

Tibetan medicine today: neo-traditionalism as an analytical lens and a political tool

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Tibetan medicine today.

Neo-traditionalism as an analytical lens and a political tool

Laurent Pordié

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Notwithstanding a marked increase in academic publications pertaining to the contemporary dynamics of Tibetan medicine in the past two decades, the light cast in this domain by the social sciences is still diffuse and the corresponding studies are scattered.¹ There is no specialized work that thoroughly examines this medicine in diverse regions for a given period and, a remarkable fact, Tibetan medicine has long remained absent from fundamental collective works and special issues of international journals dealing with Asian medicines (cf. Bates 1995, Leslie 1976, Leslie and Young 1992, Pflieger 1988).² The only comparative endeavour was the work by Connor and Samuel (2001), who included in their book three chapters on Tibetan medicine (by Adams, Janes and Samuel) concerned with the Tibet Autonomous Region and exiled Tibetans in India (Dalhousie). This edited volume examines the articulation between the global and the local in various Asian societies in order to account for the way in which modernity is manifested or produced through medicine by means of negotiation, appropriation and transformation. This was the first time that Tibetan medicine appeared in a work on social sciences specializing in Asian therapies. However, studies in comparative anthropology were never extended to the whole of the Tibetan cultural area, even though the first works on Tibetan medicine go back to the end of the 1980s (e.g. Adams 1988, 1992; Kuhn 1988; Meyer 1986, 1987, 1993) and the number of studies subsequently saw an exponential increase.³

This volume therefore occupies a space left vacant by both the anthropology of Asian scholarly medicines and by Tibetan studies. It thus responds to an imperative need for the advancement of research on Tibetan medicine by setting forth in a comparative approach the attention currently given to it in the social sciences and by deepening the knowledge developed up until now. The authors brought together in this book offer a collective reflection on the social, political and identity dynamics of Tibetan medicine in Nepal, India and the People's Republic of China (Tibet Autonomous Region and urban China), in Mongolia and in the West. The comparative perspective presented here obviously exhausts neither the questions relating to Tibetan medicine nor the areas in which it is found. Nevertheless, the subjects broached and the variety of contexts studied provide a heuristic dimension that makes

it possible to obtain a reference image on this theme, as well as to reformulate a number of questions central to ‘traditional’ medicine and to the social and political

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fields of health. This book answers three fundamental questions: What are the modalities and the issues involved in the social and therapeutic transformations of Tibetan medicine? How are national policies and health reforms connected to the processes of contemporary redefinition of this medicine? What interpretive grid can one propose so as to obtain a circumspect understanding of Tibetan medicine in the current global context?

The social, political and identity dynamics, as well as the changes related to practice and, to a lesser extent, epistemology are today affecting Tibetan medicine with an intensity that is unequalled in the modern period (Adams 2001a, 2002a-b; Janes 1995, 2001; Meyer 1993). Tibetan medicine is inscribed in the national and international medical, political and economic fields of contemporary history. It is thus redefined in the course of complex social processes involving state-controlled policies, the logics of a global liberal economy and the renewed aspirations of practitioners.⁴ Moreover, the development of Tibetan medicine for the market brings about a change in medical provision on the national level (Janes 1999, Samuel 2001) and an unprecedented expansion on the international level (Janes 2002, Meyer 1986). Tibetan medicine today has an international character: the places where it is practised, the patients and the nature of therapeutic discourse extend beyond the Tibetan cultural area and idioms.

The anthropological investigation of these phenomena not only accounts for the social construction of this centuries-old medicine, but it also provides information on the societies in which Tibetan medicine is endemic or imported, on the national and international modes of dissemination and on the types of relations it maintains with other health systems and other forms of Tibetan medicine in different geographic areas and among different ethnic groups.⁵ Tibetan medicine must be studied in its plurality: the various areas in which it is found, their history, contemporary health policies, and social, economic and political configurations have shaped this medicine.⁶ These changes correspond to varied contexts and allow over time the rising of socially and, to some extent medically, different medicines. There are, in a certain way, Tibetan *medicines*.⁷ The generic term ‘Tibetan medicine’ tends to give the impression of homogeneity to what in fact remains, anthropologically speaking, deeply heterogeneous. It also contributes to ethnicize medicine and does not reflect the way in which practitioners and populations from various Himalayan and Central Asian regions qualify Tibetan medicine in their own languages. Sowa Rigpa (*gso ba rig pa*⁸), which means the ‘Science of Healing’, is the term used in the vernacular in all of these regions. While making use of Sowa Rigpa in English is linguistically more accurate and sociologically significant in specific contexts, it also constitutes a supplementary generic in a general introduction such as this. In foreign languages, most non-Tibetans, apart from Western practitioners, differentiate their medicine from ‘Tibetan medicine’ for reasons pertaining to medical and social identities: ‘Amchi medicine’ is common in North-west India, ‘Himalayan medicine’ in Nepal, ‘traditional medicine’ in Bhutan, ‘traditional Mongolian medicine’ in Mongolia, or again ‘Buddhist medicine’ is common elsewhere. These terms are constructions essentially directed towards external use. They actually best express the various forms of Sowa Rigpa

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and the plurality of ‘Tibetan medicine’. These qualifications being made, I will use the term ‘Tibetan medicine’ in the remainder of the text to simplify the reading.

In this context, it is expedient to then raise the question of the relations that the diverse types of Tibetan medicine maintain among themselves – in a limited geographic area

(rural/urban) and between geopolitical entities (Nepal/Ladakh or Tibet/Mongolia). In turn, this plurality is involved in the emergence of local modernities. It sheds light on singular situations that make it possible to revise and adapt theories relating to the modern world (Adams 2001a) and to better understand the manner in which populations fashion their period. It also informs on the contemporary 'politics of culture' (Alter 2005) pertaining to Tibetan medicine.

The various forms and expressions of Tibetan medicine reflect sometimes divergent interests, giving rise to and/or underscoring relations of power. They constitute a rich field for the study of legitimating modalities used by the practitioners and their institutions. The processes of social and medical legitimization are at the centre of contemporary changes in Tibetan medicine. Their varied and sometimes conflicting expressions are largely part of the social redefinition of the practice. As shown by Didier and Eric Fassin (1988), the study of the types of legitimacy makes it possible to understand the social manoeuvres implemented by healers in their quest for legitimization. We will see in numerous chapters comprising this book that the implicit goal of the practitioners is to consolidate their social status and, at times, to reinforce their social power. Practitioners may use to their advantage the norms and rules governing the systems, and the situations through which these norms and rules are manifested (Balandier 1974). This process corresponds to an attempt to maximize power in the limits of the existing social order. It also contributes to forging the actors' political identity, which is directly situated in the medical field.

For the requirements of analysis, I will consider this field, in Bourdieu's sense (1980), as an autonomous space of social life structured by power relations between social groups, individuals and institutions. Therefore, societal issues, as characterized by conflicts of legitimacy and identity, also play a role in the medical field. These societal issues allow new places and new expressions of power to appear. The quest for legitimization thus imposes the political redefinition of its basic principles and prompts reformulation of the very question of legitimacy (Fassin and Fassin 1988). In this context, the examination of medical legitimacy must be linked to a study of social legitimacy and the logics underlying it. This approach would therefore be incomplete without focusing attention on the way contemporary transformations of Tibetan medicine pertain to identity, and to the corresponding strategies employed on the individual, collective and institutional levels. As much as, if not more than, the legitimacy of Tibetan medicine and its practitioners, it is also their identity that is called into question. Practitioners attempt to acquire valorized social identities and to reconstruct the coherence of their relation to others in a context of accelerated and increased transformations of social and power relations (Tonda 2001). It is, of course, incorrect to view the changes that result from these contemporary phenomena as simply passive responses to a dominant agent or system (Landy 1974). They are active transformations brought

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into play by the actors themselves (practitioners, but also institutions and entrepreneurs). They broaden and reconstruct the field of Tibetan medicine, while adapting it to new contexts.

