Paul U. Unschuld (1985) **Medicine in China, a history of ideas**. University of California Press.

Introduction (pp. 1-15).

Ever since the seventeenth century, when early European travellers brought back from East Asia information on the peculiar technique of acupuncture and on the extensive Chinese materia medica, an unceasing flow of publications on health care in China has reached interested readers in the West.[1] But this information remained fragmentary and, by the end of the nineteenth century, appeared to be irrevocably consigned to the realm of the exotic at a time when Western medicine, in conjunction with the natural sciences and modern technology, seemed on the threshold of a major advance beyond all previous medical knowledge. Again today, so-called Chinese medicine has emerged as a general topic of discussion and the subject of an enormous amount of media coverage.

In recent years a steadily increasing number of both scholarly and popular publications has been devoted to this topic for a variety of reasons. Growing criticism of the nature and practices of modern medicine, in particular an awareness of the risks and deficiencies of chemical and physical therapy, has prompted some skeptics to look beyond the confines of our own traditions. News of attempts by recent Chinese administrations to structure modern and traditional therapies within one modern health care delivery system has attracted the attention of international organizations as well as of planners from countries where antagonism persists between Western and indigenous medicine. Furthermore, medical historians and medical anthropologists have begun to focus their research on China, where a wealth of written sources permits tracing a lively tradition of health care over several thousand years and where the observation of change and continuity in contemporary communities promises further insights into the nature of the human response to illness.

In this context one might ask how Chinese health care has been portrayed in Western literature. A number of basic currents can be discerned. The first current is evident in discussions that stress Chinese concepts of illness and therapy as preferable alternatives to orthodox Western medicine. Proponents of this view depict "Chinese Medicine" as an identifiable, coherent system, the contents of which they attempt to characterize. Such an approach is both ahistorical and selective. It focuses on but one of the many distinctly conceptualized systems of therapy in Chinese history, that is, the medicine of systematic correspondence, and it neglects both the changing interpretations of basic paradigms offered by Chinese authors through the ages and the synchronic plurality of differing opinions and ideas that existed for twenty centuries concerning even fundamental aspects of this therapy system such as pulse-diagnosis. Manfred Porkert might be mentioned here as a more sophisticated representative of this tendency. His publications are restricted to those facets of Chinese medicine that seem to offer— to a scientifically educated audience—superior qualities in comparison with Western medicine, whose inadequacy results, in the eyes of Porkert, mainly from its preoccupation with causative and deductive reasoning. Unfortunately, Porkert's reinterpretation of some fundamental tenets of the medicine of systematic correspondence on the basis of the Western concept of "energy" must lead to grave misconceptions on the part of those of his readers who have no access to Chinese sources themselves (see sections 3.3 through 3.3.1).

The second current in Western secondary literature on Chinese medicine has a purely historical orientation that accepts unquestioningly the "truth" of modern scientific knowledge. Proponents of this view tend to emphasize those aspects of Chinese medicine that are meaningful to current Western medical practitioners or which at least represent an obvious embryonic form of present medical thought. Authors utilizing this approach have directed their attention primarily to those historical achievements of Chinese civilization that appear to anticipate, often by centuries, corresponding discoveries or insights in the West. The search for "scientific" knowledge in surviving Chinese sources significantly influences presentations of Chinese medicine based on this view. Joseph Needham, supported by his collaborators, appears as protagonist of this current. Lu Gwei-djen's and J. Needham's history of acupuncture (Celestial Lancets, 1980) is the latest example of a series of studies that neglect those historical thoughts and facts in Chinese medicine that are irreconcilable with what the authors consider to be scientific, protoscientific, or at least rational. Perhaps we should recall here the demands on medical historiographers formulated by Ludwig Edelstein almost half a century ago. If we just replace the word Greek with Chinese, Edelstein's words regain their relevance immediately:

> In the historiography of Greek medicine, religious and magical healing, in general, are dealt with only occasionally and very briefly. No one will deny that, throughout antiquity, incubations played an important role, nor will it be disputed that incantations, at least in later centuries, were of great importance. But since these are factors abhorrent to modern science, they are not interesting to the modern historian either.... Medicine, imbued with religion and magic or freed from both of them, . . . is after all Greek medicine; Greek medical literature is, indeed, an accumulation of the most different writings. One must depict the facts as they are without prejudice and properly determine the share which each of the different forms of treatment had in reality.[2]

A third current is discernible in recent medical anthropological publications. A number of individuals have spent months or even as much as a year or two in contemporary Chinese communities outside the People's Republic of China, interviewing practitioners of traditional Chinese modes of therapy and of Western medicine and following selected patients through illness episodes, in an attempt to assess Chinese medicine in terms of both concepts and practices. These individual researchers have encountered and documented a diversity of distinctly conceptualized systems of therapy. In a number of excellent accounts, this research has shown how patients and healers act and interact and what their conceptual premises are.

Despite the wealth of data recorded, there is a pervasive element of perplexity in many of these anthropological reports with respect to the meaning of the multifaceted nature of health care in China. One possible reason for the difficulties medical anthropologists appear to have in explaining the nature of pluralistic therapy settings may be found in the lingering influence of views published by Erwin Ackerknecht in the 1940s.[3] He suggested that medical concepts should be understood as integrated aspects of culture, rather than as independent absolutes, and he initiated the "medicine as cultural system" phase of medical anthropology, a phase that has not yet been overcome.

To point out the fact that health care beliefs make sense in the context of culture represented a significant step forward from earlier notions that discriminated only between truth, science, and rapidly advancing modern medicine, on the one hand, and false, irrational, and static beliefs, stubbornly adhered to by uneducated primitives, on the other hand. The "medicine as cultural system"

approach created a sensitivity toward the rationality and legitimacy of health- and illness-related beliefs in the context of an all-encompassing culture, and it greatly facilitated an understanding of the reluctance of many non-Western populations to accept modern Western medical concepts and practices enthusiastically.

Nevertheless, the limitations of the "medicine as cultural system" view are obvious when this approach is applied to complex civilizations. Ackerknecht's insights were based on an analysis of simple societies where most, if not all, members share one political, economic, and religious reality. It is in such societies that one may find the health care system representative of the culture as a whole. The situation is different when we turn to complex societies such as China. Here one encounters, over the last two thousand years, an enormous variety of differently conceptualized systems of therapy, partly overlapping, partly antagonistic, all of which are representative of Chinese culture. This intracultural diversity cannot be explained by the "medicine as cultural system" perspective, as long as "cultural system" remains a vague concept, correlated, for instance, with "Chinese culture" or "Indian culture." Obviously, health care behavior and the ideas influencing it are part of "culture," but we need to identify variables responsible for the emergence and acceptance of differently conceptualized systems of therapy of various groups even within one so-called culture sphere.

