THE TIBETAN MEDICAL TRADITION, AND TIBETAN APPROACHES TO HEALING IN THE CONTEMPORARY WORLD

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Abstract

The Tibetan medical tradition derived primarily from Indian Āyurveda but integrated other elements within an overall Buddhist philosophical framework. While using a theory of natural causation, medical doctors were also trained in meditative healing techniques. Since the Chinese occupation of Tibet, Tibetans have attempted to reconstruct their cultural heritage — including the medical tradition — in exile. The institutional structure of Tibetan Medicine in India is modern and secular yet Buddhism remains important, having been central in articulating Tibetan identity and in internationalizing Tibetan culture.

The purpose of this paper is to outline the main approaches to illness and healing in pre-modern Tibet, with particular reference to the Tibetan medical system, and to comment on the modifications — and also continuities — which characterise Tibetan approaches to healing in the contemporary world, especially in exile.

The first part of the paper considers the place of Buddhism in the theory of Tibetan medicine, summarises the essential features of the Tibetan medical system, and discusses its practice in pre-modern Tibet. The second part looks at the effects of the Chinese occupation on the medical system in Tibet and at

the changes brought about by the circumstances of the exodus of refugees and their attempts to reconstruct their cultural — and in this case medical — heritage in exile. The radical disruption of the refugees' social and economic life and the entirely new circumstances of life in India have meant that approaches to health and illness have greatly changed, and that biomedicine now has a central place in Tibetan refugee health care. At the same time, some aspects of the traditional Tibetan systems of healing are not only being preserved, but developed and taught beyond the Tibetan community. The Tibetan system of medicine is used in a way which is complementary to biomedicine, and its representatives have been involved in dialogue and cooperation with both western medical scientists and practitioners of various alternative medical systems. The Tibetan Buddhist meditative traditions of healing have also generated interest in the west, where they are simplified and taught to broad non-Buddhist audiences. Buddhism has also been important in the expression of Tibetan identity in India, and despite the modernization and secularization of the Tibetan medical system, its connections with Buddhist thinking and practice are unlikely to be severed.

Part I

I.1 Tibetan Medicine: its Relationship with Buddhism

Tibetan medicine in pre-modern Tibet was a complex scholarly tradition with semi-professional practitioners.[1] To a large extent, it can be seen as a coherent and rational system, although it has many strands of different origins, with rather different philosophical assumptions. Essentially, it derives from the Indian Āyurvedic system of the period when Buddhism was strong in northern India and had most impact on the medical tradition. Some elements were further developed in Tibet and Chinese medicine also had considerable influence, while at the outset, when the tradition was being introduced through royal patronage from India in around the seventh and eighth centuries AD, some ideas were also borrowed from Central Asia and other sources.

Buddhist thinking provides Tibetan medicine with a broad framework which encompasses the diverse elements of the system. Dr. Trogawa

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1 I use the word "semi-professional" here since Tibetan medics were not fully "professional" in the modern Western sense: see Section I.3.

Rinpoche, a Tibetan lama and doctor, presenting a paper to a symposium on classical Tibetan medicine organised by the Wellcome Institute in London (Trogawa 1986), characterised Tibetan medicine as having practices of disparate origins, but a "View" rooted in Buddhism. Now, since most of the main features of the system do not derive from Buddhism and are elsewhere associated with philosophical assumptions very different from those of Buddhism, it is possible to conceive that the system could operate without this Buddhist "View". Indeed, the Chinese in Tibet attempted to preserve Tibetan medicine while eliminating its Buddhist and other religious components. As I understand it, they have only had very limited success in doing so, and although Fernand Meyer writes that Tibetan medicine in exile is becoming more secular (Parfionovitch, Dorje and Meyer 1992: 2), it would seem that while the training and practice may be less monastic, may involve less recourse to Buddhist authority and may be more experimental and "scientific", in important ways, the Buddhist basis still underlies the system. This argument will be developed later.

My purpose here is to illustrate the main ways in which Buddhist assumptions are used theoretically to underpin the whole medical system. In Tibetan Buddhism, the mind is said to be the "King", generating physical, psychological and emotional habit patterns which create the conditions leading to future happiness and unhappiness, and which are the driving force of the whole of phenomenal existence. The sorry state of affairs of worldly existence is said to be marked by suffering, impermanence and the lack of any real or lasting individual identity. Its root cause is the fundamental state of Ignorance, which gives rise to the "three poisons" — attachment or desire, aversion or hatred, and indifference or delusion. This simple set of three qualities are sometimes elaborated into a group of five, or other longer lists of emotional afflictions (Sanskrit. *kleśa*), but the threefold classification is always at the basis of more complex formulations. Now, in Tibetan medicine, the "poisons" are related to the humoral theory which is at the core of the entire system, such that the "poisons" are said to be the "remote" or ultimate primary causes generating imbalances in the three humours, and thus, ill-health. In the *Blue Beryl*, a seventeenth century commentary by Sangye Gyamtso, the Fifth Dalai Lama's Regent, on the most important medical text of the tradition, the *Four Tantras* (*rGyud-bzhi*), several discussions of illness causation make use of the distinction between primary and secondary causes. Such a distinction is used in Buddhist texts, where usually, primary causes (*rgyu*) refer to the basic or inherent causes of past karma, which are compared to the seeds of a plant, with the capacity to produce a particular species of

plant. Secondary causes (*rkyen*), on the other hand, are the conditions which allow the ripening of past karma, like the soil, sunshine, rainfall and so on, which nurture or impede the growth of plants. In the context of this text on Tibetan medicine, the primary causes of illness are divided into the "remote" primary causes, which are the three poisons, springing from Ignorance, and the "proximate" primary causes, which are the classic three humours of the Āyurvedic system, when they are in an unbalanced state. Numerous secondary causes are given — usually factors such as climatic conditions, inappropriate diet or conduct, or the agency of harmful demonic forces, which activate or aggravate the primary causes. Since primary causes cannot produce illness without the supporting secondary causes, illness can be avoided or treated by eliminating such secondary causes, as well as or instead of attending to the primary level of causation. In dealing with the primary causes, the text directly relates the three poisons to the three humours (Parfionovitch, Dorje and Meyer 1992:89,95), as well as to other factors involved in the production of specific diseases. Desire and envy are said to cause diseases of serum and wind and those triggered by female demonic forces. Hatred and pride result in diseases of blood and bile and the onset of male demonic forces, while delusion is responsible for diseases of phlegm and those associated with neuter demonic forces. Complex disorders caused by unbalanced humoral combinations are connected with all three poisons.