This book has a dual purpose. It offers a rereading of Tibetan medicine in the twenty-first century by considering both the contemporary reasons that have led to its diversity and by bringing out the common orientations of this medical system, considered here as a social institution. Several tendencies reflect the contemporary situation: (1) the recourse to external instances of legitimization (such as biomedicine, 'science' or national policies), juxtaposed with traditional orders of legitimacy; (2) the political re-invention of tradition according to historical and/or ecological arguments; (3) the multiplication of activities belonging to therapists, more particularly to those having entered the complex milieu of 'development'; (4)

the industrialization, commoditization and marketing of medicine, and (5) the transnational diffusion of Tibetan medicine and deterritorialization of practitioners and practices. These phenomena may exist independently of each other or indeed intermingle. Although these tendencies assume a particularly crystallized form in the urban medical institutions, it should be noted that they are no less indicative of a general orientation, to which their even partial penetration into rural areas testifies (Pordié forthcoming). This book takes this into account by shifting the analysis from the non-institutionalized milieu to the urban institutional environment in Asia, and then in the West.

These observations suggest a renewal of the ‘grids of interpretation’ that are applied to Tibetan medicine. In this respect, I will consider the categories that are classically applied to medicines by proposing a descriptive model, namely neo-traditionalism, which will serve to circumscribe the contemporary tendencies characterizing Tibetan medicine. It will contribute an additional perspective to the chapters that comprise this volume. Finally, I will conclude this general introduction by briefly examining the book’s structure.

Interlude

An amchi in the city

Impeccably dressed in crimson flannel trousers and a mustard yellow shirt, a Buddhist rosary clasped between the fingers of one hand and a passport replete with visas clutched in the other, the *amchi* from the mountains of the western Himalayas returns to his country after another visit to the United States of America, where for two months he had delivered his teachings on his centuries-old medical art. I meet up with him again at the airport in Delhi. After exchanging the usual courtesies and evoking briefly our earlier encounters, we share a taxi to the city centre.

As soon as we get out of the car, the *amchi* invites me to accompany him to the nearest cybercafé. He wants to check his e-mail immediately. He announces proudly that he is expecting an official invitation abroad. This

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man, who a few years earlier had marvelled at my laptop computer, is today a confirmed internet user. He even amiably makes fun of me when he notices my astonishment at the speed at which his messages appear on screen. ‘You stayed too long in the mountains’, he says, and bursts out laughing. My surprise is total as I observe how the broadband connection seems so familiar to him, an extension of his worn fingers. Had I too fallen into the trap of assumptions regarding the static, backward-looking and inert character of so-called traditional societies?

These societies are often represented like artefacts, museum pieces inspiring vague feelings of loss. Other images depict decadent societies corrupted by the race towards progress or economic growth. Is it possible to view traditional societies in their contemporary state in a balanced manner? How do we avoid romanticizing their supposed ‘tradition’ and lamenting their ‘modernity’, seeing in the former an ideal and in the latter an appalling danger? In any case, that is not where the problem lies; these questions are red herrings for the anthropologist. These are contemporary societies, some of which use or re-invent their traditions in an attempt to better define their role in today’s world. Tibetan medicine may be understood in this way. It is because it is ‘traditional’ that this branch of medicine is so coveted by societies that believe they have lost contact with their origins and the mysteries that go with them. Tibetan medicine ‘speaks’ to the West. This medical language has however been reinterpreted there; it fills a void in both the Western medical and popular imagination.

So, after all, why not the internet for everyone? This mountain dweller with long hair tied in a chignon, a Tibetan physician by trade, a Tantric practitioner returning from the Americas with an ultra-

bright smile and brand new spectacles, who happily gazes at me without being distracted by the Ray-Ban label still stuck to his left lens, why shouldn't he communicate with I don't know which extremity of the planet thanks to a high-speed electronic connection? Why should this man remain trapped in the mountains, an image from a postcard or tourist's photo album, when his role is also to provide remedies for illnesses afflicting people elsewhere? We will accept for now that this is one of the profiles that globalization must assume. This *amchi* cannot be dismissed as inauthentic.

While I am thinking about all the issues that this encounter raises for me, a jumble of thoughts as disorderly as the section above, the *amchi* shakes me by the arm, bringing me back to the present. It's done; he will soon make another trip across the Atlantic. He does not attempt to conceal his candid joy; the diffusion and worldwide popularity of his medicine are a windfall for him.

We set off for a fast food restaurant at Connaught Place, a spot frequented by the trendy youth of Delhi. The *amchi* chooses this place, thinking I will

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enjoy it. As my host, he wants to entertain me in style. I am convinced he would have preferred a plate of momos, but the choice of fast food symbolizes his social status, a status consolidated by his travels. The restaurant's infamous golden arches are emblems of the West. We are even offered a small red and yellow cuddly toy representing the mascot of the international chain, 'for our children'. For a moment, I consider using mine as a voodoo doll before refusing it. Quite manifestly, the *amchi* and I have different perspectives on this type of place. But it doesn't matter; we discuss our common projects and the problems the Indian *amchi* from the rural milieu confront when practising medicine under better material and social conditions and, above all, in perpetuating them. Generally speaking, Tibetan medicine in the remote Himalayas is facing great difficulties in the very areas where it is the primary form of health care and often the only medical provision. This situation has been the subject of diverse so-called development programmes targeting rural populations, but the impact of these programmes has been marginal. My friend, moreover, is very actively involved in a local association devoted to the development of his medicine. Despite that, health development is left in the hands of the overwhelming majority of rural *amchi*. This situation is not found exclusively in the Indian Himalayas, but may be found throughout areas of Tibetan cultural influence.

Paradoxically, while Tibetan medicine today is foundering in the rural regions where it has been established for centuries, it is experiencing an unprecedented prominence at the international level. Its world expansion camouflages the mediocrity of the situation in the rural milieu where it is considered to be most vital. Tibetan medicine is today a global phenomenon. It has become a division of the international industrial edifice of alternative medicines. The development of Tibetan medicine is today characterized by clinical research and pharmacology, pharmaceutical industrialization and mass production of medicines, the modernization of urban hospitals and, above all, by the implementation of export policies. Whether it is a question of Chinese pharmaceutical policies in Tibet, of post-socialist reconstruction of the health system in Mongolia or of programmes involving several million Euros implemented by the European Commission in Bhutan, the fate of Tibetan medicine seems to be doomed to the vagaries of international commerce. Of course, the rural Tibetan world only ever sees scant benefits from this form of 'development'.

This medicine is accordingly produced and reproduced as an international commodity and is generally consumed for its indigenous traditional virtues. It embodies moral (Buddhist) values, and a Tibetan view of the world that exerts a notable seductive power in Western societies. It represents a medical, ecological and social alternative, while the very logics that make this medicine accessible in the West depend upon an ideological and economic

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domination to which its sympathizers would object in principle. This situation is part of the construction of the reality of the Tibetan world and of its medicine. The often idealistic preconceptions that beset them both do not necessarily help them, because they refine the camouflage mentioned above.

The Indian *amchi* listens to me between two mouthfuls of vegetarian hamburger. He seems conscious of the expectations the New World has of him and adds: 'You know, Laurent, I tell them something of what they expect me to tell them. I adapt myself but without, for all that, losing the essence

of my teachings.... What they want to see is the image they have made of me before seeing me. I actually put them in front of a mirror. It is themselves that they see in me... I reflect the ideas they have about the world.' In this way a virtual image of Tibetan medicine is propagated.

What is there to say about this *amchi* who embodies therapeutic globalization and is one of its vehicles? He travels the world to speak of his own world, but his own world today share an increasing number of traits with the World itself. He represents an emerging fringe among the *amchi*, well beyond archetypal descriptions. He belongs to the very influential minority who has achieved a certain degree of social success. These therapists are often regarded as examples by their fellow *amchi*: they convey certain values and ideologies that are disseminated in their community of practitioners. That is how this medical art is in part socially redefined. Tibetan medicine is subject to profound social and practical reconstructions that put to a severe test the classical categorizations that are applied to it.

Tibetan medical neo-traditionalism

The contemporary dynamics of Tibetan medicine seem to defy classical categorization (e.g. Dunn 1976, Kleinmann 1980). However, does that justify the development of another descriptive category? Would the effort of conceptual unification from which it would follow be in vain? It may be that one simply observes therapeutic reconstructions promoted by actors who reinterpret and re-elaborate discourses and practices according to what is made available in a given socio-cultural whole. Yet, as we just observed, there are an increasing number of portraits of Himalayan healers that largely depart from standard descriptions. However, is there really something new that would justify the use of the prefix 'neo' in conjunction with a medicine that was up until now seen as 'traditional'? This chapter provides a few elements in response: neo-traditionalism could thus characterize a diversification of healers' activities and a multiplication of legitimating instances, their proximity to biomedicine on the practical, epistemological and symbolic planes, or the fact that they would be both subject to and participants in globalization (deterritorialization of actors and practices, modern transnationalization of knowledge) and that they would make systematic use of 'tradition' to legitimate new practices.

