

## The Politics of Preservation and Loss: Tibetan Medical Knowledge in Exile

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**Abstract** This article analyzes the history and development of Tibetan medicine in exile from the perspective of the pervasive Tibetan exile narrative of preservation and loss. Through combined ethnographic and historical data, it shows how the preservation of traditional Tibetan medical knowledge in exile entails a process of a fundamental reinvention of its nature, not only rendering it modern but also (re)investing it with considerable hegemonic power. As Tibetan medicine in exile has come to stand for the nation as envisioned by the Tibetan government-in-exile, its preservation is imbued with a significance that far exceeds the medical realm. Indeed, despite a well-established discourse of preservation and loss that implies a precarious state of weakness, Tibetan medical knowledge functions (along with Tibetan Buddhism) as an important means to preserve a weakened but still existing and real Tibetan cultural hegemony in exile. Thus, while common rhetoric assumes a triumph of modern science and a gradual loss of traditional knowledge, the case of Tibetan medicine shows that we need to take the latter seriously as an important apparatus of power even today.

**Keywords** Tibetan medicine · Sowa Rigpa · knowledge/power · nationalism · cultural preservation · medical history

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Scientia potentia est.  
Francis Bacon

Power and knowledge directly imply one another; . . . there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations.

Michel Foucault, *Discipline and Punish*

Despite its categorical nature, the statement that “knowledge is power” often tends to assume a singular—namely, modern Western—notion of the knowledge and power to which it refers. While the oeuvre of Foucault (e.g., Foucault 1977, 1978; Foucault and Gordon 1980) and more recent science scholars (e.g., Latour 1988, 1999; Rapp 2000; Martin 2001; Mol 2002) leaves no doubt about the pertinence, power, and reach of modern technoscience, comparatively little scholarly work has addressed alternative knowledge/power configurations in the present.<sup>1</sup> To be sure, a wealth of studies document the central role of other kinds of knowledge in premodern polities, such as that of Buddhism in Central and Southeast Asia (e.g., Tambiah 1977; Samuel 1993), Sanskrit and the Vedas in India (e.g., Pollock 2006), and Islam in the Middle East (e.g., Safi 2006). Yet in the modern context, it often appears as if so-called traditional knowledge has lost its connection to power, replaced or at least threatened—along with the premodern modes of governance it was connected to—by the new nexus between modern science and the nation-state (e.g., Nandy 1988; Harding 1998).<sup>2</sup> In this narrative, “traditional” knowledge is commonly assigned a precarious status of weakness, defined by the specter of imminent loss and the imperative for preservation.<sup>3</sup>

The persistence of such assumptions is well illustrated by the way in which Tibetan medicine—also known as *Sowa Rigpa*—has been portrayed over the past decades until today.<sup>4</sup> A good example of this is on the back cover of a popular German book on Tibetan medicine, which states that “the over 2,000-year-old system of Tibetan medicine counts among the most precious but also most threatened treasures of human culture . . . , the preservation of which constitutes an urgent task for humanity at large” (Gyamtso and Kölliker 2007). On another book’s back cover, this time in English, is the claim that its author traveled to “the few places left where Tibetan refugees still

<sup>1</sup> This is not to say that no such work exists. For notable examples, see Langford 2002, Alter 2005, Mahmood 2005, or Pordié 2008b.

<sup>2</sup> Poignantly articulating this oft-repeated narrative in the context of colonial India, Sumit Guha writes, “Colonialism did more than change the political structures of South Asian society. Long-enduring forms of systematic knowledge lost their validity or mutated into unrecognizable forms in order to survive” (2011: 49).

<sup>3</sup> The very appellation *traditional* points to a modern dichotomy, which functions to relegate tradition, as modernity’s other, to a status of insignificance and obsolescence. While this has been widely critiqued by anthropologists and science scholars (e.g., Nandy 1988; Pigg 1995, 1996), the dichotomy continues to shape ethnographic realities such as those described in this article.

<sup>4</sup> In recognition of Tibetan medicine’s diversity and geographical spread beyond Tibet and the Tibetan exile, scholars increasingly use *Sowa Rigpa* as an umbrella term for what is variously called Tibetan medicine, Amchi medicine, traditional Mongolian medicine, traditional Bhutanese medicine, or Buddhist medicine. While avoiding any national delimitation, the term itself is Tibetan (*gso ba rig pa*: “the science of healing”), thus reflecting its Tibetan heritage as much as its transnational scope. However, among the Tibetan community, *Tibetan medicine* (*bod kyi gso ba rig pa*) remains the preferred appellation; thus, I use the two terms interchangeably here.

practice Tibetan medicine in entirety—one of the most powerful healing traditions in the world, perfected over centuries and now in danger of being lost with the dispersal of its people” (Fenton 1999). Exile Tibetan physicians themselves often voice similar sentiments, regardless of their institutional or geographic affiliations. One doctor from the Central University for Tibetan Studies, for example, told me in a conversation in 2008: “Preserving Tibetan medicine is preserving Tibetan identity. Some of Tibetan culture, like Tibetan Buddhism and medicine, is of great benefit for all sentient beings. This is a treasure not just for us but for the whole world. . . . So its preservation is our responsibility, and also other people’s responsibility. It’s your medical system just as it is ours. If we don’t take this responsibility, then Tibetan medicine would get totally lost.” According to such widespread rhetoric, then, Tibetan medicine as a traditional knowledge and central part of Tibetan culture is endangered by the combined threat of modernity, exile, and Chinese cultural genocide and hence in urgent need of preservation.

While acknowledging the difficult situation of Tibetans and Tibetan forms of knowledge both in and outside Tibet, this article aims to critically trace this dominant narrative of preservation and loss through four distinct phases of Tibetan medicine’s development in exile from the early 1960s to the present. Based on data gathered during a total of two years of fieldwork between 2005 and 2015 in Dharamsala and other Tibetan exile locations in India,<sup>5</sup> this article provides a critical historical analysis of Tibetan medicine in India and its close connection to the exile Tibetan nationalist project. In particular, I argue that the preservation of traditional Tibetan medical knowledge in exile entails a political process of a fundamental reinvention of its nature (but not, so far, its content), not only rendering it thoroughly modern but also (re-)investing it with considerable hegemonic power. While this process produces the very knowledge it claims to salvage and cultivates the very image of weakness and victimhood that it seeks to overcome, it renders Tibetan medicine instrumental in preserving a largely overlooked—but still existing and carefully guarded—Tibetan hegemony from exile. Thus revealing the contemporary connections between traditional Tibetan knowledge and modern power, this article’s aim is to contribute to a better understanding of contemporary knowledge/power configurations that are well illustrated by, but go far beyond, the case of Tibet.

## 1 A History of Loss

Tibet is widely associated with the tragic story of occupation, exile, and loss that began in 1950 when Mao’s troops entered eastern Tibet and culminated with the Lhasa uprising in 1959, the Dalai Lama’s flight to India, and the violent reforms of the Cultural Revolution. Since then, reports on widespread human rights abuses, periodic popular uprisings, and a massive influx of Han Chinese have trickled out of Tibet, alongside governmental statistics documenting unprecedented economic development and infrastructure investments.<sup>6</sup> An important part of what makes Tibet’s fate,

<sup>5</sup> Broadly, this fieldwork focused on the larger social, cultural, and political role of Tibetan medicine in exile, as well as its historical development since 1960.