In this way, the theoretical foundations of the Tibetan medical system are integrated with Buddhist assumptions about causation, despite the fact that the humoral theory is essentially secular and emphasises the physical natural basis of disease. In fact, in Chinese and Japanese medicine, it seems that the notion of psychological causes for physiological conditions is not accepted and even mental illnesses are attributed to physical disorders (Ohnuki-Tierney 1984:84-86;175). By giving a central role to the emotional poisons in its explanation for disease, Tibetan medicine represents an almost opposite approach, although it is quite unlike the kind of simplistic psychological explanations of illness which are a feature of some trends within the alternative medicine movement in the contemporary West.[2] On the contrary, the emotional poisons which are thought to be responsible for any particular illness episode are likely to relate to conditions stemming from lifetimes in the distant past rather than psychological tendencies in the

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2 An example of such an approach can be found in Louise Hay, 1988, "Heal your Body: the mental causes for physical illness and the metaphysical way to overcome them" (Eden Grove Editions).

present. In practice, especially in approaches to healing in the scholarly medical tradition, the emphasis is very much more on dealing with the proximate rather than the remote causes, and also on treating the secondary causes. This is not, however, the case in the Buddhist meditation practices, such as on the Medicine Buddha, which are concerned with mental purification of physical and emotional disorders. Such meditative practices were included in a doctor's training and complemented the theoretical training and practice of medicine.

The entire medical tradition was also conceived of as the teaching of the Buddha, in the form of Bhaiajyaguru. The disparate elements within the system did not constitute any problem for this perspective, since any apparent contradictions could be accommodated through the classic Mahāyāna doctrine of skill-in-means, that varieties of teachings and in this case, methods of healing, are appropriate for different people in different circumstances. The *Blue Beryl* is introduced with a description of the Medicine Buddha's maala and the contents of the entire corpus of the *Four Tantras* are explained as a series of questions and answers between emanations of the Medicine Buddha, who manifest for this purpose and who dissolve back into the Medicine Buddha after the teaching is completed. The notion that the tradition was the Buddha's word and thus infallible, was clearly of importance in pre-modern Tibet; indeed, Tucci was informed by the president of Mentsikhang (sMan-rtsi-khang) medical college, who had travelled in India and had some knowledge of biomedicine, that it was precisely this fact which made Tibetan medicine superior to western medicine. He stated that western medicine is incomplete, being based purely on human understanding, while the Tibetan medical system has the advantage of being revealed by the Buddha as the Great Physician (Bhaiajyaguru) (Tucci 1967). I shall argue that this kind of thinking is at least toned down if not discarded in the contemporary world, although there are still important ways in which the perspective that the tradition is revelation and inspired by Buddhist wisdom persists and is likely to continue to do so.

I.2 Tibetan Medicine: its Principal Features

Much has been written on Tibetan medicine; here, I would like to summarise its basic approach. I have consulted a number of recent books on Tibetan medicine, but much of my brief presentation is based upon the already mentioned seventeenth century *Blue Beryl* by Sangye Gyamtso, which

Yuri Parfionovitch, Gyurme Dorje and Fernand Meyer have summarised in English, and published together with the series of paintings which were made to illustrate the work. This text has the advantage of being a product of pre-modern Tibet rather than a modern interpretation for a western audience, but the disadvantage that some features of the tradition may have died out by the twentieth century, before the modern era. Certainly Fernand Meyer argues that some of the complex procedures are no longer followed by Tibetan doctors (Meyer in Parfionovitch, Dorje and Meyer 1992:12). However, it would seem that the basic elements of the tradition were not radically altered, and reference to them can be found in modern works, such as Dr. Yeshi Donden's *Health through Balance*.

Essentially, Tibetan medicine is based on Indian physiological theories, according to which the five fundamental elements — earth, water, fire, air and space — exist in various combinations as different phenomena. The particular combinations define the qualities of any substance, such as hot or cold, heavy or light. A substance with one quality will stimulate similar substances, while inhibiting substances with the opposite quality. The three humours, wind, bile and phlegm, themselves made up of specific combinations of the fundamental elements, circulate through networks of channels in the human body, maintaining health while they are in a balanced state. When this equilibrium is lost, medical disorders result. The scholarly tradition includes detailed information on anatomy and physiological processes, mostly deriving from Indian medical texts and tantric theory, although modifications based on research were not unknown. For example, the paintings illustrating the seventeenth century *Blue Beryl* treatise depict drawings faithful to the tradition — such as an upward pointing heart like a lotus — side by side with drawings based on the observation of dissected corpses — the heart "as observed" (Parfionovitch, Dorje and Meyer 1992:6-9; 114 (Plate 49). The resulting discrepancies are partially glossed over by the author, Sangye Gyamtso, as differences between healthy living and dead bodies or bodies which have sustained injuries. Nonetheless, it is clear that although such an explanation is not entirely adequate, the discrepancies are explicitly acknowledged, as are differences in the identification and use of herbal medicines in the two main schools of thought which had emerged within the medical traditions of Tibet by the seventeenth century.

A variety of diagnostic techniques were used. Complex pulse examinations, which may originally have owed much to ancient Chinese medicine, became one of the main hallmarks of Tibetan medicine. Visual

inspection of the tongue, other parts of the body and excretions from the body, were also important components of diagnosis, and could be supplemented by detailed questioning of the patient and/or his immediate care-providers as to the development and experience of the complaint. Essentially, the diagnostic procedure was concerned with physical examination of the patient and the natural causes producing the illness, in terms of the humoral balance and circumstances such as diet and climate, and it is presented as a rational empirical process. The *Blue Beryl* openly discusses ways in which a doctor can maximise his impact by impressing the patient and his family using "investigation through subterfuge"; he can, for example, closely question the messenger while en route to the house, and immediately announce the diagnosis on arrival. When uncertain in spite of the usual tests, he can prevaricate until he has had longer to observe the patient, or speak evasively about diet or the harmful influence of demons (in much the same way as a modern biomedical doctor in the U.K. may talk vaguely of "bugs" or viruses when an exact diagnosis is uncertain). Thus, the emphasis is on using the available evidence to rationally work out the natural causes of the disease, while not neglecting to reassure the patient and his family of the doctor's competence, even in uncertain cases. Some of the diagnostic techniques, however, are of a rather different nature: diagnosis through dreams and through omens occurring in the environment, owe more to analogical thought and non-falsifiable intuitions than to deductive reasoning. Methods of urinalysis included a whole set of divinatory procedures to be followed in cases of suspected demonic influence, using for instance, mantic grids to be placed over urine samples to ascertain the class of negative forces involved in the illness.

