



ASIAN MEDICINE

NEWSLETTER of International Association for the Study of Traditional Asian Medicine

December 1998

Editorial

Dear Colleagues,

Interest in traditional Asian Medicine and the relations between different medical systems has grown substantially in recent years. This is also evidenced by the wide range of contributions received for the current issue of the IASTAM newsletter. Admittedly, Dominik Wujastyk and Charles Leslie have been particularly helpful in revitalizing the newsletter by gently twisting people's arms to send in contributions. A grateful THANK YOU! to both of them.

If you wish to receive future issues, simply follow the subscription guidelines provided on the last page. Please do send in your research findings, information about research networks, forthcoming publications, vignettes, PhD projects, initiatives, points for discussion, and conference announcements. Letters for publication are particularly welcome. And, why not volunteer to do a review for the next issue? Please, paste your write-up into an e-mail message to WER@soton.ac.uk or, if you prefer, you may send a disk together with a hard copy to me at Southampton.

The number of members of IASTAM has risen so that future contributors to the Newsletter can look forward to an expanded readership.

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Avicenna's Links with Chinese Medicine. A Chapter of the History of Sino-Arabic Relation During the Middle Ages.

Zhu Ming and Felix Klein-Franke

Western standard works of the history of Islamic civilization give scanty information about cultural and medical exchanges between the Chinese and Muslims. The Cambridge History of Islam, with its two volumes that comprize nearly 1,900 pages, contains little information on this topic; there is no chapter on Islamic medicine, let alone on Rashid ad-Din's (1247-1318 A.D.) translation of Chinese medical literature, which he called Tansuqnamah. In his great work Science and Civilization in China Joseph Needham mentioned Rashid ad-Din, but did not research into the Tansuqnamah. The standard work of Islamic studies, the Encyclopaedia of Islam does not even mention the merits this great Muslim historian won by translating Chinese medical literature into Arabic and Persian. Islamic medicine originated in the 9th century when Muslims got access to the bulk of Greek medical literature which was then translated into Arabic. Through the translation of most of their writings Hippocrates and Galen became the greatest authorities for Muslim physicians, and Graeco-Arabic medicine became a branch of western medicine. Galen was held in such great esteem that the physician Muwaffaq ad-Din Ya'qub ibn Saqlab (d.1227 A.D.) was able to recite by heart whole books of Galen and commentaries to the Corpus Hippocraticum 'without adding or skipping anything', as the historian Ibn Abi Usaibi'a (13th century) reports. Modern historians of Islamic medicine are generally unaware of the fact that at times Muslim physicians, especially in the eastern part of the Muslim empire, got access also to

Chinese sources.

Being himself a physician Rashid ad-Din was interested in Chinese medicine. Taking advantage of his position as Grand Visier under the government of three emperors of the Mongol Ilkhan dynasty, he ordered one of his pupils to go to China and collect Chinese medical literature which he then had translated into Persian and edited. He called the collection Tansuqnamah which means 'Book of Precious Information'. Rashid ad-Din gave the book the subtitle 'Ilkhan's Treasure Book of Chinese Science'. Only one part of this book, together with Rashid ad-Din's extensive preface, has been preserved in a unique manuscript in Istanbul. (1)

The remains of the Tansuqnamah have been identified by us as a supercommentary of the Mai Jue, the 'Pulse Poem', which was very popular in China during the Song-Jin-Yuan Dynasties (12th to 14th centuries). At the time, the Mai Jue was wrongly attributed to Wang Shuhe. This mistake was repeated also by Rashid ad-Din - although the correct name Mai Jue is mentioned in the Tansuqnamah. The quotations from the Mai Jue have been embodied into the Tansuqnamah in its original Chinese version, transliterated into Arabic letters, together with explanatory remarks. (2)

When we re-read Avicenna's Canon of Medicine we still had our research into Rashid ad-Din's Persian translation of Chinese medical literature fresh in our minds, and we were struck by the similarity between some of Avicenna's and Chinese medical theories. Commenting upon these and other similarities, for example the circulation of the blood described by the Muslim

physician Ibn an-Nafis (d.1288 A.D.), Joseph Needham wrote: '[Such similarities] invite the question - or is it but a wild surmise? - as to whether Ibn an-Nafis and his contemporaries in the Arabic world could have been influenced by Chinese medical physiology... We are not, we find, the first to propose such an influence, for Li Thao [Li Tao, a Chinese historian in the 1940s], impressed by the dominance of Avicenna's pulse-lore in European medical schools such as Montpellier down to a late date, though not mentioning [Ibn] al-Nafis, felt that on his account there was a strong Chinese background to the discovery of William Harvey' (Celestial Lancets, Cambridge, 1980, p.35 f.)

Our paper proves that parallels and similarities between Chinese and Muslim medicine are no 'wild surmise' but a reality. We can support this claim with historical evidence. In this paper we focus our attention on Avicenna (Arabic: Ibn Sina, 980-1037 A.D.). He was one of the greatest Muslim physicians and philosophers. His Canon of Medicine was a standard book for medical education, and its Latin translation, edited in Venice 1507 A.D., also served as an indispensable text-book for medical education in Europe until the 17th century.