<sup>6</sup> For a good collection of references on both the Chinese and Tibetan exile positions, see Powers 2004.

otherwise only too common in world history, stand out is the Dalai Lama's successful portrayal of Tibetan culture as a rich repository of knowledge, holding unique relevance for the contemporary world (e.g., Dalai Lama 1999). Indeed, this image of Tibet and its culture has received considerable scholarly scrutiny: Robert Barnett, for example, argues that Tibet has come to be seen in terms of a "zone of specialness, uniqueness, distinctiveness, or excellence that has been threatened, violated, or abused," "needing protection and preservation" (2001: 273, 277). Another Tibet scholar, Donald Lopez, describes in detail how the Dalai Lama represents Buddhism as Tibet's cultural legacy, constituting a "universal inheritance [that] is Tibet's gift to the world" (1998: 198). As reflected by such critical scholarship, as well as the above-cited back cover descriptions, two kinds of knowledge in particular function as central identifiers of Tibetan culture: the spiritual-philosophical knowledge of Tibetan Buddhism and the medical-pharmaceutical knowledge of Sowa Rigpa, or Tibetan medicine.

Both fields of knowledge came under direct attack by Mao's armed troops. In eastern Tibet the military occupation started in 1950, triggering rebellions against Chinese reforms that led to heavy-handed reprisals from 1956 onward, including the destruction of monasteries and the deaths of hundreds of monks (Shakya 1999). In central Tibet, where Mao had initially adopted a more cautious approach of gradual reform, it was only in the aftermath of the 1959 Lhasa uprising that Tibetan Buddhism and medicine were directly affected by the Chinese occupation (Choedrak 2000; Wangyal 2007; Hofer 2011). The Chagpori Drophen Ling in Lhasa, which had been Tibet's most prestigious medical institution for centuries, was destroyed during the uprising, a fate that would be shared by most other central Tibetan medical institutions and monasteries during the following decade. Similarly, innumerable medical and religious scriptures were destroyed, while large numbers of doctors and monks were killed, imprisoned, or forced to abandon their vocations (Janes 1995: 19–20). Even though the younger and more secular Lhasa Mentsikhang medical college narrowly escaped destruction in 1959 and dissolution in the early 1960s (Janes 1995: 17–18; Choelo Thar 2000: 41), Craig Janes writes that "by 1973 Tibetan medicine as an institution had virtually disappeared" (1995: 20).<sup>7</sup> To fill the ensuing medical void, Chinese biomedicine was gradually introduced to Tibet from the 1950s onward as the new state-sanctioned primary health resource (Janes 1995; Hofer 2011).

Meanwhile, the Dalai Lama and some eighty-four thousand Tibetans fled across the Himalayas to India. However, only a handful of doctors were among the first waves of refugees, and even after five years fewer than ten fully qualified Tibetan doctors existed in exile. Among them were Yeshe Donden, Lobsang Dolma, Ngawang Yeshe, Lobsang Tashi, and Phuntsog Norbu Damdul. Two other doctors in exile were Trogawa Rinpoche, who had already moved to India in 1956, and Tashi Yangphel Tashigang, a Ladakhi (and thus an Indian citizen) who had received and completed his training in Tibet. Of these seven doctors, all except Lobsang Dolma had been trained under the standard syllabi of the Chagpori and the Mentsikhang, the two

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<sup>7</sup> However, Tibetan medicine itself had not completely disappeared in Tibet and was revived after Mao's death in 1976 and the subsequent liberalization of China's policies toward Tibet (see Janes 1995; Hofer 2011).

eminent state-sponsored Tibetan medical institutions in Lhasa before 1959.<sup>8</sup> Given the great diversity of other medical lineages, local traditions, and secret oral transmissions of knowledge in pre-1959 Tibet (henceforth “old Tibet”), the passage over the Himalayas thus proved to be a veritable bottleneck through which only a fraction of Tibet’s medical knowledge—mostly in its institutional form—passed into exile. Both in Tibet and in exile, therefore, Tibetan medicine was confronted with an unprecedented loss of knowledge, whether in the form of experts and texts, training facilities and institutional structures, or the very plurality of local experience that had marked it until then. Tibetan medical knowledge became fugitive in a geographical, political, and epistemological sense and reinscribed in a register of cultural loss and preservation.

## 2 The Reinvention of Knowledge

From the very beginning of exile, the Dalai Lama and his government-in-exile framed the loss of especially religious and medical knowledge within a discourse of cultural survival. Already in December 1959, just a few months after the first Tibetan refugees’ arrival in India, the Dalai Lama told a group of about two thousand Tibetans in Sarnath: “One day we will regain our country. You should not lose heart. The great job ahead of us now is to preserve our religion and culture” (quoted in Avedon 1997: 82). Postcolonial scholars such as Dawa Norbu (1992), Partha Chatterjee (1993), and Cemil Aydin (2007) have pointed out that in India, China, and the Muslim world, religion and culture rose to political prominence as the essentialized foundation of local nationalist movements (cf. Nandy 1983; Spivak 1995; Hansen 1999). While modern nationalism was certainly a new development in Tibetan (exile) society that triggered fundamental rearticulations of Tibetan culture and religion (e.g., Korom 1997; Lopez 1998; Dodin and R  ther 2001), both domains had long played important political and governmental roles in old Tibet. This was especially true for Tibetan medicine.

For centuries Tibetan medicine constituted the main health care resource in Tibet and a vibrant field of scholarship closely connected to the main placeholder for Tibetan cultural identity, Mahayana Buddhism (Gyatso 2015).<sup>9</sup> The emergence of professional Tibetan medicine can be traced back at least to the period between the fifth and the seventh centuries CE, when medical knowledge from China, India, Persia, and other surrounding regions was compiled, translated, and adapted to the Tibetan context (Desi Sangye Gyatso 2010: 147–157; see also Garrett 2008: 38–40). From the beginning Tibetan medicine enjoyed state patronage, its high status further reflected

<sup>8</sup> Trogawa Rinpoche received his medical training privately from Rigzin Paljor Nyerongsha, a Chagpori lineage holder, and on that basis later established the Chagpori Tibetan Medical Institute in Darjeeling, India. However, as was common at that time, he also had other teachers not affiliated with any of the large institutions in Lhasa—something that likely had been the case with some of the other doctors mentioned here, too. Nonetheless, all doctors mentioned here, except for Lobsang Dolma, had been trained in the traditions of the two major medical institutions in Lhasa, which between 1916 and 1924 even shared the same principal and syllabus (Choelo Thar 2000: 18–19).

<sup>9</sup> It was not, however, the only health resource. Religious specialists like high lamas, tantric practitioners, and oracles were also consulted for health problems, as were astrologers, bonesetters, and herbalists.

in its thirteenth century classification as one of Tibet's five major sciences (Garrett 2008: 53). In the seventeenth century, however, the Tibetan science of healing—Sowa Rigpa (*gso ba rig pa*)—acquired an additional function as a technique of governance and came to serve as an important hegemonic tool to expand and consolidate Tibetan cultural and political influence far beyond the borders of central Tibet (Schaeffer 2003; Gyatso 2004; Garrett 2007). Thus, in his efforts to “heal” the ills of a Tibet fragmented by war and strife, the Fifth Dalai Lama employed medicine and Buddhism to rule Tibet not only in a strictly political sense but also by creating a cultural hegemony both within and beyond the Ganden state (Schaeffer 2003: 636–37).<sup>10</sup>

Tibet acquired a transregional reputation for its medical knowledge and Buddhist learning, which were exported widely throughout the Himalayas, Mongolia, northern China, and Siberia (Meyer 1992: 6–7; Samuel 1993: 146–49). In this way, vast parts of Asia came under Tibetan influence, with large numbers of doctors, scholars, and monks from the entire region receiving their training at Tibetan government-controlled institutions. Even the rulers of Mongolia and China relied on Tibetan medical counsel, in what could be seen as a medical extension of the priest-patron (*mchod yon*) relationship that has shaped the Tibetan government's foreign relations until today (Kauffmann 2015). As Stacey Van Vleet points out, “If the government of the dalai lamas and its monastics relied on Buddhist expertise for prestige and patronage, grounding their power in knowledge rather than military resources, medicine was a key component of their diplomatic arsenal” (2010–11: 356). Until the mid-twentieth century, then, Tibetan medicine constituted a highly privileged body of knowledge invested with considerable political significance.