In the present study, I wish to take a new direction, contributing not only to an understanding of the origins and long-term development of diverse health care concepts in China within the socio-economic and socio-ideological context of that civilization but also to an understanding of plurality and change in health care concepts in general. This objective requires an approach that is both historical and systematic and must thus begin with the oldest available sources. In contrast to simple societies, which rarely offer any data in addition to the present, complex societies such as China, with long-established literacy, provide historical sources which enable today's researcher to trace, over many centuries, developments that form the basis of the contemporary situation. Chinese civilization offers the analyst a wealth of primary sources, reflecting concern with the experience of human illness that stretches from the fifteenth century B.C. to the immediate present. During this period of nearly 3,500 years, oracular therapy, demonic medicine, religious healing, pragmatic drug therapy, Buddhist medicine, the medicine of systematic correspondence and, ultimately, modern Western medicine either originated in China itself or were adopted from foreign cultures. The history of these seven major conceptual systems is not characterized by simple linear succession, in which practitioners exchanged each old system for a new one. Instead, the evidence reveals a diversity of concepts extending for more than two thousand years. New ideas were developed or introduced from outside and adopted by authors of medical texts, while at the same time older views continued to have their practitioners and clients.

A primary intent of this study, then, is to explore the conditions that accompanied the rise of new systems of therapy and the continued existence of old ones, and to elucidate the causes and the extent of changes that occurred over the course of time within individual conceptual systems. In this connection, I have found it useful to differentiate between two qualitatively different conceptual dimensions of the structure of medical systems, that is, between a durable paradigmatic core and a "soft coating." The paradigmatic core of any conceptualized system of health care consists of the basic

paradigm accepted by the creators of a particular system of therapy. This basic paradigm supplies the fundamental causal nexus necessary to explain the occurrence of illness. In the history of medicine in China, two basic paradigms appear to have provided the entirety of all therapy systems documented with a durable core. These two paradigms, known in other cultures as well, are (1) the paradigm of cause-and- effect relations between corresponding phenomena, and (2) the paradigm of cause-and-effect relations between non-corresponding phenomena.

The former is based on a recognition that visible or abstract phenomena may be manifestations of a varying number of underlying principles. Phenomena that are manifestations of one and the same principle correspond to one another; that is to say, any change to which one particular phenomenon is subjected will also affect any corresponding phenomenon that shares the underlying principle. As will be explained in further detail in the appropriate section of this book, one may distinguish between the subparadigms of magic correspondence and of systematic correspondence. In the former, an infinite number of isolated chains of correspondence is identified in which, in general, only a small number of phenomena are linked through an underlying principle. One example would be a person and a doll resembling that person. The doll and the person are linked through the principle of their resemblance; they constitute an isolated chain of correspondence. Therefore, under certain conditions, harm done to the doll may also result in harm to the person after which the doll is modelled.

In contrast to the subparadigm of magic correspondence, the subparadigm of systematic correspondence is based on a recognition that only a limited number of underlying principles exist and that all tangible and abstract phenomena can be categorized as manifestations of one of the two (yinyang theory) or five (Five Phases of Change theory) underlying principles identified by various schools of thought. I speak of systematic correspondence here because all categories recognized by these different schools of thought are seen as constituting one intricate system of correspondences in which each and every phenomenon is systematically allotted its more or less well-defined place. The allotment of phenomena to specific principles, be it in magic or in systematic correspondence, is a result of inductive reasoning which stands in marked contrast to the methods established by modern science to arrive at sound hypotheses. The conclusion that a swallowed comb (consumed as ashes) performs the same function in the stomach as a comb that is drawn through the hair on one's head, namely the elimination of lice, is a typical example of inductive reasoning in magic correspondence. Similar, but often less obvious, logic accounts for the lengthy chains of association in systematic correspondence (see sections 3.1.2, 3.1.2.1, 3.1.2.2).

The second paradigm, that is, the paradigm of cause-and-effect relations between non-corresponding phenomena, is based on the observation that phenomena, be they tangible or not, coexist independently and that they may, under specific conditions, exert influences upon one another that may be of a harmful or beneficial nature. Thus, men and spirits share one environment; they are separate phenomena in their own rights without any intrinsic relationship. Under certain conditions the spirits may harm the humans, and vice versa. Similarly, humans may be in relationship with many other phenomena, be they wind, moisture, food, or germs. The point is that these relationships are simply temporary, recurrent, or permanent encounters between individual phenomena and that the sum of these phenomena constitutes the universe. Consequently, the paradigm of cause-and-effect

relations between noncorresponding phenomena contains a stimulus to identify and, if possible, measure ever more specific relations between individual phenomena, and because of this it may support an analytical world view; efforts to explain the position of a phenomenon in an all-embracing system of correspondences may foster a more holistic, organic perspective.
It is apparent from an analysis of historical illness-concepts in China that both these paradigms played a major role in attempts to explain the occurrence of illness and also in the development of therapeutic interventions. Although the Chinese world view has been characterized by the yinyang and by the Five Phases of Change theories of systematic correspondence, it should not be overlooked that the paradigm of cause-and-effect relations between non-corresponding phenomena is equally well represented in Chinese literature. In fact, the two paradigms should be seen as complementing each other in various ways; they do not exclude each other.
Concluding this outline of the nature and contents of the durable core of Chinese therapeutic knowledge, the following list may serve as a preliminary survey of the two basic paradigms and of their respective subparadigms as they underlie the conceptualized systems of therapy discussed in this book.

1. The Paradigm of Cause-and-Effect Relations between Corresponding Phenomena
    1.1. Causation through Magic Correspondence
        1.1.1. Homeopathic Magic. 1.1.2. Contact Magic
    1.2. Causation through Systematic Correspondence
        1.2.1. Yinyang Correspondence 1.2.2. Five Phases Correspondence
2. The Paradigm of Cause-and-Effect Relations between Non-corresponding Phenomena
    2.1. Causation through Intervention by Supranatural Phenomena
        2.1.1. Ancestors 2.1.2. Spirits and Demons 2.1.3. God(s)
        2.1.4. Transcendental Law
    2.2. Causation through Influence of Natural Phenomena
        2.2.1. Food, Drinks 2.2.2. Air, Wind 2.2.3. Snow, Moisture 2.2.4. Heat, Cold
        2.2.5. Subtle Matter Influences 2.2.6. Parasites, Viruses, Bacteria, and others.

