EXILE, SOCIAL CHANGE AND MEDICINE

AMONG TIBETANS IN DHARAMSALA (HIMACHAL PRADESH), INDIA

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Abstract

EXILE, SOCIAL CHANGE AND MEDICINE AMONG TIBETANS IN DHARAMSALA, HIMACHAL PRADESH, INDIA

This thesis is a study of the predicaments of exile among Tibetan refugees in Dharamsala. It examines the ways in which structural and cultural factors linked to exile underpin local understandings of health and the provision of healthcare. The study demonstrates that exile uncertainty is reflected in illness explanatory models put forward by Tibetan refugees, and in the organisation of healthcare provision in Dharamsala.

The first part of the thesis (Chapters 2-3) is an account of changes in social organisation and economic strategies as a consequence of exile. Chapter 2 looks at transforming social networks in relation to exile identity politics and economic strategies. I discuss societal tensions within the Tibetan refugee community, principally in relation to the group of 'newcomer' (gsar 'byor ba) refugees, and the local Indian community. Chapter 3 focuses on two examples of economic strategies linked to dependency and the predicaments of exile: firstly ngs rnam, or the sponsorship offered to Tibetans by foreigners, and secondly, 'grogs pa, or mutual help and reliance on intra-communal networks of solidarity.

The second part of the study (Chapters 4-6) examines how the physical and psychosocial hardships of exile, in addition to social uncertainty, have influenced individuals' understanding of health and disease, and, consequently, the activities and status of the two most prominent exile medical institutions, the Delek Hospital and the Tibetan Astro-Medical Institute (Men-Tsee-Khang). Chapter 5 discusses the rise and institutionalisation of Dharamsala's Men-Tsee-Khang and the systematisation of traditional medical teaching as linked to the predicaments of exile. Chapter 6 provides individual case studies of Tibetan exiles' experiences of illness. Chapter 7 is given over to a discussion of the political significance of discourses relating to physical suffering in the context of exile.
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Notes on transliteration and the Wylie system:

I have quoted informants in the original language of the interview (either Tibetan or English), and offered translations of the Tibetan when required. The Wylie system was used for transliteration, except in commonly repeated words where an anglicised version was used with the Tibetan Wylie transliteration in brackets, for example: injiy (dbyin ji), after which I have continued using the anglicised version in italics. I have chosen not to use capitalisation (e.g. ḡRogs pa) although this is required in the Wylie system, as, unfortunately, word processors constantly modify the capitalisation set-up.

Glossary:

Baygen (bad ke?)
Gyud shi (rgyud bzhi)
Gyagar (rgya gai)
Injiy (dbyin ji)
Jinden (byin rden)
Ku (skur), Lu (lus), Sugpo (gungs po)
Lung (rlung)
Men-Tsee-Khang (sman rtsis khang)
Men (sman)
Mo (mo)
Natsa (na tsha)
Rogpa (grogs pa)
Rogram (rogs ram)
Sarchorwa (gar 'byor ba)
Tripa (mkhris pa)

One of the three humours, phlegm
Four tantras: main text of Tibetan medicine
India
Foreigner
Relic substances or pills blessed by bla ma
Terms used to designate the body
One of the three humors, wind.
Tibetan Astro-Medical Institute (Dharamsala)
Medicine
Divinatory practice (e.g. with dice or rosary)
Illness
To help, to accompany, provide assistance
Help, support, sponsorship
Newcomers, refugees arrived in India post-1980
One of the 3 humours, bile.

List of Abbreviations used:

CMO
CTA
MTK
MBBS
TB
Chief Medical Officer
Central Tibetan Administration
Men-Tsee-Khang (Dharamsala)
Bachelor of Medicine, Bachelor of Surgery
Tuberculosis
Introduction

This thesis explores the ways in which exile has impacted on the social organisation and medical knowledge systems of Tibetan refugees in Dharamsala (Himachal Pradesh), India. The first part of the study highlights how the predicaments of exile have come to shape the social organisation and economic strategies of contemporary Tibetan refugees in Dharamsala. It examines the dynamics of inclusiveness/exclusiveness at play in the interaction between earlier refugees and ‘newcomers’ (gsar 'byor ba) regarding issues of Tibetan identity as well as competition for economic resources. The study demonstrates that social uncertainty inherent in exile life has shaped an image of newcomers (gsar 'byor ba) as threatening ‘others’ in relation to earlier refugees. The study also examines emerging social and economic strategies specific to exile, i.e. the system of rogs ram, or sponsorship by foreign donors, which I oppose to the notion of 'grogs pa, designating practice and values embedded in Tibetan Buddhist conceptions of communality and reciprocity. I investigate Tibetan exiles’ developing relationship with foreigners (injiyi) and local Indians, placing specific emphasis on the contested nature of the economic and social bonds between these three groups. It is then argued that the uncertainty - or to use Nowak’s term (1984) borrowed from Turner (1967), the liminality - of exile lifestyles impacts on the agenda of prevalent medical institutions and on the ways in which refugees construe illness explanatory models.

The second part of the thesis describes the modalities of exile healthcare, presenting the different institutions and actors in the medical culture of Dharamsala. I offer a survey of prevalent diseases, and argue that exile and nostalgia for home has led Tibetan refugees to suffer most from, and give greater prominence to, diseases linked to changes in the environment and social landscape. The surveys undertaken show that there are no major differences or knowledge gaps between patients of allopathic and traditional medicine in terms of understanding of prevalent diseases. The surveys also suggest that traditional Tibetan aetiologies are still widely used and recognised, even among patients in allopathic care. Further interviews indicate that many patients attribute illness to Tibetan aetiologies in conjunction with allopathic aetiologies. Life histories and interviews with practitioners and patients indicate that sufferers navigate the plurality of medical care systems available
according to economic and social strategies tied to the particular context of exile. The mobility of many exiles as well as their often precarious financial situation impede compliance and increase the number of sufferers 'shopping around' for affordable and convenient care. Furthermore, in an area where many members of a single household may experience prevalent diseases such as TB or malaria, the advice and support of kin and friends plays a critical role in health-seeking strategies.

Chapter 5 describes how the exile 'project' of cultural preservation has shaped the recent rise of the Men-Tsee-Khang as a prominent exile institution. I argue that the MTK's modes of clinical practice and teaching have been affected by the Institute's claims to clinical efficacy in the wake of its confrontation with biomedicine, and by the increasing commercialisation of its medicinal products. This quest to 'demonstrate' clinical efficacy is also reflected in its interest towards research and development pertaining to 'new' diseases, i.e. diabetes, hypertension and cancer, and self-imposed compliance with biomedical clinical trials. Moreover, the MTK participates in the politics of exile through its work of medical outreach in the Tibetan and Indian communities, which has led it to build an 'alternative' healthcare network of traditional Tibetan medicine in parallel to the allopathic facilities existent in each Tibetan exile settlement.

The increase in demand for its medical products and services both within the community and from outsiders had led to changes in clinical practice, namely an emphasis on the method of pulse diagnosis and treatment by pills (gil bu) at the expense of other methods. Changes in the modalities of clinical practice are also reflected in the taught medical curriculum, emphasising the culturally validated 'core principles' of Tibetan medicine (the humoral system, the importance of compassionate medical practice etc), and discarding aspects of the curriculum perceived as obsolete and maladapted to the present requirements of exile practice.

In chapter 6, I attempt to convey more subjective perceptions of health by focusing on four exile case studies. These reveal the importance of illness explanatory models that place exile at the centre of understandings of health and explanations of disease. Related to this is the perception of karma as a factor in causing and affecting illhealth. The case studies however outline the flexibility of karma as part of broader explanatory models: karma is used as a 'contextual technique', which makes sense of, and organises personal
narratives of exile, but can also be rejected and manipulated to fit in with strategies of self-presentation.

The following section provides a more detailed discussion of the theoretical issues informing this study, while Chapter 2 gives some historical and socio-economic background prior to undertaking a brief survey of changes in exile social organisation.
Theoretical and Methodological Background to the Study

1.1. The ethnographic setting: Tibetan settlements in India, Dharamsala, Gangchen Kyishong

Over 122,000 Tibetans live as refugees outside the Tibetan Autonomous Region (TAR), the majority in India (c. 100,000), Nepal (c. 25,000), Bhutan (over 1,500), Switzerland (c. 2,000) and North America (over 2,000), (CTA Demographic Survey, 2000).

During the 1980s, China temporarily relaxed its hard-line policy in occupied Tibet. As a result, the Tibet-Nepal border was re-opened, and a new flow of refugees entered India and Nepal. The Central Tibetan Administration (CTA) and the UNHCR reported that, between 1991 and 1996, approximately 7,000 refugees fled Tibet. The majority of these 'new' refugees were between 14 and 25 years old. Altogether, the UNHCR estimates that approximately 25,000 Tibetans sought refuge in India between 1986 and 1996, leading to a substantial increase of 18% in the Tibetan exile population. According to these figures, 44% of the new arrivals in the decade of 1986-1996 were monks and nuns, 30% were children seeking education in the Tibetan exile schools, while the remainder were adult lay persons (Moynihan 1997). It is estimated that as much as 80% of the later generation of refugees are from the regions of Kham and Amdo, a factor which, as will be discussed later, is of crucial importance to this study. Following this initial influx, the number of Tibetan asylum seekers entering Nepal dropped significantly after the 1995 clampdown on Tibetan immigration at the Nepali-Tibetan border. Although Tibetans benefit from the protection of the UNHCR upon arrival in Nepal, in practice, the abuse of Tibetans crossing the border into exile is still commonplace, as reported by human rights agencies in Kathmandu and Dharamsala.

The CTA and UNHCR cited the refugees' motivation for coming into exile as: fleeing political and religious persecution, looking for exiled family members, seeking a Tibetan education for themselves or family members, or going on pilgrimage. In fact, it is often under the auspices of pilgrimage that Tibetans come to cross the border into Nepal (Barnett 1998: 158).
This list of motivations given by the CTA and also by Tibetan refugees themselves requires some critical unpacking, because it is constructed out of the tense experience of flight and the need to secure a passage to exile via agencies such as the UNHCR. Most refugees learn to construct an ‘exile narrative’ in the course of their resettlement, as they go through the reception centres of Kathmandu and Dharamsala and tell their story time and time again to UNHCR and NGO reporters (Cf. also, Tashi Tshering, 1997: 56f). For obvious political reasons, the narratives often stress religious and political circumstances rather than economic agendas. While Tibetans will commonly speak of pilgrimage as the primary motive for coming into exile, this may therefore often be a gloss for more complex stories of economic deprivation, loss and the quest for opportunities. Very often, the decision to leave for Nepal or India is reached through the joint pressure of the ‘push’ factors of Chinese occupation and low socio-economic status, and of the ‘pull’ exerted by opportunities in exile. As I will discuss in Chapter 2, ethnographic data collected among newly arrived young refugees suggests that opportunities for social mobility in exile are now a strong incentive for leaving Tibet.

Dharamsala (Kangra District, H-P), where I spent eleven months doing fieldwork between October 2000 and September 2001, as well as an additional month in the summer of 2002, is possibly the most cosmopolitan Tibetan community in exile. It comprises a broad mix of Tibetan population from regions across Tibet and widely diverse social backgrounds. Dharamsala is a regional trade hub and has considerable exposure to foreigners through tourism. During the first period of my fieldwork, from October 2000 to September 2001, I remained in the middle settlement of gang chen kyi shong, henceforth referred to as Gangkyi. During a second stay from June to July 2002, I lived in a group of flats shared by Tibetans in the Library of Tibetan Works & Archives in Gangkyi, from where I completed the final month of my research.

The town of Dharamsala itself is situated in the ‘foothills’ of the Himalayas, between 1,250 m. and 2,000 m. of altitude, in the Hindu-Muslim district of Kangra. Prior to the Tibetans' arrival, Dharamsala's upper settlements of Forsyth Ganj and McLeod Ganj were used as army cantonments by the British, who made Dharamsala Kangra's district headquarters in 1855. The two small settlements that formed the cantonment were
named ‘McLeod Ganj’ (or Gunj) after the lieutenant governor of Punjab David McLeod, and Forsyth Ganj after a divisional commissioner.

The town’s development ended abruptly in 1905 when a violent earthquake devastated the region, reducing the cantonment to rubble. The upper settlements of McLeod and Forsyth Ganj were not rebuilt until after India’s independence, and, indeed, not fully developed until Jawaharlal Nehru offered the unoccupied land above the reconstructed town of Dharamsala to the Dalai Lama and Tibetan exiles in 1960. The Dalai Lama and his government, who had fled occupied Tibet in 1959, were followed over time by some 80,000 refugees in need of resettlement. Analyses of the social composition of this first refugee wave reveal its heterogeneous structure: it was made up of nobles, monks, peasants, herders and traders, a vast array of social groups hailing from different regions. The Dalai Lama and his exile government left their earlier headquarters in Mussoorie and relocated to Dharamsala in April 1960, where they built the facilities of the present day Government in Exile with the support of the Government of India and foreign aid agencies. The new settlement was further expanded during the 1960s, following the displacement of Tibetans from the frontier areas into the Indian hinterland after the 1962 Sino-Indian border dispute.

Dharamsala has since then become one of the most popular tourist destinations in the Indian Himalayas, attracting both Indian national and foreign visitors. Following the first exodus from Tibet, the settlement developed into a busy administrative centre. In the 1970s, sweater-sellers and traders moved to the town and shifted its activity towards tourism, lining the streets of Dharamsala with restaurants and hotels. The town is now part of the Himalayan ‘hippie trail’, and is linked through trade and business networks to other neighbouring hill towns (e.g. Simla and Manali), the greater Himalayan tourist circuit (including Ladakh and Nepal) and key sites of spiritual interest and pilgrimage (e.g. Rishikesh, Varanasi and Bodh Gaya). Like Cohn’s (1990 [1976]), Eck’s (1983) and Cohen’s (1998) Varanasi, contemporary Dharamsala is visually overdetermined. Backpackers swirl aimlessly in the monsoon rain, groups of monks scurrying and Indian tourist cars blast the latest Bollywood soundtracks, all is juxtaposed in an unsettling landscape of discrepant signs and lost signifiers, denoting Dharamsala’s plural cultural influences. In a discussion of the spatial and toponomical creation of Dharamsala, Anand argues that the symbolic geography of the settlement, its reconstruction of a hyper-
authentic Tibetan town complete with khor ra and gcing lag khang, is congruent with views maintained by exile élites, that Dharamsala is a temporary home away from home, a repository of Tibetan culture 'in its pure form' until its eventual repatriation to the homeland (2002: 13).

Because of its key role as the seat of the Tibetan Government in Exile, as an educational centre and trading hub, Dharamsala is at the heart of a web of migrant activity. Its population is highly mobile: traders come to Dharamsala from other Tibetan settlements to sell their products before moving on to bigger Indian towns in the winter. Monks and nuns from Dharamsala travel to attend teaching sessions, while others come from South India to sojourn in Dharamsala's highly esteemed monasteries; Tibetan businessmen and women visit the town from Nepal and Western countries; students come home to Dharamsala from their neighbouring campuses.

1.1.1. Dharamsala: a multi-layered community

Dharamsala displays a deeply ironic landscape, in that its claim to Tibetan legitimacy exists among scores of tourist souvenir shops, hotels, chai huts, and cake and donut restaurants, none of which ever existed in traditional Tibetan cities (...) yet Dharamsala is a place where memories and nostalgia for a lost way of life are perpetuated as no other. (Klieger 2002:3)

The town itself may be divided into three smaller communities. On the lower part of the hill, the largely Indian town of Lower Dharamsala is home to a thriving community of Hindus, Muslims and Sikhs. The main commercial centre, Kotwali Bazaar, is located in this lower segment of the town. Indians and Tibetans mingle in the Bazaar, although few Tibetans actually live in Lower Dharamsala itself. Some Tibetan families have acquired houses in Lower Dharamsala, as land plots are cheaper than in the upper settlement of McLeod Ganj. However the population remains largely Indian (c. 20,000 inhabitants), and, to Tibetans, the lower town functions primarily as a shopping centre and local transport hub. Dharamsala is the district headquarters of Kangra and hosts important judiciary and commercial facilities. Inhabitants of Kangra’s smaller towns have long relied on migrant work for sustenance and therefore spend several months of the year away in towns like Dharamsala (Parry 1974). The district courts of Dharamsala, based in Kaccheri, employ a large number of lower Dharamsala’s inhabitants. The main languages spoken are Hindi, Punjabi, Pahari and English. Many lower Dharamsala inhabitants involved in commerce have also acquired a basic knowledge of Tibetan.
Halfway up the hill lies the semi-residential hamlet of Gangchen Kyishong, which harbours most of the Tibetan governmental departments and cultural institutions, as well as the Tibetan Delek Hospital's two buildings. A considerable proportion of Gangkyi residents are civil servants working in the different ministries of the CTA, the Library of Tibetan Works and Archives, or hospital staff members. The status of Dharamsala as the 'capital' of the Tibetan Diasporic community in India and throughout the world grows out of the political and symbolic weight of the CTA and the Dalai Lama's presence in the hill station.

Figure 1.1 Gankyi's main square and its stupa, with the Assembly of Tibetan Peoples' Deputies and the Dhauladhar range in the background.

The upper settlement of McLeod Ganj has the largest Tibetan population (approximately 9,500 in inhabitants)\(^3\), and is rapidly expanding across the surrounding pine forests. It is home to booming touristic and commercial activity, and also houses the main Buddhist temple (gtung lag khang) and the residence of the Dalai Lama, which are circled by a kora (khor ra, circumnambulatory pathway) around the temple and residence. Tibetan traders, including Ladakhis and Tibetans from the South Indian settlements, engage in trade, selling jewellery, thangkhas, sweaters and Tibetan foodstuffs. They are in strong competition with itinerant Kashmiri salesmen, traders and shop-owners selling Tibetan
and Kashmiri handicrafts to the large Indian and foreign tourist crowds attracted by Tibetan culture. The expanding tourist industry of Dharamsala has sprouted a large number of Tibetan-owned (or at least run) shops, hotels and restaurants. The tourist influx is most visible in McLeod, particularly during the Dalai Lama's teaching season (towards the end of July).

All three settlements comprised in the greater unit of Dharamsala make up a mixed population of around 29,000 inhabitants. Earlier surveys of the Himachal district have noted the presence of Tibetan traders and pilgrims in Kangra and the neighboring districts of Kullu and Manali from as early as the 17th century and districts such as Spiti have been under Ladakhi influence until the 19th century. However, this population was considerably smaller than that of the later refugees that reached India as a result of the Chinese occupation of Tibet. It is also important to note that historical references to the Tibetan Diaspora at large in fact include not only Tibetans in India, but also the Tibeto-Burman populations who migrated earlier throughout the Himalayas.

1.1.2. The Indian exile

The post-1959 influx of Tibetan refugees was channelled through the creation of settlements throughout India, with particularly high population density in Karnataka and Himachal Pradesh. Recent exile Tibetan surveys show that the population is expanding through natural demographic dynamics as well as through the influx of newcomers from Tibet (TDS 98).

There are 35 Tibetan settlements dispersed throughout six regions in India. The most densely populated region is Himachal Pradesh, with 13 settlements home to over 20,000 Tibetans. Demographic surveys of the exile population (CTA Demographic Census 1998; CTA Health Department Social and Demographic Survey 1994-1996) indicate that, among the c. 100,000 Tibetans in India, two groups dominate the demographic picture: one is the 15-25 year age group, and the other is that of Tibetans over the age of 65. The data collected also denoted a relatively low influx of new lay refugees from Tibet, but a stable flow of monk refugees into the monasteries. The Health Department Survey indicates that most of the refugees born in Tibet came from the original migration, and that a transition therefore occurs in the 30-39 year old age group. Only
2% of the population surveyed was born in India (341 out of 16,516), and 2.7% of refugees under 30 born in Tibet (807 of 30,172) (Table 2, Bhatia et al. 2002). This denotes the co-existence of largely different generational groups, which, in addition to the factor of birthplace (i.e. India or Tibet), suggest probable disparities in experiences and outlook within the exile community.

The Tibetan refugee community has found employment in a number of different economic sectors, among them agriculture, trade and tourism. According to the Central Tibetan Administration:

‘13% of the total working population is dependent on handicrafts, mostly carpet weaving, which also provide a valuable source of secondary income for many more refugees. Another 29% of the population are engaged in sweater selling and other trading. The remaining 30% are involved in providing services (including ‘government’ service in the CTA) as well as private services such as hotels, restaurants and shops.’

Outside the agricultural settlements, a large proportion of the Tibetan exile population relies on the hosiery trade. Clothes, hats and shoes are imported from Tibet and Nepal, and hosiery is bought in Indian market towns such as Ludhiana to be resold in the North Indian settlements and major Indian towns. Dharamsala’s population, however, is mostly employed in public services (the government sector) and private business, and by Tibetan standards therefore constitutes a rather élite segment of the refugee community.

Although the census reports low unemployment in the settlement, many exile Tibetans are employed part-time or on salaries that barely enable them to meet the costs of daily life. Some surveys have even reported as much as 80% unemployment among Tibetan youths (Chandigarh, The Tribune, December 15, 2002). Many of Dharamsala’s families are living on the threshold of poverty despite being reported as employed, and are dependent on external funds to provide education for their children.

The following sections provide a brief overview of the literature on Tibetan exiles and provide an outline of methodology and ethical concerns.

1.2. Tibetan exiles: literature review and critical issues

I now turn to a discussion of previous studies of Tibetan settlements in India. Through this review I delineate a set of problematic issues in relation to the treatment of Tibetan
exile modernity. This critique is articulated around three main themes: firstly, the neglect and recent rediscovery of Dharamsala as a study locale. Secondly, the problematic notion of Tibetan modernity as a reconciliatory ground for ‘modernising’ and ‘tradition keeping’ practices, or in what has elsewhere been described as a cultural state of ‘liminality’. Thirdly, the question of Tibetan modernity in relation to ‘refugee studies’ and its predicaments.

1.2.1 Re-evaluating Dharamsala

Contemporary studies of Tibetan exiles have, in many ways, suffered from a bias against Dharamsala. Following the publication of the first house census of Dharamsala’s population (Saklani 1984), most literature has focused on remaining undocumented exile communities such as the settlements of Darjeeling and Kalimpong (Subba 1990), or Mundgod in Karnataka (Goldstein 1990; Palakshappa 1978), at the expense of more urbane and ‘exposed’ settlements like Dharamsala. In the literature as well as among Tibetologists, there is a sense that, not unlike post-1950 Tibet, Dharamsala embodies the gradual demise of traditional Tibetan society. Exile life is seen as an atrophied vestige of its former Tibetan self. Scholars and visitors unofficially deride it as ‘inauthentic’ and little worthy of investigation. Indeed, one often has to work with the prevailing impression that Dharamsala is only an adulterated field of anthropological inquiry. Friends and students at university usually referred to my research field as either part of a broader cultural whole (‘so, when you were in Tibet’) or, derisively identified it as just another dot on the Indian spiritual tourist circuit (e.g. ‘where did you go again, Rishikesh?’).

With this prevailing interest in exiles as Tibetans ‘by proxy’, it is hardly surprising that the anthropologist’s motive became to assess the Tibetans’ rate of adaptation to their new surroundings, and their degree of acculturation. Anthropologists Subba, Palakshappa, Saklani and Führer-Haimendorf unequivocally agree that Tibetans have been extremely successful in retaining their ancestral way of life in the face of acculturation, and are a model of good integration with their host populations. Little is said about what exactly the ‘endangered traditions’ referred to might have been, other than religious reverence and the dutiful respect of traditional marriage prescriptions. These studies have emphasised notions of adaptation, acculturation and change as the key processes through which a history of Tibetans in exile might be charted. They have premised that exile
identity is only worth studying insofar as it contains traces of ‘how things were in the past’ and proofs of how well that past has been preserved.

In more recent years, following the substantial growth of publications on and by Tibetan exiles, this tendency has been reversed. Tibetan refugees are increasingly construed by Western audiences as the true representatives of Tibetan culture. This notion is informed by the belief that Buddhism is the dominant marker of Tibetan identity and that the diasporic Tibetan people reach a form of communal ‘apotheosis’ through their proximity to the Dalai Lama (Klieger 2002:5).

Dharamsala effectively still participates in the myth of Shangri-la. Few of the televised documentaries about exiles in Dharamsala show anything more than the town’s main temple and the refugee reception centre, thus polarising the viewer’s attention onto the two salient characterisations of Tibetan exiles: religiosity and refugeehood. The following words from contemporary Indian novelist Pankaj Mishra encapsulate the bittersweet encounter with Tibetan exile culture, describing Dharamsala as a battered descendent of Shangri-la:

Something of the private and incommunicable melancholy of permanent exile hung over its huddled houses and perched streets (...) ageing men with broad, lined faces sat still and pensive behind jars of sticky sweets. They looked remote and abstracted even while talking to you, and you wondered what memories of lost homelands were decaying behind the piercing sadness of their stoic faces. (Mishra 2000: 218-219)

After a few months spent in Dharamsala, I began to question the relevance of research agendas which tried to chart the refugees’ awareness of their ‘roots’ and heritage, common themes in studies focusing on processes of acculturation and change. This concern with acculturation did not reflect the variety of social and economic strategies displayed by Tibetans with regard to life in exile. More importantly, it did not reflect their perception of exile life: for all the local talk about the importance of cultural preservation and the faith in the eventual return, the ‘uprooted’, as many described them, had grown roots. The community of Dharamsala already had a history of its own: three generations of exiles had built their lives in the small hill settlement, starting businesses and founding families. Indeed, many of my younger informants spoke of a distinctly ‘Dharamsalian’ exile culture, with its own idiomatic language, local community networks, and a ‘style’ of being and acting recognisable among other Tibetan exile communities.
This critique finds resonance in previous research on Tibetan identity in the Diaspora that describes the strong 'cultural self-consciousness' underscoring exile cultural productions. This propensity for cultural re-creation is certainly linked to the fact that Dharamsala's economy depends largely on 'the presentation and promotion of Tibetan culture' (Calkowski 1991: 645). But as the Tibetan exiles' recollection of their past is increasingly reworked through the experience of the present, it takes on meanings and inspiration from the life of an exile community that, for many, has become a new nexus of identity (Nowak 1984).

Recent studies of Tibetan exile cultural politics have argued that the creation of a new 'Tibetan culture' in exile involves complex negotiations, representations of identity rendered ever more thorny in a community torn between the temptations of Tibetan regional and religious factionalism, the necessity of political unity, and awareness that the production of Tibetan culture is an economic lifeline for many. Thus the performance, institutionalisation and promotion of hallmarks of Tibetan culture such as traditional medicine, opera (lha mo) and certainly Buddhism, are all occasions for the presentation and contestation of culture and its associated displays of disunity (Calkowski 1991).

The re-evaluation of Tibetan exile culture has thus provided a rich terrain for scholarship, focusing on the refugees' negotiations with modernity, Westernisation, dependency on aid and the multiple incarnations of exile identity (De Voe 1981a, 1981b; Calkowski 1991; Harris 1999; Korom 1997; Adams 1996; Klieger 2002). However, these presentations of exile Tibetan culture have also come under criticism for being exclusively focused on Dharamsala, and consequently for reifying a 'story' of exile primarily constructed by Tibetan administrators, intellectuals, lamas and 'cultural performers' who are conversant with, and eager to engage in, debates about 'the construction of Tibetan culture' on terms set by Western audiences.

Toni Huber delivers the brunt of this critique:

In my own experience, most Tibetan refugees are not like these persons, and certainly do not live in Dharamsala, but in rather non-cosmopolitan agricultural and craft communities. They tend to be humble and self-effacing, conservative, often uncritically devoted to their leaders, seemingly as avid about watching Hindi films as attending religious ceremonies, and they have Hindi or Nepali, not English, as their second language. Why are these many
Tibetan exiles left backstage or merely out in the audience in the study of 'Tibetan culture'? (Huber 1999)

The present study attempts to heed Huber's warning about extending to the whole of the Tibetan refugee community what may only be the construction of a few in the 'exile capital' of Dharamsala.

This thesis thus attempts to inscribe itself into the project set out by ethnographers of Tibetan exile (Calkowski 1991; Korom 1997; Klieger 2002) to capture the specificities of modern Tibetan exile lifestyles.

### 1.2.2. The question of Tibetan exile 'modernity'

In the course of being 'understood as refugees, they have become forgotten as Tibetans' (De Voe, 1981b: 89)

When I first arrived in Dharamsala in October 2000, my aim was to research the healthcare 'culture' of Tibetan exiles. I use 'healthcare culture' as defined by Last (1981), namely as a geographical reference which may encompass a variety of different medical systems, both biomedical and 'traditional'. I planned to investigate the extent to which the many medical institutions present in Dharamsala catered to the various health problems encountered by the population. However, the study rapidly expanded to encompass changes and shifts in other spheres of contemporary exile life. Following the first set of interviews I conducted with Dharamsala refugees, in which we discussed medical histories and their difficulties with the various healthcare systems available in the area, it became apparent that the broader socio-political context of exile was inextricably linked to the refugees' sense of well-being. Thus, my initial concern with healthcare evolved into a broader preoccupation with physical and mental well-being, which was in turn linked to notions of change and modernity as experienced by Tibetan exiles.

Previous studies had boxed away the issue of modernisation by stressing the dichotomy between tradition and modernity, unilaterally equating modernity with the trauma wrought upon Tibetan refugees by the onslaught of change in exile. However, in the light of recent developments in the community, and as explored by contemporary studies of detraditionalisation and modernisation, this approach seemed to produce a simplification of the complexity of local responses to social and political change. In the following
section I attempt to outline some of the problems and strategies encountered in conceptualising Tibetan modernity.

The Tibetan cause's considerable exposure to world attention has had deep repercussions on the small community of Dharamsala. The need for visibility and political credibility in the struggle for independence has necessitated the creation of a fully-fledged government and bureaucracy in order to establish a political and economic basis for sustainable livelihoods in exile. Economically, the community is highly dependent on foreign aid and tourism, and this has strongly contributed to the rise of Western influence in Tibetan exile life. For many Tibetans and foreigners in Dharamsala, modernity is presented as a cultural and spiritual exchange in which both parties have prescribed roles: Tibetans share with their visitors the rich spiritual heritage of Buddhism and, in return, may profit from some of what foreign donors have to offer: sponsorship to children, biomedical clinics, money for temples and institutions preserving the 'traditions' of Tibetan culture. This exchange is not a substitution of traditional values for Western style modernity, but an implicitly mutually binding contract, which encourages the exile community to retain its culture in order to deserve the aid it receives. However, adjustments to the modern and foreign, on the one hand, and the necessity of the preservation of the traditional, on the other, cause very real tensions in the community, tensions which are not readily explainable with concepts such as 'acculturation'.

Previous studies of Tibetan communities have tended to adopt a unilaterally damning approach to social change, indicting the supposed loss of tradition as a sign of growing cultural anomie. Change was thought to alienate 'uprooted' populations like the Tibetans from what were considered to be their socially supportive ideological structures: traditional beliefs, religious and political institutions. This dichotomous opposition of tradition and modernity has had a particularly successful career in studies of Tibetan exiles. It is for instance evoked in Saklani's study of Dharamsala refugees in the 1970s: 'Tibet used to be an absolutely traditional society which now with the forces of modernisation and traditionalism is passing through an interesting phase of change (…) The trauma consequent upon such a sudden confrontation between traditionalism and modernity has been felt rather too strongly by the Tibetan refugees in India' (1984:5).
The social scientists’ interest in these communities was primarily to measure the degree of social change and to map out stages of assimilation and acculturation on the quasi-evolutionary scale of a generalisable ‘experience of exile’. For Stein, the refugees’ experience of exile followed a pre-ordained sequence: the perception of a threat, decision to flee, camp, settlement or resettlement, adjustment and acculturation, and so on. The social scientists’ attachment to such models is reflected in the title of studies of the refugee communities of India: ‘Flight and adaptation’ (Subba 1990), or ‘Tibetans in India: the uprooted people and their cultural transplantation’ (Arakeri 1998).

Although these studies are, for the greater part, concerned with change, it is primarily change perceived through, and modified by, value judgements that praise the refugees for their success in safeguarding traditional values, or, inversely, deplore the loss of their cultural heritage. Both views, however, essentialise pre-exile life as the necessary blueprint for exile society. This is reflected by the anthropologists’ use of methodological tools that seek to measure the extent to which exiles have distanced themselves from ‘traditional values’. In the case of exile Tibetans, this was primarily done through the investigation of the refugees’ knowledge of religious culture and of their familial past.

Authors such as Morrissey (1983) have opposed the focus on ‘uprooting’, arguing that it restricts our understanding of exile cultures because it presupposes that refugee communities are homogenous and uniformly respond to the pressures of exile. Yet the aforementioned authors have amply demonstrated that refugees come from a broad variety of social and economic milieux in Tibet. This very fact undermines the possibility of writing a history of a common, unilateral ‘acculturation’. The refugees’ familial, educational and occupational backgrounds are vastly different, rendering the reliability of indicators such as religious education or genealogical knowledge questionable.

Furthermore, our understanding of social change has long been challenged by anthropological writings on the notion of ‘detradiationalisation’. According to more recent enquiries, the postulate that modernisation advances hand in hand with ‘detradiationalisation’ in the sense of a complete and irreversible demise of tradition is hardly ever validated by ethnographic observation (Heelas et al. 1996). Instead, current social theory highlights that, alongside detradiationalisation occur simultaneously instances of ‘invention of tradition’, ‘re-tradiationalisation’ and ‘tradition maintenance’ (Heelas et al.
Modernity can no longer be shorthand for simultaneous cultural, political, and economic homogenisation. The phenomenon of cultural differentiation is manifest in observed responses to change fostered by economic and political transformations. Increased political and economic interrelatedness and the products of modernity are appropriated and interpreted in local contexts (Miller 1995, Comaroff & Comaroff 1993).

The anthropologist Margaret Nowak circumvents this epistemological crisis by using Turner's (1967) concept of liminality to describe the refugee's condition. Tibetan youths' experience of exile is one of liminality, argues Nowak, and should not be defined as adaptation, nor as acculturation, but rather as a permanent negotiation of status and identity. Refugees are caught in conflicting notions of belonging between the home and exile (1984: 46). Other authors in the field of refugee studies have since then called upon this concept of liminality in other Asian and African contexts (Harrell-Bond & Voutira 1992).

The notion of liminality is a valuable tool in investigating the issue of identity in exile society. Building further upon this concept however, the present study also aims to point at some of the contemporary strategies of Tibetans in negotiating exile life and creating meaning within the state of exile liminality. The potential for creating social networks and anchoring cultural meaning in the uncertainty of exile is an integral part of the experience of Tibetan refugees in India. Understanding this therefore requires going beyond the methodological premise of liminality to encompass the actual social and economic strategies of exiles.

1.2.3 Tibetan refugees and diasporic identities

'When refugees of any brand are referenced under a single rubric of transnational migrancy, the specific features and interests of political exiles are lost among a variety of others' (Krishnaswamy 1995: 125).

An investigation of Tibetan modernity must critically contextualise the case of Tibetan exile communities within the broader issues addressed by the body of 'Refugee Studies' literature. The perception of Tibetans as refugees (bsTan byol pa, or skyabs bcal ba, both conveying the idea of seeking the security of refuge, fleeing coercive force) has largely influenced the depiction of the community by social scientists, particularly those interested in processes of acculturation and cultural preservation. Studies that seek to
measure the degree of adaptation/acculturation make the criteria of success for 'refugee societies' clear:

a. The refugee community must reconstitute itself as an organic cultural and political whole, strongly asserting its own values and resisting acculturation.

b. From its newly found sedentary base it must find ways to interact with the host population in ways that do not imperil its own identity.

In this respect then, Tibetans in India have been uncannily successful refugees. However, this approach raises a number of issues. Firstly, as Malkki points out, it belies a tacit 'sedentary bias' which construes the refugee as 'an anomaly in the life of an otherwise whole', stable, sedentary society'. Secondly, it prescribes the need for 'management' of such societal disorder by aid and development agencies and encourages a logistical, quantitative approach to the study of exile societies at the expense of long term qualitative studies (1995: 88).

A number of authors have called into question the validity of such approaches for long term exiles like the Tibetans in India (Klieger 2002; McLagan 1998; Lopez 1998; Korom 1997). One reason for this is that the Tibetan situation brings the acculturation/assimilation model to a normative impasse: the constant trickle of Tibetan refugees into the established settlements of Nepal and India have created multi-layered exile societies where many generations cohabit, not homogeneous 'wholes'. The Tibetan exile communities of India can therefore not be regarded as harmonised, organic societies with a unilateral outlook on the process of displacement.

In this study I will use the terms 'refugee' (skyabs brol ba) and 'exile' (yul gyar ba, a person in a place other than his/her own, as opposed to being in rang yul) interchangeably for a number of reasons. Firstly, because Tibetans refer to themselves as either one or the other, although for political purposes, for example during demonstrations, the term 'refugee' is more often employed. Secondly, because the entire population of Tibetan refugees in India does not in fact benefit from 'refugee' status since India is not a signatory of the UN Refugee convention. First generation Tibetan refugees and their India-born children have been granted 'refugee-like status' and given an 'RC' (Refugee Certificate) as proof of identity. However more recently arrived Tibetans are allowed into
India but not given legal residence there. Regardless of this absence of clear legal
denomination though, one must choose to employ the terms used by Tibetans
themselves, in which case I consider both ‘exile’ (yul gyar ba or rgyang ‘bud gong ba) and
‘refugee’ (btsan byol ba or skyabs byol ba) to be applicable.

Finally, although I use the phrase ‘Tibetan exile’ repeatedly in this study, it is primarily
with reference to Dharamsala. I do not presume that the findings presented here are
generalisable to the whole of exile situations.

1.2.4. Health and refugees: critical issues

The Tibetan refugees’ vulnerability in terms of physical and mental health is one of the
foremost preoccupations of international funding agencies involved with the exile
community, and also of the Tibetan Government in Exile. The exiles’ stories are
entangled with tales of medical neglect, discrimination, and the struggle to cope with
new health-threatening conditions in India. Many newcomers from the rural regions of
Kham and Amdo did not have access to primary health care back in the Tibetan
Autonomous Region (TAR) and are consequently not vaccinated for diseases such as TB,
polio or typhoid until their arrival in Kathmandu or Dharamsala’s reception centres. A
great number of Tibetan children who reach the exile schools do not have a BCG scar
relate numerous testimonies of discrimination in access to healthcare facilities, with
Tibetans being forced to put down exorbitant deposits of at least 1000 Yuans to enter a
‘public’ hospital (TIN Report 2003). In the cities, unemployment, discrimination and
anomic under the Chinese occupation exert a toll on public health and the general morale
of Tibetans. Jamyang Norbu writes about this pervasive feeling of helplessness:

“People don’t become alcoholics for, [sic] for the love of it. There are certain conditions where
everything seems to be hopeless. And the only rosy thing in life is what you see in that bottle.
Tibetans are coming to that, and I don’t want to say it in many ways, because the official
propaganda, even among Tibetans in exile (...) is that things are improving, we can get along with
the Chinese, and something wonderful is going to happen, it’s just around the corner. I don’t see
that at all. I see a broken people; broken by the Cultural Revolution; broken by what’s happening
now.” Jamyang Norbu (2000)

Once Tibetans have taken the decision to cross the border into exile, they only face
further risks and threats. The perilous flight over the Himalayas to the Nepalese border
takes on average one month, increasing up to three months for escapees from Kham and Amdo. During this journey, refugees incur injury and frostbite, and many arrive in Nepal gravely malnourished. They also face forced repatriation, robbery and sexual assault by Nepali border patrols and opportunistic middlemen.

Tibetan political prisoners suffer extreme abuse in Chinese prisons: beatings, electric shocks, shackling and multiple forms of torture are commonly reported by Human Rights Watch and Amnesty International. Dharamsala hosts a Torture Survivor Programme (gu chu sum) with an average of 500 patients on treatment.

Once they have reached Dharamsala, refugees are usually accommodated in the reception centre funded by the Dalai Lama’s relief fund for about fifteen days. During this crucial period, they are given a basic health check, their ‘story’ is taken down, their basic needs (mostly educational and financial) are ‘assessed’, and an audience with the Dalai Lama is scheduled before they are relocated to appropriate educational facilities, or to one of the other Indian settlements. The refugees are given a ‘starting fund’ of Rupees 5000 each, many are given second hand clothes, and eager students can receive basic English training provided by foreign volunteers. Following resettlement, many newcomers develop diseases to which they have not previously been exposed on the Tibetan plateau, and many fall severely ill with malaria, TB or dysentery.
Adding to the exacerbated factors of illness, disorientation and economic deprivation, refugees are confronted with the difficulty of being cared for by medical practitioners who often do not accommodate their prevalent cultural beliefs vis-à-vis health and the body. This emerges as a typical problem of incongruity between biomedical concepts of disease and local, even individual notions of illness (Kleinman 1997). In Dharamsala, as in other contexts, such miscommunication between medical practitioners and patients is thought to be partially alleviated by a two-tiered health system that makes use of both biomedical and traditional medical practitioners. Thus, newly arrived Tibetan refugees typically have access to both traditional and biomedical practitioners in the transit schools where the majority of them spend their first few years in exile. Tibetan torture survivors are also thought to benefit from clinics run jointly by the allopathic hospital staff and Tibetan traditional doctors. This is concurrent with the prevalent view that, in refugee communities, healthcare, and particularly mental healthcare, is best provided by practitioners with knowledge of traditional cultural beliefs about health.

For the majority of my informants in Dharamsala, allopathic and traditional Tibetan medicine are seen as complementary systems, and few doubt the benefits of having recourse to both. The complexities of health-seeking strategies often go against the
admonishments of anthropologists and activists that caution against the integration of indigenous practitioners and biomedicine on the grounds that such endeavours may compromise the authenticity and benefits of traditional medical practices (see Lock 1990; Janes 1999; Velimirovic 1984). Individuals will often juggle a number of practitioners and treatments over the course of a lengthy illness. Related to this are the issues of clinical legitimacy, the professionalisation of traditional medical practitioners, and the competing claims to efficacy of traditional and biomedical practices, questions of critical importance in our discussion of Tibetan exile medical cultures. Last (1986), and in the Tibetan context, Janes (2001), reason that the health transition and its correlated health regime crises have stimulated government interest in the legitimisation and professionalisation of traditional medicines. Last speculated that the additional medical ‘labour’ provided by indigenous practitioners, once accommodated ‘into’ the dominant biomedical regime, could help decrease the financial burden of healthcare in countries with pluralistic medical cultures. Janes sees a similar situation in the TAR context, where Tibetan traditional medicine is increasingly viewed as a public health resource.

In exile however, the context in which Tibetan medicine operates is somewhat different. In India, the integration of traditional medical practices into the national health service has been a priority. The state has also licensed the creation of Ayurvedic and homeopathic hospitals, although these are not always integrated with allopathic medicine, through the Central Council of Indian Medicine Act of 1970. India has spearheaded efforts to standardise education in traditional medicine, worked to promote the integration of traditional medicines in national health care, and co-ordinated research into raw herbal materials for commercial development. Examining these developments in the Indian medical context is important in understanding why Tibetan exiles are keen to further research and development in the field of traditional medicine, and also the biomedical practitioners’ and patients’ attitudes towards them. Medical pluralism is a determining factor in Indian attitudes towards healthcare. Concurrently, this has had repercussions on Tibetan exiles and their local medical world.

Anthropologists and public health analysts have demonstrated that refugees are especially at risk from illness and psychosocial stress occasioned by the physical and mental hardships caused by displacement and the precariousness of exile situations (Ahearn 2000). Authors in the fields of minority mental health and refugee studies characterise
emigration/immigration, forced or voluntary, as a process of ‘uprooting’, highlighting the social stress involved in leaving one’s native land and the difficulty of resettlement (Kuo & Tsai 1986). According to Kuo, social stress among immigrant and refugee populations ‘resulting from social isolation, cultural conflicts, poor social integration and assimilation, role changes and identity crises, low socio-economic status and racial discrimination’ lead to a high prevalence of illhealth and psychological impairment (Kuo 1976). Migration sometimes seems to precipitate more frequent occurrences of already existing diseases, and sometimes seems to trigger the arrival of ‘new diseases’, that is ‘new’ to the migrant population and to medical systems, as for example the ‘Sudden Death Syndrome’ developed by H’Mong refugees in Thailand. The epidemiological and qualitative data on this subject gained sufficient proportions in the 1980s and 90s to warrant extensive anthropological inquiry into refugee camp behaviour, demoralisation and ‘coping strategies’ (Cohon 1981; Malkki 1992, 1995a, 1995b).

In discussions of psychosocial stress as related to exile, I refer here particularly to the work of social psychologists who have described how stress can be caused by role conflict, status inconsistency, and equally be reduced by social support (Cast & Burke 2002). Such theorists have argued that identity and stress are related in the sense that ‘the same mechanisms which provide our basic goals and directions in life (our identities) are the mechanisms which also provide our basic sources of distress’ (Burke 1991: 836). According to this theory, social and economic strategies in response to exile exigencies can also be interpreted as sources of psychosocial stress.

Furthermore, following anthropological inquiries exploring the interrelationship between the body, society and illness, a growing consensus has emerged on the necessity of combining quantitative and qualitative methodologies in assessments of health in order to engage with subjective understandings of what it means socially to be ‘healthy’ or to ‘be well’.

One of the readily identifiable pitfalls of the ‘uprooting’ approach is that social change will automatically be assumed as ‘bad’ for one’s health and well-being, and indicators of ‘successful adaptation’ ignored or missed (Kuo & Tsai 1982). It has also been documented that ethnic subcultures and the so-called community social support system (i.e. the support of kin or friends) can alleviate the burden of social stress. Hence
emphasis needs to be drawn to the study of ‘palliative’ social strategies of refugees and immigrants and how these affect their health. Further enquiries on the interface of anthropology and psychiatry have stressed the key importance of analysing the cultural configurations of mental illness among groups such as refugees and ethnic minorities in order to organise the provision of appropriate healthcare services (Littlewood & Lipsedge 1989).

Investigating the situation of exile Tibetans within the framework of classical refugee mental health evaluation is an arduous task: the Tibetan refugee population is vastly heterogeneous, with vast disparities in outlook between generations and further intragenerational differences between second generation Tibetan refugees and young newcomers from the TAR. It is therefore crucially important to back up quantitative studies of healthcare among Tibetan exiles by more qualitative assessments outlining the extent to which this fragmented social fabric has impacted on attitudes to health and the distribution of healthcare.

The present study is thus concerned with the impact of social change caused by the displacement of Tibetans on perceptions of health, but also broadly with the plural local medical culture in which therapeutic choices are made.

The first part of the thesis consists of a discussion of social change and the economic predicaments of exile as elements participating in the production of psychosocial stress (Chapters 2-3), while the second part (Chapters 4-5) is devoted to a study of the Men-Tsee-Khang, Dharamsala’s traditional Tibetan medical institute, its evolution and positioning vis-à-vis both its patients’ expectations and biomedicine. The third part (chapters 6-7) offers case studies and analyses that seek to give ethnographic depth to the experience of illness in the changing social landscape of Dharamsala.

I will make reference to the idea of ‘exile lifestyles’ as constraining or enabling health but also as connected to the body and projects of self-identity. I use Giddens’ definition of lifestyle, namely in reference to practices selected by an individual in order to give material and social form to a particular narrative of self-identity (1991). I will also refer to ‘lifestyles’ in reference to the nexus of socio-economic opportunities and constraints impacting on people’s health and health seeking strategies. Last has suggested that the
greatest poverty may not be the lack of material wealth, but rather social poverty, i.e. the absence of social support (1999: 78). Inherent to this approach is the idea that social factors such as the availability of formal and informal, material and moral support are a key to understanding health configurations in a local context (Pilisuk & Hillier Parks 1986). As argued by Schilling, lifestyles always 'occur within the constraints and opportunities provided by an individual's social location', and will affect the mind and body because individuals adopt particular 'body regimes' as part of their lifestyles (1993: 181).

This study consequently brings to the fore current anthropological preoccupations with the body and with understanding relationships between the body, society and illness (Scheper-Hughes & Lock 1987; Kleinman 1988; Frank 1991; Turner 1992; Desjarlais 1992; Csordas 1994).

Following this presentation of the theoretical orientations of this thesis, I now turn to an outline of methodologies used, and a summary of ethical concerns.

1.3. Methodology and ethical concerns

Population scientists and anthropologists have devised a number of tools by which to assess the health of populations. Many of these approaches seek to pinpoint a discretely measurable 'health status' defined by macro level indices such as morbidity, birth, death and fertility rates or the distribution of acute infectious and chronic diseases. While associated indices such as household income, employment etc, provide useful information, the standardisation produced by rigid categories of data often glosses over socio-cultural factors critical to understanding conceptions of health at a local level.

The use of anthropological methods such as semi-structured interviews and participant observation may help to redress this disengagement with the socio-cultural factors influencing health and the production of well-being. This study thus draws on an analysis of social organisation and sociality based on structured questionnaire-based interviews, semi-structured interviews and informal conversations. The chapter outline reflects a methodology that seeks to include quantitative data (in the form of a survey of prevalent diseases and their interpretations), in addition to qualitative data drawn from life
histories, and personal assessments of health gleaned from long-term involvement with key informants and families.

Because locally and culturally relevant conceptions of health were largely influenced by the medical practice and ethos represented by two leading medical institutions in the field, fieldwork involved exposure to both medical environments. In the Men-tsee-khang I had formal and informal interviews with teaching members of staff and students prior to undertaking the initial set of interviews regarding prevalent diseases with patients. In the Delek hospital I volunteered on the TB ward and regularly accompanied patients and friends on visits there. I also interviewed nurses and volunteer members of staff. My involvement with these two prominent medical institutions naturally raised the issue of informants' protection, as well as that of 'protecting' the institutions themselves. I have thus not mentioned all practitioners by name, or have changed names when necessary. The names of the persons in the case studies of Chapter 6 have also been modified. I have asked for patients' permission to use information given by them through the questionnaires.

This study draws on ethnographic research gathered during eleven months fieldwork in Gangchen Kyishong, Dharamsala's middle settlement: a first period of ten months from October 2000 to September 2001 and a second period from June to August 2002, funded by the AHRB Centre for African and Asian Literatures. During the first period I lived between an independent flat in Gangkyi and a Tibetan family home in McLeod. It was recommended to me that I stay in Gangkyi, as this was described as a more convenient location, in proximity to the Men-Tsee-Khang and Delek Hospital, the field that I chose initially.

My first four months were spent on intense language training with an instructor in McLeod Ganj, during which I also started to make contact with students and doctors at the Men-Tsee-Khang. I first conducted semi-structured interviews with MTK students who became informants as we talked about their health history, their training at the MTK, and general perception of health conditions in the area. I initially experienced a substantial setback as a result of a rebuke by a key administrator at the Men-Tsee-Khang (see Chapter 5). He told me that, to understand Tibetan medicine, I had to go to the root (rtseta) and learn Tibetan assiduously. In the following eight months, I spent two hours
each morning with a language instructor in McLeod Ganj, before going back down to Gangkyi to talk to medical students and patients in the afternoon. For a while, I learnt from Men-Tsee-Khang students by having conversations about medical vocabulary, the function of the organs and plants described in the curricular medical texts, and the routine of medical education. Soon, with the help of my Tibetan language instructor and a medical student friend, I wrote a basic health history questionnaire (see Appendix A) which I immediately set out to test on all my acquaintances and a random set of patients from the Delek Hospital and the MTK. The response to the questionnaire was only partially satisfactory as far as information about health was concerned, but always provided a good starting point for discussions on family and childhood histories. I soon renounced using the questionnaire and tried to keep track of my contacts by regularly checking up with the families and individuals I had come to know through the initial interview process.

Part of my dissatisfaction with the questionnaire lay in the fact that few Tibetans openly spoke about serious medical conditions (with the notable exception of torture victims). On one instance for example, I asked a female informant whether she had ever had what she would consider a serious illness. She answered negatively, but as she stood up to go home, I noticed she had a distinct limp and seemed to have trouble keeping her balance. When I asked her about this, she told me she had contracted polio as a child, and had been given medication by a visiting foreign doctor. I asked her whether she considered polio a 'bad disease' (na tsha sdug chà), or a 'special disease' (na tsha dmigs bsal), to which she answered that it was 'bad' indeed, but perhaps not 'special', as many Tibetan and Indian children suffered from it. I explained the reluctance of my informants to talk about serious or 'bad' diseases by relating it to Tibetans' general distrust of inquiries about their past and the potential consequences of the misuse of personal and medical histories in an exile context (see Chapter 4).^13

Shortly after, two families I was close to were stricken by tuberculosis, and I recorded their progress in a daily diary, noting their activities, their comments and preoccupations with the illness, and its influence on family life. I interviewed twelve traditional doctors on their daily practice, eight of them from the Men-Tsee-Khang and four practitioners external to the Institute. Two of the non-MTK doctors were reluctant to have their
account inserted in the study, and I have therefore omitted to refer to them. I also interviewed fifteen students at different stages of the Institute's curriculum.

January opened with a fresh prospect for research. While living in Gangkyi, I had naturally become involved in the Central Tibetan Administration's life, sometimes helping in the Library of Tibetan Works and Archives, mostly with the aim of building contacts in the administration and joining in the daily activities of the staff. As I felt that my research on medicine had come to an impasse, partly through my lack of technical linguistic skills, I was happy to find myself in a politically charged environment where I was given the possibility to help out by doing translation work or more menial tasks. In the meantime, I built on contacts with newcomers in McLeod Ganj and Gangkyi. I also repeatedly visited the Tibetan Transit School (Soga) with friends who had been students there or had relatives on the course, which further increased my contact with newcomers. I regularly met up with them in the evenings to cook food, and also sometimes accompanied them on business or administrative errands, preparing *mog mog* to sell on the market for instance, travelling with them to other settlements to visit relatives or helping with administrative issues (it was on such a basis that I undertook trips to Rewalsar (Tso pema, *mtsho pad ma*), Mandi and Kullu). I also had repeated conversations with older refugees on their perception of newcomers.

During that time I also often had recourse to teaching as an entrée into families and a way to check life histories. Although I was aware that this was a common trap of Dharamsala life and that it exposed me to only certain segments of the population, namely those who were interested in contact with foreigners, it was presented as an opportune way of 'getting to know people'. The problem was how to diversify the range of people one had contact with. It must also be said that this is one of the privileged ways in which foreigners get to know Tibetans and come to a more personal understanding of their life in exile. It is also one of the channels through which youngsters get 'sponsorships' or *rogs ram* (sometimes also called *khag theg rogs ram*). I was repeatedly warned by my Tibetan instructor and friends not to take on any students personally, but rather, if I wanted to work, to go and 'volunteer' in the Yongling School or in a nunnery. More importantly, they said, I should make sure my time was not wasted by people who 'didn't really want to learn'. Despite these warnings I continued throughout most of my stay to have at least one or two students. At the peak of these
activities I spent three hours a day with a young nun, a young Ladakhi training to be a Thangka painter, three TCV children and, of course, a young Amdo newcomer.

My reasons for engaging in these activities were multiple. The first lay in the overwhelming power of the ‘volunteering’ culture in Dharamsala, where it sometimes felt as if every foreigner was either a potential volunteer (dang blang) or a potential sponsor, hopefully both. It was strongly impressed on me that, in order not to be seen as a spiritual tourist or a ‘Tibet monger’, in short, not just another injiy (dbyin ji, foreigner, initially Englishman), one had to give back as much as one ‘took’. On the other hand, it was important not to overdo it and be taken advantage of, as that showed a serious lack of judgement. In other words, shedding my injiy robes was hard, and I was constantly being put back into the set role of volunteer, teacher or student. The fact that I was working was seen to benefit me as much as the people I collaborated with or taught, and indeed, it was generally the case. My impression was that the divide between me and the families or individuals I wanted to approach was reinforced by the fact that they were accustomed to, and unimpressed by, the ephemeral help which foreigners brought to the community.

Throughout my stay I kept looking for the shibboleth that would allow me to throw away my injiy tag. Friends mentioned that I had been too cautious not to become associated with the crowds of Buddhist devotees that populated the Gangkyi and McLeod area. But by shutting myself out of the religious circles I had, for a number of my informants, at least made a consistent choice: one was either a chos nang pa (a Buddhist, lit. an insider), or not. Monks sometimes expressed irritation with the crowds that came to ‘try’ the teachings and then left, promptly forgetting all they had learnt. At least I wasn’t pretending, I thought. In the last four months of my stay however, I became increasingly engrossed by the spiritual life of the town and started attending teachings assiduously. This pleasantly surprised my friends who encouraged me by presents and gave me advice on getting a religious teacher.

Gradually, as my linguistic skills improved, I became more confident in refusing to speak dbyin ji’s skad (English) altogether, except to those informants I had long been accustomed to speaking with in English. From then onwards my acceptance in the multiple settings I had access to broadened; I was able to carry out unstructured
interviews more casually, and have less formal dealings with the individuals who had become my main informant base.

The following chapter provides an account of social organisation in Dharamsala, and addresses the issue of socio-economic survival in exile.
Social Organisation, Sociality, and the Uncertainties of Exile

The aim of this chapter is to outline some of the types of impact effected by exile on social organisation, kinship and sociality among Tibetans in Dharamsala. In conclusion to this chapter, I offer a summary of the ways in which exile social organisation influences perceptions of health, thereby identifying potential structural and social constraints on health in exile. In order to explore these issues, I first contextualise exile social organisation in relation to pre-1950 historical studies of Tibetan society.

While Tibetan historiography and native anthropology tend to emphasise the egalitarian ethos of Tibetan society as inspired by Buddhist ethics, Chinese scholars have invariably described pre-1950 Tibet as a feudalistic, repressive theocracy. Western scholars also depicted Tibet as 'a country controlled by the hierarchic, rigidly organised Lamaistic monastic Buddhism with its boundless power over the laity' (Weber 1958: 289). The combination of orientalist views held by early Western explorers of Tibet, feudalising depictions by Chinese historiography, and the later accounts of Tibetan anthropology therefore provides us with very discordant portraits of pre-1950 Tibetan society and renders comparisons with exile society highly problematic.

