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Transmitting Chinese Medicine

Changing Perceptions of Body, Pathology, and Treatment in Late Imperial China

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Abstract

Historians of Chinese medicine acknowledge the plurality of Chinese medicine along both synchronic and diachronic dimensions. Yet, there remains a tendency to think of tradition as being defined by some unchanging features. The Chinese medical body is a case in point. This is assumed to have been formalised by the late Han dynasty around a system of internal organs, conduits, collaterals, and associated body structures. Although criticism was voiced from time to time, this body and the micro/macrocosmic cosmological resonances that underpin it are seen to persist until the present day. I challenge this view by attending to attempts by physicians in China and Japan in the period from the mid 16th to the late 18th century to reimagine this body. Working within the domain of cold damage therapeutics and combining philological scholarship, empirical observations, and new hermeneutic strategies these physicians worked their way towards a new territorial understanding of the body and of medicine as warfare that required an intimate familiarity with the body's topography. In late imperial China this new view of the body and medicine was gradually re-absorbed into the mainstream. In Japan, however, it led to a break with this orthodoxy that in the Republican era became influential in China once more. I argue that attending further to the innovations of this period—commonly portrayed as one of decline—from a transnational perspective may help to go beyond the modern insistence to frame East Asian medicines as traditional.

Keywords

tradition – modernity – body – Ming/Qing transition – medicine as warfare

Those who currently rule are . . . the heirs of all those who have ever been victorious. Empathy with the victors thus comes to benefit the current rulers every time. This says quite enough to the historical materialist. Whoever until this day emerges victorious, marches in the triumphal procession in which today's rulers tread over those who are sprawled underfoot. The spoils are, as was ever the case, carried along in the triumphal procession. They are known as the cultural heritage. In the historical materialist they have to reckon with a distanced observer. For what he surveys as the cultural heritage is part and parcel of a lineage which he cannot contemplate without horror. It owes its existence not only to the toil of the great geniuses, who created it, but also to the nameless drudgery of its contemporaries. There has never been a document of culture, which is not simultaneously one of barbarism. And just as it is itself not free from barbarism, neither is it free from the process of transmission, in which it falls from one set of hands into another. The historical materialist thus moves as far away from this as measurably possible. He regards it as his task to brush history against the grain. (Walter Benjamin)¹

As our knowledge of Chinese medical history increases, older ideas of an ancient medical system firmly rooted in the past have gradually given way to more realistic accounts of a living tradition. Composed of a multitude of currents of practice that emerge and disappear in and out of each other over the course of time, traditional medicine survives because it is able to adjust to constantly changing environments of practice.² And yet, beneath these ever present processes of change and transformation historians continue to perceive deeper layers of continuity that constitute the enduring bedrock of tradition. I shall give but two examples, one each from the Sinophone and Anglophone historiography of Chinese medicine, to underscore the pervasiveness of such perceptions even at the cutting edge of scholarship in the field.

The Taiwanese historian, Li Jianmin, begins his pathbreaking account of the emergence of what we today call Chinese medicine by contrasting the revolutionary dynamic in the centuries before the Qin unification with the persistence of essential sameness during most of the imperial era. Once the new medicine had been set up around innovative concepts such as the vessels

1 Benjamin 1974. English translation by *Dennis Redmond* 8 April 2001. Accessed on 21 October 2013 at <http://members.efn.org/~dredmond/ThesesonHistory.html>.

2 The notion of Asian medicines as adaptive systems was first suggested by Fred Dunn 1976, in the pathbreaking volume on traditional Asian medicines edited by Charles Leslie 1976. For a more recent account of Chinese medicine as a living tradition, see Scheid 2007b.

(*mai* 脈) and attached to new diagnostic and therapeutic technologies such as pulse taking and needling, only two notable breaks occurred in the subsequent two thousand years of its history. The first, dated to the historical rupture between the Han and the Sui, changed the institutional structure of this medicine from one based on direct transmission from master to disciple to a scholarly tradition grounded in canonical texts.³ The second, located in the Republican era and mirroring the break between imperial and modern China, is the still ongoing process of modernisation that seeks to establish a place for traditional medicine in contemporary health care. Given that the first two of these transformations ‘were located exceedingly close together’, Li notes that medicine throughout most of the imperial era followed along a single thread until more radical change was forced upon it by its encounter with the West.⁴

My second example is drawn from the work of Francesca Bray, one of the leading Anglophone historians of Chinese medicine and technology. Introducing Chinese physicians’ understanding of the body to an audience not necessarily familiar with Chinese medicine, Bray defines two thousand years of history as the rearranging of furniture in a building that never really changed itself:

All Chinese schools of medicine agreed on the fundamental constitution of the human body. Chinese medical theory was primarily interested in the process of interaction and transformation that nourished and maintained the healthy body and that also determined the transmission and evolution of disorders. . . . Medical schools might differ as to which organ system they saw as predominant. The Five Phase theory of systematic correspondence between organs was pushed to great lengths during

3 For an attempt at circumscribing scholarly medical traditions, see Bates 1995, pp. 1–22.

4 Li Jianmin 2000, pp. 46–9. Li’s account mirrors a long established indigenous historiographic tradition dating back at least to the Ming that imagined medical knowledge as “developing along a single thread like the main and descendant branches of an orthodox lineage.” Li traces this historiographic tradition from Xu Dachun’s 徐大春 *On the Origin and Development of Medicine* (*Yixue yuanliu lun* 醫學源流論) in the 18th century to Xie Guan’s 謝觀 *On the Origin and Development of Medicine in China* (*Zhongguo yixue yuanliu lun* 中國醫學源流論) in the Republican period and Fan Xingzhun’s 範行準 *Synopsis of Chinese Medical History* (*Zhongguo yixueshi lue* 中國醫學史略) in contemporary China. Although he appears to employ this view of Chinese medical history for largely rhetorical reasons in order to highlight the singular importance of the transformation he himself proposes to analyse, by denying fundamental change to that medicine for most of its life he also thereby reinforces established stereotypes that mark it as essentially different from western medical science with its history of progress and revolutionary change.

the Song and Yuan dynasties, and many later physicians objected that it was too theoretical, advocating a more empirical approach. But the cosmological models of how the physical and physiological world worked remained essentially unchanged, and so too did the fundamental rationality of learned medicine.⁵

Bray is, of course, familiar with Chinese medicine's historical diversity and its many different currents of practice. Yet, like the 'single thread' of transmission that defines late imperial Chinese medicine in the eyes of Li Jianmin and earlier Chinese historians, she finds in unchanging concepts about the workings of the human body the glue that holds the tradition together. Furthermore, the Chinese tradition's focus on 'the process of interaction and transformation' implies a categorical distinction with Western medicine's interest in bodily structure, an opposition evoked by many other leading historians. Sivin, for instance, distinguishes 'the predominantly functional discourse of classical medicine' in China from European medicine's concern with structure. This view is also found in by Kuriyama, who traces the roots of Western concerns for structure and Chinese concerns for function to different 'styles of being'.⁶

Unschuld, who has long been concerned with critiquing the notion that Chinese and Western medicine are categorically different, arrives at an opposition, instead, between Confucian concerns for balance and order and Daoist interests in the material aspects of matter. As Confucian values came to dominate elite medicine during its formative stage in the late Spring and Autumn period and the Han, it increasingly 'focused on the unimpeded flow of blood and *qi*' that had to be managed by the physician.⁷ Here his analysis converges with that of Li Jianmin, who singles out newly emergent practices centred on the vessels as the revolutionary break that constituted Chinese medicine as a distinctive tradition. Kuriyama, likewise, begins his exploration of Chinese medicine's 'style of being' with an exploration of these vessels. And there exists no clearer image for conveying Bray's cosmologically centred body than the maps and models of acupuncture meridians that function as one of the most important signifiers of Chinese medicine's uniqueness in the Western imagination.

In fact, the essential sameness of late imperial and modern images of the 'Chinese medical body' is a core strategy by means of which the continuity between the past and present that establishes the identity of Chinese medicine

5 Bray 2007, p. 303.

6 Sivin 1987, p. 15; Kuriyama 1999, p. 265.

7 Unschuld et al. 2011, p. 333.

as a 'tradition' is visibly affirmed to physicians, historians, and the public alike (See Figures 1–4). Not only the sameness of past and present but also the difference between China and the (modern) West to which this imaginary is attached. For unlike the anatomical body of biomedicine, which focuses on structures demarcated from each other by visible boundaries, the Chinese medical body throughout the imperial era is a body 'recast in terms of motion, as the site of the circulation of *qi* and blood, and the transformative mechanisms of Yin and Yang and the Five Agents'.⁸

This essay will challenge the assumptions that inform these accounts and, by implication, currently dominant frameworks for writing the history of Chinese medicine. To this end, I will examine a series of profound and far-reaching revisions of established medical doctrine and practice carried out by a group of influential physicians living in the wider Suzhou region between the late 16th and early 18th centuries. These critiques unsettled the hitherto dominant model of the body centred on the vessels, conduits, and associated organs and replaced it with a quite different territorial imagination that highlighted boundaries. In doing so these physicians revived, albeit in novel ways, an emphasis on eliminating pathological stuff from the body that had been pushed into the background by a new concern for systems and their regulation among the naturalist thinkers that had created vessel theory and acupuncture.⁹ These innovative ways of visualising *and* treating medical problems came to be shared by members of what historians and physicians today perceive to have been competing medical currents, attesting to a broad-based transformation of medicine among elite physicians first in China and then also in Japan.



FIGURE 1 *Diagram of the liver channel of foot jueyin, woodcut illustration from Xu Shi zhenjiu daquan (Mr Xu's Great Compendium of Acupuncture and Moxibustion), first published in 1439. Wellcome Library, London.*

8 Despeux 2005. For similar assertions of essential difference in the visual representation of the body, see Kuriyama 1999; Kuriyama 2001.

9 Unschuld refers to these two different perspectives as 'ontic' and 'systematic' in Unschuld 2003, pp. 329–31.

THE LIVER CHANNEL OF FOOT JUEYIN

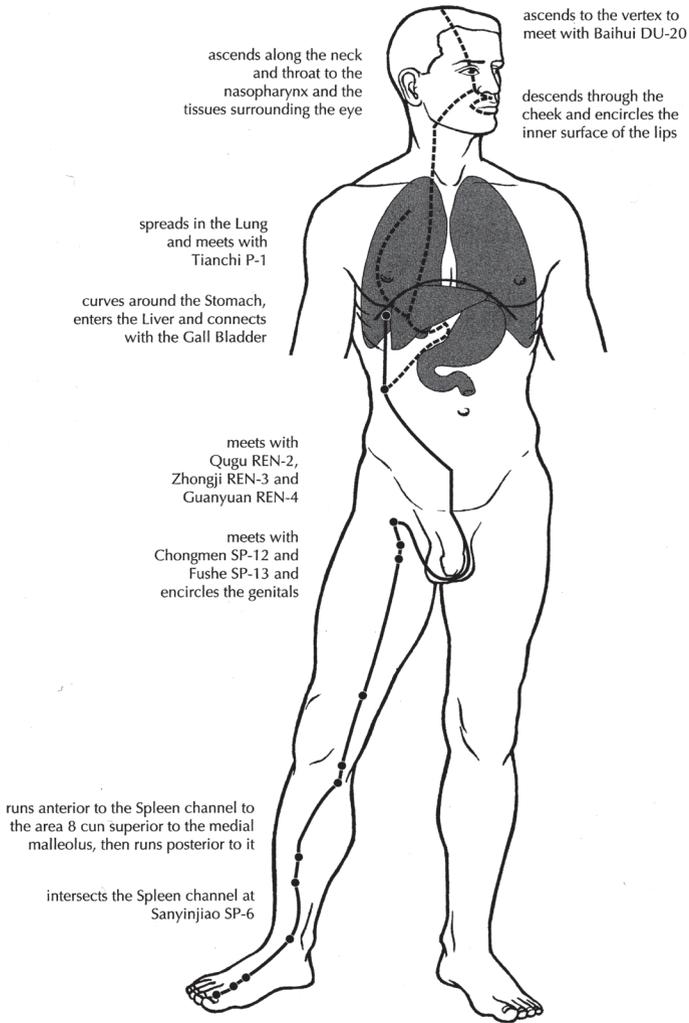
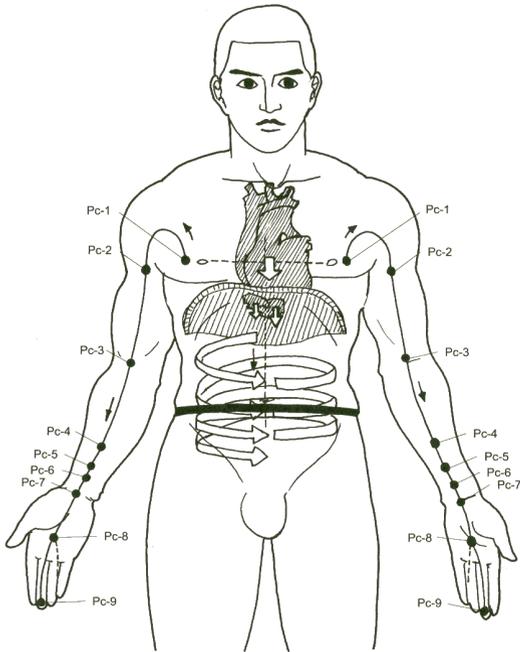
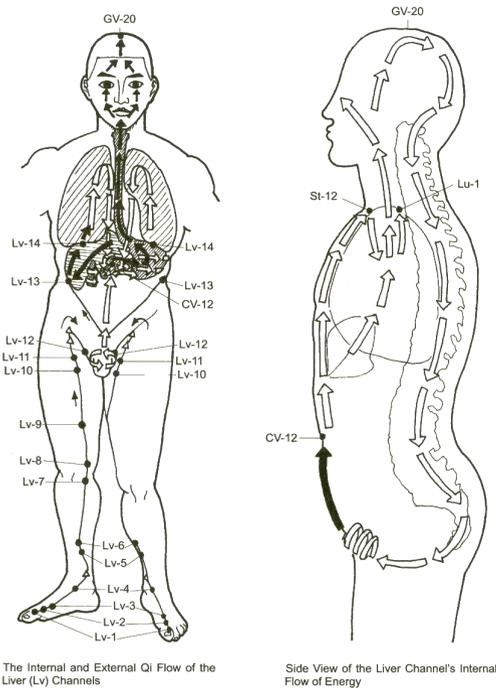


FIGURE 2 *Modern image of Liver channel from from Deadman, Peter and Mazin Al-Khafaji, A Manual of Acupuncture (Hove: Journal of Chinese Medicine Publications, 1998), p. 409.*



The Internal and External Qi Flow of the Pericardium (Pc) Channels

FIGURE 3 Modern image of the Pericardium channel. Downloaded from <http://www.evolutionofconsciousness.info/#!meridians/c248f> on 6 June 2015.



The Internal and External Qi Flow of the Liver (Lv) Channels

Side View of the Liver Channel's Internal Flow of Energy

FIGURE 4 Modern image of the external and internal flow of qi in the Liver channel. Downloaded from <http://www.evolutionofconsciousness.info/#!meridians/c248f> on 6 June 2015.

Furthermore, I am arguing that a major shift in how physicians came to perceive the body and react to its ills emerged at an historical moment that is conventionally perceived to have been a time of decline, when physicians were lost in 'a complex labyrinth, in which those thinkers seeking solution to medical questions wandered aimlessly in all directions, lacking any orientation, and unable to find a feasible way out... [until] the collapse of the Confucian social order and the subsequent weakening of the world view that had prevailed for centuries.'¹⁰ Taking note of this shift underscores the importance of conceiving of Chinese medicine as a living tradition that I developed in my earlier examination of medical currents.¹¹ As I argue in the conclusion to this paper, it adds an awareness of epistemic ruptures and breaks to the dominant image of connected difference along what is perceived to be a single thread. It is only by following both vectors without privileging one over the other that we may begin to build up a realistic picture of how living traditions develop and change without the need to fall back on outdated oppositions and stereotypes.

