

## How Tibetan Medicine in Exile Became a “Medical System”

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**Abstract** Tibetan medicine or Sowa Rigpa was largely ignored in classic publications on “Asian medical systems.” This article contends that one important reason for this oversight was that Tibetan medicine had not yet managed to establish itself as a recognizable medical system at that time. This has changed only recently with ongoing political and economic processes through which Tibetan medicine in exile has been transformed, since the 1990s, from a regional health tradition into a globally recognizable and clearly defined and delimited medical system. After some reflection on the notion of medical systems, this article focuses on the events and interests that led to the establishment of the Central Council of Tibetan Medicine in early 2004, which can be regarded as the official establishment of Sowa Rigpa as a medical system. The discussion then moves on to the consequences of this development for Tibetan medicine in exile at large, and for its most powerful institution, the Men-Tsee-Khang, in particular. The outcome of wider exile Tibetan political aspirations, Sowa Rigpa’s “embodiment” as a medical system also has direct medical and pharmaceutical dimensions, manifesting most importantly in efforts to regulate and standardize its syllabi, clinical practice, and pharmaceutical production. The article gives in-depth insights into some of the most important recent developments in Tibetan medicine in exile, its economic and political organization, and the role of its main institutions.

**Keywords** Tibetan medicine · Sowa Rigpa · Tibetan exile · Asian medical systems

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The publication of *Asian Medical Systems* (Leslie 1976) was something of a founding event for the anthropology of Asian medicines. Identifying Ayurveda, Unani, and Chinese medicine as intellectually coherent, rational, and professionally organized “systems of medicine,” Charles Leslie and his colleagues shaped the then nascent field of medical anthropology for decades to come. In their work, they defined “medical systems” as characterized by a high degree of complexity and professionalization, a long history of systematic empiricism and theorization, internal coherence manifested in core classical texts, and a distinct identity resulting from clear external boundaries vis-à-vis other medical systems. While not denying the existence of syncretism, internal heterogeneity, or exchange between plural medical systems, Leslie’s focus on systems of medicine soon foregrounded these phenomena as medical anthropology’s core problems, which can be traced through much of medical anthropological literature during the 1980s and 1990s.

Besides this immediate impact on the discipline, the work of Leslie and his colleagues also had larger theoretical and political consequences for the study of medical traditions around the world. Rather than collecting bits of apparently incoherent or irrational local beliefs and knowledge for the potential use of public health specialists eager to overcome “cultural obstacles” to modern development (see Leslie and Young 1992: 7), as had been the pervasive approach, medical anthropologists began to follow Leslie in recognizing Asian medicines as civilizational processes and epistemic systems that needed to be placed in the context of history and politics. In short, Leslie articulated an analytic framework that saw Asia’s “great medical traditions” (see Redfield 1956) as important markers of “civilization,” that is, as manifestations of a people’s antiquity, scientific genius, and cultural independence.<sup>1</sup>

In all these studies of Asia’s great medical traditions, however, Tibetan medicine was conspicuous by its absence. Neither *Asian Medical Systems* nor its 1992 sequel, *Paths to Asian Medical Knowledge* (Leslie and Young 1992), and later volumes on the topic (e.g., Bates 1995) so much as mentioned it in passing,<sup>2</sup> let alone devoted a chapter or an entire section to it (see Pordíé 2008b: 3). It is not that Tibetan medicine does not meet Leslie’s criteria for “medical systems” outlined above, as a growing number of recent scholarly and lay publications document (e.g., Meyer 1981; Donden 1986; Janes 1995; Adams 2002; Schrempf 2007; Pordíé 2008a; Adams et al. 2011). Tibetan medicine not only possesses more than fourteen hundred years of recorded history and a classical textual core (the *rgyud bzhi*) displaying a high degree of complexity and intellectual coherence, but it also has clear external boundaries distinguishing it from Ayurveda, Unani, or Chinese medicine, not to mention a well-established institutional apparatus in contemporary Tibet and the Tibetan exile. So what are the reasons for this—in retrospect quite monumental—oversight?

One important reason is to be found in Asia’s colonial history: while Western scholarly attention has long focused on India and China in connection with European (and later also American) political and economic interests there, Tibet remained

<sup>1</sup> This framework reflects the discourses of nationalist movements in India, China, and elsewhere since the nineteenth century, which used medical traditions as a means to legitimate their political claims for independence (see Prakash 1999; Chatterjee 1993; Langford 2002; Kloos 2010).