Early accounts of life at the beginning of the twentieth century (Waddell 1905; Bell 1924a, 1924b, 1928; Harrer’s impressions in Bauer 1974; David-Neel [1985], etc.) provide some description, albeit romanticised, of socio-economic and religious systems. More recent scholarship based on the comprehensive analysis of Tibetan documents describes Tibetan society as characteristically divided between estate owners, who sometimes also held political offices (drag zhan, translated as ‘nobles’), and commoners or land leasing peasants (mi sde or mi dmangs) (Carrasco 1959; Francke 1926; Snellgrove and Richardson 1968; Goldstein 1971). The clergy was exempted from tax under Yarlung king Trisong Detsen, and monasteries were subsequently endowed with land and revenues (Tucci 1950b: 53; Francke 1926: 90). The land revenue system institutionalised the subordination of landleasing peasants to nobles, with various leasing and tax arrangements. According to Carrasco, the state raised taxes from peasants on the basis of
their house allotments. This system was reformed under the fifth Dalai Lama, when taxpayers were registered on the basis of households and could be levied either in kind (barley and local products), or in manual labour (’u lag) (Carrasco 1959: 21).

This depiction of Tibetan socio-economic structures was strongly criticised by Goldstein (1971; 1986), who argued that the traditional dual opposition between estate owners and peasants was essentially one between aristocratic lords (sger pa), and serfs (mi ser), whereby serfs were attached to an estate, subjected to taxation and forced to provide labour (1971: 522-524). Despite this, serfs would sometimes own their own plots of land (tre ten) hereditarily, and being taxed on the basis (brten) of that land, they possessed distinct legal rights, including that of maintaining individual property14. Goldstein identified Tibetan social relations between mi ser and the nobles with European medieval relations of vassalism, thus fanning the flames of Chinese accusations of feudalism. Recent scholarship has brought some nuance to this picture, emphasising the degree of autonomy from which the mi ser benefited, highlighting opportunities for social mobility within the system, and forging a more heterogeneous and complex picture of Tibetan socio-economic life (French 2002; Coleman 2001). However this depiction of pre-1950 Tibet as a highly hierarchical, patronage based theocracy has remained potent in the contemporary imaginings of Tibetan society, and still permeates into exiles’ discourses about modernity and change.

At the turn of the 1960s, in the aftermath of the Chinese invasion of Tibet, Dharamsala was a small but expanding community of refugees. Following the first wave of 1,000 Tibetans across the border in August 1960, approximately 5,000 more refugees reached India over the following months. From 1961 onwards, approximately 80 to 100 Tibetans entered India every month. The Government of India instigated a policy of resettlement to funnel the population from the border camps into the newly allocated Southern Indian territories in Karnataka. Refugees from Khamdo15 migrated from the transit camps on the Indo-Tibetan border to the settlements which had been allotted to them, while the majority of aristocratic families stayed in the exile government’s vicinity or moved to the richer East India settlements (e.g. Darjeeling)16. One of the former British detention camps located in Buxa (Bengal) was used to accommodate monks in the late 1960s. Approximately 200 monks contracted TB there and died, while some 900 moved south to Bylakuppe and Mundgod (Grunfeld 1987: 196). In the forty years following the
first Diaspora, these internal migrations continued and Dharamsala expanded into the biggest single settlement of Tibetans in exile, now only rivalled in numbers by the southern settlement of Bylakuppe in Karnataka.17

Ethnographic work on traditional Tibetan kinship systems has provided much information on pre-1959 life in Tibet and on Tibetan border settlements in Nepal and India (Norbu 1997; Levine 1988; Diemberger 1993). The literature focusing on kinship patterns in exile emphasises the disjunction between Diaspora Tibetan social organisation and 'traditional' Tibetan kinship prescriptions. However pre- and post- diaspora kinship practices do share the character of heterogeneity. The variety of kinship structures paralleled the myriad of socio-economic contexts, land management patterns, and cultural histories that characterised the pre-invasion Tibetan areas. This heterogeneity is also present in the contemporary exile situation.

2.1. Elements of exile sociality, kinship and marriage strategies

Although a detailed study of Tibetan kinship in exile is too broad to embark upon in the context of this study, understanding contemporary lifestyles and their impact on health requires us to discern some of the changes it has undergone in the environment of exile. This section seeks to show the diversity of strategies adopted by Tibetans to cope with the break-up of households and the economic constraints of exile. I suggest that Tibetans seem to have adapted marriage rules to exile circumstances, and that their choices of partners reflect the contemporary changes in gender labour division as well as the emerging upward mobility of the youth.

Dharamsala is an urban settlement and, as such, presents a number of specific constraints. Tibetologists have traditionally associated Tibetan rural environments with polyandrous kinship systems. In more urbanised areas, a joint patrilocal family system was often described: a woman established her residence with her husband and his direct family, forming a new virilocal household. The relationship between daughter-in-law and the previous mistress of the house is often portrayed as a one fraught with tension caused by the gyos mo's jealousy.18
Tibetans have only been allowed to settle on land given by the government of India and many have had to change occupations after coming into exile. Families already broken up after the crossing were arranged into artificial households, and often relocated in distant settlements or separated again. Today, poorer settlements like those in Bihar or Arunachal Pradesh are depopulated of their youth who go and seek employment and education in bigger settlements or in Indian towns (Simmonds 1985).

Another factor impacting on the structure of households seems to be the prohibitively high cost of housing in Northern Indian settlements. Many families in Dharamsala cannot afford to buy property in the settlement. They are also not allowed to buy property on land that has not been donated to the Dalai Lama by the Indian government, or, if they wish to do so, need to go through Indian intermediaries or religious patrons. Small two-bedroom flats may cost from four to five Lakhs (i.e four to five hundred thousand Rupees) in the upper settlement of McLeod, but the majority of the population earns far less than the ceiling salaries of 8000 Rupees (the approximate sum earned by MBBS doctors and policemen), which makes such lodgings accessible only through lengthy saving or loans. According to the CTA, only 16.5% of the exile population live in owned accommodation. The only other alternative are settlement houses, for which a minor rent is paid, or staff quarters, which are only given to retired civil servants and workers of academic institutes. One CTA civil servant further explained that, 'even if one doesn't own his/her house one has to pay a small tax which is deducted straight from one's salary' (so so'i khang pa yod na 'khral rnyung rnyung sbrad dgos red ani gla cha nai bchod kyi yod red). The tax is paid to the Tibetan Government in Exile as a more or less obligatory contribution (there is no sanction for non-payment but it expected as a token of loyalty and co-operation with the government), as the CTA is not formally allowed to levy tax. The costs of buying and maintaining a house in Dharamsala therefore make it hard for a great majority of the population to own their own homes.

Most of the upper settlement houses in McLeod Ganj are restricted to one or two rooms, in which only a few family members can be accommodated. Despite the lack of space, exiles manage to maintain joint households, which often include in-laws and sometimes also distant kin. According to Saklani, families are usually larger within Tibetan settlements and smaller in out-of-settlement conditions (in the so-called
"dispersed" populations). Her survey of 135 exile households in North Indian settlements revealed that 41.5% of her informants lived in joint households of 4-6 members (1984).

It has become the pattern for newly married couples to move away from the parental or joint family home to find a residence of their own. This is made easier for young professionals or civil servants who can afford to rent their own premises or are able to live in staff quarters. The price of Gangkyi lodgings is only slightly more advantageous, and families can sometimes afford to accommodate one or more of the spouse's relatives, in the bigger apartments built for doctors and civil servants. Some more established families have been able to buy houses in Lower Dharamsala, where the land is cheaper. However this entails conducting negotiations with Indian landowners, which only 'experienced exiles' are willing to embark upon.

Difficult economic conditions have therefore impacted on exile familial set-ups. Many households were ruptured with the coming to exile: according to Saklani's survey of Dharamsala households in 1973, 83% of respondents had left one or more members of their primary family behind in Tibet. She describes dramatic instances in which husbands and wives who had been separated and had subsequently founded new homes in exile had then been re-united and confronted with the terrible prospect of having to choose between two households. Tibetans have had various strategies for dealing with broken homes, and in many, it has been argued, these involve 'forgetting' or 'recasting' previous kinship classificatory systems. In his discussion of the 'structural elements of Tibetan refugee society', Führer-Haimendorf asserts that many exiled Tibetans do not know their *rmi brgyud pa* (exogamic patrilineage), allegedly the most traditionally salient kinship category for Tibetan groups (Benedict 1942). *Rmi* refers to 'bone': many Tibetan societies conceptualize kinship bonds in terms of 'flesh' and 'bone', patrilineal clans being referred to by the word for bone (*rmi*) and matrilateral kin by ties of 'blood' (*khrag*), 'flesh' (*shd* or 'milk' (*mo*). Evidently, with the pressures of exile, family groups may now be living in the same locality in exile without belonging to the same *rmi* (Führer-Haimendorf 1990). In Tibetan cultural regions, anthropologists have noticed that references to *rmi* as 'clan' has tended to disappear, and has sometimes simply been replaced with the name of a territory or a house (cf. Stein 1972: 107, but also Ramble, 1982: 344, for an interpretation of *gdung* or *rmi* as 'patrilineage'). The following section examines the question of the
emergence of the nuclear family as dominant exile familial set-up, and its contestable reality in Dharamsala.

2.1.1. Nuclear families, kin networks and social support

Numerous studies have remarked that the nuclear family is becoming the dominant form of familial set up in Dharamsala: Saklani’s household survey revealed a decline in families of 7-9 members (approximately 15.5%) and a sharp rise in smaller, nuclear families of 1-3 members (51% of the population surveyed), (1984:99).

Although the nuclear family seems to have emerged as the dominant mode of familial organisation statistically, the importance of alternative sources of social support to families and individuals needs to be discussed in order to establish whether support has been de facto reduced among exiles as a result of the break-up of households and the rarification of extended family households. In this section, I argue that neighbourhood and regional community networks exist and bring support to nuclear and extended families.

In Dharamsala, informal local support networks, which may or may not include kin members, act as underlying supporting structure to nuclear families. I suggest that although the economic constraints of exile may have ‘physically’ reduced Tibetan homesteads to the semblance of nuclear households, however, in practice, these ‘downsized’ families are in contact with relatives in other households of Dharamsala, or even in other settlements. Although they may not be co-residents with members of their extended family, couples often live in close proximity to them in the settlements. Moreover strong informal networks involving friends acting as helpers (regs pa) come to supplement the family’s network of support.

The two case studies I will present here attempt to show the interaction between the family network and impromptu social support in Gangkyi and McLeod.

Choekyi has been working for over three years as an employee in one of the academic research institutions in Gangkyi, where we were close neighbours. Her father was part of the first group of exiles that arrived in India in the 1960s. Through her work, Choekyi
has secured a three-bedroom staff-quarters apartment in Gangkyi, which she shares with her two sisters and father. One of her sisters is being schooled in the Tibetan Children's Village, which has freed some space for her other sisters and father. She married a local Tibetan craftsman and settled in a new flat adjacent to her father's old apartment. The new flat is extremely spacious, and is generously put to use for hosting friends, or watching over Choekyi's older sister's baby while she is at work. Choekyi knows most of the lodgers on the Gangkyi residential compound and is reportedly envied by her female peers for the way in which she has managed to secure so much space for herself and her husband, while at the same time keeping her immediate family close. Running errands, she is often accompanied by friends from Gangkyi, and she can count on her immediate neighbours and her husband's kin and friends for help with daily tasks.

In November 2000, Namgyal, a middle aged Tibetan trader, was having a flat built in one of the most coveted areas in McLeod, near the Gu Chu Sum. He successfully circumvented the Indian laws that forbade him to build a flat making a building taller than three stories, and is in the process of completing his new apartment. The two-bedroom and one kitchen flat would become a home to him, his wife, his mother-in-law and their two children. Namgyal was the first of his family to come into exile (he was followed shortly after by his brother and sister, who now live in Dalhousie), and has worked hard making a living in business. His flawless and idiomatic Hindi has earned him the sobriquet of 'rgya gar gyi pha lag' (the Indian father/old man). After having married in exile, he and his wife, a schoolteacher, arranged for her mother in law to leave Tibet. The mother now looks after their two children while they work, and prepares food for the entire household. Namgyal is on an economic par with the most successful traders in town and has an extensive network of friends and relations across the Tibetan settlements in India. His business contacts helped him to get cheaper construction materials for his house and he able to send one of his children for further study in a good Nepalese university through contacts with his relatives in Kathmandu. He is away from home for approximately three months of the year, during which he travels to Delhi or Kathmandu on business.

These two cases illustrate the importance of both kin and non-kin support networks. Most families retain close ties to their immediate relatives. They attempt to (re-)constitute geographic proximity and support-giving arrangements, often including more distant classificatory relatives in their intimate circle, as we will see in the following section.
Furthermore, the geographical proximity of close kin, whether living in the same household or not, is a crucial factor in understanding the dynamics of therapeutic choice-making in Dharamsala. Networks of kin and friends play a critical role in an individual’s decisions about whether to start, continue or abort a therapeutic course of action. The experiences of family and friends with prevalent illnesses such as tuberculosis or diabetes bear heavily on how relatives consequently choose to manage the course of their own illnesses (see chapter 6).

2.2 Households and marriage strategies

In addition to resources pooled from close neighbourhood entraide and kin proximity, exile circumstances have pressed refugees to enlarge the traditional circle of close relatives to include other classificatory distant relatives who have also come into exile. The term khyim tsang, which directly designates co-residents, still refers to the extended family, i.e. potentially including three generations in the same household. The term nang mi, literally the people from ‘inside’21, can now comfortably be used to designate a ‘nuclear family’. However the preferred term for family relatives is spun kyag, of which the root syllable spun may be found in all kinship terms designating relatives of Ego’s own generation, including the members of collateral lines (e.g. in bu mo spun chung ba, younger sister). Same-age geographically distant cross-cousins refer to each other as spun kyag or spun ched thereby emphasising the closeness of the relationship and the maintenance of kinship bonds despite geographical dislocation. The relationship between exiled paternal and maternal aunts and uncles with their nephews and nieces is close, ideally involving much economic and social support22. Paternal uncles and aunts (a khu and a ni) in the three families I had extensive contact with in McLeod Ganj and Gangkyi hosted their nephews and nieces from other settlements frequently, and often presented them with gifts and pocket money. Similarly, family members living abroad will also be referred to as spun kyag.

It is possible to speculate that the dissolution of traditional notions of rus in exile allows such flexibility in kin designation. As exile brings the need for strong kin networks, more distant relatives who have come to India are brought physically and nominally into the tighter nucleus of close kin and resources are pooled together.
The traditional prohibition of a couple to marrying if they are nearer in terms of blood relations than seventh cousins in the patrilineage (brgyud) (Norbu 1974: 99) is said to hold in principle. Despite this I am not fully confident that breaches of this traditional rule have not happened, for example in cases when regional affiliation is the primary determining factor and therefore overrides the patrilineal exogamy rule. Traditionally, the preferred marriage is that of a daughter with a maternal uncle's son, although I have not witnessed any such instances among young married Tibetan couples. Nowadays it is said that youngsters' choices often go against their parents'. Generally speaking, however, refugees born in India tend to marry with other Tibetans raised in India. When two young men of my acquaintances set out to find suitable partners, they listed a number of their prospects, insisting that, above all, the girl had to be of nice skin tone (their favourite was a CTA worker they had nicknamed dong dkar po, or white face, for her snowy complexion), and of noble behaviour (ya rabs, which etymologically refers to 'noble people', of 'noble lineage'). The young men where clearly frightened by some of the more hard-working women in the CTA and the Men-Tsee-Khang, whose independence and ambition contrasted with the more conservative outlook of their elders. Despite this, however, they told me they saw equal partnership, or having someone of the 'same mind' (sems mthun pa, to think the same, lit. be of one mind) as preferable, because it fostered harmony in marriage. I was often asked if my own parents were still together, with the underlying comment that often injiys couples did not succeed in getting along ('cham po chams, more literally to agree) and family strife (nang mi thun) ensued. One middle-aged traditional medicine doctor told me he thought this might be due to the long hours and stressful work in Western countries. This he contrasted to the more relaxed lifestyle of Tibetans: las ka ka le ka le byed na, sku lhod lhod gnang nas bzhus (if working in an unhurried way, and remaining [with your body, sku] in a leisurely way (lhod lhod gnang). Mixed marriages between Tibetans and injiys (foreigners) are common, and tales of Tibetans marrying and going abroad are especially relished. These marriages were though to be unsuccessful because the spouses were of different minds (sems khag ga).

On the occasion of marriage, couples will generally hold a small gathering with their immediate relatives, share food and receive the byin rabs (blessing) of a bla ma. Couples start living together immediately thereafter as husband and wife, and it is the act of living together which is said to 'make' a marriage. Some younger couples chose to wear
wedding bands but most middle-aged and elderly couples prefer the traditional precious stones *g.yu* (turquoise) or *byu nu* (coral) set in large gold rings. It is common for women to keep their *pang gdan* (apron) in old age, even after the death of a husband. Some of the women I asked about this explained that these are the marks that distinguish them as wives and mothers. One middle-aged woman, who had lost her husband to a liver disease caused by alcohol, made the more abrasive comment that she kept her *pang gdan* not to remember her deceased husband, but to keep other men at bay, because she simply ‘had no interest in them anymore’, and, she said, there was ‘no need to be ashamed of that’ (*di’ r skor ngo tsha byed rgyu med*). Similarly, I saw women who had divorced or were separated wearing the *pang gdan*.24

Young women who had secured an occupation found they had more clout in their choice of partners than they might otherwise have had: often young women working for the CTA would bring their lower-earning partners into their job-provided lodgings and start their own households. In most of these cases, however, a ceremony was still held with the family. Women whose husband or close kin lived in different countries often set up business ventures of their own with the money sent from abroad (internet businesses were the most popular at the time of fieldwork). The practice of neolocality may however be specific to Dharamsala, as generally marriage in the Tibetan exile community is relatively patrifocal (according to the 1998 Demographic Survey, twice as many women had moved house as a result of marriage than men, see Fig.3: Reason for Migration by sex, p.16).

Two couples I knew closely said they were ‘introduced’ (*ngo ’phrad pa*) to each other by their families in the hope of a potential marriage. In the first, the families of the betrothed had a regional connection (they were from the same region in southern Tibet), the other was the alliance between the heirs of two powerful exile business families. I was told by young female friends of marriageable age that the practice of introducing prospective partners, or setting up marriages, occurred relatively frequently in exile. One friend from Gangkyi related his encounter with his future wife:

One summer I went on holiday to Bylakuppe [Tibetan settlement in South India], just to relax and see some friends. Before I went, my parents had asked me to go and meet some friends of theirs. I knew they had a daughter who was my age, so I thought that something was a little bit strange, I was not certain about it all. And I went. In my mind, I thought that these people were business partners of my father [who was involved in blanket and carpet crafts], but it was more strange (khyad mthar): the mother of that family was actually my
mother's best friend, and our fathers were also good friends and business partners. I was not happy about meeting that girl. I thought, oh no, she is going to be really embarrassed and shy, and I will not know what to say. I really didn't want to go there. But because there was all this family business I went. We met once then, and it was fine, although we didn't talk much. After that she wrote to me saying, 'I want to come to Dharamsala, there is a nice job for me there, please let me stay with you for a few days'. Then after that it happened, and we got along well.

The couple lived separately for two years, then for one year together before getting married. In the second case, the families owned two hotels in Dharamsala. Tibetans coming out of the day-long celebration complete with drinking and singing, jokingly referred to the wedding as 'two hotels getting married' (don khang gyis chang sa red), as the sound system boomed English techno songs. I was later told by a neighbour that this wedding had occasioned such huge celebrations because of the status of the families involved and that, usually, unless the spouses wanted official recognition (i.e. an Indian marriage certificate), the wedding ceremony mostly consisted of eating and drinking with friends and relatives (Cf. Diehl 1997: 102-4). The same informant said that separation would be equally simple, one of the spouses moving out of the common house. This was however highly unlikely, as another (male) informant reported, emphasising that the binding nature of marriage lay in its foundation of a new household. Once one is married, he said, and acquainted with the spouse's family, having a house, children, and relatives in common, and even the presence of neighbours (khyim mtshai) contributes to cement the relationship.

Thus, as we have seen, the fluidity of marriage patterns common to Tibet, with individuals moving from monogamous to polyandrous and polygynous households for instance (French 2002: 38) is somehow restricted in exile.

Before marriage, however, the uncertainty of diaspora relationships is manifest in young Tibetans' romantic encounters. The mobility of exiles, especially young India-born youngsters who have to move to gain schooling or training outside their initial settlement, meant a great deal of romantic frustration and a frenzy of e-mail communication between separated youths. In the holidays seasons, during the long winter la gir b break, or during the long weekend called 'second Saturday' each second Saturday of the month, students from the Tibetan schools (Sara, Mussoorie, or Dehradun) return to spend some time with their relatives. I would then hear young men say that it was time to dress up (gsab mshor) and go out, because freshly arrived young
women would be around. This ‘sharking’ was discussed and planned in advance, and the dances organised on long weekends would see Gangkyi young professionals at their smartest, prowling for partners. Young women who were involved in romantic affairs were said to be ‘beaming’ (‘od rgyab) when visiting their boyfriends in other settlements, and were thus teased on their return to Dharamsala. The uncertainty of exile, as well as the increasing mobility of youngsters both nationally and transnationally, generates intense psychosocial angst, which in turn exerts pressure in the domain of relationships and marriage.

Another changing feature of exile marriage is the attraction exerted by Tibetans who have emigrated to the West and return to find partners in India. One can sometimes find girls from the Western Tibetan communities in Switzerland or Germany coming back to find a husband in Dharamsala at their families’ request. Girls from Dharamsala or the southern settlements may also prefer to become engaged to a Tibetan about to move to America or a European country. A concerned exiled mother explained to me that it is difficult for Tibetan girls to find suitable partners in their host countries, as all young people there are indeed of the ‘same mind’, but in the wrong way: they are career-orientated and not in a hurry to start a family. Also, Tibetan families with one of their children leaving for the West expressed the desire to have at least one member of the new household brought up as a Tibetan, with a good knowledge of the language and customs so they could pass it on to the grandchildren.

India-born exiles whose families have migrated to the southern settlements sometimes choose a spouse from their family’s region or place of origin in Tibet, sometimes even from the same town or village. Refugees in Dharamsala, however, are surrounded with a wider mix of population and therefore a greater choice of partners. In Gangkyi, a high percentage of civil servants and ‘institute workers’ marry fellow Gangkyi workers, while McLeod Ganj residents display greater variety in their choices. Clearly, although the majority of young couples now take their decisions independently, parental advice plays an important role in the choice of partners and some parents will insist that the bride or groom’s family should be from the same area as themselves. This is significant, hinting at the persistence of sentiments of regional identity in certain segments of the community. Moreover, small sub-communities of Tibetans originating from the same regions have organised themselves into societies and clubs that cultivate their regional heritage and
maintain intraregional support in exile, whether in formal industrial settlements and handicrafts cooperatives, as for example the Khampa industrial society in Bir (H-P), or at a less formal level, in small ‘club-like’ societies such as the Toepa in Dharamsala. These societies collect money for members in need, and help each other with housing and educational costs for their children. Such small intraregional family networks create and reinforce a sense of common regional identity by recreating a community of interest in exile, and also seem to strengthen intra-regional marriage patterns.

Tibetan-Indian intermarriage is extremely rare. During my year in Dharamsala I heard of only one such occurrence, when the town went into an uproar at the news of a Tibetan businesswoman marrying an Indian man. The gossip circles had it that the bride herself had become Indian: she spoke Hindi fluently, relished Indian songs and film lore, wore bright lipstick and colourful shalwar kameez, all things coveted but rarely dared among young Tibetan women. Her reputation as a fierce businesswoman had instilled jealousy among the womenfolk: she and her Bombay-born husband were the managers of one of the most prosperous restaurants in lower Dharamsala and made no secret of their success. The marriage occasioned a major celebration, which caused much discord in the settlement: families split in their positions for or against it, and it remained the talk of the town long after the event itself had passed. Most women said they did not resent the mixed marriage so much as the display of opulence and flaunting of ‘nouveau riche’ status acquired by the couple. As least, the women said, the groom was South Indian, and not a local Indian from Dharamsala. I often heard Tibetan women complaining about the lasciviousness of Indian men, and frowning over the stories of young Tibetan shop assistants being abused by their Indian bosses. The tension between the two communities is most strongly embodied in gender relations. Tibetan women rarely talk about Indian women as a category, but often of ‘Indian men’ as a group, particularly the ‘Kache’ (Kashmiri) Muslim traders, who are thought to exemplify the cunning, deceitful and sly ways of the business community in Dharamsala. The Tibetan exile community therefore strives to maintain an ideal of strict Tibetan endogamy, although in practice marriages with Indians, Nepalis and foreigners do happen and are sanctioned as long as they are seen to be technically hypergamous.

I was sometimes privy to ‘marriage crises’, when a woman would come and visit her female friends to share her suspicions about a husband’s infidelity. I was then told that it
was common for older, married men to get infatuated with younger girls. Elderly women gave a different view of married life. Husbands, one woman said, generally behaved badly (ma rabs, bad behaviour), and if problems arose in the marriage, the couple would simply sleep apart, sometimes for years, and carry on with their daily chores. The circumstances of the diaspora also often allow marriages to carry on with one partner abroad in the West and another in Dharamsala, sometimes in of pseudo-polyandry and polygamy. In such circumstances, the partner abroad sent money home, while the one in Dharamsala raised the children. There seems to be little gender bias to this form of migration: the men and increasingly upwardly mobile young women of Dharamsala equally take their chances at migrating to the West. One female informant described being very content with the arrangement she had with her husband: he worked in America, and this preserved her freedom and gave her family material security.

The circumstances of exile also seem to have given rise to forms of 'patronage' relationships. During my time in the field I spoke to two young girls who had become partners to old, established men in CTA bureaucratic jobs. At first, both girls emphasised the romantic character of the attachment, insisting on their strong feelings of love and their hope of getting married to their suitors. Only later did they acknowledge a feeling of being 'played with' (rtsed ma rtsa byung). They both described how the men had showered them with gifts and love notes and then, after they had given in to their charms, had started to become dismissive. The girls would never reveal the identities of their lovers but the clues they gave as to their occupation and status indicated that these were men in middle bureaucratic situations who had contact with them on a daily basis through their work. One of the girls used the contentiousness of the extra-marital affair to exert pressure on her lover, pleading with him to marry her, and once even threatening to commit suicide if he refused to see her further. It was obvious that both girls had suffered and 'burnt some bridges' through these affairs when they had become known among the community. One of them had successfully obtained help with her 'IC' (Identity Certificate) from her partner, subsequently allowing her to leave India and settle in England where she hoped to make a new start.

It soon became apparent to me that these affairs were not merely the anecdotal stuff of small town life, but revealed an underlying form of established patronage, whether linked to sentimental relationships or not, between bureaucratic workers and youngsters in need.
of help. The five girls I met who had become prey to this form of attention had no or little family in Dharamsala. Four hailed from the southern settlements of Bylakuppe or Mundgod and had come to Dharamsala to receive education, find work, or in the hope of eventually moving abroad. A system of patronage enabled young people to secure favours and money through the cultivation of contacts with exile élites.

Older married women often held discourses on the moral waywardness of the Dharamsalian youth. But taking a closer look at the circumstances in which such affairs arose made it hard for me to accept unquestioningly the rhetoric of earlier refugees, who saw in the flirtatious behaviour of young girls a sign of moral decadence and acculturation. Rather, it became apparent that the pressures of exile, and notably the difficulty of finding work or help with education, had made patronage, familial pressure and the ensuing power dynamics pivotal factors of psychosocial stress in youngsters' lives. The relevance of such local webs of patronage will be further explored in the following chapter.

2.2.1. Do you have relatives in Tibet?

When asked if they have nang mi, or family members in Tibet, India-born Tibetans often either respond 'yes, many', or, more commonly, 'none at all'. This ambivalence may well be a reflection of the refugees' uncertainty about their family's situation in Tibet. Unable to tell how many of their relatives are indeed alive and where, they succumb to over-optimism, or conversely, renounce any affiliation to Tibet. I first interpreted this elusiveness as a brush-off specifically directed at me, or worse perhaps, a comment on the question's political insensitivity. But after a pattern started emerging in these replies, I realised that the answer to the question: 'Do you have relatives in Tibet?' actually engaged my informants with their own personal and collective history, and betrayed something of the shape of their hopes for the future. The dismissive reply, 'No, I don't have relatives there anymore.' could be taken to imply that ties with Tibet had been severed, manifesting a distance from the dominant political rhetoric of the possible return to Tibet, in which many refugees appeared to believe. While many first generation exiles were able to answer with more precision, giving details about the location and occupation of their nang mi, some would simply say, 'My family was from Shigatse, I still have relatives there'. Believing that one still had nang mi in Tibet, even after years of exile,
was possibly indicative of a more optimistic outlook for the future and hopes of an eventual return.

Imagining relatives in Tibet maintains an individual’s bond with the past and the potential for a future reunion. The ‘imagined community’ so often discussed in the context of Tibet is recreated through the remembrance of familial and interpersonal bonds. I was often told by recently arrived exiles that they constantly thought of, and shared, the plight of relatives left behind. As one medical student put it: ‘I am waiting here, they are waiting there, we are all waiting’. This community of thought existed through my informants’ capacity to recall and imagine their relatives, back in Tibet, labouring to survive under occupation as they, themselves, are doing in exile.

Anxiety linked to separation from relatives was heightened by the lack of communication between Tibetan exiles and relatives in Tibet. Many of my informants maintained correspondence with their TAR relatives, but the post was considered slow and unreliable. Calling Tibet by telephone is costly and refugees, especially newcomers with strong ties to Tibet but little capital, can barely spare the expense. On the other hand, contact is easily maintained among relatives and friends dispersed between Indian settlements or further abroad. Specialised Tibetan websites like ‘TibetChat’ enable exiles to communicate with each other. Portal sites such as ‘Tibetsearch’ are laden with political content that put forward a sense of common diasporic identity. Tibetchat, for instance, displays a picture of Tibet coloured by the CTA’s independent flag and, at its centre, the hyperlink ‘Home’, while a small animated character is seen urinating on the PRC’s flag in the corner of the page.

Rouse has argued that communities separated geographically are nevertheless able to become one through the circulation of people, goods and information (1991: 14). In the Tibetan Diaspora there is more communication between refugees as a group, even spread among different settlements or countries, than between refugees and the homeland. This has a noticeable impact on exile family relations and social organisation at large. Exile relatives, even distant relatives living in other Indian settlements, are more likely to be called upon and participate in family events than more immediate relatives living in the TAR. In the next sections, I examine how this impacts on the use of terms to designate immediate and distant kin, and argue that more distant kin living in exile are
drawn into the network of more immediate kin through the vacuum up opened by the severing of bonds linking exiles to the TAR.

In everyday language, the term *spun kyag* is used to refer to close relatives living in the same settlement (such as grandparents, uncles, aunts and cousins). The terms *spun kyag* and *nang mi* are somewhat conflated and *nang mi* now comes to encompass kin living on the same settlement but outside the extended family’s household. Thus two first-generation McLeod families involved in business referred to their relatives living in separate households in McLeod Ganj and in Lower Dharamsala respectively as *nang mi*. On the other hand, the patrilineal cousins of the first family, who lived in Delhi would be referred to as *spun kyag*. Four Gangkyi families agreed that if space allowed, the preference was typically to go towards a joint family household, that is including the father (*pa lagp*), mother (*a ma lagp*), grandfather on either side (*po po lagp* – non-honorific), grandmother (*rmo rmo lagp*).

Contrasting the genealogies of newcomers (refugees who arrived in India in the second influx of the 1980s) with those of earlier refugees gives an indication of the profound changes that affect newcomers in exile. Newcomers, the majority of whom originate from Kham and Amdo, have large extended families, such as that described by a 27-year-old man from Amdo newly arrived in Dharamsala.

The above diagram represents an extended family: in this household Pasang grew up with his parents, his three sisters (one married and moved to her husband’s home) and two
brothers. His maternal grandmother and grandfather lived in an attached part of the house and his paternal grandmother, who became a nun following the death of her husband, lived in the main part of the house with them. Pasang’s elder brother followed him into exile a year after his own departure, leaving his fiancée behind in Lhasa. Both brothers explained to me that they had heard from people in their hometown that there could be opportunities for them to study at no cost in the schools opened by the Tibetan Government in Exile. Although it can by no means be taken as archetypal, this description gives some indication of a young newcomer’s family background. With no news from his relatives, Pasang now lives with two friends, both a mdo ba (from the eastern region of Amdo), in a single room rented from an adjacent monastery on the outskirts of McLeod.

In the following section I look at three Tibetan exile households and examine the cultural and socio-economic influences rendered manifest through a study of their material culture.

2.3. Three Exile Homes

The exile Tibetan household is at the cross-section of diverse cultural influences. As we have mentioned earlier, Tibetan flats usually have no more than two, at most three rooms, depending on the family’s wealth and the number of dependent relatives. In a two room apartment, the space will either be divided into sleeping and living room areas, or simply be convertible into both with the help of bed rugs which are set on the beds in the morning. These carpets are costly Tibetan craftworks and represent an investment for the household. They are often gifted to families ‘starting out’, or on festive occasions such as lo gsha. The ‘transformability’ of space is a prime characteristic of Tibetan households: all living essentials, such as clothes and toiletries, may be hidden in either Indian closets, chests with covering curtains in front of them, or in more traditional Tibetan chests. The bed sheets are covered by a bed carpet, and what was a sleeping room becomes a living room devoid of any trace of personal items, and suitable to receive guests.

Tibetan exile kitchens display the myriad of plastic jars visible in Indian households, containing the different types of dal, flours and beans for cooking. At odds with this
display is the collection of tea thermoses (ja dham) displayed by the more affluent families, most preferring the large decorated ones from China, and the traditional Tibetan butter tea churner. Chinese rice cookers are also cherished items, as well as the food containers in which hot momos may be kept and carried away. Families have marked differences in taste with regards to crockery and eating styles. In one household of Tibetans from the southern settlements who had moved to Dharamsala for work, family members ate in the Indian metalware commonly found in the bazaars, and displayed Chinese ornamental plates on the wall as decoration. In another household comprising a majority of India-born Tibetans, the family ate their rice and dal lunch with their hands 'the Indian way', drank tea from exquisitely ornate china, then drank Tibetan medicine from Western joke mugs. The versatility of Tibetans in the choice of their home utensils denotes access not only to local markets, but also to goods brought from the West, or from the markets of Nepal and larger Indian stores where Chinese goods abound. I was once told by a friend displaying her new thermos with pride that 'it is made in China' (di rgya nag la bsos pa red), as she pulled out her tongue jokingly. Despite the fact that the Dalai Lama has asked Tibetans not to buy Chinese goods, doing so is fairly unavoidable, especially when it comes to the Tibetans' preferred cooking utensils. Newcomers enjoy Chinese foods and cultural programmes, having become used to them in the TAR. In cafés and restaurants where television is available, some diners, generally newcomers, often tune in to watch Chinese news programmes. This is however not an innocuous gesture, and sometimes attracts hostile reaction from politically sensitive exiles.

The decoration of Tibetan exile interiors deserves further attention for two reasons: firstly, it reveals much about the household's economic and symbolic capital; secondly, household set-ups have a great impact on the ways in which healthcare is organised within a family or among co-residents. The family's or group's possessions will be divided among the different rooms according to the amount of space: in a one room apartment the sleeping room will contain the fridge, television, books, clothes and sleeping mat. A three-room apartment may allow the family to differentiate between an office and sleeping room, a living room and a family room. In the following sections I will discuss three household examples to illustrate the diversity of influences manifest in home organisation.
The first example is that of a family of traditional doctors living in the Men-Tsee-Khang precinct (Gangkyi). In addition to the husband and wife, one three-year old son and a maternal grandmother share a three-room apartment. Theirs is a recently constructed staff building, where they share a landing and balcony with four other families. The family is considered reasonably wealthy by Tibetan standards: they were able to buy a computer and some electronic equipment, as well as to afford the services of a Pahari maid. The first room contains two couches and a chair with Tibetan carpets, a television, two shelves filled with the little boy’s toys and some curtained shelves with a stereo, photo albums and books. Dominating the room looms a drawing of the Potala palace with a small picture of the son inserted within its golden frame, and further below a picture of the mother’s Men-Tsee-Khang class, and another of the father’s relatives. On the other wall, opposite the Potala picture, is a large Indian poster (ṣbyar ‘grem) depicting a ‘glaxo’ type baby and the legend ‘a baby is a precious gift’ in English. In the adjacent room is the grandmother’s bed, although the space also sometimes serves as a consultation room. It contains a thangkha of the medicine Buddha (Tibetan: sman gyi bla, Sanskrit: bhaisajyagni), another of Shakyamuni Buddha, stacks of Tibetan medical books, both blockprinted and bound, as well as a closed altar with three statues (Guru Rinpoche, Avalokiteshvara, and Shakyamuni Buddha) and offering bowls. On the shelf is a large copper ornamented ma ni wheel. The last room is that of the parents and child, which also contains a desk and computer, and the family’s clothes stacked on curtained shelves. In this case there is not so much need for covering personal items, as the family has enough space to keep one room as main ‘guest room’, and another as the family’s private sanctum. The general impression in the flat is one of conscientiously maintained and affluent cleanliness. There are many visual references to the husbands’ pre-exile past in Tibet as well as to the couple’s scholarly achievements and prestigious attachment to the Men-Tsee-Khang.

Another family I had close contact with lived in an old building in McLeod, close to the Dolma Ling Nunnery. Their flat had two rooms with an adjacent kitchen, and an exterior bathroom accessible from the landing. The head of the family was a single widowed mother with three boys from her one and only marriage. The mother was now earning a living by teaching Tibetan while setting up a restaurant business in a house paid for by her dead husband’s parents. She had been brought to India by her paternal aunt at the age of nine and did not remember her parents or Tibet. The two rooms of their
apartment were used for sleeping, although there were not enough beds and one of the boys had to sleep on a mattress on the floor. The outer room served as a guest room, and contained a television, two sets of shelves, mostly containing gifted English books, an old Indian metal cupboard with a key lock, two beds with bed carpets, and a high altar with four statues and offering bowls. This room has a large thang kha of Shakyamuni Buddha on the wall, as well as a portrait of the Dalai Lama with its kha brtags on the wall behind the television. There is also a large ornamental traditional Tibetan chest in a corner, which serves to keep the family’s best clothes and treasured possessions. On the shelves are various pictures of the children and a picture of the mother with Richard Gere. There are also class pictures of her as a teacher, her students and the Dalai Lama. Up on the wall are traditional Tibetan instruments played by the boys, including a sgra snjan (traditional guitar). Free Tibet stickers are displayed on various shelves and a Tibet shaped ceramic decoration painted in the colours of the Tibetan flag looms next to the living room clock. In the other room a single bed and a desk are covered with the boys’ paraphernalia, such as notebooks, music tapes and clothes. Clothes are spilling out from a curtained shelf and the cluttered flat gives the general impression of barely being able to contain its contents. When the weather allows, the sons like to sleep on the roof of the house in a small, improvised tent of sheets. There they can talk late into the night when they cannot go out because they are don’t have any money (rtsa skam song, lit. ‘the grass is dry’), and have more privacy than in the crowded flat. This flat displays is an interesting mix of the traditional Tibetan household (the traditional Tibetan chest was a wedding present which has stayed in the family), symbols of political activism and visible traces of foreign influence. Through its material culture, it displays the different ‘influences’ of exile culture today. The family’s more relaxed attitude with regards to the display or rather non-display of personal items is, I believe, the result of its extensive involvement with its community of neighbours as well as its relaxed attitude towards guests and foreigners.

The last example contrasts strongly with the two previous ones. The third house is really a temporary home on the Gangkyi precinct, a house whose rent is subsidised by the Tibetan Welfare Office. There, newcomers may hope to find cheap housing shared with other residents. The house’s only room contains seven beds pushed together alongside the walls, and one lone table in its midst. At night all seven beds are occupied, but during the day the room is almost always empty as the newcomers go about their activities,
meeting friends, working, studying or loitering. In the house, decoration consists of the fantastically ornate posters that adorn the walls of restaurants and monks’ rooms, depicting flourishing gardens with temples, rainbows in the sky and, somewhere among the landscape, the figure of the smiling Dalai Lama.

In the impersonal dormitory these posters present a vision of home, i.e. Tibet, that is translated and abstracted into imperious visual and cultural symbols: the ultra-realistic drawing of a flourishing valley blessed with the presence of the Dalai Lama. The only reference to Tibet as a home is in the presence of the religious leader, with no family pictures or no other iconic Tibetan landmarks on display. Many similar pictures bear the legend ‘His Holiness the XIVth Dalai Lama Tenzin Gyatso’, although his figure occupies only a quarter of the poster space, as if to indicate that the landscape in the picture pertains to the Dalai Lama himself. The posters’ visual and spatial configurations seem to suggest that any place the Dalai Lama occupies is spontaneously transformed into the idealised realm of the mythico-religious landscape of Tibet (turquoise lakes, green pastures and high mountains, or ri klung, i.e. hills and rivers). This finds echoes in Ramble’s argument that ‘landscape offers a rich source of imagery for the expression of identity among Tibetan communities’, citing ‘pilgrimage guides, visionary accounts, propitiatory rituals for place-gods, as well as ancient and modern paintings’ (Ramble 2000; Buffetrille 2000; Harris 1999). The posters are strong statements of allegiance made all the more poignant by the obvious poverty of the home’s occupants and the
precariousness of their situation.

Their belongings are packed directly under their beds so that there are almost no personal items on display in the room. The room’s inhabitants struggle for personal space. One of the house dwellers explained that one had to be careful about one’s things as the house was always open.

Through the description of these three homes one perceive three different ways of organising space and staging self-presentation. All three spaces make reference to some idea of home in the form of an idealised Tibet, but the aesthetic modes with which this idea is represented are diverse. In the doctor’s household, there is a depiction of a religious and scholarly Tibet (pictures of professional ‘batches’, scholarly books and religious icons). In the second, a more hybrid lifestyle is apparent, and one feels the presence of youthful and politically active exiles (*rang btsan* symbols and Free Tibet stickers). In the third finally, the insecurity of exile life and the refugees’ precarious economic situation is revealed in the inherent instability that reigns in the household, with its constant turnover of people, things, and the possibility of the intrusion of outsiders’ gazes and hands.

These three different ways of relating to space, self-representation and ideas of Tibetan-ness denote marked differences in the inhabitants’ initial background and their circumstances in exile, making manifest the different cultural influences that inform their lives. In the following section I examine the particular social circumstances of a group distinctly perceived as a separate category of exiles by earlier refugees, the newcomers, or *sarchorwa* (*gsar ’byor ba*), and the particular challenges which they are confronted with.
2.4 gsar 'byor ba: the newcomers

One day a newcomer arrived in Dharamsala, visited the library. Seeing the great work done by people there and how many injun it is attracting, he decides that he too can make some profit and opens up a tourist bureau in McLeod. From there he takes tourists to Bodh Gaya and the Bodhi tree, where he says: 'Here the Buddha spent many years, pillar cutting' (ka ba bchod).

[In a religious context, ka ba bchod means 'eliminating suffering'. The newcomer has given it a literal meaning: 'pillar cutting'], which is interpreted as a symptomatic sign of religious ignorance. (CTA worker's joke, January 2001)

The gsar 'byor ba, as the 1980s refugees from Tibet are referred to, face exile with a double plight: after the hardships of the passage to India, they are further confronted with the difficulty of being accepted in the host Tibetan refugee population, particularly first generation refugees. Broadly speaking, the term gsar 'byor ba refers to the bod nas phebs mkhan gsar pa, those who are 'newly arrived from Tibet'.

According to the CTA:

In the last five years [from 1996] 44 per cent of all new refugees coming from Tibet have been between 14 and 25 years old. Another 17 per cent have been 13 years old or younger, many left behind by their parents so that they can be educated and be near His Holiness the Dalai Lama. Forty four per cent of all the refugees in the last five years have been monks and nuns fleeing religious persecution. The sudden and dramatic increase in the number of monks and nuns, which has more than doubled the monastic community since 1980, has made it difficult for the already overcrowded monasteries and nunneries to continue to absorb them.

The Government in Exile's difficulty in coping with the growing number of newcomers matches that of the local community in accepting them. The majority of these gsar 'byor ba now originate from Kham and Amdo, parts of which are the poorer regions of the TAR, and those that have come the most heavily under Chinese influence. Many of them, having received very little Tibetan education, speak only Chinese and a Tibetan regional dialect. They thus come to India unprepared for a confrontation with their more learned and established compatriots. The tension between earlier refugees and the gsar 'byor ba is extremely patent in Dharamsala. The latter are the object of all suspicions and the recipients of accusations of causing multiple social ills. Specific diseases, like Tuberculosis, are associated with the irresponsible and asocial attitude of uncouth contaminated newcomer youths, suspected of not observing the public health measures.
recommended by the allopathic hospital and its health workers. As we will see in the following chapters, it can be argued that the social boundaries which exiles set up amongst themselves are invoked in the context of health and in relation to disease, to identify outsider groups as more ‘at risk’, more ‘contagious’, less ‘socially responsible’. Such implicit moral allegations are intimately linked with the idea that earlier exiles are ‘repositories’ of true, ‘authentic’ Tibetan culture, and that outsiders, newcomers and dissolute youths are ‘contaminating agents’ of exile society both socially and physically, through their enhanced susceptibility to disease and their failure to behave as ‘moral beings’, with which they threaten the survival and purity of the group.

One of the alleged reasons why earlier refugees have grown increasingly suspicious of newcomers is the supposed parasitism of youngsters and their inability to find employment, encouraging loitering and recourse to rags ram. This suspicion is greatly reinforced by inter-regional differences: earlier Ü-Tsang refugees often perceive Kham, Amdo and Kongpo newcomers as marginal and rural folk. This is made evident from the common references to newcomers as upholding the anachronistic custom of polyandry, and being uncultured and violent or simply ka cha (Hindi: raw), roguish and unkempt (cf. Diehl 1997). This is set in opposition to third generation youths educated in the new TCV curriculum and possessing the cardinal Buddhist virtue of snying je chen po (great compassion).

But the suspicion is mutual. Some of the more educated newcomers, such as those originating from Lhasa and its environs, accuse old Dharamsala refugees of dropping the standards in Tibetan, not knowing how to write or speak properly. Some refer to ‘TCV speak’ (TCV ked), the language and slang cultivated by the youth of the Tibetan Children’s Village schools. It is thus implied that earlier Tibetan refugees and their families, particularly the youth, have bastardised the Tibetan language, which is now scarcely recognisable to the more educated newcomers.

This, however, represents only a small fraction of the population, and the majority of newcomers are now young and middle-aged men and women with little education, who have come to India seeking schooling and employment. In the 1970s, Saklani reported that refugees from Amdo perceived the move to exile as a source of radical social change, whereas refugees from Ü-tsang had experienced the change as less extreme
This further points to the difficulty of Khamdo newcomers in adapting to the exile environment.

But this unflattering portrait of newcomers is not endorsed by all. Some newcomer families or couples with a strong entrepreneurial spirit, who come to Dharamsala to start new businesses, are perceived differently. Three families settled in Gangchen Kyishong to open businesses during my fieldwork period: the first ran a bakery business, while the second and third opened restaurants. Two were from Khamdo and the third from the Lhasa area. They immediately received a warm welcome in the area and were constantly lauded as hard working and serious. All three were young couples with small children, two of whom were seeking rog ram (sponsorship). Many local Tibetans patronised their businesses, supported them with gifts of clothes, and often inquired about their family’s well-being and needs. One medical student friend painted the Tibetan calligraphy for a newcomer’s restaurant sign and told me that he had felt happy to help them because they were hardworking and had come from the same region as him. Similar solidarity was seen in McLeod Ganj between newcomer and old refugees’ families: sometimes women with skills in stitching Tibetan clothes would offer their services privately to residents who took it up with a sense of communal co-operation, albeit mixed with some economic considerations. I was told that it was especially compassionate and meritorious to support earnest newcomers in their ventures. Hardworking newcomers were admired for their determination and strength of character in the face of adversity, and held up as models of what ‘true’ Tibetan lay men and women should be: hard working, straight-talking and business-minded. It also seemed to me that earlier refugees actually enjoyed dealing with some of the newcomers to some extent, because they found in them some of the virtues of the idealised Tibetan folk in Dharamsala’s millenarian imagination, qualities that were often found absent in the bureaucratic élites of Gangkyi. This idea of newcomers as participating in a primordial re-enactment of Tibetan life, untainted by the corrupting ways of Dharamsala, was a steadfast one, and stood in contrast with the bureaucrats’ and earlier refugees’ derisive and aggressive attitudes towards them.
Yet another group of newcomers consisted of more scholarly professionals who came to pursue a course of study in India. This was the case of some of the young doctors in the traditional Medical Institute or Men-Tsee-Khang, which we will discuss in the next chapter. These newcomers are not seen without apprehension by earlier refugees, who sometimes deride them as cliquey, and resent the fact that they criticise older residents for having become too 'Indianised', particularly in their use of the Tibetan language.

Newcomers are therefore not always perceived as dangerous. However the manipulations which Tibetan exile social groups operate on the political category of newcomers, their education and their willingness to participate in the 'project' of exile, all reflect these various groups' (and within them, individuals') concerns with cultural cohesion, economic security and status. But the stereotypes are, as usual, deceptive. Amdo newcomers for instance, the most vulnerable group and the most criticised, are by no means Candides, ignorant of bureaucratic ropes and of exile society's appraisal of them.

The process of coming into exile and establishing oneself in Dharamsala requires a good understanding of the economic and social strategies needed to cope and prosper in India. It is precisely this quality of adaptability that the earlier refugees seem to envy them. The tension between newcomers and old refugees focuses primarily on idle young and single
men and women who do not manifest entrepreneurship but instead appear to 'live off' the rest of the community.

A cluster of issues crystallising questions of identity and belonging is at the heart of the newcomer/older settler tension. Firstly, earlier refugees tend to see newcomers as immigrants, and thus competition for jobs and rags ram opportunities. Secondly, newcomers bring with them an image of home that does not always fit with general expectations; for many, they appear rough and unsophisticated, incongruous in Dharamsala's cosmopolitan environment. This impression is often confirmed by the young people's loitering and their hunger for rags ram.

Another determining element in the tense relations between refugees and newcomers is the politicisation of the newcomer issue, following rumours that some of them are regularly sent from Tibet to 'spy' on activities in Dharamsala, in particular those of the Government in Exile. The conspiracy theories surrounding newcomers have increased public vigilance and suspicion. Refugees understand the rapid social ascent of some newcomers (mostly in business activities) as a proof that they are being supported by Chinese money. When mobile phones first appeared in Dharamsala in the winter of 2001 for example, earlier refugees were prompt to quip that 'all newcomers have mobile phones', disparagingly adding that they don't have any family in Dharamsala, so why would they need such luxury items? The only explanation, in their eyes, was that they newcomers had shady business to conduct. The fact that some newcomers speak Chinese amongst themselves also increases the feeling of insecurity among the community.

In March 2001, the exile government further fed this suspicion when Professor Samdhong Rinpoche told the Assembly of Tibetan Deputies' Parliament that China had reportedly launched two underground campaigns to generate instability in the community. This destabilisation strategy was to be deployed, firstly by sending over 100,000 Tibetans into exile in India over a period of ten years starting from 2001, and secondly, by facilitating the return of refugees in providing them with good facilities and citizenship in the TAR. Such rumours grew more insistent at times of increased political uncertainty, for instance during the Dalai Lama's illness in January 2002, or upon the commemoration of the fiftieth anniversary of the 'peaceful liberation' of Tibet by the Chinese forces in 2001.
The fear of infiltration in Tibetan exile society is multifaceted. On the one hand it leads to demands for the preservation of Tibetan cultural and linguistic traditions, enacted through the creation of a non-formal and often non-verbalised proscription of marriage with Indians. On the other hand, it erects barriers against imagined or actual infiltration by newcomers. Suspicious newcomers are often depicted as having a polluting effect on the settled population, both culturally and literally, through their vulnerability to disease and potential contagiousness (see chapters 5 and 6).

In the following table I have attempted to map out perceptions of the newcomer group and their relationship to older exile society:

<table>
<thead>
<tr>
<th>Group</th>
<th>In competition with</th>
<th>Supported by:</th>
<th>Perceived positive qualities</th>
<th>Perceived negative qualities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single men</td>
<td>Casual Tibetan workers (restaurant, shops), Vocational workers (e.g. thang kha painters), Tibetan itinerant traders, Indian, Kashmiri, Punjabi traders and workers</td>
<td>Regional affiliations, Local kin base, Monastic system, Rigs ram</td>
<td>Entrepreneurial spirit, Merit of Rigs ram – social capital accumulation</td>
<td>Job competition, Consuming Rigs ram, resources, Dabbling in illegal activities (drugs etc.), including spying for the Chinese government.</td>
</tr>
<tr>
<td>Uneducated</td>
<td></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Single women</td>
<td>Casual Tibetan workers (restaurant, shops), Vocational workers (handicrafts, seamstress), independent or in groups</td>
<td>Regional affiliations, Neighbours, Local kin base, Monastic system, Rigs ram</td>
<td>Entrepreneurial spirit, Willingness to study for social advancement</td>
<td>Job competition, Consuming Rigs ram, resources, Dabbling in illegal activities (drugs etc.), including spying for the Chinese government.</td>
</tr>
<tr>
<td>Uneducated</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Professional men &amp; women, Students and families</td>
<td>Professional (Administrative &amp; government staff), Business elites</td>
<td>Employing Institution co-workers, Institutional, Rigs ram, Exiled kin (West)</td>
<td>Supporting the exile society professionally, Social capital – contacts in the West, Bringing more 'authentic' Tibetan knowledge and skills (Medicine)</td>
<td>Monopolising Institutional networks</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ordained men and women</td>
<td>Institutional, Individual, Rigs ram</td>
<td>Upholding religious tradition</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This does not, of course, represent all newcomer groups. I have excluded the cases of higher monks, nuns and teachers, as well as that of newcomers who are not engaged in socio-economic activities, such as children and elderly family dependants. The following section examines the problematic relations between Tibetans and Indians, the ensuing question of hybrid identities, and the maintenance of communal 'purity'.
2.5 A Tibetan ‘Raj’: Indians and Tibetans

The internal dynamics of social inclusiveness/exclusiveness among the Tibetan community are further linked to the broader issues of communality and creolisation with the local Indian population. Since the Tibetans’ arrival in Dharamsala in the 1960s, the relationship between the Hindu, Muslim and Buddhist communities has been in a state of precarious equilibrium. In 1972, Saklani conducted interviews in Indian households around the Tibetan settlements of Mussoorie and Dharamsala, reporting that a large majority of her informants were ‘critical of the cultural closedness of Tibetan refugees’. Instead, they wanted Tibetans to integrate with Indians at all possible levels, including learning Indian languages and intermarrying with the local population (1984: 380). Palakshappa’s study of the Mundgod settlements in Karnataka in the late 1970s indicates that Indian merchants initially sought to take advantage of the Tibetans, but that the Tibetans eventually learnt enough Kannada to bargain and conduct business. He further reports that the Tibetans are now able to make enough money to be able to loan some on interest to Indians (1978: 106). Ethnographies point out the Tibetans’ need to construct frameworks of inclusiveness and exclusiveness as members of a local community in which they are both envied and resented guests.

A local Indian shop owner and ardent supporter of the Dalai Lama who had championed his interests with the local Indian authorities as early as the 1960s explained to me that, at that time, there was no telling that the Tibetan community would come to play such an important part in the district’s economic growth. ‘Before the Dalai Lama came here, there was nobody in McLeod Ganj’, he said. ‘No cars, no restaurants, no tourists’. Inside the shop, shelves hold ancient Indian and imported products gathering dust. Outside, the traffic noise booms and tourists scour around with backpacks in search of food and hotels. Although the Tibetan community honours the shop-owner and a number of local Indian intellectuals that have supported the Tibetan cause, the tension between Indian and Tibetans is barely contained.

In late 1998 a rioting crowd of Paharis and Kashmiris raided McLeod, throwing stones at local Tibetan shops and looting the contents of the small jewellery and handicrafts boutiques. More recently, the lower Dharamsala police have been making forays into
McLeod, shutting down illegal Kashmiri and Tibetans shop alike for illegal commercial activity. Many of the Tibetan shop owners in McLeod's two main commercial streets asserted that the raids were carried out with a view to clamp down on Tibetan business and to incapacitate shop-owners by collecting extortionate fines. This was seen as a mark of discrimination and resentment against the commercial success of Tibetan ventures. This resentment has been evident in the struggle led by Tibetans to secure the renewal of the lease for the land constituting McLeod Ganj's market streets in 2001. The local Indian authorities had wanted to raise the lease price, arguing that Tibetan shops had made huge profits on the location, while Tibetans retorted that Indian shops had also profited from their presence on the market.

The resentment occasioned by the prosperity of some Tibetan families and businesses has been noted by previous studies (Anand 2002: 18). De Voe writes that 'jealousy of Tibetan entrepreneurship and benefits bestowed upon them by aid agencies added to their [the Indians'] ambivalence about having Tibetans as neighbours' (1983: 20). The label 'refugee' has done some disservice to Tibetans in Dharamsala, who now find themselves confronted with the prejudice that they should remain, as one TCV teacher remarked: 'in rags because we are refugees'.

Some local shopkeepers' wives I spoke with asserted that Tibetans were using 'Indian' workers to build their houses and repair the roads because they would not abase themselves to perform such tasks. Others pointed to the fact that Tibetans sometimes have Indian or Nepali house helps. The most frequent altercations were between local business unions and Tibetan businesses and individuals, such as the taxi car alliances, or the controversial new 'Internet Union' which fixes the prices for internet charges in town. Tibetan internet café owners were accused by their Indian counterparts of bringing down the prices to unreasonable rates and forcing Indians out of business. Business was usually thriving for the many Paharis and Kashmiris who had developed good relationships with Tibetan clients. In some instances, however, local businessmen and women implicitly reproved Tibetans for overstepping their refugee status.

Once, on the way up to McLeod, a local Pahari man whose family owned a tea-shop and two cars waited for fifteen minutes for a party of Tibetans and myself to settle into his car. There was a lengthy discussion between a young woman and an older monk who
could barely walk without his stick, as to which of them should go in the car. Finally the monk ceded his seat and started on the up-hill road despite our entreaties, brandishing a hopeful smile at us as we sat silent and ashamed on the car's back seat. When we finally arrived in McLeod, the Tibetan female leader of our group, who spoke a feisty Hindi, told the Pahari man to go and get change in McLeod Ganj as she whipped out 100 Rupees from her handbag. The young man I had known as quiet and reserved suddenly erupted: 'we are not your wallahs, this is not a bus service, if you are not capable of bringing your own money, stay at home,' followed by a series of invective and his prompt refusal to go any further. The monk in our party made an attempt at reconciliation, but the Tibetan woman held her ground, bellowing in Hindi for ten minutes until we all had to get out while she and the Pahari driver fought it out on the blocked road.

