A CRISIS OF CONFIDENCE:
A COMPARISON BETWEEN SHIFTS IN TIBETAN MEDICAL
EDUCATION IN NEPAL AND TIBET

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When my father taught my brother and me, we learned at home, not in a
school. We learned what medicine is by coming to know the plants in our
area, cleaning and drying and grinding these plants into powders. We
studied and memorised dpe cha, but did not know this thing called ‘text-
book’. Someday we hope to have a program like those in Lhasa or
Dharamsala here in Nepal. This is still a dream. But when we think about
such goals, or even the future of our small schools, it is important to
think about curriculum. This concept is new for most of us.
—Chairman of the Himalayan Amchi Association, Kathmandu, and Co-
Founder of the Lo Kunphen School and Mentsikhang, Mustang, Nepal

In most colleges, students don’t get much clinical experience—at least
not enough to be considered a skilled doctor. Some get this after, in a
variety of clinical settings, but many more get channelled into other
tracks, like marketing or producing medicines. But those who produce
medicines also might not have more than a basic sense of the plants and
other ingredients, or at least not much experience collecting. They don’t
learn these skills in detail anymore. They become more like pharmacists
and marketing specialists, rather than healers. The same is true for teach-
ing. You go through training only to arrive at the other side to be weighed
down with teaching responsibilities and not a lot of time to test your own
practice.
—Professor, Tibetan Medical College, Lhasa, TAR

INTRODUCTION

The forms and content of gso ba rig pa education bear directly on the
health and well being of culturally Tibetan communities throughout the

1 This paper is based on ethnographic fieldwork I have been conducting in Nepal
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their support of this work.
Himalaya and Tibetan Plateau now and in the future. Indeed, how one comes to know the mind and body, and to alleviate suffering, can cut to the core of personal and cultural identity. Within the framework of the modern nation-state, the relationships between body, disease, and the social status of doctors often mirror the body politic and call forth nationalist imaginings (Foucault 1975; Haraway 1991; Martin 1997; Adams 1998). In general terms, education—medical or otherwise—is a vehicle by which culture changes and endures. It is also a realm that is often state regulated, and thereby implied in the production of national sentiment and citizenship, within both colonial and postcolonial contexts (Anderson 1991; Comaroff and Comaroff 1992; Chakrabarty 2000). This study of the changes occurring within Tibetan medical education in Nepal and the Tibet Autonomous Region (TAR) of the PRC reveals some of the ways that both Tibetan medicine and a more diffuse sense of Tibetan identity are constructed and experienced within different national contexts. In this sense, my work speaks to other studies of the relationship between nationalism and so-called ‘ethnomedicine’ or ‘traditional healing systems’, with a particular focus on Asian healing systems (Farquhar 1994; Hsu 1999; Langford 2002; Scheid 2002). In examining the specific changes affecting Tibetan medical education today, I also draw inspiration from literatures that explore the power of ‘science’ in shaping national, medical, and individual consciousness (Latour 1993; Prakash 1999; Adams 2002).

This paper illustrates how and why Tibetan medical education is undergoing a number of changes in Nepal and in the TAR. These changes include, but are not limited to: shifts from private, informal instruction, often tied to a particular medical or religious lineage (rgyud), toward institutionalisation and standardisation of curriculums; increasing specialisation of Tibetan medical knowledge, precipitating a separation of those who produce Tibetan medicines from those who prescribe them; pressure by governments, non-governmental organisations, and patients, as well as from students and practitioners of Tibetan medicine themselves, to integrate Tibetan medicine and biomedicine, both within medical education and clinical practice; shifts in the sources of funding for Tibetan medical education, including issues surrounding government recognition of, and support for, gso ba rig pa;  

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2 This theme is also linked to the growing national and international Tibetan pharmaceutical industries (TIN 2004).
and shifts in the roles and responsibilities of Tibetan medicine practitioners. This professionalising process involves conceptions of medical authority and the relationship between teacher and student, doctor and patient, as well as changed expectations about what social, economic and even karmic fruits a Tibetan medical education will bear for those who choose this path.

I place particular emphasis on curriculum. The issue of curriculum —what and how to teach, whether or not to introduce biomedicine into Tibetan medical courses, what the relationship is between standardised programmes and more fluid (though not necessarily less organised) master-apprentice pedagogy—plays out at the level of large, state-supported institutes for Tibetan medicine in the PRC, Mongolia, Bhutan, and India. But these issues are also having crucial impacts on smaller schools and private teachers and students of gso ba rig pa, both within the TAR and in Nepal. In relation to this investigation of curriculum, I explore ideas about conceptions of medical and social efficacy, as well as a phenomenon that might be called a ‘crisis of confidence’ in amchi (Tibetan medicine practitioners) and Tibetan medicine. Each of the trends I identify also involves examinations of the concept and currency of lineage. I attempt to show how conceptions of lineage function within networks of practitioners, between amchi and their patients, as well as within specific nation-state contexts. I also address some of the impacts that biomedicine and Western scientific models of knowledge transmission are having on gso ba rig pa medical education.

**BETWEEN NATIONAL STRUGGLE AND LOCAL DUTY: AMCHI MEDICINE IN NEPAL**

Founded in 1998, the Himalayan Amchi Association (HAA) is a Nepali non-governmental organisation (NGO) that comprises more than 100 amchi from Nepal. This relatively new professional organisation has a variety of long-term aims, including raising the standards and quality

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3 Although ‘amchi’ (alternative spellings: am chi, em chi, im ji) is actually a word of Mongolian origin, it has come to be the primary marker of people who identify themselves with gso ba rig pa, particularly in Nepal and Ladakh. Other popular words for ‘doctor’ include sman pa, lha rje, etc. I’m using the term ‘Tibetan medicine’, but I recognize that this designation of practices as inherently or exclusively ‘Tibetan’ is not accurate. Hence, I often choose the term gso ba rig pa to refer to these diverse manifestations of a system of medicine that shares philosophies and practices.
of health care that amchi are able to provide to their communities, conserving medicinal plants, improving amchi educational opportunities, and networking with amchi in other parts of the Himalaya and Tibet. The HAA was born out of the varied challenges facing amchi in Nepal: lack of state support for gso ba rig pa; increasing constraints on access to materia medica due to the (legal and illegal) commodity trade in medicinal plants; unreliable state health care services and providers in the communities amchi serve; and, over the past decade, the social, environmental and economic impacts of civil war (Craig and Bista 2005; Craig in press).4

