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**Tibetan Medicine in Exile
The Ethics, Politics and Science
of Cultural Survival**

by
Stephan Kloos

Submitted in partial satisfaction of the requirements for the degree of

DOCTOR OF PHILOSOPHY
In
Medical Anthropology
In the
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Of the
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There is an African saying that to raise a child, it takes a village. Similarly, it takes much more than one individual to finish a PhD dissertation, and indeed this one is indebted to the support, help, contribution and influence of more people than I can possibly mention in the space of a few pages. Some people stand out, though – perhaps most of all the two with whom everything began and ended (for now): Laurent Pordié, with whom my interest and work on Tibetan medicine in India began at a chance meeting in Ladakh in 1998, and who supported my work as a friend and mentor since then; and Vincanne Adams, advisor par excellence, who taught me as much by advice as by example, and whose unwavering support and dedication enabled me to bring my academic training to a happier completion than I could ever have imagined in 1998. I feel truly fortunate and very grateful to have had the pleasure and privilege to be shaped as a scholar and person by these two people.

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Tibetan Medicine in Exile
The Ethics, Politics and Science of Cultural Survival
Stephan Kloos

This dissertation combines ethnography, history and critical analysis to produce the first comprehensive account of Tibetan medicine in exile to date. Beginning with exile-Tibetan medicine’s fundamental claim, it asks how its practitioners and institutions strive to simultaneously “preserve Tibetan culture” and “help the world”. I argue that Tibetan medicine “preserves” Tibetan culture and produces a modern Tibetan nation by instantiating, materializing and validating Tibetan Buddhist ethics – and thus Tibetan culture and nation – in its medical knowledge, its institutions, doctors, pills, and efficacy. At the same time, it claims to “help the world” not only by transforming itself into a globally recognized (and recognizable) system of alternative medicine providing herbal pills to an international community of patients, but also by producing an alternative, uniquely Tibetan modernity that addresses the perceived shortcomings and desires of Western modernity.

The dissertation is organized in seven chapters including the introduction. After outlining the analytic framework and introducing the subject matter in the introduction, the chapters proceed from the historical background of Tibetan medicine in exile to the ways traditional connections between ethics, politics and money have been (and are) renegotiated since the 1960s, to the transformation of exile-Tibetan medicine into a medical system and efforts to achieve legal recognition, to finally Tibetan medicine’s engagement with modern science.

Through providing an in-depth ethnography of how the Men-Tsee-Khang, Tibetan medicine's first and most important institution in exile, engages and redefines modernity, this dissertation explores how ethics, politics and the capitalist market come together in the production of pills, a "traditional medical system," cultural identity and a nation in the transnational context of exile. This dissertation thus speaks to a number of audiences, beginning with the practitioners of Tibetan medicines themselves, to Tibet scholars and scholars of Asian medicine, to medical anthropologists interested in processes of medical standardization, the production of medical systems and the pharmaceuticalization of medicine, to socio-cultural anthropologists and political theorists engaging with contemporary reconfigurations of cultural identity, ethical subjectivities, the capitalist market and the nation.

Notes on Names and Spellings

Two of the most frequently recurring names in this dissertation are “*amchi*” and “Men-Tsee-Khang”. The first, “*amchi*” (*am chi*: doctor), refers to practitioners of Tibetan medicine, and remains the same in singular and plural. The second, “Men-Tsee-Khang” (*sman rtsis khang*: institute of medicine and astrology/astronomy), refers to the largest institute of Tibetan medicine and astrology outside Tibet, which constitutes this dissertation’s main site. Throughout the dissertation, I use the Men-Tsee-Khang’s own preferred (anglicized) spelling, partly in the interest of consistency with publications on and by the institute, and partly in order to distinguish it from the original institution in Tibet, the Lhasa “Mentsikhang.”

I generally use the Wylie system of transliteration for all Tibetan terms, except for common names and places, like “Tenzin”, “Lhasa”, or “Dalai Lama”. For the English translations, which are provided in parentheses the first time I introduce a new Tibetan term, I rely on the Tibetan and Himalayan Library’s (THL) online translation tool.¹ This tool uses all major Tibetan dictionaries, including Dan Martin, Jim Valby, Ives Waldo, Richard Barron, and Rangjung Yeshe. Thanks to the remarkable English skills of virtually all of my interlocutors, I was able to conduct all qualitative interviews cited in this dissertation in English. For my questionnaire survey, however, I mostly relied on a Tibetan interpreter as well as my own basic Tibetan language skills. Similarly, I relied on Tibetan help for translating Tibetan books, transcripts and documents into English. These texts included books and book sections on the Men-Tsee-Khang’s history, a compilation

¹ <http://www.thlib.org/reference/dictionaries/tibetan-dictionary/translate.php>

of the Dalai Lama's speeches to the Men-Tsee-Khang, the Men-Tsee-Khang's annual reports from 2000 to 2008, its internal rules and regulations, Tibetan exile-government documents, and transcripts of speeches.

I have either depersonalized or used pseudonyms for all my interlocutors, except for public figures such as the exile-Tibetan prime minister or the Men-Tsee-Khang director. The latter have all signed a UCSF CHR-approved statement declaring that they consent to being quoted by their real names. Besides them, also all names mentioned in this dissertation's historical sections are real.

Table of Contents

Prologue	2
1. Introduction	10
Tibetan Medicine	15
Of Nations and Their Sick Healers	23
Identity and Nationalism in Exile	31
Tibetan Buddhist Ethics and Politics	44
Chapter Outline	54
2. The History and Development of Tibetan Medicine in Exile	59
Medical Institutions in Old Tibet (763 – 1959 CE)	60
The Early Years (1960 – 1967)	67
Laying Foundations: The Men-Tsee-Khang (1967-1980)	72
Development and Growth (1980-1987)	79
Internal Troubles (1988-1994)	86
Other Tibetan Medical Institutions: The Chagpori, CIHTS, and CIBS	90
Internal Reforms and International Expansion (1994-2003)	94
Interlude: Tibetan Medicine goes West.....	98
Revolutionizing Tibetan Medicine in Exile (2004-present)	105
3. Politics of Compassion, Ethics of Survival	112
Mani Rilbu and Sman Sgrub	116
Representing the Tibetan Nation	126
Public Health, Split Personalities and Slow Cures	136
4. The Business of Altruism	152
Subduing Capitalism	158
Hot Profits and Cold Wars: the Men-Tsee-Khang and Private Doctors	175
5. The “Sorig Revolution”	193
The Central Council of Tibetan Medicine	195
Regulating Tibetan Medicine	207

After the Revolution.....	222
6. The Recognition of Sowa Rigpa.....	235
Legalizing Tibetan Medicine	239
Two Kinds of Recognition	251
Making Sowa Rigpa “Indian”	257
Tibetan Strategies.....	265
7. Science and the Preservation of Tradition	274
Science as Reform	282
Science as Ornament.....	299
Efficacy and Ambiguity.....	315
Preserving Efficacy	323
Conclusion	335
Bibliography	345
Tibetan Sources	345
English Sources	346
Media Sources	366

List of Tables

Table 1 (CCTM Registered Amchi)	208
Table 2 (Himalayan Amchi).....	209
Table 3 (Private Amchi).....	209

*“Tibetan medicine [...] is an asset that reasserts the truth and
existence of the Tibetan nation.”*

His Holiness the 14th Dalai Lama (2007: 62)

Prologue

A seemingly endless file of Tibetans, dressed in their best clothes and holding flags and candles in the evening twilight, slowly moves through the bazaar of McLeod Ganj. Chanting solemn prayers for His Holiness the 14th Dalai Lama's long life, they walk down Temple Road, past souvenir shops, restaurants, hunger strikers, and a few Western onlookers, towards the Dalai Lama's temple. There, like every evening for the past month since March 10, 2008, the candle light march culminates in a communal prayer for those disappeared, tortured, or killed in Tibet, especially since this year's large-scale protests there. As a thousand Tibetans stand, hands folded, facing the temple and its Buddha statue, singing their national anthem as if it could bring back their lost country, hope, devotion, and sadness reverberate through the temple's courtyard. March 10, the "Tibetan Uprising Day", commemorates the failed Tibetan uprising in 1959 against the Chinese Communist forces in Lhasa, which ended in the Dalai Lama's – and, over time, more than 100,000¹ Tibetans' – flight to India. As such, it marks both the anniversary of the end of Tibetan sovereignty,² and the birthday of the Tibetan exile.

When Tibetan refugees poured over the Himalayas into India in the tens of thousands in 1959 and the years thereafter, the Dalai Lama and his newly established exile-government were quick to re-organize Tibetan society in exile, reestablish religious,

¹ This number is based on Shakya's (1999) quote of approximately 85,000 refugees having left Tibet by the end of the 1990s. Ten years on, with an estimated average of 2000 Tibetan refugees crossing the Himalayas every year (UNHCR 2000: 63), the number exceeds 100,000.

² Greater Tibet was invaded by Chinese communist forces in 1949 (Sperling 2004), with Chinese troops crossing into Lhasa-controlled territories in 1950. However, despite the de-facto occupation by Chinese forces, the Tibetan government and the Dalai Lama retained their role as the official representatives of Tibet until March 10, 1959.

political, and cultural institutions, and provide the basic infrastructure for the Tibetans to survive as a group. It soon became clear to the Tibetans in exile that what was at stake was not only the hope to one day return to their lost country, but the very existence of the Tibetan nation. Indeed, the Chinese invasion left somewhere between 400,000 and 1.2 million Tibetans dead³ (out of a total population of about 6,330,000)⁴ and most of Tibet's over 6000 monasteries – not to mention countless books and artifacts – destroyed. As the Cultural Revolution swept across Tibet in 1966, Tibetans in exile realized that returning to Tibet was even more remote a possibility, and they took it as their responsibility to “preserve” Tibetan culture at least in exile. Over time, 46 settlements were founded in South Asia, almost all of which provide primary and secondary schools, biomedical and traditional health care centers, and cooperative societies (Phuntso 2004). The three monastic seats – Ganden, Drepung, and Sera – as well as hundreds of other monasteries or monastic colleges of all five Tibetan religious sects (four Buddhist and one Bon) were soon rebuilt in exile. Dharamsala, the center of the Tibetan diaspora, not only hosts over 10,000 Tibetan residents,⁵ the Dalai Lama's temple and the Tibetan government in exile (also known as the Central Tibetan Administration, or CTA), but also the largest secular institutions of Tibetan culture, like the Men-Tsee-Khang (Tibetan Medical and Astro Institute) or the Tibetan Institute of Performing Arts (TIPA).

After the immediate needs of physical survival were addressed and cultural and educational institutions (re-)established, the larger meaning of “preserving the culture”

³ While the exile-Tibetan Department of Information and International Relations (DIIR 1996: 63) cites 1.2 million Tibetans dead either directly or indirectly due to Chinese occupation, several Western scholars have voiced doubts over that number. Patrick French (2003: 278-82), for example, estimates about 400,000 dead, a number extrapolated from an estimate by Warren Smith (1997: 600).

⁴ People's Daily, Beijing, 10th November 1959.

⁵ Prost (2008: 33) cites McLeod Ganj's Tibetan population as approximately 9,500. Many more Tibetans, however, live in the greater Dharamsala area, which includes Lower Dharamsala as well as Sidhbari (around Norbulingka Institute).

emerged in the context of the Tibetan struggle to regain their country, sovereignty, and self-determination. It was Tibetan culture – however defined – that made the Tibetans distinguishable not only as a people, but as an ancient and highly developed civilization: a people with its own history, a people with political rights; in other words, a nation. While Melvin Goldstein, arguably one of the most influential writers about Tibet’s history and status, implies that culture and politics can be neatly separated (Goldstein 1999), nothing could be further from reality in the politically charged question of the nation of Tibet. In exile, everything is related to the political struggle for recognition as an independent nation; nothing is apolitical – culture least of all. To “preserve the culture”, as the exile-Tibetans put it, is the first and most crucial step – after bare physical survival – to re-claim the Tibetans’ status as a nation with a right to self-determination. “Culture” (*rigs gzhung*), in the absence of territory and a recognized state, has come to be the central marker of identity and unity of the Tibetans; it has become synonymous with – and inseparable from – the nation (*rigs*).⁶ The term “cultural genocide”, often used by the Dalai Lama to describe the situation in Tibet,⁷ affirms this point by conflating culture and *genus* (the people) – a conflation that underscores the importance that culture has gained in the Tibetan nationalist struggle. Both Tibetan culture and nation, then, are important terms in what is to follow: not as the heavy and over-used explanatory concepts

⁶ Throughout this dissertation, I will translate *rigs* (family, clan, lineage, blood-line, caste, race, ethnic group, nationality, nation) as “nation”. Since Tibetans as an ethnic group or “race” define themselves, first and foremost, as a group with political rights and aspirations, this translation seems the most appropriate and best conveys the intended meaning.

⁷ The term was first used in relation to Tibet by Robert Badinter, a high profile French criminal lawyer, in 1989 on the French TV show “Apostrophes”, where the Dalai Lama was invited as a guest. The Dalai Lama first used the term on his March 10 speech in 1993 to describe the destruction of Tibetan culture in Tibet (Dalai Lama 1993 – URL). The term has been in current among Tibetans ever since, and has most recently surfaced in media coverage of the Tibetan protests in 2008, when the Dalai Lama for the first time directly accused China of “committing cultural genocide.” In UN documents, “cultural genocide” appears – without definition – in the Draft Declaration on the Rights of Indigenous Peoples (26. August 1994), which was formally adopted by the UN General Assembly on 13. September 2007.

we have grown wary of in Western academia, however, but as well articulated symbols at the core of exile-Tibetan discourse. My aim is thus not to offer an explanation of Tibetan culture, but to explore the ways in which “culture” and “nation” are used and produced in Tibetan medicine in exile. In other words, rather than participate in an Orientalist endeavor of documenting an allegedly pristine and unspoiled culture, this dissertation focuses on the actual – political – work of cultural (re)making that takes place in exile-Tibetan medicine.

Of course, the concept of the nation – and a national culture – is a modern one, and it could be argued that Tibet did not exist as a nation in the modern sense before the 1950s. In its self-imposed isolation from the world, it was exactly Tibet’s lack of international relations (including with the United Nations) that prevented any serious opposition to China’s aggression and tangible support for Tibet on the international stage.⁸ After the initial shock, however, the Tibetans were quick to realize the central importance of becoming a modern nation – and of using the language and discourse of modern nationalism – for their cause and long-term survival. The stakes in “preserving Tibetan culture” are therefore much higher than merely preserving Tibetan cultural institutions – like Tibetan opera, art, or medicine – for their own sake. In the minds of many Tibetans, to preserve Tibetan culture is to preserve – to produce – the Tibetan nation, and thus to ensure the survival of the Tibetans as a people in the modern world. In view of Chinese oppression and what is characterized as “cultural genocide” in Tibet, Tibetans in exile generally regard such efforts at nation-building by way of cultural

⁸ The CIA’s military support for Tibetan guerilla troops during the 1960s was never meant as a genuine help for the Tibetans, but rather as a way to harm the interests of communist China. See Goldstein (1999: 49) and McGranahan (2005).

preservation as their particular burden of responsibility, as Tibetans in Tibet are considered unable to do so (despite being seen as the ‘real’ keepers of Tibetan traditions).

Given the predominant concern with survival – that is, life – in exile, it is not surprising that the two domains of Tibetan heritage most concerned with life and personhood – Tibetan Buddhism and Tibetan medicine – have come to represent, *pars pro toto*, Tibetan culture as a whole. In the following, I will tell the story of how Tibetan medicine in exile increasingly came to represent Tibetan culture and the Tibetan nation. Realizing that even with less politically charged issues, let alone this one, a neutral, objective stance is neither possible nor desirable, I approach my subject – the Tibetans in exile, their medicine, and in particular the Men-Tsee-Khang – with an explicit attitude of respect, and with an understanding that I support their political cause. This respect is enhanced by the fact that the protagonists of this dissertation – like those of an increasing number of recent ethnographies – turned out to be “*counterpart others* who are, almost like the anthropologist/ethnographer, concerned with problems of the emergent, of knowledge production, of institution-building, of strategic decision-making.” (Rees 2008: 118) However, this respect and understanding does not mean an abandonment of a critical analytical stance – succumbing, as it were, to the myth of Shangri-la – propagated both by Western literature and, to some extent, by the exile-Tibetan government – about Tibet being a mythical place and the Tibetans a non-violent community of saintly Buddhists (see Dodin & Räther 2001). Quite to the contrary, I suggest that a serious, respectful engagement with a given subject is the precondition for critique (rather than criticism) in its original meaning of exploring limits.

My argument will begin with the observation that contemporary Tibetan medicine in exile, as well as its history and transformations since the 1960s, needs to be read through the nexus of medicine, culture, and nation, which is both shaped by and shaping diasporic imaginaries of Tibetanness and nationhood as propagated by the exile-Tibetan government in Dharamsala. This nexus, however, is far from being obvious, given, or self-explanatory. Instead, it is a contested, inherently unstable product of recent historic developments, the policies of exile-Tibetan leaders and the Indian government, and the particular institutional dynamics and strategic decisions within the field of Tibetan medicine. Placing Tibetan medicine within a wider web of connections that go beyond medical theory and the clinical encounter, I will thus document some of the processes that link exile-Tibetan medicine, culture, and nationhood. This story is evolving as it is being told; unlike similar accounts of Ayurveda's (Leslie 1968, 1973, 1974, 1976b; Langford 2002) or Traditional Chinese Medicine's (Farquhar 1994; Taylor 2005; Scheid 2007) roles in successful nationalist movements of the previous century (which I will discuss in the introduction below), it cannot be told from a vantage point that already knows its happy end. In place of the comfort of a telos, then, there is the productive discomfort of an interesting present. For the times are interesting indeed for Tibetan medicine in exile: never before has its potential looked so bright, its challenges so great, its status so uncertain. Decades of built-up momentum are finally taking shape in events that are configuring, right now, the long-term future of Tibetan medicine. Not surprisingly, a multitude of actors and interests – political or otherwise, and not always compatible – are involved, resulting in a confusing assemblage of discourses and

practices where no-one is clear about the big picture, the direction, and the potential outcomes of current developments.

This dissertation marks the first serious attempt to trace the multiple strands of history, discourse, and practices that constitute contemporary Tibetan medicine in exile. The emphasis lies on “exile”: I am not concerned here with the much more general and heterogeneous category of Tibetan medicine outside Tibet (which would include regions as diverse as Bhutan, Mongolia, or the West),⁹ but only with the *Tibetan medicine practiced by Tibetans living in exile*. In particular, I focus on India, home not only to the most important institutions of “Tibetan medicine in exile” (as I will call it throughout this dissertation), but also to the vast majority of its practitioners.¹⁰ Thus, the following account is based on 18 months of multi-sited fieldwork since 2005, 12 months of which took place in Dharamsala from 2007 to 2008. The rest of the research was divided between Kalimpong, Darjeeling, Gangtok, and Salugara in eastern India; Ladakh, Dalhousie, Bir, Sarnath, and Bodhgaya in North India; Bylakuppe and Pondicherry in South India; Delhi, Mumbai, and Bangalore in metropolitan India; Chicago and the San Francisco Bay Area in the US; and Austria in Europe. Its data consists of over 160 qualitative interviews and in-depth conversations with various people involved with Tibetan medicine in exile; 72 questionnaire interviews with Tibetan and Ladakhi patients of Tibetan clinics; and hundreds of pages of textual material translated from Tibetan; all

⁹ See Pordié (2008a, in press) for an extensive collection of studies on Tibetan medicine in Ladakh, Spiti, Nepal, Mongolia, and China.

¹⁰ In the past decade, an increasing number of practitioners of Tibetan medicine have migrated to Europe, the United States, and Canada, continuing their practices in these countries. While many of them were trained in exile-institutions in India and remain more or less connected to the concerns of exile-Tibetan medicine, others migrated directly from Tibet. In either case, being forced to adapt their practices to the particular cultural and legal contexts in the West, they form a category of their own and are only marginally dealt with in this dissertation. See Millard (2008), Vargas (2008), or Tokar (2008) for insightful studies on Tibetan medicine in the West.

framed by long-term immersion and participant observation in the field of Tibetan medicine in the itself multi-sited context of the Tibetan diaspora, with Dharamsala as its center. The main focus of research was the Dharamsala-based Men-Tsee-Khang, the first – and still most important – institution of Tibetan medicine in exile, but also extended to other institutions of Tibetan medicine, private practitioners, and concerned non-medical officials and members of the public.

Second in reach and global renown only to the figure of the Dalai Lama and Tibetan Buddhism, Tibetan medicine is poised to play a central role in redefining Tibetan identity and culture in exile, and thereby imagining – and producing – a nation that is both modern and Tibetan. Far from just being a means to another end, however, it also constitutes a highly sophisticated body of knowledge and practice that is worthy of attention in and of itself. To do justice to Tibetan medicine in exile, it is essential to grasp it in both its aspects: as an effective art and science of healing of increasingly global reach, and as a crucial domain in which a future for Tibet as a nation can be imagined. This dissertation aspires to capture both aspects – neither of which exists independently from the other – and thereby contribute to a fuller understanding, and above all greater respect, of the work and power of Tibetan medicine in exile.

1. Introduction

Although we are refugees, through Tibetan medicine we can help the world.

Dr. Tsering

When Dr. Tsering casually made this remark in a conversation about Tibetan medicine, it was almost fifteen years since he had crossed, as a teenager, the mountainous border between Tibet and Nepal, and made his way to Dharamsala in India. His brother was already a monk there, and his letters, promising good schools and the opportunity to learn English, had convinced Tsering to go and try his luck. While visiting Tsering in the Tibetan clinic in Kalimpong, a town in the Darjeeling Hills where he worked as the resident physician, or *amchi* (*am chi*), I was struck by the change in outlook represented in Tsering's personal history and reflected in the quote above. Clearly, the motivation to become a refugee in a foreign country had not been to help the world; yet here he was, offhandedly telling me that this was what practicing Tibetan medicine in exile was all about, as if it almost went without saying. And he was not alone: *amchi* after *amchi* I talked to voiced the same sentiment: "...through Tibetan medicine we can help the world."

In many ways, Dr. Tsering's story recounts the experience of the Tibetan community in exile. In 1959, when His Holiness the 14th Dalai Lama and thousands of Tibetans fled from their homeland to India, they faced the challenge of reorganizing themselves as a people without land, a population without territory. At stake, or so it

seemed, was survival: the sheer physical and economic survival as refugees in a poor host country, but also the survival of “Tibetan culture” and the “Tibetan nation”, threatened by the conditions of exile as much as by the Chinese communists. The establishment of a center for Tibetan medicine in Dharamsala in 1961, later to become the Men-Tsee-Khang (the Tibetan Medical and Astrological Institute), was seen as integral to this effort in both senses – the physical and the cultural. For example, Dr. Lobsang at the Men-Tsee-Khang branch clinic in Darjeeling told me in 2005:

The most important reason for the establishment of the Men-Tsee-Khang, when we had to flee Tibet, was to preserve our culture. Second, to give service to the Tibetan community and the Himalayan people. Now also other people benefit from Tibetan medicine.

Three years later in Dharamsala, Dr. Lhawang la, the institute’s senior-most doctor,¹¹ similarly emphasized the Men-Tsee-Khang’s continuity of purpose:

The purpose is the same [as in the 1960s]. Because the Chinese invaded and destroyed everything, we’re here to preserve the culture of Tibetan medicine. In the beginning, the conditions were poor, unlike now, but the motivation is the same. We’re not working for money, but to preserve our culture and make it flourish.¹²

These statements are remarkable: it is fairly obvious that a medical institution can save lives in the case of sickness; but how, exactly, does the Men-Tsee-Khang “preserve”

¹¹ Dr. Lhawang was one of the first three students to be trained by the Men-Tsee-Khang in exile in the early 1960s (see chapter 2), and worked there until the end of his life in 2008.

¹² The Men-Tsee-Khang was by no means the only institution founded with the aim of “preserving the culture”, although I argue in the following that it came to play a special role in this endeavor. The centrality of “cultural preservation” – rather than health, for example – in the early Tibetan diaspora is underscored by the fact that the first department of the Tibetan government in exile was the “Department of Religion and Culture” (under which the Men-Tsee-Khang initially came), while it was not until 1981 that a Department of Health was established, which furthermore received only a fraction of the resources that the Department of Religion and Culture enjoyed (Grunfeld 1987: 194).

Tibetan culture? What is this “Tibetan culture” supposed to be in first place? What does “helping the world” have to do with it? And what does all of this have to do with the Dalai Lama’s statement about Tibetan medicine “reasserting the truth of the Tibetan nation”?

This dissertation will try to answer these questions by telling the unlikely and dramatic success-story of the Men-Tsee-Khang – the first and most powerful institution of Tibetan medicine in exile, as well as the largest, most prestigious, and most profitable secular institution in the Tibetan exile in general. With more than 120 doctors, several hundred staff members, and 50 branch clinics in India and Nepal,¹³ the Men-Tsee-Khang represents, both literally and figuratively, the shape and development of Tibetan medicine – and, as many see it, of Tibetan culture – in exile. My efforts to trace exile-Tibetan medicine’s historical and contemporary configurations – and its wider cultural and political role – were thus both focused primarily (but not exclusively) on the Men-Tsee-Khang, and necessarily spread out over the multiple sites and locations of the Tibetan diaspora in South Asia and beyond. Fieldwork took me into the homes, offices and clinics of a large number of people who were often connected by nothing more, nor less, than some kind of relation to Tibetan medicine. Of course, many of my interlocutors practiced it as professional *amchi*, and many others relied on it as patients; but there were also those who – in their function as officials or politicians – helped shape Tibetan medicine in exile by administrating or representing it; there were scholars and intellectuals whose critical views helped put the *amchi*’s discourses into perspective; and there were yet others who might have simply had interesting opinions or insights, or who had contributed to Tibetan medicine’s development in different ways.

¹³ These figures are from March 2010.

Tenzin Dorje was of the latter category. A private Delhi-based entrepreneur blessed with good health, he disliked taking pills of any kind – Tibetan or Western. His connection to Tibetan medicine – and the reason why I visited him in his South Delhi office one early March morning in 2008 – was of a different kind, and dated back to the mid-1990s. At that time, the Men-Tsee-Khang had a serious problem with counterfeited “precious pills”,¹⁴ and Tenzin Dorje had helped the institute by providing the (then) fake-proof hologram sticker that identifies the institute’s precious pills even today. At a time when the hologram was completely new in India and therefore both unknown and expensive, this had not only been a remarkable personal initiative but also a substantial donation. As I asked him, that morning in South Delhi, why he did it – especially since he himself never used Tibetan medicine – the conversation quickly turned to Tibetan medicine’s role in exile. Tenzin Dorje told me:

Tibetan medicine maintains our identity. That’s why the Men-Tsee-Khang is so important. I travel a lot, and I feel that Tibetan medicine and the three monastic seats in South India are the roots that keep flowering. They are our heritage. The Men-Tsee-Khang will never allow Tibetan medicine to get lost. Some doctors there are very stubborn, and I admire that. These are the pillars of our Tibetan heritage. Modernity has its place, but heritage also has its place. The Men-Tsee-Khang is the root from which Tibetan medicine will be reflected. [...] All the Tibetan doctors around the world should recognize the Men-Tsee-Khang as the highest standard. And the Men-Tsee-Khang has to maintain that standard; they have to follow the old tradition very strictly. The three monastic seats and the Men-Tsee-Khang have to remain pure – even if others modernize and change, they

¹⁴ “Precious pills” – in Tibetan “*rin chen ril bu*” – are special pills containing up to over 200 different ingredients, including herbs, minerals, and purified and detoxified metals and gems (hence the name). Besides their material ingredients, they are also believed to be specially empowered and blessed through tantric and ritual practices. These pills are used to treat complicated and severe disorders, but are especially popular as tonics to be taken on full-moon days. See chapter 2 for more details.

have to remain. Then, if the new loses power, the others can come back to the pure tradition.

There are several themes in Tenzin Dorje's sentiments: the Men-Tsee-Khang's well-known – and often criticized – conservative attitude; its sense of ownership of and responsibility for Tibetan medicine (“they will never allow it to get lost”), which informs the Men-Tsee-Khang's hegemonic relations with other doctors and institutions; the discourse of modernity and tradition, in which Tibetan medicine and culture are always taken as ‘tradition’ and defined as different from – but not opposed to – modernity; the preoccupation with ‘purity’ of culture, motivation, and heart. All of these will be explored in detail in the story that follows. The main theme in Tenzin Dorje's discourse, however, is that Tibetan medicine and Buddhism are Tibet's most important heritage – the symbols and pride of Tibetan culture and identity – and that the Men-Tsee-Khang and the three monastic seats¹⁵ are their guardians. The inclusion of Tibetan medicine and the Men-Tsee-Khang as central markers of Tibet's heritage and culture is remarkable, and not limited to Tenzin Dorje's personal opinion. In a speech to Men-Tsee-Khang doctors in 1994, the Dalai Lama himself said:

Tibetan medicine is an institution that beholds the socio-political values of Tibet. [...] The Men-Tsee-Khang is not merely an institute of academic training, but it is also an avenue that establishes and finely molds the Tibetan nation and culture.” (Dalai Lama 2007: 56)

Although Tibet was long known to its neighbors as “the land of medicinal herbs”, and its medicine was highly appreciated in imperial China, Tibetan medicine was – in

¹⁵ The three monastic seats (*gdan sa gsum*) of Tibet are the “great three” Gelugpa monasteries surrounding Lhasa. These three monasteries – Ganden, Sera, and Drepung – were important sites of religious, political, and economic power in old Tibet, and have been rebuilt in exile in South India.

contrast to Tibetan Buddhism – not regarded as a constitutive element of Tibetan identity until at least 1959.¹⁶ Furthermore, the original Lhasa Mentsikhang (*sman rtsis khang*: institute for medicine and astrology) was founded relatively late – in 1916 – as a secular institution, and remained second in status to the much older, monastic medical college known as the Chagpori (*lcags po ri*: iron hill) until the latter was destroyed in 1959. Although it revolutionized the Tibetan medical profession by opening its institutional training to laymen, and played an important role in defining Tibet’s move to modernity under the 13th Dalai Lama (Goldstein 1989), the Mentsikhang certainly never came close to being compared with the three monastic seats, which were the main sites of religious, political, and economic power in old Tibet. How, then, did Tibetan medicine in exile, and more particularly the Men-Tsee-Khang, gain a function and importance that was previously reserved for Tibetan Buddhism and its largest monastic institutions? This story, in which the Men-Tsee-Khang’s fate is inseparably intertwined with Tibetan medicine’s simultaneous development into a powerful symbol for Tibetan culture and a global alternative health resource, constitutes the larger narrative frame of the chapters below.

Tibetan Medicine

Before beginning the story, however, a few words are needed about Tibetan medicine itself. Regarded the second most important of the five major Tibetan sciences after

¹⁶ However, pre-modern Chinese – and presumably other neighboring peoples of Tibet – did take Tibetan medicine as a sign for the greatness of Tibetan civilization.

Buddhist philosophy,¹⁷ *gso ba rig pa* (Tib: the knowledge/ science of healing) today goes by many names: “*amchi* medicine”, “Buddhist medicine”, “Mongolian medicine”, or “Tibetan medicine” are just a few examples. As its names differ in different places, so also does its clinical practice, its legal status, its infrastructure, and even, to some extent, its theoretical base. This has led some scholars (Pordié 2008b: 4) to argue that in fact, there are multiple “Tibetan medicines” rather than one singular, homogenous medical system. This dissertation partly takes this into account by using the appropriate appellations, such as “*amchi* medicine” when talking about the Ladakhi context, or “Sowa Rigpa” when referring to the context of Indian bureaucracy. Mostly, however, I will use “Tibetan medicine” in the singular, because this dissertation is specifically about the “Tibetan medicine of the Tibetans in exile”, who themselves call it “Tibetan medicine” or its Tibetan equivalent (*bod sman, bod kyi gso ba rig pa*). Furthermore, Tibetan medicine – albeit the subject of lively debates and conflicting interests – is remarkably homogenous in the Tibetan exile context, with the vast majority of its practitioners, whether practicing privately or in an institution, having been trained under the Men-Tsee-Khang’s syllabus.¹⁸ Part of what makes current exile-Tibetan efforts to construct a “medical system” out of Tibetan medicine possible – and easier than it might have been the case with Ayurveda or Traditional Chinese Medicine, who all rely on multiple (and sometimes competing) textual sources – is its reliance on a single, core textual authority, the *rgyud bzhi* (the “Four Tantras”). Supplemented with a number of

¹⁷ There are five major and five minor Tibetan sciences. The five major fields of study (*rig gnas che ba lnga*) include: arts and crafts, medicine, grammar, logic, and Buddhist philosophy. The five minor fields of study (*rig gnas chung ba lnga*) are: poetry, synonyms, rhetoric or metrics, astrology, and dance and drama.

¹⁸ Apart from the Men-Tsee-Khang itself, also the Chagpori Institute in Darjeeling and the Central Institute of Buddhist Studies (CIBS) in Ladakh use the Men-Tsee-Khang’s syllabus, or a close version of it, to train their students. As mentioned above, this homogeneity only partially extends to Tibetan medicine in North America and Europe.

commentaries meant to explain and interpret its often cryptic verses, the *rgyud bzhi*'s 156 chapters contain the epistemological framework, medical theory, terminology, and practical techniques of diagnosis and treatment that form the basis of Tibetan medical practice and training in all its locations.¹⁹

Although regarded as distinct from Tibetan Buddhism, Tibetan medicine derives from Buddhism its epistemic and ethical framework. Thus, ignorance is posited as the root cause of all suffering, which generates the “three mental poisons” of craving/attachment (*'dod chags*), aversion (*zhe sdang*), and delusion (*gti mug*). These afflictive emotions, in turn, manifest in the body as three “defective energies” (*nyes pa gsum*), called *rlung* (wind), *mkhris pa* (bile), and *bad kan* (phlegm),²⁰ which derive their qualities from the five elements (*'byung ba lnga*) earth (*sa*), water (*chu*), fire (*me*), air (*rlung*), and space (*nam mkha*).²¹ Indeed, according to Tibetan medical theory, the entire universe – animate and inanimate – is made up of these five elements in different combinations. When the three defective energies are in a balanced state (*'du ba snyoms*

¹⁹ There are exceptions to that claim, as some lineage *amchi* in Tibet do not rely on the *rgyud bzhi* (Adams, pers. comm. 2009). Throughout this dissertation, however, I am only concerned with Tibetan medicine *in exile*, where the *rgyud bzhi* is universally accepted as the theoretical foundation of Tibetan medicine.

²⁰ Translated in most older literature as “humors”, Men-Tsee-Khang practitioners have recently changed their English terminology to the more accurate term “defective energies”. While “humor” – stemming from the ancient Greek concept of bodily fluids or “juices” (*khymos*) – connotes a material entity, this is only partially true in Tibetan medicine, where *nyes pa gsum* also encompass immaterial or subtle flows of certain qualities, translated, for lack of a better term, as “energies”. These “energies” are “defective” because they are the product of the moral flaws of craving, aversion, and confusion. Similarly, the translations for *rlung*, *mkhris pa*, and *bad kan* as wind, bile, and phlegm are too narrow to describe the qualities of each Tibetan term. For example, *mkhris pa* does refer to bile in certain contexts, but is better understood by its qualities and functions in the body-mind continuum that far exceed those of bilious fluid. While citing the standard translations here, I will therefore follow the example of Men-Tsee-Khang doctors in simply using the Tibetan terms throughout the text. For detailed descriptions of *nyes pa gsum*, see Men-Tsee-Khang (2001), Drungtso (2007), Donden (1986, 2000), Dash (1976, 1997), or Dummer (1988). For an insightful discussion of the origins and problems inherent in the translation of *nyes pa* as “humor”, see Gyatso (2006).

²¹ As with the three defective energies, the common translations of the five elements are – while not incorrect – misleading. It is not so much that everything in the universe is made of earth, water, fire, etc. in their conventional sense, but that everything possesses the *qualities* of these objects. Thus, the earth element refers to weight and texture; water element refers to cohesiveness; fire element to temperature (whether hot or cold); and air element to movement. The precondition for all of these is space.

pa, *rnam par ma gyur pa*), the individual enjoys health; in an unbalanced state (*rnam pa gyur pa*), they are the causes of mental and physical suffering.²² The proper balance of the three *nyes pa* can be disturbed due to a variety of reasons, including diet, lifestyle, seasonal changes, spirit attacks, or the effects of karma. Such disturbances can, especially if severe or prolonged, either be direct causes of sickness, or indirect ones making a person more susceptible to infections. Thus, while not denying the existence of external agents as the cause of illness, Tibetan medicine's etiology emphasizes internal factors.

There are three principal avenues of diagnosis in Tibetan medicine: visual (visual examination, urine diagnosis), tactile (pulse diagnosis), and verbal (interrogation), which are ideally used in combination to triangulate evidence and arrive at a precise diagnosis. In practice, different *amchi* have different preferences regarding these diagnostic techniques: while Dr. Yeshe Donden famously favors urine analysis (but also uses the other two), most Men-Tsee-Khang doctors today practice urine diagnosis only upon request (or, at times, with regular patients), preferring pulse diagnosis and interrogation. Very experienced doctors often impress their patients by making accurate diagnoses without asking a single question, relying solely on pulse diagnosis. The first and most important diagnostic step is to determine whether a sickness is “hot” or “cold” in nature – an important dichotomy in Tibetan medicine; then, to determine which *nyes pa* (or combination of *nyes pa*) is involved, and where the imbalance is located. Once the

²² Samuel (2001) argues that Men-Tsee-Khang practitioners as well as lay people do not regard *nyes pa* in terms of balance or imbalance, but as direct causes of sickness. In this argument, he joins Zimmerman's (1992) critique of Western New Age appropriations of Ayurvedic theory, applying it to Tibetan medicine. However, as the Tibetan terms quoted above indicate, the concept of balance has been well established in Tibetan medical theory since long before the New Age movement and Tibetan medicine's exposure to Western ideas. Samuel is correct in noting that in practitioner-patient interactions, and in lay discourse, the names of the humors are often used synonymously for the sickness itself (cf. Gyatso 2006). This, however, does not indicate an absence of an underlying notion of (im)balance, which is indeed central to Men-Tsee-Khang practitioners' understandings of health and illness.

sickness is diagnosed, an *amchi* has to determine the appropriate treatment, which generally operates on the principle of opposites: for example, if the sickness is “hot” in nature, it is treated by “cooling” it, and vice versa. There are, in theory, four hierarchies of treatment, starting with behavioral and dietary regimes as the first step, medicinal powders next, then pills, and finally external therapy if necessary (e.g. moxibustion, venesection, cupping, golden needle treatment, or surgery). However, contemporary practice in India gives overwhelming importance to pills, with some cursory dietary advice, and rarely involves external therapies.²³ Tibetan pills are mostly herbal and mineral compounds²⁴ consisting of usually between four and thirty-seven, but in case of “precious pills” (*rin chen ril bu*) up to two hundred ingredients, which are crushed or chewed by the patient and swallowed with some hot water.

What sounds relatively simple in theory is often a highly complex process requiring the practitioner to translate multiple registers of his or her sensory raw data into elaborate mind maps, link that information to relevant memorized passages of the *rgyud bzhi* and different commentaries, and translate the result back into a prescription based on the knowledge of the different potencies (*nus pa*) of foods, behaviors, and the pharmaceutical ingredients that the pills are made of. While certainly qualified to practice after the standard institutional training of five years of intensive textual study and a one-year internship in a clinic, a freshly graduated Tibetan doctor is therefore only at the beginning of his learning process, especially as far as the more difficult aspects – the

²³ Although some medicines still take the form of medicinal powders, they are not common due to their short shelf life in India’s hot and humid climate. The most frequently used external therapies in exile are cupping and moxibustion, and – in some places – acupuncture. Venesection is only very rarely used by Tibetan doctors in India, and surgery is not practiced at all.

²⁴ Animal products are also part of Tibetan medicine’s traditional pharmacopoeia, but are to a large extent substituted today by herbal ingredients, due to the Dalai Lama’s advice.

“art” – of Tibetan medicine, like pulse diagnosis or the mastery of the pharmacopoeia, are concerned.

*

Perhaps the most crucial, yet overlooked, fact about Tibetan medicine in exile and the Men-Tsee-Khang is that, while effectively treating and curing millions of people, it has always had but one patient: Tibetan culture.²⁵ When the 14th Dalai Lama established what was then, in 1961, simply referred to as the “medical center”, his vision was far greater than the wooden hut in which a lone doctor and his three students manually grounded herbs into a few medical compounds. It was greater even than today’s prestigious Men-Tsee-Khang, which this small center had become since then. And, I will argue in this dissertation, it was also greater than merely preserving Tibetan medicine for its own sake, as one part of Tibetan culture that should not be lost. In the words of Dr. Tsewang Nyima,

We have to understand the potential of Tibetan medicine: it is not just about preserving the culture or making some money, or giving employment to thousands of Tibetans, but also how we can use it in earning the goodwill of the rest of the world.

Dr. Namgyal Tsering, the Men-Tsee-Khang’s deputy director, added:

We are not doing politics, but sometimes it comes automatically. Like when we give a lecture on Tibetan medicine, the name itself includes the word ‘Tibetan’. So first we have to explain about Tibet, and to do that, we have to explain what happened in the past, and what the Chinese do to

²⁵ This is not to deny the important concern of providing medical treatment to the Tibetan refugees, but to emphasize that this more immediate purpose was subsumed, from the beginning, under the larger, longer term goal of cultural preservation and nationalism.

Tibet, and why we come to India or the Western countries... So this is related. Actually we never say we do politics, but it comes automatically.

What Dr. Tsewang Nyima and Dr. Namgyal imply here is that practitioners of Tibetan medicine are playing an important role in the Tibetan cause, even if they may not engage in overt political activism. As Dr. Sonam Dhondup from the Central Institute of Higher Tibetan Studies (CIHTS) in Sarnath told me,

The Dalai Lama said, ‘whatever you do, do it as a worship for the cause of Tibet.’ This has a big meaning for Tibetan Medicine. I may not go demonstrate in front of a Chinese embassy, but with the name of Tibetan Medicine, I am helping the Tibetan cause, I am working for the future of Tibet.

The term “Tibetan medicine” itself, as Dr. Namgyal astutely remarked, already assumes the existence of a legitimate Tibetan nation. In Craig Janes’ (2001: 216) terms, Tibetan medicine’s “very existence symbolizes a classical Tibetan culture, a native genius.” Another Men-Tsee-Khang physician practicing in a small Tibetan settlement above a north Indian hill station, explained it like this:

Tibetan medicine not only cures physical diseases, but also the mind. Tibetan medicine preserves Tibetan culture, and when people start taking it, they learn that it has thousands of years of history, and that Tibet has been free for all that time. So it helps to bring sympathy for our cause.

The mission that Tibetan medicine was to fulfill from the outset – “preserving the culture” – thus takes on a larger meaning in the context of the Tibetan exile, where both “culture” and its “preservation” are ethical *and* political problems at the same time. Indeed, I argue that Tibetan medicine in exile cannot be fully understood outside of its

triple function – helping the world, preserving the culture, reasserting the Tibetan nation – that merges ethics and politics, culture and the nation. Whether it is in daily clinical practice, in the way medical theory is taught and discussed, or in its institutional organization, this triple function centrally shapes contemporary Tibetan medicine in all its aspects. Any attempt to critically appreciate Tibetan medicine in exile – and to make sense of the statements quoted above – must therefore begin with taking such claims of altruism, cultural preservation, and nationalism seriously. Rather than seeing them as contradictory or opportunistic assertions, this dissertation will show how, in practicing, teaching, and ultimately transforming Tibetan medicine in exile, the Men-Tsee-Khang as its prime representative is not only guided by the sincere motivation to preserve Tibetan culture, but also crucially engages in efforts to imagine – and thus produce – a modern Tibetan nation.

This, then, is what I have been trying to argue so far, and what constitutes the fundamental thesis of this dissertation: Tibetan medicine is pivotal to Tibetan culture and nationalism, and cannot itself be understood in isolation from them. The link between medicine, culture, and nation in the Tibetan exile is, as anywhere else, contested, fraught and fragile; it is an accomplishment that is far more complex, a connection far more difficult to make than the verbal claims quoted above. What this dissertation will show, therefore, is *how* the connection between exile-Tibetan medicine and the Tibetan nation is produced, affirmed, and contested, and the effects this has on its theory, practice, and institutional organization. As I will show in the next section, scholars and politicians of nationalist movements elsewhere in Asia have long recognized the importance of ‘traditional’ medicines, taken as indigenous sciences, for their struggles. Scholars of

Tibetan identity and nationalism, however, have so far failed to account for Tibetan medicine's central role in diasporic identity constructions. Most of them have also ignored the fact that the Tibetan nation needs to be simultaneously modern and traditional, secular and religious, ethical and political, universal and particular, thus tending to offer rather one-sided portrayals of Tibetans in exile. It is exactly Tibetan medicine's achievement of bridging these modern conceptual divides that constitutes its importance for Tibetan nationalism, and the analytic focus of this dissertation.

Of Nations and Their Sick Healers

While Tibetan culture may be Tibetan medicine's most important patient, it is certainly not the only patient suffering from cultural malaise in Asia. For example, Ayurveda's object of healing changed, during the Indian nationalist movement a century ago, from the individual patient's "socio-psycho-somatic distress" (cf. Nichter 1981) to "cultural weakness" and finally the threat of cultural loss altogether (Langford 2002). Similarly, Chinese culture had to be revived or reformed by "Traditional Chinese Medicine" (or "TCM") after the fall of the Qing dynasty in 1911 and the subsequent half-century of political upheavals (Farquhar 1994; Taylor 2005; Scheid 2007). The medical metaphor that takes culture as a patient is neither new nor imposed – it has been used by Indian and Chinese nationalist movements since at least a century ago (see below) – nor is it inappropriate. Quite to the contrary, it points to nationalism's central theme, that is, the effort to bring into being a clearly demarcated, unified nation. No culture can fall sick and be diagnosed and treated as a patient unless it is first produced and defined as a bounded entity. Hidden in the nationalist imperative – so often invoked – of "preserving

the culture” (or healing, saving, or reforming it) is thus the creative act of producing the very culture that needs to be preserved. One could say – using well established, if somewhat misleading concepts – that this culture of “invented traditions” (Hobsbawm & Ranger 1983) provides the sense of historical continuity and unity that informs the “imagined community” (Anderson 1991) of a nation. As the emerging nation is imagined in terms of a disappearing culture, the culture must be saved in order for the nation to take birth.

Indeed, a number of authors (Prakash 1999; Hansen 1999; Langford 2002) document how the appearance of culture on the various sickbeds of Asia’s traditional healers invariably coincides with nationalist efforts to unify a heterogeneous array of peoples, interests, and loyalties into a single, bounded nation. As Partha Chatterjee (1993) points out in the Indian context, nationalism began long before its overt political battle with the colonial power. Rather, its first step was to declare culture and spirituality as its sovereign domain that bore the community’s essential markers of difference, to be defended against colonial intervention (Chatterjee 1993: 6; cf. Norbu 1992). However, he adds, this domain had to be transformed in order to make it adequate for the modern world: the postcolonial subject, or nation, had to be modern without compromising its particularity, without losing its difference from the colonizer (ibid.: 7). Chatterjee here provides a diagnosis of the cultural malaise that Tibetan medicine is (and Ayurveda and TCM were) asked to heal. In the context of nationalism, the lack of modernity is a life-threatening disease; but modernity is an equally dangerous cure, which needs to be adjusted, even reinvented, to suit the patient’s particular constitution. What of this

patient, then, and her constitution? What about the culture that comes to stand for the nation? And what about modernity, adjusted, reinvented and particularized?

Remaining with the example of India – which is especially pertinent since the Tibetans in exile take their own cues from it (cf. Lopez 1998: 186ff; Dreyfus 2005: 7) – Thomas Blom Hansen (1999) describes how Vivekananda and Gandhi appropriated European romanticist imaginations of an Indian national essence as the unifying element for their nationalist movement. However, as Ashis Nandy (1983) argues, this is not to be understood as an abandonment of Indian agency or creativity: to the contrary, he interprets the flexibility of Gandhi's use of Western ideas (turning them against the West) as the ultimate act of creative – and successful – anti-colonial resistance. Conflating the nation with an essentialist view of Indian culture that was based on Hindu values like tolerance or purity, Gandhi thus managed to not only establish Indian nationalism as the moral good vis-à-vis the absolute evil of colonialism, but also, on a domestic level, to elevate the nation above the daily strife of politics. But, as Gyan Prakash shows, the Indian nation needed more than just tolerance and purity: it needed its own science. Prakash writes:

To possess a scientific tradition of one's own not only meant that one had existed as a people before the British set foot in India, but also that one's existence as a community was irreducibly different. This was of vital significance, for embedded in it was the claim that what defined India was not the modern apparatus introduced by colonial government; rather, what made India unique was its *culture* – its learned texts, traditions, and ancient history. (Prakash 1999: 230, emphasis added)

In other words, science – as culture – was pivotal for the imagination of India and its emergence as an independent nation (ibid.: 3). Introduced by the British in order to create and represent India as a distinct, unified space and to govern its people through a grid of technologies, it also enabled Indian nationalists to appropriate modern science’s discourse of universality and rationality in legitimating their own, alternative, and uniquely Indian science. At the center of this Indian science emerged religion and medicine: the ‘science’ of the Vedas and of Ayurveda came to stand for Indian culture, which in turn enabled the nationalists to claim India as a nation rightfully theirs.

An interesting twist in the metaphor of culture as a patient emerges here: if Ayurveda was a sign of Indian culture itself (Langford 2002), and if indeed Indian culture was considered ‘sick’ and ‘weakened’ due to deviating from its original archaic wisdom (Prakash 1999; Langford 2002), then Ayurveda – symbolizing Indian culture – became its own patient. Ayurveda was thus essentially asked to heal, revitalize, and transform itself to recover its original scientific purity (as imagined by the nationalists) in order to be both Indian and modern. As mentioned above, in its role as culture/ patient, Ayurveda had to acquire a ‘body’; it had to become a bounded entity in the form of a *medical system* (Langford 2002). In its role as a sick healer, however, Ayurveda had to look elsewhere for the necessary remedy. This is where modern science comes in. In Prakash’s words: “science has always been asked to accomplish a great deal – to authorize an enormous leap into modernity, and anchor the entire edifice of modern culture, identity, politics, and economy.” (Prakash 1999: 12) While it is thus clear that science – and not only ‘traditional’ science like Ayurveda, but also ‘modern’ science – is inherently cultural and political (Latour 1988, 1999; Nandy 1988; Harding 1998), its attraction and

political power lies exactly in its paradigm of rationality, universality and objectivity. And it was this paradigm that the Indian nationalists were looking for as a remedy: the medicine of modernity, of rationality, universality and objectivity encapsulated in the term “science” would bestow on their culture – and thus nation – an undisputable legitimacy that even the British could not deny.

In order for science’s modernity to serve as a cure for an ailing culture and its traditions, it needed to be adjusted, reinvented and particularized. Indeed, as Jean Langford (2002) argues, the encounter between “traditional culture” and modernity rarely takes the form of a clash, resulting in the complete victory of the powerful latter over the feeble former. Instead, it can be seen as a mutual engagement from which both sides emerge changed, transformed and possibly “healed.” For if Ayurveda was suffering from a lack of rationality, universality and objectivity, then modernity, for its part, suffered from a lack of wholeness that only tradition could cure. Indeed, Vincanne Adams (2001a: 222f) points out, Western modernity’s fragmentation was widely diagnosed by thinkers from Durkheim or Marx up to Foucault or Giddens as a condition of lost wholeness – whether through a separation of labor from its products, of knowledge from moral goodness, or of the human from her self. It has been well documented how the resultant search for completion has manifested in European colonial encounters and Western orientalist fascinations with non-modern “others” (Said 1978). This encounter, however, was not one-sided, as these “others” have, for their part, engaged with Western modernity and orientalism in creative ways, particularly in the domains of religion and medicine. Posited as traditions of wholeness, these domains were redefined as not only in need of modern reform in order to heal their own nations, but also, crucially, as potential cures

for European modernity's loss and fragmentation (cf. Zimmermann 1992; Lopez 1998; Langford 2002). In other words, not only traditional medicine, but also modernity appeared as a sick healer: each aiming to cure itself by engaging the other, each promising to cure the other by healing itself.

In this circular engagement, Ayurveda could not be *either* modern *or* traditional, but needed to strategically employ signs and discourses of both (Langford 2002). The same is true for Tibetan medicine in exile, which in its encounter with modernity remakes not only itself but also modernity: in producing an alternative, holistic, uniquely Tibetan modernity, it aims to simultaneously heal itself, "preserve" Tibetan culture, and help the world. In as far as Tibetan medicine in exile promises to help the world by curing a fragmented modernity with wholeness, it caters to Western orientalist desires and fantasies that have been described, in regard to Tibet, by Donald Lopez (1998) and the contributors to the edited volume *Imagining Tibet* (Dodin & R  ther 2001). But, like Gandhi's use of Western ideas, the exile-Tibetan *amchi*'s strategic utilization of such desires for their own political goals is not to be understood in terms of a mere copy of foreign concepts, or an "imprisonment" in an orientalist Shangri-la. Tibetan identity and medicine are not the products of Western orientalist fantasies. Rather, as certain aspects of the latter merge seamlessly with traditional Buddhist ethics of altruism and compassion, which exile-Tibetans genuinely regard as their cultural and national identity, the ways in which Tibetanness is articulated, expressed and defined are shaped by Tibetan medicine's strategic engagement with modernity. As I will show in this dissertation, this engagement is not only mutually transformative, but also constantly evolving.

As with the cultural malaise I started with, the therapeutic use of modernity and science is not an isolated case. In the Tibet Autonomous Region (TAR) of China, Craig Janes shows how Tibetan medicine has come to symbolize Tibetan national identity and cultural expression in the face of Chinese oppression. He writes:

Tibetan medicine is thus an important and potentially revitalizing element of modern Tibetan culture [...] and may represent one of the last public contexts where Tibetan ideas about the body-mind, social ethics, and the consequences of modernity can be freely and legitimately expressed.” (Janes 2001: 204)

Under constant suspicion from the Chinese state, however, Tibetan culture – as manifest in Tibetan medicine – needs to be portrayed as “science” (Adams 2001a, b; Janes 2001). That is, it can only fulfill its function of cultural “preservation” if it is perceived as objective, universal, and emphatically non-political. Outside of Asia, too, this recurrent nexus between medicine and science has been well documented. Whether in post-Chernobyl Ukraine (Petryna 2002) or the United States (Treichler 1999), medicine emerges as one of the most important domains where science forms and articulates ethnic or national identities. More than any other field of scientific expertise, medicine mediates the truths of science into people’s immediate experience of themselves, thus making these truths of direct relevance for individual, social, and national identities. In this way, medicine can play a central role in the formation of new subjectivities and ways of conducting politics.²⁶

There is, then, much more to Tibetan medicine in exile than merely clinical practice and medical theory, or the question of how they are affected by modernity and

²⁶ See, for example, Foucault 1978; Rabinow 1996; Adams 1998; Cohen 1998; Petryna 2002; Dumit 2000; Nguyen 2005.

exile. As a domain of investigation, Tibetan medicine provides crucial insights not only into alternative ways of configuring self- and nationhood in the 21st century, but also into the ways in which an alternative modernity is produced through contemporary reconfigurations of modern dichotomies such as ethics and politics, science and religion, or modernity and tradition. Nevertheless, despite considerable academic interest in Tibetan exile culture and politics,²⁷ and to a lesser extent in exile-Tibetan medicine (Samuel 2001; Aschoff 2004; Prost 2006a, b, 2007, 2008, in press), no serious ethnographic study has yet examined Tibetan medicine's singular cultural, social, and political importance in the Tibetan diaspora.²⁸ While addressing this gap, this dissertation also aims to contribute to a more adequate conceptual and analytic framework for understanding the political and ethical problems of the 21st century. As such, its relevance extends far beyond the specific interest in the Tibetan diaspora or the anthropology of 'traditional Asian medicine'.

Tibetan medicine, so the consensus among exile-Tibetans goes, is a unique science that blends rational empiricism with a religious²⁹ ethics (cf. Men-Tsee-Khang 1999: 3-4). Following Prakash and Langford, I argue that it is exactly this – Tibetan medicine's status as a 'national' science – which renders it pivotal not only to the validation of Tibetan culture (counter Chinese accusations of "backwardness" or "barbarism") but, crucially, to the imagination and institution of Tibet as a nation. As I

²⁷ For example, see Goldstein 1978; Nowak 1984; French 1991; Jha 1992; Klieger 1992, 2002; Bhattacharia 1994; Strøm 1995, 2002; Korom 1997a,b; Lopez 1998; Anand 2000, 2002; Huber 2001; Houston & Wright 2003; Frechette 2004; Norbu 2004; McGranahan 2005.

²⁸ See Prost (2008) for an attempt to document the Men-Tsee-Khang's importance from a public health perspective. Apart from a small case study by Samuel (2001), her work is the only one to date that focuses explicitly on the Men-Tsee-Khang.

²⁹ That is, in as far as Tibetan Buddhism can be called a "religion". While Buddhism certainly counts as one of the major "world religions", it is not a "religion" in the modern Western sense of the word, which is the product of European Enlightenment and mostly refers to the three monotheistic, Semitic religions (Judaism, Christianity and Islam). See Wallace (2003) for a more detailed discussion.

will show, these functions of validating culture and imagining the nation are so interrelated that they are, in fact, inseparable. But the conflation that I want to stress here concerns the way Tibetan medicine has come to stand for Tibetan identity. In doing so, Tibetan medicine manifests – even more than Ayurveda did in India – an otherwise intangible ‘culture’ in a ‘body’ that can be preserved, saved, and healed by the Men-Tsee-Khang. And what could be a more suitable object of intervention – “preservation” inevitably being a creative process of production and (re)definition – for the Men-Tsee-Khang than Tibetan medicine? The question posed in the beginning of this dissertation – “How exactly does the Men-Tsee-Khang preserve Tibetan culture?” – thus becomes amenable to ethnographic observation and analysis. Always keeping in mind what Tibetan medicine stands for, the question can now be rephrased as: How does the Men-Tsee-Khang shape and (re)define Tibetan medicine in exile? How is Tibetan medicine made into a *medical system*, into a body that not only can be sick but also healed? And how is this body transformed, through alternate doses of modern science, traditional herbs, and Buddhist rituals, into that of a modern Tibetan nation? In order to tell the twin stories of the Men-Tsee-Khang and Tibetan medicine in exile, however, more needs to be said about Tibetan identity, both in its ethical form as ‘culture’ and its political form as ‘nation’.

Identity and Nationalism in Exile

For all its similarities to Indian nationalism, exile-Tibetan nationalism is particular in three major ways. One is that while the Indian nationalists’ political strategies turned out to be highly successful (albeit problematic in other ways: see Hansen 1999), Tibetan

nationalism is an ongoing struggle with an uncertain outcome. More importantly, exile-Tibetans operate in vastly different (geo-) political and historical circumstances: Tibet's history, society, and political organization can hardly be compared to India, and contemporary China has little in common with colonial Britain. The Tibetan nationalist movement's most important difference to the anti-colonial examples cited above, however, lies in its being a struggle of refugees, operating transnationally as a diaspora on foreign territories. While medicine and religion (i.e. Buddhism or the Hindu Vedas), taken as sciences symbolizing the nation, are at least as important in Tibetan nationalism as they were in India, and while the imperative for a modern – yet uniquely 'traditional' – nation informs the Tibetan struggle just as it did the Indian one, culture and nation clearly have to be imagined in different ways in the Tibetan exile. What kind of imagination, then, might this be?

The idea of a national culture that is both modern and traditional is crucial to an understanding of not only the Tibetan diaspora and Tibetan medicine in exile, but also of the various scholarly studies and debates on that topic.³⁰ At the center of these debates is the issue whether contemporary Tibetan cultural identity and nationalism are historically derived or simply products of clever Tibetan image-politics and Western orientalist fantasies. Thus, Donald Lopez (1998) and most of the contributors to *Constructing Tibetan Culture* (Korom 1997b) and *Imagining Tibet* (Dodin & Räther 2001) shed light on the modern construction of Tibetan identity, while Geoffrey Samuel (1993), Georges Dreyfus (1994, 2005), Åshild Kolås (1996), or Martin Mills (2001) call attention to the fact that Tibetans already had both history and an identity before they went into exile,

³⁰ See, for example: Goldstein 1978, 1999; Nowak 1984; Saklani 1984; French 1991; Jha 1992; Klieger 1992, 2002; Bhattacharia 1994; Strøm 1995, 2002; Korom 1997a,b; Anand 2000, 2002; Huber 2001; Diehl 2002; Houston & Wright 2003; Frechette 2004; Norbu 2004; McGranahan 2005; Prost 2005, 2008.

thus supporting claims of continuity and ‘tradition’. I argue that the controversy is, to some extent, rooted in the different methodological approaches taken by the two sides. That is, the ‘constructivist’ faction focuses largely on recent official discourses by the Tibetan government in exile or Tibet support groups, whereas the ‘historicity’ faction relies on historical scriptural evidence, whether of Tibetan or foreign origin. Consequently, each side makes valid and important observations that, however, at times lack an empirical, ethnographic foundation in the sense of extended in-depth participant observation.³¹ There is, however, a deeper binary structure to this debate, which corresponds to the dichotomy of modernity and tradition, and its attendant pairs of opposition like ethics/politics or secular/religious. In this sense, the ‘constructivist’ approach is located on the modern side of the divide, whereas the ‘historicity’ approach emphasizes tradition. While such concepts certainly shape exile-Tibetan discourses and perceptions, I will suggest that they are fundamentally inadequate as conceptual tools in an analysis of Tibetan medicine and nationalism, both of which need to be simultaneously traditional and modern. In the following, I will discuss the arguments of both sides outlined above, in order to not only provide a background on Tibetan culture and nationalism and the scholarly debates surrounding them, but also to open a space for an analytic framework that transcends their positions.

In his influential book *The Snow Lion and the Dragon*, Melvin Goldstein (1999) – following Robert Ekvall (1960) and a popular Tibetan saying (Dreyfus 1994: 496) – locates Tibetan cultural identity in Mahayana Buddhist ideals, the practice of certain customs such as eating *rtsam pa* (roasted barley flower), and the Tibetan language (cf.

³¹ Among the growing number of exceptions are, first and foremost, Dreyfus 1994, 2005; but also younger scholars like Strøm 1995, 2002; Diehl 2002; Frechette 2004; McGranahan 2005; and Prost 2008. I refer to the data material on which the cited arguments are based, not the authors’ ethnographic knowledge per se.

Lopez 1998: 198; Huber 2001). According to him, these cultural traits were shared by all Tibetans living in what he calls “ethnographic Tibet”, consisting of the central Tibetan province of U-Tsang, as well as the eastern regions of Kham and Amdo. Goldstein distinguishes this “ethnographic” or “greater Tibet” from “political Tibet”, limited to U-Tsang as the only province governed by – and loyal to – the Dalai Lama’s government (cf. Goldstein & Kapstein 1998). While Tibetans all over “ethnographic Tibet” thus shared the same cultural identity, there was no such thing as a Tibetan nation before 1959 (cf. Lopez 1998: 200). Tibetan nationalism, then, is a recent phenomenon, a modern invention that is, for Goldstein, separate from a supposedly apolitical Tibetan culture even today.

Leaving aside Goldstein’s problematic assumption of an apolitical Tibetan culture for the moment, there exists general agreement on his other claim, namely that Tibetan nationalism is a modern development (cf. Lopez 1998; Huber 2001; Dreyfus 1994, 2005), albeit with historical antecedents. Thus, Dreyfus (1994, 2005) argues that traditional Buddhist themes like compassion, karma, and the mythical bond between the Tibetans and Avalokiteshvara were pivotal to the emergence of a Tibetan “proto-national” awareness (cf. Hobsbawm 1990: 46) as far back as the 13th or 14th century, which provided the Tibetans with an identity as a “moral community” that was both religious-ethical and political. As such, it transcended regional and sectarian factionalism as well as Goldstein’s distinction between “ethnographic” and “political” Tibet, and continues to inform, as I will show, exile-Tibetan identity even in its modern form today. Similarly, even Lopez – who otherwise argues that Tibetan national and cultural identity is a modern product of Western influences – writes that “it would seem that [old] Tibet was a

nation in the sense of a *natio*, a community or condition of belonging, rather than a nation state in the modern sense of the term,” and that “Buddhism and its role in rulership were key elements of Tibetan state identity prior to the Chinese invasion” (Lopez 1998: 197-8). These claims are based on a substantial body of historic scholarship.

Matthew Kapstein (2000), for example, traces in great detail how Buddhism became a core component of a Tibetan ‘national’ identity between 650 and 1400 CE, especially after the adoption of Buddhism as a matter of state policy in the eighth century (cf. Samuel 1993). An indication of the link between Buddhism and a Tibetan (proto-) national – that is, political – identity is also provided by the Gesar epic, where hostile powers trying to defeat the people of Ling (i.e. the Tibetans) are explicitly described as anti-Buddhist (Samuel 1993: 572). Conversely, whenever the Tibetans expanded their sphere of political influence, the propagation of Buddhism was the first and central means in such processes of Tibetanization (ibid: 147, 560). As Dawa Norbu points out, religion played a central role in almost all “Third World nationalism” (Norbu 1992), and in the Tibetan case, it is well known that the traditional form of government combined religious (ethical) and political power (*bstan srid* or *chos srid gnyis ldan*) (cf. Wangyal 1975). Despite tensions between clerical (state-affirming, Mahayana) and tantric (state-denying, Vajrayana) Buddhism, Buddhist temples and monasteries were an important part of Tibetan state power and expected to aid in maintaining it (Samuel 1993: 555). In the case of medicine, Kurtis Schaeffer (2003) describes the political instrumentalization of a Mahayana Buddhist ethics of altruism in Desi Sangye Gyatso’s 17th century efforts to institutionalize Tibetan medicine and thereby centralize the state’s power.

None of this means, of course, that Tibetans were perfect Buddhists, that all of them identified themselves as Buddhists, or that Tibetan Buddhism itself was a homogeneous religion. Yet, since the arrival of Buddhism in Tibet, religious, cultural and political (proto-national) identities intersected to an ever-increasing extent, culminating in today's conflation, by a vast majority of Tibetans in exile, of Tibetan Buddhist ethics, Tibetan culture, and the Tibetan nation. As mentioned above, however, it was not until the 1950s that they coalesced in a full-fledged nationalism in the modern sense (Dreyfus 2005; Goldstein 1989), and there were specific reasons for that. According to Goldstein, these reasons can be found in the rigid conservatism of the social structures, and the deliberate choice of the monastic ruling elite to keep Tibet isolated from the rest of Asia and the world. This not only prevented the emergence of institutions normally linked to the development of nationalism, such as print capitalism, a well-equipped army, a census, or schools³² (Dreyfus 2005: 10; Lopez 1998: 197; cf. Anderson 1991), but it also sealed Tibet's fate in its hour of need. In the absence of international relations, the international support that Tibet sought during the 1950s remained elusive. However, both in resistance against the Chinese aggression and, later, as a conscious strategy in exile, the Tibetans were quick to embark on a transition to nationalist modernity from the 1950s onwards.

Modern Tibetan nationalism, according to Dreyfus (2005: 11), was officially born on 4th July 1957, when a pan-Tibetan awareness of belonging to a single country was expressed by a Khampa group offering a golden throne to the Dalai Lama as a sign of allegiance. The group, called *chu bzhi sgang drug* ("Four Rivers, Six Ranges"), then

³² The 13th Dalai Lama made an effort to lay the foundations of a modern nation in the early 20th century by establishing secular schools or modernizing the army. The establishment of the Men-Tsee-Khang in 1916 was part of that effort. However, the larger reforms envisioned by the 13th Dalai Lama were thwarted by the resistance of the conservative monastic clergy (see Goldstein 1989).

continued to operate as a national resistance movement, which culminated in the Lhasa uprising in March 1959. This, and the events that followed, sealed the (modern) national awareness developed in the previous decade (ibid: 12). Forced into exile, the Tibetans lost their state and were, consequently, pressed to nurture and promote their fledgling nation. Having learned from bitter experience that religious and cultural identities were weak sources of political legitimacy in the modern world, they began to mold the former into a modern national identity (Anand 2000: 281; Kolas 1996: 61).³³ With Tibetan national awareness still in its infancy in 1959 and the early 1960s, Tibetan exile leaders relied on a common culture (defined in terms of Buddhist identity) to unify people from Tibet's three regions (Goldstein's "ethnographic Tibet") into a single, modern nation.

While Huber argues that modern Tibetan nationalism was the product of Western orientalism, colonialism and nationalism (Huber 2001: 357), Dreyfus counters that Western ideas played only a minor, indirect role in this effort of nation-building: the Dalai Lama and his cabinet were influenced mainly by the ideas of Indian nationalists like Gandhi, Nehru, Rajendra Prasad, or Jayaprakash Narayan (Dreyfus 2005: 7). Of course, it cannot be denied that exile-Tibetan leaders have been, to some extent, in dialogue with Western imaginaries of Tibet as a mystical Shangri-la – whether freely using them for their own political ends, becoming imprisoned by them (as Lopez argues), or something in between. Having said that, it is equally clear that although modern nationalism did originate in 19th century Europe, the nation today constitutes a universal category that is appropriated and shaped in ways particular to the social, cultural, political, and historical circumstances of a people (cf. Norbu 1992). Thus, while the

³³ Samuel writes in this regard: "It is unfortunately one of the realities of present-day international politics that claims to independence are afforded more recognition when stated in terms of the nineteenth-century European ideal of the nation-state under a nationally representative government." (Samuel 1993: 143)

exile-Tibetan leadership has successfully appropriated Western notions (e.g. human rights) for its own nationalist ends (Barnett 2001; Huber 2001), I argue that Tibetan nationalism – or a cultural identity based on Mahayana Buddhism – in exile is far from being an imitation of Western models of the nation, a figment of Western orientalism, or a reaction against Western colonialism.³⁴ Tibetan nationalism would hardly fulfill its purpose if it were not the unique product of Tibetan efforts while at the same time striving for universal recognition. Consequently, it needs to be understood on its own terms.

