Other books by the same author:

Acupuncture, Is It For You?
Talking About Acupuncture In New York
Traditional Chinese Acupuncture Volume I Meridians and Points

Traditional Acupuncture

Volume II Traditional Diagnosis

J.R.Worsley

Founder President of the College of Traditional Acupuncture, U.K.
Professor of the College of Chinese Medicine (China)
Master and Doctor of Acupuncture, Honorary Professor of the Department of Oriental Medicine, Won Kwang University, Korea
Vice-President of the World Academic Society for Acupuncture
Founder President of the Worsley Institute of Classical Acupuncture, Inc. (U.S.A.)
Founder President of the Traditional Acupuncture Institute (U.S.A.)
Founder President of the Traditional Acupuncture Society
Honorary President of the Compagnonnage d'Acuponcture Traditionelle, France

The College of Traditional Acupuncture, U.K.
Royal Leamington Spa, 1990.

Published by The College of Traditional Acupuncture, U.K.
Tao House
Queensway
Royal Leamington Spa
Warwickshire
England CV31 3LZ

with

The Worsley Institute of Classical Acupuncture, Inc.
Tao House
Suite 324
6175 NW 153rd Street
Miami Lakes
Florida 33014
USA

Printed and bound in the United Kingdom by
Billings & Sons Ltd.
Hylton Road
Worcester

Photographs by Yona Zaloscer

British Library Cataloguing in Publication Data

Worsley, J.R.
Traditional acupuncture
1. Acupuncture
I. Title II. College of Traditional Acupuncture, U.K.
615.892
ISBN 1 873272 00 6

CONTENTS

CONTENTS (continued)

LIST OF ILLUSTRATIONS AND PLATES

PREFACE

It is now five years since the publication of Volume I of this series of books on traditional Five Element acupuncture, and to my delight I have been asked many times since then, 'When will the next volume be written?' 'Soon, soon,' I would always reply, perhaps without sounding very convincing or being entirely convinced myself. At last, however, the time has come, and I hope that the wait has been worthwhile.

The number of books about acupuncture published in this country in recent years has increased dramatically from the time when I was first in practice. Most of these focus on elucidating the Chinese theories of acupuncture and herbalism in a form which has been greatly standardised since the Cultural Revolution in China, and all do it exceedingly well. This book, however, aims to do something entirely different.

It is not intended to be a 'how to' manual, nor is it rich in theoretical considerations. This may be a disappointment to those of a scholarly nature, and in part the reason lies in the fact that I am not myself inclined to scholarly matters. My motivation is, and always will be, a passionate interest in helping students and practitioners of traditional acupuncture, whatever their school of thought, to develop their skills and thus to serve their patients better. I believe that this is best done by encouraging the student or practitioner to remain in touch with the very basics of his or her work, the development of the skills of seeing, hearing, asking and touching. These, along with a genuine compassion and a desire to help those whose lives may benefit from traditional acupuncture, are the cornerstones of this system of medicine, and together they form the message of this volume.

As I mention in the text several times, the book does not present a comprehensive checklist of what to do when conducting a Traditional Diagnosis. Human interaction is far too rich and diverse for all its possible paths to be summarised in this way, and even if we were able to create a set pattern of enquiry it would be truly boring to follow it with every patient. The excitement in this system of medicine comes from knowing that every person is unique and that each diagnosis will

be highly individual in its turn. This means, of course, that achieving excellence as a practitioner is not easy. Above all, it requires hard work, the willingness to develop and grow in oneself, and a fear and loathing of routine.

This book is intended for students and practitioners of acupuncture, and for other people involved in the health care field who are prepared to meet this challenge. Today practitioners in many different forms of medicine value the principle of seeing human beings as a whole, an integrated body, mind and spirit with each part as important as the other. I hope that this book serves to remind people of this principle and will help them to nourish and sustain it in their work and in their own lives.

As for the next volume, I can truthfully say, 'Soon, soon' this time to anyone who is kind enough to ask, because it is already in preparation!

J.R.Worsley
September 1990

EDITOR'S NOTE

This volume, the second in the series on Traditional Acupuncture, has been in production for many years. The first sections of it were written in 1984/5, edited from transcripts of lectures given by Professor Worsley on performing the Traditional Diagnosis and from his own working notes. The draft was then circulated amongst senior practitioners for comment.

Two main problems emerged from the discussions. One was a concern that the spirit of Professor Worsley's work would disappear as it was put through the mill of book production. The College has a strong oral tradition in its teaching, and this does not always translate well into prose. The second major concern was that the book could not deliver what it seemed to promise. Professor Worsley has always stressed that the techniques of diagnosis are not learned from books but from experience and from re-learning the use of our senese. The book would have to appeal to the heart and the spirit as much as to the mind, and would have to fire people with an enthusiasm to learn rather then give them ready-made answers.

These concerns were very much to the fore when work on the volume began again in earnest in February 1989. The College's teaching videotapes, audio tapes, and notes were scoured for additional material by Professor Worsley which would put the process of the diagnosis in its proper context and which would provide enough outline detail to allow even someone with no experience of Oriental medicine to understand its broad principles and spirit. Accordingly the sections on the natural laws and five elements are intended more as explanatory notes than as definitive statements. These will follow in later volumes.

The most difficult task was to preserve the spirit of Professor Worsley's teaching. The words on the page serve to illuminate his style and delivery only as well as the black dots on the scales represent musical sounds. For those of us who know the inflections of his voice and the ease and grace with which he holds an audience it will not be difficult to hear him as we read the words. I hope that a little of this magic survives the process of turning him into print.

There are one or two details which have to be mentioned here. Firstly keen-eyed readers will already have noticed that the word 'Chinese' has been omitted from the name of the College. This change has been instituted by the College in order to emphasise that the classical roots of Five Element acupuncture are found in numerous countries as well as in China itself. Throughout the text, therefore, the system of medicine will be referred to as 'traditional acupuncture' to remain consistent with this change.

It has also been decided to use the Pin Yin system to romanise the translation of Chinese words. The College has previously used the Wade-Giles system, but this is rarely used today in translations. Pin Yin has the advantage of giving better results in approximating the pronunciation of many words in Chinese. The main examples of this found in the text are: 'Qi' for 'Ch'i', 'Jiao' for 'Chou', 'Ke' for 'K'o', and 'Dao' for 'Tao'. A propos of this change the College has also adopted the use of the word 'Sheng' to describe the cycle of energy which connects the Five Elements in order to be consistent with the standard usage in the West.

Finally the vexed question of personal pronouns, 'he', or 'she', or 'he or she', has been resolved (after much discussion!) by the use of 'he', 'his', 'him' and 'himself' throughout when referring to 'the person'. Obvious exceptions are made when referring to female-only related matters. This follows the standard academic practice and is not a statement of any partisan view, conscious or otherwise, by the author or the College.

All that remains to be said is that in working with Professor Worsley to assemble the material I have tried as best I can to preserve the sense, detail, and spirit of his teaching. If there are any shortcomings in the text, the responsibility is entirely mine.

John Wheeler
August, 1990

ACKNOWLEDGEMENTS

I would like to express my sincere appreciation to the editor, John Wheeler, who used notes and taped material to reproduce my teachings in this textbook form and whose style has preserved the essence of the original lectures; to John Moore who, as the non-acupuncturist amongst us, has added a touch of professional polish to the final edit; to Marty Fromm for her thorough grammatical overhaul of the final text; to Christopher Roper for his help in preparing the initial outline several years ago; to Dean Lander for his diligent research of the College tape library; to my son John Worsley who has co-ordinated the production of this book from beginning to end and added computer typesetting to his many skills; and to my darling Judy Becker for proof reading and for her contribution in upholding the spirit of this exquisite system of medicine.

CHAPTER ONE

INTRODUCTION

In this book you will be introduced to the way we look for and find the Causative Factor of disease. This method of diagnosis is not only a fascinating aspect of classical Chinese medicine; it is what makes that tradition of medicine come really alive. When I say 'alive', I mean that in the fullest sense.

Acupuncture is not just a system of laws, point locations and techniques which a student can learn by rote and then automatically practise. To work properly, this tradition of medicine needs people who really care for others. Traditional diagnosis and treatment depend for success on that fundamental and essential desire to help those who are ill. This will demand a great deal more than many students and practitioners imagine, and will keep on making demands on them, however experienced they may be. The joy and beauty of this system of medicine, however, is that the changes which it asks of us bring riches beyond our imagination. If we stay true to this desire to help people, we will also grow both in our own person and in our ability to help Nature to heal disease.

This is our starting point. To work properly, this tradition of medicine needs people who really care for others. Traditional Diagnosis and treatment depend for success on that fundamental and essential desire to help those who are ill.

Before considering the traditional method of diagnosis, however, we need to be clear about the role of symptoms. You may think, 'How can we not be concerned about symptoms? If someone comes to us with a headache, or lumbago, or vertigo, aren't these afflictions which they understandably want to be rid of?' Of course, you are right to think that patients should be rid of such symptoms, and be rid of them for good. But you will only help them feel well when you have realised and understood that the presenting symptoms are not the disease

itself. Symptoms can arise from a cause elsewhere, anywhere, in body, mind or spirit. What is more, relief gained by suppressing a symptom is like turning off a fire alarm because you cannot bear the noise.

Viewing symptoms in their context

One of the main obstacles to restoring health today is that the majority of modern systems of medicine concentrate only on treating symptoms. If you have a pain, most practitioners will probably give you something to ease that pain. If you are lucky, it may ease a little or perhaps temporarily disappear. But the real purpose and significance of the symptom has been ignored. We realise that any pain, physical, mental, or spiritual, is a distress signal from the body, mind, or spirit saying, 'Look, I can't cope. Please help me!' Symptoms are just that and nothing more. They are not the disease itself. They are signs or signals from the body, mind, or spirit saying, 'I can no longer compensate for what is going wrong. I cannot regain proper balance.' It is through the symptoms that Nature calls for help to deal with the underlying cause of disease.

Once you have adjusted to the fact that the symptom is not the cause, you may assume that there will be a straightforward connection between outer symptom and deeper cause, that the former must lead simply to the latter. Later we shall see how wrong this assumption is, how the symptom can be related to any one of the five elements, how it can be a distress signal from any one of the twelve officials. A headache, for example, can be due to the malfunctioning of the Bladder official, the Kidney, the Liver, or the Spleen; in fact, any one of the twelve. You can thus begin to appreciate how complex Traditional Diagnosis is and how futile just treating a symptom can be if we have not learned to listen to all twelve officials and are unable to perceive for certain which official in distress is causing it.

What happens if we do treat symptoms alone? What happens if we imitate those systems of medicine which simply use treatment to remove or control symptoms? The cause, untreated, remains harmful. The longer it stays untreated, the deeper it will penetrate and the more damage it will do. As the underlying imbalance, the cause of the disease, goes deeper, the recurring symptoms become more severe and the distress signals become louder. Our power to ignore the warning signals and to carry on regardless is amazing. However, there is bound to be a day of reckoning eventually, and by then the damage may have gone too far to be reversed.

Our modern culture bears much of the blame for this lack of respect for the real meaning of symptoms. Such ignorance has not always been the case. If we read the ancient Chinese texts, written thousands of years ago when this traditional system of medicine was first developed, we can see that people realised that symptoms were distress signals and asked themselves, 'What am I doing wrong to make my body, mind and spirit unable to function as Nature ordained?' They knew that they were being warned to change some habit, to adjust their lifestyle, and to take better care of themselves. In contrast, we live in an ignorant age where we believe that diseases are caused by external factors, that they have nothing to do with our behaviour and the way we live. We blame germs for our illness, or say it is the fault of one of our organs. We look to doctors to prescribe the remedy. It is a hard lesson for us to learn and acknowledge that we are often to blame for our illness and that the remedy is often our responsibility.

To see, to hear, to ask, to feel

Once we have abandoned the Western illusion that eliminating symptoms means curing disease, we need a method of finding the real cause of disease. When I say that traditional diagnosis is one of the most effective ways of doing this, and when I add that even a moderate standard of diagnostic ability in this tradition will tell you more about a patient than you would find out with modern Western technological aids, you will no doubt think the methods and techniques must be obscure and esoteric, perhaps even of a mystical nature. They are not.

The four things you have to be able to do are see, hear, ask and feel. That is all. Through these ordinary abilities you can discover the Causative Factor of disease in any person in the whole world, whatever his race, creed or colour. No matter how any disease may be labelled due to its particular symptoms, you can discover the underlying cause of it through using these four abilities properly.

I need to add that the ability to smell is also essential. The reason for not listing it with the other four is that, traditionally, the Chinese always included developing the sense of smell in their descriptions of learning to hear. This was not intended to detract from its importance. We shall find that our sense of smell is as vital during diagnosis as any of the other senses.

I do not wish to leave the impression that in our enthusiasm to become effective practitioners of acupuncture, we should dismiss everything

that modern medical science has accomplished. What Western practice can do in cases of serious accident is little short of miraculous, and what Western research has revealed about the workings of our bodies is impressively detailed and informative. However, when we do a Traditional Diagnosis, which may take two to two-and-a-half hours, it is 'why' which concerns us more than 'how'.

During diagnosis, the practitioner listens for distress signals coming from the officials, listens to what they are asking, and hears what they need. This leads to understanding why the disease was caused in the first place. Once that cause is addressed and treated, the symptoms will disappear, not for a day, nor a week, but for all time. This is the essential difference between our complete system of traditional medicine and systems of symptom palliation. Since our system has this wonderful simplicity of aim and deeply penetrative power, it never becomes rigidly formulated or a monotonous routine. Each diagnosis is a new conversation between body, mind and spirit. The more fluent we become in the language of diagnosis, the more easily and deeply we can communicate with our patients and enable them to tell us why they are in trouble.

When I say that all you have to do in Traditional Diagnosis is see, hear, ask, and feel, you probably felt relieved, perhaps even a little disappointed. I imagine you thought that, since you have been doing these things all your life, learning to diagnose can only, therefore, be a matter of being told what to see, hear, ask, and feel, and then away you will go. If that was the case, then I fear you will be less than happy to be told now that you are for the most part blind, deaf, unable to feel anything less than the size of a boulder, and about as effective in your questioning as someone speaking double-dutch. You must realise how deadened your faculties have become and how much you will need to exercise them in order to resurrect the purity and power they had when you were very young.

Our deceiving ourselves over the use of our senses stems from our laziness with words, not truly meaning what we say. For example, 'seeing' seems straightforward enough. But when you got up this morning and travelled to work, and you 'saw' the grass on the verge of the road, you most probably did not really see it at all. You probably did not see the flowers outside the door either. If you had paused (physically and mentally) and had really seen one of the flowers, you might have been transfixed by the delicate shape of its petals, by the subtle beauty of its colour. You might have seen it in a way that goes far beyond merely seeing with the physical eye. You might have seen

that it was vibrant with life, communicating and serving a purpose. You might then have realised that there were hundreds of such flowers and that you had really not been seeing very much. We have not even considered yet whether you saw (let alone noticed) the man who collected your ticket, the woman selling flags for a charity, the person sitting opposite in the train, or anyone else. The chances are that you may even have avoided seeing them.

The same deadening happens with the faculty of hearing. By and large we tend to hear only what we want to hear. Rather than listen carefully to what we are being told, we listen for the cue or gap which will give us a chance to have our say. If we listen attentively to other peoples' conversations, we often find that they do not make sense because neither party is really listening to what the other is saying. In general, we are much better talkers than listeners and hence we rarely hear the real meaning of what we are being told.

As far as touch is concerned, if you are a student of acupuncture you will already know that there is much to be done to regain sensitivity. Early on in your training, you were asked to feel the twelve pulses of the wrists, and eventually you found most of them. Then you were told that each pulse has any one of twenty-eight different qualities. You understood that the task of regaining sensitivity of touch was a task far greater than you had imagined. You will be able to feel all of them, once you have fully restored that God-given gift of touch that you had when you were born. Watch little children. They learn everything they need to know through their hands. They can communicate with their hands, distinguish and differentiate with their hands, understand with their hands. So could you when you were very young; and to that degree you will be able to touch again.

These comments on the sharpening or quickening of the senses are meant to emphasise the need to appreciate deeper qualities rather than gain an increase of information. Seeing better, for example, is not the same as seeing more. You will not be seeing more clearly or deeply if you are just looking intently to see as much as possible, like a little boy trying to collect as many car numbers as he can. For example, an imbalance in any organ will result in a particular colour on the face. Hence, one of the more simple aids to accurate diagnosis is discernment of certain colours on the patient's face. The ability to see these colours immediately guides the practitioner to identify the official in trouble. Someone with an untrained eye looking at the average face would say, 'Of course I can see colour. Yellowish-white here, pinkish there.' These obvious superficial colours of the skin are not what the

trained eye of the practitioner sees. The practitioner looks for colour on the face, not of the face. There are certain areas of the face where a tell-tale subtle colour or hue manifests the moment an official becomes imbalanced and in trouble. These colours, yellows, greens, blues, can be seen fully by anyone whose faculty of sight has been restored by training.

When you become able to see such colour signs, you will understand what I meant when I said that at the moment you are, for the most part, blind. Most people see only about thirty percent of what is available visually because they only look with the physical eye. The ability to see these subtle colours, which are as clear to the trained eye as the colours of a person's clothes, is not a special gift bestowed on a chosen few. Anybody can see them when they are trained. Work is the key to unlocking such ability. You can learn to use your eyes properly again, then awaken your mind's eye, and then your spirit eye.

These more subtle faculties are not as strange and remote as they may sound. We do sometimes use our mind's eye. Someone explaining something to us says, 'See what I mean?' We do see what he means, but not with the physical eye. We visualise a concept or grasp a situation as though we are seeing it in the mind. You can develop the power of seeing in this way and see things which are quite abstract, complex, and difficult, things which would have been beyond you a few years before. The same applies to the spiritual eye. At present you are probably unaware of the deep richness of everything around you because you are only seeing in physical and literal terms. In the future, once you have developed the spiritual eye, you will become witness to the spirit of life manifesting in all things, even those things you previously thought of as being inanimate.

You may wonder why I am going on at such length about the importance of powers with which you may not be familiar in your experience. The reason is that Traditional Diagnosis requires you to use your faculties at these subtle levels in order to see and understand the elements alive and at work in your patients. Each person is unique and fascinating. The five elements live in him in a particular combination which has never existed before and which will never be repeated. If you are going to be able to see the whole person and his present state, you need to be able to understand the elements and be able to see them exactly as they are in that person. In this tradition we talk, for example, about the Water element. In everyday life we speak of water often enough, but pay little heed to the great variety of ways in which it manifests. Sometimes it is blue, sometimes white, sometimes silver, sometimes black; sometimes it is still, sometimes flowing, sometimes raging, sometimes frozen, sometimes boiling. All these different manifestations belong to the essence and nature of water. They are all precious to us because all the element's attributes and qualities are vital to our very existence. Unless and until we fully appreciate the manifestation of water in the world around us, we will not properly understand the manifestation of the element Water when diagnosing our patients.

So it will be with all the elements and their relationships; as in the world about us, so in the person. For example, you might look up into the sky and think, 'What a pretty cloud.' Have you really seen it, its changing shape, its drifting movement, the way it is casting a shadow on the earth below? One moment you are in the sunlight, the next moment it has gone. A single cloud can change your world. Before, you were bathed in light and warmth; now it is dark and cold. Such experience can help you to understand the state of a patient with a Fire imbalance. He may be living under a cloud. The sun within that person is hidden and he is living as if in a dark pit. Thus, as you learn to appreciate and understand the workings of Nature, so you understand the working of the elements in the body as being of the same nature. We are manifestations of the world around us; we do not live in isolated cocoons of a different nature. The Earth, Metal, Fire, Water and Wood within us manifest exactly the same as the elements everywhere else. When you have thoroughly understood this, you will be able to see when a patient's Earth has become parched, or when it has become flooded, or when it is lacking the trace elements and minerals essential for its fertility.

I have emphasised and spoken mainly about the ability to see. That is not to suggest that the other abilities are less important or that the same principles do not apply. Even at the physical level, you only hear a fraction of what you could hear. If you work as hard with listening as with seeing, you will be able to hear, for example, the sadness behind someone's laughter, the fear within someone's anger. You will be able to hear the elements in the sound of a person's voice. You can also learn to feel the elements in a person through the ability to touch, not just in the physical sense but also at the levels of mind and spirit. Furthermore, you will be able, through touch, to ask without always having to use words.

In learning to become good practitioners, the essence of our task is to become so attuned to the spirit of the elements all around us that we become able to reach them at all levels within. We work much as

experienced farmers do, correcting imbalances in the soil, responding to changes in the weather, abiding by the seasons. Their years of practice and co-operation with Nature teach them wisdom, how best to bring their crops to harvest. As practitioners of traditional Chinese medicine, we try to achieve the same kind of wisdom, and work just as hard, in order to bring the body, mind and spirit of our patients to fullness and maturity.

The importance of humility

Before moving on to explain the method of Traditional Diagnosis in detail, I would like to make one further general point. We live at a time when judgement and criticism of others, often based on the most superficial evidence, are all too frequently made. This tendency does not allow us to see people properly and we lose sight of the good qualities and beauty within them. Instead of seeing some good in everyone, we end up loving no one, frequently not even ourselves.

In order to avoid or rectify this unfortunate tendency, we need to come to terms with some very simple facts. You are essentially no different from anyone else. You are no better than anyone else. There is no one better than you. There is no one worse than you. As human beings, we are all essentially the same.

That may be a bit difficult to accept and face up to in today's world. So many troubles, worries, anxieties and tensions are generated by obsession with competition, wanting to win or not to lose, desiring success or fearing failure, thinking that one is inferior and another superior. All judgements based on comparisons of others are a load of rubbish. You must fully realise this to be a good practitioner. All people are equal, and once you fully acknowledge that fact you will find that you are entirely comfortable when treating patients. You need humility if you are going to be able to practise properly and effectively, because you will not be able to communicate with the spirit of the elements without it. You will not be able to communicate with your patients if you approach them from above or from below thinking yourself superior or inferior. Proper communication only comes through being as one with the other, and to do that you must be as one in your own mind and spirit.

Summary

Like everything else in traditional Chinese medicine, diagnosis is so fundamentally simple that you may wonder why we spend so much time studying and training. Part of the answer undoubtedly lies in the fact that we, as potential instruments of healing, have lost so much sensitivity since we were very young. I am quite sure that if I had brought my grandson or granddaughter when they were very young to one of our classes, they would have grasped many things more quickly than we adults do because they were so much more in touch with Nature.

The child's natural capacity to comprehend through its senses needs to be constantly borne in mind when reading this book. I have used thousands of words to describe the method of diagnosis. I could have used entirely different ones or have added thousands more in an attempt to improve the description. They are only words, however. The simplicity of the method becomes apparent when in practice you allow yourself to regain the child's clear vision and contact with Nature.

Thus, the biggest task you undertake in order to become an effective practitioner of this wonderful system of medicine is to bring about necessary changes in yourself.

CHAPTER TWO

THE ART OF DIAGNOSIS

For those who are not conversant with acupuncture, and possibly for some who are more familiar with it, the thought may arise that no system of medicine can be as simple as I have suggested. One might suspect that there must be an enormous amount of detailed theoretical work somewhere along the way which has to be done before diagnosis becomes as simple and straightforward as it has been made to sound. Otherwise, acupuncturists could be trained in next to no time.

Although the principle of simplicity as I have outlined in Chapter One is accurate, I have often said that after three years of training, a licensed practitioner is then just embarking on a lifetime's task of learning. There is a considerable body of knowledge within the art and science of Traditional Acupuncture. In this chapter, I will briefly explain some concepts which will help the reader to understand the methods and procedure of diagnosis described in the following chapters. Books alone, however, are not enough; they cannot substitute for years of practice and the growth which comes from experience.

The art of diagnosis would seem to be a matter of two questions: what are we looking for in order to be able to treat according to natural laws; and how do we develop the skills needed to make that investigation? We approach such tasks by learning the theory and then applying it. Nevertheless, it is most important to remind ourselves, and I cannot emphasise this enough, that it is the desire to help and care for sick people which gives this system of medicine its beauty and power. Without that desire, theory and practice will be to little avail. It is the desire to help which inspires and enables us to make the changes in ourselves which are essential if we are to master the art of diagnosis and become effective instruments of healing. We are not healers; only Nature heals. Thus the best we can do is assist Nature through becoming instruments finely tuned to understanding our patients' needs.

All of us have have friends, and I would wager that it took months, if not years, before we felt able to say with some certainty that we really knew those friends and shared a deep understanding with them. Yet a diagnosis has to establish this degree of empathy in two or three hours. What is more, the patient coming to the practitioner can be a desperately sick person who may, over the years, have learned to hide his inner problems for his own protection. If the practitioner cannot quickly and effectively win the patient's trust and confidence, no amount of acupuncture theory will do any good. Theory is essential to the process of healing but will not do the job by itself.

This book might, therefore, be a disappointment to anyone reading it in the hope that the author, like a magician pulling a rabbit out of a top hat, would be revealing techniques of diagnosis which he could learn and carry out. No book could be expected to do this, especially when we realise that every person on the planet is unique and that therefore there are no simple diagnostic formulae which can be described and then indiscriminately applied. The art of diagnosis requires considerable effort and development on the part of the practitioner before it becomes truly trustworthy.

What do we look for to determine how to treat a patient according to the natural laws? The answer fundamentally lies in a simple but profound concept which underlies much Chinese wisdom. The ancient Chinese believed that if a person functioned in harmony with the Dao, the natural laws implicit in everything that exists, he would be able to ward off every kind of illness and disease through the natural protective and healing powers within himself. A person following the Dao would make appropriate allowances for the changing phases and rhythms of life and would aim to harmonise his being with the powers of Nature all around him. From this central idea of harmony and balance, the Chinese developed an elaborate and exciting description of the way in which such harmony and balance was created and sustained in all the activities of a person's body, mind, and spirit.

Equally important in the ancient Chinese tradition was their observation and description of the internal and external factors which could threaten balance, and how such factors could affect the person when they prevailed. For, much as we might like to believe it possible, there is not a single person who can achieve and maintain perfect and invulnerable balance in all aspects of body, mind, and spirit. Through heredity, or whilst in the womb, or during the early years of life, every person has been subjected to factors outside his control, factors which

will have created weaknesses in his constitution. Such weaknesses require special help because they cause a loss of balance within the total system. It is this loss of balance which puts people out of step inside themselves and with Nature around them. Traditional Diagnosis seeks to identify the cause and nature of the imbalance.

If someone cannot harmonise his thoughts, words and actions with what is going on around him, there will be unnatural signs in his behaviour and his reactions, signs that will strike us as inappropriate. 'Appropriate' is a key word in classical Five Element diagnosis. We have to use our own standards of judgement to a degree but, generally, there is agreement as to the appropriateness of what people say and do in circumstances of danger, confrontation, loss, and other difficult situations. We know roughly how people will normally behave and react. Thus, when someone's response is noticeably different from what we expect and think of as appropriate, we question whether the balance of the person within and with their surrounding circumstances is what it naturally should be.

When faced with danger, for example, we expect people to show some evidence of fear. Fear is natural. It puts us on the alert, heightens our senses, and stimulates the secretion of adrenalin which powers our ability to take the necessary action to avoid or escape whatever danger threatens us. Nevertheless, in a particular circumstance, some will show more fear than others, because to a certain extent people are constitutionally different. Hence, according to their nature, they will experience and exhibit reactions to threat with varying degrees of intensity. There is thus a fairly broad range of what we, as practitioners, will consider as 'normal' response to fear in our patients. We will, however, soon recognise extremes of reaction which extend beyond that acceptable range. If someone has an unnatural absence of fear or shows a degree of terror disproportionate to the scale and nature of the threat he is facing, we could be seeing the results of imbalance within him. It will be clear to us that he is not able to respond to danger with a normal and appropriate degree of fear. Appropriate fear should neither blind us to all risks nor freeze us in panic.

'Appropriate response' not only applies to the expression of all other emotions but also to the operation of all our mental faculties. For instance, we are faced with having to make decisions every day of our lives. We may find some decisions difficult to make and occasionally we may realise later that we have not made an appropriate decision; but we quickly or eventually make our decisions, usually abide by the outcome, and for better or worse get on with our lives. In our practice,

however, we come across extreme cases where this general rule does not apply. On one hand, there are those who become paralysed when confronted with the need to decide. Through indecision, they become almost rooted to the spot and are at a loss to know what course of action to take. On the other hand, there are others who rush into one option, then change to another, then go back to the first, and so on. They never fully make up their minds one way or another until it is made up for them by force of event or by the persuasions of others. When we come across the former indecisiveness or the latter vacillation, both indicative of the failure of the decision-making faculty, they stand out clearly as inappropriate.

However, that is not to suggest that the boundary between good and poor decision-making ability is in practice quite so easily defined and recognizable, any more than is the boundary between balance and imbalance. Between the range of behaviour we regard as normal and the extremes we clearly recognise as abnormal, there will be a middle ground where we may not, for a while, be entirely sure. The ability to detect imbalance in this in-between area comes with experience in practice and improvement in our diagnostic skill.

Over the centuries the Chinese developed a profound, comprehensive and beautiful picture of the ways in which all of our faculties and emotions can manifest in appropriate balance with Nature and circumstance, and the degree of richness which such harmony provides. From this ideal, overall picture they were able to see when and where parts of this balance and harmony were being lost. Using this picture as our starting point, we know how to begin to re-establish the richness where imbalance is causing deprivation and poverty.

I shall be describing more about this overall picture and natural laws later, but hints of it have already been given in Chapter One. Presenting symptoms, for example, are not the focal point for diagnosis. If we encounter physical symptoms like headaches or stomach pains, or mental problems like confusion and anxiety, or problems of the spirit like despair and loneliness, we do not assume that they will lead us directly to the cause of the disease which can then be treated immediately. We may see or hear something during our examination which is obviously inappropriate, but it is very rare to find only one outstanding sign of imbalance. Because the Chinese picture describes a total system in which all parts are interrelated and thus continually affecting each other, we can expect that an imbalance at one point will be causing or be caused by losses of balance elsewhere in the system.

That is how Nature functions. If, for example, the soil in which a tree is growing is poor and shallow, the trunk of the tree may start to lean to one side because the roots cannot hold it upright. As the trunk leans, the branches tend to grow out further on the other side to help maintain overall balance. Where branches are not giving protective cover to the roots, the rain washes away even more soil and the tree becomes increasingly unstable and starved of nutrition. We can see how this process of deterioration continues as the tree leans further and further as more and more soil is eroded. As one imbalance begets another, the overall state of the tree declines. Being able to see the whole process of decline in a patient's state does not in itself help us to halt it. We need to find out which weakness or imbalance is the most important to attend to. Through diagnosis, we discover the crucial imbalance needing support, not just to bring about short-term improvement but to restore balance for as long as growth and life continue.

I said in Chapter One that symptoms can arise from a cause anywhere in the total system. A headache, for example, can arise from an imbalance in any one of the five elements or twelve officials. Now I shall go further and say that even if we can relate symptoms to an imbalance in a particular element, we are still not be able to help restore balance and harmony unless we have developed the skills of seeing, hearing, feeling and asking. Only by these abilities can we know, through colour, sound, odour and emotion, exactly where the major imbalance lies. Each of these skills needs to be developed to an acute level. That development can take years and years of patience and practice. At times, all practitioners will feel incompetent and at other times as excited as children when the skill noticeably improves. Once re-developed, the skills remain acute. The years of effort are rewarded with insight and vision concerning what the patients really need.

This chapter and the following are mainly concerned with the traditional knowledge which makes diagnosis possible and the skills needed to make that diagnosis. As we look at the laws and the skills, however, we must constantly bear in mind that they do not exist in isolation. The laws do not exist apart from people, only in people. The skills do not exist in theory, only in practice. Neither laws nor skills are any use without a desire to help the patient, for it is this desire to help which feeds the most important questions: Who is this person seeking help? What does he really need? Why has he come to us? What is he telling us? What is he not telling us? Such questioning is the spur to our being able to answer our own most important question:

How can we best make ourselves the most effective instrument in helping that person?

The model of harmony and balance - Yin and Yang

It may seem odd at first to head a section 'Harmony and Balance' and then talk about change and transformation, but, for the Chinese philosophers and sages who first wove this tapestry of medicine, the two pairs of concepts were not contradictory. In the West, we tend to think of harmony and balance as static and specific states. In our philosophical tradition, we are apt to favour exact and inflexible definitions; a thing is what it is in and unto itself and no more. To the Chinese such rigidity would not have made any real sense at all. To their way of thinking, nothing was so strictly determined and immutable; a thing was what it was only by virtue of the way it was related at any given moment to everything else. Thus harmony and balance were not seen as static states but as qualities of dynamic and ever-changing relationships.

Nowhere is this way of understanding more evident than in their concept of Yin and Yang, a concept which is fundamental to the whole tradition of Chinese medicine. Translated literally, Yin means 'the shady side of the mountain' and Yang 'the sunny side of the mountain'. The terms have been so widely and extensively used in so many contexts, however, that it has become virtually impossible to translate them so simply; they are now often used without any attempt to explain their meaning. Nevertheless, at the most basic and simple level, the key to understanding the concept is that Yin and Yang are always co-existant and mutually dependent. It is impossible to have one without the other. For them to have meaning, they always have to be seen together as complements within a unity. There cannot be only a sunny side of the hill; there must be a shady side as well. Each presupposes the presence of the other.

Beyond the principles of co-existence and mutual dependence, what makes the Yin and Yang symbolism so rich in meaning is the sense of their being in a state of continuous movement and change within the unified whole. As the sun moves across the sky throughout the day, so the areas and depths of light and shade below continuously change. There is never a single point when or where either Yin or Yang or their relationship becomes fixed and definable once and for all. Even if we consider the sunny side of the mountain in isolation, the Chinese would say that even that side will still be made up of aspects of both

Yin and Yang. As the sun first ascends higher in the heavens and then descends after noon, so the intensity of heat and light will increase and decrease on the hill side. This continuous change reflects the dynamic and ceaseless interplay of Yin and Yang on that sunny side of the hill, even though that side is itself Yang in relation to the Yin side in shadow.

The Chinese visualised the interplay of Yin and Yang in all phenomena. They saw water, for example, as Yin in relation to steam, which is lighter, thinner, hotter and more volatile than water, but Yang in relation to ice, which is denser, thicker, colder and more static than water. Beyond that, they saw that within water itself there are hotter and cooler areas, lighter and denser areas. They regarded these inner variations as the manifestation of complex movements of Yin and Yang within the water. There could be no such thing as purely Yin or Yang water, or any other phenomenon.

They also appreciated that the sun's movement regulated the amounts of light and shade. The greater the area in sunlight, the less in shade; and vice versa. Because more of one dictated less of the other, the Chinese described Yin and Yang as controlling each other. To their way of thinking, the amount of warmth was not just an expression of greater or lesser heat but the balance between the amount of heat in it and the amount of cold in it. If the heat, Yang, in something intensified, it had to be at the expense of the cold, Yin. As Yang increased, Yin decreased, hence the sense of Yin and Yang controlling each other.

Yin and Yang are also said to transform into one another. This is often illustrated by description of day changing into night and night into day, and of one season changing to the next. These natural cyclical movements demonstrate the ceaseless transformations of Yin into Yang and of Yang into Yin. The picture here is not one of passive succession but of dynamic change, of continuous growth, degeneration and regeneration. Each phase carries within it the potential for the next and thus begets its successor, just as the ripening and then rotting fruit bears and then nourishes the seed which will bring new life.

Observation of the cycles of transformation gave rise to the formulation by the Chinese of certain 'rules' within the process. These 'rules of transformation' became the basis of a particular branch of traditional Chinese medicine which applies them directly in its method of diagnosis. Illness in this system is viewed as disharmony in the energy system in terms of Yin and Yang only. 'Yin qualities' such as coldness, stillness, quiet, inner, downwards are assessed and compared with

the strength or weakness of corresponding 'Yang qualities' of heat, activity, noise, outer, and upwards. In this tradition, a patient with downcast eyes who is pale, listless and lethargic, and has cold limbs and a pale tongue represents a very different clinical case from a patient with florid face, loud and boisterous manner, hot limbs, and a red tongue. Diagnostic examination reveals not just how the predominant Yin or Yang is manifesting in the patient's condition but how corresponding weakness of the other is also affecting the condition.

The basis for diagnosis in this branch of traditional medicine is thus simple enough in principle; applied in practice, diagnosis is of necessity more complicated. Yin and Yang and their associated correspondences (cold/hot, internal/external, empty/full) are broad categories, too much so for the task of diagnosing at the depth and in the detail appropriate for a particular patient's condition. For this reason, penetrative diagnosis requires an increasingly elaborate breakdown of the functions of the body and mind into sub-divisions in order to assess as specifically as possible all aspects of Yin and Yang balance within the person's total flow of energy and vital substances. Imbalances will then be diagnosed in the particular constituents of body, mind, and spirit which are failing to function properly.

This diagnostic application of Yin and Yang apart, the most frequent and general use of them is as a means of describing the movement and patterns of Qi energy as it flows in body, mind and spirit. Harmony at all levels within the person depends on good balance in the flowing of this energy. 'Qi' is another word which is difficult to translate simply and comprehensively. Qi energy is sometimes called 'life energy' because in one aspect it can be properly understood as the vital essence upon which all things depend for growth; but in its full scope, it stands for a much broader concept. Qi is manifest throughout from the densest level as forms of solid matter to the most insubstantial level as spirit. It creates and maintains all living things.

As well as providing life and sustenance, the harmonious flowing of Qi energy is viewed as essential to the process whereby everything in creation can follow the Dao. The Dao, a fundamental concept in Chinese philosophy, loosely translates as 'the Path' or 'the Way'. It is the pathway of change and transformation which all living things must follow if they are to realise their own inner essence and purpose and if they are to recognise and understand the way of all other living things. Without Qi energy nothing can follow the Dao. Disharmony and imbalance, which manifest as illness and disease, are a result of unnatural disturbances in the flow of Qi energy.

Taken together, the concept of Qi energy and the descriptive and qualifying concepts of Yin and Yang provide a refined, powerful, and compelling view of how body, mind, and spirit naturally function. They not only provide a blueprint for understanding how all three function harmoniously when energy is in balance but also how they malfunction when it is not. The concepts of Yin and Yang, however, were not the only ones by which the Chinese were able to understand the flow and manifestation of Qi energy.

The five elements

Traditional Chinese medicine developed over the centuries in several distinct forms, each one of which had its days of ascendency and prominence before being absorbed into the total system. The cyclical flow of Qi energy, with its ceaseless transformations of Yin and Yang through phase after phase of the cycle, was described in other ways by the Chinese. They observed the cycle of seasons in the year and cycles within the day and saw another pattern of movement which they characterised by way of the five elements, Fire, Earth, Metal, Water and Wood. These elements represent phases in the cyclic flow of Qi energy. Each element is understood as the source and manifestation of special qualities of energy. The qualities of a particular element are most obvious at the times of day and year when that element is at its peak; but each element is really present all the time as a continuing source of enrichment, as a kind of 'gift' of the element to us throughout our lives.

The Chinese visualised in the cycles and tides of energy manifesting in Nature and in people the ways in which each of the elements came into prominence, held centre stage for a while, and then waned as its time passed. When I say 'visualised', I mean to emphasise the wonderful Chinese ability to relate their observations to pictorial analogies in Nature. They did not work out their system intellectually through logic and deduction, 'Well, if we say there are five elements and we have identified three, then there must be two more.' They simply observed the seasons of the year. There is a time in the year when the sun is high for longer in the day, a time when everything is in fullness and bloom, when plants and trees are at the peak of their annual growth. There then follows the season of harvest, when crops are gathered and when seeds are put aside to plant for the next year, and when the wise and prudent lay in stores to provide sustenance for the months ahead. Then the leaves and plants die and decay, and in their decay all the richness of nutriment falls back into the soil. A

quiescent season follows, one of cold and stillness when nothing grows on the surface of the earth. But changes are happening under the surface, hidden from sight, as Nature prepares to burst forth again with an enormous surge of vitality, when all will be full of movement and celebration in a new season of growth.

Being aware of changes such as these around them, the Chinese observed the same yearly cycle in themselves. They saw that, being a part of Nature, we follow the same seasonal changes and that these natural patterns emerged in what we did. As time passed, they added more and more detail to the broad picture, associating movements in the elements and the seasons with their observation of energy movement in the meridian pathways and organs of the body. Gradually, these associations formed a pattern of what they called 'correspondences'. Each element was seen to be the benefactor to human life of some of the attributes and qualities which belong to all living and growing things. The tradition thus talks of different times of the day being under the sway of different elements, different parts of the body being the responsibility of their associated elements, and even different mental powers and faculties. All these correspondences were founded on observation and experience, because the Chinese were much disposed to base their philosophy and wisdom firmly on the laws of the natural world upon which they depended.

To describe the elements one by one, depicting all the different facets of their manifestation, would be too lengthy an undertaking to include in this volume. What I can do is give a brief introduction which will serve to show how an understanding of their natures plays an essential part in diagnosis.

Consider, for example, the Fire element. This element corresponds with the season when annual growth is at the height of maturity. Openness and warmth are associated naturally with this season of summer, not only in the world about us but in ourselves also.

The element's gift to us is the ability to share openness and warmth with other people, to love and be loved in equal measure, and to aspire to the highest level of maturity of which we are capable. Fire will have its peaks of prominence during a year and during a day as it follows the tides and cycles of life but it should be available in all of us all the time. We should be able to call on the element in people, summoning it from them as response to our own warmth. If Qi energy is not flowing well however, and the Fire element is not providing a fully appropriate measure of vitality, a person will not be able to respond.

There will be no summer in his life and we will most likely find that we are confronted with a resignation and joylessness which will not relent no matter how much love and warmth we radiate. Sometimes, we will find people so desperate for warmth that they do nothing but pour out love and affection towards others in the hope of attracting what they cannot find in their own lives. Other people become very un-loving, even cruel and spiteful, because they cannot draw on love and warmth inside themselves. These are just a few of the many ways in which an imbalance in the Fire element can affect us.

We may consider all the elements in this way, looking at the powers they bestow and how weaknesses in them show up in people in simple and straightforward ways. The Earth element nourishes us as our Mother, feeding and supporting us, giving us the ability to care for ourselves and others. Sometimes we find people who are malnourished to such a degree that they have lost all ability to take care of themselves. At the same time, to their continual detriment, they may be lavishing all their time and energy giving to others what they are hoping to receive in return. Then, there are others who care not one jot for others. 'Me...me...me...' is all we hear and woe betide anyone who tries to have a conversation with them that does not revolve around them.

The Metal element is closely associated in the tradition with the Heavenly Father who breathes into us a different kind of nourishment. We think here of the nature of autumn, the season which corresponds with Metal. Plants and trees are letting go of the foliage and growth of the year but at the same time the richness of their decay is taken back as nutriment into the soil to provide the basis for next year's growth. The Chinese saw the corresponding gift of the Metal element in human beings as the ability to throw out rubbish which is no longer useful in order to make the way clear for receiving pure Qi energy, that element of quality which makes life special and vital. Earth and Metal are seen as very closely associated in this respect. Between them they provide food and air, the gifts of Mother and Father, of earth and heaven, which sustain human beings throughout their lives. We can imagine the quality of life for someone in whom the Metal element is not providing nourishment. There is no inspiration there, no guidance from above giving them the vital spark of life.

The Water element gives us reserves of power, and hence of will and determination. The associated season of winter is the hardest part of the year. It requires resolve to live on through it whilst at the same time preparing beneath the hard, cold surface to provide for the coming

surge of spring. Someone in whom the element is strong will have power enough at all times, but a person in whom the element is lacking power lives in a state of having no reserves to fall back on. The latter has little or no will to cope with life's challenges and becomes prey to fear at every turn.

Finally, there is the Wood element which provides the power for reproduction and growth. When strong, it manifests in upward, striving movement, a bursting forth of enthusiasm. We know how good it feels to be in the company of people whose vitality infects us. They have the motivation and vision of the springtime. Yet sometimes such exuberance can run out of control and become dangerous. Sometimes it can vanish quickly and leave everything in its wake flat and wilted.

The five elements between them give us all the abilities and qualities we have as human beings. When our Qi energy is full and freely flowing, the elements provide all the positive attributes which enable us to live according to the Dao and to be in harmony and balance with all living things. Perhaps it is a fault of our over-sophisticated preoccupations in this day and age that we take all our attributes and abilities for granted, often becoming unaware of them. They are always there, however, and they are the elemental gifts and blessings which allow us to meet and deal with every situation in our lives.

It would be possible to fill hundreds of pages with commentary about the elements because there is no end to the manifold ways in which they appear in our lives. But the best textbook for anyone who wishes to know about them is Nature itself. Nature tells about the elements all the time. All of our patients can be understood in just the same way as we experience and understand Nature. Consider, for example, all the ways in which fire manifests or is lacking in the world around you and you will then be able to see all the ways in which the Fire element functions within body, mind, and spirit. Or consider water. Is there just one flow of water? No; there are streams, rivers, oceans, tidal waves and droughts, all kinds of flow and quality of fluids. Thus, there will be just as many conditions of water in people as there are in Nature. Or think of all the millions of trees and how they all grow according to their own nature. The Chinese were particularly fond of the tree as symbolic of the connection between Heaven and Earth. Imagine a person as a tree. There are countless kinds and conditions of tree but each one, like each person, is unique in itself. So there will be reasons why a particular person can be likened to a particular kind and condition of tree. Understanding the resemblance will tell you

more about that person than you would learn by asking him a thousand questions. A particular person, for instance, might be like a tree on dry ground. Water is not bringing any quality of nutriment from the earth, thus causing it to become scorched and withered. The analogy tells us about the elements in relation to each other and hence tells us about the state of elemental balance in the person.

The point I am emphasising is that the elements always have to be understood in relationship with each other, because there is no such thing as one element existing in isolation. Much could be said about the interrelationships of the elements but, in order to understand them, it is far better to observe one's own experience, contemplate one's memories and, best of all, go out and see, hear, and feel them in life and Nature. It is equally important to appreciate that through their interactions, the elements are continuously moving and changing. They are processes, not immutable substances.

Plants do not suddenly appear from nowhere as new shoots in the soil; they do not suddenly mature and flower. To understand the five elements fully, we need to appreciate how they change from one to another, how they change in relationship with each other, and how the great underlying movement of Yin and Yang is intrinsic in all these transformations.

When we begin to appreciate and understand the elements in these various and subtle ways, it becomes possible to diagnose particular imbalances in patients just through observation of the way they behave and react. In such patients, instead of a natural proceeding of the elements through their cyclic flow, the process becomes literally stuck in one phase of the cycle. The signals of such blockage can be so blatant that we may simply be able to sit back and hear what the element in trouble is telling us. For instance, there are the angry ones who are like loaded guns; the slightest touch and they will explode. There are the clowns who tell one joke after another and laugh all the time. There are the fearful ones who have no resolve or will at all. When confronted, they freeze in panic and become lifeless like winter itself. There are the ones who are constantly harvesting and gathering in, food, attention, whatever they can lay their hands on. Or the empty people, longing for and grieving for the loss of quality in their lives.

In view of such obvious signals, some readers may think, 'Well then, elemental imbalance can't be too difficult to diagnose.' But let us look more closely at the angry patient. Anger is most readily associated with the Wood element. That is not surprising given that all the

upward, surging movement of springtime growth begs correspondence with the energy and noise being expressed in anger. But there are waterspouts and geysers, so Water too can have its outbursts. And what about Fire in the exploding thrust of a volcano? Or the terrible shaking and battering of an earthquake? Or the sparks that fly when Metal strikes Metal? All of the elements can, in their own way, manifest anger. When we know Nature well enough, we will be able to discern which element is responsible. Until that time, we need other help to ensure accurate diagnosis.

The officials

The Chinese had another picture representing the harmonious working of body, mind, and spirit, a picture which adds to that of the five elements. They visualised the natural balance of the different functions at all levels as being under the control of a group of officials, like the ministers of the imperial court. To the Chinese, with their long history of imperial rule, this was a powerful picture indeed. Fundamental to it were the notions of obedience and co-operation. Everyone, even the emperor who presided over the court, depended on the work of the ministers. For the court and state to be working efficiently and harmoniously, each minister needed to be functioning properly in his allotted task. Hence, the twelve major meridians (energy pathways) of the body came to be associated with twelve ministerial officials. The particular organ through which a particular meridian passed was thought of as being a particular official's domain. An official therefore represents not just the flow of Qi energy in a particular meridian but also all the functions of body, mind, and spirit fulfilled by its associated organ. We need to appreciate here that, in Chinese medicine, the word 'organ' carries much wider connotations than in the Western physiological sense.

