Evidence is more valuable than logic[1]

A post-modern take on case study evidence

By Nigel Dawes

Mark, an unassuming and gentle man-mountain with a teddy-bear soul and a single-figure golfing handicap, came to my clinic in 1994, diagnosed several months prior with amyotrophic lateral sclerosis (ALS)[2], commonly known as "Lou Gehrig's disease". He had been offered no treatment by his neurologist and little comfort or hope. Today, almost 18 years later, Mark continues to live an active and meaningful life with minimal progression of the illness and an occasional muted complaint that his handicap has recently fallen to double figures (10 that is!). His neurologist has resorted to questioning his own initial diagnosis, and though supportive of Mark's treatment choices is unable either to explain or contribute to his progress.

I BEGAN WRITING THIS article to consider the various ways in which I tend to privilege clinical evidence in my practice. The aim was to identify the origin and nature of at least some of my clinical bias and examine its influence on my clinical judgment. I soon realised the enormity of this task as I began grappling with the powerful cultural, linguistic, historical, philosophical and socio-political implications of what constitutes evidence in any discipline, but especially one that derives from a culture other than one's own. This, in turn, led me to consider the qualities unique to the two primary paradigms that seem pertinent to this issue: empirical evidence, deriving from the senses, and deductive evidence, which is based on abstract logical theory. It is clear at this point that my own clinical judgment operates with a healthy measure of bias towards the former, though this very recognition happily prevents me from dismissing the value of the latter.

So it is that I often waver between privileging evidence I have experienced first-hand in the presence of a patient versus that which has been transmitted through teachers, texts, related disciplines and other received wisdom emanating from the general discourse of East Asian medicine (EAM)[3]. The paradoxical respect I have for both these modes of finding meaning in my

work also propels me to treat, teach and occasionally attempt to write. The case study through which I frame this discussion is a deliberate choice. Case evidence has formed and continues to form the principal medium through which the entire clinical process in EAM has been evaluated since the Han dynasty in China (206 BCE – 220 CE). Its open-ended, highly personal and often anecdotal format can serve to stimulate debate, invite multiple interpretations and ultimately inspire us as clinicians into new ways of thinking.

In the process of writing up this case, I have come to a deeper appreciation of my own clinical bias as well as respectfully noting those of others from different traditions. I suspect I have raised many issues that deserve fuller attention elsewhere but if I manage to address even some of these interrelated but highly complex issues in a way that seems at least marginally useful to the practising clinician, I will be happy. The only criticism I will make in this regard is that I cannot agree with any form of conscious and deliberate privileging of what might be characterised as an attempt to distinguish between more or less "valid" evidence. Such entitled claims are newcomers to the history of medical discourse and have yet to demonstrate outcomes that justify such a hierarchical position with regard to ascribing relative validity to differing expressions of evidence.

Definitions of evidence

Evidence is defined generally as information upon which to base a conclusion. Empirical evidence refers in particular to that which can be verified without recourse to theoretical or deductive constructs (*Websters New World Dictionary*, 2003). The title of this article[1] reflects a philosophy, deeply woven into the fabric of Japanese culture, that experience (things that can be seen, smelled, tasted, touched) is able to offer richer intrinsic value to human existence than abstract ideas. This notion of what types of human experience (evidence) are to receive privileged attention permeates Japanese life until today.

One example in the popular culture that accounts for its enduring significance in the practice of medicine is the symbolic significance of the *hara* (abdomen)[a], the location of feelings within the abdomen, for example in the phrase *hara ga tatsu* (the abdomen stands up) meaning to get angry, or the description of a character trait such as *hara no ookii* (the abdomen being big) referring to someone who has a generous nature. Though sometimes translated as "mind", the concept of *hara* lends symbolic and concrete meaning to the way in which the Japanese privilege direct sensory experience that is, literally, "gut-felt" rather than the more abstract "heart-felt" more common in our own culture. A more morbid association in this regard would compare the Japanese form of ritual suicide in which literally the *hara kiri* (belly is cut) with forms of suicide in the West such as a bullet to the head. It would seem obvious here to point to recent biomedical evidence regarding the physiology of emotions, long considered the exclusive product of brain chemistry at certain specific sites, as now revealing that certain neurotransmitters are released in the gut, suggesting an interactive rather than an exclusive communication system for the experience of feelings.[b] This example of cultural bias in Japan towards empirical over abstract evidence extends very naturally and explicitly into the realm of medicine. Many of the distinguishing features of *kampo* (Sino-Japanese herbal medicine)[4] for example, reflect this empirical bias and have tended to subjugate the role of abstract theoretical methods of constructing evidence in the clinical setting.

