

Wang Shu-he Revisited

by Leon Hammer

Introduction

I deeply appreciated the opportunity given to me by the author of Thought, History and Critique: An Appreciation of Chinese Medical Canon Relative to Pulse Diagnosis to clarify once more the value of avoiding the confusion and danger posed by following the multiple sensations attributed to the Choppy quality by Wang Shu-He's Pulse Classic. The thesis offered at the time of our previous exchange was that 'since there are differing etiologies and pathologies related to blood stagnation, there must be differing qualities related to the condition of blood stagnation.' I believe that any condition can have simultaneous multiple etiologies, and that each etiology has a distinct pulse quality, each of these clearly different from that of the consequent condition, in this instance, blood stagnation and the Choppy quality.

The author of THC distinguishes "pragmatic", "anatomical", "naïve materialism" from "philosophical", "theoretical" and implied superior academics without presenting a theory or philosophy. What we do find are lists of distinguished classical writers and texts, a vague list of their laudable contributions. The author asserts his approach being a "triangulation between the three rivers of classical literature" and follows this with "contemplative hermeneutic analysis", "depth of perception and reduces error of perception" with no demonstration of how these "three rivers" validate his and Wang Shu-he's definition of the choppy pulse. Throughout there are terms such as "binary distinctions", "world view of logical positivism", "hermeneutic analysis" and "contemplative heuristics", which add nothing to the debate regarding the disagreement with the author and Wang Shu-he.

CCPD is embedded in the finest theoretical framework available, Chinese medicine, including all of its parameters, solid-hollow organs, qi, blood and body fluids and all of the complexities of these substances, pathogenic factors both external and internal, [especially emotional], retained pathogens and divergent channels and all of the disharmonies addressed by this medicine from diabetes to cancer.

A new source¹ has presented a book authored by the principle practitioner of the Ding-Menghe lineage, Ding Sha Ren, that shows a clear link between Dr. Shen's pulse practice and his teachers in Shanghai prior to WWII.

The system to which the author of THC refers in this paper is currently known as Contemporary Chinese Pulse Diagnosis [CCPD] and the names Shen and Hammer are deliberately omitted in order to free the system to develop beyond its originators, which it is doing. Anyone is free to use this appellation [CCPD] when referring this pulse model with reference to its origin.

The Choppy Quality and Wang Shu-he

Wang Shu-he [Pulse Classic, P. 4] (endnote 1)], describes the Choppy pulse as followsⁱⁱ: "it is fine and slow, coming and going with difficulty and scattered, or with an interruption, but has the ability to recover. (Other versions of the Mai Jing describe it as short and floating or another version describes it as short with interruption or scattered). When the arrival or departure is slow, there is a greater likelihood of disturbance in the flow of the fluids." The author of THC never refers to the Nei Qing's description of "scraping bamboo". And throughout his paper the term 'rough' is used to diffuse the entire discussion of what began as a discussion of the Choppy quality as with "The historic use of the term rough had two common interpretations, blood stasis and depletion of essence, qi or blood" for which there is no citation.

Wang Su-He's description of the Choppy pulse continues down to Li Shi Zhen who then in his section of pulse comparisons states that "the choppy pulse must not be confused with the scattered, intermittent or minute pulses" which differences he spells out in detail and where he bravely departs from his distinguished predecessor [by fourteen hundred years].

The author of THC asserts, "Hammer does not address the same complexities that Wang Shu-he pursued for a pulse that represented qi, blood and essence depletion along with blood stasis. It would appear that Hammer is not using the same criteria for sign, symptom and pathology as Wang. This, the notion that Wang is confused becomes a matter of perspective."

Clinically, how can a practitioner identify a quality that is defined in different parts of his Pulse classic as "fine and slow, coming and going with difficulty and scattered or with an interruption, but has the ability to recover", or is "short and floating", or "short with interruption or scattered"? Despite the author of THC's erudite presentation, the fact is that the pulse diagnosis

is a sensory experience and that the ability to use it gainfully depends on that sensory experience being more than less distinct. There is nothing distinct about “fine and slow, coming and going with difficulty and scattered or with an interruption, but has the ability to recover”, or is “short and floating”, or “short with

The author states that “Hammer does not address the same complexities that Wang Shu” and “It would appear that Hammer is not using the same criteria for sign, symptom and pathology as Wang”, the major focus of T & R is my analysis of this confused “complexity” and “criteria”. What indeed is Wang Shu-hu’s “criteria? The author of THC does not say beyond what I what I have already quoted, “fine and slow, etc.”