The organising and lobbying efforts of amchi in Nepal exist within contested national politics, at a particularly vulnerable time in Nepal’s history (Craig in press). Because amchi in Nepal can be considered culturally Tibetan, they are minority Nepali citizens. They live within the world’s only Hindu polity, poised between Nepal’s janajāti (ethnic politics) movement—particularly those ethnic groups who identify as Buddhist—a regional sense of Tibetan identity, and a more local sense of self (Gellner et al. 1997; Ramble 1997; Tamang 2000; Craig 2002). This positionality becomes strikingly clear in the language amchi use to describe themselves and their practices. Due to Nepal’s geo-political position vis-à-vis China and India, and the nation’s pro-China stance on the ‘Tibet Question’ to more homegrown prejudices about its ‘Tibetanid’ populations ( Höfer 1979), practitioners of gso ba rig pa in Nepal have identified themselves through the term ‘amchi’ and ‘amchi medicine’ as opposed to the signifier ‘Tibetan medicine’; hence the name of their professional organisation. This framing of their practices without reference to the term ‘Tibetan’ can also be said to reflect a desire by practitioners themselves not to be absorbed into the identity politics of Tibet-in-exile. Within the specific context of Nepal, this fraught connection to things Tibetan, and to ‘Tibetan medicine’ is further complicated by the fact that Āyurveda is both recognised and supported by the government. The HAA has been under internal and exter-

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4 Since 1996, Nepal has been enmeshed in a military and political conflict between the Communist Part of Nepal (Maoist) and the Nepali state, including the Armed Police and the Royal Nepal Army. At this writing, more than 13,000 Nepalis have died in this civil war. Human rights abuses by both the Maoists and the Nepali security forces have been egregious and excessive. Although most of the high mountain regions in which amchi live and practice medicine have not been sites of direct military conflict, this political crisis has impacted their ability to collect and trade for materia medica, to earn off-farm income, and to travel.
nal pressure to align itself with institutions of Āyurveda, as a channel through which to gain government recognition. However, this strategy also requires a diminishing of the differences between gso ba rig pa and Āyurveda. It also plays on Nepal’s janajāti politics as well as a sense of what has been called Nepal’s ‘internal colonialism’ (Holmberg, March et al. 1999; Gellner 2002), in that it requires the submission of a practice connected to Tibetan Buddhism under the culturally Hindu banner of Āyurveda. Framed within this identity politics, amchi in Nepal face a number of critical challenges in terms of the future of their practice. Historically, amchi in Nepal were educated within a master-apprentice framework emergent from lineage: knowledge was transmitted from father to son, uncle to nephew, or from guru to disciple. However, a variety of socio-economic forces such as an increasingly monetised economy and concomitant out-migration from high mountain villages, as well as the introduction of biomedicine through state and non-governmental channels and the discourses of ‘science’ and ‘development’ in Nepal have all had an impact on the course of amchi education and practice, often curtailing young people’s motivation or ability to study as did their fathers and grandfathers.

Despite a current interest in ethnomedicine, the state-development apparatus still focuses on incorporating such healing systems as ‘complements’ to biomedical health care, rather than as valid systems in their own right (Pigg 1995, 1997; Adams 1998, 1999). This bears directly on amchi practice, in both historical and contemporary terms and is directly related to the pressures—both internal and external—that are pushing these doctors to become professional. And, inasmuch as gso ba rig pa relies on Himalayan natural resources, this professionalisation is also influenced by national, regional, and international conservation efforts aimed at documenting, preserving, and cultivating medicinal plants (Lama et al. 2001; Aumeeruddy-Thomas et al. 2002). And yet, in Nepal the plight of gso ba rig pa is often couched in specifically cultural—as opposed to medical—terms. The need to ‘preserve amchi tradition’ is espoused both in government rhetoric in response to the HAA’s organising efforts, and by the HAA itself—albeit with different tenors. The ideas of ‘cultural preservation’ and ‘tradition’ are often stressed over what could be dubbed the ‘scientific’ elements of amchi knowledge, particularly in the context of the amchi’s struggle for government recognition.
As HAA members contemplate the future of their practice, they see the adoption of more ‘Western’ or ‘modern’ modes of knowledge transmission as inevitable, if not completely positive. Not only is learning standardised in ‘textbooks’ and ‘curriculum’ comprehensible to the Nepali nation-state, particularly the ministries of health and education, but they are also the models by which elite institutions of Tibetan medicine in India and China have positioned themselves, thereby setting a certain standard for what ‘traditional Tibetan medical education’ is and means in a modern milieu. Such adoption of the forms of modern, Western education by non-biomedical practitioners and institutions is a common feature within the histories of many so-called ‘traditional’ medical systems. Of direct relevance to the history and practice of gso ba rig pa are the ways that knowledge transmission within contemporary Āyurveda and Traditional Chinese Medicine (TCM, Chin. zhongyi) has followed similar trajectories (Leslie 1973; Farquhar 1996; Hsu 1999; Langford 2002; Scheid 2002). Often, the process of adopting models of medical pluralism, which at once valorise and undermine non-biomedical knowledge and practice, is tied directly to the process of articulating and imagining what it means to be a part of a modern nation-state. However, while some of these issues have been an active part of reshaping ‘traditional medicine’ in India and China since the late 19th and early 20th century, as the HAA Chairman stated, “This concept is new for us”.