Before looking at the Canon's 'Chinese background', we need to discuss a question which Avicenna himself invited by calling his philosophy mashriqi, i.e. 'oriental'. Much ink has been shed by scholars on the correct spelling of this Arabic word. Spelling it mushriqi, it means that Avicenna called his philosophy 'illuminative'; whereas spelling it mashriqi,

namely 'oriental', the word was interpreted as Avicenna's wish to distinguish his philosophy from that taught in Baghdad by commentators trained in Aristotelean philosophy. Both explanations – 'illuminative' and 'oriental' – make sense. Hossein Nasr recently argued that both concepts complement each other.(1)

However, another reading may be possible: by calling his philosophy 'oriental' Avicenna might have implied its links with Far Eastern sciences and wisdom – in particular as China held at the time a leading position in science and technology (paper-making, book-printing, compass, gun-powder etc). Although he had adopted many of Aristotle's ideas, by calling his philosophy 'oriental' he might have wanted to stress that he was open also to influences from the Far East.(3) In the days of Avicenna, the two main channels of contact between the Chinese and Muslim peoples were the ancient continental Silk Road, leading westwards from north-west China, and the 'oceanic Silk Road', connecting the south-west coast of China with India and Persia. This latter route especially served the exchange of herbal drugs and medical knowledge between both sides (4). This is evidenced, as far as China is concerned, by the work of Hai Yao Ben Cao ('Materia Medica from the Oceanic Route'), written by Li Xun, a Persian who knew Chinese well and who became a Chinese poet. More than fifty kinds of herbs were imported from Persia and other Muslim countries. The names of Chinese herbs which were exported to these countries, have been recorded in the book Song Hui Yao ('Historical Records of the Song Dynasty', 960-1279 A.D.). The wide-spread use of herbal medicine by Muslim physicians is attested already by al-Kindi (9th century A.D.) in his pharmacopoeia. In China, the

Uygurs were very instrumental as mediators (Hans Haussig. Die Geschichte Zentralasiens und der Seidenstrasse in islamischer Zeit. Darmstadt 1988, p.216 f.).

The extent to which western medicine influenced Chinese physicians is revealed in recent approaches to Hui Hui Yao Fang (HHYF), meaning 'Islamic Formulary'. (5) The HHYF was presumably published before 1367 A.D., when the Yuan Dynasty ended. Of the remaining book only four chapters are extant, namely 'Chapter of Contents' (Part II, Chapters 12, 30 and 34). These are handwritten transcriptions from the Ming Dynasty (1368-1644 A.D.), based on the original Yuan edition. For instance, Chapter 12 contains 199 Islamic drugs which have been cited 1,168 times throughout the book. Of these 149 drugs have been identified. The remaining parts of the book refer to 517 drugs in Arabic (or Persian) script, accompanied by their Chinese transliteration. (6)

Our argument that Chinese medicine was not alien to Avicenna can best be supported by quoting his Canon of Medicine. We payed special attention to the chapter of Materia Medica and his pulse diagnostic theory.

Avicenna has dealt with sphygmology in several of his medical writings: for example in his Canon of Medicine (first book, third ta'lim, first djumla) and in a monograph called ar-Risala fin Nabad ('Treatise on Pulses'). In his 'Treatise on Pulses' Avicenna enumerates at least nineteen kinds of pulse-qualities. Thus a pulse can be (A: Arabic, P: Persian):

1. long (A: tawil), 2. short (A: qasir), 3. moderate (A: mu'tadil), 4. broad (A: arid), 5. narrow (A: dayyiq), 6. tall (A: mushrif), 7. depressed (A: mukhafid), 8. coarse (A: ghaliz), 9. large (A: azim), 10. small (A: saghir), 11. quick (A: sari), 12. slow (A:

- bati), 13. uninterrupted (A: mutawatir), 14. interrupted (A: mutafawit), 15. smooth (P: narm), 16. hard (P: sakht), 17. full (P: pur), 18. empty, void (P: tahi), 19. even (A: mustawa).

These pulse-qualities, Avicenna explains, can be categorized under the following ten aspects: 1. measures, 2. speed and slowness, 3. strength and weakness, 4. continuity, 5. heat and cold, 6. softness and hardness, 7. fulness and emptiness, 8. evenness and variety, 9. order and disorder, 10. weight.

According to Galen there are nine qualities distributed over three groups. The qualities of the first group are long, medium and short; those of the second group are broad, medium and narrow; whereas those of the third group are high, medium and low. Each pulse has three qualities, taken from each of these three groups. Thus there were 27 possible combinations or kinds of mixed pulses. Galen qualified them in the following way:

1. long-broad-high, 2. long-broad-medium, 3. long-broad-low, 4. long-medium-high, 5. long-medium-medium, 6. long-medium-low, 7. long-narrow-high, 8. long-narrow-medium, 9. long-narrow-low, 10. medium-broad-high, 11. medium-broad-medium, 12. medium-broad-low, 13. medium-medium-high, 14. medium-medium-medium, 15. medium-medium-low, 16. medium-narrow-high, 17. medium-narrow-medium, 18. medium-narrow-low, 19. short-broad-high, 20. short-broad-medium, 21. short-broad-low, 22. short-medium-high, 23. short-medium-medium, 24. short-medium-low, 25. short-narrow-high, 26. short-narrow-medium, 27. short-narrow-low.

