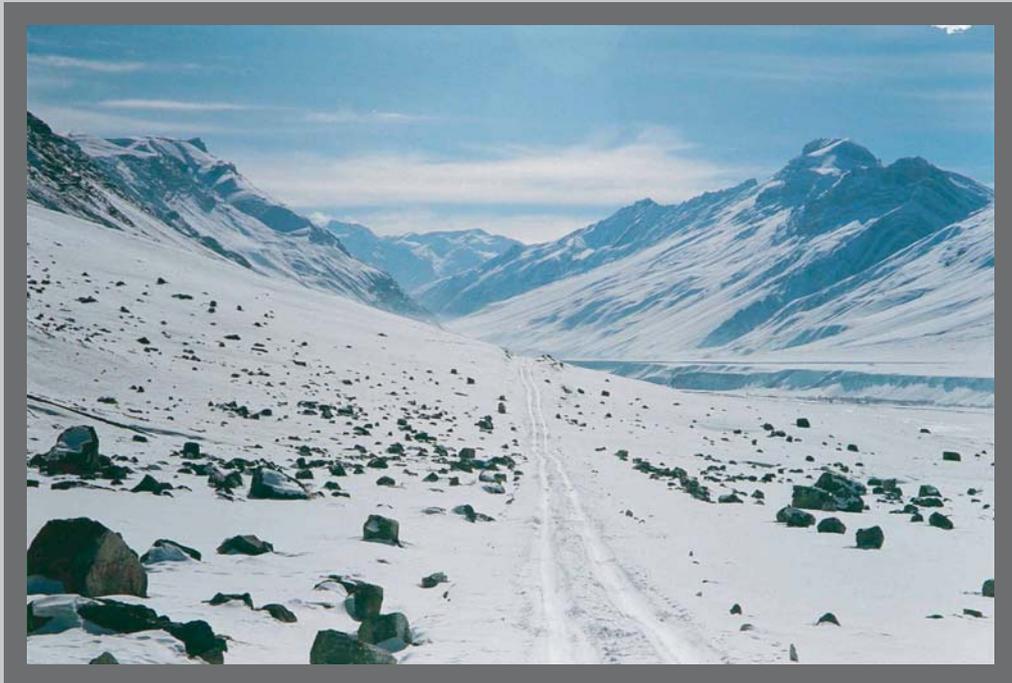


# Tibetan Medicine Off the Roads: Modernizing the Work of the Amchi in Spiti



Dissertation zur Erlangung der Doktorwürde

Vorgelegt an der Fakultät für  
Verhaltens- und Empirische Kulturwissenschaften  
der Ruprecht-Karls-Universität Heidelberg  
im Fach Ethnologie

Von Nils Florian Besch

Heidelberg, im August 2006

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## Prologue: Off the Roads with an Amchi

It is a cold, mid-November day when my assistant Tashi and I meet Tsering Dorje, as appointed, in front of our house in Kibber. Tsering Dorje is an amchi, the term used for practitioners of Tibetan medicine in Spiti. The village of Kibber contains about eighty houses, and lies at an altitude of 4,000 meters, right at the edge of a steep gorge. It's surrounded by mountains, behind which are the high pastures where the yaks graze. Even further behind the pastures are snow peaks covered by glaciers. By crossing the northward passes, one would arrive to the Changthang area of Ladakh. But back in Kibber, our young amchi is dressed in the usual trousers, shirt, jacket, and baseball-cap; in addition to this, for the long walk to the next villages, he also wears sunglasses and a scarf that goes around his neck and over his ears. He advises us to also take something to cover our heads since it will get pretty cold on the way. We are an hour later than we expected, being almost eleven o'clock.

Amchi Tsering Dorje is somewhat tired today, since he only slept a few hours last night. The reason for this is his attendance yesterday at a *śādī* (wedding) in Chichum, the next village to the west. Such festivities take place at least once a week in autumn, also including birthday celebrations (Spi. *pingri*). Birthdays are not yearly parties but rather once-in-a-lifetime events for a child, held when they are three to six years old. Amchi Tsering Dorje had to attend the previous nights' *śādī* because of long-standing tradition: earlier that year he had organized a *pingri* for his four year old son. Following custom, he now has to attend all the celebrations of those who attended his son's party, in order to reciprocate the donations that his friends and extended family gave as presents. So, yesterday he traveled to Chichum – a two hour walk through the gorge and up to the other side. He danced all night, and at five o'clock in the morning he returned back to Kibber. Now, although a bit tired, he is nonetheless smiling and in a good mood.

Often, you'll catch the twenty-six year old amchi smiling slightly to himself. If you meet him in the village, you'd probably think of him as introverted, tending towards the quiet side, preferring to observe the scenery. But when he's at home or in a small group, he is talkative, tells many stories, and laughs frequently. While he was waiting for us in front of the house, an old man came by with his grandchild and asked Amchi Tsering Dorje to examine him, for the child seemed to be a little weak.

Naturally, everyone in the village knows and respects the young amchi, as he belongs to the amchi *rgyud-pa* – the family lineage of Kibber. Immediately, the amchi turned his attention towards them and unfolded the cloth carrying the child on the old man’s back in order to take out the child’s arm. When Amchi Tsering Dorje takes someone’s pulse, it looks as if he is listening, bowing down, and holding his ear close to the arm with closed eyes. His acute ability to listen is one of his foremost personal characteristics, as well one of the most important qualities of an amchi. When I interview him, he is always acutely concentrating, listening intently to what I say. Even though he doesn’t speak English, he still listens fixedly in order to grab the few words he does know so that he can understand ahead of time what the question is about. He has trained this talent over time, and uses it in his interactions with patients. Being empathic and being available at anytime and any place are two of the most important things that make the relationship between an amchi and villagers so strong. This is especially important in times of rapid social change, such as is currently being witnessed in Spiti. But we explore more of this trend later on. For now, Amchi Tsering Dorje has finished the diagnosis of the baby, and reassures the grandfather that he has nothing to worry about, as the child will soon recover fully without any medication.

Then we are off, heading east on the goat and sheep trail, up the hilly landscape. The sky is clear, the sun is shining, but the wind is bitterly cold. The streams are already mostly frozen, yet some water still flows above the ice. The sun keeps the November days pleasant, but when there is wind, one has to wear warm gear to protect oneself. At nighttime, the temperatures already dip below freezing. After an hour of walking, we reach Gete, a small settlement of only six houses, and a bit higher than Kibber at 4,100 meters altitude. Cows, *mdzo* and donkeys try to find the last edible plants in the brown and grey fields, harvest-time having already come and gone in September/October. At the village entry, as in all villages, we pass a mani wall: a wall built of stones that have been carved with mantras and piled together. The amchi touches the stones, murmuring the popular traditional mantra “*oṃ maṇi padme hūṃ.*”

When we at last come around the corner of the last house, some old people are sitting in the sun at against the house wall, smiling, and welcoming us: “Tsering Dorje and a *phyi rgyal ba* (foreigner)! This is a good sign that you come at this moment, since we were about to erect a new *rlung rta* (prayer flag)!” Instantly, a plate with *rtsam pa* (barley flour) and butter is given to us, and obliged by custom, we eat a bit of it. Before I can get my bearings, the amchi gives us a sign, meaning we should come now to the

*rlung rta*, a three-meter high prayer flag in front of the house. A prayer flag enables the wind to carry away prayers towards the deities, so that they might be answered successfully. These prayer flags must be replaced every now and then to ensure continued good fortune. It is *tshes pa bco lnga* (the day of full moon), an auspicious day, and therefore a good day to put up a new *rlung rta*. With all of the others helping as well, we try to lift the metal bar out of the frozen ground. As you can imagine, it takes a little while until it comes free and we are able to lay it down on the ground. Eventually we achieve this, and the owner brings out a new flag – white, with black circles representing the prayers – and we tie it around the bar. Again the plate of *rtsam pa* and butter is brought out, and the amchi – who is now the best representative for this ritual – puts some pieces of butter on the top of the trident-marked *rlung rta*. All of us again receive the butter and *rtsam pa*, and shovel it in our mouths. After that, we lift up the *rlung rta* again to its rightful position, and we are then invited inside the house. Because the amchi is obviously in a hurry, the oven fire is lit quickly. *Chāy* (tea) is made on the gas oven, and the wife of the house brings sugar and *rtsam pa* to mix in the *zho* (curd). Her husband offers us *chang* (beer brewed from barley), and a place to stay for the night. But Amchi Tsering Dorje has been called on to Tashigang to see a patient. We must soon leave to set off for the next village, another forty-five minute walk behind the next hills.

Entering the Tashigang village, we walk around three *mchod rten*: grave monuments with relics. At its ends, dung has been laid out to dry for the oven fires. Once, Tashigang was supra-regionally famous for its *chowa*: religious practitioners who were also well-versed in astrology. They were even called upon by the King of Ladakh for their consultations. But today the village, with its six houses, almost looks like a ruin on the top of a hill. A cold wind blows around the corners of the houses, with not a soul in sight. In actuality, the people here earn good money because they grow *maṭar* (peas) as cash crops, but nevertheless, life up here is still pretty difficult. The jeep track from Kibber reaches the village now, but buses still go no further than Kibber. Earlier, Tashigang had a small school, but it closed a few years back since the teacher had only one student. Today, students have to trek to Kibber or Kaza to go to school. Therefore, it was all the more surprising for me when quite a number of patients came to see the amchi while we were there.

Entering the small winter kitchen of Amchi Tsering Dorje's relatives' house – his mother being originally from Tashigang – we sit down near the oven. One of the

young women of the house prepares some *chāy* for us. Just minutes later, two old women in their seventies appear, one of them being the woman who made the appointment for the amchi. She starts talking immediately and doesn't stop, telling him all about her suffering. It turns out that she had a thorn in her leg about two weeks ago, but didn't take it out. Instead, she went down to Ki, a village in the valley, where the pain really became too strong. She asked someone there to take the thorn out and, although it was just a very tiny thorn, the spot at the leg turned red and swollen, and soon turned into an inflammation. She then wasn't able to walk until someone drained the pus, and finally nine days later she could return back to Tashigang. Amchi Tsering Dorje listens to all of this, and meanwhile demonstrates his second ability that serves him very well: his will to understand, his way of searching the patient. His clear, bright eyes scan the other person, trying to detect any extra clues. You can see in his eyes that he really enjoys being an amchi, helping his patients. And his cheerful appearance also makes him someone very pleasant to have around you.

After the elderly woman's description of her pain, but before the actual consultation starts, we are served *chāy* and *zho* again. All this time Amchi Tsering Dorje has been sitting on the lower side of the oven where there is no carpet. He helps with lighting the oven and preparing the *chāy*. The amchi keeps his shoes on, although the opposite is the usual habit in Spiti. By doing this, he secures the position seated at the lower side of the oven. The higher side is the place for honored guests, where Tashi and I were seated. Through these actions, Amchi Tsering Dorje shows his humility as being the youngest of the extended family, additionally being always ready to stand up and fetch whatever is needed. He doesn't like to claim the high social status of an amchi, especially since he still feels to be too young and inexperienced (despite having served the villages for over three years now).

The other elderly woman now sits down next to the amchi, complaining about her digestion problems which she has had ever since she went to the Ki village for a celebration. There, she had *rgya thug* (noodle soup) and eggs, although usually she does not eat eggs. She holds out her left arm for the usual pulse reading. Amchi Tsering Dorje takes her wrist and hand and puts three fingers just below her wrist on the arteria radialis, then concentrates on the her pulse, 'listening' with his head close to the her wrist for about forty-five seconds. When he switches and listens to the pulse of her other arm, the amchi says that her problem has occurred because of her inability to

digest eggs. After completing the full diagnosis, he tells her not to eat any meat during the next two week course of medicine (which he gives her later).

The first old woman then sits down next to Amchi Tsering Dorje and takes off her thick glasses, complaining that her eyes are swollen, red, and watery. She has been sitting on the roof of her house for two days, which is normal since it's the best place to get warmed by the sun. Indeed, it has been sunny lately, but also very windy. Before taking her pulse, the amchi tells the woman to never to clean her eyes with the hands because the fingers always carry "poison." A clean cloth would serve better. After taking her pulse in the same manner as before, Amchi Tsering Dorje explains that the her problem is caused by two reasons; the first reason, concerning her leg pains, is due to laying in the dark for a long time and then suddenly going into the sunlight. The second reason, concerning her eyes, is due to the strong wind from being on the roof. Later, as with the first-diagnosed old woman, he will prepare and give her the proper medicine to help her with her ills.

As the same young woman that made the *chāy* starts to make *gsol ja* (salted butter tea) and lunch, the room fills with other villagers, almost turning the kitchen into a clinic. Two mothers come in with their sick children, one being about eighteen months old, the other about six months old. Since there is no medical facility in the village, the only way to receive health care is by the amchi at Kibber, or at the hospital in Kaza; since both options require long travel, and since their children aren't seriously ill, it wasn't worth the difficulty. Therefore, seeing as an amchi has arrived in their village, they decide to take this opportunity to see him now. However, before the next consultation, Amchi Tsering Dorje takes his time talking amongst the villagers about the daily news of village life. After this, the mother of the elder child brings him over for a diagnosis. The toddler has a cold, with symptoms of vomiting and diarrhea. The mother explains that a few days back at a feast, the child drank *mdzo* milk for the first time. Since then he has had these problems. While the mother gives the child her breast to feed, the amchi reads his pulse. In the meantime, the amchi also asks if the child has been eating properly, to which the mother replies, "No, not as usual." "How many times did he have diarrhea today?" The mother answers that today, so far, the child has not had diarrhea. Amchi Tsering Dorje explains that the child could not digest the *mdzo* milk properly, and this is the cause of his illness. But because children do not usually like amchi medicine and spit it out (it's too bitter for them), he cannot give the proper medicine he would normally prescribe. Later on, he will discuss with the mother about

what they can do for the child. For now, the mother also holds out her arm to get a pulse diagnosis. It turns out that she has a cold. One of the old women present states that if the mother perhaps takes some medicine, then it might help the child as well. But the amchi decides that she does not need to take any medicine.

Then the other, younger baby is brought forward for an examination because it cries sometimes at night, and is suffering from a cold as well. Obviously, it is quite difficult for an amchi to take a baby's pulse properly because a baby's arms are so small, and it will often start to cry and be upset. This is exactly the case now between Amchi Tsering Dorje and the infant. Nevertheless, he explains that sometimes at this age children are attacked by a *burī nazar* (evil sight) during the night. It is commonly believed among the Spiti people that spirits and local deities can attack people for various reasons and affect their health. Arising illnesses of this kind have to be treated with religious means, a working sphere that is occupied by several religious and medical practitioners. In this case, Amchi Tsering Dorje thinks that the family should make a *pūjā* for the baby, which can be done at the nearby *mchod rten* or at home. There is no medicinal prescription or cure for this particular illness, only the religious practices.