Although the business generated by the Tibetan community provides a lifeline for many local Indians, this wealth is heavily resented, especially among local Indian elites and middle classes. These groups are then happily recruited into local political formations that cultivate a discreet hostility toward the Tibetans. I interviewed two of the leaders of this political current, a prominent Kangra aristocrat and his wife, a Congress Party representative in the Lok Sabha. After being deposed following Indian independence, this nobleman led a sedate and comfortable life in a British cottage recycled as a luxury hotel. Aside from monthly trips to his house in Delhi, he hardly ever left the comforts of his Gangkyi home.

After having looked at a coffee table book on Jodhpur Palace, which the aristocrat claimed looked more like a family photo album than an official publication, I set out to ask him about the his impressions of the changes which the arrival of Tibetans had occasioned in the community. He explained that the influx of tourism had certainly been beneficial to the town but kept silent about his opinion of the Tibetan community itself. He said that he had not met the Dalai Lama and did not wish to do so. It later became evident to me that his views differed a lot from those of other prominent Indian officials in Dharamsala, who regularly appeared at Tibetan commemorative functions and enjoyed giving speeches about the strength of Indo-Tibetan friendship. Instead, the rajah and his wife seemed to cultivate detachment and a nonchalant intolerance toward the Tibetan community.
The aristocrat later smugly recounted how he (almost 'per chance') visited ‘the temple’ (the Tibetan upper gtsug lag khang) on a day on which the Dalai Lama was teaching. ‘Everybody was sitting cramped on the floor, it looked very uncomfortable, I felt very sorry for these people’, he said, before asking gingerly whether I attended these teachings. Clearly, the phenomena that drew people en masse to the Tibetan community intrigued him.

His wife said she had to take into account her constituents’ alleged concern about the increasing wealth of the Tibetan community. According to the political couple, the Tibetans were making life difficult for local Indian political representatives who tried to attract funds from the Indian government. As she put it, ‘we are not asking for charity like the Tibetans but for something that is due to us’.

For this Lokh Sabha MP, local development was being hijacked by the Tibetan community, who even hired Indian workers to build temples and private houses. By making the town’s facilities dependent on foreign sponsorship, they had taken away their chance of getting funding through government channels. ‘The only good thing we got’, said one of his aides, ‘is the hospital (...) but we can’t get to the hospital because they [the Tibetans] can’t make proper roads’.

2.5.1. Richard Gere’s Road

Local Dharamsala shop-owners and entrepreneurs gave further causes of despondency with regard to Tibetan local development. The famously perilous road that links Dharamsala to Gangkyi and McLeod Ganj needs constant repair works, which, although they should have been funded by local Indian authorities, had to wait for the benevolence of the Richard Gere foundation, resulting in jokes about ‘Richard Gere’s road never getting built’. Local shop owners, despite being used to this kind of delay, often complained that this was because the money was being channelled through Tibetans. A telecommunication and video shop owner who had constant interaction with Tibetans pointed out to me that this was nobody’s fault, only that ‘politicians are trying to blame Tibetans for things not getting done, but things have always been like this’. He added ‘probably they would even be worse without the Tibetans, then we wouldn’t even have any business’. The road construction project was also a recurrent topic of jokes among Tibetans, although blame was less easily ascribed to one side or the other.
Instead, Tibetans commonly blamed adverse weather conditions or landslides and avoided politically tainted comments. Conversely, the Indian MP and her husband told me that they had drawn money from their personal income to help towards the costs of repairing the road, funds which had subsequently ‘disappeared’ in CTA hands. So while many local political officials claimed some part in the fundraising efforts, few took the responsibility for the failure to carry out the project. Disputes over economic resources or the construction of common facilities thus revealed the rift between the Indian and Tibetan communities.

The aristocrat’s resentment of Tibetan presence in his wife’s constituency and traditional fiefdom seemed to be grounded on the assumption that the local Indian population suffered from economic segregation, and that not all were equally reaping the profits of tourism generated by the Tibetan community. His one consolation came from the fact that he thought the Tibetan government powerless, totally dependent on Western and Indian aid. The helplessness of the situation seemed to give this pair of hard-boiled politicians some degree of comfort as they swiftly shifted to discuss the generosity of the Indian government toward refugees, and particularly Tibetans. It seemed that as long as the refugees were kept under control, in a state of dependency, the resentment fuelled by the growing economic inequalities between Tibetans and Indians would somehow abate. ‘It’s not that we don’t like them, they are hard-working people and very religious, but it is normal for Indians to feel strange when some of their foreign (Tibetan) neighbours live like kings and they are supposed to be refugees’ said one Sikh businessman.

Indian friends also imparted to me some odd conspiracy theories according to which Dharamsala Tibetans were involved with drug trafficking networks in the region and transnationally. They claimed that Tibetan parcels sent abroad were never actually checked by Indian customs, and that Tibetan drug dealers were therefore able to resell drugs in the West at inflated prices, thanks to the presence of their many relatives who had migrated to the West. One similar story came from a Lower Dharamsala Ayurvedic practitioner: ‘Tibetans send so much medicine abroad, who knows what they can also put in there to make some profit’ (sic). The money used in the construction of Tibetan hotels in Dharamsala came, according to them, from drugs, and they looked at newly affluent Tibetan business families with great suspicion.
The economic dependency between Indians and Tibetans is thus a source of both reconciliation and conflict. While many Indians resent the wealth accrued by Tibetans, the great majority of local Indians have prospered under the aegis of what can be termed, at least for Dharamsala, a Tibetan Raj.

2.5.2. *rgya gar skyid shos red: India is the happiest [place]*

Understanding more ‘lay’ conceptions of Indo-Tibetan ‘creolisation’, as debated among Tibetan youths and local Indians accustomed to regular dealings with Tibetans, is critical to understanding feelings of inclusiveness/exclusiveness within the community. Lower Dharamsala shopkeepers, for instance, have more lenient views than those of the political couple discussed above. The Tibetans were ‘good customers’ they said, and they eagerly awaited the periods of the year when they knew Tibetans come en masse to purchase goods from Lower Dharamsala, such as the pre-*lo gar* period. Most of my younger Tibetan informants spoke fluent Hindi and were able to haggle and negotiate in Kotwali bazaar. They were equally knowledgeable about Indian outlets that provided good deals on certain coveted items like, *rtsam pa*, fruit, toilet paper, or cheap internet connections. Indian businesses have found niches selling products to Tibetans: some shops have specialised in the provision of barley (*nai*), millet (*chi ji*) and other preferred Tibetan foodstuffs. Tailors have expanded their business by making *byu bas* (chubas) for Tibetan customers. Cloth boutiques also sell and advertise fabrics suitable for *byu bas*, although many Tibetans prefer to patronise the business of Tibetan workers up in the McLeod Ganj’s Tibetan tailoring co-operatives.

Many Tibetans co-operate amicably, or are made to co-operate, with local bribery networks. One group of youngsters of my acquaintance who organised parties to earn money from local youths worried about the police coming to stop the revellers partying after the 11.00 p.m. curfew and inflicting a large fine upon them. Their mother took up the matter with police agents with whom she had had previous contacts. ‘For the police not to bother us we will give them a little present’, she said to me later on. In another instance, a young Tibetan girl studying at Sarah school of Tibetans Studies lost her RC (Refugee Certificate) in a bus. She went with her uncle, a prominent monk, to the local police station to find out how she could replace the card, and the group conversed in Hindi about an adequate settlement for a speedy replacement. The India-born monk
discussed an agreeable sum with him and both parted on amicable terms. The monk told me that baksheesh would indeed speed up the process and that, usually, nothing administrative got done without it, especially when Tibetans were involved.

The previous sections reveal a critical tension between the ‘idea’ of Dharamsala as an Indian haven and its practical requirements for the community. Embracing pluralism is a necessary part of maintaining ‘an idea of India’ as a powerful and tolerant nation. This inclusiveness is the Indian political trait that Tibetan scholars and politicians like to emphasise in their discussions of exile along with the generosity of the Indian state towards Tibetans. Indian democracy is given as one of the models for Tibetan democracy in exile, and parallels are drawn between Gandhi’s non-violent struggle leading up to Indian independence and the Dalai Lama’s own commitment to non-violence. It is also often noted that India is the birthplace of Buddhism, and, as such, also a place of pilgrimage for Tibetans. Both Indians and Tibetans thus draw on the notion of a bountiful and generous India, to which much is owed in the struggle for Tibet, but both harbour some reservations as to just how much support is to be given to refugees who do not behave as refugees anymore.

Tibetan youths educated in India are creators and actors in hybrid cultural constructions, and feel more at home in the Indian exile environment than the dominant messages of longing for the homeland may lead one to believe. Tibetan students and monks relish Bollywood films and songs, and enjoy gorging in the dhabas and restaurants of lower Dharamsala. During one lo giar evening, a group of Mussoorie TCV students, planning the following day’s outing to Kotwali bazaar and the raiding of the toy and hair accessory shops exclaimed ‘rgya gar skyid shos redt’, ‘India is the happiest [best] place!’.

For many earlier refugees too, India is a place of cherished memories and opportunities. In the CTA workers’ compound in Gangkyi it is not rare to find three generations of Tibetans eating dinner in front of an old Indian film recommended by elders because it reminds them ‘of their youth’. Gangkyi’s intellectual élites, a great number of which are trained at the Central Institute of Higher Tibetan Studies in Sarnath, have strong views about Indo-Tibetan friendship that stem from an Indian upbringing and a religious education that presents India as the home of Buddhism and a patron to Tibetans.
Cohabitation sometimes seemed more difficult in the small villages adjacent to Dharamsala where some of the poorer Tibetan families lived. Some of the Tibetans who had settled in these villages reported open displays of aggressiveness from local Indians. One man recalled how he was reluctantly given access to the government water pump in his village by local women who told him that they could see that he and his wife 'were not from around here', and asked him 'why don't you go back to your own country?'. The same family also told me they sometimes had difficulty preparing their meals, because they liked to consume beef (which is sold 'at the same price as vegetables' in shops opposite Majnukatilla in Delhi), they feared that their neighbours might smell the cooking meat.

Figure 2.4 Photograph of a young female Tibetan exile in a rented Pathan costume in Landour Hill, near Mussoorie in 1980.
The separate school system used by Tibetans also seemed to rouse some envy among Indians, who envy the sponsorships allocated to Tibetan children. In the government enclave of Gangkyi, however, the relations between Indians and Tibetans are primarily business oriented and most of the Tibetan refugees and civil servants speak fluent Hindi, which makes their dealings much more amicable.

Interestingly, though, as remarked by Calkowski (1991), the creolisation of Tibetan cultures through Indian influence is given less thought and generates less concern about acculturation than the interaction of Tibetans with Westerners. There seems to be an implicit cultural hierarchy of acculturation at work in dealings with cultural creolisation. While a reverse orientalism articulated by exile middle classes posits that Tibetans and Indians share a concern with family welfare and spiritual needs, thus forming the basis for a commonality of lifestyle and interests, in contrast, the materialistic and individualistic stance presented by the West is thought to represent a more serious departure from Tibetan ideals of sociality.

As many ethnographies of exile have argued, 'Tibetan-ness' is always perceived and defined in relation to an Other, whether Western or Indian (Strom in Klieger et al. 2002). But the type of Other referred to here is critical. While the Tibetan Government in Exile and the lay population have adopted the Indian discourse of modernity defined in culturalist terms, and draw explicit parallels between Buddhist modernism and Indian modernity, Tibetans have yet to come to terms with the broader hegemonic discourses of modernity articulated by Western sponsors and tourists.

2.5.3 The hosiery and sweater trade

Trading is one arena through which Tibetans have close contact with Indians. Trading expeditions such as winter trips to hosiery markets involve leaving Dharamsala's almost exclusively Tibetan environment for cities in which there are only small, if any, Tibetan communities. Samdhong Rinpoche once remarked that as many as 80% of Tibetans in India survive on the hosiery trade directly or indirectly. Although this number may be a slight exaggeration, there are grounds for believing that a great number of families even in Dharamsala rely directly or indirectly on the hosiery trade for part of their income. Clothes are bought and sold by Tibetans in the markets of Delhi, Kathmandu and
Mussoorie. Tibetan traders have become so ubiquitous in Indian markets that one commentator remarked on the assortment of stalls at a Mussoorie street market: ‘Mussoorie is like a little India: there are Kashmiri, Rajasthani, Saharanpuri, Benarasi handicrafts, Tibetans and the locals (...').

Tibetan clothes traders make good use of their knowledge of the Nepalese and Indian business calendars. In October, they emerge in Indian markets with clothes from Nepal for the Indian winter. A month before Diwali, Tibetan traders come to the Ludhiana markets to buy hosiery, as they know sales will pick up during that period. The traders sell everything from caps to shoes: woollen products from Ludhiana, jackets from Nepal, hats from Tibet and factory-produced clothes from Delhi.

The Tibetans' investment in the hosiery market has boosted the sales of small producers like the 15,000 or so entrepreneurs of Ludhiana, who have become dependent on them to sell their goods. Tibetans buy bulk hosiery and sell it at roadside markets in Himachal, Ladakh, Kashmir, Kargil and throughout India. This new co-operation has generated solidarity and strong ties between Tibetans and Indians. In 2001 for instance, Tibetan and Indian small-scale (with a turnover of less than 5 Lakhs) hosiery traders allied in protest against an increase in the tax on sales from 4 to 10% imposed by the government.

This interaction with Indian traders has led Tibetans to play an important role in the hosiery niche market. In the autumn of 2000, Dharamsala-based Tibetans boycotted the local hosiery market in protest against the increase in rates imposed by road transporters. The Tibetans had started to use road transport after experiencing difficulties in getting products to their selling destination on time by rail. The sizeable amount of money invested by Tibetans in the hosiery market gave them considerable bargaining power and allowed them to put pressure on Indian suppliers and transporters.

Second generation Tibetans often take up their parents' trading routes and continue well-established relations with families of Ludhiana traders and retailers throughout the region. The long standing trade relations that exist between Tibetans and Indians are praised by Tibetan CTA members and middle-class Tibetans in Dharamsala, who emphasise the entrepreneurial spirit of exiles, and this is upheld as one of the examples of Tibetan resourcefulness and will to integrate with locals. For traders, though, the
tiresome travelling and uncertainty of the hosiery and sweater trade are subjects of concern. Families that depend upon winter trade come from the poorer households in the Dharamsala region and often invest most of their savings from one season to the next in order to purchase goods to sell in the hosiery markets. As we will discuss in the following chapters, the mobility of Tibetans and the hardships of long periods spent away from their home settlements exert a toll on health and well-being.

2.6 Going Abroad and Returnees from the West

Movement is not just the experience of shifting from place to place, it is also linked to our ability to imagine an alternative. The dream of a better life and the nightmares of loss are both expressed by the metaphor of the journey. It is not only our 'life narrative' but the very 'spirit of our time' which seems to be haunted by this metaphor.

Nikos Papastergiadis 'The Turbulence of Migration'

The final section in this chapter introduces a further element in the dynamic processes of inclusion/exclusion at work in Dharamsala, by focusing on Tibetans who migrate further abroad while maintain relationships with the exile community. In an earlier section outlining changes in marriage patterns, I mentioned that Tibetan returnees from the West often come back to choose Indian exiles as their spouses. Thus, eligible exile bachelors often joke about Swiss Tibetan exile girls coming back to Dharamsala to find a groom, and about all Tibetan exile men subsequently feeling like mag pas, the term that designates grooms that go to live with their wives' family. Tibetans who have settled in the West also come back to set up business ventures in exile, or simply to visit their relatives. Returnee Tibetans are extremely visible in the community because they often display considerable wealth and extensive social networks. For their Indian exile relatives, returnees from the West are wells of information on the possibilities of going abroad, life in the west, and potential business opportunities.

Leaving India is one of the youngsters' often silent, but always present preoccupations. The now quasi-millenarian dominant discourse of the eventual return, which also prescribes the need to work for the community, conflicts with the ambitions of young and middle-aged Tibetans who want to seek opportunities in the West.

Dreams of migration, whether immediate or distant, are an omnipresent concern in Dharamsala. There are obvious financial and administrative obstacles to migration, for
the overcoming of which friends’ and relatives’ networks must be put to use. The Tibetans’ lack of passports means that they must obtain the IC (Identity Certificate) at high prices (approximately 800 Rupees), in addition to ‘invitation letters’ from a resident in their country of destination asserting that they are willing to take on the responsibility for the ‘visiting’ Tibetan.

I followed the migration of two young girls and a Tibetan couple who left India in 2001, all of whom have now settled in the west. The following are edited extracts from notes taken in England in the winter of 2001.

Sixteen-year old Norzum comes from the Bylakuppe settlement in South India. After finishing her schooling at the TCV she came to study chant and drama at the Tibetan Institute of Performing Arts in Dharamsala. As a young and promising singer she seems to have attracted the attentions of many suitors, but was putting off getting married, she said, until she secured a passage to the west. The opportunity came in the form of a young female English volunteer in TIPA who offered to give Norzum an invitation, as well as housing her and putting money down for her to study in a college in England. A few months later, Norzum got her IC and a six-month visa for the UK. Her friend’s family payed for the plane ticket.

One of my medical student friends told me that Norzum was going to study in England and introduced us. We decided to journey together to Delhi, where we would await the plane to London together. In Majnukatilla we spent much time together chatting, watching Indian television and waiting. Norzum spent a lot of her time in cyber-cafés writing to her friends on the Tibetchat network, telling them that she would soon be in England, or writing to various boyfriends enjoining them to be faithful while she was away. In the room we shared in Majnukatilla close to some relatives of hers, Norzum explained that she wanted to go and ‘become someone’ in England, ‘just make lots of money’ and become a ‘true woman’, so she could help her mother and sister in Bylakuppe. She had relatives in Dharamsala and in England she said, but none had really helped her so far. Her maternal aunt lived in Dharamsala and was, as she put it, ‘sitting on her money’, being stingy (ser sna chen po) and not giving anything away to help her relatives, while those in England were too distant to appeal to for help.
I arrived in England a few days before Norzun and waited for her phonecall. We finally spoke on the phone and she explained that she was now in a northern suburb of London (St. Alban’s), staying with her friend’s family. Everything seemed to be fine, but I detected some disappointment in her voice. She wanted to meet up urgently she said. I offered to take her around London but she wanted to stay inside the house. On our visit to the supermarket she clutched my hand at the till when addressed by the cashier. This clutching continued whenever we met friends in the house. I introduced her to an Indian friend, thinking she might feel more at ease speaking Hindi, but she consistently refused to speak and got away as soon as she had a chance. Mixing with strangers in this new and intimidating environment was clearly causing Norzun much difficulty and I scarcely recognised the bright and flirtatious teenager I had known in India.

Norzun started attending a private college in St. Albans, where she made friends with some Turkish and Albanian girls. She quickly elected one of them as her regi pa [helper, company], as she joked sadly, and often asks the girls to come and walk her to the train station to come and meet me, just as she would have in Dharamsala. Her English friend has left home to study in Cambridge and Norzun now feels isolated in her new home, with only the girl’s younger brother and mother. In her new area she observed a considerable difference between the ‘rgya gar ba’ of St. Albans and those of Dharamsala. The Indians in her area seemed richer but also less approachable to her, and she expresses considerable nostalgia when thinking of the communal feeling of Dharamsala and the TIPA.

In school, she suffered from being constantly associated with Chinese students who do not hesitate to speak to her in Chinese, despite her protestations. According to Norzum, the teacher has given the class a short briefing on the Tibetan situation. The school had a high percentage of British-born Chinese students, as well as young Kosovar and Turkish immigrants, whose family had also been displaced or were ‘labour migrants. Norzum often told me that the Turkish girls in particular shared similar feelings and experiences as her. When she ran into financial problems two months into her stay after spending the stipend given by her host family, a Kosovar girl explained to her how to borrow money from a bank. Norzum wanted to hide her problems from her host family, and I feared that she would get into increasing debt. She was finally able to get a part-time job in a local jewellery shop that supplemented the money she would receive every month from
When she came to visit me Norzum would always spend time on the internet writing to friends in Dharamsala. Their replies to her letters were often disappointing, enjoining her not to spend so much time thinking about the past and to focus her energies on her new life. Once, she asked me to take pictures of her so she could send them home. Norzum struck a pose, in what I recognised was the style of pictures I had previously been shown in Dharamsala: all ‘beautiful girls’ who had gone abroad, posing in sophisticated, glamorous surroundings, and in quasi-theatrical styles (black Borsalino hats with red lipstick or an overkill of American style street wear). Norzum affected a sensuous and content look in the pictures, and watching her I thought of the comments that would accompany the showing of these pictures back in Dharamsala: the beautiful cousin who went to London; the Tibetan singer who went to the West; the daughter who was sending money home. It had obviously been very difficult for Norzum to sever the links with her community back in India, and she seemed to be constantly striving to convey an image of success back home.

The pressure exerted on Dharamsala’s youth did not end with their departure for the West. Out there, the community’s tight networks guaranteed that one would always have one’s name and success discussed back in India.

The second young girl whom I met on her way to the West was a young student from Sarah School near Dharamsala. The 19-year old had relatives in Germany and a powerful asset in the person of her uncle, an influential monk.

Tenzin was a promising student but had become restless and dissatisfied with her studies. Her family thought it would be a good idea to send her to Germany so, as her uncle put it, she could become ‘more Western’. Her cousin, a middle aged Tibetan woman from Ladakh, had already sought asylum in Germany almost a decade ago with her father. Now the cousin was about to move to America with her husband, so her elderly father had to stay behind alone. The arrangement was that the family would enable Tenzin to come over, and she would look after the father while pursuing her own studies. The transition was to be smooth: Tenzin was to be brought to Germany while the family was still there so she might ‘learn the ropes’ from them. The girl was terrified at the prospect
of this new life, but since this was her family's arrangement, she would have to go along with it. Her uncle was instrumental in procuring her a passport and reassuring her on her prospects in the West. As I understood it, he seemed to be exerting some pressure on her to move away from India. The monk's plan was eventually to have his entire family settle in America, where he also eventually intended to make his way and teach. He was de facto acting as a middleman, moving all his relatives westward until he himself would secure a visa.

Back in Dharamsala, Tibetans around Gangkyi were often seen sporting US flag T-shirts or the Canadian maple leaf, and adopting an American accent whenever injis came in sight, in order to signal their newly-found symbolic capital. However, in the West, they often talked about the hardship of a double exile: the distancing effected from their community in Dharamsala, and the isolation experienced in the West. One Tibetan woman who had migrated to France in her twenties said: 'I worked like a dog: I cleaned, I worked in supermarkets, of course I had to learn French, no really it wasn't easy.' In Dharamsala, one student from Varanasi remarked sarcastically that three of his classmates, all acharyas, had left for the U.S. and were now taxi drivers in New York.

The maverick attitude with which Tibetan exiles embarked for the West sometimes seemed desperate, and was not understood or approved of by all Tibetans in Dharamsala. Those who had been brought up in India and had jobs in the administration often did not find it so appealing to leave their more congenial surroundings. One older CTA worker who had taken leave of her job when she had obtained her Identity Certificate for a 'holiday' in America simply never returned, leaving her children behind in Dharamsala with relatives. She was heavily criticised by her work colleagues for her callousness, and the rhetoric of 'betrayal' was then commonly employed.

'Second generation' Tibetan exiles in the West, like young Tenzin, benefit from the experience and support of their predecessors, which makes coming to the West less of a struggle. Mutual co-operation is however not always forthcoming, as some families are better at staying in touch with their Indian exiled relatives than others. A common complaint among exiles was that relatives in the West were forgetting about them, so engrossed were they with their new lives. These migrations to the West create intergenerational tensions as families often become separated, or have to negotiate the
difficult passage of their parents and relatives abroad with them, as was the case in young Tenzin’s family. For youngsters without relatives to help them migrate, two options remain open: gaining scholarships or making contact with sponsoring injiyz. It is generally thought that most studentships, though temporary, are a gateway to employment and permanent residence in the West.

Migration opportunities are a critical influence in the social life of exiles. As a catalyst for social change and a source of economic growth, the move to the West has allowed the present young generations of Dharamsala to capitalise on their relatives’ experience and ensure greater economic security and opportunities for themselves. But this hard-won accession to global migration and lifestyles also augurs the creation of a greater social divide in Dharamsala. The pressures to succeed in the race to go to the West or to achieve high posts in Dharamsala’s government institutions is a source of psychosocial stress for many young people.

Tibetans who have departed for the West have varying attitudes towards the Indian exile community. Some remain with a foot perpetually in Indian exile, supporting relatives and managing the familial migrational agenda, while others, mostly newcomers with little or no family in India, start afresh in the West, generally feeling stuck between a rock and a hard place. To a few, another attraction is the possibility of returning to Tibet with a new passport, thus allowing them to visit relatives or even explore business opportunities unhindered by Chinese control.

Returnee exiles are increasingly conscious of the growing social distance between themselves and their compatriots in India. Some express dissenting political views and seek to influence the course of exile politics from abroad, others simply seek to help their relatives and community by creating businesses and generating employment in Dharamsala. One can speculate that the increasing economic importance of the Tibetan population in the West will impact heavily on life in the Indian exile community and on exile politics at large. The rise of this comparatively wealthier Tibetan foreign middle-class, equally involved in the agendas of social promotion and cultural preservation, will perhaps be the future motor for the political middle way advocated by the Government in Exile. Back in Dharamsala however, this risks creating more social tension between
exiles, as well as increasing discrepancies between the exile capital and other Indian settlements with less opportunities for social mobility.

2.7 Summary: Exile and the Social and Structural Constraints on Health

In the previous sections we have identified several factors which may contribute in positive and negative ways to Tibetan psychosocial health in Dharamsala, and impact directly or indirectly on feelings of communal inclusiveness, support and self-reliance:

1. Socio-economic constraints: Low income; no or indirect access to individual property, thereby increasing economic burden; reliance on industries dependent on local business conditions (e.g. the hosiery market or the tourist industry).

2. Changes in social organisation (including marriage patterns), increasing upward mobility of women and decreasing income disparities (in Dharamsala) through access to education.

3. Strong inclusiveness/exclusiveness dynamic generated by the influx of newcomers and the interaction of Tibetan third generation exiles with Indians and foreigners.

4. Intergenerational conflicts emphasising the cultural chasm between first and third generation exiles.

5. Dependency on aid and foreign sponsorship (discussed in the following chapter) resulting in competing discourses about 'modernity' in relation to ideas about Tibetan culture preservation.

6. Migration onwards from India producing conflicts among exiles as well as further migrational stress for exiles.

In the following chapter, I will examine the issue of economic dependency and associated discourses about sociality and interdependence in the Tibetan exile community.
3

Social and Economic Strategies for Exile
rogs ram, 'grogs pa and the Modern sku gzhogs

The patron/client dyad is a warp and weft upon which ideas of Tibetan identity are woven. (Klieger 1994: 22)

3.1 rogs ram

In the previous chapter I have mentioned the rise of a 'patron/client' style of relationships between youngsters, young professionals, and sponsorship 'finders' or intermediaries. This patronage network is connected to the practice of rogs ram, or 'sponsorship', which refers to the money given by outsiders, generally foreigners, to support young children and teenagers through their studies, and families with young children or other dependents. Older professionals (e.g. traditional Tibetan doctors) may also benefit from rogs ram in support of their training or work. Although in exile it is most often translated as 'sponsorship', rogs ram, in a more 'traditional' sense refers in reality to 'helping' in a more general sense. In exile, giving rogs ram ranges from giving money to playing on influence to obtain official papers, invitations to foreign countries, favours, or contacts. The Tibetan men and women who act as intermediaries for rogs ram are either part of institutions (as in the case of TCV fundraisers), acting individually, for themselves, or on behalf of friends and family.

Only help from outside sponsors is considered rogs ram; help received from family members, abroad or in India, does not fall into this category. Rogs ram is sometimes still employed with the earlier meaning of help (in connection with rogs byed mchab, the 'helper'), but is nowadays used idiomatically in reference to the practice of sponsorship, the gift of financial help. Almost all families receive some form of rogs ram for their children, which sees them through primary and secondary education, after which studies have to be financed either by the family, or again by foreign sponsors. Newcomers receive an initial 'reception' sum from the Tibetan Government in Exile to set up home
(5000 Rupees), and, if need be, are directed to educational facilities where they can also have board and accommodation.

Most newcomers I have spoken with argued that the term *rogs ram* is specific to exile and to the relationship which foreigners foster with Tibetan refugees either individually or through a fundraising organ, thereby obviating the more traditional meanings of the term. The term ‘sponsor’ is also used in communication with foreigners, although among Tibetans *rogs ram* is preferred. One CTA worker suggested that this significant exile emphasis on *rogs ram* sponsorship stems from the culture of American refugee policy which stipulates that refugees may only settle in the US if they have sponsors. This suggests a direct link between the globalising discourses of US government policy on refugee repatriation and local Tibetan uses of *rogs ram*. It also demarks *rogs ram* from more established forms of sponsorship and patronage in Tibetan Buddhist communities, such the as the *shjen bdag* (sponsorship) provided by landholding families to monasteries in exchange for *byin rlabs* (blessings) (cf. Mills 1997 in Ladakh). Thus, although it can be argued that the contemporary practice of *rogs ram* finds cultural validation in older forms of patronage and sponsorship, the restriction of *rogs ram* to the context of refugee/foreign donor relationships is a new development specific to exile.

The emergence of *rogs ram* intermediaries, mostly self-trained fundraisers with experience of Tibetan bureaucracy (e.g. in TCV schools) primarily concerns the youngest segment of the population and newcomers who are unable to make the necessary connections (*sbrel thog*) to secure *rogs ram* by themselves. At ease with foreigners, they are skilful business like go-betweens, successful at obtaining money from sponsoring bodies and individuals. Older refugees and young adults are generally able to organise their own *rogs ram* through personal contacts with foreign donors, and this is a way for poorer families to subsist and improve their living conditions. The story of ‘how one has found *rogs ram*’ (*gang 'dra rogs ram rag gi red*) is often told proudly. Whilst recalling the event for me, families would often display pictures of their sponsors. Typically, there then ensued a display of photographs and letters from European or North American families, which manifested and materialised a connection not only from individual donor to recipient, but from one family to another. The interpersonal nature of this link also emerged in the stories told to me by families about ‘finding *rogs ram*’: the teller would recall personal anecdotes about their sponsor, detail their occupation and the circumstances of their meeting. Although I
often wondered whether this was not emphasised for my benefit, to make sure I did not
think Tibetan families were ‘milking it’, a long-term exposure to the dynamics of rogs ram
convinced me of the importance of creating and believing in these interpersonal bonds.
The importance of the relationship between foreign sponsors and the Tibetan recipients
of rogs ram lay not only in its financial implications to the Tibetans, but also in the
symbolic world of potentialities unleashed by the sponsor. The construction and
maintenance of personal relationships between donor and recipient was important in
assuring not only that the sponsorship would last, but also that it would deepen in
mutually satisfactory ways. Foreign donors would regularly receive news from the
recipient family. This undoubtedly constituted moral kudos, of which the Tibetan
families’ letters, and religious blessings like ritual threads, srung mdud, or blessed medical
pills, rin chen til bu and byin rten, were the material evidence. For the Tibetan family, the
strengthening of interpersonal bonds would potentially increase their opportunities for
social mobility, through invitations to visit abroad and favours or gifts exchanged. The
building and maintenance of interpersonal relationships between donors and recipients
were therefore seen as giving a mark of authenticity to the rogs ram process. It became, as
such, more about people than about money.

In a discussion of how aid impacts on the lives of refugees in a Tibetan context, De Voe
asserts that ‘the study of the relationships between the givers and receivers or
benefactors and beneficiaries attends to the elements of compassion, gratitude and
mutual trust theoretically and ideally implicit in this interaction’ (De Voe, 1981b: 80).
Throughout this relationship, refugees are kept in a position of helplessness, and gradually
learn to conform to expectations of a ‘clientele’ of aid, that is, they learn to ask for
sponsorship. De Voe further comments that: ‘Tibetans who do not ‘adapt’ to the way
things work in exile express a fear of personal failure with coping in the new system
altogether (...) their young continually compete for the attention of aid organisations’.
De Voe also contends that ‘to be connected with Westerners has become a kind of status
in itself, despite the resentment of the foreignness it brings to the heart of the
community’ (1981b: 93).

Rogs ram has two facets: the first is that of dependency, which is the result of economic
depprivation, and the second, that of social capital in Bourdieu’s sense (1990), a token of
foreign interest and recognition which makes one more valued in exile society. Whereas
De Voe’s commentary focuses primarily on institutional aid, my experience of sponsorship was more linked with the personal financial support provided by foreign individuals to individual Tibetans, and, as such, negotiated interpersonally. Such *rogs ram*, when operated outside the institutional context, is an informal agreement between individuals and families whose relationships are maintained by exchanging letters, gifts and money. The relationship is sometimes established during a visit to Dharamsala, when it follows on from a personal encounter in which affective bonds are created between the *rogs ram* donor and the recipient. These anecdotes were fondly recounted among my informants. DeVoe’s idea that benefaction ‘is not altruistic or unilateral, but virtually overwhelming in its creation of uncertain but felt obligations’ is also valid in the context of interpersonal benevolence. Such interpersonal and less accountable sponsorships are in appearance easier to arrange and maintain than official ones. However they also imply greater insecurity and compliance for the recipient, who is subjected to the individual sponsor’s fluctuating appreciation and judgement. These relationships are, in essence, unstable and charged with ambiguity, and youngsters sometimes have to hunt for more than one *rogs ram* in order to ensure a regular inflow of cash to survive. In the following section, I present and discuss the case of a young newcomer from Amdo and his struggles to obtain and conserve *rogs ram*.

Dorjee, a 26-year old man from Amdo, had become extremely weak with malaria, and had to renounce his job working in a McLeod Ganj restaurant. While in the hospital, he had met one of the female interns and started a friendship with her. Before she left to go back to Europe, she promised she would ask her family to help, as she knew Dorjee’s situation was desperate: with only one relative in the transit school and few friends at hand, he would not have much help after coming out of hospital. She was right: Dorjee’s job fell through when he came out during the low tourist season, when the restaurant was not hiring any extra staff. His rent, which he shared with an Amdo monk for a small house with a leaky roof under McLeod, was 500 Rupees a month. A few weeks after the young intern had returned to her country, he received 1000 Rupees from his new sponsor, the girl’s father. Dorjee started to plan for the future, paid an up-front 300 Rupees for a computer course, embarked on Japanese lessons at the Gu Chu Sum centre and set out on an Indian university correspondence course in ‘Social Sciences’, which I soon realised was due to my influence. The course booklets were in dense English and hardly accessible to Dorjee, who despaired getting his qualification in time. His education
had stopped after primary school as his Chinese was not good enough to see him through secondary education. He had been taught Tibetan grammar by a local *mkhas po* (expert) in his hometown. His lack of an official end-of-study qualification stopped him from being able to access any higher qualification course and his Tibetan transit school leaver’s certificate was not recognised by the Indian authorities. Thus his only income had become his friend’s father’s *rogs ram*.

Three months passed, during which Dorjee received regular payments from his sponsor through the *dngul khang yag po* (as he called the Western Union counter in McLeod, literally ‘the good bank’) and his schedule had become that of a busy student as he ran from one course to another. In between, there was nothing to do, he said, only sitting at home and talking to friends about where to go next. Maybe Japan, maybe back to Tibet, he told me. He then decided to write to his sponsor saying that he would like to use the money to buy his own computer, which would allow him to study programming on his own. The irate Swedish doctor quickly replied that he was sending the money for Dorjee ‘to do something with his life’, and not to be wasted on computers, and that if he did not change his attitude, he added, he would terminate the sponsorship. Dorjee told me that his sponsor had suddenly become very angry, and that he had sent a letter apologising but would not change his mind.

The prospect of losing the sponsorship did not seem to daunt him as much as I thought it might. I quickly caught on to the fact that for Dorjee, like most young people in Dharamsala, there were plenty of fish in the sea. Although he was reluctant to ask for help, he soon came to understand *rogs ram* as a form of natural gift from those much richer than him. In the small village under the road to Bogsu, Amdo youth gathered late at night to share cooked food and talk. They had established strong bonds. Sharing everything from food, to clothes, books and money, the Amdo boys found their fortunes were tied to those of their peers. Dorjee explained that they sometimes would sleep very little, staying up all night discussing plans for the future. Often, they talked about returning to Tibet. Occasionally one of the group would set out for the journey back, and for days Dorjee would be thinking of his friend, wondering if he should do the same. Those departures were accompanied by dramatic farewells, during which small gifts were exchanged and oral messages passed on for delivery back home.
On another occasion, after one of the Dalai Lama's grand teachings, which we had both attended, Dorjee voiced the desire to become a monk. He knew a monk in Sera monastery, and although the prospect of the Southern Indian settlements' hot climate and isolation were an obvious discouragement, he took into account the education and opportunities which a monastic training might give him. There, he said, he would not have to worry about anything anymore (*sems khrul nam yang ma byed dgos*). But this did not stop him pursuing *rogs ram*, mainly through hunting the streets of McLeod Ganj for English teachers, as many idle young men did. When his initial sponsor's friend came to be a teacher at the Transit School for a few months, Dorjee saw an opportunity for him to get help for his brother, who was studying at the school. He did not succeed in getting *rogs ram* for his brother, but introduced him to the young teacher, who occasionally chipped in a few extra hours of private help with his studies.

In the following month, Dorjee lost his *rogs ram* and had to give up most of his classes. He could not find a job in Dharamsala and so went down to MajnuKatilla in Delhi, where he had secured work as a helper in an Amdo restaurant. Unhappy in Delhi and driven to depression because of the heat and inertia which reigned in the camp, Dorjee nevertheless stayed on in the hope of getting an IC made and finding someone who might help him get out of the country. After a month's waiting he renounced this plan and set out to help some friends selling momos in Bodh Gaya during the Kalachakra initiation. He often told me that he should have been more careful with the *rogs ram*, and continued to ask around for English teachers which had become an easy bridge for sponsorship. When I offered to help after my return in England, explaining that I would get a job and send some money back through the Western Union, Dorjee refused and said that my studies were more important and I would have no time to work. He said he would find another *rogs ram*, even if this would take time, especially because, as a boy, it was difficult for him to gain the trust of potential sponsors.

When I returned to Dharamsala in June 2002 and met Dorjee again, he had secured a permanent job in a restaurant where there was an abundance of foreigners who taught English (and therefore *rogs ram* opportunities) and free-housing in a building adjacent to Namgyal monastery. He had discontinued his studies and made extra-money by taking occasional trips to pilgrimage and teaching sites to sell *mog mog* or handicrafts with friends. He planned for these trips on the basis of how much money he would earn at
the restaurant, and the probability of making a significant profit from the outing. If economic necessity was not strong enough to compel him to go, he would simply stay in Dharamsala and spend time in the restaurant. He described his life as content, and told me he was getting used to being in Dharamsala. Rather than getting rogs ram for himself, which was too much trouble, he sometimes helped friends getting invitation letters or meeting potential sponsors. He had, in a sense, become a rogs ram intermediary.

Dorjee's case is by no means archetypal, but provides a description of the kinds of motivations and concerns of young exiles, as well as the different networks they may tap into for support. Dorjee's position as a newcomer, and moreover as an older, uneducated man, excluded him from the more institutionalised forms of sponsorship. On the other hand, he could rely on the support of his amdo ha peers, who helped him in all possible ways. Although rogs ram is construed primarily as financial support, one can see how the maintenance of the relationship between Dorjee and his Swedish sponsor leads to a furthering of his social capital, by enabling him to seek favours for his brother.

The pervasive character of rogs ram, and the sometimes wayward means used by young exiles to secure it, had become a subject of concern among Indian residents and Tibetan elders, who saw it as symptomatic of social inertia, economic dependence and parasitism. This caused some acute tensions between the Indian and Tibetan communities. As one Kashmiri trader put it:

Some Tibetans, well most of the Tibetans are nice people. The ones who do business work really hard, especially the younger ones. But others just sit and wait for money, you know from sponsorship and other things. But you know, as long as the tourists come, then there will be sponsorship, so why should they work? And actually look, who would want to sponsor me. First of all, I am a Muslim, then, I do business, so people don't think I am poor. Then, I am Kashmiri, so sometimes they may think I am a terrorist. [he laughs] So really, nobody wants to sponsor me!

Late in my stay I became acquainted with an old Tibetan couple who had settled in Dharamsala in the late 1970s. Their children had not done well in securing a living for themselves and were therefore unable to support them in old age. Although they disapproved of the mechanisms of rogs ram, they had come around to the idea of it, feeling ashamed, had asked their grandchildren, more accustomed to the process, to ask their peers for contacts.
Knowing the legitimate economic need of some families, I had soon come round to accepting the system as a legitimate form of help to the community. Sometimes this involved helping Tibetans writing letters to distant foreign ‘friends’, and asking for money on their behalf. The style of those letters was generally in the manner of a long litany of illnesses and misfortunes interspersed with family news and stories of the children’s imaginary or real successes in school. Pictures were inserted, sometimes with blessed medicinal pills and *srung mdud* (the ritual protection thread given during initiations). The whole dossier was then gravely posted off in hope of a prompt reply.

For many families, *rags ram* comes to supplement more traditional economic activities, such as trading or working in the booming Dharamsala tourist industry, in shops and restaurants. One of the main problematic areas identified in fostering private business is the issue of the hindrances in seeking finance (starting a restaurant project in Dharamsala costs on average 5 Lakhs) and the great competition that exists among Tibetan and Indian businesses. Tibetans only borrow money from Indian state banks with difficulty, and are then constantly inspected for the purpose of income taxation. Many Tibetans therefore have recourse to informal sources of funding for business. Some borrow funds from relatives and neighbours or from other Tibetan businesses. Others borrow money interest free from the monasteries or, the preferred choice, from Western sponsors. One of my acquaintances, who was opening a restaurant, had reportedly borrowed two Lakhs (200,000 Rupees) from a friend in the West, and explained that this was the best kind of money, as it was *white money*. Although my informant said she intended to give the money back, she made it clear that she would be able to take her time to do so. She then proceeded to have disputes with two large Tibetan land owning families whose businesses were adjacent to her building site, and who had complained about the noise during the construction of her restaurant. My informant had a different explanation: in her eyes, they were simply jealous of her success. In my experience, *white money* was always associated with funds coming from abroad and I have never heard the expression used in connection with Tibetan financial transactions. The ‘whiteness’ of money seemed to be linked to a ‘flexible accountability’ and, perhaps more importantly, to its ‘untraceable’ character, which made it possible for Tibetans to dodge taxation. Loans from foreigners did not involve the looming menace of repayment, which threatened entrepreneurs if they borrowed from relatives or monasteries. In Tibetan lore, symbolism and religious literature, the colour white (*dkar po*) is generally associated with purity, for
instance in the pervasive references to ‘white snows’, ‘white mountains’ etc. Interpersonal rogs ram, I contend, is ‘good’ because it is negotiable. Moreover, in the context of business, it is ‘white’ because it brings a protective anonymity (at least locally) and ‘untraceability’ to financial transactions.

Another specific form of rogs ram is associated with monks and nuns, in the form of foreign sponsorship to allow them to live and study in better conditions. Donations are also sometimes channelled through a senior monk intermediary who redistributes them to monks in his monastery. In such cases foreign donors entertain a close relationship with the senior monks, often receiving spiritual instruction from them. This form of rogs ram is generally supported by Buddhist networks, which organise and institutionalise funding procedures. There, as in the lay world, intermediaries also come into play: on some occasions senior or influential monks in a monastery will ask for rogs ram for a monk in their monastery. The sponsorship bond, despite being institutionalised and managed through funding networks, still retains a strong interpersonal quality. Recently for instance, the sponsorship of nuns has taken off in an unprecedented way because of the contributions of female Western Buddhist devotees who thereby express their personal sympathy with the cause of spiritual women.

3.1.1. The value of rogs ram: re-enchanting sponsorship

Although monks themselves never suggested this parallel, some exiles mischievously referred to religious and lay rogs ram as a resurgence of mchod yon, the patron-priest relationship established by the Mongol Khans and the Dalai Lamas, through which the Mongols came to protect Tibet against its invaders in exchange for a spiritual covenant. This analogy has been drawn upon to qualify the exiles' present relationship with the West (Lopez 1998). According to this slightly millenarian vision, in an age which both Tibetan and foreign Buddhists agree is one of degeneration, economic sponsorship is bartered for religious sustenance as the spiritual teachings of the Tibetans are called upon to fill the West's existential void. The 'West' is therefore seen to act as Tibetan exiles' secular patron.

Yet, I would argue that rogs ram is more than the reincarnation of patronage for Tibetans. Rather, it is an idea embedded in local conceptions of sharing and redistribution. Part of
the act of giving is in the very creation of a bond with someone outside India, someone who sometimes even shares a similar religious faith, whose life and family can be discussed, in sum, a real person rather than a meal ticket. This is a firm departure from equating *rogs ram* with *mchod yon*. *Rogs ram*, whether institutionalised or interpersonal, always seeks to retain the idea of a personal bond established between people and families. This is congruent with anthropological theories of gift exchange, which described giving as the means to forge or sustain social relationships (Mauss: 1954).

By nature, sponsorship involves an exchange through which what is given supersedes the mere economic value of the gift. Rather, the value of it lies in the creation of the potential opened by the gift. Although sponsorship is made impersonal through its transnational character, Tibetan refugees and their sponsors seek to regain the interpersonal character of the relationship fostered by the gift. Exchange is at the core of this process: sponsors want a moral share in the Tibetans’ success at survival. The recipient is, in turn, obliged to fill the vacuum of potential opened up by the gift of sponsorship. Fulfilling the sponsor’s hopes is the only way through which the gift may be repaid, although in practice no sanction other than withdrawal is applicable if the recipient fails to comply. Understandings of what obligations and aims come with what type of sponsorship are as diverse as the motivations of individual sponsors: some give out of religiosity, some out of a form of post-colonial guilt, most out of personal attachment. Thus, grouping *rogs ram* under the depreciative gloss of new-age *mchod yon*, a sponsorship of Tibet by the West, undermines the meaningfulness of the gift for both donors and recipients.

Furthermore, it is in the hiatus between donors’ and recipients’ understandings of *rogs ram* that one may come to understand the contradictions inherent in the Tibetan refugees’ situation. Caught between the need for money in everyday life, the expectations of families in Tibet and Western ‘foster families’, the gift rarely meets its stated aim. Misunderstandings and disappointment are rife as Tibetans negotiate the various demands that are made upon them. As De Voe observes on the subject of institutional sponsorship: ‘The face to face denial of obligatory aspects contained in the relationship between members of organisations engaged in the charitable servicing of refugees and their clients forms an insistent, binding, paradoxical structure within which neither party has a chance for graceful escape’ (1981b: 90). Institutional sponsorship differs in this
from individual sponsorship: while organisations generally have an obligation to honour
their promise of funding, individuals are entitled to withdraw their support at any time.
The parallel practice of accepting institutional and individual sponsorship among Tibetan
refugees adds to the financial and social dependency generated by long term aid. Exiled
Tibetans are therefore confronted with the bitter prospect of, as Harris points out,
having their culture and livelihoods put on, ‘a life support system in perpetuity’, with little
room for agency and autonomy outside conformity to the prescribed role of rogs ram
recipient and refugee (Harris 1999:197).

I would also argue that rogs ram, or non-institutional and institutional sponsorship, hinges
upon the principle of ‘fictive kinship’. Through the creation and maintenance of
interpersonal bonds, the exchange of news and the sharing of areas of mutual ‘concerns’
(family, education, finance), refugee families and their sponsors entertain the idea of
‘fictive kinship’. The nature of this relationship is to create obligations of a seemingly
unthreatening, yet powerful, character, while simultaneously playing down the economic
reality of dependency. The economic power inherent to rogs ram binds individuals in an
endless chain of patronage. From the sponsor-finder for children, to that of the
demanding sponsor of adolescents, and later on the sponsorship of professionals, exiled
Tibetans are bound in networks of affiliation and patronage.

3.2 Rogpa (’grogs pa): Mutual Aid and Sociality

If rogs ram defines the help of outsiders, ’grogs pa is the work of insiders, the company and
assistance that family and friends give each other on a daily basis. It belongs to the
mundane arena and designates the act of helping as well as the helper. Common
instances of ’grogs pa are accompanying a relative or a friend on a shopping errand or
helping an elderly or sick person in everyday activities. More than help, ’grogs pa qualifies a
way of ‘being with’ or ‘shadowing’ another person, sometimes in very practical ways,
such as carrying things, at other times simply by being there and guarding the safety of a
companion through one’s presence (as is exemplified in the expression lus dang grib ma
bzhin ’grogs pa, lit. accompanying like a shadow). Activities such as khyer rogs byed, taking
[things], zhal lag bzo, making food, and others that are purposefully (shed mang) carried out
to help others, are ’grogs pa. A rogs pa, in older Tibetan usage as in exile, is a helper or
companion who effects ’grogs pa.
At the beginning of my fieldwork I had difficulty in understanding why people were worried if I went out walking on the road alone, even on a small shopping trip, without a companion. It was not simply that the roads or neighbourhoods were not safe but that going alone anywhere was not safe. However, it took me some time to comprehend that this meant safety not only in the physical sense but also in the social sense. After I had been seen by friends wandering around town with some ‘modern monks’, (the meaning I attach to this term will be explained further in the next section) I was told quite empathically that I should get some ngo ma’i rogs pa, that is, a ‘real rogs pa’, or proper companionship. Through this it became apparent that a more appropriate translation of rogs pa might be ‘adequate company’, or cooperation with people, in my case, women, who I could be seen with and rely on without fear of making a bad name for myself. When I, in return, started to ask people, including young men of whom I knew little, if they needed my ‘grogspa, most declined the offer with a giggle, and some even looked at me as if I had just propositioned them. The offer really only seemed to be adequate for girlfriends and women, which confirmed my idea that ‘grogspa had something to do with ‘adequate company’ and ‘adequate help’, designating people it was suitable to receive help from without it being socially compromising.

I began to notice that women, and more specifically young girls (the category in which I was usually put), were extremely cautious of whom they associated with outside the family realm. On a few occasions when I engaged in conversations with senior monks encountered on the streets while walking with a girlfriend as rogs pa, I would feel her arm and hand tense and clutch mine. Nervousness and timidity alone could not account for this kind of reaction; clearly, as a girl, contact with strangers, especially persons of importance or uncertain status, brought a feeling of social inadequacy.

On one such occasion in the Tibetan camp of Majnukatilla in Delhi, I introduced my rogpa to a high-ranking Geshe. He immediately set out to interrogate her, starting with the name of her father, her birthplace and where she had been to school. My friend sat paralysed on her chair and answered mechanically until he was satisfied and resumed his conversation with me. I interpreted this scene by speculating that age and social prestige allowed some to exercise a certain amount of scrutiny over others and that, unless one was willing to tolerate it, such people were best avoided. Why did women immediately
bring me into the circle of their rogs pa, and thereby exclude me from certain company, whereas others, like ‘modern monks’, who saw me simply as an injit, behaved as if the entire array of Tibetan society was accessible and safe for me? For my girlfriends and their mothers, the inclusive group of rogs pa encompassed friends and family with whom it was socially safe to be seen with and mingle, without fear of being exposed to others’ judgement and scrutiny. For not all exiles are brothers, I was told, and not all monks well intentioned. One India-born Tibetan exile woman quoted a proverb illustrating this point: ‘mi' ri mo nang la yod; stag kyi ri mo phyi la yod’, ‘the tiger wears his stripes outside, man wears his on the inside’. You cannot tell what a person is really like from their appearance. One should therefore adopt a certain amount of caution in dealing with strangers or persons of markedly higher status, and exercise prudence to avoid behaving in an unsuitable manner. Following these experiences and also perhaps due to a certain amount of personal cautiousness, I sometimes avoided parties and dinners crowded with strangers on the advice of my own rogs pas.

Young men also requested each other’s rogs pa, although in my experience it has specifically become associated with the security of women’s company. My teacher’s admonishments that ‘if you are walking down the street with a young unmarried man, people will suspect there is something going on between you’ certainly held its promise. The morning khor ra (circumambulation) around the main temple and the Dalai Lama’s residence was the arena of daily gossip, where groups of women sat on the roadside benches to comment on the dress and lifestyle of passers-by. This was a principal stage of social sanction, and being a rogs pa in such a setting meant partaking in the gossip without risking being exposed to it - at least not for the duration of the walk. Walking on the khor ra, people would sometimes comment on my presence, and on such occasions I was told to shad cha gyol, ‘ignore the talk’ of others, but remained with the impression that, as one female friend told me later after a particularly robust gossip session: styi tsbogs ‘diy la nang mthongs gal chen po zhe drags red: ‘reputation (mthongs) is very important in this society’.

Having rogs pa therefore engages the agent’s sense of social awareness. Knowing one’s friends and who one may safely ask for help also involves knowing ‘one’s place’, and the areas of social life which one may safely frequent. More practically, once one is involved in giving rogs pa to someone, the relationship is bound in reciprocity and refusal of
further 'grogs pa becomes almost impossible. Turning down a request for 'grogs pa, or not returning someone’s kindness (drin lan log 'jag), without a good reason expresses the intention of severing close interpersonal relations and is therefore not to be taken lightly.

I describe the two ways of helping and giving outlined here, 'grogs pa and rogs ram, to emphasise the difference in notions of reciprocity, giving and sharing among different social groups, and the different conceptualisations of social distance that characterise both, although there are obviously other - perhaps more innocuous - modes of giving outside these two categories. Rogs ram, the gift of sponsorship, tends to draw its protagonists into a relationship of moral reciprocity by creating an artificial bond that singles out the recipient of the gift as the bearer of hopes and obligations to outsiders. Yet, in practice, it does not have to be reciprocated, and its bonds can be hidden if one chooses to do so. 'Rogs pa, the help and companionship of one’s close circle, similarly singles out its recipient by identifying him/her against the broader social backdrop as belonging to a certain network of 'grogs pa. The bonds created through 'grogs pa are visible and are legitimately and immediately employable. Although to offer rogs ram and to rogs byed pa have traditionally been used interchangeably in reference to the act of ‘helping’, in exile rogs ram has become almost exclusively identified with sponsorship and contact with foreigners, thus making a significant departure from its more traditional meaning.

Sponsorship has the singularity of a gift that one does not have to reciprocate in practice, or by acts of a similar value, but rather through a symbolic act. It defines outsiders and injibs in contrast with Tibetans, among which reciprocity is construed as immediate and unequivocal. Of the two ways of giving, 'grogs pa is readily identifiable with Tibetan behaviour, the maintenance of social bonds through reciprocity and generosity, and congruent with Buddhist merit making practices, whereas rogs ram is conflated with outsider’s values, transnational relationships and patronage.

This analysis reflects a local set of categorisation between different ways of giving. It is clear that rogs ram and its colaterals of patronage and symbolic bondage exist and have existed in different shapes among Tibetans before the Diaspora. However, I argue that the differentiation between 'grogs pa and rogs ram has come to encapsulate the contemporary tension between what is perceived to be quintessentially ‘Tibetan’, and outsiders’ ways of doing and giving. As such, it is symptomatic of the emergence of a
Tibetan ‘exile’ lifestyle that involves extensive dealings with outsiders and economic dependency.

3.3  _rlung tsha pa_. short-tempered _injìys_ ( _dbyin ji_ ) and benevolence

To say that Dharamsala and its refugees have received much attention and interest from the international public is a euphemism. _Injìys_ ( _dbyin ji_ ), as most foreigners are referred to, are an unavoidable fixture of Dharamsala’s landscape. Since the early 1980s and in line with the Dalai Lama’s growing international renown, Dharamsala has been included in the ‘hippie trail’, as well as becoming a rallying point for followers of Buddhism worldwide. Much of the town’s economic activity is based on tourism. The economic impact of foreigners’ interest in the Tibetan cause thus cannot be underestimated; it is the economic pulse of the town.

This has a number of obvious implications. First of all, Tibetan refugees have developed a history of dealings with foreigners (through _rogs ram_, friendships, religious allegiances, and marriage) which have significantly impacted on their social and cultural life. Second, the heavy financial influx from abroad, in the form of institutional and personal sponsorship, means that relationships of dependency between Tibetans and Western groups or individuals are quickly established.

The first point, the emergence of a ‘joint history’ of foreigners and Tibetans, is embedded in what Lopez has described in _Prisoners of Shangri-la_ as the ambiguous relationship of Tibet with the West. This relationship tends to move, as Lopez points out, from romantic adoration to complete rejection. This is especially true in the town of Dharamsala, where _rogs ram_ systems and the less spiritual aspects of Tibetan exile social change are particularly visible. But it is romantic adventurism and the attraction of spirituality which predominate in the small hill-station. One young French female engineer freshly arrived in Dharamsala explained to me how, since she had set foot in the town, she had come to realise the striking similarities between herself and Alexandra David-Neel (1868-1969), the French adventuress who travelled extensively in Tibet in the 1920s, and sought to emulate the fearless travelling spirit of her heroine. This ‘self-quest’ mixed with a tinge of orientalistic fantasy is often a motivation to embarking on the most harebrained schemes to visit one teacher or the other in the hope of the fantasised ‘personal connection’ with the guru and a subsequent epiphany.
Visitors range from casual tourists to semi-permanent residents, mostly students of Dharma following teachings or experiencing monastic life. Casual tourists tend to stay in the upper area of McLeod Ganj where a plethora of restaurants and hotels cater for their needs. They can also sample a variety of activities, from Tibetan cooking to medicine classes, as well as the more classically new-age pursuits of yoga or massage training. The posters advertising health-related activities often propose a hodgepodge of Tibetan, Indian, and Chinese practices. Most tourists rapidly become absorbed in the task of getting to know Tibetan culture and talking to ‘refugees’, usually young newcomers who are more readily available than older established Tibetans, and on the hunt for foreign contacts. Some of these groups are formed by the recognition of common ‘youth culture’; young backpackers enjoy ‘relaxing’ with young Tibetans, who also seem to enjoy sun bathing on café terraces or trekking up the mountains of Bagsu in search of parties and drugs.

I unfortunately did not have much leisure to interact with these groups. Rather, I seemed to attract more spiritually-minded young men who insisted on showing me the monasteries, inquired on whether I took ‘Dharma classes’, and explained that they had been monks and nomads (jointly) back in Tibet. When not absorbed in these time-consuming activities, young men would not refuse an English lesson or two, or even a joint trip to see a Chinese karate film in the upper cinemas of the Temple Road. The boys sported Western-style street-wear and had adopted a relaxed attitude that distinguished them from the more conservative look of the TCV youth or young Gangkyi workers. Sporting large baggy sportswear trousers and tight tops, Tibetan jewellery and the 

ral pa style (long hair style) that is considered so attractive to Western women, the boys are easy to spot for Tibetans and trained injiys alike. Overall, older refugees did not hold young newcomers in much esteem, although their demeanour was most often considered ‘obvious’ and harmless.