<sup>2</sup> The only indirect reference to Tibet in Leslie 1976 occurs on page 3, in the introduction to Asian medical systems, where Leslie mentions Ayurveda’s “marked influence in Tibet” and other areas.

largely inaccessible—a situation that was only reinforced with China’s annexation and subsequent isolation of Tibet in the 1950s. Thus, when Tibetan medicine first began to attract serious scholarly interest in the West in the late 1960s and 1970s—at that time limited to a few historical and textual studies (e.g., Rechung 1973; Finckh 1975; Dash 1976; Norbu 1976; Donden and Kelsang 1977; Meyer 1977; Beckwith 1979)—it was from the Tibetan exiles in India and Nepal. In the Indian town of Dharamsala, the Central Tibetan Administration (CTA) had founded, upon the Dalai Lama’s advice, a small Tibetan medical center in 1961, which in 1967 was officially named “Drophen Men-Tsee-Khang” (*‘gro phan sman rtsis khang*: institute for medicine and astrology for the benefit of all beings). While the explicit purpose of this center was, from the beginning, to “preserve Tibetan culture,” its daily work consisted in compounding medicines, treating patients, and training students in Tibetan medicine and astrology. Lacking everything from human and financial resources to specialized medical texts and even the language skills necessary to operate in India, it took the Men-Tsee-Khang until the early 1980s to gain some sort of stability, and until the mid-1990s to achieve its present status as the most prestigious, profitable, and successful secular institution in the Tibetan exile (Kloos 2008). For a long time, the Men-Tsee-Khang—which practically *was* Tibetan medicine in exile until the 1990s—remained occupied with internal problems and was thus barely visible outside the Tibetan exile community. Similarly, the Tibetan medical establishment inside Tibet, which struggled with problems of its own (Janes 1995), remained closed to the international community until the 1990s. In short, Tibetan medicine had not managed to attract the same scholarly attention as other Asian medicines by the time *Asian Medical Systems and Paths to Asian Medical Knowledge* were written. At least as far as the academic realm was concerned, Tibetan medicine had not yet established itself as a “medical system” in its own right.

Of course, given more recent critiques of “medical systems” as an analytic concept, the question arises: why should it? As Jean Langford (2002) and Joseph Alter point out, “There are serious problems in looking at traditions like Ayurveda—or any other form of medicine—as an intrinsically unified, organically coherent ‘system’ of knowledge and practice” (Alter 2008: 1167). Volker Scheid (2002: 9) makes a similar observation in the context of Chinese medicine, while Lawrence Cohen (1995: 320) argues more generally that “the formalism, coherence, and synchronicity of a system do not seem to map well on to medical knowledge and practice *in situ*.” To be fair, much of this was clear to Leslie from the beginning, causing him to distinguish among classical textual, syncretic, contemporary professional, and folk variants of medicine in India (1976: 358–61). Still, the notion of the “system” that Leslie had introduced required, in Cohen’s words, “isolat[ing] that which appears most structured and coherent as the epistemology of the thing and trace it backwards and forwards to give ourselves back time” (1995: 358). Indeed, we find a strong focus on epistemology and knowledge in most medical anthropological work on Asian medicines during the 1980s and 1990s (e.g., Leslie and Young 1992; Bates 1995). However, this Bourdieuan attempt to combine structuralist and historical analysis required arresting the historicity of medical knowledge in a classical past, thus separating it analytically from its continually changing practice and politics. The result was—against Leslie’s own ethnographic insights—a problematic dualism between knowledge and practice,

between an inner (coherent, stable, etc.) essence of a medical system and its outer historical manifestations (see Latour 1999; Adams 2005).