Lunch is then ready, and we sit down to eat. Just then another woman with her two year old child appears, but 'the clinic remains closed' for lunchtime. When we're finished, Amchi Tsering Dorje unpacks the pockets of his jacket. Five or six packets of medicine powder appear, each wrapped up in used paper. He opens them all to see which packet contains which medicine. In one of them, there are small black pills; these he brought especially for the old woman's eye infection. The other medicines he brought were based on his experience as an amchi, knowing that the beginning of winter usually produces many colds and similar ailments among the villagers. The two elderly women and the mother of the eighteen month old toddler each receive a packet as well, with the advice to take it three times a day. Then the mother and child who arrived during lunch approach the amchi; the mother explains that the child has a cold and also a little fever. Amchi Tsering Dorje tries to take the child's pulse as normal but finds her not willing to give him her arms, turning frightened to her mother. Although they try various positions, the mother and the amchi are unsuccessful in getting her pulse taken. The younger woman in the room interrupts and suggests an allopathic bottled product which is in the cupboard. She had bought it for her daughter when she had displayed the same kind of illness and symptoms. The amchi asks if it is "paracetamol," but the

woman doesn't know. They check the color of the liquid medicine, but this does not help much in finding out the name or nature of the product. Often, people here receive medicines from the hospital and, not knowing what it is, they either don't use it, or use it for various similar illnesses. Amchi Tsering Dorje speculates that the medicine is probably sweet-tasting, and therefore the child would at least like it. The women agree that they could give it a try.

At three o'clock in the afternoon, we leave the house and visit a friend of the amchi's who has a video-CD player and a video-CD with the current top music video from Ladakh. Surprisingly, there is electricity that moment, but nevertheless we still aren't able to get the video started. We stay a moment to drink the offered *chāy* and eat a piece of apple, when a mother enters with her child, asking to be checked by the amchi. But her child is also frightened and refuses to go near the amchi; in the end, the mother asks him to take her own pulse instead. It's not because she has any actual problem, it's only because the amchi is here, and she wants to be checked. Again, it is the same procedure of about two to three minutes of pulse taking, and then the amchi gives her one of the remaining packets of medicine. He later says this is simply in order to give her body some support.

As we leave his friend's house, we recognize that the sun is closer to the mountainous horizon and getting ready to set soon; the wind has become noticeably colder. Amchi Tsering Dorje then asks us if we would rather stay in the village for the night or go back to Kibber. He himself is not quite sure what to do, as he is still making up his mind about the baby he diagnosed with the *huri nazar*; the mother has asked him to stay and see what would happen during the night. He decides to go to their house and check the child's pulse again, then decide what to do for the night. At the house, we can already hear a *pūjā* going on. The parents have acted promptly and called a lama to perform a ceremony that should pacify the harming spirit. Minutes later, Amchi Tsering Dorje comes out again to say that everything will be okay without his staying overnight and that we can leave to go home now. He has been away from home now for almost two days; yesterday for the celebration and today for Tashigang. Staying another night away from home, he says, is not good, and his wife would not like it either. I am quite sure that he would have stayed if necessary (and perhaps if we had not been with him). In this instant, I recognize the strains and tensions of his work reflecting on his face. Not only was the days' walk and work exhausting, but the whole of his social and

ethical responsibility of his family tradition can be almost physically seen to weigh on his shoulders. It is a heavy responsibility to follow the path of his family's predecessors.

Amchi Tsering Dorje is one of the few Spiti amchi that have been trained by their fathers during the last twenty years. Only a handful of young men today practice the art as handed down from their forefathers. Amchi Tsering Dorje, as the descendant of the amchi family of Kibber, belongs to one of the longest lineages in Spiti. The eldest man in the village knows history the best, and reports that Tsering Dorje is the fourth practicing generation he has witnessed with his own eyes, not including the four additional generations before that, which he has heard about. This makes it a lineage of at least eight generations. Today, Amchi Tsering Dorje continues his family tradition by having his four year old son around when a patient visits their house, and by starting to show him the ways of preparing medicine. It was the same way how Amchi Tsering Dorje himself learned his first lessons of medical knowledge some twenty years ago. His father, a well-known amchi, took care that his son learned Tibetan, and later on started teaching him the amchi way himself. Amchi Tsering Dorje also attended school and finished tenth grade. It was particularly hard for Amchi Tsering Dorje to learn both Tibetan medicine and school subjects at the same time. But as the future amchi of Kibber, he wanted to be well-prepared for his future tasks. Thinking that he needed additional skills in Tibetan medicine that his father couldn't offer, the young man decided in 1996 to go to Dharamshala and receive further training from a private teacher. These circumstances make him one of the few Spiti amchi to have received an education in the modern surroundings of an Indian town, and additionally in the exile-Tibetan community. But, for family reasons, Amchi Tsering Dorje had to break off his additional education and came back to Kibber in 1999. Two years later, he finally took over the amchi responsibilities for the village from his father. The old amchi died the following year. Even though he is proud to fulfill his family's vow and obligation by working as an amchi, it is sometimes a burden. Indeed, at the end of this long day, I could visibly see the inner turmoil of Amchi Tsering Dorje: his conflicting responsibilities as an amchi, and his personal needs and obligations as a husband, father, and young man. It is this tension that perfectly represents the contemporary state of amchi medicine in Spiti, and the ambiguities the carriers of this tradition find themselves in.

The way home is cold, and we wear everything we have packed, head-to-toe, to try and protect against the wind. On the way, we meet several small groups of people

who had attended the feast in Chichum and danced until sunset, now on their way home to Gete or Tashigang. After one-and-a-half hours, we are back in Kibber. We go into the house and sit down near the oven to warm up, each of us contemplating the days events.

## 1. INTRODUCTION

Tibetan medicine, and therefore its modernization, develops differently according to the various regions it is practiced. After reading the prologue, one can imagine that the medical practice located in the remote region of Spiti is thus “off the roads,” differentiating to those practiced in the urban modern centers in India or Tibet. The question that is accordingly raised is the main focus of my research: how is Tibetan medicine in Spiti being modernized on social, political, and economic levels, and in which ways does this process differ from other regions?

These questions initially struck me when I came into contact with the indigenous medical practitioners of Spiti for the first time. They started me on the dissertation project on the backgrounds of the modernization of Tibetan medicine. However, when I arrived to Spiti in 1999, I was – as most visitors are – at once fascinated by its barren beauty. The landscape, as well as the people, touched my heart and I was happy to be doing an initial anthropological survey (as the basis for my master thesis) because it allowed me to stay and get in contact with the medical practitioners of the area, who are called amchi (Tib. *am chi*<sup>1</sup>). Their practice, accordingly, is called *amchi medicine*. The amchi, in turn, were also happy in seeing a foreigner interested in their matters and quickly confronted me with the fact that their profession is in decline because of its economic inefficiency (although their openness with me was probably naturally motivated by their own interests). I had planned on studying the institutional organization of the amchi anyway, but as I dived deeper into the topic I found that a decline of the medical system was in place as a result of the breakdown of socio-economic relations between the villagers and the amchi. For this very reason, the amchi had founded an organization and were urgently looking for help in improving their situation.

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<sup>1</sup> The literal translation of *am chi* is “mother of all living beings” and is supposedly derived from Mongolian. Other terms for medical practitioners used in the Tibetan context, though rarely in Spiti, are *lha rje* (lit. the king’s master), and *sman pa* (lit. medicine man). I want to indicate here that I use the masculine form while writing about amchi in English because in Spiti there have been (until very recently) no female amchi. Furthermore, it needs to be clarified here that amchi, and other Anglicized words (like lama) are set to also mean the plural in this thesis, therefore not set-off by an ‘s’. Further notes on orthography used in this thesis, and a glossary of Tibetan, Spiti, Hindi, and Sanskrit terms are found in the appendix.

After more fieldwork in Ladakh two years later, I had by then come to terms with the scientific discourse on the modernization of Tibetan medicine (mainly led by scholars such as Adams, Janes, Meyer, and Samuel; for references, see below). Thus I recognized that the respective analyses were far different from what I found in the remote areas of Spiti (and Ladakh). For instance, one cannot compare the degree of professionalization as a consequence of Tibetan medicine's full integration into China's national healthcare system because Spiti has a completely different set of influences and parameters shaping its modernization. Or consider the fact that a 'biomedicalization' of medical care (as with the exile-Tibetan settlements) was not recognizable in Spiti. There seemed to be vast amounts of research still to be done in this field regarding the differences of central and peripheral settings and institutions affecting the locally distinct modernization forms of traditional medicine. Though these research prospects seemed to be available in Ladakh as well, two further considerations made me choose Spiti as a research site: first of all, the pool of general literature on Spiti is quite small, with many accounts composed by Indian or British civil service personnel with rather little (medical) anthropological content (Charak 1979; Handa 1994; Kapadia 1996; G.D. Khosla 1956; Lyall 1874; Mamgain 1975; Negi 1976; Sanan and Swadi 1998; Verma 1997, 2000b). To my knowledge, the first anthropological study specifically on a topic in Spiti was only published in 2003 by Christian Jahoda. It dealt with the socio-economic organization in eastern Spiti from an ethno-historical perspective and was of support concerning the analysis in the respective chapters of this thesis. Furthermore, although one can draw parallels and insights from literature dealing with western Tibet and Ladakh – first and foremost from the well-known Tibetologists (e.g., Bell 1928, 1931; Francke 1999 [1907]; Snellgrove 1957, 1987; Snellgrove and Richardson 1968; Tucci 1988 [1935]) – one has to admit that their direct accounts regarding Spiti are very limited. Though the limitation of existing ethnographical literature made the preparation for such a research project and its later analysis rather difficult, it did provide an opening in which to present a proper ethnographical study of amchi medicine. The second reason I opted for Spiti as a research site (in comparison with Ladakh) was that Ladakh has been experiencing massive support by western non-governmental organizations (NGOs) and development agencies since the 1970s. On the contrary, Spiti had almost no support from non-governmental resources until well into the 1990s. Spiti amchi were facing major problems and thus longed for governmental as well as non-governmental support. Thus, my research idea was developed along the idea of setting

up a proper data basis for the potential future projects intended to increase the development of amchi medicine. However, I must admit that this original intention has only been met in part by this thesis. Certainly, my broad range of data can be used for further projects concerning amchi medicine, but this thesis does not centrally focus on the theme. Suggestions or demands are not formulated in these aspects, and in my understanding, should be separated from scientific research. Nevertheless, I do make some comments from a scientific point of view concerning the monetization of amchi medicine in collaboration with the state or external organizations, found in Chapter 4.3.

After this clarification on my original intentions – combined with some initial remarks on the prerequisites of such research and the situation of literature – the actual theme of this dissertation now needs to be outlined before we turn to the detailed explanation of this dissertation at the end of this chapter. Chapter 1 furthers this aim, and includes the full elaboration of the theoretical approach I utilized. Therefore my current aim is to now explain the object of my examination and how I reached it.

The analysis I eventually made is built upon the basic understanding of medical anthropology; a basic understanding that medical systems are embedded cultural, social, political, and economic surroundings of the societies they are practiced in. They cannot be considered uncoupled from these parameters, including as well as their geographical and climatic settings as further influences. This assumed prerequisite means that the appearance of medicine is shaped by local factors. Consequently, scholars have started to talk not only of *a medicine* but, as for instance in the case of Tibetan medicine, of distinct *Tibetan medicines* (Janes 2002; Pordié forthcoming a). These are practiced today not only in the different regions of the Himalayas – in the Indian regions of Arunachal Pradesh, Himachal Pradesh, Ladakh, and Sikkim; in Bhutan; parts of Nepal; and the Tibetan Autonomous Region of People’s Republic of China – but also in places as far as Mongolia and parts of Central Asia. Furthermore, Tibetan medicine is practiced in the communities of the exiled-Tibetans in South Asia, and also in some of the urban centers of China and the West. Transformations of Tibetan medicine regarding modernization, however, has only been examined in Tibet and the north Indian settlements of the Tibetans (Adams 2001a, 2001b, 2002a, 2002b; Cantwell 1995; Janes 1995, 1999a, 1999b, 2001; Meyer 1995b, 1995c; Samuel 1999, 2001a). As these places are major reference points for Spiti amchi, these studies are then the main

reference points for my analysis.<sup>2</sup> Most of these studies have either a partial or entirely medical focus, examining issues of epistemology, etiology, and pathology under change. In contrast, I focused almost exceptionally on the analysis of the social and politico-economical issues at hand. Therefore, neither detailed examinations of actual clinical practice, nor an introduction into Tibetan medicine is found in this thesis.<sup>3</sup> The processes at stake here (such as professionalization, rationalization, and commodification) are produced through interactions between local (indigenous) practitioners and the actors on policies on national and global levels. These have been investigated world-wide and especially in South Asia from the viewpoint of medical anthropology, often focusing on the integration of traditional medicine into a national health care system (e.g., Green 1987, 1988; Jeffery 1982; Leslie 1968, 1974, 1976a; Pigg 1995, 1997). It has been thereby shown that traditional medicines – through subordination under government structures – undergo transformations of bureaucratization and biomedicalization that can undermine the integrity of their indigenous systems. These processes have also been examined regarding the central institution of Tibetan medicine in Tibet (especially by Janes). However, very little research has actually been conducted on the transformations among the rural indigenous practitioners in the Himalayas. Little is known about the respective sociology, economy, medical training, and practice in this area (especially in a historical perspective but as well in a contemporary perspective). My dissertation aims to closing these two arising gaps of knowledge (for a certain local frame); the one concerning the fundamental lack of data on amchi medicine, and the second concerning transformations on the local level. Regarding the latter, the interactions between amchi medicine and the state in terms of its integration into public health care are currently in the beginning stages. Though the governmental frame is, in this context, in the local and regional (Himachal Pradesh state) levels of importance for the development of amchi medicine, the frame of the nation state is still of little importance. Rather, I argue that the global streams of images and the local rise of a market economy are impacts on amchi medicine.

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<sup>2</sup> I have chosen to speak of amchi medicine in this dissertation when referring to Tibetan medicine as practiced in Spiti (though this term is as well used for Ladakh). Consequently, the term Tibetan medicine indicates in this thesis either its conceptual side or the medical practice of the Tibetans (in exile and in Tibet). Deviations from this rule are accordingly marked.

<sup>3</sup> A reader interested in this can turn to, for instance (besides the already mentioned authors) Clark 1995; Clifford 1984; Dummer 1998; Finckh 1975, 1988a, 1988b; Rechung 2001.

Processes of negotiation and conflict with these powers are accompanied by ambiguities on the side of the practitioners, and are therefore at the very center of my investigation.

Therefore, this dissertation aims to give a detailed description and analysis of today's lives and working circumstances of the Spiti amchi and their recent processes of transformation. These defer significantly to many accounts on Tibetan medicine,<sup>4</sup> ending up with the examination extracting similarities and differences between them and asking for their underlying causes. Based on the analysis of my ethnography and local representations, I examine the way amchi are reshaping their living conditions and their social organization to fit into Spiti modernity. I examine the following questions: is there competition that influences and pressures Spiti amchi from state-administered biomedical facilities and the modern Tibetan medicine of the exiled-Tibetans? If so, how do they respond to these impacts? What are the actions and (re-)actions taken by the amchi in facing these modern challenges regarding economic and social changes? Overall, how is the modernization of amchi medicine shaped in Spiti?