The thrust of my response was “each differing etiology” of blood stagnation, and there are many, is represented on the pulse by a distinct and separate quality. And while these qualities may appear simultaneously with signs of blood stagnation, they are not in themselves, a sign of that condition. As stated above, the signs of the etiology and the signs of the condition with which they are causally related are distinctly different. In fact, even more often, these signs appear with none of the accepted criteria required to diagnose blood stasis. I have pointed out over the years that the Choppy quality, on any one pulse, can be accompanied by many different qualities, slippery, tense, robust pounding, any one of the numerous qualities one can access including “fine and slow, coming and going with difficulty and scattered or with an interruption, but has the ability to recover, short and floating, short with interruption or scattered” as asserted by Wang Shu-he. The author of THC states, without any substantiation that “The historic use of the term rough had two common interpretations, blood stasis and depletion of essence, qi or blood”. I would change this statement to ‘blood stasis from depletion of essence, qi or blood’. Otherwise I must adhere to the generally accepted association of the Choppy quality as a sign of blood stagnation that can of course be accompanied by other conditions. In Tradition and Revision T & R]^{iv} I differentiate the signs that indicate the etiology of blood stagnation from the sign of the condition blood stagnation. [For a more complete dissertation this subject please see T & R- pages 9-17]

Contemporary Chinese Pulse Diagnosis

A. Distinctions

The author of THC is stating categorically that CCPD is “anatomical” and “concrete”. The CCPD is enscanted in theory, the theory of Chinese Medicine. As mentioned above, CCPD embraces every important concept of Chinese medical theory including the solid-hollow organs, qi, blood and body fluids and all of the complexities of these substances, pathogenic factors both external and internal, retained pathogens and

interruption or scattered”. Contrast this to “It is rough to the touch without moving the finger. However, if one does roll the finger, I have found it to be uneven and grating to the finger, like rubbing it across a washboard”^{viii}, or the Nei Jing’s ‘scraping bamboo’.

divergent channels and all of the disharmonies addressed by this medicine from diabetes to cancer, from neurosis to psychosis. Chapter 15^v is titled ‘Qualities as Signs of Psychological Disharmony’.

Here is a small section of a Diagnostic Catalogue that is a part of the Contemporary Chinese Medicine diagnostic process to illustrate how CCPD is embedded in Chinese medicine.

Diagnostic Catalogue

| CONDITION | SYMPTOM | HISTORY | SIGNS |
|--|--|---|---|
| LIVER-GB Toxicity Excess Heat Qi deficiency Blood defic. Yin deficiency | Dizzy-Rolling Regurgitation Energy crash Astigmatism;night vis ↓ Light sensitive; Blurring Migraine Hard to take nap | Born Jaundiced Cocaine, Angel Dust LSD- all multiple X | <u>P</u> : LMP-Choppy [3] Hollow F/O Rob. Pnd [2.5] Bld-Org D.-↓ Sub; Diff Inside R. lower eyelid: confluent |
| LUNGS Qi stagnation Qi deficiency Wei Qi def. Damp | Eyes: Squiggly lines Mucous-thick-clear | Bronchial Asthma 1985 Frequent bronchitis Strep throat 7x as child Anti-biotics Grains→Mucous | Moons <u>P</u> : SLP-Narrow [5] RDP- Deep; Int▲ [4] L, SLP- Intensity ▲ [5] Obscure R, SLP- ↔Feeble RDP: Slippery |
| KIDNEYS Essence defic. Yang deficiency Qi deficiency Yin-Essence ↓ | SOB-Inhalation On exertion Hashimoto's Disease Black round floaters Circada buzz tinnitus | Born fearful Seek faith-life [Krisha] | Hands: blue color <u>P</u> : L,RPP-Leather [3] RPP- ↔Feeble Tongue: Spittle |