The Fourteenth Dalai Lama's announcement in 1959 that there was a need to preserve Tibet's religion and culture thus marked not as much a new political departure as a form of continuity under the new and difficult circumstances of exile. What was at stake, and needed to be preserved, was not simply medical knowledge for its own or the patients' sake but for the very foundations of Tibet's existence as a distinct people and political entity. In the context of the twentieth century, this meant that traditional Tibetan medicine came to stand for the modern Tibetan nation as envisioned by the Tibetan government-in-exile (Kloos 2010, 2011, 2012), with direct consequences on the ways in which it was preserved and reinvented. The Dalai Lama's concern with cultural survival found resonance not only in the international sphere but also among the Tibetan exile community, which began to focus its efforts—at individual, institutional, and policy levels—on the preservation of what was considered Tibetan culture.<sup>11</sup> This concern has grown steadily and continues to grow today. When I talked to exile Tibetan doctors from all major institutions, as well as independent private practitioners throughout India, during the late 2000s about the

<sup>10</sup> In particular, Chagpori-trained doctors were sent to teach and practice medicine throughout and beyond the Ganden state, often relying on a network of Gelugpa monasteries. Of course, not all regions were equally susceptible to central Tibetan influence, as, for example, Garrett 2013 shows for Kham.

<sup>11</sup> The founding of the Men-Tsee-Khang and the medical faculty at the Central University of Tibetan Studies (the former Central Institute for Higher Tibetan Studies) in Sarnath was directly informed by this imperative to preserve Tibetan culture. The same can be argued for the Chagpori Tibetan Medical Institute in Darjeeling, founded by Trogawa Rinpoche in fulfillment of a promise to his teacher (Barbara Gerke, pers. comm. 2013), but also (after much urging by high-ranking Tibetans in India) to revive and thereby preserve the line of the destroyed Chagpori Drophen Ling in Lhasa.

purpose of their work as medical professionals, the most common answer was “to preserve our culture.” Today, Tibetan medicine has become a pillar industry worth hundreds of millions of dollars in Tibet (Xinhua News Agency 2007, 2011; Craig 2012) and one of the most important economic resources of the exile Tibetan community in India (Kloos 2010). Nevertheless, despite these endorsements, Tibetan medicine is still portrayed as if it were in a weak or even subaltern position, at risk of loss and in need of preservation. What should we make of this?

On the one hand, there can be no doubt that the loss and crisis of Tibetan medical knowledge were real in the historical sense and that even today Tibetan medicine—like many other non-Western, traditional systems of knowledge—finds itself structurally, economically, and politically disadvantaged vis-à-vis modern science and biomedicine. Thus, Tibetan medicine is forced to prove its efficacy and safety according to (often incompatible) biomedical diagnostic categories (cf. Adams 2002b; Adams et al. 2005; Craig 2011) while centuries of its own accumulated clinical experience and pharmaceutical expertise are simply brushed aside as unscientific or unpublishable by the biomedical establishment. Tibetan physicians cannot legally practice their medicine in most Western countries, despite undergoing rigorous institutional training similar to that of their biomedical peers. And even within the Tibetan government-in-exile, the Health Department allocates almost all its funds to biomedical facilities, leaving Tibetan medical institutions to fend for themselves. On the other hand, these realities—and their constant rearticulation in public and scholarly discourse—often conceal the connections of traditional knowledge to various forms of modern governance and power. Thus, Tibetan medicine played an important role in the Thirteenth Dalai Lama’s efforts to cultivate a modern national body and identity (Van Vleet 2010–11) and continues to occupy a central—if often unacknowledged—place in contemporary exile Tibetan nationalist politics.

Given the long-standing and tight relationship among medical knowledge, Buddhism, and political power both in old Tibet and in exile, the preservation of Tibetan medicine as culture is a political process that produces the very knowledge it claims to preserve. The Fourteenth Dalai Lama’s efforts to build a unified modern Tibetan nation in exile relied, to an important degree, on the power of traditional Tibetan knowledge and science as exemplified by Tibetan medicine (Kloos 2010, 2011, 2012). In line with the Tibetan nation it was meant to help imagine, however, Tibetan medical knowledge needed to be defined as singular rather than plural, as ethical rather than political, and as authentically Tibetan rather than foreign or adulterated. Of course, it really was none of these things—it had many different traditions, it was inextricably connected to Tibetan state power, and its syncretic origins can be traced to India, China, and Persia, among other places—so its preservation in exile entailed a radical reinvention of the nature, if not the content, of Tibetan medical knowledge. The process of preservation can therefore be understood as passing through four distinct phases from 1960 to today: (1) recovery and reassembly, (2) diffusion and cultural encounter, (3) standardization and official recognition, and (4) ownership and intellectual property rights, the latest phase that Tibetan medicine is currently entering.<sup>12</sup>

<sup>12</sup> Thomas Kauffmann (2015) identifies similar phases in the Tibetan refugee community’s overall development. While this underscores the importance of placing Tibetan medicine’s development into a broader

These phases do not refer to radical historical breaks; rather, they serve a heuristic purpose of structuring the history of Tibetan medicine in exile along gradual shifts in emphasis that reveal both the persistence and fluidity of cultural preservation as a unifying nationalist trope.

### 3 Recovery and Reconstruction

The first phase of a contemporary recounting of Tibetan medical history lasted for about two decades from 1960 to around 1980 and probably comes closest to what might conventionally be called preservation. After the traumatic losses brought by Chinese destruction and the flight into exile, all efforts focused on Tibetan medicine's recovery and reassemblage. As part of the general effort to preserve Tibetan culture, in 1960 the Dalai Lama asked Yeshe Donden, a graduate from the Lhasa Mentsikhang and at that time the only known doctor among the first wave of refugees, to set up a clinic in Dharamsala—the center of the Tibetan diaspora and seat of the government-in-exile—and to begin training new students. Yeshe Donden had to start almost from scratch: medical scriptures needed to be salvaged, what remained of the medical community and its collective experience needed to be reassembled, and infrastructures, syllabi, and pharmaceutical procedures had to be reestablished. Given the lack of financial and human resources and the generally unfamiliar context of India, this was a slow process with frequent setbacks (Kloos 2008). In 1967, however, the medical center was merged with the Tibetan astrology school to form the Dharamsala Men-Tsee-Khang (Tibetan Medical and Astrological Institute), which over time grew into the largest and most prestigious institute of Tibetan medicine in exile.