The dissertation is ascribed in many regards to the concept of movement, as is displayed already by its metaphoric heading. The course of the dissertation largely follows the journey through an amchi's life, starting from training and continuing on with their medical practice and its embedment in the community, to finally examining their contemporary economic constraints and possible envisioned solutions. Moreover, movement is also displayed through a presentation on the earlier socio-economic fundamentals of amchi medicine, which is followed by its breakdown, and finally leads us to the recent implementation of projects conducted by amchi to create new models for their future. In the understanding that movement (as well as life and progressive modernization) does not follow a linear route, this thesis has thus reflected this through its interwoven structure of strongly merged ethnographies and analyses. A consequence of this is that the reader is rather frequently referred to other chapters where the respective threads are taken up in further detail. I hope to lead through this interlacing network by providing a clear outer structure and respective introductions into each section. However, the understanding of movement refers as well to comprehension of a

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<sup>4</sup> An exception to this are the accounts on the situation of the Ladakhi amchi and rural Nepali amchi, which have been published very recently or are about to be published soon (Besch and Guérin forthcoming; Blaikie forthcoming; Craig forthcoming; Kloos 2005, forthcoming; and Pordié 2002 and 2003). These are therefore included as important references to my study.

non-stasis position regarding for instance ‘tradition’ and ‘modernity.’ This is reflected in the ethnographies by the deliberate inconsistent use of present and past tense. I express through all of this that despite conceptualization, the issues at stake are marked by a continuous change stemming from the past and leading the present into the future.

The course of this dissertation continues in this introductory chapter with the presentation of some geographical, historical, political, social, and economic fundamentals in order to make the reader familiar with the surroundings of amchi medicine (Chapter 1.1). These facts are given at an early stage so the reader can gain an initial understanding and be introduced to some Spiti-specific terms. Most of the facts on the social system, economic system, religion, politics, and history are kept short and outlined only as far as needed for the context of this thesis.<sup>5</sup> A larger section is dedicated to socio-economic changes because of their major relevance in amchi medicine changes taking place. In this way, the clarification and introduction of the theoretical approach is prepared for the analysis in Chapter 1.2. Here, Spiti’s position in time and space is initially conceptualized by Anna Tsing’s concept of marginality (1993). Further on, modernization is defined and my line of analysis is explained through an orientation towards Max Weber’s examinations of rationalization and bureaucratization (1958 [1930], 1976 [1922]). His concepts are used to suggest the prominence of the social dislocation and economic progress surrounding amchi medicine in Spiti. Chapter 1 is closed with an introduction into the historical evolution of Tibetan medicine. The analysis here is focused especially on the emergence of a standardized and institutionalized medicine relevant to the Spiti context.

Chapter 2 deals with the training needed for practicing amchi medicine and what is needed to become an amchi. This is exemplarily displayed by the description of one particular amchi<sup>6</sup> who has been educated in the traditional way. He is one out of three major informants who are thoroughly presented in this dissertation. Descriptions of the other two amchi then follow as examples of new ways of education (Chapter 2.3). In

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<sup>5</sup> The limitation of space in this dissertation created a dilemma: I could have extended the information on Spiti much further, but due to lack of space (and limits in existing literature) I restricted the presentation of data to a need-to-know basis, thus largely excluding such themes as Buddhism and Tibetan medicine. This is actually contradictory for most anthropological writing (where one generally tries to remove simple or one-dimensional explanations). Therefore, I regret having to display the main features in a style that simplifies so many things and leaves out many details; if I had more space, I would have gladly expounded upon these further topics.

<sup>6</sup> In this dissertation, I anonymized some people when the issues at hand suggested doing so. These are accordingly indicated. I kept the identity of others for two main reasons: the extensive descriptions don’t allow anonymity, and second, by indicating their names I show respect and credit for the work they are doing.

this context, I elaborate the content of local transmissions and explain the importance of the lineage system in regard to the continuity of amchi medicine. Nevertheless it is declining, and the explanation for this in Chapter 2.2 indicates the first reasons and backgrounds of social change in Spiti. After merging the basics of traditional amchi education with the requirements of modern circumstances, it is then asked in Chapter 2.4 what is needed to be a “good amchi.” Technical skills and inner qualities are thus extracted as responsible for the reputation an amchi can gain and the social status he has in the village.

Chapter 3 gives a broad analysis of the amchi practice in the Spiti village context. This chapter has two large parts, the first (Chapter 3.1) dealing with an amchi’s three essential practices: pulse reading (Chapter 3.1.1), the collection of medicinal plants and the processing of medicine (Chapter 3.1.2), and the practices of ritual healing deriving from Tantric Buddhism (Chapter 3.1.3). The analyses of these aspects of healing examines their specific way of public representation and opposes it to the observed practice. Discrepancies highlight the use of these issues in gaining social and political ends. These latter themes are then closely elaborated on in Chapter 3.2, which is dedicated to the social embedment of amchi medicine. Then, a focus on village communities and the individual amchi-patient relationship is presented in Chapter 3.2.1, and I talk about it in relation to the most modern setting of Spiti, its capital of Kaza,<sup>7</sup> in Chapter 3.2.2. Then, the reasons for contemporary social change thereby lead into the detailed study of socio-economic change.

Chapter 4 consequently investigates the breakdown of the reciprocal exchange system that was formerly the foundation of the village economy, as well as the mainstay of amchi work.<sup>8</sup> There, the question is raised as to why villagers have withdrawn support from their amchi, thus bringing them to difficult economic problems that inevitably reduce health care options (Chapter 4.1). The elaboration of the amchi sphere regarding gift exchange further leads us to the question of whether medicine and medical work is repayable (Chapter 4.2). This then opens up the analysis onto the commoditization and monetization of amchi medicine. Finally, in Chapter 4.3 the issue of how one can make a living today as an amchi to is expounded upon.

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<sup>7</sup> Village names are in this thesis written according to the most common forms used in Spiti.

<sup>8</sup> An earlier version of the case study presented in this chapter has been given as a talk at the tenth seminar of the International Association for Tibetan Studies (IATS) in 2003, and will soon be published (Besch forthcoming).

Chapter 5 first examines how professionalization of traditional medicine in general and specific contexts in China and India has been previously observed by other authors. This is compared with the analysis of the projects currently being implemented by the Spiti amchi (Chapter 5.1). Questions regarding what the amchi's goals are, and how they plan to translate these into action are then raised. The investigation of the association of the amchi and their clinic in Kaza tries to outline the parameters of bureaucratization and rationalization. This especially takes place in relation to the state and the leading institute of Tibetan medicine in Dharamshala (Chapter 5.2). Does the development in Spiti follow the footprints of Dharamshala? What are the requirements and demands enforced by the state? The analysis of these questions leads us to how the amchi are negotiating their marginal position and coping with the impacts of external powers. Finally, Chapter 5.3 brings together all the different threads of analysis gathered so far and examines overall the modernizing path taken by the amchi under the specific influences of rationalization and globalization. What ambiguities are caused by the modernization of amchi medicine? How do the projects of the amchi relate to the superior institutions of the state and in Dharamshala? Finally, what specifically shapes this modernization? We finally ask what distinguishes this local process from the processes observed elsewhere. The conclusion (Chapter 6) then reconsiders the central themes of the thesis and extracts them to the core points of analysis.

## **1.1 The Land In-Between**

The introduction so far has already touched upon the fact that the aim of this chapter is to expose the initial information in regards to Spiti. Because of the lack of content of available literature dealing with Spiti, data had to be collected from many sources, including drawing comparisons with other Tibetan culture areas. For reasons of space, and so as to not overwhelm the topic here, information was only kept as necessary. In some points, the interested reader is therefore referred to further readings. However, these introductory remarks do lead through a broad spectrum of themes, giving a solid foundation for understanding the future analyses presented in later chapters. Here, we start with the Spiti setting and move the introduction afterwards into its economic and societal issues. Spiti's religious and political history further shows its status at the

margin of influential powers. Finally, the chapter closes with explanations and a background on the recent socio-economic changes taking place currently in Spiti.

### Setting

When I first came to Spiti in 1999 (which happened more or less by chance), I was immediately impressed by its rough and meager nature. It's a genuine stone desert in the Trans Himalayas, at the very margin of the western Tibetan plateau. When entering the valley, one has to cross a pass at 3,000 meters<sup>9</sup> altitude (to the east), or one of more than 4,100 meters altitude (to the south and west). Spiti is bordered by mountain ranges that reach over 6,000 meters, especially the Great Himalayan Range to the south. These mountains prevent the monsoon from entering the valley and help make the climate arid and arctic; temperatures in winter sometimes dip to -30°C, while in summer the temperature can reach up to 28°C.<sup>10</sup> Spiti's precise location lies with the Tibetan Autonomous Region of China to the east, Lahaul to the west, India (Kullu and Kinnaur) to the south, and Ladakh to the north-west (see map 1). It is commonly reported that Spiti's name (Tib. *spi ti* or *spyi ti*) translates as "middle country"<sup>11</sup> and is derived from its location (Ham and Stirn 1998: 73; Handa 1994: 21; Kapadia 1996: 23; G.D. Khosla 1956: 70; Charak 1979: 281; Tobdan 1992: 304). In the local dialect<sup>12</sup>, the 's' sound is toneless, but after the British introduced the 's' sound to the pronunciation of 'Spiti' it thereafter become the customary name. The main valley stretches from west to east along Spiti River<sup>13</sup> at a length of about 130 kilometers. From there, the large Pin valley turns off to the south, and the smaller Lingti valley turns off to the north. By imagining the mountain ranges that surround the area, and the altitude of the passes connecting it to the neighboring valleys, one can easily grasp that Spiti has a history marked by remoteness.

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<sup>9</sup> Information on altitude and distance in the region differ between almost every author and institution. Therefore figures are given here as an approximate value or as the most referenced one.

<sup>10</sup> Spiti-pa report that the weather has changed recently, leading to some heavy rainfall in summer since the late-1990s.

<sup>11</sup> The Tibetan words do not indicate this translation and, as Rossi Filibeck explains, the term is translated as 'general' (*spyi*) and 'water' (*ti*, supposedly not a Tibetan word; 2002: 320; see as well Vitali 1996), which could be likely because Spiti is also the valley's main river.

<sup>12</sup> Spiti-pa speak a Tibetan dialect that has been named officially "Bothi/Bodhi" (Mamgain 1975: 99; B.R. Rizvi. 1987: 415). Today, the name is commonly used for the Tibetan script as well. Furthermore, it should also be noted that Spiti-pa presently speak Bodhi (as well as Hindi) as their everyday language, which is the reason both languages appear in translations and interviews in this thesis (see as well the glossary).

<sup>13</sup> Its source is near Kunzum-la, and after passing through Spiti valley it flows into the Sutlej River in Kinnaur.

Spiti's inhabited area reaches from Sumdo in the east, at about 3,000 meters altitude, to Losar in the west; the villages at the northern and southern high plateaus lie at an altitude of 4,000 meters, perhaps even 4,100 meters (see map 1). Within Spiti, there exists a traditional division of four parts; this is partly geographically based but also incorporates cultural differences as well. *Sham* is the lower valley that starts at the confluence of the Spiti River and the Pare Chu River (the first village in *Sham* is named Sumdo) and extends until the turn-off to Lingti valley. The second region is simply the *Pin* valley. The third part, the middle section, is called *Bhar*. It includes Lingti, and reaches up to the villages of Ki and Kibber on the northern side of Spiti, and up to Morang on the other side of the river. The final upper region, reaching from Hal to Losar, is called *Tud* (Ham and Stirn 1998: 73; Mamgain 1975: 7f; Sanan and Swadi 1998: 171ff). The total number of villages in Spiti varies from forty to sixty, depending on the various counting methods of recording hamlets and high-pasture residences. Approximately 11,000-12,000 people live in the valley today, giving it a population density of about one person per square kilometer (one of the lowest of all of India).<sup>14</sup>

### Economy

From the beginning of settlements until the mid-twentieth century, the basis of life for the people living in this barren landscape was built on subsistence agriculture and livestock breeding. Goats, sheep, cattle, cows, *mdzo*, and yak all graze in the high pastures, while a green belt of fields – in the past, solely cultivated with barley, buck-wheat, and local black peas – surround each village. A complex irrigation system that defies the harsh conditions of the climate and soil secures a harvest sufficient for subsistence, but not much more. According to the categorization of Tibetan societies and their economies, as explained by Geoffrey Samuel in his outstanding monograph, *Civilized Shamans*, Spiti communities are assigned to the “*samadrog*”: agriculturalists who maintain herds (1993: 41). Samuel further emphasizes that “Tibet was built on long-distance trade. At the same time, the existence of major long-distance trade routes created a differentiation between populations that were close to such routes and those that were not” (ibid.: 43). Though marginal or central positions shift over periods of time, Samuel explains that a society's closeness or distance to the center of Tibet shaped

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<sup>14</sup> For further information on the constant population growth, see Jahoda 2003: 256; Jain et al. 2003: 2; Mamgain 1975: 2; Tobdan 1992: 303; and Verma 2000a: 15.

them in crucial ways. Major trade routes<sup>15</sup> passed through Spiti but, as far as history can be accurately traced back, often had very little effect (Jahoda 2003: 175ff; Mamgain 1975: 142; J. Rizvi 1996; Sanan and Swadi 1998: 56). Spiti-pa obtained, despite their subsistence economy, only a little of the surplus of animal products (mainly wool) and horses. These would be exchanged in regional neighborhood trade during fairs at Kibber village, in the Indian plains<sup>16</sup> (Rampur, Kullu), at Lahaul, and at the Changthang plateau (Jahoda 2003: 73; Jain et al. 2003: 3).<sup>17</sup> Commodity exchange was the predominant mode of economy among Spiti-pa, as well as their neighbors, at least until the mid-nineteenth century.

A political regulation in the tenth century implemented by King Yeshe Ö (Tib. *ye shes 'od*) of Guge (Spiti was included under his rule) caused a comprehensible modification of the inner societal organization of exchange. To establish and maintain newly founded monasteries and their clergies, western Tibetan societies were re-structured according to Buddhist rules. The socio-economic organization of the villages needed stabilization and was therefore structured along mutual exchange systems, including religious performances, goods, natural produce, labor, and so forth (Jahoda 2003: 117ff).<sup>18</sup> Such objects of exchange also included medicines. This related exchange system secured the socio-economic basis for amchi medicine, which is an important aspect examined later in Chapter 4.

Having just reviewed Spiti's geographical climate and position, and its economic conditions, it's now possible to analyze its marginal setting in relation to Tibet and India. There is no indication that Spiti's status has changed considerably at any time. Samuel has categorized such communities like this as "remote agricultural"<sup>19</sup> (1993:

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<sup>15</sup> The silk route ran far north of Spiti, through Ladakh to Tibet. Its branches to India passed through Lahaul and Kinnaur. For a more detailed historical analysis on the silk route in the Western Himalayas, see J. Rizvi (1996).