Both the officials and the meridians are associated with particular elements. Thus, they play a vital part in understanding the processes governed by each element. A full appreciation of the Wood element, for example, needs to include understanding of the two officials associated with that element, the Liver official (called in the Nei Jing 'The military leader who excels in strategic planning') and the Gall Bladder official ('The important and upright official who excels through decision and judgement').

The officials are a subject to which I cannot do proper justice in this volume. To give a complete commentary on how each official is

involved in the process of achieving harmony through co-operation requires a volume in itself and what we are concerned with here is Traditional Diagnosis, not an exposition of all aspects of the entire system. In principle, the same observations apply to the officials as to the elements. If, for example, we see a patient who shows no ability to plan or who is incapable of making decisions, we would say that a certain official in that person is not functioning properly and has become unable to fulfil its allotted tasks. We could also say of the same failure that there is imbalance in the person's Wood element.

Does it necessarily help us to single out a particular official as being to blame for some problem? The answer is that it may not do so because we have to take into account the principle of co-operation, of all the ministering officials in the court working together. If one member of the group is not pulling his weight, he may not be the one whom we see suffering distress. We all know, for instance, the situation where one person, for the good of the team, does more than he is expected to do in order to help out, to compensate for the one who is slacking. Never mind that the helper's own work then begins to suffer. Eventually he becomes exhausted so that yet another person has to take on an extra load. How might all this appear from the outside? One by one everyone else has taken on extra work to cover for the weak member. Because of this help, we do not see the real source of the weakness, only the exhaustion in everyone else.

The situation can be even more complicated than that. Each official has certain talents and functions which are used to assist other officials as well as enabling the official to carry out his own role. For example, the military leader who excels in strategic planning not only has to plan his campaign against an external enemy but also has to give appropriate directions to his colleagues. The officials responsible for protection, those responsible for storing and controlling the fluids and the Qi, all need to be given appropriate information and instruction in order to be able to co-operate. If the Liver official fails to give proper instructions, it may be other officials who cannot fulfil their roles properly who show greater signs of being in trouble.

I have emphasised that these pictorial models of harmony and balance, even though they are wonderfully alive and fire us with the spirit of Chinese medicine, do not in themselves enable and ensure accurate diagnosis. The poetic descriptions which accompany and inform them clearly indicate that they are not to be taken as constituting some kind of fixed and categorised grid into which we can just slot people and say, 'This person belongs here... that person fits in there.' Expe-

rienced practitioners may, after years and years of practice, be able to see directly and with certainty clear connections between outward signs and the elements and officials within. For most students and those in the early years of practice, making a diagnosis on that basis alone is not to be relied upon no matter how much is known about it in theory. So, we need further aids to diagnosis which will help us to focus on and identify where, for sure, imbalance lies. Only then will we be safely guided to the means whereby we can be certain that treatment will restore balance to the whole system, not just temporarily remedy a part of it.

So far, I have outlined two traditional pictures of balance and harmony, the Five Elements and the Twelve Officials, and I have introduced the notion of all of them being inextricably linked in subtle and ever changing relationships. I have said also that it is impossible, without years of experience and practice, to look at the physical, mental, and spiritual distress which a patient is suffering and be able to link it simply and directly with a particular element or official. I imagine that some readers think, 'How absurd! If someone keeps vomiting all the time, surely that must mean that the stomach is in trouble and that therefore the Earth element is imbalanced or the Stomach official is in distress'. That would be a logical connection. But supposing the vomiting is due to the presence of poisoning, a poisoning due to the failure of officials responsible for the separating of the pure from the impure who are thereby not preventing the circulation of harmful substances? The Stomach official's role is the taking in of nourishment; but its responsibility includes making sure that it takes in nourishment only. Therefore, by vomiting, it is not failing to carry out its proper function at all. Contrary to what we might expect, it is not the Stomach official which is really in trouble.

I do not wish to make the task of diagnosis sound too complicated and esoteric, as though we should never trust what seems obvious and always suspect that we are deceiving ourselves. The obvious is what we seek. We just need to be observant and not be tempted to jump to hasty conclusions based on symptoms. We must continually question what we are concluding, consider other possibilities, and accept the obvious only as long as it is based on our perceptions and the use of our God-given senses, not on intellectual associations constructed from symptoms.

Having issued that over-riding warning, it may then be said that there are times when it is crystal clear from presenting symptoms that a certain element is out of balance or a certain official in distress. Serious

kidney problems or bronchitis, for instance, must indicate that elements and officials associated with the kidneys and lungs are being directly affected, but we still need to know what is the real source of the imbalance and distress. There is no doubt where disease is appearing but that is not the same thing as knowing what is causing it to appear. Treating the organs directly affected only takes us back to treating symptoms. Doing that is, in the long run, worse than not treating at all. What would be the consequence of quietening a stomach which was busy doing its best to expel poisons threatening the well-being of the whole system? The effect would be to turn off a safety valve and allow the person to become even more saturated with poisons. We need to look beyond the obvious painful symptoms to be sure of finding the cause of the disease.

Causes of disease

The idea that there is a cause of disease, knowing for sure what is causing symptoms to appear, is a very comforting one. The Chinese did not have laboratories and equipment to find microscopic agents such as viruses and bacteria, which are commonly regarded as the cause of many diseases, but they observed the physical and mental factors which appeared to be harmful if experienced in excess. They recognised seven external factors and seven internal:

EXTERNAL	INTERNAL
Wind	Anger
Cold	Fear
Heat	Joy
Humidity	Anxiety
Dryness	Grief
Damp	Worry
Fire	Other constitutional weaknesses

Today, in our technologically developed modern world, we add other factors such as trauma, poisoning, accident, chemical injury, radiation, infectious diseases, and others. These are as much a potential threat in our environment as the external and internal factors identified by the ancient Chinese.

Everyone is exposed to all fourteen traditional factors and some are likely to have a more detrimental effect when experienced in excess

than others. As far as the external factors are concerned, the Chinese were, and still are, a predominantly agricultural society and the working life of most of them still involves working on the land. They are thus constantly exposed to dampness underfoot and to the heat of the sun on back and head. The climate in China varies greatly from one region to another and so the Chinese defined a wide range of disease threatening conditions, from exposure to excessive dampness to excessive dryness, from excessive cold to excessive heat, including sudden change from one condition to another.

We may think that such emphasis on the external factors is not relevant for us. To a large extent that may be true for the majority, but it has only become so relatively recently. I can still remember from my own boyhood how many people frequently worked outdoors whatever the weather, out in the fields all day in the cold and wet. People used to come home from work to houses which were damp and had no proper heating. For many there were no hot baths, and those with no change of clothing often had to put on damp clothes in the morning. Food was not plentiful all the time. Living standards were very basic and lacking any comfort. Lumbago, rheumatism, and a whole host of similar nagging physical problems related especially to the external factors made up the bulk of my work during the early years of my practice.

However, although times have changed for the better where external conditions are concerned, and better housing, heating, clothing, and food are available, the number of cases of rheumatism, arthritis, and the like has not decreased but increased. Why should that be so? What else has changed? In my boyhood, I had two loving parents, and the whole local community was like one big family. No one could be sick without everyone knowing, sympathising and helping. If anyone ran out of food, neighbours pitched in and gave what they could. Today, such community spirit is harder to find. The terraced houses where our lives were all jumbled together are no longer deemed ideal or desirable. Instead, many people sit in expensive detached houses having no real contact with neighbours for days and weeks on end. Now we see disease caused by distress in mind and spirit. Rheumatism, arthritis, and lumbago persist, but they derive from a different cause. In fact, today very few people suffer disease from only physical causes outside of Third World countries.

Yet fundamental questions still remain. How is it that many may be exposed to the same external or internal factors yet some become ill and others do not? Why does one occupant of a house in a street of

people living under similar conditions become ill whilst none of the others do?

The Causative Factor

Much of the answer to the above questions lies in the fact that Nature within itself has wonderful healing powers. We tend to overlook the fact that so much healing takes place without our being aware of it. We take it for granted that cuts, bruises, sprains, fractures, colds, infections, and the worst climatic conditions will all usually be taken care of by the natural powers of resistance and healing within us. There are mental hurts, angers, fears, despairs and worries which we usually manage to cope with, almost as if by magic. It is extraordinary just how much we do for ourselves, how our our powers of defence against threat and stress keeps us generally healthy. This is something which we, as acupuncturists, have to bear constantly in mind. All we do in practice is assist a patient's own healing powers, and help Nature carry out its remedial work.

However, whilst the powers of self-healing keep most people healthy most of the time, there can come a point when an inner cause of disease has done so much damage to one of the elements or officials that it becomes unable either to repair the damage or draw on the healing resources within body, mind, and spirit to restore proper balance. Such serious damage usually hits an official rather than an element, but the relationship between an official and its associated element is so close that damage to the former invariably harms and distresses the latter. The affected element then becomes what we call the Causative Factor, the part of the system of energy within the person which needs extra help and support.

Sometimes the Causative Factor is referred to as a person's Achilles heel, but I prefer not to do so because that implies that the person has a permanent weakness. The Causative Factor is really a constant imbalance, which is not the same thing. Imbalances we can be aware of and can improve by acupuncture treatment, whereas fixed weaknesses will forever hinder or prevent development. The only resemblance between the Causative Factor and an Achilles heel is that we will always have a disposition towards a particular built in elemental imbalance. This does not change over time.

The question which is then invariably asked is, 'When is this imbalance first created?' The answer is by no means clear, but in the

tradition of Chinese medicine that does not matter. The important thing for the practitioner is to establish through diagnosis where to intervene to help to restore balance, not to try to trace back to when it first came about. In our experience in practice, however, we find that the imbalance most often seems to have become established during the very early years of childhood, sometimes at birth. Occasionally, it seems to owe more than a little to hereditary influences.

The difficulty, of course, is to establish what actually did happen all those years ago. The vast majority of patients do not have clear and conscious recall of their very early years. In many cases, they will recount stories about themselves which they do not remember from experience. They may sound convincing but they are really repeating stories told to them so many times by others. However, it does not take too much imagination to appreciate that in itself the process of being born must be a major trauma in everyone's life. We can imagine the baby floating in the mother's womb, warm, cocooned, nourished, and contented. Suddenly this beautiful harmony with the mother is disrupted by violent contractions. The warm waters disappear and the baby finds itself being forced out through a narrow channel to confront the harsh lights and staring faces in the delivery room. Imagine the shock of being pulled away from the mother, perhaps even with forceps, then being lifted by the feet and smacked to take in the first gulp of air, and then perhaps being placed alone in a cot whilst all the attention is given to the mother.

Such practices may have changed for the better in recent years but nothing can be done to avoid the baby's experience of being forced from the security and warmth of the womb into the outside world. The shock must be intense. Quite apart from elemental change and upheaval at the physical level, what must the baby feel? Anger at being deprived of the comforting womb, frightened by all the unfamiliar light and noise, lonely and unloved through being parted from its mother, grief for the intimate connection with her so suddenly broken, or the desire to regain the security it has lost? There is certainly enough drama and trauma at birth to cause a blow to the baby's system savage enough to send an official reeling.

It is also not difficult to appreciate the dramas and traumas which can occur in the early years of life. Children are a joy and a wonder but most have to contend with all kinds of difficult situations, with competition from brothers and sisters, and with parents who have more important things on their minds just when attention is badly needed. It is not necessary to spell out the many ways in which a child

may have to cope with difficulty during its early years. We recognise from our own childhood and from the experience of others around us the kind of battering to which the elements and officials can be subjected. As the pressures of modern life increase, fewer and fewer parents seem to have the time and inclination to give their children all the attention and support they undoubtedly need. The unhappy effects of the lack of love, the sadness, the anger, the insecurity, the lack of purpose, and the fear which many children must feel in the world today will, unfortunately, bear unwelcome fruits in future years.

What we have just covered focuses very much on internal factors as cause of imbalance and disease. We will find on occasion equally evident causes due to infection and other external factors. Some diseases, such as scarlet fever, have a direct effect on elements and officials and they can thus precipitate the Causative Factor. Although the external environment has improved considerably for the majority since I was a child, sadly there are youngsters who, despite all the love in the world, still grow up inadequately fed and in deprived conditions because their parents do not have sufficient money to provide enough food, clothing, and proper housing. It is important to bear in mind that, although there is a tendency nowadays to focus increasingly on internal factors when looking for the Causative Factor, the external can certainly not be discounted.

The most important aspect of the Cautive Factor is to identify it accurately and then provide support to assist Nature to restore balance. Once we have a Causative Factor, it remains our CF for life. (CF is used as abbreviation for Causative Factor). I should qualify the statement that there is only one CF a little further by mentioning that, in a case where there has been heavy drug-taking over a long period, it is possible that a group of symptoms have emerged which almost amount, in appearance, to there being another CF. I say 'almost' because in fact there cannot actually be a second one. Even though the symptoms may be very pronounced and need additional specific help, such treatment will not, strictly speaking, be Five Element acupuncture in the classical tradition because it is not the underlying CF being dealt with.

Heavy drug-taking will generally, but not exclusively, affect the elements and officials associated with the liver or kidney because they are likely to take a tremendous hammering from many drugs. But there are also side effects which can adversely affect any of the elements or officials. Whatever the case, steady and systematic attack on any element or official can weaken it to such an extent that as much

of a permanent imbalance is created as by the CF itself. On occasion, the imbalance created by the former can be worse than that of the latter. This is particularly tragic when the taking of drugs to gain relief and palliation of the original symptoms thus creates a group of symptoms more distressing and enduring than the first ones.

Once a person's CF is established and has become the primary imbalance in his system, its presence can be detected by the four basic signs, colour, sound, odour and emotion. A distinct colour will appear on the face and be visible to the trained eye. There will be a distinct inappropriate sound in the person's voice which will be audible to the trained ear whenever they speak and whatever they are talking about. The person's body will emit a subtle odour which the trained nose can detect. One particular emotion will predominate in the person's response to the people and situations he encounters, an inappropriate emotion which the skilled practitioner will be able to identify through communication with him. Further, secondary diagnostic evidence may be obtained through reading the pulses and through information given by the patient. The latter would include information about favourite tastes, times of day and season, and to an extent about particular areas of physical difficulty in bodily functions, muscles, or ligaments. As far as the practitioner is concerned, however, it will be the four basic signs or correspondences which will be the most important in determining the CF.

The ways in which these signs appear are summarised in the following text. I continually need to emphasise what I touched on in Chapter One, that we are really the most inefficient instruments of observation and healing and that inability to identify the basic signs with ease should always cause us to approach diagnosis with humility. All practitioners will make mistakes. This is not a bad thing, if through humility we learn from those mistakes. I have often felt sorry for the students who correctly guess CF's too quickly; they often learn less than their colleagues who at first get it all wrong.

Colour

As soon as a person becomes imbalanced, a colour appears on the face. This is not a colour of the skin but a hue on the face which is often more easily seen when the face is viewed indirectly, glanced out of the corner of the eye. The best area to see the colour is on the temple, just to the side of and above the eyes. It is also visible under the eyes, in the laugh lines, and also around the mouth. These lower areas are not

so reliable, however, as they can be affected by other things, such as lack of sleep. The idea of there being a colour on the face is not as odd as many people are apt to think. When there are serious dysfunctions of the liver or kidney, for example, the face literally goes green if a liver imbalance or blue/black if a kidney imbalance. The colours produced by elemental imbalance are similar but much more subtle in their manifestation.

The basic colours are Red - Fire; Yellow - Earth; White - Metal; Blue - Water; Green - Wood. Broadly speaking, these are the colours of the elements. A point to be made immediately is that the colour associated with the Fire element is more often a 'lack of red', represented by an ashen, grey colour. Red itself is relatively uncommon and not to be confused with the florid appearance typical of hyperactivity and hypertension. Anyone who has seen a person who has recently had the misfortune to have a coronary attack will most likely have noticed this ashen colour straight away. When seen in lesser degree, this colour can be confused with white but actual white is much brighter compared with the dirty shade of 'lack of red'.

I shall say more later about developing the faculty of sight but it is worth saying here and now that if you can envisage a paint chart with a thousand colours on it you will only be seeing a fraction of the range and shades of colour which can present themselves on the human face. There is not a single and particular blue which signifies Water imbalance. The blue can range from the very pale blue of a distant sky to the inky blue-black of deep water. Yellow can range from almost cream to the kind of orange-yellow that borders on red. This is, of course, where diagnostic complication begins. Am I seeing a shade of yellow or green, of red or yellow, blue or green? This is why accurate diagnosis requires at least three of the signs presenting in the patient to be indicating the same element. Colour alone, sound alone, odour alone, or emotion alone is not evidence enough to be sure.

Sound

It is also a fact that when a person becomes imbalanced the voice expresses an inappropriate or imbalanced sound. The five sounds which correspond with the five elements are laughing, singing, weeping, groaning, and shouting.

Just as a Wood imbalance, for example, will appear on the face and be clearly seen as a green colour, so will there also be a sound of shouting

or lack of shouting in the voice. When we hear a voice which always seems to be shouting, giggling, or singing, that characteristic sound signifies a particular elemental imbalance. Since the imbalance continually produces that typical sound, it is especially likely to to strike us when we hear it in situations where it is inappropriate. The sound of the CF often becomes most apparent in times of pressure and stress. It is thus often the case in Traditional Diagnosis that the most clear indication of typical sound in the voice occurs when patients are talking about the upsets and traumas in their lives. Sometimes it is not just the sound of the voice when speaking but also the accompanying noises which people make, especially inappropriate laughing, or self-comforting singing sounds.

Some comment also needs to be made about the quality of the sounds themselves because it is easy to miss important information through listening only superficially. Real laughter, for instance, comes from the belly and we see it in the eyes as well. This quality is distinct from a great deal of the laughter we hear when people laugh to mimic, laugh to be polite, laugh to dismiss or discomfort, laugh sarcastically, or laugh as a gesture of sympathy. It is not the face value of the laughter we need to hear but the inner quality of its sound. In order to do that, we must not be misled by the apparent reason for it but listen to the sound alone. This is, at first, a difficult thing to do. Having learned to do it, we can become aware of the incongruity of, for example, the person who sounds on the surface as if he is enjoying telling a good joke about what has happened to him when in reality it is a deadly serious matter. The superficiality and lack of credibility can be alienating to the listener.

Singing can also be confusing. Many people associate it with the lyrical sound of a regional dialect, but I can assure you that all Welsh people do not have an Earth imbalance! The most natural singing tone to be heard is that of a mother soothing her child in distress. A person with an Earth imbalance will have habitual overtones of it in the voice. They will sound as though they are always trying to be sympathetic or consoling, even when the situation clearly does not call for it. Likewise, we can forget the common idea of shouting as just the making of a large volume of vocal noise. The principal characteristic of real shouting is its emphasis and demand: 'I want something done about this now.' Such a demand can be made without raising the voice at all. Both weeping and groaning are also quite difficult sounds to discern. Both seem to lack substance, vitality and purpose, and they make it a strain for others to concentrate on what is being said. The weeping voice often sounds as though the person is crying every word

without quite breaking into tears, a sound which can be irritating for anyone listening. Groaning can be just as hard to tolerate, the tone is not only dull and monotonous but the listener tends to feel that the speaker is going to go on and on forever.

The sounds of the voice present further difficulty for it is possible to have 'lack of sound' as well as definite and excessive sound. This lack is only possible with laughing and shouting. In the case of the former, its lack is evident in a voice which has no spirit in it; it is totally flat and uninspired. It is difficult to describe something that is missing but absence of enthusiasm or a miserable quality can be particularly noticeable during diagnosis. We would usually expect to share some moments of warmth and humour with our patients. If they do not happen at all, we will soon be aware of the fact. When we find no laughter in the patient's voice, and do not find them joining us in moments of warmth, it is as if the sun is hiding behind the clouds.

In the case of 'lack of shout', the most noticeable evidence is a total absence of appropriate expression when recounting experiences which would understandably anger even the most moderate person. The voice sometimes seems to have no power to carry the telling forward; the words just tumble out on to the person's lap and fall away. It is not an easy condition to recognise and we need to remember to check for it by listening very carefully how patients describe their difficulties and problems. Everyone has something he is aggrieved about. Many patients, for example, complain bitterly about the medical treatment they have received, and it would be very surprising if someone who comes out of treatment as ill or worse than he went in did not feel rather angry. Whatever the grievance, if the sound of the voice does not match the feeling being described, or if the sound and the feeling are far too unassertive or docile when describing a situation which would be guaranteed to have everyone else climbing up the wall, we would certainly suspect 'lack of shout'.

Odour

No part of the diagnostic procedure is quite so difficult to accomplish accurately as identification of each of the five odours which are associated with imbalance in each of the five elements. When a person is out of balance , his CF element gives off a particular smell which is as evident to practitioners as any other smell in everyday experience once they have regained to some degree the sensitivity of smell they had as babies. The five odours, scorched, fragrant, rotten, putrid, and

rancid, are not described in great detail in the Nei Jing. They were fully appreciated as a diagnostic tool in later development of the tradition and they are vital to us in helping to confirm the CF.

The main problem we have to overcome as practitioners is that of having conditioned ourselves since we were very young to avoid or block off odours that we do not like. In the main, the odours associated with imbalance are not pleasant. 'Scorched' means a smell resembling anything burned, and that can mean burnt toast, burnt grass, burnt flesh, burnt chemicals or rubbish and all manner of things burnt which do not smell at all pleasant. 'Fragrant' sounds as though it should be nicer but in this context it stands for a rather heavy and sickly smell, such as that in a greenhouse full of plants in bloom on a hot day. It is cloying and thick and hence tends to hang around and stick in the nostrils. Before the days of frequent washing and bathing, many people used to drench themselves and their clothes in scent to disguise their body odours. The horrible mixture of excessive scent covering up something obnoxious gives a sense of the term 'fragrant' as used in Traditional Diagnosis. The odour 'rotten' is literally that, rotting fruit, rotting meat, rotting foliage. 'Putrid' is a metallic and sulphurous mixture like rotten eggs. The smell of a stagnant, brackish pond full of algae and gases of decomposition comes very close to what we would call 'putrid'. 'Rancid' is a much sharper smell, like that of rancid butter or cheese but with a keen and sour edge to it.

We can appreciate that the simple labels are not in themselves enough to ensure accurate identification of the different odours. In order to teach students what is meant by 'rotten' or 'rancid', we have to give them specific examples of things which are rotten or rancid and encourage them to start using their sense of smell to broaden their experience of the vast range of variations. The great diversity of smells means that for some years practitioners will encounter odours which they cannot confidently and easily place in one of the five basic categories. The best that can be done when this happens is to record what the odour smells like. If a patient's odour reminds us of hot, wet laundry, then that is how it should be described in the patient's record. The practitioner then has a reference to be able to tell, as treatment progresses, whether or not the odour is changing. If balance improves, the odour will change. Thus a description such as 'hot, wet laundry' can serve just as well to monitor such change as the 'scorched and putrid' that it may be. What the practitioner does not have in this circumstance is the precise label which helps certain identification of the CF.

Some people are offended by the notion that they smell, even when they are assured and know perfectly well that everyone does. All we can say to such people is that if they have lived all their lives without others complaining and backing away from them then their odour cannot be all that bad. Their odour will certainly be detectable by a trained nose, but how many of those are there? In fact, most people do have experience of smelling human odours. There are common ones such as stale sweat, the smells of illness when visiting hospital wards or nursing homes, or when their children have been running fevers at home in bed. They may have felt overwhelmed by the stench in a crowded tube train on a hot summer's day. In all such situations where the smells seem unpleasant, the tendency is to shut them out as much as possible. Although we, as practitioners, may likewise automatically want to avoid smelling unpleasant odours, we must allow the sense to work as Nature intended. Only then will we be able to gain the information we need through being able to recognise the full variety of odours manifesting in our patients.

Students and practitioners often do not like the idea of having to smell people any more than patients like to think that we are deliberately trying to smell them. This is a silly block which we learn to overcome. It is not so very long ago that Western doctors and hospital medical staff commonly used their sense of smell as an aid to diagnosis. There were, and, of course, still are definite and distinct odours associated with particular, serious conditions such as T.B., kidney disease, liver disease, and various fevers and infections. In those days, any doctor worth his salt would have used his nose as a valuable diagnostic instrument. In Traditional Diagnosis, we have to revive our powers of smell so that we may do the same.

Emotion

The fourth sign looked for in diagnosis is the emotion which the patient predominantly displays. This sign may be more difficult to establish than the other three because people attempt to control their emotions. When the other three diagnostic signs appear, there is generally nothing the person can do to hide them. However, most people attempt to cover up their emotions and, at first, display the mask they prefer us to see.

Getting behind such a mask to find the predominant, underlying emotion is not easy. Apart from needing to establish genuine rapport with the patient in order to do so, we must then be sure that the

emotion we detect is the principal one (out of the five possible), arising from the CF. Just as the major imbalance makes one particular colour, sound and odour predominant, so it makes one emotion predominant also. During the diagnostic procedure, however, we cover an enormous amount of ground with the patient and we expect to see all of the emotions expressed at one time or another. Our skills of detection need, therefore, to be developed to an acute degree to be sure of knowing for certain which of the emotions is the major one out of balance and thereby pointing to the CF.

Apart from the problem of getting behind the mask, the mask itself can be a problem for us. There is always the danger that we may mistake it for the real person. The more sick a person becomes, the thicker the mask is likely to become. Some people learn to protect themselves by laughing and smiling their way through their troubles. Out of some quaint idea of politeness, not wanting to be a nuisance, or because they are nervous, or frightened, they giggle and joke all through the diagnosis. Ordinarily, we might accept such continual laughing without question; it makes for ease and it is sociable. However, even though the behaviour strikes us as excessive and peculiar, we should not be fooled by it into thinking we are dealing with inappropriate joy as it is to be understood in Five Element terms.

There are some people who are full of bluster, swearing about this, that and the other, angry as hell about the way they have been treated by doctors, osteopaths, wives, bosses, children, dogs, any target for blame they can think of. All this indignation and performance can just be the mask as well. It may be interesting and useful to discover why they find that kind of behaviour to be more comfortable than, say, laughing about their experience, but we should not be deceived into thinking we are necessarily seeing the principal emotion. Although what we first see can be totally unreliable, that is not inevitably so. It is possible in some cases that we will find the inappropriate emotion standing out like a beacon. However, in order to be sure whether we are seeing real emotion or a superimposed mask, we need to test comprehensively.

I have already mentioned that anger can come from any one of the elements and I used a variety of examples from Nature to show what I meant. If we now think of all those different kinds of elemental eruption as expressions of need, as outbursts of energy saying, 'I need such-and-such', we can appreciate just how any one of the elements can be the source of anger in a person. People can be angry because they are frightened, angry because no one is paying them attention,

angry because they have lost everything which gave them their quality of life, angry because they are not being given the warmth and love in the way they crave, or angry because they are just plain mad at the injustices and abuse they feel they are suffering.

If we want to find out the real source of the patient's imbalance, we cannot just sit back, look and listen. We have to consider how all the emotions manifest in that person, by assessing how appropriate their responses are to a wide variety of situations which they describe. We need to play an active role in this overall assessment by guiding the patient to recall his memories of a range of emotional experiences. We may then discover how he responds when he is presented with situations in which we would expect them to show happiness, sadness, fear, and other emotions. Accordingly, we will begin to see clearly the source of his imbalance and thus be able to determine what help and support he needs.

The name given in our training to this deliberate and subtle enquiry or review is 'emotion testing'. This somewhat clumsy and mechanical sounding title belies the fact that it represents one of the most subtle and difficult skills to learn, and one of the most powerful skills once mastered. If we can discover the patient's real emotional needs, we will have penetrated the habitual mask and will be in touch with the person at a level where they have perhaps never been touched by anyone before. If we can learn how to provide love and sympathy naturally, how to give respect and reassurance, and how to impart structure and definition to assertiveness, we can cut through the outer expression or mask and find out the reason for it and what it really means. If, for example, a patient has really become angry because he has had no one to sympathise with his troubles and pains, he is going to feel less need to express anger as soon as he receives from us the support and understanding which he has been seeking.

We must also take into account, however, that everyone needs support and sympathy at times in his life, and it is a rare person who does not enjoy receiving them any time. Everybody appreciates love, respect, security, and structure. If someone is angry because he is not getting enough sympathy, and we find that by giving them sympathy they become less angry, that does not automatically mean that they have an undue need for sympathy and that, therefore, they must have a major imbalance in the Earth element. All it tells us is that, at a superficial level of contact, their anger responds to sympathy. We need to test further, and ask ourselves further questions: How much sympathy can the patient take? Is sympathy really appropriate for

what is wrong? If we stop giving sympathy, does he then start giving out signals that he wants more?

Little children are our best teachers. If a child falls over and bruises its knee, it will scream and cry. But, as soon as mother has rubbed the knee better and has soothed and comforted its distress, the child runs off and carries on as if nothing has happened. If the child keeps on crying, it may mean that the soothing and comforting was not done very well; or perhaps that the child was really wanting something else. But, if the child receives more than enough attention to satisfy the degree of hurt and yet still goes on demanding more, then we may begin to suspect that the little bruise on the outside is being used as an excuse for trying to satisfy a much deeper need, perhaps for mothering and love at a level which indicates that something in the child is seriously undernourished.

As with the child, so with the adult. There comes a point when the emotional need reaches beyond what we consider natural. Up to that point, the need for love, reassurance, or sympathy is considered reasonable; but, beyond that point, it seems as though the demand is insatiable. There are patients whom we reassure, and go on and on reassuring, but they still will not trust us and be reassured. There are others whose lives are beset with grief or seething with anger because of things that have happened to them. No matter how we do our best to join respectfully in consoling their loss or in acknowledging and understanding their frustration, the grief or anger just goes on and on relentlessly. A patient might come to us, for example, complaining bitterly about the ineffectiveness of the treatment he has been receiving elsewhere. Understandably, he is fed up. We may empathise with him and go along with his need to unload his anger, expecting it to die down in due course. If every time he comes he keeps going on and on about it and is still evidently furious, then we are clearly observing an excessive response which we will note.

We may also notice an incongruous response. We may hear, for instance, sounds and expressions inappropriate to their context, laughing about funerals, belittling of marvellous achievement, anger at being helped, sympathy for the undeserving, fear of trivial danger, any expression of emotion which makes us think, 'My God, that's really strange. Why on earth are they reacting like that?' There are times during diagnosis when such inappropriate expression is a golden key; the moments when an emotional response is so blatantly inappropriate that it is as if a nerve in the patient has been so sorely touched that he cannot help but reveal the nature of his imbalance.

Generally speaking, however, we usually have to work hard and patiently to discover the predominant emotional imbalance. Even if we see something which strikes us as definitely odd, we must check and double-check, not only the element under suspicion but all the other elements also to see how they are faring. In this system of medicine, no irregularity stands alone. A major imbalance nearly always creates imbalances elsewhere, and these show up from time to time just as conspicuously as the major one.

As with colour and its counterpart 'lack of colour', experience teaches that positive emotion can have its counterpart 'lack of emotion'. The distinction between them is not always clear. I have often found in the past, when in consultation with colleagues about the same patient, that one of them will have diagnosed 'excess joy' whilst another will have noted 'lack of joy'. It is easy to see why such apparent contradiction can arise. There are some people who like to be the life and soul of the party, always laughing a bit too loud and long, telling jokes as if there is no tomorrow, trying to create the response and warmth which they need to survive. When the party is over and the laughter stops, their joy rapidly subsides and they then look terrible, flat and spiritless. During diagnosis, we may see the hysterical aspect or the depleted aspect and thereby be drawn to consider excess or lack of emotion respectively. If an element is out of balance, however, the person is not going to be able to behave continuously one way or the other and, if we look and listen carefully, we will not only find vacillation between the two extremes but also be able to discern which one is dominant. An exhibition of unrelenting laughter and excessive joy has a very different quality from desperate attempts to create laughter from nothing. The person exhibiting an excess of Fire which nothing will quench will behave very differently from the person needing to generate Fire to replace the lack of it in himself.

Anger is another emotion which can manifest ambiguously. Some people who are really angry show no sign of it, except perhaps in their eyes and in a tenseness of posture which makes them look as though they are about to snap and explode. This condition can be seen as 'lack of anger' because there is no outward expression of it, only a hint of the suppressed anger inside. Sometimes the suppression is so great that there are people who seem to have no anger at all, even deep inside, when really they should have. These are the ones, for example, whose lives have been blighted by injustice but who just say, 'Well, I'm sure they didn't really mean it'; or those whose feet you could stamp on and they say, 'I'm sure you had a reason for doing that.'

'Lack of grief' is of a similar nature. It is not quite like someone trying to conceal his grief, giving only minimal expression of his loss to the world at large. It is seen in the person who is clearly not moved at all by loss, past or present, the kind of loss which others would naturally find impossible not to grieve about. The same applies with 'lack of fear'. It is not really the concealing of fear in order to put on a brave face; rather a complete absence of fear, as may be found in the novice who volunteers to make a 30,000 foot free-fall parachute jump, or wants to ski recklessly downhill, or race cars, or engage in any sport without heeding the danger.

'Lack of sympathy' is even more difficult to describe, partly because the word 'sympathy', as commonly used and meant, can be misleading. In Traditional Diagnosis, it really means a balance of care and concern for both self and others, whereas it is usually understood in the latter sense only. When imbalance arises, people often go to one extreme or the other, either totally caring for others at their own expense, or ignoring others and looking after 'Me... me... me'. The imbalance may be revealed through what they say about themselves or other people. It will reveal itself for sure when we feed them sympathy and see how they respond. For some, it is never sympathy enough; when we give it to them over one hurt, they find another, and then another. Others will pretend they do not want it and will push us away or in fact cannot deal with accepting sympathy. One patient actually said to me, 'I don't want your bloody sympathy!' He did, of course, but he was not going to admit it.

We gather from all of this that identifying the inappropriate emotion is more difficult than we may have imagined. The skills needed to be sure that we have found the one most out of balance are ones which we have to learn through developing the powers and resources within ourselves. (I shall be saying more about this in later chapters.) Once we have gained the skills and are able to diagnose accurately with the help of all four signs, we will know with some certainty what a person's CF is. Once we know this, we not only know what support the patient needs but we also have knowledge of the natural laws which determine the most effective points to needle in order to restore balance and harmony.

It is not always possible to obtain a clear indication from all four signs. There are occasions when three out of four is the best we can manage. If, for example, a patient comes for a diagnosis in the evening and we are having to use artificial light, it will be impossible to see the colour on the face. It is only visible in daylight and the diagnosis will

therefore have to depend on the other three signs. If, for whatever reason, we cannot establish more than two signs, we have to allow that any conclusion we have reached is not necessarily safe. I shall be saying more later about the relationships set up between the elements when there is major imbalance, but need to point out in this context that it is possible to find split associations or combinations of elements. With only two signs confirmed, we cannot be sure that it is these two and not the other two which are indicating the principal imbalance. We often refer to the signs or correspondences as being like the legs of a stool: four are stable, three will do, but two are definitely not reliable.

We also always have to remind ourselves not to deduce and assume the fourth sign when we have established three. If the sound is 'laughing', the odour is 'scorched' and the colour is 'lack of red', that does not guarantee that the emotion will be 'joy' or 'lack of joy'. Assumptions like this happen when we allow the head to take over what our senses should be doing. The unidentified emotion may well be a lack of joy; but if it were really something else, such as grief or lack of anger, we would be overlooking a vital piece of diagnostic information. If we cannot see, hear or smell a missing sign during the diagnosis itself, we must make the finding of it our priority the next time we see that patient.

Other signs

In Traditional Diagnosis, there is no substitute for the ability to use our senses to detect imbalance via the four signs. During training, our students must sometimes wince at the oft-repeated chant 'Colour - Sound - Odour - Emotion'. It is intended to dispel any lingering illusion that the CF can be worked out in the head. If we see someone who is angry and, without checking in depth to see where that anger is really coming from, we dash off to look for further evidence of a Wood CF, then we will probably find some. Our heads can convince us of anything. If we are lazy, we can persuade ourselves to see what we want to see, hear what we want to hear, and feel what we want to feel. All of us have all the elements within us and eventually we are bound to be able to find something to corroborate our hasty assumption. Colour, sound, odour, and emotion are always there as clear as day and, if we have worked hard to rediscover the power of our senses, those signs are so obvious that we wonder how we ever managed to get them wrong.

In addition to the four principal signs, there are one or two other signs

which should be mentioned. Whilst we are still working to improve our skills, we will not always be able to detect the colour, sound, odour, and emotion clearly and easily. These other subsidiary indications also point to the CF so, if we find one or two of them in addition to two of the four principal signs, they can help us to feel a little more confident in our diagnosis.

Colour, for example, can be an important indicator in ways other than the principal one already described. As soon as we have a major imbalance, we try to compensate for it. One way in which we may do this is to use colour to support ourselves. If a person develops a Fire imbalance, he may suddenly find that he wants to surround himself with as much red as possible. The Fire within has started to go out so he tries to make up for the deficiency by having red clothes, red wallpaper, red sheets, and so on. In any way he can, he tries to get the warmth of red around him. Another person, with a Water imbalance, may suddenly take a dislike to blue and try to avoid it. All the clothes he bought last year when blues and blue-greens were all the rage are left abandoned in the wardrobe. The blue bathroom suite has to go. Anything which makes that person feel colder inside will not do at all. In both cases the imbalance could show up in the completely opposite way. An imbalance in Fire might make someone avoid red, and a Water imbalance may lead to a craving for blue.

Some people are sceptical about this colour effect and think it is ridiculous. There have been several interesting research experiments with colour which corroborate it. If a room is kept at a temperature of 68°F and has red carpet, curtains, and wallpaper, a person standing naked in that room will start perspiring in five minutes. In a room at the same temperature but entirely furnished in blue, that same person will start shivering. The effect of colour is powerful. In my younger days, colour therapy, using the powers of different colours, was very popular and effective. The ancient Chinese in their wisdom realised, however, that although use of colour can be supportive up to a point, excessive use eventually makes the imbalance worse and actually becomes injurious to health. Despite this longer term detrimental effect, the imbalanced person is likely to persist in surrounding himself with the one colour in preference to others because initially it made him feel better. It can be helpful for us as a sign, therefore, to find out what colours a patient strongly prefers or dislikes. Such information may well help to point towards the CF.

Similarly, imbalance can be indicated in strong preferences and dislikes in tastes of food. Anyone who has eaten good Chinese food

appreciates how all of the five main tastes are brought together and harmonised in a meal. We enjoy all the tastes equally when we are in balance. When there is a major imbalance, however, the body may start to crave a particular taste, a sign that it is trying to compensate for some deficiency. One person may become addicted to pickled food, adding huge amounts of vinegar-saturated items to their diet. Another will be forever eating sweets and chocolates, not just the odd one or two but craving a constant supply. After a while, such excesses have the same effect that happens with excess of colour. Increased amounts of food with a particular taste will temporarily compensate for a deficiency, but will eventually make the inherent imbalance worse and actually begin to destroy the associated element. When first questioned, patients will often not recognise that they have strong likes or dislikes where food is concerned, but then they will say, 'Yes, I do love vinegar." In diagnosis, we need to notice such emphasis and ask ourselves, 'Why such emphasis?' Or they may say, 'I detest tomatoes.' What particular imbalances are being indicated by such extreme likes and dislikes?

There are other common effects of elemental imbalance which might help to point us in the direction of the CF. Complaints about particular areas or features of the body may give a strong hint as to the main source of disturbance. What people call their best or worst times of day may indicate, with reference to the Chinese Clock, that a particular element is in serious trouble. None of these subsidiary signs are a substitute for any of the four basic signs. But, supposing, for example, we have a patient who craves sweet things, hates humidity, has problems with weight and tends to be a slow-starter in the day, all these factors in conjunction with a yellow colour on the face may well start to guide us towards imbalance in the Earth element. That may then prompt us to look for an opportunity to test sympathy. If we found inappropriate responses here, we would then have a second of our four principal signs to corroborate the first (colour) and the other subsidiary signs. It would be dangerous to diagnose on a compilation of secondary information alone, but, combined with strong primary information, it helps to establish a more fully comprehensive picture of what is going on and going wrong.

Pulses

During diagnosis and treatment, the practitioner of traditional acupuncture frequently monitors the pulses of the wrists. In practice, there are twelve pulses, six on each wrist. The twelve readings

correspond with the twelve officials, and each one is associated with one of the five elements. They are found with the index, middle, and ring finger-tips, the middle one being placed on the radial pulse exactly level with the bony protuberance of the radius. On each wrist, three pulses are to be felt at a superficial level and three at a deeper level.

The association of pulse with the officials is to be found as follows:

Left Wrist		**Right Wrist**	
Superficial	*Deep*	*Deep*	*Superficial*
Small Intestine	Heart	Lungs	Large Intestine
Gall Bladder	Liver	Spleen	Stomach
Bladder	Kidney	Heart Protector	Three Heater

What the practitioner is feeling is not the pulse of blood in the radial artery but the pulse-energy of each of the officials. This is difficult to describe in words, and a full and detailed description is not appropriate in this volume. But, in essence, taking a pulse is like questioning an official as to its present state. It can also tell more than just what is happening at the moment; it can tell us about the past. If we see someone approaching us in the street, we can usually make an accurate guess as to their present situation; but, if we are really observant, we may also be able to read something of their background history. So it is with pulse-reading. When taken properly, the pulses reveal not only the current state of the officials but also their history.

Of all the arts and skills of Chinese medicine, pulse-reading is undoubtedly one of the most demanding and requires the greatest sensitivity to perfect. A major part of the reason for this is that, whilst a pulse's volume or strength tells us about the amount of energy an official currently commands, the pulse also has within itself any one of twenty-eight different qualities, qualities which tell of the complete life and history of that official. Some qualities are more rare than others and they can appear in a wide variety of permutations. We can appreciate therefore that understanding the pulses in depth is a very subtle art.

I do not want, through comments like these, to give the impression that pulse-taking and reading is pointless and untrustworthy until a practitioner has had many, many years of practice and experience.

Most practitioners soon become sensitive to a number of the qualities, certainly enough to practise with safety and adequate accuracy. By 'practitioner', however, I mean someone who has learned the skill though taking several thousand pulses during the course of his training. I then add that to make a complete diagnosis, or even to base the main findings of a diagnosis, on pulse-reading alone seems beyond the powers of most practitioners in this country or the West in general. In my view, pulse-reading as a diagnostic aid should be used mainly as confirmation of what has been discovered during Traditional Diagnosis. It can also play a role in alerting the practitioner to special conditions and problems which I shall talk about later in this book.

There is obviously an enormous amount of information which could be given about the pulses and some of their qualities, but that would be to go beyond what is really the intent of this book, to introduce the reader to the working methods which constitute good traditional practice. A good part of the continuing stimulation of that tradition is that in practice the practitioner never stops learning. With pulse-reading in particular, I have always felt that the time to discuss the significance and meaning of the different qualities with practitioners is when they have had enough experience to be able to describe accurately what they have felt and are asking for help to understand what they have found. The subtleties of pulse quality are better considered once the practitioner has become adept at the relatively simpler skill of being able to judge the volume and strength of the pulses in themselves and relative to each other.

Natural laws

Having introduced the fundamentally simple concepts on which Traditional Diagnosis is based, the four principal signs of colour, sound, odour, and emotion, we now come to consideration of the elements and their relationships and interactions, which makes matters more complicated. If Traditional Diagnosis were really as simple as letting people know what to look for, what to listen for and what to feel, it would be possible to train acupuncturists in a couple of weeks. Rarely is anything, especially anything important, as simple as it sounds. Take, for example, the 'simple' buttercup found in a field of buttercups. Simple? Each buttercup is a miracle of colour, shape, texture, and life. Every single one is unique, different from every other buttercup we have ever seen or ever will see. In a similar fashion, the sound of the wind rushing through the trees now will never be the same again; nor will the coolness of this little stream at this moment

ever repeat. Why should we see people any differently? Every single one is unique; not one can be reduced to membership of a typical category. So, we meet the patient as an individual, never as someone of a certain type. We do not fit people into our scheme of things; we try to determine how our scheme can best help us to understand the particular patient who comes through the door.

There are two main areas for consideration of the elements, both of which deepen and enrich our understanding of the patient's uniqueness and make any notion of simple, formulated diagnosis quickly disappear. The first of these is the system of natural laws which governs the relationship of the elements. The second is the deeper knowledge and understanding of the effects of the elements being out of balance.

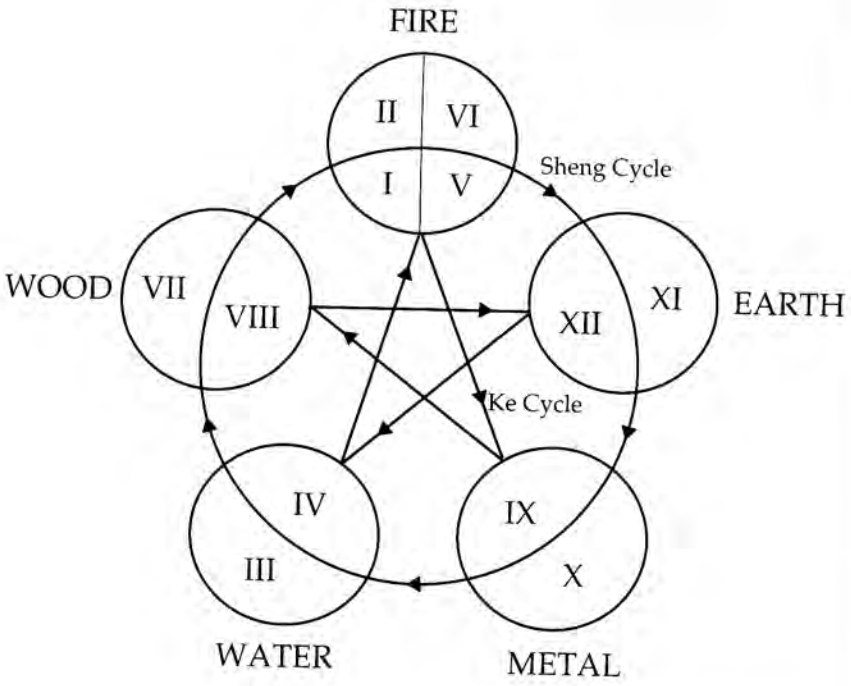
The system of natural laws is developed from the concept of the five elements relating to each other through two cyclic processes (see p.50). The clockwise circle represents the Sheng Cycle, the cycle of creation and nourishment wherein each element is visualised as the creator and sustainer of the one following it in the cycle. The circle is and always remains unbroken, indicating that there is no first cause, origin, beginning or end, only a continuously self-generating cycle. The other cycle is the Ke Cycle, which is the process of control between the elements. It represents the means by which the elements keep each other in order, each controlling another and being controlled by another. In the commentaries of the tradition, there are many beautiful descriptions of these two cycles. They draw upon the true poetry of elemental relationships and enrich our understanding of the elements in Nature.

The Chinese described the relationship between adjacent elements on the Sheng Cycle as being like that between mother and child. Each element is the mother of the element following it on the cycle and the child of the one preceding it. This is not only a marvellous way which everyone understands of indicating the nature of the support and nourishment within the relationship but it also helps us visualise what is happening to the elements when they are imbalanced through our being able to draw on our experience of mothers and children afflicted by sickness and disease. For example, we can imagine a sick child lying still and sad in its cot whilst its mother, crying in distress, calls for the doctor and seeks help and support from husband and family. We know that the mother can be soothed, comforted, and reassured for a while. As soon as that support stops, however, she will turn her attention back to her child again and will not cease to be upset until the child is better.

The same happens with the elements. If the Metal element is weak and in decline, it may well be the mother of Metal, the Earth element, which will be agitated and giving out distress signals. This is why in this system of medicine we disregard symptoms. In this example, the person may be complaining of stomach upsets, inability to take in food, migraines with vomiting, and we might well suspect Earth imbalance. We might even see evidence of it in the basic signs because everyone can manifest all the signs and if, as in this case, the Earth is in distress, we may see signs of it. In other words, everything on the face of it seems to point to an Earth imbalance. But it is not the major imbalance. When we are able to see, hear and feel properly and in depth, we will become aware that the mother, Earth, may be in trouble but that it is the child, Metal, which is really ill. We may be able to relieve the mother's symptoms but that will be of no lasting help if the child remains untreated.