It was during these first two decades in exile that Tibetan medicine was reinvented as a singular homogeneous medical tradition, at the same time as the Tibetan government-in-exile struggled to establish itself as the sole legitimate representative of a unified and homogenized Tibetan nation (Tethong 2000; McGranahan 2010). In many ways, this development reflected similar earlier moments in the history of Tibet. The most notable of these is undoubtedly the seventeenth-century establishment of the Ganden Phodrang government, which coincided with the establishment of the Chagpori Drophen Ling and a general attempt to institutionalize and homogenize Tibetan medicine (Schaeffer 2003; Garrett 2007). Later, the foundation of the Lhasa Mentsikhang in 1916 constituted another important push toward institutionalizing and standardizing Tibetan medical knowledge and practice, within the larger framework of the Thirteenth Dalai Lama's political agenda of modernizing the central Tibetan state (Van Vleet 2010–11). However, I argue that, despite their importance and impact, none of these earlier moments could quite rival the degree of homogenization and institutionalization that became possible in the exceptional situation of exile. Faced with the potential extinction of the Tibetan nation and its culture, the urgency of survival and preservation gave the Fourteenth Dalai Lama an ability to implement

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historical and political context, it also points to the value of using Tibetan medicine as an analytic lens to gain insights into larger processes that go beyond the immediate medical field.

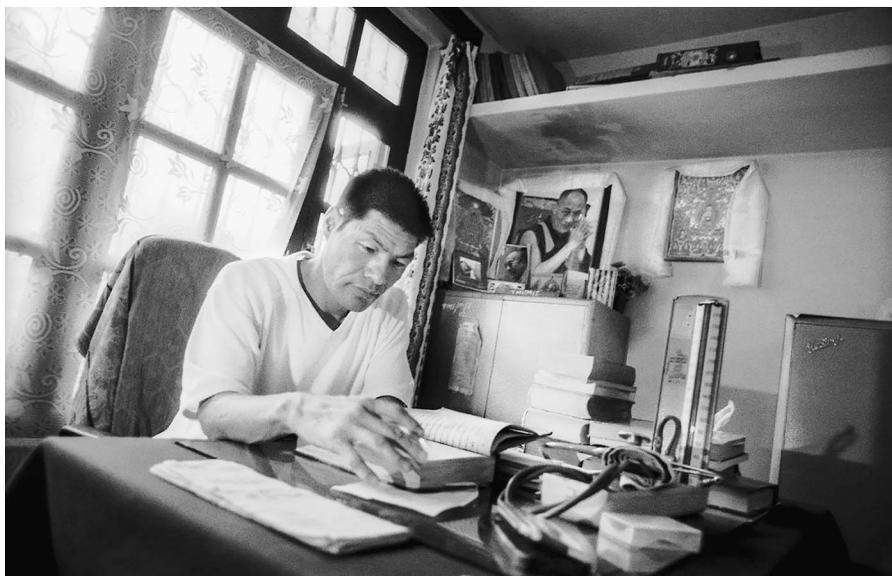


**Fig. 1** Dharamsala Men-Tsee-Khang college students. © Seb Geo 2008

social and political changes—in this case in the field of Tibetan medicine—of which his previous incarnation could only dream.

By design as much as for more pragmatic reasons, the Men-Tsee-Khang remained the sole authority and representative of Tibetan medicine in exile for a long time, accruing additional power and status through its direct affiliation with the Dalai Lama. Rare efforts to incorporate elements of other Tibetan medical traditions notwithstanding,<sup>13</sup> it mainly propagated the medical orthodoxy of the Lhasa Mentsikhang and, to a lesser extent, the Chagpori. Thus, despite its perpetual shortage of qualified doctors (to no small extent due to frequent resignations from the institute), the Men-Tsee-Khang was reluctant to employ newly arrived doctors from Tibet who had not been trained at the Lhasa Mentsikhang or Chagpori, such as practitioners from family lineages or smaller peripheral institutions. If for the first two decades of its existence the Men-Tsee-Khang's monopolistic position as the sole provider and representative of Tibetan medicine in exile was self-understood and undisputed, later it also actively discouraged any practice of Tibetan medicine outside its institutional boundaries, especially by independent doctors. For example, Lobsang Samten Taklha, the Dalai Lama's elder brother and Men-Tsee-Khang director from 1980 to 1985, introduced a rule that the Men-Tsee-Khang would not sell any medicines to private practitioners. Since it was difficult and expensive even for senior doctors—and next to impossible for all others—to open their own pharmacies at that time, this significantly curtailed the development of other clinics and traditions outside the Men-Tsee-Khang.

<sup>13</sup> Occasionally, scriptures, formulas, and rituals from other traditions were adopted, but this remained the exception.



**Fig. 2** Dharamsala Men-Tsee-Khang doctor at his office desk. © Seb Geo 2008

While creating or exacerbating tensions between the few already existing private practitioners and the institute, this strategy worked well enough until the early 1990s, when three other Tibetan medical institutions were founded and the numbers of private clinics began to rise. Yet two of the three new institutes—the Chagpori Tibetan Medical Institute founded by Trogawa Rinpoche in 1992 and the medical section of the Central Institute for Buddhist Studies in Ladakh established in 1989—were affiliated with the Men-Tsee-Khang and consequently implemented its syllabus and exam questions. Only the Indian government–funded medical faculty of the former Central Institute for Higher Tibetan Studies—now upgraded and renamed Central University of Tibetan Studies (CUTS)—in Sarnath, founded in 1993, was completely independent and used its own syllabus and degree system. Given the overwhelming size of the Men-Tsee-Khang and the relatively low numbers of graduates produced by the other three institutions, including CUTS, even today over 90 percent of all exile Tibetan doctors are or have been trained under the Men-Tsee-Khang curriculum. Furthermore, the common experience of exile, combined with the enormous influence of the Dalai Lama (who has repeatedly expressed his views on the topic—see, e.g., Dalai Lama 2007), ensured a universal consensus among practitioners—including those with completely different backgrounds—on the nature and purpose of Tibetan medicine. As a consequence, Tibetan medical knowledge in exile displays an extraordinary degree of homogeneity that is found neither in old nor in modern Tibet (cf. Craig et al. 2010; Adams, Schrempf, and Craig 2011b; Hofer 2012).

The Tibetan government-in-exile’s political agenda informing this kind of institutionalization and homogenization showcases the strong links among nationalist projects, state power, and traditional (medical) knowledge, which has also been observed in other Asian contexts. For example, Jean Langford (2002) explores how pluralistic Ayurvedic healing traditions in India developed a “national consciousness” during the

anticolonial movement in the early twentieth century, thus fundamentally reshaping Ayurveda's knowledge, practice, and organization. Similarly, Kim Taylor (2005) describes in detail how, during the Chinese Communist Revolution, Chinese medicine was transformed from a marginal, sidelined array of medical traditions into the standardized, institutionalized "traditional Chinese medicine" (TCM), serving a particular function in modern Chinese society. In the context of Chinese-occupied Tibet, Tibetan medicine had to reinvent itself as a modern, secular, and nonpolitical science to survive and—later—thrive, while continuing to serve as a safe, state-sanctioned placeholder for Tibetan culture (Janes 1995, 2001; Adams 2001a, 2001b, 2002a, 2007). In all these cases, the intersection of modern politics with traditional medicine has led not simply to a transformation or reframing but to a reinvention of the latter in the form of the singular medical systems of Ayurveda, TCM, and Sowa Rigpa that we know today (cf. Cohen 1995). As exile Tibetan medicine's remarkable homogeneity (even compared with TCM or Ayurveda) shows, this is especially true in the difficult context of the Tibetan exile, marked more than any other by the urgency of cultural preservation and survival.