<sup>16</sup> Spiti people perceive their national identity as Indian. Yet singular national identity does not touch upon the fact that Spiti-pa have a religious and cultural Tibetan identity as well, which contrasts to the people of the Indian plains. I therefore use, unless specifically mentioned, the notions 'India', 'Indian' and 'Indian plains' in demarcation to the Spiti people and their country, comparing them to the Hindu Indian population and the regions in the south of the Great Himalayan Range.

<sup>17</sup> In contrast, the Lahauli (Spiti's neighbors to the west) had much closer access to the trade routes and took advantage of this to improve their economy and living standards, especially in the twentieth century (Mamgain 1975: 156 and 171).

<sup>18</sup> An exact re-creation showing the roots of village organization is difficult. Exchange was certainly practiced before that date, but it seems that this regulation systemized it.

<sup>19</sup> The other three categories are as follows: "centralized agricultural," "pastoral," and "urban" communities (ibid.).

115). Spiti's location seems to be appropriately parallel to Anna Tsing's notion of an "out-of-the-way place," as introduced in her monograph on the Meratus Mountains in Indonesia (1993). Being "out-of-the-way" has, according to Tsing, various dimensions, two of which we have already explored regarding Spiti. Other dimensions concerning Spiti follow throughout this chapter. Building on the country's name, I now introduce a Spiti-specific notion: the translation 'middle land' seems to be very apt, but not in the sense that Spiti symbolizes a center, but in that it is 'in-between'. By this, I do not mean that the country is merely squeezed in-between other countries, although the steep mountains to the right and left of the valley sometimes do give the impression of being sandwiched in a canyon. Rather, Spiti lies in-between several political, economic, and medical centers: all with some significant distance. Even today, one still needs ten hours by bus to travel westwards through the desert-like river bed and finally cross the passes to reach Lahaul. Or consider the fact that nomads and trekkers need about ten days to get from Spiti to either the Indian plains in the south or to Ladakh in the north. In this sense, the notion of being 'in-between' points to Spiti's marginality, a characteristic that is filled with further meaning throughout this chapter.

### Society

Samuel has characterized the "remote agricultural" communities as having a "weak political centralization," "limited tax obligation," and a kinship system that usually emphasizes lineage (1993: 115). These characteristic features do indeed apply to Spiti, as we see in the following paragraphs highlighting Spiti's social and political dimensions. However, in order to clearly understand the societal web in which each village *amchi* is embedded, we have to first unwrap several layers of societal organization. This is of particular importance due to the fact that *amchi* do not work in service-oriented clinics or the like, but instead practice on demand, in constant interaction within the communities they live.

Spiti society is organized in line with family and household institutions. Their basic social stratification is divided into three groups, which are called *rigs*.<sup>20</sup> This

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<sup>20</sup> The same term is used in Tibet and Ladakh, being an object of wide examination (Bell 1928; Brauen 1980a and b; Erdmann 1983; Snellgrove and Richardson 1968). Bell has translated *rigs* as "social position" (1928: 95), while Erdmann refers to it as "caste, class or rank" (1983: 141). In modern day Spiti, people sometimes refer to the Hindi term *jāti* (caste). Though the *rigs*-system also contains status of birth and some restrictions, it cannot be compared with the Hindu *jāti*-system, due to its limited hierarchy and differentiation (cf. Mamgain 1975: 62). Restrictions and practices resulting from *rigs* are outlined in Chapter 3.2.1.

social system is led by the families of the *nono* (Tib. *no no*),<sup>21</sup> who were earlier regarded as nobility or even royalty. Five of such hereditary family lines (with regional divisions called *koti*) used to exist in Spiti, but only one or two are still in existence today. Ever since the rule of the Ladakh kingdom in the seventeenth century, the *nono* of Kyuling gained especially considerable magisterial powers (see below).<sup>22</sup> Continuing under British rule, the *nono* then lost their official positions and their influence through the Indian independence and democratic restructuring of the government structure (Datta 1973: 35; Handa 1994: 44f; Jahoda 2003: 265; Petech 1977: 155ff; Rossi Filibeck 2002: 318ff; Singh 1979: 285).<sup>23</sup> The second stratum is called *chahzang*,<sup>24</sup> which includes those people who are landholders<sup>25</sup>, with the term *samadrog* being an equivalent notion used by several of my informants. The hereditary lineages of chowa,<sup>26</sup> amchi, and the professions of tailors and traders are also transferred in these families.<sup>27</sup> Finally, the lowest *rigs* (Tib. *phyi pa*, lit. outsider) contains the families of musicians or beda (Tib. *'be dha*), blacksmiths (Tib. *bzos pa*), and carpenters (Tib. *shing bzos pa*).<sup>28</sup> These people are usually landless and bound to certain social restrictions (see Chapter 3.1.3 for further details; cf. Jahoda 2003: 265f; Mamgain 1975: 62).

<sup>21</sup> The original meaning of *nono* is ‘older brother’ or ‘young nobleman’. In Spiti, the term rose as a synonym for ‘king’ (see the political history of Spiti below).

<sup>22</sup> Originally, this *nono* resided in Dhankar, the biggest fortress (Tib. *dzong*) of Spiti, but moved later to Kyuling.

<sup>23</sup> The present *nono* of Kyuling received an education in the Indian plains and graduated from Jawaharlal Nehru University in Delhi before he returned back to Spiti. Today, he holds the position of Officer of the Child Development Project Office (CDPO) in Kaza and has thusly regained political influence through this position. Nono-jī, as he is still called by the people, is engaged in many local initiatives that aim at sustainable development in the valley and the revitalization of the local culture. During my fieldwork, I gratefully benefited from his knowledge about Spiti and from his support in various regards.

<sup>24</sup> The derivation of this term is not clear (Jahoda 2003: 266).

<sup>25</sup> *Samadrog* is used here more narrowly than the wider definition by Samuel (see above). In Spiti, landholders as well have a herd which is brought to the pastures jointly by the entire village. The herding is carried out by each household taking turns. Today, people sometimes also use sometimes the Hindi word *zamīndār* synonymously.

<sup>26</sup> The Spiti word *chowa* does not exist as such in Tibetan. The word *cho* means “ritual”, while *chos*, alternatively, is translated as “dharma/religion.” Both translations make sense: a chowa (*wa* is the phonetically changed suffix *pa*) is a person who is well-versed in the dharma and ritual performances. Congruently, Samuel explains that a “*ch'öpa (chos pa)*” is an advanced religious practitioner, who can be a layman and marry, but has taken certain celibacy vows (1993: 275ff). However, Jahoda concludes “*jo-ba*” to be the most likely translation of “*dbon-po*”, the latter term meaning an astrologer (2003: 267).

<sup>27</sup> All three strata follow marital endogamy (Mamgain 1975: 62).

<sup>28</sup> Erdmann explains that the usage of terminology for these three groups of people in Ladakh is inconsistent and that the origin of the terms is difficult to be traced (1983: 152ff).

The importance of a genealogical lineage system (Tib. *rgyud pa*<sup>29</sup>) lies in the transmission of specialized knowledge from one generation to the next, as is the case among amchi families (Chapter 2.1). As a part of their heritage, familial knowledge is commonly (though not exclusively) patrilineally transferred. Furthermore, the group formation called *pha rus* (also *pha spad*), an equivalent to the Ladakhi *pha spun* group, expresses a combination of family descent and residence (Jahoda 2003: 274; Rossi Filibeck 2002: 318). However, descriptions of these groups in Ladakh are quite contradictory. Martin Brauen clarifies that,

the pha-spun are people belonging to some more or less closely situated households who, through reciprocal privileges and duties [...], through the adoration of a mutual tutelary deity (pha-lha) and through a jointly owned furnace for the cremation of their dead (spur-khang), form a single group. (1980a: 54)

Samuel, contextualizing it in a general Tibetan frame, agrees on the emphasis of the deity as the common focus of group identity (1993: 130). Spiti households that belong to one *pha rus* join the worshipping of the same *lha*, which is a practice of particularly importance for amchi families (Chapter 3.1.3).

Besides these larger organizational units, in pre-modern times the household was the core socio-economic unit.<sup>30</sup> Each household constituted a unit of residence and production. The head of the family owned the *khang chen* (big house) to which the land and cattle belonged. The estate was bequeathed according to primogeniture rules. The *khang chen* was then handed over to the first born son at the time of his marriage. The rest of the family moved out into the small house (*khang chung*), and the grandparents to a third house (*yang chung*), if possible. The three houses were closely tied to one other by mutual support, which included the fact that the entire family was obliged to work on the land of the *khang chen* (see Jahoda 2003: 262-286; Mamgain 1975: 68ff; Negi 1976: 17; B.R. Rizvi 1987: 417ff). This system seems to have been a practical necessity in securing the cohesion of the family's property, which would have been under constant pressure by the limitations of soil and climate. The same applies to marital polyandry, whose existence fluctuates through most descriptions of Spiti society

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<sup>29</sup> Differing only in one letter, the two terms *rgyud* and *brgyud* are closely related. The first is connected to Tantra, but both words refer to lineage, transmission, and succession (cf. Samuel 1993: 150).

<sup>30</sup> The organization of households is still important today, but has altered, as is evidenced later on in this chapter.

with quite contrasting statements (see for instance, Ham and Stirn 1998: 75; G.D. Khosla 1956: 97; Mamgain 1975: 75; B.R. Rizvi 1987; Sanan and Swadi 1998: 57). However, an investigation to be taken seriously (though of a locally limited frame) has recently been carried out by Christian Jahoda in Tabo. According to his survey, fraternal polyandry occurs among *khang chen* households, though it is not the rule (2003: 291).<sup>31</sup> An explanation for this might be that large families are not very common<sup>32</sup> because of high child mortality rates, and the additional obligatory entrance of the second born son into a monastery.<sup>33</sup> The actual threat of a division of the family's land is therefore limited.

These findings prove that the *khang chen* households were in a superior position in the social and economic village organization. Regarding many matters of village concern – from irrigation to politics – they've always held the political and economic power. The *khang chung* and lower *rigs* were strongly economically dependent on them. The lama (Tib. *bla ma*<sup>34</sup>) were generally regarded as the highest social status in the population. But as most villages had neither a monastery nor a *nono*, the *chahzang rigs* and the *khang chen* households were then granted the highest social status in a village (Jahoda 2003: 252; B.R. Rizvi 1987: 419ff). Among them, the social hierarchy was led by chowa and amchi. Chapters 2.1 and 3.2.1 further analyze the in-depth relationship between an amchi and his villagers.

### Religious and Political History

All Spiti-pa follow the dharma of Tibetan Buddhism, also called Vajrayāna (lit. the diamond vehicle), which has incorporated some local pre-Buddhist religious practices. During the course of this thesis, I assume that the reader is at least basically familiar with Tibetan Buddhism, if only because an introduction into its doctrine would be too lengthy and detailed and therefore not possible in this limited space.<sup>35</sup> Rather, I will

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<sup>31</sup> Jahoda has estimated 10-20% of the marriages in the last ten years to be polyandrous.

<sup>32</sup> Uxorilocal marriages (*mag pa*), by which a man marries into a woman's *khang chen*, have also occurred (cf. B.R. Rizvi 1987: 422).

<sup>33</sup> This has caused a high proportion of monastic inhabitants (in the nineteenth century probably 25%, today less) in relation to the total population (Jahoda 2003: 256ff; Samuel 1993: 329). Since the royal edict of Yeshe Ö (see above), the *khang chen* were responsible for their livelihood.

<sup>34</sup> Lama is originally a direct translation of the Sanskrit term 'guru', meaning 'teacher.' In Tibet, lama need not be monks, who are called *dge slong* if fully ordained. Though in Spiti, the name *dge slong* is used as well and all monks and novices are generally called lama. Throughout the course of this thesis, the term 'lama' therefore refers to its Spiti use. For the different Tibetan notions, see Samuel (1993: 280).

<sup>35</sup> Vajrayāna and Tantrayāna (or Tantric Buddhism) are terms usually used synonymously with Tibetan Buddhism. It is a form of Mahāyāna Buddhism that focuses on ritual practices which supposedly lead

only mention the Spiti-specific historical remarks relevant to my focus. There are two themes of the Buddhist dharma connected to my thesis – the amchi’s ethical codex (Chapters 2.4, 3.2.1 and 4) and the belief in spirits and deities as part of Tantric medicine (Chapter 3.1.3). At the appropriate passages, I introduce any needed background of religious ideas for a better grasp of the topic as a whole.

Pre-Buddhist religious practices observable in Spiti include shamanic performances, as well as the strong connection of the people to their country and its deities (see the above note on the connection of *lha* to residences). However, the first Buddhist influences might have not originated from Tibet, but rather from the missionary activities during the reign of the Indian emperor Aśoka in the third century BC. Afterwards, lasting until the sixth century AD, Tantric Buddhism of Kashmir spread into the western Tibetan areas. The more institutionalized form of Vajrayāna Buddhism arose from the second Buddhist movement in Tibet, and probably arrived in Spiti in the tenth century, since then constituting the predominant religion of the Spiti people (Handa 1994: 31-64; Tobdan 1992: 306ff). This is also the time period when Rinchen Zangpo (Tib. *lo tsa ba rin chen bzang po*) is considered to have founded the monastery of Tabo.<sup>36</sup> Consecutively, three different orders of Tibetan Buddhism have settled in Spiti. Today, the monasteries of Tabo, Dhankar, and Ki all belong to the Gelug-pa order (Tib. *dge lugs pa*); the Kaza monastery to the Sakya-pa (Tib. *sa skya pa*); and the Kungri monastery to the Nyingma-pa order (Tib. *rnying ma pa*).

The political history of Spiti has long corresponded to the region’s ‘in-between’ status.<sup>37</sup> From earliest recorded time, the ruling powers of Spiti have changed numerous times, and Spiti only briefly gained an independent status once (around 900 AD). Mainly, the kingdoms of Tibet, Ladakh, Kashmir, and Kullu alternated as rulers. They usually

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to quick salvation. For introductions on Mahāyāna Buddhism and Vajrayāna, the interested reader can, for example, turn to Bechert and Gombrich 1989; Bell 1931; Snellgrove 1957 and 1987; Schumann 1995; or Tucci and Heissig 1970.

<sup>36</sup> In any thesis about Spiti, it should be noted that Rinchen Zangpo lived, traveled and taught in the western Tibetan areas, including Spiti, in the tenth and eleventh centuries. Spiti people are proud of the appearance of his nineteenth reincarnation, named Tenzin Kalsang Rinchen, in their valley. He is the head of Ki *dgong-pa* (monastery) and works today influentially as a layman in the Indian capital Delhi, in favor of the Spiti people and culture.

<sup>37</sup> I have drawn this brief summary from several authors: Bajpai 1987; Charak 1979; Francke 1999 [1907]; Handa 1994; Jahoda 2003; Kapadia 1996; Mangain 1975; Petech 1977; J. Rizvi 1996; Rossi Filibeck 2002; Sanan and Swadi 1998; Snellgrove 1957; Snellgrove and Skorupski 1977; Tobdan 1992; and Tucci 1988.

handed over the authority to a representative and simply demanded limited revenues, due to the low standard of living and the people's very modest surplus production.