To this end I will first show how individual scholar physicians from the late 16th century onward began to question core analytical concepts that had hitherto tied together perceptions of the human body and pharmacotherapy. As a result, they arrived at a distinctly different way of depicting the human body and of imagining medical practice. For a number of different reasons, which I will explain in due course, most of these physicians worked in the domain of 'cold damage' (*shanghan* 傷寒) therapeutics, which at that time concerned itself with fevers and epidemic disorders.

In the early 18th century, these ideas were taken up by physicians who used them to create a new way of conceiving and treating feverish disorders. For largely political reasons, this style of practice—known today as 'warm disorder' (*wenbing* 溫病) therapeutics—later came to be seen as opposed in principle to the cold damage style.¹² I will show that such accounts involve a serious misreading (wilfully or not) of the sources of warm disorder therapeutics. It is via such misinterpretations that the synchronic networks among Suzhou physicians I reconstruct in the present paper were largely erased from Chinese medicine's collective memory. In the concluding section I therefore argue that we need to pay increased attention to the memory practices embedded in the ongoing construction of any living tradition. Failure to do so will cause the historiography of Chinese medicine to be distorted by a double refraction:

10 Unschuld 1985, p. 197.

11 Scheid 2007a.

12 Hanson 2011, pp. 126–50.

an orientalist othering of tradition maintained to effect difference vis-à-vis modernity, science, and the West; and an emic or nationalist desiring of continuity informed by enduring lineage ideologies.

Setting the Stage: Vessels, Conduits, and Feverish Disorders in the Inner Canon

As Li Jianmin demonstrates, the imagination of the body that Bray and others define as underpinning all of Chinese medicine gradually emerged in the Warring States period out of the synthesis of numerology, astronomy, natural philosophy, and the technologies of touch, macrobiotic gymnastics, sexual practices, and the puncturing of abscesses.¹³ The mature elaboration of this synthesis is found in a series of texts compiled in the first or second century CE from texts dating to the first, second, and third centuries BCE, which have been viewed ever since as the canonical foundations of Chinese medicine. The best-known and most influential of these compilations was the *Inner Canon of Huangdi* (*Huangdi neijing* 黃帝內經, c. 1st BCE) conventionally divided into two separate books, the *Basic Questions* (*Suwen* 素問) and the *Spiritual Pivot* (*Lingshu* 靈樞).¹⁴

At the heart of this medicine, in terms both of its genesis and its actual practice, stood the vessels (*mai* 脈). By the third century BCE, ideas of vessels filled with blood and *qi* had come to dominate speculation about physiology, gradually establishing a systematic conceptual framework regarding illness, its causes, and treatment. Unschuld locates the origins of these ideas in an agricultural society cognisant of the importance of waterways and with a new experience of and desire for order in society.¹⁵ Li Jianmin emphasises vessels as carriers of a cosmic circulation ‘exactly analogous to the paths of rivers, say, or of the stars.’¹⁶ Lo highlights the subjective experiences of practitioners of various arts in manipulating the flow of *qi* around their bodies.¹⁷ As a consequence of all these influences, the flow of *qi*, blood, and body fluids throughout the

13 Li Jianmin 2000. See also Harper 1998; Lo 2001; Unschuld 2003.

14 Apart from the *Basic Questions* and *Spiritual Pivot*, the two components of the *Inner Canon*, these texts include the *Classic of Difficulties* (*Nanjing* 難經) and the *Inner Canon of Huangdi: Great Basis* (*Huangdi neijing taisu* 黃帝內經太素). See Unschuld 2003, p. ix; Keegan 1988, pp. 67–110.

15 Unschuld 2003, pp. 167–80.

16 Li Jianmin 2000, p. 373.

17 Lo 2001.

body by way of the vessels, which connected the organs in the body's interior with the various structures in its exterior as well as with the cosmos at large, became the focus of diagnosis and therapy, mainly by way of acupuncture and moxibustion.

If the origin of the term 'vessels' (*mai* 脈) is directly related to the blood vessels, for reasons that are as yet poorly understood, a second term *jing* 經, denoting a 'natural tube through which fluid is conveyed' and therefore translated by Unschuld as 'conduit', came to be associated with it.¹⁸ Absent in the Mawangdui manuscripts, it is more or less interchangeable with the term vessels in the *Inner Canon*. In acupuncture and moxibustion practice the 'conduits and networks' (*jingluo* 經絡), referring to the larger and smaller conduits that run throughout the body at various levels of depth, became the central focus of therapy. Reflecting the numerological influences that helped to shape the entire system, the totality of these conduits were eventually grouped into a system consisting of twelve major conduits, each associated with one of the major organ systems of the body. Different numerological systems related these conduit systems to each other and to the 'yin/yang' 陰陽 and 'five phases' (*wuxing* 五行) doctrines that underpinned the cosmological thinking of these texts. One of these was the system of the three yin and three yang conduits as outlined in *Basic Questions*, chapter six and summarised in Table 1.¹⁹

TABLE 1 *The three yin and yang conduit systems according to Basic Questions*

	Yang conduits			Yin conduits		
	Greater	Yang	Lesser	Greater	Lesser	Terminal
	Yang	Brightness	Yang	Yin	Yin	Yin
	太陽	陽明	少陽	太陰	少陰	厥陰
Conventional	Bladder	Stomach	Gallbladder	Spleen	Heart	Pericardium
associations	膀胱	胃	膽	脾	心	心包
with organ	Small	Large	Triple	Lungs	Kidneys	Liver
systems	Intestine	Intestine	Burner	肺	腎	肝
	小腸	大腸	三焦			

18 Unschuld 2003, p. 170.

19 Guo Aichun 1989a, pp. 106–13.

Unschuld argues that the then new philosophies of systematic correspondence were successful not only because they resonated with the life worlds of the elite in pre-Han and Han China but also because they were able to assimilate and, at least partially, integrate into their systematic naturalism earlier models of disease. For instance, the new notion of 'evil' (*xie* 邪) substituted climatic and other *qi* for earlier notions of ghosts and malevolent spirits as causes of disease even as it retained the idea that many diseases had specific malevolent causes that could be removed from the body by force or persuasion.²⁰

The assimilation of this earlier 'ontic' medicine with its emphasis on attack and defence into the newer 'medicine of systematic correspondence' centred on vessels, conduits, and organ systems, explains the importance of the military metaphor in Chinese medical thought and practice that endures to this day. It is apparent also in how the authors of the *Inner Canon* imagined the development of fevers. *Basic Questions* chapter 31, entitled 'Treatise On Fevers' (*re lun* 熱論), which outlines the progression of fevers through six distinct stages, is a key example.²¹ Each of these stages, beginning with the 'greater yang' (*taiyang* 太陽) and ending with the 'terminal yin' (*jueyin* 厥陰), is said to correspond to the 'contraction' (*shou* 受) of a cold evil and its transmission along the major conduit systems of the human body. It is the relation of these conduit systems to distinctive body regions and internal organs that explains the symptomatology characteristic of each disease stage as summarised in Table 2.

Several other chapters of *Basic Questions* outline the progression of pathogens entering the body from the outside by way of vessel pathology. These include chapters 27, 62, and 63, which define the progressive intrusion as a sequence of penetration that begins with the body hair, then moves into the 'tertiary vessels' (*sunmai* 孫脈), the 'network vessels' (*luomai* 絡脈), the 'conduit vessels' (*jingmai* 經脈), and finally the five yin organs and then the intestines and stomach.²² Chapter 19, on the other hand, outlines a transmission that does not rely on the vessels but rather emphasises five phases theory in terms of a transmission from the lung (metal) to the liver (wood) to the spleen (earth) to the kidneys (water) and then to the heart (fire).²³

20 Unschuld 2003, p. 331.

21 Guo Aichun 1989a, pp. 415–24; Unschuld et al. 2011, pp. 491–8.

22 Guo Aichun 1989a, pp. 216–41; Guo Aichun 1989b, pp. 745–85.

23 Guo Aichun 1989a, pp. 262–5.

TABLE 2 *Synopsis of heat disorders due to contraction of cold as outlined in Basic Questions, 37*

	Yang vessels			Yin vessels		
Conduit that receives cold	Greater Yang 太陽	Yang Brightness 陽明	Lesser Yang 少陽	Greater Yin 太陰	Lesser Yin 少陰	Terminal Yin 厥陰
Received on	1st day	2nd day	3rd day	4th day	5th day	6th day
Disease weakens in conduit on	7th day	8th day	9th day	10th day	11th day	12th day
Conduit	rules <i>qi</i> of all the yang conduits	rules flesh	rules gall-bladder	connects to stomach and throat	connects to lungs, kidneys, and root of tongue	connects to genitals and liver
Symptoms & signs	pain in head and nape of neck; stiffness of lower back and spine	hot body, eye pain, dry nose, inability to lie down	pain in flanks and chest, deafness	abdominal fullness, dry throat	dry mouth, dry tongue, thirst	vexation, fullness, shrunken scrotum

Treating Fevers with Pharmaceuticals: The Treatise on Cold Damage

If knowledge about the vessels stood at the centre of the new medicine that emerged in pre-Han and Han China, acupuncture and moxibustion most visibly embodied the application of these notions to clinical practice. The use of pharmaceuticals, on the other hand, was only gradually assimilated to its

conceptual framework and it was not before the 12th and 13th centuries that this process was completed.²⁴ Furthermore, the readily apparent effects of different drugs in eliminating physical stuff from the body, as well as their sometimes toxic nature or even deliberate use as poisons, meant that the mixing up of the ontic and systematic approaches to medicine proceeded along different trajectories. This is nowhere more apparent than in the domain of ‘externally contracted disorders’ (*waigan bing* 外感病). For long periods of time in the history of Chinese medicine, cold was assumed to be the most dangerous of all externally contracted evils. Hence, the term ‘cold damage’ came to signify ‘feverish and epidemic disorders’ (*rebing* 熱病) in a general sense as well as the more specific case of fevers due to cold. Accounts of cold damage and its treatment are found in the *Inner Canon* and the *Classic of Difficulties* but the most influential text in the field is the *Treatise on Cold Damage* (*Shanghan lun* 傷寒論) written by Zhang Zhongjing 張仲景 (ca. 150–219 CE) towards the end of the Eastern Han dynasty. To complicate things, while many commentators believe that the *Treatise* does focus on fevers and externally contracted disorders, others take a much wider view of its therapeutic objectives, a view that emerges directly from the transformations discussed in this essay. Hence, I will employ the term ‘cold damage therapeutics’ for any treatment regime that explicitly refers itself to the *Treatise* whether or not it focuses on fevers, externally contracted pathogens, or cold.

Unlike the established canons of the Chinese medical tradition, the *Treatise* does not discourse much on theoretical issues. It is a clinical manual that outlines how the various manifestations of cold damage disorders can be successfully treated. To this end, it grouped the various manifestations of cold damage into six major types of ‘disorder’ (*bing* 病) whose names match the stages of heat disorders described in *Basic Questions*, 31 (See Table 3).

This has led a majority of readers of the *Treatise* to take its six types of disease as self-evidently referring to the conduits and networks. In fact, the *Treatise* does on several occasions employ the term *jing* 經 when defining the location of a disorder in the body. It states, for instance, that a cold damage disorder may pass from one location to another,²⁵ or that it may skip a location

24 Unschuld 1986, pp. 85–122. Recent work on texts from Dunhuang indicates that integration of pharmacotherapy and five phases thinking and thus what Unschuld refers to as the “medicine of systematic correspondence” was well underway by the Sui and Tang dynasties already, albeit in a different manner than that carried out in the Song. Li Shumin 2005.

25 *Treatise on Cold Damage*, line 8 in the Song version, Mitchell et al. 1999, p. 608.

TABLE 3 *Key symptoms and signs of feverish disorders as discussed in Basic Questions, chapter 31 and the Treatise on Cold Damage*

	Yang vessels/disorders			Yin vessels/disorders		
	Greater Yang 太陽	Yang Brightness 陽明	Lesser Yang 少陽	Greater Yin 太陰	Lesser Yin 少陰	Terminal Yin 厥陰
<i>Basic Questions</i> Chapter 31	pain in head and nape of neck; stiffness of lower back and spine	hot body, eye pain, dry nose, inability to lie down	pain in flanks and chest, deafness	abdominal fullness, dry throat	dry mouth, dry tongue, thirst	vexation, fullness, shrunken scrotum
<i>Treatise on Cold Damage</i>	floating pulse, a stiff and painful head and nape, and aversion to cold	digestive excess (<i>wei jia shi</i> 胃家實 literally 'stomach family excess')	bitter taste in mouth, dry throat, and dizziness	fullness of the abdomen with vomiting, unable to keep one's food down, and diarrhoea with occasional abdominal pain	minute, thin pulse with a desire to sleep	wasting and thirsting with <i>qi</i> raising to the heart, heat and pain in the heart; no desire to eat. After one eats, round-worms are vomited; if purged, unrelenting diarrhoea results

along an ideal typical process of development.²⁶ However, it does not explicitly link the notion of *jing* in these contexts to the organ systems and it is therefore equally possible, as some commentators have done, to interpret the term in ways that detach it from the notion of acupuncture conduits. Moreover, the

26 Ibid., lines 103, 105, 123, 217, 384. The Song version employs the term *guo jing* 過經 for this purpose. See Mitchell et al., 1999, pp. 614–5, 621, 630.

Treatise does not explicitly link the understanding or treatment of cold damage disorders to any of the major theoretical concepts that define the medicine of the *Inner Canon*, specifically ‘visceral manifestation’ (*zang xiang* 藏象) and five phases doctrines.²⁷

Such conceptual ambiguities are exacerbated by the *Treatise*’s textual history. Shortly after its publication, the original version was lost in the upheavals of the Three Kingdoms Period (220–265). It was revised and re-edited from fragments of the original by Wang Shuhe 王叔和 (201–280) in the Western Jin (265–316), who divided Zhang Zhongjing’s original work, whose full name was *Treatise on Cold Damage and Miscellaneous Disorders* (*Shanghan zabing lun* 傷寒雜病論) into two separate books. He collated those passages that referred to the treatment of externally contracted disorders into the *Treatise on Cold Damage*. He also organised its text passages to follow the sequence of illness transmission through the channels that was outlined in *Basic Questions*, chapter 31, thereby establishing an authoritative link between these texts. The remaining text became the *Essentials of the Golden Cabinet* (*Jingui yaolüe* 金匱要略), which Wang assumed dealt with internally caused disorders.²⁸

Although versions of the *Treatise* circulated within medical networks during the Sui and Tang dynasties, it was by no means a dominant medical resource. It competed with other texts outlining different models for treating externally contracted disorders such as those attributed to the physician Hua Tuo 華佗 (c. 140–208).²⁹ These models, in turn, can be seen as attaching themselves to ideas about the development of feverish disorders discussed in other chapters of *Basic Questions*. It was only during the Song, specifically after 1065 when the Imperial Bureau for Revising Medical Texts (*Jiaozheng yishuju* 校正醫書局) under the supervision of Lin Yi 林億 published and distributed an official edition that the *Treatise* came to dominate the discourse on fevers more widely. No copy of this first printing survives. The first currently extant copy of the *Treatise* is a Ming dynasty reprint by Zhao Kaimei 趙開美 that, nevertheless, is referred to today as the ‘Song version’ (*Song ben* 宋本).³⁰

27 With the exception on the chapters on the pulse and the foreword, commonly perceived to be later additions, the names for liver, lungs and kidneys for instance appear only in relation to acupuncture names or treatment. The term heart is mainly used as an anatomical location, such as in ‘below the heart’ (*xin xia* 心下), or to denote certain symptoms such as ‘heart irritability’ (*xin fan* 心煩). When the *Treatise* uses the term *mai* 脈, this invariably refers to the pulse only.