Yet, even while the concept of medical systems has outlived its analytic usefulness, it continues to be seen as an effective political strategy. Thus, the essentializing function of systematization, especially in the realm of “traditional medicine,” was successfully deployed by Asian nationalists trying to reclaim their “cultural essence” in order to imagine and legitimize their nation (Langford 2002; Spivak 1988). More recently and under (geo)political circumstances vastly different from Asia’s anti-colonial movements in the early twentieth century, the Tibetan exile community has looked to Indian nationalism—as the closest example at hand—for guidance in their own nationalist struggle for a “Free Tibet.” Thus, from the 1990s onward, it became clear to Tibetan medicine practitioners (called *amchi*) in exile that the concept of “medical systems” was well established in India’s health policies, which officially recognize, promote, and subsidize “Indian systems of medicine” (ISM). In order to receive government funds, political representation, and regular access to the traditional health market, therefore, Tibetan medicine needed to be recognized by the government of India as a “medical system.” What is more, the notion of a medical system was attractive to the exile Tibetans for the same reasons as it was for other Asian nationalists before them: through its strong connection to the related notion of “civilization,” it connotes cultural greatness, historical antiquity, intellectual genius, and political self-determination.<sup>3</sup>

It is in this political rationale (against China’s opposing claims) rather than in more superficial—though also important—financial considerations that the exile Tibetans’ real interest in remaking Tibetan medicine into a “medical system” lies. The ethical and political imperative for Tibetan medicine in exile to “preserve” Tibetan culture neatly coincides with the idea that having one’s own medical system signifies one’s status as a “culture,” as a “civilization,” and consequently as a nation. Indeed, for exile Tibetans, the recognition of Tibetan medicine as a medical system doubles as a recognition of Tibet as a nation. Based on twenty months of multisited fieldwork in the South Asian Tibetan diaspora between 2005 and 2012, this article explores how and why Tibetan medicine in exile came to be conceptualized as a “medical system” and traces the earliest stages of the development that finally led to its official recognition by the government of India as an “Indian system of medicine” in 2010. While the events more directly connected to this watershed event will be the subject of another article, the following pages provide a more general study of Tibetan medicine’s “embodiment” as a medical system that in turn embodies the nation, and of the interplay between politics and medicine in the Tibetan exile.

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<sup>3</sup> Robert Redfield, from whose writings Leslie et al. borrow, uses the term *civilization* as a synonym for “great traditions,” in order to point to the complexity, historicity, and larger connections between what was previously studied as bounded local cultures or “small traditions.” In light of its modern connotation as the opposite of *barbarism* (the existence of one assuming and necessitating the other), its use as an ideological justification of colonialism and Samuel Huntington’s (1996) thesis of a “clash of civilizations,” the term is deeply problematic (hence the use of quotation marks in this article). In the exile Tibetan case, however, both meanings of the term—as synonymous with *culture* and as the opposite of *barbarism*—conveniently converge in the fight for cultural survival, political sovereignty, and resistance to common Chinese claims that Tibetans were “barbaric.”

## 1 A Body for Tibetan Medicine

Nationalism’s central theme is to bring into being a clearly demarcated, unified nation, for which it relied, in the (post)colonial contexts of Asia, on culture and spirituality as its sovereign domain that bore the community’s essential markers of difference vis-à-vis the colonial power (Nandy 1983; Norbu 1992; Chatterjee 1993; Prakash 1999). Given their long histories as “native sciences” and their undeniable effectiveness in clinical practice, such medical traditions as Ayurveda, Chinese medicine, and Tibetan medicine emerged as ideal manifestations of an otherwise intangible culture or “civilization.” But in order to do so, they needed a “body,” so to speak, that could be preserved, defended, and sovereignly governed, one that was immediately recognizable and marketable as “Tibetan” (or “Indian” or “Chinese”). The concept of a “medical system”—with its internal coherence and clear boundaries, its distinct identity and self-governing, self-policing institutional structure—provided exactly the body that both nationalists and medical practitioners were looking for. In other words, to transform a range of more or less heterogeneous medical traditions that followed similar epistemological principles into a unitary “medical system” was, and continues to be, a political act of nationalism.

In the exile Tibetan case, where Tibetan medicine is widely believed to symbolize the greatness of the Tibetan “civilization” and thus manifest Tibet’s national identity, the “preservation” of Tibetan culture is directly linked to the transformation of Tibetan medicine into a medical system. In order to give Tibetan medicine a new body provided by the concept of a medical system, exactly the criteria outlined by Leslie and his colleagues and used by Indian officials—unique historical origins, a classical textual core, internal homogeneity, and clear external boundaries—needed to be demonstrated, highlighted, and, if necessary, created. But before going into the details of these efforts and asking how, exactly, Tibetan *amchi* in exile transformed their—until recently relatively obscure—medical tradition into a clearly defined “system,” it is worth considering their timing. Why, in other words, did exile Tibetan medicine’s preservation and survival become such an urgent issue during the late 1990s and early 2000s—a time when it was actually thriving and its survival seemed, at long last, secured?