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Although neo-traditionalism disseminates an image of Tibetan medicine, it is also a concept that makes it possible to develop comparative studies and to propose paths of research. Neo-traditionalism accounts for a modern socio-political phenomenon. That is to say, neo-traditionalism both *describes* the contemporary trends that characterize Tibetan medicine and *represents* Tibetan medicine (as a potential political tool for the healers and their institutions). Neo-traditionalism involves various domains of medicine (ideology, practice) and modulates the political and social behaviours of the actors. It thus participates in the social construction of Tibetan medicine. Neo-traditionalism does not only elucidate, and contribute to, social transformation; it is also involved in gradual medical innovation. While the changes are just perceptible in the latter domain, we will see that neo-traditionalism fosters innovation.⁹

Let us make an initial comment. Even though it would sometimes be used in the literature the concept has never been fully developed in the study of health systems. For more than two decades, anthropologists have observed the emergence of 'new healers', 'syncretic' healers and 'neo-TM practitioners', the proportion of whom among all healers is today increasing in a remarkable manner. There are healers who use biomedical products, concepts

or symbols to legitimate their practice and assert their identity (Bourdarias 1996, Gruénais 1991, Leslie 1992, McMillen 2004, Wolffers 1988), members of the biomedical profession who use so-called traditional practices (Barges 1996), health practices that emerge from drawing a parallel between, or from the integration of, non-biomedical therapies and treatments related to an alleged tradition (Ghasarian 2005), in which the notion of ‘energy’ can become central (Benoist 1996, Schmitz 2005). Today, these new healers cannot be ignored in the therapeutic field (Le Palec 1996). Gruénais (2002), for example, taking up again the chronological classification by Last (1986), sees among these new healers a ‘third generation’ of healers in Africa. The latter reconstruct their practice without necessarily having recourse to biomedicine, but they are nevertheless in direct competition with it on the social, geographic and economic planes.¹⁰ The study of these new healers reveals many other types of combination, borrowing as much from the medical as from the social and political domains. The list is long.

Their emergence is generally understood to be a product of cognitive, practical, social or political developments inscribed in the continuity of a medicine or of a given medical field. The essays collected in the recent book *Asian Medicine and Globalization* (Alter 2005) open up a fruitful avenue, examining the relationship between medicine and the national and transnational politics of culture, at the level of both the production of medical theory and the modern transnational flow of knowledge. These healers may also be viewed as showing new syncretic models that have become gradually independent of the systems from which they arose (e.g. Ernst 2002). Syncretism has moreover been understood by some authors as the continuation of a tradition in itself for a particular medical system. However, these *bricolages* of practices – hybrid therapeutic knowledge – and the renewed identities of these ‘new healers’ have not until now involved new descriptive categorizations in medical anthropology.

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In the case of Tibetan medicine, this situation indicates a very clear caesura between diverse types of practitioners within one and the same system. This caesura is straightforward and the reconfiguration of the therapeutic field (on local and global levels) that is engendered is profound. Modern institutionalization, the globalization of medicine, the appropriations of medical paradigms or the change in legitimacy thus account for the transformation of Tibetan medicine, characterized by rapid and fundamental changes (acceleration of social transformations, new directions). They have thus given rise to a new category of practitioners of Tibetan medicine, whom I propose to call ‘neo-traditional’.

It is important to make clear that in what follows the term *neo-traditional* will mainly serve to qualify these new practitioners of Tibetan medicine and to distinguish them from their counterparts. *Neo-traditionalism* will be used to describe and circumscribe the social phenomenon – and its political ramifications – in which these new healers participate. In our case, neo-traditionalism is distinct from what Croizier calls ‘pure traditionalism’, a traditionalism that rejects what comes from Western science and medicine (Croizier 1976: 344). However, neo-traditionalism shares similarities with some forms of traditionalism involved in medical revivalism, such as promoting and making use of tradition while engaging in modernity, but it is not restricted to it. We will see that neo-traditionalism revisits and opens up traditionalism; it is rooted in and legitimized by tradition but it welcomes and provokes change and innovation. Its scale goes from the most localized areas to the wider global arena.

Change, identity and new practitioners

There is a strong identity dimension in the emergence of neo-traditionalism. A fringe of the medical élite today masters the art of expressing Tibetan medicine in terms of identity, not only among the Tibetans dramatically affected by China, but also in Mongolia, Ladakh or in upper Nepal. However, Tibetan medicine's neo-traditional practitioners are not individuals with a weak legitimacy in their community. On the contrary, they generally come from legitimated milieux – by tradition (family, lineage) or institutionalization – and benefit from a high recognition. The situation consequently differs quite significantly from African medicine in which the 'new healers' seem to have suffered individually from a lack of legitimacy (Gruénais 2002, Tonda 2001).¹¹ Fassin observes in this regard that the therapists who have the least traditional legitimacy attempt to gain new forms of legitimacy (rational-legal) by positioning themselves on new terrains and by playing according to new rules (1994: 351).¹² For this reason, some Africanists use the adjective 'neo-traditional' in quite a pejorative way. Neo-traditionalism easily signifies imposture (cf. de Rosny 1996), thus condemning traditional practices to a certain inertia.

This is not the dominant tonality of neo-traditionalism in Tibetan medicine. These men and women are genuine therapeutic figures of modern times. In addition, while the identity strategies are borne by particular individuals – who thereby unquestionably consolidate their social status – these strategies also stem from institutions.

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The identity to which I refer always ultimately has repercussions on the identity of the medicine. The identity claims concern the status of medicine as a social and medical institution, as well as the status of the whole community of practitioners or, in the case of the exiled Tibetans in particular, of the nation.

The transformation that neo-traditionalism both accounts for and engenders has a bearing on the *categories*. Tibetan medicine is both 'traditional' (in Tibet, Ladakh, Bhutan) and alternative (in Europe, the USA). The schematic descriptions to which systemic analyses give rise no longer allow that this medicine be explained as a *traditional* or *local system*.¹³ The therapeutic field not only becomes blurred and more complex on the world scale, but also on the local scale. Although practised exclusively by the inhabitants of the regions of Tibetan culture, it is no longer exclusively theirs. A schism of classical diagnostic categories could be added when this medicine is delivered through the internet. Neo-traditionalism also involves an historical dimension. The actual situation exhibits unique characteristics in the development of Tibetan medicine since its genesis. The rapidity with which the changes occur, the magnitude of the geographic diffusion of medicine and the role that it obtains in the international health scenario are major characteristics.¹⁴ The next caesura is social. The knowledge and ambitions of neo-traditional practitioners, who are generally boosted by an urban institutional environment, reinforce the subordination of their fellow practitioners, who are usually located in the rural areas. The existing congruence between social power and the forms of knowledge acquisition (institutionalization) thus appears very clearly among neo-traditional practitioners. Their aspirations go far beyond the (Tibetan) medical field. Neo-traditionalism today accounts for a very pronounced demarcation between healers. This divide pertains not only to medical erudition or techniques, or even to social status, but more generally to the *space of possibilities* that opens up to neo-traditional healers, inside or outside of their medical field, their regions of origin and their societies. However, the coexistence of classical, village-based healers and their neo-traditional homologues generally does not pose problems.¹⁵ On the contrary, although they tend to be hierarchically ordered, each type of

practitioner legitimizes the other: while most village-based healers become in a way guarantors of tradition (a central legitimating instance for the neo-traditional healers); their neo-traditional fellows embody a valued form of social success and are more directly equated with the exigencies of modern society. The contemporary success of the latter benefits the image of Tibetan medicine and its practitioners as a whole. As suggested, the change also potentially concerns, to a lesser extent, medical epistemology. Through exploring the space that is offered to them, the neo-traditional healers may be innovative and creative in the therapeutic field. As we will see below, they attempt to build ‘epistemological bridges and shortcuts’, without necessarily being disturbed by the incoherence therein.