28 Goldschmidt 2009, pp. 95–9.

29 Cao Dongyi 2002.

30 Goldschmidt 2009, pp. 100–1. On the content and history of the Song edition, see Guan Qingzeng and Lu Yunping 1994, pp. 21–3 and Qian Shaochen 2003. Today, three editions of

The widening use of block printing greatly facilitated dissemination of the *Treatise*, while imperial endorsement provided it with an authority it had previously lacked. Scholars searching for solutions to the epidemics sweeping through China at the time as well as practicing physicians focused their collective energies on integrating the *Treatise* into mainstream medical practice dominated by the more established Han canons. The terse nature of the *Treatise*, which reached its audience as 'literature' rather than as a tool embedded in clinical teaching and practice, and its apparent disinterest in many of the central concepts of classical medical doctrine, made this a far more difficult undertaking than we might nowadays imagine. Yet, within the relative short space of a mere century scholar physicians succeeded in accomplishing their goal.³¹ The crowning achievement of these synthesising efforts was Cheng Wuji's 成無己 (1066–1156) *Annotation and Explanation of the Treatise on Cold Damage* (*Zhujie shanghan lun* 注解傷寒論, 1144, published 1172), which up to the present day constitutes a key resource in the understanding and teaching of cold damage therapeutics.³² According to the medical historian Asaf Goldschmidt:

Cheng's goal was to use the classical doctrines of the viscera and conduits to explain the course of cold damage disorders and consequently to apply these to therapy. . . . By doing so, Cheng provided Song dynasty medicine, for the first time, a unified nomenclature that enabled physicians to comprehensively understand medical doctrines originating from different medical approaches. . . . [It] marks a milestone in the development of Chinese medicine. It embodied a new form of comprehensive medicine, which at the theoretical level integrated cold damage and classical doctrines and at the clinical level applied both doctrines to diagnosis and treatment.³³

It is this synthesis, which in the intervening years had itself become orthodox, that physicians in the Jiangzi delta region of China, an area generally known as Jiangnan 江南, began to break apart once again from the late 16th century onward. The person who initiated this transformation was Fang Youzhi

the text that may predate the Song edition have been uncovered. See Guan Qingzeng and Lu Yunping 1994, pp. 30–6.

31 Goldschmidt 2009, pp. 141–72.

32 Cheng Wuji 1172. To give just two examples of its influence, both Li Peisheng 1987 and Mitchell et al., 1999 read the text in a way that largely accords with that of Cheng Wuji.

33 Goldschmidt 2009, pp. 169–71.

方有执 (1522–99), a scholar physician from the Xin'an 新安 region of southern Anhui province.

Fang Youzhi: Re-imagining the Body

In 1593, towards the end of his life and following over two decades of intensive research Fang Youzhi published *A Critical Essay on the Clauses of the Treatise on Cold Damage* (*Shanghan lun tiaobian* 傷寒論條辨).³⁴ The title suggests affinity with an emergent intellectual movement that under the name of 'evidential scholarship' (*kaozheng* 考證) would become the focus of a major cultural re-orientation in seventeenth-century China. As Benjamin Elman has shown, the avant-garde of this movement was composed of Jiangnan scholars who during the last century of the Ming engaged in a 'private, sometimes heroic, endeavour' to return Confucian thinking to its roots in more ancient orthodoxies after five centuries of domination by Neo-Confucianism.³⁵ Such intellectual efforts reflected a more widespread interest in antiquities among the wealthy Jiangnan elite who prized ancient works of art, early manuscripts, rare editions, and magnificent ceramics. Fakes and forgeries were commonplace necessitating the development of new kinds of expertise that involved skepticism, a critical eye, and attention to detail. Private scholars turned such critical attention onto the interpretation of classical texts hoping to extract from them a more accurate understanding of the wisdom of antiquity than that embodied by Song Neoconfucianism.³⁶ Xin'an was a notable centre of such scholarship and Fang Youzhi an active member of its community of scholars.³⁷ He focused his energies on excavating the true meaning of the *Treatise on Cold Damage* employing textual criticism as a tool to improve its utility in clinical practice, following the death of several family members from cold damage fevers.

Fang argued that the editing of the *Treatise* undertaken by Wang Shuhe and the commentaries by Cheng Wuji and other post-Song writers had significantly distorted the original arrangement, meaning, and utility of the text and thereby contributed to a decline of standards in medical practice. He hoped to undo these mistakes by a process of 'revision and editing based on critical examination' (*chongkao xiuji* 重考修輯)³⁸ to produce a text he believed

34 Fang Youzhi 1593.

35 Elman 2001, p. 43.

36 Ibid., p. 44.

37 Wang Xinzhi 2008; Zhang Xinping and Xiao Ying 2005.

38 Fang Youzhi 1593, p. 230.

more accurately reflected the author's original intentions and clinical acumen. He therefore cut out an entire section from the received Song edition of the *Treatise* that he believed to be a later interpellation,³⁹ revised the sequence of individual paragraphs, and combined chapters in a different way to the Song edition. He assumed all of the remaining clauses to be attributable to Zhang Zhongjing rather than to Wang Shuhe and claimed their novel organisation reflected his ability of having grasped the authentic meaning of the text.⁴⁰

As Benjamin Elman has shown, evidential scholarship denotes a shift not only in the goals and methods of scholarship but also in styles of writing.⁴¹ Most Neoconfucian writings constitute records of spiritual quests in the form of dialogues, aphorism, reflections, anecdotes, and poetry, putting together bits of text that reflected the author's own unique synthesis and approach to problems at hand.⁴² The influence of this mode of scholarship survive not merely in Fang's belief that he could gain direct access to Zhang Zhongjing's intentions, but also, for instance, in the dialogic nature of *Questions on a Critical Essay on the Clauses of the Treatise on Cold Damage* (*Shanghan lun tiaobian huowen 傷寒論條辨或問*) appended to the main text.⁴³ Yet, in contradistinction to the syncretic nature of post-Song medical writings, Fang's thorough examination of a single topic is more closely modelled on new genres of knowledge production pioneered by late Ming scholars. Even more significantly, Fang begins his critique not with words but with two diagrams of the body. These depict yang- and yin-type disorders located in the exterior and interior of the body respectively. These diagrams signalled in the clearest possible manner Fang's rejection of post-Song interpretations of the *Treatise* and the imaginations of the body that informed them.

To understand the radical nature of this critique we must momentarily turn back to the Song synthesis of acupuncture and cold damage therapeutics. Figures 5 and 6 are taken from Zhu Gong's 朱肱 (1050–1125) *Book to Safeguard Life Arranged According to Patterns* (*Leizheng huoren shu 類証活人書*) of 1108. An important precursor to Cheng Wuji's later classic, Zhu's text was the first explicit attempt to integrate classical medical doctrines with cold damage therapeutics. Its opening sentences emphasise that establishing systematic

39 Specifically, he removed chapter 3 of the Song edition, entitled *Shanghan lie 傷寒列* (*Cold Damage Rules*).

40 Yang Yungao 1987; Chen Xuegong 2009, pp. 56–8.

41 Elman 2001, pp. 174–6.

42 For an examination of the influence of this syncretic style of composition on Ming dynasty medicine, see Simonis 2010, pp. 137–42.

43 Fang Youzhi 1593, pp. 252–74.

connections between the acupuncture conduits, the internal organs, and the six main types of cold damage disorder was central to this endeavour: 'To treat cold damage one must first know the conduits and networks. If one does not know the conduits and networks, one roams around in muddled confusion without knowing the location of the pathogenic *qi*.'⁴⁴

This programmatic statement is followed by diagrams depicting the six major conduits arising from or ending at the feet,⁴⁵ anatomical descriptions of their associated organs, an overview of the course of each conduit, and a synopsis of the key symptoms of the cold damage disorder bearing the conduits name. For example, the section on the greater yang channel begins by stating the weight, size, and capacity of the Bladder, describes the course of the associated foot greater yang conduit, lists the symptoms and signs of a greater yang disorder as outlined in the *Treatise*, and concludes that these indicate that the Bladder and its associated conduit have contracted a cold pathogen. With the exception of the new association with cold damage disorders, the diagrams and associated text stand in a direct line of transmission that can be traced back at least to Wang Weiyi's 王維一 *Acupuncture and Moxibustion Canon of the Bronze Man* (*Tongren zhenjiu jing* 銅人針灸經) of 1026, and in some editions even contain images of the internal organs as well as the channels to which they connect.⁴⁶

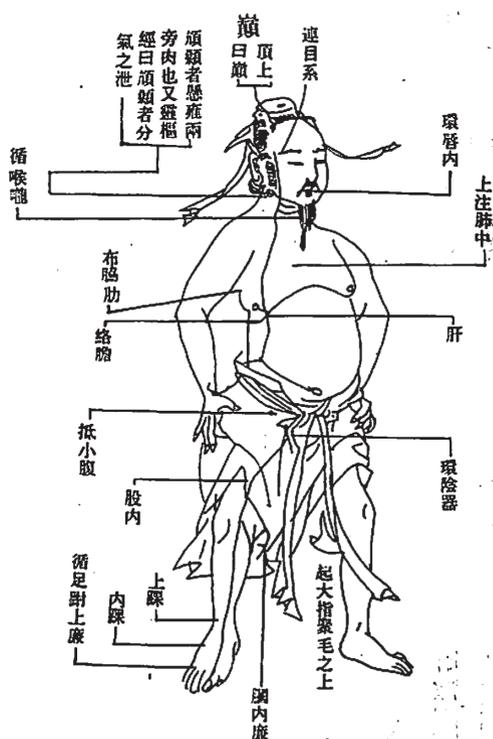
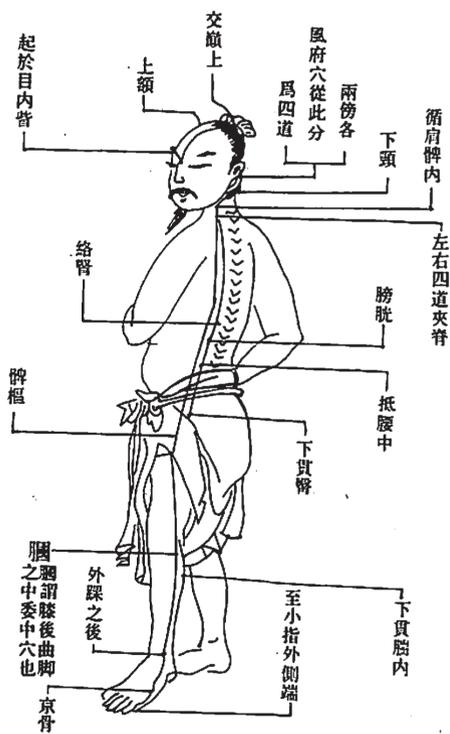
The two diagrams that open Fang's *Critical Essay* (Figures 7 and 8) are inspired by a new and different understanding of cold damage disorders as well as the bodies in which these disorders manifest. They visibly eschew microcosmic/macrocosmic resonances as both mediated by the five phases and embodied in visceral systems theory in favour of a territorial rendition of bodily space as the material grounding of disease process.

Fang does not yet dare to cut himself lose entirely from five phases cosmology as other writers would begin to do shortly afterwards. It is Fang, however, who lays the foundation of a more radical critique by limiting the relevance of five phases thinking to those disorders that arise internally within the five visceral systems. Cold damage disorders, instead, require physicians to understand how external pathogens physically penetrate into the organism and

44 Zhu Gong 1108, p. 1.

45 Leaving out the six conduits beginning or ending at the fingers resolved, for the time being at least, the discrepancy between the existence of twelve conduit and network systems that had to be matched to only six types of cold damage disorder.

46 For a detailed analysis of this genealogy, see Huang Longxiang 2001, pp. 326–63. Huang shows that Zhu Gong's book itself has a very complex history of transmission that proceeds through a number of different lines (24–25).



FIGURES 5 AND 6 The greater yang 太陽 and terminal yin 厥陰 conduits as depicted in Zhu Gong's Book to Safeguard Life, no.8.

thence spread internally through a series of clearly demarcated stages. Because all conduits equally link internal organs to the exterior, locating pathogenic *qi* in conduits and organs cannot properly explain to Fang how such contraction occurs, why interiorisation should follow a process that moves from yang bowel to yin viscera disorders, or how one organ/conduit system passes pathogenic *qi* to another. To resolve these problems—problems, by the way, that are not merely epistemological in nature but of immediate relevance to clinical practice—Fang suggests to physicians that they focus much more directly on the actual organisation of bodily space. As he notes in justifying his empirical turn, 'Later people were no longer willing to scrutinise the body (*yi shenti cha* 以身體察) but only bothered about the stubborn [views that had been] put down on paper. This is as if one was to grope for the moon at the bottom of the water because one does not know [the difference] between form and shadow'.⁴⁷

47 Fang Youzhi 1593, p. 221.

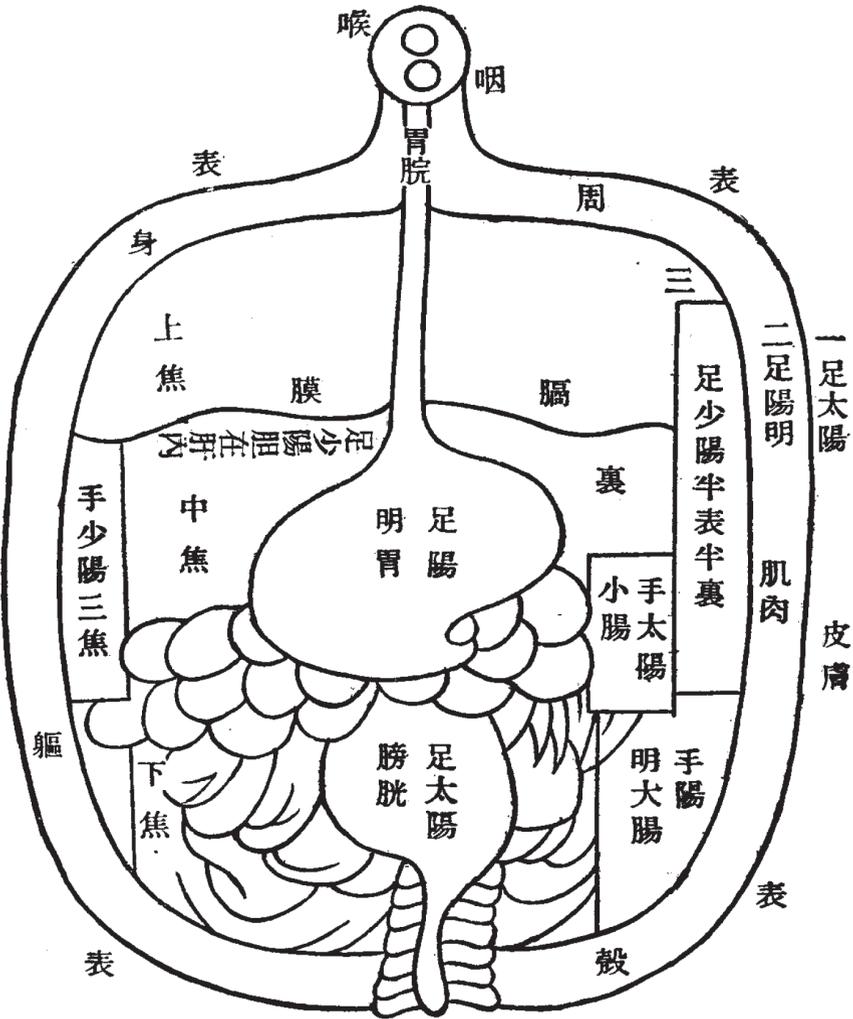


FIGURE 7 'Yang disorders located in the exterior' (Yangbing zai biao 陽病在表) as depicted in Fang Youzhi's Critical Essay.