The origins of the basic paradigms and of their subparadigms do not concern us here; rather I wish to examine how they were adapted to different conditions in various societies. Such adaptation supplies the durable paradigmatic core with what I call the soft coating of therapeutic knowledge, "soft" because it is flexible and subject to frequent mod)fication. The soft coating consists, for example, of perceptions of the nature of an illness-causing agent. That is, while the paradigmatic core contains the knowledge that there exist other-than-human beings that may influence human life, the soft coating may identify these beings as permanently evil and malevolent (as in demonological medicine) or as capable of delivering both harm and cure (as in religious healing). The soft coating also includes perceptions of the functions and structure of the organism as well as the formulation of behavioral norms designed for the prevention and treatment of illness. These behavioral norms include those which, if violated, may create conditions activating any of the basic causative principles listed above.

In analyzing and comparing the conceptual contents of the different systems of therapy documented in Chinese medical texts over the past three and a half millennia and in tracing the conceptual development of single systems of ideas over extended periods of time, I have focused my attention on the soft coating of therapeutic knowledge. The question to be asked in this context is why—even within one single cultural region—different, often antagonistic systems of ideas have been developed accounting not only for a diachronic but also for a synchronic plurality of competing concepts as to the character, causation, treatment, and prevention of illness. Why is it, for instance, that some thinkers support one system of ideas, denouncing alternative systems as absurd, foolish, or—nowadays—unscientific, while the systems of thought that are denounced in these terms have their own intellectual proponents who may think about the former in similar terms? So far, attempts at comparing different systems of ideas in health care have always started from an assumption that man is confronted with a reality of illness and diseases, and that some systems of thought have arrived at a correct explanation of these phenomena while others have not. The standard approach applied is to consider the insights of one specific orthodox conceptual system as closest to a perceived truth and to investigate whether alternative explanatory systems can be reinterpreted in terms of the orthodox system. For example, African traditional treatment of psychic disorders can be reinterpreted—to a certain extent—on the basis of contemporary Western psychotherapeutic knowledge. Hence, such African traditional therapy is acknowledged as close to the truth and is integrated, occasionally, into official health care efforts by Western-medicine-oriented administrations. Another example is J. Needham's reinterpretation of a suggestion, related in older Chinese sources, for males to absorb the influences of the sun. Needham considers this as Chinese recognition of what became known in Western medicine as the beneficial effects of heliotherapy, and he concludes that the Chinese were close to the truth. It can hardly be denied that a reality of illness and disease confronts mankind—after all, a broken bone or a blind eye are convincingly real to most people— but we have, as yet, no idea as to where that reality ends and where purely constructive imagination begins. One may assume, in a general theory of cognition, that human cognitive abilities may be suitable— as a result of adaptive evolution—to interpret correctly a medium-range reality; human common sense and linguistic faculties end where we leave that medium-range reality to extend our knowledge into the depths of space or into the secrets of the smallest particles. Concepts such as "curved space" or "wave-nature of particles" can be understood by some, but to most people they make no sense on the basis of everyday experiences, and they cannot be expressed adequately with the linguistic tools that have evolved alongside these everyday experiences. Hence, some researchers in philosophy and in the theory of cognition are in a process of turning their view away from the ageold question of what is real and what is imaginary, to an analysis of mankind's cognitive abilities. I suggest that a similar turn, or revolution, should take place in the comparison of conceptual systems in medicine. Thus, at least for the time being, we should turn our back to that probable reality of illness and disease referred to above, facing, instead, those who have attempted to grasp that reality and to formulate concepts suggesting a behavior in conformity with that perceived reality. Facing into this direction we should ask ourselves what factors account for diverging, contradicting, or antagonistic systems of ideas within complex societies, within single cultural regions, and among mankind in general. Hence, in

this study, I have focused my analysis on what I have called the soft coating of medical knowledge, that is, on health care-related concepts that have changed over time. I started from an assumption that variables accounting for the nature and contents of human cognition in health care might have left visible marks here.

Preliminary evidence suggested that social variables accounted significantly for the shape of the flexible elements of conceptualized systems of therapy. It therefore appeared essential, first, to identify the contents of all the different systems of therapy and, second, to determine any social significance they might have. To achieve this, I have developed a four-step methodology and applied it to the Chinese source materials. It includes a chronological, a linguistic, a structural, and a sociopolitical analysis of the systems of therapy concerned and may be outlined in detail as follows.

The chronological analysis required the tracing of concepts back to a point in time when they emerged in the literature and when they were accepted as meaningful by a group in society. Furthermore, the chronological analysis identified historical periods when specific ideas lost their appeal in society. This dating of the generation, acceptance, and fading of concepts proved to be very helpful in that the historical context provided initial clues for the identification of socioeconomic variables that changed simultaneously and may have influenced the nature and fate of the therapeutic concepts under consideration.

The linguistic analysis implied an etymological analysis of the terminology employed by the various therapy systems. In addition, it necessitated a search for parallel usage of key terms in therapeutic and other sociocultural contexts. Through this kind of analysis, important evidence was accumulated, suggesting relationships among therapeutic concepts, social facts, and sociopolitical ideologies.

These data were further corroborated by the structural analysis. It required a search for any hierarchies that might be discernible in conceptual systems of therapy. For instance, the fact that specific systems of therapy ranked the human body's internal organs and defined their respective responsibilities in a particular way suggested relationships between particular systems of therapy and particular groups.

The final methodological step, the sociopolitical analysis, required, first, an identification of the behavioral norms advocated by the individual therapy systems and, second, an investigation of the norms of conduct propagated by the sociopolitical ideologies of groups in society that sponsored or opposed a particular system of health care. Any systematized world view, be it a religion, an economic theory, or a sociopolitical ideology, including the less articulated perception of the universe in the minds of the common people, contains some specific notions concerning the reasons for crises in the society or community. In fact, the founders and propagators of Confucianism, Taoism, Christian dogma, Marxism, and even capitalism share the belief they have found the ultimate explanation of the origins of conflict and offer guidance toward social harmony. Each of these (and other) world views entails and propagates behavioral norms to be followed by all members of society in order to reach or maintain a state of peaceful coexistence. Any single individual deviating from these norms represents a threat to the social end desired by the dogmatists. The comprehensive nature of most sociopolitical ideologies is apparent not only in the efforts of their propagators to reach each and every member of society but also in their attempts to adapt all aspects of knowledge or science to

their central perception of harmony and crisis. Any knowledge which, in its consequences, may contradict this central perception and the behavioral norms derived from it, will be opposed and, if possible, eliminated.