Characteristics of neo-traditionalism

I do not suggest that there are currently uniform categories of practitioners of Tibetan medicine, or even that the neo-traditional practitioners would be homogeneous.

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However, neo-traditionalism in Tibetan medicine characterizes a new type of élite that has arisen in a new socio-political and economic environment. These therapists are practitioners who are generally institutionalized (associations, medical centres, government structures) in urban areas or located near urban centres and the social and political life of towns. They belong to a relatively well-educated fringe and often have a good command of the English language. Belonging to nationalities issuing mainly from the Himalayan chain, a tiny minority also comes from the West. These practitioners are regularly present on the political medical scene on the regional and/or global level. Although this is in itself nothing new for the Tibetan medical élite, apart from its global perspective, the political role of these neo-traditional practitioners is significant. As we understand it, neo-traditionalism grants a better political representation to Tibetan medicine. This characteristic does not suffice to define neo-traditionalism,¹⁶ but explains it to a large extent.

A fundamental characteristic of neo-traditionalism concerns the *appropriation* of ideologies and epistemologies, the use of modern rhetoric and practices that are, at least initially, foreign to Tibetan medicine. The clearest example is that of biomedical science (concepts, apparatus, discourses). One could cite the use of the sphygmomanometer or of the ultrasound scan along with the traditional urine analysis, the emergence of biomedical concepts (immunity translated in humoral terms), the renaming of diseases according to biomedical terminology, the practice of clinical trials and so on.¹⁷ Banerjee, for instance, used the term ‘neo-traditionalism’ in relation to biomedical science to refer to the emergence of ideological movements involving Ayurvedic medicine at the time of colonial modernity in India (2004: 89). The ‘traditionalists’, wanting to preserve the purity of the tradition as it is, confronted the ‘neo-traditionalists’, for whom the only way to preserve tradition was to make it conform to the modern orders of legitimacy, in particular reflecting biomedical authority.

Science is a tool used by neo-traditional Tibetan medical practitioners for ‘confirming’ the validity of Tibetan medicine as a science in itself.¹⁸ These practitioners may also intend to show that the theories and findings of biomedical science were somehow anticipated in Tibetan medicine. In other words, they reverse the legitimizing principle mentioned above: indigenous medicine is then understood as validating modern science.¹⁹ Generally speaking, the *rapprochements* with biomedicine and, in particular, the establishment of scientific proof, when it is the case, lend Tibetan medicine a presence superior in the global scenario. The normative dimension of science also tends to reduce differences between medical systems. In

short, we witness a process of withdrawal from the *medical culture* that consequently allows *medicine*, as a category, to appear more clearly. This process, by making Tibetan medicine more universal, favours all the more its commercial development on both national and international levels (Pordié 2005).

However, the principle of appropriation does not happen only with respect to biomedical science and ideology. Some individuals trained in Tibetan medicine do not hesitate to integrate theoretical or practical elements from other types of non-biomedical therapies. There are Tibetan doctors who practise Chinese

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acupuncture or offer Reiki and ‘singing bowls’ healing sessions together with their medicine, and Western practitioners of Tibetan medicine who combine in the same manner various alternative approaches to healing with their own. Conversely, other practitioners, including biomedical personnel, may integrate what they consider to be Tibetan medicine (or ‘Tibetan medical philosophy’) into their practice as an attempt to bring new, alternative approaches to health care.²⁰ This trend gives a new tinge to Tibetan medicine and facilitates its entrance to the ‘mystic-esoteric nebula’ (Champion 1994) of the New Age milieu in the West (see Vargas, this volume).²¹ These medical practices embody ideologies that attempt in particular to evade the individualism and formidable materiality of industrial societies. While their status was once located at the cultural periphery of Western societies, these healing practices have today become increasingly closer to the centre. They convey a morality of being and well-being. This morality is based on holistic, energy-based, even transcendental, and generally pro-environmentalist, medical discourses.

The appropriation of environmentalist narratives and precisely the idea of nature as aesthetics central to medicine also constitute a main feature of Tibetan medical neo-traditionalism. The idea that people living in distant places from Western powers and Western cultural norms are closer to nature has particularly marked out the Orientalist discourses (Clarke 1997). As far as Himalayan Buddhists are concerned, their religion is commonly perceived as compatible with conservation and environmentalist agendas.²² Buddhists are generally thought to be inherently ecologists (Huber 1997). Such discourses are today adopted by the neo-traditional practitioners of Tibetan medicine and translated into medical language. The integration of ideas concerned with the benefits of medicine as ‘natural medicine’ devoid of secondary effects and near to the ‘natural’ functioning of the body reflects this tendency. ‘Environmental awareness’ is a modern production, the appropriation of which in the medical field of traditional societies is facilitated if it is established on a basis that is meaningful for local actors. In this respect, the five elements theory in Tibetan medicine and the resulting similarity between microcosm and macrocosm allow a closer connection of the medical discourse to certain holistic ideologies that are prevalent among ecology movements. In Ladakh, the omnipresent mountains, where the basic essentials of plants and minerals are found, is the archetype ‘of nature valued as good and pure’ (Dollfus and Labbal 2003: 94), which also greatly facilitates the shifting of nature to the medical sphere. Beyond the merging of traditional conceptions and relatively recent concepts, these discourses are elaborated in counterpoint to the structural and therapeutic ‘violence’ of biomedicine, both in the East and West.²³ They favour natural treatments, the ‘taking into account of the individual in his totality’, and underscore the importance of the relation between patient and therapist in the healing process. The Tibetan medical discourse turns towards the patient and tends to redefine his relationship to healing as well as to the body/bodies.²⁴ It is directed at the behaviours of users and is manifested through Buddhist ethics and the related modes of relation to others and to the environment.

The ecology of the theoretical medical foundations mentioned above therefore also results from a principle of accentuation – and/or distortion – of existing

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characteristics of Tibetan medicine. The same is true for external and manual therapies pertaining to re-invented traditions in the East,²⁵ to Tibetan treatments with minerals and crystals in the West, and to the practical reinterpretation of massage (*bsku mnye*) as described in the classic texts. This kind of *selective accentuation* is very typical of neo-traditionalism. In this light, neo-traditionalism also reappraises the relation between medicine and religion. The growing market of Tibetan medicine in the West and for Westerners is largely based on a practice that accentuates very adroitly the presence of religious foundations. Some authors have thus emphasized the display of symbolic religious objects (i.e. *thang kha*) and the contemplative mood or the quasi-monastic atmosphere that is to be found in the clinics in this context (Janes 2002, Samuel 2001).²⁶

The media are also instrumental in diffusing partial, approximate or distorted images of Tibetan medicine, along lines which unwittingly reflect neo-traditionalist features. The media propagate neo-traditionalism and make it more real than the real thing. ‘Tibetan medical spirituality’, ‘Tibetan crystal therapy’, efficacy of ‘natural’ medicines for certain ailments, inherent ecological ethics of medicine and its practitioners are some recurrent themes alternatively or simultaneously put to the fore, so as to meet the desires and fantasies of both the users and the market.

However, we should bear in mind that the emphasis of a presumed spiritual dimension in Tibetan medicine may also be combined with the de-contextualization of the practice from its religious foundations (through science). The ‘scientific tradition’ and the ‘religious tradition’ can be used by practitioners of Tibetan medicine according to context as instances of legitimization and identity (Pordié 2003). They make acceptable, respectively, the withdrawal and the underscoring of religion. Thus, neo-traditionalism, by borrowing from multiple orders of legitimacy, makes it possible to reconcile ostensibly contradictory characteristics (scientific medicine/spiritual medicine). The pharmaceutical industry typically combines these aspects. The search for new products derived from Tibetan medicine is scientific (clinical trials, screening of isolatable active principles). Marketing and packaging then combine this modern scientific character (legitimizing tradition at the same time) with the myth of Shangri-La and the whole esoteric dimension that goes with it. In the West, Mainland China or in Tibet itself, this kind of strategy favours selling to consumers who want to take with their medicines a portion of Tibet itself.²⁷

Indeed, neo-traditionalism is found in the pharmaceutical milieu, which revisits the tradition through new galenic methods and sometimes modifies the ancestral formulae, or creates ‘new ancestral formulae’, so as to facilitate market penetration. The legitimating order of these new products is precisely the ‘medical tradition’ to which they supposedly belong. The ‘remedies’ can therefore also have a neo-traditional character.²⁸ The same holds for the reformulation of the contents of contemporary institutional training, which discards in some instances modules involving the preparation of medicines, and incorporates elsewhere rudiments of biomedicine (Garrett 2005, Adams and Li, this volume, Janes and Hilliard, this volume, Millard, this volume).