This table of possible combinations of pulse-qualities is typical of Galen's formalism as when he developed a fourth logical figure out of the three

Aristotelean ones. Compared with Galen's inflexible construction, Avicenna's list of pulse-qualities breathes the vivid air of clinical experience.

Since antiquity the correct analysis of the different qualities of the radial pulse was the core of Chinese medical diagnosis. In the second century A.D., namely in the days of Galen, Wang Shuhe, a great Chinese physician, elaborated an exact sphygmology based upon detailed analysis of the pulse-qualities. In his *Mai Jing* ('The Pulse Classic', reprinted by The People's Hygiene Press, Beijing 1982) he referred to 24 pulse-qualities. These are:

1. fu mai floating pulse, 2. kou mai void pulse, 3. hong mai grand pulse, 4. hua mai slippery pulse, 5. shuo mai rapid pulse (or quick), 6. cu mai irregular-speedy pulse, 7. xian mai wiry pulse, 8. jin mai tense pulse, 9. chen mai deep pulse, 10. fu mai hidden pulse, 11. ge mai void-tight pulse, 12. shi mai excessive pulse (or full), 13. wei mai feeble pulse, 14. se mai hesitant pulse (or hard), 15. xi mai thready pulse, 16. ruan mai soft pulse, 17. ruo mai weak pulse, 18. xu mai deficient pulse (or empty), 19. san mai loose pulse, 20. huan mai moderate pulse, 21. chi mai slow pulse, 22. jie mai interrupted pulse, 23. dai mai interval pulse, 24. dong mai moving pulse.

It can be seen that Avicenna's pulse theory has not much in common with that of Galen. While Galen's sphygmology is based upon the quantities of measurement (namely short and long, high and low, etc), Avicenna added many sorts of pulse-qualities (such as slow, interrupted, smooth, full, large, depressed). Without using Galen's rigid formalism, Avicenna's pulse-theory resembles that of Chinese medicine. Many kinds of pulse-qualities overlap with each other (for example, moderate,

depressed (or empty) slow, interrupted, quick (or rapid), full (or excessive), deficient (or empty) and even pulses - in Zhang Zhongjing's *Treatise on Febrile Diseases*, 2nd century A.D.).

We can easily find the counterpart to Avicenna's nineteen pulse-qualities in Chinese pulse-theory. Avicenna, however, did not name any Chinese source of his theory of the pulse, although the similarity between his and Chinese pulse theory extends even to the way the qualities of the pulse are described. For instance, Avicenna dealt with the symptoms that indicate fullness (imtila'), caused either by blood-stagnation or by excessive energy. While blood-stagnation, as he explains, is caused by excessive quantity of blood, the latter results from evil quality of energy. He also uses the term 'vital power' to elaborate the heart-function resulting in the pulse. Energy (Qi) is the central concept in Chinese medicine. So, we get the impression that Avicenna's explanations are close to Chinese concepts.

The chapter on 'Materia Medica' opens the second book of the *Canon of Medicine*. Among the natural drugs recorded there are ~~sixteen~~ of which Avicenna notes that they are 'imported from China' (yujlab min as-Sin). Avicenna adds that for the preparation of certain drugs the 'Chinese species' was sometimes to be preferred to other species of the plant. This means that Avicenna was well aware of the advantage of Chinese medicinal plants.

All who study Arabic botanical literature of the middle ages face the problem of identifying the plants. To avoid confusion the Muslim scholars often used the foreign names of the plants, be their origin Greek, Persian or even Chinese. So did also Avicenna. His list of drugs imported from China contains

Persian names, like dand (no.4) and even a Chinese name, khulanjan (no.16). We found these references in the chapter dealing with 'Materia Medica', according to their appearance in the *Canon of Medicine*.

Here Avicenna analyses each drug according to a certain pattern, a kind of questionnaire, containing twelve (in the Latin edition, sixteen) characteristics. Avicenna calls them alwah (plural of lah, table, in the Latin edition areola). The description of each drug opens with general remarks concerning origin, alternative names of the drug, its basic qualities (hot, cold, dry and moist). In this section Avicenna describes every plant as clearly as possible by comparing it to other well-known plants. The pattern is: the leaves of plant A resemble the leaves of plant B, but its flowers are like those of plant C, while its fragrance resembles that of plant D etc.

Then follows: - the first table: the effects and peculiarities of the drug (af'al wa-khawass / operationes et proprietates), for example, mild, strong, viscid, desiccating, pasting together, dissolving, making rough, making smooth. - the second table: characteristics of beauty (zina / decoratio), for example, making clean, rendering turbid, cleaning skin disorders caused by leprosy, ulcers. Then follow classifications of drugs according to their indications: - the third table: swellings and pimples etc. - the fourth table: wounds and ulcers - the fifth table: sore joints - the sixth table: sore organs of the head - the seventh table: sore parts of the eye - the eighth table: painful breathing and pains on the chest - the ninth table: pains at the alimentary tract - the tenth table: pains at the excretory organs - the eleventh table: concerning fevers - the twelfth table: concerning poisons.