Medical knowledge constitutes a case in point. At first glance, medical knowledge may appear peripheral in relation to the goals of social ideologies. Yet, the acceptance or rejection of concepts of disease by groups in society has rarely been independent of socioeconomic and sociopolitical determinants, be they consciously considered or not. Any therapeutic system based on a distinct explanation of illness advocates a specific life-style to avoid disease and identifies specific measures to deal successfully with disease. A particular preventative life-style constitutes, together with specific therapeutic measures, the behavioral norms of any conceptualized system of health care. Important in this regard is the well-known phenomenon that different systems of therapy not only deal differently with one and the same health problem but that they, in addition, frequently recognize or emphasize quite different health problems in the first place. Each medical system organizes the abundance of initially unordered clinical pictures or possible symptoms of illness into an illustrative mosaic which in turn motivates the members of a group or society to act and interact in certain ways in specific situations. It appears to me that it is precisely this action and interaction on a personal and interpersonal basis, required by systems of therapy, that significantly accounts for the acceptance or rejection of the systems by groups in society. This required behavior may, in its consequences, contradict the behavior required by a sociopolitical ideology to maintain its specific type of social order; in fact, the maintenance or achievement of a desired type of social order may be jeopardized if such contradictions occur. The success of a sociopolitical doctrine is enhanced if such contradictions can be avoided.

To summarize, through the application to the Chinese source materials of the four-step methodology outlined above, it became apparent that two major independent variables significantly, albeit not exclusively, shape the soft coating of therapeutic knowledge and account for the acceptance—or rejection—of specific sets of ideas by groups in society. These variables include, first, specific social facts, and, second, sociopolitical notions of order and crisis. Many examples from the history of health care concepts in China, to be discussed in detail in the main sections of this book, suggest that certain images— or social facts—from our environment possess such powerful symbolic value that they, having been experienced as part of social existence, are adopted, both consciously and subconsciously, by thinkers in attempts to understand and explain individual existence. Undoubtedly, the acceptance of a particular set of therapeutic ideas by broad segments of the population is enhanced if these ideas are plausible, for the very reason that they agree with the experiences of daily life.

A similar relationship appears to exist between medical concepts concerning the causation, character, prevention, and treatment of illness, and sociopolitical ideologies that explain the causation, character, prevention, and management of social crisis. The obvious parallels in the formulation of behavioral norms by systems of therapy and by sociopolitical doctrines have, as some historical examples suggest, been created deliberately at various times by dogmatists in order to present an all-encompassing world view. Yet, such efforts seem to be the exception rather than the rule. It may well be that most thinkers who develop ideas concerning the nature of illness are unable to realize or

to escape the logic of social existence. The way people live together and the way they cope with interpersonal conflicts as well as the existential guidelines they develop as a result of a desire for social order may also exert a powerful symbolic stimulus on an intellectual's conception of health and illness.

The congruity between a particular therapeutic doctrine and a particular sociopolitical ideology determines, in turn, the appeal of this therapeutic doctrine to individuals and groups. The actual therapeutic value of specific ideas, that is, their efficacy with respect to illness, seems to be of only secondary significance. The basic validity of therapeutic concepts is primarily social.

Realizing the impact of social facts and of sociopolitical ideologies on the conceptual contents of systems of therapy and on their acceptance by groups in society, we arrive at an explanation of intracultural therapeutic pluralism and of changes over time which the "medicine as cultural system" perspective cannot supply. In summary, the historical data analyzed and discussed in this book permit the following conclusions:

1. In a community where all members share the experience of one socioeconomic reality and adhere to one and the same world view, we will find only one conceptualized system of therapy that is adhered to by virtually all members of this community.
2. Plurality of concepts is inevitable in a society where different groups coexist who experience different socioeconomic realities and who differ in their perception of a desirable social system.
3. Change in dominant concepts of illness causation is inevitable in any society where basic sociopolitical change occurs; social reorganization is reflected at the level of medical thought.
4. Older conceptual systems of health care, which may have been dominant in former times, survive in social groups that continue to follow a consistent sociopolitical ideology.
5. Any group in society that, on the basis of a specific sociopolitical ideology, strives for political influence, or even dominance, will sooner or later support or create a specific set of therapeutic concepts consistent with its social norms while contradicting the ideology of political opponents.
6. In general, only intellectual dogmatists, who realize the consequences of a close relationship between one particular set of therapeutic ideas and their own ideology, as well as a minority of patients and practitioners, strive consciously for the persistence of "pure" conceptual therapy systems. In actual daily practice, eclectic and syncretic systems of therapy emerge in complex societies with therapeutic plurality.

Here, then, I wish to return to the theory-of-cognition aspects of this study. Obviously, our cognitive abilities account for many characteristics of reality as we perceive it, and, in turn, the reality we experience accounts for our cognitive abilities. While there appears to exist one general natural reality in which all humankind and its environment is embedded, within mankind in general, within single cultural regions, and within single societies, groups appear to experience different cultural realities resulting in cognitive differences in health care. These different cultural realities are formed by the different socioeconomic facts and sociopolitical ideologies referred to above. One could, therefore, speak of differing socio-realities. Such a term might lead, however, to reductionistic arguments, and although, in this study, the formative influence of socioeconomic facts and sociopolitical ideologies

on cognition in health care is emphasized, additional variables influencing the shape of the soft coating of medical knowledge may be identified in the future. Societies constitute intricate networks of individuals and groups, interacting pragmatically as well as ideologically. It is simply inadequate, for instance, to consider society as an aggregate of various classes, each with its class-specific consciousness, as if their members lived in separate social arenas. I have, therefore, spoken only of "different realities," and it should be kept in mind that these are not necessarily separate realities. A mutual penetration of different realities within one complex society is common and can be observed, for instance, in the resort to different health care systems by a single individual. The eclectic and syncretic nature of patient and practitioner utilization of available ideas and tangible primary resources in pluralistic health care settings of complex societies is partly a result of the healers' striving for secondary resources, that is, remuneration, and of the patients' desire to maintain or regain health by all means. Eclectic and syncretic health care behavior are, thus, mainly goal oriented, not cognition based. They may, to a certain extent, be supported, however, by the fact that in complex societies many individuals witness—in daily social life—differing cultural realities. This may especially be true for changing societies where a younger generation no longer shares all the values of a parent generation— but knows of them, remembers them—or where different social groups live close enough to one another to observe the values of the others' cultural reality. The proximity of different groups in daily life may account for mutual tolerance toward, if not partial acceptance of, one another's cognitive system.

A group is defined here, consequently, as a cohort of persons who experience similar or identical sociocultural realities. Hence, if within one society two or more socioeconomic and sociopolitical realities exist for different people, two or more groups coexist with different cognitive abilities. This definition of group, which will be employed throughout this book, is not only different from the concept of "class" but is also apart from an idea of people joining together consciously for a specific purpose. Members of a group, as it is defined here, are not necessarily aware of their experience of a common reality. To put the argument to an extreme, even people living in separate geographic regions without any links, or in different historical epochs without the latter knowing of the former, may be part of one "group" if the sociocultural realities they experience are, in their essential structure, similar or identical. Consequently, one may find similar or identical concepts concerning character, causation, treatment, and prevention of illness in diachronically or synchronically separate populations without having to assume a transmission of ideas.