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Thus, neo-traditional Tibetan medicine is partially or largely a reconstructed medical practice. These combinations lead to new discourses, knowledge and practices, the legitimacy of which, for its part, rests explicitly on the therapeutic tradition, whether real or invented.

Neo-traditionalism is based on tradition as much as it allows the tradition to be legitimated. It is also for this reason that neo-traditionalism, which arises from and accounts for a multiple schism in Tibetan medicine and which largely borrows elements foreign to 'tradition', stands in a relationship of continuity with the latter.

The next order of central characteristics of neo-traditionalism extends these principles. It is a matter of *multiplication and diversification* of the medical practitioners' activities.²⁹ The physicians of today must be, undeniably, more so than in the past, technicians and specialized bureaucrats (health care, development, research). They diversify their activities and redefine their social role. They are involved in the defence of intellectual property rights relating to medicinal plants (Pordié, this volume); they become environmentalists and intervene in the framework of conservation (Aumerrudy-Thomas and Lama, this volume). They depart from the field of medical technique to act as developers (Craig, this volume). This extension of the domain of classical (therapeutic) activity to that of development – in which conservation, indigenous rights, and health care fall – ensures that healers gain or consolidate their social status. As for those in responsible positions in associations or specific programmes, development facilitates entry into a fringe of the urban intellectual élite. Although these are also conditions to enter 'development' (higher education, social network and status), they are originally circumscribed within one particular field, here Tibetan medicine. The particularity of development is that it confers recognition on a larger scale, beyond the (social and technical) boundaries delimiting the original field. The multiplication of activities of neo-traditional healers shows the capacity of (individual) subjects to be recognized as social actors.

As the case of development indicates, neo-traditionalism accentuates the larger social networks (Castells 1996), rather than the very group of origin, as the main structural concept. This appears all the more clearly in its following characteristic: the *trans-nationalization* and the physical or virtual (internet) *detrterritorialization* of Tibetan medicine (institutions, practices and practitioners).³⁰ The most reputed practitioners traverse the world to give lectures and seminars, even at elite universities; clinics of Tibetan medicine are established in various European countries and in America; the origin and the places where Tibetan physicians practise no longer reflect the 'ethnographic Tibet' (See in this volume the chapters by Millard, Tokar and Vargas); medicines are dispensed subsequent to virtual consultation. By moving around geographically, Tibetan medicine changes status. Once an indigenous medicine, it becomes an alternative medicine. Such aspects have been underscored by Miccolier (2004), through a study of the international diffusion of the religious form of Chinese *qi gong*. This author shows how this diffusion relies, on the one hand, on the representation on the internet of *qi gong* schools and masters and, on the other, on the establishment of social networks.³¹ Miccolier describes the process of transnationalization as a

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circular phenomenon of 'detrterritorialization' and of 're-territorialization' that is also relevant in the case of Tibetan medicine. First, the practice is transformed according to 'contextualities' and follows an intrinsic logic of global practices and local significations. Second, this international diffusion grants the practice social status from which it benefits back home (ibid.). Indeed, Tibetan medicine takes various shapes and meanings according to locations and conjectures, and its international popularity confers on it a new order of legitimacy in numerous countries where it is endemic or very ancient. Alter moreover shows in the case of Asian medicines how 'transnationalisms, in highlighting links or possible links, either destabilize medicine as a category or complicate its structure, function and meaning' (2005: 16).

The neo-traditional healers not only contribute to the diffusion of medicine (as a total and unfragmented entity) but also, and perhaps mainly, to the diffusion of some key and selected concepts, to behaviours, to imaginative worlds concerned by a particular medical tradition. Hence, while it is true that the market for Tibetan medicine dramatically increased during the past decade, it is not only medicine per se which is marketed but also a way of life that goes with it. This way of life then becomes another commodity to consume and sell (Lau 2000).

I mentioned earlier the new international scope acquired by Tibetan medicine (diffusion, therapeutic validation, international clientele), and the way this 'universalization' strengthens the very category of medicine, but it must be said that it does not, for all that, completely replace the culture that a given 'medicine' embodies. On the contrary, it also diffuses fragments of culture, such as a certain *Lebensphilosophie*.³² As already noted, the combination of science and Tibetan culture is not only favourable to the introduction and success of Tibetan medicine in the international market of alternative medicines, but furthermore it gives substance and magnitude to identity claims. This linkage is adroitly mastered by neo-traditional practitioners (Pordié, this volume). Neo-traditionalism contains the necessary elements to foster regionalist and nationalist claims. Thus, a nationalist tonality readily coexists with the universalist ideal in the new forms of Tibetan medicine.

Towards a descriptive and political category?

What I propose in this text gives a representative idea, without, however, claiming to be comprehensive. The analysis is confined to Tibetan medicine and must not be extrapolated without adjustments or revisions except, perhaps, for Asian scholarly medicine – and that too only with extreme prudence. Not all terms characterizing neo-traditionalism have been exhausted and neo-traditionalism is only one possible way for interpreting the contemporary tendencies in Tibetan medicine. However, although it does not involve all locations and forms of Tibetan medicine, the penetration of therapeutic neo-traditionalism as a social fact becomes increasingly prominent. It must also be said that however significant neo-traditionalism may be for the anthropologist, it does not always imply dramatic changes in the practice (and even less so, theory) of Tibetan medicine. The degree

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to which medicine is transformed or affected may vary from one context to the other. Furthermore, the neo-traditionalist features I described do not mean that neo-traditional Tibetan medicine is a diluted form of a more authentic Tibetan medicine. Therapeutic neo-traditionalism is indicative of the course and development of Tibetan medicine, as much as it reveals the social transformations surrounding medical practice. The fields in which neo-traditionalism is manifested contain the medical system but are not limited to it. This descriptive model can be of help in understanding Tibetan medicine today.

Neo-traditional practitioners are the best placed to respond to the actual challenges of their medical system, being located precisely at the interface of the societies of Tibetan culture and the worlds that encompass them. They are able to make connections between and actuate contradictory and/or distant sectors. A few fundamental characteristics have been included in this chapter: individual, collective and institutional inflection of neo-traditionalism; multiplication of practitioners' activities; complete or partial appropriation of modern ideologies and rhetoric (environmentalism, development), and of medical practices and, to a lesser extent, epistemologies (biomedicine and 'alternative medicines'); selective

accentuation of existing characteristics, such as the reorganization of religion around medicine; trans-nationalization and deterritorialization of practices and practitioners; and development of information and communication technologies.³³

Neo-traditional practitioners and institutions thus mobilize diverse orders of legitimacy, borrowing as much from the ideologies of modernity as from science or from the ancestral ethic and moral foundations of the medical practice. The types of legitimacy are also multiple according to the levels with which they are concerned and on which they are based, ranging from the local to the global. Neo-traditionalism both induces the actors to find new modes of legitimization and highlights them. However, neo-traditional practitioners systematically use tradition in their quest for legitimization and refuse to break with it. Conversely, they in return are instrumental in legitimating it. The tradition to which they refer can be geographically and temporally distant, localized or universalized, real or invented. Types of legitimacy meet, but today they always include references to a certain 'tradition'. This, and the fact that the neo-traditional healers practice, above all, Tibetan medicine and are generally grounded in their communities of origin, is the reason why neo-traditionalism is perceived as a continuous process in the evolution of the system.³⁴

The neo-traditional actors construct and reconstruct their medicine, not with the aim of radically changing it or in order to create a new therapy, or even simply to improve it, but so as to meet political and economic, individual and collective objectives. Neo-traditionalism is therefore intimately enmeshed with issues pertaining to the social and medical identities of both the practitioners and their medicine. It gives rise to strategies of identity that materialize in the mixing of domains that are mutually exclusive in terms of classical socio-epistemological orthodoxies (Tonda 2001). Neo-traditionalism helps to mitigate a certain deficit of social and medical legitimacy of the medicine-as-institution, which does not, as noted above, refer to a lack of individual legitimacy within the community of

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practitioners. Furthermore, the identity dimension which is involved in the rise of neo-traditionalism also consolidates the latter: every register of medicine brought into play by such healers subsequently becomes a pole of identity for the whole community. Neo-traditionalism fashions a space of collective representation, which is also a relational space that reassures the practitioners and gives them new points of reference in contexts where Tibetan medicine is challenged.