The belief that clinical evidence is most accurately derived from concrete sensory experience runs deep in EAM as a whole and is clearly favoured in many of the formative classical texts. For example throughout the text of the *Shang Han Za Bing Lun* (On Cold Damage and Miscellaneous Disease) Zhang Zhong-Jing offers little by way of treatment rationale, preferring instead succinct descriptions of the empirical evidence in the form of practitioner and patient signs and symptoms and proceeding directly to the appropriate herbal formula that "masters" the situation. This trend is also found in *Shinto* (the indigenous Japanese religion), which influenced the earliest shamanistic practices that pre-dated the arrival of the

a. Ohnuki-Tierney E., 1984.
b. Pert C., 1997.

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For the first time in Australia, Nigel Dawes will be teaching abdominal diagnosis for the selection of correct herbal formulas as used by the very pragmatic School of Classical Formulas in Japan, dating back over 300 years.

Nigel has been practising and teaching for 25 years. He lived and studied in Japan for five years in the early 1980s, and also in China.

Originally from the UK, Nigel now lives and works in New York City. His Fukushin workshops are very popular in the US and Europe.

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Medical art is understanding. Understanding arrives through learning. There are no old or new formulas, only efficacious ones.

– Kamei Namei

first teachings and texts from mainland China into Japan in the 6th CE. Even in Japanese zen (meditation) we find a reluctance to demonstrate anything other than passing interest in the more abstract Buddhist *dharma* (teachings) such as reincarnation for example, preferring instead to concentrate practice on the search for *kensho godo* (enlightenment) in the here-and-now, as an experience that lies within the nature of literally every "sentient being".[c]

When it comes to identifying bias in defining clinical evidence in Japanese medical discourse, past and present, it could perhaps best be characterised by a statement from one of its more prominent and controversial figures, Todo Yoshimasu (1702-1773). He was influential in reviving an interest among Edo (Tokugawa period, 1603-1868) *kampo* practitioners in the Chinese Han dynasty classics, epitomised in his exhortation directed at colleagues to: "Return to the classics!" This slogan was notably adopted by Yanagiya Sorei almost 200 years later in his founding of the *keiraku chiryo* (meridian therapy)[5] movement in early 20th CE Japanese acupuncture circles.

Todo meanwhile, emphasised empirical focus on the clinical signs and symptoms as representing concrete evidence for the use of a specific matching formula without the need for detailed rationales of etiology and pathogenesis.[d] He relied heavily in this process on empirical evidence derived from *fukushin* (abdominal palpation), a special diagnostic feature of *kampo* practice, almost exclusive among the various traditions of EAM and which endures to this day in Japan. One of his more famous remarks, said to be his personal motto[e] will serve here as a summary of this attempt to define the term "evidence" in general, and how it is specifically interpreted in the context of Japanese traditional medicine:

Do not speak of what is invisible.

Evidence in the clinical setting

This article then is about evidence, the stuff we as clinicians seek to grasp, define, collect, analyse and interpret. Manifesting as signs and symptoms, often in the most incoherent of narratives, it is fuelled by snippets of raw, shapeless experience that nonetheless imprint themselves (more randomly than we might admit) on our discriminating sensibilities. It is then processed by privileged personal and collective filters into algorithms with sufficient coherence to differentiate a treatment rationale. All this occurs under the formidable orchestration of what Michel Foucault has famously, and critically, called "the clinical gaze".[f]

One way to define evidence is the detailed identification, cataloging and analysis of signs and symptoms. This process might unfold equally in either a "context of discovery" or a "context of justification".[g] For me, any claim for empirical evidence must ultimately survive the litmus test of clinical outcome in order truly to qualify as useful both to the practitioner and the patient. As Kamei Namei (1714-1814), a Japanese Confucian scholar physician from the late Edo period[6] noted: "Medical art is understanding. Understanding arrives through learning. There are no old or new formulas, only efficacious ones," quoted in the author's preface of *30 Years of Kampo*.[h]

In my definition of evidence as outcome-based however, I am anxious to distance myself from the term "evidence-based medicine", in its contemporary definition as "the integration of best research evidence with clinical expertise and patient values".[i] Not because this description is unappealing (it actually seems to capture a sense of the complex nature and plurality of factors that constitute clinical evidence) but because of the qualitative hierarchy it employs in apparently privileging some findings over others. My problem with this definition of evidence is that it favours "hypothesis-testing systematic research" as yielding knowledge that is more generalisable and therefore in some way more clinically relevant than the anecdotal experiences of "hypothesis-generating clinical experience".[j] While apparently offering a balanced, inclusive definition of clinical

c. Angurarohita P., 1989.
d. Yasui H., 2007.
e. Otsuka K., 1979.
f. *The Birth of the Clinic*, 1963.
g. Westen D., 2002.
h. Otsuka K., 1984.
i. Sackett D., 2000.
j. Hoffman I., 2009.