The value of CCPD is that each sensation [quality] is associated with one particular condition and likewise each condition associated with one sensation, making it clinically viable. I have never stated that etiologically and pathologically each of these other conditions are unrelated and have taught for years that a particular symptom has many etiologies. The Chinese say that "one cannot make a sound with one bao ding ball." I have categorically affirmed in many places that a heart qi deficient condition will lead to a diminished circulation that will lead, especially in dependant positions, to blood stagnation that, because qi and blood want to move, will eventually lead to inadvertent bleeding and eventually to blood deficiency [the Thin quality]. The attempt to move the blood will bring metabolic heat to the stagnation and eventually an accumulation of heat leading to Robust Pounding. The body will attempt to balance that heat with fluid and eventually one will get a damp condition marked on the pulse by a Slippery quality. Yin will become depleted and we will have a Tight quality. All of these qualities can appear associated as part of the process of blood stagnation. None are in themselves or together, other than the Choppy quality, are signs of blood stagnation. Wang Shu-he does not make these distinctions and includes many qualities in his description of one condition that makes it impossible to apply his concept clinically.

"With regard to sensory awareness, my goal is to convey a flavor for the potential richness of the pulse technique passed down by my teacher Dr. John Shen, a

richness that can be realized only with the endless refinement of our sense of touch. It has become part of my life's work to attempt to develop this exquisite sense of touch for myself, and for as many practitioners who wish to dedicate themselves to this rewarding, though demanding task. All I can hope to do as a teacher is to open a window onto a remarkable landscape of infinite varieties of sounds, shapes and hues which constitute this diagnostic terrain."^{vi}

In T & R there is an extensive discussion of qualities confused with the Choppy quality and references to modern authors such as Kaptchuck and Porkert who essentially agree with CCPD. Lu Yubin is subject to the claim that by saying that he describes the Choppy quality as "unsmooth" he "uses a tautology, defining the uneven pulse as unsmooth, in the end providing no solution for the problem of definition for the rough pulse (sè mài)." If Lu Yubin is guilty of therefore not contributing to "what aspect of the pulse is rough" who except the author of THC is clinging to the idea that Wang Shu-he's "fine and slow, coming and going with difficulty and scattered or with an interruption, but has the ability to recover, short and floating or short with interruption or scattered)" is an improvement over Lu Yubin.

B. CCPD, Open or Closed

CCPD is not a closed system. CCPD is constantly expanding, changing and learning according to observations by its practitioners. On my computer in the pulse section is a folder entitled 'update' that contains numerous new observations. A recent paper by Ross Rosen and myself on a version of the Leather quality^{vii} related to radiation is one example that also includes a new discovery during the past fifteen years of a massive increase of a once rare quality, Choppy now associated with the massive increase in toxicity in our environment and found often as a retained pathogen. It was later that I discovered that many toxins kill by creating blood stagnation, the standard interpretation of the Choppy quality.

Years ago, James Ramholz, the principal disciple of Jian Jing, the Korean pulse master, and I had an extensive ongoing exchange about our systems until his untimely death. One of my projects in the future is to collate and publish this correspondence. I have similar communications from practitioners all over the globe. The following are only two examples of an ever-growing body of knowledge that is called CCPD.

The 'split' pulse was described first by Efram Korngold in the mid-1990s, first associated with a patient who had terminal brain cancer. The 'split' has always been confined to one position, usually the left or right middle position and more rarely, the left proximal position. Since that time during my own practice, at pulse seminars and from a great deal of correspondence with students and practitioners, this split pulse has been accessed and over many years all associate this pulse with some death issue, and on the left side mostly about themselves [even suicide] and on the right side about the death of others. In "The Pulse and the Individual"^{viii} I discuss a patient with a split pulse at the left middle position then contemplating suicide.