But the relationship between injiys and newcomers was sometimes tainted with a darker hue. According to earlier Tibetan refugees, by frequenting the parties where injiys dispensed drugs to their young penniless Tibetan friends, newcomers had contaminated Tibetan exile youths with their ideas and attitudes. An elderly lady whose son had been treated for a drug overdose told me she thought her son’s involvement with injiys and
newcomers had caused his addiction. A social worker from McLeod Ganj insisted that it was the lack of opportunities in the community and social inertia that pushed uneducated youngsters into two possible alternatives: 'either staying on in Dharamsala, making a living through petty jobs, maybe even falling into drugs, or finding sponsorship and eventually getting out to the west'. The boys who used drugs would fall prey to the local patronage of other boys involved in drug use and resell, and of injiys wanting to share their 'Indian' experience of self-discovery with others. One Amdo young man recalled his despair when his room mate and fellow Amdo newcomer once returned in the morning from a party (thug spro) where he said he had been harassed (sdbus po gtsong ba) by an inji that had demanded sexual favours from him in exchange for a supply of marijuana. When I spoke to the young man in question a few days later though, he gave me his interpretation of the event: the foreign man had offered him a substantial sum of money and an invitation letter to the West in return for sex. When the young Tibetan man refused to co-operate, the inji had apparently threatened to lock him up in his hotel room and told him he would never get out of India if he did not make 'a deal' with him. The young Tibetan man was so shocked by this event that he decided to become a monk shortly after.

As we have previously seen in the case of rogs ram, youths, already economically vulnerable through the lack of employment opportunities, are rapidly incorporated into networks of patronage. These forms of patronage are inextricably linked to the presence of often benevolent but sometimes dangerously ill-intentioned injiys and to the 'escapist' opportunities they offer.

Dharamsala has also developed a volunteer culture in which Westerners can find a plethora of opportunities to serve the Tibetan cause: from English teachers to doctors, computer programmers and science teachers, the exile community relies on a host of contributors. Many volunteers I spoke to told me that their main objective in doing voluntary work was to make their time in Dharamsala useful. Others expressed a fondness for Tibetan culture, people and life in Dharamsala, that made them want to prolong their stay and make a contribution to the community. Volunteers, especially long-term ones, are appreciated in the community. Despite the fact that people knew I was doing research in Dharamsala, I was commonly introduced as a 'volunteer' (from Gangkyi), rather than as a student.
Thus the injiys of Dharamsala are divided into categories, which Tibetans are used to recognise, and to which they attach value stemming from a now long history of interaction. Volunteers are better than Dharma students, who in turn are better than casual tourists, who are better than youths chasing after drugs and parties. Despite the understandable character of this moral speciation, injiys often confess to feeling ‘used’ or manipulated by Tibetans who see in them opportunities for ngs ram, or simply contacts to build up their social capital. This, I thought, stemmed from the great economic divide that separated Tibetans from injiys and the lifestyle they brought with them. It also was in part a rebound of the intense romanticism that had fed the injiys’ interest in the Tibetan community and brought most of them to Dharamsala. In the glib and cosmopolitan Dharamsala environment, Shangri-la fantasies have a short shelf life.

The overwhelming presence of injiys, and the readiness with which they are prepared to talk in detail about their lives in the west creates a great deal of envy and angst among Tibetans. This is further reinforced through the telling of stories by Tibetan returnees from the West. On a number of occasions I witnessed the display of gifts brought from the West to Tibetans by their sponsors and friends. Such distributions made the feeling of material ease and wealth in the West almost palpable. This also appeared to further stimulate the desire for goods and stories from the West. I once sat with a married couple of successful traditional doctors from the MTK while one American friend, a disappointed Dharma student who was leaving Dharamsala to settle back in New York, donated the entire contents of her flat to them and their family. The couple looked at each other with utter amazement as they unpacked suitcases of designer clothes, kitchen utensils, jewellery and books. The wife, untangling a set of pearls, exclaimed ‘now you are my sponsor!’ in a not so jocular tone. The American lady then proceeded to explain that she would not need any of this in New York as there was nothing you could not get there (even Dharma classes, she jested). She took out a small palm pilot on which she proposed to write the couple’s address and made some grand gestures to try and explain how these small computers could ‘beam’ to one another. She would not even need to take Tibetan things, she said, as there were so many Tibetan people, shops and restaurants there.
The Tibetan husband, who did not speak any English and could not understand the conversation, was telling me that he had tried to go to England when he was younger to study but did not succeed in getting a visa. When he and his wife had their first child they felt as if they could not make such plans any more. Perhaps, in the future, he hoped to be able to visit that lady in America and work as a Tibetan doctor, as he heard that some had succeeded in setting up practices in the West. But to do this, he said, they would have to try and not have any other children. As the couple were about to leave, the woman gave some Tibetan bags to the American lady, to ‘offer to the people who will donate clothes to my son’, as the two had agreed. The exchange concluded, I walked off with the couple as they repeated to each other what an amazing stroke of luck had befallen them.

Although most Tibetan institutions in exile function through *iniy* money, this flow comes under many different guises. As institutional funding, it prescribes regulations and accountability systems. Coming as independent donations it is, as Tibetans involved in business often put it, *white money*, for which no account needs to be given, only perhaps a moral recognition of debt.

In the following section I examine the changing role of monks and the monastic system in the context of exile economic strategies.

### 3.4 Modern Monks: Monastic Social Capital

According to the 1998 Demographic Survey of Tibetan exiles, the percentage of monks and nuns in the population approaches 24%, being regularly increased by the influx of monks and nuns coming from Tibet in the past two decades. The monastic community’s infrastructures have also developed significantly: Norbu reports that, after 1960, 127 monasteries were established in India over a period of 16 years (1976). The monastic community is most visible in the southern Tibetan settlements, in the great monastic schools of Sera and Drepung, Karnataka. There, new *dge longs* undergo a lengthy and rigorous training[^1], which can last from eight to fourteen years, depending on their aptitude. Some of India’s most prestigious Tibetan Buddhist colleges, such as the Institute of Buddhist Dialectics and the Nechung Tantric College are in Dharamsala.
When I arrived in Dharamsala in 2001, monks were my allies, helping me sort out the practicalities of my stay, and I scouted them in the hope of gaining insight into what I hoped would be the more ‘authentic side’ of Tibetan exile culture. I was initially chaperoned by one young Geshe (dge bshes, the equivalent of doctor of divinity), who in turn introduced me to many friends and potential informants. Then, after the Geshe had left the country to teach abroad, he entrusted me to the care of one of his friends, who he said could help me with any problem I might have. Indeed, throughout my fieldwork and whenever need arose, this monk had the resources and contacts to help me. In the course of fieldwork and through the practice of providing 'grogs pa to young girlfriends however, I gradually came to think that I should not mingle with the monastic community, not only because of monastic etiquette, but also because of the power that some monks in authority wielded in exile. Newcomer monks often complained that high-powered Dharamsala clerics were developing unhealthy attachments to material possessions, accumulating wealth and networking for potential rog ram sources. Many monks and exiles have become somewhat critical of over-achieving monks mingling with foreigners and spending more time away abroad than in the community.

But exiles do not agree on what should be done about such sku zhogs deng dus (the colloquial and humorous version of deng dus kyi sku zhabs). For some, the accusations of corruption hurled at monks are the products of vested interests to undermine the legitimacy of the Tibetan clergy for political purposes. Thus the exiled intellectual Jamyang Norbu comments: ‘It is further no matter of surprise that that the sensational Chinese accounts of lecherous monks, grotesque and barbaric rituals, tortures, murders, and... ah, yes! Virgins [referring to the alleged discovery of virgin sacrifices performed by lamas] should go down well with the world; especially with what I imagine are a set of effete, frustrated, leftist intellectuals with a leaning towards a type of sado-voyeurism’ (1989:10). For others, like the majority of my informants, the rare examples of ‘lascivious’ monks were regrettable but inevitable instances of lapse in exile monastic discipline (Tibetan: 'dul ba, Sanskrit: vinaya). Gossip makes such instances known throughout concerned circles and people were rapidly seen to distance themselves from the culprit. On multiple occasions I was told not to propagate stories such as these, to ignore gossiping talk and to discriminate between ‘really bad’ behaviour like that of Shugden proponents, and stories made up by alleged ‘spies’ or conspirators against the
Dalai Lama and his government. Accusations against monks are thus often fended off by appealing to loyalty to the Tibetan cause and a higher moral ground guarded by a religious group above all suspicion: the Dalai Lama and his close entourage. This was encapsulated in what one monk informant said about corruption among the clergy in Dharamsala: 'when people tell you they are not taking money, not behaving badly, don't believe them, except the Dalai Lama. I believe only in the Dalai Lama'.

The display of wealth and foreign connections (phyi rtse' thog) displayed by some high-ranking monks were certainly a cause of concern among Gangkyi residents, and many expressed fears that, although the teaching of Dharma abroad was undoubtedly a good thing, the monks would eventually lose touch with their own community. Foreign Buddhist devotees have also contributed to circulating stories of corruption in the monastic system. I was many times admonished not to pay attention to these stories and not to spread rumours (khrugs gtam ma rgyal).

Indeed, the vast majority of Tibetan exile monks do not have access to the same social or economic capital as their high-ranking superiors. However they may benefit from their work and fundraising through the trickle-down effect of donations (chos 'dubs) to the monks, or by the giving of 'gyed skal, referring to the share of each monk from the general pot of alms. The monasteries and nunneries are also havens where destitute newcomers may hope to find some security and opportunities for education and social advancement. Although Amdo newcomer Dorjee criticised the conduct of monks who loitered in cafés with Western girls, or of those more affluent monks and Geshes whose affluence was displayed in the ownership of houses on the periphery of Dharamsala, he could not bring himself to speak badly of them and always addressed the monks with pious respect. The most important (gel chen shos) thing was to have good motivation (sku slong yag po), he quipped, they just stay in the restaurants like that, not doing anything in particular (da ga sa bsdad kyi 'dugs, coll). Most of the newcomer families I had contact with spoke highly of monks' and nuns' active role in the community. Many of them could relate to the notion of 'modern monk' (sku sogs dngos dugs), although generally in positive terms, as an almost progressive figure in Tibetan society, the sign that even the monastic establishment was embracing modernity and cosmopolitanism. One female baker said: 'our society will not become anything good without the monks, if the monks are working, and praying and reciting (smon lam rgyog na, kha ton byed na), then it is
meritorious (bsod nams chen po) and we will be prosperous (byang can). The close relationship between monks, nuns and members of their family living in the settlement meant daily interaction, solidified social surveillance as well as reciprocity of gifts and services.

The fear of ‘corruption’ expressed by earlier refugees may be a product of the specific circumstances of exile, yet the use of monastic credentials as a platform for political, social, and material advancement is hardly a new phenomenon. Stein, Kawaguchi and Younghusband have remarked that the pursuit of wealth and social advancement was common among high-ranking monks in Tibet (Stein 1971: 310-316). Saklani writes ‘in most cases monasteries and ecclesiastics amassed huge wealth’ (1972: 136). The accumulation and circulation of wealth between the lay and monastic community is also a subject of great interest; Stein argues that the ecclesiastic community tended to accumulate wealth, whereas the ‘prelate’ was often a factor in wealth circulation. According to Miller, ‘through religious, political and economic activity, through reincarnations and through the prospect of more rapid social mobility within Tibet, the clerical career enmeshes a very broad representation of lay families—the nobility for greater political power, the poor for economic gain’ (1961: 202).

In exile however, the patterns of wealth circulation between the monastic and lay communities follow different trajectories. Several factors impact on this: 1. The predominance of the Gelugpa (dge legs pa) sect in exile despite enduring subterranean intersect rivalries, its claim to a ris med (asectarian) outlook linked to the growing ideological currency of secularism (often interpreted as ‘a-sectarianism’ in the Tibetan exile parlance), and the collusion of the Gelugpa monasteries with the Tibetan exile government; 2. The close-knit nature of the exile community, tightening relationships between lay families and their members who have joined the monastic community, thereby increasing the number of ‘requests’ for spiritual or material favours; 3. The growth of interest in Buddhism and opportunities for social advancement through religious teaching which make monasticism an attractive proposition in the constraining world of exile.

The monasteries’ close ties with the dga’ ldan pho brang (Lhasa government) have been transferred and translated into unyielding loyalty to the Dalai Lama, to the cause of the
preservation of Tibetan culture, and consequently to the task of fundraising. Although this fundraising is channelled through the monastic networks and collected by specific sects and monasteries, much of it indirectly feeds back into the community through monks’ and monasteries’ contributions to institutions, groups and individuals. In Tibet, ‘mother’ monasteries (e.g. se ra for the dge legs pa or smin grol gle gling for the rnying ma pa) are training grounds for heads of ‘daughter’ monasteries. They maintain strong ties with their subsidiaries in the form of economic aid, or through the visits of leading monks who temporarily assume the leadership of the monastery (Miller 1961: 201). In exile, despite the apparent mirroring of the traditional set up in the re-construction of the Se ra centre in South India for instance, loyalty to the Dalai Lama overrides intersectarian politics and dissociates the centre of power (Dharamsala) from the leading monasteries, the South Indian Sera (se ra) and Ganden (dga’ ldan). Monasteries have thus become enmeshed in the political struggle that animates the exile community. Young aspiring monks motivated by the desire to forward the Tibetan nationalist cause may thus join the ranks of officials serving in the Dalai Lama’s office in Dharamsala and access greater kudos within the community. If, from the monasteries of Tibet ‘all roads lead to Lhasa’², in exile, all roads may lead to Dharamsala, but also to Washington D.C., Vancouver or Zürich, as exile religious teachers increasingly find their way to the West and to new opportunities for social advancement.

Exile has prompted greater vigilance against power abuses of the clergy and the increasing laxity in monastic discipline. This issue is such that it has even attracted the wrath of the Dalai Lama, who, during my time in the field, reportedly enjoined lay people and monks to take pictures of those monks who ‘spend their days in cafés taking ‘English lessons’ from foreigners’, often in the aim of getting rogs ram or simply spending time with members of the opposite sex. At a conference on ‘Religion and Democracy’ in December 2001, the scholar Robert Thurman warned that further increases in the number of monks in exile might in effect encourage permissiveness among monastic communities, as newcomers might get the idea of taking to the robe for reasons of comfort and security. Thurman concluded that there should be no such thing as ‘a free lunch’ for Tibetan monks, and that their responsibility in upholding the teachings, including the vinaya pitaka was even more important in exile.
Yet, in daily life, such contentious rebukes of monks were scarcely heard. I temporarily concluded that the majority of my informants simply stood on a different ground to mine, namely they only had contact with the better sort of monks and patronage, whereas I tended to attract the worse by the very virtue of my presence. Being an inji with an interest in Tibetan culture, it was assumed that religion would be my main preoccupation, and that I was there on a form of spiritual quest, as most injis laudably were.

Soon enough, however, it became apparent that many of the lapses I had witnessed and taken to be unforgivable offences against the *vinaya*, such as handling money and engaging in romantic relationships with lay women, stood as common knowledge but did not necessarily expose the guilty monk to public reprimand. Some of these stories, when alluded to, only inspired laughter and a gentle scolding such as: 'it is not good/proper for a monk to do such things'. These remarks were generally followed by an appraisal of the monk's general behaviour, his generosity, his availability to help people and accounts of the occasions when someone had benefited from his kindness.

In the following case study I will attempt to illustrate what I perceived as the popular ambivalent attitude to monks' perceived or actual deviancy. The main protagonist of this short case study, *sku geogs* Lhakpa, had first been introduced to me through the Geshe with whom I had stayed immediately after my arrival. They had studied for the Lharampa (*lha ram pa*) degree together and had remained very close friends since then. Lhakpa resided in one of the Tantric colleges in Dharamsala, and also claimed to do work for the Dalai Lama's Private Office from time to time.

One evening both Geshes came to my house after dark -but before the monastery's gates closed at 9.00pm-, and sat in my room railing at each other as I made tea. My friend introduced me to Geshe Lhakpa as a reliable source of support for my fieldwork. A few weeks later I ran into him near my house and he invited me to come and visit him the next day at the monastery. As agreed, I arrived the next day, but, rather than the monastery tour I had expected, I was sat down to tea in Lhakpa's room with the customary stack of photographs. These depicted Lhakpa in various countries and surrounded by young *drog mo langs ga *shas (a few female friends). Recent photographs had been taken in Lhasa with smiling relatives. Lhakpa explained that he was busy studying
Chinese at the request of the Dalai Lama, who needed him to perform some ‘special work’ (*las ka dmigs bsal*) in Taiwan and the TAR. I could not help but wonder what kind of mission he might be sent to Tibet for. While I flipped through these pictures he busied himself around the small room. The reason he had asked me to visit him at the monastery, he said, was to find out how he could help me in my research. Soon after, Lhakpa was at work to find me a ‘suitable family’ to stay with. Thereafter I often accompanied him on excursions around town, visiting friends and relatives.

One of these outings led us to the Tibetan reception centre, where he needed to visit an old lady who had recently arrived from Lhasa and suffered from severe health problems. We found the elderly woman in one of the centre’s small flats, in the company of three younger women who had been taking care of her as she slowly recovered. As we came in she joined her hands in welcoming Lhakpa and then pulled out her tongue to me. She explained that her legs caused her unbearable pain, which had worsened in India. She had consulted some Tibetan doctors but did not want to go down to the hospital on her own. She also had nowhere to go besides the reception centre and did not know how to go about finding a place to live. She spoke of the audience that had been arranged for newly arrived refugees like her with the Dalai Lama, and seemed to quiver with anticipation. Lhakpa listened intently, paused to think for a while, then explained that he would take her down to the hospital the following day, and that he knew of a place in which she could stay for a few months without paying rent. He gave the gravest attention to the elderly woman’s grievances, nodding compassionately as she recalled her escape from Tibet.

Later on, while we went down the mountain to Gangkyi in the dark, I asked Lhakpa how he had heard of the old lady’s case. He explained that he had been alerted to her situation by the centre’s director, who had asked him to help. When some of my female friends heard that I had walked home alone with the monk they seemed worried, and one of them later told me in private that he was part of a group who ‘likes women’, and had been known to have ‘girlfriends’ before. I nevertheless continued to have contact with Lhakpa and he regularly came to see me with gifts of food and books. Once I deflected his attentions by holding out an X-ray of my lungs to him, pointing out what I thought would be an appropriate Buddhist trope: what may seem different and ‘interesting’ on the outside was all really the same on the inside. Another time I found him dreamily
ogling posters of temptress Bollywood film stars in a lower Dharamsala shop window, upon which he demurely smiled and declared ‘I am not a god, I am a sentient being’. Despite these hedonistic bouts, Lhakpa’s generosity and sense of humour were famed to the point of becoming proverbial. After lo gfar he returned from a short trip to Taiwan with a suitcase full of donated money from the Taiwanese faithful, which he promptly distributed to the monks of his monastery (to each the round sum of 1000 Rupees). He also dispatched some of the coveted Chinese-made rice cookers and a tea thermos to friends and relatives. This was certainly eccentric behaviour, but Lhakpa never failed to impress in his daily exercises of compassion. On the trip, he had collected a new mobile phone, one of the first to reach the town, and some more pictures of girls, one of which he confessed with a seraphic grin had ‘threatened’ to marry him.

Despite the posturing evident from his outside demeanour, the genuinely ardent kindness and concern toward others displayed by Lhakpa seemed unassailable. For this reason, he was untainted by public criticism. The term ‘modern monk’ (sku gzogs deng dus), which I heard in reference to Lhakpa and others, carried an affectionate rebuke for the holy man lured by the attraction of material possessions. Yet, at the same time, it implied an appreciative comment on his ability to offer ‘practical’ compassion in a modern world, to play with the networks available to more privileged, educated exiles in order to help some of his less fortunate fellow Tibetans. The combination of concern and resourcefulness have made the sku gzogs deng dus’ ‘outreach’ brand of compassion visible, and possibly rendered the lapses in discipline tolerable.

On other occasions, I heard friends speaking of ‘a good monk’, referring to one who genuinely helped and acted with concern towards others, even at the expense of their own comfort and time. I believe that the outward behaviour of monks is the determinant factor on the basis of which they are judged by others. ‘Modern conduct’ is tolerated, as long as monks are still thought to fulfil their duties towards the community. The rest is tolerated if it is kept hidden. Such offences as handling money or engaging in relationships with lay women are not acceptable according to the vinaya rules. However, popular judgement is also influenced by the outwardly behaviour of monks. This is not merely a matter of keeping up appearances, but a reflection of a fundamental tenet of Tibetan Buddhism, which places emphasis on the everyday practice of compassion. The
more esoteric or disciplinary aspects of monasticism are less visible to the lay population than daily behaviour, what one might call the performance of compassion, and its instantiation of the Buddhist ethos.

I wish to argue here that the tolerance towards 'modern monks' and the evolution of Tibetan monasticism, at least to a certain extent, seem to reflect a practice-orientated approach to belief. The insecurity and social instability fostered by exile have given 'modern monks' a privileged terrain on which to practice their skills and resourcefulness. As a result however, the increasing power and privileges wielded by some are temptations to override rules altogether, and a fine balance is needed to weight out service to the community and troublesome behaviour. Tolerance of certain lapses in monastic discipline should not be taken as an indicator of blind devotion: male monastic pranks and shortcomings are a commonplace feature of Tibetan lore and literature, and, in the harsh realities of exile, Dharamsala refugees need to be able to distinguish a *tshul khrims dang ldan pa'i dge slong*, a true monk respectful of the discipline, from a *sku gzhogs deng dus*, a modern monk.

Looking at the pictures of the *sku gzhogs deng dus* on their cosmopolitan travels, the outsider gets an uneasy feeling, somewhere between discomfort and affection. The visual and cultural anxiety generated by the picture stems from the sense of incongruous post-modern dislocation that superimposes the ancient and holy tradition of Tibetan Buddhism on the iconic landmarks of the West. But this figure has already become an accepted part of the landscape in both East and West: it is nowadays not unusual to see Japanese, Thai and even Tibetan monks scouring the museums and universities of London, New York and San Francisco. The quirky clash of the monk sporting a mobile phone has been assimilated as another form of acceptable modernity.

The relationship between the emergence of 'modern monks' and the new power dynamics of exile is apparent in the gender bias which confines nuns to their traditional places in society. Only monks benefit from the possibilities of social advancement which come with monastic education, as nuns are not allowed to take the examinations conferring the title of geshe (*dge bshes*) and therefore the status necessary to teach. The pressure exerted by Western nuns to obtain ordination and *dge long ma* status has had some effect in expanding opportunities for Tibetan nuns. There is now one nunnery
which aims to confer the title of dge long ma to its students after a curriculum of nine years’ study. Western nuns have created pockets for themselves; they are generally reluctant to stay in nunneries with Tibetan women, and instead live outside to follow their own course of study. Many Tibetan nuns pursue secondary occupations besides their religious training, such as making handicraft objects to support their nunnery, working with relatives in small businesses, or embarking on their own small ventures (for example selling rtsam pa).

This gender bias in opportunities is by no means surprising considering the traditionally subordinate status of nuns (Havnenik 1990). However, the nuns’ silence on questions of politics and Tibetan las ka dmigs bsdal (special work, referring to the secretive politics of Tibetan diplomacy) is notable, and the domination of ‘modern monks’ in these areas is reinforced by the traditional institutional favouritism toward monks. However, as previously discussed, lay women are now wielding more power and partaking in the work of governmental institutions.

3.5 Exile social and economic strategies: some conclusions

In this chapter I have described some of the economic exigencies of exile and the strategies deployed by Tibetans in response to them. The first part focused on the social and cultural constraints induced by the dependency on foreign sponsorship (rogs ram), client/patron relationships among exiles as well as between exiles and foreigners. I have attempted to show that such relations are factors of social tension and economic dependency, and, as such, directly related to the production of psychosocial stress. In the second part, a focus on grogs pa and the importance of interpersonal solidarity among Tibetans allows us to mitigate this view, stressing the importance of communal and kin bonds in alleviating the economic and social hardship of exile. I also argue that for the majority of exiles rogs ram is presented, albeit in its ideal form, as an interpersonal exchange, thereby undermining the stigma of dependency and emphasising the qualitative aspect of the donor-recipient relationship. Finally I offer an interpretation of the rise of new religious élites who build on the traditional social capital of the clergy in the new and innovative ways, and have become agents invested with a special role in negotiating the contingencies of exile. The above-mentioned factors have a critical
impact on the exiles’ experience of exile as a cause of mental and physical strain, and on their subjective assessments of well-being.

Having concluded this introduction to social organisation, change and economic strategies among Tibetan exiles, I now turn to an account of the main health resources available in Dharamsala. The following chapter thus provides an outline of the two main medical institutions (the allopathic Tibetan Delek Hospital and the Tibetan Astro Medical Institute) as well as independent agents such as oracles. It also attempts to include some cultural perspective on how best to evaluate prevalent diseases in the context of exile.
4

Medical Pluralism in Dharamsala:
Institutions and the Treatment of Prevalent Diseases

4.1. Introducing Medical Pluralism in Dharamsala

Dharamsala has a diverse and expanding healthcare community: the town hosts a Tibetan biomedical hospital, the Tibetan Astro-Medical Institute or Men-Tsee-Khang (MTK), as well as a number of independent Tibetan practitioners and Ayurvedic clinics. The Indian Zonal Hospital (Dharamsala) and District Hospital (Chamba) provide additional biomedical healthcare facilities, which are periodically called upon by Delek Hospital practitioners. These institutions technically provide care to both Tibetan and Indian patients, although in practice, Tibetans constitute the majority of patients at the MTK. Within this pluralistic landscape, seeking and providing healthcare is an activity imbued with political and social meaning: individuals express markedly different reasons for visiting Delek and the MTK, and have recourse to a range of independent agents such as oracles to help them make such therapeutic decisions. Such strategies are commonplace in other pluralistic medical contexts where individuals will have recourse to self-directed self-therapy, self-therapy under the guidance of a group (family, neighbours), diviners, and of biomedical and traditional healers of various hues (Good 1987; Kuhn 1994; Last 1999). Furthermore, Tibetans’ health seeking strategies differ from those of their Indian counterparts.

The first characteristic feature of the medical landscape in Dharamsala is the co-existence of allopathic and Tibetan traditional practitioners, and the relative flexibility with which patients proceed to visit both in turn. Medical anthropologists have demonstrated that the coterminous presence of traditional systems of medicine alongside biomedicine can be explained by the fact that not only do these systems fulfil different healthcare needs, they also function within complementary frameworks: while biomedicine caters for the needs of a universal mechanistic body, traditional medicine cares for local, gendered, individual bodies. In relation to this, Craig Janes argues that the persistence of indigenous systems of medicine in the face of the increasing 'structural power' and 'professional sovereignty' of biomedical practice has two main theoretical explanations: firstly,
indigenous systems of medicine resonate with locally salient belief systems in ways that are beneficial to the patient, ways that 'supersede the aim of physical efficacy'; secondly, 'indigenous medical resources are perceived to be part of a larger, 'meta-medical' framework within which ethnicity, nationalism, rapid social change, and social conflict both resonate with, and are expressed through, patterns of illness behaviour' (Janes 1999: 1803).

In the following sections I will give a brief presentation of the healthcare providers in Dharamsala, outlining their main characteristics in terms of institutional status, patient care provided and types of disease treated. I will focus on two institutions: the biomedical Tibetan Delek Hospital and the Tibetan Astro-Medical Institute of Men Tsee Khang (MTK), although reference will be made to independent practitioners and other agents involved in 'therapeutic management'. I use the notion of 'therapeutic management group' with reference to Janzen, who defines a therapy management group as a body of people, whether kin, friends or neighbours, that contribute to decision making in the context of illness affecting an individual or group, by providing material and moral support, managing information about the disease and advising on practitioners (1978: 4).

Gangkyi has one biomedical facility, the Delek Hospital, run jointly by Tibetan staff, with a Tibetan Indian-trained Chief Medical Officer, and foreign volunteer doctors. Volunteer doctors generally stay from six months to a year. In addition to this, medical teams from Japan and Taiwan regularly conduct large-scale operations of vaccinations, cataract surgery, and optical and dental check-ups in Dharamsala and the nearby Tibetan transit schools. In Dharamsala the biomedical hospital is considered 'Tibetan'-run, i.e. staffed by Tibetan doctors and administration personnel, although in reality many of the doctors are foreign volunteers. As in other Tibetan settlements, biomedical facilities are run by Tibetan biomedical doctors and nurses both trained in India, assisted by Tibetan health workers and foreign doctors (see Samuel 2001 for a description of traditional Tibetan medical facilities in Dalhousie). Tibetan Gangkyi residents express their marked preference for visiting Tibetan doctors, and although Indian biomedical doctors and pharmaceutical shops flourish in lower Dharamsala, Tibetans rarely visit them.
Tibetans do not equate the sort of medicine practised in Indian biomedical hospitals with 'Western medicine'. Rather, they consider it to be 'Indian medicine' (rgya gar gyi sman), thereby identifying it with a local exile medical culture rather than with the more abstract category of 'biom edicine'. There are thus different 'types' of biomedicine: foreign, Indian, and Tibetan. The classification relates both to the origin of the practitioner and to the provenance of the medicine used. Classifying institutions with the use of labels such as 'Indian' or 'Western' can therefore be problematic: the appellations used by Tibetans reflect their local understanding of healthcare, which is tied to who provides it rather than to more theoretical distinctions between medical systems. For example, while 'Tibetan medicine' (bod kyi smai) unambiguously refers to the MTK's traditional pill production, Indian medicine or rgya gar gyi sman, can be taken to refer to either Indian allopathic or Ayurvedic medicine. I found no separate term to designate Ayurvedic preparations in Tibetan. Instead, when asking patients whether they took Ayurvedic medicine, I was told to say (rgya gar sma?i che shos nge nod sman nang shin chod kyi yod pai?): 'Do you take Indian medicine that is like Tibetan medicine?' The label 'Indian medicine' could also be used to designate allopathic drugs bought in Indian pharmacies, although not necessarily Indian-made. Medicine given by the Delek hospital on the other hand is sometimes referred to as inji or phyI gyel gyi sman (foreign medicine), because it is donated and Western-made. The category of inji or phyI gyel gyi sman furthermore encompasses medicine given by tourists either to the hospital as a donation, or directly to individuals from their own travel supplies.

Categories used by Tibetan patients are therefore dissimilar to those of local Indians, who identify Tibetan medicine as 'traditional Tibetan medicine', and also to the categories used by health planners who simply differentiate between allopathic and traditional medicines. The awareness and use of Ayurveda is low, and heightened differentiation is made between Tibetan traditional medicine and biomedicine. Rather than categorising medical systems in terms of biomedical, Tibetan, or Ayurvedic allegiance, Tibetan Gangkyi residents differentiate between them in ways that emphasise their local terms of use.

In addition to the two main medical institutions, the Delek Hospital and the Men-Tsee-Khang, there are also six Indian independent allopathic practitioners in McLeod Ganj and Lower Dharamsala. Furthermore, eight licensed Ayurvedic practitioners, allopathic
pill peddlers, and medicinal herb street-sellers advertising their services on the streets of McLeod Ganj and Kotwali bazaar. The streets of McLeod are also replete with Indian and foreign practitioners of alternative therapies (reiki, shiatsu), catering mostly to foreign visitors. Many Indians and Tibetans have set up ‘courses’ in alternative therapies, including ‘traditional’ forms of Tibetan massage, which they offer to tourists. Tibetans rarely use these forms of alternative therapies, being generally suspicious of ‘new-age’ practices, and tend to prefer allopathic or traditional Tibetan medicine. I once heard two male MTK doctors remark that young Tibetans who advertised skills in ‘Tibetan massage’ in McLeod Ganj were really being ‘ing thsapo [colloquial, meaning ‘fashionable’], i.e. trying to set a trend for something that did not really exist before. According to them, there was no such thing as ‘traditional Tibetan massage’ in isolation from traditional Tibetan medicine. Although the MTK doctors did not comment on this, I suspect they were uncomfortable with the youngsters’ use of the label ‘traditional’. These Tibetan alternative therapeutic ‘creators’ were clearly keen to affiliate themselves with socially more legitimate medical practices such as traditional Tibetan medicine, thereby benefiting from some of the system’s medical credibility. In addition to this already crowded scene, a few maverick traditional Tibetan doctors have set up practice independently from the MTK.
4.2. *ma ni ril bu, byin rden* and medicinal substances

Although the number of people that come in regularly for consultations at the Men-Tsee-Khang is relatively small (doctors see approximately 30 to 60 patients a day each), many Tibetans in Dharamsala consume the over-the-counter Tibetan pills sold in the Institute’s shops, a variety of *rin chen ril bu* (precious pills). These pills are often described as ‘general tonics’ i.e. vitality enhancing substances, although some of them are more specifically directed at disorders like indigestion (*ma shu ba*) or fevers (*tsha ba*). They are expensive medical concoctions produced by the MTK that are given the blessings of lamas and must be ingested under prescribed conditions.

Pills consecrated by lamas are called *ma ni ril bu*, and can generally be categorised as one of the types of blessed medicinal substances or *byin rden*. *Ma ni ril bu* (*ril bu* a globular form, or more prosaically, a pill) and *rin chen ril bu* are still prepared according to ritual prescriptions or *ma ni ril bu grub thabs* (methods for making *ma ni ril bu*) which include astrological recommendations as to the auspicious time for preparing the medicine.

The pills are made out of a paste containing herbal products and bread paste, sometimes mixed with mineral components. The medicinal paste obtained is then moistened with consecrated water and rolled into small pills. Traditionally, the students explained, the vessel containing the medical preparation is set upon a circle divided into six sections and a smaller central circle. At the centre of the circle the lama inscribes the syllable ‘*bri*’, an invocation to Chenrezig/Avalokiteshvara. In the other six sections the syllables of Avalokiteshvara, *om ma ni padme hum*, are laid out. The preparation remains in the vessel for a period ranging from one to three weeks during which the lamas or students recite the Medicine Buddha mantra. Students said that owing to the increasing demand for *ma ni ril bu*, the preparation process is now speeded up to one week for the commercialised pills, with an additional period for drying the medicinal paste. The initial concoction is rolled up into pills through the use of large drum-like spinning machines, after which they are left to dry out in the open air on the roofs of the Institute.

Other forms of pills are not sold but given during ritual occasions or kept as relics in monasteries and homes. For example the relic pills *ring brel ril bu*, which are found in the ashes of lamas after they have passed away, or relics which can be made in the form of pills, such as coloured ashes, pearls or bones. They are now most commonly owned by
monasteries, according to MTK students, and are not used for medical purposes. One students did however mention that these relics, when available, would be given to patients close to death.

Other widespread byin rden, or sacred empowered substances, are seeds or waters blessed by high lamas on ritual occasions. Such byin rden substances include the ma ni ril bu, small pills fabricated by the MTK and blessed by the Dalai Lama (and now by the exiled Gyalwa Karmapa), and the turmeric coloured seeds given by the Nechung sku rten (the Nechung oracle or spirit medium) after an oracular trance. Byin rden substances are kept within homes for months and distributed to friends and family that were not able to visit the temple on the day. One member of the family is usually dispatched to collect the byin rden from the temple. Giving away byin rden is considered an act of merit, which deflects the blessing of the lama who has given them onto the recipient of the medicine. The byin rden are consumed by family members whenever illness occurs, first preventatively, then sometimes as a complement to other medicine, often biomedicine. For example, three members of a family I visited in McLeod Ganj shortly after the lo gsar (New Year) festivities had fallen ill, suffering from fever and stomach pains. The female household head promptly proceeded to give out a cocktail of aspirin and ‘ma ni ril bu’ which were taken together, crushed one straight after another (zhib zhib bzos dgos red) in the same glass of boiled water (chu kbol). It was common for me to visit houses where, upon seeing that I was feeling tired or ill, a member of the family, generally a woman, would offer me ma ni ril bu or byin rden.

Such byin rden are part of the ‘preventive’ pharmacopeic arsenal of Tibetan medicine. Indeed, byin rden are consumed far more often than medicine targeted at specific, isolated illness episodes, suggesting that byin rden and precious pills are elements which signal Tibetan medicine’s key focus on the maintenance of health and prevention rather than a ‘disease-centered’ approach.

Such byin rden can also be taken when a special blessing is required. For instance, students take byin rden before government examinations to help them cope with tiredness and instil within themselves the blessings contained in the pill’s substance. Such byin rden may then act as ‘auspicious’ charms, positively influencing the fortunes of whoever takes them, or when illness caused by spirit (gdon) is suspected. Samuel also describes similar
uses of *byin rden*: ‘people may take *byin rden* if they feel in a vulnerable situation for example, when selling sweaters on the streets of dirty and polluted Indian cities or when going to an Indian hospital for the delivery of a child’ (Rozario 1996, cited in Connor & Samuel 2001: 250).

In many cases, medical and protective attributes are linked; exiles often take *ma ni ril bu* in a preventative way, as a protective measure against the threat of potential illness. Medicinal and protective properties may be transferred onto a great number of substances. I would suggest that this range has recently grown to encompass substances that have acquired strong affective meaning in the diaspora.

‘In Tibet, water tastes like milk’, I was told, or also: ‘the milk in India tastes like the water from Tibet’. Similarly, it is said that food and drink from Tibet is especially rich and nutritive: yak meat is richer, its taste more pungent. Goats’ milk is so full of goodness that it is said to possess medicinal virtues. I was sometimes offered food by newcomers or friends who proudly announced that the food displayed – often dried yak or stringed dried cheese *chu im*, came straight from Tibet. It was regularly proposed that Tibet is/was free from illnesses such as tuberculosis, and that the Tibetan people had only come in contact with them in India.46

One may suggest that there is a homology between the use of food brought from Tibet and that of *byin rden*: both are considered to have curative, protective and vitality-enhancing qualities. Offering food from Tibet may be considered a virtuous act much in the same way as the gift of *byin rden*. Therapeutic material thus includes a wide variety of substances such as herbal products, foods, and substances like water or butter. These substances have the common property of being allegedly infused with the bio-moral properties of places or persons. Tibetan water, goat’s milk and dried cheese carry within them the homeland’s reified bountifulness. Remembrance of the homeland and its positive qualities induces belief in the curative properties of substances coming from Tibet.

As I will discuss in the following chapters, exiles attribute many illnesses to the change in climate experienced in the move to India, and particularly to heat and excessive consumption of ‘hot’ food. They have become fond of Indian chilli (*se pen*), despite the
fact that the regular consumption of 'hot foods' or foods that make the 'mouth hot' (*kha tsep phyi*) is thought by doctors and old people to be bad for the Tibetan constitution. Many exiles have problems adapting to an Indian diet, especially in giving up eating meat regularly and adhering to the prescription of eating beef (*glang sha*). In opposition to foods from Tibet which are described as being infused with goodness, rich and hot Indian foods are described as adverse to health. Food and substances carrying the protective blessings of lamas, such as the *tsogs* offered at the main temple on the 10th and 25th of the month (lunar calendar) are also coveted items. In exile the *tsogs* takes the prosaic form of packets of Indian biscuits, bananas and chocolates.

Table 2. Medicinal and Protective Substances

<table>
<thead>
<tr>
<th>Medicinal Products</th>
<th>Medicinal Substances</th>
<th>Protective objects and substances</th>
<th>Vitality Enhancing Substances</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>r til bu</em> pills</td>
<td>sngo herbs</td>
<td><em>Srong ba</em></td>
<td>imported foods (e.g., <em>chu ri ba, yag</em>)</td>
</tr>
<tr>
<td><em>phyi ma</em> powders</td>
<td>sa ger minerals</td>
<td><em>Talisan</em></td>
<td>'imagined' substances (mar chu from Tibet)</td>
</tr>
<tr>
<td>preparations (pastes, etc.)</td>
<td></td>
<td><em>ma ni ril bu</em></td>
<td><em>tsogs</em> (biscuits, fruits, etc.)</td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>Byin rdeu</em></td>
<td></td>
</tr>
</tbody>
</table>

4.3. Diviners and *mo*

Other key agents in the Tibetan medical landscape of Dharamsala are lamas, some whom have trained in addition to their monastic curriculum (and are then known as *sman blo*), and lay diviners. While learned monks regularly perform divination rituals such as *mo*, lay diviners also practise *mo* and may additionally engage in other divination practices, such as the reading of tea leaves*". A number of lay diviners in Dharamsala are people who have developed oracular faculties and 'specialities', e.g. *mo* divination with prayer beads, reading from tea, etc. Three out of the five lay diviners (although I only saw one practicing) I encountered were women. While lay diviners generally have a reputation for engaging in more prosaic forms of divination, the preferred oracular mode remains the *mo*, the origins and techniques of which I will describe in the following sections.

The practice of *mo* is said to have its origins in the pre-Buddhist Bonpo tradition of Tibet (Dorje 2001). In the contemporary TAR as in exile however, *mo* is more often linked with Vajrayana practice (the adamantine vehicle), a form of Tantric Buddhism that
developed from the Buddha's teachings and rose to an increased popularity in the 6th century A.D. before developing into an indigenous tradition throughout the Himalayan regions. Tantric practice seeks to develop the mind's 'wisdom' by allowing it to see the interdependence of phenomena (or *rten 'bris* dependent arising) that govern worldly existence. When allied with the realisation of the emptiness of all phenomena, the mind that combines the realisation of wisdom and emptiness is a powerful instrument that can allow one to 'generate' tantric deities, and subsequently to generate oneself as the illusory body of the deity. The divinatory act is meant to harness the mind's inherent power to achieve 'wisdom' when untainted by the intellect's constant preoccupation with the mundane.

The most common forms of *mo* are the throwing of dice and the manipulation of the *phreng* (prayer beads), gripping the beads at random (a practice called *phreng mo*). *Mo* divination sometimes requires empowerment by a teacher so that one is authorised to visualise the deity and recite the appropriate mantra. With *phreng mo*, the lama first visualises the deity then grips the *phreng*’s 108 beads with both hands. The number of beads between the left and right hands is then reduced until it is a number between one and six, which is interpreted accordingly (1 being the best). *Mo* is regularly called upon in cases of serious illness among exiles in Dharamsala, both to identify its causes and prescribe an appropriate course of therapeutic action, whether it be biomedical or traditional.

The *mo pa’s* divination sometimes relates the illness to possession of the sufferer by *gdon* (malevolent spirit), and prescribes the appropriate exorcism, involving the purification of the home and spiritual practices such as making recitations and offerings. The *gdon chen chu nga* (fifteen great evil spirits) for instance, said to cause multiple afflictions, are particularly dangerous to young children. According to one lecturer at the MTK, after conducting a *mo* to ascertain whether the illness has been caused by a *gdon*, the lama gauges the seriousness of *gnod pa* (harm) involved. If the resultant illness is a mere weakness, fever or cold, the patient is given a charm to hang around his/her neck or to keep within the home. These charms can take the form of amulets, consisting of pieces of paper with a protective mantra or symbol of the demon’s enemy (*drag shed*). In cases of serious illness, the lama makes an effigy of the spirit out of clay or bread paste (*sku glud*, lit. ‘ransom offering’). The spirit, fooled by the effigy, recognises itself and, by entering its
own representation, is trapped in it. The effigy is then burnt or buried and purifying rituals performed in the house of the sick person. There are renowned diviners in Dharamsala, Dehra Dun and Clement Town who perform oracles and such rituals in cases of grave illness. One male astrology student reported making amulets containing the name of the deity *baryagrisa* to ward off the ill intent of the controversial deity Shugden. He told me he had torn off posters with the name of the deity and slanderous language about the Dalai Lama from walls near the Men-tsee-khang and had then found his door bolted from the outside in the morning as he was about to go to his lecture. He thought an angry Shugden worshipper may have given him a curse (*byad khad*). This was the only preventative measure I witnessed in relation to this cult. According to the MTK lecturer however, the doctors’ work is becoming increasingly dissociated with divination, at least in Dharamsala. While Calkowski (1985) reported quite a level of ritual activity in relation to spirit attacks, the enrolment of ritual specialists to carry out purification rituals is not dealt with within the MTK but rather through monasteries (in Gangkyi for instance, monks from the nearby Gadong Gompa perform funerary rites and *gdon* expurgations). It is also worth noting that Astrology is less and less popular as a subject of study among young Tibetans, in contrast to the medical course.

Exiled Tibetans also consult MTK and independent astrologers for advice on suitable dates for weddings and rituals associated with funerals or *gdon* expurgations. The Dalai Lama himself is known to perform *mo* divinations, and a number of monks in Dharamsala are solicited on a regular basis to help families in need. On one occasion, for instance, a second generation Tibetan female informant in her late twenties who had just lost her newborn baby became suspicious that her child had been a victim of *gnoapa*. She subsequently visited a local lay female diviner in McLeod Ganj to ascertain the cause of her child’s death. Interestingly, she elected to consult the lay diviner rather than the renowned Geshe living in the same building as her. My informant explained that she had known and consulted the female diviner for five years over issues such as illness, business prospects, and the possibility of a move abroad. She would feel intimidated by the more learned monk who would also probably require more elaborate rituals to be performed, which would increase the cost incurred for the purchase of butter (for lamps) and donations. Upon hearing that her child had probably been the victim of a *gdon*, she went to call upon the monk for ritual prescriptions because she felt the event was serious enough to require his help.
The presence of diviners in the medical landscape of Dharamsala is an enduring and important feature. In practice, it actualises a major link between Buddhist conceptions of illness, medical aetiologies and therapeutic management: diviners are often the ‘gatekeepers’ of therapeutic action, directing sufferers to practitioners and prescribing an appropriate course of action. One may speculate that the great number of therapeutic options available in Dharamsala forces individuals into difficult choices, and often leads them to have recourse to ‘independent’ actors such as religious and lay diviners who, by acting as gate-keepers, relieve the patient of therapeutic management stresses by conferring responsibility onto an external agent.

In the following diagrams I have attempted to map out the field of medical culture in Dharamsala and offer some examples of possible therapeutic management within its framework.
PLURAL MEDICAL CULTURES OF DHARAMSALA

Figure 4.2. Plural medical cultures of Dharamsala

POSSIBLE THERAPEUTIC MANAGEMENT SCHEMES

1. Possible TB Therapeutic Management Scheme

2. Possible Arthritis Therapeutic Management Scheme

Figure 4.3 Possible Therapeutic Management Schemes
Before embarking on a more detailed discussion of the local configurations of medical pluralism, I will attempt to describe the healthcare landscape in Dharamsala, starting with its main biomedical institution, the Tibetan Delek Hospital.

4.4. The Tibetan Delek Hospital

Opened in 1971, the hospital is an autonomously funded and administrated institution under the supervision of the Department of Health, a part of the Central Tibetan Administration (CTA) in exile. Delek is responsible for the provision of healthcare in the 13 Tibetan settlements disseminated throughout Himachal Pradesh. Its facilities have been recently expanded from a single building to two with the construction of a new clinic in the vicinity of the old hospital. The 'old' Delek Hospital is a run-down three-storey building on Khara Danda Road, which leads to the upper settlement of McLeod Ganj. In 2001, the hospital received approximately 40 patients at its morning out-patient clinics, a majority of those being Tibetan with a smaller proportion of Indian patients.

![Figure 4.4. Plaque propped against the outer wall of the Tibetan Delek Hospital, outlining its credo.](image)

The new building now hosts the outpatients department, as well as a general ward, an ocular and dental clinic, and a labour room. At the time of my last visit to Dharamsala in August 2002, the older building comprised the TB ward, an X-ray room and a laboratory with microscopy facilities. The hospital has approximately 85 beds, 40 of which were, at
the time, in the TB ward, and usually retains approximately 30 full-time members of staff, in addition to the Administrator, Chief Medical Officer and a General Secretary. Doctors are Tibetan (two residents) and foreign, and nurses are mostly Tibetan. The Delek branch of the Community Health Centre Clinic (CHCC) in the upper settlement of McLeod Ganj also provides out-patient services, with an average of 80-90 patients per day. The CHCC Clinic is supervised by a matron, assisted by two Tibetan nurses. Nurses rotate between the CHC Clinic and the Delek Hospital every month. The majority of serious cases are treated at the Delek Hospital in Gangkyi, which may refer some of the more gravely ill patients, and those requiring surgical intervention, to the district hospital in Chandigarh.

The adjacent Tibetan run laboratory carries out blood, urine, sputum, stool tests and X-rays. The majority of tests conducted in the Delek Hospital are related to TB treatment. When asked by one of the doctors to go down to the laboratory and have an x-ray, the patient is told to sit and await the laboratory technicians in the small yard behind the hospital where others wait for their results. Upon entering the small laboratory where the testing material is handled by two Tibetan technicians, the patient gives a sputum sample and is asked to remove his/her shirt for the x-ray. Test results come out some fifteen to twenty minutes later and the patient is subsequently redirected to the physician, or, if the tests are negative, sent home. The care for TB patients is usually organised from the old branch of the hospital that is now exclusively dedicated to them. Tibetans in white masks who are either staying on the ward or awaiting results of tests from the laboratory generally crowd the old and derelict hospital building. In the morning, patients line up outside the Chief Medical Officer’s office for a physical examination, and receive prescriptions for medicine. Those staying on the ward linger on the top floor balconies or receive visits from relatives bringing food and dropping in for a chat.

Most Tibetan patients informally told me that they saw the construction of the new building as a huge step in improving the community’s access to healthcare. But the disaffected atmosphere in the old building now contrasts with the clean efficiency of the modern hospital, resulting in more anxiety on the part of TB sufferers who feel relegated to the rank of second class patients. In contrast to the old building, the new Delek building has a luminous entrance hall with a large waiting area for patients and relatives,
and a wheelchair-friendly ramp going up to the top floors past a crowded, but relatively cheerful-looking ward.

The number of patients and shortage of staff are such that the hospital corridors are always crowded with patients waiting to be seen by a practitioner and relatives awaiting news. Another salient problem noted by doctors, and specifically highlighted by the Chief Medical Officer, is the shortage of Tibetan allopathic practitioners in the community. The doctors claim there are few incentives to work in the community, which, they argue, is due to poor facilities, the limited medical technology and medication available, and, most importantly, low pay scales (8000 Rupees a month on average for an allopathic doctor).

This shortage of practitioners creates a strong dependency on foreign doctors to assist local staff. Some of Delek’s patients criticised the hospital for taking on high numbers of foreign volunteer doctors rather than investing in the education of young Tibetans. In the eyes of one nurse though, ‘foreign doctors are more reliable than Tibetan ones, who just want to leave as soon as they get their diploma and work somewhere where they can get more money’. The unreliable provision of staff is often blamed for the lack of continuity in the anti-tuberculosis programmes, as well as the feeling sometimes expressed by patients that they are being used as ‘guinea pigs’ by young doctors ‘who look as if they have just come out of medical school’. This feeling of ‘being experimented on’ is reinforced by the fact that the hospital sometimes takes on unqualified foreign medical students, allowing them to examine patients under the supervision of medical staff. These students bring a fee of 15 US Dollars for each month spent at the hospital.

The wards are almost always full. In some cases, patients are cared for in beds that have been put out in the corridors or on the verandas of the hospital. Prior to the construction of the new hospital building, the waiting period for a bed was two to three months, but this seems to have been significantly reduced with the new building. The hospitalisation period is generally limited to two to three months. Patients who need to undergo surgery or more demanding treatment are usually sent to the Zonal or District hospitals in Dharamsala and Kangra.
The Delek Hospital charges 10 Rupees a day for in-patients, with additional food charges bringing the total cost to about 40 Rupees a day. As Sowa, Nishikura and Maruki reported, in their 1995 study of the hospital, roughly 70,000 US Dollars are required for its annual management, and most the money is covered by donations from foreign institutions and individuals. The three doctors discovered that:

The expenses of the hospital include not only the salaries of all the staff members and hospital maintenance fees but also the cost of the anti-tuberculosis projects, the training of Community Health Workers (CHW) and medical support staff. Furthermore the expenses of all medically related projects, such as travelling clinics, are all supposed to be covered by the hospital. Therefore, every year the financial resources are insufficient and ultimately the hospital must depend on help from the exiled government. (1995: 215)

The hospital's autonomy is therefore challenged by its economic dependency on sponsors, and, ultimately, on the Tibetan Government in Exile. Despite these constraints, however, it has maintained an allegedly successful TB management and prevention programme for the entire Tibetan exile community within the DOTS programme recommended by the World Health Organisation. DOTS (Direct observed treatment, short course) recommends the supervision of TB medicine ingestion by trained health workers or local community members over the period of treatment (6-8 months) in order to minimise the risk of 'non-compliance' by the patient, and therefore potential TB relapses leading to the development of drug resistant TB. The Delek Hospital's TB programme, launched in 1980, follows the Indian national health strategies on TB. Physicians also liaise with the Zonal TB Programme in Dharamsala. This has involved the development of a comprehensive primary health care programme since 1994. In the following chapters, I will examine the repercussions which the management of TB by Delek has had on how individuals, patients and their families view the disease and seek care for it.

4.5. The Men-Tsee-Khang and Tibetan Medicine

A few yards down the road from the Tibetan Delek Hospital, an imposing metal gate opens onto a labyrinthine complex at the heart of Gangkyi. A strong aroma of dried plants and the characteristic odour of burning juniper (shing pa) leaves and incense accompanies one's entrance into the precincts of the main education facility and provider of traditional Tibetan medicine in Dharamsala, the Men-Tsee-Khang (MTK). The MTK is a teaching institution for the training of Tibetan doctors and astrologers (through two separate training 'routes'), as well as a clinic producing its own medication.
The Men-Tsee-Khang was established in 1961. At that time, according to contemporary MTK information (1997), there were only one medical doctor and one astrologer. The first group of medical students earned their degrees in 1966, followed closely by the first batch of astrology students in 1968. By the 1970s there were 7 doctors and 6 astrologers working at the institute. In 2002, the 10 teachers dispensed their knowledge to 58 students, the majority of whom were studying for the medical degree (sman pa ka chu pa). Since its inception, the MTK has trained over 150 doctors who now work in its 35 branches throughout India. It focuses a substantial part of its resources on Research and Development, with emphasis on the fields of cancer treatment, hypertension, and the alleviation of non-insulin-dependent diabetes mellitus. These projects have sought to legitimate the status of Tibetan medicine by proving its curative efficacy clinically, with the use of Western clinical randomised control trial procedures. The stated aim of these projects is to enable Tibetan medicine to gain credibility vis-à-vis biomedicine and in the scientific community at large.

The clinical encounter in the MTK differs greatly from that in the Delek Hospital, although some interesting similarities will also be explored here. Doctors of Dharamsala's Men-Tsee-Khang usually see patients in their own rooms or staff quarters. While Tibetans generally make appointments to visit their personal doctor, foreigners are channelled to any available doctor or, for the more serious cases, are asked to come back to visit more senior physicians. Some doctors may receive as much as 80 patients a day, the consultation generally lasting around 15-20 minutes. While Indian and Western patients tend to come in alone, Tibetans often have the company of a relative.

In Dharamsala’s MTK, pulse reading tends to be the preferred mode of diagnosis, in conjunction with tongue and urine analysis. For more routine consultations, Tibetan doctors will tend to read the pulse first and then rely on other modes to ascertain the initial diagnosis. Practitioners also check on patients’ ‘nerves’ (rsta) by pressing on various points on the body (e.g. on the back and neck) and asking whether the patient is experiencing pain (sdro bsingal ’dug gais). As part of the MTK requirements the doctors jot down a list of observations in special notebooks, drawing from observation and questioning of the patient (in particular relating to disorders of the three humours, nyes pa gsun). Doctors also deliver a prescription for medicaments (generally pills), which the
patient can pick up at the pharmacy located on the ground floor of the Institute in an altogether seamless process. One is received in comfortable, homely surroundings, and there are few ‘physical incursions’ onto the body of the patient itself unless a serious disorder is suspected which would require specific procedures, such as hammer or needle therapy.

4.5.1. Roots of Tibetan Medicine

In the following section I will further investigate the ‘roots’ of Tibetan medicine as presented by MTK practitioners today, and their relation to therapeutic choice-making. In general, I will use the appellation ‘traditional Tibetan medicine’ in reference to Tibetan medicine as it is taught and practiced in contemporary Dharamsala by MTK practitioners.

The *rgyud bzhi* (generally shortened in translation as the ‘four tantras’), the principal medical text studied in exile, enumerates three principal and four secondary causes of diseases. The three principal causes are: 1. Lust, or desire, linked to *rtung* (wind) humour; 2. Passion, or anger, linked *mkhris pa* (bile) humour; and 3. Dullness, or ignorance, linked to *bad rten* (phlegm) humour. The four secondary causes of illness are: 1. Seasonal variations, cold and heat; 2. Action of an evil spirit (*gdon nas snot pa*); 3. Food (abuse of or mis-absorption); and 4. Wrong behaviours and harmful lifestyle. The *rgyud bzhi* lists appropriate dietary and behavioural rules to remain free from illness in conformity with the different seasons and astrological configurations. It enumerates the symptoms of diseases. It is also a guidebook for the physician, listing questions to be asked in order to obtain information about the patient’s diet, lifestyle and other illnesses that may influence the choice of therapeutic action (Clark 1995; Meyer 1984, 1992).

In order to understand the dynamics of therapeutic choice and illness causation in the Tibetan exile community, it is important to take note of the deep Buddhist backdrop that informs the case studies presented in the following chapters. Therapeutic interventions and teachings on medicine are commonly introduced and concluded by injunctions to the eight Buddhas of medicine (*sman lha*). Preparatory ceremonies are carried out to increase the medical potency of substances and infuse them with the blessings of lamas. The *sman lha* are also called upon when students and doctors of medicine set out to
collect plants, and when the medicine is being prepared. The patients recite mantras of the Medicine Buddha (*Bhaistajyaguru*) when taking the medicine and doctors do so when undertaking therapeutic procedures like burning moxa or needle therapy.

I will now give a brief outline of the theories that underpin Tibetan medicine in order to contextualise the upcoming discussion on the MTK's practitioners' work. The original transmission of Tibetan medical knowledge is attributed to Shakyamuni Buddha, who is said to have given the first medical teachings through his manifestation as the Medicine Buddha. The Buddha taught the medical texts to Vimalagotra at the time of the first turning of the wheel in Sarnath. While giving the third teachings on emptiness the Buddha is also said to have taught the 'Sun Rays Sutras' or 'Ways of completely curing diseases'. According to popular lore, the four tantras reached Tibet after Vairocana, Padma Sambhava's disciple, received the teachings in India from Chandranandana. The instruction of medicine was institutionalised with the creation of the Chagpori (Icags po ri) Medical College of Lhasa by Desi Sangye Gyalso in 1696. According to the MTK's official 'history' of Tibetan medicine (1997), the elder Yuthog Yonten Gonpo (708-833), royal court physician to king Trisong Detsen, synthesised the best of the then known Asian medical systems, incorporated them into the existing Tibetan tradition and compiled them into the *rgyud bzhis*. In the 12th century the younger Yuthog Yonten Gonpo added several important chapters and compiled the text into its present form.