To give but a few points of Spiti's historical relevance: after being a part of the west Tibetan kingdom of Guge in the tenth and eleventh centuries, Spiti remained largely under central Tibetan control and influence until the seventeenth century. This was only interrupted by tributary relations to Ladakh (mid-eleventh century), Kashmir (fifteenth century), and an affiliation with Zangskar (sixteenth century). The Tibetan-Ladakhi-Moghul War of 1681-1683 brought an end to this status, and until the nineteenth century, Spiti people were obliged to pay revenue to Ladakh. This burden was aggravated by the invasions of troops of the Rājās of Kullu (in 1686 and 1822) and Bushahar (1776). During certain periods, this caused even further tribute payments to two or three superior powers at the same time. During the mid-nineteenth century, the country faced numerous attacks, invasions and ransacking by the Sikh and Dogra armies.<sup>38</sup> In 1846, colonial rule under the British East India Company brought an end to this strenuous time and annexed Spiti through the 'Treaty of Lahore'. Until Indian independence, the British administration maintained the status quo introduced earlier by Ladakhi rulers, who had demanded revenues. The local authority was handed over to the *nono*, who was responsible for collecting land revenue and settling legal matters.

In 1941, Spiti became a sub-tehsil (sub-division) of Lahaul, as a part of the Kangra district. At the same time, Kaza became the capital instead of Dhankar. After gaining independence in 1947, Spiti was then ascribed to the Punjab state. In 1960, Lahaul and Spiti's statuses were raised to districts, and appointed "scheduled areas."<sup>39</sup> Next, the Chinese aggression in the late 1950s and early 1960s that focused on Tibet and India had a twofold effect on Spiti: firstly on trade – as exchange of any kind with Tibet came to an abrupt end halt – and secondly, Spiti was made a "restricted area." The restriction was at first valid for foreigners and Indians alike, but was then simplified to

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<sup>38</sup> Effective survival and defense techniques are reported from this time. Spiti-pa used their high vantage points as look-outs and forts to set fires as signals to warn other valley communities of attacks. People would then leave their villages and flee into the mountains, where they were not followed. There, they would hold out until the invaders had left.

<sup>39</sup> The Indian constitution designates a special status to people who are recognized as tribal societies ("scheduled tribes"/ST), and who are recognized as members of the lowest castes ("scheduled castes"/SC). Lahaul and Spiti gained this status because the population was considered to be "tribal." Consequently, they now have a seat reserved in parliament, government administration positions, reserved spots in higher-education schools and colleges, and many other such effects. In the following passages, I use 'tribal' and 'scheduled' interchangeably, as is the common practice in administrations as well as among Spiti people. For the same reason, I leave out the quotation-marks in the future, though I am aware of the problematic use of those notions because they promote derogatory implications.

only Indians, and in 1992, repealed for foreigners as well. With the reorganization of the states in 1966, Lahaul and Spiti were incorporated into Himachal Pradesh (H.P.). After being a political object of several political powers for centuries, Spiti's marginal location gave it a special status in the Indian nation-state, which, in the meantime, fostered considerable changes. These socio-economical changes laid the foundation for amchi medicine modernization and need to be explored in greater depth so that we can later draw from these understandings.

### *Socio-Economic Change*

Economic changes in twentieth century concerning Spiti are closely tied to the degree of government interventions. Following Indian independence, the first development programs for tribal areas were implemented in the mid-1950s. While this had little impact in the beginning, a visible change emerged with the fifth Five Year Plan of 1971, when large financial resources were made available for infrastructure (soil and water conservation, road building, land reform), social services (drinking water, education, health care), and production means in agriculture, forestry and animal husbandry. Another strong push was given when the H.P. government introduced the tribal sub-plan of 1992, which fixed 9% of total state expenditures to be invested in the state's tribal areas. These tribal areas that received investment were the districts of Kinnaur, Lahaul and Spiti, Pangi, and the Bharmour tehsils of the Chamba district; all which make up more than 40% of the state's land, but only a very small proportion of the population – less than 2.5% of total population (Verma 2000a: 19f). This meant that considerably large resources were then available for a relatively small number of people.<sup>40</sup> Today, one can see the consequences of this in Spiti in every aspect of life. Most villages have road access and watershed projects, and many villages have health care facilities and primary schools. Furthermore, Spiti's status as a sub-district led to the establishment of a large number of government institutions in its capital of Kaza. These respective buildings make up a part of the town that stretches over half of its area (see figures 7-8). In each part of Spiti, further office branches and institutions (such as schools, dispensaries, telecommunication facilities, and government supply facilities)

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<sup>40</sup> The sums available are considerable by Indian standards. Khosla reports, for instance, that ten million rupees per district per year are set free "as a lump-sum plus additional budgets" for projects (2000: 49). Another example is the watershed development in Spiti. According to the officer in charge, in 2003 the budget for a watershed project was thirty Lakhs (three million rupees) per five years and per project. Some villages had several of these projects. For a closer examination of the political backgrounds and specific development plans, please see Jahoda (2003: 227ff) and Verma (2000a).

have been set up. Consequently, in many places construction has been continuously ongoing during the last decade.<sup>41</sup> The number of jobs made available through such construction sites, offices, and institutions is substantial. Though additional allowances are paid, Indians are usually not too keen on working in this high altitude area.<sup>42</sup> Thus, the present young generation, the first of which to have a proper school education (in some cases even a college exam), have found a large market of available jobs.<sup>43</sup> Two relevant statistics concerning Spiti's economic change are as follows: in 1996-1997, 2,142 employees worked in thirty-three departments – which is about a fifth of the total Spiti population. Additionally, in the 1990s, three quarters of Spiti's income was generated from wages and pensions, with only 22% from agriculture (Jahoda 2003: 229). Through considering the past two facts, we can easily observe the major economic change that's taken place in Spiti.

Besides these closely governmentally-bound developments, the strongest modification in the local economy emerged in the 1980s in the form of cash crop cultivation (cf. Jain et al. 2003: 3; P.K. Khosla 2000: 43; Sanan and Swadi 1998: 57).<sup>44</sup> The first products grown specifically for the market were apples (in the lower regions of Spiti) and green peas (grown all over Spiti, as an off-season vegetable). Increasingly, cultivated land was expanded, and so more vegetables (like potatoes and other robust plants) were also cultivated. The yield and profit for this was so good that, according to P.K. Khosla (2000: 43) in 2000, more than 50% of the cultivated land was due to cash crops.<sup>45</sup> This indicated a strong shift away from a subsistence economy and into a production and commodity economy directed at the Indian market.<sup>46</sup>

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<sup>41</sup> Throughout the summer months, laborers from India (especially from Bihar) and local workers construct and re-build roads and set up buildings. These works shape the appearance of many villages because government buildings are not built in the local style, but out of concrete and corrugated-iron roofs.

<sup>42</sup> The proportion of non-Spiti-pa among the population continuously increased until the 1970s. Indian civil servants were transferred and worked in the Spiti administration. However, since the 1980s, the need for them has lowered as a consequence of the availability of local educated personnel (Jahoda 2003: 260).

<sup>43</sup> According to the H.P. government census in 2001, literacy in Lahaul and Spiti was raised from 56.82% in 1991 to 73.17% in 2001 (H.P. government 2006a). Jain et al. specify especially for Spiti that the rate in the last twenty-five years went from 22% to over 50% (2003: 5). This data supports the statement that increasingly qualified personnel are available among Spiti-pa. But this is not to be confused with the continuing qualitative problems in school education that make it difficult for locals to apply for higher education in the Indian plains. It should be noted, however, that the school system is the major port of introduction for increasing 'Indianization' and modernization.

<sup>44</sup> The reasons for the late introduction of cash crops lie in the previously missing infrastructure and the earlier existing fixed purchasing rates of the government (Jahoda 2003: 334).

<sup>45</sup> Spiti's cash crop cultivation benefits from the late harvest. These products obtain high prices because they are ripe long after those of the Indian plains. Additionally, they often have often a good quality.

This economic transformation, best expressed by the government-related jobs and cash crop cultivation, has naturally impacted all aspects of life and work in Spiti. In farming, work processes have been rationalized and productions have been, in part, mechanized. Wage-labor has made its entrance, as well as the division of labor. Money as means of payment has largely removed reciprocal exchange as means of commodity transactions, which is especially relevant to amchi medicine – as I discuss in more detail in Chapter 4. The arising cash flow has caused an increasing demand for commodities and services of all kinds. A business market has since opened up and is still growing, providing new jobs and businesses. Some examples of these jobs and businesses are as follows: food stores, merchandise shops, taxi companies (owners and drivers), electronic goods and electricians, construction workers, and hotels and real estate. Another fast growing market is tourism, which only started in the late 1990s because of the earlier restrictions and difficulties in infrastructure. The Kālachakra ceremonies performed by the Dalai Lama in 1996 and 2000 intrigued tourists and therefore helped to foster the increased attention. Since the turn of the century, Indian and international travel agencies have been offering tours to Spiti. However, until recently, most of the tourist interest and financial benefit was only seen in a few villages. Lately, Kaza, Kibber, Tabo, and Sagnam have especially joined in this phenomenon, building private guesthouses, restaurants, and offering taxi service, in addition to promoting individual backpacking and trekking tourism.

Limited space restricts me in examining these processes in more detail. Rather, I choose to emphasize a few aspects that particularly illustrate how the change of the economy has had an influence on the social system and the individual. Many jobs under government aegis do not require any school education, as for example in the plantations of the Forest Department, or the projects of the Watershed Department. The salary for workers is usually 100 rupees per day,<sup>47</sup> an amount that has thusly become the minimum salary in many labor sectors. Spiti-pa in government positions usually earn

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Concurrently, the Lahauli farmers have similar conditions and their production and market modes are better developed.

<sup>46</sup> Though this sector is market orientated, it is not independent of the state. Government departments support this development through subsidization and merchandising.

<sup>47</sup> In 2003-2004, approximately 50 rupees was equivalent to one Euro. Compared with other regions in India, this salary is quite high. It is a result consequence of the extra payments in tribal and remote areas.

about 4,000-6,000 rupees per month.<sup>48</sup> Also, I observed families accumulating several incomes through different jobs, for example, one member would have a government job, while another runs a guesthouse. This practice is not extraordinary, and is getting to be more commonplace. The income obtained from one or more of such jobs is often a surplus for a family because most village households<sup>49</sup> (except in Kaza) are still largely self-sufficient. Though dependency on market goods is increasing, most of the surplus is free to be spent on things that are not necessary, like luxury items. Expenditures for telephone, electricity, and television are also increasingly becoming the common standard.<sup>50</sup> Less common, but not completely rare, are investments into technical equipment for housekeeping and entertainment, or payments for education fees of one's children in the Indian plains. Moreover, intensive private construction works (apartment houses, guesthouses, and shopping complexes) are on-going in Kaza and in some of the bigger villages (figures 9-10). People are also buying cars and tractors on loans and increasingly paying for services, such as the cutting of firewood, or for Indian children who live and work in their households as helpers.

These examples shed some light on these rapidly changing societies in which many people are actively participating in a money-based economy. However, I unfortunately have no concrete data available on the socio-economical disparities among Spiti-pa. It is difficult to estimate the shares of the population having accumulated some wealth compared to those not participating in the new economy. Nevertheless, access to economic success is, at least partially, influenced by differences in social strata and regional variation (cf. Jahoda 2003: 326). Regarding the former point, families of the lowest *rigs* are sometimes stigmatized and have difficulties in securing school and job access (the consequences of this are apparent in Chapter 3.1.3). Secondly, disparities also arise out of differences in the cultivation period,<sup>51</sup> in access to the Indian plains, and in infrastructure. The areas most involved in – and most benefiting from – cash crop cultivation and new business are, thus, the eastern part (Sham), the villages in the main valley of Bhar, and especially the capital, Kaza. The

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<sup>48</sup> Safe income makes government employment especially desirable, as Pigg reports as well from Nepal (1996: 173).

<sup>49</sup> With the change of the family structure, a household today includes, on average, four to five persons.

<sup>50</sup> In each village, some houses have television and most people have electricity access. In Kaza, modern technologies are very common and present in most households.

<sup>51</sup> The specific location of a village decides the cultivation period, the time of harvesting, and the yield; all of this together has an effect on the price to be obtained by the cash crop. Due to differences in altitude, for instance, some villages in Spiti start two months earlier than others to cultivate their plants.

upper villages of Bhar, Tud and Pin valley face more difficulties in participating in the market production of crops, as these areas are also the most remote and secluded in wintertime.<sup>52</sup> The villages situated higher up are therefore economically deprived as compared to others. It is especially these villages that have some houses largely remaining with the same quality of life and lifestyles as their ancestors did in the first half of the last century. These households in particular, in economic terms, can certainly be considered ‘poor.’ Nevertheless, firewood, gas, solar panels, lamps, seeds, and various other things are subsidized by the government and so hardly anyone has difficulties in affording these things. I have not seen one house without an oven, a two-hotplate gas cooker, a gas lamp, and a solar panel for light. Most households also have changed their dietary habit in part to the Indian cuisine, which requires cash to buy the needed items (rice, vegetables, masālās). Even in the most remote village, one finds several houses with satellite dishes, televisions and/or radios. Nonetheless, it should not be misunderstood: the living conditions are harsh and difficult in Spiti; housing is simple and farming is very strenuous. However, many households have considerably raised their standard of living (cf. Jain et al. 2003: 5).

In conclusion, Spiti’s tribal status and frontier location have brought in, and continues to secure, the policy of governmental subsidization. Spiti people have become fundamentally dependent on and accustomed to it (Jahoda 2003: 229, 328; Jain et al. 2003: 5; Sanan and Swadi 1998: 59). Presently, a state has been reached in which economic growth partially reproduces itself in a private sector and fosters a boom. These developments are naturally accompanied by various social changes. Briefly noted here, and later explored with regard to the amchi, individualization and the disembedding from social networks are but two of such social changes. For example, in the past, first-born sons inherited the family estate and any following children were bound to enter a monastery, marry into other households, or live in dependence to the *khang chen*. Now, for many, wage-labor and government jobs are other main possibilities in obtaining independent income. Some various consequences of this include a decrease in monastery population (Ham and Stirn 1998: 75; Sanan and Swadi 1998: 58), that more families (especially those of the *khang chung*<sup>53</sup>) are establishing

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<sup>52</sup> Some villages of Pin are exceptions to this, from having a special micro-climate and good cultivation grounds. Furthermore, Pin-pa are especially engaged in horse breeding.

<sup>53</sup> The *khang chung-pa* proved to be more flexible in adapting to the new economic possibilities than the *khang chen* households. While the latter had to secure the main household and estate of the family, the former were freer to generate income by attaining one of the new jobs.

independent households, and that many people have left their home villages for job-related reasons. Kaza, attracting most of such job-hunting people, has faced a boom as the administrative, commercial, and trading center of Spiti. Such social changes specifically concerning the amchi will be closely examined in Chapters 2.3, 3.2 and 4.1.