The methodological approach of this study has determined its organization. In each of the nine chapters of the first part of this book, I discuss, first of all, the political, economic, and intellectual aspects of the historical epochs in China that are important for an understanding of medical thought during those periods. Second, I discuss prevailing or competing systems of health care, relating them to the changing historical background in general and to social facts and sociopolitical goals of specific groups in particular. Finally, on a third level, I consider the consequences of the concepts of illness for therapy, particularly as they apply to the use of drugs. In order to allow the authors of works analyzed here ample opportunity to speak for themselves, I have augmented my presentation with numerous quotations from Chinese sources.

The second part of the book is an Appendix containing longer excerpts from primary texts, most of them translated here for the first time. All the materials in this section illustrate specific arguments in part one and are marked accordingly.
The history of medicine in China is multifaceted; no single book could describe and analyze it in its entirety. The current volume, the first of a number of independent monographs by this author on "Medicine in China" published by University of California Press as part of the series Comparative Studies of Health Systems and Medical Care, focuses on the major conceptual currents underlying Chinese health care over the past three thousand years. A second volume, Medicine in China: A History of Pharmaceutics, recounts the development of Chinese drug lore as documented in Chinese pharmaceutical literature since the third and second century B.C. A third volume, Medicine in China: Nan-ching—The Classic of Difficult Issues, offers the first philological translation of a Chinese medical classic into a Western language and traces the history of this classic through the centuries to the present time. Further volumes are in preparation.

Unschuld's Footnotes (from Unschuld, 1985, p. 367).
1. Among the earliest Chinese medical and pharmaceutical books brought to Europe were (fragmentary?) copies of the Wan-ping hui-ch'un, a comprehensive book on prescriptions first published in 1587, and copies of the herbal Cheng-ho pen-ts'ao, first published in 1116. Both these works came into the hands of European physicians some time between 1605 and 1611. See Hintzsche 1960. For an account of the westward spread of acupuncture techniques, and their reception in Europe, see, Lu and Needham 1980, pp. 269-302.
2. Edelstein 1967, pp. 205-207.
3. Cf. Ackerknecht 1942.

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1. Illness and Healing in the Shang Culture (pp. 17-28).

1.1. SHANG CULTURE AND SOCIETY

The Shang Empire, the first Chinese dynasty to leave traces of therapeutic activities, arose approximately during the eighteenth through sixteenth century B.C. along the middle course of the Huang-ho (Yellow River), in the northeast section of modern-day Honan Province. The early history of the Shang is obscure, and the origin of their cultural achievements remains puzzling, in particular the use of horses and war chariots as well as a highly developed process of bronze casting.[1] The Shang, whose empire lasted into the eleventh century B.C., utilized a rather sophisticated early form of the script still used in China today. Some of their characters have survived to the present with a similar form and meaning. Others, however, fell into obscurity and can be identified today only with great difficulty, if at all.

The Shang period is documented by historical reports compiled during the subsequent Chou dynasty (1050-256 B.C.). But these accounts are often so strongly influenced by the political interests of later chroniclers that, if considered by themselves, they would yield a highly dubious picture of reality. A vast amount of archaeological evidence is also available, however—especially the great number of inscribed bones and tortoise shells discovered since the beginning of this century—enabling a reasonable estimation of the characteristics of Shang culture.

In order to analyze and describe the attitude of Shang society toward illness and healing, however, several methodological assumptions are necessary. Utilizing ethnological analogy, I will refer to presently existing cultures possessing a social organization similar to that of the Shang; in addition, it will contribute to our understanding of this civilization to assume that a number of cultural practices, which have been documented in China only for the first millennium B.C., can be traced back to the Shang period. An analysis of the Shang system of healing must, of course, be based primarily on Shang sources. These are provided by the already mentioned bones and tortoise shells that were inscribed in approximately the thirteenth century B.C. for oracular purposes.

Shang culture was based on agriculture and livestock. Part of the population had already settled in small towns, where an upper stratum of nobility employed numerous craftsmen, but the great masses still lived as peasants in Stone Age conditions.[2] Sovereign power rested in the hands of a king.

The world view of the Shang encompassed a community composed of the living and the dead. The existence of the dead was just as much a certainty as that of the living, and it was understood that both groups were dependent upon each other. Ancestors ruled the world, but they were dependent upon the living for provisions. If the living failed to furfill these obligations, expressions of displeasure by the departed were inevitable.

Ti was the supreme or divine ancestor. He provided the living with bountiful harvests and rendered assistance on the battlefield. Ancestors of the king were believed to have a direct influence on the actions of Ti, and it was incumbent on the king to ascertain through the oracle their will on diverse matters and, if necessary, to exert pressure by means of words or material offerings.[3] To this end, a system of communication was established, which was utilized daily to consult with ancestors regarding the weather, wars, future harvests, payment of tributes, hunting prospects, dreams, travel plans, political alliances, and, of course, lack of offspring and illnesses.[4] At first, only certain cattle bones (and later tortoise shells) were employed as a medium of communication. These were crafted in great numbers and with considerable expenditure of labor and were presented to the king. For the actual consultation of the oracle, several holes were first drilled in a bone or one of the carapaces. The king, or a diviner in his service, then made his inquiry and subjected the bone to heat, producing a series of cracks that radiated from the holes. The interpretation of these cracks by the king revealed the will of his ancestors in the matter at hand and thus provided the basis for a wide range of actions, both political and otherwise, by the ruler. It is no longer possible to determine for certain whether questions were inscribed on the bones or shells before or after the heat treatment.

1.2. RESPONSES TO ILLNESS

Turning now to the Shang behavior that we recognize today as a response to illness, it must be cautioned that available sources furnish information only about the lives of Shang kings and their immediate surroundings. At present, there is no way of determining the measures taken by the lower strata of Shang society to deal with physical distress. The surviving evidence, however, does provide a good impression of how the upper stratum of Shang society comprehended illness, and it is the history of certain concepts as they apply to specific groups that I wish to examine in the present study.