Neo-traditionalism also renders Tibetan medicine compatible with other cultures and other worlds, without for all that renouncing its anchorage in its identity, culture and history. In this way, it possesses a certain political dexterity in gaining access to new geographical and identity territories. The role of the media and of new information technologies is here very central and relays neo-traditionalism. Neo-traditionalism forms a new category for the classification of medicine that makes it possible to circumscribe certain attributes of so-called 'postcolonial' sciences. Therapeutic neo-traditionalism goes beyond boundaries and reappraises orthodoxies.

Neo-traditionalism is both a descriptive tool for analysis and a socio-political phenomenon participating to the global development of Tibetan medicine, as it combines economic growth, legitimization of tradition, cultural preservation and relative localization of power. It represents a modern type of relationship of authority and legitimization. Neo-traditionalism is not content to challenge and transform political behaviours; it also affects the social structures of Tibetan medicine. It modulates the loci where power is expressed and gives rise to new power relations. Neo-traditional practitioners indeed constitute an influential and decisive élite. They are veritable men and women of power.

We may therefore ask if Tibetan medical neo-traditionalism of today does not foreshadow Tibetan *traditional* medicine of tomorrow.

The book in a nutshell

The preceding sections have gone through the book by contextualizing or developing some of the texts comprising it. It is therefore now time to briefly present the sequence and specific content.

The first part of this volume explores the modern institutionalization of Tibetan medicine in Mongolia, Nepal, The Tibet Autonomous Region, and Mainland China, with a special emphasis on legitimization and identity. Institutionalization comprises here the logics of both governmental structures and contemporary associations of healers. It is a process that produces the neo-traditional élite. The chapters comprising this section show how institutionalized Tibetan medicine leads to a modification of the types of legitimization, and how these new legitimization modalities create new relationships between practitioners on the one hand, and medicine and the state on the other. The role of individuals in the construction of their future within their institutions is also explored in these chapters and, by the same token, in the construction of the future of their institutions. Craig Janes and Casey Hilliard use a comparative approach to show how the historical events in Mongolia and Tibet in the context of late twentieth-century capitalist development and

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post-socialist state processes have produced distinct local medical traditions and thus different identities. As for medicine in Mongolia, about which very little has been known up until now, these authors show how this re-invented tradition is today particularly intended for the global market. This comparative view highlights the degree to which global-level forces – economic and ideological – as transformed by state constructions of science and national identity, affect the training, practice and accessibility of Tibetan and Mongolian medicines on the local level. The question of identity is central in the chapter by Sienna Craig. She studies the professionalization of the Nepali *amchi* through the ethnography of a practitioners' association. The effort of construction and explanation the *amchi* undertake regarding their professional identity reveals the weakness of their position in the nation-state. This author thus shows how practitioners in Nepal are reshaping their collective identity as healers, as Nepali citizens, and as practitioners of a Tibetan healing system. Chen Hua concludes this part by describing the nature and modalities of the diffusion of Tibetan medicine in various regions of the People's Republic of China. This chapter does not constitute a theoretical reflection on Tibetan medicine but should be taken as a representative documentation of Tibetan medicine, to which this volume provides further problematization and political nuance.³⁵ This contribution contains, however, precise and detailed factual materials that were not readily accessible until now, partly because they rely on literature in the Chinese language.

Part two explores the politics of knowledge in the Tibetan world. Vincanne Adams and Fei-Fei Li study the significance and practical realities of 'integrative medicine' in the context of Lhasa's Mentsikhang (*sman rtsis khang*) efforts to survive in the climate of creeping biomedicalization. The authors are interested in the areas in which medical theories, practical knowledge and epistemologies conflict,³⁶ as well as in the domains in which the political and economic imperatives of biomedical modernity tend to dramatically affect the practice of Tibetan medicine. Based on a perspective that is first historical and then

epistemological, the authors examine the meaning, practice and consequences of medical integration in the case of diagnosis, therapeutic treatment and the interpretation of results. While integration can appear in a quite naïve way to be a valid means of medical synergy (cf. Lee 2001), in reality, the encounter between biomedicine and Tibetan medicine generally takes place to the detriment of the latter. The encounter is systematically expressed in a normative framework in which the scientific markers are intended to delimit the realm of possible actions. The singularity claimed by Tibetan medicine is first advanced, to then be gradually swallowed up and diluted in clinical practice. In this context, the idea of *medical disintegration* appears to be more appropriate.³⁷ In Tibet, ‘the effort to integrate in Lhasa’s Mentsikhang most often means adopting biomedical standards and authority and eliminating perceptions that Tibetan medicine is capable of advancing on its own, by its own rules or standards’ (Adams and Li, this volume). Although biomedical epistemology is in no way wholly accepted by the practitioners of Tibetan medicine, and generally not considered as an absolute truth to which the relative truth of Tibetan medicine must be subordinated, biomedicine fulfils its normative function. The complex and non-egalitarian nature

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of medical integration thus devalues this Tibetan medicine. This chapter indicates the precariousness of the Tibetan medical identity in contemporary Tibet, as well as the new forms through which it reveals itself when confronted with biomedicine. The chapter that I wrote also investigates the encounter between Tibetan medicine and biomedicine, and the way biomedical power is locally domesticated in the context of bioprospection. This study is concerned with bio-pirates, imaginary pharmaceutical industries and the (at times virtual) theft of medical knowledge in India. In this country, a series of measures bearing on the utilization, protection and preservation of phytogenetic resources and related knowledge have been established. Intellectual property rights regimes are one such measure. This national movement has repercussions throughout the land, including Ladakh, a region of the north-west Himalayas. However, although the local protagonists agree to follow the national policy, they redefine its meaning and purposes to serve their interests on the levels of their community and of national society. This chapter is therefore concerned with questions of social, ethnic and medical identities, which are expressed through ‘hijacking’ a relatively new subject in the field of medicine in Ladakh: intellectual property rights. This situation must not be understood as a product of modernity but as a conjectural element favourable to the introduction of Tibetan medicine to modernity, which has in turn the power to transform modernity. In Both Craig’s and my chapter, the *amchi* hold off the force of external and dominant powers – medicine, state, religion – over their own world. They endeavour in these contexts to consolidate their community and/or individual power, to affirm their ethnicity and their medical identity. In these cases, indigenous medicine is an effective means of expressing medical and social identities in societies dominated by other health care systems and in which the non-Hindu minorities are largely marginalized. These *amchi*, in Dolpo or in Ladakh, must however combine a particular identity in their country, Buddhist but Nepali or Indian, with a medicine known and recognized as Tibetan. The actuation of a Tibetan medical identity, of minority ethnic and religious identities in Nepal or in India, and a national identity in each of these cases, characterizes these therapists. To conclude this part, Aumeeruddy-Thomas and Lama explore the manner in which Tibetan physicians in a region of upper Nepal have entered, at a particular point in global conservation history, into certain forms of partnership with local and foreign conservationists. They examine how the process of forming these partnerships has created new social dynamics. Such an encounter between different worldviews, knowledge systems and practices carries various epistemological and social implications. In this context, the authors study the reciprocal redefinitions of practices and

representations between the *amchi* and the team of an environmental conservation project. While this approach is essential to elaborate, community-based conservation programmes (Law and Salick 2006), Aumeeruddy-Thomas and Lama also show how that the idea of ‘local knowledge’ is reconstructed in the process, and examine the consequences of this reconstruction in the practice of conservation and the future of Tibetan medicine.

This encounter between global politics and local practices ushers in the final part of this book, where we deal with the relations between the West and Tibetan medicine.