### *Progressive Infrastructure*

Another important aspect in the development of Spiti, also induced by governmental programs, is the improvement of the infrastructure. Roads are the medium that fosters timely and spatial merging of social relations and markets, transporting the vehicles of ‘modernization’ and ‘progress’. Initially, the 1962 Chinese war sped up road building (Kapadia 1996: 38), but only the road up to Sumdo (near the Chinese border), finished in the 1960s. Mamgain reports that until the 1970s, the road between Lahaul and Spiti was only navigable in fair weather, while the road between “Kaza and Sumdo is a mule track” (1975: 148).<sup>54</sup> Due to the difficult conditions of construction, and the repeated destruction of road sections by the weather, intensive repairing and building of roads continues into the present. The resources for infrastructure are so large that the difficulties of progress are very well compensated for. In the late-1990s, most Spiti villages had road access, though only the major routes were covered by public transport. Continuous road improvements have led to shrinking distances. Thus, improvements in access are extreme: distances to neighboring valleys that a century ago needed several weeks to be covered are accessible today in a day trip or less.<sup>55</sup> Within Spiti, connections are even further decreased to hours, if traveling by bus or car.

The increase of infrastructure includes a further substantial progress in the facilities of telecommunication, education, health care, etc. Through these means, the seclusion and remoteness of the valley is gradually dismantled. However, Spiti-pa remain at the mercy of the weather and climatic conditions. The Manali-Kaza road is usually closed between the end of October through April or May due to snow. Even the connection between Tud and Bhar is interrupted during this time as well. In wintertime, many villages frequently or continuously have no access to the market and facilities in Kaza. The road to the east should actually be kept open all year long, but a dangerous slope near Malling continues to delay any attempts of road-building. The road is often

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<sup>54</sup> Distances by road between Spiti and the Indian plains are approximately: Manali - Kaza: 202 km, Kaza - Tabo 47 km, and Tabo - Shimla: 366 km (see map 1).

<sup>55</sup> It is the missing aspect of reliable infrastructure that is responsible for the fact that developments and inventions take place in Spiti years or decades after its neighboring valleys.

closed for days or weeks at a time and is sometimes only passable by a dangerous footpath. During the past few years, small and large floods in spring and summer have caused problems regarding infrastructure and traveling. In 2000 and 2005, two flood catastrophes in the Sutlej valley between Sumdo and Rampur destroyed large sections of the road and stopped the regional traffic for months. Thus, the inaccessibility of the valley has been altered, but definitely not removed. Life and economy continue to be built on a fragile equilibrium in which natural powers are the major factor. In contrast to the days of subsistence, Spiti today relies on road traffic that carries the government subsidies of basic demands like gas, wood, construction materials, seeds, etc. When, especially in the winter months, connections are interrupted, demands must be covered by the remaining stock. Therefore if this has not been replenished beforehand, Spiti faces severe problems.

Other aspects of infrastructure are also increasingly responsible for the shrinking of spatial distances. Modern communication techniques continue to face difficulties in stability and quality, due to electricity shortages and the impact of natural powers.<sup>56</sup> Though continuously improving, telephone lines can be cut off at any time. For example, in each winter of my stays (2003-2004) there was no telephone able to make outbound calls from Bhar and Tud for some six weeks. Nevertheless, since 2005 the internet has been available (with reservations) in Kaza. A final aspect of modernity that moves Spiti closer to Indian culture must also be touched upon here: in the far-reaching absence of newspapers and magazines, television is the main medium available and used (especially in winter) to get in touch with the outside world. Bollywood and Hollywood cinema, cricket and football broadcasting, news and documentary channels are all – beside a local channel – widely received throughout the area.

The previous descriptions provided a geographical, historical, political, and socio-economic frame for the upcoming in-depth analysis of Tibetan medicine in Spiti. The above presented changes are parts of a broader transformation of modernization and globalization. However, these processes need analyzing in order to make them useful as conceptual tools for the analysis of my thesis. This is the task of the following chapter, “Marginality and Modernity”.

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<sup>56</sup> There are further factors as well, such as mismanagement or technical difficulties, whose influence also contributes to the weakness of modern technologies.

## 1.2 Marginality and Modernization

The preceding explanations revealed that Spiti has historically not been oriented towards only one center, or represented the periphery of only one center. To the contrary, the different centers (especially Lhasa/Tibet, Leh/Ladakh, and Kullu/North India) and their political, economic, social, and religious orders have existed and overlapped in Spiti. The ruling systems of these poles and their exercising powers have alternated. The politics and religion of Tibet, however, have more or less constantly influenced Spiti. In the last centuries, Lhasa (and the Dalai Lama) has been its mental and ideological focus. Geographically situated, however, the Tibetan capital seems to have never had the status of a physically ‘reachable’ place for Spiti-pa. Traveling, education, trading, and pilgrimages there were not (often) considered options.<sup>57</sup> In reference to Lhasa, Spiti was very marginally positioned. The flight of the Dalai Lama to India in 1959 brought about a radical change. This historical occurrence merged politics and religion to ultimately question Spiti’s timely and spatial situation in an exceptional way, swinging Spiti-pa’s central religious and cultural focus from the east to west. In collaboration with the improvement of roads, Spiti has finally come closer to the center of Tibetan Buddhism and culture. Today, people need only a maximum of two days to reach Dharamshala. Spiti-pa told me (with ambiguous feelings) that in this regard, they are somehow grateful to the Chinese. Through a historical incident that brought suffering to the Tibetan people, endangered Tibetan culture and religion, and swept away its former center, Spiti’s cultural and religious marginality was, as a result, removed. The re-organization of the Indian state Himachal Pradesh, on the other hand, has brought about strong transformations as well. Thus, recent political history has exposed two shifts of centers, both with strong consequences for Spiti: the establishment of the exile-Tibetan government in Dharamshala and that of the capital of H.P. in Shimla. The impacts of these shifts cannot be dis severed from recent transformations in the course of globalization. It seems that together, these factors have intensified the speed of change taking place in the past ten years.

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<sup>57</sup> It took several months to reach Lhasa on the trade routes. Though there might have been some monks or individuals from Spiti who went there, I otherwise met no one who was aware of anyone having done this journey. Whereas places like Riwalser (H.P.), Udaipur (Lahaul), or Mount Kailash (Tibet) were all mentioned as pilgrimage sites.

Spiti's historical marginal status (in relation to its various poles of influence), as well as its rapidly changing contemporary situation, both indicate impacts resulting from globalization. Spiti's marginality and globalization suggest the classical center-periphery dichotomy model is outdated when analyzing its particular situation. Here, I instead follow Arjun Appadurai, who says that "[t]he new global cultural economy has to be understood as a complex, overlapping, disjunctive order, which cannot any longer be understood in terms of existing centre-periphery models" (1993: 221). In differentiation to this model, I propose that Spiti has recently become part of global movements, or "cultural flows," that Appadurai also called "scapes" (1993: 221). The previously introduced example of television, for instance, proposes that Spiti has recently started to participate in "mediascapes." Following Tsing (1993), I therefore put forward a different form of 'marginality' to describe Spiti's position in time and space. Historically, Spiti was placed at the margin to several (changing) cores with regard to politics, culture and religion. Its borders are embodied by the towering Himalayan peaks surrounding the valley. But Spiti's marginal status cannot simply be understood as static. Shifting points of reference in history and the shift of centers in recent times have both shaped and reshaped the appearance of marginality. As roads have been built across the Himalayan passes, Spiti has come ever closer to the present crucial centers. The shrinking of time and space has become a daily experience. At the same time, each winter brings about the experience of seclusion again that is paired with an awareness of historical marginality. We can so far conclude that in regard to space and accessibility, its two extreme states (seclusion and accessibility) alternate regularly from time to time. An alternation of such contrasting states cannot be without consequence for the Spiti people, and concerns the practice of the amchi and their interactions with their communities (which I elaborate upon in Chapters 3.2.1 and 4).

Geographical marginality can be bridged by 'images', a notion introduced by Benedict Anderson (1990). The medium of television, journeys to the Indian plains, and interactions with Westerners are the three main channels that inspire imaginations of the 'outside world' for Spiti-pa. These mental imaginings partially become a vision for the future of Spiti. Yet seemingly contradictory, the images are not intended to break Spiti's margins and lead it towards a 'Westernized' or 'Indianized' future. Rather, a revitalization process of 'traditional local culture' has begun that intends to stabilize the communities and their positions (cf. Tsing 1993: 21). These generalized statements are highlighted by the application of the concept of marginalization to the presented

medical system. Chapter 1.3 initially introduces the marginal position of Spiti amchi medicine among the Tibetan medicines. Chapters 2 and 5 then display amchi's back-and-forth movements to India for education, market, and business matters. But, "fantasies of wanting to move" (Appadurai 1993: 222) – in regard to spatial emigration – are only of a temporary nature among Spiti amchi (and apprentices). Most of them return to work in Spiti after having trained elsewhere. These movements, especially to Dharamshala, foster the intentions of change among amchi (Chapter 5.1). Arising visions are central to the modernization of amchi medicine. Modernization is intended to stabilize the amchi's life, i.e., rebalance the contemporary decline of amchi medicine and secure its future.

Though I am not especially concerned with migration, it is no coincidence that the central metaphor of my thesis – "the road" – is one of movement and distance. This metaphor must be understood on several levels: The journey to becoming and practicing as an amchi is presented through images of motion and place (Chapter 2: "...on the road," Chapter 3: "...at home"). Amchi education has always been a long ordeal and today, students often additionally move beyond Spiti to receive their training. Furthermore, the local process of amchi medicine modernization is presently under way (Chapter 5: "...on the move"). This is contrasted with the superordinated "off the roads" theme, which has a double understanding. First of all, it must be comprehended practically: amchi still have to physically walk off the roads to get to their patients (see prologue). Secondly, in comparison to the 'highways' of Tibetan medicine institutionalization at Dharamshala (with clinics and research departments), Spiti amchi medicine can be considered practiced in a rather non-institutionalized way, off the modern roads. The heading is thus meant to point out the marginal position of Spiti and its indigenous medical practitioners, and the fact that the whole system is "on the road" to change. Its grade of modernization, in difference to the Tibetan (in China) and exiled Tibetan institutions, indicates that 'modernization' described in those contexts largely does not apply to Tibetan medicine in Spiti (Adams 2001a, 2001b, 2002c; Cantwell 1995; Janes 1995, 1999b, 2001, 2002; Prost 2003). However, the Spiti amchi are not at completely 'off the road' in modernizing their work, they simply follow their 'own' road. The ambiguity displayed in this metaphor ('off' vs. 'on') also represents a parallel conundrum to Spiti's double-edged state of being sometimes 'marginal' and sometimes 'central'. Ambiguities, contrasts, and conflicts are characteristic of contemporary Spiti life and amchi medicine, a kind of pattern of Spiti modernity (cf. Pigg 1996: 193). They

are expressions of “local struggles for power and meaning” (Tsing 1993: 31) on the way to a particular positioning of amchi medicine within the field of Tibetan medicines. It is this area of conflict, with Tibetan medicine at the margin, and its modernization that offers to widen the present view on ‘Tibetan medicine.’ Applying Tsing’s concept of marginality onto the sphere of Tibetan medicine, we examine the cultural difference of the margin and its exclusion from the center so as to work out their interactions with one another.

These considerations bring us now to the point of clarifying the terms ‘modernity’ and ‘modernization,’ as used in this thesis. Like the center/periphery dichotomy, other classical distinctions such as rural/urban and traditional/modern can no longer be usefully applied to Spiti today. The concept of traditional/modern is not only based on “vague, idealized constructions” (Hobart 1993: 6), but has mostly been utilized in opposing a stable and archaic past to a progressing and improving present (i.a., Janes 1999b; Latour 1991; Pigg 1995, 1999). Contemporary Spiti and its indigenous medical system are extraordinary examples that switch constantly between the imaginative poles of ‘tradition’ and ‘modernity,’ and thus demonstrate the absurdity of such a strict conceptual distinction.<sup>58</sup> Furthermore, ‘change’ has been observed as an indisputable continuity throughout time (for instance, by Hobart 1993; Berman 1982). In the context of Tibetan culture, Samuel notes as well that,

Tibetan societies and Tibetan religion have been in a process of continuous change for as far back as we can trace. There was no such thing as a ‘static’ society in Tibet in the premodern period, and the nineteenth and twentieth centuries were periods of particularly rapid change in many respects. (1993: 41)

Beyond this, it should also be pointed out that Buddhism emphasizes a constant change and cyclical existence of all times, things, and beings. The latter is extraordinarily expressed in Tibetan Buddhism through the institution of the reincarnated lama (Tib. *sprul sku*). The cyclic movement of time in eras (Skr. *yuga*) is another example of the Buddhist conviction, contradicting the existence of static conditions (see also Chapter 3.2.1). Their concepts of nature and body reflect the processes of permanent

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<sup>58</sup> Nevertheless, notions of ‘traditional’ and ‘modern,’ (etc.) must be used sometimes to mark or explain certain aspects or objects. Nonetheless, the problematic nature of these terms ought to be kept in mind.

transformation such as seen in the cycles of the seasons and patterns of days. They are naturally formulated in essential aetiological and diagnostic notions of Tibetan medicine. These understandings are incorporated into everyday experiences by Spiti-pa. Applications of the traditional/modern-dichotomy, therefore, do not accurately reflect their comprehension of chronological sequences. Rather, continuous processing determines their concept of everyday reality. Under this premise, a discussion of ‘modernization’ should be carried out, particularly because its key characteristic feature is transformations. Corresponding to this, Stacy Leigh Pigg has pointed out that “[m]odernity is a slippery object for cultural analysis because the discourse of modernity produces the very differences that it seems to be about [...]. The dichotomy between tradition and modernity makes sense only within the narrative of modernization” (1996: 163; see as well Pordié 2003).

My thesis is not a theoretical, abstract discussion or contribution to the debate on modernization theory and modernity.<sup>59</sup> Rather, I base the analysis of my ethnographic data on a working definition of ‘modernization’ in order to revise the scientific literature concerned with the contemporary transformations of Tibetan medicine. In the center of my analysis stand the processes of ‘rationalization,’ ‘monetarization,’ and ‘institutionalization’. Max Weber has intensely discussed these and related concepts, which suggests an application of his examinations to my data. One could say that the vastness of Weber’s work and his distinctive style of writing have led readers to interpret him in quite different ways. For instance, ‘homogenizers’ and ‘heterogenizers’ of the globalization theory debate have both drawn from Weber.<sup>60</sup> David Gellner explains that through Weber’s urge for universal comparison and generalizations, especially in regards to rationality and bureaucratization, anthropologists are usually quite reluctant to refer to him (2001: 7; see as well Geertz 1973: 330). But Gellner retorts that Weber also emphasized the change of systems and “rejected positivist and objectivist ways of describing social phenomena” (ibid.). Therefore, he concludes that Weber’s themes can be valuably applied in anthropological analyses. Thus, I draw from Weber’s analysis for my conceptual frame, although he gives neither a straightforward definition of modernization or of modernity. Yet this theme is superimposed on many of

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<sup>59</sup> The interested reader can refer to, for instance, Appadurai 1996; Arce and Long 2000c; Bhabha 1993; Beck 1998; Berman 1982; Featherstone et al. 1995; Giddens 1990; Latour 1991.