Similarly, there is a broad spectrum of treatments, principally dependent on the type of illness and its severity. Mild disorders might be treated through diet and modifications of behaviour, while more serious or advanced conditions would require medications. The scholarly tradition had a vast range of medicines deriving from plant, animal and mineral sources. Much of the painstaking research involved in the production of the paintings to illustrate the *Blue Beryl* was concerned with the careful identification of medicinal plants, through consulting experts from the areas where various plants grew, and assessing different scholarly opinions (Meyer in Parfionovitch, Dorje and Meyer 1992:7). While such medicines were classified according to their tastes and potencies, and their effectiveness was basically seen in terms of the humoral theory, such that the disturbed humour or humours were counteracted by opposing qualities, not all the varieties of medications would

seem to fit well in a system which is preeminently based on a theory of natural causation. The *Blue Beryl* lists numerous substances, the potency of which is presumably primarily symbolic. For instance, earth from a mouse hole facing east can be used for cold wind disorders, while a widow's underpants may protect against epilepsy and stroke and help in the healing of wounds (Parfionovitch, Dorje and Meyer 1992:75). In other words, the tradition included a medley of medications based on metaphorical associations. The preparation of medicines also included elements of ritual and symbolic importance: medicines were ritually consecrated using meditation and mantra recitation, and doctors could also prepare protective pills and charms with mantras inscribed upon them, to guard against demonic forces causing infectious diseases. A doctor might even perform curative rites for diseases particularly associated with demonic involvement, such as mental illness, epilepsy, stroke, plagues and leprosy.

In cases where medication was inappropriate or insufficient to deal with the disease concerned, there was a range of techniques of external therapy — compresses, massage, blood-letting, moxibustion and minor surgery.

A general classification of illnesses accounted for differences in treatment outcomes (Parfionovitch, Dorje and Meyer 1992:53, 165, 167). "Ostensible" diseases are self-limiting and will abate without treatment, although treatment may speed recovery. "Imaginary" diseases caused by demonic or negative forces (*gdon*) must be dealt with by ritual means. Illnesses entirely dependent on past karma may be immune to treatment and the sufferer may die despite the use of appropriate remedies, while "absolute" diseases which may threaten the life-force if untreated, will respond to the correct medical treatment. The Tibetan words which Parfionovitch, Dorje and Meyer translate as "imaginary" (*kun-brtags*), "dependent" (*gzhan-dbang*) and "absolute" (*yongs-grub*) are the same terms as those used in the Yogācāra Three Natures (*trisvabhāva*) system, where the "imaginary" or "conceptually constructed" is similarly contrasted with the "dependent" and the "absolute" or "perfected" levels of apparent reality. The "imaginary" or "constructed" level connotes the ordinary experience of events — how things appear to be at a superficial level — while the "dependent" level indicates the underlying causal process of karma, and the "absolute" level indicates the real nature of appearances. The use of these terms here may not necessarily imply Yogācāra philosophical assumptions, since the Yogācāra analysis is concerned with different levels of viewing the same phenomena rather than representing a classification of different phenomena. But the connotations of this medical classification are

clearly derived from an explicit analogy with the concepts of the Three Natures. Thus, "imaginary" illnesses are not to be equated with disorders which may be termed "psychosomatic" in the West: the word rather implies that the illness is relatively superficial, being associated with the immediate precipitating conditions of demonic influences and not with more deeply seated karmic causes or definite physiological conditions which will be responsive to the standard medical treatments. The use of this classification both justifies very different approaches to healing within the one system, and can explain failures or, for that matter, surprising successes on the part of incompetent healers.

To sum up, the Tibetan medical tradition integrates different assumptions about illness and its causes into an overall framework based on Buddhist philosophy. Elements which could be seen as contradictory — such as the humoral theory versus the notion of demonic causation in illness — were not so much synthesized as compartmentalized: each was considered appropriate for different conditions and circumstances.

I.3 The Practice of Tibetan Medicine and Other Methods of Healing in Tibet

The majority of doctors in pre-modern Tibet received their training as apprentices to other doctors. There were, however, several medical colleges. where significant numbers studied medicine. The monastic medical college of lCags-po-ri in Lhasa was founded through the patronage of the Fifth Dalai Lama's Regent, Sangye Gyamtso, in the late seventeenth century, and in the eighteenth century, two similar colleges were set up at monasteries in East Tibet. However, the emphasis at lCags-po-ri seems to have been primarily on academic scholarship rather than the training of doctors, and moreover, it apparently declined during the late nineteenth century. Thus, in the early twentieth century, the Thirteenth Dalai Lama founded a second medical college in Lhasa - sMan-rtsi-khang — which recruited from the laity as well as from monasteries, and which was more oriented to the practical application of medical knowledge. Monasteries and government institutions in Central Tibet had to supply a quota of boys who would attend the college. Most would return to their own areas to practise medicine after they had graduated, although some of the monk graduates would remain to conduct research or practise at the college (Donden 1986:22). Prospective students were chosen on academic merit — principally on their abilities in memorisation, since the medical training involved memorising the major medical treatises and

commentarial works. The doctor Yeshi Donden, who was recruited under this system, recalls that few boys were enthusiastic about the prospect of medical training because the years of intensive training would entail a massive amount of memorisation (Avedon 1985). The training would last for at least eleven years, and at various stages, there were oral examinations. Yeshi Donden describes how, in order to enter the advanced course of study, he had to recite sections of the Four Tantras both in and out of sequence over a period of four days, in front of the entire college faculty and student body. At a later stage, he successfully passed an examination in which students had to correctly identify and comment on the uses of large numbers of medicinal plants. While the better students received public acclaim, the least successful were publicly ridiculed. This form of assessment could be said to be in practice testing levels of confidence — doubtless useful in a doctor's career — as well as purely medical knowledge. After most of his academic studies were completed, Yeshi Donden underwent a further period of three years practical training as an assistant to a practising physician. Advanced students also received some practical experience by helping in the clinic which was held daily at the college for any residents of Lhasa who wished to attend. Those too ill to come might be visited by doctors from the college in their homes.

One important component of the medical training was the strict ethical code, the main elements of which seem to have derived from India, from classical Āyurveda and Mahāyāna Buddhism. This code is one indication of "professionalism" in the occupation. However, other features of professionalisation — recognised examinations and qualifications, an elite status for physicians, and practitioner's organisations with the power to expel incompetent or irresponsible members — were not fully developed in Tibet. The scholarly tradition was undoubtedly sophisticated and graduates from sMan-rtsi-khang enjoyed a good reputation. In exile, Yeshi Donden came to the Dalai Lama's notice precisely since he was a sMan-rtsi-khang trained doctor, and having been summoned to Dharamsala, he subsequently became the Dalai Lama's personal physician. Nonetheless, there were no central professional bodies to vet doctors and no requirements to attend a college or to obtain professional credentials in order to set up practice as a doctor. Indeed, Yeshi Donden himself soon gathered a group of relatives who studied with him in his own practice in the years after he had qualified. There was a strong tradition of family lineages of doctors. In the context of the transmission of knowledge and skill along such hereditary lines, it seems that the medical occupation was open to women. Dr. Lobsang Dolma Khangkhar attended her family's medical school, studying for ten years with a monk tutor and receiving

her practical training mainly from her father. In exile, both her daughters have become doctors, the eldest taking over as the head of Dr. Dolma's clinic in Dharamsala after her mother's death (Coleman 1993:272).