Of course, Tibetan nationalism is not – and has never been – a unified discourse, but rather a site of contention. There are ongoing debates among exile-Tibetans about what it means to be Tibetan today, whether the Tibetan nation should be constituted in religious or secular terms, whether the aim should be autonomy or independence, how this may best be achieved, and so on.³⁵ Nevertheless, there can be no doubt that Tibetans in exile today do feel that they belong to a unified Tibetan nation. The work of imagining this nation, of defining and redefining Tibetan culture, and of asserting Tibetan political claims, however, is still ongoing. It is this work that forms the larger political context in which Tibetan medicine in exile is situated, and in which it plays a central role. It is this role that the chapters of this dissertation will examine.

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After what has been said in the previous section, it should be clear that any claim of Tibetan culture being apolitical and separate from nationalism is highly problematic from an academic standpoint, and even appears complicit with Chinese political

³⁴ This is also evidenced by the fact that the first department of the newly established Tibetan government in exile was the “Department for Religion and Culture”.

³⁵ See phayul.com for a popular online forum where opinions on such matters are exchanged.

strategies in Tibet that similarly try to separate “apolitical” Tibetan cultural expressions from “political resistance”. Dawa Norbu argues that especially non-Western (“Third World”) nationalism “is a fusion of traditional [religion induced] culture and modern ideology” (Norbu 1992: 2), and Dibyesh Anand only states the obvious when he remarks that “[we] need to look at Tibetan cultural and political identity as intricately connected” (Anand 2000: 279). As even casual observers of the Tibetan diaspora soon discover, Tibetan culture is anything but apolitical; it is, to the contrary, central to the Tibetan cause. Thus, a number of studies focus on the function and construction of Tibetan culture as a political and economic resource (Huber 2001; Adams 1996; Lopez 1998; Korom 1997b). Others note how Tibetans increasingly come under pressure to conform to certain images of Tibetanness in order to receive Western sponsorship (Houston & Wright 2003).

Perhaps the most radical case for the political status of Tibetan culture, as we know it today, is made by Lopez and Huber, who regard it – like Tibetan nationalism above – as an “unprecedented and distinctly modern” product of Western colonialism, orientalism, and nationalism (Huber 2001: 357). Both demonstrate how the Tibetan government in exile has successfully constructed and projected an image of Tibetanness in accordance with Western orientalist fantasies. Aiming to garner political and economic support, Tibetans in exile have thus been portrayed by their leaders as “gender-equal”, eco-friendly pacifists (Huber 2001: 368) whose country was one of “cultural, religious, or environmental specialness,” violated by the Chinese (Barnett 2001: 275). Huber writes:

Tibetans have learned to express coherently particular concepts of ‘culture’ and have collected a whole range of representational styles and strategies during the process. It took some time before customs, practices,

habits, and laws long taken for granted became selected and then eloquently objectified as their ‘unique culture’. But, by the mid-1980s, the more sophisticated fruits of this process began to appear in the form of a modern, liberal, reinvented Shangri-la identity image. (Huber 2001: 366)

Similarly, Lopez remarks:

Having learnt that they have something called a ‘culture,’ the leaders of the Tibetans in exile have selected one of the many elements that together are considered to constitute the changing composition of culture, namely, religion, and have universalized it into an eternal essence, compassion. (Lopez 1998: 199)

A central part of the objectified Shangri-la image that has come to stand for Tibetan culture, both agree, is “Buddhist modernism” (Bechert 1984: 275-277) in the form of essentialized, secularized values like compassion or altruism. Buddhist modernism entails the reinterpretation of Buddhism as a rational, scientific religion that is connected to social reform, anti-colonialism, and nationalism (cf. Huber 2001: 361; Lopez 1998: 184-5). Similar to the Indian nationalists in Prakash and Hansen above, the “Dharamsala elite” (Huber 2001: 362) has, according to Lopez and Huber, consistently projected “a sanitized Buddhist modernist-style representation” (ibid.) of Tibetan Buddhism and culture to the world since the 1970s. The strength of the universal appeal of such a Buddhist modernist identity in creating a shared image of Tibet (fundamental to Tibetan nationalism), however, also has a downside, in Robert Barnett’s (2001) view: it led the exile-Tibetan leadership to adopt a largely moral – and, he argues, apolitical – discourse of human rights, which precludes more specific political action. Barnett is thus concerned

that while the production of Tibetan identity is politically motivated, the resultant image of the Tibetans as a moral community may ultimately defeat its political purpose.

There are three arguments at work here, all of which have to do with the relationship between culture, morality or ethics, and politics. Barnett, Lopez and Huber all locate modern Tibetan identity in a Buddhist modernist ethics, with compassion at its core. They also agree that exile-Tibetan identity is “a specific form of self-marketing [...], a strategic positioning for social, economic, and political advantages and resources” (Huber 2001: 367); that is, that Tibetan culture is fundamentally political. For all three authors, finally, the conclusion that Tibetan culture is both ethical and political is an untenable paradox – it cannot, or at least should not, be both. Hence their shared concern that this identity construction along ethical lines is counterproductive in a political sense (if it is ethical it cannot be political); hence also Huber’s insinuation that Tibetan identity is inauthentic – that is, if it is a political construct, its ethical claims are compromised.

It would be difficult to take issue with the first two arguments: Tibetan identity is clearly ethical, and just as clearly it is political. During my fieldwork, virtually all Men-Tsee-Khang *amchi* considered Buddhist ethics a central part of what makes their medicine uniquely Tibetan. As Dr. Tashi Norbu, a young physician working at the Men-Tsee-Khang’s *rgyud bzhi* Translation Department, pointed out, “it is the ethics that makes Tibetan medicine unique and sets it apart from modern medicine.” If these ethics were lost, he continued, “there would be no more Tibetan identity. Buddhist ethics are the identity of Tibetan medicine.” Speaking more generally, Kunga Sonam, a Men-Tsee-Khang administrative staff member, told me in a conversation: “The identity, the nation that we preserve, should be human values. Like being compassionate, trying to help other

people. Or tolerance. These things are deeply rooted in the Tibetan mind.” Such views were not only current at the Men-Tsee-Khang, but I encountered them over and over again in conversations with exile-Tibetans, in Tibetan online-discussion forums, or even in exile-Tibetan media. Consider the following online comment by Doma, a Tibetan living in New York City,³⁶ about a Tibetan culture show organized by the Regional Tibetan Youth Congress there:

There is a constant onslaught of different influences on our lives and especially young Tibetans and children [in places like New York City]. We need to maintain our identity. What Tibetanness is all about is not just [that we are] the race of the God of Kindness (the *Chenresig*) [i.e. Avalokiteshvara], but a unique *culture*. Culture is not just dance and costumes. It should be the makeup material of each individual Tibetan. Take pride in being Tibetan. [Organizers, please] also throw light on other core aspects of Tibetan culture like the everyday behavior of Tibetans taught by our lamas, parents and beloved teachers: kindness, never killing even one soul, [being] as truthful as possible, *ya rab*³⁷ and *ngo tsha*³⁸ [and so on].

In this comment, Doma expressed a common exile-Tibetan tendency to locate Tibetan culture not in external folkloristic attributes, but in inner, ethical qualities. Almost in passing, she extended these qualities to the level of race, positing ethics as the basis of biology (as we will see, Tibetan medicine, too, is based on the notion of ethics as the basis of biology) and the Tibetans as a moral community.

³⁶ Doma, on phayul.com, March 9th, 2005 (<http://www.phayul.com/news/discuss/view.aspx?id=9199#11361> accessed on 7.2.2006). I edited the language of the passage (grammar and spelling) for clarity and better understanding.

³⁷ *Ya rab*: polite, righteous

³⁸ *Ngo tsha*: sense of shame, self respect, modesty, awareness or knowledge of what is shameful

While such assertions underscore the importance of Buddhist ethics to Tibetan identity, a 1987 speech by the Dalai Lama spelled out the political aspect of such an identity: it is due to Buddhist ethics, the Dalai Lama explained, that “it is natural for [our Tibetan] identity and culture to generate solidarity and attention, and this is why Tibetan culture is key to the Tibetan cause.” Therefore, he concluded, “the study of Tibetan medicine, in preserving the Tibetan identity and drawing increasing interest and attention to Tibetan culture, has great importance in the Tibetan cause.” (Dalai Lama 2007: 28) For all its specificity, this kind of diasporic identity construction is not unique to the Tibetan case. As Liisa Malkki points out in the case of Hutu refugees in Burundi, “The ‘true nation’ was imagined as a ‘moral community’ being formed centrally by the ‘natives’ in exile.” (Malkki 1992: 35, quoted in Diehl 2002: 95)

At the same time, it is easy to see how the European Enlightenment notion that ethics and politics are separate and potentially incommensurable phenomena, is problematic in the Tibetan case. As I have argued in this section, it is a well-known fact that Tibetan identity has historically been both ethical and political, and that Tibetan Buddhism has long been instrumentalized as a political tool to centralize and maintain the state’s power. Tibetan medicine, too, has simultaneously been an ethical and political practice, and continues to be in today’s context of exile. Clearly, then, conventional notions of politics as exclusively pertaining to the actions of politicians within the framework of the state, or of ethics as referring to religious moral codes or set rules of professional conduct, are inadequate tools to understand Tibetan medicine, Tibetan identity and nationalism both past and present. As Sabah Mahmood remarked about the Egyptian mosque movement:

The political efficacy of these movements is, I would suggest, a function of the work they perform in the ethical realm. [...] Their political project, therefore, can only be understood through an exploration of their ethical practices. This requires that we rethink not only our conventional understanding of what constitutes the political but also what is the substance of ethics.” (Mahmood 2005: 35)

While the context of Mahmood’s observation might be radically different, it nevertheless also holds true for the ethical-political movement of Tibetan nationalism and the practice of Tibetan medicine. Having outlined, above, the historical connection between ethics and politics in Tibet, much of this dissertation (in particular chapters 3 and 4) will be devoted to examining the exact ways in which their relationship is renegotiated by contemporary Tibetan medicine in the context of exile, modernity and global capitalism. In order to do so, however, it is necessary to first take a closer look at how ethics and politics are conceptualized in Tibetan textual theory, which forms the basis of even lay exile-Tibetan understandings of these terms, and how this may inform the analytical framework of this dissertation.

Tibetan Buddhist Ethics and Politics

Exile-Tibetan understandings of ethics are strongly informed by Tibetan Buddhist scriptures and teachings, and an integral part of Tibetan medicine. Although no doubt their meaning and practical expression has changed under the twin influences of modernity and exile, altruism (*kun don, gzhan phan*)³⁹ and compassion (*snying rje*)⁴⁰ are

³⁹ *Kun don; gzhan phan*: altruism, benevolence, benefit of all, general interest, universal benefit.

⁴⁰ *Snying rje*: compassion, kindness, sympathy, mercy.

recurring as the two main virtues defining Tibetan Buddhist and medical ethics throughout Tibet's history since the institutionalization of Buddhism until today. We remember Dr. Tashi Norbu's assertion that "Buddhist ethics are the identity of Tibetan medicine", and the claims of Drs. Lobsang, Lhawang la, and Tsering about the Men-Tsee-Khang's purpose being to "serve the Tibetan community", to "preserve Tibetan culture", and to "help the world." The *rgyud bzhi* – and numerous medical commentaries – clearly state that a physician should be intelligent, compassionate and altruistic (*bsam pa dkar ba*: positive attitude, pure motivation),⁴¹ committed to his or her vows, knowledgeable in practice, diligent, and an expert in upholding high moral values (Clark 1995: 223; Men-Tsee-Khang 2008: 287). These prerequisites can be summed up as emphasizing two major qualities in equal measure: a physician's medical skills and knowledge, and his or her altruistic and compassionate volition. They are, furthermore, connected in so far as a physician's 'good' volition to help others through his or her profession entails mastering its skills and knowledge as much as possible. Both the emphasis on good intention and its connection to skilful action can also be found throughout Tibetan religious texts.

An overview of the most important Tibetan Buddhist literature reveals a remarkably homogeneous, systematized, and well defined system of ethical practice with altruism and compassion as its core elements. Although Tibetan Buddhist religious literature – being aimed primarily at a monastic audience – often uses *tshul khrims* to refer to ethics in the sense of monastic discipline (which refers to specific moral rules and

⁴¹ Clark (1995: 223) translates this as "altruistic", and the Men-Tsee-Khang (2008: 287) as "compassionate". The actual meaning, as conveyed in the more literal translation given in the parentheses, is broader than that, but usually interpreted and translated by Tibetans doctors in exile in terms of altruism and compassion. In other words, for exile-Tibetans, a positive attitude or motivation manifests most importantly in these terms.

regulations that can differ from sect to sect), it is the term *kun spyod* (conduct, behavior, habit, morality) that encompasses altruism and compassion both as intent and action, and that better expresses the general idea of Buddhist ethics. *Kun spyod* is also the term used by exile-Tibetans whenever claims are made about Buddhist ethics being central to Tibetan identity and culture. While the two prevailing types of Tibetan Buddhism, Mahayana and Vajrayana, differ in their respective moral codes (*tshul khrims*), they share the ethical ideal of *bodhicitta*, that is, the volition to gain enlightenment for the sake of all sentient beings (Samuel 1993). Mahayana ethics – which constitutes the mainstream of contemporary exile-Tibetan ethics – focuses on two domains, intention and action, and consists of three levels: 1) moral precepts in the form of vows to abstain from unwholesome actions; 2) the cultivation of virtue and good intentions through spiritual practice; 3) and altruistic conduct, where intention and action come together (cf. Keown 2001; Tsong-Kha-Pa [Wayman] 1991; Jamgön Kongtrul Lodrö Tayé [Kalu Rinpoche] 1998). While Mahayana Buddhism strongly emphasizes its concern for others as a sign of superiority to the allegedly more self-centered Theravada tradition,⁴² it would be wrong to interpret Mahayana Buddhism as a self-denying philosophy – or, indeed, Theravada as an egoistic tradition. Moral development in Buddhism (whether Theravada, Mahayana, or Vajrayana), as Damien Keown writes, “never occurs at the expense of one’s own long-term good: it benefits both oneself and others.” In this “simultaneity of one’s own and the other’s good” there is no separation of self and others: egoism and altruism merge (Keown 2001: 231; cf. Jayatilleke 1970: 195). As self and others are conceptualized as closely interlinked – even interchangeable – rather than opposed sites of interest, the values of altruism and compassion manifest in actions of helping others, thereby

⁴² The Theravada school of Buddhism is practiced in Sri Lanka, Burma, Thailand, Laos and Cambodia.

becoming means and ends at the same time. This, in turn, breaks down the conventional, Machiavellian wisdom of ethics and politics – and the related notions of self and others – being mutually opposed to each other (cf. Bobbio 2000; MacIntyre 1984: 39; Weber 1991, 1992): supposedly ends-oriented politics aimed at controlling and governing others (the ends justify the means) versus value-oriented ethics aimed at controlling and governing the self (the means are more important than the ends).⁴³ Indeed, in the *Precious Garland* (a 2nd century CE classic of Mahayana literature), Nagarjuna gives this advice on political rule:

At that time [when you are a ruler] you should internalize
Firmly the practices of giving, ethics, and patience,
Which are especially taught for householders
And which have an essence of compassion. (Nagarjuna [Hopkins] 1998:
148)
These practices are the best policy. (ibid: 112)

More recently, Samdhong Rinpoche – the previous vice-chancellor of the Central Institute for Higher Tibetan Studies (CIHTS) in Sarnath and current prime minister of the Tibetan government in exile – made a remarkable attempt to distill a detailed and explicit social and political theory from Mahayana sutras. In his opinion, “The Buddha has in clear terms outlined a theory of state – its principles and organizations for the maintenance of social welfare, law and order.” (Samdhong Rinpoche 2003: 77-78) Samdhong Rinpoche’s argument is based primarily on the concept of non-duality of self and others, his definition of “others” (or “all sentient beings”) as “society”, and his

⁴³ Here, I do not mean to imply that politics, in this understanding, is necessarily unethical or immoral, but only that it is conceptually separate from ethics. It is easily conceivable, even within this logic, that politics pursue “good” ends, or rely on moral means.

reinterpretation of the ten precepts or the six *paramitas*⁴⁴ as, respectively, “rights” or principles for social and political conduct. In the absence of a substantial body of political and meta-ethical theory in Buddhism (Keown 2005: 28), such texts provide important insights into Tibetan notions of ethics and their relationship to politics. While in old Tibet, politics and religion (and thus Buddhist ethics) were so closely intertwined that most authors did not find it necessary to explicitly comment on their relationship, Samdhong Rinpoche’s more recent attempt to do so shows that in the different context of exile – with an at least partially secularized and democratic political system – this relationship is increasingly problematized.

Such a merging of ethics with politics – of governing self and others – is not unique to Tibetan Buddhist thought. Indeed, it is useful to turn to European philosophy and the etymology of the term “ethics” itself in order to better understand the nature of the relationship between Tibetan Buddhist ethics and politics. Keown points to certain striking parallels between Buddhist and Aristotelian ethics that, in his view, can help make Buddhist ethics better understandable to a Western audience more familiar with its own philosophical roots (even if contemporary, conventional Western understandings of ethics and politics are hardly Aristotelian). While cautioning that there are also important differences between Aristotle’s and Buddhist understandings of these terms, he argues that “Aristotle’s ethical theory appears to be the closest Western analogue to Buddhist ethics, and is an illuminating guide to an understanding of the Buddhist moral system.”

(Keown 2001: 21)

⁴⁴ In Buddhism, the term *paramita* (Sanskrit: perfection) refers to the cultivation and perfection of certain virtues. Mahayana Buddhism knows six *paramitas* (generosity, morality, patience/tolerance, effort, concentration, and insight), while Theravada Buddhism distinguishes ten *paramitas*.

Aristotle's notion of ethics is best explained by the etymological root of "ethics", namely the Greek term "*ethikos*", which means "pertaining to the character (*ethos*)" (cf. MacIntyre 1984: 38). Another translation of *ethos*, or character, is "habit", that is, an "acquired excellence at either a moral or practical craft, learned through repeated practice until that practice leaves a permanent mark on the character of the person." (Mahmood 2005: 136) Defining ethics as a practical science with the aim to make us good persons – a practice of living an excellent life in order to achieve ultimate happiness, Aristotle uses the following analogy to clarify what he means:

Men will become good builders as a result of building well, and bad ones as a result of building badly. [...] Now this holds good also of the virtues. It is the way that we behave in our dealings with other people that makes us just or unjust [...] In a word, then, like activities produce like dispositions. (Aristotle 2004: 32)

While it is true that Aristotle regarded ethics as an inward-directed process – a "care of the self" or "technology of the self" in Foucault's terms (Foucault 2003a, b) – rather than a social or political activity per se, it is clear from this quote that he did, nevertheless, see external practices as the domain in which the character was habituated in certain virtues, and in which a person's virtues manifested (cf. MacIntyre 1984). While there are differences in the subtler points, the main principles of Aristotle's ethics resonate with those of Tibetan Buddhism, where much spiritual practice is devoted to habituating the subject in virtuous intentions through regular mental, vocal and physical practice. Remember, too, that *kun spyod*, the Tibetan term for "ethics", can be translated as "habit", "conduct", or "behavior". The manifestation of good intentions in concrete actions of altruism is directed at both the self and others; while at least in theory not

intended as political action per se,⁴⁵ it nevertheless may have political and social functions and consequences.

More recently, Aristotle has been taken up in productive ways to describe and analyze newly emergent links between ethics, politics, and knowledge (e.g. Arendt 1998 [1958]; Foucault 2003a, b; Agamben 1998; Ong & Collier 2005). Michel Foucault, for example, based much of his work on the Aristotelian definition of ethics not as socially sanctioned moral rules, but as “the care of the self,” as techniques of governing and shaping the self in order to become a certain kind of person or subject. Such techniques of the self, he pointed out, “are frequently linked to the techniques for the direction of others” – that is, politics (Foucault 2003a: 123). Other scholars, too, have formulated approaches that bring self-techniques (that is, ethics) and techniques for governing others (that is, politics) together in a single analytic, making invaluable contributions to the rethinking of classical political theory that predicated its concepts of ethics and politics upon the just-mentioned distinction between self and other. Thus, Nikolas Rose diagnoses contemporary modes of power as “ethico-politics”, which, in his words, “concerns itself with the *self-techniques necessary for responsible self-government* and the *relations between one’s obligation to oneself and one’s obligations to others.*” (Rose 1999: 188, emphases in original) A new event in the West, this is perhaps an outcome of what Anthony Giddens (1994) calls “radicalized modernity”, where our rationality – turned upon itself – undermines any certainty or objective truth. “In the absence of any objective guarantees for politics or our values”, Rose (ibid.) continues, “[we] have become obliged to think ethically.” Since, according to him, ethics appears to be the

⁴⁵ Except in certain modern forms of “Engaged Buddhism” – see e.g. Queen (2000), Queen et al. (2003), or Thich Nhat Hanh (1993).

terrain of politics and governmentality in the foreseeable future, he concludes that “we would need to find ways of evaluating the new technologies and the new authorities that seek to find a way of governing us, as free individuals, through ethics.” (ibid.)

This suggestion has been taken up in various studies of “ethical capitalism” (Barry 2004), “audit cultures” (Strathern 2000), “regimes of living” (Collier & Lakoff 2005), or “global assemblages” (Ong & Collier 2005), the findings of which support Foucault’s and Rose’s identification of ethics as an important emergent form of power in the governance of democratic societies and multinational corporations alike. In as far as they diagnose not so much a mere link between techniques of the self and techniques of governing others, but a merging of the two, these studies successfully overcome the conceptual dead end constituted by theorizing ethics and politics in mutually exclusive terms (cf. Lambek 2000; Faubion 2001; Laidlaw 2002). They thus provide a useful conceptual basis for this dissertation’s exploration of exile-Tibetan medicine’s ethical, political and epistemological function.

The following exploration of the connections between Tibetan medicine, Buddhist ethics, and transnational (diasporic) forms of governance and nationalism hopes to contribute to a better understanding of globally emerging forms of subjectivity, publics, politics and scientific truths. More specifically, this dissertation participates in efforts to highlight the role that medical techniques – whether practical or epistemic, “traditional” or “modern” – can play in negotiating, instantiating and disseminating a certain ethics and thereby help produce not only individual subjectivities but also, crucially, new forms of culture and nation. Indeed, as Stephen Collier and Aihwa Ong (2005) point out, contemporary confluences of ethics, politics, and knowledge shape and define life in all

its aspects – the physical/biological, the socio-cultural, and the political. As such, they not only hold the promise for new forms of life, as Rose suggests, but they also become especially visible in situations – like the Tibetan exile – where life has become problematic, and the Socratic question “How should one live?” acquires fresh urgency. Collier and Lakoff (2005) suggest that the question itself refers to an ethical assemblage of techniques and practices (“how”), norms and values (“should”), subjectivity (“one”), and concepts of life itself (“live”). In order to examine such “processes of reflection and action in situations in which ‘living’ has been rendered problematic” (2005: 25), they propose looking at “tentative and situated configuration[s] of normative, technical, and political elements that are brought into alignment in situations that present ethical problems – that is, situations in which the question of how to live is at stake.” (2005: 23)

One such configuration – and a crucial configuration indeed, as far as the Tibetan exile is concerned – is Tibetan medicine: in the critical situation of exile where ‘living’ has become problematic, Tibetan medicine – and especially the Men-Tsee-Khang – finds itself responsible to provide techniques of physical and cultural survival as practical answers to the Socratic question. Indeed, most exile-Tibetans regard their culture as nothing but an ethical assemblage in Collier and Lakoff’s terms: as a distinct way of life that has come under threat of extinction. Lhasang Tsering, a member of the CIA-sponsored Tibetan Resistance Forces during the 1960s, said during an interview in the documentary *Tibet – Cry of the Snow Lion*: “Our struggle is not for a piece of land. It is for *a way of life*; it is for a *culture*; it is for a civilization, which teaches us that life in the form of a human being is the most precious.” (1:31:37, emphases added)

The exile-Tibetan equation of Tibetan culture with Buddhist ethics that I discuss here indicates the extent to which their culture – their way of life – is being problematized, negotiated, constantly reworked: for it is only through assemblages of incongruent discourses, practices or values that the problem of the ethical (and thus, in the Tibetan case, the cultural) arises at all. Ethics is always already indeterminable; it is something that always needs to be worked through (cf. Sunder Rajan 2006: 66; Fortun 2000; Derrida 2002). As we will see in the following chapters, incongruence and ambiguity are indeed prominent features of exile-Tibetan medicine’s practices and discourses, and Tibetan medicine is indeed one of the prime domains in which the paradoxes of a modern Tibetan nation (modernity and tradition, ethics and politics, religion and science, etc.) are worked through and resolved. As a technique that addresses self and others equally in its attempt to ensure cultural survival and help the world, Tibetan medicine emerges as a quintessential “technique of living” (Foucault 2003a: 108).

As we have seen, Tibetan medicine’s dual responsibility in exile – to ensure cultural survival and to “help the world” – confounds the analytical framework of most scholarship on the Tibetan exile to date. It is a common experience, after all, that the ethical ideal of helping others tends to be quickly discarded when one’s own interests – especially if as existential as survival – are at stake. And would the anthropologist’s claim that Tibetans in exile are different not amount to a reaffirmation of Orientalist fantasies about saintly Buddhists? Would such identity claims by exile-Tibetans themselves not be easily dismissible as inauthentic image politics? The answer is “yes, most certainly” – for as long as one uses the modern liberal opposition between self and

others as the basis for theorizing ethics and politics (Mahmood 2005), or the concept of “authenticity” based on the related distinction between private and public (Langford 2002: 19). However, the answer is “no” if we use exile-Tibetan – rather than European Enlightenment – configurations of ethics and politics, religion and science, or tradition and modernity in the effort to understand Tibetan medicine’s cultural and political role in exile. There is no “real” or “authentic” Tibetan identity existing independently and separately from the politics of the Tibetan cause or the rhetoric of altruism and compassion. The fact that Tibetan medicine plays a political function in “asserting the Tibetan nation” does not make its intention to “help the world” less genuine, “real” or “authentic”. Conversely, engaging in such altruism or using the language of Buddhist ethics does not necessarily imply real-political naïveté or a renouncing of politics altogether. Contemporary Tibetan identity in exile is centrally shaped by both Buddhist ethics and nationalist politics: identity politics and nationalism are always also aimed at the self; the care of the self – that is, ethics – is always also political.

Chapter Outline

This dissertation is about many things: the production of a modern, yet traditional culture and nation through a “traditional medicine”; how modernity and nationalism are produced in local encounters with the global; how in the process the connections between ethics, politics and truth are renegotiated; and what all of this means for the medicine in question. It is also an ethnography of a modernizing institution (the Men-Tsee-Khang), a medicine in transformation (Tibetan medicine), and a people (the Tibetans) in exile, which all struggle with the dilemmas of modernization, globalization and capitalism

while fighting for cultural survival and a recuperated nation-state. All these topics, however, boil down to only one main question: how does Tibetan medicine in exile “preserve” Tibetan culture and produce a modern Tibetan nation? The dilemmas inherent in this truly difficult task are first and foremost *ethical* dilemmas, manifesting and becoming visible in several key issues that define contemporary exile-Tibetan medicine. I organize these key issues in the form of six chapters that follow a loose analytic thread, which I will briefly outline here.

Having outlined this dissertation’s analytic framework and introduced Tibetan medicine, identity and nationalism in the introduction (*chapter 1*), *chapter 2* will provide the historical background on Tibetan medicine’s reestablishment in exile and its subsequent international expansion. In this chapter, I will trace institutional Tibetan medicine from its beginnings in old Tibet, through the rupture of exile in 1959, to its (re-)establishment and growth in India and the world today. As we move through the events and decisions that shaped contemporary Tibetan medicine in exile, the themes of the later chapters will be introduced and historically contextualized. In many ways, this is a sketch of an unlikely success-story, of how a small medical center developed, despite all odds and difficulties, into today’s prestigious Men-Tsee-Khang, and how, simultaneously, Tibetan medicine emerged from virtual obscurity as an attractive “alternative medicine” of global reach. Neither the condition of exile nor such an expansion could remain – or indeed be possible – without profound changes to Tibetan medicine. These changes and transformations constitute the subject matter of all subsequent chapters.

Perhaps the most important of these changes was that with its growing popularity and success, Tibetan medicine became increasingly involved in the exile-Tibetan

nationalist struggle, the capitalist market and an ambiguous engagement with modernity. Unprecedented and thoroughly modern ethical dilemmas arose as a consequence: how could Tibetan medicine retain its Buddhist ethics – and thus its Tibetan identity – while also participating in politics and the capitalist market? Tibetan medicine clearly needed to be ethical *and* political *and* financially sustainable – not only were such connections between ethics, politics and the market a traditional feature of medicine in old Tibet, but they were also mandated by the struggle for cultural survival and nationalism in exile. Since allowing these connections to break was not an option, they needed to be renegotiated according to the demands of the present. These ethical renegotiations form the topics of *chapters 3 and 4*: *chapter 3* focuses on the Men-Tsee-Khang’s struggle to “preserve” the traditional link between ethics and politics through a combination of traditional practices and a redefinition of what it means to be ethical; *chapter 4* focuses on the related link between ethics and business, and the Men-Tsee-Khang’s attempts to combine financial survival with cultural survival in a context where capitalism is perceived as both unavoidable and unethical.

The Men-Tsee-Khang’s redefinition of ethical medical practice led to tensions with private *amchi*, who renegotiated their ethical status in very different – but publically less influential – ways, and a transformation of Tibetan medicine into a *medical system* that could be regulated and controlled. *Chapter 5* traces this development from the Men-Tsee-Khang’s initial claims for a monopoly of power over Tibetan medicine to the establishment of the Central Council for Tibetan Medicine (CCTM) as the official ‘body’ of Tibetan medicine in exile. I will examine how the CCTM, as Tibetan medicine’s new ‘body’, not only attempts to regulate and standardize Tibetan medicine’s knowledge,

practice and production in order to become a medical system, but also claims the cultural, intellectual and political ownership of the exile-Tibetans over *gso ba rig pa* worldwide.

All of this has, of course, the purpose to retain control over, and ensure the political efficacy of, Tibetan medicine as an essential tool in the exile-Tibetan nationalist struggle. However, in order to serve this purpose, the CCTM needs to establish Tibetan medicine's legitimacy through legal recognition both in India and abroad. Indeed, if the exile-Tibetan doctors' biggest fear (and temptation) is capitalism, then their greatest hope (and redemption) lies in gaining legal recognition for Tibetan medicine in India and the world. *Chapter 6* examines Tibetan medicine's legal status and relations to the Indian state, and the Indian state's perceptions of Tibetan medicine. Tracing exile-Tibetan – and Buddhist Himalayan – efforts to win recognition for their traditional medicine (Tibetan medicine or Sowa Rigpa) over the past two decades, this chapter argues that virtually all developments in exile-Tibetan medicine during that time need to be interpreted in light of this political effort.

Perhaps the most important of these developments is Tibetan medicine's modernization and its engagement with Western science, which constitutes the topic of *chapter 7*. This is the longest chapter of this dissertation, providing not only an overview of the clinical studies conducted by the Men-Tsee-Khang so far, or a discussion of a silent revolution transforming exile-Tibetan medicine through technologies of quality control, but also insights into the *amchi*'s reconfigurations of modernity and tradition. What all these efforts to engage with the modern world without compromising Tibetan medicine's identity and traditions boil down to, is one key problem. This problem is efficacy – ultimately, it is Tibetan medicine's efficacy that proves its validity and that

needs to be preserved at all cost. Indeed, and this is this chapter's main argument, it is Tibetan medicine's clinical, pharmaceutical efficacy on which its cultural and political efficacy of preserving Tibetan culture and producing a modern Tibetan nation are staked. In the brief conclusion, finally, I will draw together all the various threads that the previous chapters have traced, and bring the circle of this dissertation's narrative, which began with Dr. Tsering's clandestine flight across the Himalayas, to a close.

2. The History and Development of Tibetan Medicine in Exile

Much has been written on Tibetan medicine, but all in a piecemeal fashion, in quite an unsatisfactory way, because it is misrepresenting Tibetan medicine. Many scholars present Tibetan medicine like some tribal medicine, closed in itself, with no relevance or interaction with the world. We need to rectify this image, show how Tibetan medicine is relevant to many others beyond the Tibetan community...

Dr. Dorjee Rabten

In this chapter, I will trace Tibetan medicine's re-establishment in India and its subsequent spread around the world.⁴⁶ After a brief overview of Tibetan medicine's early institutionalization in old Tibet (763-1959), I will identify six periods of its development in exile: the early years (1960-1967); laying foundations: the Men-Tsee-Khang (1967-1980); development and growth (1980-1987); internal troubles and other Tibetan medical institutions (1988-1994); internal reforms and international expansion (1994-2003); and revolutionizing Tibetan medicine in exile (2004-2009). Despite its relatively short duration, it is impossible to do justice to the turbulent history of Tibetan medicine's first 50 years in exile within the space of just one chapter. The closer the history presented here moves towards the present, the more complex and multi-layered it becomes, forcing me to treat events and developments only briefly and cursorily. Some of them will be discussed in later chapters. This chapter's purpose, then, is merely to provide a rough outline of the developments that shaped Tibetan medicine outside Tibet and China, and thereby establish a basis for further research, be it of historical or anthropological nature.

⁴⁶ This chapter has been published, in a slightly abridged form, as an article in *Tibet Journal* (Kloos 2008).

Readers familiar with the subject will notice discrepancies between currently available English (or even Tibetan) language sources and the history presented here. Unfortunately, no reliable or detailed history of Tibetan medicine in exile exists in English to date, and the fragments of historical information on the topic that do exist seem to be mostly based on single oral sources merely cited from earlier publications (in the case of Western authorship), or lacking any references at all (in the case of Tibetan authorship). This chapter is based on original Tibetan documents obtained from archives at the Men-Tsee-Khang and the Tibetan Parliament in Exile,⁴⁷ as well as in-depth interviews in English and Tibetan with exile-Tibetan scholars, traditional medical practitioners (also known as *amchi*), previous Men-Tsee-Khang directors, and government officials.⁴⁸ In addition to this, I particularly rely on three Tibetan language sources on the history of the Men-Tsee-Khang, by Pasang Yonten Arya (1989: 206-276), Namgyal Tsering (1996), and Choelo Thar (2000), which together constitute the most thorough and reliable, though still not infallible, historical work on the Men-Tsee-Khang in India. Although for reasons of confidentiality it is not always possible to name my sources, I only present data here that could be crosschecked and triangulated using different sources of information.

Medical Institutions in Old Tibet (763 – 1959 CE)

Although *gso ba rig pa* constituted the only systematized, pharmaceutical-based health resource in old Tibet – modern biomedicine had only an insignificant presence in the 20th

⁴⁷ Written permission to access and copy these documents was obtained by the author.

⁴⁸ All direct quotes that do not have a reference in parentheses are from these interviews.

century before the 1950s (McKay 2007) – Tibet’s health care context was decidedly pluralistic. Apart from oracles, tantric healers, high lamas, bone-setters, and the presence of local household knowledge about the basic uses of medical herbs and baths, the theory and practice of *gso ba rig pa* itself was far from uniform. What we now call by the singular term “Tibetan medicine” was characterized by a lack of standardization: private lineages of local *amchi* with their own specialties and secret formulations, several independent training institutions, and different scholastic traditions ensured that everything from the compounds to their ingredients, from preferred diagnostic methods to treatment modalities could vary from place to place, from *amchi* to *amchi*. Indeed, the origins of many important medical commentaries and even versions of the *rgyud bzhi* itself lay in scholastic and professional competition (cf. Schaeffer 2003) and the rivalries and one-upmanship that have characterized the personal relations between many senior *amchi* up to the present.

According to Tibetan sources, the history of institutionalized Tibetan medicine began shortly after the first medical “conference” in Tibet⁴⁹ at Samye under king Trisong Detsen in the 8th century CE. His personal physician, the Elder Yuthog Yonten Gonpo established Tibet’s first medical college, called “Tanadug”, in Kongpo in 763 CE (Damdul 2008: 37; Men-Tsee-Khang 2008: v). Yuthog Yonten Gonpo the Younger, in his turn, established the famous “Yuthog Gosh Rethang” school in Central Tibet in the 12th century, where he apparently trained hundreds of students (Pasang Yonten Arya 2006: 11).

⁴⁹ Although usually termed “conference”, this event actually lasted several years, during which medical scholars from India, Persia, China, and Tibet wrote and compiled several important medical texts (e.g. Men-Tsee-Khang 2008).

While there may have been other medical schools (Avedon 1997: 140), we do not have any reliable information on Tibetan medical institutions until the 17th century, by which time the school at Kongpo Menlung and the Yuthog Gosh Rethang had long disappeared. However, from 1643 onwards – immediately after unifying Tibet under the Ganden state – the 5th Dalai Lama established three medical colleges at Drepung, Shigatse, and Lhasa⁵⁰ (Thupten Tsering 1986: 150 [Gerl & Aschoff 2005: 57]; Meyer 1995: 103; Drungtso 2007: 15) in an attempt to institutionalize medical training and thus “not merely rule Tibet from the Potala in a strictly political sense, but to create a cultural hegemony extending to a variety of areas, including [...] medicine” (Schaeffer 2003: 637). However, by 1696, almost 15 years after his demise, none of these institutes had proven successful, leading the 5th Dalai Lama’s regent, Desi Sangye Gyatso, to establish another medical institute, the Ngotsar Drophen Rigjey Ling (*ngo mtshar ‘gro phan rig byed gling*) at Chagpori (*lcags po ri*: iron hill) in Lhasa (Thupten Tsering 1986: 150 [Gerl & Aschoff 2005: 57f]; Meyer 1992). Commonly known by its location as “Chagpori Drophen Ling” or simply “Chagpori”, this was one of the most successful medical institutions in Tibet and would, over the next 200 years, provide highly trained *amchi* to religious and political authorities in central and eastern Tibet, Mongolia, and even the Chinese court (Meyer 1992, 1995: 117). The Chagpori Drophen Ling was a monastic institution, recruiting a selection of the brightest young monks from all three regions of

⁵⁰ These institutes were the Sorig Drophen-ling (*gso rig ‘gro phan gling*) at Drepung, with Shabdrung Lobsang Gyatso as teacher and Tenzin Dargye as director; the Sorig Drang-song Due-ling (*gso rig drang srong ‘dus gling*) in Shigatse under the patronage of the Tsarong family; and a medical institute at Tse Lhawang Chog (*rtse lha dbang lcog*) in the Potala (Lhasa) with Darmo Menrampa Lobsang Choedrak as director (Gerl & Aschoff 2005: 57; Drungtso 2007: 15).

Tibet as its students,⁵¹ and funding itself, as was common at that time, through feudal landownership and contributions from its students' original monasteries (Thupten Tsering 1986). Although hierarchically organized with a director (i.e. abbot) at its head, the Chagpori's directors had no decision-making power, which lay exclusively with the Dalai Lama and the Potala's Apex Secretariat (*rtse yig tshang las khungs*). Apart from training highly skilled *amchi*, the Chagpori also functioned as a popular clinic, treating an average of 50-60 outpatients per day (Gerl & Aschoff 2005: 157).

For over 200 years, the Chagpori remained the premier institution of *gso ba rig pa* in Tibet.⁵² However, as its graduates were mainly deputed to serve as personal physicians for the religious and political elite, the majority of Tibetans remained – even with some private *amchi* practicing in Lhasa and the countryside – without access to professional health care. It was not before the early 20th century that Tibet's health care situation changed, when the 13th Dalai Lama – no doubt concerned by the ease with which British and Chinese troops had been able to force their way to Lhasa – initiated a series of reforms to modernize Tibet. Apart from placing more importance on foreign relations, encouraging private schools for laymen,⁵³ and modernizing the Tibetan army, he also established, on the initiative of his chamberlain and personal physician Jampa Thubwang Dekhang (who was also the director of the Chagpori Drophen Ling) a small school for medicine and astrology in Lhasa in 1916. The Lhasa Mentsikhang (*sman rtsis khang*:

⁵¹ In the early 20th century, the Chagpori recruited its students from 64 Gelugpa monasteries in U-Tsang, Kham, and Amdo, but also admitted students from different religious orders as well as laymen (Meyer 1995: 117).

⁵² However, the Chagpori was not the only medical institution in Tibet during that time. For example, Situ Choekyi Jugney established a medical school at Derge Palpung (Men-Tsee-Khang 2008: xi).

⁵³ Rigzin Lhundrup Nyarongshar, a disciple of Jampa Thubwang, founded a private school that became central Tibet's third outstanding medical college, after the Chagpori and the Mentsikhang. He trained several eminent doctors there, including Kunga Gyurmed Nyarongshar (later to become a personal physician to the 14th Dalai Lama) and Trogawa Rinpoche, who would later found the Chagpori Medical College in Darjeeling.

institute of medicine and astrology) was born, marking the first beginnings of the concept of public health in Tibet.⁵⁴ From its inception, the institute had the explicit purpose of training doctors, including laymen, to provide medical care to the general population throughout Tibet, to procure medical knowledge from private lineage *amchi* and folk traditions, and to compile all medical and astrological texts to make them more accessible to students (*Byams pa 'phrin las* 1986; Choelo Thar 2000).

The first principal of the new Mentsikhang was Khyenrab Norbu, a Chagpori graduate and Jampa Thupwang's disciple, who was simultaneously appointed to serve also as the Chagpori's principal and, two years later, as the Dalai Lama's personal physician. The Mentsikhang's administrative structure resembled that of the Chagpori: it was managed by the Tse Yigtsang (the government's Apex Secretariat), with Khyenrab Norbu wielding no power in matters of admission or appointments; it recruited its students (exclusively male) mainly from monasteries; and it used the same syllabus as the Chagpori – indeed, Khyenrab Norbu would divide his time teaching at both institutions. However, although the Mentsikhang's emphasis still remained on training monks, it was not a monastic institution per se. In contrast to the Chagpori, if one of its students or doctors broke his monastic vows, he could – indeed, was obliged to – continue his training or practice. Private students (i.e. laymen) were more common than at the Chagpori, although they had to arrange for their own maintenance; later, students were also recruited from the army.

Under Khyenrab Norbu's leadership and with the backing of the Dalai Lama, the Mentsikhang quickly grew and developed. Three years after its establishment, in addition to treating outpatients at its clinic in Lhasa, it began to send children's medicines (newly

⁵⁴ Stacy van Vleet from Columbia University is writing a PhD dissertation to this topic.

formulated by Khyenrab Norbu) and astrological birth charts to 96 districts, for which district officials levied a certain amount of money from the recipient families (*Byams pa 'phrin las* 1986; Choelo Thar 2000). When epidemics broke out in any part of Tibet, Mentsikhang teachers and students were sent to the affected area to treat patients (cf. Avedon 1997: 151f). In order to afford the raw materials necessary for the steadily growing demand for its medicines, the Mentsikhang began to use capital provided by the Potala to do business in wool and, later, money lending. The institute also started to produce yearly almanacs, which soon became so popular that over 10,000 copies were distributed not only in all three regions of Tibet, but also in Ladakh, Bhutan, Sikkim, and India.

Like other reforms initiated by the 13th Dalai Lama, however, the Mentsikhang's growing popularity and public health ambitions met with increasing resistance, which especially gained force after chamberlain Jampa Thupwang's demise in 1923. That year, due to a rivalry between the Chagpori and the Mentsikhang, Khyenrab Norbu was replaced as the head of the Chagpori, remaining in charge only of the Mentsikhang, and the two institutes embarked on independent courses of teaching. District officials, who found the distribution of the Mentsikhang's children's medicines too cumbersome, began to resist such public health efforts, which declined as a result. Forced to reorient its priorities from public health to a stronger focus on "the preservation and propagation" of *gso ba rig pa* (Choelo Thar 2000: 29), the Mentsikhang nevertheless continued to grow and develop, and even pursue its public health agenda, albeit on a more limited scale. Its student numbers and sphere of influence increased as the Dalai Lama ordered more monasteries to send young monks for training. From 1947 onwards, by order of the

Kashag (the Cabinet of Ministers), the Mentsikhang also began to recruit students from Bhutan and Ladakh. It began to sell over 80 different kinds of medicines to private *amchi*, and in 1938, the government improved the institute's condition and status by providing regular financial support to its students and salaries to its teachers. The 14th Dalai Lama, enthroned in 1950, continued his predecessor's support for the Mentsikhang, and the institute kept expanding until 1959 despite the turmoil of that decade. In 1959, the Chinese destroyed Chagpori Drophen Ling (today the site of a large television tower), officially merged the two institutes at the Mentsikhang's location, and renamed them as "Lhasa Military Hospital Nr. 2", with Khyenrab Norbu remaining the director until his death in 1962 (Choelo Thar 2000: 39). According to the same source (Choelo Thar 2000: 41), a year later the Chinese communists decided to do away with institutionalized Tibetan medicine altogether by shifting the biomedical People's Hospital to the Mentsikhang's site. This plan failed, however, as the People's Hospital struggled to cope with 150 to 200 additional patients a day due to the ongoing violence in and around Lhasa, which effectively prevented any relocation at that time. The Lhasa Mentsikhang thus continued to operate and – despite difficult circumstances (Janes 1995) – it developed into one of the largest and most important institutions of Tibetan medicine today.⁵⁵

⁵⁵ The history of the Lhasa Mentsikhang after 1962 is beyond the scope of this chapter and dissertation. See, for example, *Byams pa 'phrin las* (1986) for more information.

The Early Years (1960 – 1967)

In the first years after His Holiness the Dalai Lama's – and tens of thousands of Tibetans' – flight from their homeland, the most immediate concern was, not surprisingly, the sheer physical survival as dispossessed refugees in a poor host country. Nevertheless, cultural survival, too, was on the agenda from the beginning. In December 1959, the Dalai Lama told a group of about 2000 fellow Tibetan refugees in Sarnath: “[O]ne day we will regain our country. You should not lose heart. The great job ahead of us now is to preserve our religion and culture” (quoted in Avedon 1997: 82). The newly formed Tibetan government in exile immediately began re-establishing Tibetan institutions in India. Among them, that of Tibetan medicine was to hold special importance as it simultaneously addressed both physical and cultural survival.

In 1960, the Dalai Lama met Dr. Yeshe Donden⁵⁶ in the North Indian hill station Dalhousie. Yeshe Donden, a Lhasa Mentsikhang graduate, was one of less than a handful of trained Tibetan *amchi* in exile at that time, and had already begun treating patients with whatever medicines he could prepare from locally available ingredients. Instructing the Council for Religious Affairs (now renamed as Department of Religion and Culture) to set up a center to preserve Tibetan medicine, the Dalai Lama summoned Yeshe Donden to Dharamsala. He was asked to teach two monks from Namgyal monastery, Jampa Sonam (Lhawang)⁵⁷ – who had already received some medical training in Lhasa – and Tashi Gyaltzen at Kishor Niwas, a small wooden hut near today's Upper Tibetan Children's Village. In 1961, they shifted to Chopra House above McLeod Ganj, where

⁵⁶ For a detailed biography of Yeshe Donden, see Avedon (1997: 137-155).

⁵⁷ Jampa Sonam was his monk name. Years after finishing his training, he disrobed and married, taking on his original name again, which was Lhawang. Dr. Lhawang la passed away in 2008 after a lifetime of service at the Dharamsala Men-Tsee-Khang, and is fondly remembered as the institute's first student.

the center was formally inaugurated as an unnamed, provisional medical institute, with Yeshe Donden as its teacher, doctor, and director all in one. The new institute remained under the administrative responsibility of the Council for Religious Affairs. Later that year, six additional students were recruited from Namgyal and Sera-mey monasteries, and in 1962, Ngawang Yeshe was appointed as a junior teacher to help Yeshe Donden with the teaching responsibilities. In 1963, the exile government managed to locate and recruit several renowned *amchi* scattered in different refugee camps. Trogawa Rinpoche was appointed as teacher, and Tashi Yangphel Tashigang,⁵⁸ Phuntsog Norbu Damdul, Jangchub Gyaltzen, and Lobsang Tashi as doctors. Yeshe Donden was appointed as the Dalai Lama's personal physician, but also remained in charge as the institute's director. In view of this progress, on 29th June 1963, the Council for Religious Affairs removed the institute's provisional status, officially named it "*bod kyi rig gzhung sman sbyin slob khang*" (Tibetan Cultural Medical School), and framed a charter of rules and regulations for its students and staff. The institute's new name, joining *sman* (medicine) with *rig gzhung* (culture), clearly shows the early conflation of Tibetan medicine with Tibetan culture.

The following year, in 1964, another *amchi* renowned for his pharmaceutical expertise – Jamyang Tashi – joined the institute as the head of the pharmaceutical production. He shifted the medicine production to Dalhousie, where volunteers from Ganden, Sera, and Drepung monasteries were available to help clean, dry, crush and grind the herbs. In this way, larger quantities of medicines (60-70 different types at that time) could be produced, which in turn enabled the medical institute to open clinics in

⁵⁸ Tashi Yangphel Tashigang was an Indian citizen from Ladakh, but studied at the Lhasa Mentsikhang until 1959. He joined the medical institute before the other doctors mentioned here, but left in 1964 to settle in Delhi, where he later opened his own clinic.

Buxa and Bylakuppe, then the two largest Tibetan refugee camps in India. All of this constituted a modest, yet remarkable success and development for Tibetan medicine in exile, considering the extremely difficult conditions its doctors and students faced. Dr. Lhawang (then Jampa Sonam) vividly remembered these first years in exile:

Back then, we did not have any resources. Whatever money was offered to His Holiness, he had to give it to all the new arrivals from Tibet. So that's why the medical institute didn't have any money, no capital to employ labor. We had to do everything ourselves. During the day, we had to study, and in the afternoon we had to mix everything, grind the herbs... And then, normally you need a dispenser to give the medicine, but since we didn't have one, we were the dispensers as well. Then, at night, we had to study again. Nothing was there, so we had to do everything. We had to climb up mountains to pick herbs, and we had to go to Amritsar to buy other herbs and ingredients. His Holiness used to give money for that. Then we had to grind everything; we had to make the medicines. [...] And there were so many patients. Tibet is very cold, and due to the climate change in India, everyone fell sick, and we had to give medicine but couldn't take any money. There were at least 200-300 patients a day. [...] Since the patients didn't come to the [medical] center for treatment, the doctors had to go to all the different places to see the patients. Sometimes they got lunch there, and while coming back, they treated more patients on the way. When people saw the doctors passing by, they would shout, "oh *amchi* la, please come and see me!"

Everything was lacking: money, facilities, manpower, medical texts, and language skills to buy medical ingredients or communicate with locals. Despite the desperate situation of Tibetan medicine at that time, Indian patients – including army officers from the nearby cantonment – soon became attracted to the medical center, whose medicines they found

to be highly effective. By 1964, some local Indian doctors seemed to have become so concerned about the competition posed by the Tibetan medical center that they informed the Indian government. In response, the Indian Health Ministry deputed Dr. Bhagwan Dash – who was to become a famous Ayurvedic scholar-physician – to investigate the Tibetan clinic and write a report. When he arrived in Dharamsala, Bhagwan Dash reportedly told Yeshe Donden that “medical practice without the permission of the Indian Medical Council was not allowed on Indian soil.” (Choelo Thar 2000: 52) After a week of observing his practice, however, he was sufficiently impressed to write a favorable report recommending the Indian government to support Tibetan medicine. Dr. Dash confirmed this story in a personal conversation with me, but added that in fact, the Indian Health Minister had strongly recommended a positive report already prior to the investigation.⁵⁹ Still, Bhagwan Dash seemed to have been genuinely impressed with Yeshe Donden’s practice, so much so that he wrote over a dozen books on Tibetan medicine in the ensuing decades. The report argued that it was in the Indian government’s interest to support Tibetan medicine since it was closely related to Ayurveda and therefore to Indian culture. It had its intended effect, and the Tibetan medical institute thereafter received ten hospital beds, some medical supplies, food rations and some funding. Albeit not officially recognized as a medical system in India and therefore operating in a legal grey zone that persists until today, Tibetan medicine has been semi-officially tolerated in India since then, without any restrictions on its practice.

⁵⁹ While I could not get any information on why this might have been the case, one plausible explanation could be the good relations between the Dalai Lama and Jawaharlal Nehru, who was the Indian Prime Minister until that year (1964). In short, it is possible that the Dalai Lama asked Nehru to tolerate Tibetan medicine in India, and Nehru in turn advised his Health Minister to produce a favorable report.

In 1965, the Tibetan medical center, which until then had offered its services and medicines free of charge to the Tibetan refugees, moved to a new location in McLeod Ganj and began charging consultation fees (initially 50 paise)⁶⁰ as well as fees for its medicines (5 paise per dose). With this income, the institute purchased raw materials,⁶¹ paid staff salaries, and maintained free inpatient care at its ten-bed infirmary. In 1966, the first students (Jampa Sonam, Tashi Gyaltzen, and Yeshe Sonam) graduated and entered service at the institute, albeit not yet as full-fledged doctors.

Despite this development, Yeshe Donden “resigned from the institute owing to numerous internal and external reasons” (Choelo Thar 2000: 56), the exact reasons remaining unclear (cf. Arya 1989: 211).⁶² In his stead, Lobsang Khyerab, the Gelug representative of the Tibetan Assembly, was appointed as director. Soon after, Trogawa Rinpoche and Phuntsog Norbu Damdul also resigned. Even though the medical center had progressed well until the mid-1960, these resignations of half of the institute’s senior doctors (three out of six) represented a serious setback. Such resignations of senior doctors have remained a feature of much of the institute’s history, usually coinciding with periods of internal discord, mismanagement, or weak administration. Official explanations of these shifts have been vague, usually invoking “the unsuitable climate of Dharamsala” or unspecified “personal reasons.”⁶³

⁶⁰ 100 paise are one Indian Rupee.

⁶¹ Until then, raw materials were purchased with funds provided by the Dalai Lama’s Private Office.

⁶² Yeshe Donden remained the Dalai Lama’s personal physician until 1980. After leaving the medical institute, he established his own, private clinic in McLeod Ganj, where he still practices today (2009). In a private interview with me, he remained vague about the actual reasons for his resignation.

⁶³ This assessment is common among senior government officials and other exile-Tibetans who followed the Men-Tsee-Khang’s development over the years, and has been expressed most clearly to me by Jigme Tsarong, Tsering Tashi Phuri, and Tashi Tsering Josayma.

Laying Foundations: The Men-Tsee-Khang (1967-1980)

Meanwhile, the Council of Religious Affairs had set up a separate astrology center in 1960, with two students and with Duekhorwa Lodoe Gyatso, a renowned astrologer from Labrang, as the teacher. They published the first Tibetan calendar in exile in 1961. The first student graduated in 1962, but left the center when the second student graduated one year later. With no students remaining and none forthcoming, two other monks from Namgyal monastery were recruited as students in 1964. They graduated in 1965 and 1967. Most of these students were high lamas with some prior knowledge of astrology, which explains their short training. As Dr. Lhawang told me, this was also why most of them did not stay at the astrology center:

Since these lamas were great scholars, and they were very intelligent, they didn't need to study astrology. They only did so because His Holiness told them to. There was not really any need for astrology when we came to India, because we were too poor to consider these things, we had to worry about food and shelter. Many of those who studied astrology went to foreign countries, because there was hardly any use for astrology in India.

On 17th August 1967, the Council for Religious Affairs merged the medicine and astrology institutes, with the smaller astrology institute relocating to the site of the medical center. The new, combined institute was officially named “Drophen Men-Tsee-Khang”⁶⁴ (*gro phan sman rtsis khang*: institute for medicine and astrology for the benefit of all beings) as a sign of continuity from old Tibet and the Lhasa Mentsikhang. The new Men-Tsee-Khang had its own administrative office and was made financially

⁶⁴ At that time, the institute did not have an English name or particular way of spelling. Nevertheless, I use the anglicized, hyphenated spelling (which was introduced only in the mid-1990s) here and throughout, in order to distinguish it from the Lhasa Mentsikhang.

self-sufficient, which gave the institute a considerable degree of independence from the beginning.⁶⁵ Organized in different departments (pharmacy, astrology, college, etc.), the Men-Tsee-Khang soon made progress and its patient numbers grew. The resulting increased demand for medicines, however, posed a problem as the institute reached the limits of its medicine-production capacities. Thus, after a visit to an Ayurvedic factory in the nearby town of Jogindernagar, Jamyang Tashi (head of the medicine production) bought electrical machines for crushing, grinding, and pill making and installed them in the Men-Tsee-Khang's "pharmacy" (as the institute's pharmaceutical production unit is called). This was the first time in the history of Tibetan medicine that non-human-powered machines were used.⁶⁶

In 1968, the renowned scholar Barshi Phuntsog Wangyal was invited to work as a teacher at the Men-Tsee-Khang, and immediately began drafting a combined syllabus for medicine and astrology, which was submitted to the Dalai Lama and approved the same year. In the following year, a second batch of students was recruited from Tibetan schools, after passing a written test in Tibetan language. The replacement of monasteries with public schools as a recruitment pool for the Men-Tsee-Khang's students was a major break from institutionalized Tibetan medicine's past: not only did this place lay-persons rather than monks (who from then on constituted only a small minority of *amchi*) at the center of Tibetan medicine's future, it also allowed, for the first time, female students. As the Men-Tsee-Khang began to resemble a modern college more than a monastic

⁶⁵ Prior to their amalgamation, both institutes – medicine and astrology – had received funding from the Council for Religious Affairs, in whose offices also their administrative affairs had been conducted.

⁶⁶ According to Sienna Craig (2006: 200), the Lhasa Mentsikhang only introduced mechanized production methods in its pharmaceutical unit between the end of the Cultural Revolution and the mid-1980s.

institution,⁶⁷ Tibetan medicine in exile underwent a significant process of secularization. Partly due to this, the Council for Religious Affairs transferred responsibility for the institute to the Tibetan Children's Village (TCV) two years later.

In 1971, the Men-Tsee-Khang's director Ngawang Namgyal passed away, and Dr. Lobsang Tashi resigned. Combined with the resignation of two senior astrologers in the previous three years, including Duekhorwa Lodoe Gyatso,⁶⁸ these losses left the Men-Tsee-Khang without any distinguished practicing doctors.⁶⁹ All of this presented a serious setback for the institute, which relied on well-known senior doctors (and, to a lesser extent, astrologers) for its image, patient numbers, financial sustainability, and thus, in the long run, its existence. Thus, in 1972, Gowo Lobsang Tenzin, a settlement officer from Rasuigiri in Nepal who was appointed director, followed public opinion and recruited Dr. Lobsang Dolma Khangkar as Chief Medical Officer. Her husband, Tsering Wangyal, joined the pharmacy under Jamyang Tashi. Lobsang Dolma, also known as "Ama Lobsang" ("Mother Lobsang") from her time working as a foster mother in the early years of exile, was the 13th generation of a renowned *amchi* lineage in Kyirong (Josayma & Dhondup 1990; Tashi Tsering 2005: 177ff). She had already offered her services as an *amchi* to the medical center in 1962, at the suggestion of Kyabje Trijang Rinpoche, the younger tutor of the Dalai Lama. At that time, however, she had been turned away by the center's administration (i.e. the heads of the Department of Religion)

⁶⁷ Neither the Lhasa Mentsikhang nor the Dharamsala Men-Tsee-Khang were monastic institutions. However, in Lhasa and in the first years in Dharamsala, they *resembled* monasteries not only in their daily routine, but also because the majority of their doctors, students, and staff were monks.

⁶⁸ After the resignation of Duekhorwa Lodoe Gyatso in 1967, the Astrology Department was headed by Dhokdun Jampa Gyaltsen until 1997, who additionally served as the Men-Tsee-Khang's astrology professor during that time.

⁶⁹ Although both Jamyang Tashi and Barshi Phuntsog Wangyal were highly distinguished in their expertise, they did not practice medicine on a clinical level. Barshi Phuntsog Wangyal was a great scholar, but had no practical experience in Tibetan medicine, and Jamyang Tashi was indispensable in the pharmacy.

on account of being a woman (Josayma & Dhondup 1990: 16f), and had opened a successful private clinic in Dalhousie instead. Highly popular among the Tibetans, she had also made a name for herself among Indians, who would travel long distances to be treated by her.

Two branch clinics opened the same year, with Jampa Sonam and Tashi Gyaltsen as resident doctors, while the third graduate from the first batch, Yeshi Sonam, continued to serve in the pharmacy. None of the other first batch students – the monks from Namgyal and Sera-mey monasteries – completed their studies. In 1973, the Men-Tsee-Khang's present site in Gangchen Kyishong (between lower Dharamsala and McLeod Ganj) was purchased with money borrowed from the Dalai Lama's Private Office, and the construction of the institute's main office building began with funds from the German catholic aid organization Misereor. That year, the third batch of students was recruited (again from Tibetan schools) and funded by sponsors organized by TCV, as well as the Central Relief Committee of India, which provided food grains for the Men-Tsee-Khang's kitchen. Today, those students from the second and third batches who remained with the Men-Tsee-Khang – like Drs. Tsewang Tamdin, Pema Dorje, or Namgyal Tsering – constitute the institute's most senior, respected, and popular doctors, fulfilling high administrative responsibilities as well as treating patients. Until that year, students and doctors had collected the herbal raw materials for the medicines in the hills around Dharamsala. However, the director (Gowo Lobsang Tenzin) foresaw much greater need for raw materials in the future, and sent different groups to explore the mountains near Chamba, Bir, and Manali for herbs. This proved to be far sighted, and especially the

mountains surrounding Manali later became an important source of raw materials for the Men-Tsee-Khang.

In 1974, Gowo Lobsang Tenzin was transferred, and in his place, Ngawang Namgyal Ngodup, the TCV's assistant director, became the institute's director. He continued the construction work of the Men-Tsee-Khang's new office building, which was completed in 1975. Ngawang Namgyal was then transferred back to TCV, and the Dalai Lama personally ordered his niece's husband, Tsewang Jigme Tsarong, to be appointed as the new Men-Tsee-Khang director.⁷⁰ With that, the Men-Tsee-Khang also came under direct supervision of the Dalai Lama's Private Office – an indication of both persistent administrative problems within the Men-Tsee-Khang and the great importance the Dalai Lama placed on Tibetan medicine and the Men-Tsee-Khang. Jigme Tsarong, with an American college degree and experience working on Wall Street, wasted no time in putting the Men-Tsee-Khang on stable foundations for progress. As he explained to me in an interview,

The medical center was a problem zone. Trogawa Rinpoche had been there, but left, and it was the same with other very good *amchi*. It used to be under the Religious Council... but it was a problematic center that nobody wanted to handle, and so it was thrown, like a ball of fire, from one hand to another. Finally it came under the Tibetan Children's Village, which was run by the Dalai Lama's sister. She offered me the job. It was a tough job; the medical center was a headache.

⁷⁰ Jigme Tsarong was the husband of the Dalai Lama's elder brother's daughter. It was actually Jetsun Pema, the Dalai Lama's sister and director of TCV (under whose authority the Men-Tsee-Khang was until then), who asked Jigme Tsarong whether he would be willing to serve as the director of Men-Tsee-Khang. No doubt she had consulted the Dalai Lama before that, and once Jigme Tsarong agreed, the Dalai Lama gave the official order.

Remembering the day he arrived at the institute, at its old location in McLeod Ganj, he continued:

I was very impressed... I had a look around, the pharmacy was just below, and I thought, my god, this is a gold mine here! But as I told you, they had only 3000 Rupees. So little by little, I said we need to work, first we need to make some money. The best way to do this was to improve our products: improve the medicines, publish books, make calendars... I said look, to make money you have to spend money, we need to produce good quality. We also started doing the horoscope for people, people like that kind of thing, and we made money. Then there was the pharmacy... They had only partially built it, since there was no money, so all my time was wasted just for building this. Of course, I got criticized... But I said, as long as I'm here, I do what I want. At that time, though, I got good cooperation from the Dalai Lama's office. When I asked for money for the medical institute, they always gave it.

One of the criticisms that Jigme Tsarong was confronted with concerned his drive to commercialize Tibetan medicine. While his open expression of the intent to make money with Tibetan medicine only seemed like common sense to him as a former Wall Street banker, it was seen as deeply problematic by the amchi, who were trained to regard their profession as a Buddhist ethical practice that should never be done with commercial motives. Yet, as we will see in chapter 4, Jigme Tsarong was only the first to raise the issues of commoditization and commercialization, which later became a central problem in the Men-Tsee-Khang's institutional discourses and practices, when Tibetan medicine grew into a considerable economic resource during the 1990s. As part of his plans to put the Men-Tsee-Khang on a solid economic foundation, Jigme Tsarong opened branch clinics in Gangtok, Bomdila, Darjeeling, Kathmandu, and Kalimpong, despite the serious

shortage of doctors due to the previous resignations. He also made several trips abroad to generate funding, which he used to construct the new pharmacy and equip it with new machines – big pulverizers, sifters, and pill making machines. Besides that, he registered the Men-Tsee-Khang (by the English name of “Tibetan Medical and Astro. Institute” or “TMAI”) under the Indian Societies Act as a charitable society, which not only gave the institute legal status (albeit not as a medical institution), but also made it technically independent of the exile-Tibetan government. In practice, of course, the government still wanted control, and although it may not have had much influence on Jigme Tsarong or his successor, it was heavily involved in the institute’s administration until 2004.

While Jigme Tsarong was busy improving the pharmacy, overseeing the construction of a new college, and generally turning the Men-Tsee-Khang into a viable economic enterprise, Lobsang Dolma, too, proved to be a valuable asset for the Men-Tsee-Khang: not only did it become well known in the Tibetan exile-community, but it also attracted more and more Indian patients who came to be treated by her. After the struggles of the early 1960s and various internal and administrative problems coupled with two waves of resignations of senior doctors and astrologers, the Men-Tsee-Khang’s condition stabilized to some degree. From 1974 onwards, in her role as the Men-Tsee-Khang’s Chief Medical Officer, Lobsang Dolma began touring the West extensively, giving lectures and treating patients in the United States, Europe, and later also Australia (Josayma & Dhondup 1990: 5), increasing the stature of Tibetan medicine and the Men-Tsee-Khang considerably. However, her commitment to the Men-Tsee-Khang became increasingly doubtful, as she spent much of her time constructing her own, private pharmacy, and questions arose about her use of the revenues generated on her official

Men-Tsee-Khang tours abroad. Finally, in 1978, Jigme Tsarong took the – then highly controversial – decision to dismiss her from office, on the grounds that she overstayed on a tour abroad and refused to rejoin her duty even after she returned (cf. Tsering 2005: 183). After that, Lobsang Dolma completed her private clinic at its present location in McLeod Ganj, and continued her popular practice and extensive tours abroad until her untimely death due to an illness in late 1989. She is survived by her two daughters Pasang Gyalmo, who now manages her mother’s (renamed) “Lobsang Dolma Khangkar Memorial Clinic” in McLeod Ganj, and Tsewang Dolkar, who runs a successful private clinic in New Delhi.

Development and Growth (1980-1987)

By 1980, the institute’s staff had expanded to 23 doctors, seven astrologers, and 23 supporting personnel, and its finances had increased from the 3000 Rupees that Jigme Tsarong mentioned to several lakhs.⁷¹ Jigme Tsarong resigned as the Men-Tsee-Khang’s director, but stayed at the institute for two more years as the head of the newly founded Research and Development Department. In his place, Lobsang Samten Taklha, the Dalai Lama’s elder brother, took over the directorship. While Jigme Tsarong’s contribution had been to solidify the institute’s assets and lay the necessary foundations for further development, Lobsang Samten’s ability to turn these assets and foundations into highly visible progress made him stand out as one of the most successful directors the Men-Tsee-Khang had so far. The same year that he took over, Dr. Tenzin Choedrak arrived from Tibet. Tenzin Choedrak had already served as the Dalai Lama’s personal physician

⁷¹ One lakh is 100,000 Rupees.

from 1956 to 1959, and had subsequently spent 17 years in Chinese prisons and labor camps before he fled to India.⁷² When he arrived there, he was immediately (re-) appointed as the Dalai Lama's senior personal physician, as the Men-Tsee-Khang's chief physician, and as a member of the institute's governing body. The following year, in 1981, Dr. Tenzin Namgyal – another renowned *amchi* – came from Tibet, and was appointed as head of the Men-Tsee-Khang's pharmacy.

With such a boost in human resources, experience, and expertise, the Men-Tsee-Khang was now ready to revive, in exile, one of the most complicated and esoteric practices known in Tibetan medicine: the production of *rin chen dngul chu btso bkru chen mo*, also known as *tsothel (btso thal)*: purified and detoxified mercury, sometimes referred to as “the king of medicines” and the key ingredient in several types of *rinchen rilbu (rin chen ril bu*: precious pills). Thus, after several years of preparation,⁷³ mercury was purified and detoxified under the supervision of Tenzin Choedrak. About 20 others were involved,⁷⁴ including security guards necessary because the procedure took place inside the Dalai Lama's residential compound, 70 meters behind his actual residence at a place he normally used for fire offerings. After two months of nonstop labor, 60 kg of *tsothel* were finally consecrated on April 28, 1982, at the Dalai Lama's residence – the location clearly indicating the importance given to the event.

⁷² For more details on Dr. Tenzin Choedrak's biography, see Choedrak (2000) and Avedon (1997).

⁷³ Jigme Tsarong, who was involved in the preparations, told me that it took a long time and much research to find the right materials necessary – besides the ingredients, even the pots and containers had to be made of certain materials.

⁷⁴ Among those present were Drs. Jamyang Tashi, Tenzin Namgyal, Jampa Sonam (Lhawang la), Yeshe Sonam, Lobsang Choephel, Pema Dorjee, Pasang Yonten Arya, Tsewang Tamdin, and Namgyal Tsering. They also received the transmission of the relevant text from Tenzin Choedrak, the “*bdud rtsi bcud kyi rgyal po rin chen dngul chu btso bkru chen mo'i sbyor bas grub pa'i bcud len du bsgyur ba'i lag len rnam par gsal ba 'tsho byed mkhas pa'i snying bcud*” by Kongtrul Rinpoche.