The *rgyud bzhis* classifies diseases in three categories: 1. diseases arising out of a humoral imbalance caused in this present life; 2. diseases arising from past negative actions, which are to be treated by religious practices and taking medicine; 3. diseases arising from past negative actions, which are further aggravated by the present conditions of the patient (Meyer: 1998).

This classification thus clearly relates aetiology to the law of cause and effect (*rgya 'bras*). Tibetan medicine is deeply integrated with Buddhist practice and theory, which stresses the interdependence of mind, body, and vitality. This system of medicine traces the fundamental cause of all suffering to the concept of *bdag dezin* (usually translated as self-grasping or ego), which manifests itself in the form of *gti mug*, or delusion, ignorance, confusion. This in turn gives rise to the three mental poisons of *dod chags* (attachment, greed, desire), *zhe sding* (hatred, aggression) and *gti mug*. These three mental poisons will
then cause 'imbalances' in the three humours of *rlung, mkhris pa* and *bad kan* (Wind, Bile and Phlegm). The *rgyud bzhis* says that the bodies of elderly people are dominated by the *rlung* humour, those of adults by *mkhris pa* and those of small children by *bad kan*.

Tibetan medical aetiologies are related to Buddhist cosmology. Patients often mention karma as an explanation for disease. Doctors, by contrast, will rarely mention karma during a consultation. Patients and doctors alike do however invoke karma more readily in the context of diseases whose aetiology is defined in the Tibetan medical canon and can be treated by traditional Tibetan doctors, i.e. those due to imbalance of bodily humours, or excessive consumption of certain types of foods. Karma was less often offered as an explanation in the context of diseases with biomedical aetiologies, but often alluded to (in discussions pertaining to AIDS, TB or diabetes for example). Conversely, however, the argument that older and more religiously inclined patients favour karma as a causal explanation does not always hold. For instance, when I questioned two India-born monks in their thirties on whether their *bad kan dang rlung ssmung po* (combined *rlung* and *bad kan*) imbalances were caused by karma, they simply laughed my suggestion away, and told me that not all things were necessarily related to karma, but could also be understood as physical disorders. It is worth noting that the MTK receives more visits from patients above 30, and few from adolescents or children. As we will see from the case studies in Chapter 6, this may well have some bearing on why some patients are more inclined than others to choose karma as a primary explanatory model for illness.

According to the *rgyud bzhis*, due to the presence of the three poisons (desire, hatred and anger), suffering is unavoidable and is present from the time of birth, when the three poisons give rise to the physical body in the form of the three humors: wind, bile and phlegm (Dhonden and Kelsang 1983; Meyer et. al. 1992). Tibetan ethnoanatomy links the material to the spiritual: the five primary elements (fire, air, earth, wind and space) which are the essential components giving rise, motion, and properties to all phenomena and consciousness, also give shape to the human body through the operation of a variety of winds at a subtle and coarse level (Meyer 1992; Adams 1999). The birth of a human form is contingent upon the presence of the regenerative fluids of a mother (red element) and father (white element), finding home in a transmigrating consciousness (*sems*). Combined, the five elements, consciousness from a past life (*sems*) meet with the five elements in the middle of the heart (*thig le chen po*) to rise as *sng*, the life force that can
give shape to a human being. The type of body that results from this combination is
dependent upon the sort of wind that propels the consciousness and elements. The body
of a human being that has not reached enlightenment is created when the las kyi rtung, or
karmic energy of negative past deeds ‘disperses’ the life force (srog mthu) (Meyer 1992).

The human body then develops around three main channels; dbu ma (the central
channel); ro ma (the right channel) and rkyang ma (the left channel). These channels and
their forces intersect at key points or khor lo (Skt.: chakra) within the body, and the
movement of energies meeting and circulating at these points is described as ‘circulating
winds’ (ibid.). The further processes involved in the creation of a human body, complete
with its white channels (created by the subtle winds) and seven bodily constituents (chyle,
blood, flesh and muscle, fat, bone, marrow and reproductive fluid), are too complex to
list here (see Clifford 1989 and Meyer 1992). However, a critical aspect in the formation
and subsequent evolution of the human body is that the elements constituting it and
those of the external world remain in constant interaction. Adams writes: ‘the body is
never in a permanent state, always changing in relation to the climate, the seasons, the
foods we eat, the emotions we feel in relation to our perceptions of the world around us,
and even by the demonic or other harmful forces we come in contact with, and the
karmic effects of action and intentions in past lives’ (1999: 7).

All disorders can generally be classified as hot, cold, or a combination of both. It is said
that Tibetan medicine is particularly effective in the treatment of chronic conditions,
such as arthritis, asthma, nervous disorders and other severe conditions such as
hypertension, hepatitis, coronary heart disease, bronchitis and diabetes mellitus. This is
also the view supported by MTK doctors, who claim Tibetan medicine is more
efficacious for chronic disorders and works over long periods of time, while biomedicine
has more immediate but also more disruptive effects on the body. One MTK doctor
phrased it thus: ‘Tibetan medicine and Western medicine are like two knives: Western
medicine is sharp (rno po): it will cut off the finger and leave the root. Tibetan medicine is
like a dull knife (rten gru): it will not cut the finger off but work slowly to find the cause of
disease’.
Scholarly Tibetan medicine as practised in the MTK recognises roughly 404 gross types of diseases (Meyer 1981:146-147): 101 of these are considered incurable, 101 treatable with medical care, 101 self-curable, and another 101 due to snot pa, harm caused by the intervention of supernatural beings (klu, water spirits, or gdon, demons). ‘New diseases’, a category which would encompass cancers and Aids, are, at the level of some medical élites’ theoretical discourses, said to have arisen as by products of modern civilisation and the advent of the ‘age of degeneration’ (Skt: Kaliju).

The allegorical tree depicting the root tantra of the rgyud bzhi is often used for a didactic explanation of the Tibetan Medical system. Tibetan medical pedagogic thang kha depict medicine as a discipline with three major ‘roots’ (rtsa ba grum): the root of aetiology, the root of diagnosis and the root of therapeutics. The root of aetiology has two trunks: the first describes the body in ‘dynamic equilibrium’, the second the body in a diseased state. The body is composed of seven constituents. When these are disturbed they become causes for disease as shown in the 2nd root of the body in a diseased state. The third root, which is the root of therapeutics, has four trunks, denoting the four methods of treatment (sman bco): diet (gas tshul), behaviour, medicine and accessory therapy. The root of diagnosis has three trunks: 1. Visual examination (bla ba, observation of tongue, urine), 2. Pulse diagnosis (three different kinds of pulses based on the three humours), and 3. Interrogation (dri ba, asking the patient about diet and lifestyle prior to disease). These three arboreal metaphors and nine trunks are enumerated and their branches described in Finckh (1988).

Pulse diagnosis involves a ‘reading of the pulse’: the physician places the index, middle and third fingers on the radial artery in order to feel the patient's pulse. The three fingers exert different levels of pressure on the wrist. Each of the three fingers of each hand are divided into an upper and lower division, making twelve divisions, so that each division reads the pulse corresponding to a particular organ. The organs read by the index fingers are reversed when dealing with female patients. The physician checks a patient's pace and strength (or depth), and it is said that a healthy pulse beats approximately five times within the completed respiratory cycle of a physician (rtsa lan geig being one beat of the pulse). Generally, if a pulse beats more than five times in one respiratory cycle, it indicates a hot disorder, whereas a pulse under five beats indicates a cold disorder. Variations in a healthy pulse are due to the difference in the natural, ‘constitutional’
pulses of individuals. The constitutional pulse is inherited from the influence of karma as well as from one's parents' dietary and behavioural habits.

Herbal medicine (*rtsa sman*) is vastly used and the preparation of complex compound medicine can involve as much as eight types of ingredients: precious metals, soils, rocks, trees, resins, herbs, animals and juices. The quality and quantity of medicine administered is matched antagonistically to the characteristics of the disorder treated. Aside from herbal medicine, Tibetan doctors may use a number of mechanical devices to help them reach a diagnosis or cure a variety of ailments. For instance, different types of hammers (*tel*) (gold, silver, bronze and brass) are used in accessory therapy: the tip of the hammer is heated until it is red hot and applied on the disease point. These different types of hammers are used to treat cold disorders, excess accumulation of fluids in the joint and conditions such as tumours or insanity. The golden hammer particularly is used to treat a lack of digestive heat, bodily aches, dazed mental states and epilepsy. While I have never seen such devices being used in Dharamsala, MTK doctors confirmed that they are still being used by practitioners from the Institute. Needles (*khab*), and specifically golden needles (*gser khab*), are used in the treatment of vertigo, dizziness due to hypertension, epilepsy, paralysis attacks, hysteria, insomnia and depression (these disease categories are the ones tentatively offered by Tibetan practitioners for Tibetan disorders). During my time in Dharamsala, I only heard one mention of a treatment with a golden needle (see next chapter), which was in the end refused by the patient, who thought it would be too invasive. Moxabustion, bloodletting and cupping are also sometimes practised to remedy a variety of disorders. These different techniques are said to be used by doctors in the Men-Tsee-Khang, but I have rarely heard them mentioned or seen them performed.

In practice, the Men-Tsee-Khang doctors seem to rely increasingly on herbal medicines rather than mechanical therapies. Furthermore, they are gradually phasing out the use of animal products in their medicines. In the early 1990s visitors reported that animal products such as rhinoceros horns (ground for powder preparations) were very much in use in the MTK at that time, although such practices, illegal in India, are now banned from the MTK. The secrecy surrounding the composition and fabrication of Tibetan medicines seems to have increased considerably since then, and it is now particularly difficult to have access to the formulations of preparations such as precious pills (*rin chen ril byin*).
The more routine work of the Men-Tsee-Khang addresses prevalent health problems in the Tibetan population. Most of my informants who spoke of their consultations at the MTK were middle-aged and elderly men and women suffering from chronic disorders, such as stomach problems (pho ba'i na tsho) or hypertension. There is a strong emphasis on diet and the digestive process in the causation of disease, and doctors almost always give some form of dietary recommendations to their patients.

The Tibetan doctors' most common form of treatment is the prescription (sman tho) of ril bu, generally two to three different kinds of herbal/mineral pills to be taken at set times during the day. Exiles are commonly seen taking such pills after a meal with a glass of boiled water. Medical pills are usually sold for Rupees 10 to 40, which is certainly not a negligible cost. It is however relatively cheaper than purchasing allopathic remedies with or without subsidies from the Delek pharmacy or from local chemists. As an example, cough syrup will cost approximately 90 Rupees in the pharmacies and 50 Rupees at the Delek subsidised rate. Tibetan medicine can therefore be considered relatively inexpensive compared to allopathic remedies. Costly medicines such as rin chen ril bu (precious pills) are only occasional investments, and are often given and purchased as presents. The MTK also lowers or increases its prices according to the financial and social status of the patient: patients in difficult financial circumstances who are habitual clients may find their bills reduced by the pharmacy cashier.

Some patients received medicine at subsidised rates, sometimes even free of charge (Cf. also Samuel 2001: 251). Many exiled Tibetans used the adage: 'if Tibetan medicine doesn't improve your condition, at least it won't make you worse'. They often spoke of the duration of treatment (over months, sometimes years) as the normal correlate of the quality and mildness of Tibetan medical preparations. One elderly diabetic monk told me of his insulin treatment: 'rgya sman phyog geig nas phan kyi yod red a ni phyog geig nas gnod kyi yog red.' (Foreign medicine makes you better one time and then worse).
Although the Tibetan medical system, whose common appellation is *gsa ba rig pa*, is practised today in Bhutan, Mongolia, Tibet, and the Indian states of Himachal Pradesh, Ladakh, and Sikkim, its practice 'styles' differ according to the institutions or individuals through which it is taught. In Ladakh for instance, it is customary for medical knowledge to be transmitted from father to son, or mother to daughter. However, in some of the more recent local developments in medical training, Ladakhi *aem chis* have broken away from this tradition and started recruiting apprentices among young locals. Such programmes are meant to create a broader recruitment base for *aem chi* training and aim to make their knowledge relevant to the provision of primary health care to the more remote provinces of the region, such as Zanskar. Aside from these recent developments however, much of the medical training in Ladakh is still hereditary.  

Other hybrid styles of practice have emerged in the Tibetan settlements of India and in Nepal. Gerke and Jacobsen reported their meeting Dinchen Rinpoche, from Mongpoo who, after taking a one year course of training in an Indian academy as a nurse, passed the examination for Rural Medical Practitioners, was given a registration number, and has since been practising with the title 'Dr.' after setting up his own clinic and dispensary in Kalimpong. The lama, interviewed by Gerke in 1997, explained the hybrid nature of his medical craft thus: 'Personally I feel eastern medical systems are the best. But if someone comes in with a severed hand, then I'll suture it. If a person comes in with severe dehydration, vomiting and diarrhoea, he will get saline' (1997: 13). Multiple hybrid medical cultures in which Tibetan medicine is a component have thus been formed outside Dharamsala. Within the exile capital however, the MTK's presence as a centre of learning dissuades practitioners from adopting creolising stances.

As we shall see later on, hereditary transmission of knowledge was regarded by MTK doctors as 'unprofessional', i.e. an 'unreliable' method for training good doctors. One of the justifications given to me for this was that hereditarily trained *aem chis* do not go through much study and hardship in order to inherit the title from their parent, and therefore do not develop the personal motivation and dispositions essential to traditional Tibetan medical practice. The notion of 'motivation' here is tightly bound to Buddhist virtues of compassion and the motivation to help suffering sentient beings, which is one
of the prerequisites of medical training and practice. The *aem ch'i* professional standards of practice are therefore questioned by Men-Tsee-Khang doctors, who tend to believe that institutional training is a safer way of ensuring the quality of medical education.

Independent Tibetan doctors's 'styles' of practice are notably different: the Men-Tsee-Khang doctors tend to prefer the method of pulse diagnosis (see also Samuel 2001) while some others seem to favour other modes, such as urine analysis. Doctors practising outside the MTK institution have leisure to experiment with their own styles of therapy, and sometimes even produce their own medicine and pharmacopeia. Famed doctors will naturally attract more patients, and some grow to develop 'specialities' based on their clinical experience and successes at curing specific diseases.

Another factor that seems to have influenced this growing difference in 'styles' between the Men-Tsee-Khang and independent doctors is the emergence of Tibetan medical clinics that cater principally to foreigners. By 'style', I refer to diagnostic and clinical preferences of practitioners (for instance the preference for pulse diagnosis over urine analysis, or the clinical setting preferred by the doctor).

The famed physician Yeshi Donden owns one such clinic in McLeod, where he sometimes receives more than fifty patients in a morning. He has recourse to urine analysis on an virtually automatic basis, in an almost 'ultra-traditional' style of practice. In doing so, he does not fear to play on the theatricality of the diagnostic act: pouring the urine into a white ‘examination bowl', he inspects it thoroughly, looking for bubbles and scrutinising its colouring, sometimes tasting it. To the foreign patient, he almost seems to 'divine' the patient’s health status from the bowl's contents. One of my India-born Tibetan informants recalled a particularly itchy problem, which he went to report to Dr. Yeshi Donden in his McLeod Ganj practice:

This was at a time when there were announcements on the Indian radio, I think it was after some numbers about rape were published and the government was becoming worried about the increase of violence against women in the country. There were these series of announcements by a doctor, a sex specialist, saying that for men to do it themselves [i.e., masturbation] was a good thing, it relieved tension and so they didn't turn against women. It was healthy. I thought this was probably true so I started doing it. Then a few months later, I started to get this itchy sensation (...) down there.

So I went to see Dr. Yeshi Donden, because I thought there was something really wrong with me. So when I came to the clinic, he asked me to pull down my trousers. I was really embarrassed, but I had to do it. Then he looked at me for about three minutes, looking at
everything! He didn't say anything but asked to see the sample of urine I had brought with me. After tasting the urine he simply asked me if I had been, you know, doing a lot recently. I laughed and said yes. He didn't give me any medicine but just told me to stop doing so much for a while. You can't fool Dr. Yeshi Donden, he knows what is wrong with you (...).

The fast pace at which a famed doctor like Yeshi Donden sees patients usually doesn't allow for a great deal of elaboration on each case. However, some doctors will regularly see the same patients and regulars of the MTK have their personal doctors. Patients who have travelled to come to the MTK and foreign visitors are often directed to the more renowned doctors in the MTK.

4.6.1. ‘Styles’ of Tibetan medicine as practised for/on foreigners

A great majority of foreigners who try Tibetan medicine in Dharamsala have no knowledge of its system and diagnostic modes. Having one urine's analysed is therefore considered the 'high point' of a consultation, the climactic moment of this 'exotic' medical encounter. Whereas Men-Tsee-Khang doctors seldom practice urine analysis for routine consultations, Donden's patients are told that they have to come to the clinic with an empty stomach and having drunk some water, so that they can provide the required urine at their morning consultation. Ironically, for some of the foreign patients I had met, this hallmark of Tibetan medicine became reminiscent of their experiences in Western surgeries, where they had to come in on an empty stomach and full bladder before a clinical examination.

Tibetan medicine as practised for foreigners thus works on the basis of a striking paradox. On one hand, it seeks to enforce an impression of authenticity by privileging a mode of diagnosis regarded as 'traditional' and uniquely Tibetan. On the other hand, through its clinical practice, it invites comparisons with the procedural rigidity of biomedicine.

In addition to these encounters with foreign patients in Dharamsala, numerous Tibetan doctors, both Dharamsala and TAR trained, have found asylum in the West, where they practice in institutions or privately. There are Tibetan practitioners in Italy, Switzerland, Germany, the UK (including the Tara College of Tibetan medicine in Samye Ling, Scotland), Sweden, Denmark, and in the US. Tibetan doctors practising abroad have had
great difficulties in cultivating or importing medical substances, sometimes even leading to legal problems when they have tried to obtain medical substances for their patients. Tibetan medical doctors from the MTK and other Tibetan institutions in India also regularly come to Europe and America to lecture on Tibetan medicine and practice.

Some exiled doctors have well established clinics, which have developed a ‘style’ of Tibetan medical practice tailored to Western patients. Dr. Dickey, a TAR born female doctor advertises her practice in Berkeley, California in the following way:

Dr. Dickey is a seventh generation Tibetan physician (her uncle was a physician to His Holiness the Dalai Lama). Her family’s mission is to preserve and promote the ancient and mystical yet highly effective holistic ways of Tibet’s healing heritage as she gives workshops and consultations seeing clients around the States as well as the clinic in Berkeley. She hopes to establish a Tibetan Medical school in the West.

ABOUT DR. Dickey:

Dr. Dickey, TMD is a traditional doctor of Tibetan Medicine. She is the sole practising female Tibetan physician in the United States today. Her family name is synonymous with compassionate medical care in her homeland Tibet. While her early training in medicine was in the Nyerongsha Medical School (as a young girl at age seven she began studying pulses etc.), she graduated from Men Tsee Khang, the most prestigious medical school in Lhasa, Tibet. Dr. Dickey maintains consulting practices in Colorado, Arizona, Texas, and throughout California as well. She resides in San Francisco.

The description lists what is required of the patient prior to a consultation:

1) NO medications except for necessary prescriptions
2) NO red meat
3) NO alcohol
4) NO coffee
5) NO black tea
6) NO vitamins
7) NO foods that are unusual to your normal diet
8) NO nutritional yeast
9) NO strenuous activity
10) NO sexual activity
11) NO beets, asparagus or red Swiss chard
12) NO shower or bath in the morning before your appointment

Dr. Dickey has clearly appropriated much of a biomedical doctor’s garb, while trying to accentuate the traditional and holistic allure of her practice: she has given herself a hybrid but institutional sounding title, ‘TMD’ which may ambiguously stand for ‘Traditional’ or ‘Tibetan’ Medical Doctor. She lists an extensive number of prerequisites prior to consultation with patients, thereby communicating an impression of clinical efficacy.
Although, in theory, these requirements are valid for MTK patients too, and most Tibetans are aware of these proscriptions, in reality, they are not always easy to respect for patients working in India. The proscription of asparagus and beets from the diet before consultation points to a probable utilisation of urine analysis, again a feature that is not so common in the routine examinations of Dharamsala MTK practitioners. Dr. Dickey refers to an established familial medical tradition, institutional legitimacy (the Lhasa MTK degree), and to an affiliation with the Dalai Lama through her uncle. She appears to be keen to draw a connection between her own 'style' of medical practice and the aspects of Tibetan culture that the West is most familiar with, namely Buddhism and the Dalai Lama. By doing so, she deliberately accentuates the association of Tibetan medicine with spirituality and holism. She is also further legitimating her own status as a 'traditional' practitioner in a setting where alternative medicines abound and have to compete which each other for 'authenticity'.

4.6.2. Tibetan institutional dilemmas

Despite the presence of idiosyncratic doctoring modes, a more standardised MTK 'style' of practice, articulated by its contemporary students, is gradually subsuming the plurality of traditional Tibetan healthcare. The MTK, with its network of 43 branches, has started to impose its branding and institutional diploma onto the whole of exile Tibetan medical knowledge, often to the dismay of the more traditionally trained doctors who receive their training in the hereditary mode of transmission and are considered 'lineage holders'. The Ladakhi aem chis in particular, have had difficulty maintaining the credibility of their knowledge in the face of this overwhelming institutional take over. Some have been targeted by development projects seeking to enhance their basic knowledge of biomedicine. The projects aim to enable them to give grassroots primary health care to the remote populations of the Ladakh and Zanskar valleys. The Ladakhi aem chis, as local independent doctors, have less authority to impose their medical practice as independently valid. The denigration of the aem chis' knowledge and promotion of the 'certified' MTK style has been described by some independent practitioners and Ladakhis as an attack on their 'styles' of practice, in truth, as form of normative colonisation of medical knowledge.
The need for standardisation develops out of increasing competition among the various providers of medicine. Formal institutions other than the MTK have also flourished in the past two decades, providing consultations and teachings on Tibetan medicine and even sometimes producing their own medications. At the time of my fieldwork, there were three other relatively large institutions teaching Tibetan medicine in India. The first was the ‘Institute of Tibetan Medicine’ run by Dr. T.Y.Tashigang in New Delhi. The second, Chagpori Institute in Darjeeling, was founded in 1992 by one of few remaining lineage holders of the Chagpori College, Trogawa Rinpoche. The Chagpori Institute offers the full degree of sman pa ka chu pa and trains foreign students with sufficient proficiency in Tibetan. It also provides religious teachings linked to the practice of Chagpori lineage holders. Although the Chagpori Institute retains a certain amount of independence with regard to teachings, its curriculum roughly mirrors that of the MTK and Chagpori students have to take their final exams at the MTK if they are to be awarded the degree of sman pa ka chu pa (Gerke, personal communication). The third training institution for Tibetan medicine is the medical department establishment as part of the Central Institute for Higher Tibetan Studies in Sarnath in 1993. All three institutions now follow the same curriculum of 5 years of study in the school and two years of clinical training, corresponding roughly to that of the MTK.

The institutional plurality of Tibetan medicine in exile poses two major problems. Firstly, the MTK attempts to affirm its status as the official provider of Tibetan medicine by stipulating that doctors who wish to leave the MTK after having trained there are no longer able to use its medical products, and therefore have to rely on their own medical supplies. This puts the majority of independent doctors in a quandary with regard to the provision of medical herbal products: should they attempt to grow or collect their own medical plants, knowing that ‘cultivated’ plants are seen as less effective than ‘wild’ ones, or should they instead succumb to buying Chinese produced medicinal products from the Tibetan Autonomous Region? Secondly, the absence of an umbrella organisation for practitioners of Tibetan medicine in India, in turn linked to the status of Tibetans as ‘foreign residents’, makes it impossible for practitioners to seek legal representation and therefore attempt to register as a traditional system of medicine under the Indian national health system. Such an attempt would furthermore be contrary to the principles of the Government in Exile, which still promotes the idea that Tibetans are on a short stay in India, and therefore do not need to preoccupy themselves with establishing more legal
ties with the Government of India than is necessary for temporary survival. Thus, although independent Tibetan practitioners resent the MTK's hegemony and control over primary herbal resources, there is no attempt to seek a mutual accord as to legal representation or the creation of a joint pool of herbal products.

To sum up then, while the Delek allopathic hospital is bound to a network of institutional and economic constraints, the MTK benefits from a certain degree of independence and leverage to impose its 'style' of practice onto other traditional practitioners. How do these differences translate into different styles of provision of care to patients? Following this presentation of the main healthcare providers in Dharamsala, I now turn to an examination of the treatment of prevalent diseases in the exile community.

4.7. Prevalent Diseases, Significant Illnesses

In the following sections I offer a description of the major health problems dealt with in the biomedical hospital and Men-Tsee-Khang. This investigation of prevalent diseases is premised on the idea that there is a certain amount of discrepancy between biomedical measures of health and local perceptions of health and well-being, and highlights the ambiguity inherent in definitions and measurements of health. For while statistics that present a medical picture of the Tibetan exile population chart the progression of prevalent diseases measurable through physiological investigations, subjective notions of well-being, and not only the appraisal of 'physical health', bear heavily on individuals' definitions of what it means to be 'healthy'. Subjective evaluations of health and well-being include culturally relevant ideas about the body and human functions. In the following section, I will outline the main health preoccupations identified by practitioners and patients at the two principal institutions, Delek Hospital and the MTK.

The Tibetan Delek Hospital identifies threats to health in the community with a number of discrete, key diseases: TB, hepatitis B and cancer. According to recent CTA Department of Health/Delek surveys, Cancer is the most common cause of mortality among Tibetan refugees. This is closely followed by TB, with approximately 300 new cases discovered each year. Bhatia's survey of health in Dharamsala showed that the percentage of people suffering from tuberculosis is on the increase. The most common
type is lung TB, but a few cases of intestinal and lymphatic TB have also been reported. \(^57\) In an assessment of TB treatment at Delek Hospital from 1985 to 1992, i.e. before the introduction of the DOTS programme, biomedical researchers reported that the two main differences between the Indian and Tibetan populations for smear positive pulmonary cases were: 1. a higher default rate among Indians (47.3\% vs. 10.7\%, for Indians and Tibetans respectively), and 2. a lower cure rate (43.2\% vs. 80.1\%) for Indian patients. The authors went on to suggest that the presence in the community of Tibetan health workers working under Delek supervision and in proximity to patients could be the reason for the higher cure rates observed among the Tibetan community (Wares et al. 2000).

The main barriers to treatment were described as ‘instability, refugee mobility, overcrowding, poor socio-economic conditions, and limited resources for food and medicines’ (Wares et al. 2000: 41). Staff and researchers at Delek have promoted a strong awareness of the social factors that influence the spread of TB:

1. Mobility impedes the compliance of patients.
2. The two largest age groups among the exile population, i.e. young adults and the elderly, have a heightened susceptibility to TB.
3. Poor socio-economic conditions in the settlements.

The cost of TB medicine for a 12 months treatment is estimated to be approximately 100 US Dollars, and although Delek tries to provide medicine free of charge to impoverished patients, the medical costs are high for the refugees’ tight budgets. Hence, despite the work done in facilities such as Delek and the aid received for medical supplies, Delek’s Chief Medical Officer has repeatedly called the tuberculosis situation among Tibetans in India a ‘humanitarian crisis’. According to the CTA, over 33,000 cases of tuberculosis have been reported in the Tibetan refugee community since 1959. \(^58\)

Although HIV/AIDS infections are spreading fast in India and much importance is given to identification and prevention in the Tibetan community\(^63\), AIDS has not been identified in the camps as of yet. Among the 60 informants I questioned on health and healthcare in Delek (see Table 2), only one had reportedly heard of a Tibetan AIDS case, and had difficulty dating it.
Other diseases, such as diabetes mellitus, diseases of the thyroid gland (most commonly hypothyroidism) and other hormone related diseases are subjects of concern for the Tibetan medical personnel. The medical staff at Delek also reported that measles, dysentery, hepatitis A, cholera and typhoid were quite common. Due to hygiene problems, skin infections caused by yellow staphylococcus, ringworm and scabies are also recurrent. This is particularly the case in the settlements with poorer sanitation and scarce water resources, such as the Transit School precincts.

I now turn to individuals' assessments of prevalent diseases and their causes. In response to my questionnaire (see Appendix A) and through informal conversations, Tibetans in Gangkyi mentioned a number of illnesses that were not considered prevalent by medical staff at Delek, but, for reasons which I will attempt to elicit, had particular resonance in the Tibetan exile community.

Individuals' mention of diseases not identified as prevalent by the biomedical staff may for instance have been due to the fact that many Tibetan refugees are mobile within India and transnationally, and thus come into contact with other diseases while visiting other communities. For example, my informants regularly mentioned leprosy as one of the most dangerous health problems in India, and as a significant danger to Tibetans. However, biomedical reports mention that the majority of Tibetan exile cases of leprosy have been recorded in the Tibetan settlements of South India and not in the northern Indian settlements like Dharamsala (Sowa et al. 1995; Tibetan Department of Health Report, 1998). Tibetan refugees from the Ladakhi settlement of Choglamsar also told me that mde’ nas, a common Tibetan appellation for leprosy, is prevalent among exiles there. Despite the fact that leprosy was not a health problem in Dharamsala itself, the Tibetans’ knowledge of cases outside the settlement as well as among the local Indian population made them cite it as an important health problem in the community. In the following sections I will try to elucidate why diseases such as leprosy are considered prevalent by exiles even though they do not enter into the category of 'statistically salient' diseases.

Along with leprosy, another health problem often mentioned by refugees born in Tibet and now living in Dharamsala was goitre (tib. Iba bā), a disorder almost non-existent
among the exile population. Contrasting aetiological explanations of *lha ba* revealed socio-cultural differences between medical practitioners and certain segments of the population: while MTK doctors explained that the high prevalence of goitre in Tibet was due to the 'poor quality of salt', older refugees would say there was something, an insect or a bacterium in the water (*chu nang *bu yod red) which harmed people. Traditional Tibetan doctors had heard from biomedical doctors that the lack of iodine in salt was the cause of this particular disease, and that refugees in India did not suffer from this problem because they consumed iodised Indian salt. Younger India-born refugees were less familiar with goitre, whereas newcomers from Amdo recalled it as extremely common in their native region, and described the swollen throat of goitre sufferers with gusto.

Similar stories were told about *rus chen* disease (lit. big bone), the Tibetan term for Kashin Beck Disorder (KBD), a disease endemic to Tibet, which causes deformations of the joints and impedes growth in infants. Although this disease is not found in exile, Tibetans born in the TAR had vivid memories of *rus chen* sufferers, and associated the disease with agriculture and rural environments. One newcomer Tibetan refugee in her late sixties, who had previously run a family farm to the south-east of Lhasa, recounted that the Chinese had requisitioned the family's crops, leaving them with nothing to eat. The Chinese *bsook srung* (police) then asked them to spray the grain in storage with pesticides, claiming that they were contaminating their own people with 'big bone' disease by using 'old' methods to treat crops.

A short survey (see Table 4) of the diseases mentioned by Tibetan doctors and residents in the community points to a number of preliminary hypotheses about the distribution of health knowledge in the community. Prevalent health problems such as TB, diabetes and high blood pressure were considered key by both traditional and allopathic practitioners, and perhaps more importantly by individuals. However, a number of disorders deemed less significant by biomedical doctors (such as leprosy or goitre), were presented to me as important health problems by the residents of Gangkyi and McLeod.

I would suggest that many of these 'symbolically prevalent' diseases have an emblematic character, in the sense that they may be recognised as distinctive markers of particular social groups or occupations in the TAR. For instance, goitre is a disease perceived as
endemic among the population of Tibetan rural areas. In exile, it has become associated with the social threat of newcomers hailing from the rural regions of Kham and Amdo (see Chapter 4). Similarly, leprosy is often associated with the dangers of Indian exile, the close contact with Indian poverty and its most emblematic doppelganger: the leper (*mdag nag pa*). Lepers are seen begging for money from affluent Tibetans and tourists on the streets of Dharamsala, and also arrive en masse for the final days of the *sa ga zla wa* (sacred month during which the Buddha’s birth, enlightenment and parinirvana are commemorated), when Tibetans give to the poor as part of practices to obtain merit (*dge ba yong*). Lepers are thus an integral part of the Tibetans’ imaginings of Indian poverty.

While some of these emblematic diseases are seen as pertaining to social ills associated with political and economic conditions in exile, others, like AIDS or breast cancer, are directly linked to perceived ‘modernisation’, and relate to socio-economic changes linked to exile and the advent of *Ka'gyung*. The popular meanings ascribed to these diseases are important because they contain information about a common history of Tibetans in exile, charting the community’s health with references to emblematic illnesses. This may be linked to Sontag’s characterisation of ‘Illness as Metaphor’, in which she attributes to illnesses such as tuberculosis, and later AIDS, the capacity to act as catalytic metaphors for the expression of prevalent social concerns (1991 [1972]). Similarly, in the Tibetan exile context, the metaphors around disease tend to isolate patients. More importantly, the metaphors constructed around diseases like goitre or ‘big bone’ KBD relate to notions of place and belonging. By doing so, they connect Tibetans to rural lifestyles and concerns, which to exiles have become emblematic of an idealised vision of home, complete with prairies and grazing yaks, and may be seen to embody a form of nostalgic imagination of disease, linking it to national identity.

The following tables show some of the results of a short questionnaire survey (see Appendix A) which I conducted twice in December 2000 and July 2001 with patients of both the Men-Tsee-Khang and Delek Hospital in Gangkyi, listing the names of diseases reported to doctors in both Tibetan and English, and the number of instances in December 2000 and July 2001. The December interviews were carried out with the help of a female assistant with no medical background.
Table 3. Health problems reported by patients from Delek (Biomedical) Hospital (December and July 2001) from 60 patients (30 male; 30 female).

<table>
<thead>
<tr>
<th>Tibetan Term</th>
<th>English Term</th>
<th>Number Reporting (December)</th>
<th>Number Reporting (July)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>grod khang bsbal ba</td>
<td>Diarrhoea</td>
<td>15</td>
<td>17</td>
<td>32</td>
</tr>
<tr>
<td>gan nyi na tsho</td>
<td>Diabetes'[^2]</td>
<td>6</td>
<td>11</td>
<td>17</td>
</tr>
<tr>
<td>th na tsha</td>
<td>Tuberculosis</td>
<td>12</td>
<td>18</td>
<td>30</td>
</tr>
<tr>
<td>khung shed (&quot;BrP&quot;)</td>
<td>High Blood pressure</td>
<td>16</td>
<td>13</td>
<td>29</td>
</tr>
<tr>
<td>rlung gi na tsha</td>
<td>rlung disorder</td>
<td>15</td>
<td>16</td>
<td>31</td>
</tr>
<tr>
<td>kunser</td>
<td>Cancer</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>pfo ba’i na tsha</td>
<td>Stomach disorder</td>
<td>4</td>
<td>8</td>
<td>12</td>
</tr>
<tr>
<td>so nad</td>
<td>Tooth problem</td>
<td>1</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>glo nad</td>
<td>Pneumonia/lung problem</td>
<td>18</td>
<td>6</td>
<td>24</td>
</tr>
<tr>
<td>mg nad</td>
<td>Eye problem</td>
<td>8</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>cham pa</td>
<td>Cold/influenza</td>
<td>13</td>
<td>3</td>
<td>16</td>
</tr>
<tr>
<td>grum ba’i na tsha</td>
<td>arthritis, rheumatism</td>
<td>6</td>
<td>14</td>
<td>20</td>
</tr>
<tr>
<td>nhin nad</td>
<td>Liver problem</td>
<td>9</td>
<td>7</td>
<td>16</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>116</strong></td>
<td><strong>113</strong></td>
<td><strong>229</strong></td>
</tr>
</tbody>
</table>

Delek patients often presented more than one complaint. For instance, many patients reported liver problems in combination with high blood pressure, or diabetes with high blood pressure and other allied problems. I have noted the specific reference to a rlung (wind) disorder, which seems to be mentioned more often than other nyes pa (humoral) disorders (for instance mkhbris nad and lad kan disorder).

Table 4. Illnesses reported by patients from Men-Tsee-Khang following their consultation.

<table>
<thead>
<tr>
<th>Tibetan Term</th>
<th>English Term</th>
<th>Number Reporting (December)</th>
<th>Number Reporting (July)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>grod khang bsbal ba</td>
<td>Diarrhoea</td>
<td>9</td>
<td>17</td>
<td>26</td>
</tr>
<tr>
<td>gan nyi na tsho</td>
<td>Diabetes</td>
<td>4</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>th na tsha</td>
<td>Tuberculosis</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>chams pa</td>
<td>Cold/flu</td>
<td>13</td>
<td>4</td>
<td>17</td>
</tr>
<tr>
<td>grum ba’i na tsha</td>
<td>arthritis, rheumatism</td>
<td>14</td>
<td>17</td>
<td>31</td>
</tr>
<tr>
<td>nhin nad</td>
<td>Liver disorder</td>
<td>9</td>
<td>6</td>
<td>15</td>
</tr>
</tbody>
</table>
The table denotes a relatively high number of complaints of diseases pertaining to the system of Tibetan medicine, i.e. related to humoral disorders of organ systems, such as the liver or kidneys, (79 complaints of nyed pa smug po nad or combined humoral disorders), although this might be taken to refer to humour disorders in general rather than to the specific category of ‘combined’ disorders. Some patients from the MTK mentioned that their condition was gshen cud can (of a ‘combined nature’). There were more complaints recorded in July, which suggests that many disorders may be linked to, or exacerbated by, changes in the climate and particularly hot weather (see also Table 5). It also shows that few patients visit the MTK in relation to diseases of ‘ascertained’ biomedical aetiologies such as TB. There is a relatively low frequency of ‘single’ humour disorders. More commonly, diseases are attributed to ‘combined’ humour imbalances.

This concurs with recent speculations that clinical practice in fact does not construe humours as balancing each other out, but rather as independently active malevolent agents, as we will come back to in Chapter 6. Samuel argues that ‘the word conventionally translated as ‘humor’ (nyépa = Skt. Dosa) means “fault” or “weakness” (...) the textual concept appears to be that each of the nyépa is a potential cause of illness, accumulated throughout daily life and provoked into manifestation through particular circumstances’, in reference to the bsbad pa’i rgyuds, ninth chapter’ (2001: 255). Thus, the idea of equilibrium and of the body ‘in balance’ can be seen as a theoretical trope, perhaps of modern origin, which is gradually replacing a different clinical understanding of humours. The medical anthropologist’s emphasis on ‘balance’ has elsewhere been challenged by Alter, who contends that ‘health and physical fitness, even from the ecologically balanced and integrative perspective of holistic medicine, are regarded,
fundamentally, as bounded, predetermined, natural states of balance that need to be
maintained rather than as unbounded goals that might be actively pursued' (1999: 44).
Alter argues that Ayurveda is best described not as a 'means of curing disease and
restoring balance through the application of humoral medications and ecologically
holistic (...) ultimately natural therapies but as a mode of radical self improvement' (ibid:
44). By the same token, in Tibetan medicine, references to the body in 'dynamic
equilibrium' and to the disruptive potential of humors reflect a concern with health as an
adjustment to suffering and disease, rather than as an embodied ideal, as in the
expression gong med, to be healthy, meaning to be without chronic suffering and disease.

The following table is the result of a questionnaire in which I asked patients from the
Men-Tsee-Khang and Delek which diseases were, to them, important (gshis chen po) in exile.
These interviews were done on the basis of free listing with 38 individuals visiting Delek
and 36 visiting the Men-Tsee-Khang, of which 35 were women, 39 were men, and all
were above 16 years old. The majority of patients were aged between 30 and 60 (34
respondents out of 50), and a good proportion had been born in Tibet (29).

Table 5. Prevalent diseases as reported by Tibetan patients in Delek and the MTK.

<table>
<thead>
<tr>
<th>Tibetan Term</th>
<th>English Term</th>
<th>At the MTK</th>
<th>At Delek</th>
</tr>
</thead>
<tbody>
<tr>
<td>grol dbog sbya ba</td>
<td>Diarrhoea</td>
<td>2</td>
<td>22</td>
</tr>
<tr>
<td>gin snyi na tsha</td>
<td>Diabetes</td>
<td>6</td>
<td>17</td>
</tr>
<tr>
<td>it bi na tsha</td>
<td>Tuberculosis</td>
<td>37</td>
<td>38</td>
</tr>
<tr>
<td>chams pa</td>
<td>Cold/influenza</td>
<td>23</td>
<td>10</td>
</tr>
<tr>
<td>grum ba'i na tsha</td>
<td>Arthritis,</td>
<td>25</td>
<td>16</td>
</tr>
<tr>
<td>nchun nas</td>
<td>rheumatism</td>
<td>28</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Liver disorders</td>
<td></td>
<td></td>
</tr>
<tr>
<td>mgyi nas</td>
<td>Leprosy</td>
<td>12</td>
<td>10</td>
</tr>
<tr>
<td>Aids</td>
<td>AIDS</td>
<td>12</td>
<td>19</td>
</tr>
<tr>
<td>khrog shed</td>
<td>High blood pressure</td>
<td>32</td>
<td>31</td>
</tr>
<tr>
<td>lgo nas</td>
<td>Headaches</td>
<td>4</td>
<td>19</td>
</tr>
<tr>
<td>Cancer</td>
<td>Cancer</td>
<td>30</td>
<td>36</td>
</tr>
<tr>
<td>pho ba'i na tsha</td>
<td>Stomach disease</td>
<td>32</td>
<td>29</td>
</tr>
<tr>
<td>mkhal nas</td>
<td>Kidney disease</td>
<td>30</td>
<td>12</td>
</tr>
<tr>
<td>snying gi na tsha</td>
<td>Heart disease</td>
<td>15</td>
<td>35</td>
</tr>
</tbody>
</table>

This table again points to the similarities between the health concerns of Gangkyi
residents and the actual problems reported following the physicians' diagnosis. For
example, a large number of individuals (66 out of 74) said they were preoccupied by the
risk of cancer. Cancer is one of the health problems that both Tibetan exiles and
biomedical doctors seemed increasingly concerned about. Many women I spoke to had
worries about finding lumps in their breasts. They told me they had found out about breast cancer by reading Indian magazines, in which they had also found instructions on how to check themselves. They were worried that they had discovered cancerous lumps that would not be treated adequately because of the poor facilities available in Dharamsala, and referred to the difficulty of accessing proper facilities, which could only be found in Chandigarh. Young and middle-aged residents of Gangkyi and McLeod Ganj are beginning to think of their elders’ health problems in relation to cancer. It is for instance increasingly assumed that cancer is the primary cause of death among elders, and that old people die of cancer, not simply of old age. When I used my questionnaire on some of the older refugees to gauge their opinion on the danger of cancer among exiles and Tibetans in general however, they would often dismiss it as ‘not very common’. Cancer is perceived as an ‘emergent’ disease, a disorder that is just beginning to affect Tibetans but of which people increasingly need to be aware. Young women particularly are much aware of the danger of breast cancer.

During the course of the interviews I became aware that patients were sometimes uncomfortable with mentioning ‘vague’ symptoms (na lugs ma gi) that were not immediately identifiable with discrete allopathic diseases or unascertainable Tibetan disorders. My concern was increased by the fact that previous surveys of health complaints in Tibetan settlements also concurred with patients’ tendency to sideline ‘vague’ symptoms, and to prefer immediately identifiable biomedical and traditional disorders (see for instance Simmonds 1985 in another settlement). Consequently, I decided to repeat the interview with 42 available patients (20 male and 22 females) using ‘pointers’, i.e. naming headaches, stomach cramps, fever and tiredness. Thirty-five patients responded affirmatively when I mentioned stomach cramps, and a surprising forty recalled experiencing some form of fever (tsha bo). Exiles tend to think of illness in terms of fever and often referred to ‘heat’ in India as a source of health problems.
Table 6. Explanations of Prevalent Disorders (36 from MTK and 38 from Delek).

<table>
<thead>
<tr>
<th>Disorder Category</th>
<th>Causes (English)</th>
<th>Causes (Tibetan)</th>
<th>N. MTK</th>
<th>N. Delek</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>grod khog bshal ba</strong> (diarrhoea)</td>
<td>Unclean water</td>
<td>chu tsog pa</td>
<td>22</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>'Bo (insect/bacteria)</td>
<td>'bu</td>
<td>17</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>Rotten/bad foods</td>
<td>ka lhag rdul ba</td>
<td>16</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Fatty/oily foods</td>
<td>ka lhag snum pa</td>
<td>32</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>Over-eating</td>
<td>lhag thad za ba</td>
<td>31</td>
<td>30</td>
</tr>
<tr>
<td></td>
<td>mkhris pa 'disorder'</td>
<td>mkhris pa</td>
<td>29</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>Heredity (descent)</td>
<td>gdang rgyud</td>
<td>13</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>Karma (past actions)</td>
<td>las</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td><strong>chi ngyi na tsha</strong></td>
<td>Infectious 'bu (TB)</td>
<td>'go bu's 'bu</td>
<td>33</td>
<td>38</td>
</tr>
<tr>
<td></td>
<td>Isolation with other TB patients/ contagion</td>
<td>'go na'd pa myam du sbed</td>
<td>26</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>Irregular/insufficient eating</td>
<td>bend med yas spyad</td>
<td>26</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Karma (past actions)</td>
<td>las</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td><strong>chans pa</strong> (cold)</td>
<td>Cold climate</td>
<td>guam gshis grang mo</td>
<td>34</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td>(Being in) cold and damp places</td>
<td>sa cha grang mo dang</td>
<td>35</td>
<td>32</td>
</tr>
<tr>
<td></td>
<td>Contagion from family or neighbours</td>
<td>lhag mi/khyim mthses</td>
<td>8</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>Karma (past actions)</td>
<td>'go na dang rgyab pa</td>
<td>31</td>
<td>27</td>
</tr>
<tr>
<td><strong>grum bu'i na tsha</strong> (arthritis, rheumatism)</td>
<td>Being in cold and damp places</td>
<td>sa cha grang mo dang</td>
<td>31</td>
<td>27</td>
</tr>
<tr>
<td></td>
<td>Cold foods</td>
<td>lhag tsha ba la</td>
<td>30</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>Heat and cold disorder</td>
<td>siny pa'i sdog bshid</td>
<td>16</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Karma (past actions)</td>
<td>las</td>
<td>18</td>
<td>12</td>
</tr>
<tr>
<td><strong>mdze nad</strong> (depoxy)</td>
<td>Living in poor, bad conditions</td>
<td>dbyin pa, sdog cha sbed</td>
<td>27</td>
<td>34</td>
</tr>
<tr>
<td></td>
<td>Karma (strongly unfavourable)</td>
<td>las</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Lepers</td>
<td>'go na d pa</td>
<td>10</td>
<td>18</td>
</tr>
<tr>
<td></td>
<td>The condition of having chu ser nag po/mkhris pa</td>
<td>chu ser nag po dang</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Cancer</td>
<td>Heredity</td>
<td>pha ma rgyud / gdang rgyud</td>
<td>2</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>Change in food habits</td>
<td>zas legs ral rgyud</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Changing from habitual place and climate</td>
<td>sa cha dang guam lekis gyur</td>
<td>17</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>Old age</td>
<td>tshus ka</td>
<td>29</td>
<td>23</td>
</tr>
<tr>
<td></td>
<td>Karma</td>
<td>las</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Aids</td>
<td>Karma</td>
<td>las</td>
<td>16</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Sexual intercourse</td>
<td>drub gi don san pa</td>
<td>21</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Virus</td>
<td>dag ca na sbya dam phra rab</td>
<td>12</td>
<td>16</td>
</tr>
<tr>
<td>khrig shed</td>
<td>Salty and rich foods</td>
<td>kha lhag snum pa</td>
<td>32</td>
<td>38</td>
</tr>
<tr>
<td>(high blood pressure)</td>
<td>Heredity</td>
<td>pha ma rgyud / gdang rgyud</td>
<td>15</td>
<td>16</td>
</tr>
<tr>
<td></td>
<td>Alcohol</td>
<td>chang / a rag / mkhris pa</td>
<td>22</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>mkhris pa imbalance</td>
<td>mkhris pa</td>
<td>27</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Hot climate, being under the sun</td>
<td>guam gshis tsha pa, nji ma 'og sbed</td>
<td>30</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td>Use of alcohol or strong tea</td>
<td>chung, a rag, ja gar po</td>
<td>25</td>
<td>22</td>
</tr>
<tr>
<td></td>
<td>'heart' rlung imbalance</td>
<td>tshung ba</td>
<td>12</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>Demon/ spirit influence</td>
<td>snying rlung</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Condition</td>
<td>Example</td>
<td>Frequency</td>
<td>Comparison</td>
<td></td>
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<td>----------------------------------------</td>
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<tr>
<td><strong>Cold foods</strong></td>
<td>kha 'bug grang mo</td>
<td>21</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td><strong>Unclean foods</strong></td>
<td>kha 'bug ma gtsang</td>
<td>30</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td><strong>Unclean water</strong></td>
<td>chu tsug pa</td>
<td>35</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td><strong>Hot or spicy food</strong></td>
<td>kha 'bug tsha po, skyur po za ba</td>
<td>13</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td><strong>Cold climate</strong></td>
<td>gnam gshi grang mo</td>
<td>29</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td><strong>bad kan/thong disorder</strong></td>
<td>bad kan/thong</td>
<td>20</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td><strong>rlung/mkhrispa disorder</strong></td>
<td>rlung/mkhrispa</td>
<td>14</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Sweet foods</strong></td>
<td>kha 'bug mngar mo</td>
<td>13</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td><strong>Alcohol</strong></td>
<td>chung, a rag</td>
<td>10</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td><strong>Cold foods</strong></td>
<td>kha 'bug grang mo</td>
<td>14</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td><strong>r lung r lung</strong></td>
<td>snyig gi na tsha</td>
<td>12</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td><strong>Fatty foods</strong></td>
<td>ka 'bug snum pa</td>
<td>30</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td><strong>High Blood Pressure</strong></td>
<td>khrag shed</td>
<td>31</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td><strong>Fatty foods</strong></td>
<td>kha 'bug snum pa</td>
<td>25</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td><strong>'brown bad kan'</strong></td>
<td>bad kan ssmug pa</td>
<td>21</td>
<td>20</td>
<td></td>
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<tr>
<td><strong>Hot spicy foods</strong></td>
<td>kha 'bug tsha po</td>
<td>26</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td><strong>mkhrispa disorder</strong></td>
<td>mkhris pa</td>
<td>19</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td><strong>Alcohol</strong></td>
<td>chung, a rag</td>
<td>30</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td><strong>Hepatitis</strong></td>
<td>hepatitis</td>
<td>13</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td><strong>Worry, anxiety</strong></td>
<td>sems kbral byed pa</td>
<td>25</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td><strong>Financial problems</strong></td>
<td>dugal gi reng phyeb rbral</td>
<td>31</td>
<td>32</td>
<td></td>
</tr>
<tr>
<td><strong>Sadness</strong></td>
<td>skyo ngal ba</td>
<td>23</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td><strong>Family problems</strong></td>
<td>byab tsog rtsod phyeb rbral</td>
<td>14</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td><strong>Changing from 'hot' to 'cold' place</strong></td>
<td>sa cha tsha ba nas bsil bar gyur</td>
<td>15</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td><strong>Unbalanced activity levels, unhappy life</strong></td>
<td>tsho tsul ma sgyens, tsho tsul ma skyid</td>
<td>18</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td><strong>Demon, spirit influence</strong></td>
<td>gdon</td>
<td>6</td>
<td>3</td>
<td></td>
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<tr>
<td><strong>Hot climate</strong></td>
<td>gnam gshi grang mo</td>
<td>15</td>
<td>4</td>
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<tr>
<td><strong>Hot foods</strong></td>
<td>kha 'bug tsha po</td>
<td>18</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td><strong>Fatty foods</strong></td>
<td>kha 'bug snum pa</td>
<td>22</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td><strong>Dirty air (pollution, esp. car pollution)</strong></td>
<td>rlung tseog pa</td>
<td>30</td>
<td>34</td>
<td></td>
</tr>
<tr>
<td><strong>Rlung</strong></td>
<td>rlung</td>
<td>7</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td><strong>Smoking</strong></td>
<td>tha sma 'then pa</td>
<td>28</td>
<td>31</td>
<td></td>
</tr>
<tr>
<td><strong>Taking snuff powder</strong></td>
<td>sna 'bug 'thong</td>
<td>5</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td><strong>Incense burning</strong></td>
<td>bsang giur</td>
<td>6</td>
<td>1</td>
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</tbody>
</table>

Examination of this short survey suggests that:

a. There is no major discrepancy between the aetiologies given by MTK and Delek patients for prevalent diseases. The two groups will generally agree on the main causes of a disorder or illness.

b. Patients at Delek still engage with Tibetan traditional aetiologies, as manifested in their knowledge of what constitutes mkhrispa or rlung disorders and their main causes.
c. The interpretation of humoral disorders for both MTK and Delek patients tends to focus on changes or extremes in the environment of the sufferer (food and climate) rather than on supernatural causes like gdon (demons).

During my time in Dharamsala, I never heard any of the doctors or patients mention the MTK as competition to the Delek Hospital. Both institutions were presented to me as having complementary functions. Individuals would explain that they visited the Delek and MTK for different types of illnesses: they went to Delek for readily identifiable biomedical disorders, and to the MTK for illnesses whose aetiologies seem to fit the description of Tibetan medical disorders, usually chronic illnesses, digestive problems, arthritis, liver problems, or even diabetes. They would also visit the MTK for disorders with less readily explainable aetiologies, although in practice, suspicion of gdon or other interference would sometimes also lead them to Delek.

This concurs with Samuel’s findings, and with Janes’ and Adams’ depiction of TAR Tibetans’ view of the relationship between traditional medicine and biomedicine as complementary. However, as the following sections attempt to show, interviews with doctor and student informants in both institutions belied the apparent status quo conveyed by patients, and revealed some deeply seated tensions between the two practices. These tensions were most manifest among medical stakeholders, namely practitioners and administrators, and, interestingly, as we will discuss in Chapter 5, not by patients. Exploring this tension is crucial in understanding the changes of institutional strategies at the MTK in reaction to the ‘scientifisation’ and diversification of healthcare in Dharamsala.

4.8 Meetings and Miscommunications

The competition between the two institutions seemed largely the result of miscommunication between foreign and Tibetan practitioners rather than between Tibetans themselves: Tibetan allopathic and MTK doctors were familiar with each other and had a fairly good awareness of each other’s credentials. Generally, I found that Tibetan allopathic doctors not only knew their MTK counterparts, but treated them with great deference. Foreign volunteer doctors, whose presence and work is so necessary to the functioning of Delek, expressed a mixture of curiosity, admiration and suspicion
towards Tibetan medicine and the MTK.

I visited one of the Western volunteer doctors at Delek early on in my stay. Located on top of the hospital, her ‘quarters’ consisted of a small converted storeroom decorated with postcards of home and some postcards of McLeod Ganj. The absence of Buddhist paraphernalia in the room and the reluctance she had previously confessed to learn Tibetan suggested to me that she had only a partial engagement with the community, which was also obviously limited by the constraints of her work. I had on some occasions walked with her around town. She was greeted by some of her patients on the streets, went out of her way to visit elderly ones and seemed generally well known after her initial six months of work in the hospital. She was on night call when I arrived and there were only three doctors working in the hospital at that time, two Tibetan doctors and herself. I first asked about her perception of the MTK and the kind of involvement she had with practitioners there:

Well at the beginning I went there because I was interested to find out, in my spare time, about Tibetan medicine and how they treat patients. I spoke to the Director and he asked me, why the MTK, and what did I want to find out? He said I would need a translator. Then he said it was fine and he would arrange something, call in a week, didn't call me back... So I called him and he arranged for me to sit with a lady doctor when she saw her patients. So I sat and she took the patient's pulse and didn't say anything, no explanation. It was really a waste of time for me. But then the Dalai Lama organised this medical reunion weekend with two Indian doctors, two doctors from the Men-Tsee-Khang and two from Delek hospitals. I sat with a doctor who had recently come out of Tibet and was going for training. He explained pulse reading, he said he could feel the pulse tension in fingers. I couldn't feel anything and then I thought I could but maybe that was just my imagination. But he was very nice.

The initial miscommunication between practitioners seems to be partially alleviated when a ‘real’ Tibetan doctor, i.e. one who has just come out of Tibet, rather than one trained in exile, explains his craft to this volunteer doctor. From this point onwards she expresses respect towards Tibetan doctors, along with the idea that they simply possess a ‘different’ kind of knowledge to hers. This knowledge worked through a practice focused on acute sensory perception (rtsa bila ba'i rig, the knowledge of pulse diagnosis) and a cultural understanding of the patient (manifest in the process of questioning and interrogating the patient on his/ her daily habits and spiritual practice). But this doctor was less convinced when it came to Tibetan medicine claiming efficacy against biomedical diseases:

Then there was a case when they said they could turn Hep B positive patients into Hep B negative. We said we were interested in seeing how they did it. So they called us in, invited all the nurses, and a doctor examined and gave treatment in front of the audience. It was all
in Tibetan and there was nobody to translate. Now how are they going to prove it? They said they have done clinical trials but they are all in Tibetan and nobody had translated them yet."

Communication seemed on the verge of breaking down:

I had meetings with them regarding patients with psychological disorders who came in with recurrent complaints to discuss how they treated some diseases or simply discuss treatment methods. Many promises and resolutions were made but soon it was all dead and buried.

Soga School is full of patients with psychosomatic problems. But strange things happen there. Dr X said they did a screening of all three hundred students a couple of years ago and endoscopies because they all complained of abdominal pains. They had nothing at all but didn't have any further testing.

Another difficulty for allopathic practitioners is negotiating the variety of medical options available to individuals: many 'shop around' until they feel better, stop their treatment before time and take unnecessary risks. Although statistically more 'compliant' than Indians, Tibetans were still not as compliant as the practitioner wished:

I get very annoyed at Westerners who go and see Tibetan doctors because they think it is 'cool'. But the Tibetans also 'shop around', they go to Men-Tsee-Khang, then to Delhi, then to Ayurvedic doctors. For example, this girl was found TB positive in Bombay, then did not wait for her test results, went to Dehradun for more tests, did not wait again, and then went straight to Dharamsala where she was treated. She knew she was TB positive and she took the risk of travelling all over the country! They expect the doctors to find solutions to everything, they take us for granted, they take for granted that the west is there to help, they act like it is an honour for us to be here. The CMO keeps a tight control on how many Westerners come to work here because he doesn't want too many of them around. Last night a young patient died and I was actually so glad that the CMO was here, otherwise the Western doctors would have had the blame for the death, for not transferring the boy to Chandigarh hospital early enough.