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The chapter by Colin Millard provides a reflection on four domains in which Tibetan medicine must adapt itself in the United Kingdom: the legal domain, the socio-economic and political environment, ‘medical ideology’ and clinical practice. This author provides a detailed analysis of what persists in Tibetan medicine, or is reinforced, and what is transformed, or disappears. This chapter revises the idea of monolithic ‘traditional’ Tibetan medicine by offering a framework for comparison with the practice of medicine in a particular context in Nepal. It shows not only the perspicacity of the actors in defining a new form of political efficacy for Tibetan medicine, but also the plasticity and the tolerance of Tibetan medical paradigms (Meyer 1987, Pordié 2007). Such tolerance is largely explored in the West, as Ivette Vargas shows by reviewing the transformation of Tibetan medicine in the American state of Massachusetts. The medicine becomes energy-based, it overlaps with the nebulous domain of Tibetan spiritualism and is reconstructed through additions of therapeutic practices. This chapter approaches in particular the scene of alternative therapies (and therapists) at Harvard University, where heterodoxy appears to prevail. This situation accounts for the composite tendency in North America in terms of ‘alternative medicines’. Tibetan medicine becomes there a ‘holistic medicine’, particularly calling to mind the discourses of the millenarian movements. This part concludes with a chapter written ‘from the inside’ by a Western practitioner of Tibetan medicine. Eliot Tokar firmly takes side. He rejects the current approaches to the integration of Tibetan medicine into the modern medical industrial complex, which subjects this branch of medicine to certain corrosive vagaries of globalization, especially in the form of bio-piracy and the hegemony of biomedicine. Based on his own Tibetan medical practice in New York City, the author enquires in particular about the rapprochements between Tibetan medicine and the industry of Complementary and Alternative Medicines (orchestrating especially the ballet of dietary supplements and nutraceuticals). Tokar shares his opinion on the social, moral and medical significance of the transformation of Tibetan medicine in the context of American normative public health policies. In this context, this chapter shows the manner in which the author/practitioner views and constructs his neo-traditional practice, so as to evolve a medicine that is, as far as its legitimization is concerned, traditional. Most significantly, he further shows how his clinical setting advances the translation of Tibetan medical concepts and terminology in a way that is intended to be both faithful to its theory and that makes it accessible and useful to the broad spectrum of patients living in New York City. This section offers a fundamental perspective on ‘Tibetan-medicine-as-a-medical-alternative’ and on the profound social modifications of which it is a reflection.

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This book thus opens up several research paths. It marks out trails that we may follow to the end, but which quite distinctly clear prospective avenues for the researcher, the student or the informed layman. The encounter of social sciences and Tibetan medicine set forth in this book hopes to contribute in a constructive manner to studies on Asian medicine. Tibetan medicine has never before been the subject of such a broad collective reflection, even though today it plays a role that

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is far from being socially and sociologically insignificant on local and international levels. Moreover, Tibetan medicine has been undergoing for more than a decade a development that is as remarkable as it is ambivalent. One witnesses today the entrance of this medicine into a major new period in its history. Its popularity, the magnitude of its diffusion and its international dynamism indicate a very clear change of scale and a no less considerable change of course. The golden century that Tibetan medicine experienced from the second half of the seventeenth century (Meyer 1997) appears to repeat itself at the beginning of the twenty-first century. But it remains to be seen if the gold in question should still be understood metaphorically, or if the literal sense will prevail at the risk of Tibetan *medicine* itself.

Notes

¹ Despite their fundamental interest for our research, I intentionally omit works on history, philology and medical theory that do not directly concern the subject of this book (e.g. Avedon *et al.* 1998; Finckh 1980, 1985, 1994; Garret 2006; Gyasto 2004; Meyer 1981, 1987, 1990, 1992a-b, 1995; Parvionovitch *et al.* 1992, Rechung 1973).

² I will forgo in this introduction a detailed review of these important works on Asian medicines, in particular what they have provided in terms of epistemological understanding. The interested reader may consult the texts by Connor (2001), and by Lock and Nichter (2002).

³ We note nevertheless the existence of collective publications on Tibetan medicine that ensued as a result of conferences and in which a number of social science articles appeared. These are the proceedings of the *International Symposium on Tibetan Medicine* organized in 1996 in Germany (Aschoff and Rösing 1997) and the proceedings of the *International Academic Conference on Tibetan Medicine*, which took place in Lhasa in 2000 (CMAM 2000). However, these two volumes were inadequately disseminated, and their comparative dimension in social sciences is absent. The recent publication of the proceedings of a seminar on Tibetan medicine (*Sources, Concepts and Current Practices*) organized in 2006 in Metz by the French Society for Ethnopharmacology (Fleurentin and Nicolas 2006) also comprises papers that do broach social issues, but their essential relevance for current research lies in the ethno-botanical factual data presented therein. While it was not designed with the exclusive aim of exploring the contemporary social dimensions of Tibetan medicine, I shall also mention the Special Issue of *The Tibet Journal* (Boesi and Cardi 2005), which brings an interesting contribution to Tibetan medical scholarship (history, anthropology, ethno-botany and medical theory). More directly related to this volume is the forthcoming publication of the proceedings of the Panel on Tibetan Medicine held during the Tenth Seminar of the International Association for Tibetan Studies, Oxford (Schrempf forthcoming), which contributes a range of comparative material that partially mitigates the shortcoming mentioned above.

⁴ The usual Tibetan word for a practitioner of Tibetan medicine, which occurs in both colloquial contexts and the classical texts, is *sman pa*. Practitioners may also be called *am chi* or *em chi* (*amchi*). This is a Mongolian loan word, which is widely used in Himalayan areas for traditional physicians. The term *lha rje* also qualifies the practitioners and/or their families in some regions. Bhutan is a unique case where the practitioners are called *drung tsho*, although this term may also designate elsewhere in the Himalayas a family in which healers are or have been present. Increasingly in Asia and in the West, practitioners are called doctors and may adopt the title 'Dr'. This is a potentially controversial matter insofar as in the West the title 'Doctor' used in the medical context takes on a legal connotation. Where this is the case, the authors in this

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book have used the term *amchi* or the title Doctor, which corresponds to the common usage in their field of research.

⁵ Tibetan medicine is found among communities scattered from west to east along the Himalayan chain, in India (Ladakh, Himachal Pradesh, Sikkim and Arunachal Pradesh), in Nepal (Mustang, Dolpo, the Mount Everest region) in the People's Republic of China (Tibet Autonomous Region, Yunnan, Sichuan, Qinghai, inner Mongolia) and in Bhutan, as well as in Mongolia and in Buryatia. It is also practised in urban China as far as Hong Kong and Beijing, and is exported with some success to the West.

⁶ While the geographical origin of Tibetan medicine is Tibet, I do not imply that some original and unique form of 'Tibetan medicine' had existed at some point in history. The early various schools and lineages have led to more or less significant diversity. Intra-local variations and heterogeneity of knowledge and practice also characterize Tibetan medicine.

⁷ In the same way as there exist diverse forms of biomedicine (cf. Berg and Mol 1998, Lock 1980).

⁸ A note regarding transcription in this volume: The terms are transliterated in accordance with the system devised by Turrell Wylie (1959) for Tibetan language. Phonetic transcriptions are generally given in the case studies and refer to the local pronunciation of Tibetan and/or Tibetan dialects, which vary greatly across the Himalayas (the physician of Tibetan medicine, for example, transliterates as *smān pa*, and is pronounced as *menpa* in Tibetan or *smānpa* in Ladakhi). They are followed by the transliteration in brackets. One exception concerns the name of the Tibetan College of Medicine and Astro-computation (*smān rstis khang*), which, following the common usage, is written Mentsikhang for the Lhasa-based original institution, and Men-Tsee-Khang for the reinstated college in Dharamsala, India. Only transliteration will be given for Tibetan terms when no precision is made on the region.

⁹ On the subject of innovation in pre-modern Chinese medicine, see the excellent volume edited by Hsu (2001). In our case, however, medical innovation does not happen systematically through the 'interplay of convention and controversy', for, as we will see, controversy does not characterize Tibetan medical neo-traditionalism as such.

¹⁰ Gruénais calls the third generation '*néo-tradipraticiens*' – using the neologism '*tradipraticiens*' created by the Organization of African Unity (OAU) and later diffused by the World Health Organization (WHO) in French-speaking countries – and divides into six classes (Gruénais 2002: 225-229).

¹¹ There exist, however, cases where the neo-healers have a traditional legitimacy in Africa, but they seem to belong to a recent and emerging fringe.

¹² Parallel to this, the development of therapeutic neo-traditionalism has greatly benefited from the poor image of biomedicine in Africa in the context of an inadequate health system (Dozon 1995).