Lobsang Samten also initiated other, less dramatic, but similarly important developments that would shape the future of the Men-Tsee-Khang and of Tibetan medicine in exile. Two in particular stand out, concerning the Men-Tsee-Khang's reach outside the Tibetan community on the one hand, and its relations with private *amchi* inside the Tibetan community on the other. Until the early 1980s, Tibetan medicine's reach was largely confined to the exile-Tibetan community and a minority of Indian patients. Although Jigme Tsarong had already realized the importance of opening branch clinics in the big Indian cities – both for economic and political reasons – this had been impossible due to a lack of doctors. Therefore, at the beginning of his tenure, Lobsang Samten made it a point to recruit 33 medical students for the fifth batch, which was by far the largest cohort the college had admitted until then. This cohort included, for the first time in exile, students from Himalayan areas in India like Ladakh, Lahaul, or Spiti, as well as newly arrived refugees from Tibet. Soon after, in 1983, 18 more students were recruited as the sixth (medical) batch. To help Barshi Phuntsog Wangyal fulfill his increased teaching duties, Pasang Yonten Arya was appointed as assistant teacher. Then, in December 1982, a “Tibetan Medicine Week” was organized (by Jigme Tsarong) at the Tibet House in Delhi, with exhibitions, lectures, and free consultations and treatments. This proved to be so popular among the people of Delhi that the Men-Tsee-Khang decided to continue its free clinic for another three or four weeks at Tibet House, and then bought a permanent place in East Nizamuddin (a prime location in New Delhi), which has since become the Men-Tsee-Khang's flagship clinic in terms of doctors, patient numbers and revenue.

Due to this new emphasis on outreach to Indians, the ratio of Tibetan and Indian patients flipped under Lobsang Samten's tenure, and today, almost 30 years later, over 92% of all patients resorting to Tibetan medicine in India are Indians (*bod gzhung sman rtsis khang* 2008).⁷⁵ While this development was certainly envisioned and prioritized by Lobsang Samten, his (or the Men-Tsee-Khang's) initiative – though important – should not be overestimated. First of all, the Men-Tsee-Khang does not, as a matter of policy, simply open branch clinics wherever it likes, but rather relies on the local population – whether Tibetan or Indian – to officially request a clinic, usually combined with an offer of a site (either a building or a plot of land). In this way, not only are the costs kept low – especially important in the big Indian cities, where real estate is expensive – but also the viability and legal security of the clinic is ensured by popular demand. In other words, the initiative to establish new branch clinics does not come – and never came – from the Men-Tsee-Khang administration, but from local people. Secondly, the Men-Tsee-Khang was not the first to open a Tibetan clinic in Delhi, and not the only one to attract public and media attention to Tibetan medicine. Dr. Tsewang Dolkar Khangkar, Lobsang Dolma's younger daughter, had opened a charitable clinic in New Delhi in 1981, and her own private clinic in 1984. Both of these clinics have, from the beginning, catered predominantly to Indians, and with her growing success and fame today also attract many foreign diplomats. In 1987, she was featured on national Indian TV (Doordarshan), and later in several newspaper articles both in India and abroad (cf. Tashi Tsering 2005: 190). Similarly, Tashi Yangphel Tashigang opened a private clinic in East Delhi in 1986, and

⁷⁵ The Men-Tsee-Khang's annual report for 2008 states that 92% of its patients between 2007 and 2008 were Indians. For Tibetan medicine in India in general (i.e. including other clinics and institutions than the Men-Tsee-Khang), this percentage is even higher since many of them cater almost exclusively to Indians. While no statistics could be obtained about that, the difference is not likely to be a big one, since these other clinics' patient numbers are much lower than the Men-Tsee-Khang's.

has published a large number of old Tibetan medical texts since the late 1960s. He remains the most eminent scholar in exile on Tibetan medical texts today.

This leads us to the second development that took shape under Lobsang Samten's tenure, that is, the Men-Tsee-Khang's relations with private *amchi*. We have already noted how the resignations of senior doctors from the Men-Tsee-Khang have constituted perhaps the most serious and persistent problem for the institute. While problems in the Men-Tsee-Khang's management and administration were important but rarely mentioned factors leading to resignations,⁷⁶ the *amchi* who resigned tended to be perceived by the remaining Men-Tsee-Khang staff as selfish and disloyal, especially in case of resignations of the institute's own graduates. In order to prevent further resignations by doctors seeking to establish their own private clinics, and thus ensure adequate human resources for the institute, Lobsang Samten decided that the Men-Tsee-Khang would not sell its medicines to any private doctors.⁷⁷ The obvious rationale was that since it was very difficult and expensive even for senior doctors to set up their own pharmacy, and next to impossible for an inexperienced young graduate, this policy would deter further resignations and ensure adequate human resources for the Men-Tsee-Khang.

However, the move was also seen by Tibetan observers (including, of course, private *amchi*) as an attempt by the Men-Tsee-Khang to monopolize Tibetan medicine.

⁷⁶ One Tibetan official, who had been working at the Men-Tsee-Khang at that time, told me: "I don't know why exactly the doctors left the Men-Tsee-Khang, but if they were completely happy there, they wouldn't have left. You cannot say now why they left, because even then they didn't give the real reason; they would just say, the weather didn't suit me, or cited personal reasons. But it's like, if a doctor gives everything for the institute and is working really hard, and then gets criticized for some small details, it doesn't feel nice. You see, the Men-Tsee-Khang was *the* institution in the exile government; it was like a mother. But if the mother is acting like a child, then it's not surprising that the children will... [not respect, or go against, the mother.] Certainly, if there were some doctors with wrong conduct, then action should be taken. But otherwise, the relations should be like between a mother and her children."

⁷⁷ Previously, the Men-Tsee-Khang would occasionally sell its medicines to private doctors, provided there were enough in stock.

This was amplified by the rarely expressed but still noticeable attitude of many Men-Tsee-Khang doctors then (and to some extent even now) regarding Tibetan medicine as the Men-Tsee-Khang's "property." Ultimately, the decision was largely unsuccessful in preventing some of the best doctors from leaving the Men-Tsee-Khang in order to open their private clinics in India or abroad. What it successfully accomplished, however, was to alienate these doctors from the institute and cement a latent, but decidedly hostile attitude on part of the Men-Tsee-Khang towards private *amchi* in general.⁷⁸ The resulting tense relations between the Men-Tsee-Khang and private doctors, which one Men-Tsee-Khang doctor referred to as "a cold war," intensified over time as the resignations increased, and only began to subside after the drastic changes of 2004 concerning Tibetan medicine in exile (see below).

In 1983, Barshi Phuntsog Wangyal, the Men-Tsee-Khang's college principal, passed away and was succeeded by his assistant, Pasang Yonten Arya. Lobsang Choephel was appointed assistant teacher, soon to be joined by Tenzin Tsephel from the Lhasa Chagpori as a lecturer, also known among his students as "*amchi rgya'u*" ("bearded doctor"). Tenzin Tsephel's introduction of the Chagpori tradition of "Yuthog Ninthig Tsechu" (*gyu thog snying thig tshes bcu*) to the Men-Tsee-Khang college was an instant popular success at that time among the students. Originated by Yuthog Yonten Gonpo the Younger, this practice of medicine consecration by students every tenth day of the Tibetan month has since remained a fixture in the Men-Tsee-Khang college's monthly schedule.

⁷⁸ As far as particular private *amchi* were concerned, there were exceptions, of course. Thus, Yeshe Donden as the erstwhile founder of the Men-Tsee-Khang continued to be held in high esteem by the institute's doctors.

While the Men-Tsee-Khang had lost its highly respected college principal, it gained two new senior doctors with the arrival of Drs. Lobsang Wangyal and Kunga Gyurme Nyarongsha from Tibet in 1983 and 1984, respectively. Lobsang Wangyal was immediately appointed the Dalai Lama's junior personal physician (Lobsang Wangyal 2007), while Kunga Gyurme Nyarongsha was deputed to be doctor-in-charge at the Men-Tsee-Khang's prestigious Nizamuddin clinic in New Delhi. He, too, became the Dalai Lama's personal physician in the late 1990s.

In the following year 1984, the institute was renamed into “*bod kyi gso ba rig pa'i mtho rim slob gnyer khang*” (Higher Institute for Tibetan Medical Studies) and “*bod kyi skar dpyad rtsis rig mtho slob khang*” (Higher Institute for Tibetan Astrological Studies)⁷⁹ (Arya 1989: 217), indicating a separation of medicine and astrology in the students' training.⁸⁰ New rules and regulations for the students and staff, as well as new syllabi for *kachupa* (*dka' bcu pa*), *menrampa* (*sman rams pa*), and *tsirampa* (*rtsis rams pa*) degrees were drafted.⁸¹

In 1985, Lobsang Samten, Jamyang Tashi (who had meanwhile also been appointed junior personal physician to the Dalai Lama), and Duekhorwa Lodoe Gyatso (the institute's first astrology teacher who had returned to the Men-Tsee-Khang under Lobsang Samten) all passed away within the same year. Lobsang Samten's wife, Namgyal Lhamo Taklha, was appointed the Men-Tsee-Khang's next director. On March 23, 1987, the great hall of the new medical and astrological college was inaugurated, and

⁷⁹ The English names given here are merely translations of the Tibetan terms. The institute's official English name remained “Tibetan Medical and Astrological Institute” or “TMAI”.

⁸⁰ Since the merger of the medical and the astrological centers, both subjects were taught together. Since 1984, however, separate student batches for medicine and astrology were recruited.

⁸¹ The higher degrees (*menrampa* and *tsirampa*) could not be given at that time, because several medical and astrological texts considered necessary requirements were not available in exile.

the Men-Tsee-Khang's first seminar on Tibetan medicine for foreigners was organized on the occasion. Since then, this day is celebrated as the Men-Tsee-Khang's "Foundation Day".⁸² From 1985 until 1987, seven new branch clinics opened, the fifth and sixth medical batches graduated, and the seventh medical batch was recruited. Furthermore, in 1987 the Men-Tsee-Khang prepared, for the second time, about 80 kg *tsothel* for *rinchen rilbu*, this time using a gas stove instead of dung and coal fires. Despite the loss of one of the most successful directors the Men-Tsee-Khang ever had (next to Tsering Tashi: see below), not to mention that of a senior doctor and the senior-most astrologer, it maintained its momentum of progress and development for a little longer. After the difficulties of the 1960s and 70s, the 1980s thus saw an unprecedented expansion of the Men-Tsee-Khang with 25 new branch clinics, several senior doctors arriving from Tibet, an expanded pharmacy, the production of *rinchen rilbu*, the stabilization of the struggling Astrology Department, and the establishment of the Research and Development Department. However, as the decade drew to a close, it became clear that the institute's internal difficulties were far from over.

Internal Troubles (1988-1994)

In 1988, on a tour through the US, Dr. Tenzin Choedrak (accompanied by Namgyal Lhamo) repeatedly claimed to be able to cure AIDS (cf. Weisman 1988). It is unclear whether he was only making the general statement (quite common among Tibetan

⁸² This means that officially, the Men-Tsee-Khang is claimed to have been founded on March 23, 1961. Technically, this claim is wrong for more than one reason: the date was only fixed in 1987, as I just mentioned; and in 1961, only a small Tibetan clinic started operating, which would later become – but certainly was not at that time – the Men-Tsee-Khang.

doctors) that in principle, Tibetan medicine had a cure for every ailment, or whether he was actually claiming the he himself could cure this new disease. Either way, this subtle difference did not matter in the American context. Recorded and broadcast by a journalist, the statement generated a considerable amount of negative media coverage, and forced the Men-Tsee-Khang delegation to leave the country immediately in order to avoid a lawsuit (Tokar 1999).⁸³ Upon return, Namgyal Lhamo was promoted to the post of the General Secretary of the Department of Health, and Achok Rinpoche appointed as the Men-Tsee-Khang's new director. Although the incident in the US had no lasting consequences, and new branch clinics continued to be opened over the next two years (including a clinic in Calcutta and another one in Delhi), the new director proved to be incapable of keeping the institute under control. Widespread discord among employees, rivalries among senior doctors, and the refusal of some of the latter to accept the director's authority, finally led Achok Rinpoche to resign after only one year in office (Choelo Thar 2000: 100f). The Men-Tsee-Khang remained without a director for the next year.

In 1990, the former Kalon,⁸⁴ Shewo Lobsang Dhargye, was appointed as director by the Dalai Lama's Private Office, continuing to open new branch clinics and to recruit new batches of students. Under his tenure, the Men-Tsee-Khang also introduced an elective basic course on modern sciences in its medical curriculum, which has continued, despite mediocre student attendance, until today. However, only a small minority of those

⁸³ Eliot Tokar, himself a practitioner of Tibetan medicine, blames the well-intentioned, but ignorant American organizers of Dr. Choedrak's trip to the US for writing and distributing a pamphlet claiming that he had a cure for AIDS. This pamphlet caused a local TV station to send an investigative reporter with a hidden camera to one of Dr. Choedrak's talks, broadcasting the footage in a damning report.

⁸⁴ "Kalon" is the Tibetan term for Cabinet minister. The Tibetan government in exile has two chambers, the Cabinet (Kashag) made up of ministers, and the Parliament or "Assembly" consisting of the departments' secretaries and people's deputies.

doctors who graduated in the early 1990s (the 7th and 8th batch) remained with the Men-Tsee-Khang. In 1991, Tenzin Namgyal, the head of the pharmacy, passed away, which resulted in a marked drop in the quality of the Men-Tsee-Khang's medicines. Doctors from the branch clinics began to complain that medicines that used to show almost immediate effects did not seem to work anymore.⁸⁵ Fights among the workers became a regular occurrence in the pharmacy, and with no efficient system of administration, accounting, and communication in place, medicines – especially *rinchen rilbu* – began to disappear as personal gifts or on international tours.⁸⁶ Moreover, counterfeit “Men-Tsee-Khang” *rinchen rilbu* began to be sold – apparently by some private *amchi* – in exile-Tibetan settlements, border areas, and in China.⁸⁷ Perhaps due to this increased “demand” for *rinchen rilbu*, the Men-Tsee-Khang produced *tsothel* for a third time in 1992, which constituted the largest production of purified and detoxified mercury until then (110 kg). Tenzin Choedrak gave another transmission,⁸⁸ declaring that now all the necessary transmissions and skills had been passed on to the younger generation. Despite this positive news, the Dalai Lama's Private Office was clearly exasperated with the overall state of affairs at the Men-Tsee-Khang, and replaced the director yet again in 1993, this time appointing Rinchen Dolma, the widow of Rechung Rinpoche. Although her

⁸⁵ Barbara Gerke (pers. comm. 2008)

⁸⁶ Tsering Tashi Phuri (pers. comm. 2009)

⁸⁷ Tsering Tashi Phuri (pers. comm. 2009). While Men-Tsee-Khang doctors were not directly involved in this counterfeiting business, the general lack of accountability at the Men-Tsee-Khang was an important element of the problem, since the counterfeiters did somehow have access to genuine *rinchen rilbu*, which they then crushed and multiplied.

⁸⁸ In Tibetan medicine as in Tibetan Buddhism, oral transmission (*lung*) of important texts holds a special importance in establishing a direct link between the listener and the text's originator, and is one of the three essential methods of instruction and training (*dbang lung khrid gsum*: empowerment, transmission, and instruction). In contrast to empowerments (*dbang*), *lung* is a simple procedure in which a senior doctor recites a particular text in its entirety while others (students or less senior doctors) listen.

predecessor stayed on for a year as an advisor, Rinchen Dolma soon had to resign from her post as her health deteriorated.

Throughout its history, the condition of the Men-Tsee-Khang is well reflected in the Dalai Lama's periodic speeches to the institute's doctors, students and staff (Dalai Lama 2007). During the 1960s and 1970s, his speeches were characterized by his interest in how the institute was doing, and repeated assertions about the crucial importance of Tibetan medicine for Tibetan culture, the Tibetan nation, and the Tibetans' political struggle. Overall, the speeches during these two decades were very optimistic about the potential of Tibetan medicine and the Men-Tsee-Khang. In 1986, reflecting the Men-Tsee-Khang's (and especially Lobsang Samten's) concern about doctors leaving the institute, he pointed out the moral and social obligation of doctors to be grateful and loyal to the Men-Tsee-Khang, exhorting them to remain within its fold (*ibid.*: 23f). One year later in 1987, he mentioned for the first time (unspecified) "huge problems" (*ibid.*: 27), but remained positive in his tone and outlook. Stating that he could "foresee a great future for Tibetan medicine" (*ibid.*: 33), he encouraged the Men-Tsee-Khang to not remain secluded but to reach out to humanity at large. In 1992, the tone became harsher, as the Dalai Lama directly requested the Men-Tsee-Khang doctors "not to demean and defame the study of Tibetan medicine and the Men-Tsee-Khang" (*ibid.*: 46-47), pointing out that medical expertise alone is not sufficient, but needs to be combined with a kind heart and the genuine motivation to help others (*ibid.*: 46). Apparently even this admonition – coming as it were from the Dalai Lama personally – was not clear enough for some, prompting him to give the assembled Men-Tsee-Khang staff an unprecedented scolding in 1994. Mentioning that it was "utterly spiteful to earn a bad reputation and then keep

beating around the bush and smooth things over by pointing fingers at others” (ibid.: 57), the Dalai Lama admitted that he was afraid “that this institute might become a platform for dissidents, for inept and inappropriate people. [...] Under such circumstances, there cannot be a successful establishment.” (ibid.: 48f) Clearly, the Dalai Lama expected radical, and fast, changes from the Men-Tsee-Khang, not only for its own sake, but also, as he kept pointing out, because it represented Tibetan medicine in exile, Tibetan culture, and the Tibetan nation.

Other Tibetan Medical Institutions: The Chagpori, CIHTS, and CIBS

As if to underscore the Men-Tsee-Khang’s problems, three other institutions of Tibetan medicine were established in India during those years, effectively calling into question the Men-Tsee-Khang’s role (and self-image) as the sole representative of Tibetan medicine in exile. In January 1991, the German association “Chakpori Verein für Tibetische Heilkunde” (with both a German and an Indian board) was founded at the initiative of Trogawa Rinpoche. A year later, in February 1992, the “Chagpori Tibetan Medical Institute” opened in Darjeeling, with a medical college, a small outpatient clinic, and a pharmacy. Trogawa Rinpoche personally requested the Dalai Lama to grant the new institution independence from the Men-Tsee-Khang,⁸⁹ for a number of historical, strategic, and personal reasons: in Lhasa, the Chagpori had been the older and thus more prestigious institution than the Mentsikhang; it did not seem wise to come under the Men-Tsee-Khang’s authority given its chaotic condition in the early 1990s; and Trogawa Rinpoche – whose personal relations to the senior Men-Tsee-Khang doctors were

⁸⁹ Barbara Gerke (pers. comm. 2008)

strained – was keen to design his own syllabus. However, to the Rinpoche’s disappointment, the request was turned down – an indication of the importance still placed on the Men-Tsee-Khang from the official side, despite its recent troubles. In consequence, the Chagpori had to request its annual exam questions, a doctor to supervise the exams, and the evaluation and grading of these exams from the Men-Tsee-Khang. It was also forced to adopt the Men-Tsee-Khang’s syllabus, although Trogawa Rinpoche added, in line with the old Chagpori tradition, more emphasis on religious practice, gave transmissions to the students, and passed on his own *lag len* (tradition, practice) of making medicines. Apart from its teaching function, the Darjeeling Chagpori is currently running three outpatient clinics (one at its main location, one in Darjeeling town, and one in Kurseong) and producing its own medicines. An additional clinic in Siliguri, as well as a new pharmacy, is planned. Until the death of Trogawa Rinpoche in 2005, the Chagpori graduated 27 doctors in three batches (all male), of whom, however, only six stayed with the institute. One batch of 20 nuns also received two years of training as health workers, although this was discontinued when Rinpoche passed away.⁹⁰ In 2005, Trogawa Rinpoche’s nephew, Thinley Trogawa, took over as the director, while the institute came – as Trogawa Rinpoche requested shortly before his death – directly under the CTA’s Health Department, where it remains today.⁹¹

Another new institution of Tibetan medicine was the medical faculty at the Central Institute of Higher Tibetan Studies (CIHTS) in Sarnath, just outside of Varanasi. The CIHTS had already been founded in 1967, according to plans by the Dalai Lama and

⁹⁰ These nuns are now in Ladakh, receiving some training by Dr. Thinley Angjor (the medical teacher at CIBS (see below).

⁹¹ Pema Damdul Arya (pers. comm. 2007); Chagpori Tibetan Medical Institute website, accessed on October 22, 2009 (<http://chagpori-tibetan-medical-institute.com/administration.htm>)

Pandit Nehru (prime minister of India until 1964), to substitute Tibetan institutions in Lhasa that had become inaccessible to exile-Tibetans and Indian Himalayan Buddhists alike as a center for the study of traditional Tibetan sciences. Initially part of Sampurnanand Sanskrit University of Varanasi, the CIHTS became independent in 1977, “deemed university” in 1988, and got full accreditation as a university in January 2009; its name has changed, accordingly, to “Central University of Tibetan Studies”, or “CUTS”.⁹² However, it was only in 1993 that the medical section was founded at the initiative of Samdhong Rinpoche, then the CIHTS’s Vice Chancellor. The idea behind Samdhong Rinpoche’s initiative was twofold: the CIHTS medical faculty was to focus on research (especially on medical literature), an area long neglected by the more clinically oriented Men-Tsee-Khang; and it was to use its official status within the Indian university system (which neither the Men-Tsee-Khang nor the Chagpori had) to push for Tibetan medicine’s recognition by the Indian government. By 2008, the faculty had graduated about 26 doctors in six batches, with 36 students currently enrolled, and was employing four doctors. The CUTS medical department is flourishing, with a hospital and a large pharmaceutical production unit under construction, several literary research projects under way, and a steady stream of pharmaceutical innovations as well as publications coming out. Unlike the Men-Tsee-Khang and the Chagpori, furthermore, the CUTS is under the authority of the Indian Department of Higher Education (rather than the Tibetan exile-government), which means that it is able to operate in complete autonomy from the Men-Tsee-Khang (own syllabus, own exams, own certificates, etc.), with considerable funding from the Indian government.

⁹² The National Assessment and Accreditation Council (NAAC) of India also accredited it, as one of only two universities in northern India, with five stars – the highest grading – for its academic quality.

The third institution founded during that time was the medical section at the Central Institute of Buddhist Studies (CIBS) in Choglamsar, Ladakh. The CIBS was already founded in 1959 to fulfill the same purpose like the CIHTS, and established a medical section later, in 1989, with Pasang Yonten Arya – who had been the principal at the Men-Tsee-Khang college before his resignation there – as its first teacher. The institute mostly trains Ladakhis in Tibetan medicine, and is, in terms of administration, a mixture between the Chagpori and the CIHTS. Although funded and administrated by the Indian government, the CIBS medical section voluntarily relied until recently on the Men-Tsee-Khang for help with the syllabi, exams, and certificates. By 2008, the CIBS medical section had graduated 13 *amchi*, with six students currently enrolled. These low numbers reflect considerable difficulties in attracting qualified Ladakhi students, for whom Tibetan medicine does not constitute an attractive career option.⁹³ Currently, the CIBS is an autonomous organization under the Indian Ministry of Culture, but has applied for university status, which would give it an increased level of independence and much more funding.

Although it is perhaps no coincidence that these three institutions were founded during one of the Men-Tsee-Khang's most challenging times, they did not, for various reasons (administrative and financial problems, small size, difficulties to attract students), become any serious competition. Leaving aside a few private Tibetan doctors (until 1990, they numbered less than a handful), Trogawa Rinpoche and the largely ignored CIHTS medical faculty, the Men-Tsee-Khang remained the sole representative and

⁹³ Due to various socio-economic reasons, *amchi* medicine (as Tibetan medicine is called in Ladakh) is not a profitable enterprise in most areas of Ladakh. In a situation where even fully trained *amchi* are finding it hard to continue their practices without making financial losses, young people look for other, safer avenues to secure their income and future (cf. Kloos 2005, 2006, in press a).

overwhelming power in the field of Tibetan medicine in exile. As the 1990s unfolded and the Men-Tsee-Khang overcame its troubles and rose to unprecedented strength under a new leadership, this became truer than ever.

Internal Reforms and International Expansion (1994-2003)

June 28, 1994, constituted a turning point for the Men-Tsee-Khang. Not only was it the occasion for the Dalai Lama's above-quoted critical speech, but it was also the day when Tsering Tashi – the CTA's Finance Secretary until then – took office as the Men-Tsee-Khang's new director. In his speech, the Dalai Lama made clear that he expected the staff to cooperate with the new director to make far-reaching changes that had been long overdue. Despite his reputation as a strict disciplinarian, Tsering Tashi could certainly use such help. In his own words,

When I joined, my colleagues told me: 'now you will have a tough time, you won't be able to control the staff... they are so uncooperative, all the other directors had a lot of problems too. They will just do what they like.'
I said, 'that will not happen.'

Indeed, this did not happen, as Tsering Tashi immediately began restructuring the institute's administration, implementing a spate of innovations that effectively put the staff to work, and generally raising the standards of the administration, workforce, and products. As one doctor remembers, "This was a busy time at the Men-Tsee-Khang." Tsering Tashi shuffled positions to put capable people where they mattered, and raised the recruitment requirements for all new staff to 10+2 standard (i.e. high school graduation). He required all departments to submit written reports on their activities in

order to put an end to the rumors that had poisoned the institute's atmosphere; he ordered the pharmacy workers to recite mantras during work hours to stop the constant gossip there, which was the main reason for the frequent fights; and he improved the kitchen, the food of which had previously been the cause of much student discontent. He began to tightly control the distribution of *rinchen rilbu*, which were from now on packaged in small plastic boxes and sealed with a hologram sticker.⁹⁴ In combination with a media campaign, warning the public about fake *rinchen rilbu*, these measures quickly reduced the counterfeiting problem, at least within the Men-Tsee-Khang's reach (i.e. in the settlements). Furthermore, Tsering Tashi established a Publication Department, a bilingual students' magazine, and the Men-Tsee-Khang newsletter, as well as the Herbal Products Research Department, which began producing a series of new health- and beauty-products under the guidance of Dr. Lhawang. An Export Department was set up in New Delhi to distribute these commercially oriented products both in India and abroad.

Since Jigme Tsarong, the institute had been officially registered as the "Tibetan Medical and Astro. Institute" (TMAI). Realizing that in times when the Men-Tsee-Khang was not the only institution of Tibetan medicine in exile anymore, this name was not a unique enough identifier, he officially changed it to "Men-Tsee-Khang", with "Tibetan Medical and Astro. Institute of His Holiness the Dalai Lama" in parentheses. The spelling with the "ee," as well as the explicit affiliation with the Dalai Lama, indicates that this change was mainly addressed to non-Tibetans, since both the correct pronunciation and the institute's affiliation were common knowledge among the Tibetans. The name change

⁹⁴ A similar practice of packaging *rinchen rilbu* began in Lhasa during the mid- to late 1990s (Adams, pers. comm. 2010). However, the introduction of the hologram at the Dharamsala Men-Tsee-Khang was unrelated to similar developments in Lhasa, and in fact the idea of Sonam Topgyal (quoted in the introduction), who at that time was involved in introducing the hologram to various companies in India.

had the desired effect, and today even non-Tibetans refer to the institute as the “Men-Tsee-Khang.” The official Tibetan name remained “*bod gzhung sman rtsis khang*” (“The Tibetan Government’s Medical and Astrological Institute”), even though up to Tsering Tashi’s tenure, this link to the exile-government had existed only in name.

This, then, is where Tsering Tashi’s biggest contribution lay. Tied directly to the Dalai Lama’s Private Office, which was an authority above and beyond the Tibetan exile-government, the Men-Tsee-Khang had, since the 1970s, been virtually independent of the exile-government. Its connection with the Private Office, however, did not mean that the Dalai Lama himself oversaw the Men-Tsee-Khang, or even that his Private Secretary oversaw it. What it meant was that the Men-Tsee-Khang’s administrative decisions were often made between the director or senior doctors on the one side, and various staff members of the Private Office on the other. These decisions were very hard to contest due to the Office’s high status, and lacked transparency because they often took place only verbally and without the knowledge of the Private Secretary, the CTA, or other Men-Tsee-Khang staff. This may have been attractive both to senior Men-Tsee-Khang staff, who were thus relatively independent, and also to the exile-government, where nobody wanted responsibility for the “trouble zone” that the Men-Tsee-Khang had become. However, the resulting absence of a clear structure of communication, decision-making, or accountability constituted the root of most of the Men-Tsee-Khang’s problems – a fact that Tsering Tashi was well aware of. He therefore changed the members of the Men-Tsee-Khang’s governing board, reducing its number of Cabinet Ministers but including instead the Secretaries of Health, Education, and Home, the personal physicians to the Dalai Lama, and the Men-Tsee-Khang’s general secretary. On

the one hand, the Men-Tsee-Khang began to take more responsibility for its own affairs, relying less on higher authorities, but on the other, it sought more involvement of the Health Department. In short, Tsering Tashi officially gave the final authority and control over the Men-Tsee-Khang to the exile-government (i.e. the Health Department), albeit with the clear understanding that any interference in the institute's internal affairs was "unnecessary." After all, the Men-Tsee-Khang was bigger than the entire Health Department, and, in Tsering Tashi's words, "your freedom to wield your stick ends where my nose begins."

In 1995, only one year after Tsering Tashi's appointment, the Dalai Lama remarked: "Of late, the gradual progress of the Men-Tsee-Khang is obvious to all of us. Because of this, I feel that things are heading in the right direction and that there is still room for hope" (Dalai Lama 2007: 59). Not only had Tsering Tashi succeeded, within a short time, to radically reform the Men-Tsee-Khang internally, but he also expanded its external reach to an unprecedented scale. He organized several international medical tours to Europe, Japan and the US, two large courses on Tibetan medicine for foreigners in Dharamsala, and established the institute's first permanent Western branch clinic in Amsterdam. Together with the increased number and quality of English language publications on Tibetan medicine during that time – by the Men-Tsee-Khang and others – this greatly accelerated the global spread and exposure of Tibetan medicine that had begun in the 1960s in exile. It also established the Men-Tsee-Khang as the most successful institution under the Tibetan exile government, both in economic and ethico-political terms. That is, as the Men-Tsee-Khang's ceased to be perceived as a "trouble zone", its moral authority and material capacity to represent, imagine and produce

Tibetan culture and the nation in terms of a moral community grew dramatically. When Tsering Tashi resigned in 1997, Pema Damdul Arya took over a well-managed, smoothly running institution from his predecessor. Soon a point was reached where the ongoing, ever growing international exposure of Tibetan medicine began to manifest profound repercussions on its organization and practice back home, that is, in the Tibetan exile-community in India.

Interlude: Tibetan Medicine goes West

Tibetan medicine had been largely unknown outside the Tibetan cultural area until well into the 1960s, when Tibetan doctors from the Indian exile began attending conferences in Europe and North America. Probably the first *amchi* to represent Tibetan medicine in the West,⁹⁵ Dr. Yeshe Donden was invited to an international conference on medicine in Spain in 1967,⁹⁶ where he gave a presentation on the history of Tibetan medicine. This trip was a great success, as not only the Tibetan flag was hoisted among those of the other nations of speakers (including China), but Yeshe Donden also had the chance to treat – and thus impress – patients, including the King of Spain. While there exists a considerable amount of (mostly untranslated) Russian scholarship and some scattered work in German and other European languages from before 1960 (see Aschoff 1996 and Rechung 2001: 98-102 for a bibliography of these works), sustained Western academic interest – both anthropological and historical – in Tibetan medicine is therefore a

⁹⁵ Not including the Soviet Union, where practitioners of Tibetan medicine from Buryatia had long been visiting and practicing in Moscow and St. Petersburg.

⁹⁶ Neither the year of this conference (1967 or 1968), nor its exact location could be confirmed.

relatively recent phenomenon, coinciding with Tibetan medicine's increasing expansion and renown in exile.

The first serious scholarly publications on Tibetan medicine focused mostly on its pre-modern history, its most important medical texts (the *rgyud bzhi* and its main commentaries), and the medical theory contained in these texts (Vogel 1965; Rechung 1973; Emmerick 1975, 1977, 1978; Finckh 1975, 1978; Dash 1976; Norbu 1976; Donden & Kelsang 1977; Beckwith 1979). Thus, in 1973, Rechung Rinpoche (Rechung 1973) published the first serious book on Tibetan medicine in English. Elisabeth Finckh's *Grundlagen Tibetischer Heilkunde* (Finckh 1975) appeared in 1975 in German and in 1978 in English (Finckh 1978), and was the first work in a European language (excluding Russian) on Tibetan medicine that dealt with the original Tibetan texts (i.e. the *rgyud bzhi*) in detail. In 1976, Dawa Norbu brought out the first edited volume on the topic (Norbu 1976), and Bhagwan Dash, who had previously written a few short articles on Tibetan medicine, published the book *Tibetan Medicine, with special reference to Yoga Sataka* (Dash 1976). Still, the fact that Tibetan medicine found no mention in the important volume *Asian Medical Systems* (Leslie 1976a) that came out the same year, shows that it was by no means established (whether institutionally, academically, or politically) as a "medical system" like Ayurveda or Traditional Chinese Medicine (TCM) at that time – or even in the early 1990s, when the sequel to *Asian Medical Systems* was published (Leslie & Young 1992).

In 1980, the Library of Tibetan Works and Archives in Dharamsala began publishing the English-language journal "Tibetan medicine", with one to two issues a year containing articles both by foreign scholars and exile-Tibetan doctors. These articles

mostly dealt with technical issues of Tibetan medicine (e.g. concerning treatment of specific diseases, diagnostic methods, or pharmacology), its history, and general introductions to its perspective and epistemology.⁹⁷ Throughout the decade, Tibetan medicine's exposure in the West continued at a growing pace, with a conference on Tibetan medicine organized in Berkeley in 1982, and two important conferences held in 1983 in Venice and Arcidosso, Italy.⁹⁸ They roughly coincided with (or even triggered) a spate of publications, including most notably Fernand Meyer (1981), Terry Clifford (1984), Yeshe Donden (1986), and Tom Dummer (1988). Vincanne Adams (1988, 1992) and Craig Janes (1995) were the first scholars to introduce Tibetan medicine to the field of medical anthropology in a theoretically and ethnographically rigorous way, effectively going beyond descriptions of its medical theory, history, and pharmacology that constituted the bulk of the literature until then. Since then, the number of medical anthropological studies on Tibetan medicine has grown steadily,⁹⁹ as has that of books addressing a more general audience.¹⁰⁰

During the 1980s, Karl Lutz, the founder of the Swiss company Padma AG,¹⁰¹ offered the Dalai Lama (which meant, in practice, the Men-Tsee-Khang) a share of his company, which produces Tibetan herbal formulations for the European and American markets. While the details of the proposed deal are somewhat unclear, it eventually fell

⁹⁷ The journal stopped publishing new articles in the early 1990s, but continued for several years by reprinting its old issues in revised form before its eventual discontinuation.

⁹⁸ The conference in Venice took place from 26-30 April, that in Arcidosso from 2-7 May, 1983. It was organized by Namkhai Norbu Rinpoche, with Drs. Tenzin Choedrak, Trogawa Rinpoche, Lobsang Dolma present, as well as Namgyal Lhamo and Jigme Tsarong.

⁹⁹ For example: Adams (1998; 1999; 2001a, b; 2002a, b; 2005); Janes (1999a, b, 2001); Samuel (1999, 2001); Pordié (2002, 2003, 2008a, in press); Schrempf (2007); Craig (2007, 2008); Prost (2006 a, b, 2007, 2008). This list is not complete by any means.

¹⁰⁰ For example: Tsewang Dolkar (1990); Aschoff & Rösing (1997); Yeshe Donden (2000); Aschoff & Tashigang (2001); Tsering Thakchoe Drungtso (2004, 2006, 2007); Yangbum Gyal (2006); Lobsang Wangyal (2007); Tenzing Dakpa (2007). This list is not complete by any means.

¹⁰¹ Padma AG was founded in 1969 by Karl Lutz, whose connections with Tibetan medicine date back to 1961 or even earlier.

through, mostly due to misunderstandings and suspicions on both sides. Since then, Padma AG has remained the only company producing Tibetan medicines according to European GMP standards, and selling them, at least in a few countries, as “medicines” rather than mere “food supplements”. Both Lutz and Padma’s current director, Herbert Schwabl, have promoted Tibetan medicine at different conferences¹⁰² and on various bureaucratic levels in Switzerland, the EU, and the USA, slowly paving the way for the acknowledgement, if not recognition, of Tibetan medicine in various governmental and bureaucratic venues. Without a doubt, this serves Padma’s own commercial interests, but it also helps Tibetan medicine’s – and the Men-Tsee-Khang’s – aspirations to expand to the West.

Nevertheless, it was only at the end of the 1990s that Tibetan medicine had established itself as a medical system globally. This was signified by the so-called “First International Congress on Tibetan Medicine” organized by Pro-Cultura in Washington, DC, from November 7-9, 1998, which may not have been the first, but certainly the highest profile event of this kind since Trisong Detsen’s medical conference in Tibet in the 8th century. In 2000, an International Tibetan Traditional Medicine Conference took place from July 15-17 in Lhasa, and from November 5-8, 2003, Pro-Cultura organized the “Second International Congress on Tibetan Medicine”, also in Washington DC, where (as on the first congress) the Dalai Lama himself was among the chief guests. Since then, numerous smaller conferences on Tibetan medicine have been organized around the world, and panels on Tibetan medicine have become a fixture in conferences dealing with Tibet, medical anthropology, or traditional medicines. Several dozen Tibetan doctors today live and practice in Europe, North America, Australia, and Israel,

¹⁰² For example, Padma AG was the main financial sponsor of the conference in Venice 1983.

and there are frequent medical tours to an even larger and diverse number of destinations, whether it is Kazakhstan or Kenya, Thailand or Brazil.

* * *

Around 1998, following a medical tour to Helsinki, and upon request of local patients, the Men-Tsee-Khang sent a large number of parcels containing medicines to Finland. However, acting on a warning by EU authorities, the Finnish customs analyzed the medicines and found levels of mercury exceeding European safety norms 100,000 times.¹⁰³ This resulted in a ban on importing Tibetan medicines to Finland, which also made it more difficult to send Tibetan medicines to other European countries.¹⁰⁴ It also resulted in European newspaper headlines like “The Dalai Lama’s Medicine Was Poisonous” (Lundberg 1998). While this was a serious enough incident, it was not until 2001 that the problem of Tibetan pills not meeting European health and safety regulations escalated. In Geneva, a woman who had been taking Tibetan pills for about six months was diagnosed with severe anemia. Subsequent laboratory analyses of the pills showed a lead content of 4.2%, that is 420 times more than the Swiss legal threshold of 0.01%. Health authorities announced a warning via public media, and offered free laboratory tests to anyone concerned about the safety of their Tibetan pills.¹⁰⁵ About 120 pills were turned in and analyzed, and the tests showed not only more cases of excessive lead content, but also excessive mercury contents in 30% of the tested pills, the highest of which were 250 times above the Swiss norms. This time, the consequences were far more serious: one resident *amchi* in Switzerland, Dr. Amipa (who had nothing to do with the original case, but whose pills were among those tested subsequently) had all his

¹⁰³ Lundberg in Dagens Nyheter (24. November 1998)

¹⁰⁴ Dr. Namgyal Tsering (pers. comm. 2008)

¹⁰⁵ Direction Générale de la Santé (31. May 2001)

medicines (about half a ton) confiscated by the Swiss authorities; Swiss mass media covered the story over a period of six months,¹⁰⁶ damaging the local reputation of Tibetan medicine considerably (in fact, creating a panic among Swiss patients using Tibetan medicine); and as an indirect result, the Men-Tsee-Khang's branch clinic in Amsterdam was forced to close down, due to the ensuing difficulties in importing medicines from India.¹⁰⁷

Besides such immediate, though relatively short-lived effects in Europe, however, these cases (especially the Swiss one) triggered a veritable avalanche of far-reaching transformations of Tibetan medicine in exile, with the Men-Tsee-Khang at its center. The scandal was widely reported in exile-Tibetan media,¹⁰⁸ and even discussed in the exile-Tibetan parliament and by the Dalai Lama personally. The Men-Tsee-Khang immediately accused unnamed private doctors of quackery, while some private doctors hit back, pointing out that it was predominantly Men-Tsee-Khang doctors who traveled to Europe in those days, challenging the Men-Tsee-Khang to put names to its accusations. In the end, no names were ever publicly mentioned, and the Men-Tsee-Khang was widely seen as uninvolved in the case. Nevertheless, Men-Tsee-Khang officials were painfully reminded that as the prime representative of Tibetan medicine, their institute suffered the negative consequences of such incidents most, regardless of who was to blame. Not surprisingly, calls for some kind of regulation of Tibetan medicine in exile (which have

¹⁰⁶ According to Dr. Tenzin Namdul on Phayul.com (Namdul 2005), the incident was reported on 6 different TV channels and in 11 different newspapers across Switzerland. For example, see Tribune de Genève (Widmer July 2001; Jan-Hess 2001); Schweizer Depeschenagentur (July 5, 2001, December 3, 2001); La Liberté (July 6, 2001); News (Moser 2001); Berner Zeitung (July 7, 2001, December 4, 2001); Le Matin (Lafargue 2001); Metropol (December 4, 2001); Le Quotidien Jurassien (December 5, 2001); Sonntags Blick (Stuedler 2001); Neue Zürcher Zeitung (February 7, 2002), or Schweiz Aktuell (April 29, 2002). This list is not complete.

¹⁰⁷ While this was the main reason, there were several other factors contributing to the closure of the Amsterdam branch clinic, including tax problems of the Dutch foundation officially running the clinic.

¹⁰⁸ Reports were published in the Tibet Times, The Tibetan Review, and on Phayul.com (Namdul 2005).

occasionally been voiced since the mid-1990s) gained momentum. Pema Damdul Arya took the initiative with a proposal to the Cabinet in 2000, suggesting that the Men-Tsee-Khang should be given official control and regulatory power over Tibetan medicine in exile. This was the beginning of a heated debate over the future of Tibetan medicine in exile (discussed in detail in chapter 5), which dragged on throughout the tenures of both Pema Damdul Arya (who left the institute in 2001) and his successor, Samdhup Lhatse, who directed the Men-Tsee-Khang until the end of 2004.

Meanwhile, the institute kept expanding to well over 40 branch clinics, its doctors kept touring the world, and research on Tibetan medicine was carried out in collaboration with Indian and foreign institutions. However, the first years of the new millennium were also marked by resurfacing internal discord and the loss of several senior doctors. Among those who resigned were Drs. Namgyal Qusar and Nyima Tsering, both of whom opened successful private clinics and regularly visit the West on medical tours. A much bigger loss, however, was the unexpected deaths of the Dalai Lama's three personal physicians within a space of three years. Drs. Tenzin Choedrak (age 78) and Kunga Gyurme Nyarongsha (age 66) passed away in 2001, and Lobsang Wangyal (age 83) in 2003. With them, the Men-Tsee-Khang – and Tibetan medicine in exile generally – lost its most famous and accomplished physicians. There was, and still is, no Tibetan doctor in exile of high enough stature to fill the huge gap they left, and the position as the Dalai Lama's personal physician has remained vacant since then.¹⁰⁹ Still, during – and to no small extent due to – their roughly 20 years of service to the Dalai Lama, the Men-Tsee-Khang, the Tibetan public and countless patients around the world, the Men-Tsee-Khang had

¹⁰⁹ Since then, three to four *amchi* (all from the Men-Tsee-Khang) take turns in looking after the Dalai Lama's health (in addition to one Tibetan biomedical personal physician). They do not, however, officially hold the title of "personal physician to His Holiness the Dalai Lama".

become one of the most successful and prestigious institutes – and by far the most profitable enterprise – under the Tibetan government in exile.

Revolutionizing Tibetan Medicine in Exile (2004-2010)

In January 2004, after four years of committee meetings, Parliamentary debates, and internal discussions, the future of Tibetan medicine in exile finally seemed decided. Tibetan medicine was to be regulated, controlled, and standardized on the basis of a new constitutional Act (passed by the 13th Assembly of the exile-Tibetan Parliament during its fifth session), in order to protect both patients and Tibetan medicine's reputation from quackery, unqualified doctors, and medicines of inferior quality. At stake was, the official discourse suggested, the preservation of the unique tradition of Tibetan medicine, which was considered particularly threatened by unscrupulous, selfish private individuals ready to trade Tibetan medicine's traditional standards of quality for quick profits. While all of this was very much what the Men-Tsee-Khang had repeatedly demanded, Pema Damdul Arya's initial request for the Men-Tsee-Khang to function as the regulating body backfired dramatically. Not surprisingly, his suggestion of monopolizing Tibetan medicine in exile had generated a good amount of opposition both from private doctors and in Parliament, resulting in the foundation of a separate council to control the proper practice of Tibetan medicine, including that of the Men-Tsee-Khang. In other words, the Men-Tsee-Khang lost its unofficial but widely acknowledged authority as the highest representative of Tibetan medicine in exile, and was demoted to an equal status with all other institutes of Tibetan medicine.

The Central Council of Tibetan Medicine (*bod kyi gso ba rig pa'i ches mtho'i sman pa'i lhan tshogs*) (henceforth “CCTM”) was founded on January 5, 2004, with the responsibility to oversee all legal and policy issues concerning Tibetan medicine in exile, and to register, standardize and regulate its practice and pharmaceutical production (Central Council of Tibetan Medicine 2008). Although many Men-Tsee-Khang doctors perceived its establishment as an unfortunate degradation of their institute and personal status, at the time the change was confined to official documents. Eventually the Men-Tsee-Khang was allotted three out of eight (but de facto seven)¹¹⁰ seats on the Central Council’s executive board – a number that the Men-Tsee-Khang has since lobbied hard (and successfully) to increase to four – and it also remained the powerhouse of Tibetan medicine in exile in terms of expertise, human resources, economic power, political connections, and overall importance. In short, the underfunded, infant CCTM – which, as the Kashag has recently made clear, should not be part of the government but rather function on its own – remained largely dependent on the Men-Tsee-Khang.

Still, the mere existence of the CCTM, and the fact that for the first time the interests of private *amchi* had an official voice and representation, caused profound changes. Soon, the Men-Tsee-Khang realized that the loss of its position at the very top of Tibetan medicine in exile also had its benefits: as senior doctors have repeatedly indicated to me, it was as if not only a part of its pride, but also a part of its burden of responsibility had been lifted. Gradually, the Men-Tsee-Khang stopped deputing its doctors to oversee and grade exams at the Chagpori and CIBS medical colleges, or

¹¹⁰ The eight seats on the CCTM’s executive council were divided as follows: 3 for the Men-Tsee-Khang, 3 for private doctors, one for a government-appointed biomedical doctor, and one for the Dalai Lama’s personal physician. Since the Dalai Lama has not appointed an official personal physician since the deaths of Drs. Tenzin Choedrak, Lobsang Wangyal, and Kunga Gyurme Nyarongsha, this seat remains vacant, reducing the number of de-facto seats to seven.

issuing certificates of these institutions' graduates, as this was now the CCTM's responsibility. Also, gradually, the Men-Tsee-Khang's relations with private *amchi* normalized, as the Men-Tsee-Khang ceased to perceive itself as the guardian of Tibetan medicine's quality and reputation, which the institute had considered as perpetually threatened by private doctors. Besides, private doctors now had an official way to prove their legitimacy.¹¹¹ In short, the Men-Tsee-Khang's role and self-image – and thus the field of Tibetan medicine in exile as a whole – underwent dramatic transformations as a direct consequence of the CCTM's establishment.

There were still more changes. Samdhong Rinpoche, who had been elected Prime Minister (Kalon Tripa) of the Tibetan exile-government in 2001, decided to make the Men-Tsee-Khang independent of the CTA, in line with his 'neoliberal' agenda of reducing and disinvesting his own government wherever possible.¹¹² Effectively reversing Tsering Tashi's reform from the mid-1990s, he gave the Men-Tsee-Khang the authority to elect its own director for the first time in history. Needless to say, the Men-Tsee-Khang staff, who had long complained about the fact that non-medical professionals were managing the institute, were happy and elected Dr. Dawa in 2004 as their first "own" director. As he told me in a personal interview, Dr. Dawa has two main goals in his tenure: the construction of a Tibetan medical university for a total of 150 to 200 students, both foreign and Tibetan;¹¹³ and the construction of a new, larger pharmacy (i.e.

¹¹¹ One important sign that the Men-Tsee-Khang is rethinking its relations with private doctors is the plan to sell them medicines as soon as the planned new pharmacy (see below) is producing enough to fulfill the demand.

¹¹² Samdhong Rinpoche (pers. comm. 2008)

¹¹³ At present, the Men-Tsee-Khang admits two batches – or classes – of about 25 students each every five years. Students are selected from a large pool of applicants (which indicates the popularity of Tibetan medicine as a profession and that of the Men-Tsee-Khang as a training institution) through a rigorous selection process. Although the majority of students are exile-Tibetan (with a more or less equal representation of men and women, but only very few monks or nuns), there have also been reserved places

pharmaceutical factory) exclusively for herbal medicines, while those pills containing minerals or metals (like *rinchen rilbu*) would continue to be produced in the old, present location. He is also planning a large hospital with 150 beds, and housing for retired Men-Tsee-Khang staff. All these projects are located in Chaundara near Bir, a small Tibetan settlement about two and a half hours east of Dharamsala.

While the vision behind these very ambitious projects is clearly an unprecedented expansion of the Men-Tsee-Khang's activities both in India and abroad, much of Dr. Dawa's focus so far has remained on fundraising and creating the necessary internal structures for this expansion. The resultant neglect of international activities or research collaborations with scientific institutions during the first years of his tenure has, coupled with a lack of success in securing funding for the projects, cost him popularity among his own staff. 2008 and 2009 also saw one of the largest waves of resignations and departures of some of the Men-Tsee-Khang's most capable physicians in two decades (five resignations, one retirement, two indefinite leaves, and several doctors who are seriously considering resigning). What is more, the retirements of the remaining senior-most doctors – Namgyal Tsering, Tsewang Tamdin, and Pema Dorjee – are due in the near future. After the demise of the Dalai Lama's personal physicians, the impact of these departures on the institute's power and morale is considerable, and signals a downward trend in the minds of many of those involved.

Somewhat hidden underneath the outcry surrounding this veritable brain drain, and veiled by the grand ambitions of Dr. Dawa's projects, however, is another agenda

for Tibetan newcomers, Himalayan and foreign students (usually Mongolians or Tibetan Buddhist Siberians, occasionally Japanese), who otherwise would not have been able to compete with their exile-Tibetan counterparts – either because of the required educational qualifications (modeled after the Indian school system), or because of language skills (whether Tibetan or English). In 2006, these reserved places have been abolished.

that is less explicit, but nothing short of revolutionary. To begin with, the new pharmacy project constitutes a quiet acknowledgement that mercury and other heavy metals used in *rinchen rilbu* have contaminated the institute's regular herbal pills via the old pharmacy's pill-coating machines, as lab-tests have shown since the late 1990s,¹¹⁴ and that this problem needs to be solved if the Men-Tsee-Khang ever intends – as it does – to seriously expand to Europe or the USA. As Dr. Dawa told me,

[W]e get many requests for new branch clinics, and we look into opening new clinics in India and also abroad. But the regular supply of medicines is a concern, so we're planning a new pharmacy unit in Chaundara. [...] [W]e plan to keep our pharmacy here in Dharamsala running even when the new one is built. That's because we make two kinds of medicines: one kind is only herbal, and the other contains minerals, metals, and gems. The purely herbal pills will be made in the new pharmacy, and the other ones we will continue to produce here. That is for quality control, and also to avoid contamination, which happens if we use, like now, the same machines for both kinds of medicine.

Leaving aside the issue of contamination, Dr. Dawa has already introduced – slowly but persistently – modern quality control standards in the Men-Tsee-Khang's existing pharmacy (see chapter 7 for a detailed discussion). In 2009, he employed two college-trained Tibetan laboratory biologists and an Indian quality control specialist at

¹¹⁴ First lab-tests were done on both *tsothal*-based and non-*tsothal*-based pills by Padma AG in 1998 (Herbert Schwabl, pers. comm. 2009), revealing mercury levels exceeding European safety standards by a factor of over 1000 in both kinds of pills (*tsothal*-based pills showed higher levels, though). Presumably, the mercury traces of the *tsothal*-based pills contaminated non-*tsothal*-based pills via the Men-Tsee-Khang's pill-making machines, which were – and still are – used for both types of medicines. This information, which Herbert Schwabl conveyed to the Men-Tsee-Khang, the CTA Health Minister, and the Dalai Lama's Private Office, was met with shock but also, in some quarters (like the Men-Tsee-Khang itself), with a lack of understanding. The results were soon confirmed by the Finish customs (see above). Years later, a collaborative study by the Men-Tsee-Khang and Israeli scientists showed urinary mercury levels of patients taking *rinchen rilbu* over three times above the European threshold (Sallon et al. 2006). However, apart from one case in Geneva (see above), no adverse health effects of Tibetan pills have been observed or documented so far.

the institute's new quality control laboratory, and made quality control into a separate sub-department of the pharmacy.¹¹⁵ This sub-department now has the power to interfere in and potentially stop the pharmaceutical production process when the medicines' quality is found to be inadequate. The Men-Tsee-Khang has already, on one occasion, discarded an entire batch of medicines because it had not passed the new quality control standards – an indication that the administration is serious about the matter.¹¹⁶

What makes Dr. Dawa's move so revolutionary is a gradual transfer of authority and control over how medicines are produced and what constitutes "good medicine" – away from the traditionally trained and usually very experienced Tibetan doctors to relatively young college graduates or Indian professionals, trained not in Tibetan medicine but in modern science. Simplifying things a little, one could describe the current changes as a remarkable double move: on one hand, the Tibetan government is voluntarily giving up control over one of its most important and valuable assets, Tibetan medicine; on the other hand, Tibetan medicine (i.e. the Men-Tsee-Khang) is voluntarily giving up control (if only partially so far) over its most important products, the medicines.¹¹⁷

Needless to say, many of the Men-Tsee-Khang's doctors regard especially the latter move as a deeply troubling development, and with the tenure of Dr. Dawa nearing

¹¹⁵ Dr. Dawa (pers. comm. 2009)

¹¹⁶ Dr. Dawa (pers. comm. 2009)

¹¹⁷ This statement, of course, needs to be qualified: while the Kashag (Cabinet) under Samdhong Rinpoche wants to give up control over the Men-Tsee-Khang and the CCTM, important sections of the exile-Tibetan Parliament are resisting this move, at least as far as the CCTM is concerned. Similarly, while the Men-Tsee-Khang's current administration is slowly giving more power to young, modern scientists to decide how its medicines should be produced, several Men-Tsee-Khang doctors are extremely critical of this move. It should, therefore, be emphasized that I am here only describing a trend rather than a completed result. Apart from the Men-Tsee-Khang, private *amchi* as well as smaller institutions of Tibetan medicine may not be willing to take the same step, and are, more often than not, financially unable to do so even if they wanted.

its end, it is open to speculation whether his quiet revolution will be continued under a new director. In the long run, however, it looks like the Men-Tsee-Khang has no choice but to adapt to the international marketplace and to modern standards and requirements (like Good Manufacturing Practices, also known as GMP), which for all their national differences are a global phenomenon today. For a long time since its reestablishment in India, the Men-Tsee-Khang has remained outside both the exile-Tibetan government's and the Indian Central Government's regulatory structures, enabling it to play the role of the conservative guardian of Tibetan medicine's traditions and identity (at least in the Tibetans' – and its own – perception). As with its other roles – like acting as the representative and highest authority of Tibetan medicine in exile – this one is bound to change soon. On September 10, 2009, the Indian government decided to officially recognize Tibetan medicine,¹¹⁸ potentially bringing the Men-Tsee-Khang under the purview and control of the Indian state. At the time of writing, nobody, including perhaps the concerned Indian bureaucrats themselves, is quite sure yet what this will mean for the Men-Tsee-Khang and for Tibetan medicine in exile as a whole (see chapter 6 for a more detailed discussion). There is no doubt, however, that Tibetan medicine – despite and because of its conservative agenda of “preserving Tibetan culture” – has become one of the most dynamic fields of transformation and change in the Tibetan exile.

¹¹⁸ The Indian government's decision to recognize Tibetan medicine – or rather, “Sowa Rigpa” – does not constitute a recognition in itself, but only a declaration of intent to do so at a later date. Nevertheless, in late 2009 there was little doubt in the minds of the concerned Indian officials I talked to that this was going to happen soon, with draft syllabi and regulations already being drafted at various levels of Indian bureaucracy.

3. Politics of Compassion, Ethics of Survival

Medicine is [...] “a thread that allows people to establish connections, a tool for creating identities, and a strategy for accumulating capital and extending influence.”

Nathan Sivin, quoting Volker Scheid (Scheid 2007: xvi)

It is the new moon day of June, and a quiet hum is audible as I approach the Dalai Lama’s temple. Although it is early in the morning, the main temple room is already filled with monks, assembled in neat rows behind the abbot of Namgyal monastery, reciting the ubiquitous Tibetan mantra, *Om Mani Padme Hum*. On the large space surrounding the temple room, hundreds of Tibetans are sitting on blankets and cushions or circumambulate the temple. Like the monks’, their lips, rosaries, and hand-held prayer wheels are in constant motion, repeating the same syllables of compassion over and over: *Om Mani Padme Hum*. As I find a space between some Tibetan families to sit down on the concrete floor, a middle-aged man shoves a folded blanket my way, and a little later, an elderly lady hands me a styrofoam cup filled with hot, Indian style chai. Among the Tibetans, I have become used to not being asked the questions one learns to expect in India: where are you from, what’s your name, are you married? Instead, I exchange smiles, adjust the blanket, gratefully sip my tea against the morning chill, and soak in the relaxed, monotonous atmosphere that feels, for no obvious reason, special. And indeed, despite an absence of dramatic ritual, the occasion takes a special place in the yearly cycle of life in Dharamsala. For the next seven days and nights, the monks of Namgyal monastery, nuns from nearby nunneries, the Tibetan public, and – for one day – the Dalai

Lama himself, will collectively generate and transfer the energy of compassion, evoked by the mantra, into tiny herbal pills called *mani rilbu*.

Mani rilbu, literally “jewel pills” but more accurately translated as “mantra pills” (Tibetans refer to the mantra of compassion – *Om Mani Padme Hum* – as “*mani*”), have been known and used for a long time, with the earliest textual references dating back to the seventh Dalai Lama’s reign (Tashigang, pers. comm. 2005). While in principle there are many kinds of *mani rilbu*, with up to 100 ingredients and blessed by varying numbers of mantras in different monasteries, in the Tibetan exile the term refers predominantly to the approximately 2000 kilos of homeopathic globule-sized pills produced once every year by the Men-Tsee-Khang, and subsequently blessed at the Dalai Lama’s temple. As Dr. Tsering told me,

The Dalai Lama supported the Men-Tsee-Khang so much in its early years, when we were very poor, with his own money from his Private Office. Now that the Men-Tsee-Khang can stand on its own and is doing well, we donate the *mani rilbu* to him. For one month each year, our pharmacy does nothing else but manufacture these pills.

Indeed, on a visit to the Men-Tsee-Khang’s pharmaceutical unit (“the pharmacy”) about two months earlier, I saw millions of *mani rilbu* drying on wooden platforms similar to bed-frames in the open air. Even before they reach the temple for the blessing, the pharmacy doctors and staff already infuse them with prayers and mantras throughout the day, in addition to the usual morning prayer recited by all Men-Tsee-Khang staff. Now, in the temple, they are packed in large white cloth bags and stacked inside a pavilion-like structure near the altar and the Dalai Lama’s throne. Barely noticeable, a string connects the bags with the abbot (or the Dalai Lama, when he is present) and another monk acting

as the “mantra counter” (*mthun*), through which the power of the mantras is transmitted to the pills. The function of the mantra counter is two-fold: one, as the title indicates, to ensure that the mantra is recited exactly 100 million times (*thung*) over the course of the seven days and nights; and two, to ensure the uninterrupted continuity of the recitation. Thus, eight monks (sometimes including one or two nuns) from different monasteries work in shifts, 24 hours a day, reciting and counting *Om Mani Padme Hum*. Finally, early in the morning of the last day, the freshly blessed pills will be distributed in small quantities to all present at the temple, attracting the biggest crowd in the even otherwise well-attended weeklong event.

Mani rilbu are popular among Tibetans. They are neither sold nor publicly distributed (except on the final morning of their consecration), but given to those receiving an audience with the Dalai Lama, or to anyone making a donation to his Private Office. On several occasions, I observed Tibetans dividing up their donations in order to maximize the amount of *mani rilbu* they would receive in return. These pills are then either sent to family members in Tibet, where they are considered one of the best gifts possible by virtue of being blessed by the Dalai Lama, or they are stored away in home altars and used for a variety of purposes: curing coughs; preventing infections; as a protection before going to the hospital or other environments considered dangerous; to counteract the side-effects – or enhance the positive effects – of biomedical drugs; after having had a bad day; on auspicious days; or even to give to dogs before they die, to ensure their good rebirth. The Men-Tsee-Khang, who manufactured and donated the pills in the first place, also receives a large portion, which is distributed to the staff. Furthermore, together with other blessed or empowered substances like *sman sgrub*

(pronounced: “men-drup”), small quantities of *mani rilbu* are added to the regular ingredients of each batch of regular medicines in order to increase their potency and efficacy through spiritual means.

While all these “spiritual medicines” serve as ingestible materializations of spiritual or tantric energy, *sman sgrub* (“Accomplishing Medicine”)¹¹⁹ plays an additional role. A powder consisting of more than 100 ingredients, it is produced every uneven year by the Men-Tsee-Khang and “empowered” during up to 15 days and nights of continuous, elaborate tantric rituals at Namgyal monastery. After that, it is turned into a granulate to increase its shelf-life, which is then distributed by the Dalai Lama’s Private Office in much the same way like *mani rilbu*. A part of the granulate remains with the Men-Tsee-Khang, where it is not only added – together with *mani rilbu* – to the ingredients of its regular medicines, but also, and crucially, to new batches of *sman sgrub*. As Dr. Pema Gyatso, an expert on medicine production working in the pharmacy, explained:

We put a small amount of it in every medicine we make. We also put some of the old *sman sgrub* into the new *sman sgrub*, so there is a line. It has to be an unbroken line, then the potency is stronger. We make about 2000 kg of *sman sgrub*, and in this we put maybe half a kilo of the old *sman sgrub*. It doesn’t matter how much, it’s only important that we put it in. [...] It is hard to say when this line of *sman sgrub* started, but it was long before we came into exile. [...] Some Nyingma monasteries also do

¹¹⁹ While *sman sgrub* has been translated in many different ways, I choose Frances Garrett’s (2009) translation as it best conveys the deeper meaning of the term and does not limit itself to merely the process of medicine empowerment as most other translations do. Thus, although in Tibet, *sman sgrub* commonly refers to the practice of empowerment, the term can also denote the material product of the practice (cf. Garrett 2009: 210). In India, the second meaning is more common. For more information on *sman sgrub*, refer to Garrett (2009) and Craig (in press).

it, and they bring us some [of their *sman sgrub*], which we mix with ours.
But mostly we use the one from the [Dalai Lama's] Private Office.

Thus, as a small amount of the previous batch of *sman sgrub* is also added to the ingredients of a new batch, a material and spiritual lineage is maintained through *sman sgrub* that goes back centuries, connecting contemporary Tibetan medicine in exile with its Tibetan roots.¹²⁰ This lineage – like a metaphorical thread – not only connects the past to the present in a vertical way, but also links, as Dr. Pema Gyatso explained, similar lineages of regionally, spiritually, and politically (in the sense of the hierarchies and power structures of different sects) different – if not independent – traditions in a horizontal, centripetal way. Each pill that the Men-Tsee-Khang produces therefore contains not just a small amount of recently made *sman sgrub*, but an accumulation – however infinitesimal – of all the previous *sman sgrub* made in this lineage and others, through the past centuries until today. In other words, each Men-Tsee-Khang pill is a spiritual and material connection point, holding together all the various threads – historical, religious, cultural, political – that make up the Tibetan nation.

Mani Rilbu and Sman Sgrub

Beginning this chapter with an account of the spiritual, ethical dimension of Tibetan medicine in exile – empowered through the energy of compassion, the Dalai Lama's blessings, and centuries of accumulated tantric power – I would like to set a counterpoint

¹²⁰ Garrett writes that *sman sgrub* teachings belong to “the very earliest of revealed Treasures in Tibet, allegedly traceable back to the time of the first diffusion of Buddhism into Tibet.” (Garrett 2009: 217) The root text used in *sman sgrub* rituals – the *gyu thog snying thig* (the “Yuthog Heart Essence”) – is held to have originated with Yuthog Yontan Gonpo (1112-1203 CE), though Garrett cautions that we cannot confidently date texts to any earlier than the 19th century (ibid. 224).

to the previous chapter's linear thread of history in the conventional, Western sense. Yet, the image of the thread remains with us: not as a string of events commonly considered as "real", but as metaphorical threads, as linkages that form and hold together the various dimensions (practical and symbolic, spiritual and mundane, historical and mythical) of Tibetan medicine in exile. These threads do not end, on the one side, in the Dalai Lama's hands as he recites the mantra of compassion, and on the other side in the sacks of *manirilbu* neatly stacked in the temple: they extend beyond them, weaving invisible connections between people and pills, ethical subjectivities and political identities, spiritual and economic capital across time and space, in both longitudinal and lateral ways.

This chapter, then, aims to trace and make visible these threads between ethics and politics – and between Tibetan medicine's practical and symbolic, spiritual and mundane, historical and mythical dimensions – and explore how the Men-Tsee-Khang might weave them into the fabric of a modern Tibetan nation. I argue that the case of Tibetan medicine can serve as a particularly insightful illustration of the processes through which "traditional," pre-modern connections between politics (and business, in the next chapter) on the one side and ethics on the other are renegotiated – but not abandoned – in a diasporic context of nationalism, modernity and the capitalist market. To quote Foucault, "you can see that power relations, governmentality, the government of the self and of others, and the relationship of self to self constitute a chain, a *thread*, and I think it is around these notions that we should be able to connect together the question of politics and the question of ethics" (Foucault 2005: 252; emphasis added).¹²¹

¹²¹ See Bernard Faure (1998) for a similar use of Foucault and the idea of the thread in relation to Buddhist notions of sexuality.

Having already sketched the general link between Buddhist ethics, Tibetan cultural identity, and nationalist politics in the introduction, it is time to specify how exactly this link is established and maintained through Tibetan medicine in exile. What do little blessed pills have to do with the “disease” of exile, as Prost (2007, 2008) so aptly calls it? How is the practice of empowering medicinal herbs related to the work of imagining and governing a Tibetan nation? How, in other words, do *ethical* practices like these double as political ones, joining the self-interest of cultural survival with altruism’s concern for others?

Mani rilbu and *sman sgrub* – conceived simultaneously as practices and products – are perhaps the most striking indicators of the centrality of altruism and compassion not just to Tibetan Buddhist ethics, but also to Tibetan medicine. We have seen how the compassion of the Dalai Lama, of the monks and the Tibetan public at the temple, evoked by the mantra *Om Mani Padme Hum*, is infused in the *mani rilbu*. Similarly, like all Tibetan Buddhist practices, the tantric visualizations and prayers that empower *sman sgrub* are ideally based on altruism and compassion as their foundational motivation. Indeed, the 13th Dalai Lama described the practice of *sman sgrub* as “a method contributing to the happiness of all beings,” which “effortlessly fulfills the good of both oneself and others” (Thubten Gyatso et al. 1988: 352-354, quoted in Garret 2009: 221). The product of this practice in exile (the *sman sgrub* granulate), the *mani rilbu* and all the Tibetan pills that contain these two substances thus materialize altruism and compassion as ingestible, storable and transferable blessings and spiritual power. In this transformation of intangible spiritual energy into material objects, the Men-Tsee-Khang plays a central mediating role between the different dimensions of Tibetan medicine, and

between the Tibetans (in exile, but to some extent also in Tibet) and the Dalai Lama. It is this role that is of significance to this chapter's attempt to trace the connection between ethics and politics, between medicine and the nation, and it is this role that needs to be examined more closely.

In order to understand how the Men-Tsee-Khang's ethical practices double as political ones, it is crucial to remember that Tibetans in exile define themselves, and their nation, in terms of a moral community. That is, exile-Tibetans locate both their cultural and political identity (the latter being based on the former) in a Tibetan Buddhist ethics, regarding themselves – according to the traditional Tibetan origination myth – as the descendents of Avalokiteshvara, the Bodhisattva of compassion whose present incarnation is the 14th Dalai Lama. In the context of the resultant circular logic where Tibetan Buddhist ethics are taken as Tibetan culture, and where Tibetan culture is placed at the basis of the Tibetan nation which is, in turn, defined as a moral community, almost any ethical practice can function as a political, nationalist one in so far as it affirms the Tibetans' moral status. In the critical situation of exile, where the Tibetans' very existence as an independent nation is placed in question both rhetorically and practically by China, even the mere affirmation of the existence of a Tibetan nation (i.e. a Tibetan moral community) is a political act in the nationalist struggle for cultural survival, and in the cultural politics of nationalism. Tibetan medicine, which is widely perceived by its practitioners in exile as an ethical practice with the aim to “help the world”, and in particular *mani rilbu* and *sman sgrub*, do just that: in as much as they are successful in manifesting the altruism and compassion of Tibetan Buddhist ethics and culture, they reassert, as the Dalai Lama mentioned, the truth and existence of the Tibetan nation – not

just to others, but also to the Tibetans themselves. In other words, they help the geographically fragmented Tibetan community to imagine and experience itself as a distinct nation; they help the Tibetan government in exile to govern the diasporic community; and they make it possible to present the Tibetan nation and its political claims to others.

Of course, there are also more specific ways in which Tibetan medicine, *mani rilbu* and *sman sgrub* help produce and govern the Tibetan nation, above and beyond simply manifesting Tibetan culture. To maintain and govern the Tibetan moral community and thus nation, two things are necessary: moral bonds that keep the community united and connected to its leaders; and moral authority that enables the latter to govern their people in the absence of a state, executive powers and legal status. Especially in the critical situation of exile, both need to be constantly reasserted, strengthened and maintained. Let us begin by considering the moral bonds, the connections and threads woven by the Men-Tsee-Khang in its mediating role between the Tibetan public and its spiritual and political leaders. As we have seen above, the Tibetan public actively participates in the blessing of *mani rilbu* by adding their own mantras – their own energy of compassion – to those of the monks and the Dalai Lama, which eventually find their way into all the medicines the Men-Tsee-Khang provides throughout South Asia and beyond. However, this participation – important and indicative though it may be – is limited to only a few hundred, perhaps a thousand Tibetans in Dharamsala, and to only one week a year. In itself, it thus constitutes only a relatively weak thread linking the Tibetans as a moral community. But the Tibetan public is involved in the ethical practices of Tibetan medicine in more – and more substantial – ways than that.