One of the challenges for amchi in Nepal is the issue of qualification and certification. Although privately taught students and those studying at Nepal’s four institutions of gso ba rig pa5 are required to master Tibetan language, most have not passed, and will not be able to pass, the national School Leaving Certificate (SLC) examination, which is based on mastery of Nepali and, to a lesser extent, English. In contrast, those students from Nepal’s culturally Tibetan regions who have enrolled in urban boarding schools—including the sons and daughters of amchi—are often illiterate in Tibetan, although they might be able to

5 The four schools of gso ba rig pa education in Nepal are the Lo Kunphen School and Mentsikhang in Lo Monthang, Mustang, the Tibetan Medical Center in Jharkot, Mustang district, the Shelkar Tibetan Medical Institute, Boudha, Kathmandu, and the School of the Four Sciences of the Early Tradition in Dhorpatan, Baglung district (for the latter, see Millard 2002). All four schools admit both girls and boys, and the Jharkot and Boudha schools are explicitly associated with monasteries (Sa skya and Dge lugs, respectively), while the Dhorpatan school is associated with Bon. None of the four schools receive state support or accreditation, and are instead run by a combination of individual donations and NGO support.
pass the SLC. In other words, those students who have remained in their home villages or within a cultural and educational context that provides a solid foundation for the study of *gso ba rig pa*—and who might feel more inclined to serve their home communities upon completion of their training as amchi—often occupy a marginal place within the Nepali educational system, with no recourse to official state certification, let alone medical licensing. Yet students who have left their mountain homes in search of a more ‘modern’ education are often unable to meet the basic criteria of Tibetan literacy to *gso ba rig pa* upon graduation from secondary school. This catch-22 also bears on the ability for young people from Nepal to qualify for the seats reserved at the Men-Tsee-Khang in Dharamsala for people from what the government-in-exile calls ‘border populations’. As such, one of the key points of negotiation and struggle for amchi in Nepal is the creation of government-approved curriculums that are also flexible, acknowledging the realities and limitations of rural Nepali education, and allowing students to move through levels of *gso ba rig pa* training and at the same time earn the equivalent of an SLC. Given the lack of current government recognition of *gso ba rig pa*, questions about who should authorise and certify amchi expertise arise: the ministries of health and education? The Āyurveda Council (within the Ministry of Health)? The HAA? The Men-Tsee-Khang? Or a combination of all of these players? Most importantly, perhaps, are larger questions about how and

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6 The introduction of state-approved Tibetan-medium teaching in Nepal has been slow and politically charged, only making policy headway after the 1990 constitution’s recognition of Nepal as ‘ethnically, linguistically, and culturally diverse’ which allowed for ‘mother tongue’ education. A number of schools in urban Nepal teach Tibetan, and draw students from the same districts where the HAA draws its members. However, the social pressure to master Nepali and English, as opposed to Tibetan, is felt among students, parents, teachers, and administrators.

7 The Tibetan Medical and Astro Institute—i.e. the Men-Tsee-Khang (Sman rtsis khang)—requires that students pass an entrance exam, which students with good Tibetan language abilities and a basic introduction to the theories and practices of *gso ba rig pa* could conceivably pass, even if trained in a ‘traditional’ master-apprentice model. However, the Men-Tsee-Khang and other institutions of higher *gso ba rig pa* learning in India also require that students considered for admission have state-authorised secondary school credentials. It is also interesting to note that, by ‘border populations’ the government-in-exile is referring to a historical and nationalistic sense of ‘greater Tibet’ that does not reflect current nation-state boundaries.

8 In India, the highest authority for Tibetan medical education remains the Dharamsala Men-Tsee-Khang. Although accredited courses of *gso ba rig pa* are offered through the Chagpori (*Lcags po ri*) Medical Institute in Darjeeling, as well as the Central Institute of Buddhist Studies and the Ladakh Society for Traditional Medicine (LSTM) in Ladakh, examinations are set and certificates granted in accordance with Men-Tsee-Khang standards and policies.
where graduates of Nepal’s amchi institutions will, or will not, make a place for themselves within private practice and/or national health care structures. HAA members recognise that without curricula that are state approved and accompanying certification, it will be close to impossible to gain state support for clinical practice of amchi medicine. Yet, they also face the challenge that they are lobbying a failing state, amidst deep social and political crisis.

FROM PRACTISED DEVOTION TO PROFESSIONAL DEGREE: TIBETAN MEDICAL EDUCATION IN TIBET

It is impossible to separate the changes that have befallen Tibetan medicine in contemporary China from the rise of the Chinese socialist state and the subsequent health care policies it has implemented, as well as the ways the PRC has classified and controlled its ‘minority nationalities’ (Chin. minzu) and at the same time valorised ethnomedicine, particularly Traditional Chinese Medicine (TCM, Chin. zhongyi) (Adams 2001; Janes 2001). China’s ‘barefoot doctor’ approach toward health care was an attempt by the newly formed PRC to officially sanction cultural diversity through its support of medical pluralism. These policies built on a history in which ethnomedical practices have existed in dialogue and sometimes conflict with biomedicine since well before the founding of the PRC. However, it is important to note that this official tolerance of medical pluralism and, by implication, cultural diversity, was also coupled with an equally strong need to control the population, particularly minority regions. As in other moments and places in history, medicine provided a key way to do just this. The ‘science’ inherent in gso ba rig pa has been both a blessing and a curse over the last five decades, as have the historical and mytho-historical connections between TCM and Tibetan medicine (Janes 1995; Adams 1999). These medical systems share aspects of their pharmacopoeia, as well as some diagnosis and treatment techniques. This shared knowledge has been folded into nationalist narratives of the PRC and can be seen as one reason why Tibetan medicine emerged from the 1950s, 1960s, and 1970s more intact than many of Tibet’s other religious and cultural institutions. Tibetan medicine education and practice was rehabilitated

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9 See Farquhar 1994 and Adams 1999 for more information on this aspect of Chinese medical history.