Once we start to consider the variety of subtle relationships within the family of elements, we realise how complicated any situation can be. If the mother is sick, the child may be screaming in distress through being deprived of food and attention. Palliating the child will not then solve the problem. There could even be a situation where the child is sick and the mother knows how to look after it, but agitated grandmother is on the phone every five minutes offering advice and wanting a progress report. The images we use of children, mothers, grandmothers and even great-grandmothers are not in themselves the most important thing to remember. Until we have grasped the essence of what they convey, we will find them indispensable in reminding us that the elements are not separate and static but actively engaged in relationships and interactions with each other. If one is in distress, then that distress is going to be felt by all the others in the system. In this sense, each of our patients is not a single entity but a family of elements and officials. Hence, in diagnosis we have to pay heed to all members of the family and find out how each one is. We must never assume anything. If we have obtained our four diagnostic signs and one of them is an odd one out, we can, with the help of the above images, begin to ask ourselves, 'How could this be so? What relationship is involved here? How else is it showing up?' Whatever our findings, we know with some certainty that when we treat the correct member of the family all the others will gradually return to their natural state of balance and harmony.

We can consider the Ke Cycle in much the same way, visualising how it operates in Nature to help us understand it in our patients. Fire controls Metal, Earth controls Water, Metal controls Wood, and so on.



I	-	Heart	VII	-	Gall Bladder
II	-	Small Intestines	VIII	-	Liver
III	-	Bladder	IX	-	Lung
IV	-	Kidney	X	-	Colon
V	-	Heart Protector	XI	-	Stomach
VI	-	Three Heater	XII	-	Spleen

Fig.1 Sheng and Ke Cycles, List of Officials

What if the Earth in someone is weak? We may pick up distress signals from his Earth officials and the element itself, and there may be signs and symptoms of distress from the mother, Fire, and the child, Metal. But there may also be insufficient Earth to give proper controlling boundaries to Water. Poor river banks allow water to run away out of control. So too in the person. Our attention would then be drawn to signs of flood, of Water tumbling everywhere because the soil banks are too weak to contain it and hold it in its natural courses. If the Water runs out of control, it will put out the Fire, for Fire is controlled by

Water. Here we come full circle because Fire is the Mother, the nourisher and sustainer of the Earth which is the real problem. Not only is the Fire in distress for its child but it is also being threatened by the Water running out of control.

We can see yet again, then, that it is not even remotely possible to use symptoms as a guide to the CF. And we can see how the distress of the CF may be obscured and almost matched by repercussions elsewhere in the system. If the resulting chaos becomes deeply entrenched, we may find that the associations, the four basic diagnostic signs, do not all come from within the one element.

The element within

A further feature which ought to be mentioned briefly is what we describe as 'the element within'. Concern with this is only appropriate for practitioners who have had considerable clinical experience and advanced training.

Putting it simply, we can say that each one of the five elements contains the five elements within itself, and also that imbalance in an element is in some way brought about by one of the elements within. At an even further level of refinement, it is possible to say that one of the elements within 'the element within' is responsible for the imbalance. A very experienced practitioner would then expect to be able to express his diagnosis as 'A' CF, 'B' within 'A', and 'C' within 'B'. Such refinement makes a difference in planning treatment. One who has mastered Five Element acupuncture may thus be able to go straight to the heart of the imbalance, thereby taking less time and using one or two fewer needles than a less experienced practitioner.

A cautionary note needs to be added, however. It is far easier to make a mistaken choice and violate natural law at this level of sophistication. The more basic and slower treatments used by less experienced practitioners are often more effective, as well as safer. For these reasons, they remain the most widely used, even by those with most experience.

The point of mentioning elements within elements and the more sophisticated levels of diagnosis is to show that the evidence on which experienced practitioners base their diagnosis is exactly the same as that used by the humblest practitioner: colour, sound, odour, and emotion. I have already described how there are many different reds

and yellows, shouts and groans, putrids and rancids, angers and joys. The more advanced skill of the experienced practitioner is due to better development of sensitivity; being able to discriminate, for example, that the colour on the face is not just green but a particular kind of green, a yellow-green, a red-green, a blue-green, a whitish green, a very green green. The colours around us in Nature are not like a child's first paintbox, just a few simple and basic ones. Look at the colour of different trees. Are they all the same green? Of course, they are not. As practitioners gain the power to see subtle distinctions of colour, they start to become sure not only of the CF but of 'the element within'. The difference between a greenish yellow and a yellowish green may not seem very much, but it can denote considerable difference between two people in diagnosis. Their needs will be entirely different and their treatment will be also.

Subtle distinctions can be easier to discern where odours are concerned. 'Scorched', as described earlier, means anything which has been burned or is burning. But the smell which we would describe as burnt or burning will vary enormously according to what has been or is burning. The smell might be of burnt toast, burning grass, burning rubbish, burning hair, boiling water, scorched ironing, baking hot sand, anything which has overheated or is overheating. The subtle quality of smell within the overall term 'scorched' can be indicating 'the element within'. So it is with sound of the voice and with emotion. There are not just five basic qualities of each sign so that everyone in the world can be simply divided into five simple categories. Each person is a unique blend of different qualities of colour, sound, odour, and emotion because inside the main elemental divisions there lies another layer, and then another layer, and even one beyond that for those who have the power to discern it. Each layer penetrated deepens understanding of the unique blend, the balance and the history of the elements within the person.

We have seen, then, how in one sense Traditional Diagnosis is a great deal simpler than we may have imagined. It depends entirely on our using our senses and discerning the commonest of signs. However, we realise that it is not at all easy because our senses have become so dull. Even when we improve our senses by one hundred percent, the task of accurate diagnosis is still a considerable challenge. The signs themselves may be common and simple enough but it can be extremely difficult to observe them clearly because, when using our sensory skills, we have difficulty disengaging our brains and mouths. It is all too easy to start thinking and trying to work things out; all too easy to be drawn into talking too much. During diagnosis, about

ninety-nine percent of what is said is a load of rubbish. We gather some information that way, but that information does not help us read the signs. We can get so carried away by the content of the words that we completely forget to give attention to what our senses are telling us.

I would guess that one of the commonest situations that inexperienced practitioners find themselves in is that they emerge from two-and-a-half hours of diagnostic consultation with fifty pages of notes and not a clue to the patient's CF. They have been so busy talking, thinking, and note taking that they have not had time to see, hear, feel, and ask properly. This is a pity because these skills are not only exciting to experience in themselves but they are the only really effective means we have to diagnose accurately.

It is by developing and using our sensory skills fully that we truly begin to see the patient in front of us and to understand what he needs and what he really wants, which may be different from what he says he wants. We begin to see behind the mask which he may have carefully built up over a long period. The mask will invariably produce a false picture, concealing as much about the person underneath as it tells us of his pretence. If, for example, we have a thirty year-old who comes to us from a hundred miles away and just complains about slight pains in the hips and shoulders, we would surely ask ourselves whether we would travel so far for a minor complaint. Common sense tells us probably not. So we suspect a mask and that something untoward is going on underneath in someone who must be really desperate and sick within to be willing to make that kind of personal sacrifice in time and effort. We have to tune our skills to such good effect that that person's hidden plea for help is not a wasted one.

CHAPTER THREE

THE SKILLS OF DIAGNOSIS

As I have emphasised in Chapter One, all that practitioners have to be able to do is see, hear, ask, feel and smell. I have also said that there is only one way to develop these skills, and that is to work. I emphasise that word also because that is the only way to develop them fully. Some students training to become practitioners may develop one faculty a little better than their colleagues because of the nature of their other interests in life. Someone who paints, for example, may have a more highly developed eye for colour; someone with past experience of practising massage may have developed a more sensitive touch than a colleague who has spent his working life in an office. No such initial advantage is likely to matter one iota. Even though one may be three times better than the rest at the start of training, it is only a difference of three to one on a scale of a hundred. We all have to work, and work, and work. Because practical experience is the essence of development in this tradition, it is not possible for me to provide a set of rules and give detailed descriptions and explanations of how to improve one's skills. All I can do is suggest the kind of things that a practitioner should be aiming to do and to find. The individual has to work out his own pathway through experience.

A further point to be made at the outset when considering the skills of diagnosis is that all the senses are working all of the time. Seeing, hearing, asking, and feeling all go on at the same time and learning to be able to concentrate on one of them alone can, at first, be difficult. Certainly, confusion can arise for practitioners because so much information comes pouring in through all the senses that they find themselves not being able to make sense of it all and to pick out what is important. What is likely to happen then is that the practitioner will cut off from the flow of information, disappear into his head and make up stories based on one or two facts or observations.

There may be occasions, when we are beginning to re-learn these

skills, when we should deliberately concentrate on one of them. We might say to ourselves, 'Today I am going to hear, not see, ask or feel. I am going to hear to the exclusion of as much else as I can. I guarantee that it will prove to be the most fascinating of days. The whole time will be taken up with wonderful experience of sound, the rustling of trees, the song of birds, the crackle of cold ground underfoot, the murmur of breeze, rain splashing through the leaves. All the riches of this experience will derive from one faculty alone, and we will wonder why we have denied ourselves such a simple and natural pleasure for so long.

To see

The first and most obvious way in which we see during diagnosis is with the physical eye, to see the colour on the patient's face. We have a problem, for this is difficult for most of us to do at first. We begin by staring, peering so hard all over a person's face that they might think us short-sighted, or mad, or both. Staring implies we are actively looking for something, but seeing, in this case, is not an activity of that kind. When seeing the colour on the face, it is more like noticing it, or letting it appear to us. It is often easier to accomplish this by moving around the person, just glancing at his face from different angles, partly because the colour can be slightly more obvious from one angle than another.

Supposing, then, having taken this advice, we definitely see something but find ourselves unsure exactly what it is. 'It may be green, or perhaps it is yellow' or, 'I'm not sure whether it is white or lack of red.' The only way to become certain is by studying the colours continually so that we learn to establish the differences by comparison. Some greens are yellowish, and some yellows are greenish. The only way to be sure of the difference between them is by looking at the whole range of colours and see how they blend into one another over the whole spectrum. Our best teacher is Nature for there is no colour in Nature which is not a natural blend of the five colours.

If we are able to see the whole range in Nature, we may learn all our lessons that way. Failing that, if we want to find out something about colour blends for ourselves, to discover the whole range of possibilities, we can do no better than to buy a paintbox, mix every combination we can, and see the results. I can imagine a few will say, 'I'm not going to play about with paints like a child at my age,' in which case, I feel sorry that the child in them has disappeared. There is no need to feel

self-conscious about doing anything, no matter how inappropriate it seems for an adult, if it will help to speed up the development of our diagnostic skills.

We may then run into the situation where someone's talent for seeing colours is progressing well but he is having difficulty deciding what is significant. Here we remember that there are different areas on the face which can be compared. The significant colour appears principally on the temples, just beside the eyes. This is the colour that really matters for diagnosis. The colour can also appear under the eyes, on the laugh lines, and around the mouth. We can use this spread to confirm what we are seeing on the temples but also remember that it is less reliable in the subsidiary areas because the colour can be affected by lack of sleep and tiredness. The subtle differences of colour on the face can be valuable for another reason. There is nothing to stop us comparing one area with another and asking ourselves, 'Is this area greener... or is it more yellow?' Comparison of subtle differences is a most useful way to learn. We find that by practising we not only get better and better at judging the principal colour accurately, but are also able to see other colours on the face which can give additional important diagnostic information.

Seeing the patient with the physical eye involves more than seeing colours on the face. When we are observing someone, we see an enormous amount of activity going on. Faces are continually changing, eyes narrowing or widening, eyebrows being pulled down and knitted together, jaws being clenched, lines deepening, eyes moving up, down, away and back again. Bodies move and change also, breathing quickens, slows down or becomes deeper or shallower; muscles tense or relax; arms are waved around or crossed tightly over the chest; hands play with each other or are put in pockets or behind the head; legs cross and feet wriggle around. Body position changes, leaning forwards, backwards or sideways, straightening or slumping. Throughout the time we are communicating, a little dance is going on between practitioner and patient. Although we have been engaged in such dances every day of our lives, we are not likely to have taken the trouble to learn from them the full range of what they can tell us. We have to become aware and take advantage of the fact that everything we do and say during diagnosis produces a reaction in the patient which is helpful to us.

We know about reading reactions to some degree because we frequently do things which give us that information. Supposing we say something which hurts a friend. By a thousand little signals we read his

upset and immediately start to make amends. 'I'm sorry; I really did not mean it like that.' We may unintentionally make someone angry. By reading his reactions,we soon become aware of what we have done. 'Oh, my goodness! What have I said?' We usually notice the big reactions, especially those broadcast by the more outward emotions. There are also small signals being given all the time in all situations. If a particular patient has had a firm mask for a long time, it will be small reactions or signals we look for in order to discover what is really going on underneath. When we first notice such a signal, we may not immediately realise what it means. 'When I asked her about her relationship with her mother, she started shuffling her feet about, whilst the rest of her body stayed still. Why did she do that?' To get some idea, we might sit down later and imitate the patient. Sitting still as she was, we would move our feet around as she did and see what it felt like, what inner effect it had. It can seem very odd, even scary, to pretend to be someone else like this, but it is enormously effective. If we have noticed something incongruous or inappropriate, no matter how small, especially if it is involuntary and different from the mask, we can be sure that it is valuable information which we must understand.

Seeing with the physical eye is, then, only a small part of the total range of seeing which we need to develop. We need to be able to see with the mind's eye and the spirit's eye, modes of seeing which are much more important than the physical. However, at times we can make too much of what we see with the mind. We try to understand by making mind's-eye pictures and have become so clever doing it that we are capable of spinning a whole story around one observed fact. It is this propensity which, if we are not cautious, can mislead us into thinking we have diagnosed the CF when we have not obtained enough reliable information to be able to do so with certainty. We take a single fact here and a suspicious detail there, and then invent an apparently convincing set of deductions. These may be the product of our imagination, and nothing to do with how the patient actually is. The fact that we can sometimes misuse a faculty, however, does not mean that we should demote it and not allow it to play its proper part in diagnosis. Seeing with the mind's eye properly takes us from simple observation to appropriate enquiry. If we see a patient's hands clutched together, wringing each other, we can use the mind's eye to visualise possible explanations and then actively look for supporting evidence in the patient.

In other words, we can certainly make useful deductions through using the mind's eye. Many will be familiar with Conan Doyle's

famous stories about Sherlock Holmes, the fictional detective. A lot of the latter's magical powers of detection derived from good observation, mind's eye visualisation, and concise deduction. Flattened fingertips implied a typist; a boot polished on top but with holes in the sole told of the desire to maintain standards during hard times. In fact, in one story, Conan Doyle has Holmes saying that it would be better for his reputation if he did not reveal how he reached his conclusions. His method would be seen as glaringly obvious, even boring, and his mystique would be lost. As a detecting instrument, we can use our mind's eye in the same way in diagnosis. It will help us to visualise and deduce connections between things that we see, and thereby help us to understand what is really happening in the patient. This inner seeing is just as vital to us in diagnosis as seeing the colour on the face. We are always up against the problem that patients have their own preferred picture of themselves and, unless we keep our wits about us, we are always in danger of being deceived. In practice, although we will not be able to avoid seeing what they want us to see, we are more likely to be concerned with what they do not want us to see. Indeed, we will see things of which they themselves are not aware.

Seeing with the mind's eye is so powerful that it sometimes eclipses our ability to see with the spirit. Yet it is this faculty which above all connects us directly with the spirit of the patient. Seeing the colour, seeing the patient's manner, behaviour and bearing, seeing what they do with their lives; all of this helps to guide us towards the CF. Seeing the spirit with the spirit's eye tells us who the patient is, and takes us to the very heart of the patient's nature. There is no technique which we can learn to enable us to do this, no laid down method of seeing which we can work at and develop. Seeing with the spirit means touching with the spirit. Such communication can come about during diagnosis only when we have established good rapport with the patient, when we have enabled them to trust that we are not judging them. They then feel free to be honestly themselves, not afraid to let us see them exactly as they are behind their customary masks. It is often in the eyes of the patient that we can see this openness and trust most clearly.

However, the same questions arise with the spirit as with colour on the face. How do we know for sure exactly what we are seeing and what is significant? Again, I would recommend learning to understand the spirit where it is most obvious, in Nature all around us. All of the different states of the spirit in people are no different from those in Nature. Here we can appreciate that this natural association of the spirit in and the person provides for the strength and beauty of the

Five Element system of acupuncture. The spirit of the warmth and joy of summer, of the enriching decay of autumn, of the upsurge of growth in spring, of the cold vastness of wintry oceans, of the golden fullness of harvest time; in all these aspects spirit appears in Nature. Once we realise our ability to see all these aspects in Nature, we will see their equivalent in our patients. There are no prescribed ways of accomplishing this; only an attitude which prevents us doing so: 'Hellish hot! Bloody cold! Boring fields, just trees, only a bunch of flowers, just a pond, just a load of weeds, only a common sparrow.'

Just as we may have negative attitudes towards Nature and ignore the beauty all around us, so may our attitude towards people harden and turn to dislike. We might find ourselves taking a cursory glance towards a patient and thinking to ourselves, 'Oh, no! I can't put up with this person for weeks on end.' If we are honest, we will admit that there have been people who on first sight were so miserable, complaining, and unpleasant that we felt our spirits sink in prospect of communicating with and relating to them. Our reaction exists because we were not seeing clearly with the spirit. There is no one on this planet who is impossible to be with and communicate with if we will allow ourselves to see them deeply and properly. The fact that we are put off by outward appearance and immediate reaction says more about us than about them. I would wager that, if we have disliked someone on first encounter, it will probably be because we have seen in them an aspect of ourselves, an aspect we do not like to see because it is ugly and antagonistic.

Being able to see with the spirit means being able to see beyond the grumpy and miserable mask of the person who is coming to us for help. A brusque demand such as, 'What are you going to do about my back, then?' should not make us feel threatened and tempted to be rude in return. We remember that this is the mask and that we need to ask ourselves instead, 'What kind of problem is making you so miserable, my friend, that you are rude and unpleasant to the person you have come to for help?' Once we get over the idea that the unpleasantness is being directed at us personally, or that the person is inherently nasty, then we have removed one of the main barriers to our being able to help with his problem.

With seeing at all levels, then, there are one or two simple things which we can do to improve our abilities. As with all the other skills, however, this improvement depends very much on removing obstacles which we often place in front of ourselves. As practitioners developing our skills of diagnosis,we are the biggest barriers to our own effec-

tiveness. This is not just because we have inhibiting predispositions and prejudices but also, and even worse, because we often find ourselves thinking, 'Now I can do it! I've arrived, I've got it, I've succeeded.' Then we start to think we are the best and can do no wrong. As soon as we do this, we will start going backwards. We must remain humble and always consider ourselves inadequate and insufficient. As long as we remember this, and allow ourselves to see a little better each day, our skills will continue to improve.

To hear and to smell

It will be no surprise to be told that we also hear with body, mind, and spirit. We obviously have to listen at the physical level to the sound of the patient's voice, but here again it is not just the physical ear that does all the work. When we listen to a patient talking to us, we are attentive both to content and sound. If someone is a bit sceptical about this, a simple test would be for them to go into the nearest street and ask the first dozen people they meet, 'Hello, how are you?' Then they should ask themselves whether they were taken in by the answers they received, polite or otherwise.

If we ask that question of acquaintances, we expect the average person to say, 'O.K.', 'Fine', 'Not too bad', 'Mustn't grumble'. Being satisfied with such a common answer, we would ordinarily carry on our business without having serious misgivings about the person we have addressed. After all, we have not received either a remarkably positive or negative answer. However, through just hearing at a superficial level, we have ignored the fact that there are a hundred qualities in the sound of saying 'O.K.', 'Fine', and only two or three of them are likely to be really honest. I would suggest that, if we listened properly, we would suspect, ninety-seven times out of a hundred, that we are hearing a quality in the sound telling us something quite different. In other words, if we are prepared to be taken in by the outward content, we will fail to hear the inner message.

This happens not just with verbal expression but with additional sounds, such as laughter, as well. A person may 'laugh' at a joke with the words 'ha-bloody-ha' and would be construed as having taken offence. If that person had simply laughed with almost no change in the tone of his voice, hardly anyone would take any notice. Laughter can be more than a genuine responsé to something funny. It can be carrying anger, fear, regret, or grief. The same applies to the sound of crying; this too can be loaded with different emotions. Hence, it

behoves us not to be taken in by the surface response; we need to be able to hear the inner sound.

We are so bombarded with external noise in our lives these days that disengaging our minds from superficial involvement becomes very difficult. Quite apart from the sheer volume of information we absorb and try to make sense of in the language we know, we even try to make sense in our heads of communication in other languages as well. How much more information we could gain if we could disengage our minds and listen to the language which is not spoken in words, those inner sounds uttered by all human beings telling of their inner state. To hear the message of the outer meaning of the sound is one thing; to hear what is going on within is quite another. A particular voice will have a typical speed of projection and a certain density and volume; it will have variations in pitch and modulation, a tendency to accentuate and emphasise in certain ways. Some of these factors are more characteristic of particular elements than others. As I have mentioned, a shouting voice can have an emphatic quality irrespective of the volume employed in speaking; or a groaning voice can have such lack of variation in pitch that it sounds monotonous.

The real beauty of the skill of hearing comes through hearing with the spirit. This happens when we have become fully aware of the sounds of Nature and are able to hear in a patient's voice such sounds coming direct from the elements within them. Nature is far from silent. Trees make noise; water, wind and rain make noise; the earth rumbles and mutters. Animals call and birds sing, differently according to the season. If we listen, really listen, to the sounds and their quality in Nature all around us, we start to hear such sounds and qualities coming from the elements within our patients and understand what they are telling us.

Listen to the blustering winds of April, beating the air and breaking against the trees and stones, and then you will be able to hear the forceful voice and emphatic tone of Wood. There is the sound of the slow, turgid rise and fall of the ocean as it wallows, or the sounds of birds and animals dulled by the thick mists of autumn, or the fullness of the sounds of joy and fun coming from a poolside on a summer's day, or the satisfied singing of birds feasting on the harvest fruits. Everywhere there is sound, and every single sound is a natural and perfect blend of the elements. Water that groans, water that sings, water that laughs, water that rages, water that weeps. I am sure that you can conjure up all such qualities of sound in your mind's ear. It is important to pay full attention to sounds before the mind leaps to

identify and label them, for it is through being able to recall and recognise the spirit within them that we become able to hear the nature of the spirit in the patient.

In expressing reservations earlier about the value of hearing at a surface level only, it was not my intention to give the impression that this level should be written off entirely. I am apt to say that most of what is said during consultation between practitioner and patient is rubbish, and as a general rule this, for the most part, holds true. There will be times, however, when the content of what the patient says will give us valuable diagnostic information. The skill we need is the ability to pick out what rings true from the rubbish. Whether we like to admit it or not, we very rarely say what we really feel about anything, especially about other people. We all create ideal pictures of who we would like to be and then adjust what we say and do to fit in with that picture, whatever our true and inner feelings may be. How we are seen by our friends and families sometimes becomes more important than who we are. Patients frequently do this because the more sick they are, the thicker their masks become, and the more they cling desperately to them. Much of what they tell the practitioner will be intended to reinforce the mask. Our task, therefore, is not only to get behind the mask but also to make it possible for the patient to drop it.

Although we can put aside much of what patients say during diagnosis, words they use sometimes stick out like sore thumbs. In hearing with our mind's ear, we should be continually alert for the telling emphasis or inappropriate phrases. We listen for that which is stronger or weaker in expression than we would normally expect, anything exaggerated: 'can't stand', 'hate', 'adore', 'crave'.

Such expressions can, of course, be appropriate. Sometimes, because of the context, over-emphasis and exaggerations strike us as inappropriate. If that happens, we follow it up because it may be a clue which will lead to our finding out a great deal about what lies behind the patient's mask. A single expression may in effect be saying, 'If only I hadn't lost everything of value I have ever had, I wouldn't feel so empty.' We hear the regret and grief coming through. Another expression might be saying, 'I just can't see a future now. Everything looks hopeless, and I have no sense of direction.' We hear frustration and despair being revealed. In other words, an element or an official in the patient can speak directly to our inner ear. Such a direct message is so important that we call it 'a golden key', a revelation of such value that it unlocks the mystery of the patient's imbalance for us and tells

us exactly what is needed. It is as if some intelligence within the patient manages to by-pass the mask and send its plea for help, and sometimes the message is so precise that it goes straight to the heart of the problem.

So, in diagnosis, we listen with our minds and hear more than just the literal meaning of the words being spoken to us. We spend a great deal of time talking to patients and usually the flow of conversation is easy. Because much information we need comes from signs and signals outside the patient's conscious control, and does not require specialist vocabulary and precise medical terms, our objective must be to establish good rapport with the patient through allowing him to talk about his problems in his own language and in his own way.

Sometimes, progress can be hard going. We can ask a simple question and before we know it the patient has gone chasing off in ten different directions. His mind is following a trail which may make sense to him but not to us. We may then feel as though we are being dragged through a thicket at breakneck speed. By the time the patient comes to the end of the answer, we have probably forgotten the question. In which case, we need to ask ourselves what has been going on and then try to consider not the content of the answer but the nature and structure of it. Why does this person need to elaborate so much, and for whose benefit? Is he trying to hide something from us or from himself?

On the other hand, a patient might be so monosyllabic in reply as to seem totally incapable of expression. There is the situation where a question gets no response at all, or a response which does not make sense. We then have to check back. Did we ask the question too fast, or not clearly enough? Did the question make sense; was it sensible? If we are then sure that it was a reasonable question clearly asked, we ask ourselves why the patient looked blankly at us, or why his eyes shifted evasively from side to side, or why he answered as if to an entirely different question. Conversation should flow naturally and easily once we have established good rapport. We can then take a step back, inside ourselves as it were, and listen to the flow of communication between ourselves and the patient. Then we can pick up more valuable information than the content of the answers alone is providing.

It should not be necessary for me to have to suggest how we may practise hearing. All we have to do is make use of the dozens of occasions each week when we are within earshot of people talking, not to us, but to each other. If we learn to disregard the content of the

conversations and listen instead to the sounds of the voices and the sound of the flow of their talk, we will develop the skill to hear and understand what is happening between ourselves and our patients.

I must now bring into the picture the ability to smell accurately because the Chinese always bracketed smelling with hearing in their description of the diagnostic method. Being able to smell sensitively is very important in diagnosis and, by and large, we are not very good at it. Once, as babies and young children, the faculty was so clear and effective in us that we were able to recognise accurately all manner of things by their smell. By the time we reached adulthood, however, the sense will have weakened and to a large extent been lost. Living in modern industrial societies, we have been exposed to all kinds of smoke, dust, dirt and other air pollution. We have been conditioned to consider that any smell which is not of wholesome food or attractive perfume should be eradicated. Every home seems to have its can of air freshener at the ready to blast away or blot out any foreign odour which happens to creep in, including natural ones.

The only way to regain the full potential of this faculty is to practise smelling, and that must include deliberately smelling things which we would usually avoid. For example, we tend to regard the smells given off by the body as being pretty unpleasant, which is why we go to such lengths to ignore, disguise or eliminate them. 'Vile putrid', 'nauseating fragrant', 'sharp rancid', 'decomposing rotten', 'singeing scorched', none of these odours will strike us as wonderful; but they are extremely important odours which we need to distinguish for diagnosis. To be able to detect them accurately in patients, we may have to go out and sample them where they naturally occur in our environment - brackish ponds, sewage works, rubbish bins, cow sheds, overheated greenhouses, burning stubble. All such smells may make us want to turn away and close our nostrils tightly but we have to learn to overcome our aversion, open our nostrils, and re-learn what their qualities tell us about the elements.

Our sense of smell is difficult to keep well-tuned because we cannot command sensitivity. We all know how we can walk into a foul-smelling room and at first recoil; but then, we become used to the smell and no longer notice it. It is as if the sense regulates itself so that we quickly become unconscious of smells or, at least, relegate them to a level where we are no longer affected by them. In order to improve our abilities, we have to keep finding opportunities to exercise the faculty, giving ourselves as many comparisons over as wide a range as possible.

We should also bear in mind that when we are with patients we should be alert for odours at those times when they are likely to have maximum impact. When the patient first walks into the room, when we lift up the blanket covering them during examination or treatment, when we approach closely to examine the back; all these are moments when odour will be easier for us to detect. If these opportunities are missed or fail to provide us with the information we want, we might have to engineer new ones. We might, for instance, go out of the room, refresh our nostrils, and then come back into the room ready to pick up to maximum effect the presence of the patient's odour in the room. Ultimately, however, all really depends on our having learned to open our noses fully to the wide variety of smells around us. It takes many years of cultivation of the sense before we regain even one tenth of the capacity and sensitivity which we had when we were very young.

To ask

The extent to which we restrict our powers of perception becomes particularly clear when students are told that all they have to do in diagnosis, apart from seeing, hearing and smelling, is to ask. Many immediately jump to the conclusion that such asking must be a series of standard questions applicable to all patients. As I shall explain in the next chapter, there is indeed a certain amount of basic information which we need to obtain from patients in this way. We expect during consultation to use a checklist of standard questions, the answers to which we record on a preface sheet in the patient's record. Such information serves two purposes. It provides the practitioner with an accurate picture of the patient's current situation in all aspects of his life, and it serves as a bench-mark against which we can check back as treatment progresses. There can be subtle changes in a patient's situation which we might only realise by looking back through records accurately and carefully kept.

For example, we might have recorded a patient's reported habit of sleeping soundly from midnight to four o'clock in the morning, at which time he always wakes up as if he has been pushed back into consciousness with a rush. After some treatment, he may mention that he is sleeping through to six o'clock in the morning, and awakes more gently. That may not seem a big issue for the patient; after all, he has been so used to waking up at four that he thinks it is a normal state of affairs. But, as we check back to confirm, we know that there has been a change in the patient which is fundamental and significant. As far as the patient is concerned, the change of habit may seem to

have nothing to do with their major complaint, but we, due to our record established through our original questions, have evidence that healing is beginning to take place.

Asking these initial questions and recording clear and definite answers is important. But it would be foolish to suppose that this is all there is to asking. If it were so, we could send the patient a questionnaire through the post and, with guidance notes, ask them to fill it in and send it back. We have to take a far broader view of the potential of asking, a much less literal and commonplace understanding of it, rather than assume it must be a matter of asking hundreds of other questions. That, in fact, proves fruitless because we find eventually that all the verbal questions we ask and the verbal answers we receive in reply from our patients provide perhaps the least useful information we can effectively use for diagnosis. We have to realise that everything we do in relation to the patient is asking, because everything we do has meaning and will prompt a meaningful effect in response. Even a failure to respond has meaning.

In ordinary life, we question non-verbally all the time. If we meet someone, we probably shake hands with him. In doing so, we in fact tell him about ourselves and at the same time ask him about himself (though we may not be consciously aware of what we are telling or being told). The feel of his handshake conveys information, which we receive along with any other messages his behaviour may be conveying. When we are at work with colleagues, at ease with friends, or in the company of close companions, we are sending messages and asking questions with body-language all the time. When we slap someone's back to congratulate him, when we put a hand on someone's arm to comfort and console him, when we grasp someone's hand with both of ours to give him a warm welcome, we are looking for a response. We are looking for an answer to our questioning. We are asking him if what we are doing is what he wants.

Most of the time we know what the response should be in most circumstances, especially with colleagues and friends. The question is so much of a formality that we may not even bother to notice the reply. But we will certainly notice if we get an unexpected response. If we slap someone's back to congratulate him and we see the face harden and the fists clench, we know only too well that our gesture touched a raw spot in him, and we will be wary if we are ever prompted to repeat it. If we encounter something similar in our practice, we might ask ourselves, 'Why did the patient respond like that? How is it that they found that threatening?' In diagnosis, if we,

for example, put a hand on the patient's arm to reassure or comfort him and he jumps a mile and withdraws his arm, we are receiving a very powerful answer to our questioning.

We need to be quite clear in our own minds about the questions we want to ask and how we are going to ask them. As I have on many occasions warned students, there is always the danger of the practitioner's voice becoming monotonous during verbal questioning. We ourselves will have one predominant tone of voice and, if we keep on using it automatically, we should not be surprised if our patients end up mimicking it. Without realising the effect that our own voice has had, we might be led entirely astray saying to ourselves, 'How is it that all my patients groan (or shout, or sing)?'

The same applies with our touching, which is one of the most powerful means of questioning. Some of us will predominantly be comforters. We will always be ready to reach out to patients in trouble with a soothing touch. Natural comforters do it all the time because that is the way they are. Many patients love it because many still like to be mothered when they are in distress. There will be four possible responses to touch in this manner: a natural warming to it, an over eagerness to be touched as much as possible, a dislike of it amounting to rejection, and a total lack of response one way or the other. But this is only one way of touching, and these four possible responses do not exhaust all the patient's reactions to touch. In reality, there is not a living person on this planet who is unable to respond to touch, and each person will have a particular way in which he best likes to be touched. We can ask with our hands, and learn to ask in as many ways as we can. But we have to be careful that our own natural or preferred way of touching, if automatically and habitually used, does not lead us into drawing false conclusions about our patients.

We might expect from this that the ways in which we can touch will relate directly to the range of possible emotions, and that a patient will respond to touch in accordance with his emotional imbalances. I would agree with that, and go even further. Unless we touch the patient when we are asking about his feelings and emotions, in many cases we will not get a genuine response. In diagnosis, touching is one the most powerful gifts we have. If we use it properly, we can ask and say things with our hands far more eloquently than we ever can with our mouths. Touching gives a hundred times more power to our questioning.

If we want to summon up and question a particular emotional

response in a patient, the best way is to look outwardly and feel inwardly as much like that emotion as possible. Because it is unfamiliar, some practitioners find this technique difficult because they get stage fright, even when practising it alone in front of a mirror. If we want to be effective in our enquiry, we have to learn how to speak, look, touch, and feel the emotion we are asking the patient about. If an emotion in him is really out of balance, the response to our questioning will be unmistakably inappropriate. If we are full of smiles, radiating joy and love, and the patient looks at us as though we are mad, then that response is telling us something. He might think that we are overdoing it, but it would still be difficult for him if he is balanced not to go along with us to some extent. On the other hand, the patient may go completely over the top in responding to us, much further than we have, in fact, gone ourselves. That would be giving us important information also. We would then want to know what happens when he stops being carried away. Does the feeling stay with him for a while, or does he collapse and look as if someone has turned off a switch inside him?

To make this technique effective, it is sometimes necessary to exaggerate an emotion to some extent in order to provoke response from the patient. We may have to overact in our performance to pull on the emotion strongly enough in the patient to reveal its true state within him. Practitioners can find this difficult to carry out because it can mean not just going over the top by their own personal standards but over the top by anyone's judgement. If a practitioner is naturally of a quiet disposition and is used to communicating emotions in a low-key and discreet manner, it may be a real hardship for him to behave in a manner which feels like clowning around. There are patients, however, whose masks are so thick that, unless we exaggerate and somewhat overact in our approach, we cannot get through to see the inappropriate state of their emotions and the nature of their imbalance. For example, there are patients whose desire for sympathy proves to be so great that practitioners can find themselves becoming almost caricatures of the solicitously caring person. 'Are you sure you are quite comfortable? Can I get you another pillow? Oh dear, that must be painful, shall I massage it for you?' Whereas most people let us know when they have had enough sympathy, patients such as these just lie there and go on and on taking it. It is by going well beyond the norm in our own behaviour that we find out the extent of an emotional imbalance in a particular patient, an excess which we would find difficult to discover in any other way.

When we call on all our resources to diagnose effectively, we find that

some emotions are easier to relate to than others. Joy is one that most of us feel we know about so that, even if we do not happen to feel as happy as larks, we can usually generate enough joy that we relate to another person full of joy. But other emotions, which can provide us with some of our most significant information, can be difficult for us to simulate. If we want to generate sympathy, look sympathetic, touch sympathetically, project sympathy with every fibre of our being, the best reference we can call upon is recollection of what it felt like on occasions when we really did feel sympathy and we will find ourselves genuinely feeling sympathy. For some people who have been generally disposed to dislike sympathy, finding this emotion in ourself is going to be more difficult. Similarly, for those who have always cut themselves off from grief, or have always disliked the expression of anger, whatever the particular disposition, there will be weaknesses in our ability to work with the whole range of emotions and touch our patients in all possible ways. We need to work and work on ourselves where we know we have such a weakness.

This challenge may dishearten some. 'Well, if that is something I'm sure I'll never be able to do, how will I ever become a good practitioner?' The answer is that there is nothing you cannot do, once you have realised that the only blockages to be removed are within yourself. The Chinese knew that the practitioner's self-development is the most important task in this system of medicine more important and demanding than all the learning of techniques, laws, points, and so forth. Everyone is capable of feeling all the emotions fully, even though they may be less familiar and less comfortable within themselves with some of them. From the outset of practice, we should be able to find in ourselves at least some recollection of all the emotions which we can use for reference. Such past experience does not necessarily have to have been in connection with people; it could have been with pets, for instance. It is remarkable how even the hardest of people seem to have a soft spot for small, furry animals. If that is where one's only experience of sympathy, grief, or joy lies, then that is what one must draw and build on to give emotional foundation to his touching and asking.

It is possible to learn to switch on and relate to any emotion and to learn through trial and error how to use touch, where the effective places to touch are, when best to touch them and what pressure to use. If the touching is done mechanically, without any feeling at all, it will not produce a response. People know, for example, when they are being given sympathy which is not genuine, not coming from the heart. They know the awful feeling when they are just getting polite

acknowledgement of their problem. If we cause them to feel discomfort or embarrassment through failing to make proper contact, our efforts will be counter-productive. In learning how to ask properly, we need to express genuine and appropriate emotion within our touch and our voice.

Another reason for this skill being difficult to develop is that it requires humility. We cannot learn it by ourselves, hoping that by acting what we imagine is sympathetic we are surely finding out how to ask someone how they respond to sympathy. We need monitoring and feedback on what we are doing. I have seen students giving sympathy so aggressively that the recipients have almost visibly cowered in fright.

If we are naturally warm towards people and we find that our giving sympathy comforts and eases them, how can we be sure whether they are being comforted by the warmth or the sympathy? Children's responses are once again our best guide. A child falls over; its mother sets about making it better. She does not laugh and try to make a joke of the child's distress, as less wise adults sometimes do. She acknowledges the hurt with proper concern, 'Ooh, that does look painful!' She deals with it. 'Let's put some ointment and a bandage on it.' She checks with the child. 'Is that better?' 'Yes, it is.' The mother has taken the distress seriously, attended to it appropriately and has then checked to make sure that all is well. The child did not need warmth, just as there are going to be patients who do not need it either. They want their pain acknowledged and understood, something done about it, and to be asked if they feel better. We show that level of care and they are satisfied. However, if that is evidently not enough to make them feel really good, then warmth and love may be called for. If we always give sympathy and warmth together, we never really know which emotional imbalance we are touching.

This is where humility enters because we have to be willing to ask colleagues to observe us and to tell us how well we are relating and whether our questioning is clear. For all of us, for a long time, the answer is going to be that we are not being as clear as we could be. It takes years of practice to become absolutely sure of what we are doing. Unless we are prepared to be humble and be advised regularly where we need to improve, we will never know where we are falling short and will never become clear in our own minds. If, by reaching into our own experience, we are able to ask with our spirit and deeply touch our patients, we find that they cannot resist our sincere enquiry and will tell us what we need to know to help them get better.

Students often ask, 'How do I find this emotion (labelled this, that or the other)? What is "sympathy", "anger", "joy"?' A great deal of time could be spent trying to define them and how they manifest, and I have no doubt that doing so might provide some keys to unlock some doors. But it would not really be helpful for this area of work to become rigidly set down in ready-made formulae. It is far better that students look inside themselves, contemplate their own experience, and discover for themselves what the emotions really mean and feel like.

It is relatively easy to work out in the head that someone grieving is likely to have become lost in the past: 'If only that hadn't happened. I do wish so-and-so was still alive. Nothing's been the same since.' Or that someone is probably stuck in fear if he is continually imagining that the most appalling things are going to happen to him. In this case, the past does not matter, there was no catastrophe; but the future holds nothing but lurking disaster. The noise at the back of the car means that the wheel nuts are coming undone and there will be an appalling crash; the spot appearing on the skin is bound to mean cancer. Or someone full of anger will be burning with a sense of injustice, of being unfairly treated by the world at large. 'They had no right to do that to me! After all I've done, that's what I get. Load of bloody hooligans! Why doesn't someone do something to stop them?' Or that someone in need of sympathy will not be grieving the past or fearing the future but will be wanting as much attention as possible here and now. 'This hurts. Make me feel better.' We may notice that people needing warmth and love may appear to be giving them out excessively because of their need to be given some back, or that they may resist every attempt to pull them out of their flat and joyless state. We could accurately deduce all these probabilities, but it is far better that we know what the emotions feel like through our own experience than simply work them out in the head.

Some of my colleagues have spent a great deal of time working through the structure and nature of some of the emotions, and provided an elegant analysis of them. I have already said that any element can, for example, generate anger; and that anger can thus be expressed in various ways. If we want to be able to detect 'real' anger, as distinct from anger 'because I'm not getting enough sympathy' or anger 'because I'm terrified,' we do indeed need to have as much information as possible about the situations and circumstances in which we are likely to encounter all forms of anger, including those which may generate genuine anger. Such information helps us to anticipate what is probably going on emotionally in our patients.

However, such foreknowledge is still likely to give us only a limited part of the whole story. In the end, we always have to come back to the one basic and essential principle. The only way to understand clearly and deeply is through our ability to use our own experience of feelings and emotions as a guide to asking patients about theirs. If we were to teach all about the emotions in theory only, many students would be tempted to eliminate working on themselves to enable that crucial empathy between practitioner and patient on which accurate diagnosis and effective treatment depend. White coats and textbooks do not make us healers.

Asking with the hands, the voice, the body and the mind only becomes effective through asking with the spirit. 'Spirit' is a word which tends to carry rather remote, ethereal connotations these days, probably because religion has for so long monopolised it to denote some special, precious, and sacred factor which has nothing to do with everyday life in the world. The Chinese did not think of spirit in this narrow sense. When I say that body, mind, and spirit are one and inseparable that is exactly what I mean. Spirit might be described as the inherent essence in all things, the essence which enlivens all things and makes them grow and thrive. To the Chinese, spirit was in everything, the air, the trees, the water, the ground, the animals, the plants, the human being, every single thing. In fact, we know and understand this in ordinary parlance. If we see someone slouching down the road with shoulders slumped and eyes cast down to the ground, we say he looks dispirited or spiritless. We have not had to consult some church official or needed to have a quick word with God to make that diagnosis. His very posture and bearing show that he is lacking in spirit.

In a similar way, if we are not able to feel on the inside that which we are outwardly presenting, and our spirit is not fully in it, patients are not going to accept and trust us. It is not because they do not want to; it is because they cannot do so. Creating empathy with the patient can often cause problems for practitioners because when they really do communicate properly, with the spirit, they are likely to feel everything in the patient as intensely as the patient himself. Such practitioners find it difficult to step back from strong rapport with the patient in time to avoid feeling as terrible as the patient. Stepping back appropriately is one of the hardest skills to learn. Unless we ask with the spirit the patient cannot tell us who they are; and yet, when we do so ask, we risk being overwhelmed by their problems. Some practitioners cannot help getting too close; others cannot let themselves get close enough. It takes much practice and experience to learn to maintain the appropriate distance. Yet we must be able to do so if we are to keep

our empathy with patients whilst at the same time retaining a clear view of what is happening within them.

To feel

Since diagnosis of colour, sound, odour and emotion obviously involves the skills of seeing, hearing, smelling and asking, it is often at first assumed that feeling must, therefore, be entirely represented by pulse-taking. Certainly the taking of pulses is a very important aspect of skill in feeling. I have already described how such a skill is developed through continual practise in pulse-taking, not just on patients but on friends and colleagues. At one time, we just used to ask students in training to take pulses regularly as their homework and hoped that they did so. Now we require that they show evidence of having taken several thousand, so keen are we to ensure that the practice is not left to chance and perhaps neglected. I have also mentioned that knowledge of all the pulse qualities takes many years, and that we are all learning even as we carry on in our practices.

There are other important ways in which we need to be able to feel with considerable sensitivity. I described earlier how important it is to be able to ask questions with all of oneself with body, mind, and spirit. Learning how to touch patients' hands, shoulders, backs with love, respect, support, and reassurance is not much use unless we are also able to understand what it is we are feeling and are able to read their reactions. How can we hope to read and understand what the patient is telling us unless we have developed the power to feel and be aware of the minute signs that are given and changes that take place? When shaking the patient's hand, for example, whose hand is holding on to whose? Where are the warm spots on the hand? What is the texture of the skin? All such information is given through just a simple handshake but we have learned to develop the sensitivity to read it. Ordinarily, we are barely conscious of what a handshake can tell. Perhaps if we shook hands in the dark and in silence, we might become more sensitive and aware of temperature, texture, strength, tension, all the signals which we can feel if we direct our attention to them. One way or another, we have to develop our sensitivity.

When we have learned to focus attention and have become able to feel sensitively, the question is bound to arise, 'What do these things I am feeling (rough and flaking skin, tense muscles, etc.) mean?' Sometimes, such signs are a direct signal from an official but in many cases, possibly the majority, they are not. It is a regular teaching exercise at

the College to choose a single condition, say, dry skin, and consider how it may be an indication of each of the elements being out of balance. The fact that there is not adequate water at the surface of the body may be due to insufficient reserves in the Water element itself. Or the condition may be due to inefficient planning for distribution within the body, arising, therefore, from an imbalance in the Wood element. It could be due to excessive heat from the Fire element causing evaporation of too much water from the body. It may be due to the Earth element's failing to transport nourishment to the outer surfaces. Or it could be the Metal element causing the problem through not giving adequate vitality and quality to the skin. The feeling of a particular and abnormal physical characteristic tells us that an elemental imbalance is present, but we can only relate the sign to a particular element and use it to help build up the overall picture when we have identified the CF via the major signs. If we feel three or four of these minor signs all seeming to point in the same direction, they may help to guide us towards the CF; but we need the primary diagnostic evidence, colour, sound, odour, emotion, for definite confirmation.

Physical information is only a small part of what feeling can tell us. When we take the pulses we are not just able to feel for their general volume and quality. The pulses are messages from the officials as to how they are functioning in all respects. We can feel the state of an official's mind and spirit as well as its physical state. The pulses extend our understanding of the relationships between the elements and officials. This understanding is very important to develop because ultimately we become able to feel from the pulses the state and history of all the officials on all levels, just as we are eventually able to understand the state and history of the patient in all respects by learning to feel with the mind and spirit when we are conducting the physical examination during diagnosis.

Summary

Much of the commentary thus far in the book may have seemed a little vague, especially to those who perhaps expected more of a 'how to' manual. In the next chapter, I shall outline the actual procedure for diagnosis,and will be giving information as to what will help to establish the diagnosis, but observation of the four basic signs, colour, sound, odour, emotion, will always remain the primary means of identifying the CF. There will be times when one sign or another is easy to establish, but usually we have to work hard with our faculties

to establish them with certainty. We must never prejudge them, trying to work them out through making deductions or assumptions. Hence, no book can provide short-cut techniques, set pieces, or detailed descriptions.

Furthermore, any account of the method has to remain vague because no amount of words can fully tell how and what to see, hear, smell, ask, and feel. Our senses are generally poorly developed and the only way to improve their power is through exercising them. Our skills have to be re-learned and improved by practice, especially those of seeing, hearing and feeling. The skill of asking calls not only for practice but for humility and personal honesty also. We must become able to generate in ourselves the emotions which we need to elicit from our patients, an ability which some can find difficult and uncomfortable to accomplish. It can be difficult because we must be able to express emotions which we are predisposed to ignore or dislike, and because we have to accept monitoring and judgement from colleagues as to how and where we are failing to give clear and effective messages. It can also be uncomfortable because we have to relive in ourselves past emotional experiences, and that can sometimes mean resurrecting suffering which we have long since left behind. Being able to call on any emotion, however, is sometimes the only way we can reach that emotion in a patient, thus establishing with them the quality of rapport which will enable us to make correct diagnosis. Accurate diagnosis is our aim and there is nothing we should not be prepared to do to achieve it.

The challenge and the task may perhaps seem a little frightening and daunting. However, we shall see in the next chapter how the procedure of Traditional Diagnosis is set up in a way which ensures that we use our skills to the fullest and makes sure that we do all that we must do in order to establish the Causative Factor.

CHAPTER FOUR

THE CONSULTATION

Initial contact with the patient

Now that we have considered how diagnosis fits into the traditional system of medicine, what information diagnosis provides, and the skills needed to obtain that information, we may now move on to the conduct of the initial two-hour consultation.

I find it worth spending as much as half an hour with a class of students discussing the first moments of opportunity to diagnose, including information we may pick up even before the patient has walked through our door. We need to remember that every patient has a mask, a mask through which he is accustomed to dealing with the day-to-day world and through which he is telling us the nature of his problems. In coming to us, he is walking into a totally new situation, and we do not know what he may be thinking and feeling. Whatever it is, it will be affecting the way he looks and the way he moves. If, therefore, we are able to observe a patient when he is unaware that he is being observed, we may pick up information which we cannot obtain in any other way. This is why I advise practitioners to set up their practices in a situation where they can see their patients arriving, parking their cars, and walking up the front path. They are then able to start their diagnosis before the patient has even entered the building.