For all practical purposes, Tibetan medicine was consubstantial with the Men-Tsee-Khang’s institutional body during the first decades in exile, for the simple reason that no other institutions—or a significant number of private practitioners—of Tibetan medicine existed in exile. However, by the early 1990s, this equation became problematic as Tibetan medicine gradually grew larger, healthier, and stronger; other Tibetan medical institutions were founded; and increasing numbers of *amchi* established their private, independent clinics and pharmacies or traveled and practiced abroad. One could say that the boundaries of Tibetan medicine in exile increasingly outgrew those of the Men-Tsee-Khang’s institutional body. This situation was aggravated by growing tensions between the Men-Tsee-Khang and private *amchi*, which had already begun in the 1960s and 1970s with the resignation of several senior *amchi* from the Men-Tsee-Khang and the dismissal of the popular chief physician at that time, Dr. Lobsang Dolma, amid allegations of unethical conduct (Josayma and Dhondup 1990: 5; Tsering 2005: 183; Kloos 2008: 23–24). In the 1980s, 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 them. During the 1990s, as the economic potential of Tibetan medicine became increasingly apparent, the sheer number of newly established private doctors (most of them originally from the Men-Tsee-Khang) began to challenge not only the Men-Tsee-Khang's market dominance but also its political power to represent Tibetan medicine.

Up to that point, Tibetan medicine in exile practically functioned without any kind of regulation or control whatsoever. The CTA did not have a single law regarding Tibetan medicine, or any institutional structures to oversee its practice and development besides the largely autonomous Men-Tsee-Khang. Similarly, although the government of India had tolerated the practice of Tibetan medicine on its soil since 1964 (Choelo Thar 2000: 52; Kloos 2008: 18–19), it was not officially recognized and thus remained outside Indian legal regulatory purview. Until the 1990s, this was not a problem, since Tibetan medicine in exile was largely consubstantial with the Men-Tsee-Khang, and the few practitioners that practiced independently were all serious senior doctors. But during the 1990s, three other Tibetan medical institutions were founded (Kloos 2008: 30–33), and the numbers of private *amchi* increased dramatically. Consequently, concerns arose at the Men-Tsee-Khang about these doctors' ability and motivation to practice and represent Tibetan medicine in a proper way. The clandestine spread of counterfeit precious pills (*rinchen rilbu*) and impostors pretending to be fully qualified *amchi* in the West—both widely discussed in exile Tibetan media—only served to justify the Men-Tsee-Khang's concerns in the public and in government circles. Tibetan medicine grew—quite literally—out of control.

The absence of any regulation was a threat not only to the Men-Tsee-Khang and Tibetan medicine but also to exile Tibetan ethical and political aspirations. One of the most common statements I encountered among exile Tibetan *amchi* was that even as refugees, through Tibetan medicine they could help the world. In order to do so, however, they needed to ensure Tibetan medicine's efficacy and the patients' trust in it, both of which seemed endangered by unqualified or unscrupulous medical practitioners. In other words, Tibetan medicine needed to be “preserved”—that is, regulated and controlled—for the benefit of its patients. While this medical manifestation of a Tibetan ethics of altruism and compassion is a genuine sentiment and should by no means be interpreted as mere “self-marketing” (Huber 2001: 367), it does have an important political aspect, insofar as exile Tibetans today locate much of their cultural and political identity in exactly this Mahayana Buddhist ethics (Kloos 2010, 2011).

By virtue of the classical—but newly reformulated—Tibetan definition of medical practice in ethical terms and its recent growth in popularity, Tibetan medicine had, by the 1990s, become an increasingly powerful vehicle to transport a certain cultural and political identity both among the diaspora population and the world. Thus, the absence of any regulation for Tibetan medicine in exile was problematic not only in terms of the profession's clinical and ethical responsibility toward its patients but also in terms of the CTA's political agenda, in which the Men-Tsee-Khang played an unofficial and indirect, but nevertheless central, role (Kloos 2012). Indeed, it was the Men-Tsee-Khang's ambiguous status both as a medical institution with hegemonic ambitions and as a quasi-governmental entity with justified ethical and political concerns that lay at the root of virtually all tensions surrounding it. When the millennium drew to a close with an internal uproar about the Congress on Tibetan Medicine in Washington, DC

(where the Men-Tsee-Khang felt slighted in its self-perceived role as the sole legitimate representative of Tibetan medicine outside China); negative press in Europe regarding toxic Tibetan pills (for which the Men-Tsee-Khang blamed unqualified private doctors); and increasingly widespread concerns among exile Tibetan doctors and officials about the deterioration of Tibetan medicine due to commercial exploitation, a tipping point was reached.