10 During the 1920s–30s, practitioners of zhongyi came under attack by biomedically trained Chinese physicians who tried to outlaw zhongyi practice while at the same time capitalise on traditional Chinese medicines. This resulted in widespread protests by zhongyi practitioners and the establishment of state support for TCM. See
more quickly than Buddhist ritual or many folk practices designated as ‘superstitious’. However, this is a relative statement. Tibet’s historical position vis-à-vis China, as well as the relationship between Buddhism and gso ba rig pa, made Tibetan medicine more ‘risky’ than other ethnomedical practices among China’s officially recognised 56 nationalities. Connections between Tibetan medicine and Tibetan Buddhism posed a fundamental problem for the Chinese state.\(^\text{11}\)

Reforms during the Cultural Revolution attempted to distil those parts of Tibetan medicine the state viewed as practical and ‘scientific’ on the one hand, and to purge those practices deemed ‘religious’ on the other (Adams 2001). In practice, this meant the retraining of Tibet’s physicians to serve the masses, imprisonment for some highly adept gso ba rig pa practitioners or the driving underground or into exile of others. Tibetan medicine continued to be taught and practised during the Great Leap Forward and the Cultural Revolution, under compromised circumstances: private practice and instruction were suppressed or only pursued secretly, while sanctioned education was stripped of links to religious practice and to medical theory (Adams 2002). This has meant that a generation of amchi educated at state institutions during this time were denied a full gso ba rig pa education—a fact that bears on current generations of students. Yet, since Tibetan medicine was already a state-supported enterprise under the pre-1959 Tibetan government, and since formal and informal exchanges between Tibetan and Chinese medical practitioners had been occurring for decades, if not for centuries, Tibetan medicine was never stripped of its state endorsement. Later, during the period of reform and ‘opening up’ after 1980, Tibetan medicine received significant state support. Within the TAR and other culturally Tibetan regions of the PRC, Tibetan medicine has been integrated into health care policy and services at the village, township, county, and prefecture levels since the 1980s.\(^\text{12}\)

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\(^\text{11}\) Here we see how the logic of China’s occupation of Tibet bears the marks of a colonial model, in that indigenous knowledge systems have been valorised and incorporated into the new nation-state on the one hand, and viewed as threatening to goals of modernisation and nation-building on the other. This logic is particularly significant when one looks at the ways Tibetans themselves began to reject—or were made to renounce—Tibetan cultural forms marked as ‘traditional’ in order to signal their entrance into Chinese modernity.

\(^\text{12}\) A number of county and prefecture level hospitals, medical factories, and teaching institutes exist in the TAR and in Kham and Amdo, particularly in and around Derge, Chamdo, Xining, and Labrang, as well as the Kongpo and Nagchu regions of the TAR. The Central University for Nationalities in Beijing also includes a Tibetan Medicine Institute, within the College of Life and Environmental Sciences. The Mentsikhang and the Tibetan Medical College, both in Lhasa, are hubs for education and clinical practice.
support has always come with a price—a set of pressures that are very different from those felt in Nepal.

In terms of education, a glance at the Tibetan Medical College in Lhasa is illuminating. The College includes a clinic and a medical factory, and has approximately 200 students.\textsuperscript{13} It offers several types of degrees and courses.\textsuperscript{14} The standard curriculum lasts five to six years and includes study and memorisation of the Rgyud bzhi and other classical medical texts,\textsuperscript{15} but also requires that students are literate in Chinese and also introduces them to principles of biomedical anatomy and physiology. The curriculum also exposes students to clinical diagnosis as well as plant identification and preparation of medicines; most programmes include summer trips to rural areas to identify and gather plants. Historically, students at the pre-1959 Mentsikhang and Chagpori institutes were expected to also have pharmacological expertise, sometimes devoting up to three years of their training just to pharmacology. However, this aspect of medical education, as well as spiritual training, no longer garners the same institutional support in Tibet.\textsuperscript{16}

The path of becoming a Tibetan doctor at the Tibetan Medical College and similar institutions is not much different from that of earning other university and advanced degrees. The structure of this college-level education can promote, by accident or design, a passive learning environment in which the ‘right motivation’ that defines a religious or ethical rationale for becoming an amchi is secondary to the concerns of passing exams and finding a job after graduation. Tibetan medical study is one of many professional paths. It is also a path that carries the stigma of being less valued than biomedical education. Students are often channelled into the Tibetan Medical College if they were not able to gain admission to biomedical colleges.\textsuperscript{17} Yet education

\textsuperscript{13} The College began in 1989 as the Tibetan Medicine College of Tibet University—a combination of the Tibetan Medicine School (estd. 1983), and the Tibetan Medicine Department (estd. 1985). The College became a separate institute under the TAR Education Bureau in 1993.

\textsuperscript{14} The College offers a 3-year vocational course (bdus ra ba), a 5–6 year Bachelor’s degree (bka’ bcu pa), and a 3-year Master’s Degree (rab byams pa).

\textsuperscript{15} However, the amount of text that students must commit to memory has decreased over time, marking a shift in not only how students learn, but also how they retain and draw on theoretical knowledge during clinical practice.

\textsuperscript{16} The same is true in exile institutions such as the Men-Tsee-Khang, although as a result of distinct social and political pressures, though both inherently connected to ideas about what constitutes a ‘modern’ life and ‘science’.

\textsuperscript{17} A similar stigma has been associated with Āyurveda colleges and universities in India (Langford 2002: 113).
at the Medical College does differ from other avenues for higher education in one fundamental respect: it is the only post-graduate course in which the primary language of pedagogy remains Tibetan, as opposed to Chinese. However there is an increasing emphasis on biomedicine and a need for Chinese linguistic competence. This reflects a future vision of Tibetan medicine in which the medicines themselves, as well as processes of diagnosis and treatment, are seen as scientifically on a par with—or able to mimic—biomedicine (c.f. Adams 2001; Langford 2002). One of the most striking elements of this state-supported education structure is the way that it is creating a generation of Tibetan physicians who are theoretically adept and quite specialised in their knowledge, but who do not necessarily have a practical understanding of Tibetan materia medica or clinical experience, but who are sent out to practise nonetheless, often with poor results.

MODES OF KNOWLEDGE TRANSMISSION: TEACHING GSO BA RIG PA IN NEPAL AND TIBET

In order to compare modes of knowledge transmission between Nepal and Tibet, I focus on two private institutions: The Lo Kunphen Mentsikhang and School, one of the four small schools of gso ba rig pa in Nepal, and the Pelshong (Dpal shong) School, one of nearly a dozen of such institutions in the TAR. These schools have not taken the place of continued private, informal, master-apprentice practice either in Nepal or Tibet, but they represent a growing trend toward institutionalisation. Their stories illustrate how the meanings and functions of lineage (rgyud) are changing, and also related challenges and potential benefits of interacting with both state and foreign collaborators. They also point to the differences in historical and political circumstances between Nepal and Tibet and reveal something of the impacts of state neglect, on the one hand, and state domination, on the other. Beyond the realm of politics, however, the fact that Lo Kunphen is continuing...
successfully today, though it has yet to graduate a cohort of students, and that after graduating two cohorts of students Pelshong was closed in 2003, reveals a number of other issues about the ideals and realities of so-called ‘traditional’ gso ba rig pa education today, and gives two strong examples of how and to what extent master-apprentice models can be adapted to suit small-scale institutions.