evidence, one that would seem to embrace the relative validity of multiple perspectives, it seems to me to point instead to a world of prescriptive authority in healthcare rather than one that generates new and exciting possibilities. I cannot but be reminded in this of *Animal Farm*'s Napoleon, who Boxer claims "is always right", when he eventually comes up with the commandment to trump all others: "All animals are created equal, but some are more equal than others."[k]

Discomfort with this epistemological approach, in which the categorisation of clinical evidence into a systematic body of knowledge inevitably leads to standardised diagnoses and interventions, has always steered me towards case study analysis and writing. The case narrative is precisely interesting because of its ability to "open up" rather than to "nail down", to pose rather than to answer questions. The power of doubt (and I use the Buddhist definition of the word here)[7] provides more enriching and nuanced interpretations of clinical evidence than conviction. A line from *In praise of shadows* seems relevant: "We do not dislike everything that shines, but we prefer a pensive shadow to a thin transparence."[l]

Evidence and context

Let me briefly turn to the clinical context at hand in this case.

In the Japanese *kampo* tradition, clinical evidence or "proof" is collectively termed the *sho*[8], or more properly the *shokogun*, a cluster (*gun*) of symptoms (*sho*) and prodromes (*ko*).[m] The Japanese *kanji* (ideograph) for *sho* literally suggests a "departure from the norm", deriving from the Daoist concept of illness as representing a deviation from the right(eous), upright or correct path, and is distinguished in Japanese from the term *byo* (illness). In *kampo*, the patient *sho* refers both to the constellation of presenting clinical signs and symptoms including the constitutional strength of the individual[9] (considered an essential component of formula prescribing and prognostic assessment). A *kampo* practitioner's skill lies in their ability to identify a formula *sho* (an existing historical prescription) that most closely corresponds to the patient *sho* (the conformation of signs and symptoms including their constitutional tendencies). This process revolves around matching clinically established knowledge (the formula) with the lesser-known variable (the patient) and is wholly dependent on the subjective scrutiny of the clinical gaze. *Sho* thus translates ultimately as a method of treatment rather than referring to either a disease name or a pathological syndrome.[n]

Through Mark's case vignette, I emphasise the problematic issue of offering up any iteration of clinical evidence, from whatever tradition, in which one's aim is merely to categorise, explain and justify. I acknowledge the potential danger in this enterprise, seeming as it might to destabilise the carefully crafted relationship between our rational and sensory abilities in clinical work. In my case, far from undermining clinical confidence, this effort has so far contributed in tangible and exciting ways to the quality and satisfaction of my professional life. It is my profound hope that a re-examination of our conceptual and practical relationship to the "evidence" we claim for our work and the factors that determine it will be of concern, interest and use to colleagues in the field.

There has always existed in the history of recorded medicine a productive tension between medical practice and knowledge when it comes to the validation of clinical evidence.[o] Lock quotes Dubos (1965, p. 319) as identifying these viewpoints as "ontological" versus "physiological" either one being emphasised depending on the prevailing ideas of the time.[p] Some examples might include the rational (dogmatic) and empirical schools of Greece and Rome, the classical (*Koho-Ha*) and revisionist (*Gosei-Ha*) schools of *kampo* in Edo period Japan[q] or in the modern era, the emergence of "functional" versus "biomedical" paradigms.

History, it would seem, has amply exposed the hollowness of successive attempts at privileging any particular expression of clinical evidence at any given point in time. Yet perhaps the most glaring

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k. Orwell G., 1945.
l. Tanizaki J., 1933.
m. Ohnuki-Tierney E., 1984.
n. Otsuka K., 2010.
o. Farquhar J., 1992.
p. Lock M., 1980.
q. Otsuka Y., 1976.