#### 4 Diffusion and Spread

The second phase of preservation—again lasting roughly twenty years from about 1980 to 2000—can be characterized as one of diffusion and spread. More students than ever before were admitted to the Men-Tsee-Khang college, including for the first time also students from Himalayan areas. The medical college recruited thirty-three medical students in 1982 (the largest cohort in exile until then) and another eighteen students in 1983 (Choelo Thar 2000: 83). Between 1980 and 2000 the number of Men-Tsee-Khang branch clinics increased from six to forty, most of them addressing the health care needs of the Tibetan exile population in its various settlements. However, some of these clinics were strategically located in large cities (Delhi, Kolkata, Bhubaneswar, and Bangalore; later also Mumbai, Chennai, Ahmedabad, and Secunderabad) or on the cultural periphery of Tibet, such as Ladakh, Sikkim, Solu Khumbu, or Arunachal Pradesh, attracting increasing numbers of non-Tibetan patients. As a consequence, the ratio between Tibetan and (predominantly) Indian patients was reversed during this phase: until 1980 most patients treated by exile Tibetan doctors were Tibetan refugees, but by the year 2000 close to 90 percent of all patients were Indians (Men-Tsee-Khang 2012: 277). Simultaneously, Men-Tsee-Khang staff numbers increased from 53 in 1980 to 208 in 1990 and 434 in 2000 (Choelo Thar 2000: 196), and the above-mentioned three new Tibetan medical institutes opened their doors, as did the first commercial private pharmacies. All these developments greatly facilitated the establishment of private clinics throughout India and Nepal during the 1990s.

In the 1980s and 1990s, then, the preservation of Tibetan medicine took on a new meaning beyond the salvage and reconstruction efforts of the 1960s and 1970s. Given its fraught existence at the little-known margins of Tibetan society in exile—not to mention India and the world—until about 1980, Tibetan medicine's best hopes for survival lay in growth and expansion. As Tibetan medicine quickly spread in South Asia and even became available in the West, this time was also a phase of cultural

encounter. Thus, Tibetan medical knowledge was made accessible to large, non-Tibetan, and nonprofessional audiences through the first popular English-language publications on Tibetan medicine. The Library of Tibetan Works and Archives in Dharamsala began publishing the journal *Tibetan Medicine* in 1980, the Men-Tsee-Khang brought out the first edition of its *Fundamentals of Tibetan Medicine* in 1981, and several new books on the topic became available in the West (Meyer 1981; Clifford 1984; Donden 1986; Dummer 1988). The first international conferences exclusively devoted to Tibetan medicine were organized in Berkeley, California, in 1982, and in Venice and Arcidosso, Italy, in 1983. In India, the Men-Tsee-Khang attracted great public interest through its successful Tibetan Medicine Week in New Delhi in December 1982.

But Tibetan medicine's cultural encounters were not limited to an interested public and growing numbers of international patients; they also led to increased interaction with other kinds of knowledge, most notably modern science and biomedicine. Thus, in the 1980s research and translation projects began to be initiated with the aim to preserve Tibetan medicine and culture by asserting the former's validity and relevance, and thereby the latter's value and ingenuity, in an international context that tended to be skeptical if not hostile to nonmodern forms of knowledge. In 1980 the Men-Tsee-Khang founded its research department, initially headed by former director Jigme Tsarong. Despite its name, for several years this department focused its limited resources on organizing exhibitions and conferences, as well as publications and translation work. Not until the late 1980s was the research department ready for its first (unsuccessful) attempt at clinical research, followed in the 1990s by more successful studies in collaboration with Indian and foreign scientists (Van Pauwvliet 1997; Neshar 2000; Sood, Pandey, and Moorthy 2000; Namdul et al. 2001).<sup>14</sup> Given the Tibetans' initial lack of even the most rudimentary scientific training, not to mention scant financial resources and Tibetan popular skepticism about the necessity of modern research, exile Tibetan medicine's engagement with modern science involved a steep learning curve that only began during this phase. Over all, however, Tibetan doctors have since been successful in strategically positioning their own knowledge vis-à-vis modern science, using the latter's power to simultaneously validate their own medicine and challenge the biomedical hegemony (Kloos 2011, 2015).

With the international exposure brought by Tibetan medicine's increasing spread and public and professional encounters, the political value of Tibetan medical knowledge as a major symbol and identifier of Tibetan culture and the Tibetan nation became increasingly clear. Tibetan medicine was particularly well suited for this role because it could be portrayed as a knowledge system that applied the essence of modern Tibetan culture—the Mahayana Buddhist ethics of altruism and compassion—in its training curriculum, clinical practice, and institutional policies. For example, monthly prayer sessions were instituted as a fixed part of the college curriculum, and much attention focused on how its practitioners and clinics aimed at helping the sick with little regard for material gains. Thus, as a registered charitable organization under Indian law, the Men-Tsee-Khang routinely provided free or concessional medicine to newly arrived refugees from Tibet, the poor and elderly, civil servants, monks, nuns,

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<sup>14</sup> For a detailed summary of these and other studies, see Kloos 2010: 284–93.

and occasionally rural Indians and in general followed a social agenda in keeping its drug and consultation prices low. Between 1982 and 2000 the value of free medicine given out by the institute increased hundredfold, from about 60,000 INR to over 6 million INR (Choelo Thar 2000: 197). Besides such actual charitable practices, the Men-Tsee-Khang was also careful to emphasize its ethical status by widely publishing materials that made this claim, along with other information testifying to its altruism. In tandem with Tibetan medicine's diffusion and the cultural encounters it entailed, then, it also underwent a process of ethicalization.<sup>15</sup>

Of course, Mahayana Buddhist ethics have constituted the epistemological and moral base of Tibetan medical theory and practice at least since the twelfth century (Gyatso 2004: 84). We also know that the Fifth Dalai Lama's Ganden Phodrang government in the late seventeenth century established a strong link between medical scholarship and the Bodhisattva ideal of altruism and compassion as part of the larger project of establishing a central Tibetan Buddhist state (Schaeffer 2003). In other words, neither the base of Buddhist ethics per se nor its instrumentalization for political ends was new to Tibetan medicine. Yet, the particular process of ethicalization that occurred during the 1980s and 1990s coincided with a larger effort to reformulate Tibetan Buddhist ethics as modern, secular, and universal, relevant to the whole world but of special pertinence to the imagination of a modern yet uniquely Tibetan nation (e.g., Dalai Lama 1999). If Tibetan medicine's Buddhist ethics had been well codified in virtually all its major texts and self-understood among its practitioners and patients until then, their rearticulation in general and Tibetan medicine's international diffusion in particular now required that they be made visible—and thus proven—new in a modern, diasporic, and capitalist context. In this context, publishing sophisticated scholarly treatises connecting Tibetan medicine to the Bodhisattva ideal would not achieve this end any more than would treating high lamas and government officials. As modern nationalism and governance, also in its Tibetan form, had replaced the rulers with the people as the prime ethical and political subject, Tibetan medicine needed to affirm its Buddhist ethics through the social agenda described above, which furthermore was conveniently measurable—and publishable—in terms of money spent.

