Terminology Standardization in Chinese Medicine: The Perspective from UCLA Center for East-West Medicine

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INTRODUCTION
by Ka-kit Hui, M.D.[1]

Because we recognize the clinical, educational, and cultural importance of translation and terminology in Chinese medicine, we feel that it is imperative to understand the perspectives of all concerned parties. This article thus addresses the issue of terminology standardization in English language Chinese medical publications from the point of view of multiple stakeholders in this field at the UCLA Center for East-West Medicine. A great deal of discussion about the issue has arisen among faculty and staff at the Center, prompted especially by my invitation by the World Health Organization (W.H.O.) Western Pacific Region to review the draft document of English terminology standards in Chinese medicine. As the discussion within the Center reflects the wider debates within the field, we would like to address the topic by inviting seven Center staff and faculty, all of whom have been trained as clinicians and teachers rather than translators or linguistic scholars, to formally provide their insights into the matter. Sonya Pritzker, M.S., M.A., L.Ac.2 will first offer a brief background derived from her presentation at the original Grand Rounds at the Center upon which the current article is based. Staff and faculty from the Center then offer their contributions to the discussion, after which I discuss participants' views and conclude by suggesting that a biomedical interface system (Brand 2006) in combination with a system of open standards (Felt 2006) offers a possible solution to the several divergent views brought up by the terminology debates.

BACGROUND
by Sonya Pritzker, M.S., M.A., L.Ac.

In the field of Chinese medicine, the issue of term standardization for English language Chinese medical publications constitutes a matter of intense debate. With many prominent authors involved, including Nigel Wiseman, Bob Flaws, Marnae Ergil, Dan Bensky, and Xie Zhufan, among others, the terminology debates have also received attention from the China-based World Federation of Chinese Medical Societies (W.F.C.M.S.) and the Western Pacific Region of the World Health Organization (W.H.O.). Both organizations have hosted several international meetings in order to develop English language Chinese medical term standards. While the W.F.C.M.S. is interested in developing these standards in order to enhance communication across the wide variety of traditional, biomedical, and integrated professional organizations that it interacts with, the W.H.O is invested in the standard terms so that they may be included in a section on Chinese medicine in the traditional medical portion of the upcoming ICD-11. This project requires standardized terminology especially because the terms will be linked to computerized international health information systems (Kang 2006).

Attendees at the W.F.C.M.S. and W.H.O. meetings have included both Chinese and Western experts, and debates have consisted of discussions focusing on specific terms as well as general themes, especially the question of whether to use biomedical terminology or more traditional terminology to translate Chinese medical terms. This argument, made public most recently in a series of Chinese Journal of Integrated Medicine articles by Xie Zhufan and Nigel Wiseman (Xie and White 2005, 2006, Wiseman 2006), revolves around the issue of what type of language most accurately represents Chinese medicine. Xie and colleagues, for instance, argue that standard English terminology for the

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2 Sonya Pritzker, M.S. (Oriental Medicine), M.A. (Anthropology) is a practicing acupuncturist and practitioner of Chinese herbal medicine in Santa Monica, CA, and has been involved with the terminology debates for over five years. She is currently a part time staff research assistant at the center and is in her third year of graduate studies in medical and linguistic anthropology at UCLA, where she is researching the role of language in Chinese medical education for her doctoral dissertation.

translation of Chinese medical material should be based on modern biomedical/Western medical concepts so as to accurately represent Chinese medicine as a viable medical system appropriate for use in international contexts (Xie 2003, Xie and White 2005, 2006). Not only does the use of biomedical terms to represent Chinese medical concepts help in making Chinese medicine feel more familiar and accessible to Western audiences, facilitating a broader bridging of the gap between the two systems, Xie and colleagues argue that translating using biomedical terms also effectively brings Chinese medicine into the current age, saving it from being considered a cultural relic in the modern world (Xie 2003, Xie and White 2005, 2006). Wiseman and others who support a more traditional approach to translation, argue that the use of biomedical terms to translate Chinese medicine "destroys the integrity and independence of Chinese medical concepts" (Wiseman 2006: 225). They suggest, for example, that when the Chinese medical term *feng huo yan*, or 'wind-fire eye,' is translated as 'acute conjunctivitis,' the fact that 'wind-fire eye' is rooted in a Chinese medical conception of the body distinct from biomedicine is ignored. Instead, the biomedical understanding of the body implied by the term 'acute conjunctivitis' is linguistically mapped onto the traditional body of Chinese medicine, thereby negating it (Wiseman 2000: 29). Standard terms that preserve the original Chinese medical conceptualization of illness, these scholars argue, are needed to prevent such degradation.