There is a conscious bias among kampo practitioners like myself in favour of clinical findings that can be evidenced through direct contact with the patient over interpretations of a more abstract nature. In particular, my focus on this type of sensory evidence experienced in the moment of the clinical encounter relies heavily on the use of abdominal palpation (fukushin).

modern example of an attempt to do just that can be found in the very *hara* of our own profession in the hegemonic narrative of TCM, which others have noted has appealed so seductively to the "unambiguous, standardised, packaged approach" inherent in the modern mindset.[r]

Lest I appear overly judgmental, I would like at this point to identify my own bias in regard to my use of the term evidence in Mark's case. The evidence I am privileging here is informed at its root by textual material primarily from the later Han dynasty period of classical Chinese medicine. With regard to Japanese acupuncture, the primary sources include in particular the *Ling Shu* (Spiritual Axis) and *Nan Jing* (Classic of Difficulties) while in *kampo* they are the twin texts comprising the *Shang Han Za Bing Lun* (On Cold Damage and Miscellaneous Diseases).

More specifically still, in both a cultural and historical sense, my main clinical filters have been influenced by the *Koho-Ha* (classical school) of *kampo* in Edo period Japan through my schooling and apprenticeship training in a modern Japanese urban setting, and later in London. This has included exposure to meridian therapy acupuncture, zen shiatsu and modern *koho-ha kampo* in the *Otsuka*[10] lineage.

There is a conscious bias among *kampo* practitioners like me in favour of clinical findings that can be evidenced through direct contact with the patient over interpretations of a more abstract nature. In particular, my focus on this type of sensory evidence experienced in the moment of the clinical encounter relies heavily on the use of abdominal palpation (*fukushin*). I have lectured and published extensively on this topic.

Patient evidence

Mark's initial main complaint was weakness and restricted mobility in his shoulders, noticeable mainly when playing (daily) golf. There was no pain involved, no history of trauma and his general medical and family history was unremarkable. No medications were taken then or since. He was 43 at the time of the first consult, not long after the initial medical diagnosis of his condition. On examination in my office he had significant muscle atrophy in both shoulders and upper arms (more pronounced on the left), especially marked in the anterior deltoids and along the midline of the biceps muscles. The lower limbs were unaffected. He showed notable thickening of the connective tissue and marked reddening of the skin surface throughout his upper body starting at the level of about the 3rd intercostal space on the chest and the 3rd thoracic vertebrae on the upper back. In fact there was a clear line of demarcation distinguishable by the relative pallor of the skin below and the redness above this line, almost as if someone had drawn it around his torso. The skin itself was extremely dry, more noticeable in the lower extremities, where multiple broken capillaries were visible around the ankles and feet and the general colour of the skin in that area was blotchy purple. His face also had this blotchy appearance with the same dusky hue and the lips in particular were always dry and purple. His pulse was *xi* (thin) but *da* (big), *chen* (deep), a little *shuo* (rapid) and had a slight *se* (choppy) flow with an occasional *jie* (knotted) quality. The weakest beat was at both *cun* (distal) positions, especially on the right. His tongue was reddish-purple, more so at the borders, with no significant coat though the entire surface was dry, especially at the centre where it was often a little peeled.

Fukushin (abdominal diagnosis) revealed a firm, well-nourished abdominal wall, uniformly warm and toned, consistent with a strong constitutional type.[s] Specific findings were limited to *sho fuku kyu ketsu* (lower abdomen spasm and knot), *shin ki* (pulsations) and *sho fuku koh kyu* (lower abdomen tight spasm).[t] On questioning, Mark reported a tendency for extreme dry mouth and lips (without strong thirst), occasional shortness of breath and sporadic left medial knee soreness he attributed to his golf swing. His temperature was normal as were his bowel movements, urination and sleep, and his affect (more or less unchanged over 18 years of treatment) was consistently even, though not passive.

r. Freuhauf H., 1999.

s. Otsuka K., 2010.

t. *ibid*.

Treatment evidence

Treatment over such an extended period has naturally involved complex and varied strategies too diverse to detail here focusing on almost weekly acupuncture combined with zen shiatsu[11] and sotai[12]. Acupuncture in the *keiraku chiryo* (meridian therapy style) has tended to focus on earth and metal root phase tonification, while branch work has included repeated focus on stimulating qi and blood in the *yangming* (sunlight yang) channels, especially in the upper arms and shoulders. The hand *yangming* (Large Intestine) and hand *taiyin* (Lung) primary and muscle channel pathways in the upper arm are the main sites of atrophy with resulting motor and sensory compromise and I usually focus on a lot of palpation-based local, shallow needling with emphasis on *kori* (knots) and indurations in these areas along with channel-based distal needling. Occasional continuous wave electro-stimulation has proved useful when feelings of numbness and weakness predominate. I have also done bleeding cupping in the upper back area when the *taiyang* (greater yang) cutaneous regions are noticeably purplish and blotchy. At these times the removal of a small quantity of typically dark purple, gelatinous blood has restored an impressive and sustained degree of mobility in the shoulders.