The implication of the lack of any effective centralised control over the profession was that there was considerable variation between the levels of scholarship, training and competence of physicians in different areas. Nonetheless, the presence of such variation and local autonomy in the organisation of the medical profession can give a rather misleading impression of the practice of Tibetan medicine, at least in the twentieth century, when the central colleges undoubtedly had a major impact even in outlying districts. For example, Michel Peissel who worked in Mustang, close to the Tibetan border in Nepal, reported in the 1960s that there were two Tibetan doctors in Lo Mantang, both of whom had studied in Lhasa (Peissel 1979). Equally, in Ladakh, there were doctors who trained in Lhasa (John Crook, personal communication). The overwhelming impression given by the literature on pre-modern Tibet is not so much that of innumerable doctors of doubtful competence as a paucity of any kind of physicians at all in many parts. Notwithstanding the fact that most of the accounts are by westerners or westernized Tibetans who were probably biased in favour of biomedicine for the treatment of disease, it would seem frequently to have been the case that religious rituals were the only available recourse in the event of illness, and the available doctors often seemed to have travelled, especially to areas where there were epidemics. The limitations to the available medical care are made clear in Jamyang Sakya's account of the principality of Sakya, where she had married the young lama heir to the religious hierarch who headed the religious and political administration (Sakya 1990). The palace had a store of medicines which Jamyang Sakya helped to dispense during a measles epidemic. However, she makes the point that there were only three doctors for the entire area and many children died through inadequate medical attention (Sakya and Emery 1990:125). Moreover, although she makes some reference to doctors at various stages of her narrative, she also mentions episodes of illness or of heightened health risk when no medical attention appears to have been sought. Despite her high position as a Sakya family wife, she delivered her children with only her mother or other experienced female members of the family present. Her first child sickened and died at the age of three months: Jamyang Sakya recalls how an astrologer was consulted and monks recited prayers, but she makes no mention of any doctors involved.

Thus, Tibetan medical doctors were far from having a monopoly on the treatment of ill-health in pre-modern Tibet. There were simple self-help remedies, which included expertise in dealing with sprains and broken bones in livestock as well as humans, and folk religious practices, including rituals for recalling a lost or stolen life force or "soul" (*bla*), or for suppressing or expelling demonic influences. Some of these rituals had parallels in the more complex and sophisticated Buddhist monastic rituals, which would be performed for the wider community benefit in times of trouble. Monks might also be consulted for divinations using Buddhist texts, which would indicate the degree of the illness's severity and suggest appropriate religious and meritorious activities to perform as a way of overcoming the disorder. Long pilgrimages, for instance, were often performed for health purposes, especially for remedying female infertility. Helena Norberg-Hodge reports this practice in Zangskar (Norberg-Hodge and Russell 1994: 524), while an Eastern Tibetan man, Aten, describes in his memoirs how he had made such a pilgrimage with his wife, in the hope that she would conceive as a result (Norbu 1979:62-63). Lamas might also be requested to perform dream practice to diagnose the cause of an illness (Chopel 1983). Mediums and oracles who would divine the nature of an illness and the treatment necessary while possessed by deities or spirits, also existed. In Ladakh, the tradition of oracles still thrives, and people continue to consult them as well as having recourse to traditional doctors and biomedicine.

Even where medical treatment was sought, cures might be rather attributed to religious rituals performed simultaneously. An ordinary doctor would be unlikely to inspire as much confidence as a high lama, who might recite texts or provide protection cords or amulets (Harrer 1953:178).[3] Certainly, for serious complaints, whether or not doctors were involved, lamas would be likely to be requested to perform religious rituals such as the meditation practices of the female deity Tãrã or the Medicine Buddha, or in cases where possession by negative demonic forces was suspected, exorcism rituals might be held. Michel Peissel discusses how people in Mustang in the 1960s would usually call a doctor at first, but later, if the doctor believed demonic influence to be responsible for the illness, monks would be requested to perform the appropriate rituals (Peissel 1979:217-220).

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3 Harrer makes this point very forcibly, arguing that faith-healing, and the consumption of substances which came from a lama, were considered more certain cures than the medicines of a monk physician, while the best possible remedy would be an object which had belonged to the Dalai Lama.

Openness to alternative therapies is also indicated by the fact that where biomedicine was made available, many took advantage of it. Snellgrove and Richardson write that some people travelled long distances to attend the British hospital established in the twentieth century, while aristocratic families invited British, Indian and Sikkimese biomedical doctors into their homes (Snellgrove and Richardson 1980:261). Rinchen Dolma Taring, a member of an élite Lhasa family, had frequently consulted Tibetan doctors and gives a favourable account of the Tibetan medical profession, especially emphasising the selflessness of doctors in considering the patient's interests first, and treating the poor without any remuneration (Taring 1970:181). However, she criticises Tibetan surgical techniques and discusses the inadequacies of Tibetan medicine for problems relating to childbirth, of which she had first hand experience (Taring 1970:77). When she experienced similar problems with her second delivery, a doctor from the British Agency was called , who later treated her child as well (Taring 1970:119). Jamyang Sakya also experienced doubts about Tibetan medicine while still in Tibet, when it failed to cure her son of a serious illness. This occurred after the Chinese occupation, and she was offered biomedical treatment instead. However, the Chinese doctor made treatment conditional on her rejection of the Tibetan family doctor. She was reluctant to take this step, but the Tibetan doctor himself was convinced of his inability to deal with the illness and begged her to reject him. Such an explicit opposition being forged between "traditional" Tibetan medicine and "modern" biomedicine was to become a feature of the experience of Tibetans under China, particularly in the following two decades and the confidence of Tibetans in their own medical tradition was also undermined in the early years of exile. However, the complementary use of Tibetan and biomedicine, which now characterises the situation in India, also had precedents in Tibet. Dr. Yeshi Donden mentions that while he was completing his practical training in Lhasa, he spent two hours a day at the British Legation, acquainting himself with western medicine; once he began practising, he administered penicillin injections where appropriate, as well as the usual Tibetan remedies (Avedon 1985:188,190).