Throughout the year, a large number of Tibetans makes donations of money or medicinal herbs to the Men-Tsee-Khang, enabling the institute to engage in meritorious actions – whether by donating, for its part, over a month of pharmaceutical labor and over two tons of processed raw materials (in the form of *mani rilbu* and *sman sgrub*) every year to the Dalai Lama; or by pursuing a social agenda of providing affordable health care to all Tibetans in exile (at least in India and Nepal). As I will discuss in more detail in the next chapter, the latter involves providing free medicines to poor and elderly Tibetans, newly arrived refugees, and CTA government employees, while selling medicines at a 50% concession to monks, nuns and students. In addition, the Men-Tsee-Khang regularly organizes free medical camps for Indians, including – but not limited to – the Himalayan populations, and keeps its regular medicine prices intentionally low, thus practically regulating the medicine prices of other institutes and clinics, who would lose patients if they charged more.

In short, it is largely thanks to the donations of the Tibetan public that the Men-Tsee-Khang can afford its charity and social agenda. The people, for their part, make these donations with the understanding that in doing so, they support the poor and elderly members of their community, and that the actual recipient of their donations is the Dalai Lama. This is indeed the case, as the Men-Tsee-Khang – apart from donating the *mani rilbu* and *sman sgrub* to the Dalai Lama – also dedicates the merits of helping the poor to him in order to ensure his long life.¹²² In other words, the Men-Tsee-Khang functions as a mediator between the Tibetan public’s charity and its final recipients, that is, exile-

¹²² The policy of providing free medicines to the elderly was specifically introduced with that intent on the occasion of the Dalai Lama’s 60th birthday (Tsering Tashi, pers. comm. 2009). Most Tibetans believe that spiritual merits of virtuous actions can manifest in mundane benefits like good health or a long life, and it is a common practice to dedicate or “transfer” them to others, especially the Dalai Lama.

Tibetan patients and especially the Dalai Lama who personifies the Tibetan nation. Such practices of lay people donating money, goods or labor to ethical institutions (usually monasteries, but to a lesser extent also medical institutions) have a long tradition in old Tibet, as have those of monastic or medical institutions making donations – or dedicating their merits – to the Dalai Lama.

But, as I said, the thread does not end in the Dalai Lama's hands, and the flow of charity, virtue and merit is not unidirectional, from the Tibetan people through the Men-Tsee-Khang to their spiritual and temporal leader. Rather, the Dalai Lama returns the people's and the Men-Tsee-Khang's donations, prayers and well wishes (originally directed at him) by freely redistributing them, in the blessed and potentiated form of *mani rilbu* and *sman sgrub*, to newly arrived refugees, anyone who makes a donation to his Private Office, and the Men-Tsee-Khang. These people, in turn, give them as gifts to others or send them back to relatives and family members in Tibet, while the Men-Tsee-Khang mixes these empowered substances into all regular medicines, ensuring a still wider distribution of the Dalai Lama's blessings and the exile-Tibetans' charity. What is more, not only the *mani* pills or the power of compassion flows both ways, but also the merits generated through charity and virtuous action. Exile-Tibetans make their donations to the Men-Tsee-Khang not only with the rationale of helping others, but also with that of gaining spiritual merits, the magnitude of which is directly related to the spiritual status of the recipient and to how many beings benefit from the donation. Thus, the initially small merit of an individual donating a few Rupees to the Men-Tsee-Khang is potentiated manifold by its transformation into free medicines for the poor and eventually into the Dalai Lama's long life, thus accruing extraordinary spiritual benefits for the original

donors. It is also worth noting that, considering the Dalai Lama's central role in Tibetan nationalism, his long life is not only of spiritual, but also of political value. To sum up, we can visualize this process as a circulation of altruism and compassion (materialized in the *mani rilbu*, *sman sgrub* and the Men-Tsee-Khang's regular pills) between the capillaries of the Tibetan diaspora and its heart, reinforced with each round; or as a weaving of ethical threads, connecting Tibetans across space and time to each other, their roots, and their spiritual and political leader. Ethically speaking – and from the Tibetans' perspective – this is a process of creating, exchanging and potentiating spiritual merits that result from virtuous actions, that is, actions benefitting others that are done with an altruistic and compassionate motivation. Politically speaking, this is also a process of forging and reinforcing the moral bonds that hold the Tibetans together as a nation, regardless of whether they live in Dharamsala, Lhasa, or New York.

But what about the second necessity to maintain and govern a moral community in the absence of state, executive power, or a sound legal basis? That is, what about the moral authority of its leaders, which – just like the moral bonds just described – needs to be constantly reasserted? Whether by personal choice or the combined compulsions of exile and modernity, the 14th Dalai Lama's moral authority today does not rely completely on his predecessors' status as god-kings anymore. Instead, a good part of the exile-Tibetans' love and devotion for their leader – and virtually all of the respect and recognition he commands in the Western world – is the result of the Dalai Lama's status as an example of engaged Buddhism, which emphasizes the expression of traditional Buddhist values such as altruism and compassion in concrete social and political action (see e.g. Thich Nhat Hanh 1993; Queen 2000; Queen et al. 2003). At least in its present

form, engaged Buddhism is a modern phenomenon that – in contrast to the custom of lay people donating to monasteries – did not exist in old Tibet. Yet, the Dalai Lama has been extraordinarily successful in establishing its modes of ethical practice (like charity or social responsibility) as important marks for Tibetan Buddhism’s traditional ideals of altruism and compassion – and hence for Tibetan culture – among the Tibetans in exile.¹²³ Certainly, his regular speeches to the Tibetan community in exile over the decades played an important role in this, but perhaps an even greater influence was his own example. Thus, in a clear departure from his predecessors’ practice, the 14th Dalai Lama has from 1959 onward consistently used his personal treasures to fund schools, orphanages, health centers and similar institutions, including the Men-Tsee-Khang. He furthermore ensured that these institutions similarly pursued a social agenda, catering to the needs of the exile-Tibetan population. Thus, the Men-Tsee-Khang provided its medicines completely free of charge during the early 1960s, and later maintained a policy of providing free or concessional medicines at least to some sections of exile-Tibetan society, as already described. Through such acts of charity and social responsibility, the Dalai Lama and the Men-Tsee-Khang embody Tibetan ethics and culture, and assert their moral authority to govern the nation (in the case of the former) or to represent Tibetan medicine and culture while simultaneously reimagining them both (in the case of the latter).

Of course, *mani rilbu*, *sman sgrub*, and free medicines are only some examples of exile-Tibetan confluences of the ethical and the political, and we will encounter more in the following sections. But the work of imagining and producing a Tibetan nation only

¹²³ This does not mean, however, that contemporary Tibetan Buddhism and its ethics in exile are entirely modern. As the example of *mani rilbu* demonstrated, Tibetans, including the Dalai Lama himself, continue to participate in – and appreciate – decidedly non-modern ritualistic practices.

begins with preserving a Tibetan identity (and national unity) among the exile-community, with maintaining its connection to its spiritual roots and political center, or with reasserting the Dalai Lama's (and, by implication, the exile-government's) moral authority to govern. At the end of this process, as its final goal and ultimate hope, stands not just the Tibetan nation, but a recuperated Tibetan *nation-state*: "free Tibet." To achieve that goal, Tibetans need to engage the world: the ethico-political continuum extends from techniques of governing the individual self to the Tibetan community's collective self to, finally, the non-Tibetan 'other', asserting "the truth of the Tibetan nation" on an international level. The ethics materialized in *mani rilbu* and *sman sgrub* have, as Dr. Dawa, the Men-Tsee-Khang's director, told me in a conversation, as much to do with engaging the world as with unifying the Tibetans as a nation.

DD: When we preserve Tibetan medicine, this is one of the ways in which we can preserve Tibetan identity. Some aspects of Tibetan culture, like Tibetan Buddhism and medicine, are of great benefit for all sentient beings. So this is one of the wishes of His Holiness... He says, "Tibetan medicine [...], this treasure is not just for us Tibetans, but for the whole world." [...] So this is our responsibility, and also other people's responsibility, because now the world has become global. It is your medical system just as it is ours.

SK: So in some way, helping the world – and not just the Tibetans – is connected with Tibetan culture or identity?

DD: Yes, of course. This is very clear. We always do some prayers, like *Om Mani Padme Hum*, and they include all six kinds of sentient beings. Not just Tibetans or Westerners or Chinese, but everybody is included.

In short, the little blessed *mani* pills, and the empowered *sman sgrub* granulate, not only constitute threads linking the Tibetan diaspora together as a nation or connecting

it to its political center and spiritual roots, but they also materialize the intention “to help the world” as medical substances. The Men-Tsee-Khang’s pills – containing these substantiated blessings – can be, and are, thus envisioned quite literally as medicine for the world’s suffering. The threads of *mani rilbu* and *smam sgrub* thus extend not only beyond the sacks of pills stacked in the temple on the one side and Dalai Lama’s hands on the other, but even beyond the Tibetan diaspora or the Tibetan homeland: they encompass the whole world, quietly and invisibly weaving networks that link individuals around the globe to the Tibetans and their cause. It is at this international level where the political aspect of Tibetan medicine becomes most visible and most expressly articulated by Men-Tsee-Khang *amchi*.

Representing the Tibetan Nation

As I have suggested in the introduction, the Men-Tsee-Khang is widely seen by exile-Tibetans as not only the prime representative of Tibetan medicine, but also as an important placeholder of Tibetan culture and the Tibetan nation in exile. The Men-Tsee-Khang, in other words, is expected to play a governmental role that is further emphasized by its well-known affiliation with the Dalai Lama and its insistence on calling itself “*bod gzhung smam rtsis khang*”, that is, “the Tibetan government’s Men-Tsee-Khang”.¹²⁴ However, inherent to this governmental role are several – at times conflicting – responsibilities that the Men-Tsee-Khang needs to successfully reconcile in order to live

¹²⁴ As I have shown in the previous chapter, the current exile-Tibetan administration (in particular the Cabinet) has made clear that the Men-Tsee-Khang is no longer part of the government. Nevertheless, the Men-Tsee-Khang persists in calling itself “*bod gzhung*”, and so does its public image as a “governmental” institution.

up to the Tibetan public's, the government's, and the Dalai Lama's expectations. The first and most important of these responsibilities is the obligation to conduct its affairs in a way consistent with the ethics of altruism and compassion – in short, to maintain and demonstrate the link between Tibetan medicine and Tibetan Buddhist ethics more than any other institution (or individual practitioner) of Tibetan medicine, whether in exile or in Tibet. Not only the Dalai Lama's good name or the reputation of Tibetan medicine are at stake here, both of which are connected with the Men-Tsee-Khang, but also, and especially, the Men-Tsee-Khang's success in representing (and “preserving”) Tibetan culture, and in imagining and producing the Tibetan nation. As I have argued in the previous section, for as long as Tibetanness is defined along Buddhist ethical values and the Tibetan nation is perceived as a “moral community”, any claim to represent or preserve them needs to legitimate itself by proving the subject's altruism and compassion. The Men-Tsee-Khang's role in producing, donating, and using *mani rilbu* and *sman sgrub*, its free medicines for the poor and elderly, and its generally low medicine prices all need to be understood in that light: as efforts to maintain and make visible this link between Tibetan medicine and Tibetan Buddhist ethics. It is in this way that the Men-Tsee-Khang legitimates itself as a powerful representative of exile-Tibetan cultural and political interests, and simultaneously fulfills – at least partly, since it also engages in other ethical practices we have not discussed yet – public and official expectations about its purpose.

However, there is an ambiguity, if not to say conflict, inherent in the Men-Tsee-Khang's governmental role. On the one hand, the word “governmental” itself already implies the political, as does the Men-Tsee-Khang's prime responsibility of “preserving

culture” and “asserting the truth of the Tibetan nation”. The connection between Buddhist ethics, Tibetan culture, and exile-Tibetan nationalism does not need to be reiterated here. On the other hand, however, many Tibetans in India consider “politics” as something immoral, opposed to the values of altruism and compassion. Even the ‘obvious’ suggestion (at least to a Tibet scholar) that the Dalai Lama is (also) engaged in political work makes many exile-Tibetans uncomfortable, often prompting assertions of his compassionate and altruistic motives. Partly due to exile-Tibetans’ misgivings about their own (elected or appointed) politicians, partly from their experience of Indian politics, and also partly due to China’s accusations of the Dalai Lama “doing politics” (as if this was not obvious, or somehow bad or in contrast to the Tibetans own claims of being ethical), “politics” has become a dirty word in the Tibetan exile, evoking associations with selfish motives and immoral practices. What is more, exile-Tibetans – including the Dalai Lama – have learnt from experience that overt political lobbying for the Tibetan cause closes, rather than opens, the doors to influential Western leaders, and is generally unwelcome with the governments of their host nations, in particular India and Nepal. There are, then, many good reasons for the Men-Tsee-Khang to *not* be political. Hence Dr. Namgyal’s ambivalent statement from the introduction: “We are not doing politics, but sometimes it comes automatically.” Politics needs to be denied at the same time as it needs to be practiced; the Men-Tsee-Khang needs to be apolitical in order to do its political work. Hence also the Men-Tsee-Khang’s ambivalent self-image that one frequently encounters in discussions with its administrators and doctors: as medical professionals they genuinely see themselves as engaged not in politics but in the ethical work of medicine;

yet, they are also well aware of their political role, as are the Dalai Lama and the exile government.

One of the most outspoken doctors I talked to about the Men-Tsee-Khang's political role was Dr. Tsewang Nyima, who at that time was involved in the institute's clinical research projects. A handsome man in his late 30s, he had extensive experience in research collaborations with Indian and Western biomedical institutions, as well as in representing Tibetan medicine to international audiences and the media. His office at the institute's headquarters was – like those of most other Men-Tsee-Khang doctors – a modest affair, with a small electric heater on the cheap linoleum floor struggling, with little success, to keep Dharamsala's infamous damp January cold out. Behind his desk and computer, a shelf carried binders of ongoing or completed research projects and a medley of English and Tibetan books on Tibetan medicine. The usual picture of the Dalai Lama and the Men-Tsee-Khang calendar of the current Fire Pig year adorned the opposite wall. When I told him that I was especially interested in the particular ways in which he thought the Men-Tsee-Khang fulfilled its governmental responsibilities, he explained:

See, whenever we talk about any project that has to do with culture, it definitely showcases the identity of a people. We are working on preserving our culture, so that we can tell our people, “ok, we are Tibetan, we are trying to preserve our identity.” And on the other side we are having a political massacre, a political jeopardy, where each day we are feeling more and more insecure, more and more unsure whether we can go back to our country. It's really a very pathetic situation that we are in. [...] So we have to understand the potential of Tibetan medicine: not just preserving the culture or making some money, or giving employment to thousands of Tibetan people, but also how we can use it in earning the

goodwill of the rest of the world. And also, if sometimes we are able to help the less privileged people – that’s the ethics of our medicine, you just have to go ahead and help the society, the people. So I think all of these things really come together, and we just have to make sure that we can play our own role in different fields.

When I used to work down in Delhi... There were so many people coming from the big administration offices, embassies, councils, etc. and they come to Tibetan medicine and get benefited, and from that day, they are far softer towards Tibetan people and culture! Because if someone has a health problem and can’t sleep the whole night due to pain, and comes to us and gets relief from it, it’s far better than praying to god all day! That’s how Tibetan medicine can play the role...

With this, Tsewang Nyima provided a clear sketch of the connections that I was, at that time, only beginning to see, and that were rarely discussed in such explicit terms by other Men-Tsee-Khang *amchi* I talked to: connections between the mission to preserve Tibetan identity and the Tibetan political cause, Tibetan medicine’s potential to transform medical efficacy into political support, and the role of an ethics of altruism and compassion. The gist of Tsewang Nyima’s explanation of Tibetan medicine’s political role, and of Dr. Namgyal’s ambiguous message (“we don’t do politics but sometimes it comes automatically”), was repeated to me a few months later, when I asked Samdhong Rinpoche, the exile-Tibetan prime minister (or Kalon Tripa), about whether he saw the Men-Tsee-Khang as carrying out any political function. His reply was straightforward, as he told me:

I don’t see any political function, and we should not expect one from them either. But they may have an invisible or indirect political function, in the sense that they treat influential people, like politicians, and during the

treatment they also educate them about the Tibetan situation... Later on, the patient is cured and grateful to the Men-Tsee-Khang. Thereby, he is also grateful to Tibetan knowledge and the Tibetan cause, and may become a Tibet supporter. So in this way they can gain a lot of support from influential people.

Samdhong Rinpoche's claim that the exile-government did not expect the Men-Tsee-Khang to play a political role – that any such role was merely coincidental and unplanned – does not fit well with the Dalai Lama's above-quoted affirmations of the Men-Tsee-Khang's political responsibility. Still, such general public affirmations – even if made by the Dalai Lama – cannot and should not be understood as necessarily reflecting the reality of actual practices on the ground; and indeed, Samdhong Rinpoche did not envision the Men-Tsee-Khang as a governmental institution, as I will explain in more detail later. Back in Tsewang Nyima's office on that cold January day, however, it became clear that the institute *was*, in actual practice, expected by the Dalai Lama – and thus the exile-government – to play its political role. Responding to my question about the international scope of the Men-Tsee-Khang's role, and about whether the exile-government was aware of it and perhaps even consciously utilized it, he gave me the example of a medical tour to Kenya:

[It] was His Holiness' wish that we send our doctors [to Kenya] and help the people over there. Because you see, in most parts of Africa, and particularly in Kenya, it is so difficult to organize any politics-related Tibetan activities. So one of the core-members of the Tibetan support groups in Africa, who are based in Kenya, in one of his meetings with His Holiness, he said, "we want to do something for the Tibetan cause, but since we can't do anything related with political activities, is there anything we can do?" And His Holiness said, "oh, why don't you do a

Tibetan medical camp, and see how we can help them? And then in that way we can also create awareness about Tibetan issues.” [...] It’s about trying to use the positive impact of Tibetan medicine to earn the goodwill of the people in Africa. You know, if you look at the political aspect, the whole African continent has more than 40 countries, and we don’t get a UN vote from a single one of them!

There could hardly be a more explicit affirmation of the Men-Tsee-Khang’s intended political function on the international level, and the simultaneous imperative to remain apolitical in order to carry it out. Although Tsewang Nyima chose examples from India and Africa as illustrations, it was clear that the Tibetan government’s – and the Men-Tsee-Khang’s – main focus is on the rich countries in Europe and North America, which have so far been the most forthcoming in terms of financial and – albeit very timid – political support. As we look at these quotes more closely, two distinct (but related) themes – we could say, two strategies or kinds of political technique – stand out: one is the use of Tibetan medicine as a means to generate the goodwill of others, and the other is the use of Tibetan medicine to educate them about the Tibetan situation – about, as the Tibetans would say, the truth of their nation.

Let us consider the creation of goodwill first: by helping others through their medicine, which is furthermore empowered and blessed by prayers for the benefit of all beings, the Men-Tsee-Khang participates as a central player in the exile-Tibetan government’s successful strategy of gaining the moral high ground vis-à-vis China. Accumulating what we might call ‘moral capital’ through the ethical practice of Tibetan medicine, the Tibetan government in exile is successfully winning the world’s sympathy in the ongoing public relations battle with China about the Tibet issue. Of course, as

many commentators have cautioned (Goldstein 1999; Barnett 2001; French 2008), the world's sympathy may not be enough for the Tibetans to realize their real-political ambitions. On the other hand, however, the moral capital of Tibetan medicine consists of more than mere public relations. It can be seen in continuity with a particular concept that has shaped Tibet's external affairs through much of its history: the "priest-patron relationship" (*mchod yon*), in which Tibet played the role of the 'priest', providing religious and ethical guidance – and legitimation – in exchange for the political and military protection of the patron. Although likely originating from the patronage of Tibetan Buddhist teachers by the Western Xia dynasty in northwestern China during the 12th century CE (Kapstein 2006: 85), the concept became a model for Tibet's 'foreign policy' only during the Mongol-Sakya rule from the late 13th to the mid-14th century CE (ibid: 84), which marked the first of a long line of sustained foreign interventions in Tibetan affairs (Goldstein 1999). The current Dalai Lama's and Tibetan exile-government's use of Tibetan Buddhism and medicine – both ethical practices and the prime placeholders for Tibetan identity – can be interpreted as a global expansion of the *mchod yon* model, in which the exile-Tibetans aim at engaging the international community (rather than a single nation) as Tibet's patron. Whether such a worldwide spread of "soft power" can match China's military and economic clout is highly debatable but beside the point. What I wish to argue here is simply that the exile-Tibetans' present ethico-politics, in which the Men-Tsee-Khang plays a central part, needs to be understood as following, at least to a certain extent, a well-established, centuries-old model that has shaped Tibetan political thought. As such, it is neither completely new and unprecedented, as some observers claim, nor a mere repetition of

tradition, but the specific and creative manifestation of the Tibetans' ethical and political identity (as a moral community, as 'the priest') in the modern, transnational context of exile. Both in order to assert this identity and role, and in order to use it for particular ends, the Tibetans in exile need to establish and propagate certain truths, or knowledges, about themselves as a nation. Indeed, we can examine the Men-Tsee-Khang's ethical practices of altruism and compassion not only as political techniques, but also as techniques of knowledge, propagating "the truth" about the Tibetan nation.

At first glance, it is quite clear what knowledge the Tibetans have in mind when they talk about the potential of Tibetan medicine "educating" others about the Tibetan situation: they refer to Tibet's long history and unique culture, its status as an independent nation before 1951,¹²⁵ the crimes and injustices committed by China against the Tibetan people, and the latter's struggle against Chinese oppression, for autonomy or independence. Essentially, the purpose of these truths – for they certainly are truths to the Tibetans in exile – is to counter the "lies" of the Chinese government, which portray Tibet as always having been an inalienable part of China, though one that – somewhat paradoxically – needed Chinese intervention to come out of its "barbaric" ways. Regardless of how "true" these truths and how "false" these lies – with truth and lie reversed in the Chinese perspective – the main purpose of such knowledge seems to be propaganda and counter-propaganda aimed at implanting certain truths about Tibet in the world's collective consciousness. However, there is also a deeper kind of knowledge that is produced by Tibetan medicine and its practices of altruism and compassion, which cannot be reduced to mere propaganda or image politics. Whether it is the communal

¹²⁵ Tibet's historical status as an independent nation is hotly debated and contested by historians and Tibetan and Chinese politicians alike. Most contemporary Tibetans in exile refer to the period between 1912 and 1951, when Tibet enjoyed de-facto independence from China.

practice of compassion in the blessing of the *mani rilbu*; the Men-Tsee-Khang's success in promoting Tibetan medicine and helping both the Tibetans and the world on behalf of the Tibetan nation; or the ingestion of blessed and empowered medicines that connects the Tibetans to the Dalai Lama (the incarnation of Avalokiteshvara) and to their homeland: in all these cases, the truth of the existence of the Tibetans as a moral community, as a nation, is asserted and reconfirmed, both to the Tibetan self and the non-Tibetan other. As I said in the introduction, identity politics is always also aimed at the self. For the Tibetans in exile, the truth of their being a moral community functions also as an ideal against which they measure themselves. The Dalai Lama often exhorts his people to live up to the world's high ethical expectations of them (that he himself has been instrumental in fostering), as for example in a speech to the Men-Tsee-Khang staff in 2000 (Dalai Lama 2007: 155), where he said:

We have succeeded in letting the world know about the Tibetan religion and culture, that the Tibetan nation has an ancient heritage, that Tibet is a beautiful country with a beautiful culture, and that the Buddha Dharma was flourishing there. [...] I have always boasted that the Tibetans are unique and very different. It is not good if foreigners who trust the words of His Holiness the Dalai Lama come to Dharamsala and then realize that our Tibetan culture does not live up to their high expectations.

At the same time, of course, the care of the self – that is, ethics – is always also political. In other words, *being* ethical is, in the long run, a much stronger and more sustainable way to create the image of oneself as a moral community and nation than mere verbal claims. This image not only reaffirms Tibetan identity, culture, and the nation that is constructed upon them, but, as the Dalai Lama never tires of pointing out, it

also ensures international help (cf. Dalai Lama 2007). The truth of a moral community (threatened by an “immoral” Chinese government)¹²⁶ thus implies a second truth, namely that of the Tibetans being worthy of sympathy and support. This, finally, is where the two themes or strategies expressed in the quotes above – the creation of goodwill and the dissemination of knowledge – come together in a particular constellation of modern power.

Public Health, Split Personalities and Slow Cures

For Foucault, the entire edifice of modern governance in Europe is built on the knowledge of ourselves – as humans, as a species, as a population with certain characteristics – gained through biomedicine, statistics, or surveillance (Foucault 1973, 1977, 1978, 2003c). Thus, it was the new biomedical notion (in the late 18th century) of the human body as the universally comparable, physical locus of disease and treatment that made possible the emergence of population as the site of modern political intervention. Even today, more than two centuries later, the imagination, governance and contestation of contemporary political spaces remains rooted in (albeit radically changed) biomedical notions of the body and statistical assumptions about its universal comparability. Indeed, statistical truths about biomedical bodies, generated through modern knowledge technologies, are also used as political tools in the Tibetan cause, to contest Chinese claims over Tibet.

¹²⁶ Widespread media coverage on the Chinese government’s human rights abuses, censorship, and corruption, coupled with incidents like the Tiananmen Square massacre, have significantly hurt China’s global reputation, even beside the Tibet issue.

Tibetan and international NGOs have long been documenting the numbers of Tibetan political prisoners, of those tortured, killed or disappeared, or other indicators of Chinese oppression in Tibet. This knowledge directly informs the human rights discourses used by the Tibetan exile-government, Tibetan NGOs like the Center for Human Rights and Democracy (TCHRD), and Western Tibet support groups to undermine Chinese claims over Tibet, and indirectly gain the world's sympathy for Tibetans in the public image battle against China. As Adams (1998) points out, however, the universal, individualist "human" in the European concept of human rights is different from Tibetan notions of collective subjectivity – principally, I would add, because it is based on biomedical notions of the body that are absent in traditional Tibetan medicine. In other words, while both types of practices – biomedicine, statistics and surveillance on the one hand, and Tibetan medicine, altruism and compassion on the other – generate certain truths and function as techniques of modern power, they differ in the kind of knowledge they produce. The Men-Tsee-Khang, for example, still does not measure or even discuss things like life expectancy, morbidity or mortality rates, even though the usefulness of such data is clear to exile-Tibetans. Rather than positing a Tibetan nation made up of suffering bodies, it asserts, as we have seen, the truth and existence of the Tibetan nation as a moral community. Although differently imagined, however, the Tibetan nation too has a particular notion of the body at its root.

According to Tibetan medical and religious theory, the human body – and life in general – is predicated on several factors, as the second chapter of the *rgyud bzhi*'s Explanatory Tantra explains:

How should one study the principles of the formation of the body? [...]

First, the causes of formation in the womb are non-defective sperm and blood of the father and mother, the consciousness impelled by karma (actions) and by the afflictive emotions and the assembled five elements. (Clark 1995: 47)

That is, while the physical reproductive fluids of the parents are acknowledged as the most immediate causes of pregnancy and birth, other factors like karma, the afflictive emotions, or the five elements play at least as important causal roles.¹²⁷ Thus, the *rgyud bzhi* states that “If the karm(ic factors) are not assembled the consciousness will not enter [the union of semen and blood]” (ibid: 48; all brackets in the original) – in other words, conception will not take place. Karma (*las*) literally means “action” in the sense of *ethical* conduct in which the individual habituates itself, either on the basis of “afflictive emotions” (the “three poisons” of craving, aversion, and ignorance) or positive mental states like altruism or compassion, during the continuous cycle of life and rebirth.¹²⁸ It is thus the individual’s ethical conduct – on the physical, vocal, and mental level – that shapes an individual’s life, body, and constitution; most specifically, in a medical sense, through the three *nyes pa* described in the introduction, which correspond to the “three poisons”. This also means that, while Tibetan medicine does classify several body and personality types (e.g. through the predominance of one or the other *nyes pa*), it ultimately considers each individual body as unique. Thus it is not possible, in Tibetan medical theory, to posit a uniform body that everyone shares, and that can serve as a universal object of medical treatment, statistical knowledge, or biopolitical interventions.

¹²⁷ See Garrett (2008) for the most detailed and interesting work yet on Tibetan embryology, in which she documents the close links between Tibetan Buddhism and embryology, making the latter (among other things) an ethical process and topic.

¹²⁸ The highest goal of Buddhism, which is ultimate liberation or Buddhahood, consists in a complete eradication of these afflictive emotions, and therefore a cessation of the otherwise endless cycle of rebirth and suffering (*samsara*).

To sum up, then, Tibetan medical theory posits the body as the unique, singular product of previous ethical conduct. While by no means denying or ignoring its materiality,¹²⁹ the Tibetan concept of the body is therefore fundamentally ethical. As Vincanne Adams remarks, “In Tibetan medicine, the basis for human life is not biology but ethics. Stated better, in the Tibetan view, the basis for *biology is ethics*.” (Adams 1998: 89; cf. Adams 2004: 8; Adams 2005: 96). It is this ‘ethical biology’ – this ethical body – of Tibetan medicine that forms the basis of the Tibetan moral community and nation.

Clearly, medicine – whether biomedicine or Tibetan medicine – plays an important political role by framing and shaping the way the population, as the target of modern governance, is understood and known. But beyond this epistemic, conceptual work, medicine – in the form of public health – also constitutes a crucial domain through which modern power *operates*. Public health is most commonly understood and conceptualized in terms of the application of biomedical, statistical and surveillance techniques, targeting the health of a given population made up of comparable biological (in the biomedical sense) bodies. As different scholars have shown (e.g. Foucault 1978; Rose 1999, 2007), this kind of intervention is a form of modern liberal governance in so far as it convinces people to govern and control their own behavior in the name of health, but with larger political consequences. Having said this, the question arises whether Tibetan medicine, too, functions – like biomedicine – not only as a epistemological technique of truth that shapes the Tibetan nation, but also as a domain through which

¹²⁹ Tibetan medical theory accounts for the body’s materiality in several ways. For example, there are the “seven bodily constituents” (*lus zungs bdun*) of nutritional essence, blood, muscle tissue, fatty tissue, bone, marrow, and regenerative/ vital essence. Chapters 4 and 5 of the Explanatory Tantra deal specifically with anatomy and physiology, enumerating the five vital organs, the six vessel organs, the nine orifices, as well as the number of bones, teeth, tendons, or even hairs on the body (see Clark 1995: 55-65).

exile-Tibetan governance operates. In other words, does Tibetan medicine in exile also play a role in public health?

Many Tibetans both in- and outside the Men-Tsee-Khang answered this question in the negative. One of the highest-ranking exile-Tibetan biomedical doctors in Dharamsala, for example, told me in a conversation about exile-Tibetan health care and the Men-Tsee-Khang's role in it:

The Men-Tsee-Khang obviously lacks a structured public health approach; it's very deficient in this, which is very unfortunate. They can have one if they really want to... That's where the development of the Men-Tsee-Khang is lagging behind, they are sticking to their old tradition, you know.

Samdhong Rinpoche's perspective as the head of the Tibetan exile government was similar:

What we expect from [the Men-Tsee-Khang] is advice on how to improve the public health, and what kind of health policy should be adopted by the Tibetan government in exile. This advice must come from the medical institutions and the medical people. But we are not getting anything yet.

Given the Men-Tsee-Khang's governmental responsibility "to serve the Tibetan community", its perceived lack of a public health strategy was clearly a source of much frustration and criticism on part of the current Tibetan exile-government and Tibetan biomedical experts. Even Men-Tsee-Khang doctors were quick to admit that such critiques about what is commonly seen as the Men-Tsee-Khang's unfulfilled potential – if not responsibility – are understandable and justified. Dr. Tsewang Nyima, himself one of the most progressive and "modern" *amchi* at the Men-Tsee-Khang, explained:

Since its reestablishment in 1961, the core objective of our institute was to revive and preserve the system [of Tibetan medicine] itself. This has put us on the back foot in terms of reaching a larger population and designing a strategic, sustainable program where Tibetan medicine can really work in terms of public health.

Let us not be too quick, however, in joining these critiques of the Men-Tsee-Khang, valid though they may be. In the recent years, the Men-Tsee-Khang has regularly organized public lectures, talks in Tibetan schools, and workshops for Tibetan biomedical practitioners, explaining and propagating the Tibetan medical perspective on topics like diet, behavior, or the prevention of certain chronic ailments. It is thus not entirely correct to say that the Men-Tsee-Khang does not carry out any public health initiatives at all. In light of the Men-Tsee-Khang's own rhetoric of serving the Tibetan community, however, more is expected from the institute.

At the root of the exile-Tibetan government's disappointment stands, I argue, an unreflected notion of public health that is borrowed – despite all calls for a uniquely “Tibetan” public health – directly from biomedicine and the West. Thus, the Men-Tsee-Khang is expected not merely to educate the public, but to make measurable interventions that target problems the CTA health ministry itself has only recently begun to see clearly, like for example the very high prevalence of hepatitis B among the exile population. During the time of my fieldwork in 2008, the CTA health ministry was in the process of setting up a computerized, central health registry with the help of the US Center for Disease Control (CDC), as a prerequisite for reliable statistical data on anything from the spread of epidemics, to prevalent diseases, morbidity and mortality rates – the

prerequisite, in short, for modern public health.¹³⁰ On the one hand, it is thus understandable – and even laudable – that Tibetan officials are keen to get Tibetan medicine, via the Men-Tsee-Khang, on board of the CTA’s (rather belated) efforts to improve the health of the Tibetan nation through modern public health interventions. However, while such an insertion of “traditional medicine” into a biomedical framework of public health certainly has its merits, and has been attempted elsewhere, it is also fraught with problems and rarely yields the intended public health results (cf. Oswald 1983; Justice 1984; Pigg 1995, 1997). What is more, despite their best intentions, Tibetan officials unwittingly set the Men-Tsee-Khang up for failure by expecting it to do things in a “uniquely Tibetan way” – since Tibetan culture needs to be preserved – while at the same time insisting on a biomedical concept of (public) health that is, if not incompatible, absent in Tibetan medicine. We have already seen that the Men-Tsee-Khang operates with different truths and knowledges – and therefore different notions of health, body, and population – than those upon which biomedicine, modern public health, and liberal Western governance are based.

This does not mean, however, that the Men-Tsee-Khang does not engage in a different form of public health. Indeed, as Audrey Prost argues in her analysis of Tibetan medicine in exile from a public health perspective (Prost 2008), Tibetan medicine *does* play a significant public health role. Central to her argument is an implicit redefinition of public health to include the needs of the ethical, rather than only biological, population. From the perspective of such an enlarged notion of public health, the Men-Tsee-Khang

¹³⁰ Previously, Delek Hospital and other Tibetan health care centers directly administrated by the CTA have kept their own records in a decentralized way. Even when, as in the case of the CTA administrated health care centers, these data were transmitted to the health ministry, they were only stored in archives (in paper form), but not computerized or analyzed in any way.

most certainly makes public health interventions on the population level: targeting the ethical population – the “moral community” – through a variety of means, from propagating dietary and behavioral advice (not only in lectures but in everyday clinical interactions), the communal generation of merit, making this merit available for consumption through medicines, to ensuring the Dalai Lama’s (and thus the Tibetan nation’s) health, the Men-Tsee-Khang makes important contributions to the well-being – both physical and ethical – of the exile-Tibetan public (cf. Prost 2008). The same knowledge that asserts the existence of a Tibetan moral community and nation, the same truth that proves the validity of its culture and cause, lies at the root of Tibetan medicine’s role in public health, too. In other words, Tibetan medicine’s concept of health – and the Men-Tsee-Khang’s role as a medical institution – encompasses all aspects of human subjectivity and well-being, from the physical and mental to the domains of ethics and politics. Adams describes this continuum in terms of the (ethical) body being the site for politics:

In much of Tibetan culture the body is thus an extremely visible site for politics while politics itself persistently refers to, and is transposed onto, the physical body, religion, the social collective, and more importantly, the karma that binds it. The notion of “political” that emerges in this world is expressed in ways that make it relevant when it pertains to a collective body and that body’s potential for moral responsibility to others. (Adams 1998: 92)

Indeed, for most Tibetans I have met, the idea that physical and mental health is closely related to ethics and politics – also and especially in the difficult situation of exile – was a matter of common sense and experience. This, and my argument about Tibetan

medicine's political role, is well demonstrated by the following case of Tashi and some final observations about Tibetan medicine with which I will conclude this chapter.

*

I first met Tashi – as I will call him here – in Bylakuppe. Bylakuppe is located near the town of Kushalnagar, about three hours by bus from the city of Mysore in the South Indian state of Karnataka, and is the oldest and largest Tibetan settlement in South Asia. It consists of nine old and sixteen new “camps”, that is, villages that are spread out over a large area of fertile, gentle hills covered with fields, vegetable gardens, bamboo groves, and patches of lush jungle. The settlement is home to the large monastic colleges of Sera Jey and Sera Mey, as well as the important Nyingma monastery of Namdroling, the golden, rainbow-adorned roof of which can be seen sparkling from far away. The first impression of a peaceful and relatively prosperous rural idyll quickly fades, however, as one gets to know the local Tibetan community better, many of whose members struggle to make ends meet. One of them was Tashi, who worked twelve-hour days as the caretaker of the guesthouse I stayed in, for a meager salary of 2500 Rupees a month (about 54 USD). Unmarried at the age of 30, he lived with his mother and sister in a one-room hut with a leaky roof, his income supplementing the 3000 Rupees a month the family made from selling the milk of its four cows. One day after work, Tashi asked me if I wanted to join him for a ride through the settlement on his motorbike, and visit him at his home.

The same evening, over a dinner of okras and beef, Tashi told me about his life. He had received ten years of guerilla training in the Indian army,¹³¹ during which time he

¹³¹ The Indian army secretly trains thousands of Himalayan and Tibetan youths in guerilla warfare, to fight behind the lines in the case that Indian territory – that is, parts of the Indian Himalayas – be occupied or

used to dream of fighting the Chinese. One day, however, he read a book by the Dalai Lama that effected a drastic change of his mind: convinced now that violence was not the solution, he left the army and joined his mother and sister in Bylakuppe. His military training, however, could not be erased from his mind so easily. As we got ready to go back to the guesthouse on his motorbike, he gave me two steel bars connected with a chain – forming a close-combat ninja weapon – to carry. Seeing my puzzled look, he explained that robberies and hold-ups by “Indians” (he left open the question whether they were bandits plaguing the whole area, or “normal” villagers specifically targeting the Tibetans) were rife on the settlement’s deserted roads after dark. Only recently, he said, a Tibetan had been killed for about 1000 Rupees. As we drove along the dark settlement roads, I felt slightly ridiculous with the ninja-weapon in my hand, but also flabbergasted at the difference of our respective perceptions of the same place: to me, Bylakuppe seemed the epitome of rural peace and tranquility, while for him, it clearly was a bleak and dangerous place far from a home he had never seen. Safely back at the guesthouse, I handed the weapon back to Tashi and asked him whether he knew how to use it at all. I immediately realized that this was a silly question: flashing some quick and lethal strokes in front of my nose, he remarked that he could easily take on up to four Indians in a fight.

The next day over breakfast, Tashi told me about his two goals in life, between which he alternated: to provide his sister a good life, and to gain freedom for Tibet. Furthermore, when he thought about Tibet, he was torn between the violent path he was trained in, and the peaceful path advocated by the Dalai Lama. Tashi was frustrated by

conquered by an enemy force (i.e. China or Pakistan). Some of these troops are regular members of the Indian army, others function as sleeper cells, living regular lives in their Himalayan villages and only occasionally attending training camps.

the sense that he might not be able to fulfill either of his goals, and this, he told me, created tensions in his mind that resulted in headaches, sleeplessness, and hot sensations in his palms and soles. His *amchi* had told him that his problems were related to *rlung*, that is, that they were a “wind disorder” (probably combined with *mkhris pa*, or “bile”) caused by excessive worry, frustration, or anger. He noticed that whenever he thought about using bombs against the Chinese – they were so insincere and inhuman, sometimes violence seemed the only solution! – his mental agitation and physical symptoms got worse.

In Tashi’s case – and the Tibetans’ case in general – it does not take an anthropologist or an *amchi* to diagnose connections between physical, mental, moral, social, economic, and political suffering. Tashi was acutely aware of them himself, not as a result of his *amchi*’s explanations but as a matter of common knowledge that I encountered among a majority of Tibetans I talked to. Indeed, in a questionnaire survey I conducted in 10 different Tibetan clinics all over India, of 72 Tibetan patients,¹³² 63 agreed with the suggestion that ethical conduct affected an individual’s health (87.5%), 7 stated that they did not know whether that was the case (9.7%), and only 2 said that there was no connection between ethical conduct and health (2.3%). Those who agreed mostly reframed the questionnaire’s statement and explained that mental agitation – caused, among other things, by unethical conduct – most certainly had a negative effect on health. Furthermore, over a third of them (35%) explicitly used the term *rlung* to either refer to

¹³² Although an effort was made to give equal representation to both genders and all age groups, men were slightly overrepresented due to the occasional reluctance of (especially younger) women to be interviewed (42 men, 30 women). My general observation was that there were no significant age or gender differences in who would visit a Tibetan clinic, although there were slightly more older patients. The common explanation of this was not that old people preferred Tibetan medicine, but that they tend to have more – and more persistent – health problems. An effort, too, was made to cover both Men-Tsee-Khang as well as private clinics (out of the 10 clinics, 4 were private). The questionnaire survey was conducted between May and August 2008 with the help of a Tibetan interpreter.

mental agitation or its connection – as one of the three *nyes pa* – to health; others, though they did not use the term, mentioned typical causes or symptoms of *rlung* disorder like excessive worry or thinking, sleeplessness, or certain kinds of head-, back-, or stomach-aches. Several respondents related personal stories similar to Tashi’s, and one even went so far as linking Tibetan medicine’s efficacy to the patient’s ethical conduct. Interestingly, informal conversations with Tibetans who never used Tibetan medicine revealed opposite results, that is, a majority of them did not believe there was a connection between ethical conduct and health.

In the context of Tibet, Adams (1998, 2001a) and Janes (1999) have repeatedly argued that *rlung* – both as a medical concept and a concrete disorder – can fruitfully be interpreted as expressing political and economic inequities, as well as pointing to the existence of a moral community of Tibetans. Thus, Janes (1999: 92; quoted in Prost 2006a: 121) writes,

[I]n Tibetan culture, the category of *rlung* encompasses the political as part of bodily suffering, and as expression of the social and moral connections between people. Its expression in ailing Tibetans thus reveals that they experience subjectivity as at least partially collective, based on notions of karma and an inseparation of body, mind and society.

However, Prost (2006a) takes issue with these analyses, critiquing Adams and Janes for obscuring “the particularities of Tibetans’ understandings of health behind a gloss that extends the Buddhist outlook onto the whole of Tibetan life,” and thus participating in the orientalization of Tibetans. At least in exile, she argues, Tibetans do not universally regard suffering as collective or caused by politics and karma. Prost is certainly correct in pointing out that Tibetans are a shrewd and pragmatic lot, who strategically use different

theories of causation depending on the situation – something that Adams and Janes have themselves pointed out repeatedly in their oeuvres. However, her otherwise valid critique is based on a misreading of their arguments: Adams and Janes claim that Tibetan subjectivity – not necessarily their ill health or suffering – is collective, ethical, and political; and that, too, not at the expense of common, everyday individualism. In the context of Tibetan exile, at least, this is entirely correct, as I have tried to show in this chapter. As Tashi and countless other Tibetans in India struggle with physical ailments and mental tensions, with poverty, political frustration, and even, at times, ethical uncertainty, Tibetan medicine provides not only medicines that effectively alleviate clinical symptoms, but equally importantly an epistemological framework in which Buddhist ethics are transposed to the register of health and disease. The goodness of being ethical, and the suffering of being unethical, thus turns from a mere religious or philosophical claim into an individual’s undeniable personal experience. Buddhist ethics – and thus Tibetan culture and identity, and in final consequence the Tibetan nation – become real.

Tashi’s story also serves as an important reminder that even though Tibetan identity is defined along Mahayana Buddhist ethics, this does not mean that all Tibetans are perfectly compassionate, selfless, non-violent Buddhists (cf. Adams 1996). Similarly, it is important to remember, once again, that Tibetan nationalism is not a single, homogeneous phenomenon, and certainly not all “traditional” and Buddhist. As I have mentioned, various exile-Tibetan governmental and non-governmental institutions operate, at least to some extent, on the basis of common Western notions of politics that are in turn rooted in biomedical notions of body and population. In addition to four

personal physicians practicing Tibetan medicine, the Dalai Lama also has, with Dr. Sadutsang, a biomedical personal physician, besides relying on regular high-tech health checks and tests performed in India's elite hospitals in Mumbai and Delhi. What is more, even within Tibetan medicine, the use of biomedical anatomical charts in the training of new doctors, or the increasing influence of the germ theory in Tibetan etiology indicates slow but real changes in the concepts of body and health (Prost 2006b, in press).

One could say, then, that there are two parallel concepts or imaginations of body and nation at work in the Tibetan exile. The exile-Tibetan body and nation is split into a 'modern' and a 'traditional' part – the former defined by exile, Chinese oppression, and modern science, the latter by a collective Buddhist morality, unique irreducible bodies, and old Tibet. One could further say that this split itself is modern, with a sense – and reality – of loss (of their country and self-determination) at its core (cf. Adams 2001a). The conceptual split thus parallels an actual one, which involves the separation of exile-Tibetans from their homeland, their families, and their ancestral properties – or vice versa, the separation of the Tibetans living under Chinese occupation from their spiritual and temporal leader, the Dalai Lama. More than that, occupation and exile have resulted in the perception of a split between nation and state: while neither existed in a modern form before the Chinese invasion, Tibetans today conceptualize their loss of sovereignty as a loss of their *state*, the recuperation of which constitutes the long-term goal of Tibetan nationalism. To keep this distant dream alive, however, the Tibetans' more immediate struggle consists in surviving as a nation while they live as second-class citizens under the Chinese state in Tibet, as non-citizens (but refugees) under the Indian state, or as scattered immigrants to the rich nations of the West. It could be said, then, that the

ultimate aim of Tibetan nationalism is to undo the fragmentation, to merge what was separated: the modern and the traditional self, the people and their territory, and ultimately, the nation and the state.

This, then, is the Men-Tsee-Khang's crucial role in the Tibetan cause: to heal the split that its patient – the body of Tibetan culture and nation – suffers from by helping to imagine a unified, modern, yet traditionally Tibetan nation. That “traditional medicine” is asked to heal such splits in postcolonial nations is nothing new, as Langford (2002) and others have shown. The aim of this dissertation, however, is to delineate exactly how the Men-Tsee-Khang accomplishes this task. Common wisdom holds that Tibetan medicine is not a quick cure: it takes time to heal, but addresses the root of the disease rather than its symptoms. Like so often, such common wisdom is largely the result of common practice, in this case that of turning to Tibetan medicine only as a last resort, having tried everything else (or nothing) while the disease has grown chronic, complicated, and hard to treat. And so it is with this patient and this malaise, too. At the root of a unification of the people and their territory, the nation and its state, lies the cure of the ‘split personality’ (one part modern, one part traditional), the recuperation of a healthy Tibetan identity. It is a subtle, slow cure, easily overlooked by those searching for bold political action that directly confronts Chinese oppression or clamors for Tibetan independence. Its efficacy untested in clinical trials, there is no proof whether it will work or not. Yet, there is no doubt that without it, the Tibetans would lack more than just bitter pills for bodily and psychological sufferings; they would be worse off not just as individuals prone to illness, but as a community and nation in crisis. In trying to cure the conceptual separation between the modern and the traditional (body, population, nation), Tibetan

medicine in exile provides an essential precondition for the ultimate cure, however far in the future it may lie, of merging nation and state in a free Tibet.

4. The Business of Altruism

It's about body, mind and money!

Dr. Tsewang Nyima, on Tibetan medicine

Even in religion-saturated India, there are not many places where spirituality and business come together in as fertile a symbiosis as in Dharamsala. While it was the orientalist lure of Buddhist wisdom represented by the Dalai Lama and the Tibetan exile-community that initially attracted tourists to this all but forgotten hill station in the 1970s and 1980s, today Dharamsala is just as famous for its Yoga schools, Vipassana meditation retreats, New Age healers, or workshops offering instruction in anything from the Kabbalah to Kundalini. Business is thriving in this bazaar of spirituality, with Tibetans, Indians, and foreigners all competing for a share of the market. Amidst the hundreds of signs and flyers littering the walls and lampposts of McLeod Ganj, advertising spiritual goods and activities of all kinds, it is easy to miss the small yellow poster on the wall of a residential building opposite the post office on Jogiwara Road. The poster announces Tibetan language classes for students of all levels; anyone interested is welcome to meet the instructor, Pema Youdon, at her home in the same building.

I met Pema Youdon within a few weeks of my arrival in Dharamsala. She was an enterprising, outgoing woman looking younger than her 50 years, and well known among generations of foreign students for her skill in making one think, talk, and understand

colloquial Tibetan within the space of just a few hours. As I got to know Pema better during our daily conversation classes, I soon realized that her relative success in attracting a steady stream of well-paying students only barely covered the reality of a hard life, common – in various forms – to so many Tibetans in exile. Left with two young children and no financial support by her husband in her early 20s, Pema had been forced to work for over a decade as a carpet weaver at the Tibetan Handicrafts Center, earning just enough to make ends meet. Although nowadays her financial fortunes have somewhat improved with her job as a language instructor, and her adult children have moved out and are supporting themselves, the years of sitting in a semi-dark, damp hall knotting thin woolen threads into colorful carpets have left their marks: today, Pema relies on Tibetan medicine to manage her arthritis and other chronic ailments resulting from the hardship and poor working conditions of that time.

As the weeks went by, and we were searching for new conversation topics for our class, I learned to appreciate Pema for something else than her jovial nature and her teaching skills. Spending her days – when she was not giving classes to students – sitting in front of her apartment opposite the post office or walking the *kora* (the circumambulation path around the Dalai Lama’s temple and residential compound), she quite literally had her finger on the pulse of McLeod Ganj’s Tibetan community. In this community, where fragments of news and rumors spread faster than the Dalai Lama’s car could make it up the hill from the airport, Pema was a reliable source for the complete accounts on the events, gossips, debates, and “public secrets” that moved Tibetan sentiments and opinions. I, of course, was particularly interested in what Pema had to report on Tibetan medicine, especially because I knew that she regularly got her

medicines from the Men-Tsee-Khang, although she lived only a few steps away from both Yeshe Donden's and Lobsang Dolma's private clinics.

One day, as we discussed the Men-Tsee-Khang's purpose and function, Pema muttered beneath her breath: "The Men-Tsee-Khang is just selling medicines. They are doing business, there is no other purpose." She was disgruntled about the prices of the medicines she took daily, and especially about how expensive the Men-Tsee-Khang's herbal products, like the hair and massage oils that she used regularly, had become in the recent years. Perhaps discomforted by my interest in her offside critique, she quickly added, "just joking," pointing out that the Men-Tsee-Khang not only gives away a lot of free medicine (though not to her), but also that its medicines are far better than those of any of the private *amchi* in the area. Responding to my question about why she thought so – especially in view of highly experienced and respected doctors like Yeshe Donden in and around Dharamsala – Pema explained that the Men-Tsee-Khang used better ingredients than others. This, she said, was because it had better sources of raw materials, receiving them as donations from Buddhist peoples across almost the whole length of the Himalayas. In return, these people received *mani rilbu* from His Holiness. Besides, the Men-Tsee-Khang could afford, and was in fact morally obliged as His Holiness' institute, to buy all required ingredients, even if they were hard to find or expensive. For several minutes, she continued to defend the Men-Tsee-Khang in an effort to play down her earlier remark, talking at length about its "special" medicines, that is, pills that required special tantric rituals or needed to be prepared in full-moon light. Finally, though, she concluded her comments by returning to her initial offside: "for sure, they are making a lot of money."

Had I not been familiar with the Men-Tsee-Khang *amchi*'s discourses on money and business by that time, I would have been surprised: if indeed the Men-Tsee-Khang was earning a lot of money, it was surely only participating in McLeod Ganj's most important economic sector, that is, the business of spirituality and healing. In other words, it was only doing what half the town was doing or trying to do – not to mention the fact that trade and commerce have been important parts of the traditional economic system in old Tibet. Yet, for Pema, there was clearly something problematic about that. Somehow, in her mind, doing business stood in opposition to what she thought the Men-Tsee-Khang's *should do*, that is, to its 'real' purpose. Pema's ambivalence about the Men-Tsee-Khang offers some good hints about what she thought its 'real' purpose was, or should be. Defusing her initial criticism about the Men-Tsee-Khang "just doing business", she talked at length about its 'good' medicines – that is, about their ethical (given for free to the poor), pharmaceutical (best quality and efficacy), and spiritual (blessed with tantric rituals) nature. The pills stood for the whole: as the most easily accessible product of an otherwise opaque institution, the Men-Tsee-Khang's medicines materialized and manifested, for most Tibetans, its character and purpose: to serve the community; to preserve the tradition and quality of Tibetan medicine; to instantiate Tibetan culture via ethical practices. It was this role, this good image, that was marred, in Pema's mind, by the Men-Tsee-Khang's business activities and the very wealth that, by her own admission, enabled the institute to fulfill its role in the first place.

Pema was not alone in her ambivalence about the Men-Tsee-Khang, and in perceiving a tension between the institute's economic and its social/cultural/ethical responsibilities. Nyima, for example, the prosperous owner of McLeod Ganj's most

successful Tibetan massage parlor a few hundred meters down the road from Pema's place, told me: "The Men-Tsee-Khang started out helping the Tibetans, they gave medicines for free. But now, they only want to do business. [...] And the Men-Tsee-Khang is rich, like the Indian Railway Ministry! They are the only institute of the Tibetan government that has money. But," he concluded, "they make the best medicines." To him, like for Pema, the quality and efficacy of the Men-Tsee-Khang's pills was the paradoxical benefit of the institute's wealth they otherwise saw as a moral flaw. Although most people were reluctant to criticize an institution bearing the Dalai Lama's name and providing them with effective medicines for their physical and psychological sufferings, Pema's and Nyima's ambivalence accurately reflected real tensions within the Men-Tsee-Khang's role and self image. Like the ambiguities surrounding the institute's political role described in the previous chapter, they resulted from conflicting responsibilities the Men-Tsee-Khang was obliged to fulfill. Unlike the institute's political role (which tended to interest only a small minority of Tibetans), however, its economic actions attracted a much larger public interest that the Men-Tsee-Khang had no choice but to address.

In many ways, the conflict that Pema – and even, as we will see, the *amchi* themselves – perceived between making money, or being rich, and being morally "good" in a Buddhist sense, is a new phenomenon. Looking back in the history of Tibet and its monastic and medical institutions, the obvious wealth of these institutions was hardly regarded as morally problematic, least of all within the framework of Tibetan Buddhist ethics. To the contrary, as elsewhere in pre-modern Asia, their wealth was often taken as a sign of their spiritual or ethical status and power. It was only with the arrival of modernity via Chinese anti-feudalist propaganda in Tibet, and the arrival of the Tibetan

refugees in modern, independent India with its materialist critiques, that the connection between money and morality became problematized and increasingly needed to be justified. Indeed, there has been a paradoxical shift in the exile-Tibetan struggle to preserve Tibetan culture. In the 1950s and 1960s, it was the Chinese communists – and their battle against private business and feudalism – who posed the most serious threat to the Tibetan nation and its culture. In the Indian exile, and out of immediate danger as far as the Chinese military was concerned, the Tibetan refugees soon found their cultural heritage threatened by a host of other difficulties, one of the most serious of which was a lack the money and resources. Gradually, however, as the financial situation of Tibetans in exile improved (and especially as Tibetan medicine’s economic potential became apparent), money and capitalism transformed from being necessary means to preserve Tibetan culture – and even, as trade and private property, parts of the traditional Tibetan economic system – into threats against Tibetan culture. So radical was this transformation that, according to Tsering Agloe Chukora in the magazine *Tibetoday*, commercialization has even replaced the Chinese communists as Tibetan culture’s biggest enemy:

Unfortunately, the Tibetan Sowarigpa that once survived the ideological holocaust of Mao’s China is now facing its toughest enemy and opponent both inside and outside Tibet. Physicians like Dr. Pema Dorjee and Dr. Namgyal Qusar maintain that the ills of greed, neglect and the commercialization of the Sowarigpa tradition in and outside Tibet would do more harm in the long run when it comes to preserving the authenticity and the professional expertise of the Sowarigpa tradition. (Chukora 2007: 14)

How did it come to this? How, exactly, do greed and commercialization harm Tibetan medicine? And what are the consequences of this radical – and recent – redefinition of

business and commerce into markers of moral decay? Beginning with the tension outlined above, this chapter will answer these questions by tracing the ethical dilemma from its gross manifestation in public perceptions and the Men-Tsee-Khang's institutional rhetoric to the more nuanced level of the *amchi*'s discourses and Buddhist ethical theory. In doing so, it will particularly examine the novel ways in which exile-Tibetan *amchi* redefine traditional Tibetan connections between business and morality in order to ensure Tibetan medicine's financial *and* cultural survival in the modern context of capitalism.

Subduing Capitalism

I have suggested in the introduction that the Men-Tsee-Khang's prime responsibility was to preserve and promote Tibetan medicine and Tibetan culture, and that this dissertation would examine how, in doing so, it centrally participates in imagining, producing and representing a modern Tibetan nation. I have also suggested that a vast majority of Tibetans in exile define their culture along Mahayana Buddhist ethics, with altruism and compassion as its central virtues. And we have seen how the Men-Tsee-Khang attempted to fulfill its prime responsibility by instantiating altruism and compassion – in form of its pills – as tangible, real threads that connect Tibetans across space and time, unifying them around their political and spiritual center, the Dalai Lama. That it is accomplishing this task with considerable success is evidenced, indirectly, by Pema's and Nyima's assertions about the superiority of the Men-Tsee-Khang's medicines. However, their simultaneous ambivalence – not to say outright criticism – also shows that this success is far from complete, as the Men-Tsee-Khang's virtues, so painstakingly manifested in the

spiritual-medical realm, are threatened to be undermined by the institute's mundane business of making money. Indeed, for most Tibetans today, capitalism and business have replaced rituals as the most convenient and best-established markers of the presence or absence of altruism and compassion: if capitalist interests are there, Buddhist ethics is not, and vice versa.

Hence the Men-Tsee-Khang's public emphasis on "not doing business". Indeed, if there was one statement that was even more ubiquitous in the institute's doctors' and administrators' discourses than "helping the world", then it was the categorical negation of capitalist interests and greed: as Dr. Tashi Norbu put it, "we are a government institution – we are serving the people, we don't think about business." Especially in my early conversations with Men-Tsee-Khang *amchi*, I was struck by their repeated affirmations of both institutional and personal altruism, accompanied by explicit denials of selfish motivations. I soon realized that I, the foreigner and 'representative' of the West, was not the main target of these claims: the West was considered hopelessly capitalistic anyway, and my seemingly naïve questions about what was wrong with making money did not help in changing this perception. They were, rather, mostly aimed at the Tibetan exile-community and even, as a kind of self-affirmation, at the institute itself. Exile-Tibetan society at large and the Men-Tsee-Khang in particular tended to be very quick in passing moral judgments against those perceived to serve their own capitalist interests while supposed to work for the common cause. Thus, Dharamsala's gossip is replete with disapproving stories of government-sponsored or -trained individuals who, given half a chance, would use their skills for selfish ends rather than for the Tibetan exile-government. As we will see below, the Men-Tsee-Khang's

discourses about *amchi* leaving the institute (after having received free education there) to set up their own, more lucrative private practices follow the same pattern. Given this common equation of capitalism and business with selfishness and anti-social behavior (at least in certain contexts), it is not hard to intuitively understand the problem about the Men-Tsee-Khang doing (or being perceived as doing) business. However, it is worth scratching the surface of such all-too-simple equations and explanations, as they gloss over both the wider aspects and the subtler nuances of business and capitalism in exile-Tibetan medicine. Mere selfishness, in itself, may be morally deplorable, but hardly justifies the lengths to which a large and powerful institution like the Men-Tsee-Khang goes in publicly denying any intentions to do business. So what, exactly, is wrong with doing business?

As we discussed this question, Samdhong Rinpoche, the exile-Tibetan prime minister, evoked the benefits of tradition in Tibetan medicine:

SR: The way of treatment [in Tibetan medicine] should be preserved in its original form. Only then will it be beneficial to humanity as an alternative system of healing. The greatest challenge is commercialization. Commercialization means maximizing the production of medicine – maximizing and mechanizing, both – and when you are maximizing the production, then naturally you use the raw materials in a different way. Then they will not have the same effect as it is taught in the treatises. So the preservation [of the Tibetan medical tradition] is absolutely important, and for that, the teaching system and the treatment system should be properly regulated...

I frankly believe that at least two things can't [i.e. should not] be commercialized. Number one is the spiritual heritage: it cannot be commercialized. Number two is the traditional health system, health care: it can never be commercialized. The basic thing is that commercialization

means looking for market and profit. Looking for market and profit means the healing of the patient is not the real object. The selling of medicine is the real object. [...] So disease is your capital, and so you never work for a disease-free society or disease-free persons. You need disease in order to keep your job and in order to keep your profit. And that is fundamentally wrong. [...] So that is why I say that commercialization is the biggest challenge for the Tibetan medical system and for the Tibetan spiritual heritage.

SK: But to some extent it is going on, this commercialization, both in medicine and in Buddhism...

SR: It is going on! So I tell my friends, you have opened Dharma-shops everywhere!

Although Samdhong Rinpoche's (neo-) traditionalist and anti-business stance was well known and quite controversial even within his administration, as far as Tibetan medicine and Tibetan Buddhism were concerned, his explanation summed up the public's as well as the *amchi*'s sentiments well. What was wrong with capitalism and commercialization was its imperative for profit, its underlying logic of money not simply being a means to another end, but an end in itself. For Samdhong Rinpoche, it was commercialization that stood behind the changes – the maximization and mechanization – that Dr. Lhawang la had referred to, in an earlier conversation, when he reflected on what he perceived as a gradual decrease of the Men-Tsee-Khang's medicines' quality and efficacy over time: “[In the early days,] we did everything by ourselves, by hand, but the medicines were more effective. It's like food: if it's home-cooked, it's the best. Also with medicines, if you make them by hand, they are more effective.” To Dr. Lhawang la and Samdhong

Rinpoche, machines might be faster and more convenient; but as far as food and medicines went, they were inherently inferior to old-fashioned manual labor.

Dr. Tsering, too young to have witnessed Men-Tsee-Khang medicines being made by hand in the 1960s, was more concerned about another aspect of tradition mentioned – albeit only indirectly – by Samdhong Rinpoche:

Today, everything is becoming a business. If you don't do anything for the people, they won't give you anything. So when patients are coming, we have to charge them. Then we feel less compassion, because it is becoming more like business. And the patients don't respect us so much, because they are paying... We develop in the same way like the world is developing. And so, while we are developing the system and the facilities, compassion is getting less.

In Tsering's perception, commercialization and business thus not only erode Tibetan medicine's efficacy – which, as I will show in more detail in the next chapter, is directly linked to Tibetan culture and the Tibetan cause – but also undermine the patients' faith and respect in Tibetan medicine and, most importantly, diminish the *amchi's* compassion. One might add, as many other *amchi* told me, that the search for markets and profits is not easily compatible with an altruistic mindset either. Given the important place of notions of altruism and compassion in exile-Tibetans' identity claims, and their manifestation as medical efficacy as far as Tibetan medicine is concerned, it finally becomes clear why capitalism is such a problematic issue for the Men-Tsee-Khang: charged with the responsibility to preserve and promote Tibetan identity and culture, the institute cannot – must not – engage in their very destruction. In the minds of many exile-Tibetans, including most *amchi*, the Men-Tsee-Khang's role is thus clear: preserve

Tibetan medicine and culture – and since commercialization is perceived as the biggest threat to this, resolutely resist the temptations of the capitalist market.

In reality, of course, things are hardly this simple. As even Pema Youdon and Nyima acknowledged, money is necessary in order to produce good quality medicines. Besides, as Tsering lamented, it is hard for Tibetan medicine to remain completely untouched by an ever more capitalistic world, especially as its enormous economic value and potential become increasingly clear. As he and Samdhong Rinpoche implied in their explanations about the dangers of capitalism, Tibetan medicine is indeed becoming more and more preoccupied with money. Of course, one could argue that if anyone in the field of Tibetan medicine could remain at least somewhat sheltered from the pressures and dynamics of the capitalist market, it would be a governmental institution like the Men-Tsee-Khang – all the more so if the government is headed by someone as opposed to Tibetan medicine's commercialization as Samdhong Rinpoche. But this is where the problem lies: in contrast to CTA biomedical institutions like Delek Hospital or the Tibetan primary health centers in the settlements, the Men-Tsee-Khang receives no government funding at all. As Dr. Phuntsog Norbu from the Men-Tsee-Khang's *Rgyud Bzhi* Translation Department told me in a conversation about the institute's stance on business:

As long as the Men-Tsee-Khang is under His Holiness' guidance, it will never go more on the line of business. Never. Of course, these herbal products, this money earning... has to be done, because the Men-Tsee-Khang has no funding at all from the Tibetan government, so it has to survive on its own. So a little bit of business has to be done. But, cultural preservation and business will go side by side, this is for sure! Absolutely no doubt at all!

From the next desk, his colleague Dr. Dawa Lobsang added with some pride and just a hint of an accusation in his voice:

The Men-Tsee-Khang is the biggest institution outside Tibet, yet there is no funding from the Tibetan government, it is very self-sufficient. Delek Hospital gets all the Tibetan government funding. Sometimes His Holiness donates some money or precious minerals for the medicines, but other than that, we are completely self-reliant.

In order to generate enough income to fulfill its ethical responsibilities as a governmental institution – to serve the Tibetan community, to preserve and promote Tibetan medicine and culture, and to “help the world” – the Men-Tsee-Khang is thus forced to act as a capitalist entity on the market. In other words, the Men-Tsee-Khang needs to simultaneously play two roles that are commonly perceived as incompatible: as a governmental institution, it is supposed to preserve Tibetan medicine and culture (which, as we just heard, are threatened by commercialization), but in order to earn the money to do so, it has to act as a private capitalist entity. It is this dilemma that explains the tensions and ambiguities in the Men-Tsee-Khang’s role and identity. It is this dilemma, too, that explains the wide spectrum of criticisms that the Men-Tsee-Khang had to face: whether too commercial or not commercial enough, too political or not politically engaged enough, too conservative or not conservative enough – the Men-Tsee-Khang is in a position where it finds it almost impossible to please everyone. Not surprisingly, at times the Men-Tsee-Khang itself was not quite sure about what to do. As one private doctor with good insights into the institute told me, when I asked him about what he

thought the Men-Tsee-Khang wanted (commercialize or not): “I think they are in a state of confusion.”

However, despite its understandable moments of confusion, and despite the inevitable range of opinions and perspectives within the institute (which is in fact smaller than in most other comparable institutions), Men-Tsee-Khang doctors were, beneath their public denials of business interests, as clear about how to square making money with preserving their culture and ethics as their private colleagues. After all, if Tibetan medicine could not do any business at all without committing cultural suicide, the fate of Tibetan culture would be sealed in today’s capitalist world. Indeed, in both Buddhist theory and Tibetan medical practice, ethics and money are not mutual opposites, but as compatible with each other as Tibetan ethics and politics are. Not surprisingly for a society that has long excelled in trade and commerce, Tibetan attitudes concerning business are more nuanced than Samdhong Rinpoche’s quote would suggest. Take Dr. Tenzin Damdul, for example, whose big car and swanky private clinic near Dharamsala, not only symbolize his success as a doctor (and entrepreneur), but also attract a generous share of behind-the-back criticism for allegedly selling out Tibetan culture. In a discussion about the ethics of contemporary Tibetan medicine in exile, he told me:

You see, doing business in itself is not unethical. It is also advised in the *rgyud bzhi* that we should make money at the right time, but with a sense of contentment. If you have excess, then it’s a problem. If you have what you need, then it’s a good thing, but if you have more than that, it becomes a problem. Because then you start to see yourself as more important, and others as less important. And with that, commercialization and ego-problems start. So the need is more important than the desire.

Back at the Men-Tsee-Khang, Dr. Tsewang Nyima specified the crux of the issue:

I think the main thing is the motivation. I would definitely not say that the business point of view is not important. Because it is important, we need to have a sound financial security, so we can go ahead and do more work. But being mainly interested in the commercial aspect can really do a lot of damage to Tibetan medicine. It's happening to some extent, but it's not really on a gross level that could effect Tibetan medicine at the moment.

