occur. It is our hope that the theories, methods, and clinical procedures that we have developed and that we present here will point the direction for others to follow. Perhaps the models we describe in this text will help this evolution through cooperation and integration of the medical systems.

To be honest and fair to these theories and clinical medicines, we should approach them with unbiased minds; we should not prejudge based on current standards. Throughout the long history of acupuncture and moxibustion many

geniuses devised and described powerful theoretical models and clinical techniques. Some of these have survived to modern times, but many have sunk into obscurity to await rediscovery. We should never dismiss something because we are unable to understand it, or because it does not fit clearly into our current model of how things are. As clinicians, researchers, or scholars, we can only make progress in unravelling the Rosetta stone of East Asian medicine with open minds and willingness to participate in this research adventure. It is our purpose in this book to give examples of how one can begin to approach the Rosetta stone, to hold up a beacon to light the way. Throughout the theoretical sections we will discuss classical theories, raise questions as to their meanings, and describe clinical research methods by which these theories can be confirmed and described.

We think that the research methods and clinical tests we have devised and the good clinical results we have obtained will justify our theoretical conclusions. But, probably more than anyone, we recognize the inherent limitations and possible contradictions of all these ideas. It is in this light that we would like to clarify our purposes and methods with a simple yet profound saying that arose in the tradition of the tea ceremony and has continued as a traditional teaching method:

In Japanese, 守破離 is termed *shu ha ri;* in Chinese, it is termed *shou po* 立. Simply put, this means what we absorb and obey, we must eventually break away from (so as to begin our own new tradition). To merely follow our teacher's tradition is not sufficient, but it is a necessary starting point. If we take the wisdom of *shu ha ri,* we can develop a suitably flexible mind and approach, and begin to make real progress.

CHAPTER ENDNOTES

1 Paul Unschuld lists more than 130 commentaries in Chinese and Japanese on the ***Nan Jing*** alone. See: ***Medicine in China: Nan Ching, the Classic of Difficult Issues,* 653-669.**

2 Joseph Needham's multi-volume work, ***Science and Civilization in China,*** gives an exhaustive and enlightening recital of such discoveries. See especially volumes III, IV and V.

3 In Japan, for example, acupuncture, moxibustion, and herbal medicine have attained a level of clinical success that compares well with Western medicine. These therapies are often found integrated with allopathy. Research is often government-sponsored and conducted at prestigious universities and medical schools. In China in the last twenty years, considerable government-sponsored research has been conducted. In France, acupuncture training is conducted as a post-graduate specialization for medical doctors. Numerous other countries use and recognize acupuncture and moxibustion to varying degrees.

4 In Japan, for instance, such therapy is favorably viewed by the populace. In a study conducted from 1975 to 1976 by researchers at the Chiba University Oriental Medicine Research Association, the researchers found that acupuncture, moxibustion, and herbal medicine were favorably judged by those who participated in the study. Questionnaires were sent to more than 2200 patients who came for therapy. With nearly half responding, the statistics clearly showed that most patients had tried Western medical therapy (75%) before coming for acupuncture, moxibustion, or herbal therapy. Most gained improvement or abatement of their symptoms (approximately 70%) following therapy using one of these three methods. Most patients reported that they would use or recommend these therapies in the future (approximately 60%) and most felt that both modern (Western) and traditional (East Asian) medical systems were necessary (80%). Clearly, in Japan, the existence of diverse medical systems is seen as favorable and complementary.

5 **S.B.: Some** serious attempts have been made to broach the problems of translation and transmission. Among the best descriptions are in the work of Nigel Wiseman. His introduction to ***Glossary of Chinese Medical Terms*** is a thorough analysis of the topic, and the work itself is notable for the inclusion of Asian clinicians in the process of term selection and definition.

6 For instance, Dr. Yoshio Nagahama defined one *cun* as three centimeters (see ***Shinkyu Chiryo no Shinkenkyu*** p. **21).** Dr. Haruto Kinoshita defines it as two centimeters (see ***Illustration of Acupoints*** p. 12).

7 Chen Weichang ***et al., "The*** determination of the depth of puncture for the development of needling sensation," ***National Symposia of Acupuncture and Moxibustion and Acupuncture Anesthesia,*** June **1-5/1979,** pp. **113-114.**

8 This is also seen in the medical literature. See for example, *Nan Jing* 7 (Paul Unschuld, *Medicine in China: Nan Ching, the Classic of Difficult Issues,* p. 122).

9 From Y. Manaka, *Ika no Tameno Shinjutsu Nyumon Kuoza* p. 135, Yokosuka: Ido no Nippon Sha 1958, 3rd edition. The books referenced come from the following approximate dates: *Su Wen,* 300 BC; *Nan Ling,* 100 BC - 100 AD; *Nan Jing Ben Yi,* 1361 AD; *Qian Jin Yao Fang,* 652 AD; *Mai Jing,* 300 AD; *Mai Jing Tu Shuo,* circa 290 AD; *Lei Jing,* 1624 AD; *Yi Zong Jin Jian,* 1742 AD. For a more complete discussion of the interpretation of the six pulse positions, see Birch, S., "An historical study of radial pulse six position diagnosis: Naming the unnameable," *Journal of the Acupuncture Society of New York* 1:324, 19-32, 1994.

10 As is evidenced in trigger points; see: Travel J. and S.H. Rinzler, "The myofascial genesis of pain," *Postgrad. Med.* 11 (1952), p. 425-434. See also, Melzack, R. *et al.,* "Trigger points and acupuncture points for pain; correlations and implications," *Pain* 3:3-23 (1977).

11 P. Nogier, *From Auriculotherapy to Auriculomedicine,* Saint-Ruffine: Maisonneuve, 1983.

12 Y. Manaka, quoting from the *Qian Jin Yao Fang* in "The treatment of several diseases of the neck, shoulders, and arms by acupuncture and moxibustion," *Modern Oriental Medicine* 3:4, 1982.

13 S.B.: There have been many publications on the problems of research methodologies in Western medicine, a number of which are referenced in the introduction.