In contrast to earlier Tibetan forms of ethical practice, this phase of ethicalization also necessitated a consistent denial of politics, even though it clearly played a political role. While Buddhism was explicitly linked to statecraft in the old Tibetan system of *chos srid zung 'brel* (politics and religion combined), in the modern Indian and Tibetan diasporic context politics tends to be regarded as “dirty” and unethical. Yet it was exactly their ostensibly apolitical status that enabled Tibetan doctors to generate international awareness of, and goodwill for, the Tibetan cause even where formal politics were unwelcome or unable to reach. Recounting one particularly illustrative example, one Men-Tsee-Khang doctor told me:

In most parts of Africa, and particularly in Kenya, it is so difficult to organize any politics-related Tibetan activities. . . . So His Holiness [the Dalai Lama]

<sup>15</sup> While no data on the topic exist, the common presentation of Tibetan medicine in the context of Tibetan Buddhist events in the West may also have played a role in the ethicalization of Tibetan medicine. However, so far the spread of Tibetan medicine in the West has played only a relatively minor role in the overall development of Tibetan medicine in exile.

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

Much like missionary medicine during European colonial expansion, Tibetan medicine became an international ambassador for the Tibetan political cause in the context of Chinese occupation and exile.

## 5 Regulation and Recognition

In the third phase, which began at the turn of the millennium, the preservation of Tibetan medical knowledge was seen as contingent upon its regulation, standardization, and official recognition. The growing popularity and economic value that Tibetan medicine had acquired both in Tibet and in exile during the 1990s did not diminish the Tibetans’ concern with the survival and preservation of Tibetan medicine and culture. It only shifted its focus away from the external enemy of China to the internal one of greed and commercialization among Tibetans themselves. As Tenzin Agloe Chukora wrote in the English-language exile Tibetan magazine *Tibetoday*: “Unfortunately, the Tibetan Sowa Rigpa that once survived the ideological holocaust of Mao’s China is now facing its toughest enemy and opponent both inside and outside Tibet. Physicians . . . maintain that the ills of greed, neglect and the commercialization of the Sowa Rigpa tradition in and outside Tibet would do more harm in the long run when it comes to preserving the authenticity and the professional expertise of the Sowa Rigpa tradition” (2007: 14).

To prevent the deterioration and potential loss of Tibetan medicine’s good reputation, effectiveness, and knowledge at the hands of unscrupulous businessmen, incompetent doctors, or charlatans, exile Tibetan doctors and government officials called upon the Central Tibetan Administration for a system of regulation. This system was to be applied to the content, transmission, and application of Tibetan medical and pharmaceutical knowledge anywhere outside Tibet. Especially the Men-Tsee-Khang lobbied hard for such regulation, frustrated by its lack of official legitimacy and real power to act as the guardian and sole authority over Tibetan medicine in exile that it thought it was. The new Tibetan medical institutions that had been established during the 1990s, growing numbers of private Tibetan doctors, and increasingly assertive Himalayan practitioners of Sowa Rigpa (e.g., Pordié 2008a) all appeared to threaten, in the Men-Tsee-Khang’s eyes, not only the integrity of Tibetan medical knowledge but also the Men-Tsee-Khang’s governmental authority as its representative.

In short, much more than the few actual cases of quackery, counterfeit, and contamination that hit the news around the turn of the millennium,<sup>16</sup> the increasing

<sup>16</sup> On several instances, Tibetan lamas with little or no medical background represented Tibetan medicine and sold pills for personal profit in the West, something Tibetan doctors in India regard as a serious breach of Tibetan medical ethics. Between 1995 and 2009, the *Men-Tsee-Khang Newsletter* routinely and prominently

heterogeneity of Tibetan medicine in exile per se—and the resultant lack of government control over it—informed this third phase of preservation through regulation. As one high-level Men-Tsee-Khang physician told me in 2008, “We need to have some control. We can’t just let independent doctors do whatever they like.” What was at stake was not simply Tibetan medicine’s medical efficacy or even the Men-Tsee-Khang’s institutional power but, crucially, its *political* efficacy<sup>17</sup> as a central domain through which a certain kind of Tibetan nation—as propagated by the Dalai Lama and the exile government (McGranahan 2010)—could be imagined, produced, and asserted. The preservation of Tibetan medical knowledge in the 2000s therefore concerned not only its power to heal sick individuals but also its power to heal the ailing Tibetan nation. It was this that gave the entire matter of regulation and standardization its political urgency and wider relevance. In contrast to the previous phase, when Tibetan medicine’s apolitical status was emphasized, this phase saw Tibetan officials become increasingly open in their assertions of Tibetan medicine’s political role. Thus, Penpa Tsering, speaker of the Tibetan parliament-in-exile, remarked in his welcome speech at the Second International Conference on Tibetan Medicine in Dharamsala on 27 October 2012, which I attended: “Tibetan medicine has played a very important role in terms of soft power to reach out to the world and promote the Tibetan cause.”

For the first time in exile, then, Tibetan medical knowledge became directly politicized. Of course, as I have argued above, it was political all along insofar as it and its preservation were centrally situated within the larger exile Tibetan nationalist project of cultural survival. But only during the early 2000s did it become the subject of actual political debate, first in the Tibetan parliament-in-exile and later in both houses of the Parliament of India, the Lok Sabha and the Rajya Sabha. As a consequence, the Central Council of Tibetan Medicine (CCTM) was founded in 2004 as an apex body of the Tibetan government-in-exile, with the explicit mission to control, regulate, and represent Tibetan medicine as its sole legitimate authority (Kloos 2013). Named after the Central Council for Indian Medicine, the CCTM was meant to give Tibetan medicine an official body that was recognizable to the Indian government. Indeed, gaining official recognition by the government of India preoccupied and shaped exile Tibetan medicine and the CCTM most during the 2000s. Although there were important economic, political, and legal interests behind these efforts (see Kloos 2016), in the end they all boiled down, once again, to the question of preservation and loss. As Tashi Dawa, a doctor working at CUTS in Sarnath told me in 2008, “Tibetan medicine won’t survive in exile if we don’t get recognition.” Besides providing legal security for Tibetan doctors in an increasingly competitive environment and providing entry into the lucrative Indian market for traditional pharmaceuticals, recognition appeared as the existential condition for Tibetan medicine’s preservation. It was also expected to

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cautioned the public against counterfeited precious pills, privately manufactured pills sold as Men-Tsee-Khang pills, and private doctors posing as Men-Tsee-Khang doctors. In 1998 and 2001, incidents where Finnish and Swiss authorities confiscated Tibetan pills contaminated with heavy metals were widely covered by European newspapers and health department press releases, such as *Dagens Nyheter* (Lundberg 1998), *Direction Générale de la Santé* (2001), *Schweizer Depeschagentur* (2001a, 2001b), and *Neue Zürcher Zeitung* (2002). For a summary account, see Kloos 2008: 35–36.

<sup>17</sup> I define *efficacy* in sociocultural terms, that is, as “the capacity to produce desired outcomes” (Craig 2012: 4).

give a significant boost to Tibetan medicine's political power as a representative of the Tibetan nation not only in India but also internationally.