Summary

It seems that the influence of Chinese medicine upon Muslim

medical theories can be traced back at least to Avicenna in the 11th century A.D. We will continue to study Arabic, Persian and Chinese medicine, and in

particular the exchanges between Avicenna's and Chinese medical theories, from a comparative perspective. This will add to the work of scholars who have

looked at the ways in which Avicenna's Canon of Medicine influenced and enriched Chinese medicine (7).

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Please contact the authors for an extended bibliography and a list of 16 drugs that refer to Chinese Materia Medica and detailed annotations on these.

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Chiang Jun-hsiang 二潤祥 (Y.C. Kong), ed., introduction by Liu T'sun-jen 柳存仁, *Hui-hui yao-fang chi yu-kuan lün-wen shu-ying* 回回藥方及有關論文書影 (Edition of the *Hui-hui yao-fang* and associated studies), Hong Kong: Hsiang-kang Chung-kuo pien-i yin-wu yu-hsien kung-szu 香港中國編譯印務有限公司, 1996, large octavo, 632 pages, illustrations, not for sale (contact Y.C. Kong, Department of Biochemistry, Chinese University of Hong Kong)

A Review, by Paul D. Buell, Seattle

Among the many texts of traditional Chinese medicine which have been published in modern editions, studied, and translated in recent years, probably none is more important than the *Hui-hui yao-fang* (HHYF), "Muslim Medicinal Recipes," four *chüan* 卷 of which survive (out of 36) in a Ming 明 Dynasty handwritten copy of what was apparently a Yüan 元 Dynasty published version, now lost. The work is unique not only in its inclusion of Arabic script entries for most of its exotic "Muslim" medicinals but because it copies out, in large part, in an adapted form to be sure, selections from various classics of Islamic medicine including the *Qānūn fi al-ṭibbi* of Ibn Sīnā. These facts make the HHYF a veritable smoking gun of cultural influences, influences in most other cases not traceable since nearly all of the other relevant works are now lost.

In its present form, the HHYF is manuscript in at least two hands comprised of the table of contents for the second part of the entire work and three content chapters (12, 30, 34), each of which is organized around various disease categories. Discussion is theoretical, with quotation of various authorities, usually but by no means exclusively those cited by Ibn Sīnā in his *Qānūn*, including Che-li-nu-hsi 者里奴西, or Julius Galenos, the great Roman physician and medical theorist, and specific, in the form of a large number of medicinal formularies. Many are called by names and categories used in Arabic medicine, including a number of *ma-chun* 馬準, Persian *ma'jūn*, "electuary," pointing up their direct borrowing from the Arabic tradition, a fact also apparent from the choice and arrangement of medicinals, by Arabic rather than Chinese traditions of use and classification. However, this is not to say that all the medicinals used are of Islamic origin. Kong and his team note, for example, many substitutions of locally-available Chinese medicines for exotic imports and the categories of disease and trauma chosen by the unknown authors of the text, despite the Arabic origins of much that is in it, are more often than not purely comprehensible in terms of Chinese medical theory, although the usual references to *yin* 陰 and *yang* 陽 and other theoretical constructions so important to the Chinese Correspondence Medicine of the era are missing.

Although we lack the key prefaces to the book that would provide the detailed information that we need regarding the origins of the text, even a table of contents for the first part, it is reasonably certain that the text is to be associated with the official establishments of Islamic medicine at the Yüan court as exemplified by the Kuang-hui szu 廣惠司, "Administration for Broad Compassion," charged with "preparing and presenting Muslim (*Hui-hui* 回回) drugs and preparations to the emperor in order to treat members of the bodyguard and poor people in the capital" (*Yüan shih* 88, Chung-hua shu-chü

中華書局 edition, 2221). The HHYF is thus representative of the official medicine of Mongol court in China, one that is also represented in the highly-Islamicized content of the court dietary *Yin-shan cheng-yao* 飲膳正要, "Proper and Essential Things for the Emperor's Food and Drink," with its electuaries, sharbats (also present as such in the HHYF), and many exotic imports including the medicinals of animal origin that also played an important role in the HHYF, judging from the surviving table of content entries (and many of the same animals at that).