This breathless flow of complaints belied a deep sentiment of unease with the 'aid' culture of Dharamsala. The working conditions at Delek were also a source of concern, as well as the specific requirements of some patients:

The nurses have it tough, they do 12 hour shifts, live in the hospital, and there are rats and mice on the ground floor. Dr X complains because he only earns 8000 rupees, which is the same as the handicrafts people down at Norbulingka. The grandmother of the family you live with came to the hospital for treatment of her bad leg. Then I was asked to come and do Dr X's private visit. I was on call so I refused but the nurse asked me to assess the situation, so I admitted the mother into hospital although she wanted 'home care'. Some people have a very peculiar notion of 'private patients'. We sometimes have problems accepting the divination thing, the fact that some patients will refuse to take medication, and it endangers their lives. But you just have to accept it. It's just like the Men-Tsee-Khang secrets, you just have to leave it.
The obvious discontent expressed by this allopathic doctor stemmed not only from the difficult working conditions in the hospital but also from the tense relations which some of the staff entertained with the MTK. The MTK's perceived lack of credibility in its experimentations with herbal products, its 'secrecy' about traditional techniques, were all motives for indictment. In the following section we examine the case of the Tibetan Transit School for newcomers, a context in which MTK and Delek doctors have actively sought to co-operate.

4.8.1. In between: transit diseases

One of the areas for which the Tibetan Delek Hospital and the Men-Tsee-Khang saw possibilities for co-operation was the treatment of mental illness among newcomers and the Tibetan torture survivor 'rehabilitation programmes'. The Tibetan Transit School was set up in 1993 to help new refugees who could not be absorbed into regular schools (because of age or language difficulties). They are given a three-year long course focusing on English, Tibetan and Mathematics. When I left Dharamsala there were plans to extend this into a five-year course.

The treatment of mental illness is a traditional area of co-operation between indigenous medical systems and biomedicine, biomedical practitioners endorsing the idea that culturally appropriate care is particularly important for sufferers of mental illnesses and psychological trauma linked to torture (Littlewood 1992). This section will specifically focus on the co-operation between allopathic and traditional medicines in cases of mental illnesses as it takes place in the Transit (or Soga) School for newcomers.

Students of the newcomers' adult educational centre the Soga School in Norbulingka, were described to me by allopathic doctors as particularly prone to psychosomatic illnesses. Most of them are aged between 18 and 30 and have undergone major hardships during the crossing to exile. The students were a major subject of concern among the biomedical doctors at the Tibetan Delek Hospital, who often expressed regret at not being able to do more than their weekly visit to the school. Both the MTK and Delek doctors involved in the care for Soga students described their interaction with the students as very satisfying from both a professional and personal perspective. One MTK female doctor said she felt extremely sad for the students, and that she could feel their
own sadness and difficulties by the strong *rlung* symptoms they manifested. She said: 'when I take the patient’s pulse, usually it takes some time to find the personal pulse, then find the disorder, but with Soga patients, they have so much *rlung*, it is the first thing you sense when you take their pulse'.

The school’s barracks were a cluttered and closed environment of bunk beds where intimacy could only be achieved by pulling blankets around one’s bed, and space for personal belongings was kept to a minimum: a few boxes for clothes and objects only were kept by the bed. When looking into some of these impromptu cubicles, one might see a few plastified pictures of family members, poems and postcards. Two students showed me scrapbooks, which comprised of letters in Tibetan and English, often poems and short proverbs, and writings in Chinese. Many entries in the two diaries I saw were letters to be sent back home which were never actually torn out of their notebooks. Some English poems were written in the form of love letters to girlfriends, expressing the loss, longing, and the nostalgia for home. One man displayed a picture of his girlfriend, a Tibetan teacher in Lhasa, in a staged photograph where she posed in a cinematic Chinese collar dress with a sun umbrella in a photographic studio. The boys’ dormitories were as ordered as army barracks, but the space near and around the beds was replete with neatly arranged personal belongings that betrayed deep nostalgia and attachments to home.

The school environment, adding to the trauma of exile and resettlement, can therefore be considered a strong exacerbating factor in the development of psychological disorders and mental illnesses. Despite the fact that school residents have access to traditional Tibetan medicine, their first port of call on health related matters is usually the local health worker. Students told me they didn’t have much time to speak with the doctors, whether Tibetan or foreign, because they were on ‘rounds’ or ‘just passing through’. This was however not identified by them as the primary motive for dissatisfaction. They resented the scarcity of the visits and the fact that it was so difficult for them to arrange a trip to Delek for serious health problems. But the hospital is essentially ill-equipped to deal with mental health problems and thus physicians often have recourse to Men-Tsee-Khang doctors for not readily identifiable mental illnesses or suspected cases of depression. At Soga, some allopathic doctors talked about the not unusual discovery of a patient referring to ‘pain in their neck, stiffness in the arms and the upper body’. One
doctor explained: 'We could not diagnose any muscle stiffness, but it turned out that this patient has been tortured, and having dreams and disturbances, had lost his job and was unable to meet his families' needs. We see so many of these in Soga'. Here the psychosocial components of illness are clearly identified and related to the physical symptoms expressed by the student.

The two institutions, Delek and the MTK, compete in the care of newcomers from the Soga transit school. Both clinics hold weekly visits to the school, where they are equally popular. Upon one such visit, an MTK doctor saw approximately 75 patients in a day, which she considered to be quite a low turnout. Both allopathic and MTK doctors would do some of the more routine check-up work, visiting the school on two week rotations. A great number of Soga patients, they said, were subject to rlung disorders, especially men. Similarly to cases observed by Janes in a Lhasa hospital, refugees in Dharamsala, particularly newcomers and torture survivors, are considered to be extremely susceptible to rlung disorders. Likewise, the widespread equation of rlung imbalances with mental afflictions was also often commented upon in Dharamsala. Most of the biomedical doctors, both foreign and Tibetan, were aware of this association and even directly questioned the patient on whether they felt they had any rlung problems, sometimes surprising the patient who had not envisaged this possibility.

It was not made clear to me which of Delek or the MTK had institutionalised visits to the Soga school, but I was told that it was Delek that had sought out the MTK's cooperation for cases which they saw as more 'psychological'. Delek therefore went along with the MTK's claim to provide holistic treatment and culturally appropriate therapies. The association between the MTK's doctors and Delek in Soga was regularly emphasised by Delek. While the MTK doctors felt a responsibility to treat Soga patients because they were 'more at risk' than any other group of the Tibetan population, some privately resented Delek's definition of their approach as 'the just talking approach', a form of counselling. This was naturally not intended as an insult to MTK doctors' skills as practitioners, but rather as an acknowledgement of the validity of culturally appropriate treatment and the importance of conversing about their psychological state of mind. MTK doctors did not see their treatment of Soga patients as 'just talking'. Male doctors especially emphasised the efficacy of Tibetan medicine in diagnosing discrete diseases and thus staked a claim to clinical efficacy beyond the benefits of 'just talking'.

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The two female doctors I saw practising there seemed more inclined to see benefits in letting patients suffering from *riung* vent their feelings, and considered it a critical part of their intervention.

The co-operation of Delek and the MTK in the treatment of 'transit diseases', as they became known, therefore revealed another side of the relationship between the two institutions. Through the treatment of patients they had in common, practitioners at both institutions were able to compare their interventions and began to engage in an interpretative exegesis of their respective clinical practices.

4.9. Summary

As can be seen from the previous sections, healthcare among Tibetan exiles can only be understood at the crossroads between plural systems and exigencies. Tibetan traditional medicine is undergoing radical modifications both in exile and in the TAR. Meanwhile, the MTK is shaping the overall Tibetan medical practice, imposing its particular blend of institutionalisation and strongly defend its own interests vis-à-vis other practitioners. The medically plural scene of Dharamsala defines both opportunities and constraints for therapeutic management. Both opportunities and constraints are managed in local terms, for instance with the use of diviners, or in going back and forth between allopathic and traditional practitioners. Plurality is therefore as constraining as it is enabling, depending on the degree of agency expressed by the patient and the varied strengths of the therapeutic management groups involved in decision making. Although Dharamsala patients view traditional and allopathic medicine as complementary, interviews with local practitioners reveal clashes in competing claims to clinical efficacy, where the MTK seeks to define its status as a key provider of 'culturally adequate' healthcare for the exile community.
The Men-Tsee-Khang: Construing Traditional Authority

This chapter will examine the MTK’s emergence as an important healthcare provider both in Dharamsala and also on the Indian and international scene, paying specific attention to the growing institutionalisation of its styles of teaching and practising medicine. I firstly suggest that Men-Tsee-Khang traditional Tibetan medical practitioners have modified their practice and teachings in order to make Tibetan medicine more appealing to a non-Tibetan clientele. Secondly, I attempt to show that the new ‘styles’ of practice developed in the MTK paradoxically reflect a degree of ‘invention of tradition’ in attempts to systematise teaching and clinical practice. I argue that a major component of the MTK’s institutionalisation has been its adherence to traditional forms of knowledge transmission. While conserving its image as a guardian of Tibetan traditional cultural heritage, the MTK has also imposed institutional and clinical innovations by and large dictated by the predicaments of exile.

Vincanne Adams, in her emerging work on women’s health in the TAR, notes that Tibetan apprehensions of biomedicine reveal a particular stance towards modernity (2001:224). In Tibet as in exile, traditional doctors have attempted to ‘scientifise’ Tibetan medicine: attempts have been made to test the efficacy of Tibetan medicine through clinical trials and Tibetan doctors from institutions such as the MTK are putting increased emphasis on the ‘scientific’ logic of Tibetan medical theory (cf. Men-Tsee-Khang 1998; Namdul et al. 2001). In addition, practitioners in the TAR and, to a certain extent, in Dharamsala, are discarding the more esoterical and spiritual components of the medical system in favour of a more systematised and ‘disenchanted’ medical practice.

It is of course not my wish here to equate ‘scientifisation’ with ‘modernisation’. Rather, I will attempt to show that the Tibetan doctors’ concern with scientific modernisation is a tactic for authenticating and legitimising traditional practices. As Adams argued in the context of the TAR, the scientifisation of Tibetan medicine cannot be taken to imply a unilateral shift to a more biomedical ‘style’ of practice. Rather, the recasting of Tibetan
traditional medicine as 'science' is part of a strategy for the preservation of its status and role within exile structures.

My first dealings with the MTK and its doctors were rather difficult. I was in the presence of an institution whose teachings and practices inspired reverence and stimulated curiosity, but were also protected by stringent secrecy. My interest, as I explained to the senior MTK administrator who had granted me an initial interview, lay in the functioning of the institution itself: I wanted to know how much medicine it produced, of what kind, and what percentage of it was exported. Through the administrator's response, it soon became apparent that the MTK was not just a home for traditional Tibetan doctors, but an institution intending to defend its knowledge and status both within and outside the exile community. This was no doubt due to the Institute's financial success, which had made many in the community envious. I was to have no access to information on how the MTK planned its production or kept records of patients and their ailments. The political naivety of my initial approach created many setbacks: for many months, the administrator's suspicion meant that my interactions with the MTK were limited to informal contacts and interviews with students and patients, not with doctors.

The administrator's reaction to my undue inquisitiveness was my first introduction to the MTK's power of traditional authority:

You say you want to look at statistics, production. We are not a business, we do not want to be big. If you look at the way we run the institution, you will see that costs equal profits. We sell at the cost of raw materials. What costs one rupee here will cost $100 in the US because retailer, wholesaler and distributor all get a share.

This response showed a marked defensiveness to perceived allegations of corruption and profit making. This distrustful attitude revealed an uneasiness with the uncertain status that came with being an 'exile institution' turning to a more professionalised and politically visible practice. The status of Tibetan medicine vis-à-vis state-sponsored Ayurveda, as well as biomedicine, was also a subject of concern and raised the difficult political issue of Tibetan integration within Indian legal and political frameworks:

(...) We are not in our country, we have to protect ourselves. It is because of the protection of His Holiness and the greatness of the Government of India that we can do this. We are competing with Ayurvedic medicine and biomedicine. We do not want to go through legal procedures in Europe and the States. It takes 20 years to be recognised as a medical system.
Tibetan Medicine was officially sanctioned as a component of the health system in India in 1962 and given funds for clinical work and training programmes. The Men-Tsee-Khang now has the status of 'charitable association' under the patronage of the Dalai Lama. Because of this status the MTK does not pay income tax to the Indian government, although it does pay some tax on export sales. However, Tibetan medicine’s growing fame abroad has exacerbated the MTK’s insecurity vis-à-vis issues such as taxation, the modalities of allowing doctors trained at the MTK to practice outside India, and the challenges of clinical efficacy trials imposed by biomedical authorities in the West.

Our talk did not end there, but led to an exposition of the ‘proper way’ to study Tibetan medicine, which deflected the conversation from the topic of the MTK’s professionalisation. Rather than studying the medical system’s modern dilemmas, I was told that I should be content with the traditional student’s lot of learning about the practice itself:

If you want to learn about Tibetan medicine, then you have to go to the root, learn about the history, the peripherals. There are 3 elements in Tibetan medicine (rungs, the wind that goes through the body, the liquid in the body, phlegm, and bile). With these three you have everything.

Do you believe in the soul? We Tibetans believe in the soul but when you look for it, it is difficult to find it. You will find that more old people like Tibetan medicine, the young want quick relief. Tibetan medicine gives effect long term. His Holiness says: ‘Tibetan medicine works best when you are not ill’. It helps maintain a balance between healthy body and mind.

There are three methods. First diagnosis: check the eye, tongue, pulse and urine. Second: prescribe, it is not the same for every category of disease. When disease is not very serious, the doctor asks patients to change habits, drink and food. If it is more serious, then the patient should change his habits and take medicine. If is very serious then you can have treatment like moxabustion or gold needle.

(…) Ayurvedic and Tibetan medicine are essentially similar, the only difference is in one nerve (he points to his forearm).

The success of the Institute with its Western clientele was measured through the reputation of its staff in traditional learning and diagnostic excellence, which even allowed the Men-Tsee-Khang to develop a humanitarian vocation in India:
Many VIP media people come here and say, 'Ah you diagnosed my disease right, I have been doing this and that treatment for years but no one had diagnosed my disease right'. Not many people are open about it, but some are.

Here it is considered medicine, in the US it is food supplement! Go to the root, study the peripherals, then look at numbers and then write your thesis.

We have enough medicine for our 35 branches, but not for more. There are two types of doctors, some certified, trained here, others hereditary like in Ladakh. Then we have branches where it is necessary to help our Indian brothers... in Delhi, Bangalore, Calcutta, but sorry to say, not Bombay. We had one female doctor who worked in Punjab with a treatment for infertility and helped many people there.'

Perhaps because he was faced with a foreign interlocutor, the director felt compelled to list the MTK's credentials. The aspects to which he wished to draw my attention were: 1. The emphasis on the medicine's holistic character (and its promotion of well-being); 2. The importance of the official accreditation delivered by the Institute; 3. The reputation Tibetan medical tradition for exact diagnosis; 4. The Institute's newly found humanitarian vocation (caring for Tibetans and Indian 'brothers' alike etc.).

Although this discourse clearly appropriated some of the values which foreigners attribute to Tibetan medicine, most obviously holism and diagnostic accuracy, even using non-Tibetan clients as witnesses (in the reference made to 'VIPs'), it also formulated some ideas specific to the modern MTK's credo, such as the importance of certification and the new value attached to the humanitarian work of Tibetan doctors for their Indian hosts. This interview also unveiled some deep-seated preoccupations about the MTK's positioning vis-à-vis Western scientific knowledge and other medical institutions, and, more specifically, regarding the Institute's legal status, as is clearly expressed in the remark 'we are not at home here'. With hindsight, it seems that this preoccupation was fed by the increasing financial success of the MTK: with commercial expansion ahead, the Institute's taxable income and its accounts would become subject to even more external scrutiny. The MTK was not producing enough medicine to satisfy demands (although it was producing enough doctors), and the ways to increase its productivity without compromising its standards of production and compromising its legal status as a charity were a constant subject of preoccupation and negotiation within the institution. From the point of view of the administrator, this was indeed a turning point in the MTK's institutional life, one where proving legitimacy had become critical.
In the following section I attempt to show how the contemporary process of institutionalisation of Tibetan medicine is informed by an earlier history of political and economic development in Tibet.

5.1. Tibetan medical institutionalisation: a historical perspective

This section provides a brief history of the institutionalisation of Tibetan medicine up to the contemporary period. The rise of the Tibetan medical system is linked to two physicians. The first, Yuthog Yontan Gonpo the Elder (AD 708-833), is said to have been one of the nine court physicians of King Trisong Deutsen (AD 742-797) in the period of the first introduction of Buddhism to Tibet. Yuthog the Elder is said to have acquired his knowledge through the translator Vairocana, a disciple of Padmasambhava and one of the first Buddhist monks in Tibet. Through him, Yuthog the Elder received the teaching of the *rgyud bzhis*, or ‘Four Tantras’. The *rgyud bzhis* is now believed to have been written around the twelfth century (Karmay 1989; Tsering 1980). The body of medical works produced by Tibetan scholars during that period is believed to comprise mostly translations of texts from neighbouring countries such as India (Gerke 2001: 32-33). Other notable medical centres flourished outside the court’s direct influence, for instance the school of the Tholing complex, established in the eighth century in Western Tibet, which later gave rise to the translation-based medical tradition of Rinchen Zangpo (AD 958-1055). Rinchen Zangpo received the teachings of the *yan lag brya’g pa’i snying po bshid pa*, which were translated into Tibetan by Jarandhara. The process of continuous learning and exchange with Indian scholars continued as Tibetan doctors from Yarlung and Tshalung visited India and brought further medical teachings back to Tibet. Rinchen Zangpo’s lineage tradition inspired the work of Yuthog the Younger (AD 1112-1203), who sought to incorporate indigenous and Chinese elements into the *rgyud bzhis* (Gerke, 2001:33). Yuthog the Younger also reportedly travelled to India six times in order to research the Indian sciences (Rechung 1973: 20).

The *rgyud bzhis* came to be considered a *gter ma*, part of the visionary literature hidden in Samye monastery on Padmasambhava’s orders and later ‘re-discovered’ by a monk named Trapa Ngonshe (*gra pa’i mgon she*) in connection with this rediscovery. The transmission of the *rgyud bzhis* through teacher-student lineages (*rgyud pa*) has played an important part in shaping and adjusting medical knowledge: the input of new teachers
and their reinterpretations of the text have significantly transformed the teachings over time.

During the 15th century, the teaching of Tibetan medicine was split between two main medical lineages. The first was based on the teachings of Changpa Namgyal Dragzang (1395-1475), and is known as the chang pa tradition. The second was based on the teachings of Zurkharwa Nyamnyi Dorje (1439-1475), and is known as the zur lug tradition.

From the alleged re-discoverer of the rgyud bzhi, Trapa Ngonshe, the medical teachings reached Yuthog the Younger, making him Yuthog the Elder’s thirteenth descendent in the lineage. Yuthog the Younger’s lineage teachings were passed down to the founders of the first state-founded medical colleges under the fifth Dalai Lama. The first institution was a medical school attached to the dga’ ldan pho brang (Lhasa government) in the ‘bras spung monastery, soon followed by the establishment of a smaller college in bsam grug tse. In 1696, upon the fifth Dalai Lama’s orders, the regent Desi Sangye Gyatso (sde srid sangs rgyas rgya mtsho) built a medical college and hospital on the mountain of Chagpori (dchags po ri) in Lhasa. Sangye Gyatso also composed the Blue Beryl (baidurya sngon po) the most influential commentary on the rgyud bzhi to date and had 79 thangka paintings made to illustrate its contents (Parfionovitch, Dorje & Meyer 1992). Doctors were sent from Chagpori to the main monasteries and districts under Lhasa’s government. Some doctors trained in Lhasa set out to establish other medical institutions such as Labrang (1784), Kumbum (1757) and Yonghegong in Beijing in 1750 (Meyer 1995: 118). A further institution, the sman stsis khang, was established at the time of the thirteenth Dalai Lama (1895-1933) by Khyenrab Norbu (mKhyen rab nor bu) (1883-1962). Lhasa’s MTK grew to become a unique teaching institution that trained and sent students back and forth to the main provincial monastic centres.

The Lhasa MTK diploma was a government-approved certificate. The MTK degree candidates studied grammar, poetry, Tibetan anatomy and anthropometry, memorised the rgyud bzhi and went on plant gathering expeditions (Rechung 1973: 22-24). After the destruction of the Chagpori in 1959, the Tibetan exiles re-founded the MTK in India in 1961, reclaiming the tradition of Yuthog the Younger as the inspiration for their own teaching.
The creation of the Tibetan medical curriculum and its modes of diffusion reflect the intense knowledge-borrowing which took place between Tibet and its neighbouring countries from the eighth century onwards. Although the association of Tibetan medicine with Buddhism dates back to Yuthog the Elder (a rnying ma pa), Buddhism was not the sole cultural and spiritual influence to inform medical practice. The theories and clinical skills acquired by Tibetan physicians through their translation of foreign works and incorporation into the medical corpus brought foreign cultural and cosmological ideas into the theory of Tibetan medicine. Looking at the indigenous, Indian and Chinese influences of Yuthog the Younger and his students, one can see the eclecticism of the physicians’ borrowings.

The close association of Tibetan medicine with Buddhism and monasticism seems to have consolidated itself over the years. An important factor was certainly the increasing weight of Tibetan hierocratic structures within Tibetan polities. At the time of the fifth Dalai Lama, Tibetan medicine was therefore emerging as a state-sponsored and state-patronised system linked to dominant religious sects. Indeed Adams (1998), in a Foucauldian transposition, has paralleled the rise of Tibetan ‘official’ medicine and its technologies of ‘self-management’ with that of the Tibetan state.

Contemporary exile MTK physicians relate their own medical tradition to the lineage of Yuthog the Younger. By claiming affiliation to this lineage, physicians acknowledge the plural inspirations of Tibetan medicine. However, with the increasing institutionalisation of its practice and the breakdown of exchanges with neighbouring countries from the twelfth century onwards, Tibet developed an increasingly institutional system of practice and some uniquely Tibetan features. This process continued in the diaspora, influenced by the nature of exile politics and the confrontation of Tibetan medicine with other medical systems. In the context of exile politics, medical practice has come heavily under the patronage of the Tibetan Government in Exile and thereby tied to the Dalai Lama and the Gelugpa establishment. The Men-Tsee-Khang official title is ‘Tibetan Governmental Astro-Medical Institute’ (bod gzung sman rtsi khang), or sometimes ‘Tibetan Medical and Astrological Institute of H.H. the Dalai Lama’. Tibetan medical practice tied to politics internal to the particular hierarchies of the Tibetan exile community and to the broader politics of Tibetan identity. In the following sections I will examine the
5.2. Making traditional Tibetan doctors

On the basis of the semi-structured interviews I conducted with Tibetan lay patients at both Delek Hospital and the MTK, I would suggest that Tibetans in exile usually accord as much status and kudos to the traditional medical doctors as to Delek Hospital staff. This was explained to me with the argument that students and doctors of the MTK are upholders of a traditional and internationally recognised knowledge, a knowledge that, like chos is recognisable as uniquely Tibetan. The length and depth of training are considerable: five years for medicine and astrology respectively, as well as comprising teachings on grammar, versification, Buddhism and botany. The study of Tibetan medicine is reputedly so difficult that only the most gifted students can succeed in the entrance examinations (jig tshad), and, later on, in the yearly tests. Most MTK students have been educated up to the twelfth grade and must show a considerable proficiency in Tibetan language to succeed in the entrance examination, which is a significant obstacle for students from Ladakh or Nepal with no education in classical Tibetan. Students thus admitted to the Men-Tsee-Khang were considered to be among the most scholarly young Tibetans in exile, on a par with Varanasi IHTS (Institute of Higher Tibetan Studies) students. Most of the students I spoke to commented at length on the rigidity of the training and the difficulty of the curriculum. For many however, it was precisely this structural rigidity that led them to pursue a career in Tibetan medicine: after the set five years and a year's worth of work experience (nyams rtags), the Institute guaranteed the students employment in one of the MTK's branches in India or Nepal. One female first year student commented:

It's not that I always wanted to study Tibetan medicine. But I was very good at grammar and Tibetan language at school, and my uncle is a well-known doctor in the MTK. I thought this would be a good profession, where you do good for people, especially here, where people have so much rnyag rtags. And then I knew I would get work straight after. Many people when they come out of TCV, they don't know what to do, they have to go and look for foreign sponsors to go and study or go to Delhi or something. Here I don't have to do that. I have a sponsor for my studies but I know I will be able to work after that.71

The student body at the MTK forms a cohesive group, and one feels their awareness of representing the Institute to outsiders. Students live within the MTK precinct in what is
in all respects a mini-campus. They share dormitories and take their meals together in a mess hall at set times in the morning and evening, taking turns to cook for each other. The students are geographically and hierarchically separated from the staff, whose quarters are in separate buildings. However, almost all members of staff, from pharmacy workers (staff in charge of the MTK’s preparations) to students and teachers, live within the constantly expanding MTK precinct. This seems partly due to convenience, and partly because of the financial incentive of subsidised or free housing. The overall effect however is that of a contained and autarchic institution that clearly distinguishes itself from the rest of the community.

To outsiders, MTK students form an integrated, cohesive group, which organises its own activities and social life. They regularly put on plays and melas, whole day fairs with food, games and lotteries organised by students in order to raise money, which CTA workers and nearby residents are invited to attend. Although such institutional group mobilisation during cultural events, for example on the Dalai Lama’s birthday, or the anniversary of his ‘assuming state responsibility’, is by no means exceptional, the MTK students have a reputation for putting on some of the best glu gar (song and dance) performances. On such occasions I often found myself paralleling the MTK’s life to the ‘institutional apprenticeship’ described in Sinclair’s study of biomedical education in London, ‘Making Doctors’ (1997), as well as on Freidson’s (1970) study of medicine as a profession. Sinclair describes medical learning as the management by students and teachers of ‘dispositions’ that serve or hinder their relationship with the institution. This parallel is worth expanding in detail here, for it provides much insight on the MTK’s progressive institutionalisation.

Sinclair argues that, if the medical school ‘can indeed act as an institution in the sense of a physically bounded space, it is less in terms of space and more in terms of time spent within the conceptually bounded and cognitively limited organisation of the profession itself, that student’s institutional life should be seen’ (2000:15). In ways similar to Sinclair’s Medical School, the MTK is a bounded space, and the place of practice is a form of ‘total institution’: many of the students do not leave their training location but stay, practice and live within it, some also marrying among their colleagues or fellow students.
The creation of an 'exclusive cognitive identity', with the core valorisation of text learning (memorising passages of the *rgyud bzhi* by heart), recitation (*kha ton 'don*) and examination is also strikingly resemblant to Sinclair's ethnographic account of biomedical training. Millard in his study of 'learning processes' in a West Nepal Tibetan Bonpo medical school (2002), outlines the progression which leads students from relying on propositional memory (with an emphasis on memorisation), to an increasing use on procedural memory (with an emphasis on skills). In the Tibetan medical school, he argues, medical knowledge becomes situated through practice. In the early stages of the learning trajectory, the emphasis is on acquiring propositional knowledge, 'which takes the form of 'context free' objective facts and rules that govern behaviour'. Then, as the training progresses, 'expertise develops as this knowledge is increasingly situated in practical contexts, and propositional memory is transformed into the performative memory of expertise' (2002: 79).

Within Tibetan exile society, possibly the most likely parallel for the MTK is the monastic institution. In many respects, medical training follows a pattern similar to that of religious training. The monasteries foster a similar cognitive apprenticeship through learning, recitation and ritual prescriptions. In the Gelugpa schools, training involves the three main components present in medical education: memorisation of key texts, listening to explanations and using the commentaries on these texts, dialectical debate and revision. As Millard asserts: 'education in medical school is consonant with the wider cultural pattern of Tibetan education' (2002: 85).

The similarities between the MTK and the 'total institution' of the monastery are manifold. At the start of lectures (*kha gta'n*), students recite verses requesting the teachings of *Bhaisajyaguru*, the Medicine Buddha, whose embodiment the teacher becomes (in addition to the practice of worship of the Medicine Buddha performed by medical practitioners, known as *sman bla'i mdo chog*). The eightfold way of medical practice (*sman yan lag bregad po*) further echoes the eightfold path of the Buddhist practitioner. The *rgyud bzhi* indicates that accomplished practitioners should meditate on the medicine mandala and practise realisation at three levels: (1) identifying oneself with the Medicine Buddha (the inner level); (2) realisation of Buddhahood as one's true nature and one's own body as the medicine mandala (the secret level); (3) devotion to the Buddha and medicine (the external level). When prescribing medicines for particular conditions, the
lama practitioner also acts as intermediary between the patient and the divine: the person taking medicine has shared the blessing of the deity with the lama and is bound by a vow (dam tshi^ which enforces the bond between patient, healer and deity. Clifford states that breaking the vow is a major source of illness among Tibetans (1989: 68). Medical students also undergo examinations (kha gsher) in the form of question/answer patterns reminiscent of the monasteries' debating exercises. Just as Sinclair sees the medical dispositions as historical products of the profession's heritage of surgical training in the West, one can suggest that much of the MTK's learning methods and resulting 'dispositions' derive from religious training. The two may indeed never become completely separated, as the student's curriculum would not be considered consistent without its necessary component of religious learning, and because learning methods are in great part derived from monastic memorisation techniques.
One student drew an interesting parallel between learning medicine and learning chos: ‘We are told that if you know the rtsa rgyud [root tantra of the rgyud bcshi], you know the essence of medical knowledge; this is like saying that if you master the paramita (phar phyin), you know all is there is to know about chos’. The subtext of this comment if one mastered the rtsa rgyud in all its complexity is so difficult, that if one succeeded in doing so, then one would truly master the essence of the medical teachings. The religious component of medical training is also manifest in the doctors’ subsequent medical practice: the physicians perform recitation of mantras during certain forms of treatment, such as moxibustion (me btsa) or golden needle therapy (gsis kbañ), and must keep in mind the virtuous disposition for patients’ treatment as outlined in the rgyud bcshi.
Physicians are also meant to perform a dedication of merit to the Medicine Buddha before consulting with a patient, although in practice this is seldom observed.

Equally significant here is the requirement of impeccable mastery of the Tibetan language, grammar, and of the complexity of medical terminology. For this purpose students refer to mnemotechnic devices derived from religious training (mostly lists and versification) in order to help them memorise the list of physical organs, attributes, and the properties of medicines. The two main techniques are numbering and versification, generating a certain 'rhythm' in recitation, again comparable to reading Buddhist texts.

The versification of medical texts into nine syllable phrases (tshig khang) for easy memorisation is also similar to that of religious teachings. Many students make taped recordings of recitations of the *rjug *bezhi, which they can then listen to in their spare time in order to facilitate memorisation. I was told that one particular recording of the *rjug *bezhi by a monk medical student was particularly valuable because the monk had the perfect pitch and pace for the recitation, which he had acquired through the spiritual practice of chanting and reciting texts.

Furthermore, students are told to treat medical teachings as those of the Medicine Buddha, focusing their religious activity on him, and handling medical texts as they would religious ones (by placing them on their head as a sign of reverence for instance). Therefore, partly due to the social cohesiveness of its student body, and partly due to the MTK's cultivation of the traditional Tibetan mode of learning common to monastic and Institutions of Higher Studies, the MTK is constituted as what is in all respects a 'corporate body'.

MTK students therefore appear to manifest medical 'dispositions' comparable to those outlined by Sinclair. These dispositions are, however, the result of belonging to an institution inculcating a specifically structured form of knowledge, and not a reflection on the potential similarities between biomedical and Tibetan medical training. These dispositions were however shaped quite differently in the case of the MTK: the students' relationship to the MTK did constitute itself through a form of 'institutional apprenticeship', but the development of 'an exclusive cognitive identity' was influenced in great part by a sense of their own privileged status in Tibetan society and of the
common ground shared with religious practice, which accorded the students special
cultural cachet within a community beset with the task of cultural preservation.

Sinclair's medical dispositions of 'Co-operation, Idealism, Status, Knowledge,
Responsibility and the Economic disposition' can be further explored in relation to the
ways in which the MTK students' training is structured. Co-operation exists, to take
another of Sinclair's Goffmanian distinctions, on the 'front-stage', i.e. the official space
of learning: students are together brought to see patients, read each other's pulses as
exercise, learn the preparation of medicine (thus encouraging cross-departmental co-
operation), and go together on plant collecting trips. Students are encouraged to learn
about the work of the MTK's different departments. 'Back-stage', away from the more
formal environment of the classroom, students help each other memorise by going
through thirty minutes question and answer sessions or making each other recite sections
of texts, both coming under the general term of go sbar byed pa (to discuss in the form of
question and answer). When asked, older students also guide more junior students with
difficult texts. Most students profess a tendency to Idealism, which, in contrast to
Sinclair's setting, is highly encouraged by teachers. Medical texts give a description of the
physician's need for correct and compassionate motivation, which is noted as a
prerequisite to good medical practice. This disposition of Idealism is particularly
emphasised in exile with the repeated assertions that, in these difficult times, the practice
of medicine is an especially praiseworthy occupation. Teachers' warnings however do
temper the students' ardour for the Economic disposition: students are told not to
expect salaries as good as those of offered at the biomedical hospital, and are liable to
be sent to 'difficult' placements with tough working conditions. Doctors who have
concluded their year of professional experience (nyams rtags) and come back to the MTK
will recall that time as an opportunity to 'work for the community', the equivalent of
'giving something back'. These placements are even jokingly referred to by students as
the 'bar do', the Tibetan term for 49-day passage through the intermediate realm between
death and rebirth, thus pointing to the uncertainty and liminality of this phase and its
often painful nature. Possibly in order to counterbalance this, student Idealism is
stimulated with praise of the humanitarian quality of doctors' work, helping their fellow
exiles and locals.
Knowledge is imparted throughout each year's training with a step-by-step progression through the Tantras, culminating in the final year's teaching of the phyi ma'i ngyud (the final tantra in the ngyud bzhin). The testing of knowledge is conducted at the end of each year with examinations, ending with the final examinations during which students have to diagnose a set number of patients' diseases correctly and pass a test of four-hour consecutive text recitations examined by their teachers. This test is a terrifying and climactic moment. The students particularly dread being asked to recite sections such as those detailing the forearm nerves and pulses where many difficult and detailed names are employed. Knowledge is thus primarily instilled through book learning, recitation, and lectures. Acquiring medical knowledge involves three steps: a. memorising the ngyud bzhin, b. listening to the explanations of the text with the help of commentaries during formal lectures, and c. partaking in medical practice in selected clinical contexts and through the learning of pharmaceutical preparation techniques. Although I did participate in the first two stages, looking at students memorising and attending selected lectures, I was not allowed to participate in the making of medicines.

The normal schedule consists of four hours of lectures from 9 am to 1 pm, and free afternoons for 'self study', where students learn the texts by heart and recite them to each other. Students get up around 7:30 am to commence lectures around 9:00 am. They sing the Tibetan anthem before the beginning of the day's classes. According to students, in 2000, two hours each week were devoted to classes in 'Western' science, including anatomy, physiology, etc. Students are expected to contribute small articles in English to the College Journal gang ri la tso, in which they often debate the similarities and differences between biomedical and Tibetan ways of treating various diseases, or the health hazards of exile modernity, such as smoking or unhealthy lifestyles. They are also required to give public presentations, which are meant to hone their public speaking skills. Students also often use their free time to satisfy their curiosity about biomedicine through biology books purchased in local Indian stores.

According to MTK students, the 'scientifisation' of healthcare in Dharamsala is coterminous with increased scepticism on the part of the patients. The students described this to me as a recent development. As a young male doctor in his final training year at the MTK put it:
In Tibet, and still now with most Tibetans, when someone goes to see a doctor, and the doctors says 'eat this food, do not eat this food, eat this medicine', they just say 'fine' and do as the doctor said. These days, some of these foreign people, they come, and they go and they see a doctor, then they ask lots of questions: they want to know what the medicine is, how it is made, what exactly the disease is. Then it becomes very difficult.

Another student who had been listening to the conversation joined in and said:

Yes, then there are patients who are bad mouths (gyag kha), evil-minded (ngan sems pa) [laughs]. There are two types. Some have bad attitude (sems nag po). They come to the doctor when they are not ill, and when the doctor just tells them they are healthy, get angry and refuse to take advice, saying the doctor is bad and does not know enough. This is one type. The second type is, [when] some patients do not want to listen to the doctor's advice and just carry on doing as before, then come and complain that the medicine did not make them better.

Besides these 'difficult cases' of gyag kha, young students also have difficulties within the student body itself, particularly with regard to the integration of non-Tibetan students, such as the few visiting Mongolian or Bhuryat recruits. Interestingly, these students are also sometimes referred to as gsar 'byor ba, 'newcomers', the appellation we have already encountered with reference to refugees newly arrived from Tibet. These students have different cultural habits and their difficulty in mastering the necessary level of Tibetan to study the normal curriculum makes them the subject of pranks and abuse from others in the MTK community. Thus the MTK students jealously guard their right to the status and knowledge gained through membership of the institution.

Finally, we should make a more thorough investigation of the last disposition, Responsibility. Student responsibility in patient treatment is extremely limited, if not nil, although students do practice pulse reading on each other and this is considered nyams kbrig, or 'teaching through personal experience'. During the five-year training there is almost no clinical experience, which is generally gained during the student's one-year placement with an MTK branch after the completion of the diploma.

The following section looks at the curriculum of the Men-Tsee-Khang and changes effected upon medical education by exiles.

5.3. The Curriculum: Studying the rgyud bzhi selectively

Students at the Men-Tsee-Khang study for five years to earn the degree of sman pa ka chu pa, following which they undertake one to two years of clinical experience under the
supervision of a qualified MTK practitioner in one of the school’s 35 branches. Their education is divided into five semesters with breaks for glo sar and plant collecting trips. The curriculum given to me by the teachers and published by the MTK in 2002 mainly focuses on the study of the rgyud bzhis. The compendium is composed of four tantras, which are studied one after the other:

1. rtsa rgyud  The Root Tantra
2. bsbad rgyud  Explanatory Tantra
3. man ngag rgyud  Oral Instruction Tantra (also called Quintessential tantra)
4. phyi ma'i rgyud  Subsequent or Final Tantra

 Chapters of the rgyud bzhis are memorised in the order of the text, although the students’ progress in through the entire memorisation does not match the sequence of lectures given in the MTK; students may be more advanced in the memorisation than in the topics covered by the lectures and this is considered to be the best possible trajectory for learning. Each semester, students are given deadlines for the memorisation of certain sections of the rgyud bzhis, after which examinations are conducted in front of teachers and peers. During such examinations, students are asked to recite sections of the rgyud bzhis for up to ten minutes. Failure in passing the semestrial exams can lead to them retaking a year. Although teachers did not give consistent information on this, students told me that they were only allowed to retake two years, after which they risked being expelled from the school.

In the first semester, students memorise the six chapters of the rtsa rgyud and its ‘tree’ (the arboreal ‘map’ of the tantra displayed on medical thangkhas, cf. Meyer et al. 1992), as well as chapters 12,5 and 9-11 from the bsbad rgyud, the first half of the sngo sman 'khrungs dpe sdis pa (a materia medica compendium by mkhyen rab nor bu), the dka' gnad gsal sgron, a grammar text, and a Tibetan vocabulary treatise, the dag yig ngag sgron.

In the second semester students memorise chapters 12-20, 27, 28, 31 of the bsbas rgyud and its ‘tree’; chapters 1-11 of the man ngag rgyud, the second half of the sngo sman 'khrung dpe sdis pa; the grammar siti’s drel chen.
During the third semester students undertake the memorisation of chapters 1-4 and 13-31 of the *man ngag rgyud* and the *byang khog yul thig*, an anatomical treatise. They study the *sa kya legs bshad*, or Sakya writings, and the *shes pa'i spring yig*, a moral treatise composed by Nagarjuna for his friend, King Gautama Putra. The abovementioned two texts are also studied by astrology (rtsi) students.

In the fourth semester chapters 1-5, 20-21 and the ‘tree’ of the *phyi ma'i rgyud* are memorised, as well as an outline of bloodletting points, *gzhon nu'i ngag rgyan*. Students also study the *snyang ngag*, a book of traditional Indian poetry. Finally, in the fifth semester, students must memorise the *sman ming brda sprod*, a lexicon of medical terms, *nus pa phyogs lbsdus*. They also learn the *khyad par phags stod*, hymns in praise of Shakyamuni Buddha composed by *mtsho brtson rje sgur* 79, and the *lha las phul du byang bar bstod pa*.

MTK education focuses primarily on the *rgyud bzhi*, its exegesis and commentary in lectures, and the study of its auxiliary texts. Numerous authors have emphasised that the heterogeneity of sources brought together in the *rgyud bzhi* (Ayurvedic, Chinese, Persian etc.) has created substantial tensions within the text, particularly between the theoretical content (expounded in the first tantras) and the sections orientated towards clinical practice (the last two tantras) (Samuel 2001).

As I have mentioned previously, there has been a tendency for doctors to minimise the study of more esoteric sections of the *rgyud bzhi*, but also, as I found, of the sections dealing with traditional anatomy and primordial causes of disease. The chapters are still taught in formal lectures and students are required to know their content. However, the practice of selective memorisation is uniquely contemporary in the study of Tibetan medicine and, I argue, reflects a shift in methods of learning.

Sections from the *rgyud bzhi*’s *bshad rgyud* which do not need to be memorised by heart (kha slab) 80: *dra dpe* (3: similes of the body); *lus kyi gnas lugs* (4: anatomy); *lus kyi las dang dbye ba* (6: actions and classifications of the body); *cha byad dbyad* (21: medical instruments); *mi na gnas ston* (22: normal health); *nyes pa dngos ston* (23: techniques for correct diagnosis); *ngan gyo skyon brtag* (24: techniques for gaining a patient’s confidence); *spang blang mn bzhi* (25: four diagnostic techniques to verify if the patient can be healed or not); *go thabs gnos* (29: the healing techniques); *sman pa'i le'u* (30: chapter on the healer physician).
One can see that the majority of the sections that have been taken out deal with traditional Tibetan anatomy, physiology and medical instruments (including 'surgical' instruments). Similarly, the MTK teachers have discarded the majority of chapters dealing with classification of the body and disorders. Interestingly, the two final chapters of the Explanatory Tantra, which explicitly deal with 'healing' (gsd) techniques and the role of the physician have been taken out. These chapters specifically deal with the more ethical and moral aspect of medicine, for instance with how the doctor's speech (nag tri) to patients should be soothing, establishing a relationship of trust that will make the patients have confidence in the doctor and the medicine and follow the treatment (sman dbyad brten).81

The man ngag rgyud is the least memorised of the four tantras. Only a third of the 92 chapters are learnt by students today. Chapters memorised include: zbus pa (1: request for the teaching of the man ngag rgyud); rtung (2: diagnosis and treatment of rtung disorders); mkhbris pa (3: diagnosis and treatment of mkhbris pa disorders); bad kan (4: diagnosis and treatment of bad kan disorders); tsha grang gal mdo (13: method to distinguish between hot and cold disorders); tsha ba ri thang mshams (14: method to distinguish the border – tshams- between hot and cold disorder); Chapters 34-41 comprising snying nad, glo nad, mchin nad, mcher nad, mkhal nad, pho ba'i nad, rgyu ma'i nad and long nad.82 The final chapters of the man ngag rgyud, which deal mostly with 'psychiatric' disorders are memorised in the fifth semester of teaching (78: smyo byed, insanity; brjed byed, amnesia; gza', epilepsy, etc.).

Two lecturers and the majority of the students however affirmed that they did have to study the remaining chapters, although memorising them was not needed (dgos pa med). One female final year student told me that this was because they had to know about 'old diseases' (rnying gi nad).83 This was however not a view shared by her teachers, who thought a complete knowledge of the rgyud bzhi was needed to make a well rounded, accomplished practitioner, but admitted that the study of some diseases like lda wa (goitre), was perhaps not so useful to contemporary students. They particularly emphasized the value of experience or practice (lag len), in the making of a good practitioner. The sections cut out of the quintessential tantra were primarily descriptions of specific disorders and their causes, usually one or a combination of the three nyes pa.

In the curriculum these disorders were unequivocally translated into biomedical terms. Thus, 'brum pa is identified with smallpox, yi ga 'zhus pa with anorexia and gchin snyi with
diabetes. The diseases whose descriptions are still memorised are more complex and general disorders primarily related to the digestive, pulmonary and hepatic system (chapters 34-41). They are the diseases diagnosed more frequently by Tibetan doctors today, and some of the disorders for which their skills are reputed (e.g. hepatic disorders).

This gradual phasing out of the third tantra has already been noted by Samuel, who argues that the quintessential tantra is ‘at the core of how Tibetan doctors manage the transition between textual study and clinical practice, by clarifying many of the standard treatments and causes of commonly encountered diseases’ (2001: 257-260). The fact that a large number of these diseases have been taken out of the compulsory curriculum may be read as a sign that Tibetan doctors in exile have grown cautious about pinpointing specific discrete syndromes based on traditional categories, and feel more secure invoking general disorders of the Tibetan physiological system. As Samuel also points out, some of the disease categories have been more or less replaced by biomedical ones, such as in the case of ‘se je’, for which the biomedical category ‘tuberculosis’ is nowadays more frequently employed. The phyi ma'i rgyud’s chapters on methods of diagnosis and treatment have also been subjected to a purge: only seven chapters out of twenty-seven are memorised today. These chapters relate to pulse diagnosis, urine analysis, the preparation of decoctions, the making of powdered medicine, pills and moxabustion. Chapters from the phyi ma'i rgyud required for memorisation also correspond to the more common methods of diagnosis and treatment used by MTK doctors today: rtsa (1: pulse diagnosis); chu (2: urine diagnosis); thang (3: decoction); phyre ma (4: powdered medicine); til bu (4 pills); gtar (20: blood letting); bserg (21: moxabustion). Other less popular treatments (such as the use of jam tsi, suppositories) or medicines less realistically available in exile (such as rin po che, gem medicine), have been left out.

The Men-Tsee-Khang’s recent publication of an additional textbook recasting the subject categories of the man ngag rgyud, the gso rig lab dpe (or bod kyi gso rig lab dpe), comes to adjust the rgyud bzhed’s theoretical background to contemporary exile clinical practice. Other texts, such as the sman jor gyi nus pa (uses of medical compounds) are also reworking old categories in the light of new clinical needs and the growing shadow of biomedicine. The gso rig lab dpe (Textbook of Tibetan medicine), for example, brings in elements of biomedical anatomy and reworks some of the disease categories of the man ngag rgyud.
Much of the recasting of the medical curriculum’s texts finds its impulse in the research and publications of Tibetan doctors based in the Tibetan Autonomous Region (TAR). The TAR Men-Tsee-Khang has been more prompt in incorporating new elements into medical teachings for complex political and economic reasons. The medical dictionary گر ہ ں ریگ پالی تیگ میجند گیو ثیگ دنگنریگن, for example, presents anatomical drawings with traditional and newly created Tibetan terms. It is available in India, is commonly owned by younger Men-Tsee-Khang doctors and is sometimes used by students for revision, although it is considered a precious and costly item. Gerke notes that ‘compared to the traditional Thangka paintings, there is a trend to be more detailed and accurate regarding gross anatomy (...) however, the subtle channels (rtsa thig) and invisible anatomy of the subtle body as depicted on the traditional Thangkas do not appear here’ (1998:11). The aim of these new textbooks of Tibetan medicine is to impart a comparative knowledge of anatomy that seeks to legitimise the older anatomical terminology by juxtaposing it with its biomedical counterpart. However, the disappearance of the ‘subtle channels’ from the textbooks does not mean that doctors do not refer to them. In clinical practice, they still speak of disorders caused by damage or blocks in the rtsa thig ‘subtle channels’ which exist on the traditional Tibetan anatomical charts. The following two figures are examples of such TAR ‘reworked’ Tibetan medical charts which display Western anatomy with terminology adapted from the traditional Tibetan medical lexicon.

Figure 5.2 Anatomical drawings from گر ہ ں ریگ سینگ ہکسی پالی ریگ سےریگ گیار پال (The New Dawn- سیما رنگ- Condensed Compendium of Healing Knowledge), manual published by the Lhasa Men-Tsee-Khang in 1978. The title of this work gives some indication of the innovations it proposes.
In the first drawing, depicting the anatomy of a human chest (brang kha), the terms identifying traditional organ systems have been retained, although they seem to designate discrete organs (e.g. mchin pa, liver) rather than systems or processes. There are references to brang skyi (outer chest), glo ba (lung), mchin pa (liver), mkhris pa (gallbladder, also designating bile - the substance-), pho ba (stomach), long (gut/intestines), rgyu ma (intestine), lgang pa (urinary bladder).

The second anatomical drawing depicts a human heart and presents some interesting medical terminology: phar rtsa a ma (mother great external vein) refers to the aorta, ‘phar rtsa is used in equivalence to the term ‘artery’ (as it is in contemporary translations of older medical texts, e.g. in Parfionovitch et al. 1992). Also, ‘dab lo (lit. petal) is used to refer to ‘valves’, as in ‘dab lo rtsa gsum can (lit. the point endowed with three petals), designating the tricuspid valve. Much of this new terminology recycles the vocabulary of more traditional Tibetan anatomy and its arboreal metaphors (with roots, trunks, stems and petals)\(^1\). There is, however, a clear contrast between the contemporary Lhasa Men-Tsee-Khang charts which make use of biomedical anatomy with Tibetan medical neologisms, and former Tibetan anatomy charts such as the thang khas displayed in Meyer (1996) and Parfionovitch et al. (1992), which are less and less frequently called upon to explain anatomy to Men-Tsee-Khang students.

In parallel to this eclipse of traditional Tibetan anatomy, some notions present in older medical texts have been given new salience because of their proximity to biomedical terms. For instance srin, which is commonly translated in Tibetan medical books as ‘micro-organism’, has never actually been used with the same content as its biomedical counterpart. Nowadays however, it regularly finds its way into discussion of infectious diseases as a term designating biological disease agents (as does the word 'bu srin, i.e. insects or worms, is now often used to designate the concept of 'germ' \(^2\)).

Related to this re-creation of Tibetan medical terms is the ‘invention’ of linguistic terms for organs which did not previously exist in traditional Tibetan anatomy. Gerke (1998: 11) notes that the Tibetan word for pancreas was only created in the twentieth century. With the advent of biomedical culture and the prevalence of diabetes in Tibetan settlements, increased emphasis was given to the biomedical model that ascribed the cause of diabetes to a dysfunction of the pancreas, as opposed to a model rooted in the
imbalance of the three humours. A word was therefore coined to designate the organ, *sher men*, or literally moisture gland, which had come to take on a new importance in the clinical practice of Tibetan medicine.

The selective use of curricular texts, the creation of ‘hybrid’ textbooks combining traditional Tibetan medical theory with biomedical anatomy, and the renewal of the traditional anatomical language to fit the changes in clinical practice are reflections of ongoing changes in Tibetan medicine. I would suggest that these changes partly stem from the radically different circumstances of clinical practice in exile. Present exile circumstances are rendering links between the environment and disease more tangible. I would argue that Tibetan medicine is now in a liminal phase, when disease categories and treatment methods are being reworked, while older ones are being eroded and even voluntarily discarded. An example of this ‘re-creation’ of disease categories will be examined in detail in the final section of this chapter with the treatment of type 2 diabetes.

These ‘reworked’ categories of disease have to fulfil a fourfold set of requirements: they have to be applicable within the prevalent humoral theory, that is, suitably diffuse to permit their affiliation to general physiological disorders. Secondly, they have to fulfil the expectations of ‘holism’ imposed by Western clienteles, including relatedness to the underlying aetiology of karma. Thirdly, they have to be congruent with (at least to a certain extent) within biomedical anatomical and physiological thinking. Fourthly, these new categorisations of disease emerge out of the altered clinical practice of doctors in exile and their experience of dealing with disorders prevalent among communities exposed to endemic disease and psychosocial stress. It is evident that such different influences will be taken up at different rates by the various groups of Tibetan practitioners. Within the MTK, this is bound to create tension between doctors practising in the more remote settlements of India, and the cosmopolitan doctors of Dharamsala, who are increasingly curious of biomedicine. Thus there is the risk that a two or even three-tiered practice of Tibetan medicine will emerge in the future, with different groups championing different styles of practices aligned with their increasingly divergent agendas.
5.4. Biomedical equivalents and problems in translation

Although the learning of specific biomedical terms is not actively encouraged by the MTK, and many students have only a minimal level of competence in English, some of them, as well as doctors who seek to practice with Western patients, learn to make their own tables of biomedical/Tibetan equivalent diseases through book learning and experience with foreign patients. This is allegedly so that they may be able to explain their prognosis to foreign patients, but in my experience, it is also often a symptom of professional curiosity. These tables are highly problematic however, as many simply equate a broad set of Tibetan symptoms (as we will see in the following chapter with the example of hepatitis B) with one biomedical aetiology. Direct translation and equivalence-making between Tibetan medical syndromes and biomedical diseases is of course hazardous: Tibetan medicine sometimes defines a disease by its causes or symptoms without giving it the name of an actual condition, while sometimes regrouping a set of diverse symptoms under one term. An example of this is the gynaecological disease riung tibabs, which refers to an excess of riung humour in the womb, but can cover a vast array of problems ranging from infertility to hysteria and their associated disorders. Thus, one term can encompass a variety of symptoms. This problem is accentuated by contemporary doctor’s use of Western terms to gloss over Tibetan disorders. I was once surprised to hear one Tibetan doctor who spoke no English refer to damage inflicted to his rtsa dkar po (sciatic nerve) occasioned by sitting under the cooling effect of a fan with his back in an uncomfortable position for long hours, as ‘spondylitis’. The students’ rapid adoption of biomedical terminology and their equation of terms from it with Tibetan medical symptoms is an indicator of the MTK’s increasing contact with biomedical doctors and foreign patients, and to the progressive ‘biomedicalisation’ of its language. This is manifested in part in the MTK’s adoption of Latin botanical terms on most of its prescribed medicine and medical products.

Doctors have differing views on the systematised translation of Tibetan disorder names with biomedical terms. One male doctor who had been involved in the ‘clinical trial’ project on diabetes said that he found the use of biomedical terms ‘safer’ when dealing with biomedical doctors. His fear was that they would not understand references to the three humours, and might be misled by literal translations of traditional Tibetan anatomy. Another male student, perhaps more ‘traditionally’ inclined (having studied astrology),
told me that that the new system of transliterating biomedical terms phonetically in the Tibetan alphabet would be more appropriate. He explained that there was no reason why Dharamsala doctors should change their practice because clinical tests where being performed. He did not believe the tests would ‘prove’ (*na sprod*) anything because they were looking for disorders in different ‘systems’ (*lugs*). This student also reflected on the more lax practice of some doctors who had become used (*goms par byes*) to prescribing pills without really trying to pinpoint the exact causes of disease through interrogation, but simply by recognising typical sets of symptoms. This, he claimed, was a result of poor motivation, which was in turn a consequence of poor incentive (hard working conditions and low pay). Having not reached his clinical training stage, this student saw very strong links between medical theory, the traditional anatomy of Tibetan medicine and the wider cosmological background of medicine given to him through his astrology training.

The use of biomedical terms is taken increasingly seriously by Tibetan doctors, who, also for legal reasons, have been stressing the importance of differentiating between the Tibetan disorders and biomedical diseases with similar symptoms and aetiologies. For instance, Tibetan doctors now draw the line between the Tibetan *gŪn snyi’i nad* (lit. sugar disease, an appropriation of the Hindi *chinni* for sugar which is common among exiles) and biomedical diabetes, now commonly referred to as *da ya sbi tis*. However, the eight monks I spoke to about their diabetes treatment all referred to it as *gŪn snyi’i natsa*, which shows that although the distinction may hold water among medical practitioners, it is still not uniformly adopted by the ‘lay’ population.

The translation of Tibetan medical terms into biomedical ones is by and large coming to be seen by doctors and students as hazardous and undesirable. Reasons for this are twofold. Firstly, doctors involved in the MTK’s research activities and clinical trials have been confronted with the legal and epistemological difficulties arising from hastily drawn equivalences. Problems specifically arise when high expectations about the efficacy of Tibetan medicine are combined with the ascription of biomedical categories to diseases treated by Tibetan doctors (as in the case of hepatitis B). But Tibetan doctors are now striking back and drawing up defence lines, outlining the differences between Tibetan physiological systems and biomedical ones, as is apparent from Gerke’s (1998) citation of Dr. Lobsang Tonpa’s paper ‘Diabetes is not *gŪn snyi’i nad*’ (Diabetes is not *chinni nad*).
On the other hand, the growing popularity of Tibetan medicine has heightened the general level of knowledge of its aetiological premises, and doctors in the MTK are gaining confidence in using their own terminology over uncertain biomedical ones. However, the need to make Tibetan aetiologies more accessible to the lay public may result in an overemphasis of certain modes of diagnosis (pulse diagnosis in particular) and treatment (pills) which have been authenticated as Tibetan by this early wave of knowledge diffusion.

5.5. Researching traditional medicine

The two main ailments I shall focus on in the following two sections are those for which the most documentation is available: 1. research on the treatment of hepatitis B, and 2. Diabetes (in section 5.6.). Experimentation with Tibetan medicine for the treatment of Hepatitis B is one of the most controversial areas in MTK research today. The challenge of this experimentation is particularly high as the geo ba rig pa is traditionally famed for its success in curing diseases of the liver, which explains its interest in hepatitis. In Tibetan medicine, hepatitis is known as a cold ‘mkhris pa’ (bile) disease of the liver and biliary system that stems from disturbances in the liver tissue itself. The nature of mkhris pa is hot, but this disease, mkhris grang, is called ‘cold mkhris pa’ because it is purportedly caused by a loss of digestive heat. This loss subsequently weakens the liver, which becomes susceptible to severe malfunction, can be overwhelmed with excess bile and subsequently become inflamed.