The following analysis will demonstrate that, in addition to a general awareness of illness, the Shang had already developed the notion of diseases. Illness is defined here as the primary experience, that is, the subjectively perceived feeling of indisposition that can lead to changes in behavior. Disease, by contrast, is a socially determined product, a conceptual reshaping of the primary experience of illness. Therefore, I characterize disease as a clearly defined deviatian, within a specific set of ideas concerning the causation, character, and treatment of illness, from a normal state of human existence, however that normal state may be conceived. As a result, certain manifestations of illness may, in different societies, be comprehended as completely different diseases. For instance, the condition diagnosed by modern biochemical-biophysical medicine as a heart attack may be conceptualized in a society that practices demonic medicine as the "blow of a demon." The Shang, as I will show, were familiar with many different forms of illness, but they recognized only a very limited number of diseases, the most important by far being the "curse of an ancestor." Toothache, headache, bloated abdomen, and leg pains were only different symptoms of the same disease. To illustrate the enormous extent of the difference between Shang healing and modern medicine, it should be noted that a poor harvest and misfortune in war were also considered symptoms of this same disease—"curse of an ancestor." In the analysis that follows, it should be remembered that "disease" and "medicine" are categories that did not exist for the Shang; they arise from our own culturally determined approach. By examining an "ancestral medicine" of the Shang, I arbitrarily isolate the treatment of medical emergencies from its cultural context in the general solution of crisis situations—a differentiation not yet conceptualized by the Shang in the same manner.

Detailed indications of how the Shang perceived illness and the resulting methods of treatment and prevention can be deduced from the pictographic symbolism of certain characters as well as from the contents of the oracle texts themselves.

The character chi appears in oracle inscriptions as an equivalent for the modern concept of "illness." The pictograph is composed of the two elements: "man" and "bed."[5] In addition, one to four small strokes surrounding the component "man" are discernible. Various hypotheses have been advanced to explain these marks, ranging from "drops of blood"[6] and "arrowheads"[7] to "invisible pathogenic particles."[8] A comparison of additional characters in the oracle texts seems to support the meaning "drops of blood," since the small strokes were frequently used to designate blood and other fluid as well as solid bodily secretions. They are present, for example, in the pictograph for "parturition" around the character for "vagina,"[9] in a character identified as "urination,"[10] and in the symbol used for "to kill."[11] Moreover, it is possible that the drops of blood indicated in the pictograph "illness"

result from injury to the sufferer. Thus, it can be argued that the entire meaning of the character would be a "person bedridden because of injury." If such a reading is accurate, this pictograph contains the original concept of illness caused by the evil intentions of a hostile third party, forcing the victim to remain in bed beyond the time necessary for rest. Such a theory of "injury caused by the evil actions of third parties" is supported, as I will demonstrate below, not only by textual usage but also by the subsequent development of the character chi. It is likely that the pictograph was given the form still valid today—a composite of "bed" and "arrow"— during the orthographic reform of the Ch'in dynasty (221- 206 B.C.).

The use of the character chi in Shang oracle texts, however, indicates that the concept of illness during that period had already diverged considerably from the literal basis discussed above. One inscription, for example, reads "the king has a tooth illness."[12] It is no longer necessary that the symbol "illness" include the basic meaning of "bedridden." But, as I will show, it does retain the notion of "injury caused by evil." In addition, later oracle scribes frequently omitted the "blood" strokes around the "man" component of the pictograph.

In the oracle texts, chi was generally used in conjunction with a part of the body or bodily function. Of the approximately 200,000 oracle bones and tortoise shells discovered to date, 14 different combinations have been identified with certainty: combinations with the pictographs for head, eyes, ears, nose, mouth, tooth, neck, abdomen, foot, heel, as well as for voice, urination, and parturition.[13] Only a few such combinations have remained unclear. The combination of the characters for "illness" and “child,”[14] for example, may indicate a sick child; that of "illness" and "year, harvest" could signify either "ill year" (epidemic?) or “ill harvest.”[15] Certain physical abnormalities were expressed in oracle texts without using the symbol for illness, such as "swollen abdomen”[16] and "tooth decay.”[17]

Oracle inscriptions point to three causes of illness. Predominant is the concept of actions by deceased ancestors or other third parties. The following five inscription samples exemplify the overwhelming majority of oracle texts pertaining to illness:

> Question: Will there be an illness?[18]
> Question: Will there be no illness?[19]
> Tooth illness. Is there a curse? Perhaps from the deceased father-I?[20]
> The king is ill. Was he perhaps cursed by the deceased grandmother Chi? Or the grandmother Keng? Will his condition become serious?[21]
> Swelling of the abdomen. Is there a curse? Does the deceased Chin-wu desire something of the king?[22]

The influence on living persons by the hostile will of departed ancestors or others was expressed in the oracle texts by such concepts as "sent from above" or "rained down from above" whenever Ti, the deified ancestor, was himself believed to be the originator of the suffering,[23] apparently indicating the notion of a supreme "ruler on high." The pictograph sui, meaning "curse" or "to curse" was generally used in oracle texts pertaining to whether an illness had been caused by a direct ancestor, or perhaps by a former minister of the king.[24]

Their understanding of the causes of illness and disease led the Shang to adopt rational preventive and therapeutic procedures. If the deceased, when aroused, were able to induce illness and disease, their potential displeasure had to be forestalled with gifts. If the deceased had already carried out their curses, an attempt was made to remedy the situation, that is, to bring about the removal by means of offerings. One oracle text, for instance, reads: "Severe tooth illness. Should a dog be offered to the departed father Keng, and a sheep be ritually slaughtered?”[25]
It often appears that effort was directed solely at placating, through conjuration, the dead spirit suspected of causing the illness. Here the severity of the illness may have played a role. Three terms have been identified in the oracle literature that convey the meaning "conjuration," or "driving out by means of incantation"—kao, yü, and ch'iu.[26] In later texts, beginning in about the third century B.C., this therapeutic technique was designated chu-yu, "exorcism of the cause."[27]
Medicinal preparations, such as drugs made from plants, apparently found no place in the ancestor medicine of the Shang. Oracle inscriptions contain no specific drug names, and no character has been found that represents the abstract meaning "medication." Yen I-p'ing, who has studied the medical oracle texts in great detail, has pointed out several inscriptions containing the character for "wine." Based on the fact that these wines were prepared from herbs—millet, for example— Yen I-p'ing has concluded that the Shang were familiar with medicinal herbs (and recent finds in a Shang tomb have supported this conclusion).[28] However, the character "wine" appears only in conjunction with sacrificial potions for ancestors and not in what could be understood as a consciously therapeutic context.