Outside of the W.F.C.M.S. and W.H.O. meetings, other Chinese medical scholars suggest that any form of standardization betrays the multiple meanings inherent in most Chinese medical terms, a plurality that has developed over 2,000 years of use by different scholars in different contexts (Beinfield & Korngold 2001, Bensky et al. 2006, Fratkin 2006, Shima 2006). In addition to arguing that more than one English term for a single Chinese medical word "does not necessarily obscure its meaning," these scholars suggest that "the rigid application of the principle of one to one correspondence in translating Chinese terms into English easily oversimplifies Chinese medical ideas" (Bensky et al. 2006: 14). In American Chinese medicine in particular, these scholars have engaged in a heated debate with proponents of standardization, who counter that multiple and un-standardized English terminology leads to a loss of critical knowledge. Citing cases where multiple Chinese words for a type of symptom or illness pattern, such as pain or diarrhea, are translated into a single English term that doesn't differentiate between the multiple concepts originally represented in Chinese, supporters of standardization argue that lack of term standards leads to a decline in clinical efficacy (Ergil 2001, Ergil & Ergil 2006, Felt 2006, Wiseman 2000, 2002). They also point out that when different authors use different terms, cross-referencing books and relating them back to the original Chinese becomes impossible.

The American debates have continued for several years, carried out in journals, informal meetings, and internet discussion groups, and recently culminated in a day-long conference on nomenclature in Chinese medicine, hosted by the American Association of Oriental Medicine (A.A.O.M.). The discussion at the conference, as elsewhere, revolved around several main issues arising out of the principal debate about whether or not standards are necessary. Firstly, the discussion around the notion of *translatability* is especially animated. Many scholars thus feel that, as a result of the cultural and linguistic divide between China and the West, completely accurate translation is impossible (Beinfield & Korngold 2001, Bensky et al. 2006, Fratkin 2006, Shen 2006, Shima 2006). Alterations are thus bound to occur, and should in fact be welcomed as American authors adapt Chinese medicine to meet the needs of their English speaking audience. For those that support standardization, on the other hand, it is clear that when the original concept is altered via inaccurate or multiple translations, new ideas emerge and the fundamental concept changes. This translates into an essential adaptation of Chinese medicine that abandons the original, traditional knowledge that Americans are supposedly seeking to represent. For these scholars, the true meanings of original terms are translatable, i.e. they can be accurately represented in English, but only using a standardized, coherent set of translation strategies (Ergil 2001, Ergil and Ergil 2006, Wiseman 2000, 2002).

Secondly, the issue of whether or not Chinese medical language in English should be comprised of specialized and standardized technical terms has also been debated. Those seeking standardization feel that the translation of Chinese medical language is a technical language that "differs from other forms of translation chiefly in that technical writing is characterized by technical terms that must be given equivalents in the target language if the concepts they

represent are to be upheld in the transmission process" (Wiseman 2001: 11). This argument thus classifies Chinese medical language as a "Language for Special Purposes" (LSP) that qualifies for a formal, standardized terminology. The notion that Chinese medical language is an LSP, however, is contested. Because the words that are used to make up Chinese language Chinese medical terminology are often the same words used in common Chinese language, some argue, we do not need a highly specialized terminology in English (Beinfield & Korngold 2001).

Finally, the issue of deciding upon the best way to teach Chinese medicine to clinical students is a prominent theme of American debates. Some scholars thus suggest that a multiplicity of terms creates a "terminological chaos" that actually benefits students as they learn to negotiate the depths of Chinese medical concepts (Bensky et al. 2006). Others argue that terminological precision is necessary for instructing students who will eventually become experts in the field of Chinese medicine (Ergil and Ergil 2006).

The salient themes in both the international and American debates can thus be separated into two major themes:

1. Single standards versus plural terms

(involves issues of clinical accuracy, historical diversity, translatability, and technical language)

2. The basis for standards

(biomedical or traditional knowledge/terminology)

As this brief introduction alludes to, perspectives on all of the issues contained within these two categories are very different and often incompatible. Participants' viewpoints on standardization differ greatly in both degree and orientation, and reflect a widely variant set of priorities, goals, and philosophical biases.