To gain official recognition, however, Tibetan medicine needed to be made legible to the state (Scott 1998). Consequently, the CCTM's specific objectives included, as stated in its legal code, the inspection and registration of Tibetan medical colleges, pharmaceutical units, and physicians; the standardization of the colleges' syllabi and academic quality; and the prevention of fake or adulterated medicines by standardizing and monitoring the pharmaceutical production of Tibetan medicines (Tibetan Health Department 2003). Although the CCTM could achieve only some of these objectives, it did provide Tibetan medicine in exile with a recognizable and relatively unified body (Kloos 2013). This allowed the CUTS vice chancellor, Geshe Ngawang Samten, to shepherd the case of Tibetan medicine through the various expert committees, departments, and both houses of the Parliament of India to finally secure its official recognition under the name "Sowa Rigpa" in September 2010 (Kloos 2016). While Tibetan medicine was now formally subject to Indian laws, standards, and norms, the process of actual legitimation has only just begun with these events. An expert commission was set up to draft an official syllabus, as well as a degree system (along the lines of the existing Indian BAMS, BUMS, and BHMS degrees)<sup>18</sup> for Sowa Rigpa, to be approved by the Central Council for Indian Medicine. Although Sowa Rigpa is now officially administrated by the AYUSH Department of the Indian Ministry of Health and Family Welfare,<sup>19</sup> many questions of power, control, and representation still need to be negotiated.

## 6 Ownership and Hegemony

The politicization of Tibetan medical knowledge had several consequences. One was a renewed focus on the question of the origins of Tibetan medical knowledge. While this question has been a matter of lively debate in Tibetan medical circles for centuries (Gyatso 2004, 2015), the orthodox opinion represented by the Dharamsala Men-Tsee-Khang was that it should be regarded as the Buddha's direct teaching. However, in the political context of the exile Tibetan nationalist struggle, which presented Tibetan medical knowledge as authentically Tibetan and vigorously contested India's claims that it was just a lost version of Indian Ayurveda (Dash 1976: 4; cf. Kloos 2016), this orthodox view of Tibetan medicine's mythical origins became inopportune, since it implied that Tibetan medicine's origins lay in India, the country of the Buddha.

Exile Tibetan doctors therefore began, around the late 1990s, to systematically change their official position and claim that Tibetan medical knowledge was in fact the

<sup>18</sup> The Indian BAMS degree is a Bachelor of Ayurvedic Medicine and Surgery; BUMS, Bachelor of Unani Medicine and Surgery; and BHMS, Bachelor of Homeopathic Medicine and Surgery.

<sup>19</sup> *Ayush* is a Sanskrit term for "life" or "long life," but as an acronym AYUSH stands for the officially recognized Indian systems of medicine: Ayurveda, yoga and naturopathy, Unani, Siddha, and homeopathy. It is still unclear whether the recent addition of Sowa Rigpa will effect a change in this department's name. One Indian official half-jokingly suggested SWAYUSH—*swa* connoting "self" in Sanskrit and resonating not only with "Sowa Rigpa" but also with the *swaraj* or "self-rule" advocated by Gandhi during the Indian independence movement.

product of Tibetan scholarship. As Tsering Thakchoe Drungtso from the Men-Tsee-Khang told me in 2008,

When we go through all the history of Tibetan medicine, we find that there was some slight mistake in the way we Tibetans presented our history. You see, anything coming from India is very precious, because of Buddhism. So we may have overemphasized the Indian origins [of Tibetan medicine], which creates problems now because it supports the views of these Ayurvedic scholars [who claim that Tibetan medicine is Ayurveda]. We need to correct this bias. . . . It is changing now, even in the books coming from Tibet.

Indeed, the historical preface of the Men-Tsee-Khang's English translation of the *rgyud bzhi*, Tibetan medicine's standard treatise, presents Tibetan medicine as the outcome of centuries of indigenous scholarship and makes no mention at all of the Medicine Buddha (Men-Tsee-Khang 2008: i–xv). A comparison of publications by exile Tibetan doctors before (Rechung 1973; Rabgay 1981; Donden 1986; Khangkar 1990) and after the turn of the millennium (Norchung 2006; Drungtso 2004, 2007; Men-Tsee-Khang 2008) similarly illustrates this shift in historical representation.

Besides redefining Tibetan medical knowledge as empirical and scientific rather than mythical and religious,<sup>20</sup> in line with Tibetan medicine's quest for recognition as a legitimate (because "scientific") system of medicine during the 2000s, this move also claimed Tibetan authorship—and therefore ownership—of Tibetan medicine. In this context, questions about Tibetan medicine's historical origins and its present control and ownership are closely linked. What counts as authentic Tibetan medical knowledge, and who has the authority to decide the answer? Until the early 2000s, this was mainly an internal affair between the Men-Tsee-Khang and private practitioners. Soon, however, the efforts leading to Sowa Rigpa's recognition by India, as well as its growing economic value, turned it into a larger issue between the exile Tibetans and other communities, whose Sowa Rigpa practitioners did not share the same educational background, clinical experience, technical terminology, or medical and botanical knowledge. The ingredients and their quantities in a standard Tibetan formula can vary widely between the Men-Tsee-Khang and doctors from Ladakh, not to mention those farther afield in Bhutan or Mongolia.<sup>21</sup> Similarly, plant names, pathology, and the use of external therapies such as cupping, moxa, cauterization, and bloodletting differ among communities, regions, and even individual doctors. Large parts of the exile Tibetan medical community regard this plurality of knowledge with suspicion and tend to interpret non-Tibetan variations from their own knowledge simply as wrong.

Exile Tibetan doctors regard themselves as the ultimate authority over Tibetan medical knowledge outside Tibet, and their calls for the regulation of Tibetan medicine were attempts to claim—or, in their words, preserve—their ownership and control

<sup>20</sup> For a detailed discussion and analysis of the ways in which Tibetan practitioners engage with modern science, see Adams, Schrempf, and Craig 2011b. In that volume, Kloos 2011 deals specifically with the exile context; for earlier articles on this issue in Tibet, see, e.g., Adams 2001b, 2002a, or 2002b or Adams and Li 2008.

<sup>21</sup> That ingredients and quantities also vary among Tibetan institutions in India and Tibet is conveniently forgotten in this discourse but is problematized in the above-discussed drive for standardization.

over it in an increasingly competitive context. This, then, was the objective of the CCTM, which was established to represent and regulate Sowa Rigpa not just among exile Tibetan practitioners but worldwide. The political function of Tibetan medicine in exile is thus not limited to the well-known struggle for a united, modern, and free Tibetan nation. Rather, it also extends to securing Tibetan influence beyond the Tibetan nation through the “soft power” of medical knowledge and practice. What needs to be preserved at this latest stage, therefore, is also a Tibetan hegemony that even now, after more than half a century in exile, has lost none of its self-evidence for Tibetans, who continue to regard their nation as the great civilization and cultural power that Tibet once was.

Like in old Tibet, centers of scholarship and learning constitute the crucial nodes of contemporary Tibetan cultural power. Widely considered the best institutions of their kind outside Tibet, the Dharamsala Men-Tsee-Khang, the Darjeeling Chagpori, and the CUTS medical department in Sarnath attract students from all over central Asia and the Himalayas looking for knowledge and prestige. Exile Tibetan doctors are also frequently invited to countries in this region to share their knowledge or treat high-ranking officials, thus maintaining strong cultural but also economic and political ties that are by no means limited to medicine per se. As mentioned before, the Men-Tsee-Khang has opened several branch clinics in Tibetan border areas, such as Ladakh, the northeastern states of India, and the Solu Khumbu district in Nepal, to strengthen the relationship between Tibetans and the local populations.<sup>22</sup> While this is a welcome gesture in poorer regions like the tribal areas of Arunachal Pradesh, it also evokes ambivalent memories about Tibet’s older hegemonic relations with its border areas. Especially in Ladakh and Bhutan, both of which fought wars with Tibet and were exposed to varying degrees of Tibetan hegemony, Tibetan doctors are often resented for their perceived arrogance but at the same time respected and welcomed for their undisputed knowledge and expertise.