Part II

II.1 The Chinese Occupation

Changes in the approach of Tibetans to illness in the modern era can be related to the upheavals engendered by the Chinese invasion and subsequent

exile of about 110,000 Tibetans. Unlike some accounts of third world peoples being brought into contact with biomedicine, here, one is not dealing simply with general modernizing forces or the integration into a wider economic system involving social and economic subordination to outsiders or new elites. In Tibet, not only was the entire political, social and economic structure dismantled by the Chinese, but all aspects of Tibetan culture were attacked, especially during the Cultural Revolution, although a long process of undermining Tibetan identity and culture had begun long before the Cultural Revolution, and the process continues today. The recently publicised destruction of Tibetan style housing and architecture in Lhasa is one example. Religious practice was under threat from the start. Monasteries, which were the focus of political and religious life, were attacked in the east during the 1950s and throughout Tibet after 1959. The Cultural Revolution brought a further ban on any private religious expression, so that by the late 1960s, there was virtually no possibility of openly using religious healing rituals of any kind. The Tibetan medical tradition fared little better until the late 1970s. The lCags-po-ri medical college was entirely destroyed by the Chinese forces during the Tibetan uprising of 1959. sMan-rtsi-khang survived but the scholarly medical tradition was vigorously attacked in the Cultural Revolution. One of the Dalai Lama's personal doctors, Dr. Tenzin Choedak, who was arrested in 1959, spent well over a decade in prisons and labour camps before any interest whatsoever was shown in his medical expertise. In the mid-1970s, he was allowed to start giving medical consultations in prison after having successfully treated a Chinese prison doctor whose condition had not responded to either biomedicine or Chinese medicine. Even then, he was given far inferior facilities to those of the biomedical doctors, he had difficulty in procuring sufficient medicines on his small budget, and there were continual attempts to discredit him and Tibetan medicine in general (Avedon 1985:382). Matters improved in 1979, when he was made head of a new research project on Tibetan medicine, although his status as a "class-enemy" was not publicly removed until he was freed to go to India in 1980 as a concession to the Dalai Lama. Since then, some revival of the medical tradition in Tibet has been allowed. For example, sMan-rtsi-khang has been enlarged and a 150 bed hospital was opened in 1985 (F. Meyer in Parfionovitch, Dorje and Meyer 1992:2). However, this revival has taken place in the context of modernizations which undermine the whole ethos of the tradition. For example, Tom Dummer quotes a Chinese source extolling the modern factory production of Tibetan medicinal drugs, and contrasts this with the situation in exile, where some of the medicines are consecrated with religious ceremonies (Dummer 1988:114). A recent report by an American doctor visiting the

Tibetan traditional medicine college in Lhasa (Stillman 1994) presents a picture of inadequate funding, dilution of the tradition with Chinese medical techniques and philosophy (including classes in Chinese history and political thought, taught in Chinese), significant modifications of the classical training and practice, and a strong emphasis on also learning about biomedicine, which is said to fill gaps in Tibetan medical knowledge. The Chinese Government effectively monopolizes control over all training in Tibetan medicine since more traditionally oriented private practitioners are no longer Government funded and are unable to compete financially with the Government-run institution, so that their numbers seem to be rapidly declining, at least in the Lhasa area.

II.2 Tibetans in Exile

II.2.1 The impact of Exile

For the Tibetans who escaped from Tibet in the period following the 1959 uprising, the early years of exile involved extreme physical and psychological upheaval. They were brought into contact with infectious diseases and parasites which had been practically unknown in the cold dry climate of Tibet. Large numbers died en route from Tibet or in the transit camps, and the survivors were forced to learn new notions about hygiene and health (Murphy n.d.:46).[4] When the refugee settlements were established during the 1960s, they had a completely different political, social and economic organisation to that of pre-modern Tibet. The settlements were mostly located in south India, in radically different environmental conditions from any Tibetan area, so that an entirely new lifestyle, new agricultural methods and diet were imposed on the refugee population. Under such circumstances, biomedical notions about disease and its treatment penetrated the Tibetan community, and led to a greater acceptance of biomedical health-care than among some other peoples who have been spared such an abrupt and violent thrust into the modern age. For example, Robert Welsch writing of the Ningerum of Papua New Guinea, argues that while biomedical facilities have been accepted, they are entirely integrated into the traditional conceptual

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4 Devla Murphy's account of her voluntary work in the nursery camps for refugee children in Dharamsala in the early 1960s gives an idea of the kind of adjustments the Tibetans had to make — for example, accepting the necessity of thoroughly washing children in the appropriate solution to combat scabies. In Tibet, bathing had been very infrequent.

scheme of illness and its cure, such that biomedicines are seen as an alternative to certain less convenient herbal medicines, for which they are simply substituted in the overall classificatory system (Welsch 1983). A much more radical change has taken place in the Tibetan case, where diseases such as tuberculosis, which decimated the exiles in the early years and is still a widespread problem, is usually referred to by the English term, pronounced in Tibetan as "ti-pi", rather than by one of the Tibetan terms under which it could be classified, such as "glo-nad" or "glo-gcong", and biomedicine is seen as essential for its treatment, even when it may be backed up by Tibetan medicine.

What I want to suggest is that while a radical change has taken place, so that biomedicine now has a central place in Tibetan refugee health care, and some aspects of traditional treatment have been altogether discarded, other elements of the traditional approach have been retained and perhaps paradoxically, become even more important in the exile context. Since I have not conducted research specifically on healing, I am not in a position to give an in depth analysis; here, I am rather outlining what would appear to be the broad general trends.

II.2.2 "Folk Cures"[5]

Essentially, much of the "folk" level of response to illness has been abandoned. Two incidents in Stan Mumford's study of Tibetans and Gurungs in Nepal close to the Tibetan border, might have had parallels in pre-modern Tibet. In the first, a Tibetan woman performs a simple "soul-recalling" ritual for a sick child whose illness is attributed to one of the area gods (Mumford 1989:168). In the second, a young woman is diagnosed by a Nepalese government health assistant as suffering from rabies (Mumford 1989:196). This diagnosis is dismissed by everyone present; not only does the Gurung shaman attempt an exorcism of the evil spirits which are possessing the girl as a result of witchcraft, but the local lama agrees with the verdict of

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5 I am using this term following Tucci (1980) and Samuel (1993), and here I am specifically using it to refer to aspects of Tibetan religion which are not exclusively Buddhist. A rigid dichotomy between "folk" and "Buddhist" practices is impossible in the Tibetan case, but some Tibetan religious notions and practices belong more to a "folk" heritage than to Buddhism, and it is these I am referring to here.

witchcraft. He only differs in his response, which is to accept the inevitability of her death after his own exorcism has failed. With the exception of the Buddhist recitations for guiding the consciousness at the time of death which the lama then performs, and which would also be performed by Tibetan refugee lamas, it is difficult to imagine similar incidents among the exiles. Firstly, the refugees are much more orientated towards biomedical explanations of disease. I found in the early 1980s that they were, for example, knowledgable about rabies, and anyone bitten by a suspected rabid dog would immediately go for the biomedical treatment. Secondly, individual or family rituals for exorcising troublesome spirits have declined in India. This is part of the wider phenomenon of the decline of the folk religion in exile. Folk rituals have become less important for a number of reasons. The Tibetan Government-in-exile has tended to discourage them, since it attempts to project an image of Tibetan exiles as civilised and intellectually sophisticated Buddhists, in the process of modernizing their institutions. Clearly, the Government-in-exile position is designed to elicit Indian and international sympathy and support, and it is partly a reaction to the Chinese attempt to paint Tibetans as backward and superstitious, but there is a considerable element of truth in the Government-in-exile portrayal of its people. Official discouragement has not been the only factor in the decline of the folk rituals. Rewalsar, where I did fieldwork in the early 1980s, was not an official Tibetan settlement and the Tibetans there had hardly any contact with the Dharamsala administration, but they did not perform such folk rituals. There would seem to be two other main reasons for the decline. The first is that many of the folk rites were specific to certain areas or communities, involving deities and spirits of the particular environment, so that they are inappropriate in exile (Epstein 1977). The second is that in the new context of relatively compact settlements with monasteries close at hand, the monastic rituals fulfil the local lay requirements. Krystyna Cech writes that people at the Dolanji Bonpo settlement reported that they no longer performed the end of year expelling rites in their own homes, because they were able to attend the elaborate monastic expelling rituals (Cech 1987:227).