Recently a patient of a recent graduate of DRCOM presented with a split pulse covering the span of the left side of the wrist. "There is without a shadow of a doubt 2 distinctive pulses running side by side from the proximal through the middle and into the distal. " Though reports about the Split pulse have mostly concerned death issues, at the time I felt that we had to consider this possibly as an anomaly and was concerned about other anomalies. However, Korean pulse diagnosis [James Ramholz] suggested previously that a 'split' pulse on one entire side might be a sign of cancer.

The graduate reported "confirmation on that cancer finding with the split pulse on entire left side of body." I admitted my patient to the hospital this morning with a Kidney stone attack. I begged and pleaded for imaging to be done of his abdominal area and they did it. My patient just called me and told me that he was

told he had Liver Cancer. The imaging showed tumors on his Liver."

CCPD is now incorporating this information from Korean pulse diagnosis so that when an entire side of the pulse is split into two separate vessels, we will be alerted to its possible meaning and make appropriate referrals.

During my work with Dr. Shen he mentioned that the Organ Depth had within it three depths of its own. Over time we have found the two deepest involving the blood aspect of parenchyma [tissue] and even deeper, the most dense aspect of tissue in which both we have found retained pathogens. It was suggested by the author of THC that I invented this as a way of upstaging other pulse practitioners. CCPD is growing rapidly incorporating information based on clinical observation. From the concrete comes conception, theory. This is the inductive form of science based on analogue logic, from the particular to the theory, and allowing many variables in contradistinction to allopathic science that starts with a theory and tests it by isolating one variable, characteristic of what the author of THC is suggesting that we do with Wang She-He, begin with theory.

Quoting from T & R, "My experience in teaching, during which sessions I see many patients of the participants, is that we are only beginning to understand the implications of the qualities and of their combinations. Each patient teaches me something new, and I have encouraged others to adopt an investigative rather than a passive attitude toward the medicine. Simply repeating what was written five hundred years ago, [Li Shi-zhen] or 1900 years [Wang Shu-he] ago is inadequate for our time. I foresee some kind of ongoing conduit by which people can exchange information and contribute to a new body of knowledge. Paraphrasing Krishnamurti with whom I agree, 'Learning is the very essence of humility, learning from everything and from everybody. There is no hierarchy in learning. Authority denies learning and a follower will never learn'."

Therefore, if the author of THC is correct that "Hammer's construct has little capacity for analyzing the involvement of the eight extraordinary vessels or the six channels" how would he explain that the author's construct, his model for the eight extraordinary meridians was taught to me by one of our mutual colleagues many years ago on my initiative. We eagerly solicit new information to be made a part of CCPD and this occurs constantly. Unfortunately, books such as Chinese Pulse Diagnosis: A Contemporary Approach, are revised rarely compared to the exhaustive amount of new information. Attempts to write papers on each falls far behind the availability of material.^{ix}

The author of THC states, "Hammer's attempt to create a new nomenclature was performed without participation with stakeholders within the field of acupuncture and Chinese medicine". The author himself was part of seven years of lively discussion among a distinguished group of practitioners about all aspects of CCPD. Public dialogue has been attempted at many symposiums at which few pulse experts responded. As mentioned, correspondence has been extensive over the years with practitioners from around the world as well as here in the United States. I have 'sat' with well known, very experienced and respected figures in Chinese medicine comparing our systems. I have learned from this interaction, especially from the now deceased James Ramholz, whose holographic model based on the Korean system and attempting to incorporate all others was a part of our interchange. An example of this exchange was given above in the discussion of the split pulse.

In this lifetime one person can make only a limited contribution. Mine in the realm of pulse diagnosis is an eight hundred page documentation of my years of 'sitting' with the recognized master of pulse diagnosis who Giovanni Maciocia no less paid tribute in his Acknowledgements in *The Foundations of Chinese Medicine* as follows: "I am indebted to Dr. JHF Shen for communicating his great skills, particularly in pulse diagnosis". The claim recently on the internet by the author of THC that he shared time and space simultaneously with me and Dr. Shen is simply not so. I have never been in the same room at the same time with the author of THC and Dr. Shen. (<http://health.groups.yahoo.com/group/chineseherbacademy/message/49657>)

Theory and Practice

The distinction between theory and practice was stated succinctly as follows by two authors: the first, [Barraclough, Kevin, "Medical heroes" *British Medical Journal*. 326, no 7378[Jan 11 2003; 111] said "In theory, there is no difference between theory and practice; in practice there is." Audubon added: "If the book and the bird disagree, believe the bird". What does that mean? It simply means that if your patient and your favorite textbook disagree, believe your patient, and believe in yourself. Dr. Shen repeatedly reminded me of "book wrong". He said quite truthfully that the scholars of old were just people, like us, who made mistakes. Believe the bird.