The View from UCLA Center for East-West Medicine by Ka-kit Hui, M.D, and Sonya Pritzker, M.S., M.A., L.Ac.

Center staff and faculty below provide their commentary and perspective on the two major issues **(the basis for single standards versus plural terms and standards)** comprising the terminology standardization debate as outlined by Sonya Pritzker above. Where most or all members of the discussion agree, that perspective is summarized. Members with distinct or outstanding positions on an issue are offered the opportunity to describe their viewpoint in their own words.

1. Single standards versus plural terms

All but one of the members of the discussion agreed that some form of standardization should be developed in Chinese medicine. Reasons included increased ease of communication with other practitioners and providers and increased clarity in terms of conducting clinical trials and other medical research. Only one discussant, **Marc Brodsky, M.D.**[3], felt that any standardization of terminology in the field would be inherently limiting. He explained that the use of different terms by different authors facilitates the student's ability to use more than one resource to get the full meaning of the term. Multiplicity and plurality, he noted, help build conceptual clarity in the same sense as when a member of the public gathers an impression of the situation in the Middle East from various media sources. Rather than focusing on exact words, Marc argued, efforts should be directed towards helping English speakers grasp the essence of the concept, a feature that is often best expressed in multiple terms that reflect the change in meaning over its 2,000 years of use in China. Marc Brodsky also pointed out that one-to-one translation of Chinese medical terms is difficult to impossible because of the changes that the meanings of the Chinese words have undergone over the course of their 2,000 years of use in China.

Although they agreed on the need for standardized terminology, many discussants' feelings about the usefulness of standardization were tempered by various limitations they felt to arise from the nature of language.

3 Marc Brodsky is a board certified family practice physician who has been associated with the Center as a clinician for four and half years. His interest in Chinese medicine was sparked by experience as a family practice physician in the U.S. Navy, when he was exposed to many forms of Asian medicine in Japan and other Asian countries. In addition to several courses in acupuncture and Chinese medicine offered by faculty at the Center, he has completed the 300 hour course in medical acupuncture at UCLA Extension and finished a 2 year fellowship in Integrative East-West medicine at the Center. His formal title is Assistant Clinical Professor of Medicine at UCLA. He speaks no Chinese.

Lawrence Taw, M.D.[4] expressed the opinion that, while standardized language is useful and necessary in texts, it is not necessarily a requirement for accurate communication in a clinical context. "In dialoguing with people," he said, "you can still convey or communicate what you're trying to say." Dr. Taw emphasized that the importance of standard terms for teaching clinicians does not necessarily translate into the need to use standard terms when expressing the concept in order to help a patient. Because this is his overall goal, he maintained that the usefulness of standardization would be limited to an academic context only. Furthermore, he felt the standardization of specific words to be less important than the standardization of general concepts.

Lawrence Taw also expressed the opinion that standardized terminology should not be formulated using overly technical language. Instead, he argued, common language that common people can understand should be used to translate Chinese medicine and formulate standardized terms. This view stems from his goal of wanting to be able to more clearly communicate with patients. Because he believes that common terms are sufficient in this context, he argues that they are also sufficient for standardized Chinese medical terms.

Malcom Taw, M.D.[5] also pointed out the limitations of standardized language in terms of helping students and patients understand Chinese medical concepts. Stressing the importance of experience in learning the meaning of concepts like qi, he noted that many Chinese medical concepts require direct experience before one is able to fully appreciate their meaning, regardless of the word. He thus expressed the opinion that for many Chinese medical technical terms and/or concepts, one-to-one translations are often impossible. The meanings of such concepts, such as qi, cannot be captured in language alone. Instead, they require both experience and discussion within an educational context, especially because the concepts are so foreign to a Western audience.

In relation to the issue of whether or not Chinese medical terminology is a technical language, Malcolm Taw suggested that while common terms are often useful in a clinical context, more technical terms are appropriate in professional and educational contexts. This view led Malcolm to point out that part of the reason standardization is so difficult has to do with the different backgrounds of people consuming Chinese medical language. What a biomedical practitioner will understand is thus vastly different from what a student of Chinese medicine or patient will understand, a fact which makes any single standard difficult to decide upon, especially from the perspective of integrated East-West medicine.