The Lo Kunphen School and Mentsikhang, located in Mustang District, Nepal, is run by two brothers, both of whom are respected medical practitioners—lineage holders in the line of royal physicians and astrologers of Lo. In 1993, they started Lo Kunphen as a clinic, and registered it as an NGO with the Nepali government. In 1998–99, after the death of their father, and taking in his advice and concerns about the future of gso ba rig pa in Mustang, they decided to open a school. Their vision in establishing the Lo Kunphen was to ensure the continuation of the ancient tradition of Tibetan Medicine in Mustang; to provide medical service for the people of Mustang; and to provide training and professional opportunities for young people from poor families (Bista 2003).

Lo Kunphen combines academic and clinical training in Tibetan medicine with a curriculum of Nepali, Tibetan, English, and mathematics for its more than 25 students, ages 13–20, more than 50 percent of whom are girls. The students are divided into two main cohorts: an elder group of 12 students all of whom entered the school with at least a class five education in the Nepali school system, and a younger cohort of students from particularly poor families who would otherwise only have recourse to accessing the poor quality, and non-Tibetan language medium, Nepali schools. The curriculum also includes gso ba rig pa instruction based on the Rgyud bzhi but inclusive of teachings from Mustang’s medical lineages (through oral instruction and extant medical texts), as well as religious and ethical education. The brothers teach primarily from two readers and one prayer book they designed, which

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19 Mustang district is located in the rain shadow of the Himalaya, bordering Tibet. The approximately 7,000 inhabitants of northern Mustang (Baragaon and Glo stod tsho bdun) speak dialects of Tibetan, practise Buddhism (Rnying ma, Bka’ rgyud, and Sa skya schools) and Bon. Local health care needs are met primarily by amchi, although there is a district hospital in Jomsom, and a few marginally functional government health posts at Village Development Committee (VDC) levels.

20 This latter fact represents a great shift within amchi practice in the Nepal Himalaya, which has historically been the province of male practitioners.
include key chapters in the *Rgyud bzhi* as well as details on plant identification, collection, and preparation of medicines; they also teach from treatises on Lo’s medical history and medicinal plants written by their father before his death. No biomedicine is currently taught at the school. Attached to Lo Kunphen is a small medicine factory and a clinic. Students are intimately involved as apprentices in both endeavours and practical experience is viewed as an essential part of the Lo Kunphen curriculum. The Lo Kunphen founders consider their curriculum to be geared toward local clinical practice but they also feel that the brightest students would benefit from further formal study, preferably in Dharamsala or Lhasa. Their programme lasts five years, followed by a commitment by each student to practise and gain clinical experience for at least two years under supervision by an experienced local amchi, at Lo Kunphen branch clinics or in private settings in their home villages.

Lo Kunphen has received support from international foundations and individual donors, but has received no support from the government of Nepal. The amount of money generated by the Lo Kunphen clinic is small. It is becoming easier for amchi to charge fees for medicines themselves, as Mustang’s population becomes more imbedded in a cash economy. Yet older cultural expectations play out between amchi and their patients: there is no set fee for medical service or medicines, and amchi often accept what they are given. The brothers believe that without Nepali government recognition of and support for amchi medicine, it will be very difficult to maintain Lo Kunphen in the long-term. Although they have been able to make a living as private practitioners, they fear this will not be possible for their students. These local concerns inspire their involvement in the HAA and other regional affiliations.

Lo Kunphen has also begun cultivating medicinal plants, training some villagers as medicine-makers, and establishing a small herbarium, thereby trying to promote sustainable harvesting and use of materia medica and providing local employment. As is the case for most amchi in rural Nepal, many of the ingredients Lo Kunphen needs to produce medicines can be collected locally, but the institution still spends approximately Rs 100,000 each year on the purchase and transport of raw materials and ready-made Tibetan medicines available in Kathmandu.

The majority of funding for Lo Kunphen has been provided by a British charity, KINOE (Kids in Need of Education). The amchi’s family donated the land for Lo Kunphen. Students’ families contribute food, clothing, and fuel.
In the TAR, a school for Tibetan medicine just outside Shigatse, at Pelshong, was created with financial support from the Swiss Red Cross and authorisation from the TAR Health Bureau and relevant Shigatse Prefecture authorities. The buildings that comprise Pelshong once housed an army camp, but were transformed into a lovely expression of Tibetan aesthetic: the main classroom decorated like a prayer hall, with medical thangka lining the wall. The school opened in 1990, under the direction of a senior amchi from Shigatse. Before joining Pelshong he was the director of the Traditional Tibetan Medicine section of the Shigatse Municipal Hospital. The explicit aims of Pelshong—to improve rural health care in Shigatse Prefecture through training Tibetan doctors and to aid in the preservation, transmission, and utilisation of Tibetan medicine—mirror the goals of Lo Kunphen, despite the historical and political differences between Nepal and Tibet. Indeed, both institutions can be seen as a response to economic, political, and social change—the fears and realities of a decline in gso ba rig pa knowledge and practice.

The first batch of 36 students at Pelshong, and the second batch of 54 students were recruited by the director in 1990 and 1999 respectively, and were graduates of primary schools in Shigatse prefecture. Some came from amchi lineages; unlike Lo Kunphen, all were young men. The first batch of students studied for six years along the lines of a ‘traditional’ curriculum that was based on memorisation of medical texts\(^{23}\) and some limited practical training in plant identification and medicine production under the director’s guidance, and included no biomedical component. After they graduated, the curriculum went through a series of reviews and revisions over a three-year period before the second cohort entered the school, under a revised four-year curriculum. In addition, based on recommendations from evaluators of the school the Swiss Red Cross supported a six-week introduction to biomedicine for the first cohort of students three years after they graduated. In addition to Tibetan medicine, students were also instructed in Tibetan language, but in line with the director’s vision, they were not instructed in Chinese. Upon graduation, students received a school diploma but not a medical licence by the Shigatse Prefecture Health Bureau.