¹³ I refer to the works by Kleinman (1980) and Dunn (1976) which, notwithstanding their high heuristic value, no longer reflect the contemporary situations of numerous health practices.

¹⁴ Although the phenomenon is today at the height of expansion (Janes 2002), it nevertheless dates back more than twenty years. Meyer (1986) has already analysed the reasons for the diffusion of Tibetan medicine in the West and Leslie observed in 1980 that Asian medicines were an integral part of the globalized world. See also Leslie (1989).

¹⁵ When dissension occurs, it is more likely to happen between neo-traditional practitioners in the form of jealousy of displays of wealth, foreign travel and so on.

¹⁶ For instance, the Ayurvedic revivalist movement during the last century in India was deeply political. Brass spoke of this movement in terms of 'traditionalistic revivalism' (1972).

¹⁷ In this volume, Adams and Li provide a detailed ethnography of 'integrative' processes pertaining to Tibetan medicine. On clinical trials, see Adams (2002a) and Adams *et al.* (2005).

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¹⁸ Throughout the Tibetan world, Tibetan medicine claims to be a 'science' (*rig gnas*) on its own terms; that is, a traditional domain of knowledge that is logical, valid and proved. While the practitioners distinguish the science of healing (*gso ba rig pa*) from 'modern' science (*tshan rig*), this distinction accounts for a certain art of equilibrium and ambiguity between what constitutes science and knowledge. Vincanne Adams has moreover explored the ambiguous relations that science maintains with the sacred, in the case of the Tibet Autonomous Region, in a very interesting work on the semantic uses of science by physicians and on related discursive strategies (Adams 2001b). See also Adams (2002b). Audrey Prost has explored the meaning and practices of Tibetan translation of science among exiled Tibetans, the aim of which is not to promote secular culture (such as in the TAR) but to stimulate dialogue between Buddhism and Western science (Prost 2006).

¹⁹ This type of discourse is still quite embryonic in the case of Tibetan medicine and only appears among the most inspired practitioners, whereas it is much more widespread in the case of Ayurveda (cf. Cohen 1995).

²⁰ Salient examples are found in nursing (cf. Begley 1994) and childbirth practices (cf. Hubbell Maiden and Farwell 1997), for which Tibetan medicine becomes a model or a tool to improve existing practices.

²¹ New Age is a loose and vast category that would need to be precisely defined. This being so, in our particular case this term refers to a common understanding attributed to syncretic and holistic practices, sometimes connected with new forms of religiosity and combining different medical systems, the paradigms of which are at

times very different. The production of this type of new therapy continues very actively today. On the subject of New Age therapies, see English-Lueck (1990), Ghasarian (2005) and Reddy (2004).

²² See, for example, the article *Buddha and Mother Earth* by Robert Thurman (1997), published in a volume which underscores and interprets the relationship between Buddhist thought and the environment.

²³ On the violence of science, see Nandy (1998). On the social re-transcription of the dialectic relation between the chemical violence of biomedicine and the natural, inoffensive character of traditional medicines, see Zimmermann on Ayurveda (1992) and Tan (1999) in the case of indigenous medicines in the Philippines.

²⁴ Other Asian medical systems show similar patterns. See, for example, the article by Bode (2002) on the moral dimension of the concept of nature conveyed by Ayurvedic and Unani industrial pharmaceutical products in India.

²⁵ Janes and Hillard (this volume) show the existence of various re-invented forms of Tibetan medicine in Mongolia, some of which are very clearly based on external therapeutic practices.

²⁶ However, a point should be made regarding this subject. An analysis of clinics intended for tourists in the region of Ladakh would lead to the same conclusions. Nevertheless, it would be exactly the same for all village 'clinics' (which are generally rooms in someone's house), or for government offices devoted to *amchi* medicine. Both are furnished with religious photographs, statues, *thang kha*, incense and so on. The perception of the atmosphere depends above all on the observer. I am not sure that a Ladakhi would find a clinic for tourists very different from any other (except, perhaps, for higher and fixed rates). And a tourist who experiences this 'spiritual atmosphere' feels this sentiment in any clinic, all the more, let us note, when the clinic is run by an *amchi*-monk. Moreover, some tourists in Ladakh are also heard to say, regarding clinics to which they were preferentially directed (explicit announcements in English or English-speaking *amchi*), that they were disappointed by the short time accorded to them by the *amchi* or by the lack of esotericism in his or her discourse.

²⁷ Tibet, after having been described as a cruel and barbarous place, today has a highly valued image in Western societies. See on this subject Lopez (1998) and Brauen (2004). Tibetan treatments, such as the precious pills, are also valued in China because they

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embody the esoteric knowledge of the 'mysterious Land of the Snow'. The cohort of clinical researchers investigating the therapeutic potential of Tibetan medicine in China would also, by their presence and enthusiasm alone, confer some paradoxical form of scientific legitimacy on this medicine.

²⁸ The 'Tibetan' drug Padma 28[®] produced in Switzerland is an example. The same applies to the manufacture of day creams, anti-wrinkle and nourishing creams by the Dharamsala Men-Tsee-Khang revisits 'tradition', upon which one expressly bases oneself to legitimate these products. Elsewhere in India, the range of health care products of the Himalaya company flaunts an 'Ayurvedic concept' (Ayurvedic Proprietary Medicine) for protective sunscreen lotions, toothpaste, gentle wash gels or lip balms. Cohen moreover mentions the 'neo-chyawanprashes' to underscore the recommodification of Ayurvedic 'tonics' (chyawanprash) and their new uses (1995: 326).

²⁹ It is interesting to note that while the healers multiply their activities outside the field of medicine, their medical practice may become highly specialized in institutional settings. Some practitioners are today full-time pharmacists; others belong to specific medical yards and specialties. They may be relieved of anything that is non-therapeutic, such as taking money, packing medicines, keeping records and so on.

³⁰ It should also be remembered that the drastic conjuncture of Tibet at the time of the Chinese invasion in the 1950s contributed to the international diffusion of Tibetan medicine. The exiled Tibetan communities have been very dynamic and enterprising in this respect, benefiting furthermore from the positive image Tibet has in the West.

³¹ Elsewhere, Kuczynski shows the role of international networks in the delocalization of the practices of African Marabouts (2002).

³² For a detailed study in the case of Ayurveda, see the work by Zimmermann (1995).

³³ Medical tourism was not considered in this section. Although it exists, it still remains very marginal in Tibetan medicine, but its actual development allows one to foresee a rosy future for it. On the subject of medical tourism in Ayurveda and its role in the recasting of certain social and medical aspects of the practice, see Langford (2002).

³⁴ The marginal case of Western Tibetan medical practitioners raises another problem regarding the understanding of continuity or discontinuity in medical practice. I will not consider this here.

³⁵ As this chapter shows, the Chinese government did not play the devastating role in respect of Tibetan medicine which has been commonly attributed to it. However, Tibetan medicine has been severely oppressed and undermined during the Cultural Revolution due to its affinity to religion and because it represented a clear expression of Tibetan culture, but the ambivalence stems from the fact that government policies have also supported Tibetan medicine by integrating it in socialist modernity (e.g. local recourse, complementarity with

biomedicine, supposed affinity to Chinese civilization). The Chinese government has largely contributed to the transformation of Tibetan medicine according to this selective principle. See on this issue the article by Janes (1995), and the chapters by Adams and Li (this volume), and Janes and Hilliard (this volume).

³⁶ On conflicting biomedical and Tibetan medical epistemologies see the article by Samuel (2006).

³⁷ The case of Bhutan could be an exception, embodying a peculiar model of 'development', if we take the words of McKay and Wangchuk (2005) at the letter. The Bhutanese National Health Care System integrates 'traditional medicine' (Sowa Rigpa) and biomedicine in the state health services, 'offering patients the choice of systems under one roof' (Ibid.: 208). According to these authors, although biomedicine is hegemonic in certain domains, biomedical physicians' attitudes to traditional medicine are generally tolerant, and 'the two medical systems have positive interactions and personal links that determine patterns of referral' (p.216). The very fact that the state supports traditional medicine also seems to confer social legitimacy on the latter (p.215). Despite the fact that one would have wished a thicker ethnographic description to support the authors' assertions, no

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definition is given, however, as to what 'integration' precisely means in this context, besides implying the ubiquitous presence of one system next to the other in the same medical structures.

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