2. The basis for standards

Two discussion participants, Marc Brodsky and **Xiuling Ma, O.M.D. (China), Ph.D.**[6], strongly expressed the belief that biomedical terminology can and should be used to explain and translate Chinese medical concepts other than those that are unique to Chinese medicine, such as qi, yin, or yang. In Marc's view, the knowledge that biomedicine has of the body, such as how the different systems are interrelated and how and why it breaks down, should be utilized in describing and translating Chinese medicine to a Western audience. For Dr. Ma, Chinese medical concepts and disease categories, such as stroke, are often no different than the corresponding biomedical concepts. The use of different terminology is therefore unnecessary. This ties into her view that a single, correct translation is possible for most Chinese medical technical terms.

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4 Lawrence Taw, M.D., is a board certified internist and Center clinician who is currently completing his final year of a Masters in Traditional Oriental Medicine at Emperor's College of Oriental Medicine. His original exposure to Chinese medicine was as a fourth year medical student at UCLA, when he attended the 2 week elective course in East-West medicine held at the Center. He has been associated with the Center on and off for four years, the last of which he has spent as a fellow in Integrative East-West medicine. He speaks minimal to no Chinese.

5 Malcolm Taw, M.D., is also a board certified internist and Center clinician who is currently completing his final year of a Masters in Traditional Oriental Medicine at Emperor's College of Oriental Medicine. His original exposure to Chinese medicine was as a fourth year medical student at UCLA, when he attended the 2 week elective course in East-West medicine held at the Center. Having just completed the 2 year integrated medicine fellowship at the Center, he has been associated with the Center for 6 years. He has studied Chinese for two years.

6 Xiuling Ma, O.M.D. (China), Ph.D. earned her doctorate in Chinese medicine and acupuncture over 12 years of formal study at Beijing University of Chinese Medicine in Beijing, China. She is currently the Director for Chinese Medical (TCM) Education at the Center, where she has worked for 4 years. Her duties at the Center include teaching the fellows, residents, and medical students, in addition to helping compile their curriculum. Dr. Ma is fluent in both Chinese and English.

Ryan Abbott, M.T.O.M., L.Ac.[7] and **Ed Hui, M.D.**[8] disagreed, arguing that translating Chinese medical concepts directly into biomedical terms comes at the expense of true integration. Emphasizing that Chinese medicine and biomedicine are distinct systems, Ryan Abbott explained that integrating terminology sends the incorrect message that they share a similar set of core beliefs. Because of the different way in which the two medical systems fundamentally approach health and disease, he stresses, the terminology is not equivalent.

CONCLUSION
by Ka-kit Hui, M.D.

From my perspective, it is crucial to consider all of the diverse opinions on terminology in Chinese medicine expressed by East-West Center discussants, as well as in the broader debates.

In considering opinions on the matter of whether or not to standardize terminology in Chinese medicine, for example, it is important to note that when we look closely at the details of their opinions on the issue of single standards versus plural terms, there is no clear black and white separation between those who support standardization and those who don't. Marc Brodsky's doubts about the translatability of Chinese medical terms are thus echoed in Malcom Taw's point that finding an exact term for many Chinese medical concepts is next to impossible. Even though Dr. Brodsky does not support standardization and Dr. Taw does, their points are actually quite similar and reflect the positions of those in the U.S. who argue for a plurality of terms (Beinfield & Korngold 2001, Bensky et al. 2006, Fratkin 2006, Shen 2006, Shima 2006). Like these scholars, both of these physicians also brought up the issue of how best to teach the complexity of Chinese medical concepts and the need for students to be introduced to multiple ways of thinking about terms. Finally, while they agreed that standards are necessary, both Lawrence and Malcolm Taw agreed that some variability in terminology is necessary depending on the audience being addressed (patients, biomedical students, Chinese medical professionals, insurance companies).

All of these points are critical to consider when approaching the terminology standardization issue. Given the developments at the W.F.C.M.S. in China and the W.H.O., however, it is clear that we no longer can debate about whether or not there should be standards. Standard terminology is an imminent occurrence at this point, and is going to need to be developed for its inclusion in the new ICD, as well as for communication across international organizations. Along with most of the discussants in the present conference, I agree that such standards are necessary for the smooth integration of Chinese medicine to mainstream medical culture through clinical trials and patient care. Similarly, as many supporters of standardization point out, standards ensure the preservation of critical clinical details as well as they allow a reader to cross-reference different authors terms (Ergil 2001, Ergil & Ergil 2006, Felt 2006, Wiseman 2000, 2002). Our contribution to the discussion at this point can therefore most appropriately consist of suggestions as to how these standards can be built to represent Chinese medicine in the best possible way, and to do so with the utmost respect, diplomacy, and understanding for the views of all concerned parties.