<sup>60</sup> For a more detailed analysis of the Weber reception among authors of the globalization theory, see Fiedler (2003).

his examinations and conceptualizations (especially that of rationalization), and hence show close coherence to the processes expounded by my data.

Weber's analyses of religion, society, and capitalist economies are centered around the multiple processes behind rationalization. His basic understanding of the term is of human behavior increasingly marked by an efficient and calculating organization of social life. Rationalization is, according to Weber, based on "Zweckrationalität," an orientation of behavior according to its purpose, means, and consequences, and then a balancing of each of these aspects against each other (Weber 1976: 13). The main characteristic of rationalization emerges thus as value spheres fall apart. Focusing initially on religion, Weber observes emancipation from magic leading towards a rational systematization. He identifies the restriction of religion from more and more spheres of life as the "disenchantment of the world."<sup>61</sup> This religious process is not identical but rather a part of the entire process of rationalization (Tenbruck 1999: 66). Other parts are found in the examination of capitalism, which Weber sees (in regard to rationalism) as a further development of the Protestant ethic. In capitalism, "Zweckrationalität" finds its own expression, especially in bureaucratization, understood as an operative mode of calculation, coordination, and hierarchy. According to Weber, bureaucratic organization has become the main instrument of a modern economy and polity. It is entirely directed towards making various processes and working modes efficient, particularly observable in industrial production. Consequences of bureaucratic organization are found in the division of labor, the professionalization of working processes, the appropriate experts, and wage-labor. If included, or affected, by rational organizational and procedural structures, people are pushed towards a promotion of control and self-discipline. Actions are not longer value-led but – framed by bureaucracy – generated by purpose orientation. Retrospectively, as part of the pattern, people's norms and values are thus influenced. Weber has found here a loss of sense, an alienation from the community, and a rise of individualism. Inevitably, Weber claims, bureaucratization leads to depersonalization of the modern world. Rationalization thus means to lose meaning and, in a pessimistic prediction, Weber states that it can eventually lead people to be locked into an "iron cage" of rule-based, rational bureaucracy and economic compulsion (1958: 181). This negative outlook has been criticized for its one-dimensional view and close identification of rationalism and

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<sup>61</sup> This famous notion, as well as the beginnings of Weber's analysis of rationalization, is found in "The Protestant Ethic and the Spirit of Capitalism" (1958).

modernity (see for instance, Beck 1998; Giddens 1990). It has been argued that in the context of globalization, modernity is a much more complex process and that people adapt and respond to rationalization in more various ways (see below). Actually, Weber has a similar view when generally reflecting on rationalization and the individual. Though his analysis focuses on Western societies and capitalist economies, Weber also argues that his conclusions can be transferred onto other cultures. He outlines that rationalization traverses through all parts of life in all different cultures, though it develops specific local or individual forms, saying that “one may [...] rationalize life from fundamentally different basic points of view and in very different directions” (1958: 77f).

An application of Weber’s understanding thus asks how rationalization can emerge in a specific setting (in this case, amchi medicine in Spiti). How are the actions of the amchi shaped by modern bureaucracy? Does a move towards rationalization annihilate the ritual and/or charismatic aspects of amchi medicine? Does bureaucratization entail a redefinition of moral norms among amchi and patients? Consequently, modernization in this thesis is understood as a transformation in which people are the subjects and objects of its characteristic processes (such as rationalization, bureaucratization, industrial production oriented towards the world market, and worldwide communication).<sup>62</sup> A further aspect of importance for the following analysis is pointed out by Anthony Giddens’ phrase of “the disembedding of social systems” (1991: 21). The insidious removal of social relations from local networks can be, in regard to amchi medicine, observed in the relationship of practitioners and their communities. This social system used to be at the core of amchi work and we need to examine the causes and consequences of its removal (Chapters 3.2.1 and 4).

In an equivalent concern over the questions above, anthropologists have emphasized culture-specific and site-based examinations of the various modernization processes. This approach counters the assumption of a progressive homogenization of the world. Instead, varying contexts – and their agents – produce in particular, local ways of “alternative modernities,” which have thus become transnational and transcultural (e.g., Appadurai and Breckenridge 1996; Arce and Long 2000c; Comaroff

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<sup>62</sup> I do not consider here the ‘nation state,’ though it is often listed as another characteristic of modernization, because it is of minor relevance in my view of investigation on Spiti as a marginal site (see Chapter 5.2).

and Comaroff 1993; Featherstone et al. 1995; Gaonkar 1999; Pigg 1996). Building on Spiti's local particularities, initially described above, it can be said that the phenomena of 'modernity' has only taken shape here in the middle of the twentieth century. Indian independence and the Dalai Lama's flight – as major incidents causing considerable change – are the reasons that fix the notion of 'pre-modern' in this thesis as a term meaning the time prior to the 1950s (cf. Samuel 1993: 3). The more recent observable and extraordinary rapid transformations (since the 1980s) can be further assigned not only to the processes of modernization, but to globalization (as one of its specific aspects) and its impacts. These transformations unambiguously represent globalization's space/time characteristics. Consequently, globalization in this thesis is meant as a real and individually experienced shrinking of time and space that fosters an increasing network between communities and people. Unconcerned with national boundaries, this process connects and interchanges people, commodities, ideas, and images which all mutually influence each other.<sup>63</sup> This 'flow' contributes to changes in social practice and in the reinterpretation of identity. Local modernities are thus often examined as dialectics of uniformity and difference. Related to this context, Janes says that "the central theoretical and practical question in the study of indigenous medical systems is to understand how they transform themselves in response to these aspects of radical, transnational modernity" (2001: 198). In investigating the globalization of Tibetan medicine in China and the West from a medical point of view (especially in regard to psycho-social treatments), Janes comes to the conclusion that "these processes of globalisation unfold to produce contextually unique and yet in some aspects surprisingly similar Tibetan medicines" (2002: 270). Analogous to this, I examine the uniformity and differences present in Tibetan medicines in social, political and economic regards, especially in a comparative manner concerning the particularities of amchi medicine in Spiti. What is the uniqueness of the situation regarding the amchi as a consequence of a multi-faceted marginality of the valley, and what causes this (cf. Pigg 1996: 165)? What does the modernization of amchi medicine in particular look like, what are its specific elements, and how does it come into being?

To find the answers to these questions, I follow the orthodox anthropological method of analyzing the expressions of the global and the local from a local perspective. On the one hand, the indigenous medical practitioners are increasingly engaging in the

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<sup>63</sup> For further anthropological readings on 'globalization,' see for instance Appadurai 1993 and 1996; Beck 1998; Featherstone et al 1995; Inda and Rosaldo 2002.

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global web by trying to cope with their local circumstances and contemporary modes of their practice. On the other hand, two gateways – Shimla/Delhi and Dharamshala – impact the money economy, the world-wide alternative health market, and the standards of the public health system. The latter aspect pulls us back into the investigation on the national level, which questions the negotiation of the integration of traditional medicine into public health care. Charles Leslie shows in the Indian context that this process is accompanied by “ambiguities of modernization,” in relation to indigenous medicine (1974). This applies to Spiti amchi medicine as well, and the analysis of Chapter 5 extracts its locally specific ambiguities. These are produced through the interplay between state, modern Tibetan medicine in exile, patients, and the amchi. The amchi’s response to the superiority of Shimla/Delhi and Dharamshala (like their reworking of questions of identity and labor modes) is what establishes the difference in amchi medicine.

Finally, we need further clarification here of the anthropological approach that additionally structures this dissertation. Being based on extended anthropological fieldwork, this ethnographical analysis focuses on the observations of practices, rather than the investigative theory of amchi medicine. The aim of my fieldwork in Spiti was to primarily examine the actual practice of amchi medicine in its locally shaped social and cultural settings. Secondly, my fieldwork was meant to investigate this particular kind of Tibetan medicine under its contemporary process of change. This meant, overall, to observe what the amchi actually do everyday, which then afterwards needed to be set in relation to their representations of what they do. These representations were mainly captured through the well-known different kinds of interviews. And, naturally, I must note here that this approach and methodology does give the observer a role, which is neither invisible nor without influence. Therefore, my fieldwork and ethnographies have been carried out and written in a reflexive way.<sup>64</sup> This ethnography therefore shows my role where necessary, but is principally aimed at giving a voice to the actual beliefs and practices of Spiti amchi.

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<sup>64</sup> Some of the relevant literature dealing with the researcher’s reflexivity is indicated here for the interested reader, like for instance Bourdieu and Wacquant (1992); Davies (1999); Willis (1997). And from a critical medical anthropology perspective, see for example Scheper-Hughes 1990 or Singer and Baer (1995).

Coming back to the thread at hand, the presentation of ethnographic material here therefore emphasizes the social practices surrounding and constituting Spiti amchi medicine. Such situated practices can be initially defined here as products of embodied processes built on experience and learning, investigated further in Chapter 2.1. Apparently, these are located and determined by time and space, which orients our focus on the rapid changes of the last ten to fifteen years, i.e., the modernization of the work of the amchi. While some aspects of institutionalization and the local/regional/global interactions are concentrated in Chapter 5, the actual practices embedded in the local communities is found in Chapters 2, 3 and 4. This explains why many of the later chapters explore the differences and ‘areas of tension’ between theory and practice, following the inner structure from theory to practice. ‘Theory,’ as the ideal representation of the amchi work, is portrayed threefold: in the decisive ancient medical scripture, by modern authors (largely writing for a Western audience), and by the Spiti amchi themselves. This theoretical approach is compared and confronted with the social practices of the amchi and their interactions surrounding amchi medicine as observed during my fieldwork. The arising “gap between theory and practice” (Bourdieu and Wacquant 1992: 70) is today (as there is no evidence if and how this gap existed in the past) a consequence of the changing modes of labor, governmental standardizations, and rationalizations of Tibetan medicines resulting from an orientation towards the global market (see Chapters 5 and 6).

Samuel follows a similar approach in his two articles on the issues of health and Tibetan medicine in contemporary North Indian settlements of exile-Tibetans (1999 and 2001a). He emphasizes the gap between theory – as set down in the *Rgyud bzhi* and publications intended for Western readers – and practice – as examined mainly among doctors and patients in the two Men-Tsee-Khang branch clinics in Dalhousie and Delhi.

What happens in actual contemporary Buddhist society is more complex than one finds in the text, for several reasons. In particular, (1) the texts are old, and are often far distant from current practice, and (2) other things are happening which are not reflected in the texts. (Samuel 1999: 85)

While Samuel focuses his analysis largely on medical practice, the same examination in Spiti encounters the social and politico-economical aspects of amchi practice. From its changing context, the central question arises then as to whether and in which way such practices and the corresponding ideologies are transformed. While these first chapters

start with this examination regarding specific themes – such as education (Chapter 2), diagnosis (Chapter 3.1.1), medicine production (Chapter 3.1.2), Tantric medicine (Chapter 3.1.3), and the integration of amchi in their communities (Chapter 3.2) – it is brought to a systematic climax in Chapters 4 and 5. Chapter 4 is completely devoted to the economic aspects of amchi medicine. The breakdown of the reciprocal exchange system, which was in former times the economic basis of the work of the amchi, has been followed only partially by the implementation of money. Socio-ethical considerations as strong local expressions now conflict with commercialization. Chapter 5 then deals further with the modernization of amchi medicine and its adaptation to supra-regional and global processes. Branching off from the central causes of change – in short, school education, modern infrastructure, medical pluralism, a monetary economy, and wage-labor – the various processes of rationalization and globalization are investigated.

To summarize the object of my investigation here, I ask how modernity is affecting the practice of amchi medicine and in what ways the modernization of Tibetan medicine is being shaped and influenced by the Spiti amchi themselves.<sup>65</sup> Who defines the lines along which modernization takes place, and how are they defined? How is ‘theory’ eventually readjusted vis-à-vis social practices? What are the influences emerging from the state, ‘Dharamshala,’ and global trends, and how do these specific people respond to it?

After this outline of the theoretical approach used in this dissertation, we can now focus on the main object of investigation. Chapter 1.3, the final chapter of this introduction, finally deals with the institutional history of Tibetan medicine, making up the foundation for the analysis of amchi medicine in Spiti.

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<sup>65</sup> Earlier representations of the Spiti-pa as passive, enduring people, whom history has passed by (Bajpai 1987; Charak 1979; Khosla 1956), are consequently contrasted and opposed in my approach and findings. Processes of transformation are always marked by interplays of subjective (internal) and objective (external) activities. The presentation in this thesis is mainly based from the amchi’s perspective, and offers dynamic and constructive activities driven by their visions.

### 1.3 A Brief Institutional History of Sowa Rigpa

In order to group Spiti amchi medicine into the generic term of Tibetan medicine, it is first necessary to present and analyze the common origin of their historical and medical contexts. This thesis does not contain a detailed study of the medical practice and traditions of Tibetan medicine. Rather, I focus on its socio-economic and political ramifications and conditions. Therefore, instead of concentrating on medical fundamentals (such as humoral theory), body concepts (embryology, anatomy and physiology), or illness (pathology), I investigate and explain the aspects that visually characterize the daily work of the practitioner. I have found the following three aspects to be the most important to a practitioner: pulse reading (3.1.1), herbal healing/medicine making (3.1.2), and Tantric healing (3.1.3). Therefore, this introduction to these topics focuses on the central literary work for learning and practicing Tibetan medicine, as well as the rise of the educational medical institutions. By examining these two themes, I lay down the literary and historical foundations needed for the explanation of Spiti amchi medicine modernization.

#### The Origin of Tibetan Medicine

In Tibetan epistemology, medicine belongs to the *rig gnas che ba lnga* (the five major sciences<sup>66</sup>) and has therefore obtained an important cultural status. The science of healing, called *gso ba rig pa* in Tibetan (sometimes shortened to simply *gso rig*), is subsequently referred to as ‘Sowa Rigpa’. This equivalent phrase was created according to its Tibetan pronunciation and is now the common phrase being used in English literature as Tibetan medicine enters more mainstream research.

Descriptions and narrations of the history of Tibetan medicine circulate very frequently around its mythic or possible origins, but also vary considerably according to the background and intention of the one presenting it. The Buddhist version emphasizes an origin that dates back to the historical Buddha Śākyamuni. This account is also believed by orthodox Buddhists and is the history most often presented to Western

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<sup>66</sup> The literal translation of *rig gnas* is “field of knowledge,” and today is often synonymous with “science.” Aside from medicine, the other four major sciences are: *bzo rig pa* (arts), *sgra rig pa* (grammar), *gtan tshig rig pa* (logic), and *nang don rig pa* (‘inner’ science of Buddha’s word). The Tibetan sciences are completed by the five minor sciences (Tib. *rig gnas chung ba lnga*): *snyan ngag* (poetry), *mngon brjod* (etymology), *sdeb sbyor* (metrics/rhetoric), *zlos gar* (drama), and *skar rtsis* (astrology).

spiritual audiences. Buddha Śākyamuni's central doctrine of the "Four Noble Truths" is expressed in medical terminology, and teaches the way to the cessation of suffering (Skr. *duḥkha*; cf. Bechert and Gombrich 1989: 44f; Janes 1995: 10; Samuel 1999: 85).<sup>67</sup> It is also believed that Śākyamuni taught complete, detailed instructions on medicine, diet, and healing substances (Birnbaum 1990: 20ff). Ancient Tibetan scriptures attempt to recollect an unbroken transmission of the Buddha's medical teachings in India (Finckh 1975: 17), which were later carried on in Tibet and became the basis for the evolution to a scholarly medical tradition.