Doctors themselves acknowledge that the disorder of ‘cold mkhbris pa’ has been identified with hepatitis only after Tibetan medicine came into contact with biomedicine. The ingestion of fatty foods is said to increase the amounts of bile (which is the gross form of mkhbris pa) in the liver, and is considered to be the primary cause of hepatitis. Hyperactivity, overexposure to heat and the cultivation of violent, aggressive emotions can lead to disruptive increases in mkhbris pa. It is also said that hepatitis ‘strikes’ most commonly in the late summer and autumn, during which a normal body is most susceptible to the influence of mkhbris pa. The aetiology of ‘cold mkhbris pa’ and of mkhbris pa disorders generally is widely known among Tibetan exiles, as demonstrated by my own data (see Table 3 in Chapter 4). Patients in both the MTK and Delek relate liver diseases
to both mkbris pa disorders and hepatitis, and it is often implied that the former in fact causes the latter.

The traditional Tibetan treatment for ‘cold mkbris pa’ begins by alleviating the fever (tibsh ba sgyi, generally rgyas, or high fever) with a prescription of men ngag bshil sbyor (known as the ‘cooling formulation of the secret oral tradition’): calcite (rdz dar ya kan or cong shi), musk (gla rtsi), elephant’s gallstone (glang chen mkbris pa). These three substances all have the properties required to cure epidemics, poisoning, liver disorders and fevers. Because these substances cannot be found in exile, they are replaced by other ‘cooling’ medicaments. Calcite and musk are said to have cooling properties, while the last ingredient, the elephant’s gallstone, is considered effective because it is derived from animal’s livers and bile (from Yonten’s ‘Tibetan Dictionary of Materia Medica’, 1998: 33), which are of a cold nature, and therefore act by similarity to the disease combated, in what is described as rigs mthun nus pa, the power of medicine by virtue of being from the same part of the body as the disease it is intended to cure. On the full moon of the eighth Tibetan month (September), the calcite is boiled with different plants until it is soft and is then reduced to powder and mixed with the milk of a dzo mo (the female offspring of a female yak and a bull), and finally made into two cakes which are dried in a cool place away from sunlight. In practice, doctors from the MTK report that they try to diminish the use of animal substances in their medical preparations and to replace them with mineral or herbal alternatives (this is also confirmed by Samuel, 2001). Tibetan doctors have justified this tendency to me with a number of reasons, but the most commonly cited concerned the unavailability of many of these products in India. Others talked about the ecological drawbacks of using animal products in that using them harms the local fauna. Some related it to Buddhist precepts that specifically forbid the killing of animals. To this I would also add the benefits of using almost entirely herbal products when marketing Tibetan medicine to local and international clienteles, who find this safer, and more in keeping with the precepts of ‘holistic medicine’. Part of the justification for using animal products in the context of hepatitis B treatment seemed to be that the disease was ‘violent’ and therefore required more potent therapeutic agents.

The MTK doctors said they have never made the claim that they could turn a hepatitis B positive patient into a negative one. Instead, they asserted that the medicine was of ‘beneficial effect’ (phan thogs po byung, proved beneficial) for hepatic disorders, but only in
alleviating their symptoms. When biomedical doctors from the Delek Hospital asked for some proof of these claims, the MTK produced a series of notes that were intended to pass as the account of ‘clinical trials’ of the medicine. But the results of these ‘experiments’ had never been translated and the Delek doctors remained sceptical (see Chapter 4). It is noteworthy that only the foreign volunteer doctors showed any interest in these results while the two Tibetan practitioners steered away from the conflict by not attending the meeting in which MTK doctors shared their findings with the biomedical practitioners.

But the experimentation had been fraught with misunderstandings. While the allopathic doctors wanted to see a biomedically ascertainable result (i.e., a ‘hepatitis B positive’ patient going negative as a result of taking Tibetan medicine), the Tibetan doctors, although equally eager to produce such a result, were able to advocate the holistic approach of traditional Tibetan medicine in order to account for what was seen by the biomedical doctors as an inconclusive test of efficacy. Thus, although privately, Tibetan doctors confessed to fantasising about ‘finding the correct medicine’ for hepatitis B or even diabetes, publicly they would assert that such a result should not be expected within the aetiological framework of traditional Tibetan medicine. Indeed, three of the four doctors I questioned on the subject said that if they suspected a hepatitis infection in one of their patients, they would automatically ask them to go to the hospital to ‘check’ (brtag dphyad byed pa, to investigate) the diagnosis. This was also the common scenario for suspected cases of diabetes, where Tibetan doctors would send their patients to have their blood tested, and then prescribe Tibetan medicine according to the diagnosis. One doctor explained that pulse diagnosis was still reliable in such cases, but that it was always good to be sure (gsal pa). The Tibetan doctors who sought to tackle the problem of hepatitis B seemed to see it very much as a ‘disease’, a set of biophysical symptoms, rather than as an illness, a socially and individually meaningful experience of bodily disorders (Kleinman 1972). There was a disease that they identified with the biomedical category of ‘hepatitis’, and a Tibetan disease whose symptoms overlapped but did not entirely correspond with those of hepatitis. This is evident in the disclaimers later put forward about not being able to turn a positive patient into a negative patient, as if that was the only tangible result there could be, and not, say, the betterment of the patient’s condition in a more general sense. The fact that they were trying to treat a disease undermined the potential of viewing it in a more integrated way, as part of a system of
associated symptoms and psychological experiences more readily treatable by the holistic approach of Tibetan medicine. Such a holistic approach was, on the other hand, attempted in the treatment of diabetes.

5.6. Experimenting with *di ya bi tis* (diabetes)

Diabetes is an area in which Tibetan medicine has already undergone a number of clinical tests. There were obvious difficulties in setting up these pilot clinical trials: what should be the criteria used in measuring efficacy? Should the treatments assessed only take into account the curative properties of plants or should they also encompass the more holistic approach characteristic of Tibetan medicine, which includes an evaluation of diet and lifestyle? A colloquium held at the MTK in 1996 prepared a protocol for the clinical trials on diabetes mellitus: the team of traditional Tibetan doctors refused the single drug use tests and modified the project's guidelines to incorporate diet and behavioural regimen with multi drug use. In other words, the possibility of a more conventional, one might even say 'traditional' clinical drug trial was in effect ruled out, because the holistic approach used in Tibetan medicine would not allow for the design of a single model therapy for diabetes mellitus. Yet the term clinical trial was retained, because the results were measured not with the traditional Tibetan medical criteria of well-being and health, but with the arsenal of blood tests made available to them by their supporting Indian medical institutions. The following paragraphs will explore in more detail the settings, results, and implications of these 'clinical trials'.

According to traditional Tibetan medicine, there are several causes and types of *di ya bi tis*. The basic factors are excessive production of fats and phlegm (*bad kan*) in the body due to over-consumption of foods dominated by the earth (*su*) and water (*chu*) elements. According to the Chief Medical Officer Pema Dorjee, 'the substance formed by such predominance of elements is cold (*grang mo*) in potency and sweet (*mngar mo*) in taste (*ro*). Due to its antagonistic potency, the heat (*drod*) of the digestive fire gets degenerated and results in weakness of digestion.' (Dorjee: 1984). Thus, a diabetic patient's treatment consists in the correcting of the digestive function so that the food taken will be well assimilated by the body.
The following experiment was designed by MTK doctors in collaboration with a Delhi based research laboratory. The authors of the report on the experiment described it as the 'Double Blind Randomised Controlled Clinical Trial of Diabetes mellitus', and its objective: ‘To assess the efficacy of Tibetan Medicine in controlling the Plasma Glucose and Glycated Hemoglobin (GHb) in newly diagnosed or untreated type 2 Diabetes Mellitus’. The study was to last from April 1997 to March 2000, i.e. just under three years. In 1997, a group of doctors from the MTK gathered to establish a protocol for the experiment, and took the significant decision to extend it from a 'single drug study' to a 'multiple drug study', thereby more suited to the Tibetan method of prescribing more than one kind of pill for a given problem. The author also notes that the protocol seeks to explain the traditional virtues of Tibetan medicine (which includes diet and lifestyle regimen) with the help of 'modern' methodologies. The efficacy of Tibetan medicine was therefore clearly ascribed not only to its herbal agents, but also to its prescription of diet and lifestyle changes. The study’s list of objectives comprised assessments of changes in the diabetes patient’s well-being, including: 1. Relief from symptoms (defined not as increased comfort but as the ascertainable measurement of sugar levels in the blood); 2. Change in weight (again, a quantifiable factor); 3. Comparison of response between male and female patients; 4. Change in blood pressure; 5. Appearance of new complaints (described as biophysical symptoms). None of the above factors therefore mentions assessing the patient’s humoral imbalance as reflected in the pulse, or even the patient’s level of ‘comfort’ and ‘well-being’. Rather, they all circumscribe health as assessable through biophysical measurements.

In this study, 200 newly diagnosed diabetes mellitus patients were divided into two groups randomly. The first group took Tibetan medicine in the form of powder or pills with ‘dietary and lifestyle modification advice as prescribed by the American Diabetes Association’. The second group followed the same dietary and lifestyle modification advice but without ingesting any medicine, not even a placebo. Patients were given a physical examination at the end of the 12th and 24th week.

The pills used in the treatment of patients were Kyuru 6, Yung wa 4, Che nji A ru 18 and Sug mel 19. Kyuru 6 was prescribed to all patients, along with at least two of the above medicines. Variations were said to depend on the severity of the case. Doctors could make modifications to the treatment in progress if they found notable changes in plasma
glucose levels as measured by biomedical doctors. The herbal pill regimen was therefore not subject to individual tailoring through other factors (e.g. personal reaction to one particular substance for instance), and the Tibetan doctors attempted to standardise the treatment as much as possible. While a greater degree of medical ‘flexibility’ could have been given to dietary and lifestyle recommendations, the protocol stipulated adherence to the recommendations of the ‘American Diabetic Association’.

It is clear from the methodology devised that the experiment sought to verify the biological properties of the herbal medicines employed, and that little concern had in fact been given to the other essential aspects of treatment in Tibetan medicine, such as the individual tailoring of treatment with regard to diet and lifestyle. The potential placebo effects of traditional medicine have also not taken into account. This was certainly due to the obvious difficulty of creating a placebo for herbal medicine, a problem acknowledged by the World Health Organisation’s report on research methodologies in the study of traditional medicine. It is also interesting to note that 82 patients out of 200 had reportedly withdrawn from the treatment, the great majority because of ‘social reasons’, and only two complaining of worsening symptoms as a result of treatment. Overall, the experiment was declared a success: biomedical observers noted a decrease in fasting and post-prandial plasma glucose values in the group treated with Tibetan medicine. The researchers concluded that Tibetan medicine with exercise and diet was therefore more efficacious in controlling glycemic levels than exercise and diet alone.

It is evident that Tibetan doctors have been forced into a number of compromises in order to comply with the requirements of clinical trials as designed by biomedical scientists: 1. They had to reduce the efficacy of their medical practice to the efficacy of herbal substances, risking the habitual association with ‘herbalism’; 2. The experimental protocol was designed to limit their diagnostic and prescriptive ‘creativity’ (thereby constricting the traditionally larger array of possible therapies) in order to standardise the treatment procedure and make the results generalisable. Many of the alleged benefits of Tibetan medicine therefore seem to become lost in the trade-off for a more biomedically acceptable system.

One possible area of research for Tibetan doctors might therefore be the design of a new type of ‘clinical trial’ protocol. This might involve more flexibility with treatment
procedures, a form of ‘carte blanche’ given to doctors to design individual regimens for their patients. Selection and differentiation of patients by social groups (lay and religious), age groups and gender, and a brief outline of health background and lifestyle would also be relevant to an understanding of the therapeutic efficacy of Tibetan medicine. Researchers might also want to take into account the placebo effect, i.e. attempting to create some form of placebo for Tibetan medicine, with the doctor’s understandings of what, if possible, might constitute ‘suitable’ herbal or mineral placebos. Finally, clinical trials would have to take into account the changing power relations involved in the clinical encounters with biomedicine and Tibetan medicine and the history of the patient’s treatment by one and/or the other system. This might perhaps shed some light on the high numbers of patients (close to half) who chose to withdraw from the experiment.

While these remarks merely constitute suggestions for future protocols to be discussed by Tibetan doctors, one can only acknowledge the openness with which they have lent themselves to the trials, and the creative stance they have taken in suggesting a multi-drug trial.

5.7. Summary

The plethora of medical institutions available in Dharamsala often involve complex therapeutic strategies for patients, especially those who suffer from minor and chronic illnesses, and for whom a greater variety of practitioners are available. The rehearsed character of the MTK’s administrator’s speech to me and the suspiciousness with which he treated my initial inquiry showed a certain ease at putting off Western researchers who wanted an easy entrée into Tibetan medicine. This was legitimised by the MTK’s purported status as a traditional institution operating under certain codes of secrecy, although this secrecy seemed to defend knowledge as a subordinate correlate to the MTK’s status itself. The MTK’s institutionalisation has also pushed independent clinicians and other non-allopathic practitioners, such as lineage holding *den gyes* to the margins of the healthcare network.

Craig Janes’ research on the institutionalisation of Tibetan medicine, conducted in the Tibetan Autonomous Region (TAR) from 1988 to 1993, is also relevant in the
Dharamsala context. Janes states that, 'in the expansion into the state bureaucracy, Tibetan medicine has acceded to institutional modernity through transformations in theory, practice, and methods for training physicians. With the collapse of the traditionally pluralistic Tibetan health systems into the professional sector of Tibetan medicine, contemporary Tibetan medicine has become to the laity a font of ethnic revitalisation and resistance to the modernisation policies of the Chinese State' (1995:6). In Dharamsala too, Tibetan medicine constitutes a fund for ethnic revivalism: doctors, as much as patients, perceive MTK practitioners as guardians of an endangered Tibetan knowledge, and consequently, because they are able to partake in the programme of cultural survival, as enviable and successful members of exile society.

The explosion of medical pluralism has also contributed to religious revitalisation in unexpected ways, i.e. by serving the interests of intermediaries and advisers in therapeutic choice-making. The mo pa (diviners) who advise some of the more elderly MTK patients more likely confronted with difficult therapeutic choices, have seen their activity profit from the growth in medical pluralism. Although the consultation of mo pas for gdon related illnesses continues, their help is also now called upon in order to resolve difficult therapeutic choices, for instance TB cases (see Chapter 6).

The institutionalisation of the MTK in the face of the progressive scientifisation of healthcare, its preservation of the principles of secrecy and traditional transmission methods as economic and political strategies, corroborates Lock's (1990:43) assertion that modernity's circumstances reshape and transform local medicines, making them conform to state political, ecological and cultural authority. In this case however, the absence of (Tibetan) state control over local medical institutions means that bodies such as the MTK are subject to the polymorph influence of the Indian State, its legislation, and of the local institutional framework dominated by the looming figure of the biomedical hospital.

The reinforcement of the MTK's institutional supremacy has involved the following elements: a. the institutionalisation of a set curriculum 'adapted' to exil practice; b. the scientifisation of Tibetan medical terms and attempts to find equivalents for Tibetan disorders among biomedical diseases; c. the creation of an institutional branding distinguishable among other exile organisations. All these have contributed to the
creation of a 'corporate identity' that distinguishes the institution for its traditionalism (in the form of the preservation of Knowledge and Status) as much as for its innovations (see the following section on research). The MTK has therefore followed a 'middle path' to reform that sought to preserve the economic and social advantages of its traditional institutional status while seeking to position itself as a credible outfit vis-à-vis Western science. This pattern of institutionalisation reflects an 'exile agenda' apparent in other Tibetan exile institutions. This exile agenda demands a middle-way approach to change and the confrontation with alien modes of practice: 1. The preservation of traditional knowledge; 2. Research and development leading to accession of scientific/political credibility.

Despite the 'medicalisation' of health issues apparent in Dharamsala, and its significant impact on the population (with the increase of references to 'cancer' and 'breast lumps' for instance), the MTK has succeeded in maintaining its status as an independent and authoritative medical institution. It has done so by embracing some aspects of institutionalisation (the adherence to a set curriculum and codification of its practices), in creating a spirit of 'corporate corporality' among staff and students, and by imposing its own knowledge 'branding' over other branches of Tibetan traditional healthcare. The MTK crucially maintains a strong sense of corporate identity in emphasising its role as guardian of a key domain of Tibetan cultural heritage, one that is becoming increasingly popular internationally and offering vast economic promise.

The following chapter draws on Chapter 5 and other studies in order to outline a more subjective understanding of the Tibetan body and of individual experiences of illness, particularly of Tuberculosis.
Diseases of Exile

With exile and the passage to India, a whole battalion of new, ‘modern’ and ‘foreign’ diseases appeared for traditional Tibetan doctors to grapple with. The radical changes experienced by exiles have had a very real impact on public health in the community (Bhatiaa et al. 2002):

Due to the Tibetan community's legal status in India and orientation to self-sufficiency, a feeling of despair grips Tibetan youth who have difficulty finding employment within their own communities (…) in seeking employment Tibetans either move to large urban cities which may only have a small Tibetan community or none at all; or they attempt to emigrate, which is almost impossible; or they stay in their own communities and are under-utilised. This is problematic from a public health point of view because it can lead to severe depression in Tibetan youth, which in turn can lead to drug and alcohol abuse and unsafe sexual practices. (Seidman 1997)

But is not only unemployed youth who suffer: older generations seem to find adaptation equally difficult, and are often heard complaining about the deterioration of their health since their arrival in India. One Tibetan student said: sa cha ‘di ma ‘phrod na sma dang na tsha ‘dra min ‘dra yang gi red, ‘if one is not used to this place, wounds (smd) and diseases will come.’

Hence, refugeehood and exile are often identified as causes of ill health and suffering. When I questioned India born Tibetans on the subject of prevalent illnesses in their homeland, the majority told me that Tibet is free of the majority of diseases endemic to the subcontinent because of its high altitude and dry, cold climate. This belief is encapsulated in the following words from a retired Tibetan soldier living in exile, which are constantly echoed among exiles: bod la rlung rbad de gtsang ma dang sa ‘dzam gling nas mtho shos yin tsang na tsa ‘dra min ‘dra yod ma red (In Tibet the wind is always blowing and it is the highest place in the world, therefore there really is no disease).

Over half of the informants (38 out of 79) who responded to my initial questionnaires in Delek and the MTK had experienced new ‘Indian’ disorders such as malaria or dysentery upon their arrival from Tibet, and this experience was clearly identified with the coming into exile. A number of patients were able to recognise the symptoms of
diseases such as tuberculosis and malaria, whose signs are well known in the community. Thus many of them had experienced a member of their family falling ill with such diseases and could describe the course of illness in approximate biomedical terms: for TB, coughing and loss of appetite were usually described, while high fevers and sweats were widely identified as malarial symptoms.

Similarly, the ten traditional Tibetan doctors I questioned on the subject all had a heightened awareness of the various symptoms for these prevalent diseases, and were generally able to give a gross account of the biomedical treatment and diagnostic method. This awareness was certainly greater among young doctors, who manifested a great interest in comparing therapies and disease aetiologies between Tibetan medicine and biomedicine. This interest in prevalent biomedical diseases is reflected in the great number of articles published by young Tibetan doctors in the Men-Tsee-Khang journal 'gang ri la tso', which compare Tibetan and biomedical perceptions of ageing or pregnancy, and listing compared aetiologies for diseases such as diabetes or AIDS.

As examples of these parallel aetiologies, I present some of the Tibetan medical options for the treatment of tuberculosis, hepatitis B and diabetes.

6.1. Tuberculosis, TB na tsha, and glo nad

In traditional Tibetan medicine, as observed at the MTK, after having conducted an initial pulse reading and tongue examination the doctor will proceed to examine the patients and ask them about diet, appetite and activity level. If the patient manifests loss of appetite and other TB related symptoms, such as coughing with sputum (kha chri), MTK doctors have instructions to send them to the hospital for a sputum test without delay. This decision was reached among MTK and Delek doctors following a meeting with the head of the TB clinic at Delek Hospital. However, the MTK doctors will also often prescribe general herbal preparations such as ma ni ril bu to help them right the humoral imbalance that is perceived to arise from TB until the diagnosis is ascertained. Elderly patients often keep on taking ma ni ril bu or other traditional Tibetan treatment throughout their biomedical therapy. The Delek hospital does not discourage patients from taking Tibetan medicine but insists on patient compliance with the biomedical treatment (see Appendix B for Delek Tibetan TB information). It in fact recommends
two kinds of MTK pills to TB patients wanting to have traditional treatment: *bse ru 25*
and *tso bo 25*. Both formulas are commonly used to treat cough and excess mucus. For
other types of tuberculosis, such as meningeal TB (affecting the brain) or miliary TB,
Tibetan doctors have greater difficulty identifying the humoral disorders that may lead to
a diagnosis of TB, in the absence of immediately recognisable symptoms.

However, following a few dramatic instances of TB patients dying while under Tibetan
medical treatment, often with their disease undiagnosed, Tibetan traditional practitioners
increasingly rely on allopathic doctors to cross-check their own diagnoses. In one case,
Tibetan doctors accurately diagnosed a bone (*rnu*) problem due to a humoral imbalance
and prescribed the adequate medicine for treatment on an elderly nun who had come to
the MTK complaining of pains in her costal and hip areas. After sending the patient over
to the Delek Hospital for an X-ray, a junior volunteer doctor discovered what looked like
a hip fracture and should technically have incapacitated the patient, which after further
examination, revealed that she was in fact suffering from an advanced form of TB
affecting her bones. By the time the allopathic diagnosis was reached, it was already too
late for a new form of treatment to be effective. She died shortly after, and although her
relatives blamed themselves for the belated diagnosis, they did not ascribe fault to the
Tibetan traditional practitioners. Rather, the relatives mourned that they should have sent
her to see a doctor, *any* doctor, whether traditional or allopathic, and, that between the
two of them they should have been able to help her in time.

MTK doctors have thus contributed to TB prevention in the community by increasing
awareness of the disease as well as promoting collaboration with biomedical colleagues.
Their role is particularly important in creating awareness among elderly exiles who have
little trust in biomedicine and a minimal knowledge of the symptoms. No research on
Tibetan traditional materia medica has been conducted for the treatment of TB, and
Tibetan doctors do not make any claims on possible treatment of TB. Patients therefore
have to rely exclusively on the allopathic hospital. But the relationship between TB
patients (referred to as *TB nad pa*, or people who have been *phog pa* by TB, i.e. ‘touched’
or ‘struck’) and Tibetan medicine is hardly ever severed as patients often keep ingesting
Tibetan pills in combination with their daily intakes of common anti-tuberculosis drugs
streptomycin and isoniazid.
One of the first TB patients I had contact with was Namgyal, a 23-year old Tibetan man born in the neighbouring settlement of Bir, whom I met as he was undergoing treatment on the Tuberculosis ward at Delek. As I could not record meetings on the ward, I have only included the Tibetan jotted down during our interview.

Namgyal reflected on his condition after two months of treatment: "lus kyi nus pa med (I have no body strength). Then, almost as a corrective afterthought, he adds:

ngas gnugs po nang la nus pa mi 'dug (inside my body, there is no strength)I cannot walk out of this room you see. So the world ('dzam bu gang) is my room. My brother came to visit yesterday, he also had TB (TB na tsha) two years ago. Now he is better.

He adjusts himself on the bed, painfully pulling up his legs and propping up his back against the wall.

I often think, it is this medicine that is making my body sick. But I don't know about this disease, I don't know the cause (rkyen) of it. Yes, I know the cause is a 'bru, a bacteria, but why are you not sick? (he laughs and pulls out his tongue, signalling that he is teasing me) You have the BiCiGi (BCG), and Tibetan children get it too, but they still get sick. Maybe there is a special problem with Tibetans and with Indians. With these new diseases (na tsha sar pa 'dus tsho nas), like TB, it is like there is a war inside your body (dimar nang brjod red). ngas gnugs po nang la rgya gar gis 'bu a ni rgyi gel gis sman dimar rnam bzhag res rgyal gis 'dug [inside my body, Indian 'bu and foreign medicine are fighting a war]. Because of this, I have no strength inside my body.

When I see old people with TB, I feel I am not the only one with (who experiences) suffering (idug bongal). Old people have a virtuous mind (sems dge bu), they really use the mind as a guide, to understand the disease (so sorg gi na tsha'i sems kyi 'dren btsug gis red). I am not [so] good. Usually, I am confused (nam rgyun 'la mgo nyes po 'dug)...

This young man's description of the body as a battleground for Indian infectious agents (rgya gar gis 'bu) and foreign medicine reflects an idiosyncratic understanding about the nature of tuberculosis and its effect on the body. The illness is perceived as having a cause (rkyen) in the body, but this cause is described through a personification of the infectious agent as an 'Indian 'bu', and placed in the context of a lineage of suffering that ties into prominent exile social themes: the liminal position of Tibetans and Tibetan bodies, and the uncertainty of exile.

Here illness is neither exclusively in the body, nor in the mind: locating the illness within the body and recognising its physical symptoms (loss of strength) involve making connections with states of mind. Furthermore, dealing with the illness, 'understanding' or even 'using' it in the context of spiritual practice, however, is a task which only chos-(Dharma) minded individuals can embark upon. But for exiles, engaging in mindfulness
and spiritual practice is not always easy: the physical exigencies of the body, made more stringent by the sadness (sams skyo bu) occasioned by exile hardships (dka’ thsegs), take over the mind’s capacity to watch itself and to practice chos.

In Dharamsala, conversations often turn to bodies and their discomforts (lus ma longs): the food rots too quickly; it is too hot; one cannot wash one’s own body or cover it with clean clothes; one’s stomach gets upset; animals and insects eat one’s clothes and papers, humidity (skam rlon) spoils food and clothes. The Indian exile puts one’s body in an extreme mode of self-awareness, precluding the possibility of recourse to the spiritual practice required to subject it. I was often told of such frustrations with the overwhelming bodily burden of exile, which rendered spiritual practice difficult at the same time as necessary.

A few months after my arrival in Dharamsala, TB struck again a family close to me. Ani Tseyang-la, a 62-year old woman, had fallen ill after one of her nunnery roommates had contracted the disease. Tseyang had a 43-year old son, Norbu, as well as relatives living in other Himachal settlements. She had decided to become a nun after the death of her husband and her son’s marriage. Norbu’s wife, her daughter-in-law, had left Dharamsala to live in Canada, from where she sent money home to her husband. Norbu’s salary as a low-paid assistant in one of Gangkyi’s institutions and the money from Canada were the family’s main sources of income.

Tseyang experienced her first TB symptoms during the winter of 2000:

I am really not well (ngo ma bdepo rang mi ’du). First, I got breathing pains (thog mar dbugs bsags pa rag song). I started to cough everyday, no blood, just coughing and sometimes it was so much, I had nausea (skyug mer lang pa red). One of my friends, a nun, had just been sick with TB. I had helped her go down to the hospital, take her medicine, and sometimes brought her food when she was down [in the hospital]. I had a mask when I helped her but sometimes I took it off. You cannot speak clearly with the mask, and you cannot recite mantras.

During the winter, Tseyang left the nunnery to come and stay with her son in his two-bedroom flat located in a quiet part of McLeod Ganj. There she attempted to recover from what she thought might be a riang imbalance, or perhaps, she said, mgul cham, a cold (in the throat, mgul). Meanwhile, Norbu cleaned and cooked for her with the help of their neighbours, stretching his working day so significantly that during the weekends he would often be found drinking heavily. ‘Even if he wants to go somewhere, he doesn’t
dare', said his neighbour Rinchen (kho geig la 'gro dgos bsam na'i 'gro nus kyi jog ma red). During that time, Norbu and Tseyang visited a local lama twice for mo divinations. After a few weeks of hearing his mother's prolonged coughing, Norbu felt certain that Tseyang had TB. He even put an ear to her back and tried to detect a wheezing sound or the 'crackle' that doctors looked for with their stethoscopes when they inspect patients in the clinic. Tseyang continues:

Norbu took me to the hospital for the first time when he heard me cough. I wanted to have a mo to find out if I would die soon. I am old, am I not? I thought it was the good time, the right time.
What Tseyang believed was the indicator of her general health, her *rtsa* (pulse), had apparently been improved by the ‘foreign’ medicine from the hospital. Despite this, her eerie death premonition made her redouble religious practice in preparation for the time when the medicine would stop sustaining her *rtsa*. From our talks, I gathered that she knew TB was not necessarily fatal. However she thought she was too old to survive it and also had ‘aggravating’ circumstances pertaining to unbalanced *rlung*. Her apprehension grew when she learnt how long the treatment would last. Norbu claimed she wanted to die, that she thought she was beyond treatment (*dusʼdar*), and deliberately tried to avoid taking her biomedical drugs, though she would not stop taking Tibetan medicine. When I attempted to make her speak on this subject however, Tseyang virulently denied having any such thoughts.

After the biomedical diagnosis was reached, Norbu did not take Tseyang down to the MTK to have her pulse taken and buy pills. Norbu accompanied her to weekly appointments with the Tibetan TB specialist who examined her X-rays and delivered the prescriptions. The treatment routine greatly improved when Norbu’s neighbour and friend, a non-practising nurse, offered to administer Tseyang her daily injections so that she would not have to stay in the hospital or constantly travel up and down the hill for treatment.

Meanwhile, Tseyang ‘ate’ some of the *byin rden* brought back by her family from the temple. She could now no longer walk safely down the road to the hospital alone, as she had become weaker, perhaps, I thought, through the effect of the medicine. Her family thought that *TB na tsha*, caused by *TB srinʼbu*, was weakening her, causing her body’s strength (*bus kyi nus pa*) to diminish. A friend of Tseyang, also a nun at nearby Gaden Choeling said that *tse srog skyel song*, her life-force (*tse srog*) was being taken used up.

Family members were therefore taking turns in bringing her down by taxi on the winding road to Delek, and I was then often called upon to help support her along the painful trip. On one of these occasions, Norbu confessed that he thought the nurses and doctors might see Tseyang more promptly if a foreigner was there with them. I also sometimes felt as if they somehow wanted a witness to the clinical procedure, and Norbu often asked for my opinion of the treatment despite my limited knowledge of medicine.
At a typical weekly consultation, after the technicians in the laboratory had taken an X-ray of her chest, Norbu, Tseyang and I waited on benches outside the TB consultant's office for her appointment. They sat silently on a bench, looking at the swarm of patients and nurses going out of the sick rooms with bedpans and trays of food. They looked around anxiously, her son with a handkerchief over his mouth in lieu of a mask. I found the mask’s relative anonymity comforting (as I suspect they did too) and walked repeatedly through the ward as Norbu and Tseyang sat in silence.

A toothless elderly nun came to greet Tseyang, inquired about her health, then embarked on a litany of complaints about her own TB pains. She explained that the medicine had made her grow older quickly: her teeth had fallen out, so she could not eat any of the food given to her at the hospital. The nun insisted on giving Tseyang some bananas, arguing it was rich food and good for her health. Tseyang patted the nun on the shoulder, accepted her gift, and said that she need not stay around but should go and rest. Tseyang carried the banana with her throughout the consultation with the allopathic doctor. As we came out, she gave it to me with a wry smile. 'I won't eat it' she said, 'I don't eat sick people's food' (nga za gi med, nad pa'i kha lag za gi med).

Tseyang became more and more reluctant to visit the hospital. Although she was in all respects considered a ‘compliant’ patient and did not openly oppose the trips, she stayed quietly in a corner, and wore her protective mask and robe over her head so that she would not be recognised, small acts that nevertheless betrayed her discomfort in the clinic.

At home she would lie on the family’s carpeted bed (khr), resting and reciting ma ni, then sitting up and reaching for the mask lodged under her chin whenever somebody came into the room. Her young neighbours’ children sometimes came to visit, and neighbours together would regularly bring cooked food and help with the house laundry. On the whole however, Norbu carried out most of the house duties and worried about his mother constantly. This preoccupation visibly added to his own concerns with his job and absent wife, which in turn seemed to contribute in aggravating his drinking habit and his other Epicurean penchant for sho (dice) gambling.
After three months, Tseyang appeared to be on the mend. Norbu was still taking her regularly to the mo pa, a local bla ma. The monk would give them appraisals of the treatment's progress and suggest certain spiritual practices. Tseyang’s religious practice focused on the white Tara nam gyal ma (known as the ‘all-victorious’) and on recitations of the Medicine Buddha mantra. But although she would recite the Mantras before taking her Tibetan medicine and continuously during the day, she would not do so before injections.

On one occasion, she was sitting in her designated room and reciting the Avalokiteshvara Mantra on her carpeted bed when one of the neighbours’ five-year old children came in and sat on the floor in front of her. Without breaking her concentration, she continued to recite the mantras, until, a few minutes later, the little boy started mimicking the syllables. She opened her eyes, touched by the child’s behaviour, and let her phreng (rosary) slip down from her lap into his hands. The child held and shook the beads, repeating the mantra in time with Tseyang. As Norbu walked into the room he smiled a contented smile, and as he led me out, told me how thankful he was that his mother was not staying in the Delek Hospital.

Meanwhile, Tseyang’s neighbour, Rinchen, who occasionally moonlighted as a ‘nursing aide’, was ceremoniously preparing her injections in the adjacent room and sharing some thoughts about TB. Rinchen’s present occupation barely allowed her to support her family, and she constantly reported difficulties with her landlord, a Tibetan female ‘nouveau riche’ (nor bdag, a wealthy person) who was constantly increasing her tenants’ rent with no concern for people, no compassion (snying rje med na), as Rinchen put it (snying rje med pa’i rkyen kyi ‘di ’d ras byed kyi jog sred, the reason why they behave like this is that they have no compassion). Her present job gave her freedom to manage her time, and she spent most of it at home with family or neighbours. Although she was not part of the contingent of trained health workers, Rinchen played an important role in the alleviation of Tseyang’s suffering. Their support network also allowed them to get by in other domains, such as when one of the neighbours needed to borrow a sum of money or required goods from other settlements in which some Rinchen’s relatives lived (Delhi, Bir, Shimla).
Thus, while Norbu and his neighbours had *de facto* constituted themselves into a ‘care group’, sharing the responsibility and care for Tseyang, the group was also part of a greater and more complex network of affiliations binding the neighbours together. The implication of this was that the benevolence of Rinchen’s help, albeit undoubtedly sincere, had to be understood in the context of her multiple obligations to Norbu’s family and of the relations of reciprocity that tied them together.96

One day, I came into Rinchen’s house as she was preparing Tseyang’s injections, and asked her how one could help TB patients:

(R): *ti bi nad pa ’dji tsho, ngein gan rig la sghu rkyang brgyu’us pa’i skah/ na sgha skar sems tel byed gi red/they cannot get better that way/ a ni kha lag chzin po, spus leg yag po’i kha lag rig gi ma red/ dal, ’bras, alos, bag leb zhi gas. ti bi nad pa (...) de nas ga re dgos sam...*/ They need a high protein diet/ I know, ngeas sman khang chen po nang las ka byed pa yin/ ni zhem la ma red, sa cha bet (coll.) yag ba yod pa red/ ti bi nad pa kha lag pe mi ni pe dmig bsal method dgos red/ tol, a ni sha, a ni ’protein’ mang po method dgos red.

These TB patients, when they stay by themselves the whole day/ [they] worry about their sickness/They cannot get better that way/ and they don’t get tasty food, good quality food/ only dal, rice, potato, bread/ TB patients... what do they need?/ They need a high protein diet. I know, I worked in a big hospital/ Not down here [i.e. Delek], there is a better place/ TB patients really need to eat [according to] a special diet/ they need to eat vegetables, and meat, and lots of protein.

(Norbu): *Ti bi na tsha shugs chen po red (TB [disease] is very strong)*

(R): *sman dang kha lag za gi med na/ khyed rang gri gzugs po la shed chung ba byung gi red/ da shi ba yod gi red/ khong tsho’i sems pa yang shed mi ’rug/ de yang mi dang sman khang chen po byed dgos*, ’di la bet (coll.) gal chen po red/

If you don’t eat food and medicine, your body will get weaker and weaker, then death will come/ Their mind is also weak, so they need to talk to people and relatives/ This is very important.

(A): *Ga re je ne? (why?)*

(R): *Ti bi mang po yod na, skad cha mang po byed dgos red/ skad cha mang po byed pas?/ Nurses, or ka re sa social workers/ bedun phrog rang par gling ba byed dgos/ ga re ga re bsang grus bidur byed dgos/ yod pa dang ga ’dras ggs byed thubs dgos red/

Where there is a lot of TB, you have to give lots of talks/ Do they have a lot of talks?/ Nurses, or what is it (...) social workers, every week, there should be talks, on what to do, how we can prevent it/

‘Prevention is better than cure’, nga tsho la aem chi tshang ma gyungs song (the doctors all told us that). Once you get sick then there is a problem. If you are good doctor, if you are a good nurse, you don’t think just about your salary! Doctors can get sick too...
These people they really need help/ I have seen some nurses who were really not good/ When checking a patient, they would do something like this/ No/ When we were training, we worked in the hospital/ [we learnt] we must stand near the patient's bedside until he takes the medicine/ and we should talk, we should give them hope/ 'you should be happy that you are here in hospital now, we are here to take care of you and you are going to get well with this medicine'/ Sometimes these nurses just said, 'here is medicine, take, eat! EAT! / Because [they have] no time/ Maybe the patient won't eat the medicine, hide it under the bed/ Sometimes patients really suffer, and they worry, and [they] think 'taking medicine everyday, why?'/ In their minds, they think about this...

I then questioned Rinchen about the length of her training as a nurse and whether she thought people helping their relatives with TB treatment should have specific training:

If people need help, I help. But: 'yes, yes, I'm a nurse', I don't say that. For example, [Norbu's] mother, she's very weak, she can't walk. Every week she needs to go to the hospital. Up, down [the hill]. So I said: ask the doctor if he can give us injection [materials] for a week. So they ask Dr. Tseten, he's the highest [in rank] in the TB clinic. From now on, on Monday[s], we will go and take the medicine.

Now [Tseyang] it is better better, but she is very weak all the time. She's taking medicine.
Until she’s better she has to. That’s why people get sick, young ones, boys, girls, they take medicine for a while, then they feel better so they don’t care. And then they go out till late, they go to parties, dancing, without eating well. Okay, if you go to a party, fine, then sleep. Many young people get ill. My opinion is, it is because they don’t sleep in time, they don’t eat in time, they don’t get a proper diet. They think [posturing] ‘oh, I’m getting fat, I can’t be fashionable, I should not get fatter’. And then, [you] have to get injection, so?

I ask whether she thinks Dharamsala refugees are also exposed to other diseases.

(T): Tuberculosis... and then what... a few years ago, until now, we never heard, very rare...Now people go to the doctor, they have to check, isn’t it? In Tibet of course, there are not many hospitals, not many doctors...Older people getting stomach cancer, we heard about it many times now. Monks, old monks, what they found is, you know, they get ill from incense burning, and also from having too much Tibetan tea with this special kind of milk, when they boil it, I saw it, it’s full of dust... How many people have you spoken to? You know, people are afraid to talk about diseases...

At this point, one of the neighbours, Dolma, whose husband is working as a helper down the hill in the MTK, calls to ask Rinchen if she can make a phonecall for her. From the other room, I hear Rinchen explaining that Dolma’s husband is ill and will not be able to come to work. She comes back and sits down, busy herself with her injections, preoccupied. ‘Norbu and his friend got very drunk yesterday’ (ra ra ba song), she explains, and ‘were not able to get up to go to work’. Then suddenly she jumps up and runs to the kitchen shelves, from where she pulls down a bottle of whisky. It is half-empty. ‘Chu rgyung rgyung ‘thang byang’, she says, ‘they drank it like running water’. Frazzled, she fixes her pang gdan and steps out onto the common landing, the non-disposable syringes placed on a hospital-like metal tray, ready to give Tseyang her injections.

When, a few months later, the landlord’s daughter fell ill with TB, Rinchen’s help was not called upon. Rather, the ‘nouveau riche’ lady used one of the health workers from Delek’s branch clinic in McLeod Ganj. Rinchen snapped bitterly that she was confident the landlord was trying to bribe the health worker with money from her own rent to provide better care for her daughter. Her otherwise unflinching faith in the Tibetan exile administration and the hospital personnel failed her somewhat on that occasion, and she sought solace in the circle of the ‘Tibetan Women’s Association’, whose members enjoined her not to become jealous, but instead rejoice that she had helped Tseyang back to health. Indeed, when I returned to Dharamsala in July 2002, Tseyang had been cured, and was still living at Norbu’s in the company of her neighbours and their children. Following her female friends’ advice, Rinchen had temporarily buried her quarrel with the landlord by going about her daily khor ra circuit at six thirty in the morning, thus, as she said avoiding
the gossiping women and taking in the 'healthy air of Dharamsala in the morning, before the rickshaws and the people come out'. She added: khjim tshes mnyam du 'cham po byed yas ga chen po red, it is important to get along with your neighbours.

In the neighbours’ eyes, it was a blessing that Tseyang been able to escape staying at the Hospital, as this seemed to be a place that would only expose her to more hardship. Tseyang and her ‘care group’ seemed to desire distance from the medicalised world of Delek, and the local neighbours’ group provided them the framework to do so. Only newcomers, or people who had fallen out with their kin would stay in the hospital. This, as I later observed, was not exactly an accurate scenario, but it characterised the received opinion about family involvement during ‘sick time’: family and neighbours had to help one another to avoid the hardship of sending one of their own to the hospital, where they would be too isolated. I would therefore suggest that the care of relatives and social relations generally were seen as critical to the sufferer’s improvement.

The management of TB by Tibetan exiles took all sorts of alternative routes around the orthodox hospital quarantine. Fortunately, home treatment was also the route prescribed by the TB management programme DOTS (Direct observed treatment, short course), which was used in the hospital, and which encouraged home care under the supervision of a responsible person who could administer the medicine. Rinchen had preferred to present her role as an act of benevolence and often criticised nurses or health workers who gloated about their training and salary. One should look after patients at home, she said: naad pa gyog rgyogs nas bysad degs red.

Home treatment was possible as long as one has a space to isolate the patient, allowing for a reasonable amount of distance from relatives or room mates, as is the case in nunneries and monasteries. Often a room is set aside for the patient during the contagious period (rims keji dusl), and a TB sufferer is only sent to the ward if there is no space available in the monastery. This being said, so-called ‘home bound’ TB patients are suspiciously mobile: one would regularly see contagious TB patients trotting about town with their masks on, passing time practising Indian board games in the roadside tea houses. More than just a fight with the tubercle bacillus, TB treatment is a struggle against time and isolation. Or at
least, this was the perspective which one had from the hospital, as the following section attempts to show.

6.2. Perspectives from the Hospital

At eight o’clock in the evening, from the top of the ‘old’ Delek hospital’s TB clinic, patients surveyed the passers-by. There was not much conversation during such times. Most of what needed to be said by way of introduction had been said a long time ago, and most of the preoccupations nowadays were to do with bodily needs and foreseeable visits. One never tired of whinging about food or the lack of water. There were small rooms of two, sometimes three beds, and the doors remained open most of the time so one could see people wandering around and observe the general life of the hospital.

When an emergency came in, TB patients clustered around the staircases to observe the proceedings and then report to each other the day’s events. Very often this happened in the dead of night and patients could not sleep, so the radio was kept turned on as they waited to hear what had happened from one of the nurses. One night in early January a young man came in with the ambulance, stricken down by what we heard was a drug overdose. The nurses said he was a newcomer with no family in McLeod Ganj, and had been staying with some people from his area in the little Amdo community below the Bhagsu village. At four o’clock in the morning we were told he had passed away, and, a few hours later, some monks from the nearby Gadong monastery performed the first bar do rituals in the hospital. A nurse then told me that many of the emergencies are drug-related, involving both Tibetans and foreigners. Some of the boys on the ward explained to me that many newcomers would arrive from Tibet before lo ghar and that this means that there will be more patients in the hospital: many of them fell ill during the journey, or in the crowded reception centre in Dharamsala7. The boy who died was the first of many to come, they said.

In the morning, the ward got into a buzz of activity: patients came in for consultations or visit relatives. They very often brought home-cooked food in small containers, and patients could eat outside on the laboratory’s roof. The afternoon brought apathy for most patients.
The least feeble ones were able to go outside the hospital and see nearby relatives or friends for a game or a drink. In Gangkyi's small tea houses and restaurants, TB patients were seen gently removing their masks over steaming chhâi, then, eyes roaming around, then putting it back on, sip taken.

For those staying inside the ward, time in the 'quarantine' period stretched on. With no other distraction than visits and the radio, patients were left with plenty of time to think about their past, and, often with more anguish, about the future. While it seemed natural for newcomer reminiscences to turn to Tibet and a lost home, patients born in India also succumbed to fantasies of the homeland.

Patients are told explicitly to spit in an isolated place or on the garbage dump next to the hospital. I sometimes heard this mocked by patients, jesting that, it is bad enough to be sick, now they even have to go and spit 'in secret' (gsang ba'i chu ying thog nas). It is not uncommon for TB patients to spit bitterly over the hospital's top floor banisters, cursing the heat and their immobilisation through this inflammatory and strictly forbidden act.

Their progress being checked weekly, TB patients on the ward have little suspense as to the development of their illness: they know they have to sit through it and wait. The mix of people on the ward allows for new friendships to form and for interesting cross-generational exchanges. Old patients enjoy telling young boys and girls about life in Tibet and the importance of carrying on with religious practice. It is not unusual for these friendships to last long past the hospital sojourn.

6.3. Dolma and 'girl's TB'

Despite the heavy public health measures put in place by the government and the Delek Hospital to prevent the spread of tuberculosis, the number of cases has more than doubled in the last ten years (Cf. Bhatiaa et al. 2002). Moreover TB has been particularly virulent among young adolescents. Information on the causes and symptoms of the disease is widely disseminated (see Appendix B), yet the hospital's forty beds never seem to empty and the vast hallway of the TB ward, where patients spend months quarantined, is
perpetually filled with the young and old, monks, nuns and lay people. During my time on
the ward however, I was surprised to see that few young women and girls actually stayed in
the hospital during their contagious period of TB. Perhaps the ward was not safe for
women, I thought, and parents and other relatives, would be concerned about young girls
being exposed to a mixed environment.

When I asked Tibetan doctors and patients why so many adolescents, and particularly
adolescent girls, were falling ill with tuberculosis, a significant number told me that young
Tibetan women were increasingly concerned with their looks and that being slim, dieting,
was a 'new disease' they had contracted in India. One of my older woman friends often
pointed out girls to me in the market place who displayed the characteristic brown spots of
malnutrition (ras ma nus kyi sha rtags) on their cheeks, and tutted disapprovingly, saying they
should eat and not be so concerned with their attractiveness. One female traditional doctor
from the MTK also made a connection between malnutrition, dieting and infertility, stating
that young girls were now having sexual intercourse at a much earlier age and more
frequently than was traditionally acceptable in Tibet. This resulted in the internal disruption
of their reproductive organs and prevented them from being able to conceive children. The
innocence of older women who had been brought up in Tibet was constantly contrasted to
that of the India raised new generation. One woman, who had been brought to India at the
age of 16 told me how she would find and collect used condoms around her school
precinct in India and use them as hair bands, oblivious to the general hilarity which this
triggered among her more savvy classmates. Clearly, the exile generation of young girls was
morally reprehensible in its quest for attractiveness and sexual freedom.

When young women starved themselves to look good, this made them more susceptible to
catch rampant diseases such as tuberculosis, which thrived on weakened immune systems.
Tuberculosis had partly become a lifestyle disease. Although the hospital presented it as a
straightforward biological disorder, the ascription of cause was rooted in moral grounds.
Monks and nun who had contracted TB often questioned themselves as to the religious
and moral causes of the ill fortune that had befallen them. They interpreted this in terms of
a return of past karma, which was exhausting itself in the illness.
Although TB is mostly regarded as a disease of poverty and inequality related to exile conditions, its causes are open to further interpretations, such as the involvement of karma.

The case of one young girl in particular provided some insight as to the dynamics of TB treatment among adolescents. Eighteen year old Dolma, one of the patients who came to the hospital regularly to get her TB medicines, recalled how her family had immediately assumed she had tuberculosis when she started coughing heavily and losing weight. But health was not Dolma's only preoccupation. She had a boyfriend, Tsultrim, studying science in the nearby faculty of Chandigarh, a three hour bus ride away from Dharamsala. The two had recently met and a romance had been sparked but Tsultrim soon had to go back to school and left, promising to write often. 'Most importantly', he had told her, 'take good care of your health'. A few weeks after this innocuous admonishment, Dolma started developing symptoms (described to be as 'signs', tagi) that prompted her parents to send her to the TB clinic. She wrote to her boyfriend, describing her symptoms at length, enjoining him to come back or at least give her some advice on what she should do. She appeared more and more gaunt, and when her birthday came, refused to eat the foods she would normally enjoy, getting angry when her sisters and mother teased her for acting lovelorn at a time when she should have been concentrating on her studies. Her preoccupation with boys, they said, had caused all sorts of trouble, making both her mind and body weak, and probably causing her illness.

Dolma's sputum test returned positive, denoting an exposure to the TB bacillus, but her X-ray showed none of the characteristic spots. She then received the long awaited letter from her boyfriend, who recommended her to go and see a bla ma for a mo divination to ascertain the diagnosis. Dolma seemed concerned about this request, but was certainly not as puzzled as I was, who saw a complete contradiction in this student's attitude. Paradoxically, in such an atmosphere of diagnostic uncertainty, where patients evaded tests and the treatment quarantine, the oracle was the only agent to offer some form of certainty: it never lied and would be able to see through any pretence. Despite his 'scientific' training, Dolma's boyfriend trusted the oracle's ability to discern the truth and diagnose her illness correctly.
Thus, even in the area of apparent biomedical certainty, factors linked to profound change in Tibetan exile society, like women’s emancipation or preoccupations with escaping the constraints of the medical environment heavily influenced patients’ strategies. The key point here, however, was that the culturally appropriate scheme, which involved going to the oracle, was also an actual mode of practical clarification which complemented rather than stands in opposition to the biomedical approach. Dolma’s boyfriend did not only recommend the oracle because it would be able to offer a culturally appropriate explanation of her illness, but because he may be able to identify the actual disease and ascertain its biomedical diagnosis.

Two salient points emerge here. Firstly, the clear stigmatisation of TB points to its identification as a ‘lifestyle disease’, linked to the changing morals of the youth. The underlying social reproach here condemns the laziness and moral waywardness of young exiles, and this despite the general acknowledgement of their difficulties. Secondly, Buddhist beliefs play a crucial role, even within a process involving treatment through biomedicine. The oracle, as a respected religious institution, has the power to make and unmake the biomedical diagnosis and prescribe an adequate course of action.

6.4. Karma and the problematic aetiologies of suffering

A number of the patients I spoke to, the majority TB patients from the Delek Hospital, mentioned karma at some point during their illness. Such references must be understood in the context of Tibetan aetiologies’ relationship to Buddhist practice. Both Ayurveda and Tibetan medicine understand disease ultimately as a product of karma. One of Ayurveda’s key text, the Caraka Samhita, of the fourth century AD and its later commentaries, assert that therapeutic measures can only be effective when karma is favourable: medicine does not provide a way to clear karma. Instead, the Ayurvedic medical system accepts it as an important factor in causing diseases, and in limiting the efficacy of the therapeutic measures. The incurable character of some diseases is seen as being caused by karma, for instance, congenital deformities or deficiencies in physical and mental make up. Diseases caused by having committed unrighteous acts in past lives may only be cured once this past karma has been exhausted. Similarly, diseases that befall a whole community, as distinct
from individuals, such as epidemics, can be attributed to collective forms of karma afflicting the community as a whole (Krishan 1997).

Tibetan exiles' constant reassertion that their disease was caused by karma often came as the baseline explanation, the last causal factor in a chain of many. One of my friends suffered from chronic stomach pains and had taken Tibetan medicine for a year and a half before going to the hospital and getting a stool sample analysed. He dutifully took his full course of antibiotics, and then returned to taking Tibetan medicine. The disease had been caused by *srin 'bu* (germs), he said, the germs had come because of an imbalance of the *njes pa*, and this imbalance was due to karma, he said, looking increasingly frustrated with my repeated enquiries. This meant that a comprehensive treatment of this condition would involve three therapeutic layers corresponding to the three linked causes of illness: biomedical treatment to get rid of the germs, Tibetan medicine to correct the imbalance, and finally a series of prescribed rituals or recitations to annul the bad karma.

As Young pointed out (1976: 714):

"while the content and organisation of medical beliefs are the product of both cultural and biophysical realities, it is culture, by determining which biological signs are selected and which are ignored, which objects and events are implicated in disease episodes and which are dismissed as irrelevant which dominates in traditional medicine."

The fabric of Buddhism and culture of Tibetan medicine gives karma a key role in the meaningful explanation and interpretation of illness. In order to understand these interpretations in practice, I now turn to some of the illness narratives and life histories of Tibetan exiles.

### 6.4.1. Thagpa

Thirty-two-year old Thagpa was a third year medical student at the MTK in Dharamsala when I met him. His impressive command of Tibetan grammar and knowledge of classical Buddhist literature was much appreciated among his fellow students.

After some time talking to him about medical texts and his studies, our conversations recurrently turned to the topic of his family and life in Tibet, a subject which, unlike most
recently arrived refugees I had spoken to, he was very reluctant to broach. I became aware 
that Thagpa suffered greatly from the separation from his family and that his new-found 
life in Dharamsala was not as fulfilling as it first seemed. He was the middle child of three, 
in a family of farmers from the eastern outskirts of Lhasa. He had not always wanted to 
study medicine but had taken the examination at the Men-Tsee-Khang Institute in Lhasa 
when one of his school friends urged him to do so. When the time came for him to decide 
where he would pursue his studies, he feared he would not be able to meet the Institute's 
high standards. He became increasingly depressed and restless, not knowing where to turn, 
and started to think about leaving his family. He told his parents of his wish to go to India 
to try his luck at medicine there, but they disapproved and asked him not to leave. After 
procrastinating for few months, Thagpa found a travelling companion and left the house 
without saying goodbye to his family, setting out for the journey to Nepal via the village of 
Dram and the Friendship Bridge. Thagpa recounted how, just before leaving Tibet, he had 
a dream (mi lems) vision of the Dalai Lama sitting on a white horse, waving at him and 
urging him to come forward. 99 

After finally crossing the border to Dram, he and his travelling companion were arrested by 
a Nepalese border patrol who took their identity papers and the rest of their money, 
threatening to take them back to the Tibetan Autonomous Region's border if they did not 
co-operate. The two of them finally found help in a nearby monastery and made their way 
to Kathmandu, where they received new papers and some money for the fare to India. 
There they were accommodated in one of the Tibetan Transit Schools. After reaching 
India, Thagpa joined the Soga School near Dharamsala for four years, during which he 
acquired some rudiments of Hindi, English and more instruction in Tibetan grammar. 

During his time in the rough tin barracks of the Tibetan transit school, Thagpa contracted 
tuberculosis and was sent to Dharamsala's Delek Hospital for treatment. The Transit 
School where he had stayed was a breeding ground for chest infections and rampant 
disease, as the students lived in barracks of fifty and in conditions of poor hygiene. Thagpa 
recalled monsoons in the barracks and students driven to desperation by the hammering 
noise of the rain on the tin roofs, unable to concentrate and unable to go out. He had 
already lost five kilos by the time he was admitted in the Delek Hospital in Dharamsala. At
that time he was a heavy smoker – he referred to himself as a dud khung, a chimney -, and had a penchant for fatty and starchy mogy mogy. The Western doctors encouraged him to continue taking Tibetan pills and praying at the hospital. His health was rapidly deteriorating and his doctor constantly enjoined him to stop smoking. Finally, after five months of antibiotic treatment, he told the nurses who tried to snatch his cigarettes that he would die if it was his karma, but that he needed to smoke to make himself feel better. This at least was how he recalled the incident to me three years later. Thagpa started smoking openly in the hospital premises and, contrary to expectations, his condition improved drastically. He was finally discharged from the hospital after close to eight months of continuous treatment.

After this episode, Thagpa often joked that cigarettes had saved him from TB, but then, correcting himself, said that it his karma was to be cured. When I asked him why he thought he had caught the disease in the first place, he simply said that, in the schools, diseases were everywhere, and that a lot of his companions had suffered the same fate. In this case, karma was seen as being the vehicle for cure but not the primary cause of disease.

Thagpa’s experience of biomedicine had not dented his motivation to study Tibetan medicine, in fact, quite the contrary. For him, this rocky recovery was something of a miracle, one that he would only explain as the work of karma: after separation from his family and the troubles he had endured in exile his perseverance in the meritorious vocation of doctoring, had finally been rewarded.

Still, in the years that followed his recovery from TB, Thagpa suffered from low mood, irritability, as well as from a series of stomach and skin disorders. He oscillated between pangs of guilt at the thought of his abandoned family, doubt in with his ability to finish his studies, and an unusually high consumption of alcohol and cigarettes. His professors became alarmed to find such a good student in the dark restaurants of Lower Dharamsala where idle Tibetan youths go and drink among Indian businessmen. These episodes alternated with outbreaks of religious fervour during which Thagpa followed Dharma teachings and took vows to give up smoking and concentrate on his studies.
Thagpa did not seek the help of a Tibetan doctor during these episodes of disorientation and despair, but instead had recourse to mo divinations. The mo pa he consulted was a famous lama who lived in the nearby Old People’s Home. He advised Thagpa to take refuge in the Buddha Maitreya and go to a doctor to identify what he thought was a humoral imbalance. He also encouraged Thagpa to go to the Dalai Lama’s annual teachings, even though this would make Thagpa miss out on some of his lectures at the MTK. In Thagpa’s eyes, the underlying force behind these disturbances was undoubtedly karma. When he failed to uphold his vows, he complained of irrepressible headaches (gy nad), of a lazy mind that prevented him from learning his texts by heart (kha ton du shes mi ‘dog), and, worst of all, he suffered from ‘athlete’s foot’ (in his own words) which signalled that, as he put it one evening, even everything in him, even ‘his feet had started to rot’ (rul bza). The fact that Thagpa did not suffer from a readily identifiable illness made it possible for him to have recourse to the explanatory power of karma to unravel the threads of causation. He was displaced, had abandoned his filial duties and was misbehaving in the eyes of his peers, it seemed natural to him that the accumulation of bad karma would manifest itself in further humoral imbalances, which, in turn, would cause further mental disturbances.

The medical cure would only work in combination with a strengthening of ethical discipline, and the oracle made this quite clear to him. Thagpa saw in the medical profession a form of redemptive existence, and a way to ameliorate his karma. It should be noted here that the virtues born from practising medicine are constantly emphasised in medical texts and praised by lay persons when speaking of Tibetan medical practitioners. The opportunity for generating merit in a religious sense is also regularly mentioned by students as a motivation for undertaking medical training. From his experience with disease, Thagpa reinforced his motivation to become a doctor. This notion of disease as a rite of passage, allowing one to enter the world of healers and thus help others out of sickness has been repeatedly described by anthropologists in the context of ritual healing (Lévi-Strauss 1959; Kakar 1991; Turner 1967 [1994]).