1.3. HARMONY BETWEEN THE LIVING AND THE DEAD

The discussion of harmony between the living and the dead, the most important Shang concept pertaining to the origin, prevention, and treatment of illnesses, raises the question of why these ideas, and not others, became pre-eminent, at least in the ruling segment of this society. Shang culture was primarily agrarian. Ancestor worship by the upper stratum, and consequently the ancestor medicine outlined above, reflects, on a metaphysical level, a constant fear of one's fellow man, as well as a deep distrust of neighbors and even relatives. Such traits are characteristic of traditional agricultural societies of the present—Central and South America or Africa, for example; it does not appear far-fetched to postulate a similar basic attitude in Shang society.
George Foster was probably the first to identify the static nature of the economic system of such cultures as an important cause of this mental climate.[29] Traditional agrarian societies are characterized by a constant level of production, year after year. In other words, we have here a situation of true zero growth, in which the resources available to the society do not expand at a steady rate. Exceptions do occur, of course, through the catastrophic effects of climate or the intervention of enemy forces, which reduce available resources, or raids into enemy territory, which produce the opposite result. A comparison of societies with a static economy and societies with a growth-oriented economy reveals that significant accumulations of wealth by individuals, families, or groups are tolerated for long periods only in the latter. The prevailing outlook in these societies—whether conscious or subconscious—is that such wealth is not gained at the expense of others, but originates from one

huge, inexhaustible source, from which every person, with sufficient effort, can and may withdraw as much as he desires. The situation is perceived quite differently in those societies with little or no foreign trade and where the fields or other sources of livelihood visibly yield approximately the same amount every year. Here it is generally felt that since the total amount available to society remains constant, any enrichment of one person, family, or group inevitably occurs at the expense of all remaining persons, families, or groups. All known societies in this situation have, as a result, developed social mechanisms that in some way ensure the orderly distribution of the total product among members. As far as available sources indicate, the Shang adopted similar measures.

The ubiquitous presence of such mechanisms can be viewed as an indication of their necessity, that is, of the impossibility of maintaining a social order that assures survival and the freedom of movement without likewise adopting social conventions for the distribution of all available resources. The motivating impulse behind the establishment of such conventions seems to be the effort of individuals or entire groups to increase their share of the wealth at the expense of other individuals or groups. Mistrust is the omnipresent manifestation of a precautionary consciousness toward such efforts by others; envy is the underlying attitude of those who suspect that others have already appropriated a larger portion of available resources than they are allowed. The social conventions that arise from these attitudes aim for the continuous balance of resources in society. The egalitarian principle that opposes the accumulation of material goods by individuals or social subgroups has, in all known societies in the world possessing static economies, and even afterward in growth-oriented advanced cultures, led to the establishment of rituals whose significance appears to be the redistribution of material goods—which for various reasons have accumulated in the hands of individuals—and the compensation of the victim with an immaterial, transitory substitute, namely prestige. This is the only way to understand the fiestas in Latin America, which appear excessively costly to outside observers and which bestow the greatest glory to the most zealous spendthrift. The same is true for the ngbaya ceremonies in Africa,[30] the potlatch celebrations by Indians in the Pacific Northwest, and numerous similar examples. All of these rituals, no matter what additional functions they may have, help to preserve mutual goodwill among the members of a society by limiting mistrust and reducing or even completely eliminating the possibly fatal consequences of envy.

Let us now return to Shang society, where the equal distribution of resources included the dead as well as the living. The Shang buried their dead with an abundance of gifts. Carts, horses, weapons, jewelry, foodstuffs, diverse containers, and, occasionally, an entire complement of servants were to remain at the disposal of the departed.[31] Regular offerings on a smaller scale and, on occasion, more extensive presentations, such as several hundred head of livestock, were continued by the living. Since the quantities of meat left over from such occasions were subsequently consumed by the living, earthly distribution was also provided for at the same time.[32] As early as the first millennium B.C., following the decline of the Shang dynasty, similar rites of exchange survived in the winter celebrations of the peasants. Marcel Granet has fashioned his analysis of the relevant sources into a lively portrait of the "communal revelries and drinking bouts."[33] As he points out, such gatherings generally resembled fairs. Competition in gift-giving was the motivating force; in order to obligate the partners to even greater return gifts, one always had to give more than one had received. "Men

competed with one another to see who was able to give his possessions away in the most ostentatious manner."[34] Those who participated in these festive occasions returned home with prestige for the coming months; the resulting hierarchy changed from year to year.[35]

1.4. ILLNESS AS AN INDICATION OF CRISIS

In the same manner that a person can suffer bodily injury in a dispute with one's fellow man, the Shang believed that the deceased, when neglected, could vent their hostilities on the living. Their weapon was the curse, and it could produce crop failure or a loss on the battlefield. But it could also result in an offending descendant being "bedridden," that is, with an illness. The first two consequences, which stand here for numerous other examples, represent a crisis in relations between the living and the dead that involves the entire community. Illness, by contrast, generally indicates a problem between a living individual and one or more ancestors, and concerns the entire population only when the king is involved. The specific measures taken to prevent or overcome such crises remained the same, regardless of whether an individual or the entire population was threatened. Thus, Shang ancestor medicine was completely integrated into the attitudes and mechanisms developed by this society to understand and solve social crises.

1.5. ILLNESS AS THE RESULT OF "NATURAL" INFLUENCES

The Shang recognized other causes for illness in addition to ancestors. In some inscriptions the deceased are asked whether "malignant wind" or "snow" produced the affliction.[36] One such inscription asks: "Question: Has the Princess Hao fallen ill because of an evil wind?"[37]
There is clear evidence on the oracle bones that the Shang believed in the existence of wind-spirits. According to the bone inscriptions, so-called wu-shamans could control the forces of the wind; they "either performed the rites of [the divine ancestor] Ti to cause a good wind to blow and to cause rain to the extent that it supports the growth of the crops, or they performed the rites of pactfication in order to prevent or stop an evil wind."[38] It is possible that the evil wind that had to be pacified was the same entity that caused Princess Hao's illness. Evil wind, as an illness-causing spirit, may have acted in its own right, or it may have been considered to be merely a tool of Ti. Wind, if I may jump ahead here, remained, up to the present, one of the most important etiological principles in traditional Chinese medicine (see below pp. 67-72).
The oracle inscriptions mention yet another "natural" phenomenon as a source of illness: "snow." We do not know, though, whether "snow" was considered to be a spiritual entity as well or whether it was accepted as just an occasional phenomenon of the natural environment.
Finally, it should be noted that Shang oracle texts occasionally contain a character used since the Han period as a term for black magic, that is, the intentional illness-causing action of living persons that is visible only in the end result.[39] Since there is no evidence indicating exactly how Shang scribes used the pictograph known as ku, I will discuss it in connection with the more substantial sources of later periods (see section 2.4).

1.6. SHANG HEALERS

One aspect of Shang therapy has so far only been touched upon—the nature of its "physicians." We have encountered the wu-shamans in their function of pacifiers of (illness-causing?) evil wind; I will have to return to this group of practitioners in the course of my discussion on demonic medicine, of which they became the central personnel.