## 2 Conflicting Interests

In early 2000, the Men-Tsee-Khang’s director at the time, Pema Damdul Arya, submitted a draft law to be passed by the Assembly of Tibetan People’s Deputies (the Tibetan parliament in exile, often simply called the Assembly). This law was intended to regulate Tibetan medical practice and pharmaceutical production by bringing Tibetan medicine in exile under the Men-Tsee-Khang’s official control—or, in other words, of expanding the Men-Tsee-Khang’s institutional body and power. Not surprisingly, given the tense climate of mutual suspicions and accusations, this decision was met with vigorous opposition from other quarters in the field of Tibetan medicine, notably the private practitioners, and set in motion a nearly four-year-long showdown, with political battles and heated confrontations between the Men-Tsee-Khang and private *amchi*. The Assembly rejected the Men-Tsee-Khang’s proposal—not least because of numerous spelling mistakes in the Tibetan original (an indication of the haste in which it was written)—but instead passed a resolution on 27 September 2000 calling for the establishment of a Central Council of Tibetan Medicine (CCTM).

Both the idea and the CCTM’s name indicate an important reference point for Tibetan medicine outside the exile community. It was not only Tibetan medicine’s dramatic expansion and economic success—coupled with the events just described—that led to a growing consensus among exile Tibetans about the need of some sort of regulation, but also the developments in the Indian health care context. In 1970, the government of India had established the Central Council of Indian Medicines to recognize the so-called Indian systems of medicine (ISM): Ayurveda, Unani, and Siddha.<sup>4</sup> In 1979, it amended the Indian Drugs and Cosmetics Act to include regulations for the commercial production of “Indian” medicines, and in 1995 it brought ISM-H under the Indian Ministry of Health and Family Welfare in the form of a separate Department of ISM-H, which was renamed the Department of AYUSH in 2003.<sup>5</sup> Especially the latter development constituted a major boost for ISM, providing them with a high level of political representation and access to billions of rupees of government funding. Although the exile Tibetan *amchi* tend to regard especially the development of Ayurveda very critically, all of this constituted a powerful example for “embodying” Tibetan medicine in the form of a “system.”

As a first step in the establishment of the CCTM, a committee consisting of members from the CTA Health Department and the Men-Tsee-Khang was formed in November 2000. This committee met in December to draft a legal code for the

<sup>4</sup> Later, yoga and naturopathy were added, as well as homeopathy (the latter indicated by the “H” in ISM-H).

<sup>5</sup> AYUSH stands for Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homeopathy. In Sanskrit, *āyus* (commonly pronounced “ayush”) means “health” or “long life.”

CCTM, which was then presented to the health department. Considering the makeup 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 doctors and one for Tibetan pharmacists in exile. Each set was to be overseen and implemented by a council heavily dominated by Men-Tsee-Khang representatives and members of the health department. Most important, 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.

For example, Article 18 stated: "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." Regarding pharmaceutical production, the CCTM's above-mentioned committee was to investigate anyone producing medicines and "take an appropriate decision and immediately report the matter to the government." Furthermore, "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. No Tibetan doctor can engage in Tibetan pharmaceutical practices [for commercial purposes] without prior registration." The document continued with a call for a government pharmaceutical investigator—again 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, and if there were any signs of adulteration. Finally, in order to keep medicine prices affordable for the poor, 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—and the strong representation of the Men-Tsee-Khang and the CTA on the CCTM—demonstrate the concerns of all three parties involved. The exile government's interest in controlling one of its most valuable cultural and political assets would be ensured, and the well-known anti-commercialization stance of Samdhong Rinpoche (who would be elected prime minister the next year) is clearly visible in the last rule. The Men-Tsee-Khang would have finally obtained the official power to carry out what it saw as its main responsibility, that is, to protect and "preserve" Tibetan medicine by ensuring the quality of its education, clinical practice, and pharmaceutical products. At the same time, these plans only confirmed the private doctors' 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. Like the Men-Tsee-Khang's own concerns, these suspicions were partly justified and partly a product of the escalating tensions within Tibetan medicine in exile.