In the context of TB, when foreign aetiologies and cures came into play, karma was the basis on which Thagpa escaped cultural anomie, and which drew him back to the realm of
intelligible, Buddhist conduct. In the context of Tibetan humoral imbalance, it provides the explanatory toolkit and the vehicle for the cure.

6.4.2. Dawa and her aunt Tsering

The second case I wish to discuss here is that of an aunt, Tsering, and her niece, Dawa, 64 and 43 respectively. Aunt Tsering was born and brought up in Lhasa, the sixth child of a family of eight. I first met Tsering and Dawa at a religious teaching held in McLeod Ganj. Tsering told me she had come from Lhasa on pilgrimage, and was hoping to see the Dalai Lama. She was accompanied by her niece Dawa, who had left India in her late twenties and married a Swiss man with whom she had emigrated to Bern. She had held many jobs in Switzerland but was now semi-retired, claiming benefit and living half of the year in India. She had divorced her husband and, since she had no children, now lived alone in her flat in Bern. Dawa regularly complained of joint and back pains. When I inquired about the kinds of pains she was suffering from, it prompted a flood of complaints ranging from arthritis to homesickness, and troubles she thought were due to climatic changes. Her aim, she said, was to move to Lhasa, where the climate was kind to her ailments, the air pure, and where she might finally be able to spend the rest of her life among family and friends. During one of her recent trips to Lhasa she had met a man she had become interested in, and was considering moving back and starting a new family with him.

Dawa mused: ‘you know, what they say is really true, the water in Tibet is like the milk in India, it is so rich and wonderful, and the meat tastes like... you have never tasted anything like it...’, ‘Whenever I go back there, at once I feel better, you will not believe me, but I feel like I am ten years younger’

For Dawa, who had lived in exile almost all her life, thinking, and talking about Lhasa had become the panacea to her existential and physical ailments. She could talk for hours about the warmth of Tibetan people and the faith that animated them despite the hardship of Chinese occupation. There, she thought, she would always be surrounded by family. Lhasa, which she had only known as an adult, had become a new Elysium in which she placed all her hopes for the future. She continuously expressed her regret at having left for the West where life had not kept its promises. Dawa also recalled her father, who had held an administration post in the Government in Exile, and
ended his life peacefully in the Old People's Home of Dharamsala, having served his people and lived close to them. She called him a 'hero of the Tibetan resistance' and remarked she would also have liked to be able to do something for her people. Her work with Tibet support groups in Switzerland generated some revenue, which she redistributed to organisations and families in Lhasa. In that way, she commented, she was helping a little. She did not know why she was constantly ill, but felt oppressed by karma, haunted by the past and, it seemed to me, anxious to settle accounts.

A few months later, Dawa and Tsering became my neighbours in Gangkyi. I then learnt the reason behind Tsering's pilgrimage: a lama from Lhasa had predicted that she would die of a violent illness that year. However, the oracle added, if she could survive the year, she would live another ten years in complete health. Tsering, determined to expurgate her karma, had immediately set out on an elaborate pilgrimage, which consisted of a long and arduous tour of India's Buddhist religious sites.

Tsering's journey to India through Nepal has striking similarities to that of Thagpa the medical student. Robbed and abandoned by the middlemen who had arranged her border crossing, she arrived in India to meet her niece without belongings and with a heavy heart. From her explanations, I gathered that she had had a difficult life in Lhasa. Both her and Dawa recounted that her husband used to drink a lot and sometimes be physically violent towards her and her sons. Throughout these years Tsering had retained a strong faith and hoped that one day she might be able to devote herself fully to religious practice by becoming a nun. As her husband became sick, Tsering said she helped him to eat and go to the doctor. However, she did not consult an oracle, as is customary at times when a family member's life is endangered. This, she said one day mournfully, was the cause of her present situation. The care she had not given her husband in his last hours had now rebounded on her as negative karma and was endangering her own life. She had not told the oracle about her moral dilemma but thought that he had clearly seen through her past. His command to go on pilgrimage was thus to be taken very seriously indeed.

I personally felt very sceptical at the thought of Tsering being overcome by illness: to me, her health seemed unassailable. She would refuse to take medicine other than Tibetan pills
and her only concession to her niece's entreaties was to stop drinking butter tea. On an ordinary day she would be up at five o'clock in the morning reading the *lam rim chen mo* and reciting mantras, then would set out to wash clothes and prepare food for herself and her niece. She was also using the opportunity of her stay in exile to meet up with distant family members and maintained the daily schedule of a busy pilgrim, circumambulating, offering *tshags* and going to the temple.

Dawa seemed to consider helping her aunt on her quest for merit accumulation an opportunity to bask in the pious example of her elder, and an indirect way of bringing some of the merit onto herself. Her life in India clearly contrasted with the relative isolation she lived in in her suburban home in Bern. Throughout her stay, however, her pains, arthritis combined with the remains of other illnesses, worsened enough to force her to stay in her rooms under the care of Tsering and myself. A cosmopolitan Tibetan exile, Dawa would command that we bring back aspirin and portions of Tandoori chicken from her favourite restaurant in Lower Dharamsala.

Tsering became convinced that she had somehow contaminated her niece with her bad karma, while her niece would not forgive herself for delaying her aunt's pilgrimage and putting her life in danger. For both these women the fruition of karma was clear and visible in their own lives, not as a secondary, accessory mode of explanation, but as the primary cause for their present ill fortune. The counter-poison to this negative karma was also in the here and now, and active engagement in the creation of positive karma was a daily and time-consuming occupation for them.

Their belief in karma, as was also the case for Thagpa, seemed to develop in conjunction with the elaboration of a personal moral history, which was both created and affected by karma, and in turn affected their illness. For Thagpa and Dawa the departure from Tibet and life in exile had come with a series of what they considered personal betrayals, shortcomings in their fulfillment of their familial and political duties. For Tsering, the personal drama which had shaped her life for years, the resentment against an abusive and non-religious husband, seen as a trial to her own strengths, had been the perceived cause of her karmic downfall and the sword of Damocles that endangered her health.
6.4.3. Lobsang

While the moral preoccupations which assailed the three previous informants bore witness to a very practical and immediate view of karma and its results, the final case I will discuss here presents a very different picture of karma and its relation to illness.

Lobsang was born in exile in the camp of Choglamsar, near Leh, in the region of Ladakh, North India. He entered monastic education at the age of nine and had a particularly successful ascent in the clerical hierarchy. He completed the degree of Geshe (dge bshes) at the young age of thirty and had travelled widely as a member of the Dalai Lama's private office, teaching and conducting business on behalf of the government. A number of my friends expressed concern at my dealing with him, as he appeared to be too enmeshed with politics. Many referred to him as a mi chenpo, an important (big) person. Indeed, as far as I could see, the Geshe's lifestyle was far from ascetic. Like many monks, he suffered from high blood pressure and had been told by both biomedical and Tibetan doctors to watch his diet.

Geshe Lobsang's concern with health took a number of unexpected forms: he carried with him an imported American sphygmometer and checked himself with it regularly. The instrument produced a strident noise once it had made its measurement and was the subject of great admiration among other monks. This apparatus had earned him the nickname sku gebo sgos deng dus (see chapter three), which was as not as much derogatory as it was affectionate, teasing the cleric who had been lured into fascination for Western luxuries and gadgets.

Geshe Lobsang attempted to rein in his blood pressure by controlling his diet. He also pointed out to me on a number of occasions that diseases occasioned by high blood pressure were very common in the West among mi chen po, men who assumed positions of power. This was due, he explained, to their high commitments and unnatural level of activity. High blood pressure was therefore a disease of busy and important people. Now that Tibetans in exile had started enjoying some of the luxuries of the west, they also
suffered its ailments. But for Geshe Lobsang, this apparently was less a sign of decadence than of material, almost evolutionary progress: hypertension (*khra* *bsad*) was a disease of *mi chenpo* and was validated by a certain cultural cachet.

Despite his efforts and cross-cultural musings, Lobsang had gained weight in my time there. He finally resolved to ask for the advice of an elderly and experienced Tibetan doctor from the MTK, who diagnosed him as having a potentially very dangerous form of *rlung* humoral imbalance.101

Medical students had already explained to me that such *rlung* illnesses are common in people involved in intellectual occupations, particularly in religious, meditative activities. *rlung* imbalances therefore characteristically affect monks and students of Buddhism, who, through their constant preoccupation with abstract considerations, sometimes become hot-tempered, nervous and irritable, as illustrated in the expression used for short-tempered people, *rlung tsha po*, or literally: hot strong wind. Geshe Lobsang's particular illness arose from the overwork of his mental faculties, engrossed with spiritual matters, which had caused a dangerous increase of *rlung*. Yet even after the traditional doctor's diagnosis, Lobsang referred to his disorder as a 'BP' (blood pressure) problem, resisting engaging with the traditional aetiology of *rlung*.

The Tibetan herbal pills that Geshe Lobsang took punctually after every meal would be of no help to avert the danger of severe mental disorder. A urine diagnosis by his personal Tibetan doctor revealed large bluish looking bubbles, confirming the diagnosis of a *rlung* disorder. A radical treatment for this illness was to apply a long, heated golden needle to the patient's cranium at prescribed points. Through this treatment, the symptoms of such a *rlung* imbalance could be radically, and almost always permanently, relieved. But Geshe Lobsang was repelled by the invasive nature of this treatment and pointed out that he did not wish to have a hole in his tonsure. He managed to persuade his regular physician to let him continue his normal pill treatment. The doctor nevertheless asked him to go for a blood test at the hospital to check his sugar levels. Although Geshe Lobsang had heard his results in January, he only told me in April that they had suspected he had diabetes mellitus. The reason for his ambivalence in telling others about his suspected condition was,
according to one of his relatives, because he did not want to be associated with the other monks whose intake of rich foods was thought to aggravate their diabetic condition.

Lobsang thus avoided the local hospital where nurses and doctors were prone to gossiping about their patients’ illnesses and retreated to the quiet haven of the MTK. The diagnosis and rapid treatment of diabetes has become a public health priority in the Tibetan community, as diabetics are very prone to infections, particularly to tuberculosis. One possible traditional form of treatment consists of a daily half cup of bitter gourd juice and black berries (ka wed kag khotri) in black dal with a spoonful of honey. The roots of black berries are traditionally used in Ayurveda to cure diabetes, and the bitter gourd’s essential property is to reduce the levels of sugar in the blood, as Geshe Lobsang’s doctor explained. When I asked Lobsang whether he believed this illness might have been caused in some way by karma he shrugged the remark off and said: ‘if that is the case, then everything is caused by karma’. I was thus left rather perplexedly trying to explain to myself why one of the most erudite Buddhists in the settlement did not himself believe in the all-pervasiveness of karma but seemed more concerned with his tonsure, his endangered social status, and the bad reputation which his condition might attract to him.

According to the traditional Tibetan doctor who had treated him, the Geshe’s busy lifestyle, diet and high level of intellectual activity had caused the imbalance. Behind this diagnosis lurked a slight reproof of the Geshe’s quick social ascent in the exile religious hierarchy. The choice of golden needle treatment implied that there was a serious rlung problem to be treated.

One might suggest that the Buddhist emphasis on selflessness and altruism is increasingly coming into conflict with perceived ‘modern’ values of self-promotion, ambition and self-conservation which have emerged in the Tibetan community in exile. This tension is still being reworked within the notion of karma, or moral responsibility. The disorientation of the youth, their frustrated ambitions, women’s desire for emancipation and the general climate of social insecurity induced by exile have given rise to new opportunities for social ascent, sometimes creating jealousy and internecine conflicts, and perhaps also conflicting
with the idealised egalitarian values of exiled Tibetan society where, all refugees are presented as being ‘in the same boat’ economically and socially.

In this chapter, I have shown that Tibetan exiles are meaningfully selective in the way they present and legitimate the intervention of environmental factors, humors, karma, ‘bu, and the relationship between these factors, in the course of their illnesses. Some, like Dawa and her aunt Tsering, will relate the emergence of disease to personal histories and karma. Others, like Thagpa, will draw meaning from physical and social constraints, from the hardship of exile. Others yet, such as Geshe Lobsang, sideline karmic explanations in favour of more biophysical motives. Geshe Lobsang’s reluctance to adhere to a karmic explanation, and his choice to segregate the biophysical from the social, are a reflection of his concern with social status and exile politics: by doing so he is able to shrug off social sanctions which judge his rapid social and financial ascent.

As Geertz points out: ‘the movement back and forth between the religious perspective and the common sense perspective is actually one of the more obvious empirical occurrences on the social scene (...) human beings move more or less easily, and very frequently, between radically contrasting ways of looking at the world, ways which are not continuous with one another but separated by cultural gaps for which Kierkegaardian leaps must be made in both directions’ (1993: 119-20).

The diversity of explanation modes presented by Tibetan exiles reveals their margin of agency in the search for causes: the spheres that Adams and Janes see as interrelated are only so in as far as exiles choose them to be, indeed insofar as their integration may legitimate or compromise their social status, and make sense of their own personal narratives of exile.

Related to this, humors, ‘bu and karma are motives easily invoked to create order in otherwise piece meal exile trajectories, which must also be realigned with dominant exile discourses about refugees, health, and the sanctioned list of ‘reasons for coming into exile’. Karma is a cognitive and narrative vector that helps to make sense of one’s life and instil significance in traumatic events, but it can also be a means to obviate questions and
potential criticism (the explanation 'it was karma' can then act as a 'silencing' statement, fending off further questioning). As such, it can be seen as a contextual 'technique' rather than as an ontological statement. Individual agency determines the recourse to karma in selective strategies of presentations of the self and contextual negotiations of status. This is congruent with Janes’ findings in the TAR: 'Interviews with a wide variety of Tibetans from different backgrounds show that they express notions of causality that mix notions of mind management, appropriate social behaviour of self and others, pollution or defilement, the actions of deities and demonic misfortune, misfortune or bad luck, strong or 'poisonous' emotion, diet, and weather' (1995:11).

In the daily practice of medical choice-making involving the elaboration of complex explanatory models for illness, exile Tibetans operated more complex and individual negotiations between a traditionalist view allocating the causes of illness and misfortune to Karma, and therapeutic choices dictated by social circumstances and affiliations. The experience of being a Tibetan exile body, I speculate, connects the experiential mode of exile (the constant maladjustment and discomfort of the body with its surroundings), with subjective interpretations of illness and misfortune, which are constructed out of individual histories and strategies for social advancement.
Conclusion

In this study, I have shown that the social uncertainty brought about by the circumstances of exile is reflected in the types of illness explanatory models put forward by Tibetan refugees in Dharamsala. In part one (Chapters 2-3), I have dealt with changes in social organisation and outlined two forms of economic strategies specific to exile, рғғ рғғ, or sponsorship, and 'gyogs pa, the social and economic support of kin and friends. Chapter 2 shows that the tension between earlier settlers and newcomers is manifest in the way in which newcomers are commonly seen as bearers of disease such as TB. Competition for sparse jobs and the stresses linked to further migrations out of India lead to an increase in psychosocial stress among the youth, as is described in Chapter 3.

In part two, I have shown how social change and exile predicaments are linked to perceptions of healthcare. Social 'inclusiveness', reliance upon kin, friends and networks of 'gyogs pa affect therapeutic strategies, and play a critical role in management of prevalent diseases. Chapters 4 and 6 show how, at a symbolic level, the 'unhealthy' state of exile has led to an increase of the Tibetan community's moral investment in Tibetan medicine. Tibetan medicine has gained ground because it deals with the disorders caused by environmental and psychosocial factors linked to exile, which Tibetans often feel are causes of illness. The exile environment also impacts on perceptions of health in more literal ways: data from the surveys presented in chapter 4 show that the 'hot', 'humid' and 'polluted' Indian environment are deemed partly responsible for the exacerbation of humoral disorders and the advent of 'new diseases' such as TB and diabetes. The uncertainty of exile, coupled with the plethora of medical services on offer, also explain the refugees' reliance on mo pas who are able to predict the nature and course of an illness, and an adequate mode of therapeutic action. Chapter 6 has offered four case studies dealing with experiences of illness, showing how the circumstances of exile are fitted into the refugees' illness explanatory models.

Exile uncertainty is thus reflected in Tibetan refugees' illness explanatory models, and in
the organisation of healthcare provision in Dharamsala.

7.1. Hierarchies of suffering: instrumentalising the Tibetan exile body

In the following concluding remarks, I build on the material presented in this study to argue that a hierarchy of discourses relating to bodily suffering exists in the exile context. In this hierarchy, physical suffering is given greater salience if it has potential political use in the context of the exile political rationale of non-violent resistance. In order to demonstrate this, I examine two examples in which the body is used as a vehicle for mapping out exile political agendas: firstly, the case of torture survivors, and, secondly, the rise of exile rlung disorders. Through these two examples, I highlight an exile hierarchy of discourses about the body, illhealth and disease that privileges politically meaningful suffering.

In order to introduce this discussion, the next section explores Tibetan conceptions of the body, leading into a discussion of its political instrumentalisation in the context of exile.

Part of the problem with trying to define or categorise different discourses about Tibetan suffering, is that accounts of Tibetan ethnoanatomy, aetiological systems and 'idioms of distress' are scarce. Some information can be drawn from historical inquiries (Tucci 1967; Snellgrove & Richardson 1968), from more recent anthropological work on illness in the TAR and among the Tibetan Sherpas of Nepal (Ortner 1978; Adams 1992, 1996; Desjarlais 1992), and from biographical accounts of life in Tibet (Tsarong 1981; Norbu 1987). As we have seen previously, Buddhist theory and practice underscore Tibetan understandings of the body. Tibetan physicians must meditate on the Medicine Buddha Mandala and identify their own body, speech and mind with the Buddha nature of body, speech and mind (Sanskrit: tri kaya). Indeed, Clifford argues that Tibetan medicine, through its tantric roots 'provides the bridge between Dharma and the somatic system' and traces the correspondence between the 'under-karmic body', the 'human body' and the 'Buddha body' (1989). Tibetan ethnoanatomy's complex system of channels (rtsa thig) and veins juxtaposes the 'coarse' physical anatomy with a 'subtle' physiology and a cosmological one: actual veins are thus supplemented by 'subtle veins' through which the bile humor
operates, corresponding to the Nirmanakaya (the form body); 'subtle airs' activate the
\textit{mkhbris pa} humor, corresponding to the Sambhogakaya (the apparitional body); 'subtle
essences' vehicle \textit{riang} and correspond to the Dharmakaya (\textit{chos sku}, the ultimate truth
body). The body is thus described as a composite physiological and cosmological
palimpsest connecting the material to the immaterial, and coarse anatomy to external
environmental and internal mental influences.

Tibetan has many terms to designate the body: a.) \textit{lus}, designating the physical body, is
commonly used in medical and religious texts; b.) \textit{sku} applies to the body in relation to the
world, as well as to objects in the world which have relation to, come into contact with, or
stand for, the body (e.g. an image) and is also used in religious and medical contexts; c.)
\textit{gsungs po} is the more mundane, non-honorific term that designates the individual body. All
three terms lend themselves to complex association. The term \textit{sku}, for example, has
manifold meanings: it can be used to refer to the physical body (\textit{sku gungs}) and to a person
(\textit{sku gebogs}, hon.), and is also commonly prefixed to names of parts of the body imparting
to them respectful terms' (Das 1902: 88). The syllable \textit{sku} is also prefixed or subfixed to
words for buildings or images (e.g. \textit{rdo sku}, a stone image; or \textit{sku mkhar}, a fortress), relatives
(\textit{sku mchods}, i.e. brothers and sisters), and also to the notion of lifetime or longevity in \textit{sku
ring}. What is referred to as \textit{sku} thus encompasses much more than simply the physical form
of the body: it is also used as a prefix to describe a person’s moral attributes (as a marker of
respect) and to the extra-corporeal functions and values attached to the body (e.g. \textit{sku
rkyang}, to be alone, lit. an isolated body, and \textit{sku kham}, referring to a state of health and
well-being).

Exiles, when speaking of their own bodies will prefer to use the term \textit{gsungs po}, as the
honorific \textit{sku} is seen as inappropriate when referring to oneself. The syllable \textit{gsungs} designates
the visible, physical form of the body. In practice though, some of the associations that
pertain to \textit{sku} and \textit{lus} will be used by people when thinking about their own \textit{gsungs po}, their
own bodies, particularly about matters of health (e.g. in \textit{sku gungs bde ba}, \textit{good health}).

Contemporary western sociology and anthropology attach significant importance to
understanding how the body articulates ideas of personhood in modernity. According to Giddens, the body has now become the medium and focus of lifestyle orientated projects of self-identity, where health becomes a trope for regimes of self-care (e.g. exercise and dieting). The body is seen as an enabler for individual’s narratives of self (Giddens 1984). Are such ideas applicable to the Tibetan exile context? First of all, one might emphasise the difference between Western and Eastern modes of relating to the world and the body, as Lawrence Cohen, drawing on Marriot’s work (1976) proposes that, ‘within a comparative context many Americans and Europeans act and experience themselves as autonomous and bounded entities, highly individuated selves within quite separate bodies, while many Indians act and experience themselves primarily in terms of their relations with others, as linked and interdependent selves continually sharing and exchanging substance with other bodies’ (Cohen 1998:32). However, Cohen argues that this dichotomy can be called upon in certain contexts, but that it should not be reified into an all-encompassing mode of explanation. This scepticism would serve our understanding of the exile context: the Tibetan refugees’ level of involvement in Buddhist practice is heterogeneous and selective, and so, consequently, is their participation in an imagination of the body as ‘collective’. Furthermore, as we have seen in Chapter 6, the role of Buddhist epistemology in determining which aetiology will be adopted by exiles is contingent upon strategies of self-presentation.

Vincanne Adams has adopted a more radical view in her attempt to characterise Tibetan understandings of the body and health. In her view, the Tibetan model of health posits that morality is embodied, and that ‘people’s’ bodies are literally expressions of their accumulated virtue and non-virtue in relation to past sentient beings in past lives’, thus making the ethical domain constitutive of the physical domain (1999: 8). In the Tibetan exile context however, this process is dialectic: while the ethical is certainly in part constitutive of the physical, the physical, i.e. bodily suffering and diseases linked to exile circumstances, is also constitutive of the ethical domain. In Dharamsala, I argue, physical and social suffering constitute a form of symbolic capital with currency both in and outside the community. Through the process of legitimating ‘refugeehood’ to funding agencies and rags ram-endowing outsiders, physical, social hardships and bodily suffering become imbued with value as social and economic validation. In the next section, I examine how torture
survivors' accounts have become key to the contemporary exile depiction of Tibetan bodily suffering to foreigners, and to the process of political resistance.

7.2 Palden Gyatso's story

In exile, the most common accounts of suffering and illness are not related to TB, but to the atrocities endured by torture survivors in the TAR. Accounts such as Ani Pachen's 'Sorrow Mountain' (2000), and Palden Gyatso's 'Fire under the snow' (1997), for instance, are commonly available in Dharamsala and in the West. Palden Gyatso, one of the most outspoken witnesses of torture in Tibet, was imprisoned for eight years in Drapchi prison near Lhasa before being released on demand of Amnesty International. Gyatso regularly gives talks about his experience in Dharamsala and in the West. I attended one of his numerous talks in Dharamsala in order to see how he made sense of his experience of suffering as a torture victim. The talk was held in one of McLeod Ganj's restaurants which also functionned as a community centre. About fifty people were present in the room, the majority Westerners. Palden Gyatso spoke with the assistance of a translator who had worked with him previously during similar talks.

After an emotionally charged account of the conditions in Drapchi prisons and modes of torture used by the Chinese against Tibetan prisoners, Gyatso went on to explain that he did not resent the Chinese for their acts. Rather, he said, he felt sorry for them, because of the amount of negative karma they had accumulated through their exactions. With great faith, he affirmed that the suffering experienced in prison has enabled him to strengthen his tolerance towards the Chinese, and empowered his spiritual practice. Palden Gyatso's depiction vividly conveyed the violation of Tibetan bodies and the deliberate, progressive erosion of the prisoner's morale by the torturers. The talk ended with Palden Gyatso removing the set of false teeth given to him by his sponsors at Amnesty International (his own had fallen out as a consequence of the electrical shocks inflicted upon him in the Chinese prison). He then candidly exposed a grin of naked gums, the 'embodied' proof of his suffering and of the faith that transcended and beatified it.
This account shows how the refugee's stories move the listener from the particular, exemplary force of individual suffering (embodied in the absence of teeth), to the socially sanctioned appraisal of suffering as a mode of empowerment for the teaching of tolerance.

Indeed, it was this specific section of the account, focusing on tolerance, rather than that of Palden Gyatso's individual story of suffering, which was picked up by the Westerners present in the room. One woman subsequently said to Palden Gyatso: 'I was very touched about how you said this experience had taught you how to be more tolerant, and I feel like this is something very relevant to my own life as well... Could you explain to me a little bit about how you developed this tolerance?'. At this point in the talk, we are no longer concerned with the individual's testimony, but have moved to the exegesis of Buddhist teachings on compassion and tolerance, which Palden Gyatso proceeded to elaborate on. Following the talk, the crowds gathered around the monk, some wanting to speak to him, others just to shake his hand. One woman said: 'He's amazing, just look at him, look at this small little man, he is so frail, and he has taken all the suffering in the world onto his shoulders'.

The erection of martyrs of torture and resistance is a regular feature of exile life, with religious figures' books and testimonies constantly appearing in print and in flesh. This is in keeping with the strategy of non-violent resistance (satyagraha), which requires a constant display of suffering in order to impress upon the opponent the injustice of his violent actions. Recently another martyr was added to Dharamsala's landscape and busy commemorative calendar by the Tibetan Youth Congress: a statue of Thupten Ngodup, who immolated himself in April 1998 during a Tibetan hunger strike in Delhi was unveiled on April 27th, consecrated as 'Tibetan martyr's day', and consequently offered a memorial, a *sku gshegs dpa' bor mya ngan tjes dran zhu*, or as translated by Garratt, a memorial to the passing of an Heroic Being (2002: 73).

In elite religious and political discourses, the instrumentalisation of the body is connected to the Dalai Lama's commitment to the non-violent struggle for Tibetan freedom. An example of a local political speech illuminates the above remarks on the saturation of Tibetan freedom politics with the discourse of non-violence:
The first responsibility of humankind is to work for the happiness of all living beings. The second is to preserve and promote one's respective religious teachings and culture. The third is to work for the interest of one's own people and nation. As followers of His Holiness the Dalai Lama and believers in Mahayana Buddhism, we Tibetans must practice this teaching in our day-to-day life, both at individual and at community levels. As a matter of fact, I recognise this as the Tibetan people's unique universal responsibility. Our freedom struggle is not merely to serve the interests of Tibetans; it is to preserve the tradition of inner wisdom and unique culture for the benefit of the whole world. Therefore, I do not see our movement as a political struggle; rather I see it as spiritual practice.105

Exile Tibetans have appropriated the Indian ideological heritage of non-violence (*satyagraha*), and this informs the political meanings given to social and bodily suffering of Tibetans. The CTA and the Dalai Lama, concerned about the sectarianism eroding the exile sangha and the need to promote social unity among Tibetan exiles, appeal to the higher moral order of Buddhist ethos in order to safeguard the fragile borders of the Tibetan moral community. As spiritual and temporal leader of the Tibetan Buddhist community, the Dalai Lama commands over a body politic that instrumentalises its own bodily and social suffering for political purposes. By setting the Tibetan struggle within the broader context of a Buddhist experiment with non-violence, the exile élites have given it a universal appeal that extends its ideological impact far beyond Dharamsala. The body is used to make exile distress manifest, though sometimes with conflicting agendas: the exile Tibetan Youth Congress, for instance, against the Dalai Lama's advice, instrumentalise bodily suffering through hunger-strikes and the celebration of immolated martyrs, in order to demonstrate their frustration with his political approach to the freedom struggle.

Other possible political readings of Tibetan bodily suffering are revealed in the rise of exile *rlung* disorders to parallel *rlung* disorder epidemics in the TAR. In the following section, I argue that the role of *rlung* (wind) in regulating bodies and making social distress manifest in somatised ways is similar in exile and in the TAR. In exile, *rlung* disorders are related to adverse social and environmental circumstances, and manifest bodily suffering at the level of the 'social body'.

7.3 The significance of *rlung* disorders

As we have seen in Chapter 4 and 5, *rlung* disorders have emerged as a specific problem linked to the hardships of exile. They are symptomatically found among newcomers in the Soga schools, monks, nuns, and persons absorbed in contemplative activities. The exile
environment is thought to cause \textit{rlung} disorders linked to the unhappy and worrisome states of mind brought about by exile hardships. The physical environment of exile further exacerbated such disorders: \textit{rlung} imbalances occur primarily in the hot summer season, when Tibetan refugees recurrently complain of the heat in the Indian settlements. Some have told me that they see the religious teachings coinciding with the monsoon as an opportunity to cleanse themselves from the accumulation of \textit{rlung} incurred during the summer. Disorders linked to \textit{rlung} also appear if there is insufficient or inadequate food and water, causing hunger and thirst (\textit{bkeres skom}). This often occurs during the extended Indian 'summer', when exiles regularly comment on the scarcity of foods, especially meat, and water.\footnote{232}

Adams' and Janes' research has sought to construe \textit{rlung} (wind) disorders as a somatised 'weapon of the weak', a syndrome through which meaningful individual experiences of oppression and resistance are articulated. Connor further articulates this idea: 'Tibetan medicine provides a context in which people can express their distress in their own cultural idioms as a vulnerable and disenfranchised minority in the PRC, subjected to forms of racism' (2001:16). The identification of the Chinese government with 'the government of \textit{rlung}' (Adams 1995: 3) is the exemplary statement which sums up these endeavours. Here \textit{rlung}, or wind is seen to designate a force located both inside the body and outside it, through the intermediary of the body as body politic, thus permeating the boundaries of the social, cultural and political. The Tibetan body is therefore constituted by the social, and experienced at least to some degree as a 'collective' body, encompassing the suffering of individual Tibetans as one 'body politic', in Lock & Scheper-Hughes' terms (1987). According to Adams, in Tibetan medicine, 'unfulfilled desires' are a disruptive influence which can destabilise the body's \textit{rlung} humor. She argues that 'living under conditions that are in any way oppressive, whether family arguments or political discontent - can cause illness' (op.cit.).

Janes, in his analysis of \textit{rlung} diseases, offers a similar conclusion: 'in Tibetan culture, the category of \textit{rlung} encompasses the political as part of bodily suffering, and as expression of the social and moral connections between people. Its expression in ailing Tibetans thus reveals that they experience subjectivity as at least partially collective, based on notions of
karma and an inseparation of body, mind and society.' (op.cit: 92). Adams furthers these claims by arguing that winds, because they are linked to the mind and perception of phenomena, are both constitutive and reflective of the relationships one has with others, and with the physical conditions of one's life because they are mediated by perceptions.

In exile, references to rlung disorders are more than common. Transit school patients examined by Tibetan doctors are said to be full of rlung, and so are over-worked Geshes like Lobsang and torture survivors. The exile environment is thus perceived as conducive to rlung disorders. Tibetan medicine, because of the emphasis it places on the environmental determinants of health, is particularly suited to the care of misfit exile bodies.

Dealing with exile disorders such as rlung has become a matter of 'public health', linked to the biomoral imperative of survival in exile. The Men-Tsee-Khang's role in defining an 'alternative' public health agenda is clear from its commitment to offer services in all Tibetan exile settlements in parallel to allopathic clinics. The Men-Tsee-Khang student's idealistic dispositions, their writings about the importance of not drinking, smoking, following the guidance of teachers -most importantly the Dalai Lama's- explicitly link the Tibetans' survival in exile to a prescriptive biomoral programme. The Men-Tsee-Khang's work in public health and dealing with problems like rlung outbreaks can also be understood as part of the Institute's adherence to a greater agenda of political and moral reform that invests Tibetans with the responsibility of non-violent activism. The Tibetan exile leader's promotion of Tibetan medicine as a culturally adequate system of healthcare with foundations in Buddhist practice elevates Tibetan traditional medicine to the role of key provider of healthcare and orchestrator of public health.

Thus, the exile political agendas of cultural preservation and non-violent militancy privilege ' politicised' physical suffering. Conjunctly, individual narratives of suffering are given a political hue through their expression in illness explanatory models that identify exile as a source of ill-health.
Endnotes


2 However Saklani asserts: 'the study reveals that the population movement from Tibet was selective in some ways, particularly in the earlier phase: the first stream comprised of the 'elite' society, members of the Dalai Lama's family, the cabinet (Kashag) members, monks, lamas and Khampas' (1984: 40). The 1998 Demographic survey located only 23,980 out of the 80,000 initial refugees, the majority of which came from the U-Tsang region and Kham.


5 The findings of this survey have been reported in Bhatia, Dranyi and Rowley 2002.


8 Interestingly, Das reports btsam: "a species of demon, inhabiting a given locality and sometimes entering into a person visiting the place for a brief period and causing thereafter serious illness" (1902 [2000]: 1002).

9 In 'Dreams of Tibet' Frontline Documentary Transcripts: http://www.pbs.org/wgbh/pages/frontline/shows/tibet/interviews/norbu1.html

10 This is a contentious issue: some newcomers reported that because the Government in Exile can no longer cope with the influx of new refugees, they are now being offered Rupees 4000 to make the journey back to Tibet. However, most Tibetan exiles deny this, and Gangkli workers are simply outraged at the suggestion. Some even declared that these assertions were the work of Chinese infiltrators spreading lies about the Government in Exile (see Chapter 2 for accounts of newcomers as 'spies').

11 Caldwell et al. 1990.

12 Ayurveda, Unani and Siddha medicines, naturopathy, homeopathy, and yoga.

13 Some informants, on the other hand, were extremely keen to provide me with 'illness narratives', and this was often associated with specific political and personal motivations (e.g. in raising sponsorship or in the context of political rallies).


15 Khamdo is the compound word to designate the eastern regions of Kham and Amdo, in opposition to U-Tsang (central area of Tibet).


17 The 1998 Tibetan Demographic Survey registered a population of 8,694 with a household questionnaire in Dharamsala, and 7,631 in Bylakuppe, Lugsung Samdupling.

18 On the traditional weakness of the daughters in law and power of the household mothers, see also Hildegard Dierberger's work on gender among the Khumbo of North eastern Nepal (in Del Valle 1993: 100).

Grent's recent study of polyandry in Dharamsala reveals that 'by the year 2000, three generations of long-timers [sic] had settled in Dharamsala and in 31 cases polyandry was still practised (...) also four cases of polyandry among newcomers were reported, adding up to 35 polyandrous families of 108 spouses from three different generations' (2002: 113). Grent found the majority of instances of polyandrous marriage among two groups: the older generation of refugees, and newcomers from the eastern provinces of Kham and Amdo. In the majority of cases, polyandry was bi-fraternal. She reports that, often, exile polyandrous marriages appeared to fulfil a similar role to that which it occupied in Tibet, whereby polyandrous households could pool together land and income derived from agriculture. The critical difference in the exile setting seems to be that Dharamsala's polyandrous spouses (including increasingly productive Tibetan women) leave the household to engage in sweater trading, or on other jobs outside the community. Grent suggests that polyandrous marriages afford high status because they bring about greater material wealth and stability to the household. However, the cultural cachet associated with polyandry has somewhat lost its lustre in Dharamsala, as many third-generation Tibetans deride it as anachronistic. Unaware polyandry and polygamy (e.g. when one spouse is left behind and the other remaries), and pseudo-polyandry and polygamy (e.g. in the case of one partner living abroad with one spouse and maintaining another in exile for instance) are also reported by exiles.

This is to be interpreted in the same way as Nagpai chos, literally, 'the insider's faith' or Buddhism, not as a geographical category but as a category of group belonging in the larger sense.

Non-honorific kinship terms for paternal uncle: a zhang, maternal uncle: a khur, maternal aunt a nr, paternal aunt a rn mo, nephew: bu tsha, niece bu mo tsha.

They added that she should not be spotty, that is, have the characteristic dark cheek freckles denoting an unbalanced diet (sha rtags), not be nag po (black) as is the case for some female refugees who have darker skin than others, and not have b:hin ras ngan (an ugly face, with acne).

One female informant told me that the size of the coloured rectangles on the panggdan betrays the origin of its owner: a tight, condensed patchwork of rectangles is the mark of an urban lady, while the panggdan with larger squares is worn mostly by rural women. This could be taken as an indication of the wealth of the apron bearer, as the busier patterns require greater craftsmanship in weaving, and are therefore costlier. In Dharamsala one would most often see the tighter looking pattern, although some newcomer women would wear the larger ones. I also noted that women tend to come to cultural gatherings and commemorations with panggdan displaying the larger rectangles as worn in their traditional regions, panggdan which they would not normally wear on everyday errands around town. This is perhaps indicative of an emergence of exile 'wear' expressed through the choice of a more 'urban', sophisticated style of dress and choice of jewellery and where regional styles of dress are only displayed during cultural festivals.

Tibetan households, depending upon the ages and life cycles of the inhabitants, often exhibited a sequence of these marriage styles rather than a permanent pattern established at one key point. Deaths, the addition or loss of economic holdings, the birth of children, individual desires, and the availability of in laws and others as sexual partners all contributed to great fluidity in marriage and household arrangements' (French 2002: 38).

These are not 'exiles' but possibly displaced traders who come attracted by the business in Dharamsala and return regularly to Kashmir to buy more handicrafts to sell on the markets and see their families.

This family, along with others in its neighbourhood, often receives young Westerners as part of group trips during which they are supposed to stay with local inhabitants. They are paid for the boarding and food of these youngsters, but are often challenged for space during such visits, as was the case for this family which gave up one of their three beds for that purpose.


One of the mistakes which the youth are commonly accused of is that of misreading the complex syllabic
Tibetan system and simplifying words, e.g. pre' u (monkey; correctly pronounced tei' u), which they pronounce ‘pin’.


31 The rumours were unfortunately consistent with the Tibetan Centre for Human Rights and Democracy’s report, which stated that 1,375 refugees had reached India in 2001. The centre reported that the number would have been considerably larger had it not been for the arrest of approximately 2,500 refugees on the Tibet/Nepal border due to more stringent Nepalese border control policies. This discovery further fed into the conspiracy theories of ‘spying’ abounding in the exile community, leading to increased suspicion towards newcomers.

32 Although the case of elderly newcomers is also difficult to classify, as some are engaged in economic activities within the home to support their kin.

33 One of the first occupations of Tibetan exiles in India was working on the roads.

34 When an attempt to repair the road was made, female CTA workers were often heard empathising with the Bihari women working on the road who carried, on their heads, stones to fill up the holes.

35 The Tribune of India, Chandigarh, October 6, 2002.


37 TCV and the Men-Tsee-Khang have their own sponsorship intermediaries, whose jobs it is to find sponsors for their students to help through their education.

38 ‘IC’: The ‘Identity Certificate’ necessary for Tibetans to go abroad.

39 The town shops are regularly inspected by the local Indian police who try and arrest traders without permits. Following the events of the 11th of September, although I was not in town at that time, many Kashmiri traders reported that the raids intensified and specifically targeted Kashmiri businesses.

40 De Voe seems to hint at this when she describes how the refugee-helper relationship is sometimes paralleled to that of a child with his/her ma baap, or mother-father in Hindi. ‘Expectations of nurturance and reliable, continual support are the ma aspect of interveners; the paternal authority, the controlling, punishing figure who judges the worthiness of the refugee is the baap aspect’. (1981b: 90).

41 The usual training involves three years of logic, five years of study of the Perfection of Wisdom Sutra (Prajnaparamita), two years of study of the Emptiness view (Maddhyamika), two years of discipline studies (Vinaya) and two years of study of the Treasury of Philosophical notions (Abhidarmakhosa).


43 The latter sell products such as gingerroots, medicinal stones, etc. See picture on the following page. This plurality is characteristic of Indian urban healthcare systems where allopaths cohabitate with homeopaths, naturopaths, herbsellers, etc. It is not therefore solely a result of Dharamsala’s burgeoning tourist ‘health market’ for visitors.

44 Foreign volunteers wanting to set up physical therapy practices in aid of exiles and ex-torture victims were faced with initial suspicion on the part of both allopathic and traditional Tibetan practitioners, because of the potential associations drawn between their work and massage practitioners. The initial reticence was
eventually overcome and regular clinic hours with foreign physical therapists were held within the MTK precincts and at Delek Hospital in 2001 and 2002.

45 I was not able to get an account of the departure of Dr. Yeshi Donden, erstwhile first director of the MTK (1961-1966) and now figurehead of Tibetan medical practice worldwide. From other cases though, I gathered that some doctors who left the TMAI did so seeking financial gain and greater clinical independence. The forced placements that the TMAI inflicted on its students are sometimes the cause of great distress because of the difficulty of resettling in another community (students particularly dislike the southern settlements).

46 Although today many exiled Tibetans claimed that Tuberculosis did not exist in Tibet before the Chinese invasion, there are strong reasons to doubt this. Firstly, Tibet has long entertained trade relations with China, India, Nepal and other Central Asian countries, making its isolation from diseases like TB highly doubtful. Secondly, TB is now reported as endemic in the Tibetan Autonomous Region. I was also cited evidence about ultraviolet light on the Tibetan plateau not allowing the survival of the tubercle bacilli by traditional Tibetan doctors.

47 Recourse to divinatory practices has been severely undermined in the Tibetan Autonomous Region, as reported by Janes and Adams (2002). I was told that some divinatory practices which existed in pre-1950 Tibet, such as the burning of sheep’s shoulder blades and interpretation of the cracks thus created in the bone, are rarely practised in exile, although no specific explanations were given to me for this.

48 On the topic of gdon, Calkowski (1985) argues: ‘Two efficient causes of illnesses result in spirit attack: (1) the first attributes spirit attack to human violation of hierarchical tenets; (2) the second, to the illegitimate status ambitions of evil spirits. The logic of the ritual cure addresses the resolution of status ambiguities. Successful ritual cures are appreciated in terms of two idioms denoting two aspects of charismatic authority. When the spirit attack results from human violation of hierarchical tenets, the patient’s cure is contingent upon his or her unsystematically acquired power (rlung-rta). When the second efficient cause obtains and evil spirits are responsible for the attack, the patient’s cure depends upon the outcome of a duel between an exorcist and the spirit(s), and the successful cure is described in terms of systematically acquired power (dbang).’ (1985: abstract).

49 The WHO publication by Maher, ‘What is DOTS?’ (1999), defines DOTS’ five key components: (1) Government commitment to sustained TB control activities, (2) Case detection by sputum smear microscopy among symptomatic patients self-reporting to health services, (3) Standardised treatment regimen of six to eight months for at least all confirmed sputum smear positive cases, with directly observed treatment (DOT) for at least the initial two months, (4) A regular, uninterrupted supply of all essential anti-TB drugs (5) A standardised recording and reporting system that allows assessment of treatment results for each patient and of the TB control programme overall.


51 Dorje notes the importance of the reproduction and dissemination of such sets of paintings in the Tibetan medical tradition, and gives three main categories: 1. Arboreal metaphors (sdong 'gremi) encompassing physiology, pathology and treatment; 2. Topographical lines of the body (yul thig) with blood vessels, nerves, the energy system of the subtle body etc.; 3. Linear sequential compositions with Tibetan materia medica etc. (1992: Introduction).

52 Some Dharamsala physicians have also followed a hereditary path of training, for example Dharamsala’s famous female physician Lobsang Dolma Khangkar, who could not join the MTK at its inception because it did not accept women.

53 My informant told this story in English.

54 Description available from http://www.dharma-haven.org/tibetan/medicine-clinics.htm

55 Plants used in Tibetan medicine are found in Tibet, Ladakh, Bhutan, Sikkim, Himachal Pradesh and
Arunachal Pradesh in varying quantities and while there is much demand from centres like Dharamsala and Darjeeling, independent practitioners like the lineage holders of Ladakh have to provide for their own needs or purchase plants from these major centres.

The Tibet Information Network's 2003 report entitled 'Delivery and Deficiency: Health and Health Care in Tibet', reports that 'the Tibet Autonomous Region has the highest rate of tuberculosis in the PRC'.

Sowa and Muraki noted that campaigns of BCG vaccination were underway, with the aim of vaccinating 75% of children under five by 1995. It is now estimated that this campaign has been successful in the Kangra district.

From 'Tibetan Women: Oppression and Discription in Occupied Tibet' report issued by the CTA for the Fourth World Conference on Women, Beijing, September 4-15, 1995.

This is confirmed by Phuntsog Stobdan's findings in Ladakh (1992: 167). Stobdan reports that Tibetan refugees account for most cases of leprosy in Ladakh, and that one refugee settlement alone had 37% of the cases in the whole region.

The survey of Bhatiaa et al. indicates that cancer is the most common cause of death among Tibetan exiles, closely followed by pulmonary tuberculosis.

MTK doctors later denied this when I questioned them about it.

Many students seemed to think this was excessive considering the poor living conditions in the school and the lack of employment prospects following the curriculum.

There was a commemoration in McLeod Ganj on that day and many newcomers had gone up to see the celebrations.

Looking at the developments of Tibetan medical practice in India in relation to its TAR counterparts may provide us with an interesting comparative framework to analyse the influences of social and political factors on the integration of traditional and biomedical systems.

Some scholars, such as those belonging to the medical tradition of mkhar, believe that the rgyud bzhis was in fact composed by Yuthog Yonten Gonpo the Younger in the twelfth century (cf. Pasang Yonten Arya, 1987).


The expression nyams rtags is also used in a religious context to designate temporary meditation experiences and realisation of the nature of things in Buddhism.

In English except the italicised Tibetan word.

TCV and Tibetan Institute of Performing Arts groups in particular are very active in such events.


Students commented that monks have a facility for medical training due to their trained powers of memorisation.
Here I refer more specifically to training institutions such as Sarnath and Sara, whose curriculum mixes the study of Tibetan language with that of religious studies. The study of Tibetan grammar, particularly, makes use of mnemonic and didactic methods similar to those described above (e.g. in the study of Sambhota's seventh century *snum-'du pa*).

This is a particularly interesting development, for, if students stay and practice within the MTK, they will not often have the leisure to go and collect their own plants, which are gathered by more local MTK workers. Nevertheless, the yearly trip to nearby mountains and Manali every August is seen by students as one of the highlights of the year.

Students can also get paid work in the institute, for instance, preparing pills with the MTK technicians.

Literally, 'shit-mouthed', using the same syllable as in *gag pa*, excrement.

Authorship from Gerke, personal communication, June 2003.

Although they do need to be studied.

In reality, *go* is a multifarious term: etymologically, it encompasses activities as diverse as feeding, nourishing, mending, repairing, and curing. As the verbalised clause *go bar byed*, it relates more specifically to medical treatment, with references to curing, stopping, or putting an end to disease (Das 1902: 1312).

Namely disorders of the heart, lungs, liver, spleen, kidneys, stomach, small intestine and large intestine.

This could also have been interpreted as 'chronic diseases' but I clarified the meaning with the lecturer.

Here I use Dorje's clarification on arboreal metaphors, i.e. *sdong 'grem*: metaphors illustrating 'the entire structure of Tibetan physiology, pathology, diagnosis and treatment' (Dorje 1992)

The term *srin bu* is used in the *rgpud bsig* to characterise parasites and microorganisms. It is said that there are *sarin* both in and out of the body and that invasion of external *sarin* may disturb the internal ones.

This was identified as bezoar (or *dang ri*), Yonten 1998: 33.

Although I was not able to get more details on this specific area of research, the MTK has reportedly been engaged in herbal research for treatments against cancer, and has recently set up a three month camp in Dharamsala with the Cancer Detective Society of India to incorporate the indigenous Tibetan medical system into the detection and cure of cancer as part of a holistic multidisciplinary approach. The MTK has also held 'Breast Cancer Camps' with the help of visiting Indian doctors, responding to the increasing fear of breast cancer in the community. Nuns are told to be particularly attentive to health problems as they are thought to be more susceptible to breast and ovarian cancer. One traditional Tibetan female physician explained that prolonged sexual abstinence had repercussions on the female organs and that nuns should be particularly careful in checking their health regularly. A female nun friend in her mid-forties went to see an MTK doctor complaining of influenza signs, back pain, and that her period had stopped, and was told to go and get a 'mammogram' and see a gynaecologist at the district hospital.

According to the report, the definition of a 'successful outcome' was: 1. Fasting Plasma Glucose less than 140 mg/dl; 2. Post-Prandial PG less than 200 mg/dl; 3. Glycated hemoglobin (GHb) less than 8.5%.

Type 2; 136 males and 64 females.


If the effects of Tibetan herbal pills on Diabetic patients become ascertained however, MTK doctors may have to think of designing a placebo for Tibetan pills, which would certainly put them and the observers in a
practical and medical conundrum.

'Treatment blinding in the evaluation of herbal medicines should adopt the approach of conventional medicines, e.g., using active and control formulations with similar colour, taste, and weight. However, if the herbal medicine cannot be administered in a predetermined standardized formulation, it will be impossible to keep the treatment blinded. Treatment blinding is also difficult to implement in most types of traditional procedure based therapies.' In: General Guidelines for Methodology on Research and Evaluation of Traditional Medicine, WHO, 2000.

Through the MTK's website, one can now order medicine and have a consultation with doctors of the institute. It also organises courses on Tibetan medicine for foreigners once a year, and teachers from the institute regularly travel abroad to practice or give talks on the subject of Tibetan medicine.


Although exiles living in the 'Old People's Home' receive weekly visits from allopathic doctors, those who are in the care of relatives often escape the net of TB surveillance.

During this interview, Rinchen switched regularly from Tibetan to English and I have quoted her in the original language with translations in parentheses for the Tibetan.

It is generally acknowledged that more Tibetans attempt to cross the border to Nepal during the winter months when there are fewer border patrols operating because of the snow.

The Sanskrit root kr, means 'to do, make, perform, accomplish, cause'. In the religious and philosophical sense, karma means 'an action potential', which manifests itself as moral result in subsequent lives. One can trace the essential features of the doctrine of Karma to the Indian Vedas: notions of soul transmigration and accumulation of actions that bear fruit in future lives. Desire or attachment to the ego is seen to be the source of all karmic activity.

I came across three instances of patients having dream visions of the Dalai Lama either at the onset or at the end of an illness episode. One patient with digestive problems also said she had had a dream of the Buddha, clad in white, coming down towards her while she was sleeping.

In English.

The humor of rlung, generally translated as wind, is one of the three fundamental forces that regulate the functioning of the body. It is traditionally said that the mind rides on rlung like a horseman on his mount, illustrating that this humor is akin to a nervous system, largely responsible for carrying and regulating emotions and states of mind. Therefore an imbalance in rlung can have grave consequences on the mind: a block in the healthy circulation of rlung can lead to mental sickness and even insanity (see also Jacobson 2000 for examples of rlung disorder treatments). I am grateful to Prof. Geoffrey Samuel for pointing out the common conflation between rlung as vata (one of the three humours) and rlung as prana (or 'vital breath' in tantric theory).

I owe this interpretation to Prof. Murray Last's comments during an earlier presentation of this material.

Tenzin Khynenrab Penpo, a second year medical student, wrote this 'Tribute' to Thupten Ngodup in 1999 (In: gang ri la too, No.5 (1999): 71):

"Was it a fit way to glory?
Or a bid to illuminate the self,
With its own light?
He merged in the air with the slogan of 'Rangzen',
Unsurrendered to the invaders, behind the great wall,
Choosing the path of self-immolation, with the mighty soul,
Sacrificed his life, for the human right of his nation fellows."

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Samdhong Rinpoche on the day of his swearing in as Kalon Tripa: A commitment to strive for culture of Democracy, September 5th, 2001.

It should also be noted that there are also more diseases related to wind than to any of the other humors (42 out of 101 overall disorders) and that rlung is seen as the original cause of all disorders because of its influence on the regulation of heat and cold in the body (Finckh 1988: 22). Furthermore, the wind humor is easily influenced by the two other humors, and, similarly, its own disruption easily creates an imbalance in the other two. Adams notes that Tibetan doctors explain the wind’s role with a modernistic metaphor making an analogy between the three humors and three fighter planes flying in unison: ‘the ditung is the lead pilot who, when he detects small deviations in his flanking planes, moves towards them rather than keeping them on course himself’ (1999: 12). In: Princeton Weekly Bulletin April 12, 1999.

The rlung humor thus plays a critical role in orienting the general humoral behaviour of the body, and also as an internal force ‘tuning in’ with external forces like environmental, mental and karmic changes. Its close relationship to the mind and perceptions of the environment is exemplified by the fact that severe rlung disorders both stem from and create serious distortions or disorders in one’s perception of self and the environment. This is the case for instance in unexplained fainting or coma, or rlung gi khyer te gongs theng gi yang bying [when the wind carries one off].

Cf. The Men-Tsee-Khang’s journal gang ri la tso, for example in No.5, 1999, 102-104, on AIDS and its causes.

The Dalai Lama’s commitment to non-violence and its correlated biomoral ethics draws much from Gandhi’s idea of Satyagraha. Discussing the link between ahimsa, satyagraha and Gandhi’s agenda for public health, Alter writes: ‘non-violence was, for him, as much of an issue of politics, morality and religion. To read ahimsa simply as practical philosophy, political theory, ethical doctrine, or spiritual quest is to misunderstand the extent to which Gandhi embodied moral reform and advocated that reform’s embodiment in terms of public health- a kind of health which may be understood as inherently political, spiritual, and moral in the context of late imperialism’ (1996: 304). Although the Dalai Lama’s commitment to the prescription of dietary and behavioural programmes is certainly not as deep as Gandhi’s was, he plays an important role in publicising the strengths of Tibetan medicine for prescribing rules of healthy living, often demonstrating its virtues on himself.
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Appendix A: Health Questionnaire (Tibetan and English, phonetic)

1. Personal Information

1.1 Khye rang gyi tsen la ga re yin?
What is your name?

1.2 Khye rang dgun lo ga tshod yin?
How old are you?

1.3 Khye rang ga par kyie pa red?
Where were you born?

1.4 Khye rang bod nas pheb pa da yin pas?
Have you just come from Tibet?

1.5 Khye rang gi pha ma bod (rgya gar) la ga par thrung pa red?
Where in Tibet (India) are you parents from?

1.6 Khye rang diyr pheb ne rgyu ring los chin song gas?
How long have you been here?

1.7 Khye rang diyr lob ta la pheb nyong gas?
Did you go to school here?

1.8 Ga par?
Where?

1.9 Khye rang diyr cha le ga re nang gi yod?
What is your occupation here?

1.10 Khye rang chang sa rgyab star pas?
Are you married?

1.11 Khye rang pru gu yod pas? Ga tshod yod pas?
Do you have children? How many?

2. Basic Health History

2.1 Khye rang na nyiong ne? Ga dus la?
Have you been sick [have you had the experience of...]? When?

2.2 Gare nyung song gas [na tsha], ga re snyung gi 'dug?
What was it [the illness]?

2.3 Gyu ring lod nyung song gas?
How long did it last?

2.4 Am chi lags ton nang pas?
Did you show it to [a] doctor?
2.5 Am chi ga gi?
Which doctor?

2.6 sman chod ga re nang song gas?
What treatment (eating medicine) did you do?

2.7 sman rin gon chen po red pas?
Was the medicine expensive?

2.8 khye rang khrag tog byed byed pas?
Did you have a blood test?

2.9 dag ru di ye la gyun ring lod gor song gas?
How long did it last until you got better?

2.10 shen tag sman cos ga re nang pas?
What other medicine did you take?

2.11 khye rang na tsha pe sdug cha na nyong gas? Ga re nyung song ne?
Have you ever had any serious illness? What was it?

2.12 khye rang gi pha ma rgyu nas na tsha diy chung pa red pas?
Did any illness come from (through) your parents?

2.13 tag par aem chi cig ton nang gi yod pas?
Do you always show one (the same) doctor?

2.14 sman gyu ring po byed kyi yod pas?
Have you taken medicine for long periods of time?

2. Treatment Background

3.1 bod sman yang se chod kyi yod pas?
Do you take Tibetan medicine often?

3.2 bod pa aem chi su la ton nang gi yod pas?
Which Tibetan doctor do you show (see)?

3.3 na tsha ga re la bod sman kyi phen kyi yod red?
Which diseases do you think Tibetan medicine can treat well?

3.4 rgya gar sman che shos nge bod sman nang shin chod kyi yod pas?
Do you take Indian medicine (that is like Tibetan medicine?)

3.5 de leg sman khang la chin nyong gas?
Have you been to Delek hospital?

3.6 Gang yin zer na?
Why?

3.7 Aem chi kyo ga dang kyie men ga gi dag ba yod pas?
Which is better (do you prefer), a male or female doctor?
3.8 Khye rang gi che nas na tsha ga gi nyin kha tsa shos red pas?
What do you think is the most dangerous disease here?

3.9 khye rang gi che na tsha ga gi sdug shos red pas?
What do you think is the worst disease here?

3.10 khye rang gi nang mi nang nas tb na nying chung yod res pas?
Has anybody had TB among your relatives (in your family, nang mi)?

-chi ni na tsha?
Diabetes (sugar disease)?

-grum bu'i na tsha?
Arthritis?

-chin pa na tsha?
Hepatitis?

-le be na tsha yang ten?
Brain disease or tumour?

-gyab lo na tsha
Back pain?

-pag pas na tsha?
Skin disease?

-snying nad?
Heart disease

-Khrag shed?
High blood pressure
Appendix B: Tibetan Delek Hospital Guidelines on TB prevention and treatment:

The Delek Hospital, in co-operation with doctors from Men-Tsee-Khang, offer some advice on taking Tibetan medicine while undergoing allopathic treatment (in the section titled bod sman 'phyod sbyor gyi lan brda). The notice states that taking Tibetan medicine in combination with foreign medicine (phyi lugs kyi sman) can be beneficial (phan thog).

Tibetan medicines particularly recommended are (in the section titled aem ch'i sman tho 'god srid pa'i bod sman, list of possible Tibetan medicines): bse ru 25 and tso bo 25, both formulas commonly used to treat cough and excess mucus in Tibetan medicine (MTK students added that chu gang 25 and a gar 15 are also employed to treat these symptoms). It also advises to have at least a one-hour gap (chu thsod gcig tsam bar mthams) between the ingestion of the two different types of treatment (gsal sman gnyis) and that taking the two together is improper (mi rung). The leaflet then goes on to detail the allopathic treatment for TB.