The text is reproduced extremely clearly, in this case directly from copies preserved in Pei-ching 北京, in this most useful edition which not only includes the full, surviving text but a number of papers and articles which Y.S. Kong and his team have produced on the text over the years. The most important include:

1. Chiang Jun-hsiang (Y.C. Kong), and Kuan P'ei-sheng 關培生 (P.S. Kwan), "Ts'ung 'Hui-hui yao-fang' k'an chung wai yao-wu chiao-liu 從回回藥方看中外藥物交流" (A look at the trade in medicinals within and without China in terms of the HHYF).
2. Y.C. Kong, P.S. Kwan, P.H. But, A. Ulubelen, and Y. Aneychi, "A Botanical and Pharmacognostic Account of *Hui Hui Yao Fang*, the Islamic Formulary," reprinted from *Hamdard*, XXXI, 1 (1988), 3-33.
3. Sung Hsien, Ch'en Ta-sheng (D.S. Chen), and Chiang Jun-hsiang (Y.C. Kong), "*Hui-hui yao-fang*' yü a-la-po i-hsüeh chu-liu ti ch'in-yüan kuan-hsi 回回藥方與阿拉伯醫學主流的親緣關係" (The intimate connection of the HHYF and the principal currents of Arabic medicine), originally published in *Ming-pao yüeh-k'an* 明報月刊, April, 1991
4. Hu Shiu Ying (Hu Hsiu-ying 胡秀英), History of the Introduction of Exotic Elements into Traditional Chinese Medicine, originally published in the *Journal of the Arnold Arboretum*, 71 (1990), 486-526.
5. Kong, Y.C. and D.S. Chen, "Elucidation of Islamic Drugs in *Hui Hui Yao Fang* - A linguistic and pharmaceutical approach."

From this reviewer's perspective, the most interesting of these are the two articles in Chinese which cover ground only touched on in passing in the English-language articles. While the largest audience for this new HHYF edition is without a doubt Chinese, it is unfortunate that Y.C. Kong and his team did not choose to provide English translations of these valuable articles which would be greatly useful to scholars of Medieval Islamic medicine but will probably remain inaccessible to them. The team can also be faulted for not providing at least a rudimentary index to make navigating through the many components of this new edition easier and for not making a better effort to summarize the contents of the HHYF itself, at least in terms of its major divisions. The linguistic elements of the text are particularly weakly presented and the important question of the origins of the terminology used (basically Persian in form, but with some clear Turkic influence) is touched on only in passing although Kong and his team do provide useful lists of Arabo-Persian terminology along with their tentative identifications.

In conclusion: this is a most useful edition of an important work, one published with a great deal of supporting material including many highly interesting illustrations that add much to the discussion. The book is well printed and is highly readable with its large size duplicating the size of a traditional Chinese book and apparently of the manuscript from which the edition is produced itself. None the less, the present edition by no means makes the HHYF totally accessible nor are the interpretations of the supporting material definitive or even comprehensive in many areas. They do, however, mark a beginning to the comparative study of this important text, made generally available for the first time although in a limited, non-commercial edition. It is hoped that Y.C. Kong and his team will, in the near future, make a more popular edition available including with it translations of the valuable Chinese-language studies.

Living with Death: A Guided Tour in and around Ottoman Hospitals

Miri Shefer

In the Ottoman Empire, as in other Muslim societies, hospitals founded by Muslims for the benefit of the Muslim community were part of charitable institutions (*vakif*). The logic behind the *vakif* system is that institutions or activities not initiated and funded by the state could be set up by individuals, and their functioning was ensured by the existence of an endowment (at least in theory). The foremost service offered by Ottoman Hospitals (*darüssifa*, *bimaristan*, *bimarhane* or *timarhane*) was health care. Medical care was based on the humoral medical tradition and had a holistic approach to curing: patients were treated both physically and mentally. It is not surprising, therefore, to find out that hospitals catered for both the physically and mentally ill. Good bedside manners of the attending staff, peaceful environment, balanced diet and tasty food were important factors of the healing process.

The 17th century Ottoman traveller Evliya Çelebi was obviously impressed by the quality of the food served in a hospital in Istanbul founded by Sultan Mehmed II (1451-1481). He reports that twice a day the patients were generously served with very delicious food. He goes on to say "The deed of endowment is so strong that among its stipulations is written the following: If fowl is missing in the kitchen, let nightingales, house-sparrows and pigeons be served to the patients." And indeed food for personnel and patients certainly constituted a large portion of the expenditure as shown in annual budget reports.

As other charitable institutions, hospitals were also a place where

many earned their living. These included physicians of different specialisations, people in administrative jobs and in service positions. There were three specialisations in the humoral/Islamic medicine based on Galenism. These were general/internal practitioner (*tabib*), ophthalmologist (*kehhal*) and surgeon (*cerrah*). Most of the personnel in hospitals, however, were non-medical. Some of them were menial workers. There was a group on the borders of the medical profession, like herbalists and syrup makers. In the hospitals they were under the physicians' supervision. Outside the hospital, however, people sought them out as experts on their own, and they could operate independent shops in the market place. Yet another group was the administrators, such as the *seyh* of the hospital, the accountant and the steward in charge of the storehouse. The differentiation among non-medical personnel was expressed in their salaries: it is not very surprising to discover that people in white-collar jobs earned more than those in blue-collar ones. Among the medical practitioners the surgeons and oculists were considered inferior to the general physicians.