I have no disagreement with the author of THC that "theory and practice have informed each other throughout the history of Chinese medicine" and "that there is practical value in both literary and family traditions". My issue in T&R is that the author of *Scraping Bamboo* about which T&R was principally concerned confused the two when he asserted the clinical practicality of "fine and slow, coming and

going with difficulty and scattered or with an interruption, but has the ability to recover", or is "short and floating", or "short with interruption or scattered" as a tool to identify blood stagnation, and which I discuss more fully just above.

I wrote previously: "Models are blueprints of reality. They must never be confused with the real thing. Models of medicine, science, social interaction and cosmology are an expression of the needs of a culture and of individuals for a workable organization of experience and phenomena within the limits of their awareness. Human beings with rare exceptions are not blessed (and perhaps cursed) with the sight that illuminates all of reality at once. We have had visited upon us from the beginning a dread of uncertainty which no faith has totally mitigated. Throughout the ages the structure provided by Models, whatever their limitations, has assuaged this atavistic fear of the unknown and allowed us to function as if we know. Of course we do not know. A Model is never more than a sliver of the totality of existence. This workability within a given social context limits the model to an accurate grasp of only one area of reality. Each model that has evolved through the course of history is true to its limited purview of the truth. Each has its distinct and separate value. Beyond that value we must never lose sight that Models are only metaphors for the truth and must never be confused as the truth. Dogmatic faith in a Model must be limited to its usefulness, not to its essence."^x

Regarding the CCPD 'map' the author of THC claims it to be anatomical and the "canonical literature is "built in part from a plural conceptual framework that involves content such as the Shang Han Lun, five phases, six divisions, channel theory and the cycles of essence, nutrient and protective qi." Having practiced, studied, taught and written about Chinese medicine for thirty-nine years I am impressed that the author of THC would have the temerity to assert that the CCPD model has not been influenced by these parameters of the "canonical literature". In our Diagnostic Catalogue illustrated here we find the complete gamut of Chinese medical conditions that fit within those aspects of Chinese medical models claimed to be missing from CCPD. Indeed, how would this author eliminate the only anatomical aspect of this pulse system, the radial pulse.

To repeat, CCPD is ensconced in theory, the theory of Chinese Medicine. It cannot be repeated too often that CCPD embraces every important concept of Chinese medical theory including the solid-hollow organs, qi, blood and body fluids and all of the complexities of these substances, pathogenic factors both external and internal including emotional, retained pathogens and divergent channels and all of the disharmonies addressed by this medicine from diabetes to cancer,

from neurosis to psychosis. Chapter 15^{xi} is titled 'Qualities as Signs of Psychological Disharmony'.

I make no such assumption that a practitioner manages his practice based on one finding. That argument obfuscates the central issue of T & R that using Wang shu-he's description of the Choppy quality is seriously flawed in itself. That an experienced practitioner might notice this error does not obviate it being defective. A separate issue is the relative inexperience of the vast body of new practitioners who are now yearly flooding the field from sixty colleges and for whom Wang-she-Hu's description of the Choppy quality can create doubt and confusion that can lead to serious mistakes.

Again, the ineluctable value of CCPD is that each sensation is associated with one particular condition. I have never stated, in fact I do state that etiologically and pathologically each of these other conditions are unrelated and have taught for years that a particular symptom has many etiologies. In Chinese the saying is that "one cannot make a sound with one bao ding ball." I have categorically affirmed in many places that a heart qi deficient condition will lead to a diminished circulation that will lead, especially in dependant positions, to blood stagnation which because qi and blood want to move will eventually lead to inadvertent bleeding and eventually to blood deficiency. The attempt to move the blood will bring metabolic heat to the stagnation and eventually an accumulation of heat leading to Robust Pounding. The body will attempt to balance that heat with fluid and eventually one will get a damp condition marked on the pulse by a Slippery quality.