Diagnosis can actually begin even before the patient's arrival. It can do so when the person gets in touch with us to enquire about treatment and to make an appointment. The majority first make contact on the telephone and they often find it an ordeal. They may be apprehensive because they know little or nothing about acupuncture; they may be tense because they are frightened of needles; they may be worried about what their doctor or their friends will say; they may even be scared stiff that certain people might find out they are looking for

treatment. It is amazing how many people say they are approaching us just to please their wives, husbands, or parents, and not because they really need or want to. Whilst acupuncture remains relatively unfamiliar and little understood in the West, we are likely to encounter such signs of apprehension when people first approach us.

Furthermore, such anxieties occur simultaneously with the problem which is worrying the person enough to cause him to approach us in the first place. It may not be a relaxed person who speaks to us on the telephone. This initial situation can provide ideal opportunity to listen to the voice, the choice of words, even the emotion, without the person being aware this is what we are doing. They usually know nothing about the way we diagnose and will probably not have prepared the 'script' they will bring if and when they come to see us. The telephone is not, of course, the only form of initial contact. Some will turn up at the door wanting to make enquiries, wanting perhaps to talk for half an hour to find out what acupuncture can do for them. It may be a free consultation, but we may usefully pick up more about the person in an informal, off-guard chat than from a full diagnostic session. Others may write us letters, which informs us a great deal more than the patient realises.

If we have already been alerted with a few strong signals from the initial contact by telephone, we may then make good use of the patient's arrival for the first appointment. We may watch a female patient arrive and park her car. We see her struggle to get out of the car, struggle to close the door, and then stop to rest, leaning back against the car. We see her shuffle slowly up the path to the entrance. But, as soon as she rings the bell and we open the door, she pulls herself together and walks in upright and purposeful. We think, 'Here is someone who puts on a brave face, makes light of all her problems.' We have seen from the change in her behaviour how she prefers to mask her pain, suffering and anguish. This is important information which we would have been denied if we had not watched her arrival. We would have seen only the upright back and the firm walk through the doorway and might have thought that there could be little the matter with her. By catching her behaviour when she thought she was unobserved, we know she is coping with real stress and difficulty. We would, no doubt, discover the mask in due course but we have given ourselves a head start.

At the other extreme, we may see another type altogether, someone who parks his car, leaps out, slams the door, and charges up the path. By his behaviour once he is inside, we wonder how he even had the

strength to drive. Looking at him coming up the path, we would think he could qualify to compete in the Olympic Games; once inside, it looks as if he is hardly going to make it to the chair. This is the dramatist. If he has a headache, he thinks he must have a brain tumour; if he cuts his finger, then tetanus is bound to follow. Through our early observation, we know in advance that we have someone who is really going to lay it on and we will be circumspect in giving credence to what he tells us. At the same time, we are asking ourselves, 'Why is he doing this? If he is over-dramatising his illness to this extent, is he desperate for love, or sympathy, or what? What is he really asking for in coming here?'

Everyone recognises people from his own experience who put on masks of one kind or another. In fact, all people wear masks to some extent some of the time. Sick people are apt to wear particularly thick ones, putting on the guise of clowns, cowboys, nurses, and so on. For them, it is the only way that they can cope with their problems and survive. Usually we find the person who puts on a domineering pose is weak as jelly within but dares not show vulnerability to the threatening world around. The person inside the clown's outfit is often sad, empty and desperately needs the attention and warmth that he hopes his pose will generate. The great reward for us as practitioners comes from our ability to see behind such masks and find out why they are worn. In finding out why the mask is needed, we discover valuable clues to identification of the Causative Factor.

The handshake

We may have already learned quite a lot about the patient by the time he reaches the front door. As he comes in, we expect to shake his hand.

Handshaking may be something in everyday life that we are not used to doing; even if we are, we will not be used to doing so consciously. When we learn to give full attention to our handshakes, we obtain much useful information, enough to raise questions in our minds which will take us towards the mind and spirit of the patient. Some people grip the hand as if they want to crush it. When we ask ourselves why they do that, we generally find it is a sign of inner weakness and of feeling inferior. If they express such weakness by trying to grasp us and gain control over us, we want to know how much they try to exercise control over others, such as wives and children. Others proffer a hand that feels like a wet fish; they do not seem to want to give or receive a welcome. Why can they not receive or give warmth?

Others want to pull their hands away as quickly as possible. Are they frightened that they might catch something, or that they might be taken advantage of? Yet others hold our hand, and go on holding it, and will not let go until we make an effort to release. Do they want comfort and sympathy, just like little children hold their parent's hand when they are feeling ill?

We need to be able to read what people are conveying through their hands. They are subconsciously expressing a need, not a want, but a need. Very few people realise what they are telling about themselves through so simple a gesture as a handshake. We have to learn the relationship between different qualities of handshake and different elements and officials. When we are able to do this, we will start to appreciate details which may tell us everything we need to know. Is the hand cold and wet, or cold and dry? Is it hot and wet, or hot and dry? Are there areas of varying temperature on the hand? Is the area along the Small Intestine meridian freezing cold whilst the palm is boiling hot? Or is the area of the Lung meridian freezing cold?

I could add question after question, what texture the skin has, how clean or dirty it is, a dozen different features, but that would perhaps place too much emphasis on the physical level alone when really, as first point of contact with the patient, the handshake allows getting in touch with him at all levels. When we are shaking hands, we should try to notice any effect on the patient's face. With some, we will see a draining of blood from the face; with others, the face flushes. It can also have effect on the colours on the face.

The way in which patients may become stronger or weaker in the moment when we make physical contact will tell us just how the mind and spirit of the person responds to touch.

Seating position

After an exchange of greetings and the hanging up of coats, we invite the patient to sit down. Here we need to remind ourselves that we are establishing a relationship between two human beings who have not met before and who do not know each other. So, we place our chair and his chair side by side, facing in the same direction, not quite parallel, and slightly angled towards each other. We do not sit facing him directly because he does not know us; face to face can seem rather demanding, perhaps even confrontational and threatening. If we force too much eye contact on a person, he may become defensive and

reluctant to reveal all that he wants to reveal. If he feels comfortable and relaxed with us, he is more inclined to regard us as someone in whom he can confide rather than someone who is prying and demanding his attention.

Fig.2 Seating Positions for the Consultation

This may seem to be overdoing a seemingly trivial matter but, during the examination, there can be dramatic and traumatic moments. Patients may feel released and reveal to us confidences which they may not have shared with anyone else. They may break down and weep, and need support. If we are sitting next to them, we can, without difficulty, put a hand on their arm or shoulder, or take their hand, and thus give them comfort. If this happens, we will at the same time learn from them whether it is sympathy, or warmth, or reassurance that they are truly seeking. If we are too far away or sitting directly opposite, we will only be able to reach and touch them with a longer range movement and gesture which may seem too deliberate and obvious to be acceptable and comfortable. We could easily damage our chances of building up the good rapport we need.

It is obvious from the above that sitting on either side of a desk would be worse than anything; it is far too much of an intervening obstacle. Two comfortable chairs, side by side, are all we need. Even as we invite the patient to sit down, there may be little things of significance

to notice. Perhaps the person will move his chair a little further away from ours; or turn it a little more to face ours. What subtle non-verbal messages is he unconsciously sending out?

Name

We have come now to the point which would conventionally be thought of as the beginning of the interview. We ask the patient for his name which we need for our record sheet.

All we expect to be given in reply is a straightforward word or two, such as 'George Smith'. George Smith might reply 'George Smith', but we might find him saying 'Smith', or 'George', or 'Mr. George Smith', or 'Smith, George', or 'Smith, G.' or 'George Arthur Thomas Baldwin Smith'. How a person uses his name is very important. A name says in different ways, 'This is who I am.' It tells not only how a person likes to be addressed but also how he is used to being addressed, thus telling something of background and history. It is how we give ourselves particular identity, how we differentiate ourselves from everyone else. Others may have the same name if it is a common one, but no one is going to refer to us by any other name than our own. Thus, the way in which people give their name can tell us much about the importance they attach to themselves, how they see themselves, and who they think they are.

I remember, when I was once conducting an examination in front of a class, asking the patient her name. She spelled out her whole name letter by letter, not just her surname but her Christian name as well. A person with a complicated surname might be used to spelling it out, but the sad thing in this case was that the Christian name was Jane. I can spell 'J-a-n-e', as she might have expected we all could. But she wanted to make absolutely sure I knew exactly who she was and be absolutely certain that I would not confuse her with anyone else. In that instance, a blatant distress signal had been given to us from the official in trouble.

The way the name is given will tie up with the emotion, tie up with the sound, and will tie up, at a deeper level, with how a person feels about himself and how he sees himself in relation to others and the world at large.

Address

Even asking someone for his address, or just where he lives, may tell us a lot. We may be surprised at the variety of ways in which such a straightforward question can be answered.

I once conducted a diagnosis with a patient who had flown over from America. I asked him where he lived, and he replied, 'America'. I said, 'My friend, it's a big place. Where in America?' 'On the East Coast,' he replied. 'Fantastic. I love the East Coast. But where exactly? I mean,the East Coast covers an area about five times the size of Great Britain.' By stages, I invited him to narrow it down to the state, to the town, to the street, and finally to the house number. Why was he so reluctant to be specific? He did not want me to pin him down, to be able to pin-point him. He did not want me to know exactly where he could be found. He did not, in fact, want anyone to know exactly where he was, because in essence he did not know where he was himself.

This man was desperately sick. For him, 'America' as the answer to 'Where do you live?' was as close as he wanted anyone to get to him. At the other extreme, a patient might say in answer to the same question, 'In Warwickshire, in Leamington, that's Leamington Spa, in Eastdene Road, that's just off the High Street, at the top, on the left-hand side, number nine, it's the one with bay windows and a blue front door.' This person wants us to know exactly where he lives, exactly where he can be found, because his house is his home, exactly where he is. The man from 'America' no doubt thought to himself, 'What does it matter where my home is? It's only a building. And who cares what its number is?' The nature of his response was a golden clue for me right at the start of the diagnosis.

We also need to ask how long he has lived where he is at present and where he used to live before. Supposing, when we have asked a woman patient for her present address, she has replied, '1, Marlborough Drive, Kenilworth' and we have detected the sound of grief and anguish in her voice. Then, when we ask, 'Where did you live before?' and she replies, 'I used to live in Scotland', we hear traces of joy and laughter. We would immediately suspect that we might have a pointer towards the cause of her illness, and would investigate further. We find out that she and her husband were very happy in Scotland where they had many friends and good neighbours. But then her husband's job was relocated and they had to come down to Kenilworth where she has no childhood memories and, even after two years, has

been unable to find friends to whom she can happily relate. She lives in a detached house and has scarcely been able to make contact with her neighbours who seem to be far too busy leading their own separate lives. She feels trapped at home all day, her heart crying out for companionship, some friends to be with and talk to. This could be the cause of her illness, and we have been led towards it simply by asking where she lives and used to live.

People will tell us all manner of things through giving account of where they live and where they have lived. For example, we might get the reply, 'We've only been here a year. Before, we lived in so-and-so, we moved there from so-and-so, and when I was first married I lived in so-and-so.' We ask ourselves why there has been all this moving about all over the country. Was it because they kept thinking that the grass would be greener elsewhere? Did they expect that life here would be more exciting than there, but, in fact, they kept on finding it just as dull and boring, perhaps because the problem has more to do with their relationship than where they happen to be? Is it the husband or the wife forcing the change? It may be the wife being dragged around the country because the husband keeps changing his job; or it may be the husband trying to satisfy the wife's latest change of mind.

By asking simple questions about where the patient lives and has lived, we can discover how he relates to where he is and where he has been. We will hear his enthusiasm, his depression, his anger, or his fear how he is being or has been affected emotionally. Elsewhere, I shall be stressing the importance of writing down some of the key words used by the patient; but, at the time of inquiring, we are just listening, not merely to the content but the sound behind it. If all we wanted was literally the person's name and address, we could ask him to fill in a form and send it through the post. If we do not listen attentively, that is what we might just as well do, for we will only end up with some facts written down by us on his behalf. We have to listen for what lies behind the factual information, for what he really wants to tell us, even in so simple a matter as giving his name and address.

Date of birth and age

It is predictable from what I have said about names and addresses that asking for someone's date of birth and age can produce a response just as full of valuable information.

Our birthdays, when we were young, were special days. Most of us will have happy memories of those wonderful childhood days when we felt ourselves to be the most important person in the world. No matter what our circumstances, rich or poor, famous or humble, on that day our family made us the centre of attention. When we ask patients, 'Now, tell me, when were you born?', we may be surprised not only at how unimportant their birthday is to some but also at the variety of answers we may get. One patient will flatly say, 'Nineteen forty-seven', just like that; the month and the day do not matter. Another will snap out, 'Twenty-one, eleven, fifty-one', in such a dismissive way that we can almost hear him saying, 'Next question' before he has finished giving the answer, as if he wants to run the examination himself. Another will start to become a little confused, 'The twenty-second... no, sorry, twenty-fourth of March, nineteen thirty-seven... Beg your pardon, I mean thirty-six...' Yet another will answer in a way which is probably already familiar to us after the earlier simple questions, 'Twenty-fourth of August, nineteen forty-two... that makes me a Virgo... we're supposed to be temperamental, you know; but I'm not... never have been, except when Colin was born... and then the doctor said it was because of the hormones...' All we have asked is, 'When were you born?' The way patients answer often tells us something valuable about themselves.

We never ask patients their age. We can calculate it from the date of birth. We can, if we wish, confirm our answer with the patient, using it as an opportunity to ease any sense of interrogation, feeding the patient a little bit of warmth and reassurance, perhaps giving a little compliment. Or, if the patient has been very unyielding and brusque up to that point, we might do the same to see how he responds to similar abruptness. Does he relax a bit and breathe differently? Or does he bridle and look annoyed? Such little signs are very important. Not only do they tell us about the patient but they help guide our choice of words, our tone of voice and our gestures so that we can build up communication and trust with the patient. We need to establish this as quickly as possible so that he will feel, 'Here is someone who is going to understand me.' The quicker we accomplish the trust, the sooner we are able to get through to the core of the patient's problem.

Occupation

We then ask what kind of work the patient does. Even if we are given only bare details, the nature of the occupation can give us important information. For example, we will find that some patients work in

circumstances which cannot help but be harmful to them, such as working with computers all day under artificial lights, or working under continual pressure so that there is no time for proper breaks for relaxation, or working in situations where there is an excess of noise, dust, and poisonous fumes, in addition to the other pollutions of the modern environment which we all have to suffer. Sometimes we will find very obvious connections between our patients' work and the problems they are suffering from. In cases where patients cannot change their working situation, we have to work that much harder to give Nature the extra help needed to restore the balance which will give such patients strength to withstand stress and aggravation better.

Work is not just a subsidiary feature in people's lives; it occupies an enormous part of their time, whether they are in paid employment or working in the home. It would be impossible for a person not to have any feelings at all about his work. We often hear such feelings when patients tell us what they do, and how and why it is important or not to them. 'I assemble back axles for the new Rover. It's a beautiful car. I feel proud I help make them when I see one out on the road.' This feeling tells us something very different from, 'I work in the typing pool at Baxter's. It's really boring work. I wouldn't stick it if it weren't for the girls down there. Great they are for having a laugh and sharing your problems with.' If we listen carefully, we can learn a great deal of what it is going on behind the factual content: pride and sense of achievement, frustration and stress, and so on. Any such feelings may throw light on the nature of imbalance within.

It can sometimes happen that a particular imbalance in the five elements is reflected in the type of occupation that the person has chosen. One person, for example, may have an imbalance which will incline him to spend more time and energy looking after other people's needs than his own, a disposition which he may follow even at the expense of his health and well-being. Such a person might be found to have taken up a career in one of the caring professions, such as nursing or social work. Another person may have an imbalance which causes him to strive to be the centre of attention because he feels the need for love and adoration. Such a person might want to be a celebrated actor or performer but the stage is not a viable option for everyone. We might find such a person doing something else which requires giving a performance in front of others, teaching, training, marketing, and other such occupations. Another person, with an excessive disposition to organise things and tell other people what to do, may find an ideal outlet for his need in a managerial or bureaucratic job. It is important not to get too carried away by such associations and

correspondences but there can, quite often, be helpful clues in this area of occupation if we listen carefully.

Marital status

The last information we need to record at this stage is whether the patient is married or single, and whether he has any children. We will return to these matters at much greater length later in the examination because we need to know in depth how patients are and have been affected by these major influences in life. By now, we find it easier to anticipate the kind of response we are likely to receive from a particular patient and ask about such potentially sensitive areas in his life with appropriate care.

Husbands, wives, unmarried partners, boyfriends, girlfriends, sons, and daughters share relationships in which those involved are rarely likely to feel neutral. If a patient happens to have strong feelings about any of them, those feelings will soon clearly emerge during the examination. We may encounter a great deal of sadness. It may be due to separation, divorce, death, any loss which has affected the patient deeply. Even the mention of such a loss at this early stage of the examination may be enough to release an overwhelmingly powerful reaction. In this case, we would put aside our note-taking for the moment. Not only will what we are seeing, hearing, and feeling in that situation be far more important than anything we are writing down but we must give priority to dealing caringly with such evident distress. There will be plenty of time to ask further questions in due course.

All of the information we have been asking for, name, address, date of birth, occupation, marital status, number of children, may amount to no more than a set of recorded facts. Most people are used to giving such information, when visiting a doctor or some other professional person, and will, therefore, reel it all off just as a matter of fact. On occasions, however, as I have already suggested, a patient will be evasive, or become upset, or launch into unnecessarily elaborate explanation, or give an entirely inappropriate answer. Then we are alerted, all eyes and ears. We can either take the matter up again later or we can let the conversation flow if the patient obviously has something he really wants to get off his chest. Whatever we think it best to do, in the back of our minds we will be asking ourselves, 'Why does he want to tell us about this now? Why is it so much more important to talk about than the reason he has come to see us?'

What I have discussed so far in this chapter covers approximately the first five minutes of the examination. In my experience, they are five minutes that some practitioners rush through and get out of the way so that they can get on with the main part of the diagnosis, finding out why the person has to come for treatment. But nothing I have introduced can be dismissed as unimportant or extraneous. I would like to think that within the next twenty years, every practitioner will be placing exactly the same importance as I do on the patient's arrival, the handshake, the asking for name, address, and other details. In fact, the more experienced we become the more these preliminaries gain importance. As our abilities to see, listen and feel improve, so we will find that on many occasions we will be able to narrow down the Causative Factor to three, two, or one of the elements within those first five minutes.

The main complaint

The patient is now sitting at our side and, if we have already done a good job of making him feel at ease and understand that we are there to do the best we can, we are on our way to establishing trust and good rapport. We should anticipate, however, that this may not be so in all cases. Some may be frightened because they are predisposed to be so in all unfamiliar situations; some may be apprehensive because they have conjured up too many fearful images about acupuncture. The examination itself can be a daunting experience. We need to put ourselves in the patient's position and remind ourselves what it is like to participate in something which is totally new and unknown.

For the main part of the examination, we cannot expect to follow a set format, working through a prescribed list of areas to cover and questions to ask. Most patients will be eager to tell us why they have come to us, and we will generally be able to concentrate on that at first. But some will be too frightened to reveal anything but a minimum; others will just burst into tears and become speechless; others will be so angry about so many things that it will be a job to tell just what their main complaint is. In all these cases, we will have to work out just when and how we are going to bring purpose and direction back into the examination. The handshake, name, address, and other basic details come first in all cases, but the course from then on varies from person to person. We may even find in some cases that the best way to continue with the examination is not to embark upon it formally at all. We may find that we may be provided with more information by not asking specific questions than by pressing on with doing so.

I once had a patient who had flown over from Canada, the first time he had left his country in his life, even though he was quite elderly. At first, he tried to give the impression that there really was nothing very much wrong with him. This was clearly not true. To fly from Canada to England, especially when having never flown before, to consult an acupuncturist, is not something anyone is going to do if they have 'nothing much wrong' with them. If you had a mild headache and I suggested that you ought to fly to America to see someone who could cure it, you would rightly assume that I was joking. If something was deeply troubling you, and you were really scared, however, you might willingly travel all round the globe to have it sorted out.

In this case, therefore, I really had to listen for what lay behind the outer mask. When he first sat down and talked, he seemed a jovial fellow and really did look as though treatment for some serious illness was the last thing he needed. But from what I was then able to see, hear and smell, I knew within minutes that he was in a desperate state and scared to death behind his mask. I chose not to embark on a formal examination at all. I just said, 'Hi, Bob, how are you?' He replied, 'I'm pretty rotten.' 'How do you like it over here in England?', I asked him. He said, 'It's the first time I've been anywhere outside my own country.' I continued with sociable questions about his flight and his stay. 'How was the plane journey?' 'What do you think of the weather?' 'Where are you staying?' Whilst we were chatting at this level, I found most of the information I needed to be able to tell what really was wrong with him.

If I had launched straight away into a formal examination, or, rather, what he would have felt to be a formal examination, I would have been told nothing significant because his fear of the truth would have caused him to put up such a defensive front that he would have continued to present his unconcerned mask. Because the conversation seemed to him to be casual, he did not realise that he was being seriously examined, and did not realise that he was telling me all I needed to know.

We need, then, to realise that we can be flexible in our approach to the main part of the examination. We also need to bear in mind the principle that we should not ask questions which call only for a 'yes or no' answer. No reply in the context of our examination can be that simple. What is more, some people will say 'yes' when really they mean 'no', and vice versa. So much can depend on the particular circumstances at the time of asking. When we want to know why a patient has come to us, what his problem is, the best way of doing so

is by means of general enquiry. 'Would you like to tell me what is troubling you?' 'How long has this been going on?' 'What treatment have you had in the past?' These questions are not to be presented as some kind of detailed cross-examination but as invitations to the patient to express himself as freely and fully as possible. After the patient tells us about what is troubling him, we will find ample and suitable opportunity to ask how long it has been going on, how he has been managing to cope, how it has affected his day-to-day life, what help he has sought, whether that help has in fact improved or worsened his situation.

This basic information is important to record because we need to know how and by how much the patient's expressed problem is changing during treatment. At the same time, we will also hear what is really going on in depth because patients react superficially in so many different ways. Some patients will take our invitation as permission to relate their troubles in the greatest detail, and they will carry on as long as they have our attention, or longer if they cannot stop themselves. Such a response might go like this, 'It's this pain... this pain I get just here... it's excruciating, this one... though sometimes it spreads all round here... and then sometimes I have it here also. But then, there is the pain I also get in my head... just here. I clearly remember when I first had that. It was in nineteen fifty-four. I remember because I had it at my older sister's wedding. I know it was then because it was a wonderful do, about eighty people there, and it suddenly started in the middle of the speeches. She went to Italy for her honeymoon. When Mummy and I got home after the wedding, the house was cold because Michael had forgotten to turn the central heating on...' On and on she goes, the point of the story fading into the background. Patients such as this could fill a book with the chronicle of what they have done, where they have been, what has happened to the people they know but only about two pages of it will actually be a relevant answer to the question they have been asked. Nevertheless, such a desire to elaborate and to wander away from the central issue can point us clearly in the direction of a particular element or official out of balance, or, indeed, to the Causative Factor itself. Flexibility means not only being much less than rigid in dictating how we want the examination to proceed but also being open to the fact that whatever happens can provide crucial information.

Another patient may sit down and, when we come to enquiring about the major complaint, simply say, 'Well, I've come because of the pain in my head.' Full stop. That, of course, is simply not enough to go on. Instead of 'pain in the head', we might just as well write in our record

'pain in the backside'. We might then ask, 'How long have you been having it?' When they reply, ' Since January the fourth, nineteen seventy-eight', (further full stop), we know we have a patient seeking help from whom extraction of voluntary information is going to be about as difficult as the proverbial extraction of teeth. 'What have you done about it up to now?' we ask. 'I went to the doctor once. Had some pills. Didn't do any good' (full stop). Even in this case, however, despite the apparently unhelpful response, we are being given useful information, directing us strongly towards imbalance in particular elements and officials. Between such extremes, the ones who are excessively talkative and those excessively withholding, the average patient will probably take about half an hour to describe his problems fully in his own way.

When a patient is telling us about his problems as he sees them, we make careful note of what he says. Such a record can be of great importance later. In the recording, we must resist any temptation to translate what the patient actually says into 'proper' English or what we think he means. If the patient says, 'It's the bloody arm', we do not write down, 'It's my arm.' The latter is what we expect people to say. Why is this person saying 'the' and 'bloody'? Whose arm and why swear at it? If he is disowning his arm, what else in mind and spirit might he be trying to get rid of? If he is angry with a part of his own body, what else does he hate within himself? The patient may not be conscious of the implications of how he expresses himself, but a particular formulation he chooses to use may provide the practitioner with an important clue as to what is happening within the person.

If the only diagnostic information needed was a set of clinical facts, we could just ask patients to fill in a questionnaire or have a secretary ask the questions and make simple notes of the answers. We do not do that, because the significant information we need comes from what we can see, hear and feel behind what they say. There is always the temptation to dwell on the physical problems which our patients tell us about because they are usually uppermost in the person's mind, and it is very easy to find ourselves taking down large amounts of clinical detail. But, as we have already established, very few people indeed are troubled by physical complaints alone. The vast majority have much deeper troubles underlying the physical ones, stemming from internal factors, such as grief, fear, hatred, worry, any disturbance and distress in mind and spirit. Although a patient may come to us with evident arthritis, lumbago, rheumatism, we should not let ourselves get over involved in lengthy discussion of that particular ailment or in consideration of its chemistry, physiology, and pathol-

ogy at the physical level. We are primarily concerned with finding the cause of it at a deeper level.

Apart from noting down the basic facts and any key formulations or expressions which the patient uses, it is the sound of the voice, the emotional state, and the colours on the face as he is speaking which are really important to note. These are the all-important signs which indicate the CF. We know that an imbalance in any of the elements will result in expression of particular colour, sound, odour and emotion, often in a manner inappropriate to the circumstance. Certainly every patient is expected to express grief, fear, anger, joy and will, to a degree, need sympathy, reassurance, comfort. We are not surprised if all or any of them occur to a moderate extent in appropriate contexts during the examination. But any major elemental imbalance, major distress in an official or serious organic disturbance will, at certain points, cause inappropriate expressions or demands. That is why we must record carefully not only what the person actually says about his problem but also our own observations of the accompanying inappropriate responses which point to the inner nature of his problem.

An inappropriate sound or emotion is a key signal, an official saying, 'For heaven's sake, I am the one needing help.' Imagine a patient complaining that he has a persistent problem with his back. Some time ago, he has been to his doctor, been examined, and the doctor told him that there is nothing that can be done about curing the back but that it will remain reasonably comfortable if he exercises regularly and does not strain it unduly. The patient has then read about some 'wonder machine' promising to cure any back problem and he has decided to buy one. He has used it for a month or two and has then found that his back has become worse than before, so painful that he cannot lead a normal life any more. The makers of the machine have said, 'We can't understand it. You must have been using it incorrectly. We've had no complaints from anyone else. I'm afraid there is nothing we can do about it.' Our poor patient is not only now worse off than ever but he has become almost frightened to move because of the pain and for fear that his back might collapse completely.

Now, we would expect that patient to feel some anger; we would judge that to be an understandable reaction in the circumstances. After all, he has the back problem he started with and much more. He must feel let down by what has happened to him. If, however, he says, 'Tried this machine; didn't do any good,' and is laughing about it, we might wonder, 'Laughing? What on earth is there for him to laugh about?' We might wonder if we found excessive fear and panic, 'God,

it's terrible. It's getting worse and worse. I'll have to have a wheelchair. Will I become paralysed?' Or if we found useless regret and grieving, 'Oh dear, I wish I hadn't bought that machine. I do wish I had tried another doctor, or gone to a specialist.' There is no sense in wishing that what has been done had not been done. Or we might wonder if we heard debilitating anxiety, 'It's hopeless. I'm not going to be able to do anything soon. Life just won't be worth living any more.' Any excessive or inappropriate responses would be a valuable key for us in looking for the underlying imbalance. Hence, we listen carefully throughout the examination to make sure we do not miss any sound or emotion which strikes us as inappropriate.

Whilst a patient is talking, we should never interrupt. This is important for several reasons. We have to be, above all, good listeners, and we are not if we cannot resist the temptation to keep pitching in with our own comments and prompting. Furthermore, if we do interrupt, the patient is likely to be side-tracked. He will then be inclined not to continue with what he was about to say but either goes off in another direction or feels that he has to start all over again. A common reason for interrupting is that we can become so busy recording information that we miss or forget something and become tempted to ask the patient to repeat it. This is so disconcerting, perhaps irritating, for the patient, that the best advice is, 'Forget it! Let it go!' It is important that the patient's talking is allowed to flow freely at his own pace. As his talking gathers its own momentum, he gains confidence. The longer he is allowed to express himself, the more likely we are to hear things coming to the surface which he would not have dreamed of saying when he started. If he is continually made to stop and start, this will not happen. Generally speaking, if the patient is allowed to talk for a while without interruption, it is most likely that the last few minutes will contain more useful information to help guide us to the CF than all the previous time. We must never interrupt and thereby lose the chance of hearing deeper signals behind the formal mask.

Once the patient tells the whole story of his situation and problem, he is likely to feel much better and happier for unburdening himself to an attentive and caring listener. Now we move in from what he has told us to other things which we need to find out.

Other complaints

At this stage, we make sure that the patient does not have other problems troubling him which it may not have occurred to him to tell

us about. In a few cases,we will find that we do not need to question too hard because the patient is more than willing to comply. 'Oh yes, beside the headache, I sometimes get awful shooting pains at the bottom of my back and down the legs,' and even while we are making a note of this, he is pressing on, 'And then I get this trouble with my feet. I've had it for years, every winter.'

Such a full account given without any prompting is not likely in most cases, however. The majority of patients know little or nothing about traditional Chinese medicine and therefore about such concepts as the balancing and harmonising of energy. They usually come to tell us about a single, specific problem which they can only describe in conventional Western terms. The central complaint may be headaches, or rheumatism, perhaps depression or insomnia. However they describe their complaint, as far as they are concerned that is what they are suffering from and that is what they want put right. It may not occur to them that other ailments they experience, less frequent or less pressing, may be pertinent to their main complaint and may be capable of resolution by this tradition of medicine which enables restoration of balance and harmony throughout the whole system at all levels. They may have suffered from something so long, and are so used to it, that it does not occur to them to mention it, until prompted. 'Oh yes, for years I have only slept two or three hours a night. It really used to worry me, but I suppose I've got used to it now. Happens to lots of people, doesn't it? Yes, I do often feel exhausted during the day, and have a lie down.' This may be the norm for a lot of people; but that does not mean there is nothing wrong. Sometimes it can take quite a lot of gentle enquiry to uncover problems which the patient may have forgotten for the time being or which they do not think worthy of mention.

It is not at all unusual for a patient to come just looking for treatment for a particular physical problem, and then, when he is asked if anything else in his life troubles him, he will say something like, 'Well, my father died five years ago and I felt really upset about it. In fact, I still cry when I think about it. I suppose I haven't really got over it yet. But that's not the sort of thing you deal with, is it?' We often have to persuade and assure patients that everything which troubles them is relevant. Thus, as in this example, a patient will often come with a physical complaint but, during diagnosis, something else from a different level emerges, such as unresolved grief, underlying loneliness, or suppressed frustration. It can then happen that, after two or three treatments, the patient will almost put aside the physical problem, which is probably still there but improving, and focus nearly

exclusively on the problem of mind or spirit which he had not thought suitable to mention at first.

We need to be a bit careful, however, when we are asking about other complaints. Although it is possible, even probable, that a patient with a presenting physical complaint will have other underlying problems, that does not mean that we should go hunting relentlessly until we find a list of other things, We need to give patients time to consider and to respond to us only when they are ready to do so. It is dangerous if we probe too specifically and thereby give the impression that acupuncture is a guaranteed panacea for all the patient's problems. We do not want to arouse expectations which prove too great for us to satisfy in the short term. Without proper consideration, a patient might go away after the consultation thinking, 'I only wanted my shoulder sorting out, but he's going to fix my legs as well, and get rid of my bouts of depression. Marvellous!' Two months later, after some treatment, that patient's arm may be better and the depression seems to have lifted, but he is still disappointed. 'Acupuncture doesn't work; my legs are as bad as ever.' The best course is not to over reach and bring too much upon ourselves. We should focus on what the patient clearly expresses as his main area of complaint. Improvement there is what he is mainly looking for. He can accept any other beneficial changes as a kind of bountiful windfall from Nature.

Another good reason for keeping clear focus on what the patient expressly tells us about is that, if we go off in apparently other directions, we may not seem to be taking their immediate concern seriously enough. If they have come, for instance, telling us about their history of terrible migraine attacks and we then say in effect, 'Yes, but what else have you got?', he may begin to feel unsure about us. Even if a patient is complaining of a pain in his little finger whilst we can see that really his whole life is in tatters, we must focus on and share with him the trouble which is presently making his life miserable, the little finger which is the focal point of his immediate suffering. If we appear to be dismissing his finger as being unimportant by moving on to what only we know as being more urgent, how can the patient be expected to have confidence in us?

When asking about other complaints, we can also be tempted to concentrate on a feature which we feel we can best hone in on, a temptation which, if we give in to it, may also disconcert the patient. The patient might, for example, present us with only a vague description of his main complaint. 'I don't feel quite right, you know. I just feel depressed all the time; no enthusiasm for anything.' We take note of

this but then he later mentions that he suffers from constipation. Because the secondary complaint, the constipation, or it could be failure to sleep, or lack of appetite, is so much more tangible and accessible, we can be tempted to give all our attention to that and dismiss the vague feelings of depression. When we are asking about other complaints, we should bear all these cautionary points in mind.

Family

We then move on from discussing the patient's main complaint and other complaints to asking about other aspects of his life. We usually start by asking about his parents and life in the parental home. We do this because a person's years of childhood, especially the early years, have laid the foundation for his adulthood. It is the time when the patterns of behaviour for coping with adult life become established. In these formative years, the nature and quality of the child's relationship with its parents in the home will have been crucially important in influencing conduct of relationships from then on.

It is easy enough to frame a whole series of suitable questions to ask patients. Were relationships with both parents reasonably happy? Did home life have the usual share of good and bad experiences? Did the parents get on well, or was there a lot of animosity and fighting? Was the patient allowed plenty of freedom to follow personal interests and see friends, or was it a case of restrictive discipline, pressure to achieve? We have no difficulty, through drawing on our own experience and that of others we know or have known, in being able to formulate a whole range of questions, the answers to which will tell us whether the patient's recollection is of a predominantly hurtful and wretched childhood or an enriching and happy one.

Probably the easiest way to begin such an enquiry is simply to ask patients whether their parents are still alive or not. We could, of course, find this out in much more roundabout ways, through asking other questions, but the patient's answer to this simple one is likely to tell us immediately what his attitudes towards his parents are. For example, we might hear, 'Oh yes; Dad's still alive, and Mum' or 'Yes, my father's still around, and my mother.' Apart from the significance in which parent is mentioned first, we might not only notice the slight difference in wording but also, and especially, the fact that the one answer is spoken with warm feeling and enthusiasm, the other with ill-concealed hatred and contempt. In the latter case, we would immediately be alerted to the possibility that the patient suffered

badly during childhood. Perhaps the father was mean, threatening, punishing. Perhaps the mother paid no attention and was uncaring, being only interested in looking after herself, giving no warmth and love so that the patient grew up feeling unwanted and uncherished. In some cases, we may find ourselves feeling that it would have been better had the person had no father or mother around, so terrible can be the effects of having bad parents.

Where there have been bad relationships with parents, we may be guided quickly towards the CF, so upsetting and distorting are the long-term effects of bad childhood influences. If someone says, 'Oh yes, my father's dead; died about a year ago,' and sounds laughing about it, we will immediately perceive inappropriateness and know that something was seriously wrong. If someone else says, obviously with resentment, 'My Dad's dead; my mother's outlived him many years now', we will know it is significant that the love for the mother we would naturally expect to be felt has been replaced by coldness and hardness.

As we ask these questions about the patient's background history, we will gather much important information. If the father or mother, or any other close relative has died, we should ask about the cause of death in case there are inherited, congenital conditions. We need to know the nature of the stock that the patient comes from. Many people's problems stem from trying to ignore their background and by trying to be what they can never be. Consider trees. Even if we have two trees of the same species, say oak, they can be very different in variety, size, and height. We also have pines, elms, beeches, birches, hundreds of beautiful but totally different kinds of trees, each with special characteristics and qualities. An experienced carpenter, for instance, knows that different types of wood have particular properties. He will make some things from a hard and durable wood, and some things from a soft and pliant one. If there was only one type of wood, we could not have anything like the number of things made from wood that we do enjoy. For some things, one particular type of wood can be unsuitable, too hard, too soft, not pliable enough, too heavy to handle.

So it is with types of people. Just as acorns grow into oaks, and not pines or elms or anything else, so each person belongs to a specific type. We need to know the nature of the stock material from which a patient comes. Otherwise, we might try to treat a patient who is like a willow or a birch as if he is an oak. We might, for instance, want to tell a person to stand up for himself, and stop giving way to pressures.

We could say this appropriately to an oak tree type, but not to a pine type. The latter is made to yield; that is its nature. Whereas we might say to ourselves, 'Pull yourself together', it may be inappropriate, even senseless, to tell someone else of a different nature to do so. When we are asking about parents, we are listening for clues to tell us the kind of stock the patient comes from. When we know the type of material we are working with, we will know how to handle it and what kind of responses to expect as treatment progresses.

If we find that the patient's parents are still alive, we can follow up our enquiry by asking, 'Do you see them very often?' In answer, they might reply, 'Whenever I possibly can' and that tells us next to nothing. We could get the same answer from asking, 'How often do you win the football pools?' We need a much more specific answer to be able to establish the quality of the relationship. If, for example, we ask, 'When did you see them last?', much more revealing answers can result. 'Three years ago' or 'Every week, if I can. Sometimes it's once a fortnight when I'm very busy.' Such answers can give us something much more definite to consider. The former answer might prompt us to ask why he has not seen his parents for so long. If the answer is then something like, 'Because they have moved to Australia', that would be solid reason enough; but, if it is because they cannot be bothered to make the effort, definitely do not want to or are not welcome, then that could be significant information for us.

Practitioners will often find that the parental relationship which reveals most is not the one with the parents but that of being a parent. One of the greatest gifts and blessings in this life is to have children. It is a wonderful experience, and most parents love their children because it is natural to do so. If we ask a woman patient if she has children and she replies, 'Yes, three', just that, nothing else, and dismissively said, we suspect that something has gone badly amiss. In following up the signal, we might then find that, as far as she is concerned, her children have been nothing but a pain in the neck, she did not really want them in the first place. She sees them as the cause of her frustration because they destroyed her career. She resents them and has never been able to accept being their mother. Quite apart from how those feelings have affected her, I hate to think what such a situation does to the children, how they are bound to suffer in life through receiving their mother's indifference and hostility instead of her love. We can be sure that we have a very sick patient if she does not show some joy and elation at being a parent.
In contrast to this, we sometimes ask patients about their children and very soon begin to wish we had not done so. 'Yes, I've got one

daughter... she's twenty-six... beautiful girl... and very clever... went to university... and then she got a marvellous job... she married last year and I'm expecting to be a grandmother in June...' On and on she goes, like a chattering stream. It is natural to be proud of one's children and want to tell other people about them, but there are times and places when an over-long account is inappropriate. However, it is more natural to say too much than to have next to nothing to say about them. If we find the situation where a parent clearly has a problem over parenthood, it is important to follow through with specific questions to make sure we have a full picture of what has happened. We could find a situation, for example, where our patient was very happy to be a mother at the time when she had two children. Then she had a third, fourth and fifth and that is how and when the trouble started. She had really wanted only two, with the third began to feel as if she could not cope, with the fourth and fifth, there was no way she could manage. We can see, in this case, that we might at first have thought that the patient did not like being a parent. The follow-up points to quite a different problem. Overall, the value of questioning about parenthood lies in the emotional content of the response. When asking about children, we invariably get strong signals about the state of the person's emotions.

We may obtain equally strong emotional responses also when asking about brothers and sisters. Once again, it is not a matter of numbers, whether older or younger. It is the way in which the question is answered. As always, we are listening for unwitting signals. If we ask, 'How do you get on with them? Do you see each other often?' and we receive a reply something like, 'We don't get on at all. Hardly ever see them; glad I don't; we always argue', we can imagine that there may have been quite a lot of anguish going on when they were children together. A reply such as, 'I see them occasionally' would be fair enough. We can choose our friends but not our brothers and sisters. We expect to love and respect them and be happy to have them in our lives, but we would not expect to live in each other's pockets. So, if we hear of jealousy, rivalry, or enmity, we may suspect a history of competition, perhaps resentment and hatred. We will hear such emotional content in the sound of the patient's voice and take it seriously as a possible indicator of persistent imbalance.

I recall a patient once saying to me, 'Yes, I've got an older sister. I wish I hadn't; I wish she was dead!' I said, 'Do you really mean that? Dead?' She replied, 'Yes. I sometimes think I could kill her myself, if I had the guts.' We might imagine that no adult would ever say that about her own sister. No balanced and healthy person would, but it is quite

possible for someone who is very sick to degenerate into such an extreme state of mind. Serious sickness can cause a person to lose all sense of values, all sense of judgement, and eventually self-control. She becomes unable to make reasonable decisions and loses the ability to differentiate between the pure and impure. When the officials are out of balance and in distress, a person will do things which he would normally never dream of doing. I can imagine what it must have been like for that patient when she was a child year after year of hearing her father or mother saying, 'Why can't you be like your sister? Why don't you behave like she does?' I can imagine the profound misery and bitterness in that younger sister having to compete all the time for the attention of her father and mother against their favourite daughter, with whom she was continually being unfavourably compared.

Small wonder then, that this patient should have begun to think years ago, 'I hate always being made to feel inadequate, never good enough, always second best... If it wasn't for her, perhaps my parents would love me... If she died, I'd have all their attention.' So deeply had she been affected that she was still thinking the same long after growing up. After a few months of treatment, I casually asked her again about her sister. I was not surprised to hear her still saying she disliked her, but the 'I wish she was dead' and 'I could kill her' had gone. As her inner balance was improving, so was she finding a better sense of proportion.

Discussing the patient's family, then, serves several purposes. We see back into the patient's history and obtain some idea of the stock from which he has come. We are able to look at parental and other family relationships to see if there have been or are situations where the officials have taken or are still taking repeated and heartless battering. In particular we listen for inappropriate emotional responses from distressed officials crying out for help.

Relationships

In many ways, people's experience during their early years is projected onto and reflected in their close personal relationships as adults. They may look to their husbands, wives or partners to provide some of the things they felt deprived of in the past. As practitioners, we can often see the nature of imbalances in the patient from the nature of the relationships he has created and sustained. We also know that people can become very dependent on the nourishment such close relationships provide. If, therefore, we are told of upsets and difficulties in this

area, we anticipate that they will be deeply painful. In talking to patients about their current and past relationships, we are touching on matters which invoke very private , ambivalent, and profound feelings.

We have already touched on relationships when asking about the patient's marital status. Sometimes, we will find all the information we need then and there. 'I'm married. I met Derek about four years ago and we've been married almost three. He's a wonderful man and we're very happy. We met at a friend's party and it was love at first sight. We're like a couple of big kids half the time.' All the joy, warmth and love spills out straight away. We might be a little surprised by the amount said in reply to a simple question, but there can be no doubting the honesty of the feelings being expressed. Most people, however, are not so articulate in the beginning. By the time we come to this stage of asking more penetrating questions about personal relationships, we probably have only simple and straightforward notes on paper as a result of the earlier questions.

We have to be careful how we approach this subject. Not only must we avoid being overly inquisitive; we must also take into account that people are generally guarded when talking about their partners. We are often very sensitive, even brought up to be secretive, about what happens inside our own homes. When we are not happy, we are frequently reluctant to tell others than the closest of friends about our intimate troubles, partly out of sense of loyalty, partly through fear as to how such problems reflect upon ourselves. If we bluntly ask a patient, 'How do you get on with your wife?' he may put up barriers immediately and that will put an end for the time being to questions on that subject. It is better to enquire in a much more gentle and indirect way, 'You said earlier that you are married. Had you known your wife long before you were married? Where did you first meet?' Then, as the patient relaxes and the conversation starts to flow easily at a more social level, we become able to enquire a little more deeply.

We have to be guided by the patients' own responses in these matters. When we ease them into talking openly, we should have no difficulty in picking up leads which we can tactfully follow. Do they talk about their partners with love and affection? Is there a hint of irritation, dismissal, fear, or doubt? Did we hear regret when they talked of some past relationship? Were there relationships which ended in acrimony and which have irritated them ever since? Or relationships, forced unexpectedly apart,which were never resolved as far as the patient is concerned. 'I shall always miss her. I was shattered when she told me

it was over.' From our gentle enquiry, we will begin to piece together and understand what the patient is looking for in a close relationship, and what he values in another person. Is it love which is important? Or is it security? Does he like the structure to his life that a stable relationship can provide? Or is he afraid of being alone and lonely? No one is likely to admit any selfish motivation since most people usually prefer to think that they give to a relationship rather than take from it. During the time that we encourage the patient to speak freely and fully so that we can hear the emotion behind the content, we also listen to the sound of the voice and look for colour and expressions on the face.

Inevitably, as part of our enquiry into relationships, we seek to find out about patients' sexual experience and activity. Whilst a few will be reluctant to talk, most will tell us about them freely enough without embarrassment because it is so important to them. This is an area in which, out of some kind of false modesty, or mistaken concern for the patient, practitioners may prefer to cover briefly or treat so off-handedly that it scarcely seems to matter. But we have only to look at the personal problem pages of magazines, or listen to phone-in programmes on the radio, or watch social-concern programmes on television to realise beyond any doubt just how much trouble, pain and anxiety the sexual aspect of intimate relationships can cause. We might be appalled at the number of people who are evidently failing to enjoy the sharing in love and openness of this gift of Nature. Again, the approach to this subject cannot be made too directly and insensitively. In fact, it is one of the few subjects where it may be appropriate to ask questions which allow the patient to give a simple yes or no answer. A question such as, 'Are you happy with the sexual side of your relationship?' does not force the patient to say anything further if he does not wish to do so. On the other hand, if he does have problems in this area which he feels he wants to talk about at this stage, the question may be taken as clear invitation to tell us about it.

When we ask about relationships, we may feel it useful to find out more about the value the patient places on friendship. Many people set as much store by their social friendships as they do by their marriages and other family relationships and their feelings about them can tell us a great deal. One person may say, 'Oh, I have lots of friends. We're always up to something every night and week-ends. I'd be lost without them.' Such a response might prompt us to wonder about the balance of his life. Of course we need to share experiences with company we enjoy, but we should also be able to enjoy time on our own. A person who cannot stand being alone is as badly imbalanced

as another person who may say, 'Friends? Always let you down. I don't need them, never have.' The duration of people's friendships, what they are based on, what value is placed on them, what they enable the person to do, all such information can help us gain a clearer sense of the patient's strengths and weaknesses, and his needs and desires. Relationships are crucial to the health of body, mind, and spirit.

Family medical history

I have already described the importance of knowing the kind of stock from which a patient comes. When we ask whether parents are alive or dead, we may find out that there is a history in the patient's family of certain diseases and afflictions. Recurrence of problems such as T.B., diabetes, lung and breathing-related conditions such as asthma and hay fever, blood and heart disorders, and many others can be afflictions passed on from generation to generation. Inherited weaknesses are far too important not to be taken into account and at this stage of the consultation we must therefore address the matter of family medical history in some detail.

Apart from other considerations, information in this area can make a fundamental difference to the results we expect from the treatment we plan. For example, asthma or hay fever which has persisted from one generation to the next is likely to respond to treatment quite differently than an asthmatic condition which has arisen over a matter of months due to temporary imbalance in the patient's energy. In other words, a long-standing family history of a particular disorder may not affect the planning of treatment but it may influence our prognosis.

Family medical history can also alert us to look out for conditions in the early stages of development. People nowadays are familiar with the names and incidence of many diseases, but they are likely to know little about early symptoms indicating their emergence. Diabetes, for instance, can develop slowly and insidiously, its first signs being easily mistaken for a general and seemingly insignificant malaise. If we find that a patient has a family history of the disease and we then detect early signs of its presence, such as an unquenchable thirst, over-frequent urination, or sudden bursts of over-eating alongside a loss of weight and apparent wasting, we may decide that the patient should be referred to his G.P. for appropriate tests.