In the face of such historical sensitivities (but also due to financial constraints), exile Tibetan medical practitioners and institutions have to tread lightly, couching their hegemonic agenda in a rhetoric of development aid. According to this rhetoric, the Himalayan medical community has much to learn from the Tibetans, and the Tibetans are happy to share their expertise in the interest of the patients and the profession at large. For example, the Men-Tsee-Khang has a special admission quota for non-Tibetans, and the CCTM (usually in collaboration with the Men-Tsee-Khang and/or CUTS) regularly organizes seminars, workshops, and empowerments that particularly target its non-Tibetan members. Besides that, as just mentioned, senior Men-Tsee-Khang doctors frequently visit all regions within the traditional Tibetan sphere of influence to give talks, free medical consultations, and professional advice. On a smaller scale, the same is true for Chagpori doctors, who maintain long-standing and close relationships to medical communities in Ladakh and Bhutan and who provide free medical care to thousands of poor Nepali patients in the Darjeeling hills area. It is

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<sup>22</sup> See, e.g., the *Men-Tsee-Khang Newsletter* (2004–5) on the opening of a branch clinic in Tuting, Arunachal Pradesh, to serve both Tibetan settlers and local tribesmen who, according to the article, depended on Tibet for all their basic needs prior to 1959 and even today strongly believe in the efficacy of Tibetan medicine. Besides providing basic health care services to this remote area, the explicit rationale was to foster “better understanding and relationship between the two communities.”

clear, however, that the Tibetans—especially at the Men-Tsee-Khang—expect certain benefits in return for their expertise, such as access to medicinal raw materials or official memoranda of understanding that indirectly imply a political recognition of the Tibetan government-in-exile. When these benefits are not forthcoming despite repeated goodwill actions on part of the Tibetans, as in the case of Mongolia and Bhutan during the past decade, this kind of Tibetan “development aid” is temporarily scaled down to a minimum.

As far as the Indian Himalayas are concerned, however, this strategy has worked remarkably well, partly due to the very limited means of the CCTM to wield any actual power over local practitioners there. Besides organizing the above-mentioned activities, the CCTM has managed to register a majority of Sowa Rigpa practitioners residing or trained in India (including Tibetans now abroad and non-Tibetans, such as Ladakhis, Himachalis, and Monpa); establish clear standards for teaching institutions, professional titles, and degrees; and draw up a list of recognized (“authentic”) Tibetan medical texts. With Sowa Rigpa’s recognition by the government of India in 2010, however, the future role of the CCTM is in question, as most of its functions will likely be taken over by the AYUSH Ministry and other Indian governmental bodies. With this, also the exile Tibetans’ control over one of their most important medical, cultural, economic, and political resources is at stake, making its preservation all the more imperative. With the ongoing commodification of Tibetan medical knowledge, the currently beginning fourth phase of preservation will thus be centered on the issues of ownership and intellectual property rights (Kloos 2017).

## 7 Conclusion

It is clear that the preservation of Tibetan medical knowledge in exile was an ethico-political project throughout, which in many ways stood for the preservation of the Tibetan nation at large. Ironically, this project entailed the reinvention of the knowledge it claimed to preserve and the cultivation of the very image of weakness and victimhood that it sought to overcome. In the context of the exile Tibetan struggle for cultural survival, the loss of this knowledge—real or projected, but always fluid in form—served as a powerful legitimation for any act of preservation, regardless of how much it meant changing the very traditions it hoped to hold on to. Thus, in the first stage of recovery and reassemblage, a previously pluralistic Tibetan medical knowledge was singularized and homogenized. In the second stage of diffusion and cultural encounter, a historically political Tibetan medical knowledge was depoliticized, ethicalized, and globalized. In the third stage of standardization and official recognition, this syncretic knowledge of many origins has been repoliticized and portrayed as authentically and purely Tibetan, but also as compatible with modern science and national health bureaucracies. The fourth stage of ownership and intellectual property rights, the beginnings of which we can witness today, involves efforts to preserve Tibetan medical knowledge in the radically new form of property and capital, entailing pharmaceutical commodification within capitalist markets (Kloos 2017).

That exile Tibetan efforts to preserve Tibetan medical knowledge have been successful is indicated not only by the continuing existence and rapid growth of Tibetan medicine but also by its global image as a single, authentic Tibetan knowledge of

healing that is closely related to Tibetan Buddhist ethics. Even though this image is—with good reason—increasingly contested by scholars and non-Tibetan practitioners of Sowa Rigpa alike (e.g., Pordié 2008b: 4; Adams, Schrempf, and Craig 2011a), there is little dispute over the fact that Tibetan institutions and practitioners still dominate the field. In doing so, they are, together with the Dalai Lama and other high Tibetan Buddhist monks and monasteries, at the forefront of exile Tibetan efforts to revive and maintain Tibet's cultural connections throughout Central Asia and the Himalayas—inspired by the politics initiated by the Fifth Dalai Lama in the seventeenth century and pursued, to a greater or lesser degree, by the central Tibetan state until the 1950s. I have suggested that this can be interpreted as an effort to preserve a weakened, but still existing and real, Tibetan cultural hegemony in and from exile.

As with many other types of non-Western knowledge, the political context of Tibetan medicine cannot be reduced to the much-discussed hegemony of an all-powerful modern science over its feeble, nonmodern Other, or a simple dichotomy between “the West and the rest.” Rather, what emerges is a multilayered field of power, in which a distinctly modern Tibetan medical knowledge needs to assert itself against biomedical hegemony from a subaltern position, at the same time as it continues to serve as a hegemonic tool of a cultural empire without a state. This is well illustrated by the shift from the second to the third phase of preservation discussed above: while the former was defined by traditional Tibetan medicine's confrontation with modern science and biomedicine, the latter is now marked by the confrontation of an orthodox, literate Tibetan medical knowledge with even more “traditional” non-Tibetan, often orally transmitted variants of Sowa Rigpa. Of course, it is also clear that these are cumulative phases, characterized more by subtle shifts in emphasis than by radical breaks. Thus, Tibetan medicine's engagement with modern science and its translational work have by no means stopped after the year 2000 but rather have increased, just as the early efforts to recover and reconstruct Tibetan medical knowledge are, in many ways, still ongoing today. Conversely, the opening of branch clinics in Tibetan border areas such as Arunachal Pradesh or Solu Khumbu already had a clear hegemonic rationale in the 1980s and 1990s, and Tibetan doctors have been rejecting Indian attempts to incorporate Tibetan medicine into Ayurveda since at least the 1970s. Similarly, the drive for standardization in the third phase was already anticipated by the homogenization of Tibetan medical knowledge in the first phase, and the Dalai Lama had predicted Tibetan medicine's current economic potential already decades ago.

Contrary to the common rhetoric that proposes the triumph of modern science and the gradual loss of traditional knowledge, we need to take traditional knowledge seriously as an important apparatus of power even today. The politics of such knowledge may not resemble the formal politics of classical political theory, or even the biopolitics or governmentality of an overused Foucauldian analytic. But this is exactly the value of taking these traditions seriously in their own right, rather than simply participating in the modern rhetoric of preservation and loss. Through close scrutiny of what happens to these medical traditions, we gain crucial insights into modes of governance and power that tend to escape the Western gaze but nevertheless shape large parts of the contemporary world.

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