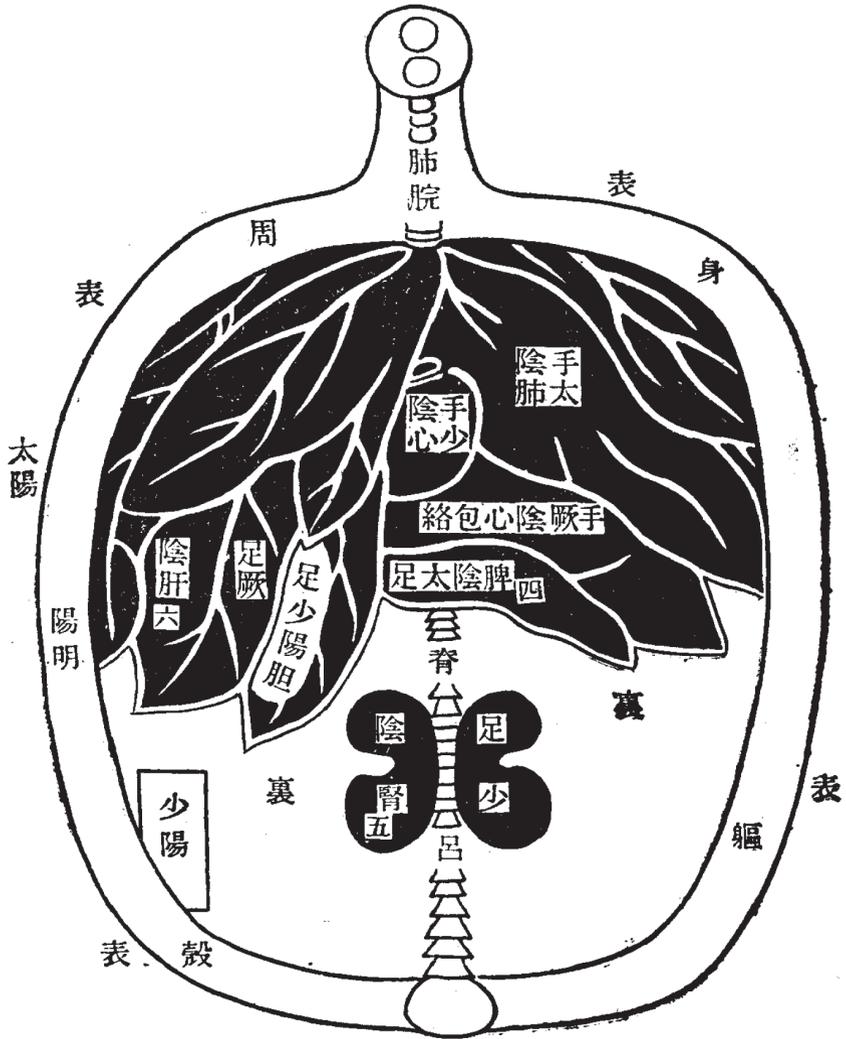


FIGURE 8 'Yin disorders located in the interior' (Yinbing zai li 陰病在裡) as depicted in Fang Youzhi's Critical Essay.

For a Ming dynasty audience of scholar physicians, simply pointing to empirical observation would not do, however. To be heard Fang needed to anchor his radical proposition in the textual foundations of the received canons, a task at which he truly excelled. In his opinion, Song dynasty authors like Zhu Gong and Cheng Wuji had committed a serious error, when they had read the term *jing* as a rubric for understanding the process of pathogen transmission in the *Treatise* as conduits.

The conduits, networks, and sinew vessels are [grouped into] altogether twelve kinds. When ordered according to the three yin and three yang as overarching [categories] they are named the six conduits. The [character] *jing* in the [term] the six *jing* [associated with the *Treatise*] and that in the [term] conduits and networks [however] is not the same.⁴⁸

Proceeding by way of careful textual analysis Fang argued that in the context of the *Treatise* the ideogram *jing* should be read not as conduits but as *bu* 部, a term denoting government departments or offices and, by extension, a region or division of bodily space. Hence, I will from now on translate the term *jing* as interpreted by Fang and his successors as 'division' to differentiate it from the earlier meaning of *jing* as denoting conduits. The six divisions circumscribe the totality of the human body's physical form, and in as much as it is in the territoriality of that form that all disease process plays out, they become essential to understanding and treating the myriad manifestations of human illness.

The [*jing* of] the six divisions is like the *jing* of six Confucian canons, which are also referred to as divisions. Another analogy therefore is to the six departments [of state]. The hands and feet are divided in upper and lower just as the post of first minster is divided into left and right. The Way of the Sages, the three cardinal guides and five constant virtues, the hundred professions and affairs of state are all within the scope of the six canons. The vastness of all under heaven and the myriad things are entirely within the scope of the six departments. Anything that belongs to the human body and its [various] parts is entirely within the scope of the six divisions. Viewed from this perspective, which encompasses the one hundred diseases in all their detail, is not the principle linking them all together within one's grasp? Yet, if there is nowhere within the

48 Ibid., p. 11.

human body that does not pertain to the six divisions, one must understand where exactly they are within the entire body.⁴⁹

This changed orientation—from *jing* as conduit to *jing* as division—is visibly expressed in the composition of the diagrams shown in Figures 7 and 8 above. Seeking to depict the development of cold damage disorders these diagrams focus on the space in which the bowels (in white viewed from the front) and viscera (in black viewed from the back) are located and on the structures that separate this space from the external world. While still referred to by name, the conduits are not otherwise visually represented. This marks an important departure from the importance accorded to conduits not only in Zhu Gong's *Book to Safeguard Life* (some versions include not merely the conduits but also depict their respective internal organs, Figures 9 and 10),⁵⁰ but also in anatomical representations of the body more generally, which frequently added diagrams of the acupuncture pathways to diagrams of the body's interior.⁵¹

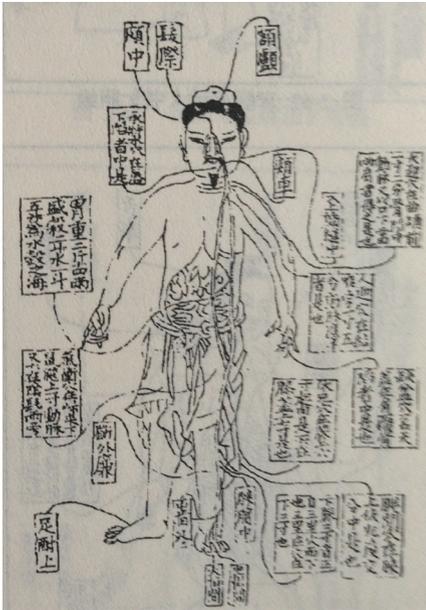
This does not mean that Fang saw the body with entirely new eyes either, however. Genealogically, his diagrams appear to be based on Song dynasty representations of the body's interior (Fig. 11), specifically the well-known anatomical diagrams of Emperor Huizong's physician Yang Jie 楊介 (12th c.). According to both sinophone and anglophone historians these drawings functioned as templates for depictions of the body's interior in the field of medicine until the early 19th century, whence they gradually began to be revised under the influence of western anatomy.⁵² Once again we come across the consensus view that fundamental change in Chinese medicine became possible only after

49 Attentive readers will note that the concept of a 'division' *bu* 部 goes beyond the mere anatomical but includes within it an attribution of functions. The metaphors used to underpin this model are derived from the organisation of the state and that of the Confucian textual tradition. It thus could be said that Fang's thinking is philosophical rather than anatomical in orientation. However, in my opinion, there is no neat dividing line between the two, in as much as all thinking is ultimately based on metaphor Lakoff and Johnson, 2003 and what Fang is driving at is an organisation of the body that is both all-encompassing and not arbitrary in the way it organises corporeal space in a functional way to constitute an integrated system.

50 Huang Longxiang 2001, p. 355.

51 According to Despeux 2005, p. 27, in a preface to Yang Jie's *Charts of the True Circulatory Vessels* (*Cunzhen huanzhong tu* 存真環中圖) of 1118 it says, 'Yang Jie, styled Jilao 吉老, observed and drew the actual form of the five viscera. He examined the depictions of the viscera made by Yanluozi, arranged and amended them; he then added the twelve channels and entitled his work *The True Circulatory Vessels*'.

52 Huang Longxiang 2001, p. 363; Despeux 2005, p. 32.



FIGURES 9 AND 10 *Song editions of Zhu Gong's Book to Safeguard Life depicting the kidney and bladder acupuncture conduits connecting to internal organs.*

its encounter with the West. I argue, instead, that Fang's drawings point to a rather different story. Namely, that Chinese physicians were already engaged by then in a critical examination of their tradition, including its depiction of the body, and that this critique was entirely indigenous in origin. It emerged at the conjunction of critical textual research, empirical observation, and the ongoing effort to improve clinical practice and reflected a shift of attention in the investigation of things away from cosmological resonance and introspection toward more directly observable relationships.

Hence, if Yang Jie's sketches were inspired by an imagined inner landscape of *qi* circulation and transformation that 'eschews the integral representation of the body'⁵³ but endures to this day, Fang's diagrams and his attendant explanations emphasise the importance of anatomical space in determining the contraction, elimination, and transmission of pathogens between and through various bodily spaces. To this end, Fang presents us with anterior and posterior

53 Despeux 2005, p. 24. This imagination owes as much to Daoist 'inward contemplation' (*neiguan* 內觀) as it does to the study of anatomy based on the physical dissection of bodies, usually those of executed criminals Despeux 2005, pp. 25–32; Huang 2011.

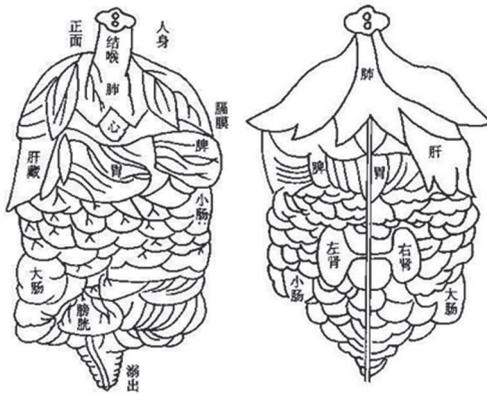


FIGURE 11 Yang Jie's depiction of the body and its organs, Charts of the True Circulatory Vessels (Cunzhen huanzhong tu, 1118).

views of the body that differ significantly from the conventional side-ways or frontal depictions of the body in Song and Ming dynasty texts (Figures 12 & 13).

These earlier representations of the body's interior focused entirely on the organs. The body's boundaries were sometimes omitted altogether (Fig. 12) or otherwise represented by means of a thin line (Fig. 13). Fang's diagrams, instead, seek to depict the body as a three dimensional space whose interiority is separated from the external world by a new boundary structure termed 'the body shell' (*quke* 軀殼). This shell is a complex structure constituted by three interconnected layers: 'the skin' (*pifu* 皮膚), corresponding to the greater yang division, at 'the shell's exterior' (*quke zhi wai* 軀殼之外); the 'muscles and flesh' (*jirou* 肌肉), corresponding to the yang brightness division, as 'the shell proper' (*quke zhi zheng* 軀殼之正); and the lesser yang division, which encompasses all 'unoccupied space' (*xidi* 隙地)⁵⁴ at 'the shell's interior' (*quke zhi nei* 軀殼之內).⁵⁵

The body's internal organs are the occupied spaces within this interior. The 'bowels' (*fu* 腑) are found anteriorly (i.e. facing the sun) because they are yang in nature, but located inferiorly because yang is rooted in yin. The 'viscera' (*zang* 臟), being relatively more yin, are positioned posteriorly but located superiorly because yin is rooted in yang. If this division between bowels and viscera appears conventional, a close reading of the explanation that accompany Fang's diagrams reveals significant departures from orthodox understandings

54 Fang Youzhi 1593, p. 104.

55 Ibid., pp. 3–5.

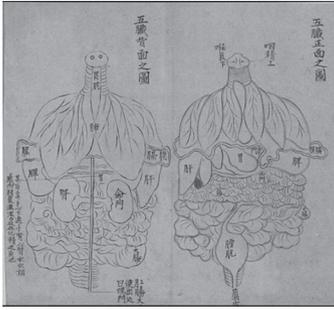


FIGURE 12 *Late imperial depictions of the body and its organs, example one, from Anon. Lingmen chuanshou tongren zhixue 凌門傳授銅人指穴 (The Lofty Portal Teaching Text of Acupoints on the Bronze Man) Qing. Wellcome Library, London.*

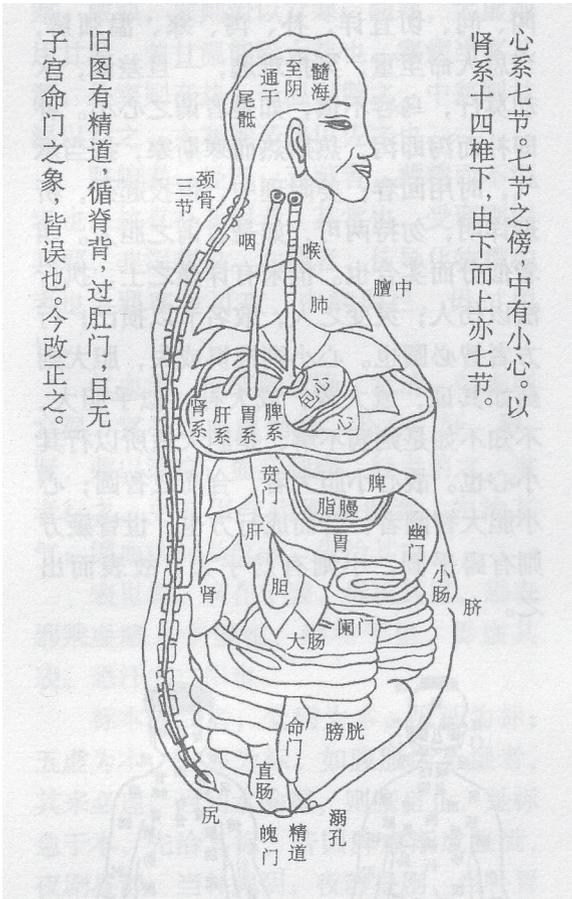


FIGURE 13 *Late imperial depictions of the body and its organs, example two, from Li Zhongzi 李中梓, Yizong bidu 醫宗必讀 (Essential Readings in the Medical Lineage, 1637).*

of internal anatomy that for over a thousand years had been rooted in the *Inner Canon's* notions of cosmological resonance. While Fang continues to draw on resonance thinking whenever it suits his goals, he accords at least equal importance and often priority to the physical organisation of bodily space. As a consequence he severs long established connections between conduits, bowels, and viscera and reorganises the entire body according to the territoriality of the six divisions. This reorganisation is most readily appreciated by following the route of pathogenic *qi* from the outside into the body's interior through the three yang and three yin divisions as discussed throughout Fang's *Critical Essay*.