Whilst for many years practitioners have been used to having large

numbers of patients who have come for acupuncture as a last resort, we now find more and more people coming to us first. They are making a choice on principle to seek an alternative to Western medicine. This places increased responsibility on us to ensure that we identify any serious and urgent conditions, either as they are revealed during our initial diagnostic examination or as they emerge during treatment. Finding out about the family medical history helps alert us to the possibility of such serious problems being present.

Patient's medical history

Once we have explored the patient's family medical history, we need to look into his own history. We will probably start with childhood illnesses. Most people are vague about them. Measles, mumps, chickenpox, and German measles are the commonest ones. If a patient says, 'All the usual ones', these are the ones they probably mean. But terms such as 'usual' and 'common' are too imprecise and we should seek to identify each one.

Many of our present patients belong to an age group in whose childhood such illnesses as whooping cough, measles, diphtheria, and scarlet fever were common. If a patient had one of these as a child, we need to know. We also need to know how severe any illness was. With scarlet fever, for instance, most have it mildly and are just in bed for a few days; others are at death's door for several weeks and then need six months or more to recuperate. It is dangerous to assume that everyone's experience of a common illness will be the same. If we have a patient who does not know exactly what illnesses he had or the degree of severity, we suggest that he tries to find out from parents, relatives, or anyone else who might know.

After we have covered childhood illnesses, we move on to later medical history. We may have to prompt patients' memories quite forcefully and persistently to get all the information we need. Once an illness, broken bone, or an operation has been recovered from and is no longer something to worry about, it can easily be forgotten. A person will overlook the appendectomy he had ten years ago, or the arm broken while skating, or the food poisoning which kept him in bed for three weeks, or the continual bouts of flu suffered during the year after he was divorced, or the almost permanent catarrh which he learned to live with many years ago. People not only have a great capacity to forget past problems but also an equally great capacity to put up with continuing problems which others would probably think

unbearable. We need to bear in mind this ability to overlook things. If someone says, 'I've never had a day's illness in my life,' we have to be prepared to pursue it. 'Really? Not a single day?'

Past illnesses, accidents resulting in broken or fractured bones and severe bruising, operations, niggling chronic complaints, periods of generally poor health during or after times of crisis, headaches, insomnia, digestive or excretory problems, any and all matters which have affected or are affecting health and well-being are of interest to us and should be carefully recorded. We must also ask specific questions to make sure that we understand how the patient was or is being affected. It may be that some of the effects were or are directly attributable to fundamental imbalances in elements or officials. In order to monitor any reappearance of such effects as they follow the Law of Cure, we need to have a very clear idea as to the severity and duration of previous outbreaks of disease and illness.

When we have gathered information about the patient's medical history, we move on to gaining information which will help us to see how the officials in the person are working.

Sleep

As the examination proceeds, there are various specific areas of the patient's condition which we must make sure we have covered. A list of essential areas for questioning forms part of the preface sheet in each patient's file. This information, which includes a record of symptoms, plays a particular and important role. Whilst we know that the symptoms of disease are not the cause of it, there are some functions of the body which are more closely associated with certain elements and officials than others. This symptom information can help us build up a picture of how the principal imbalance is having repercussions throughout the whole system. The particular role of the preface sheet information, however, is that it provides a fixed benchmark for us to be able to assess changes taking place in the patient during treatment. We can refer to this base information before and after every treatment in order to monitor improvement in the patient's condition. As we move on to more preventative treatment, it provides a clear reminder of where distress appeared at the beginning.

We use the list of questions as a kind of checklist because we cannot rely on the patient volunteering useful information. For instance, I had a patient who, for many years, had been unable to put her hand

behind her head. She could not reach back far enough even to comb her hair. She was also suffering from breathing difficulties. She came in for treatment one day and I asked how she was. 'Absolutely awful,' she replied, 'no better at all. I've hardly been able to get my breath some days.' I then asked, 'How is your arm?' and received the reply, 'That's fine; nothing wrong with that.' It was as though she had forgotten that there was ever anything wrong with it. If I had not asked her about it, she would not have remembered to tell me that she had completely recovered the use of it, the very thing she was hoping for when she first came. It is very easy for the practitioner to become drawn into a patient's current concern and thereby fail to register important changes for the better. A patient will often omit to tell of improvements in one complaint because something else has taken over as a greater worry.

Similarly, there are patients who come during the course of treatment and say they are 'just the same.' Yet when we consult the preface sheet and ask them a question or two, they are reminded that, in fact, things are not just the same but much better than they were at first. We might, for example, tactfully remind someone that he had been complaining about insomnia a few weeks previously. 'Oh yes,' he answers, 'So I was. As a matter of fact I've been sleeping very well lately.' Yet our record shows us that it was a major problem at the time of the first examination. 'Oh God,' he was saying then, 'if only I could get just one decent night's sleep. I sleep an hour or two, wake up, so wide awake I go downstairs, make a cup of tea and read a book. Might doze off for another hour or two later.' When these patients say, 'just the same', they usually mean that they are still less than one hundred percent. They do not notice that they have improved thirty percent since they began treatment.

Some patients, therefore, are likely to see themselves as 'not much better' if they currently still have something wrong to worry about. Often we find that patients demand that something be put right, and then, as soon as we have done so, they find something else which needs attention. Of course, this is not always so. Many notice the changes in themselves and appreciate that the process of cure may take some time to follow through its ordained stages. In the cases where progress is not as visible as it might be and the process of cure is not appreciated, we have to be prepared to accept negative comments from the patient even though we ourselves can see that he has really a good deal to be thankful for and has, in fact, improved considerably.

It is worth re-emphasising at this point that we must obtain clear and

considered answers to our questioning. Patients who tell us, for instance, that they sleep 'like a log,' 'fine, thanks,' 'not too badly,' 'O.K.,' or 'much better' are not telling us anything useful. In fact, such answers can be worse than nothing because they are apt to sound satisfactory, as if there is no problem worth mentioning. We have to be absolutely sure not only that we do not allow patients to get away with vague and ambiguous answers but also that such answers do not result from inattentive, off-hand questioning on our part. Ordinary, everyday conversation is full of polite questions in which there is no serious interest in the answer. For example, the expected response to 'How are you?' is a bland and meaningless 'Fine' or 'Not too bad.' The person enquiring asks without caring about the reply. The respondent just makes a polite noise back because he knows that the questioner does not want to know the truth, the terrible earache last night, what a painful week it has been, how awful everything is. So, if we are asking about sleep, we must ask in a way which conveys that we really do want to know exactly what the patient's experience is. If we still receive a vague answer such as 'Not too badly', we pursue to find out just what that means.

All of the specific preface sheet questions are a direct line of enquiry about the officials. The following consideration of the patient's sleeping and eating habits describes the method by which we learn what we need to know about the state of the officials.

In the case of sleep, the answers to our questions need to be accurate and comprehensive. If we ask what time a patient goes to bed and he replies, 'Oh, around half-past ten to eleven,' we then check whether that means in order to sleep straight away and, if so, whether he falls asleep as soon as his head hits the pillow. Frequently, the reply will be something like, 'Oh no, I always read for a couple of hours.' Bed is a place to sleep. If someone wants to read, why does he not do so in the comfort of his sitting room? Does reading in bed represent a kind of dummy, an inducement without which he cannot easily fall asleep? Why can he not get to sleep without reading? If that person has a full and active day-to-day life, should he not be ready and grateful to get off to sleep as soon as he goes to bed? If he does not have his spell of reading, does he toss and turn and feel restless for half-an-hour or an hour before dropping off? This situation is likely to tell us something important.

It may be that the person goes to bed and falls asleep immediately. Then we need not be concerned and can move on to the next question. However, we would not know one way or the other if we had not

checked whether going to bed meant going to sleep. The same applies when asking what time the patient gets up. He may say, 'My alarm goes off at six.' Does that mean it wakes him up and that he gets up straight away? 'Oh no, I doze a bit... Hate getting out of bed in the morning; I'd love to stay there.' Here again, perhaps, is another important piece of information. The number of hours in bed is one thing; the amount and quality of sleep quite another.

After we have determined accurately the number of hours asleep, we then need to assess the quality of that sleep. Two hours of good sleep can be worth twelve hours of shallow and restless sleep. The latter is the case with a great many people. They sleep for a long time, and yet they wake up ..ll feeling tired and exhausted. They do not regain their energy and vitality because their sleep is of such poor quality. Even then, knowing the number of hours and getting a sense of the quality is still not enough information. Like detectives, we have to probe further. Do they wake up and lie awake during the night? If someone wakes up three or four times during the night and then each time takes a while to settle down again, then the nine hours of sleep he claims to have is really more like six, probably quite fitful and shallow ones.

Knowing if and when a patient wakes up during the night is important information. One person may say, 'Oh yes; I frequently wake up around three o'clock in the morning and don't get back to sleep again until five.' Another may say, 'No matter what time I go to bed, I always wake up at one o'clock. You could set your watch by it. I get up and go downstairs, have a cup of tea, potter around, go back to bed and drop off again about three.' Yet another may say, 'No matter how tired I am, I can never get to sleep before one o'clock.' Such statements give us direct information about particular officials as they function in accordance with the Chinese Clock. If an official which has its peak or low point of activity at certain times during the hours of sleep gives way under stress to hyperfunctioning or hypofunctioning, it will send out disturbing alarm signals which will rule out any hope of a good night's sleep.

There are, of course, many questions we can ask which will help us obtain a better picture of the patient's situation where sleep and energy are concerned. We need to know whether the patient enjoys good sleep and wakes up feeling rested, full of energy and ready to go, or whether the hours spent in bed are just a tiresome interruption in an exhaustingly monotonous or pressured life. We come to understand in this system of medicine, through matters as commonplace as sleep,

how seriously we must take the advice that everything about the patient's life can provide important information about the state of the elements and officials within them. Every area we are instructed to cover yields information by which we can measure the changes taking place during treatment. A patient's presenting physical or mental symptoms may not seem to be improving, but if we know from our notes that that patient is sleeping better, not tossing and turning restlessly before falling asleep, not needing to read, not continually waking up at ungodly hours of the night, then we have encouraging evidence that Nature has started to restore balance, and that the patient's officials are beginning to function the way Nature has ordained.

I have dwelt at some length on the example of sleep because failure to sleep properly is one of the clearest and surest signs that something is deeply wrong. During the course of our daily activities, we can busy ourselves with so many things, and thereby turn our backs on the officials and ignore their distress signals. In effect, people say to themselves, 'If I work like mad, I don't have to stop and think about what's going on.' This is crazy. People should work because they enjoy it, and they should be willing to stop and take stock of what is going on. Why do they drive themselves so relentlessly that they do not look at and analyse what they are doing? Within themselves they know that they may not like what they will see, and they may then become frightened or angry with themselves. Avoiding such discomfort seems the better alternative.

Avoiding the distress signals during the day is one thing; but it is a different matter when the person goes to bed and tries to sleep. Then the officials become able to force their disruptive messages to the surface. Do people even then acknowledge that something has gone badly awry? No; they will still attempt to suppress the signals. Millions of sleeping tablets are taken each year, all to make them deaf to the alarm bells which are ringing within.

Insomnia thus becomes a blanket term to indicate that one of several alarm bells is ringing, the particular bell depending on which official is in distress. By deadening the alarm, the distress is not dealt with. Where sleep is concerned, children should be our teachers. Children only lie awake at night if they are sick, in pain, worried, or frightened. When they tell us so, we know that something must be done to help them deal with their distress. Likewise, we adults should be alerted if we do not sleep easily, regularly and soundly. If we do not, something is wrong.

Dreams

Whilst considering sleep, it is worth mentioning that reports of dreams can play a useful part in diagnosis. However, as with all other symptomatic evidence, it must be kept in proportion and perspective.

The significance given to dreams and their interpretation in some forms of psychotherapy has resulted in making some people over-emphasise their importance, sometimes making them seem something akin to 'dream mad'. In our tradition of medicine, it is not appropriate to get involved in patients' dream experiences. But it can be useful to ask our patients casually, 'Do you dream?' All people dream but many forget the content, unless it happens to be a persistently repetitive dream or a vivid, nightmare dream. Such a dream can signify a message from a particular official. This could be a dream involving predominantly metallic objects, such as planes or cars; or it could be something to do with earth, such as trying to run away from some danger but becoming bogged down in mud; or a dream in which wood always features, such as being lost in a forest; or a dream featuring water and the threat of drowning; or a dream in which fire plays a dominant role, a dream involving heat and the threat of being burnt. Such a dream, oft-repeated, may point specifically towards the element in distress which is causing element-related images to disturb the unconscious mind.

We need to be very cautious, however, not to jump to conclusions. Repetitive dreams involving images of fire do not automatically mean that the patient is a Fire CF. As I pointed out earlier when describing the wise Chinese law of Mother/Child, a sick child can make the mother appear far more distressed than the child itself, and the grandmother can appear more distressed than child or mother. Thus, the repeated appearance of a particular element in a dream can be caused by any CF. Generally speaking, however, when we look at the nature of a persistent dream within the context of all that a patient has told us, we will find that the element involved is usually associated with either the Mother element or the Child.

Appetite and diet

When we ask about appetite and diet, we can receive especially emphatic answers, some of which strike us as incongruous. A thin and lithe person will say, 'Oh dear; I eat far more than is good for me.'

Another, clearly some five stones overweight, will say, 'Oh well, one has to eat. Food doesn't interest me much; I don't enjoy it.' Hardly anyone will say, 'Well, I think I eat pretty normally. I really enjoy my food.' In other words, people tend to claim either that they have an appetite like a horse and eat far too much or that they are not interested in food and scarcely eat at all. What we need to do in diagnosis is to find out precisely what the patient eats and when. So, after the initial response, we will then ask, 'Well then, let's go back to yesterday. What did you have for breakfast?' We will then move on to find out what was eaten throughout the whole day.

When noting down the patient's replies, we should bear in mind the Chinese Clock and the appropriate functioning of relevant officials. When asking about breakfast, for example, a person might say, 'Oh, just a bit of cereal,' or 'Well, I don't bother much with breakfast. Perhaps a piece of toast, but usually a cup of coffee and a cigarette.' At that time of day, the Stomach official responsible for nourishment is ready and waiting to take in from Mother Earth the best we can lay our hands on. It is at its optimum strength to 'rot and ripen' all the goodness which can then be distributed to every cell in the body. Nature ordains that this should be so because, as we expend our physical, mental, and spiritual energy throughout the day, we need the maximum possible amount of resources available within us. Children are our best teachers. When they awake and dress in the morning, they like to gobble down a good breakfast. They want to make sure that they have sufficient energy to function and survive their dashing around all day. No wonder the person setting off with a few cornflakes or just a cup of coffee flags before the morning is over, then comes to us complaining that he does not know why he is always feeling so exhausted.

The need for a good intake of nourishment at the beginning of the day is a lesson which most of us have ignored and forgotten. That ignorance is the cause of a great deal of unnecessary illness. If we start the day with a near-empty tank, we are soon going to run out of fuel and come to a halt. Of course, we do not live by food alone; but we will not function properly for long without it. That is why having a good breakfast is essential, more so than having a substantial meal in the evening a few hours before going to bed. We do not get into our cars in the morning and say, 'Not much petrol. Never mind; I'll get some on the way home tonight before I put the car away in the garage.' If the fuel runs out, we will not get home at all. It is indeed foolish to drive our bodies into the day's business without filling up adequately before we start. We will be relying on residual reserves when it would

be far simpler and better to fill up before we set off, confident that we have a full tank.

As children, we would not have dreamed of missing a good breakfast. In fact, it is often the case that the only reason adults have a decent breakfast is because they, as parents, are expected to provide a good breakfast for their children and are prompted by this to sit down and join them. It is not simply a case of not really wanting the food. When people have a holiday and stay in a hotel, they often find they have no difficulty, in fact, they find enjoyment, in eating everything on the menu. This leads us to suspect that it is not inclination but time which causes people to ignore their need for fuel at the beginning of the day. If a patient tells us that he eats next to nothing for breakfast, we are not surprised to hear that he feels exhausted later in the day, and also that he feels over-pressured in his life generally.

Such a situation leads us to take into account the possibility of deleterious habits affecting the other side of the Chinese Clock. Whilst we should put the fuel in when the Stomach official is at its peak of strength in the early morning, we are apt to put it in when it is at its lowest ebb, in the evening. A pound of steak, a pound of chips, three slices of gateau, four cups of coffee, two glasses of Drambuie, possibly a little snack and a nightcap last thing, is, perhaps, fed in just at a time when the Stomach official is the least ready to deal with it. In this case, we are likely to have a patient who says 'I don't know why, I just don't seem to get a good night's sleep.'

Finding out what the patient eats at each meal will be only a part of the story we need to hear. We need to remain vigilant to make sure that we have the whole story. A conversation about food intake during the examination might go as follows:

'What do you have for breakfast?'
'Well, I usually have a piece of toast, and two cups of coffee.'
'And for lunch?
'Just a sandwich; maybe two if I'm hungry.'
'Do you have anything at all between breakfast and lunch?'
'Oh yes. I have a cup of coffee mid-morning... And a biscuit or two ... Perhaps a piece of cake.'
'What do you have in the evening?'
'Well, that's my main meal of the day. I usually have some meat, sometimes fish, with vegetables and a potato or two. We always have a pudding of some kind. Then a cup of tea or coffee.'
'Do you have anything between lunch and dinner?'

'I always have a cup of tea or coffee in the afternoon. Sometimes, if friends come round, you know, we'll have a bit of cake or some biscuits.'
'After dinner, anything else before going to bed?'
'Well, we usually sit and watch the television, and probably have a few chocolates. My husband often makes us a cup of tea last thing, and we generally have a bit of cake or biscuits with it.'

A detailed account like this can be elicited from a woman who may initially have said that, by and large, she did not care much for food and did not eat very much. We might have believed her if we had only asked about breakfast, lunch and dinner and had added up that she only had a piece of toast, a sandwich, some meat or fish, a potato or two, some vegetables and a pudding. But, when questioning more thoroughly, we find out that during the course of the day, in between meals, she probably consumes a gateau and a half, a pound or two of biscuits, half a box of chocolates, and two or three spoons of sugar in each of her dozen cups of tea or coffee. People generally do not notice the amount they eat until they are taken through a step by step analysis of their daily intake. Then they suddenly realise, 'Gosh! I'm eating three or four pieces of cake a day, and all those biscuits. Oh dear. Then there's those chocolates while I'm watching television.' They are surprised and sometimes find it frightening when they are asked to look back and count it all up.

Not only would this information lead us to ask ourselves why that person needs to keep nibbling away all day to that extent but it also tells us something about their preferred taste. In the above case, biscuits, cake, chocolate and sugar obviously indicate an excessively sweet taste. Another person can have a craving for pickles and sour-tasting food. Another will like to have everything smothered in salt; and yet another will always be eating curries and heavily spiced foods. It is important for us to know not only how much food a patient eats but also about his tastes in food. A taste strongly favoured or rejected by someone can guide us to look at the state of a particular official. If we hear something like, 'No way can I eat anything sweet, never. Hate it,' we know something is wrong. Anyone in good balance will accept and like all five tastes. If one taste is strongly avoided therefore, we know that this is a distress signal. Likewise, if we find an evident craving for a particular taste, 'I love pickled onions; could eat a whole jar in one go' or 'Can't eat anything without lots of salt,' that too indicates imbalance. Once we have established the amount being eaten and know of any strong preferences or dislikes in taste, we can move on to considerations at a different level. In the above case, for

example, we could return to wondering why that person is eating all day long. Is it that she is so empty within herself that she is having to try to fill the emptiness with food? Is food being taken in as substitute for the comfort and solace she is otherwise being denied?

We come to understand that, like sleeping habits, eating habits tell us of distress signals being sent by particular officials. A common problem with many people who are sick is that they put on a lot of weight. It is as if they are trying to mother and comfort themselves by eating. Their friends, seeing them getting fatter, may then say, 'You know, you really ought to lose some weight.' Hence, we may find such people coming to us asking for help with their weight problem. From our point of view, we know that gain and loss of body weight is not just a matter of controlling food intake. We want to know why the body is really putting on weight. It may be over-retention of water, or bad distribution of energy. It may be poor assimilation of food, or inadequate 'rotting and ripening' during digestion. It may be malfunction of the Small Intestine official causing retention of too much impurity, or it may be breakdown of the Colon official causing an accumulation of waste and rubbish. It may be a failure of the planning official inasmuch as the person may have planned to eat properly to produce plenty of energy but cannot then plan what to do with it, so the fuel just sits there unused. It may be a problem with decision-making in that the official responsible has lost the power to judge how much food is enough and hence cannot decide when to stop eating.

We can see, therefore, that a patient can be fat and overweight due to the malfunctioning or breakdown of several different officials. Thus, the greatest disservice that a fat person's friends may do, and that we too may do if we are not mindful of the above, is to recommend losing weight through dieting. Such a person is most likely already suffering from a failure to gain proper nutritional value from what he does eat. If he goes on some strict diet, the underlying problem may become considerably worse. This is why many people weaken and faint when they are on a severe diet; their situation is going from bad to worse.

In our practice, when we treat people who are overweight, we need to listen carefully for specific distress signals from the officials. They tell us what is needed and, when we have met that need, the excess weight disappears, whatever the cause of its previous gain. Likewise, a patient who is badly underweight starts to put it on again, whatever the cause of its previous loss. Nature knows how to restore correct balance. We need to bear in mind that the balance varies from one person to another according to his constitution. That can be determined,

for example, by the stock from which the person comes, the typical build of his parents and family. If the person comes from short, broad, heavily-built stock, he cannot expect to be tall, delicate, and slim. He is going to follow his inherited traits. If the mother is a beanpole, the daughter is probably not going to become very fat.

In the matter of weight and shape, it can sometimes be dangerous for people to be strongly influenced by the fashion of the time. In particular, the sense of natural proportion can be lost in deference to a popular notion that thin is beautiful. A fat tree is as beautiful as a thin tree; neither tries to imitate the other; they are content to be as they are. Although this is how people should regard themselves, far too many, unfortunately, spend their lives trying to be different from what their genetic make-up has already determined they should be. Inevitably they fail, causing themselves unnecessary suffering and bringing upon themselves terrible consequences. Better to be a stone or so over the fashion-recommended weight, be laughing, and good company, rather than be a wraith-like picture of so-called perfection with no energy, filled with misery because of constant dieting and under-nourishment.

In the areas of sleeping and eating, we obtain a large amount of helpful information through asking specific questions, being constantly careful to avoid assumptions and not to jump to conclusions. If it is thought that what has been suggested is obtaining detailed information to an absurd degree, then let it be understood that, if the patient's main complaint is something to do with sleep or appetite, we would, if necessary, go to ten or a hundred times this extent of detail to discover what help the patient needs. In the process, we become secure in the knowledge that every single reply, and every single observation of change in colour, sound, odour, and emotion, tells us more and more clearly and accurately who the patient is, where his problems lie and what we need to do. We ask all these questions because it is our duty to understand the patient as fully as possible so that we can assist Nature to correct the imbalances we find.

Bowels

Having covered the patient's habits of sleep and appetite in detail, we now need to learn about other rhythms and appetites in his life. These include the functions of elimination, menstrual periods in women, intake of fluids, and whether the patient smokes. All of these factors contribute to the overall pattern of movement into, within and out of

the patient's body, mind, and spirit. The same twofold purpose lies behind our questioning. We need to know how the officials involved or affected are coping and then establish the bench-marks against which we can monitor the effects of our treatment.

First, we will ask about the patient's bowel functioning. As usual, we need to be careful how we formulate our questions. 'Do your bowels move regularly?' begs a yes or no answer. If the patient answers, 'Yes,' we learn next to nothing; even worse, we might make the assumption that all is well when in fact it is not. The patient may regard once every ten days as 'regular', not what we meant by the term. To make sure we are not misled, a question such as 'Do your bowels open regularly every day?' is useful, followed by 'At what time?'

A problem which practitioners can find with this subject is that for many patients defecation in the privacy of the toilet is such an extremely personal function that they are reluctant to talk about it. It does not matter that they really know that everyone defecates, from the most humble to the most important, from the poorest to the richest. The English, in particular, are prone to reticence over such matters. It can be a problem for practitioners as well as patients, and embarrassment can needlessly arise during the consultation if the questioning is not dealt with objectively to gain the vital information which we need.

Through asking about regularity of bowel function, we are making a direct enquiry about certain officials and we may, perhaps, find ourselves homing straight in towards the CF. The answers we receive will demonstrate a wide variety of conditions. 'I go regularly these days. But I often used to be constipated. Had trouble for years and years.' 'I always used to be very regular. But these last two or three years I've been having a real problem with constipation.' 'No, I don't go every day; probably every other day.' 'I've been having diarrhoea quite a lot lately and am really getting quite worried about it.' Eventually, patients overcome any initial embarrassment and are willing to tell us in detail as much as we need to know, especially when they appreciate that we are not asking out of mere curiosity but are taking the matter very seriously. We are, in fact, getting direct information from the Colon official, the official responsible for drainage and the carrying away of impurities. If this official is hypoactive, it may be that the waste cannot be properly ejected, thus giving rise to constipation. If the official is hyperactive, it may be that the waste is eliminated four or five times a day and the person is suffering from diarrhoea.

Consideration of bowel rhythm leads us to another aspect of Traditional Diagnosis which becomes more important later when, during treatment, we can begin to advise patients on how best to assist the officials in their work. Poisons and toxins must be regularly and effectively eliminated from the body and the Colon official performs this function best between five and seven o'clock in the morning. People suffering with persistent constipation often end up taking repeated doses of laxative which, in the long term, do them no good at all. With a little education during treatment, it is far better that patients learn to respect natural law by making the effort to go to the toilet when the official is at optimum strength, thereby clearing themselves out without using laxatives. We may not advise this course of action early on because, in order to be sure of clear feedback from initial treatment, we may want to minimise the number of areas in which we are looking for change in the patient. But, as treatment progresses, it should be possible, if we have found a problem with elimination, to educate the patient to such good effect that one month after following the advice his bowels will be functioning properly.

Waterworks

After dealing with evacuation of the bowels, we come to evacuation of the bladder. We might ask the patient, 'How are your waterworks?' We use this informal term instead of a technical one, not only because it seems less daunting to the patient but also because it tends to attract a wider range of response. The most likely immediate answer will be 'O.K.,' 'Fine,' 'Not too bad,' 'No problem.' So, again, we need to question further. We often find that patients have never given much attention to the matter. If we ask how many times a day they urinate, we may get an answer, 'You know, I've never counted. This is probably the first time in my life I've even thought about it.' It is certainly not an issue that is likely to crop up in everyday conversation. Furthermore, it is not something which people consider of any importance. However, by giving the matter some thought, it is usually possible to work out a rough calculation of the number of times per day. We can find considerable differences between one patient and another where reports of average or 'normal' frequency are concerned. Then, we have to make allowance for size of bladder. Three visits of good volume by one person can be the equivalent of eight visits of lesser volume by another. Our questioning on the matter of urination, therefore, needs to press for accurate reports of both frequency and volume.

These questions are only the first of many we ask in order to obtain a clear view of the state of the associated officials. When the patient feels the need to urinate, must he rush to the toilet very quickly, indicating that he cannot hold the urine and may have poor bladder control? When he urinates, does the flow come freely and easily? If the patient is a man, we may ask if the force of the flow is such that he has to be careful not to splash it all over floor and shoes, or does he usually have to stand there and wait, and wait, for the urine to emerge? When it flows, does it then just dribble out? We also need to find out if the patient experiences any burning sensations, irritation, or soreness. Such questions may prompt a reply such as, 'Oh, now you mention it, I do get recurring cystitis. I've had it about four times over the past couple of years.' Such a reply would prompt us to ask whether it is painful when the patient passes water, or whether it is painful afterwards, or whether there is a degree of pain most of the time. Any feature of the patient's experience in respect to urination which we regard as a divergence from what would broadly be considered normal will be a signal indicating that something is wrong with the officials concerned. They are telling us that there is an imbalance in the person's energy which needs attention and correction.

By the time we ask about the patient's waterworks, we may begin to find occasion, through reference to earlier questioning, to cross-question the patient. Having noted previously, whilst asking about sleeping habits, that the patient regularly wakes up a couple of times during the night, we are prompted to ask whether he gets up to urinate. 'Oh yes, that's what happens. Perhaps that's what wakes me up? I always have to go once during the night, sometimes twice.' If the patient has been doing this for so long that it has become a habit, he will, most likely, think of it as a normal thing to do, even that it is something most people do. The fact is that it is not normal. Being 'normal' for this person, they forget that it happens and do not think to mention it. The capacity of people to assume that their habits are commonplace may lead us to believe at the start of this person's diagnosis that he always goes straight off to sleep and has a good eight hours' rest. If later questioning produces answers which link up with, and are at variance with, earlier information, we need to go back and re-check so that we make certain we have the full, accurate, and consistent account. We need to be alert for possible omissions, discrepancies, and contradictions as the questioning proceeds. The force and familiarity of habits causes patients to overlook irregularities and anomalies which we might imagine would be impossible for them to be unaware of or to ignore.

One comment which we are likely to hear quite often is, 'Well, of course, as you get older,' usually used as an excuse to account for or to dismiss as acceptable something which is not as it used to be. This statement is rubbish and should be immediately discounted. The body should function as Nature ordained nearly as efficiently when older as when it was younger, with slight adjustment for wear and tear. There will, of course, be certain degrees of limitation; but, in principle, there is nothing we cannot do when older that we were able to do when younger. The only difference is that the function takes a little longer to accomplish its purpose. If a person is reasonably healthy in body, mind, and spirit, there is no natural reason why his sleep should be disturbed by the apparent necessity to get up in the middle of the night in order to urinate. If he does, then it is a warning sign from the officials that something is wrong and needs attention.

Fluid intake

We can only really tell what someone's daily volume of urine should be when we know the extent of his fluid intake. If a patient tells us that he gets up every night to go to the toilet, we do not think that particularly significant if he also tells us that he usually drinks ten pints of beer every evening. Unless this patient has a cast iron bladder, there is no way he is going to be able to hold the amount of fluid he has drunk all night. Therefore, we need to find out exactly what the patient's fluid intake is, especially if we suspect that there may be problems in this area. We want to know exactly how many cups of coffee or tea, how many pints or glasses of beer, water or any other liquid, are usually drunk during the average day.

We must remember to ask specific questions to obtain the degree and accuracy of detail we need. If we just ask, 'What do you drink in the morning?', the patient might say, 'Oh, just a cup of tea,' when that is not accurate. If, instead, we ask, 'When do you have your first cup of tea?', we may get a reply, 'Well, my husband generally brings me a pot of tea first thing in the morning.' And then? 'I get up and go down to the kitchen. I usually have a cup or two of coffee with the family while they are having their breakfast. And perhaps a glass of fruit juice.' Is that it? 'Well, I'll probably finish off the coffee pot while I'm clearing away and washing up.' With this detailed information, we may find that the amount of liquid intake is actually at least three times what we were first told. In addition, we may discover that she is talking about mugs, not cups.

Moving on, we then find that it is not really one cup of liquid at mid-morning, not one cup at lunchtime, not one after lunch, not one mid-afternoon, and not one drink while cooking the evening meal, not just one glass during the meal, not just one glass during the evening. It may come as a surprise to the patient to realise just how much he is drinking daily. Both patient and practitioner may end up wondering where on earth all that liquid goes.

When we have full information about liquid intake, we can compare that volume with how much urine is passed per day to see if it is similar. If the intake is clearly excessive, we probably advise the patient to reduce it, especially if we find symptoms indicating that the body is failing to deal properly with the total volume. The patient may be aware that he is drinking a great deal of tea or coffee. What he does not take into account is that he is also drinking three or four pints of beer, two or three glasses of fruit juice, wine, water, half a pint of milk, and other liquids. When adding everything together, we may be talking about a gallon or more of liquid, which is far too much.

There will also be patients at the other extreme, 'Well, I usually have a glass of milk at breakfast. Don't like it much, and I don't like tea or coffee. I don't drink alcohol. Might have the odd glass of water or fruit juice.' Poor fluid intake is as bad as excess because not drinking enough liquid will mean that the lymphatic and fluid-processing systems will not be able to function properly. As a consequence, a patient is likely to show signs of dehydration and fluid deprivation, irregular and poor menstrual flow, anaemia, wasting (from lack of blood volume), and an accumulation of toxins (because they are not washed away).

Alcohol

Asking about fluid intake inevitably reveals whether the patient drinks alcohol or not. With those who do, we need to know how much. That can prove a problem area of enquiry because many people drink more than they know they should and will be reluctant to admit that fact. When they do so, we find a wide variety of reasons and excuses.

The incidence of alcoholism in the U.K. is growing at an alarming rate. Amongst young people, in particular, the increase over the past five years has been frightening. People drink to excess to give themselves solace and comfort; to escape from responsibility, boredom, frustration, worry; to ease fear, pain of loss, grief, despair, loneliness, lack of

love, bitterness, and resentment. We find that patients, because they have a deep-seated concern about what they are doing and fear alcoholism and the social disapproval it invites, are often inclined to conceal the extent of their drinking or tell us downright lies about it.

'Do you drink any alcohol?', we ask. 'Well, I have an occasional sherry,' or 'I usually have a glass or two of wine with my evening meal', or 'I have a pint or two in the pub at lunchtime,' or 'Just the odd whisky if we have friends in.' These are common, ordinary responses. Sometimes the puritan says, 'Hate the stuff!' A simple 'No' is quite sufficient. When we meet this vehement reaction, we are likely to be dealing with a sanctimonious and judgemental person who not only does not drink but thinks that no one else should either. He may be in no danger of becoming alcoholic but his reaction tells us something significant about him, possibly a distress signal of another kind. Even if we do not like drinking alcohol ourselves, that certainly does not give us licence to express hostility and disapproval towards those who do so in moderation.

We are alerted to the possibility of concealment and lying when we hear patients introducing excuses, 'I really do need a couple of whiskies to help me relax when I come home in the evening. Lot of pressure at work these days. Endless business meetings, all sorts of financial and staff problems. You know what I mean.' When we hear justification of this nature, it is worth probing further, 'Do you drink at these meetings, or perhaps afterwards? And with lunch?' 'Oh yes, sometimes a martini or two before lunch. And a bottle of wine with lunch if we have clients. Depends who's around.' 'Anything else? After work, say?' 'Sometimes have a whisky or a gin before we call it a day.' 'And is that it?' After calling in at the club, wine with dinner and a double brandy before going to bed, we find that the patient has been drinking on and off most of the day and evening, including at least half a bottle of whisky rather than the couple of tots he first told us about. Furthermore, this is someone who has come to us complaining of migraines and stomach disorders, saying he cannot understand why he has them!

People tend not to calculate and admit to themselves how much they drink. It is only in a situation such as our diagnosis that they are asked to do so. Although our enquiry is as objective and methodical as when we ask about sleeping and eating habits, when we come to the area of alcohol intake we will often find patients who drink to excess avoid admitting it to us and themselves. As they begin to trust us and realise that we are not going to make judgments or be satisfied with lies, they

are relieved to be honest. They are able to admit to themselves, as well as to us, that they are drinking to escape responsibility, trying to cope with pressure, and that the situation has become badly imbalanced.

There are other details about people's drinking habits which may give us useful information pointing towards the CF. Alcohol differs in type and potency, and particularly in taste. A person who goes for 'fire-waters' like whisky and brandy is looking for something different from the person who habitually drinks gin, beer, campari, champagne, wine, and advocaat. Going into such detail may turn up a signal which tunes us in directly to a particular official in distress.

Smoking

We have seen how careful we have to be with people who drink a great deal of alcohol, since they do not always realise or want to confirm how serious their habit has become. The same applies with heavy smokers.

We may ask, 'Do you smoke?' As with censorious non-drinkers we will sometimes get the answer, 'No, of course not. Never have, never will. Horrible habit,' rather than a simple, 'No, I don't,' which is all the question requires as an answer. I mention such over-reaction again because, whilst we may see significance in the patient's implied criticism, their sanctimoniousness or smugness, and their lack of tolerance and compassion, we need to watch also for similar attitudes in ourselves. Drinkers and smokers are most likely to provoke disapproval and condemnation within us, and this is something we must resist and eliminate at all costs. Drinking and smoking are, in effect, forms of dummy; people rely on them to provide a releasing and calming influence. Even if we totally disapprove of such habits, we have to learn to be tolerant and accept the situation if we are going to help the patient restore the balance which will make such habits unnecessary. Humility is the essential prerequisite of compassion and good practice; none of us are perfect saints.

Smokers never really count how many cigarettes they smoke. When we ask how many, they will reply in round numbers, like ten, twenty, and thirty. But there is not a smoker on the face of this earth who smokes exactly such a convenient number each day. So, when we press for accuracy and say, 'So, if you smoke twenty a day, you just buy a packet in the morning and then don't buy any more until the following morning', the reply is likely to be, 'Well, usually. Sometimes,

when I go out for a drink with the lads, or we've got friends coming round for the evening, I'll probably buy another packet after work.' Now we are probably talking about an average of at least twenty-five rather than twenty. When we press even further, we begin to suspect thirty, or perhaps even forty, because it turns out that the person often buys two packets at a time and ends up not being sure whether one left in the packet means that he has smoked nineteen or thirty-nine that day.

Generally speaking, the heavier the smoker the more he loses track. The only ones likely to be accurate are those who smoke ten or less a day. If a patient says, 'I smoke eight cigarettes a day,' we can rely on that being true, though we might wonder what might be inferred from such meticulous precision. It is the ones who glibly say, 'About a packet a day', whom we need to question further, and the ones who are apparently being more honest, 'Oh, it can be forty a day. I wish I could stop.' The truth is that the person does not want to stop enough and that he is probably smoking nearer sixty.

If we think the patient is concealing or lying, we must explore until we are satisfied we have the truth. We are not interrogating in order to make the patient feel guilty and sinful; we need him to own up to himself, to realise what he is really doing. Since the problem is usually a reluctance to count accurately, an effective approach can be to say, 'Look, what I would like you to do when you get up each morning is to open a brand new packet, no matter how many cigarettes there are left in yesterday's packet. Stay with that packet all day, and see how many are left when you go to bed. If you start a second packet, the same applies. I want you to know exactly how many you smoke each day. Then tell me next time you come.' When the patient consciously realises just how many the real number is, he may start reducing of his own accord. Certainly he will not be deceiving himself any more and be more inclined to seek help.

Smokers will often ask how dangerous smoking really is, and whether by smoking they will undermine the effect of treatment. I think many people undoubtedly get a great deal of pleasure out of smoking in moderation. I would not wish to imply for one moment in saying this that a non-smoker is being deprived of something essential any more than I would suggest that a teetotaller is being deprived of an essential pleasure through not drinking. The problem comes with attempt to define moderation.

The body can probably handle one or two cigarettes a day with no

difficulty. Where moderation is concerned, we have to take into account not just the number being smoked but also their strength. Ten full-tar, full-strength, unfiltered cigarettes are equivalent to a considerably larger number of low-tar, mild, filtered ones. One way to move towards moderation therefore is to advise the heavy smoker of strong brands to change to brands with reduced levels of nicotine and tar, saying that even if he continues to smoke the same number, he will be effectively cutting down. Ten very mild cigarettes are about the equivalent of three strong ones. So, even if he smokes the same number, the resultant seventy percent reduction in strength brings the tar and nicotine levels down to a level which the body will be able to handle more easily. The eventual ideal, of course, is that the patient will stop smoking altogether, but that is not something we should try to force, especially as an isolated issue. It is far better to see it as a feature in the overall picture of the patient's state of body, mind, and spirit. In the course of treatment, balances are naturally restored and habits will moderate accordingly.

We have now asked the patient about six important areas of his everyday life, and we have recorded answers to these enquiries on the patient's preface sheet. When we have been treating the patient for a while, we return to these subjects and ask about them again so that we can compare updated answers with those we obtained originally. When we enquire again about sleep, appetite, bowels, waterworks, fluid intake and smoking, we are looking to see whether irregularities, abnormalities and excesses are beginning to disappear and whether functions are stabilizing to what we consider near-normal. We take this improvement as positive signs that body, mind, and spirit are once again functioning as Nature ordained.

Perspiration

There are other matters about which we must ask specific questions. Perspiration is one. This can be embarrassing for some patients to answer. One reason for this is that some people do not like to think that they sweat. They do not realise that sweating is not only natural but essential. As much poison, toxicity and waste matter can be excreted through the sweat glands as through bladder or bowels. Sadly, too many people put pore-blocking deodorants on themselves, thus suppressing the efficiency of a natural function which promotes health in body, mind, and spirit. Small wonder that the blocking of sweating promotes abscesses, boils, carbuncles, constipation, blood disorders, and headaches. By preventing the sweat glands from

carrying out their natural excretory function, the body retains an unhealthy excess of toxins and rubbish.

We know that some patients are loath to talk about perspiration and are often unsure in what terms to describe their experience of it. We ask, 'Do you perspire normally, excessively or hardly at all?' Usually, on reflection, people are aware if they fall into the second or third category. Frequently during the course of treatment we also hear from the patients who claimed to sweat hardly at all that they are beginning to sweat more, whilst the ones who claimed to sweat excessively may find they do so to a lesser extent. In both cases, we have a positive sign of improvement, the importance of which should not be underrated. Since we are seeking to cleanse from the inside, our efforts will be defeated if the system responsible for excreting the toxins and rubbish is not functioning properly, especially if it is a case of blockage and the rubbish stays trapped and continually circulating.

Menstrual cycle

Another major area we need to know about from our female patients is the menstrual cycle. It is a pity that men do not have a menstrual cycle as well, because a woman's account of her experience of her periods is really one of the best ways of finding out about the state of the officials. It makes diagnosis of a woman's situation easier than that of a man because of the amount of important information which this physical rhythm provides.

We need to take into account popular misconceptions about periods so that we may establish in our own minds what should be considered normal. In looking at ancient and modern texts on the subject, we find that menstruation is often regarded negatively and is even called 'the curse'. So it may aptly be called by those women who, during their periods, suffer excruciating, cramping pains, and also feel exceedingly edgy or depressed, uptight, irritable, and generally so rotten that they cannot but curse its recurring effects. For what can make the curse especially invasive, dramatic, and debilitating is that it does not just happen once; it happens every month, month in and month out for many years. Those women who have what are called 'painful' periods find that the cycle governs their entire lives. 'Oh no, I'm afraid I can't do that, I'll be having my period that week' or 'No, we can't go on holiday until the beginning of July. I know I won't feel like it the last week in June.' They know that their suffering will be so severe at a certain time of the month that they have to plan and arrange their lives

year in and year out as best they can to avoid doing anything special or important at that time.

We really do need to work towards getting menstruation back into its natural and proper state. It is the most natural of all functions and should, therefore, occur without any physical or mental pain or discomfort. During their period women should not feel depressed, irritable, ten degrees under or anything else untoward. There should not be any associated physical pain. The trouble is that women have been conditioned for so long to expect to suffer at this time that they believe it and assume it to be normal. Furthermore, it is even more unfortunate that many people in health-care professions share the same belief. As a result, suffering during menstruation has come to be accepted as an unfortunate fact of life when it should be seen, just as clearly as any other unnatural sign, as a signal telling us that something is wrong.

When asking women patients about their periods, therefore, we need to keep this fundamental principle clearly in view. When enquiring whether periods are regular, we mean quite explicitly that they should be recurring every twenty-eight days. Using this criterion, we will find that many patients do not have regular periods. Every thirty-two days, for example, is not what we mean by regular. Regular means twenty-eight; anything more or less, no matter how consistent the duration of the cycle, is not normal. We may hear a patient say, 'Exactly twenty-eight? to the day?', as if to protest, 'What does it matter if it is twenty-nine?' The answer is that it does matter. The nearer to perfect health in body, mind, and spirit the woman is, the nearer her menstrual cycle will be to precisely twenty-eight days. Nobody is, however, likely to be as perfect as that. Periods will often be found to fall one day early or one day late. This is indicative of the price that women unfortunately pay for the common stresses and difficulties which disrupt harmonious living in the modern world, diverting them from living in accordance with the Dao. As a general rule, the greater the violation of the natural laws of body, mind, and spirit, the more likely that periods will be irregular and painful.

In addition to the length of the cycle, we also need to know about evenness of flow and loss of blood. Does the patient flood so badly during the first day that she wonders if there is any blood left in her? Does she just spot a little for four days, or five, or six, before any substantial show? Does she continue to menstruate like this for seven days, or even longer, so that she begins to wonder if the period has really started or if it is ever going to end? Does she flood profusely for

two days and then stop? During those first two days, does she become so exhausted that she almost has to go to bed to rest? Does she spot for a while, then stop, then start again, then stop again, so that she never really knows what is happening? The flow is so spasmodic over such a protracted period that she hardly knows whether she is having a period or not. All such specific information serves, as usual, our two-fold purpose, to establish a reference point against which to monitor changes as treatment progresses as well as significant evidence to help us to establish particular officials in distress.

When we have asked fully about menstruation with our female patients, we have completed all the set questions on the preface sheet. That does not mean that there is nothing else left to ask, that there is nothing else we need to know about the patient's life. There are, of course, other important areas which we will come to as and when they are relevant with a particular patient. We will be guided towards them according to what the patient clearly indicates as being important factors in his life, particular experiences during childhood, at school, at work, with influential friends, sexual partners, and so on. We will notice that these items are important to know about and we will want to look at them as closely as possible, especially when the patient has gained sufficient confidence in us to tell us about his most private and intimate thoughts and concerns. We might find, for example, that there are particularly important matters on the patient's mind which he wants to spend a lot of time talking about: his marital situation, a terrible childhood experience, a sexual or parental difficulty. The particular area which he chooses to talk about does not matter. We encourage him to express his concerns so that we may see and hear how the underlying officials are being affected and are manifesting their distress.

It is important to emphasise again that what I am describing here is our special method of diagnosis. The list of subject areas and the set questions we should ask are designed to provide an initial framework or structure. Once the practitioner has grasped the underlying principles involved, <u>everything</u> the patient says and does, <u>everything</u> the practitioner sees, hears, feels, and asks becomes potentially relevant and important. Diagnosis is an adventure and exploration with a thousand possible courses and a thousand different endings. If I achieve nothing else in this book, I want to convey the sense of excitement and respect with which we approach every single patient, knowing that we may discover the real cause of his sickness, knowing that we have the skills and methods to fulfil our role as Nature's instrument of healing.

Climate, season, colour and Chinese Clock

A further set of questions we may ask concerns the patient's preferences for and dislikes of particular climatic conditions, seasons, and colours. We need to know the times of day when he feels decidedly better or worse. These may seem to be simple matters, but they sometimes produce responses which speak volumes about elemental balance within the person.

We notice, for instance, a person's excessive dread of winter or the excessive love of summer in someone who cannot get enough heat; or a person wearing a thin jumper in icy February and expressing a hatred of damp and humid weather; or a person who loves spring and becomes depressed when autumn comes. We notice when we see a patient always wears the same colour or colours, that he says that he always has a car of a certain colour; or that he likes flowers of a certain colour; or decorates his rooms a certain colour. We notice if someone says that he prefers the early morning and finds it hard going in the middle of the afternoon; or that someone is only at his best late in the evening and does not go to bed until the early hours of the morning.

All details can be important signals because, as we know from the correspondences of the elements and the Chinese Clock, there are various natural rhythms and tides in our lives. If the elements are in balance and harmony, there will be enjoyment and contentment in the progression of all seasons and their climates, in all the succeeding qualities of the day, all being appreciated for their inherent properties and gifts. Likewise, the colours which we wear and with which we surround ourselves will happily display the same riot of colours with which Nature blesses the world around us, all being appreciated for the special quality each reflects. We have within us the capacity to enjoy the quality and richness of all the qualities and phases. If there is failure to flow with the natural variety and rhythm, and thus strong preferences and dislikes emerge, then we will surely be seeing signs of imbalance and hearing direct messages of distress from the officials.

Prescribed drugs

Finally, I need to mention drugs, both the medical drugs prescribed by doctors and the non-prescribed variety. I prefer not to call the latter 'recreational', as some people do, because the purposes for which they are commonly used are far removed from what most of us regard as recreational. It is an insult to borrow the word and use it in association

with such drugs as heroin and cocaine.

Many of the drugs prescribed by doctors and dispensed by pharmacists can, if properly used, save lives. They can also help disabled people live near-normal lives, an achievement which, without drugs, would otherwise be impossible. As I acknowledged in Chapter One, we owe an enormous respect to the research and initiative of Western medicine which has restored life and hope to people who would otherwise be crippled or dead.