What Tenzin Damdul and Tsewang Nyima tried to explain, then, was that business and money in themselves were not unethical. What counts, rather, is the attitude, the motivation: if one practices medicine, for example, with an altruistic and compassionate motivation, and as a result becomes rich, there is no moral problem at all. In fact, as Dr. Tenzin Damdul correctly pointed out, Tibetan medicine's standard text, the *rgyud bzhi*, is surprisingly pragmatic when it comes to matters of wealth or power. Thus, its section on ethics explicitly mentions "happiness, power, wealth and prosperity" as the temporal results of practicing medicine (Men-Tsee-Khang 2008: 304), cautioning physicians to "accept food, money or measures (of grain, etc.), for if this is deferred (then later when the patient has) forgotten the kindness rendered to him (by the doctor) he will offer nothing to repay him." (Clark 1995: 232f; parentheses in original) This is especially important because in order to produce good medicines, an *amchi* or institution needs adequate funds to be able to afford all required ingredients, which can be very expensive. If, on the other hand, one practices medicine only with the intent to earn money or become rich, then regardless of one's practical skills or knowledge, one is considered a bad physician in both the moral and the clinical sense. Again, the *rgyud bzhi* is very clear

on this: “(One who) out of desire [for material gain merely] assumes the guise (of a physician) is a destroyer of life.” (Clark 1995: 229; parentheses in original)

Before examining this last quote about “destroyers of life” more closely, let us recapitulate. If the ethical issue lies not in doing business but in the actor’s motivation, then the problem becomes slightly less intractable: avoiding the lose-lose situation of having to choose between financial and cultural survival, the doctors are now confronted with the problem of how to ensure that the motivation is right. After all, even for Tibetans, the capitalist market is a slippery slope as far as motivation and ethics are concerned, and everybody knows how easy it is to deceive even oneself – let alone others – about one’s motivation. While money and business could be made with a good motivation, the intention behind capitalism and commercialization was by definition only that of making profits. This problem has not escaped the *amchi* at the Men-Tsee-Khang, and it explains the unease of many – despite the above-quoted, well-known passages in the *rgyud bzhi* – when it comes to business. Tsewang Nyima, for example, who belonged to the ‘modern’, liberal end of the Men-Tsee-Khang’s spectrum of perspectives, told me:

I always joke with my friends: It’s about body, mind, and money! Most people talk only about body and mind, but while talking about body and mind, they are only focused on money... There is a great chance that down the road, Tibetan medicine – provided that it has all these unwanted objectives and desires – might end up in the same soup [that Ayurveda is in today because of its commercialization]. [...] It’s so easy for any institution to get carried away when you’re all of a sudden at the center of focus. Over the last couple of decades, Tibetan medicine has enjoyed a lot of popularity and attention. So we really have to make sure that along with all this attention, acceptance and popularity, we are also very aware of our

high responsibility, and that we need to have a lot of commitment [to our cause].

As both Pema Youdon's criticism and the *amchi*'s own admissions indicate, the Men-Tsee-Khang was indeed susceptible to this danger. I became aware of this early in my research, in 2005, when I visited Dr. Tsering in Gangtok, where he worked at that time as a resident doctor. One evening, on a stroll through the tranquil hill town together with Dr. Tsering Jigme, his classmate who was then stationed in a nearby branch clinic, Tsering told us that he had recently received a letter from the Men-Tsee-Khang headquarters in Dharamsala. The letter had asked him to explain why his branch clinic received so few patients, and Tsering had replied that they should be happy, because the low patient numbers meant that people were getting cured by him and did not need to come back. We all laughed at Tsering's dry wit, although Tsering pointed out that the Men-Tsee-Khang's administration was not going to be convinced by his explanation. Indeed, he and Kunga agreed critically, the letter showed that the administration cared less about the health of the population than the profits for the institute: after all, as Samdhong Rinpoche would point out three years later, less patients meant less income. While Men-Tsee-Khang doctors, including Tsering and Kunga, tended to view their administration as at times carried away – though only moderately so – by capitalist motivations only to be pulled back periodically by the Dalai Lama's pressure, for Samdhong Rinpoche, the Men-Tsee-Khang was already hopelessly commercialized. The prime minister told me in 2008:

I do not see much hope for the big institutions [like the Men-Tsee-Khang]. The big institutions have their own logic. They say, we have to maintain the institution, we have to pay the salaries of our staff, we need to

maintain all the machinery and houses and all this, and we need money, and therefore we have to commercialize.

Needless to say, the Men-Tsee-Khang administration saw the situation in a different way. On the one hand, of course, they were well aware of the connection between the Men-Tsee-Khang's lack of government funding and its resultant necessity to generate income through business – a connection that Samdhong Rinpoche had conveniently chosen to overlook in his criticism. On the other hand, as I showed above, they did not posit commercialization in direct opposition to Tibetan ethics and culture, and therefore did not see the situation as hopeless. Compare, for example, Samdhong Rinpoche's previous statement with the following quote of Dr. Namgyal Tsering, the Men-Tsee-Khang's deputy director:

We have to think a little bit commercially. We have to pay the staff, we have to buy the ingredients, and so on. But one shouldn't always think about the money, without thinking about the patients, that's wrong. Actually both sides are necessary: a little bit commercial, but the main thing is to think about the problems of the patients, how we can cure them, how we can help them... To think, maybe he will recover, maybe I can cure his problem... so this is a strong desire, this should be the motivation. Otherwise, for example when making medicine, and there are ten different ingredients in the recipe: if the doctors only think about money, if they don't easily get two or three real ingredients, then they put some substitutes, and if they don't find the substitutes either, they will substitute the substitute, and so on...

With this, we come back to the *rgyud bzhi's* statement about those who, assuming the guise of a physician only for material gains, are “destroyers of life”. As Namgyal

Tsering's explanation just showed, this statement is not meant as a dramatic metaphor, but coincides with the widespread opinion that the medicines of profit-minded physicians are – if not necessarily life-threatening – quite likely of inferior quality. More fundamentally, the *rgyud bzhi* as well as Namgyal Tsering point to a clear connection between motivation and practice. As a bad motivation manifests in bad practice and bad medicines, and good motivation in good practice and medicines, the question of how to judge the motivation with which Tibetan medicine is practiced can thus be answered. The following excerpt from the same conversation with Namgyal Tsering illustrates the point nicely.

SK: Where do you draw the line? When do you say, now it's too much commercialization, now the motivation is only money? One can do the same thing, but the motivation can be this or that, so it's hard to tell, no?

NT: It's both the motivation and the practice. Some people may say, we have to do that for the patients, but that's just outside, practically they do wrong things. It's very important they go together, motivation and practice.

SK: So what you're saying is that as long as the medicines are made correctly, according to the tradition, and as long as the patients are benefited and not harmed, even commercialization is ok?

NT: Yes. Yes.

Clearly, then, making mere verbal claims about one's good motivation – as in, “we don't do this for business”, or “we are here to help the world” – were not enough, but rather needed to be proven in practice. But even good medical practice and good medicines did not seem to be enough for the Men-Tsee-Khang to remove doubts about its intentions and ethical status, as Pema Youdon's or Nyima's ambivalence shows. The

Men-Tsee-Khang was thus under pressure – from large sections of its own staff, the exile-Tibetan public, the CTA, and the Dalai Lama – to constantly reassert its ethical nature, that is, its altruism and compassion, not only in the medical, spiritual or political spheres, but above all in the domain of money and capitalism. For as we have seen, in a context where good medicines are both the product and visible proof of good (ethical) motivation and sufficient monetary resources, the Men-Tsee-Khang was in an ambiguous position where it needed to prove both its wealth (its *capacity* to afford even expensive ingredients) and its altruistic motivation (its *willingness* to use expensive ingredients). In short, the Men-Tsee-Khang needed to show, without denying its economic success, that it did not just practice medicine for money. How does it do that?

To begin with, the Men-Tsee-Khang strategically withholds and disseminates information about its finances (cf. Prost in press), leaving most Tibetans ignorant about the institute's fortunes. Of course, CTA and Indian income tax auditors are well informed about the Men-Tsee-Khang's annual turnover and profits, which were about 39,900,000 Rupees (886,700 US\$) and 20,000,000 Rupees (445,000 US\$) respectively in the fiscal year 2007-8. Also, when I finally dared to directly ask a high administrative staff member of the institute about these figures near the end of my research,¹³³ he had no problem giving me the approximate numbers while on record. For most everyone else, however, it is exceedingly difficult to obtain even a vague sense of the institute's profits, annual turnover, or medicine production – data that are considered, in the words of one Tibetan doctor working for another institute, “the big X-file” in the Tibetan exile community.

¹³³ Audrey Prost (in press) had made the mistake of asking for this information at the beginning of her research at the Dharamsala Men-Tsee-Khang, causing the director at that time to deny her permission to conduct her research. Aware of this, I avoided the question for a long time (it was not central to my research anyway), and was surprised by how easily I was given the information when I finally did ask.

Although, as we have seen above, the *rgyud bzhi* itself encourages physicians to obtain adequate remuneration, it seems that the Men-Tsee-Khang prefers – at least as far as the Tibetan public is concerned – to keep the X in the file, lest its image as a “charitable institution” be disturbed by 8-digit figures of profits. Clearly, the Men-Tsee-Khang is aware of its modern dilemma of having to mediate others’ perceptions that making money equals being greedy.

On the other hand, the Men-Tsee-Khang openly demonstrates its altruism by engaging in charitable activities and publishing detailed accounts of them in both Tibetan and English. Thus, the Men-Tsee-Khang provides on an ongoing basis free medicines to poor and elderly (above 70 years) Tibetans, newly arrived refugees, and CTA employees; monks, nuns, and students receive medicines at half the price. Even its regular medicine prices are kept low, despite exploding production costs: the prices for some medicinal raw materials double every year, labor costs rise, new equipment and technologies need to be bought. In addition, the Men-Tsee-Khang frequently organizes free medical camps for Indians (including, but not limited to, the Himalayan populations), and pays the maximum tax to the Tibetan exile-government. In Dr. Dawa Lobsang’s words,

When we calculate all this in money, it is a huge amount. [...] We have some clinics in the cities, where we can get more money, but in many places in the Tibetan settlements or remote areas [where most people are poor or elderly], it is absolutely a service, sometimes there it doesn’t even pay for the doctors. So I think this is a great achievement.

In contrast to its profits, the Men-Tsee-Khang did not keep such achievements secret. According to its *Information Guide* (Men-Tsee-Khang 1999: 45-47) the institute provided 5.17 million Indian Rupees (ca. 123,000 US\$) worth of free or concessional medicines in

the year 1997-98, an amount that doubled to 10.67 million Rupees (ca. 237,000 US\$) ten years later, according to its 2007-8 annual report. Referring to such reports, the Dalai Lama jokingly remarked in a speech to the Men-Tsee-Khang in 1998 (Dalai Lama 2007: 134f):

Your annual report boasts of various achievements and seems to reflect a complete absence of selfish endeavors, as if everything you did was directed to the welfare of others. I don't know if this is believable. But even if one's acts are 50% or 60% selfish, then at least the other 50% or 40% are for the benefit and wellbeing of the society. Therefore it is excellent if you all work very hard and with a strong dedication and determination.

Both the Dalai Lama's skepticism about the institute's claims, and his appreciation of its actual social work were justified; even his "estimate" (no doubt he was aware of the exact figures) of the Men-Tsee-Khang's extent of practiced altruism and compassion was accurate. While the above amounts – in US Dollars – may not sound much for Western standards, they constituted just over one quarter (26.7%) of the Men-Tsee-Khang's total turnover – and over one third (34.8%) of its net profits – for the same time. With the voluntary CTA tax of around 10% not included in these figures, it is clear that the Men-Tsee-Khang is serious about giving altruistic service, which goes well beyond the usual tokens of "social responsibility" or "community service" common among Western companies or corporations concerned about their public images.

By skillfully employing financial information and a substantial part of the institute's earnings according to the logic of Tibetan medical and Buddhist ethics, the Men-Tsee-Khang thus reinterpreted the act of doing business from being categorically

opposed to Tibetan ethics and culture to a necessary – and acceptable – means to preserve it. At least in the discourses and minds of exile-Tibetan *amchi* who struggle to fulfill both mundane necessity and ethical ideal, capitalism could be subordinated to Tibetan culture and turned from a dangerous rival into a useful servant – much like the wrathful demons tamed by Tibetan Buddhist saints to protect the Dharma. This is a common and recurring image in Tibetan Buddhist legend, with Tibet itself being depicted as a demoness pinned down by strategically placed Buddhist temples, and the Tibetan people as the descendants of the union between an ogress and an ape (the latter a manifestation of the Bodhisattva of compassion), whose demonic heritage is balanced and held in check by Buddhist compassion. In Tibetan Buddhist theory, altruism and compassion are thus perfectly compatible with doing business or politics, and their combination is in fact the sign of ideal ethical livelihood and government. And yet, ethical ambivalence – expressed so well by Pema Youdon – remains the Men-Tsee-Khang’s defining feature. Victory against the ‘demons’ of capitalism is far from accomplished, and even optimistic, ‘modern’ *amchi* like Tsewang Nyima regarded the loss of Tibetan identity through capitalism as a real danger. Still, despite the overwhelming odds, the Men-Tsee-Khang has not lost the battle yet.

The Men-Tsee-Khang’s most fundamental task, then – what all its discourses and practices described in this and the previous chapter aim for – is to make possible, to re-imagine and manifest the otherwise merely theoretical connection between politics, business, and Mahayana ethics in the modern world. In other words, it is expected to practice an ethics that is politically and economically sound; to engage in a kind of politics and business that is based on altruism and compassion; and to produce, in the last

consequence, a modern nation that is genuinely, traditionally Tibetan. Of course, this is by no means an easy task: politics and business have acquired bad names; people's intentions are easily – and imperceptibly – corrupted; and both institutions and individuals find themselves grappling with conflicting interests and desires. Nowhere is this more the case, and nowhere does the Men-Tsee-Khang's ambivalent nature become more visible, than in its relations with private doctors.

Hot Profits and Cold Wars: the Men-Tsee-Khang and Private Doctors

That the Men-Tsee-Khang's relations with "private doctors" – *amchi* who run their own private clinics and are unaffiliated with the Men-Tsee-Khang or any other institution – were troubled became clear to me very early in my research: although Men-Tsee-Khang doctors largely avoided explicit criticism – especially when directly asked – their disapproval was tangible between the lines or even in occasional comments. Similarly, I noticed how some private doctors I talked to seemed to overly emphasize the Men-Tsee-Khang's authority, with a hint of unexpressed resentment. As I learned to know both Men-Tsee-Khang and private doctors better, and even became friends with some of them, they became more outspoken in their criticisms of each other. Still, the question of what lay behind this "cold war", as Dr. Tsewang Nyima called it, kept puzzling me: the common explanation, invoking the private doctors' ingratitude and selfishness on the one side, and the Men-Tsee-Khang's arrogance and monopolistic aspirations on the other – though true in many ways – did not seem to go deep enough. Indeed, as I was to find out, the Men-Tsee-Khang's difficult relations with private doctors were closely linked to Tibetan medicine's political and economic aspects, and to the Men-Tsee-Khang's

conflicting responsibilities. The “cold war” was a visible manifestation, a result of the Men-Tsee-Khang’s ambiguous role in the multifaceted context of Tibetan medicine in exile: one could not be understood without understanding the other. In my research, it was only through trying to sort out these tensions that I gained a full understanding of the Men-Tsee-Khang and Tibetan medicine in exile; vice versa, the strained relations between the Men-Tsee-Khang and its private competitors can only be fully understood in the context of what has been said so far in this and the previous chapter. In this section, I will trace this relationship from its most apparent level to its less visible dynamics, before concluding the chapter by looking at its renegotiation and consequences in the last section.

At the most apparent level, the tensions between the Men-Tsee-Khang and private doctors revolved around the problem of commercialization as a barometer of ethical commitments. Despite occasional accusations against the Men-Tsee-Khang in this regard, the institute has managed to resist its complete commercialization both in practice and in public perception. That is, its inevitable partial commercialization has been balanced – to a large degree due to the Dalai Lama’s direct or indirect influence – by the institute’s service to the Tibetan community, whether through its charitable programs, its low medicine prices, its College offering free¹³⁴ training in Tibetan medicine to exile-Tibetans, its clinical studies, or its lobbying for the Tibetan cause all over the world. On the other hand, as Dr. Pema Gyatso pointed out, private doctors are unable – even if willing – to do the same:

¹³⁴ The Men-Tsee-Khang has provided free education in medicine and astrology since its inception. In 2007, however, it began charging its new students tuition and boarding fees, for reasons described in the next section.

I think the Men-Tsee-Khang is more important than other Tibetan clinics, because it works more effectively in Tibetan medicine. If you only work as an individual, you only care about your clinic, you cannot do anything else. But if you work at the Men-Tsee-Khang, the institution works very strongly in Tibetan medicine, and your work is more effective than that of a private doctor.

Incapable of engaging in ethical work at a level even remotely approaching that of a large institution like the Men-Tsee-Khang, it is thus the private doctors who bear the brunt of criticism, both from the public and the Men-Tsee-Khang, for commercializing Tibetan medicine. Unlike Pema Gyatso's explanation, however, such criticism is based on moral judgment rather than structural factors involving things like financial capacity. One of the most outspoken Men-Tsee-Khang doctors was Dr. Tsewang Nyima, whose feelings were representative of the Men-Tsee-Khang's view as a whole, and even – in a milder form – of widespread public opinion. The following excerpt is from the same productive conversation in January 2008 on business and politics I quoted from above.

SK: When you say this commercialization is going on to some extent, where is this going on? Private practitioners, or also in the Men-Tsee-Khang?

TN: Private practitioners. I mean, the Men-Tsee-Khang is such a big organization, not internationally, but in terms of Tibetan culture centers and organizations, it's quite big. It has far more turnover per year than any other Tibetan organization. Yet, due to the fact that we have the patronage of His Holiness, it's always so, so uneasy to be completely commercial. [...] [Despite some commercializing tendencies in the Men-Tsee-Khang's administration], I think that so far, the Men-Tsee-Khang has really been working well, we have been giving massive amounts of free medications to elderly people, I'm sure you know about all these things... lots of social

work. Privately, however, we are losing track, we are really losing track. For example, if it's me, and we earn only like 5000 or 6000 Rupees a month here,¹³⁵ and all of a sudden I get an offer from someone in Europe or America – it's really happening so much these days! – “Why don't you come over there for a month and see patients and give some talks, and then you can go back with 150,000 Rupees!” Wow! Ok! I can only earn this money here in two years, and I get it in a month! And I might go once or twice, but once you get trapped in that tangle, it gets more and more tangled. So, it keeps on increasing actually, and it's not good, because... I don't have any reservations against any private Tibetan doctor going around with suitcases full of medicine and earning lots of money. But I have a reservation when they forget about how much they have to give back to the system itself, or how much they can contribute to the society. If you earn ten lakh [i.e. one million] Rupees, which is a lot of money for one individual, how much money do you want to give back to Tibetan medicine? Because whatever you are able to do, it's completely due to the blessing of Tibetan medicine, and Tibetan medicine is not something one can pretend, it's a cultural treasure. So when people go and make lots and lots of money and forget to give something back, then they get detached from their own root. I think that's really a problem now. [...]

Most of the private doctors who are not working with the Men-Tsee-Khang have graduated from the Men-Tsee-Khang. I sometimes have fired up discussions with some of the doctors with whom I used to have a very good relationship – some of them are even my relatives – and I always tell them, “Even if you had a sour relationship when you resigned from the Men-Tsee-Khang, just because one or two people who happened to be director at that time weren't administrating properly, and you were really down and depressed and said, ‘ok now I quit’... You need to understand

¹³⁵ In 2008, the salaries of Men-Tsee-Khang staff have been raised to be in accordance with those of other CTA employees. Since then, Men-Tsee-Khang *amchi* earn between 8,000 and 10,000 INR a month, depending on their rank, position, and additional allowances. Overtime work, as is very common in the busy clinics in big Indian cities, is paid extra.

that whatever you are now, whatever you have now, the respect, the fame, the money, everything, is solely due to Tibetan medicine, it is solely due to the Men-Tsee-Khang! You don't necessarily have to be biased, but you have to know where you came from." Everyone should have that understanding. [...] We still have plenty of doctors who really think positively, but there are a few black sheep... some of them are very senior doctors, and they are laying down a very bad example. [...]

There is always this kind of cold war, misty atmosphere when it comes to the Men-Tsee-Khang and some of the private doctors making all this money. It can't really go on like this for a long time, because then you lose focus on the main objective. [...]

So the important thing here is to knock on the heads of these people and say, "Guys, listen to us, you are not really doing the things that you are supposed to do! Because whatever you are, you got six years of completely free education!" – Now, since the last batch it has changed, they have to pay some fees, but before – "You were taken care of, looked after just like kids are by their parents!" And it's not only that. We are in a very critical situation, where we must not even think about selfish goals at the expense of Tibetan medicine or the institute that has taken care of us. So each medical student, each young graduate doctor needs to have that understanding, that awareness.

For Tsewang Nyima, the overriding motivation for Men-Tsee-Khang *amchi* to leave the institute and open their private clinics was clearly money: the prospect of earning up to 30 times more than the meager Men-Tsee-Khang salary is an attractive temptation indeed, especially for *amchi* already frustrated with the Men-Tsee-Khang's administration or institutional structure. Had the Men-Tsee-Khang made it almost impossible for its graduates to open private clinics due to Lobsang Samten's policy of not selling any medicines to private doctors, the possibility to earn hundreds of thousands of

Rupees abroad made it much easier for *amchi* to do so today: they could now afford to rent or buy a clinic, hire the necessary staff, and either set up their own pharmacy or buy their medicines from one of the private pharmacies around Dharamsala. In line with the general exile-Tibetan perspective on commercialization, however, for Tsewang Nyima the problem with private doctors was not the act of making money per se, but the selfish motivation behind it. The private doctors' inability to even remotely match the Men-Tsee-Khang's altruistic services was here reinterpreted from a lack of capacity to a lack of willingness, thus proving the initial accusation of selfishness and greed. In short, rather than merely their actions, the entire concept of a private doctor – based as it was, for Tsewang Nyima, on selfish motivation – appeared as morally wrong.

In the exile-Tibetan context, where Buddhist ethics, Tibetan culture, and nationalism are merged, this is an especially serious issue that goes well beyond mere accusations of losing one's Tibetanness along with one's altruism and compassion, important though that may also be. The Men-Tsee-Khang being a training institution as well as a regular clinical institution, one of its most important priorities has always been to ensure an adequate supply of human resources – in form of well-trained doctors – for its medical work and overall development. The loss of its brightest graduates (for it is mostly the best who leave) thus has grave implications for the institute, which not only loses its investment in their training (which was free until recently) but is generally weakened as an institution. The problem is thus not only moral, but also economic, and above all cultural. As the Men-Tsee-Khang remains exile-Tibetan medicine's flagship institution in terms of both preserving and modernizing its traditions, the perception – common among many Men-Tsee-Khang doctors – that the mere act of leaving the

institute is harming and undermining Tibetan medicine as a whole is therefore, at least to some extent, justified.

For a long time, however, the problem was framed exclusively in ethical-cultural terms, while its economic and structural components remained unaddressed in both discourse and practice. Thus, in a 1994 speech at the Men-Tsee-Khang, the Dalai Lama said: “It is disheartening and discouraging to see many of you developing your experience under the wings of the institute, and then use them as wings to fly to greener pastures.” (Dalai Lama 2007: 56) Four years later, in another speech at the institute, he added: “If [...] out of greed one thinks of earning big money abroad, then this is pathetic. This will mar the essence of our Tibetan culture.” (ibid.: 135) While greed, selfishness, or economic considerations were (and are) certainly important reasons for doctors to leave the institute, they were by far not the only ones. The following three cases of Men-Tsee-Khang graduates – one still working for the institute, one in between leaving and staying, and one working as a private doctor today – illustrate the various considerations – economic and otherwise – behind such a move. Consider Dr. Tsering Jigme, for example, who today works as a resident doctor in a Men-Tsee-Khang clinic in Nepal. When I first met him in 2005, on the same evening in Gangtok where Tsering recounted his response to the administration’s letter, he told me:

Today the *amchi* face a dilemma: it’s clearly written in the *rgyud bzhi* that we shouldn’t practice medicine for business [i.e. with the motivation to make profits]. But the Men-Tsee-Khang salary is not enough if we have a wife and children. Now, for me, it’s ok, because I’m a bachelor, but later this will be a problem, and I will have to think of a solution. Many Men-Tsee-Khang *amchi* go abroad and practice in the West for one month each year, in their holidays, to earn money. In one month there, you can earn

60,000 Rupees or something like that, that's a lot. Here, we only get 6,000 Rupees a month, but with the money from the West, it's ok. I don't feel drawn to go to Europe or America at the moment. Maybe when I marry, it will change. But anyway in that situation, whatever you do is a problem – you either don't have enough money for your family, or you do what you know you shouldn't do: practice medicine for money. But we have no choice.

Dr. Tsering Jigme's problem was not only the low salaries offered by the Men-Tsee-Khang, but much more profoundly about where to draw the line between earning an income to support oneself and one's family and making profits for the profits' sake. As Dr. Tsewang Nyima had pointed out – and as everyone knew from those who did travel to the West regularly – this line was easily and imperceptibly crossed; there was nothing that corrupted one's motivation as quickly as a suitcase full of dollars or Euros. Aware of that, Dr. Tsering Jigme enjoyed his life in South Asia and put off the decision of whether to move to the West for later, despite the better money and having close family relations there.

Dr. Tashi Dhargye, a jovial and energetic resident doctor at one of the institute's South Indian branch clinics, was faced with a related, but different dilemma. One evening, after a long day of meetings and appointments, I met him in his guest room in the CCTM headquarters in Dharamsala. I mentioned that I heard he might move to America soon, whether that was true... Yes, he replied, this was a difficult issue for him:

I don't know what to do. My family lives in America, and my two children are now entering high school there. This is the time when they really need me, to do well at school and get into a good college. So my wife is pressing me hard to move to America for at least five years. For some

amchi, it doesn't matter much. They don't care if Tibetan medicine disappears in the sky or goes under the ground – that's one saying we have – as long as they can practice, treat their patients, and earn a living from that. So for these *amchi* it doesn't matter much if they leave to America or stay here. But I am in a position where I can actually do something for our system, where I have a responsibility towards it, and I also have the motivation, personally, to do what I can in this respect. But I'm still undecided. My kids need me now – if I didn't go, what will they say afterwards? They will say, “our father wasn't there when we needed him most...” But I don't know, I also have a social obligation here, to do something for Tibetan medicine. [...] And I have many patients in [South India] who need me. There are many serious or chronic cases, so many cancer patients and other things, asthma, even AIDS... I have been treating many of them for a long time, and they depend on me. [...] Anyway, I thought about spending half a year in India and half a year in America, as a compromise, but that is also very difficult. For my patients, and also for the Men-Tsee-Khang – where can they post me if I'm gone for half the year? So this is also no solution. For many, moving to America means going to greener pastures... But frankly speaking, I don't want to go to the greener pasture.”

Like Dr. Tsering Jigme, also Tashi Dhargye would have been happy to remain with the Men-Tsee-Khang and the CCTM in India, money not being an important consideration for him at his present stage of life. However, in contrast to the former, his family obligations clashed with his professional obligations (and passion) as a doctor. Dr. Tashi Dhargye ended up taking an indefinite leave from the Men-Tsee-Khang – thus not entirely severing his ties – and moved to America, occasionally visiting Dharamsala for important meetings. The third *amchi*, Dr. Tenzin Damdul, had already left the institute several years ago and is, as mentioned above, now running a successful private clinic

near Dharamsala. For him, there was another important consideration about becoming a private doctor, besides the obvious economic benefits:

I'm on my own, I can do whatever is possible to learn Tibetan medicine. If I had stayed at the Men-Tsee-Khang, I would have to do whatever they want me to do, and that's it. I'd attend my office at 9 and leave at 5, and it's finished. And I could always put blame on others if things go wrong; here I can't blame others, I do everything myself, I must lead. This way I learn a lot. This is one thing. Another reason is that it's also important for Tibetan doctors to represent the old tradition. Our ancestors practiced in this way, the genuine way – they made their own medicine, they had their own students, they had their own patients, everything. And from my experience, in these eight years, I learned a lot.

Dr. Tenzin Damdul here mentioned several drawbacks that are common to many governmental institutions worldwide: in an environment of complete job security, ossified structures, endless bureaucracy, and a culture of “keeping one’s head down” (and pulling those down who don’t), mediocrity reigns while innovation and effort are discouraged. Under such working conditions, it is hardly surprising if, despite all good intentions to serve the community, the institute’s best and most ambitious doctors end up leaving – and indeed Dr. Tenzin Damdul was only one among many. Like other private doctors I talked to, Dr. Tenzin Damdul made another critique, too, effectively reversing the Men-Tsee-Khang’s claims of preserving tradition: according to him, it was the Men-Tsee-Khang, rather than private doctors, who undermined Tibetan medical traditions through the inevitable division of labor required in the context of a large institution. Although this attempt to portray private *amchi* as the real keepers of tradition remained unsuccessful as far as popular opinion is concerned, it did reflect some Men-Tsee-Khang

doctors' concern about the gradual erosion of the *amchi*'s skills in medicine compounding at the institute, and of their traditionally holistic approach to medicine.¹³⁶

As these three cases demonstrate, it would be overly simplistic to interpret the resignations of the Men-Tsee-Khang's best doctors as mere cases of moral failure or, at best, as unfortunate results of personal differences with the administration. Yet this is exactly what the Men-Tsee-Khang was doing since the 1980s: failing to critically reflect on the reasons for these resignations and look for practical solutions, the institute has consistently – with the exception of Tsering Tashi, under whose tenure no *amchi* left the institute – preferred to diagnose them as symptoms of a deterioration of the *amchi*'s moral fiber. So concerned has the Men-Tsee-Khang become about this that its college recently revised its syllabus, upon Samdhong Rinpoche's suggestion, to include more Buddhist philosophy, meditation, and monastic debating sessions in the hope of boosting its students' ethics. Dr. Tsewang Tamdin, the college principal, told me:

The government suggested building the mentality of the students. So right now we have made some changes in the subjects on Buddhist philosophy, to increase the students' *bodhicitta* [compassionate mind]. [...] The mentality is very important, it should be positive. Those who want to be doctors nowadays, they have a different mentality, different aims and objectives. That's why it's more important now to know about religion, not to practice medicine for personal gain, but to give service, to help the community and society.

¹³⁶ It also reflects the widespread discourse among Ladakhi *amchi*, who similarly stress the importance of each *amchi*'s skills to compound medicines (Blaikie, pers. comm. 2009). In line with Pordié's (2008b) concept of "neotraditionalism", this discourse can be fruitfully understood as a strategic use of "tradition" for political ends. In this case, the political end is a shifting of criteria of superiority away from the powerful Men-Tsee-Khang to the more traditional lineage *amchi* in Ladakh.

No doubt, high ethical standards are always commendable and, as Dr. Tamdin went on to explain, a good motivation is likely to increase the doctors' efficacy and job satisfaction. It is doubtful, however, whether this increased emphasis on Buddhist ethics alone will prevent Men-Tsee-Khang graduates from leaving the institute, as long as the institutional and economic reasons for them to do so remain unaddressed.

While the move from simplistic accusations of moral failure to a consideration of institutional and economic factors helps to better understand the tense relationship between the Men-Tsee-Khang and its former doctors (and might go a long way in reducing the Men-Tsee-Khang's problem of resignations), it still does not adequately explain the "cold war" and its stakes. In order to understand them fully, we have to consider Tibetan medicine's international spread, its commercialization, and its politics not as separate issues, but as fundamentally interconnected phenomena. As Tibetan medicine achieved a sufficient level of popularity in the West during the 1990s to make medical tours there viable and lucrative, it became possible for larger numbers of Men-Tsee-Khang *amchi* to open their own clinics. For the first time, then, did these doctors – as a group – become a serious competition for the Men-Tsee-Khang, not only in terms of market share but also for the (political) power to represent Tibetan culture. Business and politics, had they ever been separate in exile, became firmly entangled.

Again, Dr. Tsewang Nyima expressed the Men-Tsee-Khang's view of the situation most clearly:

Ten years ago [i.e. in the mid-1990s], our institute was able to send our doctors to different parts of Europe, to the US, to England, and the money that our institute was able to make from them, we were able to divert it for social work, for research, for clinics like here in Dharamsala, where over

90% of the patients who come get free medications, because most are elderly people, school kids, monks, nuns... Now, we are sending our doctors to Kazakhstan, Ukraine, one or two in Europe, and most of the other places where we were able to organize exhibitions or consultations or workshops are actually taken by our private doctors! It is not a healthy development.

Of course, nobody – and no institution – is happy if the competition makes inroads in their market. But what Tsewang Nyima meant when he said that this was an unhealthy development did not only pertain to the Men-Tsee-Khang's business interests, which the institute normally denied in any case. It pertained to its governmental interest – or responsibility – to engage in social service in form of cheap public health care, to promote and develop Tibetan medicine through new clinics and clinical research, and – most crucially – to represent the political interests of the Tibetan government in exile. We have already seen in the previous chapter how closely the international promotion of Tibetan medicine was connected with representing the Tibetan political cause, not to mention the Men-Tsee-Khang's role in unifying the Tibetan diaspora as a nation. It is this governmental role and responsibility that the Men-Tsee-Khang perceived as threatened by the commercial interests of private doctors. The institute's problem with private doctors thus only appears to be one of economic competition, but was in fact much more serious than a few million Rupees in lost profits. Consider Dr. Tashi Norbu's sentiments, which echoed Tsewang Nyima's:

[A few years ago,] the Men-Tsee-Khang used to have three branch clinics in the West; now, it has none. Instead, private doctors are now filling this gap in the West, which is not good because they can't be trusted to represent Tibetan medicine accurately. The Men-Tsee-Khang is the best

institute of Tibetan medicine, and as such it should be the one to present Tibetan medicine. This is important.

In the Men-Tsee-Khang's view, private doctors harm Tibetan medicine and the Tibetan cause as a whole by undermining the Men-Tsee-Khang's governmental work only for the sake of quick economic gains. Like Tsewang Nyima pointed out, as private entrepreneurs, these *amchi*'s profits go into their own pockets rather than the training of future doctors, free medicines for the poor, or the exile-government's budget. What was more, since they were beyond the government's control, they could not be relied on to propagate the Tibetan cause, especially if this was against their economic interests (as in the case of Kenya, which incurred financial losses for the Men-Tsee-Khang). In the Men-Tsee-Khang's view (and public opinion), they could not even be counted on to produce good quality medicines, since the imperative for profit maximization would tempt them to substitute expensive ingredients with cheaper but less potent ones. As another Men-Tsee-Khang doctor told me,

If private doctors make medicines and go to Europe or America to promote Tibetan medicine, then that's very good, the Men-Tsee-Khang should thank them. But we can't know what their intentions are, maybe they have other intentions. Only we [the Men-Tsee-Khang] can ensure that the quality is very good, that it's pure. Private doctors might leave out some ingredients, or make the medicines less pure... Like in Switzerland, when a private [Tibetan] doctor sold medicines with [unpurified] mercury... Even though the doctor was private, the Men-Tsee-Khang gets a bad name like this.

In other words, the private doctors' allegedly inferior medicine posed a direct threat to the Men-Tsee-Khang's reputation, and that of Tibetan medicine in general, which

negatively affected its political power to promote the Tibetan cause. To sum up, while increasingly taking over the Men-Tsee-Khang's market, private Tibetan doctors were not taking over the Men-Tsee-Khang's medical, cultural, and governmental responsibilities.

On the other hand, if the Men-Tsee-Khang saw its governmental interests threatened by the private doctors' economic interests, then the latter were wary about the institute threatening their economic interests by seeking to distort the market through political means. In particular, private doctors have long accused – if only quietly – the Men-Tsee-Khang of abusing its governmental status for suppressing the competition and monopolizing the market for Tibetan medicine – that is, for economic ends. Though not a private doctor himself, former Men-Tsee-Khang director Jigme Tsarong was highly critical of the direction in which the Men-Tsee-Khang had developed since his tenure in the late 1970s. In a conversation in 2005, he clearly expressed what most private doctors only implied in less direct ways:

They [the Men-Tsee-Khang] are very small-minded. I mean, look at Tibetan medicine. It's thousands of years old, such a long tradition, and who is the Men-Tsee-Khang? Even the Chagpori existed before them! They are just a small organization, and now they claim that they *are* Tibetan medicine. It's a good thing if *amchi* open their own clinics and pharmacies. It's good if it spreads. [...] The Men-Tsee-Khang's main idea is to create a monopoly... But this is completely wrong, there are so many private *amchi* around, they don't have a monopoly.

Indeed, such accusations were not very far fetched. First of all, as we have seen in this chapter, the Men-Tsee-Khang indeed needs to balance its governmental mission with business acumen, and operate, in the absence of government funding, as a private entity on the market. In other words, it did represent a formidable and powerful competition for

private practitioners, who were in a much more precarious economic position than the Men-Tsee-Khang, and therefore much more sensitive to economic threats in form of monopolistic tendencies. And Jigme Tsarong was right, the Men-Tsee-Khang did indeed have such tendencies, although its doctors and administration were usually very careful not to express them. Still, they could be detected in much of the Men-Tsee-Khang's institutional discourse, as for example in Tashi Norbu's above-quoted argument that only the Men-Tsee-Khang should represent Tibetan medicine. It became even more apparent when Dr. Tashi Dhargye recounted the Men-Tsee-Khang's reaction upon first hearing about the "First International Congress on Tibetan Medicine" organized by ProCultura in Washington, DC, in 1998:

We had a heated exchange at the Men-Tsee-Khang, whether ProCultura had asked permission from the Health Department or us to organize this congress. You know, they hadn't asked for any official permission from the Health Department, nor was the Men-Tsee-Khang officially approached. To me, this seemed kind of like trespassing into others' properties... I mean, they were talking about IPRs, about patenting, all these things, whereas the real owner was kept totally ignorant about all this! [laughs]

Even more than the choice of words here, Tashi Dhargye's genuine indignation about the incident – ten years after it happened – spoke volumes about the Men-Tsee-Khang's self-understanding. As the representative of the Tibetan people (or nation) – especially in matters regarding Tibetan medicine – the Men-Tsee-Khang clearly regarded itself as the "owner" of Tibetan medicine. In its own logic, Tibetan medicine was its "property", which had to be defended not only against appropriations by non-Tibetans as in the case of the Washington congress, but also against its exploitation by private Tibetan *amchi*.

Although Tashi Dhargye's concern was more about cultural survival than market share, the words "property" and "ownership" do have strong capitalistic connotations, making the private doctors' accusations about the Men-Tsee-Khang pursuing economic ends by using its political power seem justified.

All of this clearly shows how the Men-Tsee-Khang's conflict of interest in trying to fulfill both its governmental and economic responsibilities manifested in – and actually lay at the root of – its "cold war" with the private doctors. This confrontation over morality, market share, and money signified the shift in the exile-Tibetan struggle to preserve their culture mentioned in the beginning of this chapter. In a paradoxical reversal of roles, the exile-Tibetan government today fights a similar battle (albeit with far less firepower and a different ideology) as its Chinese communist adversaries – who have meanwhile embraced capitalism and become the world's emerging economic superpower – did some decades ago. Economic enterprise, once a "traditional" strength as Tibetans excelled as traders, was first unsuccessfully defended against Chinese communism and then rebuilt (to some extent) in exile, only to turn from being an essential part of the Tibetan way of life into its biggest enemy. In many ways, then, the Tibetan battle for cultural survival has exchanged the "hot" confrontation with China for a "cold war" against the commercialization of Tibetan culture, personified by private *amchi*.

Although, as the above quotes indicate, this war was still very present in the minds of many doctors in 2008, its intensity had abated considerably after reaching its climax in high stakes politicking and heated confrontations between the two parties at the beginning of the new millennium, from which the private practitioners emerged

victorious and the Men-Tsee-Khang weakened. This ‘final showdown’ of nearly four years (from 2000 to 2004) was to significantly shape the future of Tibetan medicine in exile through the “Sorig revolution” (Chukora 2007: 14) that was the establishment of the Central Council of Tibetan Medicine.

5. The “Sorig Revolution”

We need to have some control. We can't just let independent amchi do whatever they like.

Dr. Dorjee Rabten

The problematic relationship between the Men-Tsee-Khang and private doctors has a long history, dating back to the early beginnings of the Men-Tsee-Khang in the 1960s. The resignation of senior *amchi* like Trogawa Rinpoche not only hurt the struggling institute at that time and left a bitter aftertaste, but was likely the result of already tense relations or differences in opinion. After Dr. Lobsang Dolma's offer to join and help the institute had been rudely rejected during the 1960s, she was asked to give up her private clinic in Dalhousie and serve the Men-Tsee-Khang during the 1970s, only to be dismissed from service a few years later amidst allegations of unethical conduct. In the 1980s, under Lobsang Samten's tenure, the Men-Tsee-Khang decided to stop selling its medicines to private *amchi* in an attempt to discourage the establishment of private clinics, which was widely perceived as a hostile gesture against the already existing private practitioners. During the 1990s, as the economic potential of Tibetan medicine became increasingly apparent, the sheer number of newly established private doctors began to challenge not only the Men-Tsee-Khang's market dominance, but also its political power to represent Tibetan medicine. In addition to that, problems like counterfeit *rinchen rilbu* and impostors pretending to be fully qualified *amchi* in the West only increased the institute's suspicions and its hostile attitude vis-à-vis independent

doctors. Tsering Tashi had, as the Men-Tsee-Khang's director in the mid-1990s, still rejected suggestions by Tibetan government officials to give his institute the official power to control Tibetan medicine in exile; but as the millennium drew to a close with the Men-Tsee-Khang's internal uproar about the Washington Congress on Tibetan Medicine, negative press in Europe regarding toxic Tibetan pills, and increasingly widespread concerns about the deterioration of Tibetan medicine due to commercial exploitation, a tipping point was reached. In early 2000, Tsering Tashi's successor, Pema Damdul Arya, wrote two draft rules to regulate Tibetan medical practice and pharmaceutical production with the aim of bringing Tibetan medicine in exile under the Men-Tsee-Khang's official control.

More was at issue here than the troubled relationship between the Men-Tsee-Khang and the private doctors. As I have suggested in the introduction, in order for the Men-Tsee-Khang to fulfill its modern responsibility of "preserving" an ailing Tibetan culture and nation, the latter needed to acquire a 'body' that could not only be sick but also healed. And if indeed Tibetan medicine has come to stand for – to *embody* – Tibetan identity, then the Men-Tsee-Khang's task became to "preserve" – to shape and redefine – Tibetan medicine in exile. At issue, thus, was nothing less than the preservation of Tibetan medicine, figuring not only as the healer, but also as the sick body of Tibetan culture and nation. But how does a diffuse and pluralistic healing tradition like Tibetan medicine (even if considerably homogenized in the Indian exile) acquire a body with a distinct shape and boundaries? How, in other words, is it made into a "medical system" in order to fulfill its dual function as patient and healer in the exile-Tibetan nationalist project? In answering these questions, this chapter will document the ongoing political

processes through which Tibetan medicine's body is shaped and redefined as a medical system that can be regulated, controlled and legally recognized. It will examine, in other words, the modern remaking of a "traditional" medicine as a way to make claims about – and thereby produce – a particular culture and nation in the context of nationalism and exile.

The Central Council of Tibetan Medicine

For the first few decades in exile, Tibetan medicine's 'body' was, for all practical purposes, consubstantial with the Men-Tsee-Khang's institutional body. However, as Tibetan medicine gradually grew larger, healthier and stronger; as other Tibetan medical institutions were founded and increasing numbers of *amchi* established their private clinics and pharmacies, the equation of Tibetan medicine with the Men-Tsee-Khang became increasingly problematic. One could say that the Men-Tsee-Khang's institutional body became too small to demarcate the boundaries of Tibetan medicine in exile and to represent – on behalf of Tibetan medicine – Tibetan culture and the nation. Clearly, something needed to be done, and two possible solutions were identified: either expand the Men-Tsee-Khang's institutional body, or create a new, larger body that represented the wider field of exile-Tibetan medicine. Not surprisingly, the Men-Tsee-Khang – backed by the Health Department and unwilling to abandon its role as Tibetan medicine's representative (which it saw as something of its birthright) – opted for the first solution. Not surprisingly, either, this decision met with vigorous opposition from other quarters in the field of Tibetan medicine.

Pema Damdul Arya first circulated his draft rules to regulate Tibetan medical practice and pharmaceutical production among high lamas, ministers, and some intellectuals to test the waters. Then, Yangkyi Samkar, the Health Kalon, formally introduced them to the 12th Assembly of Tibetan People's Deputies (the Parliament of the Tibetan government in exile) on March 21, 2000. Of all the deputies (Members of Parliament), only the Assembly Chairman Pema Jugney – who had been forwarded the draft by a friend – had read the proposal closely, and strongly suggested that the Assembly reject it. As he told me in 2008, not only was the document hastily written (as evidenced by numerous spelling mistakes), but he also considered it the parliament's duty to represent the interests of all Tibetans (including private practitioners) rather than just those of the Men-Tsee-Khang. The Assembly did reject the proposal, and decided to set up a committee – including Samdhong Rinpoche as its chairman, Pema Jugney, Lobsang Shastri, Dr. Thokmay, and the Assembly's deputy speaker – to deliberate the matter further. As the exile-Tibetan Health Department diplomatically put it (Health Department 2003: 1):

After going through the draft rules and finding them most relevant and practical, the committee did not feel the need to get them passed in the Tibetan Parliament. Instead [following Samdhong Rinpoche's suggestion] the committee felt it would be a better idea to frame a legal code for a Central Council of Tibetan Medicine to standardize and control the quality of Tibetan medical colleges, physicians, and the preparation of medicines.

Thus, on September 27th, 2000, the 10th session of the 12th Assembly of Tibetan People's Deputies passed Resolution 12/10/108, calling for the establishment of the Central Council of Tibetan Medicine (henceforth CCTM). A committee consisting of members

from the Health Department and the Men-Tsee-Khang¹³⁷ was formed on November 6th, and met from December 25th-28th to draft a legal code for the CCTM, which was then presented to the Health Department.

Considering the make-up of the committee (with the Health Department at that time clearly siding with the Men-Tsee-Khang), it is hardly surprising that the result was, in its main ideas, not very different from Pema Damdul Arya's original proposal. It contained two sets of rules and regulations, one for Tibetan lineage doctors in exile (Document 11), and one for Tibetan pharmacists in exile (Document 10). Each set was to be overseen and implemented by a committee heavily dominated by Men-Tsee-Khang representatives. Thus, the committee for controlling Tibetan lineage doctors consisted of six Men-Tsee-Khang representatives (including the Dalai Lama's two personal physicians), three representatives of the Department of Health (including its General Secretary), and three elected lineage doctors. The committee for the regulation of Tibetan pharmacists included only two elected private pharmacists, five representatives from the government (including the Health Kalon), and six senior Men-Tsee-Khang representatives. Most importantly, the rules stipulated that any Tibetan medical institute, private practitioner, or pharmacist must be registered under – and controlled by – the Men-Tsee-Khang, and must follow the latter's rules, ranks, norms of promotion, and exam specifications. Article 18 of Document 11 stated that:

Since the Men-Tsee-Khang is recognized as the standard center for the study of Tibetan medicine, the institute is endowed with the responsibility and authority to regulate registration, conduct training programs and examinations, and issue certificates.

¹³⁷ Apart from the director (who had no medical degree), all Men-Tsee-Khang *amchi* with a junior *menrampa* degree or higher were invited to participate.

Any lineage doctor setting up a private practice, the document continued in Article 21, must obtain a registration certificate from the Men-Tsee-Khang. Regarding pharmaceutical production, Article 10 of Document 10 stated that the CCTM (consisting of the above-mentioned committee) had to investigate anyone producing medicines, “take an appropriate decision and immediately report the matter to the government.” If a brief look at the committee’s set-up left any doubt, Article 12 made clear that the full responsibility for this lay with the Men-Tsee-Khang. The most important rule, however, was left for Article 17:

Any Tibetan lineage doctor planning to start pharmaceutical practice must obtain prior permission [from the Men-Tsee-Khang] and get registered under the Tibetan government in exile. Barring the practice mentioned in Article 20, no Tibetan doctor can engage in Tibetan pharmaceutical practices without prior registration.

Article 20 clarified:

In contrast to the practice mentioned in Article 17, a Tibetan doctor is allowed to administer a concoction to cater to the immediate need of his patient according to ancient practice, but is not allowed to manufacture in bulk such medicine for commercial purposes without prior permission.

Document 10 continued with a call for a government pharmaceutical investigator – explicitly from the Men-Tsee-Khang – to check whether any private *amchi*’s pharmaceutical production was “at variance with the Tibetan medical system, whether the ingredients are in standard proportion”, whether hygienic conditions were kept, or there

were any signs of adulteration. Finally, in order to keep medicine prices affordable for the poor (Article 29), Article 30 concluded:

The government has the power to control and fix prices for sale as well as export of the medicines taking into consideration the cost price. The government also reserves the power to reduce the prices or repeal the registration certificate in case of medicine sales solely for personal gains.

These draft rules demonstrate well the concerns of all three parties involved – the Tibetan government in exile (and especially Samdhong Rinpoche, who would be elected as prime minister the following year), the Men-Tsee-Khang, and the private doctors – as outlined in the previous chapter. Thus, Samdhong Rinpoche’s anti-commercialization stance is clearly reflected in Articles 29 and 30 of Document 10; and the government’s interest in regulating and maintaining control over Tibetan medicine, which at least at that time it considered a valuable political asset, was ensured by its strong representation on the CCTM’s two executive councils (especially that concerning pharmaceutical production). Similarly, the Men-Tsee-Khang’s dominance on both councils finally gave it the official power to carry out its responsibility, that is, to protect Tibetan medicine and ensure the quality of its education, clinical practice, and pharmaceutical products. The institute had long perceived itself – and acted – as the sole legitimate authority over (or body of) Tibetan medicine in exile, but never had the official mandate and legal backing to actually wield this power openly. Now, as the institute increasingly saw its power threatened by private doctors (and non-Tibetans ignorant of its role), a Men-Tsee-Khang-controlled CCTM was meant to take care of both problems: the lack of official power, and the challenge of private practitioners. As we have seen above, private *amchi* were perceived by the Men-Tsee-Khang as both an economic and a political threat that

ultimately endangered not merely its power but Tibetan medicine itself – whose ‘body’ the Men-Tsee-Khang regarded as consubstantial with its own institutional body – and its role in the nationalist struggle. On the other hand, such plans only confirmed the latter’s worst suspicions, namely that the Men-Tsee-Khang wanted to monopolize Tibetan medicine, marginalize private practitioners as much as possible, and use its political power to distort the market of Tibetan medicine to its own advantage. In the words of Dr. Tenzin Damdul, who was one of the two private *amchi* centrally involved in the later stages of establishing the CCTM:

We regard the Men-Tsee-Khang as an official institute, “*bod gzhung* Men-Tsee-Khang,” and so they thought they could do everything with the “*bod gzhung*” in their name. But they didn’t know that they are only an institute, and an institute has no authority to run a council. [...] So initially, it was somehow to put everyone under the Men-Tsee-Khang’s control.

Unfortunately for the Men-Tsee-Khang, its dreams of almost absolute power and control – of expanding its institutional body to incorporate even those elements of exile-Tibetan medicine previously outside its boundaries – were not to come true. There was another meeting to discuss and amend this draft code from March 16th to 17th, 2001, where not only all Men-Tsee-Khang doctors above fourth rank¹³⁸ but also independent,

¹³⁸ That is, all Men-Tsee-Khang staff in higher positions. All Men-Tsee-Khang employees occupy a certain rank according to their position and education. There are 10 ranks, which determine the staff’s salary, entitlements, duties, etc., rank 1 being the highest and 10 the lowest, with doctors practicing in clinics occupying ranks 5 and 6. According to the Men-Tsee-Khang’s 2005 “Rules and Rights of Men-Tsee-Khang Employees”, the ranks are: 1st rank: Director, Head Teacher of Medicine, Head Teacher of Astrology. 2nd rank: Deputy Director, General Secretary, Head of Pharma Dept., College Principal. 3rd rank: Overall In-charge of Branch Clinics, Head of the Astro. Department, Head of Clinical Research Department, Head of Materia Medica Department, Head of the Medicine Research Department, Head of Medicine Control Department, Deputy Head of Pharmaceutical Department, Vice-Principal. 4th rank: Deputy Head of the Astrology Department, Deputy Head of Medicine Research Department. 5th rank: Senior doctors, Head of Audit Section, Chief Accountant, Head of the Ladakh Medical Centre, Head of the Export & Marketing

private physicians were invited (Health Department 2003). While private physicians were up in arms against the proposed regulations and turned out in large numbers, most Men-Tsee-Khang doctors at that time seemed to have regarded the whole issue as just another unnecessary political exercise. As one Men-Tsee-Khang *amchi* told me,

At that time, the Men-Tsee-Khang doctors were careless, they didn't pay any attention. Our director sent out a letter to all our doctors, informing them about the plan to establish the CCTM, and asking them to vote yes or no, whether they felt the CCTM was necessary or not. [...] But most Men-Tsee-Khang doctors didn't care, they didn't reply. Then, there was a big meeting with all the Tibetan doctors, to decide on the CCTM, and again, only very few Men-Tsee-Khang doctors attended. So it was mostly the private doctors who made the decisions.

Thus, the private doctors managed to significantly change the proposal in their favor, which was then presented to the Health Minister and to Pema Damdul Arya. As Pema Jugney, who was centrally involved in the process, recounted, the Men-Tsee-Khang director had strongly opposed the changed version of the draft, and a heated discussion had ensued. Pema Damdul Arya only gave in – though very reluctantly – when Pema Jugney pointed out to him that his version would never be passed in Parliament anyway, and that he therefore better agree to the present proposal. Having no other option, the Men-Tsee-Khang officially requested the Health Department to inform the Tibetan Parliament about the CCTM code on July 21, 2001, via the Cabinet. The

Office in Delhi, Chief Artist. 6th rank: Junior doctors, Office clerks, Store in-charge, Estate manager, Junior Artist. 7th rank: Office Clerks and Accountants at Export & Marketing (Delhi), Ladakh Medical Centre, Auditors, Computer In-charge, Staff related to Science. 8th rank: Office Secretaries at Branch Clinics, Receptionists at Headquarter and the Branch Clinics. 9th rank: Medical Attendants, Staff at Medicine Sale Counters, Accountants of Branch Clinics, Drivers, Carpenters, Smiths, Tailors, In-charge of Furniture, Store-keepers, Head Cook. 10th rank: Employees at pharmaceutical center, overseer of construction, peons, sweepers, watchmen, cooks, ayahs. Since 2005, there have been slight changes in the allocation of ranks.

Health Department thus wrote a letter dated July 23, 2001, to the Tibetan Cabinet, asking it to introduce the code in Parliament and seek its approval (Health Department 2003). The Cabinet – in the process of dissolution after the July elections in which Samdhong Rinpoche received 80% of votes to become the next Kalon Tripa (prime minister) – replied on August 2, 2001, to raise the matter again when the new Cabinet was installed. The Men-Tsee-Khang – itself under the new directorship of Samdup Lhatse – did so on January 16, 2002, and this time, the Cabinet introduced the issue to the 13th Assembly. Again, however, the code did not pass the parliamentary vote, this time due to objections by Yungdung Gyaltzen, a Bonpo deputy who insisted on a stronger emphasis on Bon influences in Tibetan medicine. So yet another committee was formed and changes were made to the draft, including, most significantly, strong references to the *bum bzhi* (the Bon version of the *rgyud bzhi*) and a Bonpo member on the CCTM’s governing board. The result – Document 13, also known as the “Exile Tibetan Doctor’s Association Act”, or simply the “CCTM Act” – was then read by the Health Minister during the fifth session of the 13th Assembly, passed unanimously in March 2003 and approved by the Dalai Lama a little later. On the basis of this Act, the Central Council of Tibetan Medicine (*btsan byol bod mi’i bod kyi gso ba rig pa’i ches mtho’i sman pa’i lhan tshogs*, or short: “Che-thoe Men-pae Lhen-tsog”) was officially established as an “Apex body” under the Central Tibetan Administration on January 5, 2004 during the “First Conference of Sorig Practitioners” in Dharamsala.

After more than 40 years in exile, Tibetan medicine thus finally took birth as a “medical system”. That is, for the first time in its history, there existed a body – separately from any particular medical institution – with the sole purpose to regulate,

standardize and control Tibetan medicine in order to make it into a clearly demarcated “system” of medical (and pharmaceutical) knowledge and practice. No doubt, as I will discuss below, for the time being this was merely the weak and dependent body of an infant. Nevertheless, as such it was also full of promise and potential: the potential to achieve the Tibetan nationalist goal of healing the nation by saving (or reforming and “purifying”) Tibetan culture – in its guise as medicine – from the perceived corruption and weakness of exile, capitalism and modernity (cf. Norbu 1992; Chatterjee 1993; Prakash 1999; Langford 2002). In other words, as Tibetan medicine was called upon to regulate and define the contours of an identity under threat of assimilation – of a nation under threat of disappearance – it became essential to regulate that medicine as a recognizable body with a distinct shape and enforceable boundaries. This body was the CCTM; as it turned out, however, its shape – the result of four years of intense political battles – was hardly what had been envisioned at its conception in 2000.

The profile and attendance of the “First Conference of Sorig Practitioners” was indicative of the importance given to the event: besides over a hundred Tibetan *amchi*, almost the entire exile-government was present, including the Prime Minister (Samdhong Rinpoche), the Assembly Chairman (Pema Jugney), two of the Cabinet’s three ministers (Health and Finance; Education, Religion and Culture), and the Health Secretary (Tenpa Samkhar). The speeches indicated a strong concern over the deterioration of Tibetan medicine due to its commercialization, and the resulting need to protect it. Thus, while Samdhong Rinpoche expressed his Cabinet’s concern about “the upliftment [sic] of the Tibetan healing tradition” (CCTM 2004), the Kalon for Health and Finances, Lobsang Nyandak Zayul, argued that since Tibetan medicine was being commercialized, a

governing body was needed to preserve and promote it. Lest anyone mistook Lobsang Nyandak's speech for a positive and proactive approach to business, the Health Secretary Tenpa Samkhar added that the Central Council's mission was not to regulate and promote, but to *prevent* Tibetan medicine's commercialization: everyone was concerned about the deteriorating condition of Tibetan medicine, he told the assembled doctors, and the CCTM's function should be to "bell the cat" (ibid.) – the "cat" being those *amchi* guilty of commercially exploiting Tibetan medicine. We can clearly see here how the political debates around Tibetan medicine and the CCTM were the direct result of the problem of commercialization and the related tensions between the Men-Tsee-Khang and private doctors. Indeed, as I showed in the previous chapter, the entire problem of commercialization was in fact a political problem, regarded as potentially undermining Tibetan culture and with it the Tibetan nationalist struggle. It was therefore only to be expected that any new body meant to regulate Tibetan medicine and control Tibetan identity would be opposed to commercialization.

According to the official tenor, then, the CCTM's mission seemed to be clear: control and govern Tibetan medicine in exile in order to prevent its commercialization. Except that politicians' speeches do not always correlate with reality. Had the first draft code for the CCTM in 2001 still contained an explicit statement that Tibetan medicine had to remain affordable to the poor, and given the exile-government the power to regulate the prices of Tibetan medicines accordingly, there remained no trace of such rules in the final CCTM Act. Not only that, but instead of establishing governmental oversight – carried out by the Men-Tsee-Khang – over Tibetan medicine's preservation and development, the Central Council's governing board now consisted of only one

government appointee (a biomedical doctor, not a politician), three Men-Tsee-Khang representatives, and four private *amchi* (out of which at least one had to be a *bum bzhi* – i.e. Bon – lineage holder).¹³⁹ In other words, the Men-Tsee-Khang only had a minority of votes in the CCTM's decisions, while the exile-government was left with no direct political control over Tibetan medicine at all.¹⁴⁰ Both Pema Damdul Arya's as well as the Cabinet's (and parts of the Assembly's) initial plan to counter the perceived threat of private practitioners and bring Tibetan medicine under the government's and the Men-Tsee-Khang's control had thus backfired dramatically. The Men-Tsee-Khang was demoted to an equal status as any other Tibetan medical institution – and even private doctors – registered under the CCTM, while the fledgling CCTM was charged, in the Men-Tsee-Khang's stead, with the governmental responsibility of preserving, regulating, and representing Tibetan medicine in exile.

Needless to say, the Men-Tsee-Khang was not amused. Even in late 2007, almost four years after the CCTM's establishment, many Men-Tsee-Khang *amchi* I talked to were unhappy about it. On one occasion, I asked Dr. Tsering about this:

SK: So what do you think, is the CCTM good for the Men-Tsee-Khang or not?

T: It is not good. So many private doctors can open their clinics now, because they get a certificate from the CCTM. I don't know if they are all qualified... [...] Before, the Men-Tsee-Khang was the main institution of Tibetan medicine. The other doctors looked up to us, they respected and followed our decisions. To be a Men-Tsee-Khang doctor was something

¹³⁹ As mentioned previously, there was a ninth seat reserved for the Dalai Lama's senior personal physician, which however remained unoccupied since nobody had been officially appointed to that position since the demise of Tenzin Choedrak, Lobsang Wangyal, and Kunga Gyurme Nyarongsha.

¹⁴⁰ Other Tibetan medical institutions like the Chagpori had no representatives at all on the CCTM's first and second governing boards (2004-2010), a clear indication of the extent to which the CCTM was the product of the conflict between the Men-Tsee-Khang and private *amchi*. The third governing board, elected in March 2010, however, has one member each from the Chagpori and the CUTS.

special. The salary is not bad, and then it's His Holiness' institute, so it has a good name. We get a lot of respect in society; there is some prestige. Now this is changing; the Men-Tsee-Khang is not the highest institution anymore, because it's under the CCTM – just the same like private doctors. So the private doctors don't respect us anymore, they only respect the CCTM. Many Men-Tsee-Khang doctors feel bad about this. We are working for the government, to serve the people, not to do business, so this gives a special feeling. But now, we don't feel special anymore, because we are just the same like the private doctors who are doing business. This is not good for the Men-Tsee-Khang; it will harm our development.

Although Dr. Tsering lamented what he perceived as a loss of respect and prestige on a personal level, he was also strongly concerned about the Men-Tsee-Khang becoming “just the same like private doctors” who are doing business. In other words, Tsering feared that the CCTM – heralded as a decisive step against the commercialization and misappropriation of Tibetan medicine (CCTM 2004; Chukora 2007: 14ff) – might have the opposite effect than intended, dragging down the Men-Tsee-Khang to the same – ethically lower – level of private doctors. Before we turn to the important question of what, indeed, the CCTM's effects turned out to be, however, it is necessary to take a closer look at the CCTM's aims and objectives, and its accomplishments during its first five years of existence. What, exactly, did its governmental responsibility to preserve and regulate Tibetan medicine consist of, and how did it go about fulfilling it?

Regulating Tibetan Medicine

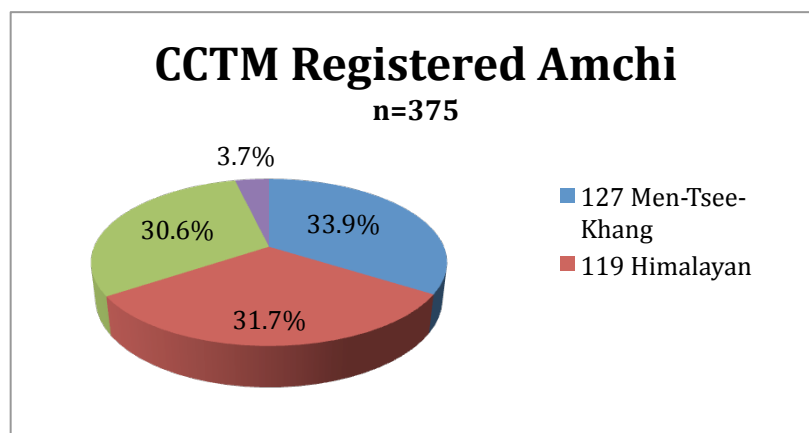
Summarizing from the Legal Code of the Central Council of Tibetan Medicine in Exile (Health Department 2003), the CCTM's objectives are: 1) to inspect and register Tibetan medical colleges, pharmaceutical units, and physicians; 2) to prevent fake or adulterated medicines by establishing guidelines for, standardizing, and monitoring the pharmaceutical preparation of Tibetan medicine; 3) to evaluate and approve newly developed pharmaceutical formulations; 4) to standardize the syllabi and academic quality of Tibetan medical colleges; 5) to stop those not complying with CCTM's pharmaceutical standards from producing medicines; and 6) to provide help to registered physicians in case of legal problems. The CCTM's jurisdiction applied to all "traditional Tibetan physicians under the exile Tibetan government, and to those practitioners of Tibetan medicine who voluntarily respect and accept its legal code." (Health Department 2003) In other words, while non-Tibetan Himalayan *amchi* – Ladakhi, Nepali, or Monpa, for example – could choose whether they wanted to come under the CCTM's jurisdiction or not, Tibetan nationals¹⁴¹ had to accept its rules as part of their government's laws.

By January 2010,¹⁴² the CCTM had compiled lists of standard treatises on the theory, practice, and pharmacology of Tibetan medicine, accredited the four main colleges of Tibetan medicine in India, and registered 375 medical practitioners in India, Nepal, Europe, North America, Australia, and Israel. The CCTM distinguishes between two kinds of registration: "qualified medical practitioners" and "registered medical practitioners." The former possess graduation certificates from Tibetan medical training

¹⁴¹ Tibetan nationality in exile is defined by an individual's possession of the so-called "green book", which is the most important document issued by the Tibetan government in exile, serving both as a proof of Tibetan nationality and a register for the payment of the voluntary tax.

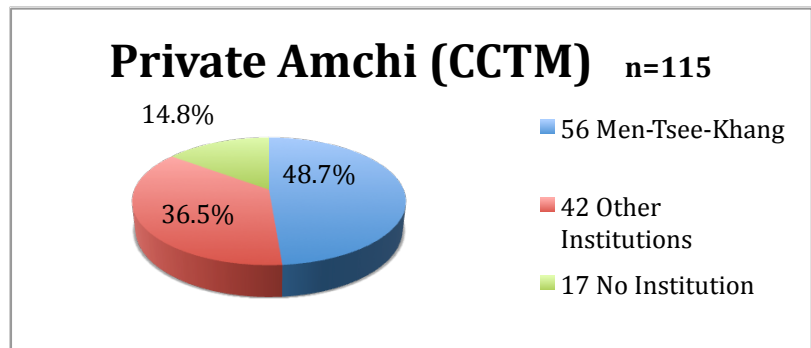
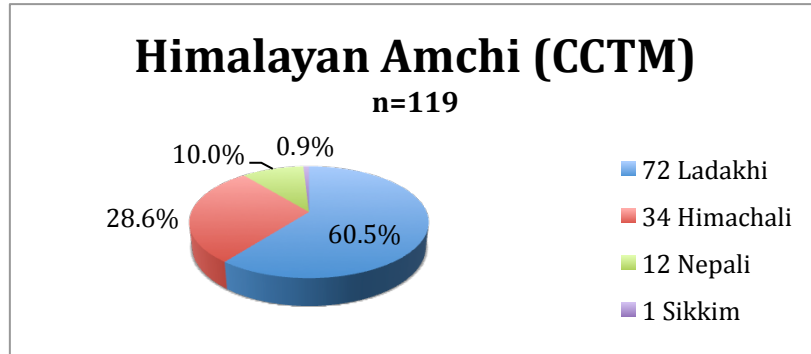
¹⁴² http://www.tibmedcouncil.org/reg_doc_list.html, accessed February 2010.

institutions recognized by the CCTM (i.e. the Men-Tsee-Khang, Chagpori, CUTS, and CIBS), while the latter – mostly Himalayan *amchi* trained in the traditional teacher-apprentice system (see Pordié in press) – do not. Instead, they were required to prove that they had well-known practices since at least 1992 in form of institutional supporting letters in order to register under the CCTM,¹⁴³ and anyone not fulfilling these requirements had to pass an examination. All *amchi* registered under the CCTM (regardless of their status as “qualified” or “registered”) had to pay an annual membership fee of 300 Rupees or, if based in the West, 365 US Dollars.¹⁴⁴ While many Men-Tsee-Khang doctors and well-established private Tibetan doctors only registered because this was mandatory for them as Tibetan nationals, there was a veritable run for voluntary registration among non-Tibetan lineage *amchi* without any institutional training, most of them Ladakhi and Himachali. For these *amchi*, both the authority conferred by the CCTM registration certificates, as well as the seminars, workshops, or empowerments it occasionally organizes, were attractive benefits, and by 2008 almost all of them had joined the CCTM as “registered medical practitioners”.



¹⁴³ In Ladakh, these letters were provided by the Ladakh *Amchi* Sabah.

¹⁴⁴ These amounts are from 2008.



Of the 375 practitioners recorded under the CCTM in January 2010, 63.7% were “qualified” and 36.3% simply “registered”. 127 were affiliated with the Men-Tsee-Khang (33.9%); 115 were practicing in private clinics (30.6%); 72 were Ladakhi *amchi* (19.2%); 34 were Himachali from Spiti, Lahaul, or Kullu (9%); 14 were affiliated with one of the other three Tibetan medical institutions (3.7%); 12 were Nepali (3.2%); and one was Sikkimese. Among the 115 private practitioners (which did not include Himalayan *amchi*), 56 were Men-Tsee-Khang graduates (48.7%); 42 were graduates from the Chagpori, CUTS, and CIBS (36.5%); and 17 were “registered medical practitioners”, that is, did not have any institutional certificates (14.8%).¹⁴⁵ Furthermore, 12 of the 115

¹⁴⁵ Some of them had various kinds of training certificates from institutions in Tibet, which however are not recognized by the CCTM in exile.

private *amchi* registered under the CCTM lived and practiced abroad (in North America, Europe, Australia, and Israel), 10 of them former Men-Tsee-Khang graduates.

Apart from such bureaucratic work, the CCTM had, until 2009, organized several large conferences, workshops, and high-profile medical empowerments. In 2008, it finally also made it possible, for the first time in exile, for senior private *amchi* to receive higher *menrampa* degrees after passing an exam.¹⁴⁶ All of this has gone a long way in establishing the CCTM as a benign (in contrast to the Men-Tsee-Khang's image in some quarters) official authority in the field of Tibetan medicine in India. With only few exceptions, private and lineage *amchi* I talked to all over India (whether Tibetan or not) expressed a generally positive attitude vis-à-vis the CCTM, which was well summed up by Dr. Tenzin Damdul:

Now, it is good that we have this CCTM, because we need somebody who can take care of all of us. And with the CCTM we feel that there is someone we can address with our problems, who can also think about the future promotion of Tibetan medicine.