I do not, however, wish to overstate the case. Although it is generally true that "folk" traditions are less central in exile, they are not entirely eclipsed everywhere. Per-Arne Berglie (1992), for example, reports that Tibetan spirit mediums continue to thrive in a refugee settlement in Pokhara, Nepal, now attracting Western and Nepalese as well as Tibetan clients.

II.2.3. Buddhist Healing Practices

Although folk healing rituals have declined, Buddhist practice continues to be important. It is less often the only resort in cases of illness, perhaps because alternatives are more readily available in India, so that it tends to be used in a complementary way, together with biomedicine, and/or Tibetan medicine. In the contemporary world, Buddhist practice has become the main way of articulating Tibetan ethnicity. It always had served as a unifying force throughout the Tibetan cultural world and lamas and monasteries had often acted as political mediators. The exodus of refugees also coincided with an upsurge of interest in Buddhism in the west, so that Tibetans can take pride in their religious heritage, not only as expressing the religious aspirations of their own people, who had their self-confidence undermined by the Chinese, but as a contribution to the world community. Some types of Buddhist healing practices are performed more or less exclusively in India and are not likely to be taught in the west. Exorcism and expelling rituals do not have a wide appeal among westerners, partly because western Buddhists tend to be more attracted to relatively simple meditation practices with little accompanying ritual, and they may also be sceptical about the existence of the various harmful forces to be expelled. It is also the case that most of these types of rituals are essentially community based healing rites. Expelling rituals are performed by monasteries during times when the community is felt to be threatened — on the eve of the New Year, when invasion or political upheaval is imminent, or during epidemics. They focus on gathering up *all* the accumulated harmful agents which are afflicting the community, redirecting and expelling them, sending them off to destroy the thoroughly negative forces of the three poisons. Such ritual activities would be less appropriate in the western context, where consolidated Buddhist communities are the exception. More significantly, they do not fit well with the usual western individualistic approach to illness. However, both Tibetan medicine (which I will return to) and rites such as the Medicine Buddha practice, which can be performed at both a community and individual level, are much closer to the western approach. The meditations on the Medicine Buddha can be performed in a group, or an individual may perform the practice for the benefit of other specific people, but the orientation of the practice is that of individual purification of personal negativities and illnesses and realisation of the pure healing powers of the Medicine Buddha. In assumptions about the causation of disease, Tibetan Buddhist thinking gives a place both to primary and secondary causes (see above, Section I.1). However, family and social disturbances are unlikely to be included in explanations for illness as secondary causes. Discussion of

the three poisons as primary causes for illness may include a social dimension: Dr Yeshi Donden includes the dishonesty of those in positions of power and throughout society, inappropriate behaviour on the part of religious practitioners, and deprecation of religious practice, as general indicators of the presence of the three poisons, responsible for increased types and numbers of malignant tumours in the world (Donden 1986:197). However, social factors — by which I specifically mean the patient's present social relationships and his/her social and economic position — are not emphasised either in meditation practices which focus on the individual emotional afflictions or in Tibetan medicine, which gives more attention to factors such as climate, diet and individual behaviour.[6]

It is interesting to compare the introduction to the West of the Tibetan meditative healing practices, which are increasingly being taught openly to audiences including non-Buddhists, with the process by which Indian yoga was westernized. In the ASA conference in Oxford in 1993, Sarah Strauss gave an interesting paper, showing how Indian yoga was taken to western countries, presented as a system of spiritual value which India could offer to the world community (Strauss 1993). In the process, it was transformed from a system practised by male ascetics with the purpose of release from mundane existence, to a secular lay system, with the goal of living life in the most positive, stress-free and harmonious way, which fits better with a modern western outlook. The modified system was then brought back to India and has become popular especially with the urban middle classes. In the case of Tibetan healing meditations, it is too early to say how far their internationalization will ultimately affect the practices as they are performed by Tibetans in India. But certain trends can be seen in the way in which they are taught in the West. Unlike the Indian teachers who transmitted yoga to

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6 Nonetheless, although the theory of Tibetan medicine may largely ignore the social dimension, it does not follow that this is likely to be entirely absent in practice. Mark Nichter's work on a south Indian village, discussed by Charles Leslie (Leslie 1992: 202-3) shows how both an astrologer and an Āyurvedic practitioner could enable patients to be open about family problems and release them from the burden of seeing misfortune in terms of the social environment in which it had arisen. By talking respectively of planetary influences or humoral imbalances, the specialists could displace the patient's responsibility for the complaint and give advice which — apparently coincidentally — might necessitate appropriate social adjustments. Tibetan medical treatment could have similar implications.

the West, who had already adopted westernized values and lifestyles, the Tibetan meditation masters tend to be thoroughly committed to the traditional Tibetan Buddhist perspective, which they are anxious to preserve in the time of crisis for their people. Although stress may not initially be laid on the ultimate goal of the meditations in terms of Buddhist liberation, it remains implicit, and is gradually introduced to those who wish to become more deeply involved in the practices. The main modifications to the meditations is that they are often greatly simplified for western audiences, and sometimes the visual imagery is modified or even dispensed with. The emphasis is on the essential purposes — the symbolic functions of the religious imagery — rather than its complex outer form. Thus, for example, when a Tibetan doctor, Dr. Lobsang Rabgay, gave teaching on the Medicine Buddha in London in 1986, he gave students the option of either visualising the Medicine Buddha, or instead one's own image of an "ideal doctor", holding whatever preventative and curative medicines one may be using, in place of the myrobalan flower and the bowl of nectar held by the Medicine Buddha. Dr. Rabgay even suggested imagining in the ideal doctor's heart whatever words one may associate with healing qualities, rather than the mantra syllables which are in the Medicine Buddha's heart. He did not, however, suggest that the mantra could be altered for recitation purposes, and all the usual visualisations such as the healing light rays emanating from the Buddha's (or ideal doctor's) heart and purifying oneself, were retained, including the distinction between the general Mahāyāna way of performing the practice, which is open to all, and the Vajrayāna method of ultimately identifying with the Medicine Buddha, which, the doctor made clear, should only be performed by those who have received the necessary empowerment from a lama. Similarly, Sogyal Rinpoche, in his recent best-selling book, *The Tibetan Book of Living and Dying*, presents many simple meditations which can be used for the purposes of healing or helping at the time of death. Most of these practices are techniques which simplify elaborate recitations and visualisations, such that they become accessible to anyone without any knowledge of Tibetan Buddhist symbolism. Sogyal Rinpoche's *Essential Phowa Practice*, for example, involves imagining any form embodying the beliefs with which one identifies - whether Christ, the Virgin Mary, a Buddha or simply a form of pure golden light for those who are not drawn to any particular spiritual figure. It has a very short supplication, a meditation on purification through light rays from the presence of light and the subsequent merging of oneself in a pure form of light into the form above. While Sogyal Rinpoche describes the meditation as, "the heart of the phowa practice" (Sogyal 1992:215), he is nonetheless very careful to distinguish it (in the next chapter), from the full traditional practice,