Unfortunately for the Men-Tsee-Khang, its dreams of almost absolute power and control were not to come true. There was another meeting to discuss and amend this draft code in March 2001, where both Men-Tsee-Khang and private *amchi* were invited. 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 showed little interest in such political issues, which allowed the private doctors to change the proposal in their favor. When the changed proposal was presented to the health minister and to Pema Damdul Arya, the Men-Tsee-Khang director strongly opposed the new version but ultimately had to agree to submit it to the Assembly. However, this was in July 2001, and the entire exile government was in transition after the first general election, so it was not presented to the new parliament before January 2002. Again, however, the code did not pass the parliamentary vote, this time due to objections by a Bonpo deputy, who insisted on a stronger emphasis on Bon influences in Tibetan medicine.<sup>6</sup> 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 thirteenth Assembly, passed unanimously in March 2003, and approved by the Dalai Lama a little later. On the basis of this act, the CCTM (*btsan byol bod mi'i bod kyi gso ba rig pa'i ches mtho'i sman pa'i lhan tshogs*, or *Che-thoe Men-pae Lhen-tsoq*) was officially established as an “apex body” under the CTA on 5 January 2004, during the First Conference of Sorig Practitioners in Dharamsala.

### 3 The Central Council of Tibetan Medicine

After more than forty years in exile, Tibetan medicine was thus finally born as a “medical system.” That is, for the first time in its history, there existed a legal body—separate 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, which could in turn define the larger contours of an exile Tibetan cultural and political subjectivity. This body—no doubt weak and dependent for now, but also full of promise—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.

According to the official tenor at that First Conference of Sorig Practitioners, the CCTM's mission seemed to be clear: to control and govern Tibetan medicine in exile in order to prevent its commercial exploitation and degradation. But the reality behind the politicians' lofty speeches spoke a different language. While 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 gave 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 over

<sup>6</sup> Bon is usually considered to refer to pre-Buddhist religious traditions of Tibet, which are still practiced by a part of the Tibetan population and recognized by the fourteenth Dalai Lama as one of six Tibetan religious schools (Kvaerne 1995). The historic competition between Bon and Buddhism extends to contemporary Tibetan medicine in the form of debates over its origins, which are located either in the Buddha's teachings or in the Bon tradition. See also Colin Millard's contribution to this issue.

Tibetan medicine's preservation and development, the CCTM'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*. In other words, the exile government was left with no direct political control over Tibetan medicine at all, and the Men-Tsee-Khang only had a minority of votes in the CCTM's decisions. Both Pema Damdul Arya's and 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 or private doctors registered under the CCTM, while the fledgling CCTM itself was charged, in the Men-Tsee-Khang's stead, with the governmental responsibility of preserving, regulating, and representing Tibetan medicine in exile.

The CCTM's legal code, as it stands today, explicitly states as its objectives the registration, regulation, standardization, and control of Tibetan medical colleges, pharmaceutical units, clinics, doctors, and newly developed pharmaceutical formulations. Its jurisdiction applies 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" (CTA Health Department 2003). In other words, while non-Tibetan, Himalayan *amchi*—for example, Ladakhi, Sherpa, or Monpa—can choose whether they wish to come under the CCTM's jurisdiction or not, Tibetan nationals have to accept its rules as part of their government's laws. Especially the Men-Tsee-Khang doctors but also some of the more established independent Tibetan *amchi* were less than amused by this turn of events and privately grumbled about this imposed new authority. Most Himalayan *amchi*, on the other hand, were attracted by the status conferred by the CCTM's registration certificates, as well as the regular conferences, workshops, and high-profile empowerments organized by the CCTM. Thus, at present 425 practitioners of Tibetan medicine in South Asia, Europe, North America, Australia, and Israel are registered under the CCTM (Central Council of Tibetan Medicine 2013),<sup>7</sup> which represents the vast majority of Tibetan medicine practitioners trained and practicing outside Tibet, Bhutan, and Mongolia.