We should not lose sight of the fact that traditional Chinese medicine is primarily a way of maintaining health and preventing disease. In ancient China, people went to traditional doctors as a matter of course at the change of every season. They went for a diagnosis to check whether any official within them had started to deviate from normal since their previous visit. If a deviation was found, it could be corrected. Thus, any disease could be prevented from developing. If a person failed to go to the doctor at the change of season and then fell sick, the responsibility for his illness was his own. But if he made seasonal visits regularly and then fell ill, the doctor was responsible for failing to keep him healthy. He then treated him free of charge until he was well again. This is a far cry from what happens today where people wait until they are ill before seeking help.

People often look after their cars better than they look after themselves. At the first knock, rattle, or squeak, the car goes straight to the garage and money is spent putting it right. The owner does not wait until it breaks down. Personal attitudes are frequently different towards ones own body, mind, and spirit. Never mind the distress signals, press on. Only when something serious eventually develops will the individual go to his doctor and say, 'Something's wrong with me. Please put it right.'

Until recently, most patients coming to traditional practitioners have been doing so as a last resort. They probably have tried all other means to obtain medical help and come to us as a last hope. Consequently, we often find that our patients have been suffering degrees of illness and disease for a long time, perhaps as long as twenty or thirty years. This is a sad and unfortunate state of affairs because it means that we are continually being asked to apply our traditional practice at the wrong end of the process. Our treatment still works, of course; but it would be far more satisfactory and rewarding to be working at the proper end of the time frame, preventing the development of disease rather than having to disperse it after it is already well established.

We commonly find that our patients are or have been on a variety of drugs. We need to know in minute detail what drugs they are or have been taking, and the strength and frequency of the doses. We need to do this because we are likely to face the problem that there may be a secondary group of symptoms which have arisen from the extended use of prescribed drugs. These have become superimposed on those caused by the CF. That means that we see both the symptoms of the underlying disease and the symptoms brought on by continual intake of drugs. A large proportion of modern drugs will, for example, damage the Wood element. Their toxicity has primarily to be dealt with by the filtering and cleansing function of the liver and, after prolonged use of drugs, the organ is likely to be in a devastated state. This damage will then produce symptoms from the Liver, or the child of the Liver on the Sheng cycle, which have nothing to do with the original disease. This is especially likely with cortisone-based products, which can also cause damage to the kidneys. Similarly, many stomach malfunctions and ulcers are drug-induced and have nothing to do with the CF. Our additional task, therefore will be to establish which effects are due to the CF and which to the drugs, a situation made more complicated by the fact that drug-induced symptoms are often worse and more prominent than those arising from the underlying disease.

Finding this out may not be too difficult with drugs for which adequate pharmacological information is available and with which practitioners are familiar. But there is now an increasing number of drugs which have not been fully tested and whose side-effects, especially long term, are not properly understood and, therefore, not warned about. For example, I was tempted to mention in the section on menstruation that many menstrual problems are caused or worsened by contraceptive pills, particularly where their effect on hormones is concerned. Present knowledge about the very important, intricate, and delicately-balanced mechanisms of the hormonal system is still very limited. Endorphins, natural chemicals which suppress pain, were only discovered in recent years and they have already prompted a complete reassessment of what we thought we knew before in this area.

If the body, mind, and spirit have been subjected to drugs whose total effect is not fully understood, our diagnosis becomes considerably more complicated and difficult. We are constantly having to ask ourselves which symptoms, and particularly which correspondences, arise from the patient's use of drugs and which from the underlying Causative Factor. Even if the drugs have done no physical damage,

officials whose functions have been supported or taken over by drugs may fail to respond properly when they are given their work back again, as the drugs are withdrawn. Many women, for example, who have been put on the pill to regulate their menstruation find themselves with worse problems when they stop taking it. Therefore, we may have to cope with problems arising from the introduction of drugs intended to relieve other problems.

In our system of medicine, we will not regard anyone as better until he stops depending on drugs. No practitioner is authorised to suggest a patient withdraws from prescribed drugs until he has completed advanced training and has been practising for several years. Some drug therapies are essential to the maintenance of a person's life, such as insulin for diabetes. Cortisone and other steroids are so much a part of a person's artificially-regulated balance that the effects of too rapid a withdrawal could prove too much for his heart or kidneys to withstand.

This is a well-recognised danger in Western medical practice. Most hormone secretion is controlled by negative-feedback loops, where the body adjusts its hormone levels by assessing how much is already present in the blood and lymph. If artificial drugs are supplied to make up for some hormone deficiency, the body's own glands stop receiving signals to produce necessary amounts themselves. This suppressing effect can sometimes reach the point where gland tissue atrophies and secretion ceases totally. If the situation has gone this far, there is nothing we can do to remedy it; but if we are able to start treatment before such an extreme condition has been reached, we can certainly help restore appropriate production of cortisone, thyroxine, insulin and so on, so that the drug substitutes can be gradually withdrawn. Needless to say, this has to be done with great caution and care, and only by experienced practitioners.

There are some drugs, however, which can and should be dispensed with as soon as possible, with no danger, such as some of the pain-killers and sleeping tablets. Both can all too easily be taken habitually. A doctor may initially prescribe a moderate amount of a pain-killing drug. The trouble is that if the patient then complains of continuing pain, the dosage is simply increased again and again, until the pain is truly suppressed. The trouble is further compounded by the fact that the body gradually becomes accustomed to the level of intake. To maintain the pain-killing effect, therefore, it becomes necessary either to increase the dosage once more or move on to a more powerful drug.

Patients are usually very obedient to medical instructions, and this can prove troublesome for careful doctors who want to keep their patients' drug intake to a minimum. Even when the pain has receded and is no longer experienced, patients still keep taking their two tablets four times a day because that is what it says on the bottle. They think they are pain-free due to the drug. Since they dare not go for a day without taking the drug as instructed, they do not, in fact, know whether the pain-inducing problem is still there. From our point of view, the first thing we can safely say to a patient on a pain-killing drug regime is, 'Forget about having to take fixed amounts every day. Just take a tablet when you really feel you need it. Only take a second if the pain starts to become uncomfortable.' Hence, instead of waking up and thinking immediately, 'Must take my tablets. The pain will start if I don't,' the patient starts to regain some measure of self-control. He may soon realise that it is possible to reduce the amount of drug ingested, and eventually stop taking it altogether. Instead of abusing the body by taking more than necessary, the majority of patients find that they can soon reduce their intake of pain-killers by a good fifty percent simply by following the instruction to take them only when they are actually needed. There is no danger in this self-discipline because most people prefer to take the drug if they do have pain. But the discipline will eliminate the quite unnecessary 'just-in-case' tablets.

We can use our influence during diagnosis to modify the patient's pain-killing drug habits. The same influence should be brought to bear where sleeping tablets are concerned. Once taking them has become a habit, it can become difficult to break. It requires an effort which many people are not prepared to make voluntarily. There are times when people do, understandably, need to take sleeping tablets, times of great worry, tension, and distress. If people continually fail to get a single good night's sleep, they can start to feel as if they are going crazy. In that situation, sleeping tablets provide essential relief. Far too many people, however, start to take tablets to make sure of a few good nights of rest and then a year later find that they are on their twelfth repeat prescription. Furthermore, a good number of those will still be taking tablets five years from the time when they really needed them.

We can do our best to persuade patients to stop relying on sleeping tablets, but it does not always work. 'Why not have a hot drink when you go to bed, perhaps milk with some molasses in it ? See if you can do without the tablets.' But the patient lies there in bed, sleeping tablets on the bedside table, thinking, 'I mustn't. I'll try. I ought not

to. It's getting late. Should I? Just this once. No, I shouldn't. I can't stand it. I think I'll have to. Yes, I will.' On the other hand, there are those who really do want to break the habit and, when they realise that their practitioner is someone whom they can trust and who really cares about them, they will respond to advice. 'Look, what I would like you to do is see if you can manage just this week without a tablet. I expect you will have a couple of rough nights and may feel awful the following days. But it's really going to be worthwhile if you can go through with it.' More often than not, these patients will come back at the end of that week and say, 'It was fine. No trouble at all. I don't need the tablets any more.' Whatever the attitude and response of those patients taking sleeping tablets regularly, we will find that they are widely differing. Reducing and eventually removing the need for artificial sleep inducement is something we will aim to do as soon as possible.

Non-prescribed drugs

Given the strictures about drugs that are largely unnecessary, the same applies, with far greater emphasis, where totally unnecessary drugs are concerned. As I mentioned earlier, I have strong feelings about so-called 'recreational' drugs because I have often seen the terrible toll such drugs have on people. No patient should be allowed to think that he can safely take any form of non-prescribed drug, not even the so-called 'soft' ones. It is possible to tell immediately from someone's pulses if he has been taking marijuana. Its potential to create havoc is so great that it will cause greater imbalances than drinking half a bottle of whisky and smoking thirty cigarettes a day. This comes as something of a shock to people who argue that marijuana is less harmful than drinking alcohol.

If we have a patient who takes drugs, we need to know what kind, how much and how often. We must try to discover why they are being taken, just as we look for the reason behind a person's drinking heavily. No one reasonably healthy in body, mind, and spirit would touch drugs knowing the irreversible damage they can do to the officials. If the person is seeking beautiful experiences, or God, or Nirvana, we need to know why his officials are preventing him finding it through his own natural powers in the beautiful and bounteous world in which he lives.

Substance abuse is getting worse and the number of people suffering from drug dependency looking to acupuncture for help is increasing

all the time. Different drugs have detrimental effect on different elements; and different CF's predispose particular patients towards certain drugs. The great value of acupuncture is that it provides not only the means to find out what the person needs and what he is looking for the drugs to provide, but also, by providing for that need, the means to help reduce dependency on the drugs. Appropriate treatment ensures that giving up the drugs becomes no more difficult than giving up a habit such as smoking.

Drug-taking then, whether prescribed or non-prescribed, is a problem that we are increasingly likely to encounter. Diagnosis will thus involve not just finding out about the extent of the abuse but also giving advice to addicted patients in order for treatment to have the maximum beneficial effect. We must never become so used to encountering cases of drug-taking that we begin to underrate the enormous amount of damage that any drug can cause to body, mind, and spirit. The tragedy of the habit must never be taken less seriously because we hear about it so frequently.

By this stage in the diagnostic procedure we will have accumulated an enormous amount of information about the patient, through observation, asking questions, listening, and feeling. We now ask the patient to lie on the treatment couch so that we can read the story the body tells.

CHAPTER FIVE

THE PHYSICAL EXAMINATION

'There is no such thing as a physical examination...'

For the majority of patients, the physical examination will be a more familiar procedure, something they will have anticipated. Most people come to us with a physical problem and many of them may wonder why we spend so much time asking so many questions about other matters. They probably expect that we will only be concerned with the presenting complaint, especially when there are obvious physical symptoms. Given their past experience with Western medicine, they assume that we will be giving immediate attention to those symptoms. It may, therefore, be disconcerting to find themselves being asked about parents, brothers and sisters, eating habits, bowel function, and so on. When we now ask them to undress and lie on the couch, they frequently think, 'Ah, at last; now we are going to get on with the reason why I came here.'

Although the patient may assume that it is the physical examination which is really important, we practitioners always need to bear in mind that there is no such thing as just a physical examination. When we examine the state of the body, we are also reading the state of the mind and spirit. At first, this can be a difficult notion for some students to grasp and it may take some time before they fully understand it. There is absolutely nothing about the patient which does not tell us something about the state of the officials within, whether it be what the patient says, what he does, what he wears, or what he eats and drinks. If an official is in distress, the signs of that distress are going to be manifest at some level in whatever that official controls. The state of the body not only conveys physical malfunction but mental and spiritual malfunction also. The extent of any imbalance will not be clear until we have done a complete diagnosis and have found out where the root of the official's problem lies.

It is essential for us to remember constantly that, at body level, the officials can tell so much. In doing a physical examination, we discover at that level what the officials are telling us about the patient's total state. For example, we might call someone 'a pain in the neck'. Why? Because we know that personal behaviour affects us in such a way that, before we realise what is happening, we literally find ourselves with a pain in the neck. If, therefore, we have a patient who is complaining that he is unable to raise his shoulder without pain, we do not merely look to see what may be wrong with the mechanics of the shoulder. We do not immediately diagnose that patient as simply and only having a mechanical problem because the difficulty with the shoulder may prove to be something akin to 'the pain in the neck'. The problem could be due to emotional stress caused by children, spouse, job, or something further back in his history. If we conduct this part of Traditional Diagnosis properly, we may learn more from the state and and nature of the patient at a mental and spiritual level than we did when questioning them.

Using all our faculties

During the physical examination, students and inexperienced practitioners can easily find themselves concentrating on touch only, feeling different areas of the body, checking the spine, testing joints. It should be clear by now that we never only feel to the exclusion of looking, listening, and smelling. We have to learn to bring all our sensory faculties to bear on the patient during this part of the examination.

The faculty of touch does, however, assume greater importance at this stage, not just from our diagnostic point of view but where the patient is also concerned. We need to remember that many patients come for acupuncture treatment as a last resort, out of sheer desperation because other systems of medicine have failed to meet their needs. It is quite likely that when people come to us they will have had little or no experience of some areas of their bodies being medically examined in detail. Since it is crucial for effective diagnosis that we establish and maintain good rapport with the patient, it follows that when touching such areas during our examination it is vital that we do so with great care and respect. If we lose rapport, trust will be forfeited and it will become impossible to obtain the information we need to lead us to the Causative Factor.

The patient's reaction to touch

The need for care and respect when touching the patient is not meant to imply that our touching ought not to stimulate a response. We can and do get reactions which give us vital information. When assessing the Three Jiao, for example, we may touch the Middle Jiao and find that the patient remains totally impassive. His colour and odour do not alter and it is as if nothing has happened at all. But then, when we move down and touch the Lower Jiao, there are suddenly signs of fear and distress. We may ask ourselves why we are getting a reaction here in particular. Then we may move up to the Upper Jiao and find that this is really the key because our touch causes tremendous changes in colour and odour.

Touch may provoke fear,or anger, or joy in a patient. If a patient is already showing strong signs of an emotion, touching one of the Jiao may have the opposite effect and calm it down. All such responses are valuable information, especially when we remind ourselves that no two patients will ever react exactly the same because each person is unique. Particular responses to touch tell us about the state of the elements and officials at all levels in each individual patient. We can touch one patient and read from his reaction that he is in effect shouting, 'Don't!' It is not the body rejecting touch; it is the mind saying, 'I don't want to be touched,' and our doing so immediately provoked anger. We can touch another patient and he obviously feels in seventh heaven. 'At last someone is making contact with me. At last someone cares about me.' Yet another may become terribly frightened, 'Oh no! He'll find a lump and tell me I've got cancer!'

Clearly it is important that we establish very quickly whether the patient likes or dislikes being touched. With one person we may find that we are naturally led into making a lot of physical contact, with another a reasonable amount, and with another the absolute minimum. If a patient's reaction tells us that he does not like being touched, then we must refrain from doing so as much as possible in order to avoid offending him. Where there is a strong response of fear or anger, touch must be kept to the bare minimum because the more we provoke such a response, the more dissociated from us the patient will become, and thus less and less happy to maintain rapport with us. If, on the other hand, the patient obviously likes being touched, we may touch him whenever and however is appropriate. Frequent contact is what he needs to feel happy. Need is the key. In the first case, touch is not needed; in the second, it is.

We evaluate the patient's response to touch as quickly as possible because it greatly influences the rapport crucial to his progress. We should bear in mind that our initial findings should not be considered permanent. The fact that the patient changes during treatment means that we need to watch continually for signs of such change. This will provide valuable guidance for us, possibly even more valuable than other changes such as those in pulse, colour, odour, or emotion. Changes in the patient's response to touch are something we soon notice. If once there was evident fear or hostility, we quickly appreciate their disappearance and the increasing readiness to respond positively to our touch. The fact that he is no longer fearful of or hostile to touch is a valuable indication that balance is being restored and that the patient is starting to get better.

Before I describe the physical examination procedure in detail, it is important to mention that the practitioner must be clear and precise when asking the patient to undress, in telling him how much clothing to take off. We ask women to undress to underpants and bra, and men to undress to underpants. There will always be a blanket available on the examination couch so that, when the patient lies down, he can immediately cover himself if he wishes to do so.

In the main, people tend to feel uncomfortable and insecure when undressing and undressed in unfamiliar situations. Being asked to undress may seem invasive and threatening. Apart from invoking a sense of vulnerability, the removal of clothing can also represent the abandonment of status. Without the Saville Row suit or the overalls, there is no difference between the bank manager and the dustman. The point is that clothes are put on as a habit, costume or facade, to project or defend self-image. When clothes are removed, and the security and status they provide is divested, the patient may feel naked in all respects. We do not want the patient's vulnerability to be so exposed that we lose the rapport we have carefully established. Of course, we cannot carry out the physical examination without the patient being undressed; but given a blanket, with which he can cover himself to leave only the face exposed, we can avoid the danger of his feeling unduly uncomfortable or threatened. For the same reason, we always leave the room while patients are undressing and give them time to settle on the couch.

How the patient walks

We can actually start the physical examination at what might be

thought to be an insignificant and hardly relevant point. In directing attention to it, I am once again stressing the importance of all information provided by the patient. We have, at this stage of diagnosis, primed ourselves, so that we are now ready, via touch especially, to ask about the patient's state of body, mind, and spirit. We have done our very best throughout to maintain rapport with the patient to ensure the success of our enquiry. Just as the first few moments of the consultation are very important, paying attention to the patient's arrival and the first handshake, we can now use an apparently unimportant event to pick up the quality of detail which may help lead us directly towards the CF. I am referring to how the patient walks across the room.

The patient walks towards the couch, or may perhaps walk out of the room and then back in again, having needed to empty his bladder. 'Well,' you might ask, 'doesn't everyone just walk? All one does is put one foot in front of the other, and that's walking?' It is not so simple! People walk in all manner of different ways. Some are controlled and meticulous in their movement, making sure all the way that they really feel the ground under their feet before they put a foot forward towards the couch. Others pay little heed to how they are going to get to it, their feet all over the place as they head in the general direction of it. Yet others stride towards it like sergeant-majors with their heads in the air. All they see are the clouds, and they expect their bodies to do exactly what they are told. As observers, we may find ourselves wondering if some official is over-involved in or failing to take proper responsibility for this simple operation.

An imbalance in the Wood element, for example, might make the person so controlled as he walks that it seems as if he has to plan ahead exactly where each footstep will fall and is more than ready to avoid any yet unseen obstacle. He seems to move so cautiously and deliberately that it is as if he is saying to himself, 'Ah, there might be something in the way over there so I won't go that way... There's definitely a difficulty here so I'll come over this way.' Every detail must be worked out in advance.

The widely differing methods of approach are not difficult to observe. They are simply the ways in which people behave all the time in their everyday lives. Yet it still comes as a surprise when we realise just how diverse different people's approaches to a simple task can be. If anyone finds it hard to believe this, then I suggest that he goes to a place where there is a ladder over a pavement and spend half an hour watching people negotiating the situation, walking under it, or round

it, or crossing over the road to avoid it. Some, it will seem, would prefer to get run over by a bus than run the risk of what might happen if they walk under the ladder. Whatever way they eventually choose, everyone will reveal something of his imbalances by how he approaches the danger. The point I am making is that in walking across the room to the couch the patient may tell us more about himself than he recognises.

Colour and clothing

Preference for a particular colour of clothing has already been mentioned. It is not only the fact that when people are first sick they may crave a certain colour in order to counteract a particular imbalance within themselves but also that later they may suddenly hate that same colour because they sense that it is actually making them feel worse. People can be fastidious about the colour of their clothes and, when asked, they can give us the most extraordinary reasons for their likes and dislikes. At this juncture in the proceedings, it is also important for us to take note of the patient's choice of colour for underclothing.

Because underwear is the clothing closest to the surface of the skin, its colour is more likely to have a vibrational effect on the person than the colours of outer clothing. When the patient has undressed therefore, we need to look discreetly at the underclothing. It is not only a matter of making a mental note of preferred colour, important though that may be. When a person is sick, he can become resigned in body, mind, and spirit, and that will often show in the care, or lack of care, that he takes in all aspects of his well-being. If someone has, in effect, come to the point of saying to himself, 'Life's not worth it. I can't be bothered with anything. I feel too awful to care about anything,' then the hair goes, the face goes, the nails go, shoes do not get cleaned, trousers do not get pressed, all care of personal appearance deteriorates. I am not suggesting for one moment that everyone should be walking around all the time done up to the nines. That would be to carry things to extreme the other way. We do, however, expect anyone with self-respect to wear clean underclothes regularly.

We may find an indication of serious sickness at all levels if we have a patient whose underclothing is in a disgusting state. We might have difficulty deciding whether the underwear is really grey or if it was once white. We might notice that a bra has obviously been worn week after week and has clearly never been washed. We might see that

someone's underpants have stains which have clearly been there for a long time. It is all too easy to feel disgusted and judgemental about such a lack of self-care. We have to remind ourselves, however, that we are looking at illness. People become so sick that their lives become a continual struggle and they do not have the incentive or the energy to bother about washing and changing their clothes. They do not intend to give offence; they have simply lost the power and strength to look after themselves.

As usual, we simply make note of any irregularities or idiosyncrasies for future reference. If we, at first, note soiled underclothing and then later notice regularly clean and fresh underclothing, a clear sign that a person is taking care of himself, then we know that the person's well-being is improving. Similar considerations apply with colour. If we have noted originally a proclivity for white (or off-white) underwear and then later see blue, yellow, red, all the colours of the rainbow, we know that we are seeing a sign of progress, a resurgence of self-interest. Such mundane signs of improvement may seem too trivial and obvious to be worth mentioning. The trivial and obvious can, however, easily be taken for granted and overlooked. Any sign, no matter how apparently insignificant, can be very important for us.

Although it would not commonly be thought a matter of importance, we find it useful to look briefly at the patient's shoes, sufficiently closely to see, for example, whether he wears soles and heels made of rubber or some other man-made synthetic material. Nature made us that we should keep in vital contact with Mother Earth via the surface of our feet. Soles of rubber and other synthetic materials deny this connection. Hence, we may find patients who tend to feel lost, aimless and ungrounded for most of the day, but who say they feel much better when they get home and are able to throw off their shoes and walk about barefoot or just with socks or stockings on. Leather footwear also permits fluids to permeate outwards and escape. If it is worn in conjunction with socks made of natural fibres, which also allow such passage, then toxins expelled through the skin of the feet can escape. Man-made materials prevent such 'breathing' and hence trap the toxins. That blockage can lead to their being re-absorbed back through the skin. Checking the patient's footwear can be important if we are finding problems in any way associated with retention of toxins.

As I have repeated several times, everything we observe about a patient helps to guide us towards understanding the state of the officials. Bearing that in mind, and having now covered in principle

all the major areas to be considered in the preliminaries leading up to the actual physical examination itself, it should not be necessary to elaborate in detail every single thing which may strike us as being significant. One example could be whether patients neatly arrange their clothes as they undress or whether they just throw them into a heap on the floor. The possibilities are endless and, when we fully appreciate the principles involved, we will soon become confident that, if we are attentive, we will pick up and select information which we know is important to the making of accurate diagnosis.

Pulses

With the patient now lying on the couch, the first thing we do is take a reading of the pulses. We record them together with the time of day and the season.

We may have to discount the first reading. The patient, having recently undressed and being now in a 'vulnerable' position, may not only feel exposed and threatened but also apprehensive as to what is going to happen next. The resultant excitement, agitation, fear, anxiety, or apprehension may be so prevalent at this juncture that the pulse picture may be wildly distorted. Even so, taking the pulses at the beginning is important for two reasons. First, we want the patient to become accustomed to the practice of having the pulses taken. We will be continuing to take them during the examination, perhaps four or five times. As the patient becomes relaxed and used to the pulse-taking procedure, our readings will become more reliable and accurate. Second, holding the patient's hand will probably be our first real and sustained physical contact with the patient and we can convey certain messages far better with our hands than with words. We know that, if the patient is worried or distressed, holding his hand with one of ours and touching his wrist with the other can be very comforting and reassuring. Touching the patient in this way to take the pulses, therefore, helps to calm nervousness, comforts the patient, and demonstrates our care to him.

The hand holding the patient's hand can be a marvellous source of information at this point, in ways similar to those described earlier when we first shook the patient's hand on arrival. Does the patient's hand feel relaxed and comfortable with the hand-holding? Or does it feel as though it is trying to pull away? Or is it gripping rather tightly? If I take a patient's hand and feel that slight tightening of the grip saying something like, 'It's lovely to have someone hold me and offer

a helping hand,' I do not press on immediately and take the pulses with the other hand but, talking the while, use it to touch the patient's arm gently and watch for further response. While the patient remains happy with the touching, then I keep adding a little more pressure to gain an idea as to how much physical contact he can comfortably accept. As soon as I feel a negative reaction, or the grip, or the colour on the face, or the odour changes, that will be a signal saying, 'Enough!' At that point I stop testing, having learned what I want to know, the measure of what is needed.

Fig.3 Pulse-Taking

As the gentle procedure of pulse-taking continues, we have an opportunity to ask any questions which may have arisen in our minds whilst we were talking to the patient earlier, particularly ones which we may have felt at the time we could not ask because the patient was not sufficiently at ease. Since we are entirely in control at this point, because the patient is relaxed and has no expectation as to how long we shall be taking the pulses, we can ask such questions.

Fig.4 Pulse-Taking

The Three Jiao

The next part of the examination is measuring the Three Jiao. To do this, we need to take away the blanket and move underclothing so that the front of the body is exposed as far down as the pubic bone. This degree of exposure is likely to produce a reaction in the patient and we should pay careful attention as we are doing it.

It is worth mentioning that the patient's use of the blanket can be informative (and sometimes amusing!). The blanket is there primarily for the patient's comfort and reassurance. Reactions to it can vary considerably when we cover the patient with it, leaving only the head and neck exposed. Some will clearly like it that way and will make sure it is covering them as much of the time as possible. If we have, for some reason, taken it off, he will pull it back as soon as he can. Others will want to throw it off and will continually refuse to stay covered, no matter how many times we put it back. Others will keep just their arms outside, and will take them out from under it every time they become covered. All these reactions provide us with useful information, especially about how much heat the patient generally needs. Assuming that the treatment room is kept reasonably warm, a light covering should be adequate and acceptable. When we find strong

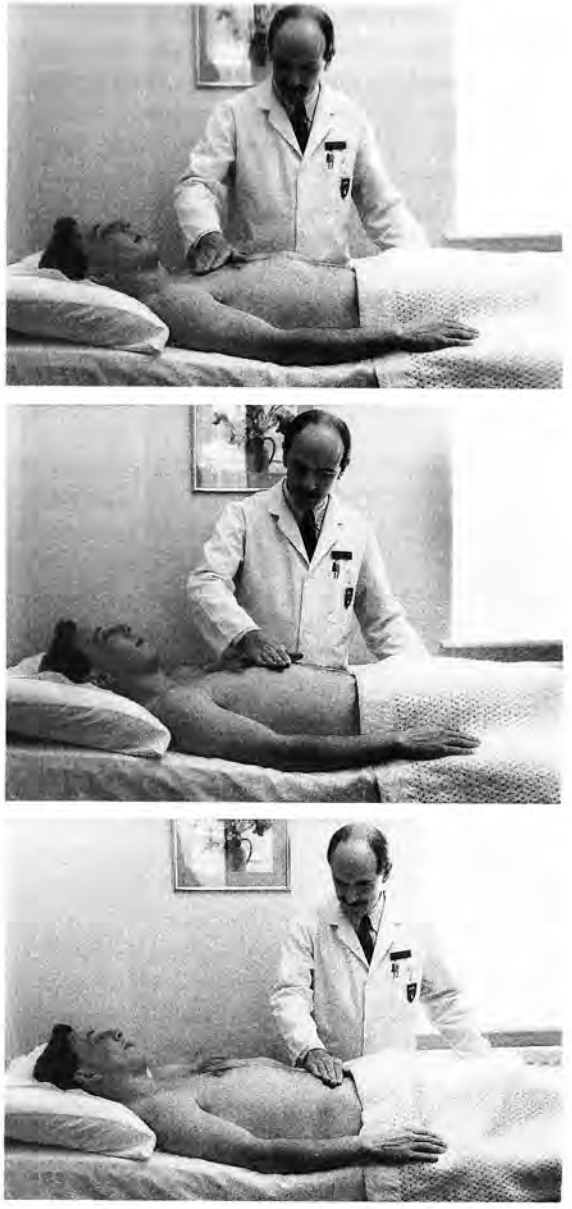


Fig.5 Measuring the Three Jiao

indications that the patient is not comfortable, we ask if he is feeling too cold or too hot. We cannot conduct a proper examination if the patient is not at ease and thinking either, 'Hope this doesn't take long. I'll be glad to get my clothes on again' or 'Phew! I'm hot. Wish I could get rid of this blanket.' Although the blanket is not meant for keeping the patient warm, we can learn from his reaction to it whether we need to do anything to make sure we have the best possible conditions to continue with the physical examination.

When we have removed the blanket and have exposed the patient enough to be able to compare the Three Jiao, we allow a certain amount of time to elapse before doing so because the underclothing will have kept the Lower Jiao comparatively warmer than the Middle and the Upper which have been unclothed longer. Whilst we are waiting, we can perhaps re-check a particular pulse or perhaps check the umbilical pulse. Once we are satisfied that there are no longer any effects on body temperature because of clothing, we can proceed with testing the Jiao, placing a hand gently but firmly on each Jiao in turn and thereby assessing relative degrees of heat. The record of what we find can be of considerable importance to us as future treatment progresses. The temperatures of the Three Jiao will alter as the Three Heater official, if it has been in difficulty, starts to function more efficiently. Perhaps also, within one of the Jiao, there is an imbalance, in the Lung or Heart official, for example. Such an imbalance can itself make the Jiao too hot or too cold. As balance returns to the whole system, the temperatures of the Three Jiao will become more even.

Fig.6 Checking the Umbilical Pulse

Umbilical pulse

Whilst the front of the patient is uncovered, we also palpate the umbilical pulse. Fingers (positioned in the manner shown in the photograph opposite) are pressed firmly into the abdomen around the navel. We do not need to ask the patient to breathe in any particular way while we are doing this. If his stomach muscles are very tense and rigid, however, it can help if we ask him to bring his knees up. This should reduce the tension of the muscles enough for us to be able to palpate the pulse with ease. Having felt the pulse, we record our reading and move on to the abdominal diagnosis.

Abdominal diagnosis

Checking the umbilical pulse is followed by Japanese abdominal diagnosis. This is a brief examination during which areas of the abdomen closely related to specific officials are palpated. On many occasions, this examination provides good 'second grade' diagnostic information. It can reveal weaknesses and evidence of disturbances which can corroborate our diagnosis of the CF.

This abdominal diagnosis can also, however, be unreliable and hence be the weakest link in our chain of techniques. All of our other techniques provide clear and unambiguous indications; this one may not. For example, a patient may have a major malfunction in the gall bladder, but, when we palpate the area of the abdomen associated with the gall bladder, we find no undue sensitivity there at all. Conversely, we can find extreme sensitivity in the gall bladder area when there is nothing wrong with the organ.

Some patients will have experienced similar abdominal examination in Western medical practice; but for many it will be the first time in many years that they have been examined in this way by another person. It is worth repeating yet again, therefore, that when touching these areas of the body we must not lose our sense of care and respect. We should tell the patient exactly what we are going to do, 'Now I am going to press here rather deeply.' We then do so very slowly at first so that they can become used to the sensation and the depth of the pressure. We keep checking all the time to make sure that he is all right. We must also tell him quite clearly what he should expect to feel, and that he must tell us if he feels anything unusual; whether, for instance, a particular area feels a bit tender or whether anything is acutely painful.

In abdominal diagnosis, we often learn more from reaction to the physical contact than from physically testing the officials. When touched on the abdomen, some patients immediately tighten their muscles and may make some exclamation. Their reaction has nothing to do with pain; they simply do not like being touched in such areas. The person may, in effect, be saying, 'No, I will not yield to you. I will not let you invade my body, or my mind, or my spirit. Get off! I don't want this.' Yet others will be especially sensitive to being touched on the lower abdomen, a reaction which has more to do with the area's proximity to the genitals and the implications of that than with any special sensitivity in the area itself.

We will be alert at all times to monitor the response to touch but our need to touch almost the whole of the front of the body during this stage of the examination provides us with a particularly good opportunity to discover what we need to know. This examination also gives us an ideal opportunity to use all our faculties fully. Apart from feeling flesh and muscle tone, we are able to look at the skin condition, distribution of body hair, any blemishes or irregularities, smell odour, watch breathing, and listen for reactions. We are able to gather a great deal of information which will help us to add much detail to our mind's eye picture of the patient's state and how he has evolved.

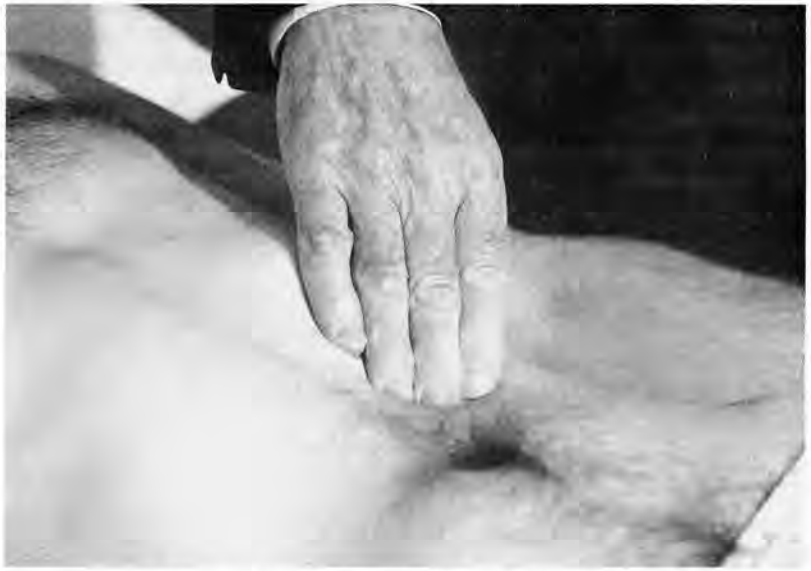


Fig.7 Conducting the Abdominal Diagnosis

Alarm points

In order to improve the precision of our diagnosis, we make good use of the alarm points during this part of the examination. These acupuncture points can become spontaneously tender in the same way that areas of the abdomen can. Sensitivity found at these points can sometimes serve as a very useful check and cross reference. However, as with the testing of abdominal organs described above, we have to allow for the same degree of uncertainty. A point may be tender but the official is actually fine; conversely, a point may show no sign of tenderness even though the official is in real trouble.

When we have finished this part of the examination, we cover the patient and make sure that he is comfortable. We might adjust the room's heating or open windows for fresh air. It is very easy to become too absorbed in examining the body and forget that we are still relating to the patient and looking after his needs. If this happens, we may lose the rapport we have established and alienate the patient. By looking after his basic comfort we remind him that we are still caring for him.

Fig.8 Checking the Alarm Points

Examining the lower limb

After abdominal diagnosis, there are various ways to proceed. We do not have to follow any set pattern providing we cover everything essential. Many practitioners, however, carefully follow an established sequence to make sure that they do not omit something important. Once the front of the patient's body has been covered again, it is probably most convenient to move down to the legs and feet.

When we first look at the feet, the most obvious feature to attract our attention will be the toe nails. As we look at them, we will have in mind the connection between the nails and the Liver official. We will already have seen and noted the state of the finger nails while taking pulses and, although we may have found them well cared for and presentable, we may find the toe nails quite a different matter, soft or brittle, ridged, distorted, or discoloured.

We should not read too much into the state of the patient's toes and toe nails , however, because very few people have decent feet. I mean decent in the sense of form and appearance rather than function. We see patients with one toe riding on top of another, with toes bent under, twisted, squashed together, usually the result of wearing socks, stockings or tights which have been and probably still are too tight. Most people think that shoes are to blame for such distortion but they are not necessarily the primary cause. Many deformities of the feet are caused during infancy and childhood when the feet are still growing, the bones are relatively soft and the foot structure is still malleable. Putting infants' feet in close-fitting, all-in-one romper or stretch-suits, or tight-fitting socks or bootees, has the same restrictive effect as the binding which used to be put round women's feet in ancient Chinese tradition. Badly formed toes restrict and deprive the nails of vital Qi energy, a deprivation which leads to their very poor condition later in life. In addition to looking at the condition of the toes, we will also need to check their warmth. Any lack of heat would corroborate our suspicions of a poor flow of Qi energy.

Inspection of the ankles is also important. Many muscles and tendons work on the ankle joint and we need to know the quality and condition of these. In particular, we need to check for fluid on the ankles because many illnesses cause excessive accumulation of fluid in this area. If we suspect a problem we need to be careful when asking about any history of swelling. For example, 'Do you have any problem with swollen ankles?' may elicit a simple 'No'. However, what that patient may understand by 'swollen' and means by his answer is that, as far as he is concerned, his ankles do not come up like balloons one day and then go down the next. It seems to the patient that his ankles stay pretty much the same all the time. Yet, when we feel the ankle, it seems that there is excess fluid. Since the amount does not fluctuate dramatically, the patient does not notice anything abnormal and does not, therefore, recognise that there is a problem. Excessive water retention is an important matter and, if we find evidence of it in the ankles, we need to question very precisely in order to obtain a clear picture of what is happening and has happened in the past.

As the examination of the lower limbs proceeds, we are continuously assessing the temperature of different parts. With the blanket drawn back up to the hips, we can check the relative temperatures of thigh, lower leg and foot while we are doing a general check of muscles, joints and limb mobility. We find that many people have very cold feet, but when we ask, 'Do you suffer from cold feet?', they will say they do not. We have to be guided by our own assessment in this matter because they do not realise how relatively cold their feet are. As usual we record our findings, 'Very cold and dry', 'Very cold and wet', or whatever description is accurate. We will later, as treatment progresses, check back and look for signs of improvement.

During the entire physical examination, it is extremely important to keep an eye open for scars, bruising, or anything else which indicates surgery or injury which the patient may have forgotten to tell us. It is not likely to occur to a patient, for example, that a cartilage operation he had as a result of playing football has anything to do with his present suffering from migraines. If we find that some major surgery or injury more or less coincides with the start of migraine attacks or stomach problems, we may then discover that the surgical incision or the injury damage has at some point severed tissue right across the spleen or stomach meridian, or the liver or gall-bladder meridian. Such an intervention can cause a block in the meridian pathway, in which case the surgery or injury may have everything to do with the headaches or gastric disturbances.

If we do find evidence of surgery or injury and we have not previously been told about this in the diagnosis, we question the patient and find out as much as we can. People have an extraordinary capacity to forget serious things which have befallen them in the past. I recall a patient who, early in his life, had T.B. and yet, during the whole of the consultation part of the diagnosis, he never gave so much as a hint that he had had any such trouble in his medical history. It was only when I was taking his pulses and I asked him, 'Have you ever had any serious chest trouble?' that he remembered. 'Oh yes,' he said, 'I did have T.B. rather badly many years ago', implying in the way he said it that it was all so long ago that he did not think it could be of any present relevance, even though he had come very close to death. The main reason for people overlooking what has happened to them in the past is that it has long since ceased to worry them and their attention is focussed on what has brought them to see us.

For these reasons, the patient's medical history can be extremely important and relevant to the present problem. If we see unexplained

scars, we are very curious to find out what caused them.

Examining the upper limb

The procedure for the upper part of the body is similar to that followed for the lower. Whilst looking carefully at the arms and the hands, especially the finger nails, we again give attention to the warmth and coldness of different areas and take note if we find extremes of heat or cold, or clear discrepancies of temperature between one area and another.

Hands are especially informative. The two parts of the body commonly exposed to the view of others are the hands and face and, generally speaking, people tend to take more care over the appearance of what others can see than what they cannot see. Hence, if we come across someone with dirty and neglected hands, we are curious about what that lack of care means to that person.

When examining the hands, we look at the form, nature and condition of them, expecting all such features to be in keeping with the patient's occupation. We do not expect a manual labourer's hands to be similar to those of an office worker. The effects on structure and skin of continual manual work will be quite different from handling little other than paper and pen. If we see a bank manager whose hands are rough and somewhat worn looking, with nails that are dirty and uncared for, we might regard that as telling us something significant. On the other hand, if we see a building worker with hands in similar condition, we would not think that at all significant, since the daily work of the labourer produces weathered and rough hands and nails over time.

We also pay close attention to the patient's skin. Although the skin is most closely associated with the Lung official, it can also tell an enormous amount about all the other officials. There are many aspects of this subject which could be mentioned but I will point out just the most obvious. Is the texture of the skin elastic or rigid? Is it alive and vibrant, or dull and dead? Is it soft and smooth or hard and rough? Does it have a glowing bloom when it is creased, or does it appear as if covered with a sheen like the scales of a fish? Does it feel cold and damp, or warm and dry? Does the texture of the skin on one part of the body differ from the texture on another? The nature and condition of the skin varies considerably from one patient to another, and it can change in a patient from time to time.

The practitioner should regard it as an important source of immediate information about the state of the officials. Through the skin we make our physical contact with the world around us and the effects of that interaction will be clearly evident on the skin surface. I can remember clearly the case of a patient who had nicotine stain on his fingers and yet told me most emphatically that he did not smoke. Perhaps he was in the habit of holding cigarettes for somebody else!

The patient is likely to assume that the physical examination will not take very long. Furthermore, we usually are doing something obviously active and deliberate for most of that time so that the patient does not begin to feel that he is being scrutinised. Nevertheless, we ensure that we have all the time we need to find out everything we have to know. Periodic taking of the pulses will ensure that we have that time. Apart from the fact that taking pulses several times is important anyway, the act itself is something which the patient will easily understand and accept as being part of the procedure. Being a passive and relaxing interlude, it allows us time to ensure that we have not overlooked something significant. We might suddenly notice, for instance, that the patient has inverted nipples. Although it will not be so in every case, inverted nipples are usually a sign of congenital malfunction relating to the lungs. That might lead us to discover that the patient's mother or grandmother had T.B. or some other serious chest disease. The pulse-taking intervals also allow us time, especially as we move around the couch to take the pulses on each side, to cast those half-glances which enable us to see colours on the face, to smell the odour, to note a passing expression on the face, or any other minute sign.

Examining the head

Appearing to be nonchalant, as if we are not inordinately or impertinently inquisitive, is particularly important when we come to examination of the head. We need to feel the texture of the hair but we cannot put on our glasses and inspect it as though we are looking for scurf or lice. People are very self-conscious about their hair and close scrutiny may make them feel very uncomfortable. To accomplish our aim, we can either position ourselves behind the couch and, as they lie down, feel the back of the head as we cushion the head's impact with it, or we can wait until we have to hold the head to check neck rotation. Any subtle tactic that allows us to check the hair, whether it is soft, fine, tough, wiry, or split at the ends, will suffice.

Much earlier, we have seen how sparse or profuse, how thin or thick, the patient's hair growth is. Without having to get too close, we should also be able to tell whether he is wearing a wig or an artificial hair piece. We need to take appropriate care with someone who has gone to some trouble to hide the fact that he is bald or balding, whether due to ageing or to some illness. It is better not to make contact with the head at all than run the risk of embarrassing the patient by accidentally displacing the wig, an event which could seriously disrupt, or even destroy, good rapport with that patient. If we are not totally sure but only have a suspicion, it is still wiser to stay away. Even if the patient voluntarily tells us that he is wearing a wig or hair piece, we must still take into account that he feels sensitive about it. If he volunteers the information and also elects to remove wig or hair piece, then well and good, no problem. Needless to say, the last thing we should do is make any kind of joke about the matter.

When examining the face, we will look at the state of the eyebrows to see whether growth is healthily active or weak and sparse. In the case of some women, we will find that they have plucked their eyebrows to the point where there is only a thin, faint line of hair remaining. We may ask ourselves why they want to go to this extreme. Similarly in the case of excessive make-up, we need to ask ourselves why there is such a 'cover up'? Make-up in moderation is not a particularly strong statement but if we come across thick layers of foundation cream, powder, skin-tone, lipstick, lip-gloss, eye-shadow, eyebrow liner, mascara, evidence of effort to create a mask so thick that we cannot see the natural face behind it, we might ask ourselves why such a patient needs to present herself as other than she is naturally. Why does she not think she is beautiful when wearing just enough make-up to enhance the features and complexion with which she is naturally endowed? What is it about herself that she is really trying to hide?

On the other hand, there are female patients who take things to the opposite extreme. There are those who clearly take no interest in their appearance, as if to say they do not care what anyone thinks about them. Some women naturally have rather pale and dull complexions and a judicious touch of make-up would bring a liveliness to their facial appearance. They refuse to make the best of themselves. We will be alerted, then, by any presentation which strikes us as excessive one way or the other. What is actually done or not done to the face at the physical level is not in itself particularly important from a medical point of view. What is important is what it may tell us about what is going on behind the mask. We must not forget men too. Skin and hand care for men, and stylish haircuts are becoming increasingly popular,

and we must also make note of the attention males pay to personal grooming.

Next, we should mention teeth. The patient will not expect a dental examination, so we cannot appropriately say, 'Please open your mouth', and then carry out an inspection. Since we are not dentists, we can only presume to take such liberties with horses (and even then I am not sure that horses like having their teeth examined any more than humans do). Some time during the examination we expect the patient to smile and perhaps even laugh. Such occasions will give us the opportunity to assess the general state of his teeth. If he smiles or laughs whilst lying down on the couch, we should be able to see inside the mouth to tell whether he has just the odd filling or a mouthful.

If a passing glance reveals evidence of a large amount of dental treatment, we look for a suitable opportunity to ask casually, 'Do you have much trouble with your teeth? Have you had many fillings?' The patient's reply may give us more information than just his dental history. One will proudly reply, 'Only one here, and one here', showing us exactly where. Another will say, 'I've got about four or five', in a way suggesting that there is no more to be said on the matter. Yet another will guardedly say, 'Just a few', when in fact he has a large number but he is so worried as to what that might mean that he is frightened to tell us.

If we find that a patient has had a lot of dental work, we need to know exactly what has been going on over the years. Nature did not intend us to have a mouth full of metal, and that metal can be a source of imbalance. Some people with silver fillings would be better off with gold. Others would be far less adversely affected if their fillings were made of some neutral substance rather than metal of any kind. With some patients a large number of metal fillings could be directly causing distress to one of the officials. We will therefore record information about the state of the teeth and the amount of dental work in case it proves relevant in how the person will respond to treatment.

Examining the back

When looking at the patient's back, we examine in a similar style as an osteopath or a chiropractor. That, however, is as far as the similarity extends. The differences between these practices and that of traditional acupuncture are important to appreciate, and I have added a short note after this section to explain the distinction. The principal difference

is that we do not conduct the examination with a view to correcting structural defects by any form of pressure or manipulation. For our purposes, we need to observe the structure of the back in order to recognise any abnormality so that, as treatment progresses, we are able to monitor improvement as it takes place. It is also possible for a structural imbalance to block the effect of treatment.

Before actually examining the back, we have a good opportunity to pick up information relating to one of the principal diagnostic signs. The patient has been supine, covered by the blanket, for a period of time. As the blanket is lifted off and the patient sits up in order for us to inspect his back, we will have a good chance to smell the prevailing odour. Since the body is warm, the odour released is stronger than at any other time during the whole examination.

The fact that the back has become warm through lying down needs to be borne in mind when we come to feeling the temperature and texture of the skin. It is often the case that, whereas the skin surface on the front of the body is clear and unblemished, we will find spots, boils, blackheads, scars, birth-marks, and moles on the back. As usual, it is important that we take note of anything which is possibly significant.

With the patient now sitting on the edge of the couch, we check how well the head rotates from side to side. Having asked the patient to keep straight and still, we turn the head as far as possible to the right and then as far as possible to the left. In most people, especially when older, there will be some restriction in this movement. We are interested in discovering the degree of overall mobility and how much one side may be more restricted than the other. Limitation can come from malfunction of the atlas, axis or cervical vertebrae, or it can be the result of tension or spasm in the muscles. For those practitioners with the requisite experience and sensitivity of touch, it will also be possible to run fingers down the sides of the transverse processes of the cervical vertebrae to feel if they are balanced and straight or slightly rotated and out of proper alignment. However, rather than concern ourselves with what can be difficult to detect, we concentrate on that which is more important and easier to feel, the head rotation and amount of restriction. We note this because although we will not touch the patient's neck at all during treatment, we may find that any restriction in head movement eases as overall balance is restored.

We then examine the spine. The easiest way to do this is to ask the patient to get up and stand where we can see the back in good light.