The two cohorts of graduates from Pelshong are now practising on their own, without certainty of further support from the Swiss Red

\(^{23}\) Primarily the Rgyud bzhi, along with the commentaries of Desi Sangye Gyatso, The Blue Lapis Lazuli, and Amplifications.
Cross or the government, and often without further connection to their classmates or other practitioners. A few have taken up apprenticeships with senior amchi in Shigatse, arranged either through the director’s contacts or through Swiss Red Cross connections. Some are spending a year at Shigatse Prefecture hospitals, getting a crash course in maternal and child health, epidemic prevention, and basic biomedical public health and few will have an opportunity for further clinical practice and study at the Lhasa Mentsikhang; but most live and work in their rural communities, attempting to make a place for themselves locally, within or outside the state Cooperative Medical System (CMS). Although the school had, at times, been a showcase for this European aid organisation, Pelshong as a model institution for contemporary Tibetan medical education has been deemed a disappointment and, at worst, a failure. The school was begun with the hope that novice amchi trained at this school would provide health care at a local level. But after the first class was graduated, many of the novices were having trouble surviving as amchi and a few had quit practising altogether; many had turned toward practising both biomedicine and Tibetan medicine—even though they had received no biomedical training. When asked about this situation, many sited a lack of confidence in their own abilities, scanty clinical training, lack of access to Tibetan medical supplies and an inability to make their own medicines; many cannot compete with the cost of health care provided by the (primarily biomedical) CMS system (Heimsath 2004). Others described encounters with patients who would rather have an IV antibiotic drip than a Tibetan medicine pill (ril bu) and who equate health care with the instant, powerful allure of biomedical treatment as it is administered in the TAR (ibid.). In addition, as novices with often little connection to a lineage-based practice or to biomedicine, local patients who still might seek out an elder amchi are often skeptical of the Pelshong students’ abilities. Some Pelshong graduates are doing well and committed to practising Tibetan medicine; others simply don’t have a strong enough connection to the

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24 The Cooperative Medical System (CMS) is the state health insurance system, a recent introduction into rural Tibet. Individuals contribute approximately 10 yuan per year, which is supposed to entitle them to a 40–70% subsidy on medical care. In practice, confusion and mismanagement pervade this system, although the system has brought an increase in the kinds and amounts of biomedical drugs available at township clinics and county hospitals.
community in which they are now practising, and lack motivation, ability, or authority to practise as a result.

Lo Kunphen and Pelshong share many notions of what a gso ba rig pa curriculum should entail, yet the aims of their curriculum and teaching methods differ greatly—with a direct impact on the success or problems facing students at both institutions. Although the director of Pelshong taught along the lines of a master-apprentice model, he did so with a group of students that was much bigger than that which would have been taught by one master historically. Kunphen, in contrast, has two gso ba rig pa instructors in the two brothers and they have also sought out other amchi from Mustang and beyond to teach their students. Likewise, both schools do not teach biomedicine—for both practical and philosophical reasons. However, given great differences in the realities of state health care and patient demands for biomedicine in Nepal and Tibet, this curricular choice has different implications.

On the question of language acquisition, the schools also differ fundamentally in their approach. It can be said that both schools are operating under the constraints of a colonial system in the ways that Chinese and Nepali are languages imposed by the state and also crucial to social advancement, while Tibetan is marginalised in both contexts. Yet, while the brothers who founded Lo Kunphen believe that not only Nepali, but also a basic knowledge of English, is fundamental to their students’ future opportunities, the Pelshong director saw Chinese as unnecessary, or counter to the school’s goal of preserving Tibetan culture. While Lo Kunphen students will hopefully be able to negotiate a place for themselves within or between state health care and private practice, Pelshong graduates are inadequately prepared to interact with a health care system in which the principal language is Chinese. On a related note, these two schools differ fundamentally in terms of the relationship they would like to forge with the state. Lo Kunphen sees its future success as linked directly to garnering some level of state support. The brothers would view their endeavours as a success if they were able to place their students at government health posts, where they would function alongside biomedically trained health workers, or get some basic biomedical training themselves and serve a local community. In contrast, one of the initial stipulations in the founding of Pelshong was that students would commit to practising outside the state health care structure. However, in reality, this has served to marginalise many Pelshong graduates and undermined their ability to practise. One of the
great differences between these two institutions is the integration of theoretical *gso ba rig pa* knowledge with practical, hands-on experience. Although the Lo Kunphen students are, on average, five years younger than students at Pelshong, they have been exposed to much more clinical practice. And although the number of medicines they can make are limited, they still produce their own medicines with local ingredients, for local use—in marked contrast to Pelshong graduates, none of whom produce their own medicines.

**Playing the ‘Culture Card’ and Pushing ‘Integration’: NGOs, States, and Biomedicine**

It is worth considering the relationship between state and non-governmental support, and the impacts of this support on the medical schools’ outcomes. As we have seen, many small schools and training programmes of Tibetan medicine have been established in the TAR and Nepal, and are being funded by international non-governmental organisations. Given the Chinese state’s strict stipulations on, and concerns with, foreign involvement in the TAR, as well as the demands for ‘local partners’ and ‘accountability’ as part of foreign aid, NGOs in the TAR are, for the most part, required to work with prefecture-level as well as local (village, township and county) government. In this respect, even though NGOs can be classified as a ‘third sphere’ or a ‘network’, the reality in Tibet is that they still work within strict state regulations and agendas that are often driven by complex negotiations between state representatives and foreign donors. However, private foreign aid is often garnered for such endeavours in Tibet by playing the ‘culture card’: by supporting a Tibetan medical school or clinic donors in the UK or US feel they are contributing to the survival of Tibetan culture under the circumstances of ‘occupation’ and culture change. Yet what it means to support Tibetan survival, particularly in the realm of medicine and health care in the TAR, remains open to debate.