Hospitals were founded by very-high placed people: sultans, their wives/concubines and mothers, and when not by them - then by very high-placed bureaucrats (i.e. grand vizier, local governor). The people who were associated with the day-to-day management of hospitals were also high-placed functionaries: the chief physicians of the empire, the chief black eunuch in the sultan's Harem, local judges etc. Hospitals were located in urban centres; the most prominent cases are the three Ottoman capitals -

Bursa, Edirne, Istanbul. Sometimes they were even in the very centre of town. Taking into consideration these pieces of evidence, one may conclude that hospitals were a very central institution in Ottoman society and culture.

However, hospitals were very costly to found and maintain. They required a special architectural structure to accommodate patients and staff. The site had to have its own water supply. The founder had to provide for medications and instruments, and to find suitable professional staff. According to Halil Inalcik, the high costs caused prospective founders to choose other venues for their benevolence in the 18th century: at this period hospitals were no longer part of a charitable complex. Libraries, water fountains, schools, and the like were considered cheaper options for prospective benefactors, and they were also believed to achieve more: more buildings and thus more publicity, more people on the pay-role and so on. Another possible explanation centres on the marginality of hospitals patients: lunatics, the poor and foreigners. The benefactors may have hesitated to be associated with the likes of those.

The number of hospitals was in fact relatively small. Philanthropists, who financed the construction and maintenance of many public institutions allocated little to the expansion of hospital care. Hospitals, apparently, had no high priority. Ottoman society tended to treat itself. Naturally, not all maladies could be self-treated. As a result a private sector of medical practitioners of all sorts flourished. Yet people were very active in the medical

treatment they were given: they chose whom to consult, according to which medical

tradition they wished to be treated - as several options existed - and they did not hesitate

to sue the doctor for malpractice if the result was not satisfactory.

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NEW BOOK

Elisabeth Hsu, *Ways of learning Chinese medicine and Qigong*, Cambridge University Press.

Chinese medicine, though widely practised in the West, has often been the subject of mystification. This forthcoming book, based on one and a half years of ethnographic fieldwork, makes basic concepts of Chinese medicine more transparent. The reader is taken to "backward" Kunming in the People's Republic of China and let through the processes of learning that the author underwent, in three different settings of urban China: in a private practitioner's family practice, together with another disciple of a *qigong* master; in a collective of a Chinese acupuncturist and masseur, with followers of a *laozhongyi* (senior Chinese doctor); and in a government

work unit, with undergraduates at the Yunnan College of Traditional Chinese Medicine. Through micro-social studies, the author examines the similarities and differences in the concepts and practices of these different Chinese medical traditions. Their interdependences are explored: an examination of the medical vocabulary, as used in social interaction, shows how the same terms may take on different performative significances, connotation and meaning, in different contexts of medical practice.

The book, primarily written for medical anthropologists, and students specialising on Chinese medicine, will be of interest also to the historian of medicine and

science. First, it contributes to the new field of "the anthropology of the text", for it shows how styles of knowing interrelate with social practice and how the approach to "textual" knowledge differs in different contexts of social interaction. Secondly, the book addresses ongoing debates in cognitive anthropology concerning questions of concept acquisition, though it does this from a perspective firmly grounded in ethnography. Finally, it provides insights into medical education by highlighting the implications of medical practice and the social life of alternative ways of learning medicine.

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ONGOING RESEARCH

Joseph (Joe) S. Alter

Building on my ethnographic study of Indian wrestling (1992a, 1992b, 1993a, 1993b, 1994b, n.d.a), the relationship between celibacy, nationalism and health (1994, 1997a), yoga and nationalism (1997b, 1997c), Mahatma Gandhi's ideas about

health and politics (1996, n.d.b.), and most recently an analysis of the ontological assumptions underlying Ayurveda (1999), I have just begun a study entitled "The Science of Yoga: A Cultural Analysis of Biomedical Research on Indian Physiology,

1900 -1998." This research focuses on the scientific work done by Swami Kuvalyananda and his associates at the Kaivalyadhama Ashram in Lonavala, Maharashtra. Among other things, Kuvalyananda initiated a series of scientific

experiments to prove the existence of the various dimensions, functions and attributes of subtle physiology. Starting in the mid 1920s, this work has continued up to the present. To a large extent, Kuvalyananda's applied, clinical studies of yoga efficacy have come to define the way in which yoga is now used both as a popular form of physical therapy as well as as a therapy for the treatment of many diseases, most notably chronic conditions such as ulcers, hypertension, asthma, and diabetes. Kuvalyananda was most certainly not alone in this endeavor. Swami Sivananda of the Divine Life Society developed a program of yoga hygiene in the 1940s and 50s, and research done by Shri Yogendra during this same period, Swami Rama and his disciples, and more recently by Sivananda's disciples, most notably Swami Satyananda Saraswati, has greatly contributed to the tremendous national and transnational popularity of yoga since the late 1960s. Since 1970 there has been phenomenal growth in the use of yoga to promote health and cure disease. This is reflected in hundreds of publications on the practical value of yogic therapy ranging in scope, scale and quality from B.K.S. Iyengar's internationally known publications, the writing and teaching of Swami Gitananda, Dharindra Brahmacharya and others, through to much more popular works published by less well known practitioners. The research I am doing is based on the following assumption: Even though they are alike in many philosophical respects, Yoga, unlike Ayurveda, was not used as therapy until fairly