While the CCTM's most visible activities since 2004 consisted of registering doctors and accrediting the four main Tibetan medical colleges in India, standardizing syllabi, compiling lists of recognized classical texts, and organizing the just-mentioned conferences and workshops—thus establishing a hitherto nonexistent platform of communication and exchange among most actors in the field of Tibetan medicine in exile—this is not its main objective. As Dr. Dorjee Rabten, CCTM chairman from 2007 to 2010, repeatedly stressed both in public speeches and in private interviews with me, the CCTM's real mission is to control, regulate, and represent Tibetan medicine in exile as its sole legitimate authority and thereby claim "the authority and ownership of the Tibetans" (Chukora 2007: 16) over Tibetan medicine. As Tibetan medicine is growing into a multimillion dollar market on a global scale, exile Tibetan authorities are clearly concerned to reassert their control not only over Tibetan

<sup>7</sup> The CCTM distinguishes between two kinds of registration: "qualified medical practitioners," who possess graduation certificates from Tibetan medical colleges recognized by the CCTM; and "registered medical practitioners," who are mostly Himalayan *amchi* trained in the traditional teacher-apprentice system (and thus lacking any official certificates).

medicine’s economic potential or cultural capital but also over its quality and shape, and thus its long-term future. It is for this reason that the CCTM, as Tibetan medicine’s official body, is asked to standardize its knowledge, regulate its practitioners, and control its boundaries. Thus turning Tibetan medicine into a “medical system,” the CCTM simultaneously aims to protect it from and connect it with modern politics and the global market. In other words, the “medical system” appears as the ideal form for a reformulated Tibetan medicine at the intersection of the capitalist market system, Tibetan (medical) ethics, the demands of Tibetan nationalism, and transnational governance.

For all its boldness and clarity, the CCTM’s mission is anything but easy to accomplish. Although established as an apex body of the Tibetan government in exile, the CCTM has never been integrated into the CTA’s governmental apparatus—for example, as a new division of the health department, as in the case of ISM-H or AYUSH in India. Therefore, although the CCTM’s regulations are in theory legally binding to all exile Tibetan *amchi* as part of the CTA’s legal code, the CCTM is forced to operate, for all practical purposes, as an independent, nongovernmental organization. Thus, it neither has the exile Tibetan government nor the Dalai Lama in its official name, it cannot use the CTA’s emblem on its letterheads or stamps, and it has no direct relations (e.g., in the form of representatives) with the government. Its ambiguous official status is best demonstrated by its funding: it neither receives the funding normally reserved for official governmental agencies, nor is it financially independent altogether, receiving nominal but unreliable support from the CTA. This used to be two grants of 125,000 Indian rupees (INR) for its office rent and the salaries of its three permanent employees, but in 2012 only one of the two grants was transferred, and in 2013 the CTA health department signaled that it may not be able to provide any financial support at all. The CCTM thus relies on donations to bolster its yearly income from membership fees of around 200,000 Indian rupees to a total budget of between 800,000 and 1 million INR, which is mostly spent on a yearly conference, workshops, and teachings.<sup>8</sup> Clearly, this is nowhere near the amount the CCTM would need to fulfill its official responsibility of regulating and promoting Tibetan medicine in exile.

As a result, although today the CCTM—and not the Men-Tsee-Khang—is charged with the governmental responsibility to protect and govern Tibetan medicine, in reality it does not have the legal, executive, or financial powers to do so. Practically speaking, 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 more than 50 branch clinics, around 130 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 young, underfunded CCTM with its three permanent staff members, heavily relying on

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<sup>8</sup> These approximate figures were gathered in July 2013 and refer to the period between 2011 and 2013. At the time of the original research in 2008, the CCTM had only two permanent staff members and a total budget of between 500,000 and 600,000 INR, of which around 100,000 INR were acquired through membership fees. Although still operating on very limited funds, the CCTM has thus grown considerably in the last five years.

the Men-Tsee-Khang's resources and expertise, could not be greater. In view of this situation, the question arises of what, if any, consequences the CCTM's establishment had for the wider field of Tibetan medicine in exile, and particularly for the Men-Tsee-Khang as its flagship institution. What is the shape and condition of Tibetan medicine in exile today, post-2004, in its new form of a "medical system"?