The dominant conceptualization of illness by the Shang, which differs so greatly from modern understanding and which is most evident in the creation of practically only one disease, whose symptoms range from headache to crop failure, necessitated a type of healer totally different from what we are familiar with. Ancestor therapy neither knew nor required a physician who directed his attention to the patient and carried out medical therapy. As a consequence of their understanding of the nature and origin of illness, the Shang required only social therapy, in the sense of an adjustment of the disturbed relationship between the two large groups of society, the living and the deceased. The obligation to consult ancestors and interpret the oracle appears to have been reserved for the king alone, or for diviners in his service; he was therefore the sole practitioner of ancestor therapy. His clientele was restricted to himself and possibly the upper nobility. As already indicated, the extent to which the rest of the population was involved in ancestor therapy is unknown. Only occasionally, during epidemics and other catastrophes that transcended the concern of individuals, did the king function as the "physician" of the entire population. In every case, he was responsible for both diagnosis and therapy.

David Keightley has stressed the "powerful psychological and ideological support that ancestor worship provided for the political dominance of the Shang kings."[40] The sociopolitical significance of the "diagnoses" of oracle medicine has been demonstrated for present-day societies in which such a system has survived.[41] Although no direct evidence exists, it seems likely that the Shang king and "physician" also combined the "medical" prescripts given to the members of the upper stratum and perhaps the entire population, based on the consultation of the oracle, with his own political intentions. "If, for example, the king discovered (by means of the oracle) that his senior uncle, father Keng, was causing his toothache, he may have blamed father Keng's descendants at the court for inducing his distress."[42] Because of the kind of evidence that has survived, it is impossible to determine to what extent the sanctions resulting from such accusations and the underlying "diagnosis" may have been motivated a priori by political considerations.

1.7. CONCLUDING REMARKS

Any account of Shang therapeutic ideas, practices, and institutions must remain, because of the nature of the documents available, limited and preliminary. As the following chapter will show, the Chou dynasty, succeeding the Shang, saw the development of new concepts and techniques concerning the origin, treatment, and prevention of illness. Ancestral healing, although becoming gradually discontinued in the way it was practiced by the Shang, has persisted as an important facet of the broad range of health care strategies employed by the people of China to this day. The continued existence of beliefs in the possibility of ancestral intervention to cure or prevent illness is most notable in Chinese communities on Taiwan or in Hong Kong. The basic principle underlying the relationship

between the deceased and the living is the idea of reciprocity; this notion has remained the same since the remote times of antiquity. Ancestors wish, for instance, to have their bones passed, in their grave, by good "wind and water" (feng-shui) influences, and are expected, in return, to guarantee prosperity and health of those descendants who arrange a suitable burial site and who cleanse and rearrange the bones in proper fashion once the corpse has decayed. Just as the human body, beginning with the third or second century B.C., was conceived as an organism whose life depended on the flow of proper influences through specific transportation channels (see below pp. 74-77), a concept of the earth as a living body containing hidden channels filled by a flow of beneficial contents was developed at about the same time. It became the task of special diviners to discover, for the establishment of tombs or other structures, favorable sites where such channels convened, and to avoid others where evil influences might be present. Hence, the belief in the potential of the ancestors for health care remained directly linked to a divination method, but the ancient technique of questioning the deceased through cattle bone and tortoise shell oracles was replaced, in accordance to views dominant in the early Han era, by a literally more down-to-earth technique of investigating the perceived properties of the world inhabited by man.

As important as the selection of suitable burial sites is the continued integration of the ancestors in the daily processes of decision making and resource exchanges among the surviving members of a lineage. Ancestral tablets, neatly arranged according to past generations in special halls or on a family altar in one's own house, are not only the focus of specified worship ceremonies signalling continuing filial piety on the side of the living; these tablets are also treated as witnesses of, and participants in, all decisions deemed important to the lineage. A lineage elder acts as link between the living and the dead; he is responsible for pleasing the ancestors by ensuring the continued adherence of later generations to the moral norms transmitted by former generations. In addition, regular offerings of, for instance, roast pig, provide further evidence of a persistent appreciation of the deceased by the living family members. The latter can expect that the former will fulfil their duties with equal attention; if the material well-being or health status of the living fails to meet a desired level, despite a sincere observation of all ritual norms, this shows that a particular ancestor has lost the power to protect later generations, for instance against evil spirits. Such a "person" will, naturally, be excluded from worship and offerings.[43]

Unschuld's Footnotes (from Unschuld, 1985, p. 367-368).

1. Franke and Trauzettel 1968, p. 27.
2. Ibid., p. 34.
3. Keightley 1975, p. 4; Keightley 1978.
4. Keightley 1975, p. 3; Franke and Trauzettel 1968, p. 32.
5. Hu Hou-hsüan 1944, pp.2a—3a; see further: Ting Shan 1928, pp.243—245.
6. Yen I-p'ing 1951, p. 20.
7. Hu Hou-hsüan 1944, p. 2a.
8. Chang Tsung-Tung 1970, pp. 6, 17.
9. Hu Hou-hsüan 1944, pp. 2a-3a.

10. Ibid., p. 6b.
11. Ibid., p. 3a.
12. Chang Tsung-Tung 1970, p. 34.
13. Hu Hou-hsüan 1944, p. 7a.
14. Ibid.
15. Ibid.
16. Chang Tsung-Tung 1970, p. 41.
17. Yen I-p'ing 1951, p. 14.
18. Ibid., p. 22.
19. Ibid.
20. Chang Tsung-Tung 1970, p. 34.
21. Ibid., p. 36.
22. Ibid., p. 15.
23. Hu Hou-hsüan 1944, p. 11a.
24. Yen I-p'ing 1951, p. 14.
25. Chang Tsung-Tung 1970, p. 69.
26. Yen I-p'ing 1951, p. 17.
27. See appendix 2.6, and appendix 9.
28. Yen I-p'ing 1951, p. 17; Ma Chi-hsing 1979.
29. Foster 1965, pp. 293-315; see further: Schoeck 1974, pp. 83-112.
30. Ardener 1970, p. 146.
31. Franke and Trauzettel 1968, p. 35.
32. Keightley 1975, p. 4.
33. Granet 1976, pp. 31, 67.
34. Ibid., p. 34.
35. Ibid., p. 36.
36. Yen I-p'ing 1951, p. 15.
37. Chang Tsung-Tung 1970, p. 45.
38. Akatsuka Tadashi quoted in Kano Yoshimitsu 1980, p. 283.
39. Hu Hou-hsüan 1944, pp. 12a-b.
40. Keightley 1975, p. 4.
41. Ibid., p. 10.
42. Ibid., pp. 9-10.
43. For further details see Ahern 1973 and Jordan 1972.