However, while the CCTM has managed to successfully establish a hitherto non-existent platform of communication and exchange between most actors in the field of Tibetan medicine in exile (at least in India), and provided private Tibetan doctors with a voice to make their own interests heard, this was not its main objective. As Dr. Dorjee Rabten, its chairman from 2007 to 2010, repeatedly stressed both in public speeches and

¹⁴⁶ Until then, only Men-Tsee-Khang doctors could receive *menrampa* degrees, which was a major point of contention between private doctors and the Men-Tsee-Khang. In 2008, the CCTM recommended that promotional examinations to obtain junior *menrampa* degrees should be offered to private *menpa kachupa* degree holders (that degree had to be from a recognized institution, however). The Men-Tsee-Khang's Academic Council, which was the only body able to confer higher medical and astrological degrees in exile, discussed the recommendation and agreed to it in June 2009. The Men-Tsee-Khang then organized a promotion training in November and December 2009 for both eligible Men-Tsee-Khang and private *amchi*, with the actual examinations scheduled for 2010.

in private interviews, registering practitioners or organizing workshops were merely short-term strategies meant to help achieve the CCTM's real mission: to control, regulate and represent Tibetan medicine in exile as its sole legitimate authority, and thus create the conditions for Tibetan medicine's legal recognition first in India and then worldwide. In other words, as the body of Tibetan medicine, the CCTM's job was not only to standardize its knowledge, regulate its practitioners and control its boundaries in order to give shape to the identity that Tibetan medicine was meant to produce. It was also to represent that identity to the world in a particular way – solid, valid, true – in order to achieve, at least for Tibetan medicine and culture, the international legitimacy of legal status and official recognition that was also the goal of the Tibetan nation. I will return to this latter objective in the next chapter.

Ultimately, the CCTM was nothing but the most concerted effort so far, on part of the Tibetan government in exile, to claim “the authority and ownership of the Tibetans” over Tibetan medicine (Chukora 2007: 16). This political claim, which was explicitly confirmed to me by Dr. Dorjee Rabten in 2008, was not only extremely ambitious, but also certain to be strongly contested by a multitude of local interests. The only reason this has not happened yet was the CCTM's complete incapability to put its aims into practice. Professor Lobsang Tenzin Rakdho, the head of the CUTS medical faculty in Sarnath, only stated the obvious when he told me in 2008: “[The CCTM] is weak now, it can't control much.” On part of the CCTM itself, Dr. Dorjee Rabten conceded, “Of course, our direct authority to control anything is very, very limited, especially among the Himalayan practitioners of Tibetan medicine.” Similarly, Dr. Tsering at the Men-Tsee-Khang diagnosed: “The CCTM is nothing really, they don't even have any permanent staff

doctors, only an accountant and a secretary. Nor do they have any money... It is still the Men-Tsee-Khang who has most power and control.”

There are, besides the CCTM’s relative infancy, several interconnected reasons for its weakness, most of which are well expressed in the following conversation excerpt with Dr. Dorjee Rabten:

DR: Let’s put it this way, there is no clear-cut official policy [on Tibetan medicine by the CTA]. [sighs] It is not there, although it is very important. There even were some questions by well-informed people about whether our exile-government really recognized our medical system or not.

SK: Even in spite of the legal code of the CCTM? This is not a legal basis?

DR: This is one of the legal bases. This is the only document to prove that the Tibetan exile government has some policy towards Tibetan medicine. But in terms of fulfilling all the policies, you know, concerning future plans to make Tibetan medicine legally acceptable to all those who are interested, whether the Government of India or legal institutions abroad, there is no proper policy. [...] So we have made an effort to impress upon the new Kashag the need to recognize the CCTM officially, and make it an official body of the Tibetan exile government. [...] You see, we are functioning as a sort of NGO, not really as an official body of the exile government, not like the other departments. We don’t get all the funds, or a budget for the basic expenses – the government doesn’t give us that. Ok, they have a grant for us, an annual grant of some money, with that we try to work... [laughs]

SK: Which is not enough of course.

DR: Of course not. They want us to stand on our own feet, and then work independently. The new Kashag has the view that if we work independently, not directly under the bureaucratic jurisdiction of the Tibetan government in exile, we might be able to function better. I don’t

know. But until and unless this becomes an official body, it is difficult for us to legally monitor all the medical institutions, hospitals, doctors, etc. If we try to impose our own rules and regulations on them, as an independently functioning body, we have less weight or authority. With the legal stamp of the government, we would have more chances of success.

Indeed, as Dorjee Rabten argued here, the CCTM's biggest problems were its lack of funding and its unclear legal status under the Central Tibetan Administration. Although established as an Apex body of the Tibetan government in exile, it was never integrated in the CTA's governmental apparatus as, for example, a new division of the Health Department. And although the CCTM's regulations were – in theory – legally binding to all exile-Tibetan *amchi* as part of the CTA's legal code, the CCTM was thus forced to operate, for all practical purposes, as an independent, non-governmental organization. For instance, it neither had the exile-Tibetan government nor the Dalai Lama in its official name; could not use the CTA's emblem on its letterheads or stamps; did not have its offices in the governmental complex in Gangkyi; and it neither had any governmental representatives on its executive board nor a CCTM representative in the government. Its ambiguous official status was best demonstrated by its funding: neither receiving the funding normally reserved for official governmental agencies, nor being financially independent altogether, it received nominal support from the CTA in form of its office rent and the salaries for its two permanent employees (a secretary and an accountant). With only a limited income from membership fees of less than 100,000 Rupees per year, the CCTM was forced to spend considerable energy and time in attracting donations from within and outside the Tibetan exile-community. For 2008, it had a total budget of

between 500,000 and 600,000 Rupees, which it mostly spent on a large conference, workshops, and teachings. Clearly, this was nowhere near the amount the CCTM would need to fulfill its official responsibility of regulating and promoting Tibetan medicine in exile. As Dr. Tsering pointed out, they could not even afford to permanently employ medical or pharmaceutical professionals to monitor Tibetan pharmacies or medical colleges.

Even if the CCTM had the money to employ adequate human resources, however, its unclear legal status would make actual inspections of private pharmacies – let alone charges of malpractice or adulteration – very difficult. Especially inspections of pharmacies are a very sensitive matter, as the traditional sense of secrecy around Tibetan medicine production has never completely disappeared in exile, and access to Tibetan pharmaceutical units (including the Men-Tsee-Khang's) is usually highly restricted for outsiders and colleagues alike. The pronounced skepticism of the CCTM that I encountered among well-established, senior private practitioners who produced their own medicines could mostly be explained by their reluctance to let anyone regulate their practices or inspect their pharmacies – especially in the absence of a clear legal mandate. Dr. Tashi Yangphel Tashigang, for example, told me in his private clinic in East Delhi:

TYT: There is some politics involved in this Central Council, I don't like that. In all the [old Tibetan medical] books, I've never seen any reference about special recognition, regulation, or anything like that. Let them show me where this is written, I would be interested!

SK: So why are they trying to regulate Tibetan medicine?

TYT: Because they [the Tibetans] have to show their identity. But in Buddhism, there is no identity! Buddhism teaches that all identity is illusion, we should come out of it. So it's mostly a modern influence.

Unlike Dr. Tashigang, who as a Ladakhi could (and did) choose to not accept the CCTM's authority, Dr. Tsewang Dolkar – Lobsang Dolma's younger daughter and a Tibetan national – had no choice but to respect whatever rules her government decreed. Nevertheless – or perhaps precisely because of that – she was much more practical in her skepticism of the CCTM's powers when I visited her in her busy clinic in South Delhi:

Once in a meeting they [the CCTM] said, “we have to check the quality.” But who's going to check the quality!? That's one thing. Second, to check the toxicity: I don't have to go up there, I do it in an Indian scientific lab, I have a whole file on this. This is one of my responsibilities; this is “Dolkar Herbal Medicine.” I have to check this, I don't have a university or the Dalai Lama behind me... [...] They also asked me to provide a list of all the medicines I make. That I didn't understand. Many of my medicines, I make myself. I don't stick to the same combinations of the old texts. That doesn't mean I'm going against them. I have to change the combinations because we are not in high altitude anymore. The diet, behavior, the oxygen, everything is changed! And then I don't want to use so many minerals etc., because I think the Indian and foreign patients here don't have the stomach for that. So, I mostly stick to the herbs, and I make six or seven varieties of combinations for each disease, and two of them work very well, and then I stick to them. So that is my product. It is Tibetan because it has Tibetan ingredients, and it is Tibetan knowledge, because if I know about the plants, then I can make my own combinations. It's in the scriptures! You use your brain and make your combinations! And then, these combinations – who is going to check them? How?

Leaving the technical difficulties involved in deciding where the limits of “Tibetan” medicine might be vis-à-vis innovation and modern science aside for now (see chapter 7), the issue of monitoring medicine production is clearly a thorny one, requiring both a

large bureaucratic apparatus and a considerable amount of legal power and moral authority, neither of which the CCTM possessed. The CCTM's dilemma is well illustrated by the imaginary example of the CCTM inspecting Dr. Yeshi Donden's pharmacy to check whether he compounded his medicines according to "Tibetan tradition" or not: this was, quite simply, unthinkable, not least for the CCTM governing board members themselves.¹⁴⁷ What was more, this dilemma was in serious danger of being exacerbated if Samdhong Rinpoche's Cabinet carried out its plans of turning the CCTM into a completely independent non-governmental organization, as it had already done – or tried to do – with several other institutions, including the Men-Tsee-Khang and the Tibetan Institute of Performing Arts (TIPA).

This leads us to a still deeper problem concerning the CCTM's legality, one that touches the very core of the Tibetan condition in exile. While Samdhong Rinpoche's well-known, and self-professed, aversion against the idea of government in general, and his Cabinet's efforts to reduce governmental spending in particular, certainly informed his plan to remove whatever weak links there still existed between his government and the CCTM, the overriding rationale of disinvesting the CTA from its (former) institutions was a different one. Like all Tibetans in exile, Samdhong Rinpoche was painfully aware that his government – despite its very real existence, its tacit (though not official) recognition by the Government of India, and the Dalai Lama's authority well beyond the Tibetan community – ultimately lacked, in the absence of an own state, not only executive powers, but also a legal basis. In this context, one strategy – the one apparently chosen by Samdhong Rinpoche – to gain undisputable legal security was to register as

¹⁴⁷ Credited for re-establishing Tibetan medicine in exile, Dr. Yeshi Donden was the most highly respected *amchi* alive in the Tibetan exile in 2008.

many institutions and parts of the CTA under Indian law as possible, for which however it was necessary to officially dissociate them from the exile-government (which, in itself, cannot be registered under Indian law).

Given the uncertain future of the Tibetan government in exile, especially after the inevitable demise of the current Dalai Lama, these (then officially “Indian”) institutions would survive even the worst-case scenario of the CTA’s collapse or dissolution. The government’s strategic, conscious transfer of its functions and responsibilities to non-political institutions and ostensibly non-state actors can be interpreted as an instance of both neoliberalism and governmentality, pointing to an interesting connection that is, however, beyond the scope of this dissertation. The drawback of this strategy, of course, is that the Tibetan government in exile voluntarily gives up whatever power and authority it has, and thus undermines its own claims of being the sole legitimate representative of all Tibetans. For the CCTM, this means that although its desired governmental status under the CTA would improve its authority among exile-Tibetan practitioners of Tibetan medicine, this authority would remain – in the absence of the CTA’s executive powers – largely a moral one; that is, transgressions would entail no real consequences apart from losing CCTM membership and gaining a bad reputation within the exile-community. As far as the legitimacy of its main objective – to establish a monopoly of power to control, regulate, standardize, and represent Tibetan medicine *anywhere* in exile – is concerned, an affiliation with the exile-Tibetan government would hardly make any difference at all: in real-political terms, the CCTM does not have the legal or moral power to represent Tibetan medicine either way. Dr. Tsering Jigme summed up the situation like this: “The CCTM can’t really do anything if someone practices without registration. This is because

although the CTA or the CCTM have passed laws regarding the practice of medicine, there isn't really any legal basis." Like the Tibetan government in exile, the CCTM is thus forced to employ alternative strategies of governance that do not rely on a state and its legal and executive powers. Unlike the exile-government, however, the CCTM not only lacks clear legitimacy and recognition within the Tibetan exile-community, but also the Dalai Lama's international moral authority.

The question, then, is how the CCTM envisions to regulate and control Tibetan medicine not just within, but also beyond the Tibetan exile-community. When I brought up this question in a conversation with Dr. Dorjee Rabten, he began by reiterating the need for control – especially as far as non-Tibetan medical practitioners were concerned:

DR: Definitely we need to have a little bit of control. Otherwise it will be very difficult, we can't just let them go roaming around freely and do whatever they like. After all, the job of the Council is to protect the interest of the people, and if the *amchi* from remote areas just go with their crude instruments and give physical therapy [e.g. venesection], without considering the risks of infection and so on... There are very rudimentary practices still going on, you know, so unless we control them...

SK: But that is my question: how do you control this kind of thing? I mean, too much control, and the people will not like it...

DR: No, no, when we say control, it is only through education and workshops. We bring experts, like last October [2007], and give them teachings, and tell them about the importance of all these rules and regulations, the importance of following the preliminary procedures, so that they don't end up in any legal trouble. All this is through education.

It was not without reason that Dr. Dorjee Rabten placed so much emphasis on education as the CCTM's primary means of governance and control. On the one hand, workshops

and seminars provided a convenient avenue to exert some measure of influence and control especially over less-educated *amchi* not only by training them in “correct” or “safe” medical or pharmaceutical procedures, but also by indirectly producing the truth of the Tibetans’ superiority in – and ownership of – Tibetan medicine. Indeed, as became clear in conversations with dozens of *amchi* from all backgrounds all over India, the consistent distribution of roles between Tibetan *amchi* – usually from the Men-Tsee-Khang – as teachers, and non-Tibetan, non-Men-Tsee-Khang *amchi* as students, significantly shaped identities and relations of power. On the other hand, as long as the latter aspect did not become too obvious and the education was offered in a more or less genuine way, the concerned *amchi* would voluntarily accept the CCTM’s authority as just and beneficial for their practices and concerns. Dr. Stanzin Wangchuk, a Ladakhi Men-Tsee-Khang graduate who had left the institute to teach Tibetan medicine at the CIBS, made this point very clear:

The Ladakhis or others, when we go with the CCTM, it is mostly for good relations and more facilities, that’s why we do it. [...] The CCTM sometimes comes here, and organizes workshops together with the CIBS; last year there was a three-day workshop at CIBS... But if they start to claim by this that the Ladakhi *amchi* know nothing, and therefore we have to train them, then the Ladakhi *amchi* will not accept this. We have our own value. If the Tibetans have a kind of attitude of superiority, of looking down upon us, then we would certainly not go with them anymore. Even the CIBS, if the CCTM makes lots of requirements for us, then we will not try to get further registration. But otherwise, it is a nice link with the Tibetans and good to keep harmony. Only if they feel superior or have a political agenda, then we will have nothing to do with them. We are two different countries, and that’s just an association.

In a context of already ambivalent relations between Tibetans and Ladakhis, where the latter's latent (and historically derived) feelings of cultural inferiority manifest as an extreme sensitivity against any signs of Tibetan hegemony, the CCTM had to tread very carefully indeed. Until 2008, when I visited Ladakh and had the above conversation, it seemed to have been relatively successful in avoiding any bad feelings, as also Dr. Stanzin Wangchuk conceded: "so far they haven't shown any superiority complex."

The benefits of a CCTM registration and membership did not remain limited to access to workshops and seminars, however. They also included official certificates and ID cards – especially attractive to those *amchi* without graduation certificates – and, as CCTM representatives never tired of emphasizing, legal support in the case of lawsuits against a member *amchi*. Dr. Tsewang Tamdin, who – like most Men-Tsee-Khang doctors in higher ranks – was careful to demonstrate his support of the CCTM, summed it up in this way:

If someone is not registered, then the CCTM will not help him in case of legal problems. There will also be no support for study. It is of more benefit to be registered. Only benefits, no disadvantage! It's to upgrade education, for registration, recognition, legal protection... It is also good for everyone else: You can ask a Tibetan doctor for his registration, and if he doesn't have one, you know he is fake.

What Dr. Tamdin only implied between the lines, of course, was the fact that the CCTM was less concerned about providing legal protection for its individual members than about protecting Tibetan medicine as a whole against potential legal challenges and damages to its reputation in the future. On the one hand, apart from the twelve CCTM members who practiced in the West, legal protection was of not much concern to most

amchi practicing in India. On the other hand, and much more importantly, the CCTM's power to actually provide legal support to its members in the case of a lawsuit was highly doubtful in any case, lacking as it did both the necessary financial resources and a sound legal basis itself. Therefore, the CCTM's strategy was one of prevention, by ensuring that all its members practiced Tibetan medicine according to the highest possible standards, and to exclude those who did not. There were two rationales involved here: one, that those practicing Tibetan medicine properly (i.e. its members) were unlikely to run into legal trouble; and two, that the CCTM could distance itself – and, as its official representative, Tibetan medicine – from any non-member endangering, out of ignorance or greed, the health of the population through malpractice, adulteration, and the like.

In the end, all the CCTM's discourses about the benefits of registering as a member boil down to a simple fact. That is, its power to regulate, control, and represent Tibetan medicine in exile ultimately depends on its good relations with – and the voluntary acceptance of – the community of *amchi*. This applies to institutional *amchi*, private *amchi*, and especially to non-Tibetan practitioners of *gso ba rig pa*. As usual, Dr. Tsewang Nyima identified the crux of the issue most clearly:

The important thing for the CCTM right now is to establish relationships with all the concerned Tibetan medical institutes and colleges wherever they are situated in the world. And to gain the acceptance from all the Tibetan practitioners and medical staff. That's the main thing, to have a good understanding with the people who you are actually working for. [...] You see, it's so difficult for the CCTM to control the private activities. They can definitely lay down guidelines, create an awareness how we should work together hand in hand, trying to preserve and develop Tibetan medicine, but they can't really lay down a rule that you can't go

abroad and do a consultation. These days we can't dictate anything, we just need to earn the respect and acceptance of the people.

In other words, as the CCTM lacks both the legal and the executive authority to govern Tibetan medicine in exile, it is forced to establish itself as a moral authority instead – an authority that people submit to voluntarily, whether out of self-interest, a sense of moral obligation, or a mixture of the two. In contrast to the exile-Tibetan government, which, as described in the previous chapters, also relies primarily on ethical practices and moral authority to govern its nation without a state, the CCTM however had no traditional legitimacy to build on. Quite literally starting from scratch in an already complicated situation of multiple, conflicting interests and legal uncertainty, the CCTM was charged – like the Men-Tsee-Khang before it – with the governmental responsibility to protect Tibetan medicine, preserve Tibetan culture, and represent the interests of the Tibetan nation.

After the Revolution

In view of the CCTM's undeniable weakness, the question arises whether the "Sorig Revolution" was in fact a revolution or merely a bold magazine headline. I suggest that this question is best answered not by focusing on the CCTM's achievements – or absence thereof – in terms of its theoretical objectives, but by considering its real – even if partly unintended – effects. Indeed, although the CCTM has so far been relatively unsuccessful in fulfilling its envisioned governmental responsibilities, its official taking over of what had previously been the Men-Tsee-Khang's duty and privilege could not remain without

far-reaching consequences for both the Men-Tsee-Khang and Tibetan medicine in exile in general. Let us consider the Men-Tsee-Khang first: did it really become, as Dr. Tsering suggested, “just the same like private doctors”? Was its development really harmed?

As one might expect, considering the Men-Tsee-Khang’s ambivalent status between ethics, politics and business (as both political and apolitical, both governmental and business-oriented) described in the previous two chapters, there is no straight answer to this question. It is certainly true that the Men-Tsee-Khang has been officially relieved of its responsibility to protect the quality of Tibetan medicine beyond its institutional boundaries. Thus, neither does it have the duty to conduct exams or issue certificates for other institutions (like the Chagpori or CIBS), nor are these institutions obliged to approach the Men-Tsee-Khang for such matters anymore. Indeed, it seems that after its initial outcry, the Men-Tsee-Khang was quite content about this burden of extra work being lifted from its shoulders. In 2007, the institute told the CIBS – which would have been happy to receive continued support from the Men-Tsee-Khang – that this was not its duty anymore, and the CIBS better look elsewhere (i.e. the CCTM) for help with its exams and certificates. In short, there is no doubt that it has become easier for the Men-Tsee-Khang to shrug off inconvenient governmental responsibilities, especially since Samdhong Rinpoche had warned the institute in 2007 to not use the title “*bod gzhung*” (Tibetan government) in its official name anymore.¹⁴⁸ In a way, then, Dr. Tsering had a point: in principle, since 2004 there was increasingly little that distinguished the Men-Tsee-Khang from private doctors.

¹⁴⁸ According to senior Men-Tsee-Khang *amchi* I asked about this, Samdhong Rinpoche had indeed said something to that extent, but did not issue any order in writing.

On the other hand, there is much evidence that directly contradicts this conclusion. By late 2008, the Men-Tsee-Khang had shown no signs of intending to remove “*bod gzhung*” from its name, whether on its rubber stamps and letter heads, its precious pill containers, or the speaker’s podium in its main assembly hall. Even more importantly, as is evident from the quotes I have presented so far, all the interview data that I gathered between 2005 and 2009 (the bulk of it between 2007 and 2008) strongly suggest that the Men-Tsee-Khang still very much regards itself – and is seen by the Tibetan public – as the most important guardian of Tibetan medicine in exile. Indeed, many Men-Tsee-Khang doctors explicitly denied that the CCTM had much effect on the institute’s role or progress. In Dr. Tsering Jigme’s words, “the Men-Tsee-Khang is progressing regardless of the CCTM; it doesn’t have such a big effect.” One of the institute’s senior-most doctors I talked to similarly remarked when I asked her about the CCTM’s effects on the Men-Tsee-Khang: “It doesn’t have much effect. The Men-Tsee-Khang is on its own way.”

There is little doubt, even among non-Men-Tsee-Khang *amchi*, about where the real power lies as far as Tibetan medicine is concerned: with its 50 branch clinics, over 120 doctors and several hundred staff members, a well established infrastructure, full bank accounts, and its status as the first and oldest Tibetan medical institution in exile, not to mention the Dalai Lama’s backing, the Men-Tsee-Khang remains the dominant power of Tibetan medicine in exile. The contrast to the five-year old, underfunded CCTM with its single office shared by its two permanent staff could not be bigger. When I asked Dr. Dorjee Rabten about his opinion on that matter, his answer was straightforward:

I would say the Men-Tsee-Khang tops, when it comes to having influence on Tibetan medicine. That's because the CCTM is still only trying to stand on its own feet, while the Men-Tsee-Khang has all sorts of infrastructure available. So even in the CCTM, if we want to do something in terms of policies, or giving higher workshops to improve the doctors' skills, we depend on the Men-Tsee-Khang in terms of finances and human resources.

However, the very real imbalance of power between the Men-Tsee-Khang and the CCTM – manifest so visibly in the latter's dependence on the former in virtually every respect – stood in stark contrast not only to their official distribution of roles and responsibilities, but also to the Men-Tsee-Khang's weak representation in the CCTM governing board with only three out of eight de-facto members. It does not require much imagination to surmise that the Men-Tsee-Khang, unhappy from the beginning about its loss of official power, was lobbying hard to gain more influence within the CCTM. Indeed, after much petitioning, it was finally granted a fourth seat on the Council with effect of March 2010, making the number of its representatives equal to that of the private practitioners. When I brought the matter of the Men-Tsee-Khang's influence up with Dr. Tsering, just after his complaint about the CCTM's harmful effects on the institute, he half jokingly gave me his vision of making the CCTM acceptable to the Men-Tsee-Khang:

SK: But the Men-Tsee-Khang still has quite a lot of power, doesn't it, since four CCTM members are Men-Tsee-Khang doctors...

T: Up to now we only had three out of eight members. But yes, we asked the CCTM, so now we get a fourth member, I don't know who it will be. Then maybe a fifth, a sixth, a seventh, an eighth member, then it's ok again. [laughs]

According to Dr. Dorjee Rabten, however, the number of representatives hardly ever mattered in a direct way under his chairmanship since 2007, since the CCTM governing board made efforts to avoid votes on important decisions (which would inevitably be along partisan lines), and instead reach its decisions unanimously. This was not to say, of course, that these decisions were not preceded by at times heated debates, during which the relative strength of each faction did influence the direction of the CCTM's policies. When I asked him to describe CCTM board meetings, which except for one or two short occasions I was not able to observe, he told me:

DR: Of course, on some policy issues there definitely are very heated exchanges between the representatives of the Men-Tsee-Khang and those of the private practitioners. This was especially the case during the first tenure of the CCTM [from 2004 to 2007]. Now, during my tenure, the CCTM's second term, we tend to really understand each other well and try to see the larger interest. We always try to come to some kind of consensus... there has not been a single instance where we had to vote. You know, if we don't come to a consensus, we have to vote. So when it comes to voting, this creates some conflict and tensions... [laughs] But yes, of course [sighs], even the private practitioners bring some issues that concern them...

SK: Can you give me some examples?

DR: Well, for example when it comes to the centers and colleges of Tibetan medicine, of Sowa Rigpa: the Men-Tsee-Khang tries to have a stronger, a more broad-minded approach, and really focus on the standardization and the quality of the institutions, the doctors, and the students. Whereas the private doctors – and there are *many!* – they want to serve their own interest; so they want more liberal policies from the CCTM in this regard, while the Men-Tsee-Khang wants stronger policies. Then there is a tension! [laughs]

SK: And who gets the upper hand usually? Is it the Men-Tsee-Khang who gets its way?

DR: I think so, yes. In our meetings we try to come to some kind of consensus, in which the real need and wisdom prevails over the private needs [laughs].

While Dr. Dorjee Rabten's account provides valuable insights into the CCTM's internal decision-making processes, it is clearly colored by the fact that he himself represents – self-consciously so, and not without a sense of irony – the Men-Tsee-Khang's standpoint. This is very obvious in his contrasting the private doctors' "selfish interests" to the Men-Tsee-Khang's "broad-minded approach" representing "the real need and wisdom". What is less obvious, and what this kind of discourse aims to hide, however, is the fact that the Men-Tsee-Khang's political power, both within the Central Tibetan Administration and the field of Tibetan medicine in exile, is – and has always been – very limited.

For example, the CCTM's recent decision to offer *menrampa* degrees to independent *amchi* – an old demand that the Men-Tsee-Khang had long resisted – can hardly be seen as a demonstration of the institute's power to have its "wisdom" prevail over "private needs". We have also seen the Men-Tsee-Khang's virtual impotence to push its draft rules concerning the regulation of Tibetan medicine through the exile-government, which was at a time when all three personal physicians to the Dalai Lama were still alive and the institute much stronger than today.¹⁴⁹ After having been unable to prevent the CCTM from taking over its official role, it was similarly unsuccessful in at least securing a majority of representatives on its governing board, or preventing its

¹⁴⁹ Whether this was actually a matter of a general condition of political impotence or rather one of an astounding lack of professionalism, coordination, and planning on part of the Men-Tsee-Khang administration at the time, is an open question. Whatever the reason, however, the fact remains that the Men-Tsee-Khang had little direct political power before, during, and after the establishment of the CCTM.

initially stringent rules from getting watered down in the interest of private doctors. For one of the most attentive and critical observers of Dharamsala's political and social developments over the past decades that I talked to, the ultimate sign of the Men-Tsee-Khang's impotence was the government's extensive inclusion of Bon references in the CCTM's charter: "If they can't even oppose this Bonpo deputy throwing his Bon stuff into the CCTM's constitution, then they can't have much power. No, they have no power, the others do what they like..."¹⁵⁰ According to Professor Lobsang Tenzin Rakdho at Sarnath, this state of affairs was nothing new: "Even before the CCTM, the Men-Tsee-Khang did not have much influence. So there is not much change – it's only psychological for them." The Men-Tsee-Khang's very limited power to regulate Tibetan medicine at large was also confirmed by Dr. Pema Dorjee, one of the Men-Tsee-Khang's senior-most physicians and the CCTM's first chairman, when he explained to me the rationale behind the CCTM:

PD: See, the CCTM was mainly established to keep the Tibetan medical tradition alive. This is very important. Otherwise, if you leave it like that, it will be spoiled by untrained practitioners, who maybe studied for a few months and then claim that they are Tibetan doctors. [...] So it's important to have a council: we need somebody to take care and lead, for the preservation of Tibetan medicine...

SK: In that regard, wasn't the Men-Tsee-Khang more or less responsible for this, before the CCTM?

PD: Definitely. The Men-Tsee-Khang is the official institute in and outside of Tibet. But it is just an institute, and its rules and regulations are not applicable to every medical practitioner. We have many private practitioners, and we cannot really order them, as a medical institute, to do

¹⁵⁰ Indeed, even during the CCTM's first tenure under the chairmanship of Dr. Pema Dorjee, the Men-Tsee-Khang had still tried to reduce the Bon references in the CCTM's constitution, but to no avail.

this or that. To order, you really need to have some kind of legislation, and we don't have that. [...] So that is why we felt that it is necessary to have a medical council, which is accepted by all the medical practitioners, including the Men-Tsee-Khang, Varanasi, the Chagpori in Darjeeling...

To sum up, the question about the Men-Tsee-Khang's power seems to be yet one more ambivalence added to the institute's ambiguous nature. Having always been, and still remaining, the most powerful institution of Tibetan medicine in exile – be it in terms of financial power, human resources, public health presence, public opinion, or political connections – it has also been, throughout its history, strangely powerless to exert any direct control over its field of expertise. This is not to say, of course, that the Men-Tsee-Khang has not profoundly shaped Tibetan medicine and its global spread by its sheer presence and success, nor that it did not wield considerable influence by prescribing other institutes' syllabi, conducting their exams, or issuing their certificates. It is to say, however, that – as much as the Men-Tsee-Khang may have desired to do so – it has, as an institute without clear legal powers, consistently been unable to directly regulate and control Tibetan medicine in exile according to its wishes. Against the Men-Tsee-Khang's hopes, the CCTM did nothing to improve this situation; but contrary to its fears, the CCTM also had few, if any, negative effects on the institute so far. It did, however, as both Dr. Tsering and Professor Lobsang Tenzin pointed out, have a lasting psychological effect on the Men-Tsee-Khang.

To be sure, this psychological effect did not include a sudden and dramatic change in the Men-Tsee-Khang's perception of its role or governmental responsibilities (or, as private doctors would see it: hegemonic ambitions). Rather, it was as if the CCTM's establishment finally created a shock that was strong enough for the Men-Tsee-

Khang to be jolted out of its long-cultivated illusions of power. In other words, the psychological effect consisted in the belated, but all the clearer, realization that the Men-Tsee-Khang was not alone anymore in the field of Tibetan medicine: the institute did not, and would never have, its desired monopoly of power, but rather had to operate in an increasingly pluralistic context of independent clinics and pharmacies that pursued their own interests. The private doctors, just like the Himalayan *amchi*, were here to stay, and their presence and demands could neither be ignored nor silenced. The Men-Tsee-Khang had to fundamentally rethink its position in relation to them.

By the time the CCTM's second three-year term had begun in 2007, there were clear signs that the Men-Tsee-Khang was indeed adjusting to the changed realities. This was mostly visible in two strategic decisions: to introduce, beginning with the 16th medical and 8th astrological batch of students in 2007, tuition and boarding fees at the Men-Tsee-Khang college;¹⁵¹ and to rethink Lobsang Samten's decision from the 1980s to not sell medicines to private practitioners. Men-Tsee-Khang officials were very outspoken about the rationale behind the first decision, which was that nowadays, the Men-Tsee-Khang could not count on its students to work for the institute after their graduation. Instead of continuing, as the institute had done for so long, to be upset about those who left after receiving free education (and accuse them as being selfish and ungrateful), the Men-Tsee-Khang now made sure that the loss of manpower at least did not incur financial losses as well. More than just preventing financial losses, the tuition fees also prevented bad relations between the institute and its former graduates, who were now neither expected nor under any moral obligation to remain with the Men-Tsee-

¹⁵¹ In 2007-8, these fees amounted to 2500 Rupees per month, and included tuition, boarding, and lodging. The College still actively helped students find sponsors (and indeed more than half of all students were sponsored), but did not guarantee sponsorship anymore.

Khang. In short, the Men-Tsee-Khang conceptually separated its college from the rest of the institute, thus fundamentally redefining the college's purpose from producing the *Men-Tsee-Khang's* future human resources to producing *Tibetan medicine's* future practitioners. The Men-Tsee-Khang's plans to shift its college to Chauntara and expand and upgrade it to a Tibetan medical university (see chapter 2) are merely a logical expansion of that idea.

The institute's administration was less outspoken about the reasons behind its plans to start selling its medicines to private doctors. These plans were connected to another part of the Men-Tsee-Khang's plan of expansion, namely the construction of a new, much larger pharmaceutical unit in Chauntara. The Men-Tsee-Khang's own growing demand for medicines, as well as the importance to separate the production of its regular herbal pills from that of its metal-containing pills (like *rinchen rilbu*) to meet international safety standards, were both obvious and important reasons to build a new pharmacy; but why change a decade-old policy all of a sudden and help private *amchi* meet their own growing demands for medicines as well? The explanation, again, is the Men-Tsee-Khang's newfound awareness that private doctors would neither disappear nor be prevented to expand their practices abroad simply because the Men-Tsee-Khang refused to sell its medicines to them. Instead, as some had already foreseen and warned in the 1980s, Lobsang Samten's policy had only served to make private *amchi* stronger and more independent, leaving the Men-Tsee-Khang with almost no influence over them.¹⁵²

The policy change, then, marked a radical shift in the Men-Tsee-Khang's attitude towards private *amchi*: instead of regarding them as morally flawed enemies in a "cold

¹⁵² To be fair to the Men-Tsee-Khang, it would have been unable to sell its medicines on a wider scale anyway, as it often struggled to produce enough even for its own, internal demand.

war,” the institute now seemed to realize that it could benefit from them by selling them its medicines – still widely considered the best – for a profit. For the Men-Tsee-Khang, this move brought several advantages. Apart from the added income from selling its medicines in bulk, and the resulting increased capacity to engage in ethical practices that would further cement its dominance in the field, the Men-Tsee-Khang now also stands to gain a certain amount of control over its competition and Tibetan medicine in exile as a whole. On the one hand, to the extent that retailers depend on the wholesaler, private doctors would come to depend, at least to some degree, on the Men-Tsee-Khang for their medicine supply. The Men-Tsee-Khang could thus not only indirectly influence the prices these doctors would charge for their medicines – and offer them cheaper to its own patients – but, depending on its market share, it would automatically have some influence over the quality of Tibetan medicines beyond its own clinics. In short, it would directly compete, from a position of strength, with the private pharmacies that have so far had a monopoly in catering to private practitioners, and thus re-establish itself as an active and powerful player in the changed context of contemporary Tibetan medicine in exile.

In many ways, then, the CCTM’s “Sorig Revolution” was indeed a revolution, with profound and far-reaching effects on Tibetan medicine. By establishing, for the first time in exile, a platform of communication where the most important actors in the field could negotiate their interests as more or less equals, the CCTM reshuffled old and obsolete power structures. On the one hand, it gave private practitioners a strong voice and an unprecedented level of influence at the Men-Tsee-Khang’s expense. On the other hand, however, it also confronted the Men-Tsee-Khang with certain realities it had long chosen to ignore, thus forcing it to productively rethink its position in the increasingly

pluralistic field of Tibetan medicine. Although in 2008, the Men-Tsee-Khang's power was still visibly declining, as it had since at least 2003, there was every possibility that the institute might emerge stronger and better able than ever before to fulfill its governmental responsibility of "preserving" Tibetan medicine through constant reinvention. In any case, for better or worse, Tibetan medicine in exile has at long last re-acquired some of the pluralism that marked its traditions in old Tibet, and the Men-Tsee-Khang's days of acting as – or imagining to be – the sole legitimate owner of Tibetan medicine in exile are over for now. The Central Council of Tibetan Medicine's achievement was not so much to initiate or cause this development, but to make it visible and help shape its future course.

It is at the intersections of the different interests of Tibetan medical practitioners, institutes, and concerned governments where Tibetan medicine in exile is shaped and its development determined. As I have tried to show in this and the preceding two chapters, these interests can be summed up as business and politics in their widest sense, ranging all the way from exploiting Tibetan medicine for quick personal profits, through making an honest living as an *amchi* or engaging in ethical practices as an institution, to developing Tibetan medicine, preserving culture, and producing a Tibetan nation. One such intersection between business and politics is the Men-Tsee-Khang, which, as we have seen, needs to balance its governmental, political duty with the necessity and temptation to make profits. Another is the CCTM, a platform representing the varied professional – but mostly economic and political – interests of the Tibetan exile-government, the Men-Tsee-Khang, other Tibetan medical institutes, and private doctors of both Tibetan and non-Tibetan nationality. Struggling to provide a distinct body and

shape for Tibetan medicine and culture to protect them from, and simultaneously connect them with, modern politics and the global market – with the aim to imagine, produce and govern a modern Tibetan nation – the CCTM (and also the Men-Tsee-Khang) functions as a modern reformulation of a traditional ethical institution (Tibetan medicine) within the capitalist market system, nationalism and transnational governance.

As we will see in the next two chapters, yet other intersections can be seen in the ongoing efforts by Tibetan and Ladakhi *amchi* to get Sowa Rigpa officially recognized by the Government of India (chapter 6), or the related encounter of Tibetan medicine and modern science (chapter 7). At each of these junctures, different economic and political interests of a multitude of actors become visible as they meet – at times conflicting, partly overlapping, or supporting each other. After centuries of isolation on the roof of the world and decades of near-homogeneity in exile, Tibetan medicine seems to have returned to its beginnings, when it was the product of a global exchange of knowledge, goods, and ethics. This time round, it is politics and the capitalist market that form the matrix through which Tibetan medicine is reinvented, and that are, in the process, reinvented by Tibetan medicine.

6. The Recognition of Sowa Rigpa

Saving, preserving, and promoting Tibetan medicine is not only about clinical practice, pulse and urine analysis. It's also about getting legal recognition. Our doctors get visas to travel to Europe, but Tibetan medicine does not have a visa.

Dr. Dorjee Rabten

If there is one theme that has informed and shaped the development of Tibetan medicine in exile – and its efforts to save Tibetan culture and help the world – during the past decade more than any other, then it is the legal recognition of Tibetan medicine. Indeed, whether it is Tibetan medicine's political or economic role; the CCTM's ongoing efforts of regulation and standardization; the Men-Tsee-Khang's modernization and interactions with modern science (see next chapter); current re-articulations of the Tibetans' (historically hegemonic) relations with other Tibetan Buddhist peoples along the Himalayas (especially the Ladakhis); the Tibetan exile-government's relationship to the Indian state and other countries; or even Tibetan medicine's historiography – there is hardly an aspect of exile-Tibetan medicine that is not directly connected to the issue of legal recognition. One of the first questions I asked different *amchi*, at the beginning of my fieldwork in Dharamsala in late 2007, was about what they thought was the biggest and most pressing challenge for Tibetan medicine today. The answers were virtually uniform: “The most important thing is to meet the legal needs at this time.” (Dr. Dawa Lobsang) Some, like Dr. Sonam Dhondup from the CIHTS, even went so far as to see

Tibetan medicine on an existential brink between life and death: “if we don’t get recognition, Tibetan medicine won’t survive in exile.”

As strong and universal the exile-Tibetan doctors’ emphasis on the importance of Tibetan medicine’s legality may have been, though, it was a very recent phenomenon. Indeed, Tibetan medicine’s technical illegality in India and most of the rest of the world¹⁵³ – expressed by Bhagwan Dash already in 1964 at the occasion of his official visit to Dharamsala (“*medical practice without the permission of the Indian Medical Council is not allowed on Indian soil*”) – had remained of little concern to both Tibetans and Indians for the first three decades after its re-establishment in India. Clearly, there had been no need for concern: despite its technical illegality – or perhaps *because of* its remaining outside the Indian state’s bureaucratic and regulatory apparatus – Tibetan medicine in exile grew from a poor medical center with less than a handful of doctors and students in the early 1960s to over 70 Tibetan clinics¹⁵⁴ all over India (not counting Himalayan *amchi*), catering to over 700,000 patients per year (over 90% of whom are Indian) in 2010. From poor villagers in Bihar and Orissa to business leaders like the Tatas or Ambanis, from individual Indian MPs to elite institutions like the All India Institute of Medical Sciences (AIIMS) or the Indian Ministry of Defense,¹⁵⁵ India seems to have

¹⁵³ Tibetan medicine is recognized as a legitimate part of the official health care system only in a handful of countries, including China, Bhutan, and Mongolia. In India, Tibetan medicine is recognized at state level in Jammu & Kashmir, Sikkim, Arunachal Pradesh and Orissa, and semi-recognized in Himachal Pradesh, but not by the central government.

¹⁵⁴ This number includes 50 Men-Tsee-Khang branch clinics, the clinics run by the Chagpori Institute in and around Darjeeling, the CIHTS in Sarnath, and the CIBS in Choglamsar, and an estimated number of private clinics in Dharamsala, Delhi, Kolkata, South India, and elsewhere.

¹⁵⁵ In early 2007, the Indian Ministry of Defense contacted the Men-Tsee-Khang about possibilities to treat altitude sickness with Tibetan medicine. As one Men-Tsee-Khang employee told me: “They [the Indian army] have the problem that they train their *jawans* in the plains, and then, as soon as they transfer them up near the Tibetan or Pakistani border in Ladakh and so on, they are completely useless. Apparently they heard about the Men-Tsee-Khang and Tibetan medicine from some Tibetan serving in the Indian army. So some senior Men-Tsee-Khang doctors and I went to the army headquarters and gave a presentation. The first question they asked after the presentation was, ‘do you have an official

embraced Tibetan medicine. Indeed, the embrace is tighter than many contemporary exile-Tibetan *amchi* would wish for: Tibetan medicine is claimed as being “Indian”.

The claim itself is not new, and has in fact served the Tibetans well for over three decades. Deeply impressed by Tibetan medicine after his visit to Dharamsala, Bhagwan Dash wrote a report to the Indian Health Ministry arguing that Tibetan medicine was actually a form of Ayurveda that India had lost, and that it was therefore in India’s own interest of cultural preservation to support it. As he told me in an interview in March 2008,

It’s about preserving Indian culture... Ayurveda has lost a lot of texts in the medieval period, because of the Mughals and also the Buddhists. All that’s lost in Ayurveda is in the *rgyud bzhi*! There are very few new concepts in Tibetan medicine. For example pulse diagnosis: it was there in the Shaiva tradition of Ayurveda. Then there were internal conflicts with the Brahmic tradition, and the Shaiva tradition got lost. Today, Ayurveda is only the Brahmic tradition, but the Shaiva tradition is preserved in Tibetan medicine. [...]

All the meters in the *rgyud bzhi* indicate that it’s a translation from Sanskrit. It’s not original. But the Sanskrit texts on which it is based are lost. So the two should complement each other. What Ayurveda has lost is preserved in Tibetan medicine, but Tibetan medicine can’t be understood without Ayurveda. [...]

Now, for India to think that Tibet is a foreign country is a mistake. For Tibetans to think that they have a different culture is a big mistake!

Of course, Bhagwan Dash’s denial of a unique Tibetan culture, and of the Tibetans’ authorship and ownership of Tibetan medicine, flies directly in the face of everything

registration?’ Of course we told the truth and said no, but then they said that it was no problem, since we are quite established and have been practicing for a long time in India.”

Tibetans in exile stand and fight for. Coming, as it does, from one of India's most influential Ayurvedic scholars with direct connections to the central government, this makes the Tibetans' discomfort about India's embrace of one of their most cherished symbols for a unique culture and existence as a nation more than understandable. Yet, for a long time, the Tibetans had suffered the embrace gladly. Bhagwan Dash's 1964 report served as the foundation for the semi-official rationale in Indian government circles that Tibetan medicine – as just another form of Ayurveda – did not need any separate recognition. The resultant freedom to practice and expand Tibetan medicine without any official interference on part of the Indian government suited the Tibetans well, all the more so since they were not aware of the detailed contents of Bhagwan Dash's report, which remained classified. The Indian government, for its part, had its hands full with the recognition, regulation and standardization of Ayurveda, Unani, and Siddha, and was glad to oblige the Dalai Lama's request to not cause Tibetan medicine any trouble. Thus, for much of the next three decades after 1964, both sides – the Indians and the Tibetans – were happy with this practical arrangement, and with the belief that their own unique cultures were being preserved.

This peculiar situation, however, had drastically changed by the time I arrived in Dharamsala in 2007. Tibetan *amchi* across all institutional affiliations and internal divisions were up in arms against Indian attempts to appropriate Tibetan medicine as a lost form of Ayurveda, that is, as an “Indian medicine”. As Dr. Sonam Dhondup from the CIHTS put it:

We need to be very cautious, because if we acknowledge that it [Tibetan medicine] is just Ayurveda, then we have a total cultural genocide. On the

surface, the Indian government is quite genuine and kind to us Tibetans, but underneath they are killing us slowly.

While this statement may sound drastic, it summed up well the Tibetans' concerns in 2007. Between the 1960s and the 2000s, the Indian embrace of Tibetan medicine had somehow turned from a cozy arrangement of mutual happiness into a threat against Tibetan culture and nation. What had happened? And what had turned Tibetan medicine's legal recognition into the *amchi*'s top-priority so suddenly, after such a long and comfortable existence in the legal grey zone?

In answering these questions, this chapter will reveal the complex political context in which Tibetan medicine's ethical, cultural and nationalist agenda that we have learned about so far operates. Indeed, we will see how exile-Tibetan efforts to legalize their medicine in India and beyond in order to "preserve" their culture and "help the world" (and heal their nation while doing so) need to negotiate multiple economic, cultural and political interests – including those of Buddhist Himalayan peoples, the Indian government, the shadow of China's might, and a global public. Beneath the multitude of political strategies, economic interests and personal ambitions that we will encounter in the pages below, however, is one main theme: how, and for what reasons, is a "traditional medicine" linked to – or disconnected from – a particular national identity?

Legalizing Tibetan Medicine

Let us begin with a brief look at the wider context of traditional or alternative medicines in India, and the history of Tibetan medicine's relations with the Indian state. In the

1960s, when Bhagwan Dash visited Dharamsala, biomedicine was still the only officially recognized and supported medical system in India, although political battles for and against the recognition of Ayurveda had already been underway for quite some time then (cf. Leslie 1968, 1973, 1974, 1976b). The so-called “Indian systems of medicine” (ISM) – that is, Ayurveda, Unani, and Siddha – only gained official recognition as legitimate Indian medical systems in the late 1960s, first with the establishment of the Central Council of Research in Indian Medicines and Homeopathy (CCRIMH), and then, in 1970, with the passing of the Central Council for Indian Medicines (CCIM) Act and the simultaneous establishment of the CCIM.¹⁵⁶ Homeopathy, which also enjoyed strong political support in India but was grouped together with the Indian systems of medicine in the acronym “ISM-H” (“H” standing for homeopathy), received its own Central Council for Homeopathy in 1973. Apart from lobbying for power and funding as the political representatives of ISM-H, these Central Councils had the purpose of regulating and standardizing the practice of ISM-H especially through the introduction of educational standards and degrees (like the BAMS or the BUMS),¹⁵⁷ the registration of medical colleges, and the enforcement of pharmaceutical standards. The erstwhile CCRIMH was split up in 1978 into different research councils in order to better promote and coordinate scientific research into these medicines: the Central Council for Research in Ayurveda and Siddha (CCRAS),¹⁵⁸ the Central Council for Research in Unani Medicine (CCRUM), and the Central Council for Research in Homeopathy (CCRH). In 1979, finally, the

¹⁵⁶ The similarity in name and structure between the Central Council of Indian Medicines (CCIM) and the Central Council of Tibetan Medicine (CCTM) was an intentional strategic decision on part of the Tibetans.

¹⁵⁷ BAMS: Bachelor of Ayurvedic Medical Sciences. BUMS: Bachelor of Unani Medical Sciences.

¹⁵⁸ In March 4, 2010, the Indian Union Cabinet decided to bifurcate the CCRAS and establish a separate Research Council for Siddha. This decision was the culmination of over a decade of efforts by representatives of Siddha medicine to escape Ayurveda’s dominance.

Indian Drugs and Cosmetics Act was amended to include detailed regulations for the production of Ayurvedic, Unani, and Siddha medicines intended for commercial sale. In 1995, the political representation of ISM-H received a further boost with the establishment of the Department of ISM-H under the Indian Ministry of Health and Family Welfare, which was renamed in 2003 into the Department of AYUSH.¹⁵⁹ All together, the Indian systems of medicine under AYUSH today receive several billion Rupees of governmental funding for research and education each year, and form a powerful political and medical establishment with Ayurveda at the helm.

With all the political battles and bureaucratic marathons surrounding the official recognition and establishment of ISM-H during the 1960s, 70s, 80s, and 90s, it is not surprising that Tibetan medicine's arrival on the scene was happily disregarded, all the more so since both its medical and its political presence were negligible. There were sporadic offers on part of Indian bureaucrats since the 1980s to "recognize" Tibetan medicine as Ayurveda, an uncomplicated and quick process that would have brought considerable funding for Tibetan medical institutions, but they were consistently turned down by the Tibetans. Besides the issue of cultural identity, the Tibetans had their hands full with reestablishing Tibetan medicine in exile, even without having to navigate the jungles of Indian bureaucracy or battling Ayurvedic chauvinism. Thus, apart from some discussions at the Men-Tsee-Khang in 1967 and again under Lobsang Samten in the early 1980s, and some half-hearted individual attempts by private *amchi* (Dr. Tashigang and Dr. Tsewang Dolkar) to get official recognition for Tibetan medicine during the 1980s,

¹⁵⁹ AYUSH stands for Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homeopathy, all of which are officially recognized health care traditions under Indian law. "Ayush" is also a Sanskrit term referring to "life", with the connotation of a "healthy, long life". The AYUSH Department is charged with the standardization and regulation of ISM&H, especially by upholding educational standards, supporting research, and the cultivation of medicinal plants. See <http://indianmedicine.nic.in>

nobody gave Tibetan medicine's legal status much thought until the 1990s. All the while, the Men-Tsee-Khang and the Tibetan exile-government followed their strategy of ensuring a certain amount of legal security by cultivating good relations with high Indian politicians in Delhi, whether by posting some of its best physicians to Delhi's Nizamuddin branch clinic, or in arranging private meetings with the Dalai Lama. In a long conversation at his Tibet Center in Chicago in 2008, Tsering Tashi told me an anecdote from his days as the Men-Tsee-Khang's director during the 1990s, illustrating both Indian attempts to recognize Tibetan medicine as Ayurveda and the Men-Tsee-Khang's strategy of using its high-profile patients as a security against legal challenges:

TT: The Ayurvedic officials were, in a way, quite jealous of Tibetan medicine. So they wanted Tibetan medicine under them, and offered a lot of financial help. Our policy was to stay away from them, for many reasons.

SK: Could you tell me these reasons?

TT: Well, because they wanted to recognize Tibetan medicine as Ayurvedic medicine. Many things are similar to Ayurveda, but it's not the same. We want to call it Tibetan medicine. And once it comes under Ayurveda, financially we may benefit, but the Men-Tsee-Khang would surrender our medicine to them. If we are under their authority, but they let us do our own thing and make our own medicine, that's ok. But that would not be the case. We had good relations with Unani, and they know what's going on with Ayurveda. They told us, "never go with them, they always will be the bigger ones, and they are jealous and will prevent your progress. They will have a step-motherly attitude." It also took Unani many years to get away from Ayurveda, to get independence. Now they are much smaller than Ayurveda, but they function as an independent system. And now Siddha is struggling to get away from Ayurveda... So when we said no... One time they told us in quite a high level meeting that

we can't have our clinics, that we are illegal, and so on. I explained how our medicine helps, and then I said, "ok, first of all, we'll close our Nizamuddin clinic, where so many Indian ministers, MPs etc. go." [laughs] He got the message... He was the Deputy Secretary of the Health Department in Delhi or something. They were trying to control the Men-Tsee-Khang, you know.

The strategy certainly proved effective, but it suffered from two serious drawbacks in the long run: based merely on goodwill and gratitude, none of the support was official; and based to a considerable extent on the Dalai Lama's huge popularity in India, it could not be counted on after the Dalai Lama's passing.

Aware of all this, Samdhong Rinpoche, in his function as CIHTS vice-chancellor, founded a new section for Tibetan medicine at his institute in 1994. With the CIHTS being an officially recognized educational institution under Indian law, his main rationale was to lobby for Tibetan medicine's recognition from inside the system. In other words, once Tibetan medicine was officially taught at an Indian university, once official Indian degrees were awarded to its graduates, and once Tibetan medicine received official funding from the Indian government, it would be easier to ask for Tibetan medicine's overall recognition. Apart from that, firmly embedded in the Indian university system, Tibetan medicine's future would be secured regardless of what happened to the exile government or the Men-Tsee-Khang, who were both ultimately dependent on India's goodwill. Thus, as soon as the medical department was established at the CIHTS, Samdhong Rinpoche sent an official application for Tibetan medicine's recognition to the CCIM in Delhi. The CCIM ignored the application and never replied, but Samdhong Rinpoche tried again in 2000, this time with more success. The Department of ISM-H

sent a committee of Ayurvedic scholars to inspect the CIHTS medical department and submit a report to the government. However, the report apparently (it remained classified) portrayed Tibetan medicine as a less developed version of Ayurveda, criticized a lack of hygiene in their facilities, and ultimately led to nothing.

If efforts to claim official recognition for Tibetan medicine in India had remained largely limited to individual initiatives such as Samdhong Rinpoche's until the turn of the millennium, a number of events in the early 2000s created a more general awareness among exile-Tibetan *amchi* about the importance of Tibetan medicine's legal security, which eventually led to a more sustained strategy of political lobbying. On the one hand, Tibetan medicine had by then developed into a still small, but definitely noticeable presence on India's marketplace for traditional medicines, exposing it to potential legal challenges by competitors, as it already had in 1964 in Dharamsala. Its success, furthermore, had not remained limited to India, but extended to the highly regulated health markets in Europe and North America – countries that were far less flexible and tolerant vis-à-vis unknown medical practices than India. The Men-Tsee-Khang had already been unpleasantly reminded of its doctors' precarious legal situation on foreign tours in the early 1990s, when Dr. Tenzin Choedrak and the Men-Tsee-Khang's director Namgyal Lhamo had to “flee” the US to avoid a lawsuit. Such incidents could still be dismissed as “bad luck” in the early 1990s; by the 2000s, however, the exponential increase in foreign tours both by the Men-Tsee-Khang and private practitioners – not to mention the Men-Tsee-Khang's permanent branch clinic in Amsterdam – had made the risks involved in practicing Tibetan medicine in the West too big to ignore. The Men-Tsee-Khang's fears of legal problems were, furthermore, exacerbated by the incidents in

1998 and 2001 in Finland and Switzerland, respectively, where high levels of heavy metals were found in Tibetan pills (see chapter 2). In short, both the stakes and the risks involved in Tibetan medicine's growth and spread had risen exponentially: Tibetan medicine – and particularly the Men-Tsee-Khang – had grown into important sources of revenue and political support for the exile-Tibetan community in India and around the world; as such, however, they were more exposed than ever to legal threats both in India and abroad.

We have seen in the previous chapter how Tibetan medicine's increasing economic success, coupled with the mercury scandals in Europe and concerns about quackery, led to the establishment of the CCTM in order to regulate and control Tibetan medicine in exile. The most important rationale behind this move was clear: to create the necessary conditions – and lobby – for Tibetan medicine's legal status. That is, it provided Tibetan medicine with a distinct body that could be governed, treated and – standing in for Tibetan culture and the nation – also healed. As Tibetan medicine's malaise had increasingly come to be defined (just like that of the Tibetan nation) as its lack of international legal recognition, the attainment of the same thus appeared as an important part of its cure. The first and most basic condition of this cure was, of course, the legal recognition of Tibetan medicine by the Tibetan government in exile itself, which had until then taken Tibetan medicine for granted and not bothered to include it in its legislation or administrative structures. Secondly, it was evident that the name, function, and structural set-up of the CCTM was modeled closely after the CCIM, partly because this was the closest example available, but no doubt also partly in order to make Tibetan medicine look more recognizable to Indian lawmakers. Thirdly, the more standardized,

quality-assured, and regulated Tibetan medicine in exile became – the more it became a “medical system” with a distinct “body” and clear boundaries – the higher its chances of gaining legal status were. Finally, the CCTM was to provide Tibetan medicine with a political voice to represent its interests – which could be summed up in one word: recognition – vis-à-vis the AYUSH Department and the Government of India.

If this trajectory explains how Tibetan medicine’s legal status became the central preoccupation of exile-Tibetan *amchi* in the 2000s, we are still left with the question why Indian attempts to incorporate Tibetan medicine as an “Indian medicine” under Ayurveda – which date back to Bhagwan Dash’s 1964 report and manifested in sporadic offers of recognition since the 1980s – only came to be perceived as a serious problem after the turn of the millennium. In order to answer this question, we have to turn to a fourth player besides the exile-Tibetans, the Ayurvedic establishment, and the Indian government: the Ladakhis. We have already seen, in the context of the CCTM, the sensitive and complicated nature of the relations between Tibetan and Ladakhi *amchi*. While the Tibetan-run CCTM was widely perceived, among Ladakhi *amchi*, as beneficial to their own interests (albeit for reasons not entirely congruent with the CCTM’s purpose), however, the issue of Tibetan medicine’s legal recognition divided Ladakhi and exile-Tibetan *amchi* in two groups with very different interests. Indeed, it was the Himalayan *amchi*, led by a small Ladakhi elite, who turned the Indian embrace of Tibetan medicine – in the eyes of the Tibetan *amchi* – into a serious problem.

For Ladakhi *amchi*, too, legal recognition had become an increasingly important concern during the 1990s. It was during that decade that the repercussions of the capitalist market – which had slowly transformed Ladakhi society since the 1970s – on

the *amchi*'s traditional system of remuneration, and hence their social role, became radically visible (cf. Kloos 2004, 2005, 2006, in press a). “*Amchi* medicine,” or “*amchi sman*” in the Ladakhi language – the common term for *gso ba rig pa* in Ladakh – had already been recognized, technically, on the Jammu & Kashmir (J&K) state level since the 1970s with the foundation of an “Sowa Rigpa Research Center” in Leh and the appointment of about 40 “government *amchi*”.¹⁶⁰ Despite this early inclusion on the periphery of state-sanctioned health care, however, *amchi* medicine remained largely ignored by central and state authorities as some kind of “tribal medicine” (the Ladakhis are classified as a “Scheduled Tribe”). Thus, during the 1980s and 1990s, it was actually the Tibetan government in exile - rather than the Indian central government or the J&K state government – who supported the Ladakhi *amchi* most, whether through the establishment of the CIBS medical faculty, the special allotment of reserved seats for Himalayans (who generally did not fulfill the standard educational requirements) at the Men-Tsee-Khang college, or through sporadic training seminars provided by senior Men-Tsee-Khang doctors in Ladakh. As one Ladakhi who was centrally involved in the Himalayans’ efforts to gain legal recognition for Sowa Rigpa from the central government told me in 2008: “*Amchi* medicine didn’t get any help from the Indian government, only from the Tibetan exile government. They [the Ladakhi *amchi*] didn’t know they could also apply for support from the Indian government.” This changed during the late 1990s, as *amchi* medicine became economically unsustainable enough to trigger more concerted political efforts to uplift its official status and thus increase government funding. These efforts were part of a wider political movement lobbying for

¹⁶⁰ These government *amchi* received a nominal salary and some material support from the J&K state government in return for making regular health rounds to a number of designated villages in their region. See Tondup (1997) or Kloos (2005, 2006) for more information.

the “preservation” of Ladakhi culture (defined as Buddhist),¹⁶¹ that included the struggle for a higher degree of autonomy for Ladakh and the demand for official recognition of “Bhoti language” (the various Tibetan-related languages and dialects spoken by Tibetan Buddhists across the Himalayas) and *bod yig* (the corresponding Tibetan script). The Himalayan Buddhist Cultural Association (HBCA), formed in 1985, came to play a leading role in Himalayan – read: Ladakhi – efforts to get full national recognition of “*amchi* medicine.” Since the late 1990s, its president, Lama Chosphele Zotpa, a former vice-chairman of the National Commission for Scheduled Castes and Scheduled Tribes and presently a member of the National Commission for Minorities of the Government of India, has consistently used his political clout in Delhi to that end.

Thus, by the time the CCTM was founded, there existed two independent movements for the recognition of Tibetan/*amchi* medicine, one headed by the exile-Tibetans, and one by a small Ladakhi elite around Lama Zotpa and Dr. Padma Gyurmet, the head of the Sowa Rigpa Research Center in Leh. Clearly, some form of coordination – if not collaboration – was desirable, and in February 2004, the first National Seminar on Sowa Rigpa convened in Delhi, with both Tibetan and Himalayan *amchi* attending to debate how best to reach their common goal. The debate began and ended with the name: if a common strategy was to be followed, it could not be that the Tibetans kept referring to “Tibetan medicine” and the Himalayans to “*amchi* medicine”. As it became clear that the Tibetans would not agree to the Ladakhi term, but that “Tibetan medicine” was out of question due to the sensitivity of India’s relations with China, a compromise was found in

¹⁶¹ Despite Ladakh’s carefully cultivated image as a “little Tibet”, roughly half of Ladakh’s population is Muslim. See Martijn van Beek (e.g. 2000, 2004) for insightful discussions of the politicization of Buddhism, cultural politics, and the increasing tensions between Buddhists and Muslims in Ladakh during the 1990s.

the Tibetan term “Sowa Rigpa.” Although the compromise seemed sensible, neither side was very happy with it and kept reverting to its own terminology, periodically reviving the debate. Indeed, Dr. Pema Dorjee from the Men-Tsee-Khang, who had agreed to the compromise on behalf of the Tibetans in his function as the CCTM’s first chairman, was later heavily criticized both internally and in exile-Tibetan media for giving up Sowa Rigpa’s Tibetanness. For example, one high ranking CCTM member from that time strongly distanced himself from the decision in an interview with me in 2008:

They made a resolution that this can be called Sowa Rigpa – this was completely foolish, complete ignorance! [...] Ok, the Himalayan people can call it Sowa Rigpa, from the Indian government’s perspective. But we cannot ignore that it is Tibetan. No, no, no chance! How can we sacrifice our efforts of the last 50 years in just one conference, without doing proper homework?! That was a big mistake!

What this doctor referred to with “our efforts of the last 50 years” was the Tibetans’ achievement of not only reestablishing Tibetan medicine in exile, but turning it from an obscure regional health resource into a profitable medical system of global renown. In other words, although Tibetan medicine had been practiced for centuries in Ladakh and other parts of the Indian Himalayas, its recognition would not even have been an issue in 2004 had it not been for the efforts of the Tibetan refugees. This was confirmed even by Lama Zotpa’s Ladakhi assistant, Maling Gombu, at the National Commission for Minorities in Delhi. In one conversation in late 2008, he told me:

India is a big country, and the government is not aware of many things that are going on. It’s thanks to the Tibetans that Sowa Rigpa came to the awareness of the government, because they developed it. In the

Himalayas, although we also have Sowa Rigpa, there is not much development.

The former CCTM member – and the many angry readers’ comments on the phayul.com article reporting about the National Seminar – thus seemed to have a point: deleting the “Tibetan” from Tibetan medicine, after all the Tibetans – as refugees, no less – had done to make it into the global health resource it now was, amounted to adding insult to the injury of an already vulnerable Tibetan culture and nation. Yet, Dr. Pema Dorjee and the Himalayans also had a point: India’s fragile relations with China were already a big enough headache for the Indian government to exacerbate it by officially recognizing anything that had “Tibetan” in its name. “Sowa Rigpa” thus remained the only pragmatic compromise.

Still, the shaky nature of this compromise reveals a friction between the exile-Tibetans and the small Ladakhi elite representing the Himalayans. Indeed, as I will show in the next section, the debate over the nomenclature stands for more than just a name: it stands for two different strategies to achieve two different kinds of recognition, which were ultimately informed by the different agendas the two sides pursued. It also highlights the presence of yet other interests and agendas – like that of the Indian government or China – that impinge on something even as seemingly simple as choosing a name. Clearly, to the same extent as Tibetan medicine expands its international scope not only in terms of medical practice (which it had already for a few decades) but also in terms of its political claims (as evidenced by its newfound interest in legal recognition), it becomes the subject of political and economic agendas different from merely those of the exile-Tibetans, too. In this case, the name “Sowa Rigpa” was the smallest common

denominator acceptable to all parties involved: the exile-Tibetans, the Himalayans, the Indian government, and China. This did not mean, however, that a compromise had been found for all the different interests involved in its legal recognition in India. Indeed, as far as the main players – the exile-Tibetans and the Ladakhi medical elite – were concerned, the compromise on the nomenclature was about the only thing they agreed about.

Two Kinds of Recognition

There were several reasons for this rift between the exile Tibetans and the Ladakhis, ranging from personal ambitions and aversions to the exile-Tibetans' and Ladakhis' larger, collective interests (cf. Pordié 2008c: 148ff).¹⁶² At the most basic level, however, it was the Indian legal context that predetermined and shaped the two positions. That is, under Indian law, there were two possible avenues to officially recognize Sowa Rigpa. The first – and easier, faster – way was to amend the already existing CCIM Act, which regulates Ayurveda, Unani, and Siddha, and to simply add Sowa Rigpa as a fourth “Indian system of medicine”. The second, rather more complicated way was to follow the example of homeopathy in India, and pass a completely new act for Sowa Rigpa on the grounds of Sowa Rigpa's substantial differences to Ayurveda or Unani. As with the first option, Sowa Rigpa would be administrated by the AYUSH Department in New Delhi, but retain a much larger degree of independence from the other medical systems, in particular Ayurveda. As it turned out, the Ladakhis – being Indian citizens and thus

¹⁶² While these two camps certainly exist, the lines between them are at times less clear. Thus, there are exile-Tibetans who strongly disagree with the CCTM's attempts to standardize and control Tibetan medicine, and there are Ladakhi *amchi* who are uncomfortable with the anti-Tibetan stance of some of their representatives.

having no problem with the classification of their medicine as “Indian” – strongly favored the first option, while the Tibetans, not surprisingly, favored the second one. Although by now we already have an idea of some of the reasons for the two groups’ respective choices, it is worth examining their rationales in more detail.

In contrast to Tibetan medicine in the Tibetan exile community, *amchi* medicine in Ladakh was in dire straits.¹⁶³ *Amchi* lineages were dying out as old *amchi* found it difficult to financially sustain their practice (unless they moved to Leh or outside Ladakh), and the younger generation – interested in economic security and progress – took up different vocations (cf. Pordié 2002; Kloos 2004, 2006, in press a). Understandably, Ladakhi *amchi* were concerned about the future of their medicine in Ladakh, which they saw – with good reason – as dependent on its economic viability. The central government’s full recognition of Sowa Rigpa was to solve that problem: Sowa Rigpa’s hoped-for legal status would directly translate into highly attractive government jobs, new facilities, and plentiful funds for education and research. In short, the Ladakhis expected that Sowa Rigpa’s recognition and the material, financial benefits that came with it would turn *amchi* medicine into the attractive vocation again that it once was. As Dr. Dorje Smanla, a considerate, soft-spoken man in his late 40s and one of the most respected *amchi* in Ladakh, told me in a conversation in Leh in 2008:

DS: Our tradition of *amchi* medicine in Ladakh will not be sustainable [without official recognition]. If we don’t get proper government jobs, the younger generation will not come towards Sowa Rigpa. So government

¹⁶³ While the situation was especially precarious during the late 1990s and the turn of the millennium, in the late 2000s, at least public demand for *amchi* medicine was on the rise again. Despite that and a number of programs to support it, however, *amchi* medicine in Ladakh is struggling for its long-term relevance, if not survival.

jobs are very crucial. And if we get recognition, we will get government jobs.

SK: So you think recognition is basically a question of survival for *amchi* medicine in Ladakh?

DS: Yes. This is our main concern. Otherwise it will disappear. We have only one training center here [the CIBS], but without good facilities, and only five or six students are attending. If you look at government schools, on the other hand, and how much funding and facilities they are given... So there needs to be some security, and then the future generation will also be interested in Sowa Rigpa. People study not only with the objective of education, but they also think what job they can get with that education, you know...

With the future of their medicine at stake, Ladakhis cared little about how or under what name Sowa Rigpa got recognized, but much about how fast this happened and how much they would stand to gain from it.¹⁶⁴ Consequently, they chose what exile-Tibetan *amchi* often referred to, disdainfully, as the “shortcut option”, that is, the less complicated and faster recognition of Sowa Rigpa as an “Indian System of Medicine” under the CCIM Act.

Although the exile-Tibetans were, if anything, even more concerned about the preservation of their culture and traditions – represented so strongly by Tibetan medicine – than the Ladakhis, their situation was radically different and more complicated. Rightly or wrongly, the Ladakhis saw the preservation of *amchi* medicine mostly as an economic problem, that is, as a problem relatively easily solved through government jobs, new facilities, and a few million Rupees in yearly subsidies. In contrast to that, the only

¹⁶⁴ Pordié (2008c) argues that the term “*amchi* medicine” did serve to express Sowa Rigpa’s Ladakhi identity – its “Ladakhianness” – vis-à-vis the Tibetans, which explains why also the Ladakhis reverted to this term even after the 2004 conference in Delhi. Nevertheless, faced with the potential disappearance of their medicine, economic considerations trumped those of ethnic identity in 2008.

problem Tibetan medicine had in financial terms was how to square its substantial profits with the necessity to retain its “Tibetanness” in form of the Buddhist ethics of altruism and compassion.¹⁶⁵ Indeed, Tibetan medicine was by far the largest and most important economic resource and provider of jobs – if one did not count foreign donations and grants – within the Tibetan exile-community in India, and was not in any immediate danger of disappearance. For the Tibetans, then, money or the survival of Tibetan medicine per se did not constitute – despite Dr. Sonam Dhondup’s drastic statement above (“*if we don’t get recognition, Tibetan medicine won’t survive in exile*”) – the most important reasons to gain legal recognition. While Indian government funding or the ability to legally collect wild raw materials in the Indian mountains were certainly welcome, they were considered only secondary benefits.