The first stage in this process is the penetration of 'heavenly *qi*' (*tian zhi qi* 天之氣) into the human organism, where it does not belong and therefore turns into pathogenic *qi* (*xieqi* 邪氣). Fang is careful to distinguish this initial 'transfer' (*chuan* 傳) across the physical boundary between outside and inside from subsequent processes of 'transmission' (*zhuan* 轉) of pathogenic *qi* from one division of bodily space to another. Transfer only occurs at the greater yang division, which demarcates the exterior boundary of the body's physical shell at the level of the skin. This is why greater yang disorders constitute the first and most important stage in the development of cold damage disorders, and why roughly half of the core text of the *Treatise* is devoted to them. Once more, he employs philological methods to arrive at a new and innovative reading of key passages in canonical sources, berating previous authors as much for failing to properly understand the true meaning of the similar terms *chuan* 傳 and *zhuan* 轉—and thus of misapprehending the entire organisation of the *Treatise*—as for reading books instead of observing the body with their own eyes.

In the *Inner Canon's* sixfold categorisation of conduits and networks, the greater yang is comprised of the 'hand greater yang conduit' (*shou taiyang jing* 手太陽經), which connects to the 'Small Intestine' (*xiaochang* 小腸), and the 'foot greater yang conduit' (*zu taiyang jing* 足太陽經), which connects with the 'Urinary Bladder' (*panguang* 膀胱). As outlined in Table 2, according to the *Treatise* a greater yang disorder manifests with symptoms such as neck stiffness, headache, and backache. All of these symptoms are located along the course of the foot greater yang Bladder conduit. As a greater yang disorder progresses, it produces symptoms such as urinary retention. It is this connection between the location of a greater yang disorder in both the Urinary Bladder and the foot greater yang conduit that allowed commentators like Zhu Gong and Cheng Wuji to posit equivalence between the human body of the *Treatise* and that of the *Inner Canon*. However, as Fang points out, while some of the more exterior manifestations of a greater yang disorder match the

distribution of the hand greater yang Small Intestine conduit along the shoulder, back, and head, disorders of the Small Intestine organ are not generally associated with the greater yang anywhere in the *Treatise*.

Previous commentators had either ignored these inconsistencies or, like Zhu Gong, tried to explain them away by creating *ad hoc* exceptions of dubious logical consistency.⁵⁶ Fang Youzhi proposed a more logical consistent explanation based on the anatomical organisation of the body into two interconnected functional spaces, each again subdivided into three divisions. Each of these divisions was associated with one or more internal organs based on actual anatomical relationships instead of connections extrapolated from the conduit system. For example, as the most exterior division of the body the greater yang included both the skin and the Bladder, imagined as a pouch separated from the other internal organs, but it excluded the Small Intestine.

The greater yang is where wind and cold enter. To enter they must be received by the skin, and when they are received there is fever [indicating] heat in the skin. The skin is on the exterior of the [body's] shell. Hence it is called the exterior. Whether one sweats or not depends on nutritive and protective, hence nutritive and protective are also in the exterior. The exterior joins with the greater yang foot bladder. How does it join? Is not the Bladder connected to the other bowels via a sinuous membrane? Hence it is referred to as the solitary bowel. Its opening hole is at the front.⁵⁷ The front is the pathway of the exterior yang. Hence, [the greater yang and the bladder] join. Hence, it is called greater yang and not Bladder conduit plus skin, though one does not need those terms to understand [the connection]. Now as the greater yang also encompasses the hand greater yang Small Intestine conduit [within the *Inner Canon's* scheme of the twelve channels], how can one ascertain that this doctrine not also applies [in the present case]. The Small Intestine does not join with the skin. As it does not join [with the skin] it does not govern [its] diseases, and if it does not govern its diseases it should not be talked about [in this context]. And if it should not be talked about, then one can also know that it is not encompassed within [the scope] of the present doctrine.⁵⁸

56 For an example, see note 4 above.

57 Hsu 2010, pp. 216–20 provides a detailed account regarding the historical emergence of this view, which viewed the Bladder as a pouch.

58 Fang Youzhi 1593, p. 11.

According to Fang, it is more logical to subsume the Small Intestine to the yang brightness. This is because the Stomach, Small and Large Intestines constitute a single anatomical whole that connects to the 'stomach duct' (*weiwan* 胃脘) ending in the 'oesophageal opening' (*yan* 咽) above, and to the rectum below. Like the muscles and flesh making up the centre of the body's shell, the Stomach/Intestine system is located in the centre of the body connecting to both the exterior and interior. Hence, both belong to the yang brightness division. The hand yang brightness Large Intestine channel, however, does not share these connections and thus is excluded from this division.

The Gallbladder, which traditionally was considered to 'adhere closely to the Liver' (*nianlian yu gan er buli* 粘連于肝而不離) and thus not constitute an 'independent' (*bu ziwei* 不自立) organ resonates with the lesser yang, which denotes the unoccupied space that lies between the internal organs and the external shell. As a demarcating boundary it belongs to the shell. But as a boundary zone that already lies within the body's interior it is more correctly referred to as being 'half exterior half interior' (*ban biao ban li* 半表半裡). The half exterior half interior, hitherto a somewhat vague concept that had been defined therapeutically (yang-type conditions that could not be treated by either purging or sweating) as much as anatomically (territories associated with the Gallbladder and, in some views, Triple Burner conduits), is thereby rendered anatomically concrete.

With respect to the three yin divisions, Fang notes that these are 'all subordinated to the viscera' (*yin jing ci shu zang* 陰經皆屬臟).⁵⁹ This leaves him with the perennial problem of distributing five viscera across three divisions; or, more generally speaking, of aligning five phases cosmology with the dualisms of yin/yang thinking and numerology with empirical observation. The consensus solution, first elaborated in the *Inner Canon*, had been to add a sixth organ, the Pericardium or 'heart enveloping network' (*xinbaoluo* 心包絡), when discoursing about the twelve conduits, and drop it, when enumerating the five viscera. Fang proposed a new anatomically based solution. He argued that the Spleen, Kidneys, and Liver—corresponding respectively to the greater yin, lesser yin, and reverting yin divisions—are physically connected to the 'three yang divisions through sharing common pathways' (*yu biao sanyang he dao* 于表三陽合道). While Fang does not outline the precise nature of these pathways, one can assume they are constituted by the physiological and anatomical interfaces—including those mediated by conduits and collateral networks—that canonical texts posit to exist between the viscera/bowel pairs Spleen/Stomach, Liver/Gallbladder, and Kidneys/Bladder.

59 Fang Youzhi 1593, p. 12.

Once anatomy is foregrounded, such relationships are more difficult to envisage for the remaining organ pairs of classical five phases doctrine, the Heart/Small Intestine and Lungs/Large Intestine. Furthermore, Fang subsumed the intestines together with the Stomach into the yang brightness division. This leaves Lungs and Heart, located in the chest rather than the body cavity and, in Fang's view, no longer directly connected to yang bowels, outside the systems of the six divisions. In fact, he specifically states that these two viscera 'furthermore do not connect to the exteriorly [located] three yang divisions [of the body shell]' (*you bu yu wai zhi sanyang he* 又不與外之三陽合). However, 'the Heart and Liver both connect to the Lungs' (*xin gang tong fei xi* 心肝同肺系) and thus, via the 'Lung duct' (*feiwan* 肺脘) and the 'pharyngeal opening' (*hou* 喉), to the outside world.⁶⁰

This view appears to be borrowed from two texts compiled earlier in the 16th century: Yu Tuan's 虞搏 *Managing Destiny for the Common People* (*Cangsheng siming* 蒼生司命) published in 1515, and Xu Chunfu's 徐春甫 *Great Collection of the Medical Tradition Past and Present* (*Gu jin yi tong daquan* 古今醫統大全) published in 1556. Both of these texts link one group of internal organs to the oesophageal opening, namely the Stomach and Spleen, the Intestines, and the Bladder; and another group to the laryngeal opening, namely the Lungs, Heart, Liver, and Gallbladder. This yields two anatomo-physiological systems, one responsible for *qi* transformation and movement via the vessels, the other for the production of *qi* and blood from food and drink.⁶¹ Fang, who is primarily interested in the organisation of anatomical space, adds a third system via the Bladder's connection with the Kidney.

As for conduits and networks, even though Fang does not dispense with them, he considerably downgrades their importance. They still play a role in interconnecting organ systems and bodily regions but they no longer constitute places where pathogens collect or pathways for their transmission. As a consequence, they are no longer the key strategic sites on which to focus

60 Ibid., pp. 12–4.

61 This two-fold division is also taken up by Zhao Xianke 趙獻可 (16th c.) in his *Medicine Pervaded by One* (*Yi guan* 醫貫), which however was published in 1617 at the earliest and thus cannot have influenced Fang Youzhi. For a detailed discussion, see de Vries 2012, pp. 92–9. Other diagrams of the period, such as those contained in Zhang Jiebin, *Illustrated Wing to the Classified Classic* (*Leijing tuyi* 類經圖翼) and Li Zhongzi 李中梓, *Essential Readings of the Medical Lineage* (*Yizong bidu* 醫宗必讀), also depict the laryngeal and pharyngeal openings but do not use them to divide the organs into physiological systems. See Zhang Jiebin 1624 and Li Zhongzi 1637.

medical interventions. It is worth quoting Fang in full to underscore the nature and implication of this critique.

The exterior routes lead from outside to inside. The interior routes lead from below to above. The three yang and three yin divisions gather the channels and collaterals and link them into one so as to constitute one system. Hence, with regard to [the process by way of which the six divisions become saturated with pathogenic *qi*, the *Treatise*] does not refer to 'progressing' (*jin* 進), to 'entering' (*ru* 入), or 'movement' (*xing zou* 行走) [from one conduit to another]. Instead, it refers to transfer and then to transmission, borrowing the [metaphors] first of conveying official documents and then of transmission [from one place to another] to express the idea. The Way [of the *Treatise*] is grounded in the natural world. Unfortunately, later people no longer observed but merely engaged in wilful and empty speculation about the absurdities of transmission here and transmission there. Why in the entire universe has no one managed to systematise the three yang and three yin disorders? Alas! [Zhang] Zhongjing died and [with him] the six divisions became extinguished. The discourse on disease multiplied in the name of 'medicine is intention' (*yi zhe yi ye* 醫者意也). If things are all apprehended by intention, can one still call this the Way?⁶²

'Medicine is intention' was the banner under which Jin-Yuan revisionists and their followers in the Ming had aligned elite medicine with Neo-Confucian doctrines and orientations and attempted to create a medicine appropriate for their time.⁶³ Fang's acerbic critique thus was more than an effort to add merely one more personal synthesis to an ever enlarging archive of texts, or to re-interpret cold damage theory. It was an attempt to move medicine away from philosophical speculation and ground it in observing things in nature. For a Ming scholar like Fang Youzhi such observation was still mediated by texts and the insights of exemplary persons in the past. Reading, however, now demanded a far more critical engagement with these texts, beginning with a careful excavation of the original meaning of terms. Hence, rather than explaining the *Treatise* line by line with reference to other canonical texts as Cheng Wuji had done, Fang Youzhi employed the very different hermeneutical strategy of seeking to understand the text in relation only to itself, and to extend that understanding outward onto the body and its disorders.

62 Fang Youzhi 1593, pp. 273–4.

63 See Volkmar 2007 for an extensive analysis.

Penetrating to the true meaning of a text as ancient as the *Treatise* was not an easy undertaking, however. Despite the critical stance he took vis-à-vis the interpretative license post-Song medical writers took, in the last instance he, too, therefore resorted to a scholar's interpretive capacity of grasping meanings beyond the written words on the page. This gave him license to elevate the *Treatise* from a mere clinical manual to a comprehensive 'canon of medicine' (*yi jing* 醫經) and to re-organise its content so as to make its value accessible also to others. To this end he argued that the *Treatise* should be conceived as 'outlining a series of rubrics' (*ti gang* 提綱) at different levels of abstraction that were recursively nested within each other. For instance, just as cold damage constituted a focus for outlining the model of the six divisions that was applicable to other pathogenic *qi*, the discussion of greater yang division disorders, the largest chapter within the *Treatise*, functioned as a model for outlining general principles of pathophysiology and strategies of treatment equally applicable to the other five divisions.⁶⁴

Fang's new hermeneutics reshaped the way that the *Treatise* was read and how medicine was practiced. The most immediate link in this process of reorientation was Yu Chang 喻昌 (1585–1664), a scholar turned monk turned doctor, widely regarded as one of the most influential scholar-physicians of the Ming/Qing transition.

Yu Chang: From Diseases to Strategies

Unlike Fang Youzhi, who spent his entire life in a small Anhui country town and who focused his scholarly energies on a single text, Yu Chang was a more restless person with far wider interests. Born in Xinjian 新建 in Jiangxi Province, Yu left home early to travel the country with a literatus friend. He spent some time in the capital studying as a government student without actually passing any examinations. Turning to religion next Yu became a Buddhist monk and once more travelled throughout the Jiangnan region. He eventually settled in Changshu 常熟, in Wu 吳 Prefecture (modern-day Suzhou) of Jiangsu Province, where he changed his career one last time. For the remainder of his life Yu practiced medicine, gaining fame for his clinical acumen and sometimes for his unusual treatment methods. Throughout his life Yu moved in literati circles with friends and patients in high places. Apart from the social advantages such connections afforded, he was thereby exposed to intellectual currents en vogue among the Jiangnan elite at the time.⁶⁵ Yet, compared to

64 Wang Xinzhi 2008; Yang Yungao 1987.

65 For a biography and a synopsis of Yu Chang's central ideas, see Chen Yi 1999.

Fang Youzhi, whose influence on his own thinking he acknowledged, Yu was a more conventional Ming dynasty scholar physician concerned with synthesising various currents of tradition into a single intelligible and coherent practice rather than breaking away from the mainstream.⁶⁶

Yu thus never focused exclusively on a single text and his medical thinking and practice point to influences from a wider range of sources. Besides various trends of Confucian scholarship and Buddhist doctrine these included Daoist therapeutic practices and an awareness of western ideas about the body recently brought to China by Jesuit missionaries.⁶⁷ Yu succeeded in blending all of these influences into a practice all of his own that aimed at creating universally valid principles. As a consequence, proponents of both cold damage and 'warm disorder' (*wenbing* 溫病) therapeutics, of classical as well as the contemporary formulas, as well as syncretists of various persuasions today include Yu Chang in their imagined lineages of descent.

Essays on the Revered Treatise (*Shang lun bian* 尚論篇), published in 1648 and one of only four extant works by Yu Chang, professes his personal debt to Zhang Zhongjing's Han dynasty classic. It was also extremely well received. The book was lauded by Tang Dalie 唐大烈 (d. 1801) in his well-known assessment of medicine in Suzhou as the best critical commentary on the *Treatise*;⁶⁸ the editors of the *Four Treasuries* (*Siku quanshu* 四庫全書) praised Yu Chang for having 'overcome eight centuries of misinterpretation' and 'rediscovered the principles of Cold Damage illnesses' after 1500 years;⁶⁹ and the editors of the *Qing Draft History* (*Qing shi kao* 清史稿) singled him out as one of the first scholars to apply evidential methods to the interpretation of this text.⁷⁰

Yu was also one of the earliest popularisers of Wu Youke's 吳又可 (1582–1652) novel ideas on epidemics and disease causation, whose momentum many historians credit with providing impetus to the emergence of warm disorder therapeutics in the Suzhou region. Yu's own innovative analysis of these disorders by way of the Triple Burner directly influenced the work of Xue Shengbai 薛生白 (1681–1770) and Ye Tianshi 葉天士 (1664–1746), the other key figures in this emergence.⁷¹ I therefore include Yu Chang here not as an exemplar of a

66 On the centrality of insight and judgement *yi* 意 in Ming medicine, see Volkmar 2007. Yu elaborates these themes most forcefully in the introduction to his *Notes on My Judgement* (*Yu yi cao* 寓意草). See Yu Chang 1643, p. 371.