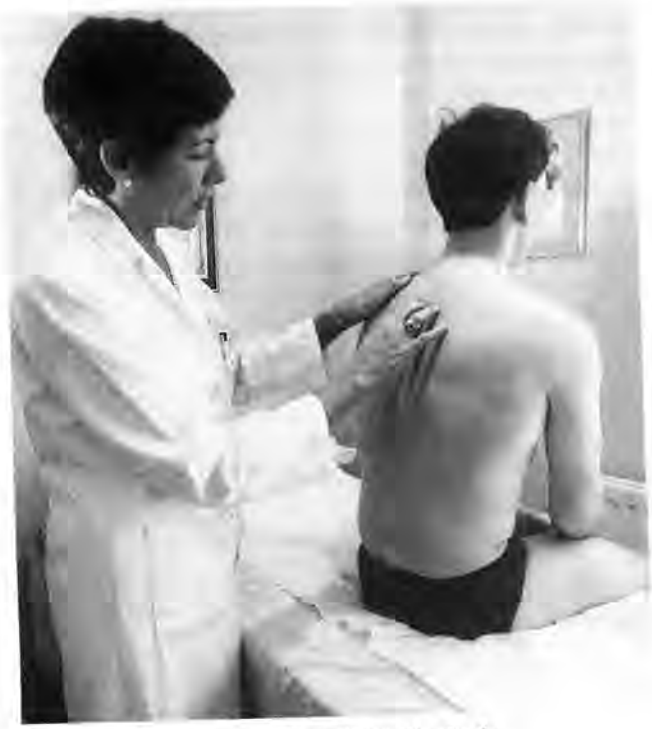


Fig.9 Examining the Back

Then we ask him to bend forward enough to put his right hand on his left knee, and left hand on right knee. If the spine is still not sufficiently pronounced for us to see it clearly, we can ask him to bend forward a little more. The prominences of the vertebrae will now be revealed and we will be able to see which ones, if any, are out of line. We can also see whether and where the spine as a whole deviates from a straight line. Nature always attempts to compensate for imbalance. If the spine goes out of true at the top, the fault will be counterbalanced by a movement of the spine in the opposite direction lower down. Otherwise the person would be inclined to lean to one side and be in danger of continually falling over or the spine would break under the strain. By looking at the patient's back from a distance, and noting the course of the spine, we gain a clear idea of how good or bad that person's carriage is and whether any associated problems may be connected.

While the patient is standing, we also ask him to put his ankles together and to stand straight for a moment. We then look to see if the

creases underneath the buttocks are horizontally in line. If they look as if they are not, we can double-check for asymmetry by placing our hands on the crest of the ileum and, bringing our thumbs horizontally across to the centre, see if they meet at the same level. Also, many people have a dimple on each side of the spine in the sacral area. These too should be horizontally level and can thus serve as a further check. The standing-back view gives us a good picture of the patient's basic body structure and of any structural imbalance.

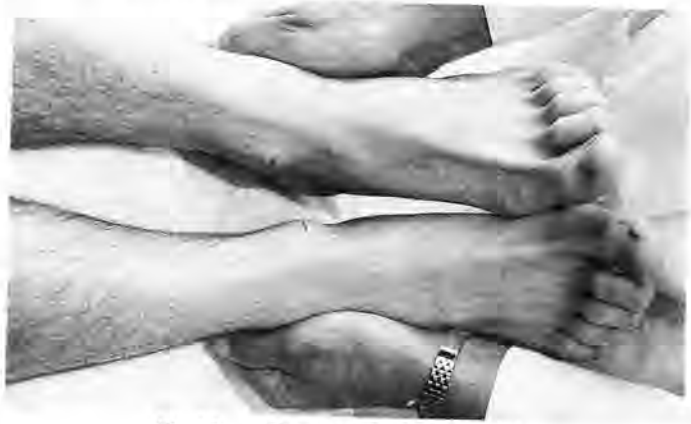


Fig.10 Checking the Leg Length

The last thing to be checked at this stage is comparative length of leg. It is likely that eight out of ten people we pass in the street have one leg longer than the other. Consequently, they have to walk slightly askew in order to keep direction in a straight line. Generally, this situation is not seriously detrimental in any way, but it probably means that there is something amiss in the spine for which the body is compensating from the top of the neck to the tips of the toes. The simple way to check comparative length of leg is to ask the patient to lie down again and to put a thumb dead-centre on each of the inner malleoli. We ask him to place his feet flat on the couch by bending his knees, to lift his bottom off the couch, and to lower it again. We then pull his legs out straight again. The practitioner's thumbs should then be found to touch symmetrically. If they do not, we have indication that one leg is longer than the other, and we will be able to see which one.

Finally, a note of caution. If we know that the patient presently suffers from, or has in the past suffered from, any arthritic or spinal problem, we must exercise great care during this part of the physical examination. In many cases, we should not ask them to move bones to the

maximum limit possible, or to attempt to move them excessively ourselves. Such extreme movement by, or manipulation of, someone with serious adhesions and ossification can cause damage to surrounding tissue.

Relationship of acupuncture and physical structure

It is appropriate here to make further points about the relationship of traditional acupuncture to osteopathy and chiropractic. Traditional acupuncture is in itself a lifetime's study. So too are osteopathy and chiropractic. Although there are practitioners who combine acupuncture practice with osteopathy, I do not think it is possible to practise more than one discipline at the highest level.

As must be evident from the previous section on examination of the back, acupuncturists must have a good knowledge about the skeletal structure of the body. They must know about the spinal vertebrae and be able to recognise whether or not these are properly aligned in their patients. As practitioners become more experienced, they may also be able to feel and recognise obstructions, subluxations, and qualities of rotation. All this can be useful, but in traditional acupuncture we do not make any attempt to rectify such irregularities and defects by any form of physical intervention or manipulation. We would no more expect to do so with our limited knowledge of such techniques than we would countenance the practising of acupuncture by any other practitioner merely on the basis of his having completed a three-week training course in acupuncture techniques. Ideally, acupuncturists and osteopaths should have a healthy respect for each other. There are times when each should refer patients to the other, each being willing to recognise that there are certain problems with which the other is better able to deal. This leads to the need to understand principles appropriate to each discipline, principles which cannot be too strongly emphasised.

Osteopathy and chiropractic are based on the fundamental principle that structure governs function. In other words, structural defects adversely affect organic function. It does so because the controlling nervous system of the body radiates from the spinal cord and, if there is obstruction of any kind in the spine, some part of the body is going to be functionally impaired. To an extent, such an effect can be described in quite similar terms in acupuncture. If there is malfunction in the physical structure, the flow of vital Qi circulating round the body will be disrupted or impeded and thus cause organic imbalance.

Such a description applied, for example, in what was said earlier about surgery and injury where intervention was seen to cause imbalance in parts of the body totally unrelated, in Western terms, to the site of the intervention.

In traditional Chinese medicine, however, we also have the principle that function governs structure. This difference in principle is not something which osteopaths, chiropractors, and acupuncturists need to argue about because each principle is valid for its respective discipline. In the discipline of acupuncture, we uphold that, if all functions in the person are balanced, then all will be well with the structure. A certain element feeds the muscles, another feeds the tendons, and yet another feeds the bones. If all such feeding is taking place as Nature ordained, there is no way that the overall structure can fail. For example, a small child can fall downstairs, yet pick itself up and, though perhaps upset by the shock, walk away quite unharmed. Witnessing such an accident, we think that the fall would have been enough to kill us, or at least break a dozen bones. But, in fact, Nature so makes us that we are able to withstand tremendous impacts. It is the strength of the ligaments, tendons, and muscles that hold the bones in position which enables us to do so. If they are healthy, the structure will be balanced and resilient.

Fig.11 Checking the Lower Back

If, then, we have a patient whom we can see has a displaced vertebra, we do not attempt to rectify the bone itself but treat the organic functions responsible for controlling and maintaining the structure. We ensure that the muscles, ligaments and tendons are being properly fed. And then, one day, when these functions have regained their

strength, the patient will hear the click of the bone moving back into place. Nature does the manipulation, and when Nature puts a bone back where it should be, it will not become displaced again. If the bone is manipulated back into place whilst the muscles are under strength, it only needs another awkward or strained movement for it to be displaced again.

If we have a patient with a structural problem, our aim will be to nourish the muscles, ligaments, and tendons so that they may gain sufficient strength for Nature to rectify the fault. However, if we see that the problem is too long-standing and deeply established for this strategy to succeed, we may recommend the attention of an osteopath. Before enlisting such help, however, we will treat the patient to ensure that his muscles and tendons are in the best possible condition to hold any manipulated correction so that it will remain permanent.

When we are doing our examination of back, head, and limbs, therefore, we are not looking with a view to working on the structure as amateur osteopaths or chiropractors. We need to be sufficiently knowledgeable and experienced to be able to discern and note faults accurately so that we can monitor changes as treatment progresses. The degree of change accomplished will help us to determine whether Nature is going to be able to remedy the fault completely in due course or whether it would be advisable to recommend the assistance of an osteopath or chiropractor.

Blood pressure

Next, we take a reading of blood pressure. Patients tend to be encouraged by the sight of the sphygmomanometer and stethoscope. They will have seen doctors using them and our doing so reassures them that we are not totally unorthodox in our medical practice. As well as using the stethoscope to check blood pressure, we can use it to listen to the chest.

The extent to which we use these instruments and techniques largely depends on how much of the information obtained we can usefully interpret for diagnosis. Information elicited at the most simple and basic level can serve a useful purpose for any practitioner. Experienced practitioners may gain the ability to detect and interpret far more subtle information. Nevertheless, such information and its interpretation is really of no value if it is not applied strictly within the framework of our tradition. It is therefore not really helpful on the

whole to encourage the use of techniques and the gaining of information which may take years of experience to interpret and understand appropriately. For the purpose of this book, there is no point in further considering these Western techniques.

The Akabani test

After we have taken the blood pressure, we then do the Akabani test. The test is described fully in Appendix Six. While we gain our information from this test, the patient has a good opportunity to relax.

Fig.12 The Akabani Test

Finally, to complete the physical examination, we will once again take the pulses. By now we have taken them three, four, or five times because pulse-taking not only allows continual monitoring of what is going on in the patient, but also gives us a gentle and pleasing way of controlling and pacing the examination. This last reading, however, is the one which we usually find the most important to record. It is likely to be the most accurate assessment because by now the patient is usually at his most relaxed. This, therefore, will be the pulse picture on which the refining of our diagnosis will rely. Having taken this final reading, we invite the patient to leave the couch and get dressed.

Looking after the patient's needs

It is easy whilst conducting the relatively fixed procedure of the physical examination to forget that the body lying on the couch is the

person whose every gesture and word held our attention completely while we were doing the first part of the examination. I have seen practitioners conduct the physical examination as though they were bench-testing a piece of equipment. Looking after the patient's needs means going beyond the reason they have come for treatment.

We can create unnecessary blocks in our relationship with the patient by being inadvertently thoughtless. Imagine, for example, the discomfort or even agony of a patient who has been in the room for an hour or two and has wanted to go to the toilet. Furthermore, the practitioner has been pressing on the lower abdomen, moving limbs around, asking him to stand up, lie down, and move in other ways. We might think that in such a situation the patient would ask to go to the toilet. Some may, but others are too shy to ask, do not want to be a nuisance, or do not want to interrupt the proceedings. We should remember to ask before the patient is undressed and lying on the couch whether he needs to visit the toilet or, indeed, wants anything else.

Some patients may long for a cup of tea or some water, others for a cigarette. We should adapt and deal with each situation as feels appropriate at the time but, generally speaking, if we pick up such messages, it is better to accede to them rather than deny them in the interests of making the patient feel as relaxed and comfortable as possible. While someone is gratefully drinking a cup of tea, his relief may be such that he will tell us more than at any other time. A patient addicted to smoking may be surprised to be invited to smoke a cigarette. 'My God, I didn't think I'd be allowed to smoke here.' Cigarette in hand and feeling affable, tension will ease and out come confidences which would otherwise have remained untold. We may open the windows because we do not like the smoke, but this is a small price to pay in return for information which helps us to get to the cause of the patient's problem. All depends on the practitioner's awareness and ability to respond appropriately. We cannot afford to lose any opportunity to improve our rapport with the patient. If we cannot learn to put his needs before our own concerns, our ability to help him will be jeopardised.

Answering the patient's questions

Having now completed the diagnostic procedure from our point of view, we check to see if the patient has any questions. For the most part, the patient has no idea why we have been doing what we have

been doing, and no idea what our examination has been telling us. When the patient is dressed again, we therefore invite him to sit down and enquire whether he wants to ask us anything.

Of course, the first questions most people ask are, 'Can you cure me?' and 'How long will it take?' They may not ask quite so directly or bluntly but that is essentially what they want to know. We must be honest in giving our reply. We explain why we cannot give simple answers or definite guarantees.

First of all, we explain that we, as practitioners of acupuncture, do not cure; we only act as instruments assisting nature's power to cure. Then we need to clarify what we mean by 'cure'. Suppose a person is suffering from inability to lift an arm higher than the level of the shoulder. After some treatment, he becomes able to lift it a good deal further but not totally freely. Would that be regarded as being cured? The same applies to a patient whose three migraine attacks per week are reduced by treatment to once a week. We explain that we cannot offer a cure in precise and absolute terms, such as a total return to normality. We can only invoke and follow the natural laws so that the body is assisted to heal itself to the best of its ability. That may mean, according to the nature of the condition, having to settle for partial recuperation, perhaps eighty or ninety percent. The majority of patients will find that acceptable, happy that it is an honest and sensible assessment.

From our point of view, if we allow the patient to think in terms of 'total cure' and nothing less, then they are not going to be content with anything less than one hundred percent recovery. Suppose we have a patient complain of an arm he cannot move and also frequent ear ache. After some treatment, the arm becomes free to move and the ear aches only occasionally. It is quite possible, if that patient has been allowed to think in terms of 'total cure', that he will feel let down and will go away believing we have failed and that acupuncture is no good. The freeing of the arm is dismissed and all attention is focussed on the fact that the ear ache has not entirely disappeared. It is, therefore, very important to make sure that we establish only realistic expectations when answering the patient's questions concerning cure.

We are equally careful in answering how long the recovery will take. As competent practitioners, we will be confident that all patients will leave after treatment feeling better than when they came. We are sure of this because we will see pulses, colour, sound, odour, and emotion improve as the result of that treatment. We also know that does not

necessarily mean that the patient will continue to improve until the next time we see him. There may be periodic aggravations in the healing process, apparent set backs which the Law of Cure teaches us to anticipate and accept. The point, however, is that although we can tell from the correspondences and pulses that the patient's overall state is gradually and surely coming back into balance, we cannot predict whether it will take a week, or a month, or even six months, before the effects of that inner change become evident in the patient's general condition, that is to say, evident to both practitioner and patient.

We know that the inner improvement is taking place and that it must eventually result in alleviation of the presenting symptoms, but we cannot pretend to know how quickly. To be honest in answer to the patient's question therefore, we can do little more at this preliminary stage than tell the patient that we need to work through our notes and plan treatment, and that results will depend on response to that treatment. If he responds favourably after two or three treatments, we are then able to tell him that he is improving and will continue to get better. 'Improve' and 'get better' are terms which we can safely and appropriately use. Commitment to cure within a definite period is, however, a promise which we cannot responsibly make.

A further question patients are likely to ask is, 'How frequently will I need to come for treatment?' Our answer will probably be something like, 'On average, once a week. You may need to come twice a week for the first couple of weeks, and then once a week. Then, depending on how well you are responding to the treatment, perhaps once every two weeks, then once a month. It is really impossible to tell in advance how frequently, and how many times. It may be that you will respond extremely well with the first one or two treatments, or it may take many more.'

It is particularly important to make sure that the patient understands the situation where the extent of treatment is concerned. He needs to be aware that he may need to come to us not for just a matter of weeks but possibly for a period of years. Treatment over such a long period may not be necessary, but there is no harm in explaining the concept of seasonal changes throughout the year. It is no good planting seeds during the wrong season. Nor is it possible to guarantee the quality of harvest. If the first season of harvest is poor, then we may have to wait for the next before we gather maximum benefit from the work that has been done. A patient's response to treatment means waiting for Nature's healing power to bear bountiful results in its own good

time. A full harvest from our treatment may not happen in the first year but the second. On the other hand, four or five treatments within one season may be sufficient to rectify a temporary imbalance.

The patient needs to understand, then, that we cannot be specific about frequency and duration of treatment because there are numerous influential factors which we cannot predict. If he also appreciates that continuing periodic treatment helps to prevent recurrence of the problem and maintains good health, then it is more than likely that he will be happy to think in terms of continuing visits. Even though his presenting complaint has disappeared, it makes sense that a seasonal or periodic check-up is as realistic a precaution as taking his car in to be serviced at regular intervals. Such continuity moves us into the area of preventative medicine, which is what traditional Chinese medicine was and is primarily intended to be. We should feel gratified and honoured the more this aspect of our practice becomes commonplace, and the more our patients come to value us for our perspective on their long-term prospects for optimum health.

Familiarisation with needles

If the patient has not already asked about needles during the consultation we finally discuss the needles we will be using during treatment. People imagine that acupuncture needles are like sewing needles, or hypodermic needles, or perhaps like some six-inch veterinary acupuncture needle which they have seen being used on a horse in some television programme. To dispel such ignorance, and allay unfounded fears, it is worth showing how fine the acupuncture needles actually are. We might even demonstrate what we will be doing by sticking one into ourselves and saying 'That's all there is to it.' Whilst some practitioners may be somewhat apprehensive of doing this, it can be worth overcoming any reluctance for the sake of reassuring the patient.

When told that the needle does not hurt, people usually say or think, 'I don't believe it. You must be joking.' It is helpful to suggest that they see for themselves. We can put a needle in just below the skin in an area where there are no acupuncture points. Most people, with some surprise, will then themselves say, 'Oh, is that all there is to it?' In reply, we explain that we have not demonstrated on an acupuncture point and that when we do so during treatment there may be more sensation, but that it will only last for a very short time. We can describe the kinds of momentary sensation commonly experienced,

like a tiny electric shock, a numbing feeling, or a burning sensation. This serves to reassure the patient that treatment will not be an unduly painful experience.

It is very important to discuss this matter, and if appropriate demonstrate use of the needle, because it can preclude unnecessary worry. For example, a patient may go home after the diagnostic session and a friend will ask, 'Did you have needles stuck into you? Heavens, I wouldn't like anyone doing that to me.' The patient has to say that he has not had needles yet, and then lies awake every night before the first treatment worrying that the needles are going to hurt. If we have demonstrated, he can reply, 'Oh yes. Didn't hurt at all. Nothing to it.' What is more, he happily tells everyone else about it and enjoys them replying, 'How brave. I couldn't do that.' Instead of anxiety about possible pain for days on end and coming for treatment full of tension, the patient comes along confident and relaxed.

Closing the examination

When we have answered the patient's questions, we leave the room and allow the patient to get dressed.

Some patients will dress hurriedly as if the world is going to end in the next three minutes and there are a dozen things they must speed off to do. They do not bother with the mirror provided and are ready to dash off with their tie knotted somewhere around their left ear or with buttons in the wrong buttonholes. Others will dress methodically and carefully, so slowly that it begins to look doubtful if they will ever leave. After about fifteen minutes, they have still only managed to get as far as shirt or blouse, and socks or stockings. As their tie is being reknotted or skirt adjusted for the twelfth time, we begin to regret that we have left them in a room with a mirror.

Noticing such extremes of behaviour is valuable because it can have a direct bearing on the identification of the official in distress. Why is someone in such a desperate hurry after one commitment to get to the next? Is he not able to enjoy the interludes when no one is asking or expecting him to do something useful or important? Why is someone so fastidious that he is prepared to spend ages making sure that he is immaculately dressed? Is it a form of escape? Is it that while he is perfecting the detail of his appearance he can avoid facing some major problem in his life? Perhaps he feels so inwardly inadequate that he has to hide it by making sure that everything is outwardly perfect?

There can be many different reasons why people behave in ways which strike us as extreme. We should be alert for such distress signals from the moment the patient approaches the front door until the moment he leaves through it.

Summary

We have now fully completed our procedure for Traditional Diagnosis with the patient. The next step is to correlate the information which we have obtained. We will have anything from ten to thirty pages of notes which we must read, digest and contemplate. Apart from reminding us of what we observed at the time,we will be looking for pointers, the significance of which we may not have fully realised at the time, what the patient said but we did not hear, what the patient showed us but we did not see, what we actually felt but overrode, and the importance of what was dismissed or ignored or omitted. A distillation of all this guides us towards our goal: the identification of the CF, the fundamental, elemental imbalance which is the basic cause of all else. At this stage, we do not aim to identify the particular official in distress. We want to establish which element is in trouble and to plan our treatment on that basic imbalance. After four or five treatments, we can turn our attention to the particular official in that element which is the principal cause of the elemental imbalance.

CHAPTER SIX

SPECIAL CONSIDERATIONS

By and large, the skills of diagnosis tell us not only everything about the patient and his CF but also about the relationships of the elements and officials within. We have established a sound basis for treatment and a comprehensive record of the patient's initial situation from which we can monitor progress resulting from that treatment. Before actually starting the treatment, however, there are two other major issues which need to be considered.

First, there are practical decisions to be made: what form of needle action to use; the level of treatment required; and whether we should incorporate the burning of herb moxa. Moxibustion may be appropriate in conjunction with or instead of needles, or it may be entirely inappropriate.

Second, we need to consider three other factors which may be having a serious effect on the patient's energy flow. Two of these, possession and Husband/Wife imbalance, can be diagnosed directly during the initial examination. They can so overwhelmingly affect the patient's energy-system that, unless they are removed, no treatment of underlying problems will be effective. The third, Aggressive Energy (AE), is a possible factor which we must always test for at the beginning of treatment. The test to check for its presence also acts as treatment for it. It is important to remove any Aggressive Energy at the outset because otherwise it can be transferred and spread throughout the patient's energy system during the course of the main treatment. It is far safer to remove AE and be sure of the diagnostic signs than run the risk that it is influencing them and making them unreliable. If we do strongly suspect the presence of AE and yet our tests reveal no evidence of it, it is advisable to question the accuracy of our point location and test again rather than immediately accept that the negative reading must invalidate our suspicion.

To many people, including students of acupuncture, the terms 'possession and 'being possessed' may sound rather melodramatic and archaic. They are usually associated, in the psychological sense, with stories from the Bible and those modern horror films depicting the way people used to explain madness years ago. However, we only need to consider 'possession' in the basic and simple sense of 'taking over' to appreciate how appropriate it can be as the description of what we may find happening to some patients. It is as if some external agency or force has taken over a part of that person's control of energy. In a very real way, that person is no longer in control of his whole self. Someone who has lost control of a part of his energy system is not going to be able to respond properly to treatment.

The idea of someone being possessed is, as I have said, generally regarded as being outmoded, or reminiscent of superstitious, medieval notions. Having developed all kinds of wondrous modern technology and sophisticated gadgetry, we are reckoned to have now grown up and to have left all that primitive nonsense behind. If we had collectively succeeded in developing our mental and spiritual potential to the extent we have advanced our physical well-being and our material wealth, such an assumption might be valid. The reality is, however, that a person who is strong in spirit, no matter how weak or defective his body, will not be as affected by internal or external destructive forces as someone whose spirit is weak. People whose mental and spiritual resources are deficient are vulnerable. They can more easily become possessed by obsessions of one kind or another. Sadly, this vulnerability is becoming more rather than less common and its incidence owes a great deal to the priorities which our present society sets for itself.

How do we recognise that somebody is possessed? If his energy state is partially or seriously beyond his own control, we will soon sense that we are failing to reach him, that we are not really communicating with him. We will find that we are not getting honest responses, that we are continually talking to a mask or shell. The worst cases are those where the person has lost control of mind and spirit to such an extent that he ought to be in a mental home under external care and control. In such cases, where the person is totally possessed, he simply cannot be reached, nor can he make any sense of what is happening around him. We are not likely to see many such extreme cases of possession, but we will find less drastic degrees of it. During the course of our diagnostic examination, we may reach a point when we realise that we

are not reaching an essential level in the patient, where his spirit is simply unable to respond freely. Up to that point, and on the evidence thus far, he may have seemed perfectly normal and intelligent, able to hold a straightforward and lucid conversation with us. We probably have found that he has a responsible job, a family, plenty of relationships, and an active social life. Gradually we become aware of this point where we sense a block or discrepancy, a kind of vacuum or forbidden area, and we know we have encountered something which is preventing our fully reaching through to the spirit.

An impasse of this kind is quite different in Nature from a person's being very reserved or deliberately secretive. The blocked state of 'being possessed' is not some obscure condition which only the trained eye of an acupuncturist is able to diagnose; most people will sense it when they meet it. The person's eyes often give a particularly clear indication of its presence. With most people we can easily make eye contact and, as it were, see into them. They are willing to meet us and want to see into us. But with the person who is possessed it seems as if there is nobody there. Thus, we will find that where there is possession the patient may not be able to make, let alone keep, eye contact. He will keep his eyes averted as much as possible, as if he does not have the power to do otherwise.

I am emphasizing here the need to be able to see with more than just the physical eye. There are many and usually insignificant reasons why a person might temporarily want to avoid eye contact, and just as many reasons why it might be difficult for us from time to time to reach through to the spirit. If diagnosis of possession were simply a matter of recognizing a particular look in the eye or a particular kind of introverted behaviour, then we would simply be able to look it up in a textbook and diagnose it in five minutes. Possession, however, is far too subtle for that. It is not simply a temporary failure to communicate. It is a failing of the spirit of the person, and in order to see it clearly, we have to be able to see with our own spirit. It is difficult, if not impossible, to expound a comprehensive set of manifest signs and symptoms which will ensure that we can, with certainty, diagnose possession. Even the best practitioners have to work to some degree by trial and error in order to reach a definite conclusion in this area. If possession is diagnosed, then the practitioner knows that treatment of the CF and restoration of balance is impossible while it persists.

It is obvious why effective treatment is impossible if there is possession. Restoring balance means bringing about harmony throughout the whole system. Treatment of the CF will have beneficial effects at

all levels. If there is a blockage of such magnitude at such a depth, completely isolating a part of the system, then overall balance and harmony becomes impossible. Even if the practitioner successfully identifies the CF and is able to make good contact with Qi energy circulation, treatment will be to no avail. Even after three, four, or five treatments, the patient will not improve one iota. This is more than a matter of just not improving as much as would be expected; it is a matter of not improving at all. The pulses remain roughly the same; there are no changes in the patient in any respect; and it is as if the treatment is simply not getting through. If possession has not already been suspected, then such a lack of response to treatment would alert the practitioner to its being a real possibility.

Since the ability to diagnose possession means development and use of the physical, mental and spiritual eye, less experienced practitioners often do not feel confident in making such diagnosis during their early years of practice. They tend to be too conscious of their limitations. Hence, they are quite likely to see a patient's failure to respond to treatment as somehow being their fault rather than evidence of possession. It can be helpful to them therefore to be aware of other indications which point towards the presence of possession.

Causes of possession can be internal or external, and they are not necessarily confined to mental and spiritual levels only. A physical shock, such as exposure to a sudden and extreme change of climate or temperature, can lock a person's energy system into an abnormal pattern which he cannot unlock and restore to normal. At the mental level, possession can be caused by an external influence, as in the case of people who succumb to the hypnotic power exercised over them by others. In this scientific age, we tend to look upon reports of the trance-inducing activities of witch-doctors and the like as being some non-sense practised only by primitive peoples, but there are any number of examples in modern Western society where powerful and charismatic individuals so influence others with their ideas and beliefs that they take over their minds. At worst, the followers can be persuaded into behaving in the most anti-social ways. There are thousands of people involved in many cults which can severely upset the balance of mind and common sensibility. Many people are persuaded to give away some or even all of their spiritual control to others, and in the process become seriously possessed by such external influences.

In the majority of possession cases, however, the causes are internal. Such possession can take place either suddenly or insidiously over a period. The former can happen as the result of some terrible and

shocking experience which literally terrifies the person out of his mind. The latter can happen, for example, in the case of drug-taking where the person is taken over by so-called 'mind-expanding' drugs; or in the case of meditation techniques intended to induce 'out-of-body' experiences. The incidence of possession cases in these areas has increased enormously in recent years. If we have patients who tell us of experiences such as acid trips or mystical experiences, we are not only alerted to the possibility of possession but will also have clear indication of probable cause. We also make sure that we know as much as possible about the context and history of the person's experience in this area so that we can assess the depth and magnitude of the problem confronting us.

Gradual possession is also evident in cases of obsessive behaviour. Such cases usually begin as a slightly odd habit which then grows over time into a compulsion so overwhelming that the person becomes unable to conduct a normal life. There are the sad cases of people who have become so worried about dirt and obsessed with hygiene that all through the day they have to wash themselves over and over again. They dare not leave home to go to work or go shopping or do anything else, so strong is the fear of dirt. The fixation to keep themselves absolutely clean is so intense that it is impossible for anyone else to convince them that their fear is irrational and unnecessary. There are other people who become obsessed with the idea that they are failing to do something perfectly. They will continue to repeat the same sequence of actions over and over again because they are never satisfied. If we come across anything in the patient's behaviour or case history which suggests obsessions of any kind, we become alerted to the possibility of possession.

Whatever the cause, possession has to be eliminated before we can sensibly and effectively carry out normal treatment. For this purpose, there are two sets of points, seven points in each set, which can be used to break the hold of the possession. Such treatment follows set formulae and hence belongs to what we call a different 'patron' of acupuncture, that is, it does not belong to the Five Element tradition. However, since Five Element acupuncture will not work if possession is present, we must 'borrow' this method of removing it. The exact points and the accompanying needle technique need not concern us here. It is usual to expect a reaction from the patient as the possession clears. This reaction can be so mild as to be scarcely perceptible, but in some cases, it can be dramatic, and we should be prepared for it.

In the clearing process, many patients will experience a degree of

shivering or uncontrollable movement. Sometimes there is a sequence of reaction which mirrors the pattern of the patient's decline into illness. I recall one patient whose illness had started with her having fits of violent shaking for several minutes at a time. After she had taken drugs to help ameliorate these fits, she started to have migraine attacks which were so severe that they brought on bouts of vomiting. She then had further drugs prescribed for these after-effects, and they duly abated. But then, as time went on, she started to have sudden rages in which she would go berserk and try to smash anything within reach. When she came to see me, I diagnosed possession and treated accordingly. As soon as I had inserted the needles, she began to shake so violently that the whole couch was shaking as well. This continued for what seemed like an age but was probably only about two minutes. She then got a terrible and instantaneous headache, and then she vomited. Eventually, the sequence of reactions subsided and that was it. She was no longer possessed. She said, as many patients do when possession has been cleared, 'What happened? I feel like a different person. It's as though I have come back into myself.' It is difficult to imagine how it feels not to be aware of or in control of one's own behaviour, not to be in contact with one's whole being. Yet most patients who are cleared of possession speak in similar terms when describing what it feels like to be their own selves again.

Dramatic reactions are not always the case. I would not want to alarm practitioners by suggesting that they are likely to unleash and be witness to something they would only expect to see in some horror film. We are not talking about some kind of medieval exorcism and the casting out of evil. All we are doing is helping to re-integrate the patient's energy into a unified and harmonious system, no part excluded. Although there may be signs of upheaval as adjustment takes place, these signs are not necessarily at all dramatic. It may only be the pulses which give any indication that integration has occurred. Furthermore, it may be that the patients concerned do not notice any perceptible change in themselves. Proof that the blockage has been removed will, however, always be evident in that changes start to take place with normal treatment which have obstinately refused to appear before the clearance treatment.

The ancient Chinese used picturesque language to describe possession and its removal. They spoke of people being taken over by external or internal devils, and needling the special points as releasing the seven external or internal dragons which could drive the devils away. In the rather less poetic language used in Western acupuncture, the use of these dragons in treatment is referred to as 'I.D.s' and 'E.D.s'.

Aggressive energy

Aggressive Energy, or perverse energy, as it is sometimes called, is simply Qi energy which no longer fulfils its proper function of providing nourishment and life to body, mind, and spirit. It is not a different type of energy, but Qi energy which has become contaminated and polluted, and whose quality is poisonous and destructive.

Aggressive Energy will cause problems within the total energy of the body, mind, and spirit. When energy is destructive instead of nurturing, it affects the officials and begins to affect the flow of energy at all levels. Instead of following the natural cycle of nourishment, the Sheng cycle, the Aggressive Energy travels across the Ke cycle and little by little begins to contaminate all the elements and officials. For a further analogy, we could liken AE to cancer. Cancer cells are not alien invaders; they are ordinary body cells out of control. They are living human cells and they are part of the total organism, but they are working counter to the interests and integrity of the rest of the body as they gradually take over the life of the cells around them.

We can measure the extent to which AE is contaminating the total system by assessing the extent to which it has travelled round the Ke cycle. It starts in one predominantly Yin official (Kidney, Heart, Heart Protector, Liver, Lung, or Spleen). This contaminated official, out of self-preservation and in sheer desperation not to poison its child on the Sheng cycle, throws the unwanted, disruptive energy across the Ke cycle. Hence, AE might erupt in the Spleen official, and then travel the Ke cycle to invade the Kidney. From there, it may move on to the Heart or Heart Protector, then to the Lung, and finally to the Liver. In fact, it will never spread right round the cycle because, by the time it has completed three 'legs' of the cycle, the person will most probably be dead. A 'leg' describes the movement from Spleen to Kidney, from Kidney to Heart or Heart Protector, from Heart or Heart Protector to Lung, from Lung to Liver, and from Liver to Spleen. Three legs will, therefore, mean that four out of the five elements will be affected. AE only affects a predominantly Yang official if the AE is transferred from a predominantly Yin official during treatment.

AE is not possible to diagnose without testing for it. Practitioners should test for its presence at the first treatment. Needles are inserted into the Associated Effect Points ('AEPs') on the back which not only reveal the presence of any AE but also actually drain it away. If AE is present, erythema will show around the needles inserted into the AEPs of the affected officials. The disappearance of erythema is the

sign that AE has been cleared. This preliminary treatment must be carried out as a matter of course. The reason for making sure that there is no AE present in the energy system is fairly straightforward. When we have established the CF and planned our treatment, that treatment will most likely be both to transfer energy from one meridian to another and to make connection between different elements. If the energy in one official or element is contaminated with AE, we risk transferring it around the system and hence actually speed up the progress of any life-threatening disease. By testing and treating for AE at the outset of treatment, we eradicate the possibility of any such danger.

Practitioners should never forget that they are the weakest links in this otherwise immaculate system of medicine. We should, therefore, allow for the fact that our needling of the Associated Effect Points will be ineffective if our point location is only as little as one millimetre astray. If we strongly suspect the presence of AE, we must re-check the points we have needled if we do not obtain the expected effect.

It is then important to continue checking for any sign of the presence of AE. One sign of AE can be erratic and unstable pulses. We generally expect the pulses to be a little inconsistent, especially if we know that the patient is in a state of worry, anxiety, or apprehension. Sometimes, however, we come across significant signs of pulse unrest which strike us as far more serious. After we have re-checked and ruled out any misreading on our part, such an aberration will prompt us to investigate what is really happening. Unusual variations in the pulse picture, as though everything in the person's energy system is unsettled and agitated, are often signs that there is a major block such as possession or AE.

Another common effect of AE is the splitting of correspondences where we find the colour, sound, odour and emotion signals divided between two elements across the Ke cycle. The four correspondences normally correlate in indicating a single element in distress but, with AE travelling across the Ke cycle and afflicting two elements, the signs of distress can be split between them. We might find, for example, lack of red and laughing combined with fear and putrid; or yellow and fragrant combined with anger and shouting. The relationship of these correspondences is across the Ke cycle.

Aggressive Energy often arises because one of the officials is being so battered that it begins to lose integrity. Our systems have enormous tolerance and self-healing resources, and they are able to withstand an

extraordinary amount of pressure and abuse. However, we will see patients with burdens which have become too much for them and they can no longer cope. 'Modern lifestyle' is a term too often used to explain or excuse a multitude of bad habits. Many people push themselves for twenty hours a day, snatching a few hours sleep, for years on end. 'I'll be out of the running if I don't keep up', they say. Others fly round the world week after week, their officials being forced to adjust over and over again to continual time change.

In our modern, fast-paced, pressurised world, thousands upon thousands give themselves good reason to abuse their systems, 'Oh, it'll only be for a year or two until I get promotion and I can take control' or, 'Until I retire, get full pension and can afford to relax', 'There's so much to do and so little time to do it. I have to keep going, otherwise it will all get on top of me', 'I'll be alright if I jog twenty miles a day to keep fit', 'Don't have time to eat properly. Keeps the weight down though.' Some will be able to stand these demands on themselves better than others, but everyone eventually pays a price for telling Nature what to do. Such self-deluding abuse is not what Nature ordained as the wholesome way to live.

Fitting in with the demands of modern living causes abuse of many kinds. One example is failure to take proper nourishment. A piece of toast snatched here, a sandwich grabbed there, followed by a dose of greasy take-away food, a make-weight doughnut, an ice-cold drink. All this convenience food is not a sensible and balanced way to sustain the energy system with proper fuel. The relevant officials will do their best to cope with such input for a while, but eventually they will begin to crave regular and balanced meals, and will start to despair and sicken if the junk keeps on being sent down month in and year out. This is true for all other forms of habitual abuse. Alcohol and cigarettes are relied upon for day-to-day support or escape; so, too, are the drugs prescribed by doctors and those sold on the street corner. None of this behaviour aligns with how Nature ordained that human beings should work, feed, and take care of themselves. The officials directly affected take an appalling battering through such continual mistreatment and, as soon as the burden becomes too much for any one of them, a process of deterioration and destruction is set in motion, with ultimately dire consequences.

As with possession, AE can just as easily be caused by contamination at the levels of mind and spirit as at the physical level. We have only to think of the emotional battering that people often suffer, through discordant close and intimate relationships, or the terrible shocks and

traumas they can be subjected to by tragedies and disastrous events in everyday life. Such shocks can, of course, originate at the physical level. They can, for example, be the after-effects of injury or sudden illness. Wherever they come from they can be disruptive enough to cripple an official, so contaminating and perverting its energy that its normal pattern of functioning breaks down under the stress.

In view of all this stress, we might well wonder how on earth anyone can avoid AE, given that no one can entirely avoid such problems. In fact, people cannot avoid it; most, however are able to deal with it and recover from it. Those who do not recover are usually aware that something is wrong. Because of AE contamination, they feel that they are not functioning naturally. They will give out the kinds of signal which we as practitioners will recognise and perhaps relate to something we have noticed about the patient's behaviour. A patient's indication of a continuing, underlying feeling of illness along with our knowing that AE is pervasive will alert us very quickly to the fact that we have been missing its presence or that it has been triggered by some trauma during the course of treatment. Not only will the treatment seem to be having no effect but the patient's condition will deteriorate. When this happens in spite of our remedial help, we can be certain that the AE is particularly destructive.

Husband/Wife imbalance

Of the three major energy imbalances, the Husband/Wife imbalance is the most serious, being the most immediately life-threatening. With possession and Aggressive Energy, Five Element treatment will have little or no effect because they operate as blocks to such treatment. AE also causes the state of body, mind, and spirit to deteriorate gradually as its contaminating effect spreads. The Husband/Wife imbalance, however, is far more dangerous because it is a sign of capitulation. It signifies that Nature is giving up, that the natural inner healing resources of the person are becoming powerless. Losing the power to recover means that the person is actually dying. Many terminally ill patients show pulse signs of a Husband/Wife imbalance as they near death. When a person is deteriorating towards the point of being beyond help, it is inevitable that signs of AE and a Husband/Wife imbalance will be increasingly prominent and frequent.

The nature of the Husband/Wife imbalance is such that the sum total of the energy associated with the Wife side, the right-hand side, become qualitatively stronger than the sum total of those of the

Husband side, the left-hand side. This means that the right-hand pulses (Lung, Colon, Spleen, Stomach, Heart-Protector and Three Heater) will have a clearly stronger quality than the left-hand pulses (Heart, Small Intestine, Liver, Gall Bladder, Kidney and Bladder). Stronger does not necessarily mean in terms of volume alone, since by nature, and thus normally, the left-hand pulses are slightly stronger than the right. What truly characterises the imbalance is the hard, tight, and aggressive nature of the pulses on the Wife side in contrast to the weak, feeble, and flaccid pulses on the Husband side. Generally, however, there may well be an associated difference in volume as well as in strength and quality.

For the Chinese, with their tendency to think in terms of analogous pictures, the relationship between the stronger and predominantly Yang nature of the left-hand pulses and the weaker and predominantly Yin nature of the right-hand pulses was readily appreciated and expressed as being like that between the traditional male role (the husband) and the traditional female role (the wife). The husband embodied the predominantly Yang qualities of outer strength, activity, and movement in contrast with the wife's predominantly Yin qualities of inner strength, support, and stability. Hence, rather than speaking of Yin invading Yang, or of Yang deficiencies, the picture of typical bilateral imbalances could be readily described and understood in more familiar and easily accessible terms. A family in which the wife ruled the husband could not function properly because there was then bound to be continuing competition and strife. The wife's taking on of uncharacteristic active roles robbed the family of its inner strength and diminished the husband's responsibility to hunt and gather. The household would thus be doomed. Variations on this theme of the husband and wife relationship aptly describe numerous states of Yang/Yin imbalance and we can see that such states run fundamentally counter not only to nature's intent but also, inevitably, to the integrity of the individual person.

This picture of the relationship of husband and wife will no doubt be seen by many as controversial in these modern times. Women in particular protest that there is no such natural division of responsibility between the genders and that women and men can successfully interchange nearly all roles if they so wish. To avoid such a controversial issue, I could easily dispense with the Husband/Wife terminology and speak only of Yang and Yin. But that would not change fundamental facts of Nature that are as true for us today as they were for the Chinese thousands of years ago. Men are still, on the whole, physically stronger and faster, and women have the capacity to bear

children whose nourishment, both physical and spiritual, is usually provided by them during the first months of life. That is how Nature decreed gender difference. It is not something which human beings dreamed up one day by themselves. It is because Nature decreed the differentiation that the analogous pictures of the Husband/Wife relationship and imbalances carry the force and clarity that they do. In the matters of health and remedial medicine, Nature provides the criteria by which we should abide at all times. Imbalance implies an offence against Nature, a deviation from natural law. The perpetration of such offence and deviation can be so devastatingly destructive of the person's energy system that it becomes no longer possible for that person to survive.

Diagnosis of a Husband/Wife imbalance can be made just by reading the pulses. The fact that the strength of the pulses usually corresponds with their volume means that even a relatively inexperienced practitioner can quickly become ninety percent certain of correct diagnosis. This is fortunate, since a Husband/Wife imbalance is a life-threatening condition, and we cannot afford for weeks to elapse between suspecting its presence and the definite identification and treatment of it.

Immediate and one hundred percent certainty of diagnosis comes with ability to read subtle qualities of pulse and such ability is too much to expect of practitioners even after five years or more of practice. However, what usually happens is that patients themselves tell us in so many words that they have a Husband/Wife imbalance. We will often hear of a typical progression. The condition may start with a small physical problem which not only proves persistent but gradually seems to get worse. There may come a stage when the physical problem starts to matter less than a succeeding mental problem. This, in turn, becomes worse and so invasive that the patient's whole life seems frustrated and blocked. The problem may then go to the spiritual level and the debilitating mental confusion gives way to utter despair. We may see this progression as evidence that imbalance has penetrated deeper and deeper into the person and will, thus, be left in no doubt that a Husband/Wife imbalance is indicated.

What then of the patient we find already in utter despair and on his last legs? Progress towards this terrible state can only have come about because body, mind, and spirit have already capitulated, and such a patient may be beyond our help. How do we distinguish this extreme condition from one where there is serious deficiency in spirit and similar problems at other levels but all arising from a different and less

intractable cause? There is no simple answer to this. In the extreme case, pulses are generally very, very unnatural and imbalanced, and the person in such terrible decline because of a Husband/Wife imbalance will often express total resignation and a lack of will to continue living. Nature has literally given up at the level of survival instinct. It is as if that instinct is no longer operating in the person and he does not care whether he lives or dies.

We will quite often find that our diagnosis of a Husband/Wife imbalance is corroborated by the patient's having suffered some catastrophe in his private life, usually in the context of a close personal relationship. The trauma or loss will have left a wound or block which has not been properly resolved. The loss quite often may be the death of an intimate partner or a close relative; the trauma often due to the break-up of an intimate relationship. People with a Husband/Wife imbalance often seem to have a history being unable to form and maintain good and stable relationships. The patient will often speak of the catastrophic event as being an indelible turning-point in his life, the point when his life started to go inexorably downhill. 'Ever since my wife died...' or, 'After the break-up of my marriage...' They are in effect telling us that the event has proved too difficult to resolve. Traumatic causes of a Husband/Wife imbalance also include such experiences as sexual abuse during childhood and terrible relationships with parents or siblings. Such early life situations often lead to appalling conflict in the mind because the natural instinct to love all such close relatives has to contend with the shame or hatred of something sordid or horrible associated with them. If, as practitioners, we are fully alert to see, hear, feel, and ask, patients will themselves guide us towards diagnosis of a Husband/Wife imbalance and tell us the cause of it.

The principal aim of treating a Husband/Wife imbalance is to transfer excess energy from the Wife's side back to the deprived Husband's side in order to reinstate proper and natural balance between them. It is simply a case of the patient's energy being biased, with the Wife's side holding on to energy which does not rightfully belong to it. Treatment varies in degree of strength rather than in kind. Just the one transfer of energy can be given at increasingly powerful levels until control has been returned to the Husband, in effect literally coercing energy across from the Wife's side to the Husband's side. Once the previously established imbalance is broken, recovery is dramatic and quickly complete. However, we have to bear in mind that the energy system may have been unnaturally biased for a long time and that, therefore, we may need to maintain support in order to avoid the

imbalance slipping back. The process is rather like preparing waste ground for cultivation. Getting rid of the rubbish and pollution only creates the potential for new growth. We have to be sure to tend and nurture the ground through a whole year's cycle of seasons to be sure that what we have planted will grow and produce a full harvest. Once we have cleared the imbalance, we must carefully nurture the patient throughout the following months. If proper balance is then maintained for twelve months, we can be sure that the imbalance has been fully and permanently rectified.

The three major imbalances or blockages of energy I have discussed, possession, Aggressive Energy, and Husband/Wife imbalance, are becoming more frequent in our modern world. As people become further removed from natural lifestyles, and thus become increasingly out of touch with Nature in the barren and bleak environments we are creating for ourselves, they become deprived of spiritual resources. In turn, that leads to people becoming increasingly prone to these blockages and imbalances. In Traditional Diagnosis, we have to keep this tendency very much in mind all the time because treatment will be almost or totally ineffective if any one of them is present in the patient. What is more, if we treat while one of them is present and we have not diagnosed it, the patient may steadily deteriorate rather than improve and recover.

Other energy blocks

There are other, simpler energy blocks which we may encounter during diagnosis. Energy in the body, mind, and spirit flows according to natural rhythms in the days and seasons. The cycle of nourishment (the Sheng cycle) and the cycle of control (the Ke cycle) have already been mentioned. There is another flow of energy, at a more superficial level, which follows the pathways of the meridians in their numerical order: I - Heart, II - Small Intestine, III - Bladder, and so on. This is called the Wei flow of energy and its function has much to do with the protection of the body from outside influences.

The word 'superficial' is not used in the sense of little importance but in the sense of surface level. Although this flow is primarily associated with the body and physical function, it is none the less as important as any other. If we consider the tide at the seaside, we know that it both ebbs and flows daily and that its levels change during the year as the seasons change. The two movements, in and out and up and down cannot be divorced from each other. Likewise with the flow of energy

at the Wei level. The energy flows of body, mind, and spirit are inseparable and so, if the energy flow round the surface of the body is blocked, then it is impossible for the mind and spirit not to be affected. The immediate, manifest effect may be predominantly physical, but mental and spiritual effects take place as well.

In order to maintain overall balance and harmony, the Wei flow must be smooth and even. During diagnosis, we sometimes find evidence that this is not so in some patients. This may be due to a blockage of energy along the pathway of a particular meridian or it may be due to a blockage between the exit point on one meridian and the entry point on the next one in the cycle.

The basic method for diagnosis of such a blockage is the taking of pulses. Any blockage will act like a dam and, if this happens along or between meridians, a reservoir of energy will build up behind it. On the other side of the blockage, there will be little or no energy flowing at all. The most obvious sign of this situation will be the relative volumes of the associated pulses. There will be an enormous difference between the pulse of the meridian before the blockage and that of the pulse after it on the Wei cycle. Blockage is not the only reason for large disparity in the relative volumes of pulses but, if we do diagnose it, it must be treated first because normal five-element treatment cannot establish balance where there is a serious disruption of flow. Energy needs to be freely and smoothly flowing at all levels.