#### 4 Tibetan Medicine in Exile Today

Despite being the most powerful institution of Tibetan medicine in exile, the Men-Tsee-Khang's direct political power within both the CTA and the field of Tibetan medicine in general has always been very limited. Against the Men-Tsee-Khang's hopes, the CCTM's establishment has done nothing to improve this situation, but contrary to its fears, the CCTM also had few if any negative effects on the institute's status so far. It did, however, leave a lasting impact on the Men-Tsee-Khang and, by extension, on Tibetan medicine in exile at large. To be sure, this did not include a sudden and dramatic change in the Men-Tsee-Khang's perception of its 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 Men-Tsee-Khang realized belatedly, but all the clearer, that it 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, has to operate in an increasingly pluralistic context of independent clinics and pharmacies that pursue their own interests. The private doctors, just like the Himalayan *amchi*, were here to stay, and their presence and demands could be neither ignored nor silenced. In short, the Men-Tsee-Khang had to fundamentally rethink its position in relation to them: instead of regarding private *amchi* as morally flawed enemies in a "cold war" (as one practitioner described the situation before the CCTM), and Himalayan *amchi* as second-rate country doctors, the institute has come to realize that inclusion and support are a more profitable strategy than exclusion and discrimination.

This realization is visible in two important decisions the Men-Tsee-Khang has made since 2007: the first, to redefine its college's purpose, and the second, to begin selling its medicines to non-Men-Tsee-Khang *amchi* in the future. With the introduction of tuition and boarding fees for its students, and plans for upgrading its college to a Tibetan medical university, the Men-Tsee-Khang basically expanded the focus of its college from merely training future Men-Tsee-Khang doctors to producing well-qualified practitioners of Tibetan medicine, regardless of whether they stay with the institute or not. Similarly, there are plans for a new pharmaceutical factory, which would enable the Men-Tsee-Khang to produce enough medicines to sell to independent *amchi* for a profit, rather than shutting itself out of a lucrative and fast-growing market. As a wholesale supplier, it might even wield a certain level of influence over their business practices, not to mention ensure the quality of the medicines they are selling. This change in the Men-Tsee-Khang's self-perceived role, though so far man-

ifesting mostly in plans rather than concrete actions,<sup>9</sup> has already led to a noticeable easing of tensions between the institute and the rest of Tibetan medicine in exile.

Despite its problems, the CCTM has also managed, in the recent years, to represent Tibetan medicine in exile toward outsiders in a relatively united, homogeneous form, be it on international conferences on the topic or in the Indian health bureaucracy. Indeed, it was due in part to its existence and the successful transformation of Tibetan medicine into a “medical system” that the government of India officially recognized, on 25 August 2010, Sowa Rigpa as an “Indian system of medicine.” Even more than the establishment of the CCTM in 2004, this was a watershed event in the history of Tibetan medicine in exile. After operating in a legal gray zone for almost half a century, Tibetan medicine now has full legal status in India and will accordingly be subject to Indian standards and regulations, and administrated by the AYUSH department in New Delhi. What this might mean for the CCTM, which played this role until now, is unclear: while it expects to be centrally involved in the task of governing Sowa Rigpa in India, it is also possible that it will lose its relevance in the longer term.

Although the CCTM has created an outward image of homogeneity by giving Tibetan medicine a tangible body and uniting its practitioners behind a number of common interests, it has also accentuated and enhanced Tibetan medicine’s internal heterogeneity. Never before have private doctors and other Tibetan medical institutions had as strong a voice to claim their varied interests as they have now. To be sure, so far the CCTM has made it a point to reach all its decisions unanimously, even if this involved heated debates among its members in the process. However, this new democratic platform also came at a price, as described in this article: the CCTM’s legal powers were watered down considerably in order to accommodate all involved parties, and the exile Tibetan government’s representation on it was virtually eliminated. Consequently, the CTA lost interest in the CCTM just as it was established, leaving it—and Tibetan medicine—to fend for itself without any substantial governmental support, whether financial or political. For better or for worse, this support will now be provided or withheld by the Indian government and its representatives, who have their own political and commercial interests in Sowa Rigpa. It seems like Tibetan medicine’s most important transformations in exile have only just begun with its birth as a medical system.

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<sup>9</sup> At the time of writing this article, both the medical university and the new pharmaceutical factory have remained in the planning stage for several years, mainly due to a lack of funds.

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