For exile-Tibetan decision-makers, the recognition of Tibetan medicine was first and foremost an issue of legal security – something that the Ladakhis, who enjoyed special privileges as a “scheduled tribe” (that furthermore lived in a strategic border zone with Pakistan and China and therefore had to be kept on good terms with Delhi) and few of whose *amchi* were practicing outside Ladakh, were not worried about. Furthermore, as mentioned above, exile-Tibetans decision-makers regarded their medicine as an important source of revenue and political support, the amount of which increased with the distance to the exile-Tibetan community: Tibetan medicine was more profitable (both in economic and political terms) in the big Indian cities, and most profitable in the rich countries abroad. In contrast to the Ladakhi elite, which was mostly embroiled in local politics and personal ambitions, the Tibetan focus was thus decidedly global. In other

¹⁶⁵ In fact, as I have shown elsewhere (Kloos 2004, 2006, in press a), on Ladakhi *amchi* were struggling with a very similar problem on the local level. However, what was at stake for them was less their Ladakhi identity but their social status and reputation in the village.

words, the Tibetans considered a recognition by the Indian government only as a first step towards their actual goal, which was *international* recognition and legal security for Tibetan medicine. With that, not only could Tibetan medicine spread around the globe uninhibited by legal fears, educating the world about Tibetan culture and garnering support for the Tibetan political cause, but exile-Tibetan claims to the cultural and national identity that Tibetan medicine produced would also be substantiated by the latter's international legal recognition.

I had several long conversations with Dr. Dorjee Rabten – who, as the CCTM's chairman, was leading the exile-Tibetans' push for legal status – about what they actually expected from Tibetan medicine's official recognition. He told me:

DR: Well, the important thing is that we get relieved! [laughs] You know, first we need to become legal. We also expect some official help from the Government of India, financially and through their policies – the systematic preservation and promotion of Tibetan medicine, legally and with the help of funds and facilities. Then, although we are practicing in India and the government has no formal objections, sometimes when we go for herbal collections, we have some legal problems. Now, if we get recognized, these things will become legal. But most importantly, if the Government of India – India being a big country – accepts Tibetan medicine legally, this will also be an incentive for other countries, like Europe, the USA and so on, to adopt a similar approach towards Tibetan medicine. So we look at this as a first step forward, to bring Tibetan medicine also to the Western world, legally.

SK: And what about the Ladakhis? Why do you think they want recognition for Sowa Rigpa?

DR: For them it's the money; for the Himalayans it's the money. Because if the government doesn't recognize Tibetan medicine, they won't get any

grants or aid. But for us, it's not about money. For us, it's mainly a legal issue.

Similarly, Dr. Thokmay Paljor, the CCTM's general secretary and head of the Men-Tsee-Khang's *rgyud bzhi* Translation Department, explained:

We would really like to see that Tibetan medicine is developed not only in India, but promoted to the rest of the world. Because Tibetan medicine is not only for Tibetans or Indians, but also for the people of the world. More people should benefit from it. However, for the last 10 to 15 years, we have seen that when we tried to promote Tibetan medicine in the Western countries, there were some occasions where the Tibetan doctors had to face some difficulties. So this is one reason. Also, Tibetan medicine is getting more developed now in India... So we have said that now is the time to do something to get legally recognized.

Of course, it is clear that the ability to legally practice Tibetan medicine internationally would constitute a business opportunity that dwarfs any amount of funding the Indian government could provide. But much more importantly, the exile-Tibetans' ability to "help the world" with Tibetan medicine, without legal restrictions or fears, coincided with their ability to draw attention and support to their political cause. For all of this, however, it was essential to keep the word "Tibetan" in the name of Tibetan medicine, and even more than that, to retain control over "their" medicine. After all, for the exile-Tibetans, control over Tibetan medicine means control over one of the most important symbols for Tibetan culture and nation today. Giving up the Tibetans' cultural ownership of Tibetan medicine by having it declared as an "Indian system of medicine", and ceding control over it to the Indian government, the Ayurvedic establishment or the Ladakhis was a very unattractive option indeed. As the Tibetans saw

it, however, all this was exactly what the Ladakhis' "shortcut option" entailed. Hence the Tibetan effort to pursue their own goal of a separate recognition of Sowa Rigpa – if it had to be called that – under a new act (not the CCIM Act). In Dr. Dorjee Rabten's words, "we want a separate identity, a separate recognition." This, the Tibetans hoped, would leave Tibetan medicine largely independent, give the CCTM official power and control over all practical matters concerning Sowa Rigpa under Indian law, and, above all, tacitly acknowledge Sowa Rigpa as Tibet's (and not India's) unique heritage.

Making Sowa Rigpa "Indian"

Although the 2004 National Conference in Delhi served to expose the fault-lines between the Tibetans and the Ladakhis, the terminological compromise of "Sowa Rigpa" officially meant that the two groups joined the same effort to reach one common goal, that is, Sowa Rigpa's recognition by the Indian government. In March 2006, the CCTM unanimously passed a resolution outlining the Tibetans' strategy to gain recognition. This was not only the first official decision, on part of the Tibetan government in exile, to pursue Tibetan medicine's recognition, but it also reconfirmed the Tibetans' will to cooperate with the Himalayans on this matter, at least under certain conditions. The resolution had four points: 1) Yes, the Tibetans should apply to the Indian government for Tibetan medicine's official recognition; 2) the terminology to be used was "Sowa Rigpa" in English (but with "Tibetan system of medicine" added in parentheses), "*bod kyi gso ba rig pa*" in Tibetan, and "Bod Chikitsa Vidya" as the literal translation of the Tibetan term in Sanskrit; 3) yes, the ongoing effort of Himalayan regional associations to gain recognition for Sowa Rigpa should be supported, but only as long as they do not go

against the interests of Tibetan medicine (i.e. as long as they acknowledge Sowa Rigpa's Tibetan identity); and 4) to establish a common committee for recognition with representatives from all four Tibetan medical institutions in India (Men-Tsee-Khang, Chagpori, CIHTS, CIBS).

However, it soon became clear to the Tibetans (if it had not already been clear when the resolution was passed) that the Ladakhis were not ready to officially acknowledge Sowa Rigpa's Tibetan identity, but rather stressed its *Indian* identity. As we have just seen, the two groups pursued different goals, and these goals necessitated different strategies. The result were thus two – instead of one – parallel efforts to lobby for Sowa Rigpa's recognition according to each group's cultural, political and economic agenda. This, in turn, gave rise to a polyphony of contradictory perspectives, hopes and opinions among exile-Tibetan and Ladakhi *amchi*, Indian bureaucrats, and Ayurvedic representatives: some were convinced that Tibetan medicine would be recognized within a year, while others talked of a long, drawn out process; some said scientific research and the implementation of GMP standards were essential conditions to gain recognition, but others were of the view that this was the Indian government's job *after* Sowa Rigpa was recognized; some argued that the Indian government would only recognize Sowa Rigpa if its Indian identity and origins could be proven, yet others insisted that Sowa Rigpa's origins were of no concern at all to the Indian government. Assuming that there was, as everybody assured me, only one push for recognition, my confusion grew with every conversation on the topic. And I was not alone in my confusion: the recognition process was a multilayered bureaucratic and political labyrinth, and few if any Tibetans or Ladakhis had a clear understanding of it and its potential consequences. The few Indian

and Ladakhi individuals who apparently did, furthermore, either refused to divulge any information or intentionally spread misinformation to suit their own purposes.

It was only after I returned from the field and sat down to take a closer look at my notes that things became clearer: what I had read as contradictory statements about the same process were in fact coherent statements about two separate processes. More importantly, however, I realized the extent to which most, if not all, important developments shaping exile-Tibetan medicine in the past decade were actually part of – though not reducible to – the Tibetans’ strategy to win global recognition for their medicine. The processes of pursuing recognition that the two groups were involved in were, as it soon turned out, not only separate, but actually directly opposed to each other. Although both strategies – and, correspondingly, the tensions that I observed between the two groups – can be traced back to the late 1990s, they became more visible after 2004 and culminated during my fieldwork between 2007 and 2008. In 2007, the AYUSH Department deputed an expert committee – consisting of two Ayurvedic professors, one Indian biomedical doctor, and Dr. Padma Gyurmet, the head of the recently upgraded National Research Center for Sowa Rigpa in Leh as the only representative of Sowa Rigpa – to evaluate and report the differences, if any, between Sowa Rigpa and Ayurveda. The committee was to decide whether Sowa Rigpa needed to be recognized as a different medical system, as the Tibetans wanted, or whether it could come under the existing CCIM Act, as the Ladakhis wanted. It was clear to both sides that after a recent reshuffle of CCIM officials, intensive lobbying on part of Lama Zotpa and Padma Gyurmet, as well as an official application from the CCTM following its 2006 resolution, that the Indian government had finally begun to take Sowa Rigpa’s recognition seriously.

The success of the Tibetan or the Ladakhi agenda was hinged on the committee's final report to AYUSH, thus turning the committee's two visits of the Men-Tsee-Khang and its comparative seminar on Sowa Rigpa and Ayurveda at CIHTS (Roy 2008) in the latter half of 2007 into the focal points of both groups' intense lobbying.

During the expert committee's visits and the seminar, the Ladakhi standpoint was represented mainly by Dr. Padma Gyurmet, who was on the committee himself. With his flawless Hindi, Indian mannerisms, and good contacts to senior AYUSH officials, Ayurvedic scholars, and other members of the Indian government, he knew exactly how to "sell" Sowa Rigpa to an Indian audience in order to maximize its chances of a speedy recognition. As he told me afterwards, in summer 2008, his approach was, above all, pragmatic:

I told them [the Tibetans] that we should tell AYUSH that we are quite close to Ayurveda. If we told them that we are completely different, it will be difficult. My second political argument was that if we present it as having Indian origins, it will be easier to push the Government of India to recognize it. We can tell them that it is a Buddhist system of medicine, which has been lost in India. So it's the Government of India's duty to revive this tradition. They also gracefully accept this, that they have lost a lot of traditions, knowledge, even texts. [...]

So our number one argument is that it is an Indian medical system. Number two, it is the main medical system in the Himalayan regions of India. A large number of people are following and accepting this system. So whatever is practiced, there should be some legislation for it. This is how we argue with the Government of India.

Padma Gyurmet certainly had a point, which was confirmed by virtually all Indians I talked to, including those who were sympathetic with the Tibetan cause. Thus, at the

National Conference-cum-Workshop on Tibetan Medicine” (note the terminology) jointly organized by the CCTM and the Men-Tsee-Khang from March 24-28, 2008, Darshan Shankar, one of India’s leading proponents of traditional sciences and in strong favor of Tibetan medicine’s recognition, told me after his keynote speech:

Tibetan medicine has the best chance of recognition if they stress their similarity to Ayurveda. If they stress the opposite, that is, that it’s not Indian, then they will have a lot of difficulties. They would need a lot of research to prove its efficacy. Ayurveda already has all of that, so they could just use that.

Indeed, as the Tibetans knew very well, the bureaucratic process of Sowa Rigpa’s recognition as Ayurveda – or at least as an “Indian system of medicine” – was much easier and faster, not least because it was culturally, politically and economically attractive for the Indians.

There was, of course, the cultural aspect of “preserving” – or rather, reclaiming – a lost part of Ayurveda, that is, Indian culture, mixed with many Indian politicians’ attraction to assertions of Indian cultural greatness, especially if flavored with mysticism.¹⁶⁶ Padma Gyurmet cleverly catered to such sentiments by presenting Sowa Rigpa – in line with the most common literal interpretations of the *rgyud bzhi* – as Buddha’s teaching. This enabled him, first of all, to argue that Sowa Rigpa was Indian since the Buddha had lived in what is today India; secondly, to represent it as a testament to India’s spiritual (and thus cultural) greatness; and thirdly, to stir the interest of those

¹⁶⁶ One example was the issue whether Hanuman, the popular Hindu monkey god, had actually built a giant bridge with rocks between India and Sri Lanka, as stated in the epic Ramayana. Serious scientific, economic, political and strategic debates ensued in the mid-2000s over the issue, with some respected geologists providing proof supporting the Hanuman thesis and others debunking them, the parliament divided along party lines, and economists and the Indian Defense Ministry – concerned about the fate of a planned deep-sea harbor near, and shipping lane through, the alleged remnants of the bridge – joining the fray.

who were mystically inclined. As Darshan Shankar had pointed out, furthermore, the argument had the advantage of avoiding the need to scientifically “prove” Sowa Rigpa, not only because of its similarity to Ayurveda, but also because of the added legitimacy conferred by its status as the Buddha’s words.¹⁶⁷ For Padma Gyurmet, who told me that it was the Indian government’s – not the *amchi*’s – duty to conduct research on Sowa Rigpa, this was also a welcome excuse for his Sowa Rigpa Research Center’s lack of scientific or scholarly output in the last decade.

As Padma Gyurmet knew well, in the context of Indian politics, Sowa Rigpa’s legitimacy was most easily established upon a certain nexus between religion, science and politics. The religious belief that the Buddha had taught Sowa Rigpa was combined with well-known historical evidence that the Buddha had lived in what is today India, and the modern political claim that he was therefore “Indian”. Following this argument, which projects the modern Indian state over 2500 years into the past, the *rgyud bzhi* – taken as the Buddha’s words – was thus “Indian,” too. Sowa Rigpa’s “Indianness,” in turn, could be translated into scientific legitimacy by associating it with that of Ayurveda. After all, not only were Ayurveda’s scientific credentials firmly established in India, but it also claimed (and was seen by many Hindu politicians) to encompass all of Indian medicine, including, as we learned from Bhagwan Dash, Sowa Rigpa. That Sowa Rigpa was furthermore considered as the teaching of India’s biggest spiritual masters no doubt also helped convince Indian politicians to give Sowa Rigpa the benefit of doubt: if not out of scientific reasons, then at least out of nationalistic ones. In short, Sowa Rigpa’s

¹⁶⁷ Although most Indian politicians and Ayurvedic experts involved in Sowa Rigpa’s recognition process were Hindu rather than Buddhist, Hindus generally held the Buddha in high esteem as the 9th – or 24th, depending on the texts – reincarnation of Vishnu, and were fascinated with Tibetan Buddhism’s more esoteric aspects.

“Indianness” – established by way of religion – translated into an assumption of scientific validity and political legitimacy. This, finally, was all that mattered in New Delhi’s corridors of power, where Sowa Rigpa’s legal recognition would be decided or denied.

Quite apart from this religion-science-politics nexus that the Himalayans utilized for their medical claims, Sowa Rigpa’s recognition as an “Indian system of medicine” also carried with it concrete political and economic attractions for the Ladakhis, the Indians, and for Padma Gyurmet personally. We have already encountered the Ladakhi *amchi*’s realistic hopes for government jobs and additional funds to make their profession economically viable again. The Indian government – and the especially the powerful Ayurvedic establishment –, on the other hand, was eager to incorporate and control a medicine that was increasingly becoming a competition to Ayurveda, especially on the world market. Padma Gyurmet, for his part, stood to gain in both power and resources as his Sowa Rigpa Research Center was poised to become the Indian government’s prime institution of Sowa Rigpa. Finally, there was also the unspoken, oft-denied, yet very real hope to reap economic benefits from Sowa Rigpa by patenting its formulations at some stage in the future. Both Padma Gyurmet¹⁶⁸ and a high representative of the AYUSH Department in New Delhi admitted to such plans, and it can be safely assumed that other Indian players shared these plans. Indeed, it seems like the above-described conflation of religion, science and a national Indian culture was above all a powerful way for the Ladakhis and the Ayurvedic establishment to politically legitimize their economic interests. In all of this – the cultural, political, and economic appropriation of Tibetan medicine by an Indian and Ladakhi elite – the Tibetans clearly had no place or function.

¹⁶⁸ I am grateful to Calum Blaikie for sharing this information with me.

Not surprisingly, the Tibetans were not pleased at all. First of all, they perceived Padma Gyurmet's attempts to emphasize Sowa Rigpa's *similarity to Ayurveda* as attempts to present Sowa Rigpa *as* Ayurveda, which caused a silent uproar among exile-Tibetan *amchi*. According to Padma Gyurmet, this was a misunderstanding: although he had emphasized the similarities between Ayurveda and Sowa Rigpa, he had never said they were the same, nor was it in his interest for Sowa Rigpa to come under Ayurveda's authority. In his own words,

Many of the committee members – I found it quite interesting – they argued that even if there was only 1% difference between Ayurveda and Sowa Rigpa, it should be recognized as a different system of medicine. Even if the genes of chimpanzees and human beings are 99% same, it's the 1% that makes all the difference.

Still, Padma Gyurmet was walking a fine line. It was common knowledge that there was a strong faction of Ayurvedic doctors at AYUSH and CCRAS – including Bhagwan Dash – who wanted Sowa Rigpa to come under their authority, and Padma Gyurmet's tactics played directly into their hands. But his currying favor with the Ayurvedic establishment was not the only reason that made the Tibetans unhappy. Above all, it was Padma Gyurmet's repeated attempts – in line with his strategy quoted above – to portray Sowa Rigpa, *vis-à-vis* Indian officials who knew nothing about its history, as the Buddha's teachings that had been preserved mainly in the Indian Himalayas (and especially Ladakh), without even mentioning Tibet, that left exile-Tibetan doctors fuming.

Tibetan Strategies

Faced with Padma Gyurmet as the nemesis of everything they stood for, the representatives of exile-Tibetan *amchi* were galvanized into action and made, in 2007 and 2008, a concerted effort to contest his portrayal of Sowa Rigpa and assert themselves as the real owners of Tibetan medicine. The Tibetan standpoint was clear, and the exact opposite of Padma Gyurmet's: Sowa Rigpa was a fundamentally "Tibetan" science, the origins of which – despite undeniable similarities to Ayurveda and strong Buddhist influences – could be traced back to pre-Buddhist (and thus pre-Indian-influence) Tibet. Although the main message was obvious – that Sowa Rigpa was Tibetan – it consisted of a number of interesting claims about its origins and the status of its knowledge that were designed to reinforce it. Before discussing them in more detail, however, let us remain for a moment with Sowa Rigpa's Tibetanness.

Padma Gyurmet had repeatedly tried to convince the Tibetans that Sowa Rigpa's "Indianness" was a precondition for its legal recognition in India, essentially presenting the rationale behind his chosen strategy as a legal fact. This claim, however, was quite obviously untrue, and the Tibetans knew it: neither homeopathy nor Unani medicine had Indian origins. While Unani had been recognized as an "Indian system of medicine" and for a long time remained under the "stepmotherly" authority of Ayurveda, however, homeopathy had been independent right from the beginning. Although the Tibetans were aware of the difficulties involved, their strategy was to emulate homeopathy's example, whose non-Indian (German) origins and autonomy were clearly acknowledged. Indeed, the debate over Sowa Rigpa's origins was only one between the Tibetans' and the Ladakhis' different strategies. Legally speaking, Maling Gombu told me, "the origins of

Sowa Rigpa are not an issue for the Government of India. This is just an issue between the Tibetans and the Ladakhis.” The only legal precondition for recognition, he explained, was whether the medicine in question benefitted the Indian population in a significant way. What he did not say, of course, was that it was in the strong interest of large sections of the AYUSH Department to side with the Ladakhis in claiming Sowa Rigpa as an Indian medicine. Bhagwan Dash made this discrepancy between legal theory and actual practice clear when he expressed, surprisingly frankly, the heart of the matter: “It doesn’t make a difference whether it’s the same or different from Ayurveda. The AYUSH committee is not concerned whether they are similar or not. It’s to have control over the practice of Tibetan medicine.” Indeed, after all was said and done, what the whole recognition process of Sowa Rigpa boiled down to – whether for the Tibetans, the Ladakhis, the Ayurvedic establishment, or the Indian government – was this: to gain or retain control over a booming economic resource potentially worth millions of dollars, which, in the case of the Tibetans, was also one of their most potent political tools to produce a modern Tibetan nation.

Given the stakes, neither Padma Gyurmet’s nor the exile-Tibetan *amchi*’s attempts to redefine Sowa Rigpa and rewrite its history in accordance to their political agendas are surprising. Still, the shift in exile-Tibetan *amchi*’s presentations of their medicine during the past 10 to 15 years is nothing less than remarkable. Let us begin with Tibetan medicine’s origins: the *rgyud bzhi*’s Root Tantra clearly identifies Sangye Smanla, the Medicine Buddha (himself widely considered an emanation of the historical Buddha Shakyamuni), as the originator of the medical teachings contained in this scripture (Clark 1995: 26ff), and even in the 2000s, a vast majority of both exile-Tibetan

and Himalayan *amchi* considered this the final word on the matter. In old medical scriptures, in early post-1959 publications in exile (e.g. Rechung 2001 [1973]; Donden 1986), in the public discourses of the Dalai Lama's personal physicians, and at the Men-Tsee-Khang college up to today, Tibetan medicine was consistently portrayed as the Buddha's teaching, and references to India were common.

In light of the exile-Tibetans' efforts to present their medicine as "Tibetan" rather than "Indian", however, this Buddhist historiography became problematic – especially since Padma Gyurmet used it for his own ends. Said Dr. Dorjee Rabten:

Earlier we placed more emphasis on Buddhism, the Medicine Buddha, and so on. There was more interest in these things then, whereas now, we are trying to get Tibetan medicine recognized as its own medical system, so we have to show that it is authentically, originally Tibetan, not something borrowed from somewhere else. Buddhism, after all, came from India, but we can show conclusively that there was a medical tradition in Tibet much before that. There are still some medical texts from that time, and although we haven't done any in-depth study of them, we have four or five of them and on their basis, we can be sure that Tibetan medicine has pre-Buddhist origins.

Dr. Tsering Thakchoe Drungtso, one of the few Men-Tsee-Khang doctors who believed that Tibetan medicine had strong Bon elements (Drungtso 2004, 2007), agreed:

When we go through all the history of Tibetan medicine, we find that there was some slight mistake in the past, the way we Tibetans presented our history. Because you see, anything coming from India is very precious, because of the Buddhism. So we may have overemphasized the Indian origins, which creates problems now, because it supports the view of these Ayurvedic scholars [who say that Tibetan medicine is Ayurveda]. We

need to correct this bias, this pattern of writing history. It is changing now, even in the books coming from Tibet.

Indeed, the historical preface of the Men-Tsee-Khang's recently published English translation of the *rgyud bzhi*'s first two tantras (Men-Tsee-Khang 2008), which presents Tibetan medicine as the outcome of centuries of scholarship, strongly emphasizes Tibetan medicine's Bon origins, but contains no mention at all of the Medicine Buddha. Though unacknowledged in the book, this preface is actually, at least partly, a translation of the *gso rig kun sdud*, published in the 1980s in Tibet. The convergence of the Tibetan and exile-Tibetan interests to deny or belittle Tibetan medicine's Buddhist origins – due to two completely different political reasons – is interesting, and was not lost on Dr. Padma Gyurmet.

In our conversation at his office in Leh in 2008, he brought up the matter with visible pleasure to criticize the Tibetan strategy:

PG: Now, their [the Tibetans] new thing is that they completely deny that Sowa Rigpa was taught by the Buddha. Really. Even office bearers in the Tibetan community say so. They say it is purely *bum bzhi* [the Bon equivalent of the *rgyud bzhi*], with some Indian elements. This is the basic difference between the Himalayan people's approach and the present Tibetan community. [...]

This mentality has come up only in the last 3 or 4 decades. Before that, the Tibetans were also quite proud to say that it is an Indian text; that it was from the Buddha's land. But now, probably due to their exile status, they want to keep their system alive. [...]

Even if you go through the research papers of Tibetan scholars, of Men-Tsee-Khang scholars, and compare their earlier writings with the more recent ones of the last 10 to 15 years, they completely changed the way

they write about the origins of Tibetan medicine. A really strong change was even just in the last five to ten years. You must have noticed that yourself.

SK: Yes, I did. But what is your explanation for this?

PG: The strongest reason is that they want to keep their distinct culture and identity. Initially, the Tibetans were quite proud to say that we imported all our art and culture from India, the land of Buddha. But now in India... In Tibet, we can understand there is a compulsion from the Chinese government. They force the Tibetans to delete all the Buddhist aspects of Tibetan medicine. But outside China, there is no compulsion – how this mentality is taken up so strongly by the Tibetans outside of Tibet, I cannot understand...

Padma Gyurmet, for all his usual propaganda, was right. There was indeed a marked change, within the past decade or so, in the way exile-Tibetans officially represented their medicine. Besides the fact that both Dorjee Rabten and Tsering Thakchoe had openly admitted it, even a brief comparison of publications by exile-Tibetan *amchi* before the mid-1990s (e.g. Rechung 2001 [1973]; Rabgay 1981; Donden 1986; Khangkar 1990) and after (e.g. Men-Tsee-Khang 1999, 2008; Norchung 2006; Drungtso 1995, 2004, 2007) testified to the shift from an emphasis on Buddhism to Bon as the foundation of Tibetan medicine. However, the exile-Tibetans' shift in representation went beyond the issue of Sowa Rigpa's origins. They knew, as Darshan Shankar had cautioned, that in order to win recognition as an independent, non-Indian medicine under Indian law, they had to prove their medicine's value, efficacy and safety through statistics, clinical studies, and scientific publications. Hence, while Padma Gyurmet catered to the Indian fascination of mysticism by portraying Sowa Rigpa as the Buddha's teaching (thereby, ironically, representing the majority opinion of both Ladakh

and exile-Tibetan *amchi*), the representatives of Tibetan medicine – including the Dalai Lama himself (Dalai Lama 1999, 2006) – took pains to emphasize Sowa Rigpa’s history of scholarship and its scientific status. Apart from mere outward presentations of Tibetan medicine as a scholarly – rather than spiritual – tradition, especially the Men-Tsee-Khang’s increasing engagement with modern science since the mid-1990s has to be seen in this light, and will be discussed in detail in the next chapter.

This strategy to gain legal recognition as an independent medical system under Indian law also coincided with the exile-Tibetan *amchi*’s long-term objective, that is, international recognition. For although they were well adept to catering to Western orientalist fantasies about a spiritual Buddhist medicine, they also knew that in this case, it was not the Western public but governments and legal systems that needed to be addressed – and these, at least, were patently immune (if not allergic) to the charms of exotic mysticism. It was for this reason – that is, the need to appeal to both an international public *and* international law makers – that contemporary exile-Tibetan *amchi* carefully balanced their representations (and indeed their own opinions, as we will see in the next chapter) about Tibetan medicine’s status as scientific or spiritual.

* * *

After the AYUSH expert committee had concluded its inspections and the seminar at CIHTS, most participating exile-Tibetan doctors I talked to voiced their satisfaction that sufficient differences could be demonstrated, and that especially the Ayurvedic committee members had been visibly impressed by Tibetan medicine’s degree of development, as manifested especially in the Men-Tsee-Khang’s large pharmacy. When I discussed the chances of the Tibetan vis-à-vis the Ladakhi strategy with Dorjee Rabten in

early 2008, he sounded confident: the Tibetans were acting upon professional advice, the exile-government was in contact with the Government of India, and even the Dalai Lama's Private Office was involved. Surely, with this kind of support and an impressed AYUSH expert committee, nothing could go wrong.

Unfortunately for the Tibetans, however, it was Padma Gyurmet who wrote, in his function as its chairman, the expert committee's final report. Although he told me that he had fairly represented the views of both sides in it, other committee members informed me that the report strongly claimed that Sowa Rigpa was Indian. Padma Gyurmet was clearly winning his battle against the Tibetans, and Bhagwan Dash's prediction about Sowa Rigpa's recognition seemed truer than ever: "Tibetan medicine *will* get recognized, it's just a question of time. It will be good for India, and it will be good for Ayurveda." Indeed, on September 10, 2009 – the same day I presented a conference paper on which this chapter is based – the Indian Union Cabinet approved a proposition to amend the Central Council of Indian Medicine Act (1970) in order to include Sowa Rigpa as an officially recognized Indian system of medicine (PIB 2009). While this decision did not legally recognize Sowa Rigpa yet, it declared the Indian government's intent to do so in the near future.

The following quote from *The Hindu*, one of India's bigger daily newspapers, on Sowa Rigpa's recognition removed any lingering doubts about whose presentation of Sowa Rigpa – the Tibetans' or the Himalayans' – had been adopted by the Indian government:

'Sowa-Rigpa,' also known as '*Amchi*,' is practised in Sikkim, Arunachal Pradesh, Darjeeling (West Bengal), Lahaul and Spiti (Himachal Pradesh) and the Ladakh region of Jammu and Kashmir.

The theory and practice of ‘Sowa-Rigpa’ are similar to those of Ayurveda, and include some principles of traditional Chinese medicine. The fundamental text book ‘rgyud-bzi’ is believed to have been taught by the Buddha himself and is closely linked to Buddhist philosophy. (Dhar 2009)

According to this article (and many similar ones in other Indian dailies), Sowa Rigpa was the traditional medicine of Indian Himalayan peoples, close to Ayurveda, and was taught by the Buddha. Most significantly, the word “Tibetan” was not even mentioned: Tibetan medicine was being made Indian. As I visited various involved Indian government offices in New Delhi a week later, meetings and panels were already taking place designing graduate and post-graduate curricula and degrees in Sowa Rigpa, modeled directly after the Ayurvedic BAMS curriculum. Neither the CCTM nor the Men-Tsee-Khang or the CIHTS were asked to participate in the process. Moreover, any time I steered the topic to the exile-Tibetans, my interlocutors from the Indian government would refuse to answer or make ominous remarks like, “we are discussing this issue and I cannot make any comments.”

With the official recognition of Sowa Rigpa as an “Indian medicine” imminent, nobody on the Tibetan side seemed very sure about the repercussions for their medical institutions. Many Tibetan doctors felt secure in the belief that the Himalayans – who for the most part were poorly educated and organized – could not do anything without them anyway.¹⁶⁹ In the worst case, they told me, they would simply consider Sowa Rigpa’s recognition as merely applying to the Himalayans, but not themselves: what the Tibetans were practicing was “Tibetan medicine”, and certainly not some “Indian” tribal medicine

¹⁶⁹ One senior private Tibetan doctor, for example, told me: “There is no way but to ask us – the Tibetan people – for proper help. Without us they cannot do it by themselves. The Himalayan people have no knowledge, there is no chance at all without us.”

called “Sowa Rigpa.” Besides, Men-Tsee-Khang officials repeatedly assured me, they would never accept direct Indian interference in the way they produced and practiced Tibetan medicine or trained their students – their responsibility, after all, was to preserve their culture. At least the first belief was not too far from the truth – most Himalayan *amchi* knew themselves that they were unable to formally teach, devise syllabi, or conduct research on their medicine – and Tibetan involvement was indeed unavoidable if any of these endeavors were to be carried out properly. Thus, although my visits to the Indian government offices left me decidedly less optimistic than the Tibetan doctors were, the question how Sowa Rigpa’s recognition would affect Tibetan medicine in exile remained open for now. What seemed clear, however, was that the Tibetans were about to lose, in the near to medium-term future, a significant amount of control over the practice, training, regulation, and organization of Sowa Rigpa in India.

7. Science and the Preservation of Tradition

Tibetan medicine is reinventing itself without compromising its position.

Dr. Tsewang Nyima

When Dr. Tsewang Nyima made this statement in a lecture to foreign students of Tibetan medicine in April 2008, he was stating the obvious just as much as he said the unspeakable. That Tibetan medicine was reinventing itself in exile was indeed obvious to anyone who inquired about the newly constructed building on the Men-Tsee-Khang's pharmacy compound: while its entire top floor was to house a modern quality control laboratory, the two floors below were awaiting new machines, which would, for the first time in exile, package Tibetan pills in modern strips of plastic bubbles, reminiscent of biomedical drugs. The whole pharmacy was in the process of being upgraded to comply to Indian GMP standards, and the institute's Clinical Research Department was busily planning large-scale follow-ups of already completed clinical trials on the efficacy of Tibetan medicine. Elsewhere at the Men-Tsee-Khang, the curriculum was redesigned to place more emphasis on both Buddhist ethics and modern science, the *rgyud bzhi* was being translated into English and Latin plant names into Tibetan, and official agreements of research collaboration with foreign universities were being prepared. Beyond the Men-Tsee-Khang's institutional boundaries, the CIHTS in Sarnath was constructing a large new GMP compliant pharmacy and conducting research on breast cancer and *bad kan smug po* ("brown phlegm": a complicated digestive disorder common among Tibetans in exile), while in Ladakh, the previously local Sowa Rigpa research center in Leh was

upgraded to a “National Research Center for Sowa Rigpa”, with a manifold increase of its budget. Clearly, Tibetan medicine in exile was reinventing itself, and modern science took a central place in this development: as I argued in the introduction, science became an increasingly important means through which Tibetan medicine could make produce a culture and nation that was both modern, scientific, and “traditionally Tibetan” (cf. Prakash 1999; Langford 2002).

In many ways, the just-described developments in the late 2000s were not new, though. They had, in fact, already been envisioned by the Dalai Lama at the very beginnings of Tibetan medicine’s reestablishment in exile. In his first recorded speech to the Men-Tsee-Khang in 1969, the Dalai Lama told the assembled doctors and medical students (Dalai Lama 2007: 4-5):

We must combine our [medical] teachings with modern science in order to assess and evaluate them. [...] In today’s world, [...] when man is able to land on the moon, we cannot afford to foolishly and blindly follow scriptures or practices [even if they are considered the teachings of Lord Buddha]. [...] If we combine Western and Tibetan medicine, there can be an unprecedented growth, development, and benefit. [...] It is also essential to introduce changes in the way Tibetan medicine is packaged and presented. Modified and beautifully packaged in small and effective dosages, their distribution can be expanded.

If this was the first, then it was certainly not the last time the Dalai Lama encouraged the Men-Tsee-Khang to modernize Tibetan medicine and engage with modern science. Exhortations to be “broad minded” (1978) or “compliant with modern times and current practices” (1982), to “seek the expertise and advice of modern medical science” (1987), “to tread the path of science” (1994), to “make innovative discoveries” and “package the

medicines in order to sell them on the market” (1995), “to research and evaluate Tibetan medicine through the prism of modern science” (1998), to “take the best bits of Western medical practices and create a fine blend” (2000), or “to be able to explain Tibetan medicine in terms of Western medicine” (2006) can be found in virtually all his speeches to the Men-Tsee-Khang.¹⁷⁰

Yet, despite all of this, Dr. Tsewang Nyima had also said the unspeakable: in a context where cultural and national survival was seen to be hinged on the *preservation* of traditions like Tibetan medicine, to talk of *reinventing* the same amounted to breaking a taboo in the Men-Tsee-Khang’s official discourse. After all, “preserving Tibetan culture” was the Men-Tsee-Khang’s primary *raison d’être*, its first and foremost responsibility. While exile-Tibetan official and public discourses about cultural preservation are strong, however, in practice this conservatism often gives way to an even stronger pragmatism. Especially exile-Tibetan intellectuals, within and outside the Men-Tsee-Khang, were well aware that “preservation” could not mean an absence of change and adaptation. Tenzin Tsundue, for example, the thoughtful poet-activist famous for having single-handedly unfurled a multi-storey “Free Tibet” banner in front of Chinese prime minister Zhu Rongji’s hotel in Mumbai in 2002, told me:

These days, whatever someone does – play the flute, practice medicine, whatever – they say it’s to preserve our culture. Of course, I am Tibetan too, and I understand that in our situation, there’s a justified fear of losing our culture. But what is Tibetan culture? Is it what we had in Tibet before 1959? If you just preserve culture the way it was at a certain point in time, it becomes redundant. Then it’s not culture, it’s history; it’s like something in a museum. Culture is alive, though, and therefore it has to change, you

¹⁷⁰ All years above refer to the date of the speeches. All speeches are compiled in Dalai Lama (2007).

can't prevent that. I mean, have you noticed how we Tibetans here in India speak Tibetan? People coming from Tibet often don't even understand us! The sounds and pronunciation have changed so much. And not everything about our culture, the way it was before the Chinese invaded us, was good. So we have to evolve, keep what's good and develop or change the rest. In my opinion, this is the only way our culture – any culture – can survive.

Similarly, for Tashi Tsering from the Amnye Machen Institute, the modernization and development of Tibetan medicine using the insights of modern science was inevitable:

In the case of medicine, you have to move on. If you just preserve it, you stagnate. [...] Take Sangye Gyatso's commentaries [of the *rgyud bzhi*], for example: absolutely excellent scholarship! But for his time. We have to move on. I mean, if you compare Tibetan medicine to whatever medicine they had in Europe until a century or so ago, we were far ahead. But then the Industrial Revolution happened, and biomedicine took off big time. Things have changed, and whatever excellence Tibetan medicine had centuries ago, it needs to catch up now. So we shouldn't be stuck with 17th century knowledge.

Volker Scheid, who similarly argues that tradition is a process that has to constantly change in order to continue, sums up these Tibetans' critiques of all-too-static definitions of culture and tradition with the provocative question: "Is lack of change a criterion of authenticity?" (Scheid 2007: 8) Pointing to the original meaning of "tradition" – derived from the Latin *tradere*: to hand over, to deliver – as "the handing down of knowledge or the passing on of a doctrine" (ibid.: 5), Scheid argues that its contemporary Western definition is a thoroughly modern phenomenon. That is, during European Enlightenment, the meaning of "tradition" slipped from signifying a process to a more static focus on what was being transmitted (ibid.), becoming more or less

synonymous with ‘culture’: customs and beliefs that persist over time and provide identity to social groups. As Byron Good (1994) explains in a related argument, the meaning of “belief” changed around the same time from connoting faith in someone or something (that was passed down, for example) to the opposite of objective, rational knowledge. Since then, conventional understandings of tradition, culture, and belief – surfacing especially in 20th century development discourses (cf. Pigg 1996; Adams & Pigg 2005) – as productive of (national) identities (Hobsbawm & Ranger 1983) but as inherently different from rational knowledge, place them in opposition to a modernity based on the ideas of science and objective “truth”. Such understandings can be called “modern” because, as Stacy Pigg has pointed out, modernity is a discourse that “produces the very differences it seems to be about (Latour 1993). The dichotomy between tradition and modernity makes sense only within the narrative of modernization.” (Pigg 1996: 163)

It is revealing, here, to compare Scheid’s and Good’s etymologies of the English terms “tradition” and “belief” – as well as modernity’s discourse – with the common Tibetan terms for “traditional” (*srol rgyun*) and “modern” (*deng dus*, *deng rabs*). These terms are frequently used both by *amchi* and laypeople to distinguish, for example, Tibetan medicine from biomedicine and science. Although *srol rgyun* is simply translated as “tradition”, *srol* and *rgyun* by themselves have a variety of related meanings. Thus, *srol* means “tradition, system, custom, habitual practice, habit”, with the latter two terms pointing to the processual nature of tradition, and even its relation to Tibetan notions of ethics (*kun spyod* – see introduction). Secondary meanings of *srol*, such as “scar, track, or remains”, point to the persistence of tradition over time, which is further emphasized by the term *rgyun*, which means “continuity”, with “stream” and “everlasting” as secondary

translations. *Deng dus* and *deng rabs*, the terms used to translate “modern”, on the other hand, literally mean “nowadays”. The difference between modern and traditional, for Tibetans, is thus first and foremost one of temporal duration: tradition an ongoing thread that reaches from the past into the present and the future; modernity simply connoting newness. In contrast to modern understandings, “traditional” for Tibetans does not imply obsolescence or false belief; “modern” has no inherent flavor of superiority or objective truth; and, most importantly, the two are not considered incompatible.

As we have seen from the quotes above, there exists an understanding among Tibetans in exile (sometimes more, sometimes less explicit) that their culture and traditions need to change and be updated in order to survive and prosper. We have also seen, most explicitly so far from the Dalai Lama’s speeches, that the most important point of reference – and the most important tool of transformation – in this endeavor was considered to be modern science. Indeed, there was a general agreement among exile-Tibetans that modernity, as represented by modern science, was helpful – even essential – in the effort to preserve their culture and traditions. Especially the *amchi* considered – no doubt partly due to the Dalai Lama’s repeated emphasis, and partly due to their own interactions with Indian and foreign patients and professionals – Tibetan medicine’s survival, not to mention its ability to “help the world,” to be strongly linked to its international legal recognition, which in turn was seen dependent on its successful validation by modern science (see chapter 6). As a recently graduated Men-Tsee-Khang doctor told me in 2006, when I asked him about the importance of science:

It’s about the survival of Tibetan medicine in an age of science and skepticism. If we don’t prove Tibetan medicine scientifically, people –

even Tibetans – will stop taking it, and this great treasure of knowledge will get lost.

Two years later, Dr. Namgyal Qusar, who had been in charge of the Men-Tsee-Khang's Research and Development Department during the 1990s, gave me a similar answer to the same question of why research was important: "First of all, to authenticate our medical products. Also, for the preservation of the Tibetan medical knowledge. And of course for the international recognition of Tibetan medicine. It's important for all three reasons." Geshe Ngawang Samten, the CIBS director and vice-chancellor, drove home the latter point in his opening speech at the 2008 National Conference-cum-Workshop on Tibetan Medicine in Dharamsala by evoking Tibetan medicine's history of international exchange and innovation from the 4th to the 12th centuries CE. He then continued:

Today, it is high time for us to interact again, because we are in a crucial situation. Tibetan medicine and Ayurveda are facing the same challenge: getting recognition from the modern medical system and in the West. We need to work hard on this. We need to maintain our tradition intact, while developing it further by doing research. We need to learn the language of modern medical science. On top of preserving and maintaining our tradition, we should interact, show our stand, and show our potential to modern scientists. Then, we don't need to go to them for recognition – they might come to us.

Such positive attitudes of representatives of traditional culture vis-à-vis modern science stand in stark contrast to a relatively common view among development professionals, anthropologists, or science scholars, claiming that science is not only incompatible with traditional epistemologies, but that it inevitably destroys them. The most radical expression of this view is offered by Ashis Nandy and the contributors to his

edited volume *Science, Hegemony and Violence* (Nandy 1988), who call for the total replacement of modern science by traditional sciences (see also Harding 1998). I have shown elsewhere (Kloos in press b) that such radical critiques not only shoot beyond their target, but – more importantly – are also guilty of the same (reductionist, vivisectionist) logic that they reject in modern science. They do raise some valid points, however, which are more productively explored in several recent studies of Tibetan medicine in Tibet (Adams 2001a, b, 2002a, b, 2007; Janes 2001, 2002; Craig 2006; Adams & Li 2008). Despite the forceful introduction of Chinese modernity in Tibet and the resultant political pressure on Tibetan medicine there to legitimize itself through scientific means, however, Stacy Pigg's (1996) characterization of modernity as a language that has concrete uses and benefits for those conversant in it is as true there as in the Tibetan exile. Thus, Vincanne Adams (2001b: 234) observed in Lhasa,

Rather than seeing the incorporation of biomedical forms of knowledge and practice as contributing to a hegemony of biomedicine at the expense of traditional practices, many Tibetan doctors feel that biomedicine validates traditional forms of knowledge and practice under new political and ideological circumstances.

If modern science is seen as a tool to preserve Tibetan medicine – as a remedy for the nation's sick healer (see chapter 1) – then the question arises, how do Tibetan *amchi* use this tool in exile? Although Tibetan medicine's engagements with science in the TAR (which is well-documented by Adams, Janes, and Craig) and in exile bear obvious similarities, the political differences are equally obvious, with a powerful state apparatus but no political freedom on the one side, and the absence of state control but a democratic set-up on the other. Indeed, it is exactly the absence of any official state control – due to

the lack of legal recognition in India and the CCTM's weakness – that has given Tibetan medicine in exile a considerable amount of liberty to choose whether, and especially how, to engage with modernity and its dominant institution, science.¹⁷¹ That it chose to do so (at least in principle) almost from its inception in the 1960s, well before its counterpart in Tibet was forced to do the same differently, we have already seen above. This chapter, then, will explore *how* exile-Tibetan *amchi* chose – and choose – to engage with modern science, and how, in doing so, they use and redefine conventional Western notions of modernity, science, tradition and religion to save Tibetan medicine – and with it, the Tibetan nation.

Science as Reform

Contrary to many scientists' perceptions, a section of Men-Tsee-Khang *amchi* and virtually all exile-Tibetan intellectuals keep stressing that Tibetan medicine's knowledge is the accumulated product of centuries of research. In a similar way like the Tibetan meanings of *srol rgyun* ("traditional", connoting continuity) and *deng dus* ("modern", connoting newness) imply difference but not opposition or incompatibility, these voices posit Tibetan medicine not as the opposite of science, but simply as a *different kind of science*, based on a different kind of research. No doubt the most passionate of these voices within the Men-Tsee-Khang was Dr. Tsewang Nyima. When we met in 2008 to discuss his job at the Clinical Research Department, which centrally involved negotiating

¹⁷¹ Although this may change in the near future with the pending recognition of Sowa Rigpa by the Central Government of India, in 2010 it was still traditionally trained Tibetan *amchi* – and not professional (and potentially non-Tibetan) scientists – who controlled the aim, form, and direction of the exile-Tibetan medicine's interaction with modern science.

the relationship between Tibetan medicine and modern science in the design of clinical research studies, he told me:

When we go to conferences and so on, we always encounter a lot of skepticism and doubt about Tibetan medicine: “How can you guys say that Tibetan medicine can be effective for diabetes, for cancer?” At the end of the day, the big question always is, have you done any scientific, clinical studies, has your medical system been recognized by any government or any health care system? So these are the questions that are always thrown on us.

We have to take these things in our stride, and see how best we can address these issues. Say in a conference presentation, a senior guy stands up and starts bombarding me with all these questions, saying that as long as you don’t have any evidence-based studies, or scientific cooperations, everything you say is bullshit. I just can’t sit there and tell myself, “oh pity, how come we weren’t able to do that?” One thing I always try to tell these people – even our own doctors and students here – is that we need to look back in history. Tibetan medicine has made important advances through research and development. So we actually need to have a little bit more confidence, and realize that we already have the foundation...

If you look into the texts, the compounding the medicines, the practice, everything, without having in-depth research in those early times, we would not have what we are seeing now in those texts. So they have done research. Now the challenging thing for us today is to do research that employs the Western scientific system. This is a big challenge for us, because it’s so difficult, and so improper in a way to try to insert the Western scientific approach in Tibetan medicine. So we need to see how best we can do it, making sure that we keep the Tibetan medical tradition intact, but are also able to do evidence-based research studies.

Conducting evidence-based research studies – all the more so in a way that kept the “tradition” intact – constituted a big challenge for the Men-Tsee-Khang indeed. Eleven years passed after the Dalai Lama’s first speech in which he encouraged the institute to “walk the path of science” that the Men-Tsee-Khang actually began taking its first steps on that path. Considering the institute’s difficulties in reestablishing Tibetan medicine in exile from scratch, and its struggles to preserve Tibetan medical knowledge at the brink of extinction, it is easy to understand that the “reinvention” of Tibetan medicine through science was the least of the *amchi*’s concerns. In 1980, however, the Men-Tsee-Khang had finally managed to establish Tibetan medicine well enough in India to come out of its survival mode and devote some modest resources to the foundation of a Research Department. Headed for its first two years by the institute’s previous director, Jigme Tsarong, this department mainly organized exhibitions, information weeks, and conferences on Tibetan medicine for non-Tibetan audiences. It was also actively involved in the preparations for the first production of *tsothel* (purified and detoxified mercury) in exile, which necessitated some research into what ingredients and materials were necessary and where to find them. Although the department began focusing more on clinical research in the modern sense in 1984, this focus was still limited mostly to infrequent discussions, a few publications, and some minor translation work. The task of doing modern science was, to put it mildly, daunting for the Men-Tsee-Khang: its doctors and staff lacked even the most rudimentary scientific training, and had consequently no idea about things like research design, hypotheses, methodology, statistics or documentation. There were no experts within the exile-community to ask for help, and the *amchi* either lacked the will or the contacts to resort to non-Tibetan professionals.

Considering how to pursue its goal of boosting Tibetan medicine's acceptance and credibility among non-Tibetans through modern science in view of all these limitations, the Research Department decided to pursue a strategic approach: it would focus only on diseases that biomedicine had little success in curing, and for which the *amchi* knew from experience that Tibetan medicine was very effective. As it turned out, these were mostly chronic disorders like diabetes, asthma, arthritis, hypertension, cardiovascular diseases, and cancer. When the Men-Tsee-Khang finally conducted its first "scientific" study in the late 1980s, it was thus on hypertension – a widespread problem among the exile-community in India. The study ended up a failure, however, with the "placebo" emerging as more effective than the actual medicines.¹⁷² Although this was not surprising given the Research Department's lack of expertise, experience, and resources, it only contributed to the department's negative image within the Men-Tsee-Khang of being a useless waste of money and time. Indeed, staffed with only one doctor who was untrained in science, the department remained largely unproductive until 1994, apart from publishing the occasional English flyer with basic information about Tibetan medicine.

Its fortunes began to change in the early 1990s, however, when the Men-Tsee-Khang's engagement with biomedicine and science received unexpected support from Dr. Nandi of AIIMS,¹⁷³ at that time one of India's most famous and respected surgeons. His wife had suffered from a sudden onset of unexplainable seizures, which left half of

¹⁷² The study's aim was to "prove" the efficacy of two standard Tibetan hypertension medicines, *skyu-ru 25* and *ko-byi 13*. In order to do so, hypertension patients were divided into a test group, which received the two hypertension medicines, and a control group, which received – as a placebo, so to speak – relatively weak medicines supporting digestion.

¹⁷³ The All India Institute of Medical Science (AIIMS) has its headquarters in New Delhi and several branches across India. It used to be India's most acclaimed medical institution and remains one of the best and largest hospitals in India today.

her body paralyzed, and which could not be treated even by the best physicians in India, Europe, and the USA. Finally, they consulted Dr. Tenzin Choedrak, who within a few months managed to effect a complete and lasting cure. Highly impressed, Dr. Nandi visited the Men-Tsee-Khang with some of his colleagues in 1993, and offered to give two *amchi* the chance to receive free intensive training at the AIIMS for six months. Much more than this offer, the ensuing relationship between the Men-Tsee-Khang and AIIMS – and especially Dr. Nandi’s personal sympathy and support for Tibetan medicine – proved to be a valuable asset for years to come,¹⁷⁴ and an important boost for the Men-Tsee-Khang’s Research Department, whose activities steadily intensified since then. After a pilot study on rheumatoid arthritis¹⁷⁵ in collaboration with biological anthropologists from Oxford in 1994, the Men-Tsee-Khang organized a large symposium on cancer and diabetes in 1995 that concluded with a decision that Tibetan medicine’s efficacy on these two diseases should be scientifically researched. In light of their clinical experiences, especially the senior doctors were confident that Tibetan medicine could successfully cure both diseases. Furthermore, diabetes and cancer were strategic economic and political choices indicating the Men-Tsee-Khang’s prime sites of expansion: while India had the largest number of diabetes patients worldwide and thus constituted a huge market for diabetes drugs, any cure of cancer was bound to create international attention. The Men-Tsee-Khang approached Dr. Nandi to see whether AIIMS would be interested in a

¹⁷⁴ Even today, long after Dr. Nandi’s retirement from AIIMS and Dr. Choedrak’s demise, professional ties between the two institutions persist. Similar success stories of Tibetan medicine lie behind the establishment of almost every Men-Tsee-Khang branch clinic in Indian cities (e.g. Bangalore, Mumbai, Ahmedabad).

¹⁷⁵ This 3-month pilot study compared the efficacy of Tibetan medicine with that of biomedicine. 103 Tibetan patients enrolled at the Men-Tsee-Khang’s McLeod Ganj branch clinic, with one half of them given Tibetan dietary and behavioral advice as well as a herbal paste for external application, and the other half receiving biomedical arthritis medication. The results were interesting – Tibetan medicine was better at improving joint movement, while biomedicine was better in alleviating pain – but statistically inconclusive, and were never published.

collaboration on its planned diabetes study, with the result that AIIMS promised to provide both facilities and experts. For the first time, then, Men-Tsee-Khang doctors would directly collaborate with biomedical professionals – a collaboration that was to prove highly productive, but in its early stages also complicated by a nearly two-year long process of negotiations and compromises.

Meanwhile, the Men-Tsee-Khang's director Tsering Tashi kept the Research Department busy with different projects. In 1996, it developed – under Dr. Lhawang la and Dr. Namgyal Qusar – a new line of commercially oriented “Sorig” Tibetan healthcare products,¹⁷⁶ which grew so successful that it necessitated a separate “Herbal Products Research Department” in 2002 and generated, by 2008, a full quarter of the Men-Tsee-Khang's annual turnover and profits. From 1996 to 1997, furthermore, the Research Department conducted a one-year open-label, non-interventional, single-center pilot study on rheumatic diseases (arthritis and osteoarthritis) in collaboration with the Dutch Foundation for Tibetan Medicine (NSTG) (van Pauwvliet 1997). Although the results were positive (though not spectacular) and statistically significant this time,¹⁷⁷ the study's exclusive reliance on subjective parameters prevented it from getting published as a research article in a scientific journal as the Men-Tsee-Khang hoped.

In 1997, finally, the preparations for the diabetes study were completed. After many discussions – marked by considerable openness and flexibility on part of the biomedical experts, but also compromises on part of the Tibetans – the study was

¹⁷⁶ For a full list and description of these products, see for example: <http://www.men-tsee-khang.org/hprd/index.htm>

¹⁷⁷ In this study, patients already receiving biomedical drugs were additionally treated with Tibetan medicine (no specific medication), and were asked to evaluate their condition according to twelve subjective parameters, like pain, well-being, vigor, fatigue, anger, or mood. See van Pauwvliet (1997) for detailed preliminary results.

designed as a multi-drug trial of Tibetan medicine as an adjunct in the treatment of type 2 diabetes. As Dr. Tsewang Nyima, who had been centrally involved in this study, recalled:

When we did the study on diabetes, we first had eight different Tibetan medicines, but when we met with the Indian researchers, this was a bit of a problem, so we came down to four drugs: *skyu-ru* 6, *aru* 18, *nyung-wa* 4 and *sug-mel* 18. We gave instructions to our physicians that each doctor had to prescribe at least two out of these four medicines. Then, because we usually prescribe three or four dosages per day, we could give the third dosage according to our own understanding of the patient. So if we thought the patient has too much *mkhris pa*, we would give these two medicines, and then a third one for calming down the *mkhris pa*. That's how we did it.

Although this study had limitations – it was randomized and controlled but not blind, and it had a high dropout rate – it turned out to be the Men-Tsee-Khang's most successful to date. It is also the only one conducted in collaboration with exile-Tibetan *amchi* so far that managed to get published in a Western scientific journal, albeit only as a letter of observation rather than a research article (Namdul et al. 2001). The results were statistically significant, and clearly showed Tibetan medicine's efficacy in improving FPG, PPG and GHb levels vis-à-vis the control group that only received biomedical drugs. Most Men-Tsee-Khang doctors, though interested in the results, were at a loss when confronted with tables of abstract numbers and acronyms that stood for things like “postprandial plasma glucose” – just as biomedical doctors would have been if given a diagnosis involving “weak downward-cleansing *rlung*.” Consequently, enthusiasm about the results remained limited to the Research Department and the biomedical doctors, and the study ended in early 2001 after calls for a larger-scale follow-up study were ignored

by the Men-Tsee-Khang's administration. After the excitement of success and possibility, this was a considerable personal disappointment for Dr. Tsewang Nyima:

The doctors that I have been working with down at the AIIMS were actually far more excited than some of our own doctors! Again, because they could understand all these statistics and findings, while our doctors here, they were like, “ah ok, what’s happening?”... So they [the doctors from AIIMS] would write me, call me, email me, telling me, “ok now we need to make sure how we can use these findings and design a follow-up large-scale study.” Unfortunately that didn’t happen, and we wended up the study in early 2001. [...] I still remember, all our team was very excited, and we were full of confidence, and we were thinking “ok, now what next?” I personally went to meet the director [Pema Damdul Arya], and I told him that there were some parties interested in our research, especially one party from Cambridge, England... But he thought that there must be some hidden interest from the other people... Actually this has been one of the drawbacks in our society, because... Of course, our people, we have gone through lots of difficulties, lots of heartbreaking situations, and probably this results in us not being able to trust and rely on other people so easily. [...] So, I was really disappointed at that time, and I have openly raised the issue a couple of times, but... [waves his hand] Also when we were doing a program in South Africa, in Durban, I went to this really nice medical school, the Nelson Mandela School of Medicine. They had invited me to their newly opened hospital at that time, and the majority of the patients were diabetics, and most of them were of Indian origin – they have a huge Indian population down there. The dean of the medical school at that time was a South African Indian. So we had a brainstorming discussion, and they said, “this is it, we need to do this...” This was not about patenting drugs or making money, but just about how we can help these people who have multiple diseases, because most of them are HIV positive, and then they have diabetes, and then they have

TB... So, again the same thing, I came back with a lot of excitement, thinking at least we can do this now, and it didn't happen either.

Notwithstanding such internal setbacks, which I will further discuss below, there was no turning back for the Research Department, which continued to conduct – on its own or in collaborations with other institutions – various kinds of clinical trials and studies. Even while the diabetes research with AIIMS was still going on, two other diabetes studies took place. One was a collaborative survey with AIIMS in South Indian settlements about the prevalence of diabetes mellitus among Tibetans in 1997 (Sood et al. 2000), which apart from a diabetes prevalence rate of 4.3% found alarmingly high rates of hypertension (84.9% and 53.3% among diabetic subjects and non-diabetic subjects, respectively). The other was a retrospective case study conducted in Bangalore in 1998 by Dr. Dorjee Rabten, head of the local Men-Tsee-Khang branch clinic, using 82 selected cases from 1995 to 1998 (Neshar 2000). Although this study was presented at the First International Congress on Tibetan Medicine in Washington, D.C. in the same year, the difference in scientific quality to collaborative studies was evident.

From 1998 to 2001, the Research Department conducted a baseline cancer study to identify the types of cancer for which Tibetan medicine was most effective, the most effective Tibetan drugs, and preliminary data on clinical improvements, in view of later designing a clinical study on cancer with AIIMS.¹⁷⁸ Despite its official purpose, most Men-Tsee-Khang *amchi* understood the study as a trial evaluating the efficacy of Tibetan medicine against cancer, and explained the poor results with the fact that the

¹⁷⁸ Between 1998 and 2001, 638 cancer patients from 15 Men-Tsee-Khang branch clinics were registered and their case histories evaluated. According to an article in the Men-Tsee-Khang Newsletter (Namdul 2005), “the study showed marked improvement in alleviating the symptoms; controlling the disease; improving the quality of life physically & mentally and prolonging the life span. 9 patients were reported completely cured.”

collaborating hospitals would not – out of bioethical reasons – refer newly diagnosed patients to the Men-Tsee-Khang, but only cases that were considered hopeless. A second clinical case study on cancer, based at the Men-Tsee-Khang’s Bangalore branch clinic from 2002 to 2005, suffered from the same problem, as around 90% of all participants had already undergone surgery, chemotherapy, and radiation therapy, and only between 2-4% relied on Tibetan medicine alone (Neshar 2007: 53). After a pre-clinical cell line study of the Tibetan formulation *pokar 10* in collaboration with Portland Community College in Oregon (Pierpoint 2007),¹⁷⁹ the Men-Tsee-Khang carried out, with the help of the head of the Biostatistics Department of AIIMS, a randomized controlled trial of Tibetan medicine in the treatment of hepatitis B. The trial took place in 2004 in Bylakuppe, the largest Tibetan settlement in India, which had a typically high prevalence rate of hepatitis B of 11.66%. Although this study was hardly remarkable either in its design, which was to test the efficacy of “specific” Tibetan medications versus regular Tibetan medications, or in its outcomes (no significant differences could be found as both types of medicines slightly improved the general well-being, but did not eradicate the virus), it stands out for explicitly combining modern scientific, Tibetan medical, and subjective parameters. Thus, in its published report (Sangmo et al. 2007) next to statistical tables with bilirubin counts and the like, we also find detailed statistics on pulse characteristics (e.g. rolling, firm, weak, sunken, declining, etc.) and urine analysis (regarding its color, bubbles, sediments, and scum), as well as subjective and observational parameters like fatigue, appetite, pain, or jaundice. Unfortunately, however,

¹⁷⁹ This laboratory study showed that *pokar 10* favorably affected the metabolic behavior and proliferation rate of an NIH 3T3 fibroblast cell line. *Pokar 10* is routinely used in Tibetan medical practice to treat joint disorders, connective tissue inflammations, blood and serum disorders, and skin problems (Pierpoint 2007: 24).

the article discussed and interpreted neither the statistics involving pulse and urine diagnosis, nor the subjective parameters.

Since the mid-1990s, the Research Department was renamed several times, first into “Research & Development Department,” and then, with the increased specialization of its various research-related activities that resulted in new, independent departments (Herbal Products Research, Materia Medica, Literary Research, *rgyud bzhi* Translation), into the current “Clinical Research Department.” Since the fundamental changes that restructured exile-Tibetan medicine and the Men-Tsee-Khang in 2004 and 2005 (see chapters 2 and 5), the Clinical Research Department was involved in three research studies: a small collaborative toxicology study about *tsothel* (purified and detoxified mercury) in Men-Tsee-Khang precious pills (Sallon et al. 2006);¹⁸⁰ a larger-scale follow-up study on the same topic (*tsothel*) with the same Western research institutions that began in 2009; and a multi-year, large-scale survey on the prevalence of hypertension among Tibetans in India that was concluded in 2009. As mentioned above, several studies are in various stages of planning, design, or ethical review, among which the most important is a collaborative study with AIIMS on Tibetan medicine’s efficacy in the treatment of ovarian cancer. After having been rejected by an unsympathetic AIIMS

¹⁸⁰ This study was conducted in collaboration between the Men-Tsee-Khang Research Department, Delek Hospital, Hadassah Medical Organization and University School of Medicine in Jerusalem, the Departments of Chemistry of the Universities of Liverpool and Manchester, and the Department of Toxicology of Sheba Medical Center in Tel Aviv. There were a total of 11 participants in this study: 6 subjects took *tsothel*-containing precious pills on a daily basis (ingesting over 30 times the established reference dose for chronic oral exposure), three subjects regularly took regular Tibetan medicine that did not contain *tsothel*, and two healthy volunteers who did not take any medicine at all (Tibetan or Western) served as a control group. Results showed that blood mercury levels remained non-detectable, but mean urinary mercury levels were more than three times above EPA levels. Renal and liver function tests were within the normal range, but the *tsothel*-taking group had more loose teeth and higher mean diastolic pressures (which could also be explained by that group’s significantly higher average age).

ethics review board, at the time of writing this, a completely revised version was waiting approval of the – now reconstituted – board.

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Despite the above focus on clinical studies as Tibetan medicine's most visible, and most discussed, way of modernizing itself and engaging with modern science, it is important to note that this engagement is by no means limited to randomized controlled trials or the implementation of GMPs. It also, and crucially, includes botanical research on medicinal plant identification and taxonomy (Dr. Dawa 1999; Kletter & Kriechbaum 2001); the translation of medical scriptures into English (e.g. Men-Tsee-Khang 2008); literary research; or the development of new pharmaceutical formulations (e.g. the Sorig products). Nor is Tibetan medicine's interaction with science in exile limited to the Men-Tsee-Khang: although the Men-Tsee-Khang leads the field in terms of clinical studies, not least due to its human and financial resources, it lags behind the CIHTS/CUTS – or even individuals like Dr. Tashigang – in terms of literary research. Dr. Yeshe Donden's involvement in an – eventually discontinued – breast cancer study with UCSF in 1999 and 2000 is well known,¹⁸¹ and several other exile-Tibetan *amchi* have engaged in various kinds of research in India, Japan and the West. Last but by no means least, there is the vast field of Tibetan medicine in Tibet and China, where both the government and private entrepreneurs are, with clear commercial motives, investing millions of dollars in the research and modernization of Tibetan medicine. While many of these studies are of similarly weak scientific quality as those conducted in exile, with only few of them

¹⁸¹ For a detailed NBC news report, see: http://www.buddhapia.com/tibet/dr_dhonden.html

published in English, there is no doubt that both the degree and the quality of Tibetan medicine's interaction with science is considerably larger in Tibet than in exile.¹⁸²

Within these limitations, this section's outline of the Men-Tsee-Khang's history of clinical research has the purpose of allowing certain observations that are only possible with a broad overview – rather than an in-depth analysis of one particular case – of the most direct encounters of Tibetan medicine in exile with modern science. Perhaps the most fundamental observation concerns the difficulty for 'outsiders' like the *amchi*, even if genuinely supported by 'insiders', to enter the exclusive realms of scientific respectability, of validity and "truth". Reading the reports or listening to presentations about even recently conducted studies, it becomes clear that modern science still remains an essentially foreign concept and practice for most exile-Tibetan doctors. Their inability to conduct research that could pass the stringent criteria of the modern scientific establishment without professional help constitutes a potentially serious obstacle in the endeavor to "reinvent" and modernize Tibetan medicine on its own terms. At the same time, we could also see that to some extent, the inability to publish research articles in a Western scientific journal – the Research Department's immediate goal – was also the result of a conscious refusal to completely submit to a reductionist scientific paradigm that insisted on quantitative data, dismissed subjective data, and limited trials to one drug, one disease, and one effect. Indeed, all clinical studies were marked by visible efforts to respect Tibetan medicine's individualistic and flexible treatment or its holistic epistemology – frequently at the expense of their scientific validity. We remember, for example, the exclusive reliance on subjective parameters in the rheumatic disease study;

¹⁸² See Craig (2006), Craig & Adams (2008), and several chapters in Adams et al. (in press) for the most recent discussions of the topic in Tibet and adjacent regions in China. Martin Saxer's forthcoming dissertation also deals with the issue in detail.

the flexible multi-drug trial on diabetes; or the inclusion of detailed statistics on pulse and urine diagnosis in the hepatitis B study. On the other hand, all studies purported to focus on biomedical, not Tibetan, disease categories, a fact that can be interpreted as a significant concession to modern science. In the report on the hepatitis B study (Sangmo et al. 2007), for example, there was not a single reference to Tibetan understandings of the disease, despite the inclusion of Tibetan diagnostic statistics. In short, Tsewang Nyima's emphasis that "we need to make sure we don't try to fit Tibetan medicine into the Western medical framework, but see how we can best fit the Western research tools into our Tibetan medical framework" applies mostly on the level of research methodology, but not on the more fundamental, epistemic level of diagnosis and disease classification. Although this may partly be the result of a conscious, pragmatic choice to engage (or even compete) with biomedicine on its own epistemic turf (to hope for anything else would be unrealistic), it also indicates a certain degree of unawareness about the disadvantage at which this choice places Tibetan medicine vis-à-vis biomedicine. The Men-Tsee-Khang's goal to do science without losing the essence of Tibetan medicine – to modernize without losing one's tradition – clearly involves an uphill tightrope dance.

But the above overview of this tightrope dance, to remain with this circus metaphor, also reveals a safety net: precisely because most Men-Tsee-Khang *amchi* have so far remained relative strangers to modern science, they also remained skeptical about some of its claims, in particular those of being the sole arbiter of truth. Tibetan doctors in exile *know* that their medicine works; as far as they are concerned, they do not need science to tell them so. Indeed, the safety, efficacy, and validity of Tibetan medicine was

such a strong fact for Men-Tsee-Khang *amchi* that even if science said otherwise – say, a clinical trial shows that a medication has little to no effect on a given disease¹⁸³ – a majority of them would dismiss (or at least reinterpret) the research rather than the medication.¹⁸⁴ An occurrence as described by Adams (2005: 285) in Tibet, where the production of a certain Tibetan pill was permanently discontinued after research results were (wrongly) interpreted as showing that it was less effective than a biomedical drug, were unthinkable in exile. There, clinical studies are generally characterized by a strong bias for Tibetan medicine, which is especially visible in Men-Tsee-Khang authored study reports, and an overall attitude that considers research as merely a tool to prove to others (non-Tibetans) what Tibetans already know.

This attitude, of course, stands in contrast to calls by the Dalai Lama, the above-quoted intellectuals, and doctors like Tsewang Nyima to reinvent and modernize Tibetan medicine through a serious engagement with science. Indeed, despite its strong *esprit de corps* and its general institutional cohesion and homogeneity, when it came to the topic of modernization and science, the Men-Tsee-Khang was broadly divided into two camps: a conservative majority and a progressive minority. As one Men-Tsee-Khang doctor told me,

There are different opinions among Tibetan medical practitioners. One group says that research is not necessary, that the knowledge of Tibetan medicine is complete, because it is from the Medicine Buddha. Since he was perfectly enlightened and omniscient, there is nothing to add to Tibetan medicine. The other group says, it is important to continue to do research and innovate...

¹⁸³ Depending on the research criteria, this could be said of several Men-Tsee-Khang studies described above, including the early hypertension study, the hepatitis B study, or the cancer studies.

¹⁸⁴ That this is a sensible idea even from a modern perspective, given the quality of the research conducted so far, is another matter.

As this doctor hinted at, the difference between the two camps was rooted in different understandings of the epistemic status of Tibetan medicine. The progressive view, reflected in the quotes at the beginning of this chapter, saw Tibetan medicine as the product of centuries of research and scholarship, based on a logic of continuous improvement and progress. Dr. Tsering summed up this view well when he told me:

Science means finding some results, it's not necessarily related to technology. Many people think that science is linked to modern technology. As if without electricity, science is not working! [...] The method is experience. Like in Tibetan medicine. How do you know that a certain plant is effective? Because it has been tried so many times. You know by experience.

The conservative view, on the other hand, regarded Tibetan medicine as the product of spiritual insight, or even the direct teachings of the Buddha himself, and thus based on the ultimate truth. The two opinions were a matter of lively debate among Men-Tsee-Khang *amchi* – some asking me for my opinion – and commonly referred to as *bka'* (speech, the Buddha's word) and *bstan bcos* (treatise, text, composed by a scholar). With most Men-Tsee-Khang doctors being – even for Tibetan standards – quite religiously inclined, and furthermore trained throughout college to consider the *rgyud bzhi* as *bka'* (just as the scripture itself claimed), it was not surprising that the majority leaned towards regarding Tibetan medicine as the Buddha's speech. That there was a controversy at all was to no small extent due to the Dalai Lama's well-known stance on the matter (e.g. Dalai Lama 1999), who particularly jarred Men-Tsee-Khang sensitivities in a 2003

speech to Tibetan and Ladakhi practitioners of Tibetan medicine in Leh. The transcript of the relevant paragraph reads like this (Dalai Lama 2007: 183):

It also needs to be considered how our Tibetan medicine was established. The fact is that it was established before the time of Lord Buddha. I think that the concerned people established it after thinking about it and after gaining credible experience in the field. Do you all agree or not? Maybe the orthodox will not agree with what I said (*His Holiness laughs and asks Dr. Lhawang la whether he agrees or not*).