67 Long Fengxi 2010; Qiu Le and Zhu Jianping 2010.

68 Tang Dalie 1793, p. 21.

69 Elman 2005, p. 234.

70 *Draft of Qing History* (*Qingshi kao* 清史稿), p. 289. http://www.guoxue.com/shibu/24shi/qingshigao/qsgx_502.htm, accessed on 28 December 2012.

71 Hanson 2011, pp. 116–7.

distinctive style of practice. Rather, I see him as a transitional figure whose critical creativity, eclecticism, and social influence helped to place Fang Youzhi's new model of the body and hermeneutics at the heart of Jiangnan medicine and, shortly afterwards, of medical practice in Edo Japan.

Essays on the Revered Treatise reiterates Fang Youzhi's critical assessment of Wang Shuhe and the post-Song commentators that had adopted his edition of the *Treatise*. Yu also borrowed Fang's exegetical approach of cutting and re-arranging the received Song edition so as to arrive at what he believed to be a more authentic interpretation of the text. Once more, the technicalities of these re-arrangements need not concern us here in detail. Suffice it to say that they mirrored Fang's reading of the text as providing a series of nested principles (*gang* 綱) as well as a model for thinking of and treating externally contracted disorders:

For externally contracted disorders one employs cold damage as the principle. Amongst the six divisions of cold damage one employs the greater yang as the main principle. Within the greater yang division one employs wind damaging the protective, cold damaging the constructive, and wind cold together damaging the protective and constructive as the main principle.⁷²

If Fang's commentary focused on models of pathophysiology, Yu emphasised treatment strategies (*fa* 法). As we shall see, the idea that the *Treatise* supplied general models and strategies for understanding externally contracted disorders but not necessarily the formulas for their actual treatment would soon be taken up by Ye Tianshi, Xue Shengbai, and their followers. These physicians would also follow Yu Chang and, by extension, Fang Youzhi in addressing externally contracted disorders by removing pathogens from a body they perceived to be composed of a shell-like exterior that contained the viscera and bowels inside. That is, they were not merely actively creating knowledge about the body and its structures; they were simultaneously integrating these new structures into novel treatments.

For instance, in one of his case records Yu expounds on the importance he attached to this new image of the body precisely because it provided clear guidelines as to the routes by which a pathogen might be expelled:

The ancient methods are extremely perceptive but later generations were crude and failed to comprehend them. With respect to the human body, this is [constructed] like a shell that contains the bowels and viscera in its

72 Yu Chang 1648, pp. 7–8.

interior. If we deliberate [the present case] with regard to this shell, then the bones belong to the exterior. If we deliberate it with regard to places near the shell, the external opening of the bladder constitutes a pathway for emitting via the exterior. On the outside, the skin and body hair are the exterior of the exterior. On the interior, the larger and smaller passages are the exterior of the interior. One always expels heat pathogens towards the outside through [these structures]. . . . Today, those who treat cold damage forget to divide the shell covering the viscera and bowels into exterior and interior. Hence, they make mistakes at every turn.⁷³

Later on in the discussion of the same case Yu extends this view of the body to the head whose bony shell encases the brain. Fusing physiological notions from the *Inner Canon* with Daoist alchemical anatomy and with what appear to be western notions of brain function that were circulating in literati circles at the time,⁷⁴ Yu argues that the brain has a status independent of the five internal organs, which, in fact, he argues it governs. The principles for treating diseases of the head, just like those of the body, derives not from this function, however, but from their anatomical similarity. In both cases, pathogens located in the shell need to be vented back towards the exterior via the surface. Pathogens located in the interior, instead, need to be purged via orifices that connect the interior to the outside, specifically the anus (for the body) and the nose (for the brain).⁷⁵

73 Yu Chang 1643, p. 380.

74 See Ma Boying et al., 1994, pp. 469–79 for a discussion of the influence of Western understandings of the body, specifically regarding the brain, on late Ming medicine. It is interesting to note that Yu Chang is absent in his list of physicians who had access to such knowledge, nor have I found this discussed elsewhere. However, as Elman, 2001, p. 46 points out, Jiangnan literati associated with the *Fushe* 復社 or 'Return to Antiquity Society' that had such an important influence on shaping the research agenda of evidential scholarship were directly or indirectly influenced by Xu Guangqi 徐光啟 (1552–1610), a powerful scholar official who cooperated with the Jesuit Matteo Ricci. Given Yu Chang's circle of friends and patients it is not inconceivable that he had access to this knowledge.

75 The entire passage translates as follows: 'The students also asked, we received your instructions as to the kernel containing the five viscera. Having received your first-rate instructions and having opened-up our minds, we still have some doubts. Ignorant about a person's head, please instruct us as to which viscera governs it? I replied, the head is the entire body's head of state. Like a dome it is located above. It governs the viscera but does not receive orders from them. Although the eyes connect to the Liver, the ears to the Kidneys, the nose to the Lungs, the mouth to the Spleen, and the tongue to the Heart, these are merely borrowed doors and windows that are not governed by them. The viscera that governs them is the brain and marrow contained within the kernel of the head. The

While I cannot explore this innovative re-articulation of anatomy and physiology in detail, its profound challenge to classical views of the brain as an appendix of the Kidneys and of the Heart as governor of consciousness and the internal organs provides further evidence about the willingness of physicians like Yu Chang to move their tradition in radically new directions. For if the treatment strategies Yu recommended were not novel, relating them to the division of the body into an outside shell and an interior cavity each with their own different exit routes detached them from an alternative model of the body focused on internal organs, conduits, and networks. Furthermore, in the same manner in which he applied these strategies to his novel understanding of the brain, he also employed them to treat epidemic diseases, which he focused on emitting pathogens from various locations in the body.⁷⁶

The next step in the development of this newly emergent approach to medicine consisted in generalising the ideas of Fang Youzhi and Yu Chang regarding cold damage disorders to one in which the entire body became a territory for the waging of war and of the *Treatise* as a manual that enabled physicians to conduct their battles in the most effective way.

Ke Qin: Medicine as Territorial Warfare

Metaphors of medicine as warfare and of the physician as military strategists have a long provenance in the history of Chinese medicine. According to Unschuld such metaphors are grounded in an ontic view of medicine that thinks of disease as entities that need to be removed from the body. Systematic views, on the other hand, imagine the human body as a system that needs to be regulated both internally and vis-à-vis the larger macrocosm into which it

brain is the sea of the marrow. It governs the essence marrow within all of the body's bones. Hence, as the marrow of old people diminishes, their head slants to the side and seems sunken. The *Inner Canon* originally contained a doctrine of nine viscera [meaning] the five viscera plus brain-marrow-bones, the vessels, the Gallbladder, and the female womb. Five treasure spirits, four treasure [stuff with] forms. Together they make nine. Now is the brain not naturally that which governs all the viscera? I say that even though the brain does not store spirits within at the top of the brain is the heavenly gate. This is the place where the myriad spirits within the human body gather to meet, the mud-pellet palace referred to as the upper eight scenic spots. Only by attaining the ultimate void can we begin to connect with the shadowy nether worlds. You students rashly asked what [the head] governed'. In 'Experience from the Treatment of a Child in the Sha Household' (*Fu Shazhai xiao'er zhiyan* 附沙宅小兒治驗), Yu Chang 1643, p. 380.

76 Hanson 2011, pp. 261–5.

is embedded. By locating cold damage pathologies within the conduits Song commentators and their Ming followers had attempted to assimilate ontic aspects of cold damage disorders (the invasion of evil climatic *qi* into the body) to a more system-oriented perspectives grounded in ideas of cosmic resonance. By emphasising the location of pathogenic *qi* in distinctive body regions rather than conduits and collaterals and by highlighting the boundaries through which pathogens passed in and out of the body, Fang Youzhi and Yu Chang initiated a process that once again reversed this shift in emphasis. These tendencies are nowhere elaborated more clearly and decisively than in the work of Ke Qin 柯琴 (c. early 17th century),⁷⁷ the intellectual heir of Fang and Yu.

Ke Qin was a native of Cixi 慈溪 in Zhejiang Province but later settled in Changshu, the city in Wu Prefecture where Yu Chang had practiced a generation earlier. Accounts by friends and admirers paint a picture of a bookish person not much given to self-promotion. Hence, even if his erudition and skills as a physician ‘disgraced common scholars and quacks’, Ke remained a poor scholar throughout his life. It was only after his death that he gradually came to be acknowledged as one of the most sagacious readers of the *Treatise* of all times.⁷⁸ The stated goal of his life’s efforts was to provide once-and-for-all clarity in the domain of medicine and his chosen tool towards these endeavours was the genre of ‘commentaries’ (*zhushu* 註疏) on the canonical texts of the tradition. Ke is said to have produced such commentaries for both the *Inner Canon* and the *Treatise*, but only the latter survives. Published for the first time in 1706 under the title *Anthology for the Revival of Cold Damage* (*Shanghan laisuji* 傷寒來蘇集), Ke’s three-volume exegesis of the *Treatise* was re-printed over thirty times in the subsequent two hundred and fifty years attesting to its status and enduring influence on writers and physicians throughout China and East Asia.⁷⁹

77 Ke Qin’s life dates are conventionally given as 1662–1735. However, this cannot be true as it means he only would have been six years old by time he wrote his most important book, which can be dated to 1669. See Zhu Deming 2006, p. 77. As it seems quite obvious that Ke Qin influenced Ye Tianshi, it is likely that he lived in between Yu Chang (1585–1664) and Ye Tianshi (1664–1746), that is in the first half of the 17th century.

78 Biographical data on Ke Qin is included in Sun Jiefu’s 孫介夫 foreword to his *Supplement to [the Treatise] on Cold Damage* (*Shanghan lun yi* 傷寒論翼) of 1674. He is equally praised by Feng Mingwu 馮明五 in his foreword to the same text. For biographies and analyses of Ke Qin’s thought, see Jia Zhu Deming 2006, p. 77; Jia Xuelin and Li Jianping 2001; Fan Yongsheng 2009, pp. 52–3.

79 Ke Qin 1705, pp. 5–6.

Like Fang Youzhi and Yu Chang, whose influence he acknowledged but whose views he rejected as generally misguided, Ke's efforts were influenced by the intellectual currents of his time, specifically those of early Qing evidential scholarship. However, like Fang Youzhi and Yu Chang before him, he did not think of the application of philological tools as an end in itself but rather as a technique that 'allowed one to perceive the author's mind outside the language of the actual text'.⁸⁰ This provided him with the authority to cut out sections of the received Song edition he considered not to be authentic and to rearrange the remaining texts in a manner he believed more suitable for successfully applying its formulas and strategies in clinical practice. To this end, Ke emphasised 'manifestation patterns' (*zheng* 證) rather than pathophysiology or treatment strategies as the most important 'overarching rubrics' (*dagang* 大綱) for organising the text.

Ke Qin also followed Fang Youzhi in de-emphasising the role of the conduits and collaterals. Instead, he grounded all medical practice in the territorial organisation of the body into six distinctive domains.⁸¹ This transformed the *Treatise* from the canonical text of the cold damage tradition into the most important therapeutic manual of pharmacotherapy whose diagnostic model and formulas were applicable to all disease:

[Zhang] Zhongjing's six divisions represent 'six distinct territorial regions' (*liu qu dimian* 六區地面). Although in the broadest sense [the term] vessels [in the *Treatise*] stands for the conduits and collaterals, he did not establish his theory with specific respect to the conduits and collaterals. Irrespective of whether one deals with wind, cold, warmth, or heat, with internal damage or external contraction, exterior disorders progressing into the interior; those who have chills or fevers, or excess or deficiency, all of these are included [in this perspective]. Accordingly, cold damage and miscellaneous disorders were brought together into a single book comprehensively titled *Treatise on Cold Damage and Miscellaneous Disorders*. Although it took the six divisions as its overarching scheme of organisation, each division referring to a specific 'bounded domain' (*ju* 局), it did not thereby restrict itself to the conduits and collaterals, neither was it delimited solely by wind and cold. That is, although [Zhang] Zhongjing employed the terminology of the *Inner Canon*, he extended the meaning of the six divisions concept.

80 Author's Foreword in Ke Qin 1705, p. 1.

81 For analyses of Ke Qin's innovations see also Guo Wei et al. 2011; Jia Xuelin and Li Jianping 2001; Yu Baosheng 1982.

To this end Ke read the controversial term *jing* 經 as referring to ‘the tracks of territorial boundary markers’ (*jingjie zhi jing* 經界之經) and not, as in the *Inner Canon*, to ‘the tracks of the conduits and networks’ (*jingluo zhi jing* 經絡之經).⁸² These boundary markers mapped the topography of the human body into six clearly bounded territorial domains or divisions.

I ask [my readers] to employ the metaphor of geography [to grasp how], the six divisions might resemble different territories. Above the waist are the yang regions. The three yang [divisions] govern the exterior but have their root in the interior. The Heart is the area bordering each of the three yang [divisions]. Extending internally from the Heart and chest and externally from the crown of the head, reaching the forehead anteriorly and the shoulders and back posteriorly, reaching down to the feet while joining the Bladder in the interior is the greater yang division. This division commands the constructive and protective. It governs exterior symptoms of the entire body and corresponds to the frontier territories resisting the enemy.... The yang brightness division extends interiorly from the Heart and chest to the Stomach and Intestines, exteriorly from the forehead anteriorly to the abdomen and downward to the feet. The lesser yang division extends from the Heart to the throat exiting at the mouth and cheeks, reaching up to the ears and eyes slanting towards the crown of the head, while from the flanks externally it conjoins with the Gallbladder in the interior. The greater yang is thus quite similar to the yang brightness, while [the lesser yang] resembles the environs of the capital.

From the waist downward are the three yin regions. The three yin govern the interior and are not connected to the exterior. The abdomen is the area bordering all of the three yin [divisions]. The greater yin division extends from the Spleen in the abdomen towards the two Intestines and anus. The lesser yin division extends from the abdomen to the two kidneys, the Bladder and urinary pathways. The terminal yin division extends from the abdomen to the Liver upwards through the diaphragm to reach the Heart, while from the flanks it reaches downwards towards the lower abdomen and the ancestral sinew. These divisions are connected via the Triple Burner and govern all of the body’s interior

82 Ke Qin 2009b, p. 217. It may be noted here that one reading of the term *mai* 脈 is ‘to see’, so boundary markers may also be interpreted as the lines that can be seen to divide a territory into natural regions or domains.

symptoms. They resemble the territories adjacent to the capital that assist the ruler in governing.⁸³

If Ke Qin's mapping of bodily terrains leads back to Fang Youzhi, it redefines their nature as well as their relationship to each other and the rest of the body. It does so by subsuming connections that previously had been established contextually by combining notions of cosmological resonance with anatomical and physiological relationships to a single territorial and administrative map. Although some of these relationships will not make sense to someone viewing the body through the eyes of modern Western anatomy, they are not difficult to follow for someone who takes the *Inner Canon*, the *Treatise*, and their various commentaries seriously. An analysis of Ke Qin's mapping of the greater yang division will serve as an exemplar.

The external territory of the greater yang domain Ke Qin described matches the external distribution of the foot greater yang bladder conduit and network system. This system governs the distribution and circulation of the constructive and protective throughout the exterior regions of the body, i.e. the skin. This includes but is not limited to peripheral circulation and the regulation of sweating, which in Chinese medicine relate to the function of the Heart and the vessels. Ke Qin outlines this relationship by way of another analogy:

Because the greater yang governs the constructive and protective, the Heart and chest are the roots of the constructive and protective, while the constructive and protective *qi* circulate ceaselessly [throughout the exterior]. In this, they resemble the officials and soldiers of outlying cities that [eventually] return to the capital in a ceaseless coming and going.⁸⁴

We already know from Fang Youzhi above how the skin and the Bladder can be conceived as a single anatomical unit. Adding all of these pieces of information together, and without suggesting the possibility or even necessity of a one-to-one translation into biomedical anatomy, the greater yang domain begins to resemble a system that is comprised of the dermatome and connective tissue structures mapped by the greater yang Bladder conduit and network including the Bladder (imagined as a pouch), as well as peripheral circulation of blood and body fluids at the level of the skin and superficial connective tissues.