The Tight Quality

My position is that all models of reality must be tested over and over by each succeeding generation in the light of current reality. The tight quality is again and excellent example, raised by Morris and discussed in T & R. Recently a colleague with more than thirty years or more of experience shared with me his experience apprenticing with a series of Chinese physicians who came to the USA in the mid-seventies. Each separately recounted to him that when they came from China, a country without central heating at that time and still largely now, that they treated the tight quality as a sign of excess invading cold and made people worse until they realized that the tight quality in older people was a sign of yin deficiency usually from prolonged liver qi stagnation.^{xiv}

If as the author of THC claims, "Hammer describes does not suggest the presence of a cold pathogen." it is not because I am ignorant of conventional teaching, it is because neither I or the people with whom I have associated with over the past thirty-nine years in the West have found the tight quality and an invading cold pathogen more than very occasionally under extreme

circumstances. I live in the mountains where the temperature can frequently descend to forty degrees below zero. Even here the incidence of an invading cold pathogen is rare and is usually accessed by the Floating Slow Tense quality which answers the author of THC's question "what image is used to identify the presence of a cold pathogen?" In our culture by the time the cold would reach the shao yang stage or deeper the patient has been treated with antibiotics and the process blunted. Yes, in many cold parts of the world cold would invade and the tight quality might be encountered for this reason.

The author of THC is suggesting the sensation CCPD ascribes to the tight quality is incorrect and suggests that many features all of which I am familiar with in my research for Chinese Pulse diagnosis: A Contemporary Approach, must be considered as indicating invading cold. They have been considered and it is clear that the descriptions of a "twisted rope" is closer to our taut or tense quality [as is the bowstring that I encountered during my three months in a Chinese Hospital in 1981], more associated with qi stagnation, and that our tight is closer to Deng's "tight cutting string". The Wiry quality is sharper and thinner.

To repeat, while no one is challenging the efficacy of associating the tight quality with an invading external cold pathogenic factor, in places without central heating, in our culture the tight quality in older people has most often been a sign of yin deficiency often thin as well with accompanying blood deficiency, especially in women. In younger people I have encountered it on the entire pulse with extreme pain as with a fulminating rheumatoid arthritis and in individual positions with pain in the parts of the body that those positions represent. These assertions are based on endless clinical experience by myself and many others over the past thirty five years. Here, once again, a traditional teaching must be tested in the clinic and tradition must give way to experience.

Conclusion

All models are theoretical until tested daily and concretely in the clinic. A model that does not meet the criteria of success with patients is one that Chinese medicine has discarded over the millennia. CCPD survives for only one reason. Not because it is all-inclusive, which it is not despite its striving. It survives only because, and as long as, it succeeds.

All models of pulse diagnosis, however different, Tibetan, Ayurvedic and the many Chinese varieties that have stood the test of the clinic and of time are correct; they are informing us of different aspects of the person and of the medicine. The inability to understand this fact and tolerate this multiplicity has led to the diminishment of the pulse as a diagnostic tool in the

country of its probable origin, to the frustration of many [James Ramholz],

Arriving at a consensus in a field that he himself once described as “trying to herd cats”, a profession of individualists, thus far resistant to even the type of discussion of which he was a part for seven years. Attempts to create a public dialogue on the pulse that was in his power to create as president of the AAAOM never occurred. Several people were invited, including myself, all at different times.

Imposing what many in the past have called for, as a uniform pulse system on the Chinese medical community by what the author of THC calls “the stakeholders”, would not only be impossible but highly undesirable as stifling creativity. Who specifically are these “stakeholders”? We see this in the biomedical community, silenced by protocols that not only inhibit individual creativity, but punish it severely with loss of hospital privileges and even the license to practice, a medical system that the author of THC as president of the AAAOM, has promoted as a model for Chinese medicine [specialty boards].