The *kampo* evidence for different formula *sho* has varied over the years with Mark presenting most consistently with the following formula *sho.* Initially he manifested the *Bu Zhong Yi Qi Tang* (Tonify and Augment the Middle Decoction) *sho,* with poor appetite, loose stools, fatigue and a sense of heaviness in the limbs along with the constitutional pulse finding suggesting a weakness of the middle burner function. I had the fleeting (and erroneous) thought that perhaps the muscle atrophy reflected a straightforward case of depletion of the *ying* (nutritive) fluid due to poor transformational function of the Spleen and Stomach. Though his stools firmed and his appetite returned, that's all this formula achieved. Clearly building the middle would not be sufficient in this case.

I then identified the *Ba Wei Wan* (Rehmannia Eight Pill) *sho*, as Mark had developed some weakness in the lower limbs (although no appreciable atrophy there). In spite of his having no urinary or sexual dysfunction, typical evidence for the use of this formula, I based my thinking on an introductory section dedicated to Otsuka's personal understanding of this formula in his book *Kampo: A Clinical Guide to Theory and Practice*.[u] He remarks that, although from the *Koho-Ha* (classical) school himself, which "abhorred the use of *Di Huang* (Rehmannia Radix)", his own interpretation of lines from the *Xu Lao Pian* (Vacuity Taxation Disorders) chapter in the *Jin Gui Yao Lue* (Essential Prescriptions the Golden Coffer) led him to use this formula in cases of what might be termed "consumptive" symptoms, especially when blood stasis in the channels was also present. This formula cured Mark's lower limb weakness although after a short time he complained of gas and abdominal fullness so he stopped taking the formula.

It is significant to me that Otsuka clearly demonstrates both a deep respect for the purist ways of his teacher, Kyushin Yumoto (1876-1941), to whom he refers in this section of his book, as well as a willingness to break with tradition and attempt more diversity in his own clinical process. This commitment to plurality in medical practice can be perceived in his positive response to a challenging question put to him by one of his later teachers, Kenji Kakuya, quoted in his preface to *30 Years of Kampo*: "You say that you belong to the school of old formulas, a school that tolerates no dissent from other schools. Don't you think this is a weakness of the school of the old formulas?"[v]

In my own reading of the same chapter of the *Jin Gui Yao Lue*, I noticed the reference to *Zhi Gan Cao Tang* (Honey Fried Licorice Decoction) for the treatment of "weakness fatigue (*xu lao*), deficiencies ... a knotty pulse (*jie mai*) and cardiac palpitation in the presence of normal activity".[w] Since Mark's *sho* was primarily characterised by signs and symptoms indicating an upper *jiao* imbalance, I decided to prescribe this formula as indicated in the final line of the chapter. Use of this formula is also mentioned in the following chapter of the *Jin Gui Yao Lue* (on Lung Atrophy, Lung Abscess and Cough

u. Otsuka K., 2010.
v. Otsuka K., 1984.
w. Hsu HY., 1983.

Ante Babic's
Tips for running a successful clinic ...
Treat like you don't need the money.

I have also done bleeding cupping a few times in the upper back area when the taiyang cutaneous regions are noticeably purplish and blotchy. At these times the removal of a small quantity of typically dark purple, gelatinous blood has restored an impressive and sustained degree of mobility in the shoulders.

with Qi Counterflow): "*Zhi Gan Cao Tang* treats Lung atrophy ... agitation (*fan*) and discomfort in the heart (*xin fan*)." In Mark's case I read Lung here as referring both to the Lung channel and organ.

This last formula has proven to offer the most reliably consistent results over time and Mark has been taking it continuously (with variations of dose and substitutions for other formulas for short periods such as *Mai Men Dong Tang* (Ophiopogon Decoction) when his breathing is especially laboured for many years. At this point, I feel Mark's *sho* belongs at the very least to what has been referred to elsewhere as a certain "family" of formulas, related by their inclusion of key "herb family" ingredients.[x]

Mark has also received regular massage therapy and chiropractic from a colleague and works out daily in addition to his intensive, year-round golf schedule. His diet is intelligent and tends to reflect seasonal and constitutional considerations deriving from his own research as well as my input, focusing particularly on yin and blood moistening foods. He also has a deep and long-term meditation practice (his brother teaches meditation at the Esalen Institute in California as well as internationally).