recently. Up until the turn of this century it was a metaphysical philosophy grounded in a clearly defined theory of physiology and set of embodied practices, but it was not used for any purpose other than the purpose of yoga. As a "science of long life," on the other hand, Ayurveda has a clearly defined applied, clinical orientation. As is common knowledge, Ayurveda has been subject to scientific experimentation to evaluate its clinical effectiveness for many years, even though it can be argued that the epistemological assumptions underlying Ayurvedic practice are fundamentally antithetical to the criteria used by clinical experimentation to prove or disprove efficacy. Thus, any clinical study of Ayurveda must, on some level, come to terms with the theory, practice, and epistemology of Ayurveda itself. In the case of yoga, however, there is no clearly defined epistemology, no diagnostic protocol, no etiological theory as such, and no system of treatment spelled out in the classical texts.

My hypothesis is, therefore, that the clinical study of yoga using biomedical techniques and biomedical assumptions, has led to a very different understanding of yoga as an Indian medical system. Whereas one can speak in terms of practitioners of "traditional" Ayurveda in contrast to "modern" practitioners of and advocates for syncretic, scientific Ayurveda, yogic medicine -- in contrast to yoga as such -- is by definition exclusively modern. Yet, in an important way, yogic medicine articulates an "alternative modernity" that is not locked into the structural contrast of the past with the present, East

with West, and scientific particularism with embodied holism. The research I will do will show how yogic medicine is distinctly modern, inherently transnational, but also uniquely Indian at the same time. That is, the research will show how yoga is an Indian medical system but not a traditional system of Indian medicine.

There are a number of interesting implications this might have for better understanding the history of medicine in India. As a number of scholars have pointed out, it is difficult to understand the relationship between Ayurveda and nationalism in India's colonial history in large part because of the ambiguous status of Ayurveda in relation to tradition and modernity. Is it possible that yogic medicine has a more clearly defined status within the nationalist movement? Does yogic medicine define a field where the Nehruvian project of modernization is reconciled with the ideals of Hindu revivalism? If so, what are the implications of this reconciliation.

As these questions suggest, the research I am doing engages with the recent historical turn in anthropology and shows how an analysis of culture and cultural practice only makes sense within the context of an historical frame of reference. Yoga should not be seen as either a quintessential example of de-cultured, rootless, transnational, post-modernity or as the most venerable, pure form of an ancient civilization's sacred tradition. As the research will show, the contemporary practice of yoga as medicine is rooted in the history of colonialism, the culture of postcolonialism and the ideology of various different forms of nationalism.

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- Forthcoming: "Subaltern Somatics: Gama the Great and the Heroic Indian Body." Body and Society.
- Under review: "Nietzsche and The Nature of Gandhi's Fasts: Ethereal Power, Moral Violence and the Politics in Digestion."

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Paul D. Buell of Seattle, wrote on 28 May 1998:

"As for what I am doing these days: primarily waiting for Kegan Paul International to publish my (with E.N. Anderson, Charles Perry) translation of the Yin-shan cheng-yao. If you are unfamiliar with the work, it is Mongol era and the most important Chinese dietary. It is of particular interest to me, among other things, because it contains substantial Turkic and Mongolian material (my primary hat is as a Mongolist and Turkologist). I hope now to work on the recipes in the Chuchia p-yung shih-lei, a mid-14th century encyclopedia which also contains substantial non-Chinese material, none of it medical. Just food. I have an article on this coming out in a conference volume to be published by Brill.

Then on to the Hu-hui yao-fang. Recent publications include "Chinese Medicine on the 'Gold Mountain': Tradition, Adaptation, and Change', in Martha L. Heldreth and Bruce T. Moran, Disease and Medical Care in the Mountain West. Essays on Region, History, and Practice. Reno: University of Nevada Press, 95-109, 137-39. This summarized my long-term work on Chinese medicine in the new world. I have also recently revised (entirely) my correspondence course taught through Western Washington University, Independent Studies: EAS 417t, History of Chinese Medicine. This will have a WEB (HTML) presence including a down-loadable bibliography on

the history and anthropology of traditional Chinese medicine listing English, French, and German sources. I hope to expand this to include Asian materials in the future if I can figure out how to display the characters easily. I will be developing programs in C++ and Visual Basic this summer to make the Chinese Medicine course more accessible. I can arrange to have a copy of the syllabus (86 pages, uses Unschuld's History of Ideas as the text) sent if anyone wants to see it there." [Dominik Wujastyk adds: "When this web-site goes live, a link will be provided from the IASTAM home page".]

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Ayurvedic Medicines in India: An Anthropological Inquiry into Medical Knowledge and Social Change

Maarten Bode

In India Ayurvedic medicines are produced and consumed on a large scale. Their acquisition is responsible for about a fifth of the money spent on health care. The technology of production and marketing is based on indigenous as well as Western knowledge and the medicines express

ambivalent cognitions and feelings. The aim of the research is to study indigenous medicines in their historical, social and cultural context. The target is to analyse the meanings of these medicines for consumers, healers and producers. Special attention will be given to the way in which

the use of these Ayurvedic medicines can be read as a political and cultural comment on the inroads of Western culture in India. The research will also focus on the way the Indian indigenous pharmaceutical industry influences developments within indigenous medicine.