Apart from pulse irregularity, there are quite often physical signs of blockage. Sometimes these indicate the cause of it. Scars from injury, past bone fractures, surgical interventions, amputations, contusions, congestions, tumours, and oedema alert us to the possibility that the energy flow may have been seriously affected. If we find such indications during the physical examination of a patient, and also find that relevant pulses are quite badly imbalanced, we will certainly suspect a blockage. This often leads to pain or physical problems in the patient. When energy is not flowing freely and smoothly, it becomes congested and aggravating. We are not surprised, therefore, to find complaints such as migraines, headaches, sinus problems, tinnitus, and rashes in the area where the blockage has occurred. Sometimes these areas become acutely tender and painful and we are soon guided to the site of the blockage through the patient telling us where he suffers such discomfort.

The fact that such blockages often manifest themselves most obviously at the physical level should not lead us to overlook the fact that, since

all levels are interconnected and interrelated, there can also be signs of serious blockage at mental, emotional, and spiritual levels. We have only to think of the various functions of an official to realise that, if it has no energy or an over-abundance of it due to a blockage, then its performance of all those functions at all levels will be affected. We can imagine the damage to the whole system that could result if all the energy of the Wood element and officials became pent up, or if the other officials became deprived of sufficient energy to carry out their tasks of regulating and harmonizing the whole system. We must never forget to take into account the interconnection between and the interrelatedness of all the levels when dealing with any aberration, no matter how superficial its manifestation.

These blockages of the Wei cycle, which we refer to as exit/entry blockages, are just as important to diagnose and treat as the major imbalances. It is often that a relatively simple treatment of an exit/entry or an entry/exit block relieves the patient of some physical symptom which has been troubling him for years. There are many times when the progress of treatment according to the natural laws comes to a halt because of an exit/entry blockage. Once careful investigation reveals the blockage and it is removed, the progress resulting from normal treatment resumes.

During diagnosis, therefore, we look out for blockage at the Wei level along with everything else. If there is a problem disrupting the energy flow, the signs are bound to be evident. Imagine the state of the poor officials who are bursting with excessive energy and have nowhere to send it. What better way to cause them distress than by feeding them with more and more energy which they simply cannot cope with? And what about the officials on the other side of the block? No energy is feeding them and the more depleted they become, the greater their signs of despair and the louder their cries for help. Colour, sound, odour and emotion signals may play their part in indicating blockage. They may provide evidence which we are confident is unrelated to the CF, which will lead us straight to the cause of the distress.

Occasionally, blockages can occur at a more fundamental level, in the two meridians which together circle the trunk of the body, the Conception Vessel and the Governor Vessel. These meridians in relation to the others are as oceans to rivers. If there is some blockage here, the effect of depletion will be severe because all of the meridians dependent on one or other of the Vessels will be affected. The signs of such depletion will be low pulse readings on all meridians and a tremendous overall loss of strength and quality, manifesting as a serious loss

of vitality and spirit in the person. No energy is reaching any officials and they are barely surviving. This situation is not always easy to diagnose because there can be other reasons why the pulses are low and why the patient may be desperate and spiritless. If after a few normal treatments there is no improvement in condition and we suspect that blockage at this fundamental level could be the reason, treatment of the exit and entry points of these two Vessels may be necessary.

Levels of disease

If we carry out Traditional Diagnosis properly, then we will have all the information we need to be able to plan treatment. In planning, there are three matters we have to consider, the level of the patient's illness; whether to use moxa; and what technique of needle action to use.

We need to be very careful in determining the level of illness. We could be tempted to conclude that a patient is sick in body only, in mind only or in spirit only. This is impossible. If the body is sick, the mind worries and the spirit grieves. If the mind is sick, the body and spirit will suffer from its confusion; if the spirit is sick, there will be no will to care for body or mind. As I have emphasised over and over again, imbalances, and the illnesses arising from them, are always experienced at all levels.

There are times when we find that principle difficult to believe because we will sometimes meet the patient whose problem does really seem to be on one level only. There can, for example, be those whose spirit is shining clearly from their eyes, whose minds are as lively and lucid as can be, and who come complaining only of something like a troublesome knee. Apart from the odd minor pain here and there, now and again, there seems to be nothing else wrong at all. There are those who are clearly bursting with physical fitness and health, and whose eyes are full of good spirit. The only reason they say they have come is because their minds are so active and busy that they find it hard to relax and to get a good night's sleep. They are apparently not at all troubled either physically or spiritually. We may even be impressed to hear that they make good use of their mental overdrive by harnessing it to accomplish extra work or good deeds, or pursuing several hobbies. It is simply that they do not feel quite right and they want us to give them a little more peace of mind. We can have patients who come looking like gods or goddesses, fit, tanned and

healthy. They also seem perfectly sound in mind, full of good humour and have as balanced an outlook on life as anyone could wish for. The only trouble they say is that they often feel aimless and without purpose in their lives. We can see from their eyes that they are lacking the fire and spirit of interest, enterprise and enthusiasm. They are spiritless.

All three such patients are extremes, not at all typical, and, no doubt on further investigation, deceptive. In conscientiously following the principles of our practice, we will surely find that if one level is clearly out of balance the others, to some degree, will be also. However, we make a decision about the primary level of illness and that will determine our selection of points and the type of treatment required. We decide which of the three levels is in the most trouble and needs to be the focus of our help at this time.

Just as sickness does not occur on one level alone, so there are no acupuncture points which affect one level alone. The least to the most experienced practitioners will most frequently use the command points which beneficially affect body, mind, and spirit in a variety of ways. Simply using a source point also helps to restore balance at all levels simultaneously. It is thus possible to treat the spirit with command, source, and simple element points. There are, however, certain points which reach the spirit even more directly. If a person's illness is primarily at this level, we may select these points in order to bring help directly to his spirit. The same principles apply with mental problems. There are a few points which we know bring about greater stability at this level more quickly. We can select appropriate points when we are certain of the primary level of illness and judge it important to reach the root of the problem at that level as quickly and effectively as possible.

Knowing the primary level of a patient's illness and the seriousness of it also gives us a much clearer idea as to how long it is likely to take to bring about beneficial changes and the kind of changes they ought to be. The prognosis for a patient who has had a bad knee problem for six months is going to be very different from that for a patient who has suffered from depression for twenty years. Whatever the forecast, we will be trying to the best of our ability to bring Nature's healing powers to bear on the problem at whatever level. Occasionally, we achieve what some might call 'a miracle cure', an unexpectedly rapid, complete, and wonderful change for the better. In general, however, we know that the deeper the level of disease and the more troubled the spirit, then the longer the natural healing process will take.

This assessment of the patient's prospect is important because we need to have a rough idea in mind of the rate and kind of progress we can realistically expect. Then we can be sure that our treatment is properly effective and that all is going according to plan. If we judge that improvement is likely to be subtle and slow, then we can adjust our expectations accordingly and be appropriately patient. This is especially true at the physical level. Someone who has had arthritis for twenty years is going to make much slower progress than someone who is suffering from a knee injured a month or two ago. Exactly the same logic applies to mental and spiritual problems. Someone who has been carrying the burden of a terrible childhood for forty years cannot be expected to heal as quickly as someone who has been stuck in grief for a year.

It is astounding how much the level of disease has changed within my lifetime. When I first began to practise, the vast majority of my patients were relatively strong in mind and spirit and they thus presented predominantly physical problems, usually the result of the poor conditions in which they lived. Despite all the modern advantages of good housing, heating, and food, physical problems have not only persisted but have become more common. This is not, however, because the physical level is still the primary source of illness; it is because people are so much more troubled at the level of the spirit. It is illness at that level which is causing damage to the elements and hence causing all problems at the mental and physical levels. There is now so much more illness at the level of the spirit that we increasingly need to use points which make direct and strong connection with the spirit in order to facilitate the healing process.

Use of moxa

To treat illness and imbalance, we can use the herb moxa on the points as well as needling them. The herb traditionally used by the Chinese is similar to the English plant mugwort. The plant is dried, crushed into powdery grass and rolled into small cones a few millimetres high. These cones are then burned on the acupuncture points, the heat generated directly warming the Qi energy in the meridians. Moxibustion, as this technique is called, has been used in the practice of traditional medicine just as long as the insertion of needles. It can be used either by itself or in conjunction with needles for the purpose of stimulating flow of energy.

Moxa must be used with care. It is very important during diagnosis

and when studying our notes afterwards that we take heed of all factors which may affect our decision as to whether the use of moxa is appropriate. It would probably not be used on patients showing external signs of excessive body heat such as flushes, florid appearance, and reddish skin hot to the touch. Having siad that, there are some circumstances where the diagnosis may lead us to use moxa even though these signs of excess physical heat exist. There may, for instance, be a tremendous deficiency of heat at the level of the mind or spirit.

Patients showing exactly the opposite signs are likely to benefit from moxibustion, although again this depends on the diagnosis rather than being a hard and fast rule. If such patients have a pallid complexion, frail appearance, and are cold to the touch because of low blood pressure and poor circulation, then they need heat as well as energy-adjustment to help restore balance. Such patients may express strong preference for the heat of summer and tell us how they like to sit in front of fires in the winter and hate going out in the cold. From our diagnostic notes and other information given by the patient, we soon know whether moxa will be beneficial or not.

Apart from these two clearly indicated categories of patient, we encounter a third for whom the use of moxa proves important. Although we have found nothing during our examination to suggest the use of moxa, this category of patient does not clearly improve unless and until we do use it. We cover this possibility by using needles first, and if the reaction is poor, by then using moxa and needle in the same treatment and checking whether the reaction is better. Even in the case of a patient who clearly appears to need moxa, we can use this strategy just to make sure. In the majority of cases of patients whose diagnosis does not clearly indicate the use of moxa or avoidance of it, we may choose to try moxibustion after two or three needle treatments to check whether using needle and moxa is more effective.

It is useful to stress again that the crucial category to identify at the outset is the one where moxibustion would definitely be dangerous, and that is where the blood pressure is elevated. To do this, we must essentially rely on our own observations and not allow ourselves to be deceived by what the patient may tell us. I mentioned earlier, in the context of taste, that a patient's excessive intake of a particular food can initially help to restore balance, but that after a certain point a continuing intake can create an even worse imbalance than at the outset. In just the same way, we will find patients whose craving for heat and warmth to restore inner balance has become so insatiable that

they go on asking for more when every physical sign is screaming that the body is already boiling over. In such a case, moxa would most definitely be out of the question.

Needle Action

The final matter which we have to resolve in planning treatment is what needle action we should use. Usually we will use the same action on all points selected for a particular treatment. We are therefore making a straightforward choice to use tonification only or sedation only.

The two techniques are as follows:

Tonification
Insert needle slowly, as the patient breathes out
Insert needle in direction of flow
Rotate needle 180° clockwise, as the patient breathes in
Remove needle immediately
Remove needle quickly
Seal needle hole with swab and pressure

Sedation
Insert needle quickly, as the patient breathes in
Insert needle against direction of flow
Rotate needle 180° anti-clockwise, as the patient breathes out
Leave needle in for between 5 - 45 minutes
Remove needle slowly
Leave needle hole open and uncovered

The words 'tonification' and 'sedation' suggest speeding up and slowing down, increasing and reducing. Whilst these associated meanings can be helpful, they sometimes lead us astray. Judgment as to which needle action to use comes from our reading of the pulses. If the patient's energy levels, especially those relating to the CF, are lower than the norm which we consider appropriate, we want to use the action of tonification to stimulate and increase the energy flow. At the same time, however, we might also observe that the patient is outwardly showing signs of manic hyperactivity, and we might then think that the last thing the patient needs is 'speeding up'. What we have to remember is that the hyperactivity is a sign of imbalance and that such outward signs, whether suggesting too much or too little energy, do not matter. It is the underlying imbalance itself, indicated

from the pulses, which matters. A child who is being fed too much may not be jumping around complaining but may be sluggish. A child who is not getting enough food may be the one making a racket in order to try to get some until it becomes too weak to make a fuss. So, inner depletion can beget frantic outward activity. In the above case, therefore, we must tonify on the basis of what the pulses dictate, not sedate on account of the person's behaviour.

Conversely, if the CF pulses are too high, then we will need to sedate the CF. It will not matter that the patient sits limply in the chair or drags across to the couch looking like the very antithesis of an Olympic sprinter in action. If the pulses are too great in volume, the energy needs to be calmed down and dispersed, despite any outward contradictory signs. Pictorial analogies drawn from Nature are always useful in diagnosing a situation. If we imagine a swollen river threatening to flood, there are several ways in which its flow returns to normal. Water can be drawn away or barriers impeding its course can be removed. This is how we should visualise sedation.

The choice between tonification and sedation is obviously very important because we are deciding what kind of help to offer to the officials. If we make the wrong choice, we are going to be a hindrance rather than a help and will thus make it difficult or impossible for them to co-operate with us. If they are already over extended and we then pile on the pressure, there is no way that they are going to be able to restore harmony and balance. If they are already depleted and we pull the plug and drain away the energy they have left, they will be considerably worse off. Although it is difficult to do serious harm through incorrect acupuncture treatment, because most of the points we use have a kind of 'safety factor' which prevents any negative intervention from being irretrievably disastrous, we must never think that we have a margin for carelessness. We must be sure every time that we are helping rather than hindering the officials; otherwise they will no longer trust and respond to us. If we do not pay proper respect and attention to their needs and in any particular treatment choose the wrong needle action, it may take five to ten further treatments to redeem our mistake, and to earn their forgiveness. As a general rule, the vast majority of the patients we treat are likely to need tonification. Pulses showing a need for sedation are less common.

Summary

Having now looked at all aspects of Traditional Diagnosis, including

relationships between the elements and guidance towards the Causative Factor, we have established an extremely powerful and firm basis for treatment, for feeding the officials with exactly what they need to restore balance and health to the patient. We must, however, keep in mind that diagnosis is not just a one-off event at the beginning but a continuing process. We refer back to the original diagnosis over and over again as treatment progresses, but we also monitor the signs and messages from the elements and officials over and over again during the treatments. In other words, we continually diagnose all the time.

Our patients under treatment will be adjusting and changing continually and we may, therefore, find new situations arising as old ones recede. If we have a patient who has never needed moxa, has always been tonified, did not have AE, was not possessed, had strong Metal officials and plentiful reserves of energy, we cannot assume this is a permanent state of affairs. We keep looking afresh at the patient every time he comes for treatment. That is why so much emphasis is placed on diagnosis in this system of medicine. It is not like some party piece which we perform with each patient and say to ourselves, 'Well, that's over and done with.' We learn to see diagnosis as a continuing process which is so essential and exciting that we find ourselves wanting to do it as long as the patient remains in our care.

I hope it will be evident that Traditional Diagnosis is challenging, exciting and, given the uniqueness of each patient, never the least bit repetitive or monotonous. As practitioners fully committed to this system of medicine, we need to give our full attention to the diagnostic examination of each and every patient, being aware of the person's every movement, every gesture, every sound, every emotion. When we do this, and are then able, through diagnosis and treatment, to help Nature remove the cause of his disease, in body, mind, and spirit, then we will find that there are no words which will be able to adequately describe the pleasure we will share with patients whose lives have been changed beyond measure by the incomparable insight and wisdom of this system of medicine.

LIST OF APPENDIXES

APPENDIX ONE

OTHER QUESTIONS

It will be no surprise to hear that colleagues with whom I have discussed this volume have expressed their views on the contents. In particular there have been suggestions that I should mention areas of questioning in the TD which they found to be of great value in making a diagnosis. Every one of these suggestions is valuable and I, too, have over the years gleaned enormous amounts of information from simple questions such as 'What are your hobbies?' and the like. My main purpose in this book has been to illustrate the method, however, and I am not exaggerating to say that someone who uses his God-given skills could perform a diagnosis talking about train-spotting, if that is what the patient loves most of all in the world. The body, mind, and spirit will make use of any material to tell us where its problems lie. It is up to us to be able to see, hear, and feel the message however it may be expressed.

It would have defeated my purpose in explaining the beauty and simplicity of the method which we use by burying it under thousands of words, and so this volume has not included everyone's favourite questions. I have, however, listed in this Appendix some questions which practitioners seem to use regularly to good effect. We must remember, indeed, that we do not always look for great emotional depth and insight with every question and answer. It is sometimes handy to have questions which appear very neutral just to encourage the patient to talk, and something as basic as, 'What is your daily routine?' can be very helpful in establishing a flow.

Examples which come to mind are:

'How do you spend your leisure time?' 'What are your hobbies?'

'What is it that you get from your hobbies?'

'How do you see your future developing from here?' 'Where do you see yourself in five years' time?'

'If someone asked you to give a short description of yourself, what would that be?'

'Are you having any other form of therapy besides acupuncture?' 'Have you ever tried any other therapies before?'

'What would you like to do when you are better that you are not able to do now?'

'What is your daily routine at home?' 'In the office?' 'At work?'

'Do you ever get any general aches and pains that you just put up with?'

There are occasions when I have known practitioners to ask the elements and officials directly how they are by questions such as:

'Do you get angry very often?' or 'Do you feel frightened very often?'

This can be followed up very quickly by asking the patient to be more specific in telling us what types of things or situations make him angry or fearful. Other practitioners make very effective use of the kinds of context in which the emotions are expressed by asking open questions. I have already mentioned in the text how someone in whom an imbalance has made grief his all-pervading emotion is likely to spend a great deal of time regretting the past and not being able to let go of things which are best left behind. To ask someone if there is anything missing in his life or if there is anything which, if he had it, would have made his life different may draw a very powerful response from a grief-stricken person. We can do the same with anger, fear, sympathy and joy by converting the abstract emotion into the kind of situation where we might expect it to be in evidence. This can lead to some very elegant emotion testing by revealing whole new areas of a patient to us, and touching him at a very deep level.

The most critical factor remains the same, however, and that is that we have to be in touch with that emotion in ourselves when we use these kinds of questions to have any hope of establishing sufficient rapport with the patient to allow him to trust us. It may be worthwhile, in fact, for people reading this volume to try a little exercise that we set our students on occasion. All it demands of them is that on twenty occasions in a day they ask people they pass in the street or meet in the shop, 'Could you tell me the time?' with as much joy or anger or grief as they can muster. The results are always fascinating, especially when they realise that the miserable looks and blank responses are not aimed personally at them but are the message from the officials in the stranger saying, 'I'm not having any of that, thank you very much!'

Just as important are the looks of total recognition that they get when the emotion which they are projecting really reaches a stranger. The question is just as valid as any of the ones which I have mentioned above. It is probably as valuable to think of all the other ways in which we can ask questions rather than to become too dominated by the idea that there are areas which we have to know about at all costs.

APPENDIX TWO

EXAMPLE PREFACE SHEET

Patient: May Clark D.o.B.: -/-/28 Age: 62

Address: 47 Somewhere Street, Any Town

Married 40 years
3 children, 7grandchildren

Tel: -

Occupation: Civil Servant

Main Complaint
'I have this sort of malaise, and I don't feel right in myself'. 'I feel as if I've got nothing'. 'When I have the malaise I get these pains around my side that come on with it.' 'I've also got back trouble, and I really feel a lack of vitality most of the time'. 'I'm just so tired.'

Other Complaints
'I used to get terrible migraines, and also a feeling of terrible cold, like I could never get warm, but these both went when I went through the change'. I get the occasional headache now, and sometimes a little cystitis but neither as bad as I used to get them'.

Medical History
'I had this problem when I was 3 when most of hair fell out, but I don't know what it was. 'I've had mumps, measles, whooping cough, chicken pox which was so bad they thought it might be smallpox'. 'Also cystitis and migraines. I had my gallbladder removed twelve years ago and my appendix was removed during same operation. I wasn't very pleased about that'.

Sleep
'I must be in bed by 10.30 or I can't sleep after that'. 'I wake up during the night at least twice to go to toilet, and once I'm awake I tend to stay up, usually from 3.00 till 6.0.'

Appetite
'I do enjoy food, and I've put on weight.' Enjoys salads, wholemeal bread, dislike salt, and doesn't like sweets. 'I like chocolate but I try not to eat it. Small main meal in evening.'

Fluid intake/alcohol
6 teas and 2 coffees with milk and 2 sugars in each. A little beer or white wine (dry, homemade). Fruit juices.

Bowels
'Every other day, it's always been a little problem.'

Waterworks
'I have to go often, especially at night, and I used to get cystitis really badly.'

Perspiration
'Normal now, but I never used to perspire at all before the change.'

Periods
'They started when I was 15 and they used to be really heavy with terrible cramps.'

Prescribed Drugs
'I used to take aspirin painkillers but not if I can help it.'

Smoking
'I used to smoke from when I was 18 till I was 33, when I gave up.'

Season
Prefers Summer, dislikes Winter.

Colour
'I adore red, but can't stand brown or black.'

B.P. 145/85

C.	Yellow
S.	Singing
O.	Fragrant
E.	Sympathy

C.F. Level EARTH Spirit

Spring 10.30 GMT

-1	-1	-2	-2
+1	+1	-2	-2
-1	-1	-1	-1

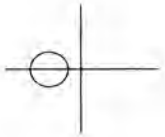
APPENDIX THREE

RECORD OF PHYSICAL EXAMINATION

PULSES
Spring 10.30 GMT

-1	-1	-2	-2
+1	+1	-2	-2
-1	-1	-1	-1

CENTRE PULSE



THREE CHOU

-1
+1
-1

J.A.D.

I	No	V	No	IX	No
II	No	VI	No	X	No
III	Yes	VII	No	XI	Yes
IV	Yes	VIII	No	XII	No

ALARM POINTS

I (CV 14)	No	V (CV 15)	No	IX (IX 1)	No
II (CV 4)	No	VI (CV 17)	No	X (XI 25)	Yes
		(CV 12)	No		
		(CV 7)	No		
		(CV 5)	No		
III (CV 3)	Yes	VII (VII 23/24)	No	XI (CV 12)	Yes
IV (VII 25)	No	VIII (VIII 14)	No	XII (VIII 13)	No

AKABANI

I	7/9	V	9/9	IX	8/10
II	6/7	VI	9/10	X	5/7
III	12/11	VII	5/5	XI	10/13
IV	10/12	VIII	9/7	XII	9/12

BLOOD PRESSURE
145/85

SPINE Straight, pronounced curvature to LHS, C7 - T5

SACRO-ILIAC JOINT Restricted both sides, less movement LHS

LEG LENGTH Left leg 1" shorter

JOINTS Cracking in shoulder and knee joints without restriction of movement. No major restrictions in other joints

HEAD MOVEMENTS Restricted to both sides, head moves out of vertical plane rapidly

POSTURE Rounded shoulders, spine curved forward and head carried downward as a result. General air of 'slumped' pose and reluctance to move

FLESH Ample, especially in lower abdomen and upper thighs, not oedematous but firm and relatively elastic to pressure

MUSCLE TONE Muscles not maintaining shape and size, and movement and grip do not suggest that they retain their former strength. Poor tone

SKIN TONE Generally dry, especially on shins where the flaking is very noticeable

SCARS Scars from gall bladder removal and appendectomy

OEDEMA Moderate

TEMPERATURE DISTRIBUTION Feet slightly cold to touch, remainder of body and limbs warmer than average

HEAD HAIR Grey, dry, and well kept

BODY HAIR Scanty, very fine and fair

TEETH Yellowing but straight, no signs of marked decay or multiple fillings

EYES Clear, myopic, no other reported problems

APPENDIX FOUR

TAKING THE PULSES

I have said in the main text that pulse taking is a subtle and complex art which takes many years of practice. The twelve pulses have to be measured for relative volume and each may have any one or more of twenty-eight distinct and separate qualities. After many years of practice a good practitioner should be able to read a good deal of a patient's history and current state from the pulses.

There is no prescription for learning pulse taking other than hard work and humility. Where practitioners find that they are not making progress in recognising more of the subtle characteristics of the pulse we are very often able to identify simple mistakes in their basic technique which cause most of their problems. Even before the practitioner has taken the wrist, he should ensure that the patient is relaxed, sitting or lying with the arm level with the heart, have his legs uncrossed, and have no jewellery or watches restricting any of his limbs. It is not possible, for example, to take a sensible pulse reading from someone who has just run to the door because he is worried about being late. The only thing which we can do in these circumstances is to let the patient relax, take the pulses in twenty minutes time, and hope that leaves enough time for treatment. If the person is both late and out of breath from rushing it is probably better not to treat at all than to trust a pulse picture taken under these conditions.

The practitioner should also be properly grounded. The best stance is balanced with equal weight on both feet, eyes closed, and with the patient's arm grounded against the practitioner's leg or stomach so that is is not able to move around. There should be as little external noise as possible, and the pulse taking should not be done at inordinate length. It becomes more difficult to feel anything with great subtlety the longer that contact is maintained. Care should also be taken to use only the sensitive parts of the tips of the fingers, and fingernails must necessarily be short to let the tip be used.

These are all common sense, and yet many practitioners forget simple rules and wonder why their pulse reading is not very effective. The same applies to the positioning of the fingers. The middle finger is lined up with the styloid process of the radius, the bony prominence

near the wrist, on the lateral edge of the forearm. The centre pulse position, that which corresponds to the Liver and Gall Bladder on the left hand and the Spleen and Stomach on the right hand, lies directly inside this. If the middle finger is rolled over the styloid process and raised, the tip should be perpendicular to the skin and directly on the pulse. The index finger, when placed down directly next to this will fall directly on the distal pulse position, Heart and Small Intestine on the left, Lung and Colon on the right. Similarly the ring finger, when placed down directly next to the middle finger will lie on the proximal position, Kidney and Bladder on the left, Heart Protector and Three Heater on the right. The thumb is used as a fulcrum to maintain the finger as vertical as possible to allow the tip to remain on the pulse.

This may all sound a little condescending, especially to experienced practitioners, but it bears repeating because many people think that they can change or adapt this technique. My strong belief is that this is not the case. We always insist that each position is palpated individually, and that the practitioner should ensure that the pulse is directly beneath the centre of the finger. This may necessitate a small amount of adjustment but may be essential to obtain the clearest picture. One reason for this may be the different size of patients, although the importance of this can sometimes be over-estimated. A six foot tall basketball player will have pulses slightly more widely spaced than a six year old, but not so much that a slight adjustment of the fingers will not do the trick.

Perhaps the most common question asked by patients is, 'What exactly are you feeling? Surely you are feeling the pulse of the artery.' The answer is that although the pulse which we are feeling lies on the artery it is not the same as that of the artery. If anything we find that exerting too great a pressure for taking the pulse causes a false reading by creating a 'bounce' from the arterial pulse which can confuse the picture. The pressure required for taking the superficial pulse is very light indeed, with only a slight increase in pressure taking the finger down to the deeper position of the predominantly Yin officials. Greater pressure again takes the fingertip to the level of the artery itself. Most students find this difficult to believe when first told how this is done, and ask very much the same sorts of questions as patients do. Within a very short space of time, however, they are able to detect the two different levels and even the subtleties of 'splits' in the pulses where the two officials within an element, the superficial pulse and the deep pulse are out of balance with each other. More often than not the change which makes this ability develop is losing the fear of feeling nothing at all. This makes them press so hard on the wrist that it

creates some really startling and inaccurate readings.

The pulses are recorded as I have shown in the main text and in Appendix Two. The principal concern is balance between the meridians, and the recording of the volumes of the pulses both reflect this and are the basis for treatment planning. The volumes all relate to what the practitioner would regard as a norm for the person, with a 'check' being the ideal pulse volume for the patient's size and state of health. There will be a world of difference between the 'check' pulse of a fourteen stone athlete in training and a seven stone teenager with anorexia. The range from -3 to +3 covers the barely palpable to the pulse which is almost leaping out of the wrist. Many people assume that an ideal reading would be twelve 'checks' and that the main aim is to create as many 'check' pulses as we can as quickly as possible. We have to remind them, however, that balance is far more important and that twelve pulse of -1 would be far more healthy than six of 'check' and six of -2. With the former we have balance but need to give the body, mind, and spirit more strength. With the latter we would still have several unanswered questions as to why some officials have a great deal more energy than the others.

Qualities which belong to pulses are recorded separately, but do not form part of the usual 'format'. Many people have asked me why this is so and I have given the same reply which I have on many occasions to a whole range of questions. Once we create a slot which has to be filled in we start using our heads and where we use our heads we start losing the use of our senses. The most accurate assessment of qualities comes not when we ask ourselves what quality something has but when the quality literally strikes us by how the pulses feel.

APPENDIX FIVE

MEASURING THE THREE JIAO

The word 'Jiao' is loosely translated as 'burning space' and the 'Three Burning Spaces' are areas of the thorax and abdomen which are considered by the Chinese to have particular responsibility for the maintenance of the flow and production of Qi energy and the creation of a suitable environment for the officials whose corresponding organs fall within each Jiao.

The Upper Jiao is located over the rib cage on the area between the nipples and above, the Middle Jiao falls between the navel and the base of the rib cage and the Lower Jiao falls below the navel on the lower abdomen. The Upper Jiao 'contains' the Heart, Heart Protector and Lungs. The Middle Jiao 'contains' the Spleen, Stomach, Liver and Gall Bladder. The Lower Jiao 'contains' the Kidney, Bladder, Small Intestine and Large Intestine.

Measurement of the Jiao is done by placing the palmar surface of the hand gently on the areas in turn and gauging the relative levels of heat. To obtain an accurate reading the pressure must be light and the patient's chest and abdomen must be exposed to the air long enough to let the heat created by clothing wear off. We have to make a judgement about what we would regard as a norm of temperature for the patient, but of more importance to us is the relative levels of heat in the different Jiao. If one area is much hotter or cooler than the others it may mean one of two things. Either one or more of the officials which reside in the Jiao is hyper- or hypo-functioning, with the result that the whole Jiao is affected, or the Three Heater official which is responsible for the maintenance of balance is itself out of balance and unable to maintain its own function.

The reading is recorded as shown in Appendix Three. More importance is attached to an even balance between the Jiao than each individual Jiao being roughly 'normal' in temperature. It is rare for any treatment to focus immediately on the Jiao themselves. If there is a general lack of balance between the different Jiao it is normally rechecked after five or six treatments on the Causative Factor. This should in itself be sufficient to create change and improvement. The same applies to a general over- or under-heating. In this respect the

Three Jiao are a good source of secondary diagnostic information and evidence of progress rather than a particular imbalance to treat directly. Clearly an official operating in an atmosphere which is too hot or too cold will not function as Nature ordained. If one official is out of balance and its heat problems affect the others within the Jiao the changes from successful treatment can be dramatic not just within the CF element but across the board. If a Liver imbalance is causing the Middle Jiao to overheat this may affect the function of the Spleen and Stomach in the same Jiao. This may produce symptoms from either of these and is one more illustration of the problems which working from symptoms alone can cause.

APPENDIX SIX

THE AKABANI TEST

This is a simple but very important test of the balance of energy within an official. The twelve primary meridians are bilateral and balance between the two halves is as important as balance between the meridians themselves. If there is an imbalance between the two halves this causes all manner of disturbances in the functions of the official. It can also spread along the Sheng Cycle to succeeding meridians and create further disturbances. The importance of testing for this is such that any serious imbalance which is revealed by the test must be corrected prior to any Five Element treatment.

The test itself is straightforward. The patient will be lying down at this stage of the diagnosis and the test is explained to them. They should be told what to expect and a clear signal should be agreed for when the patient feels a reaction to the lighted taper used in the test. Then the practitioner accurately marks the nail points, the points on the meridians which lie next to the nails of the hands and feet. The Kidney meridian, which does not have a nail point, is tested on the medial edge of the little toe nail opposite the Bladder nail point. The hand of the patient is loosely supported so that the patient still has the opportunity to remove the hand if he so wishes. The lighted taper is then passed over the points at a height of about one eighth of an inch above the nail and at the rate of about 2 to 3 passes per second. When the patient feels the point become hot, the taper is removed and the number of passes is recorded. We may also put a finger on the point for a second to take the heat away because the sensation can be slightly sharp, especially on the feet. Each point is tested first on the left hand side, then the right hand side for each meridian in turn, starting with the hands and then moving to the feet. The results are recorded as a fraction left over right, e.g. 8/10 and may warrant treatment if there is a difference of over 30% between the two figures. Hence 8/10 would be an acceptable reading, but 8/18 would not.

This is not an infallible test and if any result is more than 30% out it is re-tested. This is done after a rest of 10 minutes or so to let the point cool down and if the same result is found, it is left again and retested immediately before being treated. This may sound like a rather elaborate procedure but there is everything to lose and nothing to gain

from an unnecessary treatment. The progress of treatment can sometimes be set back if a point is needled unnecessarily. On many occasions, in fact, I have advised students at the College to make a note of very small disparities and to leave them untreated until the CF has been treated perhaps 4 or 5 times. More often than not, they have found that treating the CF restores balance and harmony within the meridians as well as between them.

The average reading should be between 5 and 20 passes. Less or more than that probably means that the taper is too close or too far way, or moving too slow or too fast. Sometimes the taper just touches the skin and causes an immediate sensation of heat, and sometimes ash falls from the end and does the same. There is no alternative then but to start again with that point after a suitable interval.

If the test is done carefully and accurately, however, it can help to reveal imbalances, the correction of which can have profound effects on the patient.

APPENDIX SEVEN

ABDOMINAL DIAGNOSIS AND ALARM POINTS

Both of these simple tests can provide useful diagnostic information by making use of the fact that there are areas of the body which become spontaneously tender or tender to light palpation when there are imbalances in the officials. Neither are entirely reliable, because it is possible for an area to become tender without the corresponding weakness in the related officials and equally possible to have no tenderness at all when there is serious imbalance in an official. On the whole, however, they tend to corroborate the evidence which we get from the primary signs (Colour, Sound, Odour, Emotion and Pulses) and in addition give us a chance to gauge a patient's reaction to touch and pressure, both of which can give us important information.

Abdominal Diagnosis, sometimes called Japanese Abdominal Diagnosis and recorded as JAD in the abbreviated form, involves palpating areas of the chest and abdomen which correspond to the officials. The areas cover all the officials except V and VI, the Heart Protector and Three Heater. Feedback from the patient is vital and the test should be clearly explained to him, together with a suggestion that it would be helpful if he could distinguish between dull tenderness and sharp pain. The fingers of one hand are placed together, flat against each area to be tested. Gentle pressure is applied until the hand is at about a 45° angle to the body. It is best, but not essential, to press in as the patient breathes in and to carry on pressing in until resistance is met. On the area for the Heart official (I) only one finger is used because of the greater sensitivity which people generally have in this area. The results are recorded in any form which can be quickly inspected at a later date if we need to recheck anything.

The test is very simple and can be very reassuring to many patients because it has more than a passing similarity to palpation done by doctors. There are one or two commonsense factors to remember, however. The test is never done on pregnant women or women having or just about to have their period. Equally it would be unreasonable to do it while the patient has a full bladder or should the patient have just had a full meal. Many practitioners are also oblivious to the fact that they are prone to cold hands as much as anyone else and warming the hands up before touching a patient is essential.

The one thing which we must never do, however, is to scare a patient. If we palpate the abdomen and feel lumps or anything which strikes us as odd for anatomical or structural reasons, we must never frighten the patient either by what we say or how we react. If there is some cause for concern there is absolutely no harm in seeking a second opinion and if two practitioners agree that there is something worth checking, it should be possible to suggest that the patient visit his or her GP without giving undue alarm.

Alarm points are listed as part of the Preface Sheet (see Appendix Three). They have a similar function but are slightly more precise in their location. The pressure used with these, because they are actual points, is slightly less, nearer to that used for taking the deep position of the pulses.

GLOSSARY

AGGRESSIVE ENERGY (AE) This is a condition in which the flow of Qi energy in the body, mind, and spirit becomes polluted. It no longer provides nourishment but instead destroys the creative work of the elements and officials. It generally begins with contamination to one of the predominantly Yin officials, such as severe shock or repeated battering from over-use of drugs, or alcohol, and spreads through the system across the Ke Cycle.

AKABANI TEST. This is a short test used in the physical examination to determine the relative levels of energy in the two channels of the bilateral meridians. Any major discrepancy between the amounts of energy in the two channels is referred to as an Akabani imbalance and may be corrected by simple treatments early in the course of treatment.

APPROPRIATE. This is a key word for this system of medicine and for the wider Chinese philosophy of Daoism with which it shares many concepts. All of the pictures of harmony and balance within the tradition contain patterns of elements and phases which should follow and complement each other as a part of the ceaseless flow of Nature. The elements also create and contribute all of the faculties and attributes which human beings have. If the flow of energy is good and the elements are in balance one will be able to meet all the situations with an appropriate response. When there is danger one will be afraid. When there is loss one will grieve. When the flow is poor and the elements are out of balance, one cannot make appropriate responses and may act inappropriately by laughing off loss, being angry when offered warmth and so on.

ASSOCIATED EFFECT POINTS (AEP's) These are points on the Bladder meridian on the back which are directly linked to the organs and officials. Any of the points can be used to bring direct and powerful assistance to an official. The Associated Effect Points of the predominantly Yin officials are also used in the test for Aggressive Energy.

BODY, MIND, AND SPIRIT. These three words are used together nearly all the time at the College when we wish to discuss the patient's

symptoms, the treatment which we give and the changes which we see. They remind us that there is no such thing as 'a body' or 'a mind' or 'a spirit'. There is one flow of energy which moves through all three levels. Using these words together reminds us that the flow can be interrupted anywhere and have effects across the whole person. Hence a problem of the mind or spirit can just as easily emerge as a physical problem, or a physical problem may emerge as a problem of the mind or spirit.

CAUSATIVE FACTOR (CF) This is one of the central ideas of Five Element acupuncture. The Causative Factor is the name given to the element whose weakness, whether congenital or caused early in childhood, is the key to all the patterns of disharmony within the body, mind and spirit. Finding the Causative Factor is the aim of the Traditional Diagnosis and it is primarily revealed by the Colour, Sound, Odour and Emotion, together with the Pulses and other secondary diagnostic information. Treatment is generally geared to supporting the Causative Factor and allowing the system to return to balance.

CAUSES OF DISEASE. The ancient Chinese had relatively few concepts of disease as a result of bacterial or viral infection. If disease arose it was assumed to be either the result of extremes of climate or prolonged exposure to one climate, the so-called 'external causes' or extremes of emotion and the prolonged effects of a single emotion, the so-called 'internal causes'. In practice, matters were never quite that simple and the ability of the body to resist an external factor would depend also on the internal constitutional strength. Although the internal causes are often more relevant to modern clinical practice, the external causes do still feature in many case histories.

CHINESE CLOCK. The Chinese Clock is an alternative name for the Law of Midday/Midnight (q.v.).

COLOUR. This specifically refers to the colour which appears on the face when one of the elements is out of balance. It is seen predominantly on the temples and also, but not as reliably, around the mouth, under the eyes and on the cheeks.

CONCEPTION VESSEL. This is the name given to one of the eight extra meridians. Its pathway runs mainly along the anterior midline of the trunk. This, and the Governor Vessel, are rather like seas in comparison to the rivers of the twelve meridians associated with the officials. Points on these two meridians can have a profound and

powerful effect on the patient.

CURE, LAW OF. This is one of the Laws of the Five Elements. It is most simply expressed by saying that as the body, mind, and spirit return to balance, symptoms tend to re-appear in reverse chronological order, to disappear from above to below, and to leave the body from within to without. This arises from the idea that the disease, which travels deeper as imbalance increases, reverses its path as Nature effects a cure. Patients commonly report a short recurrence of earlier symptoms, sometimes even more severe than the first time, but carrying with them a sense of 'feeling better inside'.

DAO. The Chinese word 'Dao' literally means 'way' or 'pathway', and is virtually untranslatable in its philosophical context. Its general meaning is that of the pathway which all living things must follow in order to find their individual fulfilment. It cannot be precisely defined. In fact, the classical Chinese text of Daoism, the Dao De Jing, opens with the line 'The Dao that can be told is not the eternal Dao'.

DRAGONS. This is an alternative name given to the treatment used to release a possession (q.v.) in a patient. The Chinese pictured the person as being taken over by internal or external demons and the two sets of seven points used to deal with this imbalance were seen as internal or external dragons which were released to expel the demons.

ELEMENT. The term element, in the context of 'the Five Elements', describes a stage in the ceaseless flow of energy in Nature and in the person. The Chinese word is sometimes translated as 'phases' to avoid any suggestion that the elements are like the ultimate building blocks of all matter, a concept that arises much later in Greek and Roman philosophy. This does not do justice to the idea, however, that an element is vital and alive at all times, not just in its 'own time'. The elements do indeed describe the way in which the different facets of the whole come to the fore in their natural rhythms, both annual and daily. The Fire element, for example, represents the phase or the cycle where things and people are in their summer stage of warmth, fullness and maturity. By association this is extended to include many of the mental, emotional, and spiritual qualities of a similar type. In contrast, the Water element represents the winter stage where growth has ceased and activity is under the ground and characterised by determination, resolve, and a will to survive until the spring. The elements together represent a whole cycle of birth, growth, decay and death, and rebirth; but the faculties and attributes which they control and create are with us all of the time and allow us to met the changing

circumstances of our lives appropriately.

EMOTION. This is used to denote one of the five emotions associated directly with the five elements (Joy, Sympathy, Grief, Fear, Anger). Its most common use as a term is in the phrase 'Colour, Sound, Odour, Emotion' where emotion is taken to mean the emotion which manifests most inappropriately in the person as a result of his elemental imbalances and forms a key part of the diagnostic conclusion. It is possible to find a 'lack of' any of these emotions.

GOLDEN KEY. There are occasions in a diagnosis where patients tell us something, or occasionally do something, in a way which identifies the Causative Factor immediately. This can be in the words themselves, especially those using the correspondences of the elements (a famous film director is reputed to have intoned in a deep groaning voice that 'what I fear most is the deep blue sea'), or more often in turns of phrase which show us the person without the mask at all.

GOVERNOR VESSEL. This is one of the eight extra meridians (q.v. Conception Vessel) whose pathway runs along the posterior midline of the trunk and over the top of the head to end on the upper jaw. Points on this meridian can have a profound effect on the person.

HUSBAND/WIFE, LAW OF. This is one of the Laws of the Five Elements. This law states that the sum total of energy in the elements represented in the pulses of the left hand side should be qualitatively stronger than the sum total of energy in the right hand pulses. When this situation is reversed the patient is said to have a Husband/Wife imbalance. This is a serious disturbance in the energy field which must be treated urgently prior to ordinary treatment.

KE CYCLE. This is one of two major relationships between the elements. Whereas the Sheng Cycle (q.v.) is a cycle of nourishment, the Ke Cycle is one of control. The element Fire is said to control Metal, Earth controls Water, Metal controls Wood, Water controls Fire and Wood controls Earth. Some Qi energy flows naturally along this cycle. Also, when Aggressive Energy spreads, it travels across the Ke cycle.

'LEGS OF A STOOL'. This is an expression used in the training of students at the College in Leamington Spa to remind them of the importance of having adequate evidence for a conclusion in their diagnoses. The four 'legs of the stool' are Colour, Sound, Odour, and Emotion and the expression reminds them that one or two legs are insufficient for a conclusion and that three are only just adequate.

MIDDAY/MIDNIGHT, LAW OF. This is one of the Laws of the Five Elements. Sometimes known as the Chinese Clock, it states that in a twenty-four hour period each official has a two hour period of maximum energy, which is known as the 'horary time'. Treatment of the corresponding official at this time is more effective than at other times during the day. This law can also be used to advise patients on how they can most efficiently organise their days to help their natural functions, i.e. the stomach is at its peak first thing in the morning (7.00 - 9.00 a.m. GMT) and food eaten then is digested better than food eaten at any other time.

MOTHER/CHILD. This is sometimes referred to as the Law of Mother/Child and is one of the Laws of the Five Elements. The relationship of the elements on the Sheng Cycle is one of nourishment and care, with each one being described as the mother of the following element and as the child of the preceding element. The wisdom of this description is to direct our attention to the elements on the cycle when we see symptoms coming from a particular element. When the child is sick, the mother can be even more distressed. Treating the mother will only have a short term effect because it is not addressing the real problem. The importance of the picture is to remind us of all the relationships between the officials and elements before we jump to any conclusions about what we see.

NEI JING. The Nei Jing, The Yellow Emperor's Classic of Internal Medicine, is one of the earliest and most important Chinese medical texts. It takes the form of a series of dialogues between the Yellow Emperor and his minister and teacher Qi Po which cover both the theoretical basis of Chinese medicine (mainly in the first half, the Su Wen) and also the practical details of acupuncture and moxibustion (in the second half, the Ling Shu). Much of what follows in all traditions of Chinese medicine has arisen from detailed exposition and elaboration of themes in this book.

ODOUR. This is generally used in the sense of the predominant odour which is used as the basis for the diagnosis of the Causative Factor. The five odours (Scorched, Fragrant, Rotten, Putrid, and Rancid) are a sign of major elemental imbalance.

OFFICIAL. The concept of an official comes from the Nei Jing. It describes a group of faculties, physical, mental, and spiritual, which are seen as under the control of the official and as its domain. The picture used for the officials is that of a group of ministers of the court and great importance is attached not only to what they provide for the

whole person but also how they are vital to the functioning of each other. The concept of the official embraces both the meridian associated with it and also an organ, but is not reducible to either.

POSSESSION. This is a condition in which there is a deep disturbance in the energy within a person which acts as an invading force. The effects of this can range from total insanity, where the person is literally beyond reach, to something barely noticeable which nonetheless is a barrier to successful treatment by any therapy.

QI, QI ENERGY. Qi Energy is the basic force of energy which pervades all living things. However, the Chinese concept is much broader than the modern Western notion in popular use and the idea of living things would extend to cover everything on the face of the planet. The Chinese would see the heaviest and thickest materials as the most dense manifestation of Qi energy and spirit as its least substantial with everything else in between. The Chinese were more concerned with understanding what the various actions of Qi energy were within the body, mind, and spirit than with trying to analyse philosophically what it was.

SEDATION. This is used to describe both a needle technique which involves leaving needles in the body for up to one hour and a general approach to the treatment of someone's energy. Sedation can mean reducing as much as it can mean calming down. The general indicator for the use of sedation as a needle technique is over-full and over-active pulses.

SHENG CYCLE. The Sheng Cycle is the cycle of nourishment where the natural flow of the elements is seen as one in which each element feeds and nourishes the following one in the cycle. The cycle runs Fire, Earth, Metal, Water and Wood. The direction of the flow is important for determining how and where to move energy during treatment and for understanding how a failure of one element may produce effects elsewhere on the cycle because of the lack of nourishment. The Chinese often refer to the fact that a poor winter leads to a worse spring or that a poor summer leads to a bad harvest.

SOUND. This is most often used in the book to describe the sound of voice which becomes apparent when there is an elemental imbalance. The five sounds are Laughing, Singing, Weeping, Groaning, and Shouting and the voice of a person develops one of these as its predominant sound when the corresponding element becomes the Causative Factor.

THREE JIAO. The trunk of the body is divided in Chinese medicine into three areas: the upper chest from the level of the nipples upwards, the area from the nipples to the navel and the area below the navel. These were called the Three Jiao, the three 'burning spaces'. They should be roughly similar in temperature and are tested for this in the TD. If there is a marked disparity in their relative temperatures it can point to serious imbalance in the organs within the Jiao or imbalance in the Three Heater official which is responsible for maintaining an even and settled temperature within the body.

TONIFICATION. This describes the needle action used to stimulate energy, the principal feature of which is that the needle is only inserted for a very short time to achieve the necessary effect.

WEI CYCLE, WEI LEVEL. The Wei Cycle describes a flow of energy along the meridians which follows the numerical order of the officials (I-Heart, II-Small Intestine, etc.). This is at a relatively superficial level within the body and serves as a protective layer of energy for the body. However, any blockages here, either along or between meridians, can affect the flow at the level of the Sheng Cycle and are treated seriously.

YIN AND YANG. These two terms are fundamental to an understanding of the Chinese philosophical landscape within which traditional acupuncture exists. The literal meanings of the terms are 'the shady side of the mountain' and 'the sunny side of the mountain'. What they express is a central feature of Chinese culture and philosophy inasmuch as they reveal that the emphasis is on the relatedness of all things and the complementary unity of parts within the whole. To understand change and transformation is to look at the whole as much as at the individual parts. This is very different from the Western approach which has more of a tendency to look at discrete units and to seek individual causes without reference to the whole. The symbol of Yin and Yang is said to show the relationships between them, namely that each creates the other and that each transforms into the other.

0

INDEX