Interpreting evidence

It would be usual at this point in a case study treatment section for the author to offer some rationale by way of explanation for the various clinical interpretations and treatment choices referred to above. Certainly I could provide, and have already done so in detail elsewhere,[y] a detailed rationale for my clinical judgment and decision-making in Mark's case, particularly in regard to the herbal treatment. However, I am not about to do that for reasons of consistency with arguments I have proposed above. Mine is a deliberate choice here, designed to preclude the influence of the privileged bias of this author upon the reader (itself an illusion of course!).

Nonetheless, I am electing consciously to avoid an approach that might seem to offer, in this example, a Japanese *kampo* version of "scientific knowledge", properly supported of course by the appropriate references from esteemed classical texts and case-studies and comments by revered clinicians, past and present. In support of this decision, I have in mind a quote from an early Edo period ode, written as a farewell to a favourite Samurai student of his, Morikawa Kyoroku (1656-1715) entitled *The Rustic Gate:* "Do not seek to follow in the steps of the men of old; seek what they sought."[z]

I rely instead on the reader's willingness to reflect on the bare procedural facts of the case with exactly the kind of open-ended, reflective consideration I have attempted to describe above. In this endeavor, I base my trust in socio-anthropological interpretations of the value of case studies to act as lived experiences in a system that can only be embodied in its practitioners[aa] and on clinical ones that seek a free and creative relational engagement to the material.[ab]

Of note is the fact that ample interpretations of a quasi-objective nature can however easily be offered from a biomedical perspective, especially as one might imagine with regard to the diagnosis. In Mark's case, this was based on available clinical evidence at the time, including relevant physical and neurological exams, as well as electrophysiological and neuro-imaging tests. These were repeated at least twice at intervals of six months to establish progression. The clinical outcome to date is clearly atypical with regard to the mean progression of the disease as defined by the evidence, however, the literature does acknowledge a 10 per cent statistical variance among patients.[13 ac] The best known example of such a surviving individual is the theoretical physicist, Stephen Hawking. Few attempts have been made however to study or explain such exceptions to standard medical understanding of the disease and cases such as Mark's are unsatisfactorily placed into the not unfamiliar category of "medical anomalies".

Similarly, we are not deprived of categoric interpretations from a TCM perspective either. Indeed, a diagnosis of ALS would seem to approximate to some form of *wei zheng* (flaccidity syndrome):

x. Huang H., 2009.
y. Dawes, N., 2002.
z. Basho M., 1693.
aa. Farquhar J., 1992.
ab. Hoffman I., 2009.
ac. Chio A., et al., 2008.

"marked by muscular flaccidity or atrophy of the limbs with motor impairment".[ad] This author also offers a clear-cut diagnostic framework with associated herbal formulas in each case, one of them corresponding quite closely in fact, although couched in the abstract conceptual language of this tradition, with the function of several of the formulas that Mark has taken. Reading it, however, gives no sense of what personal, social, psychological, cultural, political or historical factors might be involved with actual living patients who suffer with this disease definition.

Discussion

If I have avoided specific interpretations and justifications for my clinical decisions in Mark's case, it might nonetheless be tempting to hold up this relative success story as outcome-based evidence for the myriad virtues of EAM, and in the process to take a passing swipe at the apparent limitations of the biomedical model, thus introducing the familiar dialectic of holistic versus reductionist paradigms of healthcare. Mark's case, it could be argued, does indeed seem to offer a compelling example of biomedical logic apparently confounded by empirical evidence, clinical outcome seeming to defy the scientific odds. After all, the prognosis and statistics for median survival time associated with his diagnosis are hardly encouraging.[ae]

This discussion assumes instead a perspective that many contemporary social scientists, historians and philosophers have adopted in challenging the theory of modernisation in general and that of scientific knowledge in particular.[af] This perspective, postmodern if you will, takes issue with the very notion of "objective" evidence in the physical world, preferring instead the struggle for meaning where universally valid answers do not exist.[ag]

Relativist thinking in modern scientific discourse is quite recent, although already prevalent, inevitably challenging the view of progress in "normal" science.[ah] Of particular relevance here is the effect such a radical paradigm shift has had on cultural studies of traditional Asian medical systems, the first groundbreaking example of which is found in the Introduction to *Asian Medical Systems*.[ai] Other medical anthropologists and sinologists[aj] have since contributed in important ways to this epistemological debate and his-

ad. Zhang, E., 2008.

ae. Chio A., et al., 2008.

af. Leslie and Young, 1992.

ag. Weisskopf V., 1972.

ah. Kuhn T., 1962.

ai. Leslie C., 1976.

aj. Anthropologists Kleinman A., 1980; Lock M., 1980; Ohnuki-Tierney, E., 1984; sinologists Porkert M., 1974; Unschuld P., 1988.