The Nepali state, on the other hand, maintains a longstanding alliance with, and dependence upon, foreign aid (Des Chene 1996). After the demise of the Rana regime in 1951, the centralised Panchayat government introduced biomedicine to Nepal on a broad scale, with capital and expertise provided by foreign aid organisations (Justice 1986). This trend has continued in the wake of Nepal’s 1990 revolution,
with connections made by government, civil society, and aid organisations between the assumed neutrality of science and biomedicine, the universal applicability of democracy as a mode of governance, and the goals of development (Adams 1998). The introduction of health-related development programs marked a watershed moment in conceptions of ‘belief,’ ‘science,’ and medical efficacy, in both local and national Nepali discourse (Pigg 1996). Even today, much of the authority to create and actualise development policy exists in a realm where the boundaries between state and development agency are porous, in flux, and sometimes tied to ethnic projects (Bhattachan 1995).

Many of these schools and training programmes are an attempt to provide educational opportunities that valorise and adhere to Tibetan culture in general and medical knowledge in particular. Yet many of these schools and programmes also attempt to prepare students to practise medicine in rapidly changing social, economic and political contexts—with greater and lesser degrees of success. More and more schools or educational programmes funded by NGOs are premised on, or have begun to adopt, ‘integrated’ curricula, in which a more ‘traditional’ course of study is altered to include biomedicine. This often takes the form of emergency care, maternal and child health skills or the ability to administer intravenous drugs including antibiotics. Part of this shift is dictated by the physical and geographic circumstances in which most amchi work and the lack of quality health care services in such regions. Another reason for the emphasis on biomedical training comes directly from the health care problems faced by many Tibetan communities: tuberculosis, hepatitis A and B, Sexually Transmitted Infections (STIs) and other communicable diseases for which biomedical treatments can be made available. And part of this pressure has everything to do with the power of biomedicine and science: defining paradigms, practices, and belief systems that are far from value-neutral, despite their universalising tendencies.

Paradoxically, although the goals and perspectives of foreign projects might seem to stem from a radically different place than state policies in regard to health care, in either Nepal or Tibet, they can also begin to mirror each other. The power of biomedicine—both in practice and as an ideology about health, well being, and development articulated by bodies from the Lhasa Health Bureau to the WHO—can come to dominate or erase that which is unique about Tibetan medicine in the process of supporting it (c.f. Adams, this volume). The emphasis placed
on ‘modern science’, including a biomedical worldview, as opposed to ‘tradition’ and the interesting but still ‘backwards’ aspects of gso ba rig pa is a discourse that surfaces among international NGOs and government agencies, and that can continue to undermine attempts to both support Tibetan medicine and create meaningful and successful programmes in ‘integrated’ medicine. To a certain extent amchi medicine is construed simultaneously as an exemplar of ‘indigenous knowledge’ and as a hindrance to ‘development’ in Nepal and politically suspect in Tibet. Indeed, this can be viewed as a trans-national manifestation of the marginalisation of non-Western sciences and healing systems, bound up within particular political histories and national imaginaries. A growing awareness of the potentially negative impacts of ‘integration’—as well as a valorisation of ‘traditional’ curriculum merely for tradition’s sake—has prompted some programmes of Tibetan medicine in the TAR to revamp approaches to education along the lines of some of the approaches we see at play in Nepal: models that are fundamentally geared to a marriage of theoretical learning and practical experience from the very beginning, and that are open to, yet also guarded about, the ways that biomedicine might be incorporated into the curriculum. But it is important to reiterate that pressure to include or incorporate biomedical practice is not only a result of governmental or non-governmental pressure; it is also a force at play in the interaction between doctors and patients, as well as a reflection of changing expectations and understandings of what medicine is and does, what it means to heal and be healed in the Tibetan context.

CONCLUSION: LINEAGE, EFFICACY, AND A ‘CRISIS OF CONFIDENCE’ IN TIBETAN MEDICINE

From both a sociological and an historical perspective, Tibetan medical practice has been structured around lineage-based master-apprentice relationships. For many centuries, Tibetan medicine was not primarily taught through large schools such as the original Chagpori, but rather was a body of knowledge passed down through a combination of oral and literary sources, often connected to lay or religious lineages. In fact, to distinguish the early ‘schools’ of Tibetan medicine, such as the byang and zur (Hofer, this volume), from the master teachers who were also key ‘lineage holders’ is to miss the ways that these modes of knowing Tibetan medicine were—and still are—connected. Yet it is also
important not to create ideal types out of religiously-inclined, lineage-based instruction or more secular institutional learning. While such distinctions are important, and reflect larger social, economic, and political change both within the TAR and Nepal, we should not view these categories as mutually exclusive, either historically or in the present.

Particularly in the TAR, it is neither necessary nor possible for all amchi to act as religious specialists in fulfilling their role as healers. It is also important to recognise that although Tibetan religious and medical practice are philosophically intertwined, they need not be so in practice; indeed many contemporary practitioners of gso ba rig pa both in Tibet and in exile stress a separation of religious from medical expertise and have themselves adopted a stance in which gso ba rig pa draws its legitimacy from interaction with Western scientific thought and method—for instance a Tibetan medicine’s ability to be proven efficacious by the logic of double-blind placebo trials. One sees the effects of this trend within Tibetan medical education, in the sense that people who go through a secular (or otherwise ideologically inclined) secondary education have already experienced a shift in how they conceive of the world—a phenomenology that depends on many of the taken-for-granted binaries such as the distinctions between ‘religion’ and ‘science’. To expect such students to enter into the study of Tibetan medicine and instantly adapt to or embrace a more ‘traditional’ mode of learning is to be naïve about the extent to which modern educational structures have an impact on modes of thought. In this sense, there is much support, both by state agencies and by amchi themselves, for classifying gso ba rig pa as a technical practice in which the ‘religious dimension’ is not fundamental to successful healing. Within Nepal, this has surfaced through the untranslatability of certain aspects of gso ba rig pa education into a language that makes sense to the Nepali government, either in English or Nepali, and therefore the seeming secularisation of what becoming an amchi entails. However, for those members of the HAA who are invested in creating these new curricula, there is an implicit understanding that certain subjects or kinds of knowledge will be taught, but will not be described in the official curriculum plans that they will submit to the government.