83 Ke Qin 2009b, p. 218.

84 Ke Qin 2009b, p. 219.

Similar accounts could be given for each of the remaining five divisions but go beyond the scope of this essay. The above analogy should suffice to make these connections appear grounded in the actual observation of bodily function and structure. In each case, the relationships that establish and hold a division together are elaborated by Ke Qin without recourse to the logic of cosmological resonance that was still necessary for Fang Youzhi to explain, for instance, why the flesh as the centre of the body shell related to the Stomach and Intestines at the centre of the body's interior.

This new mapping also allows Ke Qin to overcome another difficulty that had plagued Fang Youzhi's account and that can ultimately be traced back to his inability to let go entirely of the bodily order established by way of the organ/conduit system: namely the involvement of the Heart and Lungs in cold damage pathologies. While Fang Youzhi had connected the Heart and Lungs anatomically to the Liver, he also argued that being located in the chest they did not partake directly in the transmission of pathogenic *qi* through the body. This flies in the face not only of empirical observation but the *Treatise* itself, where coughing and wheezing are prominent symptoms of greater yang disorders at the very onset of a fever, as well as of other types of disorders and patterns later on. Likewise, while 'irritability and vexation' (*fanzao* 煩躁) is a prominent symptom of patterns associated with all six divisions, and one clearly related to the Heart's function of storing the 'spirits' (*shen* 神), Fang Youzhi had argued that the Heart as ruler of the body could not contract pathogenic *qi*. Connecting the chest to all of the yang divisions, and the Heart to all yin and yang divisions, made it much easier for Ke Qin to account for observable clinical realities in terms of his model.

In contrast to both Fang Youzhi and Yu Chang, Ke Qin thus does not oppose the body shell with the body's interior, an opposition that leads directly to the problematic status of the chest and its organs as a body cavity (yin) located above the diaphragm (yang). Instead, he defines the yang exterior as comprising the chest, which he connects to each of the three yang divisions. This larger yang domain is opposed to the yin domain of the abdominal cavity, in which the three yin divisions are rooted. Including the conduits and collaterals, which are 'main and subsidiary roads' (*daoluo* 道絡) for the six divisions this establishes a wide range of transitory zones and boundary regions that allow for multiple channels of communication and transition between interior and exterior aspects of the body, as well as between individual divisions. Not all unlike China's body politic at the time, Ke Qin's territorial body had two vital centres: the Heart, linked to all divisions by a complex network of relationships; and the abdomen as the source of the body's vitalities, which Ke Qin

explicitly likened to the ‘territories adjacent to the capital that assist the ruler in governing.’

Again in a manner that builds on and yet also transcends Fang Youzhi earlier ideas, Ke Qin extends this new territorial imagination of the body to a conception of medicine as territorial warfare. To this end he defines all illness as arising from the presence of pathogenic *qi* in one or more bodily domains. Like invading armies such pathogenic *qi* may enter the body from outside, but like robbers and bandits it may also arise entirely from within. The task of the physician, like that of a general, is to determine the nature, location, strength, and origin of these pathogenic *qi*, and then to counterattack and route them in the most expedient manner.

I furthermore would ask [my readers] to use the analogy of military strategy as the essence of military strategy lies in understanding the terrain. One must first understand the pathways of the six domains as only then can one know from where the rebels come. Understanding any formula implies knowing the roads that lead to the seat of government and those that lead out of any given prefecture. The incoming roads have strategic border positions. These are the three yang [domains]. The outgoing roads are the internal boundaries. These are the three yin domains.⁸⁵

As in warfare so in medicine, strategic agency is impossible without intimate knowledge of the terrain, a knowledge that extends beyond topology to an understanding of the multifaceted interrelationships between a land and its people.

As there are different reasons for deciding on what formula [to use in a given situation], one must furthermore [carefully] differentiate between them. For instance, each division can [potentially] be affected when wind, cold, summer heat, or dampness damage a person, so that the presenting pulse will be different. Alternatively, the pulse may be the same but the symptoms may differ; or the pulse and symptoms will be the same but the main symptom will differ. This is because the *qi* of each division is different. For the territories demarcated by the six divisions, like the nine [mythical] provinces of China, each has [its own distinctive] local conditions. Likewise, cold and heat, excess and deficiency in the exterior

85 Ke Qin 2009b, p. 220.

or interior of the body all differ because of differences in the *qi* of each division.⁸⁶

These considerations lead Ke to propose that the formulas listed in the *Treatise* focus not on the location of diseases in particular conduits but on manifestation patterns, which reflect the condition of (a) particular terrain(s) under attack from specific enemy configurations.

[Zhang] Zhongjing's formulas were composed because of the symptoms [they treat], not because of the conduits [they enter]. Whenever one sees a specific manifestation pattern, one employs the [corresponding] formula. This is [Zhang] Zhongjing's simple yet flexible method (*huofa* 活法).⁸⁷

Defining manifestation patterns as the true target of formulas downgrades the importance of 'patho-mechanisms' (*bingji* 病機) and 'disease causes' (*bingyin* 病因). Ke's paradigm shifting innovations, hidden behind claims for reviving ancient medical practice, thereby challenge post-Song medicine far beyond its interpretation of the *Treatise*. From the Song onwards and finding its apogee in the late Ming, scholar physicians had rooted clinical effectiveness in each physician's ability to formulate a correct 'conception' (*yi* 意) of an illness episode and to translate this conception into an appropriate formula.⁸⁸ Furthermore, because each single illness episode was unique no one single formula could ever be written twice. Formulas listed in books thus were nothing more than models to be adjusted to the singularity of each clinical encounter.⁸⁹ This emphasis on singularity at the bedside was reflected in a hermeneutics of deliberate 'syncretism' (*zhezhong* 折中) by means of which each individual physician and author arrived at their own synthetic understanding of the ever multiplying voices of tradition.⁹⁰ Grounded in Neo-Confucian philosophy but deeply influenced also by Chan Buddhism, late Ming physicians

86 Ke Qin 2009a, p. 351.

87 Ke Qin 2009b, p. 247.

88 On the centrality of *yi* 意 in post-Song medicine see Volkmar 2007, pp. 213–91.

89 The idea that formulas should be singular reflections of specific illness episodes in post-Song medicine developed out of a critique of the state-sponsored standardisation of formulas. It is most influentially developed by Zhu Danxi 朱丹溪 (1281–1358) in his *Inquiry into the Propensities of Things* (*Gezhi yulun* 格致余論). See Zhu Zhenheng 1347, pp. 43–4.

90 On the centrality of *zhezhong* 折中 in the development of medicine in post-Song China, see Simonis 2010, pp. 139–42.

emphasised notions like 'sudden insight' (*xinwu* 心悟) and knowledge 'beyond the written transmission' (*jiaowai biezhuān* 教外別傳) as central to their medical practice.⁹¹

Ke Qin, following Fang Youzhi, opposed the subjectivism of personal insight and the syncretic hermeneutics advocated by its proponents with the universal applicability of empirical truths embodied in a single text. Consequently, he redefined Zhang Zhongjing's *Treatise* as the only manual necessary for solving any problem in clinical practice.

Responses to Ke Qin in China and Japan

Contemporary anglophone and sinophone histories of Chinese medicine downplay the radical nature of Jiangnan medical thought during the Ming/Qing transition. Most assimilate its various exponents into the familiar image of medical currents that despite their diversity link to a common source.⁹² Alternatively, by focusing on individuals rather than scholarly networks, any critique of mainstream ideas is easily turned into an heroic but ultimately forlorn pursuit.⁹³ Largely excluded from these historical accounts is the reception of the works discussed here outside China, where they contributed to a radical reworking of what at the time was very much a shared tradition. Likewise, by relying on etic accounts of similarity and difference between various medical currents, historians have failed to recognise broader transformations that cut across apparently opposing strands of the tradition. In this concluding section, I will show that shifting to transnational and more thoroughly emic perspectives radically transforms the familiar landscapes of Chinese medical history in the late imperial period, rendering visible a vastly more productive terrain.

It took not very long for Fang Youzhi, Yu Chang, and Ke Qin's texts to reach Japan where they fell on fertile ground and became a major inspiration to physicians associated with the emergent 'ancient formula current' (*gufang pai* 古方派, Jap. *kohōha*).⁹⁴ Unconstrained by Chinese physicians' desire to

91 See for instance the foreword to *Notes on My Judgement* (*Yu yi cao* 寓意草) of 1643 by Yu Chang, who as we saw was both a scholar and a monk. The work of the pediatrician Wan Quan 完全 (1500–85) as analysed by Volkmar 2007, pp. 213–91, is another exemplary case study. For an overview of medical practice in the late Ming see also de Vries, 2012, pp. 6–34.

92 See for instance Chen Dashun 1985; Qiu Peiran and Ding Guangdi 1992.

93 An example pertinent to this discussion is Unschuld 1991.

94 Yu Xueru 2001a and 2001b.

be seen as part of the scholarly elite and emboldened by nascent nationalist sentiments, proponents of this current in 18th-century Japan pushed the re-evaluation of tradition and its empirical orientation toward their logical conclusions by detaching the *Treatise* from whatever vestiges of post-Song syncretism still remained.⁹⁵ Leaving no one in doubt of these intentions, Yoshimasu Tōdō 吉益東洞 (1702–73), widely seen to be the most radical representative of the ancient formula current doctors, entitled his exposition of their new approach *A Break in Medicine* (*Yi duan*, Jap. *I dan* 醫斷).⁹⁶

Going beyond all earlier Chinese authors Yoshimasu Tōdō rejected in their entirety the metaphysical systems of cosmological resonance elaborated in the *Inner Canon* and the *Canon of Difficulties*. Instead he proposed to ground medical practice solely in empirical observation. Rather than concern themselves with hypothetical causes and disease dynamics physicians should focus their attention solely on diagnosing the location of toxin (*du*, Jap. *doku* 毒, i.e., Fang and Ke's pathogenic *qi*) in the body, remove it, and then let the body/person take care of themselves. No knowledge of conduits and networks, organ systems and their micro and macrocosmic relationships, not even of disease causes was necessary in the pursuit of this goal. The *Treatise* was a precious guide in this endeavour precisely because it matched effective formulas with clearly defined manifestation patterns without requiring a detour via the subjective understanding of illness episodes.⁹⁷ And that, according to Yoshimasu Tōdō, was all that mattered: '[Zhang] Zhongjing [only] attended to where the toxin was located and composed his formulas accordingly. From this we can see that it is possible [to practice medicine] without knowing the cause.'⁹⁸

Two centuries later, the ancient formula current and Yoshimasu Tōdō, in particular, became models for Chinese physicians in Republican China striving to place their own tradition on the solidly empiricist foundations demanded by advocates of western science and modernity. Ke Qin, too, was rediscovered as a privileged access point to a pre-Song medicine perceived as not yet having been polluted by Neoconfucian metaphysics. Zhang Taiyan 章太炎 (1869–1936), a politically revolutionary but culturally conservative intellectual who played an important part in the overthrow of the Qing government and who personally taught most of the leading medical reformers of the 1920s and 30s, for instance, rejected as misguided all commentaries on the *Treatise* with the

95 Wu Zhongping et al., 2000.

96 Yoshimasu Tōdō 1747.

97 On the influence specifically of Ke Qin on Yoshimasu Tōdō, see Yu Xueru 2001a, Yu Xueru 2001b.

98 Yoshimasu Tōdō 吉益東洞, 1747, pp. 16–7.

exception of those by Ke Qin and You Yi 尤怡 (d. 1749).⁹⁹ In as much as the latter greatly admired the former, not least ‘for drawing on metaphors from geography and military strategy’, Ke thus became the single most important voice of what Zhang Taiyan defined to be the authentic medical tradition of China. Under the influence of Ke Qin and Yoshimasu Tōdō he emphasised two points as central to the value of that tradition and, specifically, its universal and timeless effectiveness: an emphasis on manifestation patterns rather than causes of disease; and the organisation of the body into six divisions (*liu bu* 六部) that allowed physicians to do away with speculative constructs, such as the five phases and even ‘formless *qi*’ (*wuxing zhi qi* 無形之氣), as foundations of their medical practice.¹⁰⁰

In one of the sublime twists of history, the radical restructuring of tradition proposed by the cultural conservative Zhang Taiyan and his followers, which entailed removing everything not in line with Ke Qin’s and Yoshimasu Tōdō’s empiricist reading of the *Treatise* from the domain of Chinese medicine, was curtailed by the Communist revolution. After 1949, Mao Zedong’s decision to recruit traditional medicine into the construction of his new China privileged an inclusionary approach that acknowledged many currents even as it sought to mould them into a single system. Modern university textbooks that teach the *Treatise* as one of the ‘four canons’ (*jingdian* 經典) of Chinese medicine exemplify this vision. They give voice not only to the source text but also to a wide selection of commentators drawn from all historical periods, placing excerpts of their writings side-by-side as if they were engaged in a common task. The Chinese medicine of the Maoist period thereby stepped into the footsteps not of Republican era radicals and their models from Japan and Jiangnan but of Qing imperial institutions and their attempts to order the body politic through the creation of orthodoxies.

In the medical domain, the Qing court’s desire for the creation of such orthodoxy emerges nowhere more visibly than in the *Imperially Commissioned Golden Mirror of the Orthodox Medical Lineage* (*Yuzuan yizong jinjian* 御纂醫宗金鑒) of 1742.¹⁰¹ Used as a teaching manual at the Imperial Academy for the remainder of its existence, the *Golden Mirror* represents an imperially sanctioned effort at repairing the cracks that had opened up between the body of the *Inner Canon* and that of the *Treatise*. The very first sentence of its first

99 You Yi 尤怡 (zi-name Zaijing 在涇), was a physician from Changzhou in Jiangsu Province, famous for his criticism of warm pathogen current therapeutics. See Sun Zhongtang 1999, pp. 389–414.

100 Lu Yuanlei 1931, Foreword 序, pp. 13–5.

101 For a detailed discussion of the production and status of this text, see Hanson 2003.

chapter, which is devoted to the *Treatise*, could not be clearer in stating this objective: 'The *Treatise on Cold Damage* was written by Zhang Ji in the later Han. It expounds the main themes of the *Inner Canon*'. The next paragraph introduces the notion of greater yang disorders. It borrows Fang Youzhi's innovative concept of the three main rubrics of greater yang disorders but then states unequivocally that '[t]he greater yang is the Bladder conduit'.¹⁰² The following pages employ selective commentaries by a wide selection of authors that sometimes place Cheng Wuji side-by-side with Fang Youzhi without the slightest hint of the tensions that exist between their very different readings of the *Treatise*.

Such desire for synthesis was by no means limited to the Imperial Court. It characterises the writings even of empirically minded scholars like Xu Dachun 徐大椿 (1693–1771), widely perceived to be one of the foremost physicians of his time and a staunch advocate of Han learning and evidential scholarship, who also lived in the vicinity of Changshu.¹⁰³ Xu readily embraced Fang Youzhi's critical attitude and shared Ke Qin's focus on eliminating pathogenic *qi* from specific bodily regions. Yet, he tried to reconcile their innovations with existing models of clinical practice rather than develop them further. The opening lines of his *Treatise on the Body Shell, Conduits, Networks, Bowels, and Viscera*, the second chapter of his famous *Treatise on the Origin and Development of Medicine* (*Yixue yuanliu lun* 醫學源流論, 1757), unequivocally express this stance:

Whenever a disorder arises it must have a cause. Likewise, the places that have contracted a disorder can be specified in terms of distinctive [body] 'parts' (*buwei* 部位). Today's physicians say that in case of a disorder one must discern the conduits and networks and then treat accordingly. This is quite correct. However, do they also know that the location of a disorder is by no means restricted to the conduits and networks?¹⁰⁴

Xu Dachun's question confirms that the *Inner Canon's* body of visceral systems, conduits, and networks dominated medical practice in the mid-Qing. He does not deny the clinical utility of this approach but suggests to expand it by including more recent ideas regarding the body shell.