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torians, among whom the work of Joseph Needham is too extensive and influential to begin to quote here. More recently, clinical scholars in our own field have entered the debate,[ak] broadening the scope of the discourse to include concrete clinical issues.

Referring to exactly those issues, in particular the perception and application of evidence in *kampo* medicine as applied in Mark's case, it is becoming clear that this paradigm shift is not limited to the social sciences nor to how their contribution has helped reframe consideration and legitimisation of some medical traditions from other parts of the world. It has been taking place within the prevailing medical establishment for some time already here in the West and is fast gathering momentum. In the field of psychology, even in Freud's lifetime there were those who questioned the validity of one of his models of clinical evidence (dream analysis), proposing instead a less abstract relational methodology of practice focusing on sensory observation.[al]

Indeed, Hans Strupp, a German psychologist and analyst who fled Nazi Germany to study psychology at George Washington University (where the department of psychiatry was founded by Sullivan) claimed: "Given the uniqueness of every therapeutic dyad and the multitude of relevant interacting variables influencing the course of treatment, the 'empirical validation' of any therapy is utterly illusory." This quote appeared in a brilliant article by Irwin Hoffman, "Double-thinking our way to scientific legitimacy: the desiccation of human experience", in which he argues an even more controversial point: "Is it *desirable*, clinically, for a practitioner to have a mindset in which he or she even *aspires* to 'know' what 'standard intervention' to apply in working with a particular patient at a particular moment?"[am] He goes on to perfectly capture the essence of the paradigm shift referred to here as suggestive of a move away from mere analysis and justification towards a more constructive, relational engagement between the patient and practitioner. He points out that this inevitably requires more, not less, subjective reflection and criticism between and by both parties towards an inclusive, not exclusive, therapeutic end.

I will conclude this examination of some of the recent attention to genuinely alternative ways of thinking that exist in orthodox medical circles with a reference that really surprised me. In a recent article in the *New England Journal of Medicine*, a well-published and not uncontroversial husband and wife team, both MDs at Beth Israel Deaconess Medical Centre in Boston (Harvard Medical School's teaching hospital) raised striking concerns about the state of medical practice in the US.[an] I will not attempt here to do justice to this provocative and courageous article, but in essence these esteemed authors, champions themselves of the prevailing medical establishment, dared to question both the ethical and clinical validity of modern medicine from the linguistic, economic and socio-political perspective. The alarm has been raised, the post-post-modern era in medicine is upon us!

Conclusion

My main intention is to point to the inherent biases of the clinical filters we all use to confirm what we refer to as evidence in all its forms. I have tried to suggest that the only real evidence of which we can authentically speak with any conviction is that of the patient's progress. My method of attempting to achieve this has been to subvert the tendency to categorise and explain clinical outcomes within some kind of rational paradigm. Instead I have put forward the case study as a form, traditional in our field of course, in which clinical evidence can be formulated as an open-ended expression of multiple possible outcomes on multiple dimensions of human experience as it relates to health and disease.

In this enterprise, I have to thank my many teachers, colleagues and students for constantly offering unique and unexpected challenges to the accepted wisdom that the richer one's clinical experience, the more positive will be the clinical outcome. Not necessarily. "But habit is a great deadener," says Vladimir in *Waiting For Godot*, and "experience" can surely sometimes pass for

ak. Scheid V., 2002 and 2007; Bensky D., 2009, Freuhauf H., 2010.

al. Sullivan H., 1953.

am. Hoffman I., 2009.

an. Hartzband & Groopman, 2011.

a whole lot of unchallenged and repeated mistakes, especially in spaces where powerful transference is at work. I am also deeply indebted to my wife, Dr Orna Guralnik, for the amazing gift of demonstrating to me the concrete benefits of serious inter-disciplinary study in lending meaning to the life of the practising clinician. I have been inspired by her seamless application of conspicuously abstract theories drawn from the contemporary post-modern discourse (in particular those deriving from structuralist and cultural theory) in her work as a clinical psychologist and in her body of published work, among which perhaps her most recent is quite related to this article.[ao] This has encouraged me to re-examine my own relationship to clinical evidence from the perspective of language, culture and society and, I believe, to begin to open up a space for myself to experiment, reflect and begin to truly learn.