Despite the many divergent views raised by the issues, I believe that it is possible to arrive at an acceptable solution to many of the problems. Firstly, in terms of the peoples' reservations about the ultimate translatability of Chinese medical concepts into single English words, a system of **open standards** (Felt 2006) encourages plurality in teaching, speaking, and clinical use, at the same time allowing for different texts, ideas, and systems to be linked via a single standard. In this system, standard technical terms can continue to be discussed and debated at the same time they are acknowledged as standards. As Robert Felt explains, "A

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7 Ryan Abbott, M.T.O.M., L.Ac. is a licensed acupuncturist as well as a second year medical student at the University of California at San Diego. He first became involved with the Center 4 years ago, when as a UCLA undergraduate he embarked on a major in "Integrative Medical Theory". Concurrently carrying out his B.S. and Masters. in Traditional Oriental Medicine (M.T.O.M.) at Emperor's College of Oriental Medicine, Ryan also worked at the Center, where he served as principal investigator of a randomized controlled trial of Tai Chi for tension headaches. He has had 2 years of formal training in Chinese language.

8 Ed Hui, M.D. is a board certified internist and geriatrician currently on the faculty practicing general internal medicine at UCLA. He has been associated with the Center for 13 years since its inception and is currently seeing patients part time at the Center clinic and as a teacher. He has completed a limited fellowship in Integrative East-West medicine at the Center while completing his fellowship in Geriatrics at UCLA. He speaks some Chinese, but is not fluent in terms of medical language.

term standard is not a list of words you must use, but a method for linking your words to those of others" (2006: 18). It is therefore comparable to the ICD-9 or the DSM-IV, where standard definitions are constantly contested and revisions made to each new edition (Bowker & Star 2002). Furthermore, like these biomedical standards, open standards in Chinese medicine need not dictate the behavior or thinking of teachers, students, or clinicians, who can use common terms or other technical terms when talking to patients or teaching students. In fact, it is certainly true that Chinese medical terms often indicate multiple and variant realities. As long as they are linked to a single technical standard, I am thus in agreement with Marc Brodsky, Malcolm Taw, Lawrence Taw, as well as supporters of terminological plurality, that all of these must be discussed and taught via both text and experience in the context of Chinese medical education in order to convey the full depth of Chinese medicine to future practitioners. An open system of standards allows for this diversity in teaching at the same time as it makes communication across contexts possible.

Secondly, in terms of the disagreement around whether biomedical or traditional knowledge and terminology should be used to translate Chinese medicine, the possibility of a **biomedical interface system**, which has been suggested by several experts involved in the debates at the W.H.O. and the World Federation of Chinese Medical Societies in Beijing (Brand 2006), creates a flexibility wherein a standard traditional or literal translation is paired with a standard biomedical translation only when a precise equivalent exists. Both terms are acknowledged as official, and the translator or author can variably draw upon these terms depending on the audience that he or she is writing for. This solution fashions a bridge between the views of Xiuling Ma and Marc Brodsky (as well as Xie Zhufan and colleagues), who argue for the use of biomedical terminology in the translation of Chinese medical texts, and Ryan Abbott and Ed Hui (as well as Nigel Wiseman and colleagues), who support a more traditional approach. Chinese medical concepts are thus not forced into biomedical categories, but a conceptual and linguistic connection between the two medical systems is established. Furthermore, this system solves the problem of needing to use different terms for different audiences, brought up by Malcolm Taw in the present discussion.

By way of conclusion, I therefore suggest that a a system of open standards in combination with a biomedical interface system is an ideal solution to the terminology standardization problem. In addition to allowing for the continued debate about specific terms, it also makes clear communication between experts within the field and in the broader international medical context possible. In short, it generates a responsible flexibility that incorporates both theoretical and clinical concerns and ultimately helps facilitate the ethical treatment of patients and the accurate transmission of Chinese medicine to the contemporary Western world.

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