The controversy between *bka'* and *bstan bcos* can also be seen as related to the recent repositioning of the Men-Tsee-Khang's official stance on Tibetan medicine's status for political reasons, that is, its official recognition by the Indian government (see chapter 6). As I just pointed out, however, this official change of position from *bka'* to *bstan bcos* should not be mistaken as a general one among a less vocal majority of Men-Tsee-Khang doctors,¹⁸⁵ which refuses such a disenchantment of Tibetan medicine and retains its conservative attitude vis-à-vis science. While this attitude was already noticeable in our overview of the Men-Tsee-Khang's clinical studies (which were mostly conducted by progressives like Tenzin Damdul and Tsewang Nyima), it fully manifested in the Men-Tsee-Khang's *discursive* engagement with science. What, then, did the *amchi* have to say about research?

¹⁸⁵ Nevertheless, the fact that there is a controversy about the issue at all indicates that the view of Tibetan medicine as solely the Buddha's speech is increasingly problematized. While few Men-Tsee-Khang *amchi* are ready to give up this view altogether, they are looking for a "middle-way solution," which accepts both stances and rejects neither.

Science as Ornament

In light of the opinions we have already encountered about the Men-Tsee-Khang and its responsibilities, about politics and capitalism, or about the CCTM's efforts to regulate Tibetan medicine in exile, the observation that exile-Tibetan *amchi*'s attitudes about modern science are *ambivalent* will not come as a surprise. On the one hand, as we have seen above, Tibetan medicine's engagement with science is generally perceived as essential in order to preserve it, and with it Tibetan culture, identity, and the nation. As I will show in this section, this perception is held – in different ways – both by those who regard Tibetan medicine as the product of scholarship and thus in constant need of improvement and development, and by those who take Tibetan medicine as the perfect product of spiritual insight. On the other hand, however, science is also perceived – again, by both camps – as a potential threat to Tibetan medicine, giving rise to fears either of losing Tibetan medicine's "essence" and identity, or of losing control over what Tibetans regard – with good reason – as one of their most valuable cultural "properties" (next to Tibetan Buddhism). While those arguing for Tibetan medicine's reinvention and modernization believe, like Dr. Tsewang Nyima, that these two dangers can be avoided through careful research design and prudent choices about who to collaborate with, the more conservative camp prefers to limit Tibetan medicine's interaction with science in terms of both quantity and quality.

One case in point for the latter stance was the Men-Tsee-Khang administration's repeated blocking of any follow-ups on the diabetes research, first in collaboration with Cambridge, then with the Nelson Mandela School of Medicine in Durban. Although Dr. Namdul's explanation, citing the Tibetans' general suspicion of above-average outside

interest in their affairs (partly due to the trauma of their dispossession by the Chinese communists, partly due to their awareness of the fate of other “traditional cultures”, and partly due to a historical lack of openness to anything foreign), makes sense, I argue that these administrative decisions can also be interpreted as expressing more fundamental fears of losing control, and of losing Tibetan medicine’s identity. It was no coincidence that this happened exactly – and only – with the one research that was successful and promising enough to have the potential to develop into a more serious interaction with science (as a follow-up with AIIMS would have been) and outside interests (the collaboration with Nelson Mandela School of Medicine). Indeed, as Kunga Sonam, a high ranking administrative member of the Men-Tsee-Khang’s told me:

Some people [at the Men-Tsee-Khang] have the view that too much exposure will cause us to lose our identity. This doubt and speculation is also justified by the fact that some other disciplines, like Ayurveda, have gone too much into modernization, and have lost their identity. So the fear that these people have is quite justified.

Although the incidents surrounding the diabetes study had taken place under the administrations of Pema Damdul Arya and Samdup Lhatse, with the current administration being much more progressively-minded, the fact that Kunga Sonam made this observation in 2008 shows that such fears have anything but abated. Indeed, Ayurveda is frequently cited by Men-Tsee-Khang doctors – even publicly, as by Dr. Dawa (its director from 2004 to 2010) at a large international conference on traditional Asian medicines in 2009¹⁸⁶ – as a negative example for the destructive effects of over-

¹⁸⁶ On the 7th International Congress on Traditional Asian Medicines (ICTAM 7), organized by IASTAM from September 7-11, 2009 in Thimpu, Bhutan, Dr. Dawa portrayed Ayurveda as having lost its identity

enthusiastic modernization and interaction with science. Clearly, the Men-Tsee-Khang's mission to "help the world" was strongly tempered by a simultaneous reluctance – and even fear – to seriously engage with the modern world.

If the Men-Tsee-Khang's engagement with modern science resembled that with capitalism in provoking fears (though less explicitly articulated) of losing control and identity, then there was a good reason for this: science and modernity were, as the *amchi* agreed with science scholars, intrinsically connected to capitalism; and all three of them – science, modernity, and capitalism – were seen as problematic according to the Buddhist ethics of altruism and compassion. Vandana Shiva, for example, has made a forceful claim that "capitalist logic is inseparably and dialectically linked with the reductionist character of contemporary science." (Shiva 1988: 235) Indeed, according to her (*ibid.*: 238, 239),

The reductionist worldview, the industrial revolution and the capitalist economy were the philosophical, technological and economic components of the same process. [...] As a system of knowledge about nature, reductionist science is weak and inadequate; as a system of knowledge for the market, it is powerful and profitable.

While Shiva used the case of Ciba-Geigy's anti-diarrhea drug "Mexaform" that was proven "safe" in clinical trials and remained on the market despite having already permanently crippled tens of thousands of people by the 1970s, Sienna Craig (2006) referred to the more recent case of Merck's "Vioxx" – a non-steroidal anti-inflammatory

due to excessive modernization. With about a dozen representatives of Ayurveda in the audience, Dr. Dawa was probably the only one surprised when his statement provoked vigorous contestations.

drug used to treat osteo-arthritis and acute pain¹⁸⁷ – to make a similar point. Randomized controlled trials, considered the “gold standard” for measuring pharmaceutical efficacy and safety, cost a lot of money, thus creating not only pressure for the drug manufacturers to recover their expenditures through higher profit margins and aggressive marketing of the drug, but also a strong interest in successful study outcomes. This, in turn, often leads researchers to design the trials in ways to maximize chances for favorable results, to redefine efficacy to suit the interests of the producer, or to interpret inconclusive results as successful outcomes. While the clinical value of medicines is thus largely irrelevant in randomized controlled drug trials – which in any case are designed to reduce the clinical component as much as possible –, it is their economic value that often determines their outcome (Craig 2006: 167ff). Janes makes the same observation when he writes that “it may be said that market efficacy, that is, the potential for medicines to be a successful commodity, and biomedical efficacy have been conflated.” (Janes 2002: 273f) While Craig’s and Janes’s points are well taken, I agree with Shiva that the connection between modern science and capitalism goes beyond such issues of (mis-) application, to the underlying logic upon which modern scientific drug trials are based. That is, modern drug trials are based on risk-benefit calculations that follow the logic of the capitalist market, where the results are considered good (or “effective”) as long as the profits outweigh the expenses.

This logic stands in sharp contrast to Tibetan medicine’s (and even biomedicine’s, to some extent) ethics of ‘do no harm,’ which makes many *amchi* deeply uncomfortable with common scientific practices like placebo control groups (which they see as an

¹⁸⁷ Vioxx was removed from the market in 2004 after the release of clinical evidence that it could increase the risk of stroke and heart attack in some patients, and accusations that Merck had suppressed data on the drug’s adverse effects for years out of economic considerations.

intentional deception and potential denial of the best-possible care) or animal tests, even leaving aside the epistemological problems of such practices in the context of Tibetan medicine.¹⁸⁸ The root problem, Men-Tsee-Khang doctors agree with Shiva, is the reductionist paradigm underlying both capitalism and science: capitalism reducing medicine to a mere profit-oriented business; science reducing efforts to help the patient to a mere war against disease (cf. Shiva 1988: 250f). This became most evident on one occasion in 2008, when I asked Dr. Tsering about what he saw as the current Men-Tsee-Khang administration's priorities. From his critical answer it was obvious that he had spent considerable thought on the matter, which clearly was of personal concern for him:

Actually, what they want is international recognition for Tibetan medicine, to spread Tibetan medicine all over the world. But to do that, we have to modernize, to show the world that we are modern. And to modernize, we need research, more machines and new buildings, and for all that we need money. And where does the money come from? From the patients! So this is not for the benefit of the patients, and this is wrong. We have to think about the benefit of our patients; that should be our motivation. If from the beginning, our motivation is not good – if it is to earn money – then Tibetan medicine will develop in the wrong way. Like Ayurveda, they modernized a lot, and it's not good at all.

Our discussion turned towards the question of tradition, and how it was different from modernity. Dr. Tsering continued:

You see, what is tradition, after all? Tradition is basically compassion; it's the motivation. If we lose our tradition, it means we lose our compassion,

¹⁸⁸ For example, what is called “placebo” is considered an essential part of – and consciously used in – Tibetan medical practice. Furthermore, animals are considered completely incomparable to human beings in their physiological and mental constitution, which varies even from one human individual to the next. An other important epistemological problem lies in modern science's reductionist approach, as discussed above.

and then we have lost the most important thing. Because modernity, modern science, it's all about killing: this medicine kills this virus or that germ, it "kills" the disease... It's always "anti-" something. In our traditional medicine, you could also say it works like that, but we never say this. When you say "killing", there's no compassion. We say, "it helps, it pacifies, it heals"... So modernization, it's changing the motivation, and compassion is lost.

It is interesting to note Dr. Tsering's explicit identification of Tibetan tradition with compassion, with a Mahayana Buddhist ethics, and I will return to this – very common – sentiment in the conclusion. We also note the way in which the traditional Tibetan terminology – both Buddhist and medical – evoked by Dr. Tsering conceives of confrontation (as between medicine and disease) not in a language of *elimination* (to kill, to eradicate) but one of *transformation* (to pacify, to heal).

The point I wish to make here is that exile-Tibetan *amchi* were clearly well aware of scholarly critiques that revealed science's reductionist logic, its violence, or its nature as a cultural, political and capitalist phenomenon (cf. Kloos in press b). Partly, this awareness came from interactions with Indian or foreign scholars and intellectuals,¹⁸⁹ and partly from reaching the same conclusions on their own, as in the case of Dr. Tsering. They were also well aware that in any interaction between Tibetan medicine and modern science, the playing field was uneven, both epistemologically and economically. Epistemologically, the scientific imperative of visibility, reproducibility, and objectivity posed considerable problems, given that Tibetan medicine's fundamental concepts – such

¹⁸⁹ For example, Darshan Shankar (the founder of the Foundation for the Revitalization of Local Health Traditions, or FRLHT) gave a keynote speech at the 2008 National Conference on Tibetan Medicine in Dharamsala, in which he provided an eloquent argument for why traditional sciences like Tibetan medicine should not engage with reductionist modern science on its own terms. The speech was very positively received and referred to for weeks after by Men-Tsee-Khang doctors.

as the three *nyes pa* or the eight potencies of medicines (*nus pa*) – could only be *experienced subjectively*, but not be made visible in an *objective* way.¹⁹⁰ Any attempt to make them visible through clinical trials thus put Tibetan medicine not only at an epistemological, but also an economic disadvantage, since such trials required funds that not even the relatively wealthy Men-Tsee-Khang could afford (Kloos in press b). Given the fundamental relationship between such clinical trials and the very logic of capitalist commercialization that exile-Tibetan *amchi* regarded as unethical and as existentially threatening Tibetan medicine and culture, the reluctance of the conservative majority of Men-Tsee-Khang doctors to seriously engage with modern science becomes understandable. Yet, while most *amchi* agree with scholars like Nandy, Visvanathan, or Shiva about modern science’s problematic aspects (just as they agree with Marx and his followers about the problems of capitalist commoditization), they cannot afford the academic luxury of completely rejecting science as evil and not engage with it at all. In other words, although conservative *amchi* seem to regard modernity as opposed to tradition after all, they do not consider this an unchangeable fact of life.¹⁹¹ For in modern science’s – like in capitalism’s – power lies not only its danger, but also its usefulness: properly harnessed – that is, *transformed* instead of *eliminated* – it can help, as Men-Tsee-Khang doctors of both camps believe, to preserve tradition.

With this, we return to the initial question of this section, namely: what do the *amchi* – especially the more conservative-minded ones – have to say about modern science and research? How do they transform the “poison” of a reductionist science seen

¹⁹⁰ For a more detailed discussion of this, see Kloos (in press b).

¹⁹¹ As I have shown above, in Tibetan, modernity and tradition are different but not opposed or mutually exclusive concepts. My point here is that some Men-Tsee-Khang doctors do interpret them as opposed and mutually exclusive in their unmediated forms, but also potentially compatible and complementary if properly adapted.

as opposed to Buddhist ethics into an “elixir of health and rejuvenation” (to use an alchemist metaphor common in Tibetan medicine) for Tibetan medicine, culture, and ultimately the nation? As I mentioned above, this transformation takes place mostly on the discursive level, albeit with direct implications for the Men-Tsee-Khang’s practical engagement with science. Let us begin, therefore, with the most common opinion about science at the Men-Tsee-Khang – expressed, in this case, by the institute’s deputy director, Dr. Namgyal Tsering:

We actually don’t need to do research on our medicine, because it has already worked for many thousand years. But at this time, we really have to do research. We can’t just say, ‘Tibetan medicine is good for this and that,’ but we have to prove it in a scientific way. That’s why we need research...

In other words, the Men-Tsee-Khang needed to “prove” what it already knew, and prove it through scientific “research”. Note the transformation of the meaning and aim of “research” inherent in this statement, from the objective of *discovering* something new to the mere *documentation* of something already known. Indeed, as also Dr. Tsewang Nyima pointed out, the biggest shortcoming of Tibetan medicine was not an historical lack of research, but its lack of proper documentation. In other words, while the research and science were there, few people knew about them because there existed no tradition of documenting the process of research. Quite to the contrary, the scriptures frequently portrayed Tibetan medicine’s knowledge as the product of spiritual insights or revelations, or as the direct teachings of the Buddha. Of course, by agreeing with Dr. Namgyal Tsering about Tibetan medicine’s lack of documentation, Dr. Tsewang Nyima did not necessarily agree with the former’s view of science and research. We have seen

how, at least in theory, progressives like Dr. Namdul regarded science as a means to reinvent, change, and update Tibetan medicine, and evoked the lack of documentation only to support their non-literal, secular understandings of Tibetan medicine.¹⁹² But we have also seen how, in practice, their efforts to do so mostly ended up as attempts to “prove” Tibetan medicine in the conservative sense. In short, whether out of faith in the Buddha and the spiritual masters of the past, or out of conviction that centuries of scholarly research and clinical practice – not to mention direct personal experience in the present – were more trustworthy than the constantly changing knowledge of modern science, there existed a strong tendency at the Men-Tsee-Khang to redefine, or limit, modern research to documentation.

In the following, I quote Dr. Pema Gyatso from the Men-Tsee-Khang pharmacy at length. In 1999, he had spent a year in Switzerland, where he had the chance to visit several pharmaceutical laboratories and become acquainted with modern science. To him, there was no doubt about the importance of engaging with modern science, just as there was no doubt about the efficacy and safety of Tibetan medicine. He explained:

PG: Of course we can't stop the traditional way, but at the same time, we can use science for documentation. This is very very important. Once, for example, a scientist came to me, and I explained to him that we make the medicine in this and that way... and he asked, “where are the documents, where is the proof?” At that time, I told him, “this medicine should be bitter, and taste it, it's bitter.” But that's not the right way...

¹⁹² Dr. Tenzin Namdul also identified documentation as the aspect of modern science presenting the greatest difficulties to the *amchi*. Indeed, whether in the Research Department's clinical studies or the Men-Tsee-Khang pharmacy's attempts to comply to GMP regulations, the greatest challenge was often posed not by technical requirements or professional know-how, but simply the need of proper and diligent documentation.

SK: But what do you care about these scientists? Why is it important what they think?

PG: I think it's very important. Because you see, the herbal medicine is very effective, and people who wish to have it, they should have it. Westerners are very interested, but they believe in science, so if we show them documents, they will be more satisfied, they will think, "ok, this really works." They may wish to have this medicine, but they may also have some doubts. So it's very important. And also for international recognition... without that, we cannot work, we cannot export our medicine, we cannot do anything. [...]

Did I tell you, one time it happened in Switzerland... I was very shocked! In a very big laboratory, "Interlabor", they just do analyses, and I was there and got a tour, I visited all the different departments. One person, after I visited his department, he followed me all the way through the lab, and when I left, outside the door, he held my hand, and said, "I'm very sure you're doing your job perfectly. I hope you will not become what we are doing." He said this! He said, "We are doing only these papers... for one sample, we have this much of paper [shows thick stack of papers]..." He said, "I hope you will not become what we are doing!" He really said that... I was like, "what happened??" [laughs]

Leaving aside for a moment the irony of progress and modern science implicit in the image of the stack of papers, let us remain with the issue of documentation: as for Dr. Namgyal, so also for Dr. Pema Gyatso, Tibetan medicine's engagement with modern science was hardly informed by a desire to interact with science on a serious epistemological or medical level. Tibetan medicine being perfect as it was – and Dr. Pema Gyatso was convinced that the *rgyud bzhi* was the Buddha's teaching – any such effort would have been a futile waste of energy and resources, exemplified well by the contrast between Interlabor's stacks of paper and an *amchi* tasting a medicine to check

whether it was bitter enough. Instead, the Men-Tsee-Khang's engagement with science was shaped by a desire to prove – that is, to document – the validity of Tibetan medicine. This science-as-documentation (which, in Pema Gyatso's experience, was an accurate characterization even of its practice in the West) – and the stacks of paper it produced – furthermore, was portrayed as a potentially powerful political tool to lobby, on an international level, for Tibetan medicine's acceptance and recognition, with all its wider political and economic implications. As Adams (2001a: 544) has pointed out in the context of Lhasa in Tibet:

[T]he term *science* and its Tibetan glosses [...] are primarily a political strategy rather than an empirical basis for communicating with scientists from other places or a means of establishing such things as shared evidentiary bases, methods of reasoning, or facts about the natural world.

Leaving aside the exile-Tibetan's use of science as a strategy to lobby for Tibetan medicine's international recognition (which I have already discussed above), there was another, more fundamental argument embedded in Dr. Pema Gyatso's and Dr. Namgyal's quotes. That is, Tibetan medicine needs to engage with science today because non-Tibetans need scientific documentation in order to believe in something – in order to develop that crucial element in Tibetan practitioner-patient interactions: faith.

I suggest that this reasoning, this conclusion provides the key to understanding how exile-Tibetan *amchi* redefine and transform modern science into a political (in the widest sense of the word) tool to preserve and promote Tibetan medicine's interests.¹⁹³

The transformation is as simple as it is remarkable: Men-Tsee-Khang *amchi* subtly but

¹⁹³ One should note here that modern science is not so much transformed from an apolitical technique of knowledge into a political technique of cultural preservation and nationalism, but rather that the agenda of science as an already political institution is subverted and co-opted for radically different aims than originally intended.

radically redefined science as *a* convenient, because internationally accepted, means to instill *faith* – normally considered the very opposite of scientific reasoning – rather than *the only way to produce knowledge and establish truth*. Note that science’s own claims of universality are not denied, but transposed from an epistemological level to the political level of international acceptance. What is denied, however, are modern science’s claims of being the opposite of, and superior to, culture, politics and religion – or, to be more precise, to Tibetan Buddhism. Indeed, science is asked, by the Tibetan *amchi*, to fulfill Tibetan Buddhism’s *cultural, political and religious* role of producing faith in contexts where Tibetan culture and Buddhism have no currency. The *amchi*’s redefinition of modern science as a kind of ersatz-Buddhism for non-believers is, furthermore, matched and reinforced by comparable efforts of the Dalai Lama and other authors to redefine Tibetan Buddhism as a science (Wallace 2003; Dalai Lama 2005; cf. Lopez 1998). Indeed, Tibetan Buddhism understands itself as a systematic way to develop knowledge and insight (next to altruism and compassion), and Tibetan *amchi* regarded it as a given that faith (religious or otherwise), lest it be of the blind sort, is always preceded by – and the product of – knowledge. What all of this shows is that most Men-Tsee-Khang doctors tended to conceptualize and understand the ‘exotic’ phenomenon of modern science in terms of their own epistemic framework. In doing so, they effectively subordinated science to Tibetan Buddhism, subverting its language of superiority and of mutually exclusive dichotomies in order to harness its powers for their own ends. The sole purpose of engaging with science, then, was to make Tibetan medicine attractive to non-Tibetans. As Dr. Tashi Norbu succinctly put it, “Modern knowledge is like an ornament for traditional knowledge.”

The metaphor of an ornament (*rgyan*: ornament, adornment, decoration, enhancement, gloss, jewelry) was well chosen indeed, as it captured virtually all the characteristics of a modernity discursively subdued by the Men-Tsee-Khang's conservative majority. As an ornament, modernity could decorate Tibetan medicine, and make it attractive to others without changing its inner substance. Above all, the visual nature of an ornament – its characteristic of enhancing visibility – coincided with modern science's ability (much admired even by the most conservative *amchi*) to make things visible, whether bone fractures, germs, or a plant species' internal structure. Indeed, as Dr. Tashi Norbu told me, it was exactly this visibility that Tibetan medicine was lacking, and that modernity and science offered:

I really appreciate modern science – it makes it possible to see with the naked eye all the nerves, the blood vessels, all the “systems.” In the Tibetan texts, we cannot see that, we have to imagine. There are many things to be added to Tibetan medicine. For example anatomy, there is not much material information in the *rgyud bzhi*. So we should use the new information – then it automatically becomes an ornament. In terms of quality control and packaging, it's just that we have to present it in a modern way, to make it more acceptable and popular.

Modernity's gift of visibility went both ways, then: by making human anatomy visible, for example, it added to Tibetan medicine's beauty and attraction as far as Tibetan *amchi* and medical students were concerned; in its form of new packages for Tibetan pills or modern quality control standards (which, as Dr. Pema Gyatso had found out, revolve to a great part around documentation), it made Tibetan medicine more attractive to non-Tibetan patients and law makers. When I expressed concerns that the adoption of modern anatomy might lead to profound changes in Tibetan medical ontology and epistemology,

Dr. Tashi Norbu disagreed: Tibetan medicine would remain Tibetan medicine; its modernization was merely a superficial addition. From this perspective, one could say that anatomical charts, stacks of paper documenting samples of medicine, or blood pressure machines were all ornaments, adorning an unchanged traditional Tibetan medicine with modernity. Even Dr. Tsering, who – as we have seen above – believed that modernity ultimately harmed tradition, made the same point:

T: Today, people think that modern is something that comes suddenly, that is new. Traditional, on the other hand, means that it comes from many generations, not relying on electricity, not changing. People think like this. But I don't agree. Some of the modern medicines today have been practiced even in ancient times. Only the form of them changed, the packaging, and so on. When it comes from machines, and it has modern packaging and labels, then people think it is modern. But actually, inside it is ancient and traditional. Modernity is mostly what is visible outside, what people can see. [...]

If the [Men-Tsee-Khang's] pills come like we sell them today, people say that it [Tibetan medicine] is traditional. But if the same pills are nicely packaged by machines, then they will say it's modern.

SK: But then they open the package, and see this brown pill with a very bitter taste...

T: Still it is modern, because of the outside packaging. Modern, for me, is just about the outside, about outside change. But the inside is the same. The knowledge is the same, it has developed over many generations.

In this conversation, Dr. Tsering offered a radically different view of modernity than in his quote above: here, modernity operates merely on the level of appearances, bereft of any epistemological substance of its own. Packaged in plastic bubbles by modern machines – perhaps with English labels on them – Tibetan medicine could become

modern, while remaining traditional inside. It is exactly in the shift from Dr. Tsering's first explanation about modernity posing a threat to the very core of Tibetan tradition, to this image of modernity as mere decoration, that we can see both the conservative *amchi*'s ambivalence about modernity and science, and the way in which they discursively transform enemy into ornament.

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To conclude this section by way of summary, we have seen how exile-Tibetan medicine's engagement with modernity – manifested most visibly in capitalism and science – was characterized, first and foremost, by ambiguity. We have also seen how *amchi* actively and creatively sought to resolve this ambiguity by integrating them into their own epistemic and ethical framework of Tibetan Buddhism. In doing so, they strategically subverted modernity's claims, and redefined capitalism and science in order to be able to use them as means and tools in fulfilling their main responsibility, that is, cultural preservation. While all of this was true for virtually all *amchi*, both in- and outside the Men-Tsee-Khang, there were two diverging opinions about the tradition that needed to be preserved, and about the preservation of tradition. While the conservative majority took Tibetan medicine as the Buddha's words and spiritual insights that needed to be preserved in an unadulterated form for the benefit of humanity, a progressive minority regarded Tibetan medicine as a tradition of scholarship and innovation that needed to be preserved by continuing to develop and improve it. For the former, then, modern science was unnecessary from an epistemological and medical perspective, but an important strategic means to propagate Tibetan medicine (and culture) beyond the Tibetan community. For the latter, modern science was essential to update and reinvent

Tibetan medicine in order to save it from a slow death by stagnation and irrelevance. Whether ornament or reform, however, science was seen by both groups as an essential tool in the struggle for cultural survival.

At the end of the day, it is the image of the ornament that shapes the Men-Tsee-Khang's – and Tibetan medicine in exile's – engagement with modernity and science most. Research projects are, from the administration's perspective at least, mostly conducted with the dual purpose of making visible the Men-Tsee-Khang's engagement with science, and of potentially proving the wisdom of the scriptures by modern means. New packaging systems for the pills have already been decided and purchased, and the institute's pharmacy, quality control laboratory, and Materia Medica Department are busily increasing their production of the proverbial stacks of paper, aiming to document all stages of the medicine production process. Meanwhile, none of this seems to change the Men-Tsee-Khang's ways of practicing and producing Tibetan medicine. In Dr. Tsering's words, "We don't use much science, it's only in addition to our Tibetan methods. Science hasn't replaced any traditional methods; so far, the Men-Tsee-Khang is mostly traditional." Dr. Pema Gyatso confirmed this in a conversation about the use of modern technologies in the institute's pharmacy:

PG: Actually we work fully according to the tradition. But for the documentation, we also try to develop the other way, like scientific tests. For example now, when we are drying the pills, our doctors check whether they are dry or not by chewing them – in the Buddhist way. But for quite some time now, the scientists are testing them too. When we say, "ok the pills are dry," then they also test them, to collect some documents. Sometimes, some medicines that are very oily, it happens that we say they

are dry, but when they check them, they say the oil content or moisture is high.

SK: And then what happens? You say it's dry, and they say it's not dry...

PG: They say that this [the moisture] is a little high. But it may be because of the nature of the plants. So they just note it down.

SK: And do you dry them more because of that?

PG: No, no. Actually, the doctors and people who work there, they are very efficient, they have many years' experience, chewing and testing the pills...

Despite its modern appearance, then, the Men-Tsee-Khang seems to live up to its reputation as a conservative guardian of tradition. However, hidden below the glittering ornaments of clinical research or new packages for pills, conservative assertions about the superficiality of the Men-Tsee-Khang's engagement with modernity, and the *bka'* – *bstan bcos* debate, science is already becoming an inextricable part of Tibetan medicine, increasingly replacing Buddhism as the foundation that safeguards its ultimate manifestation of an intact tradition: efficacy.

Efficacy and Ambiguity

When Tibetan *amchi* in exile talk about preserving their tradition – that is, Tibetan medicine – today, they commonly refer to the preservation of its institutions, its knowledge, its practice, and – most importantly – its ethics. As a prime symbol of Tibetan culture, which in turn is placed at the foundation of the exile-Tibetan nationalist movement, Tibetan medicine's preservation (and simultaneous modernization) has come to occupy a central position in Tibetan efforts of cultural survival and the building of a

modern Tibetan nation. In the preceding chapters, I have shown how Tibetan medicine – and especially the Men-Tsee-Khang as its main institution in exile – tried to fulfill this heavy responsibility of saving itself and the nation by creating, maintaining and renegotiating the threads that link Tibetan medicine with the Tibetan nation and the world. What all the various efforts to engage with the modern world – politically, economically, legally, or scientifically – boil down to; what all the strategies to preserve Tibetan medicine’s institutions, knowledge, practice, and ethics are hinged on, is one key problem: efficacy. It is medical efficacy that is at stake in Tibetan medicine’s encounter with capitalism, in political efforts to regulate and control its practice and production, and in its engagement with modern science: ultimately, Tibetan medicine’s preservation is nothing but the preservation of its efficacy. And it is medical efficacy on which Tibetan medicine’s role as a powerful tool in the political struggle for cultural survival, and the cultural struggle for political existence as a nation, are staked. Ultimately, Tibetan medicine’s *medical efficacy* cannot be separated from its *cultural and political efficacy*.

Most patients – whether Tibetan or not – care or know little about Tibetan medicine’s status as a symbol for Tibetan culture and civilization, its power to imagine a Tibetan nation, its scientific or legal legitimacy, or the details of its production. What they do care about is its medical potency to heal their immediate physical or mental ailments. For all their nationalism, faith and religiosity, Tibetans in exile – like anyone faced with pain and suffering – are eminently pragmatic: no matter how “Tibetan” a medicine might be, it is useless if it doesn’t work. Tibetan medicine is thus judged by whether it works, and both patients and doctors regard medical efficacy as its crucial

quality. Consider, for example, the following statement by Dr. Dorjee Rabten in a discussion about the uniqueness of Tibetan medicine one afternoon in September 2008:

I agree that Buddhist ethics make Tibetan medicine unique, but not only that. Much more than that it's Tibetan medicine's efficacy that makes it unique – otherwise, if it didn't work, people wouldn't take it! In some cases there are really stunning effects... for example in Ahmedabad, the sponsor of our new branch clinic there got cured from a disease that was considered incurable. Whole Ahmedabad is talking about Tibetan medicine now! And that's not because of ethics. The Navi Mumbai branch clinic's sponsor's son was cured by Tibetan medicine of lymphoplasmic leukemia that nobody could treat before. Or the medical camps we do in Chennai, they started because of Col. Gopalachari.¹⁹⁴ He's a highly decorated army official, and he spent quite some time in Ladakh, where he probably heard about Tibetan medicine. He got metastatic lymph cancer, and the doctors gave him three months to live. So he contacted the Men-Tsee-Khang in Dharamsala, and they referred him to me. Now, years later, he's not only still alive, but healthy and active. His friends and doctors just considered it a miracle, but we have many patients like that. I don't want to boast, but it's true... But then, we have the belief that it's not really me, the doctor, who cures, it's only thanks to the blessing of the Medicine Buddha.

I had mentioned to Dr. Dorjee the widespread view among Men-Tsee-Khang *amchi* that it was its Buddhist ethics that made Tibetan medicine truly unique and “Tibetan”. As we could see, Dr. Dorjee – though acknowledging this view – made it a point to explicitly downplay the importance of Buddhist ethics for Tibetan medicine. According to him, its success was due to the fact that it worked, and that had little to do

¹⁹⁴ See the 2-page article “Healing the Ancient Way” in The Hindu newspaper's Sunday edition on 7th January 2001.

with Buddhist ethics. New Men-Tsee-Khang branch clinics were opened upon the initiative and support of wealthy or politically influential Indians who were “miraculously” cured by Tibetan medicine; the same people – ministers, government officials, community or business leaders, medical professionals – often also extended political or professional help to the Men-Tsee-Khang and the Tibetan cause (see chapter 3, and Dr. Nandi’s story in this chapter); and even in the Tibetan settlements, Tibetan medicine manifested the ethics of Tibetan culture and the reality of the Tibetan nation in the people’s experiences, as Tashi’s story showed (chapter 3). All of this happened, Dr. Dorjee implied here in line with his colleagues, because of the simple fact that Tibetan medicine “worked”. Tibetan medicine’s cultural and political efficacy was thus contingent, first and foremost, on its medical efficacy.

One could easily interpret this as an insistence on the scientific, rational nature of Tibetan medicine as opposed to merely being based on religious faith – at least until the last sentence, where Dr. Dorjee suddenly invoked the very same blessings that are contingent upon ethical practices like mantras or prayers. Dr. Dorjee thus merged in one statement about Tibetan medicine’s uniqueness and efficacy what I have so far portrayed as two separate schools of opinion, understanding Tibetan medicine as either Buddha’s word or as scholarly work.

The resultant ambiguity about Tibetan medicine’s efficacy, and indeed the related effort to portray Tibetan medicine as *both* Buddhist (which partly means religious)¹⁹⁵ *and* scientific, was evident in the Men-Tsee-Khang doctors’ discourses as much as in the Dalai Lama’s speeches. In 1998, for example, the Dalai Lama devoted his entire keynote

¹⁹⁵ See Wallace (2003) for a critical discussion of the problems of classifying Buddhism as a “religion” in the Western sense, a term defined as much by the monotheistic, semitic religions dominant there, as by the concepts of European Enlightenment and modernity.

speech at the First International Congress on Tibetan Medicine in Washington, D.C., to counter the understanding – propagated to no small part by his own personal physicians – that Tibetan medicine’s efficacy was based on religion:

Because of [its] complex textual and historical background, we might come away with the impression that Tibetan medicine is inseparable from religious practice or religious belief and myths, though I don’t think that is necessarily true. We should be clear how we understand Tibetan medicine. I believe that Tibetan medicine itself – especially the drugs that are produced according to the tradition – must be appreciated in scientific terms, in terms of scientific understanding. In other words, the nature of the drugs and their power to heal must be understood in terms of their constituent elements. [...] One should not get the false impression that, somehow, through a ceremony of blessing, the drugs magically acquire this power of healing. (Dalai Lama 1999: 68)

This statement – indeed, the entire speech – was remarkable, because the Dalai Lama said exactly the opposite of what the audience expected to hear from him, and wanted to hear about Tibetan medicine. There were, of course, the senior-most Men-Tsee-Khang doctors present, who strongly believed that Tibetan medicine was essentially Buddhist and had Buddhist ethical practices at its very core. Many of the Americans in the audience, furthermore, were attracted to the Dalai Lama, the Tibetan cause, and Tibetan medicine precisely because they saw them as embodying the spiritual message of Buddhism;¹⁹⁶ others might have been willing to respect Tibetan medicine as a faith-based healing technique, but not as a scientific medicine. Thus, when the Dalai Lama told the audience that Tibetan medicine’s efficacy could be scientifically explained, and that there was

¹⁹⁶ For insightful and critical discussions of the ways in which Tibetans have been portrayed – and portray themselves – as mystical or even saintly Buddhists throughout recent history, see Lopez (1998) and Dodin & Räther (2001).

nothing magical or religious to it, a loud murmur went through the hall that only stopped when the Dalai Lama finished his speech.¹⁹⁷ The murmur during the speech was replaced by silence afterwards: the congress's panels and discussions proceeded as if the Dalai Lama had never spoken, many of them debating Tibetan medicine as a Buddhist practice, but none of them discussing, or even referring to, the Dalai Lama's speech.

Yet, what was lost in the initial uproar during his speech was the fact that the Dalai Lama did not deny that Buddhist religious practices could affect Tibetan medicine's healing potency. Indeed, just a paragraph after the above statement, he added (ibid.):

Of course, if a patient is a religious practitioner, the process of healing through the medicine might be complemented by such things as engaging in a blessing ceremony, having the substances blessed through a certain form of ritual, or reciting certain mantras and developing a particular state of mind or attitude. All these things could be highly complementary to the process of healing.

This line of argument was dominant in the Dalai Lama's speeches at the Men-Tsee-Khang in Dharamsala, where he explicitly and repeatedly portrayed Tibetan medicine as a Buddhist spiritual practice (Dalai Lama 2007). Most significantly, of course, he personally participated in ceremonies blessing *mani rilbu* and empowering *smān sgrub* that had the explicit purpose of increasing the Men-Tsee-Khang's medicines' medical potency, as described in chapter 3. Clearly, then, the ambiguity about Tibetan medicine's efficacy was an intended one, allowing the Tibetans to strategically stress one aspect and downplay the other depending on context and audience. Thus, in front of Indian and

¹⁹⁷ I am indebted to Herbert Schwabl of Padma AG for his observations and detailed descriptions of the event.

international audiences, concerns about the legal (and therefore scientific) recognition of Tibetan medicine took precedence over pleasing Orientalist sensibilities; if the audience was Tibetan, on the other hand, it was more prudent to stress Tibetan medicine's ethical rather than its scientific status, both to increase the patients' faith and to control the *amchi*'s commercial ambitions. Besides, with Tibetan identity in exile being defined around Mahayana Buddhist ethics, Tibetan medicine could not give up its connection to the latter without losing the former. In short, Tibetan medicine needed to be both religious and scientific simultaneously in order to fulfill its dual responsibility to save Tibetan culture and help the world (cf. Kloos in press b).

Compared to the more complex ambiguities surrounding Tibetan medicine's engagement with politics, capitalism, or modern science, Men-Tsee-Khang *amchi* found it easy to reconcile the 'magic' of mantras with science's disenchantment when it came to the issue of efficacy. They believed in the medical efficacy of prayers, blessings, and tantric empowerments – which to them were not 'magical' but empirical in any case – as firmly as in the pharmaceutical potency of their herbal medicines, and generally echoed the Dalai Lama's carefully balanced stance. Dr. Dawa, the institute's director, for example told me:

We are doing these religious rituals because if you believe in it, you will see some effect. But if you don't believe, it doesn't matter, because the medicine's [pharmaceutical] potency will be there. But we have to do that, because all these prayers, they are for the patients...

At the Men-Tsee-Khang's pharmacy, Dr. Pema Gyatso illustrated Dr. Dawa's statement with his trademark wit:

I think mantras or religious ceremonies are something extra. Those people who believe in it, they get the full [benefit] and the extra. Those who don't believe in it, they will get the full, but not the extra. [...]

I always give this example: The medicine works 100%, but if the patient is a believer, it works 120%! [laughs] So they [pharmaceutical efficacy, faith and mantras] are always related, but it doesn't mean that all the patients have to be religious.

Note how these explanations carefully guard the claim that Tibetan medicine is not just faith-based placebo, but works regardless of whether one believes in it. At the same time, they also leave room for the power of ethical practices like blessings, prayers, and faith. The strength of such explanations lies in their acceptability to both Tibetan Buddhists and modern scientists. Yet, I argue that ethical practices have been, and still are to a considerable extent, linked to a much greater extent to medical efficacy than Dr. Pema Gyatso's extra 20%, and that they are not limited to prayers and tantric empowerments alone. Indeed, while traditionally there was no such thing as "quality control" in the modern sense of a single, clearly defined process, the quality and efficacy of Tibetan medicine depended on the *amchi*'s ethics, that is, his or her character and motivation. The *amchi*'s motivation determined how diligently (s)he would follow the prescribed ideals of collecting, drying, cleaning, storing, and compounding his ingredients. Far from being limited to the mere examination of ingredients by taste and sight, such "quality control" was thus an integral part of Tibetan medical production and practice. In the words of Dr. Tamdin, former head of the Men-Tsee-Khang's pharmaceutical department and college principal in 2008: "You could say that being ethical, being Buddhist, is the best quality control."

Despite the Men-Tsee-Khang's strong emphasis on Buddhist ethics, however, this traditional system of quality control seemed to increasingly lose its potency by the late 2000s, prompting even some of the conservatives who otherwise saw modernity and science as mere ornaments to look to modern technologies of quality control as the only way to preserve Tibetan medicine's efficacy. As Dr. Pema Gyatso poignantly put it: "When we lose the potency of tradition, then we need the help of modernity."

Preserving Efficacy

The story of modern quality control and the standardization of Tibetan medicine in exile began in 1997, with the Men-Tsee-Khang's clinical trial on diabetes in collaboration with AIIMS. As we have already seen, this study constituted a threshold for the Men-Tsee-Khang's engagement with modern science in several ways, beginning with the strong collaboration with India's prime biomedical institution, through the trial's unprecedented quality and success, to the Men-Tsee-Khang administration's conservative backlash of blocking follow-up research. Ironically, while the study's success resulted in administrative limits on Tibetan medicine's engagement with science, its shortcomings set in motion a process – initiated and pursued by the institute's administration – that would change Tibetan medicine more profoundly than the Men-Tsee-Khang's clinical studies ever could. After all, the main problem that arose during the diabetes study was not one of research design or statistical validity – issues that have failed to attract the Men-Tsee-Khang administration's interest and attention before – but one that concerned Tibetan medicine's efficacy: its single most important characteristic, the very manifestation of its tradition and validity. During the study, patients who had initially

responded well to the Tibetan pills – say, *sugmel 18* –complained that suddenly, the same drug did not seem to work anymore. The *amchi*'s traditional diagnoses – using pulse, urine, and interrogation – that concurred with these complaints were, furthermore, confirmed by the same biomedical tests that had previously demonstrated the Tibetan pills' efficacy. In other words, Men-Tsee-Khang doctors were, for the first time, confronted with hard evidence that the efficacy of their medicines varied from batch to batch. It became clear that the standardization of their medicines' efficacy was imperative, both for sake of successful future clinical trials and out of ethical responsibility towards their patients.

Although the institute's senior doctors – especially those who had been involved in the study – repeatedly emphasized the need for standardization and quality control in official meetings since the turn of the millennium, however, it took several years and a new director who was a doctor himself before any action was taken. In 2005, the Men-Tsee-Khang took a first step in establishing contacts with Shriram Institute of Industrial Research in New Delhi, spending about 200,000 Rupees on a two-day workshop on GMP implementation. Since then, Shriram Institute has offered chemical analyses of herb samples (e.g. for pesticide contamination) at reduced fees to the Tibetans. In 2006 and 2007, the Men-Tsee-Khang began serious efforts to upgrade its pharmacy and to increasingly implement GMP standards. Indeed, while the institute's engagement with science in form of clinical studies stagnated despite being at the center of the *amchi*'s debates about modernity, modern technologies of quality control were acquired and implemented at an ever-increasing rate. In other words, far from *improving* Tibetan medicine through research, it was clear that even *maintaining* its quality and efficacy was

a hard enough struggle, for which the help of modernity was readily enlisted. Tsewang Gyatso, a biologist who had worked at the Men-Tsee-Khang's Materia Medica Department until 2009, told me,

Actually, although everybody talks of research, our priority is the quality control of the medicines and raw materials, the shelf life of the medicines, how to prevent fungus. It's important to test the quality of the herbs we buy on the market....

What should we think of all this? Has Tibetan medicine always been unpredictable in its efficacy, has it always lacked effective procedures of standardization and quality control – deficiencies that have only now come to light, thanks to pharmaceutical mass-production and modern science? To some extent, perhaps. Although, as I mentioned above, Tibetan medicine does have its own, traditional, systematized methods of both standardization and quality control, they probably never were – or needed to be – as accurate as modern technologies promise to be. However, there is no doubt that they worked well enough for Tibetan medicine's efficacy to become famous in large parts of Asia during the past centuries, and around the world in the 20th century. Similarly, there is no doubt that even in 2008, the Men-Tsee-Khang took its traditional methods of standardization, and Buddhist ethical ideals and practices in regard to medicine production, extremely seriously. If neither the traditional methods of quality control and standardization *per se*, nor their lax implementation in practice, could be blamed for the Men-Tsee-Khang pills' fluctuating efficacy, then what was the reason for the problem, and for the Men-Tsee-Khang's embrace of modern quality control?

To begin to answer this question, let us return to Dr. Pema Gyatso's statement: "When we lose the potency of tradition, then we need the help of modernity." The

ingenuity of this statement lies not only in its poetry and choice of words, but also in its depth of meaning. On the face of it, with tradition, Dr. Pema Gyatso clearly referred to Tibetan medicine, the potency – i.e. the efficacy – of which was in danger of getting lost. As he explained *why*, though, he quickly arrived at the issue of quality control: the efficacy of Tibetan medicine is lost when traditional methods of quality control lose their ability to ensure the potency of the ingredients. As we have just seen, furthermore, traditional “quality control” is strongly connected to Buddhist ethics. “Tradition” in Dr. Pema Gyatso’s statement thus not only refers to Tibetan medicine, nor just to specific processes that today we might term “traditional quality control”. Like for Dr. Tsering above and most other Men-Tsee-Khang *amchi* I talked to, for Dr. Pema Gyatso “tradition” meant, at the deepest level, Tibetan Buddhist ethics with altruism and compassion at its core. Remember Dr. Tsering’s quote: “What is tradition, after all? Tradition is basically compassion, it’s the motivation.” So how, exactly, is the potency of tradition – of Tibetan medicine, of traditional quality control, of Tibetan Buddhist ethics – lost, as Dr. Pema Gyatso claims? And what kind of help can modernity provide?

Ironically, it was Tibetan medicine’s very success during the past two or three decades, and its connected entrance in the global market, that lay at the root of the problem. With the rapidly increasing need for raw materials to produce ever-growing quantities of medicines, traditional plant collection in the mountains by the doctors themselves has decreased in importance. In 2007-8, for example, Men-Tsee-Khang doctors and students only collected 2.7% of the 52 tons of raw materials used during that year, with another 8.2% donated mostly by Tibetan Buddhists (including Ladakhis or Monpa) across the Himalayas. Roughly 89% of the Men-Tsee-Khang’s raw materials

were therefore bought from various dealers and markets, leaving the institute with little or no control over, and knowledge about, how, where, and when they were collected, cleaned, dried, stored, and transported. Although even traditionally, Tibetan doctors or medical institutions would purchase or barter a certain percentage of their raw materials from traders or villagers, this overwhelming reliance on the market constitutes a major change in the practice of Tibetan medicine. Dr. Tsewang Nyima explained the situation like this:

We are never saying that in our ancient medical texts there is no proper way of ensuring the quality of the raw materials, or of standardizing the finished pills. But we need to understand that with today's global changes, so many herbs are becoming endangered species. Even if they are available, they tend to have far less efficacy than they used to have earlier. Take *amla* [Indian gooseberry], for example, which is a widely used ingredient not only in Tibetan medicine but also in Ayurveda, Unani, and Siddha. Now if I get it from Kangra this time, then next time from Amritsar, and the third time from Delhi – the same ingredient, we get it from three different places and agencies. We can't be sure about its potency, whether they have the same qualities, how they were dried and stored... So to make sure that we maintain the quality, we need to have tools to check whether they have the same potency.

Similarly, and adding to this, Dr. Pema Gyatso pointed out:

Nowadays it's not like before. All the plants, all the medical ingredients are changing... not because of nature, but because of the people who are selling them. If they want to make money, they may mix other plants in, so one really has to be careful.

In short, losing control over the first stages the raw materials pass through on their way to the market is thus nothing else but a loss of control over their quality. It is difficult to check, by traditional means, whether the plants have been collected, cleaned, dried, and stored correctly, or whether they are polluted with pesticides or other chemicals. As the traders struggle to satisfy the huge demand for raw materials created by the recent boom in herbal medicines and products in India and abroad (whether under the name of Tibetan medicine, Ayurveda, Unani, Siddha, or TCM), it is almost inevitable that the quality of their herbs is inferior to those collected by *amchi* themselves. Besides, as Dr. Pema Gyatso mentioned, inferior quality of medical ingredients may also be a direct result of traders' attempts to maximize their profits by unethical means. Examples of such cheating include: not drying or cleaning plants properly so that they weigh more; adulterating expensive raw materials with cheaper ones; or substituting them altogether. As altruism and compassion are lost on the market place of greed and corruption, the potency of Tibetan medicine is directly affected. Thus, it is not that traditional quality control is inadequate today, but that it has become impossible in today's market economy. The only solution to ensure a certain level of quality, then, is the use of modern scientific methods, such as microscopic and chemical analyses, with which adulterations, moisture levels, and pollution can be measured and detected.

There was yet another problem with buying raw materials from the market. As traders source their herbs from different, and often changing, locations all over South Asia and even beyond, what is in question is not only the quality of the raw materials, but also their type, that is, their species. However, traditional Tibetan plant taxonomy is, by many *amchi*'s own admission, imprecise and often confusing, with different names given

to the same species (according to Western taxonomy), or different species conflated under one Tibetan name. Traditionally, this was not a problem, as the herbs were collected locally by doctors who knew them through generations of experience. Nor was it a problem with a large percentage of the raw materials bought from the market today, the bulk of which consists of common food spices like cloves or cardamom. However, especially with certain mountain herbs, dried barks and roots, or plant material that has already been processed in powder form, Tibetan doctors found it difficult to check whether the raw materials they are getting are the ones they actually want. Unless, that is, they employed the help of modern science in the form of Linnaean taxonomy, microscopic analysis, or chromatography. This, however, was not as straightforward a process as it may sound, since it can take a lot of research to match or translate Tibetan plant names into Western taxonomy (cf. Kletter & Kriechbaum 2001).

Still, all of this only touches on, but does not directly address the issue of efficacy or potency (*nus pa*) and its standardization, which – as Dr. Tsewang Nyima pointed out – is the ultimate goal of quality control. At the same time, this is also the most interesting issue, because it shows not only the indispensability, but also the limits of modern science. Unlike any experienced Tibetan *amchi* who can easily check the potency (*nus pa*) of medical ingredients, modern science is completely incapable of doing so. In other words, *nus pa* is beyond the grasp of science – immeasurable, invisible, irreducible to a particular chemical, molecule, or active ingredient. Even if it could be reduced to the presence of certain chemicals or patterns in a raw material, Tsewang Gyatso explained, “there are no established norms or standards that we can rely on to check if the

[chemical] values are in the normal range or not. Besides, Tibetan medicines have so many ingredients, it really gets complicated.”

Yet, modern science is needed in order to standardize these potencies. As the diabetes study showed, it is difficult for Tibetan *amchi* to compare and regulate potencies diachronically, that is, over time. Furthermore, with their traditional methods alone, they are unable to establish any reproducible standards of *nus pa*, or any reliable system of documentation acceptable under GMP regulations. The solution, as Dr. Pema Gyatso told me, lies in joining the forces of both modern and traditional approaches. According to him, first the potency of an ingredient can be checked by traditional means (mainly by taste and smell). If found good, the ingredient would then be chemically analyzed to establish the values of its chemical composition, which could finally act as norms for subsequent tests. In Dr. Pema Gyatso’s words, “we are trying to make standards, and then follow the standards. Like this we can prove it’s good quality.”

While this complicated and labor-intensive work has yet to be done at the Men-Tsee-Khang or anywhere else in the Tibetan exile, recent developments at the Dharamsala Men-Tsee-Khang indicate that its administration, at least, is serious about reforming – indeed, revolutionizing – Tibetan medicine production along the lines of modern quality control. Thus, in 2009, three new scientifically-trained staff – one of them Indian – were hired to replace Tsewang Gyatso, who had been the only quality control expert at the Men-Tsee-Khang before he left to the US, and given a large new laboratory at the pharmacy. To give them more power and independence, a Quality Control Sub-Department was founded under the exclusive authority of the pharmacy, which tests samples of every batch of raw materials purchased, as well as inspecting finished pills for

moisture levels, mold, or fungus. And while their test-results of moisture levels, for example, might still have no other purpose than documentation as Dr. Pema Gyatso told me, on other occasions, whole batches of pills were discarded at their advice. The administration's gradual transfer of power away from traditionally trained, experienced *amchi* to young college graduates with degrees in natural sciences caused, not surprisingly, concerns among the doctors. Dr. Tenzin Rabgay from the Materia Medica Department, for example, told me:

I sometimes feel very doubtful about the scientific results. If we say, "science is modern and therefore it has to be accepted" – I don't think so. It still needs experience too. And the basic, basic, basic thing is to have a good heart. Also, sometimes people say that according to science, something is the case. But on what kind of scientific basis do they say that? Is the basis really firm and true, and were the experiments that have been done in the past – if they have been done at all – really reliable? And how reliable will this knowledge remain in the future? Science is changing all the time, knowledge is constantly upgrading. So we cannot depend on scientific methods 100%. Therefore I feel that whether in case of the raw materials or the finished products, the doctors should be the main ones in charge. Not the scientists, which sadly is sometimes done here at the Men-Tsee-Khang. I do not agree with this at all, from my personal view. Doctors who have a lot of experience should control this. But, if they need some backup from the scientists, they can do that, they can tell them to do tests. And then they can combine these two knowledges, and say what is ok and what is not. And that should happen on the basis of a good heart, a good motivation.

Dr. Tenzin Rabgay's concern was not only that the doctors' experience is increasingly subordinated to modern education, but even more so that Tibetan medicine's

Buddhist ethics – the value of having a “good heart” – was slowly being replaced by the cold machines of modern science. And with this, Dr. Tenzin Rabgay indeed identified the crux of the issue – an issue, however, for which the Men-Tsee-Khang administration bore less responsibility than the larger structural pressures that bore on Tibetan medicine. Yet, for now, despite such valid concerns, everyone at the Men-Tsee-Khang – whether Dr. Tenzin Rabgay or Dr. Dawa – insisted that what was at issue was not replacement but complementation: while modern technologies of quality control might make up for a lack of Buddhist ethics in Indian herb-traders and businessmen, no amount of documentation or lab tests could replace Buddhist ethics among the *amchi*. In the Indian context, this was especially evident to the *amchi* in the negative example of Ayurveda, which was both more modernized and more corrupt. As Tsering Tashi, the Men-Tsee-Khang’s famous director from the mid-1990s, told me:

They have lots of scandals in Ayurvedic factories, you know. Despite all their control systems: first they have to send a tender for herb suppliers, then they have scientists with all sorts of equipment to monitor the quality, so many things! We have none of that. But somehow, dirt comes into their medicine! [laughs] On the other hand, we are somehow able to control that.

Indeed (as we have seen in chapter 4), in the *amchi*’s eyes, the biggest threat to Tibetan medicine’s efficacy remained greed and corruption, making Tibetan medicine’s traditional ethics more important than ever. While modern quality control was necessary in a broader, non-Buddhist context of capitalism and science, Buddhist ethics remained the foundation for Tibetan medicine’s efficacy by ensuring virtuous behavior where it mattered most, that is, among the *amchi*.

Modern technology and science's powerlessness, however, does not remain limited to the prevention of corruption and malpractice in Tibetan medicine (which may be considered beyond its scope), but extends to their core functions of measuring, discovering, and making visible. Indeed, Dr. Pema Gyatso's idea (and it should be stressed that for now, this is not much more than just an idea) of establishing modern scientific standards for Tibetan medicine's efficacy is revealing. For it implies nothing else than a reversal of his statement: yes, it is true that "When we lose the potency of tradition, then we need the help of modernity." But traditional potency – i.e. *nus pa* – also brings to light the impotence of modern science, which by itself is completely unable to grasp, measure, or make visible *nus pa*. Ironically, modern science is asked to prevent the loss of something it cannot even see or understand, and in turn requires the help of the same traditions it is supposed to help. It is thus also true, at least in the case of standardizing *nus pa*, that modernity, confronted with its impotence, needs the help of tradition. In short, tradition and modernity have come to rely and depend on each other for their respective powers.

The same is true of spiritual insight and scholarly research, as exile-Tibetan *amchi* consider both as essential parts of Tibetan medicine. Dr. Tenzin Rabgay explained this to me using his topic of expertise – Tibetan *materia medica* – as an example:

This morning I asked myself one question. The medical uses of the plants, which are mentioned here [points to an old scripture], based on the insights of past scholars, compared to some [modern] research work that describes the medical uses of the plants: which one do I feel is more authentic? And my answer was, this side [points to the old book]. The authentic wisdom is through insight. This is like a final, completely done research, because it's through insight. Whereas my opinion on the research

work based on science was: maybe it's on the middle way, maybe even on the final path, but still something is wrong. This is what I felt. [...] When I talk about insight knowledge, I refer to the taste of the plants, their post-digestive taste, and their medical uses. This is the work that I consider based on the knowledge of someone with insight. Whereas the [plants' taxonomic] descriptions are done in a scholarly way. And it's with these that I see some shortcomings. Not all of them, but some. And I don't blame these scholars, because they were not in a position to access, check, and go into the field to see these plants. They were not able to do it because they lived in Tibet... So this is our responsibility in India, to close this gap, to add information that is missing there by scientific means.

Tibetan medicine in exile, Dr. Tenzin Rabgay thus implied, is not either modern or traditional, it is not either scientific or religious, but it is both and it has to be. In some ways, Tibetan medicine's traditions – and pills – are indeed losing potency in the modern world of GMP regulations, capitalism, and mass production. In other ways, however, its Buddhist ethics, epistemic methods, and centuries of experience emerge as more important than ever before in the effort to preserve not only the medical, but also the cultural and political efficacy of Tibetan medicine.

Conclusion

In the beginning of this dissertation, I argued that Tibetan medicine needs to be grasped in both of its aspects – as an effective art and science of healing of increasingly global reach, and as a crucial domain in which a future for Tibet as a nation can be imagined – in order to fully understand and appreciate it. I also suggested that neither of these aspects exists independently from the other; that they are inseparably connected by threads both strong yet fragile, real yet invisible. The chapters that followed traced these threads, and made visible the connections that joined past with present, politics with compassion, capitalism with altruism, science with religion, modernity with tradition – and in doing so, most importantly, Tibetan medicine with the Tibetan nation. Each chapter identified a different node through which these threads passed, a different constellation in which they were articulated, problematized and renewed. Beginning with the reestablishment of the Men-Tsee-Khang in exile and the subsequent international spread of Tibetan medicine, we moved on to the renegotiation of the traditional connections between politics and business on the one hand, and Tibetan ethics on the other, which were made necessary by Tibetan medicine’s expansion in exile. This renegotiation led, I then showed, to a transformation of Tibetan medicine into a “medical system” that could not only be regulated and controlled, but also stand for Tibetan culture and the nation. In order to serve its purpose, however, such a medical system needed to establish its legitimacy through legal recognition both in India and internationally. One important strategy to achieve this, finally, was the engagement with modern science, which was envisioned to

fulfill both the political purpose of winning recognition for Tibetan medicine and boosting the legitimacy of the Tibetan cause, and the reformatory purpose of remaking Tibetan medicine and culture as an alternative modernity. Ultimately, however, all these nodes, and the lines of connection that pass through them, are merely different strands of the same thread: linking the contemporary transformations of Tibetan medicine in exile with the past, “preserving” tradition; and constituting the single most important link between Tibetan medicine and the nation, which stands at the center of all efforts of cultural preservation – that is, Tibetan Buddhist ethics.

For contemporary Tibetans in exile, from the Dalai Lama down to illiterate farmers in South Indian settlements or supermarket employees in the San Francisco Bay Area, Tibetan Buddhist ethics is identical with Tibetan culture; exile-Tibetanness resides in the ethics of Mahayana Buddhism. Not only has this fundamental claim shaped Tibetan medicine more than anything else during its past 50 years in exile, but it also stands at the basis of this dissertation, its conceptual framework, and its main argument. The main argument was that Tibetan medicine “preserves” Tibetan culture and produces a modern Tibetan nation by instantiating, materializing and validating Tibetan Buddhist ethics – and thus Tibetan culture and nation – in its medical knowledge, its institutions, doctors, pills, and efficacy. Indeed, we have seen how, for exile-Tibetan *amchi*, there exists a direct connection between Tibetan medicine’s ethics and its pharmaceutical, cultural, and political efficacy to heal sick individuals, an ailing culture, and a split nation. We have also seen, however, that despite its power, the thread of Tibetan Buddhist ethics is a fragile one, threatened by Chinese communism as much as Western capitalism, by Indian corruption or Tibetan complacency as much as romantic,

essentialist images of Shangri la. In order to be protected and preserved, it needs to be constantly renewed, re-woven according to context and situation; and with it, Tibetan culture and nation, too, are redefined and re-imagined. It is in this work of redefining and reimagining the nation that Tibetan medicine in exile plays a central role, and it is this work that I have tried to document in this dissertation.

One of my central concerns in this ethnography was to record the sincerity, effort and creativity with which exile-Tibetan doctors protect and constantly renew the thread of Buddhist ethics that links their medicine with their nation, and that ensures their cultural survival. For if exile-Tibetan doctors consider Mahayana ethics, with altruism and compassion at its core, as Tibetan medicine's defining identity, then they do so not out of simple cultural sentiment or clever political rationale, but as a matter of immediate practical consequence: for them, Tibetan Buddhist ethics is directly connected to Tibetan medicine's pharmaceutical, cultural, spiritual and political efficacy. What is more, an ethically defined Tibetanness also has practical benefits in the wider context of the Tibetan diaspora, where other, more conventional markers of identity (e.g. place of origin, language, customs, dress) are no longer useful: in exile, Tibetans need to identify with the Tibetan nation regardless of whether their roots lie in U-Tsang, Kham, or Amdo; the younger generations increasingly lose their Tibetan language; and old Tibetan customs, food habits, or dress styles inevitably change and adapt to different times and places. In such a context of change, dispersion and heterogeneity, it is clearly unwise to attach Tibetanness to outer appearances; identity is much more easily preserved and produced as inner qualities. Although we have seen that exile-Tibetans genuinely worry about the preservation of these inner qualities in themselves and in Tibetan medicine,

such identity statements should not be taken as ontological or historical ones, even though they are often expressed as such. It would thus be naïve to consider – or judge – exile-Tibetans as Buddhist saints simply because they formulate their national identity around the values of altruism, compassion and nonviolence. Similarly, the existence of warfare in old Tibet or the CIA-sponsored armed resistance movement during the 1960s, for example, do not invalidate exile-Tibetan self-perceptions and -representations as inauthentic self-marketing.

But this dissertation also sheds light on larger issues than the particular case of Tibetan medicine and Tibetan exile identity. Probably the most obvious of these concerns medicine's role in nationalist movements, the production of ethnic or cultural identities, and emerging forms of governance. While being the first to explore this role as far as Tibetan medicine in exile is concerned, this dissertation joins a well-established body of similar work on other Asian medical traditions, like Traditional Chinese Medicine (Farquhar 1994; Taylor 2005; Scheid 2007), Ayurveda (Leslie 1968, 1973, 1974, 1976b; Cohen 1995; Langford 2002), or Tibetan medicine in Tibet (Adams 1998, 1999, 2001a, b, 2002a, b, 2005, 2008; Janes 1995, 1999a, b, 2001). What all of these studies agree about, regardless of their regional focus, is that these “traditional medicines” have constituted a central domain in and through which modern forms of cultural identity and nationalist politics were – or are – negotiated and produced, while themselves being transformed in the process. This dissertation's ethnographic and historical account of exile-Tibetan medicine's cultural and political role thus participates in the larger project of tracing ethnicity, governance and nationalism in modern Asia through recent history and an emerging present.

However, the Tibetans' efforts to culturally organize and politically govern themselves as a nation in exile – lacking territory, boundaries, coercive state power, and even a geographically and culturally cohesive community – also present an exceptional case that reflects globally emergent socio-cultural and governmental forms. As several authors have shown us (e.g. Ong 1999, 2003; Barry 2001; Brysk & Shafir 2004; Sassen 2004, 2008; Rose & Novas 2005), territory, boundaries and homogeneous communities have become inadequate markers for the nation, government or citizenship in the contemporary world, be it due to economic and political migration, increasing social and cultural heterogeneity, or transnational political interests. By ethnographically and historically documenting how exile-Tibetan nationalism is neither a distorted copy of a European original, nor simply an adoption of a universal, global concept, this dissertation participates in ongoing efforts to rethink conventional notions of the nation and nationalism. That is, it regards them not as monolithic concepts, but as shifting assemblages of practices, discourses, norms and values (Collier & Ong 2005) that congeal in locally and historically contingent forms. What is more, we have also seen how the exile-Tibetan struggle for a recuperated nation-state not only manifests in political actions directed at others, but also, crucially, in ethical practices directed at the self. In other words, the study of Tibetan medicine in exile reveals a type of nationalism that is both ethical and political, and which, despite its particularity, may be relevant to larger discussions of the importance of ethics and religion – articulated through medicine – in modern governance, nationalism and citizenship.¹⁹⁸

¹⁹⁸ See, for example, Malkki (1992, 1995); Rose (1999); Strathern (2000); Axel (2001); Fassin (2002); Petryna (2002); Barry (2004); Collier & Lakoff (2005); Mahmood (2005); Hirschkind (2006).

If medicine, as an ethico-political institution par excellence, plays a central role in all of this, then this is by no means natural or a given. To the contrary, we have seen how hard it is for Tibetan medicine to perform this role and to establish and maintain its connection to the nation. I have documented in detail how not only a “traditional medicine,” but through it a whole people in exile struggles to ensure its (cultural) survival through an ambiguous engagement with modernity. Such an engagement, especially in the transnational context of exile, is necessarily shaped by a multitude of economic, cultural and political interests, at times overlapping, at times conflicting. Thus, Tibetan medicine is simultaneously asked to be political and apolitical, public and private, governmental and non-governmental, modern and traditional, religious and scientific; it needs to be uniquely Tibetan, or Indian, or universal; it must be protected from foreign appropriation and exploitation, but at the same time open itself to international engagement. Exile-Tibetan *amchi* want nothing more than international acceptance for their medicine, yet they are suspicious of the world’s interest in it. They simultaneously regard science and modernity as superficial but politically useful ornaments for traditional knowledge, as necessary tools to reform Tibetan medicine, and as threats against Tibetan medicine’s integrity. Correspondingly, Tibetan medicine is portrayed as the product of millennia of indigenous scholarship – as a traditional science with strong Bon roots –, but religiously revered as the Buddha’s perfect words. To some extent, such different interests, perspectives and ambiguities reveal the *amchi*’s uncertainties and ambivalences; but much more than that they indicate the dilemmas resulting from their medicine’s ethico-political role and their engagement with modernity.

If Tibetan doctors in exile find it necessary to modernize and reform their medical institutions and traditions around new notions of culture, politics and truth in order to fulfill their task of healing the nation, then this is by no means a unidirectional process. Indeed, to speak of a “modernization of Tibetan medicine” would not only assume a non-modern other, but also its passive role in the encounter with a reified, universalized modernity. Thus, instead of uncritically positing Tibetan medicine as a bounded medical system, an ethnomedicine that could be compared to other “Asian medical systems” or examined as to its “scientificity” and validity, I have traced in detail the various processes through which it *is made* into a medical system. In contrast to TCM or the Indian systems of medicine (Ayurveda etc.), which have largely completed this particular transformation, however, exile-Tibetan medicine’s reshaping into a political and legal ‘body’ is still going on, which enabled me to document and analyze it – and the multiple economic and political interests behind it – not only in an historical but also an ethnographic way. Furthermore, instead of making an assumed dichotomy between Tibetan medicine and modernity its central analytic concern, this dissertation focused on their *mutual engagement*, on the reworking of one through the other. While refusing to frame this dissertation in terms of such a dichotomy, however, I took occasional exile-Tibetan perceptions of their medicine’s or culture’s incompatibility with modernity seriously as important elements shaping their engagement. Ultimately, though, neither Tibetan medicine nor modernity emerge as bounded entities clashing, but rather as “fluent bodies” (Langford 2002) of discourses, knowledges and practices: sometimes wrestling, sometimes dancing, but always changing as each tries to engage the other for its own purposes. This encounter is undeniably “medical” in that each takes the form of a sick

healer, uprooted and suffering from a lack of boundaries, who simultaneously offers healing to, and seeks salvation from, the other. By providing an ethnography of Tibetan medicine in exile, then, this dissertation has also provided insights into how a people, in critical circumstances, tries to embrace modernity (but resolutely on its own terms) in order to re-imagine and produce a particular kind of nation, culture and truth.

Clearly, just like nationalism or truth, modernity appears as negotiated and produced; not as a globally singular phenomenon but one that is evidently multiple and particular. Here, I have offered an ethnography documenting the processes and strategies through which exile-Tibetans aim to produce their own particular modernity, their own modern Tibetan medicine and culture and nation, that despite – and because of – their modernity also remain “traditional.” As we investigated this particular exile-Tibetan modernity, we have also encountered its reference point: Western modernity, the product of European Enlightenment, identified by Marx, Arendt, Weber, or Foucault as a separation of knowledge and moral goodness, of labor and its products, of the human and her lost wholeness. This, then, was the modernity that exile-Tibetan doctors regarded as opposed to their “traditional” medicine, the modernity they feared would commoditize their pills and separate their medical expertise from the practice of Buddhist ethics. To them, this was a modernity of broken links, where the connection between knowledge, practice and motivation – that made the *amchi* good, the pills effective, and Tibetan medicine unique – was disrupted. In short, it was a modernity that denied Tibetan Buddhist ethics, which is nothing but the thread that merges knowledge, practice and motivation; that reconciles all of Tibetan medicine’s seemingly contradictory qualities;

that connects Tibetan medicine with the nation; and that ultimately stands for Tibetan culture and its survival.

Realistic and fearful though this modernity was to them, it was not inevitable, not the only one possible. Indeed, what the Dalai Lama in his books and speeches, Tibetan Buddhist monks in their spiritual practices in New York or Toronto, and exile-Tibetan doctors and medical institutions in India and elsewhere are all aiming to accomplish, each in their own ways, is to create a modernity different to that, an alternative modernity: a modernity that is as particularly Tibetan in quality as it is universal in scope and appeal – a modernity characterized not by loss and fragmentation but by interconnection, symbolized by the image of the thread. For who would not wish for a modernity where capitalism can be responsible and altruistic, where politicians see the good of others as their own, where science and religion complement – rather than battle or deny – each other? If European modernity was characterized by the loss of wholeness, then Tibetan medicine promised to heal it with tradition, to provide wholeness through Tibetan Buddhist ethics materialized in bitter brown pills.¹⁹⁹

I began this dissertation with the curious observation of how, for Tibetans in exile, cultural survival was inextricably linked to “helping the world”; that is, how ethics (the care of the self) and politics (the government of others) coincided in the struggle to imagine and build a modern Tibetan nation. I spoke about the exile-Tibetan cultural malaise, about Tibetan medicine’s need to heal itself in order to save an ailing Tibetan culture, and about modernity’s role as an ambiguous cure. After all the discussions of Tibetan medicine, Tibetan culture, and Tibetan Buddhist ethics, we have finally come full circle in the end: not only an ailing Tibetan culture needs the cure of modernity, but as

¹⁹⁹ Langford (2002) has made a similar argument about “Ayurvedic modernity”.

modernity is subdued, “detoxified” and compounded by Tibetan medicine to make it palatable – without side effects – to the Tibetan patient, modernity itself is healed of its chronic fragmentation and loss. This, then, was the real meaning of Dr. Tsering’s remarkable words with which everything began:

“Although we are refugees, through Tibetan medicine we can help the world.”

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