which he emphasises can only be practised after the appropriate transmission and under the guidance of a qualified master (Sogyal 1992:233). In other words, he is not substituting his new "heart" practice for the traditional practice, nor modifying the traditional practice as such, but rather, introducing a large number of people to the basic principles of Buddhist healing meditations. The minority who become enthusiastic enough to become committed Buddhists may take the necessary empowerments and perform the elaborate practice.

Thus, both Dr. Rabgay and Sogyal Rinpoche are simultaneously concerned with making some of the simple meditative techniques widely available to westerners and with preserving the original practices in the traditional way. Both objectives are viable, given the present level of interest in Buddhism and healing through meditation in the west. I am not able to comment on the extent to which the trend of emphasising simple meditative techniques has affected lay Tibetans in India, but it is certainly the case that the success of Tibetan lamas in attracting western students has boosted the Tibetans' confidence in their religious traditions.

II.2.4 Tibetan Medicine

Tibetan medicine has similarly been encouraged through western interest, especially in the last fifteen years. In the early years of exile, not only were traditional responses to ill-health undermined by the circumstances of exile and the inability of the Government-in-exile to set up any institutional support for Tibetan medicine, but Tibetan doctors came under attack from Indian biomedical doctors. It is worth pointing out that in the Indian context, while good biomedical facilities do exist, in many areas, local doctors are poorly or unqualified practitioners of biomedicine, reliant on pharmacists — and thus ultimately on the pharmaceutical companies — for information on drugs and their usage — (Taylor 1976:285ff). As Carl Taylor puts it, "indigenous practitioners of medicine" are widespread, but not "practitioners of indigenous medicine" (Taylor 1976:287). Tibetan medicine, of course, has much in common with Āyurvedic medicine, and nowadays, Tibetan medicines are administratively classified as "Āyurvedic" (Dummer 1988:121), but in the early period, Tibetan doctors attempting to practise medicine frequently had to contend with often poorly qualified biomedical doctors, who felt threatened by the Tibetan physicians. Dr. Yeshi Donden describes how when he set up a clinic at a refugee camp in Dalhousie, local doctors attempted to discredit him

and prevent him from practising (Avedon 1985:191). After he moved to Dharamsala, local doctors complained about him to the authorities (Avedon 1985:193) and eventually he was investigated by the Government Health Department. Ironically, after some Indian army officers had given evidence in support of Dr. Donden (p.194), claiming that he had cured complaints which had not responded to other forms of medication, a health minister arranged for funding for Dr. Donden to set up a Tibetan Medical Centre in Dharamsala, and institutional support for Tibetan medicine in India began. There are now good Tibetan medical facilities in Dharamsala, including a small hospital of fifteen beds, with branch clinics and dispensaries in Tibetan settlements in India and Nepal, and most importantly, the medical centre, renamed the Tibetan Medical and Astrological Institute, has seven year training courses for Tibetan medical students, and research programmes, and it also produces an English language journal, *The sMan-rTsis Journal*. In early 1992, Dr. Trogawa Rinpoche established the Chagpori Tibetan Medical Institute in Darjeeling, as the reconstruction of the lCags-po-ri medical college in Lhasa. Like the centre in Dharamsala, a seven-year training course has been instituted, along with a pharmacy, two clinics, research programmes and contacts with western universities and scientists. The specific intention is to preserve what their publicity material describes as Chagpori's "own unique combination of medicine and spirituality" (*Chagpori News*, February 1993:5). The Board of Governors is not dominated by monks, and the training is open to students without a monastic background, although a spiritual bond between teacher and student is said to be crucial for instruction, and it is clear that ritual transmissions, prayers and meditation practices are central aspects of the curriculum.

Such developments are mainly the result of the refugees' sense of urgency and dedication to preserve their cultural heritage; as with the religious reconstruction, some sympathetic support has come from the host country and the West. It is possible that Tibetan medicine is now actually more readily available in some of the settlements in India than it was in many areas in Tibet. This building up of Tibetan medical facilities is not seen by the refugees as an alternative to modern biomedicine. In Dharamsala, the Delek Hospital, which provides biomedical health care, was built with the help of the Indian Government Ministry of Health and international aid. The hospital project was initiated by and it is administered by the Tibetans. Such involvement with modern biomedicine is not seen as contradictory to simultaneous support for Tibetan medicine.

Since the 1970s, there has been increased awareness in the West of the way in which some aspects of biomedicine may be culturally relative and not necessarily applicable cross-culturally, and also awareness of the present limitations of biomedicine, especially in dealing with chronic disorders. In fact, recognising this, Dr. Yeshi Donden is explicit that it is with chronic disorders — and he specifically mentions hepatitis, some kinds of mental disorders, ulcers, paralysis, gallstones, kidney stones and arthritis — that Tibetan medicine is particularly effective (Donden 1986:20). In the modern world, "complementary" medicine of various kinds has received serious attention and increased popularity in the west. In the late 1970's the World Health Organisation developed a policy seeking to integrate certain kinds of indigenous medical practitioners into health care programmes (WHO 1978:49). These developments have been favourable to the Tibetan refugees, and have also helped to encourage the preservation and development of Tibetan medicine in the wider Tibetan cultural world, such as in Bhutan and Ladakh. In Ladakh, for example, the Save the Children Fund has a project which involves training local "amchis" (doctors) in the rudiments of biomedicine as a complement to their expertise in Tibetan medicine. Along with such official recognition of the value of their skills, the Ladakhi amchis have made attempts to become more "professional", collaborating in a more formal way. Their traditional training continues to be mainly locally based, with most amchis coming from hereditary lines of doctors, but just as there was contact with the Lhasa medical schools, some prospective doctors travel to the settlements to train with qualified refugee doctors (Maria Phylactou: personal communication).