The author of T & C is suggesting that we begin with a theory [Wang Shu-He] and move to the concrete where he feels that I operate. This is deductive scientific methodology characteristic of the West and allopathic medicine, one that starts with a theory and tests it by isolating one variable, in keeping with his propensity for the biomedical model. We, those of us less esoteric in nature [inferred by the author of THC] begin, as the Orientals have for thousands of years, with inductive analogue logic and begin with the particular and build from that multiplicity, a theory.

CCPD is a precipitate of seventy years of one master’s experience, drawn originally from the lineage of Ding Sha Ren, his amazing common sense, and the work of another, his pupil, to systematize it for his own and for the sake of a profession. Well over much more than one hundred years of hard work, insight and experience have created an exquisite diagnostic tool, one that this participant sees growing by the participation of many in the process and one who would welcome the dialogue that he has sought since beginning to teach it twenty-eight years ago.

Recapitulation

Sweeping aside the verbiage, mine and the author of THC, that such discourses generate, I shall end where I began, that the central issue of T & R and THC is how can a practitioner clinically identify a quality with his fingers that is defined in different parts of his Pulse Classic and supported by the author of THC as “fine and slow, coming and going with difficulty and scattered or with an interruption, but has the ability to recover”, or is “short and floating”, or “short with

interruption or scattered”? He states that “Hammer seeks to abandon the complex for the simple image of the rough pulse” and “he distinguishes what he considers to be a mistaken and dangerous amalgamation of distinctly different qualities and reduces them into one.” The fact is that the pulse diagnosis is a sensory experience and that the ability to use it gainfully depends on that sensory experience being more, than less, distinct. There is nothing distinct about “fine and slow, coming and going with difficulty and scattered or with an interruption, but has the ability to recover”, or is “short and floating”, or “short with interruption or scattered”.

References

- ¹ Hammer, Leon I., M.D.; Chinese Pulse Diagnosis: A Contemporary Approach; Eastland, 2001,5, P. 362
- ¹ Hammer, Leon I., M.D.; Tradition and Revision; Clinical Acupuncture and Oriental Medicine; Vol. 3 #1 Pgs 59-71
- ¹ Hammer, Leon I M.D.; Rosen, Ross, L.Ac.: The Pulse, the Electronic Age and Radiation: Early Detection; The American Acupuncturist; Spring 2009
- ¹ Hammer, Leon I., M.D.; the Pulse and the Individual; The American Acupuncturist; Spring 2008; Vol 43
- ¹ Hammer, Leon I M.D.; Rosen, Ross, L.Ac.: The Pulse, the Electronic Age and Radiation: Early Detection; The American Acupuncturist; Spring 2009
- ¹ Hammer, Leon I. M.D.; The Chinese Medical Model in the West- A Journey in Paradox; Chrysalis Journal of the Swedenborg Foundation, Vol VI Issue I, Spring 1991
- ¹ Fruehauf, Heiner; All Diseases Come from the Heart; The American Acupuncturist; Spring 2008; Vol 43; www.calssicalchinesemedicine.org/clinicalinfo
- ¹ Hammer, Leon I M.D.; Rosen, Ross, L.Ac.: The Pulse, the Electronic Age and Radiation: Early Detection; The American Acupuncturist; Spring 2009
- ¹ Hammer, Leon I. M.D.; The Liver in Chinese Medicine; Medical Acupuncture, Sept 2009, Vol 21, No. 3: 173-17

ⁱ “Ding, GanRen Ling Zheng Yi Ji” (Ding’s clinical experiences summary)

^{iv} Hammer, Leon I., M.D.; i. Tradition & Revision; Clinical Acupuncture & Oriental Medicine ; Vol. 3 # 1 Pgs. 59-71

^v Hammer, Leon I., M.D.; Chinese Pulse Diagnosis: A Contemporary Approach; Eastland Press, 201, 2005

^{xi} Hammer, Leon I., M.D.; Chinese Pulse Diagnosis: A Contemporary Approach; Eastland Press, 201, 2005