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NEW CENTRE

A new Ayurvedic Research Centre has recently started functioning in Karnataka. More information and The Armarc Newsletter are available from P. Ram Manohar, Armarc, Aroor Ravi Memorial Ayurvedic Research Centre, Koppa, Chikmagalur Dt., Karnataka - 577 126, India.

AN 'ALLIANCE' OF CHINESE MEDICINE ASSOCIATIONS IN AUSTRALIA

The word 'alliance' presents an image of a group of people being 'under siege' and a group of people 'sieging'. It seems as if there is a war raging between 'allies' and 'enemies'. Well, the 'Alliance of Traditional Chinese Medicine Associations in Australia' or ACMAA, does not see its 'alliance' as being 'under siege' or an organization which is 'sieging' somebody else. Neither does it see its 'alliance' as a form of united front against perceived enemies.

The 'alliance', as the equivalent Chinese word lian he conveys, is something which 'unites and brings together' six disparate Chinese medicine organizations with over 300 members from the

cities of Melbourne and Sydney. The Alliance is relatively new (about two years old) and its birth signals the growing maturity of the TCM profession in Australia. At the same time, the birth of the alliance also marks the growing maturity of the Australian community in coming to terms with the growing plurality of health traditions in the country. At present, the state government of Victoria is entering the second phase of its three-stage process of regulating the TCM profession in the state as well as federally. On July the 30th of this year, the Health Minister of the state of Victoria presented a set of recommendations on the statutory regulation of the TCM profession

before the meeting of all health ministers in the country. If all state ministers agree to this proposal, then a bill will be introduced in the Victorian parliament regulating the practice of TCM. Undoubtedly, if this happens, it will legitimize a health care system that has been marginalized, but has survived, for more than a century. And that is what our alliance is all about. The ACMAA will ensure that the profession of TCM will continue to survive in the land of Oz and take its rightful place in the diverse and plural family of health care systems in Australia.

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INDIAN ASSOCIATION FOR THE STUDY OF TRADITIONAL ASIAN MEDICINE

The Indian chapter of IASTAM continues to have a full programme of events and News, as reported in the IASTAM India Newsletter.

Subscription fee: Rs 100,-- for four years, or US \$ 20,--.

Contact: IASTAM-India, Zandu Foundation for Health Care, Gokhale Road South, Mumbai, 400025, India

CONFERENCE REPORTS

"Women and Health", Sociologists for Women in Society, Atlanta, Georgia, 27 February - 1 March 1998.

The winter meeting of the Sociologists for Women in Society in Atlanta was split roughly into three sections which spanned the three days of the conference. The overall focus was on women's health in the USA and the rest of the world.

The first day was devoted to papers given by the Centre for Disease Control (CDC) which is based in Atlanta. This involved a total of nine papers divided into three panels (moderated by Judith Lorber, Joan Sokolovsky and Rose Weitz). Research was mostly epidemiological. Papers were given on a number of existing projects from "Women and HIV" to "Assisted Reproductive Technology". Other focused specifically on health care issues concerning minority women within the USA,

or example Dan May gave a paper on breast cancer among American Indian women.

The second day focused more on qualitative research and engaged with non-western medical systems. The morning was kicked off with a talk on ancient healing and feminist thought which involved a focus on rites and rituals associated with menstruation. This was followed by a panel on midwifery, home birth and local activism. This included papers by people such as Sondra Abdulla-Zaimah. She talked about traditional African and Native American, as well as modern customs, beliefs, and techniques of midwifery.

The afternoon session was based on a panel from the Atlanta Feminist Women's health centre. This involved a look at the

historical development of women's health activism beginning with the land mark book, 'our bodies ourselves'. The focus of the last day was health careers for women. This involved workshops on both teaching and research.

The meetings covered a wide range of areas and was interesting and informative. The overall impression of the conference was good. It successfully represented both quantitative and qualitative research and bio-medicine and other health discourses. It also maintained a balance between the importance of the academic and the practical. The members were warm and welcoming and encouraging to people at all stages of their research career.

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"Medicinal Plants Conservation, Utilisation, Trade and Cultural Traditions - Medicinal Plants for Survival", 16 -19 February 1998.

Jointly hosted by Foundation for Revitalisation of Local Health Traditions, Bangalore; Centre for Ecological Science, Bangalore; Jawaharlal Nehru Centre for Advanced Scientific Research, Bangalore.

Medicinal plants can save lives,

livelihoods and cultures. It is therefore not surprising that medicinal plants in recent years have gained considerable importance all over the globe. This importance stems not only from the value of medicinal plants, but also from serious

threats to populations of medicinal plants due to habitat alterations. Thousands of medicinal plants are facing extirpation due to deforestation and habitat degradation.

The International Conference on medicinal plants brought together