The organisation of Tibetan medicine in exile is inevitably much more "modernized" and secular than in Tibet, with students at the Tibetan Medical and Astrological Institute and the Chagpori Tibetan Medical Institute recruited from the modern Tibetan refugee schools rather than from monasteries, as was primarily the case in pre-modern Tibet. Moreover, in order to justify and encourage western scientific interest in the cross-cultural validity of Tibetan methods of diagnosis and treatment, any previous emphasis on the infallibility of the medical texts as the Buddha's words has been toned down.[7] There have been some reinterpretations of Tibetan medical

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7 It is not altogether absent. In response to a question on whether his views about specific diets were based on theory or empirical observation, Dr. Yeshi Donden responded that both were the case, adding that, "Buddha's knowledge

concepts to bring them into line with biomedical notions of physiology. For instance, in Tom Dummer's discussion of conception and embryology in Tibetan medicine (Dummer 1988:45), he refers to the ovum, but notes that this is a modern updating — the *Four Tantras* in fact talk of "menstrual blood" (Dummer 1988:285). This process of the modernization of Tibetan medical conceptions is perhaps similar to that described by Arthur Kleinman among the Chinese-style medical doctors in Taiwan: traditional concepts have been transformed into a modern and usually biomedical idiom, both because the patients were more familiar with western-style medicine and because the doctors themselves had integrated modern scientific ideas with Chinese medical notions (Kleinman 1980:264-265). Another instance of such reinterpretation is that of the Indian medical revivalists described by Charles Leslie (1992:172ff), who were primarily motivated by a political strategy to secure recognition of Āyurveda as a legitimate medical tradition. Leslie discusses the example of Dr. C. Dwarkanath who translated "*sattva*" as "essence" or "intelligence", "*rajas*" as "energy in motion", and "*tamas*" as "mass" or "inertia" (Leslie 1992: 189). In the Tibetan case, concern with international presentation and the need to modernize the tradition within the Tibetan exile community, who have in many respects accepted the superior expertise of biomedicine, are equally important.

Tibetan medical practitioners and institutions in exile frequently express some willingness in principle to participate in scientific investigations of Tibetan medical techniques, and they exhibit an interest in the comparative study of the Tibetan with other medical systems, and in experimental and cooperative approaches to help find solutions to modern medical problems, such as cancer and AIDS. In practice, they seem to be ambivalent about and cautious in pursuing collaborative research. Moreover, they are not reinterpreting all their medical theories. No attempt is made, for example, to hide the role of demons in disease causation in the traditional thinking; indeed, Dr. Donden discusses urinalysis through divination in his published series of lectures given in the U.S.A. The concern to modernise and communicate with the west is tempered with the concern not to lose any of the scholarly heritage: for instance, a recent project is the reconstruction of lost manuals from the memories of the trained doctors.[8] In this respect, the Tibetans can be contrasted with the Taiwanese, who appear to be relatively

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is non-delusive [and thus his explanation of the nature of foods is without error]" (Donden 1986:68).

8 This is Dr. Tenzin Choedak's project (Coleman 1993:273).

uninterested in the complex theoretical framework of traditional Chinese medicine, simplifying and limiting the number of indigenous medical concepts and treatments, while creating a practical and syncretic system of theory and practice (Kleinman 1980:280). Clearly, unlike the Tibetans, the Taiwanese doctors do not see themselves as the only representatives and guardians of the threatened cultural tradition of a small and powerless group. Similarly, at least at present, the Tibetans have not gone as far as Āyurvedic physicians and pharmacists, who, according to Francis Zimmermann (1992), have radically modified and commoditized certain remedies in order to appeal to modern Western and Indian sensibilities. Thus, the willingness of Tibetan exiles to adapt and modify their medical tradition has limits and while they may cooperate with biomedics, they are concerned to develop their separate institutional and theoretical framework for their practice.

Moreover, the practice of Tibetan medicine has not yet become entirely secular and it is likely to remain intertwined with Buddhism. I have mentioned the religious aspects of the curriculum at the Chagpori Tibetan Medical Institute, and that the exiles still have consecration rituals for their medicines. These are performed both under the auspices of the Government-in-exile Tibetan Medical and Astrological Institute in Dharamsala (where most common remedies receive no special treatment, but a few "precious" remedies are consecrated) and elsewhere. For example, Krystyna Cech discusses long and expensive rites (*sman-sgrub*) for preparing and consecrating medicinal herbs through mantra recitation at the Bon-po monastery in Dolanji (Cech 1987:272-3). The local Tibetans sponsor these rites and in return, receive quantities of the medicinal powders. The powders are in great demand, especially by Tibetans in Tibet, to whom they are given by refugees visiting relatives in Tibet. The value of such powders — in this case, imbibed with Bon-po rather than Buddhist mantras — is related to the Tibetans' concern with expressing their religious and cultural identity, and it is unlikely that simultaneous resort to more modern biomedical and Tibetan medical facilities will do anything to undermine it. This is especially so since the Buddhist meditative practices have gained respect in the contemporary world. The doctor's training was always combined with Buddhist practice and this religious component could act as a channel for intuitive understanding and inspiration in a system which was primarily scholastic and rational. Both Dr. Yeshi Donden and Dr. Tenzin Choedak describe incidents involving religious inspiration as turning points in their lives (Avedon 1985:189-190, 320-321). When Yeshi Donden first became a qualified doctor, he was sent to help control an influenza epidemic which had been introduced into southern Tibet

from India and had caused many deaths. After his arrival, he dreamt of a dākinî — a fearsome looking woman representing the forces of "female" inspiration in Vajrayāna Buddhism - who thoroughly questioned him about a urine specimen. On waking, he was brought the specimen of his first influenza patient, which he recognised from the dream, and successfully treated the patient and others accordingly. He interpreted this dream as his *real* final examination. Dr. Choedak was dying in a labour camp, when he recalled Tibetan medical theory concerning the loss of "heat" in the stomach and secretly began a Buddhist yogic practice which has the effect of increasing the internal body heat. He believed that it saved his life and was responsible for the fact that he had no further digestive complaints. Also significantly, his ability to regularly continue this religious practice secretly, gave him inner confidence and solace throughout his years in prison.

The central place which these doctors give to religious inspiration and practice is a feature of the Tibetan medical tradition which remains strong today. Great respect is given to doctors who are also lamas and although it is theoretically possible to divide the Buddhist meditation practices from the medical theory, given both the importance of religion in the expression of Tibetan ethnic identity and the fact that the Buddhist meditative traditions have won widespread international respect in the modern world, it is unlikely that further modernization of Tibetan medicine would involve complete secularization.[9] In fact, even in contemporary Tibet, despite the fact that students and doctors at the Tibetan traditional medical college are not trained in Buddhism and are instead exposed to Chinese political philosophy, *all* the Tibetans to whom Stillman spoke (1994:12), commented that they considered themselves "spiritual healers".

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9 For the purposes of this paper, I have mostly relied upon publically prominent representatives of the tradition in exile, who were trained in Tibet. As Fernand Meyer has pointed out to me (personal communication, March 1994), a study of the new generation of exile trained physicians is desirable for understanding the full extent of the current process of change in exile.

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