102 The association between the conduits, organs, and six types of disorders is made in the first pages of the sections on cold damage in Wu Qian 1742, p. 10.

103 Unschuld 1991, p. 4.

104 Xu Dachun 1764, p. 164.

A person's physical appearance consists of skin, flesh, sinews, and bone. These form the so-called physical shell. The empty space inside this shell is filled by the viscera and bowels. They are interconnected and communicate with each other through the conduits and networks and transport within the physical shell. They are the pathways of transmission, transformation, and circulation. Hence, when pathogenic *qi* harm a person, they may settle in his skin and flesh, in his sinews and bones, in his viscera and bowels, or in his conduits and networks.¹⁰⁵

The tone and wording of this discussion directly point to Fang Youzhi, Yu Chang, and Ke Qin, even if he mentions none of them by name. This allows Xu Dachun to paper over once more the gaps between the bodies of the *Treatise* and that of the *Inner Canon* that these authors had opened up. It distinguished his approach clearly from that of his Japanese contemporary Yoshimasu Tōdō, whose empirical orientation and critical attitude he otherwise shared. For while Yoshimasu Tōdō rejected the *Inner Canon* as insufficiently empirical and suggested to do away with speculating about causes, Xu Dachun's overriding concern was to re-assimilate the innovations of the preceding period into a universal framework of medical practice rooted in the ultimate authority of the *Inner Canon*. This puts him on par with the editors of the *Golden Mirror*, whose appreciation of post-Song medicine he otherwise rejects.

Examining in detail the reasons for this very different reception of the same body of work in Qing China and Edo Japan goes beyond the scope of this essay. We may note, however, that writing for an audience of scholar physicians whose orientation was ultimately towards the imperial Court was always likely to lead Xu Dachun into a very different direction than Yoshimasu Tōdō, a professional physician and educator, who wrote books in order to convince other professionals who were by definition not scholars to study with him. Furthermore, the history of what we conventionally refer to as Chinese medicine but what would be much more accurately described as East Asian medicine, will look very different depending on whether we include within its scope all those who addressed a shared pool of problems, or whether we delimit the field by way of modern national boundaries.

105 Ibid.

Conclusion

In this essay I have examined attempts to redefine the meaning and scope of Zhang Zhongjing's *Treatise on Cold Damage* in the period between the mid 16th and late 18th centuries as tools for opening up a new window on the historical development of Chinese and East Asian medicine. I started by attending to things hitherto not discussed by medical historians, such as Fang Youzhi's diagrams of the body, and ended up by redrawing, at least in outline, the boundaries of the medical landscape that should orient its historiography in the future. This reorientation, then, emerges directly from the critique of certain insidious assumptions that continue to define this landscape despite our collective attempts over many years to create what TJ Hinrichs referred to in 1998 already as the 'new geographies of Chinese medicine.'¹⁰⁶

I argued in the introduction that even as we have become aware of the historical diversity of Chinese medicine, it appears to be difficult for us to let go of the notion that there must be some threads that tie all of its diverse strands together, or that there exists some fundamental bedrock underneath all of its surface difference. One way into this problematic is to see it as inevitable as long as we define Chinese, East Asian, or any other 'ethnic' or 'traditional' medicine with reference to the 'universal' or the 'modern'. Even if it is not spelled out, perceiving Chinese medicine to develop along a common thread until it encounters modernity, evokes comparisons with the very different history of science, marked as it is by constant change and revolution. I will return to this problematic shortly but only after having charted a second route with which this first one is inexorably intertwined but which has so far received far less critical attention.

I am referring here to the lineage discourse that has been exploited by Chinese and other East Asian physicians at least since the Song to organise the domain of medicine. This discourse accommodates a plurality of practices along both diachronic and synchronic dimensions by linking physicians and styles of practice to each other through real and fictitious lineages of descent. Tracing all of these lineages back to a common source provides tradition with a history and demarcates it socially in both the past and present. If late imperial scholar physicians were concerned to draw boundaries between themselves and less scholarly 'quacks' (*yongyi* 庸醫) or 'hereditary physicians' (*shiyi* 世醫), aligning all of Chinese medicine along a shared trajectory of ideas or a common developmental thread does much of the same work for modern historians.

¹⁰⁶ Hinrichs 1998.

Within this mode of discourse struggles about how medicine should be practiced or how disease might be known invariably translate into struggles about the 'authenticity of transmission' (*zhengchuan* 正傳). If a practice or knowledge claim can establish authentic connections to an apical ancestor or widely accepted textual source, it becomes orthodox no matter how different it is from what went before. Yet, the very necessity of maintaining such connections circumscribes the possibility for change.¹⁰⁷

Comparing reactions to late 15th- and early 16th-century reinterpretations of the *Treatise* in Qing China and Edo Japan underscores this point. At a historical juncture that allowed Chinese intellectuals to examine long-established truths with newly critical eyes, Fang Youzhi and Ke Qin offered readings of the *Treatise* that radically reinterpreted its place within conventional narratives of transmission. As Fang Youzhi pointed out in unequivocal terms, Zhang Zhongjing's text should no longer be read as a treatise that developed themes contained within the *Inner Canon*, but as a canonical work in its own right. These ideas were developed to their logical conclusion in Edo Japan by physicians such as Yoshimasu Tōdō, who broke the *Treatise's* connections with all lines of transmission that tied it to the *Inner Canon*. Yet, even as he strove to ground medical practice in empirical observation, he still found it necessary to legitimate his innovations in lineage terms, turning to culturally authoritative texts like the *Annals of Lü Buwei* (*Lushi chun qiu* 呂氏春秋) that predated the *Inner Canon*. This offered Yoshimasu Tōdō a different way of narrating history to an audience of physicians whose daily life was organised through lineage-based relationships but who were not constrained as to the texts on which they based their practices.

In Jiangnan, on the other hand, the irreconcilable break towards which the definition of the *Treatise* as a canon on par or even above the *Inner Canon* was leading was too radical an option even for empirically minded scholar physicians like Xu Dachun. More conservative writers rejected them out of hand.¹⁰⁸

107 Wu Yiyi's 1993–94 prosographical study of Liu Wansu 劉完素 and his followers was the first systematic account of how lineage thinking shaped the development of Chinese medicine in the post-Song era. Hanson 2011 provides an excellent overview of lineages of thinking, real and constructed, in the conceptualisation and treatment of epidemic disorders. Scheid's 2007 study of the history of the Menghe current (*Menghe xuepai* 孟河學派) demonstrates the importance of real and imagined lineage discourse in the development of Chinese medicine from the late Ming to the present. Simonis 2010, pp. 136–201, analysis the textual construction of lineages focused on the Yuan dynasty author Zhu Danxi 朱丹溪.

108 Besides the state-sanctioned reading of the *Treatise* found in the *Golden Mirror*, the most vocal group of physicians opposed to Fang, Yu, and Ke's hermeneutics is the so-called

They did so out of a desire to be part of a scholarly elite that by the 18th century had integrated the critical impulses of the Ming-Qing transition into prevailing orthodoxies. That is, precisely because the *Inner Canon* was read and revered as a classic not merely by physicians but the entire Jiangnan elite, displacing it from its position as the original source text of scholarly medical practice would have required a restructuring of society that physicians alone were too weak to effect.

For a brief moment in the 1920s and 30s, Zhang Taiyan and his students, most importantly Lu Yuanlei 陸淵雷 (1894–1955), who were seeking to establish a national medicine (*guoyi* 國醫) that fitted modern China but was rooted in ancient forms of empirical practice, rediscovered the radical potential of the writers of the Ming-Qing transition. Given that in China itself this radicalism had by then been largely tamed, this excavation had to proceed instead via Yoshimasu Tōdō and the ancient formula current in Japan. Unfortunately, once Japan turned from model to enemy in 1937, what had recently seemed attractive quickly became a liability. A second reason for the ultimate failure of the national medicine project was its lack of inclusiveness. There simply existed too many physicians aligned to other currents of practice for a definition of national medicine whose orthodox transmission passed from Zhang Zhongjing via Ke Qin and Yoshimasu Tōdō but which excluded, for instance, warm disorder therapeutics, then the most popular style of traditional medical practice in Jiangnan, to work. As long as they accepted lineage discourse as the defining model of tradition Zhang Taiyan and his followers were thus always likely to lose the struggle over how the national medicine they cherished might insert itself into a modern nation state.¹⁰⁹

This struggle was won eventually by Ren Yingqiu 任應秋 (1914–84), the father of the contemporary academic discipline ‘Doctrines of the Various Schools of Chinese Medicine’ (*zhongyi gejia xueshuo* 中醫各家學說). Following the example of Xu Dachun and Xie Guan, Ren Yingqiu defined Chinese medicine as a field of multiple lineage-like currents (*pai* 派) that all originate from a common source. Each current can divide into sub-currents, or it can join and intersect with other currents at various levels of scale. In a brilliantly inventive move the problematic nature of this diversity is resolved not by getting rid of the lineage discourse that produced it, but by inserting it into a modern (Hegelian-Marxist-Maoist) reading of history. ‘Going back to

Qiantang 錢塘 current (so named after the town in Zhejiang Province in which its main proponents lived) associated with the work of Zhang Zhicong 張志聰 (1616–74) and Zhang Xiju 張錫駒 (n.d.).

109 For a summary, see Scheid 2007b, chapter six.

the source' (*suyuan* 溯源), the invariably first step for any late imperial scholar, remained important in order to determine whether or not a practice belongs to the domain of Chinese medicine. Sorting out that domain, however, was placed under the tutelage of a new slogan: that of 'carrying forward' (*jicheng* 繼承) tradition by selectively developing its inheritance with the help of modern science and technology.

Locating one's topic within two thousand years or more of history thus constitutes an obligatory element in the introduction of any contemporary conference presentation, journal article, or medical text on Chinese medicine. However spurious such claims may be—and I cannot help but imagine the derision that most of them would evoke among scholars like Fang Youzhi, Xu Dachun, and Zhang Taiyan—they manifest an enduring valuation of descent-based relationship in the structuring of distinctive Chinese medical worlds. In the final paragraphs of this paper I want to exploit these valuations as a means for returning to the critical question posed in the introduction. Namely, how might we attempt to understand the coming into being of these worlds without distorting them by way of the *a priori* imposition of essentially modern values, aesthetics, desires, and frameworks for ordering the world or, vice versa, falling back on the lineage discourse that itself appears to structure these worlds.

Described and analysed by Mei Zhan in her account of Chinese medicine in the late 20th century, the term 'world' here refers to the always emergent entanglements between humans and things that do not exist in and of themselves ready for us humans to enter into, but that are brought into existence in processes of 'worlding'.¹¹⁰ To put it in a way that resonates with the theme of this paper, worlds are created in and through struggles over what relationships count and which do not. As Eric Hayot notes, "To world is to enclose, but also to exclude".¹¹¹

All of the physicians encountered in this essay were involved in the creation of new worlds. They discovered and described new things and they got rid of old ideas and relationships that were no longer useful or meaningful to them. They claimed that they could produce more comprehensive accounts of illness than their competitors and teach others how to be clinically more effective.

Fang Youzhi employed critical philology, a new emphasis on empirical observation, and a text centred on hermeneutics to uncover a body constructed of an outer shell housing the vital organs. Zhang Zhongjing's *Treatise* became the single most important clinical manual for treating disease now imagined as the transfer of *qi* not ordinarily belonging to the body across its

110 Zhan 2009, pp. 22–4.

111 Hayot 2012, p. 40.

external boundary and its subsequent transmission through contiguous bodily spaces. To make this new understanding of the *Treatise* intelligible and clinically useful, Fang embarked on a radical reorganisation also of the very text on which the authority of his vision was founded.

Yu Chang integrated Fang Youzhi's model into an eclectic medical practice that equally drew on other innovations of the time. His visibility and social status conferred authority on these innovations and made the accessible to others, specifically Ke Qin and Xu Dachun, who all lived in the same Jiangnan town. Ke Qin developed a model of bodily geography that overcame many of the problems he had inherited from Fang's earlier account. His conception of medicine as warfare aimed at dispelling pathogenic *qi* by exploiting knowledge of bodily topography likewise constituted a more mature and coherent vision of conceptions first proposed by Fang Youzhi. Xu Dachun re-assimilated these ideas to the body of the *Inner Canon*, forestalling a break between the two traditions that in Japan was openly forced by physicians of the ancient formula current, most exemplarily by Yoshimasu Tōdō.

However, neither of these actors actively set out to overturn earlier worlds by way of revolution. Rather, by reordering their attachment to the past they created a space for redefining the present. The ethics of filiality that oriented such attachment did not inhibit but rather produced intellectual and social change. Fang Youzhi venerated Zhang Zhongjing with an intensity few earlier commentators could match. He claimed to have gained more immediate access to the true meaning of his *Treatise*, even as he put philology and empirical observation to the same ethically charged task. Ke Qin claimed to be reviving cold damage therapeutics even as he was fundamentally reframing it. Xu Dachun's reverence for the *Inner Canon* directed him to integrate the new ideas about the body shell with existing notions of conduits and networks while consistently advocating empirical observation. Unlike us moderns, who tend to frame innovation as breaks, shifts, transgressions, and revolutions, these physicians employed the imagination, ethics, and discourse of lineage to manipulate and (re)create ever changing medical worlds. That this discourse evokes continuity should not blind us to the fact that it can enable significant transformation: a reverse *gattopardismo*, so to speak, where things change so that the world can essentially stay the same as it always has.¹¹²

112 The term 'gattopardismo' refers to the novel *Il gattopardo* by Giuseppe Tomasi di Lampedusa 1958, which describes Sicily during the period of Garibaldi's *risorgimento*. It contains the memorable line, 'If we want things to stay as they are, things will have to change'. Lampedusa 1958, p. 29.

Viewed from this perspective, the transformations discussed in this paper are not hopeless attempts at rescuing a tradition in decline but bold attempts at creating new bodily and therapeutic worlds. Rather than being the spark that did lead to the eventual modernisation of tradition, the intrusion into these worlds shortly afterwards of western anatomy and science may have strangled the development of a more profound native East Asian medical transformation. Or perhaps, entertaining such a possibility is itself already coloured by specifically modern expectations. As, indeed, is the term 'world' itself. Heidegger, from whom Zhan takes her concern for worlding, already claimed that, '... the fact that the world becomes picture at all is what distinguishes the essence of the modern age'.¹¹³ The world picture thus is thoroughly historical and for Heidegger, at least, a direct product of science. In fact, none of the physicians examined in this paper attempted to produce exhaustive accounts of the world or even the body. Their goal, rather, was to create practical solutions to problems of clinical practice. That is, to become a more effective clinical strategist it was necessary to survey anew the bodily terrain.

Producing historical accounts of the development of Chinese and East Asian medicines that do not privilege distinctly modern points of view—and all accounts that oppose local traditions to universal science, or that seek to account for the co-existence of different cultures within a single world do—is thus revealed to be an even more difficult task than we might have imagined. I suggest that its solution will lie in taking historical actors seriously without merely replicating their own explanatory frameworks.

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113 Heidegger 1977, p. 130.

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