My current interpretation of the title of this article, "Evidence is more powerful than logic", no longer reflects a belief that practical experience is somehow intrinsically more legitimate than abstract thinking, but rather that they exist on the same continuum, constantly complementing, opposing and interacting with one another. With this in mind, I will leave the last words to Dr Otsuka, quoted by his son, Yasuo, in his preface to *30 Years of Kampo:*

Skill comes before study, and lack of skill is just like a fading flower for it looks pitiful.

In closing, I will attempt an interpretation of this quote, as I believe it may carry some unwarranted and misleading emphasis in translation. I think that Dr Otsuka, whose own life-example was the epitome of inclusive respect for medical diversity and tradition, is not commenting here on the hierarchical importance of skill (we might say sensory experience) over study (we might say abstract logic). Rather, I think he means that when the realm of ideas is firmly couched within the immediacy of one's authentic, lived experience, as opposed to shaping and directing it, the richness, colour and fragrance of the resulting bloom will effortlessly overshadow its impermanence.

ao. Guralnik O., 2011.

Endnotes

1. My deliberate use of this title refers to the familiar Japanese proverb *Ron yori shoko*, one of the 48 proverbs in the *Iroha Karuta*, a Japanese card game dating from the Tokugawa Shogunate (1603-1868) that is still used as a way of learning the Japanese phonetic alphabet. There are many literal translations of this proverb, for example: "Proof rather than argument" (Buchanan D., 1965), "A single fact is worth a shipload of arguments" (Bulletin of the Language Institute of Gakushuin University, 1998). The closest English parallel may be: "The proof of the pudding is in the eating."

2. "Amyotrophic lateral sclerosis is considered a form of motor neuron disease involving various degenerative neurological changes such as weakness, atrophy, spasticity and muscle twitching ... it is progressive and often fatal, respiratory compromise being the most common cause of death, with some individuals surviving many years." (*Dorland's Illustrated Medical Dictionary*, Elsevier – Health Sciences Division (2011).

3. I borrow this term from Margaret Lock, Professor of Anthropology at McGill University, Montreal, to denote the plurality of traditional medical practices common to East Asia (*East Asian Medicine in Urban Japan*, 1980).

4. Literally "the Chinese method", this term was originally used in reference to any and all traditional medical practices deriving from the study and adaptation of Chinese medicine. In modern Japan the term is used specifically with reference to the practice of herbs, which differentiates itself from contemporary herbal practice in China in diagnostic methodologies and treatment styles.

5. For a definition of this term refer to: Denmei S. (1990). *Japanese Classical Acupuncture: Introduction to Meridian Therapy*. Seattle: Eastland Press.

6. For a fascinating characterisation of the Japanese adaptation of Confucian influences in the Edo period refer to: Angurarohita P. (1989) Buddhist Influence on the concept of the Neo-Confucian Sage. *Sino Platonic Papers 10*.

7. I am using doubt in the context of open and intelligent questioning and consideration such as is suggested by the following quote: "O monks and wise men, just as a goldsmith would test his gold by burning, cutting and rubbing it, so must you examine my words and accept them, not merely out of reverence for me." – Shakyamuni Buddha.

8. This term has many translations including "conformation" (Hsu H-Y, 1980), "pattern" (Kaptchuck T, 2000), "presentation" (Mitchell et al., 1999) and the ubiquitous "syndrome" (as used throughout contemporary TCM literature).

9. The concept of *taishitsu* (constitution), literally the "root of a person", is critical to the practice of *kampo*. It is referred to variously in terms of yin, yang, qi, blood and fluid body types (Otsuka K., 2010) and strongly influences diagnosis of the patient and formula prescription, each of which is seen as being appropriate for a certain constitutional type. The unique concept of *jibyo* (my illness), related to one's constitution, is embedded in Japanese culture at large. It manifests in everyday descriptions characterising someone's personality and physiology as, for example, *ijaku* (weak digestion), *hirosho* (easily tired), *hiesho* (easily cold), *nobosesho* (a tendency to flush or be anxious) or *shinkeisetsusho* (hyper-sensitive), (Ohnuki-Tierney E., 1984).

10. For a bio on Dr Otsuka and his lineage, refer to: Watanabe K., Notes from Japan (2010). In (Otsuka K.) *Kampo: A Clinical Guide to Theory and Practice*. Oxford: Churchill Livingstone.

11. A style of shiatsu massage developed by the late Masunaga Shizuto (1925-1981).

12. A form of muscle release work developed by Hashimoto Keizo (1897-1993).

13. Prognostic factors in ALS: A critical review published in *Amyotrophic Lateral Sclerosis Journal*, December 2008, Adriano Chio et al.

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