By a ‘crisis of confidence’ in gso ba rig pa, I refer to the phenomenon by which Tibetan medicine is viewed through the lens of biomedical conceptions of the body, health, and disease, by practitioners and patients, as well as by the state and international interlocutors; or where
Tibetan medical education is meant to mirror either urban, elite biomedical education or be construed as vocational training with an ethnic marker—a formalisation of ‘indigenous knowledge’. This crisis of confidence echoes colonial patterns whereby judgments are passed on bodies and forms of knowledge that render this knowledge as ‘tradition’ waiting to be put to the use of modernisation or, in some cases, purged from national memory. Yet the nature of this ‘crisis’ is also an example of what Jean Langford has dubbed ‘postcolonial imbalance’ (2002). Namely, the need to recoup ‘tradition’ as a site of authenticity and national pride, as a way of rectifying the ills of modern life. Indeed, we could see this need to defend and yet transform so-called traditional practices as a fundamental component of what it means to be modern (Appadurai 1996). And, in each national context, we see the play of both colonial models of governmentality and the neo-colonial tendencies that often characterise international aid (Ferguson 1990; Marglin 1990; Arnold 1993; Escobar 1995). These conceptions of the crisis of confidence in Tibetan medicine meet, and intermingle, in the planning and execution of health development policies, as well as in the efforts by individual amchi and collectives of gso ba rig pa practitioners to reinvent themselves and their practices under an array of cultural, economic, and political pressures.

This ‘crisis’ also bears on how lineage is conceived. The efficacy of lineage-based medical expertise often derives as much from a patient’s valuation of a practitioners’ membership in a rgyud as his or her diagnostic skill and medicines. Lineage can also be a gloss for the relationship between a particular socio-physical environment and medical expertise. As in northern Nepal, some lineage amchi in Tibet will specialise in certain kinds of medicines or therapies and will pass on not only this technical skill—such as golden needle acupuncture or bone setting—but also a sense of authority and trust vested in this line of healers. Likewise, others produce medicines whose potencies are tied to a particular sense of sacred geography: the power vested in medicines from a particular place, and to the practitioners from that place. In Tibet, some private amchi have often explicitly disassociated their practices from the Chinese state and have sometimes suffered the consequences. Part of the efficacy of their practice is political in nature: a choice against being absorbed into or restricted by the Chinese health care system, or against making medicines in a ‘standardised’ way (c.f. Schrempf this volume). This is complicated by the fact that, in both
national contexts, there is a tension between patients who view biomedically-inclined practice as more ‘powerful’ and those who continue to seek out links to medico-religious rgyud pa’i am chi because they view their practice as the most efficacious. Furthermore, sometimes what kind of medicine an amchi practices is not of concern to some patients; rather, they look toward lineage as the main mark of certification. In this sense, efficacy sometimes stems from a sense of social legitimacy and is not necessarily a matter of what an amchi prescribes.

In Nepal many amchi feel that it is important to encourage students who have a family background in gso ba rig pa. And yet, there is also a sense that lineage should not be an exclusive reason for admission into any of the existing schools. They recognise that lineage can sometimes function as ‘entitlement’—as opposed to skilled practice, deep medical knowledge, or aptitude and motivation for study. In turn, amchi in Nepal associate this reliance on lineage as one factor that has contributed to the decline (nyams) of amchi’s reputations and socio-economic positions at a local level. For some Tibetan amchi, lineage is also viewed as an ‘excuse’ for mediocre practice, although the logic behind this sense of ambivalence toward lineage is construed differently given the particulars of political history. Practitioners at both private clinics and state-run institutions in Tibet often say that lineage should not be considered a primary criterion for whether or nor one can become a skilled amchi. Indeed, some Tibetans view this notion as an ‘old’ way of thinking—one that does not take into account the notion in Tibet’s ‘new society’ (spyi tshogs gsar pa) that class or heritage should not determine one’s profession. Other amchi cite the inherent bias against women within a lineage-based mode of medical learning and say that this emphasis on private master-apprentice instruction does a disservice to the future of Tibetan women, in their potential as healers, and in relation to maternal and child health care.

In the final analysis, the changes occurring within Tibetan medical education are part of larger movements and pressures to standardise and ‘modernise’ Tibetan medicine, to garner state and international NGO support, to tap into the transnational interest in ‘alternative’ therapies, and to allow amchi to survive in market economies. These changes are also a part of nationalist agendas and touch on the places Tibetan medicine can, or cannot, occupy within different nation-state contexts. In a more general sense, the transmission of knowledge means the ability to reinvent and revitalise what is meant by ‘tradition’, to create webs of meaning that both sustain a culture and incorporate change. In this
sense, the efficacy of medical education is physiological and psychological, social and political. It is worthwhile thinking how this ‘crisis of confidence’ in Tibetan medicine, and all the social, political and economic challenges it entails, might also hold potential for a renaissance of Tibetan medical education and practice in both national contexts, but also in the spaces between the nation—spaces that amchi on both sides of the Himalaya are beginning to explore and traverse themselves. It is worth asking what might emerge if Tibetan medicine is construed neither as ‘traditional’ nor ‘modern’—exemplified through the ideal types, in a Weberian sense, of lineage amchi or state certified Tibetan physician—but as an essentially fluid set of practices, involving the appropriation and reconfiguration of different modes of learning and knowing, diagnosing and treating, models that might not need to be ‘integrated’ but that, in combination, allow for a transformation of this medical system without the loss of all that makes gso ba rig pa both diverse and unique.

BIBLIOGRAPHY


Plate 1: Ralo rimpoche with Lo Kunphen Students: A visiting scholar who came to Lo on religious pilgrimage gives instruction to students at Lo Kunphen. These sorts of “guest lectures” and teaching opportunities are encouraged by the founders of the school.
Plate 2: Lo K at HAA—Students from Lo Kunphen registering as official members with the Himalayan Amchi Association (HAA) during the 3rd National Conference of Amchi in Nepal. January 2003

Plate 3: Chokhang instruction—a view inside the now closed Pelshong School outside of Shigatse, TAR. One can see medical thangka paintings displayed in the background.
Plate 4: Ingredient displays—Examples of raw medicinals displayed in the main instruction room at Pelshong

Plate 5: MTK Lhasa—Statue of Yuthog Yonten Gompo the Elder outside the Lhasa Mentsikhang