Despite the lack of hard historical evidence, it is an undisputed fact that *Mahāyāna* Buddhism constitutes the fundamental base of Tibetan medical theory<sup>68</sup> and ethical codex, the latter of which is of great importance in the later discussion of the social integration of the amchi. It is likely that Tibetan indigenous folk medicine was based not only on empirical and magical-religious origins of the diverse healing practices, but also on pre-Buddhist oral traditions (cf. Janes 1995: 10; Meyer 1992: 2). Some authors have even traced certain elements of Sowa Rigpa (such as diet, medicinal herb usage, or dealing with evil spirits) back to the medical practice of the Bön tradition<sup>69</sup> (Drungtso 2004: 2, 8f; Men-Tsee-Khang 2005; Yonten 1989: 33). Yet despite these findings, a single, undisputed influence on the development of Tibetan medicine remains unproved. However, traces of ancient local religious beliefs have been found in Tibetan medical systems, evident in Spiti as well (see Chapter 3.1.3).

A definite beginning of Tibetan medicine can be found in the medical initiatives of King Songtsen Gampo (Tib. *srong btsan sgam po*), who died in 650 AD.<sup>70</sup> His initiative led to a great number of medicine-related compositions (Meyer 1992: 3;

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<sup>67</sup> Symbolic usage of medical terminology is very common throughout Buddhist literature and thought. For instance, in the Pāli canon, the Buddha is named as the highest physician or king of healers (*Bhaiṣajyārāja*; see Birnbaum 1990: 37; Meyer 1995b: 110).

<sup>68</sup> It's clear when looking at the assignments of the roots of suffering that the three illusions or poisons (desire/*'dod chags*, hatred/*zhe sdang*, ignorance/*gti mug*) are aligned to the three bodily humors (Tib. *nyes pa*), which are *rlung* (roughly translated as wind), *mkhris pa* (bile) and *bad kan* (phlegm).

<sup>69</sup> The ancient Bön religion (Tib. *bon*), or 'early Bön', was supposedly developed around 1000 BC and had a strong influence on all aspects of Tibetan culture. Academically, there has been great confusion and disagreement over the usage of the term *bon* and its ascription to the pre- or non-Buddhist religion in Tibet. This is partly because another Bön-religion was founded later on in the eleventh-century, sometimes called 'systemized Bön', which goes back to the teachings of Shenrab Mibo (Tib. *gshen rab mi bo*). Though the Bön-po see themselves as practicing a separate religion, Bön shares considerable elements with Vajrāyāna Buddhism, especially the Nyingma-pa sect. The 'systemized Bön' continues to exist today, while the order of the older one has not been continued until the present (Bechert and Gombrich 1989: 330ff, Samuel 1993: 10ff and 273).

<sup>70</sup> It is likely that during the reign of Songtsen Gampo, Buddhism was introduced to Tibet from India, where it then continued its dissemination.

Taube 1981: 10). During this time, physicians from India, China and Persia were invited to Tibet, bringing with them medical texts that were (afterwards) translated into Tibetan. Under royal direction, the first medical school was then founded. Janet Gyatso has analyzed the division processes that led to the distinct systems of Buddhism and Tibetan medicine and estimates this time as the beginning of “professional medicine” (2004: 84).

In the eighth century, King Thrisong Detsen (Tib. *khri srong lde bstan*) invited physicians from India, Kashmir, Nepal, China, Iran, and the Turkic regions of Central Asia to what some call the “first international medical conference” at Samye (Tib. *bsam yas*; Drungtso 2004: 10; Men-Tsee-Khang 2005). The debate that then took place was led by a Tibetan physician, Yuthog Yontan Gonpo the Elder (Tib. *gyu thog yon tan mgon po*; 708-833 AD; see Finckh 1975: 18). He was supposedly the best well-versed physician of his time and a far-traveled scholar.<sup>71</sup> As a direct consequence of the conference, many medical texts were then translated into Tibetan. After a period of decline in the ninth century under the reign of Langdarma (Tib. *glang dar ma*), Buddhist culture was largely destroyed. But the work of translating texts and compiling medical treatises was revived in the tenth century, with a strong influence by Indian sources. In particular, Rinchen Zangpo (see Chapter 1.1) translated numerous Indian medical texts, a few of which later became part of the canonical literature of the Tanjur (Tib. *bstan sgyur*). The most prominent of his medical translations is the *Aṣṭāṅgahrdayasaṃhitā*, originally written by Vāgbhaṭa.

### The Rgyud bzhi

With regard to terminology, the *Aṣṭāṅgahrdayasaṃhitā* corresponds with the central Tibetan medical work, the *Rgyud bzhi* (‘Four Tantras’, spoken as *Gyü Shi*).<sup>72</sup> Since the fifteenth century, there has been controversy over whether the *Rgyud bzhi* should be regarded as an authentic Buddha word, or rather as compiled by Tibetan authors (Gerke 1999; Gyatso 2004: 91). The Buddhist tradition claims that the medical teachings were handed down orally in a successive lineage from Śākyamuni to Nāgārjuna and

<sup>71</sup> Some authors also ascribe Yuthog the Elder as the establisher of Tibet’s first medical institute at Kongpo Manlung, in 763 AD (Drungtso 2004: 11; Men-Tsee-Khang 2005).

<sup>72</sup> The full title in Tibetan is *bdud rtsi snying po yan lag brgyad pa gsang ba man ngag gi rgyud*, which can be translated as “The Essence of Ambrosia: Tantra of the Secret Oral Instructions on the Eight Branches.” The short name, by which this text is commonly known, is derived from the book’s four parts. Dorje explains that the word Tantra here “indicates a systematic or streamlined presentation in which an entire subject, such as medical science, is covered from beginning to end, in contrast to the more discursive approach of the *sūtras*” (1992: 14).

Vāgbhaṭa (Obermiller 1989: 8f; Rechung 2001: 9f). More recently, the debate has revolved over how much of the main work of Tibetan medicine is essentially Indian, being respectively derived from an original Sanskrit text. However, modern philological research concludes that the *Rgyud bzhi* was indeed based on Indian text material, but then also compiled and synthesized with further diverse medical elements (Meyer 1992; Obermiller 1989; Taube 1981). Therefore the author is shown to be more of a compiler than a creator, albeit one that must have been “of creative and original intelligence” (Meyer 1992: 4).

Yet no matter whom the author or its origins, the *Rgyud bzhi* started its influence early on in history. Going back to the above mentioned Tibetan physician, Yuthog the Elder, it is believed that he received a translation of an Indian medical text from Vairocana. He and his successors presumably reworked this text by adding from Tibetan sources. It was then hidden and only rediscovered in the eleventh century. Eventually, it is assumed that Yuthog Yontan Gonpo the Younger (who probably lived from 1126-1202 AD<sup>73</sup>) finally reworked and compiled the *Rgyud bzhi* again by adding various different sources. However, it is now a well-known fact that the *Rgyud bzhi* was certainly used as the main textbook of Tibetan medicine by the fourteenth century (Gyatso 2004: 85).

Taking a look now at the medical content of Tibetan medicine, we see numerous sources for its inspiration and influence. It not only has Mahāyānic Buddhist philosophy as its base, but has been strongly influenced by Indian and Chinese medicine and – though to a lesser extent – by local pre-Buddhist healing traditions as well as Greek and Persian medicine. While there are many parallels between Tibetan and Indian medicine, most noticeably concerning the basic principle of the three humors or the constitution of the body, the method of pulse diagnosis and the usage of mercury were derived instead from Chinese medicine (Finckh 1975: 15; Meyer 1995b: 132ff; Obermiller 1989: 12; Taube 1981: 26). Other features, such as urine analysis, indicate elements and developments unique to Tibetan medicine<sup>74</sup> (Meyer 1995b: 134).

As the *Rgyud bzhi* is the main work studied by Tibetan medical practitioners, I provide here the subjects and structure of the text (but not the medical details and

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<sup>73</sup> The existence of two scholars with the same name, both connected with Sowa Rigpa, brought about confusion over their persons, their work, and the dating of the *Rgyud bzhi*. That’s why they are now named by “Yuthog the Elder”, and respectively, “Yuthog the Younger”.

<sup>74</sup> Finckh explains that the usage of certain numbers (the holy ‘nine’), and the dealing with evil spirits, point to the Bön religion (1988a: 11).

content). This description is necessary in order to recognize the vastness of content of Tibetan medicine, and so that it is understandable later on what the amchi must learn during their training. Therefore I now provide a short overview of its subjects going through the work's structural content. Overall, the *Rgyud bzhi* is constructed with Buddha appearing as the Medicine Buddha Sengye Menla (Tib. *sangs rgyas sman bla*) teaching the framework and content of the work through a question-and-answer method between two Rishis (Skr. *ṛṣi*). The Four Tantras contain one hundred fifty-six chapters and 5,900 verses. The treatises then follow a systematic tree metaphor by dividing into three roots, nine trunks, forty-seven branches, and two hundred twenty-seven leaves. The first root contains the description of the body and the basis of diseases. From this root, one of its trunks depicts the healthy organism, while the second trunk shows the unhealthy one. The second root deals with diagnosing illnesses, as there are three methods: observation (shown in trunk three of the tree), palpation (trunk four), and questioning (trunk five). The therapeutic practice explained in the third root is fourfold, containing nutrition (trunk six), behavior (trunk seven), medications (trunk eight), and treatments (trunk nine). Each trunk is then further divided into branches and leaves.<sup>75</sup>

Delving now into the four parts of the *Rgyud bzhi*, the first of the books is called *rtsa rgyud* (“Root Tantra”) and is composed of six chapters. It gives an introduction into Sowa Rigpa and outlines its principles through a synopsis of the contents of the other Tantras. Additionally, the tree symbolism, the basic structure of the body, the diagnosis, the treatments, and the classification of medical knowledge are introduced here in “eight branches”. These eight branches show the differentiation of the *Rgyud bzhi*:<sup>76</sup> 1) *lus* (body → general therapy [F]); 2) *byis pa* (child → pediatrics [D/F]); 3) *mo* (woman → gynecology [D/F]); 4) *gdon* (evil spirits → psychiatry [F]); 5) *mtson* (weapon → surgery [F]); 6) *dug* (poison → toxicology [D/F]); 7) *rgas* (aged → rejuvenation [D/F]); and 8) *ro tsa* (sexual instinct/desire → virilification [F], aphrodisiacs [D]).

The second book, *bshad rgyud* (“Explanatory Tantra”), is a detailed theoretical account of all of the elements of Tibetan medicine given in its thirty-one chapters. It starts off with the formation, the general constitution, and the classifications of the body

<sup>75</sup> The entire tree system has been translated and explained in written form by Finckh in her two volumes on the “Foundations of Tibetan Medicine” (1975/1988a).

<sup>76</sup> In order, I first give the original Tibetan term; second, the exact translation; and third (after the arrow), the translation according to Drungtso ‘[D]’ (2004: 37) and/or Finckh ‘[F]’ (1988a: 113). This is done as an example of the condensed usage of Western terminology by contemporary authors. It should be added that, unlike Drungtso, Finckh gives both the direct and the transferred translation terms.

(usually translated as embryology, anatomy, and physiology). Furthermore, it explains not only the causes, characteristics, and classifications of diseases, but also the rating and influences of behavior and diet, as well as other factors in remaining healthy. The principles and production of the remedies are purposefully arranged before the methods of diagnosis and therapy. The last chapter delves into the ethics and qualifications of a physician, this being of special importance to this thesis, and discussed further in Chapters 2.4 and 3.2.1.

The third (and by far the largest) book, *man ngag rgyud* (“Oral Instruction Tantra”), contains ninety-two chapters. It explains and details the practical application of diagnosis and treatment through presenting all known diseases with their respective causes, classifications, symptoms, modes of diagnosis, and courses of treatment. And finally, the fourth book, *phyima rgyud* (“Subsequent Tantra”), contains twenty-seven chapters, twenty-five of which describe diagnostic and therapeutic techniques in detail. In the final two chapters, it then provides an overall summary of the entire Rgyud bzhi.

Remarkably, the *Rgyud bzhi* in its presented structure continues to be the authority for learning medical knowledge today. Examining literary development in the seventeenth century, Gyatso concludes that a “medical genre [...] the *nyams-yig*, literally, ‘writing from experience’” and commentaries gained much importance during that time, and theoretically displaced the *Rgyud bzhi* (2004: 85f). Nonetheless, she concedes the overall authority of the work:

While we can find examples of commentators overtly correcting the *Four Tantras*’ statements, these tend to be cautious and minor. More commonly, the *Four Tantras* is upheld, in a display of loyalty that is more important for what it says socially than what it actually means for the practice and theory of medicine, which was evolving. The impulse to show loyalty also has something to do with reticence to dismiss tantric anatomy, even when there was really no way to make its extravagant claims empirically plausible. (ibid.: 90)

The *Rgyud bzhi*’s authority today continues as a fundamental base of Tibetan medical learning, in Tibet as well as India (Janes 2002: 275; Pordié forthcoming a). In general – also applying to Spiti – three of the four Tantras are memorized by students, with only the *man ngag rgyud* considered too long and the least relevant to memorize (see Chapter 2.1). This practice “likely dates to the early twentieth century revisions to

Tibetan medical training implemented by the thirteenth Dalai Lama” (Janes 2002: 275). Nowadays, the *Rgyud bzhi* attracts an increasing amount of contemporary interest among non-Tibetans who study Sowa Rigpa. As a result, the first two Tantras have thusly been translated into English (Clark 1995; Dhonden 1977; Rechung 2001), with the other two works still remaining to be done.

*Developments since the Seventeenth Century*

At the end of the seventeenth century, Desi Sangye Gyatso (Tib. *sde srid sangs rgyas rgya mstho*) became the regent of the fifth Dalai Lama. He was a well-known physician and wrote various books on astrology and medicine, including the Blue Beryl (Tib. *vaidūrya sngon po*), a most popular commentary on the *Rgyud bzhi*. Desi Sangye Gyatso was also able to found the first central medical institution of Tibet in 1696, mainly as a result of his political position. It was named *Chagpori*, referring to “The Iron Hill” (Tib. *lcag po ri*) near Lhasa on which it was built. Chagpori, and the other medical colleges established around the same time in Eastern Tibet, was set up according to the structure of the monastic colleges in the Gelugpa-tradition (Gyatso 2004: 85; Meyer 1992: 4; Yonten 1989: 43). Chagpori became the most important medical education center up until the twentieth century (Gerke 1999; Janes 1995: 13; Meyer 1992: 3). Examining the seventeenth century, Gyatso made a valuable point regarding the historicity of questions, very relevant for my thesis, as to how medicine was actually practiced:

In fact, medical practice in Tibet was far from limited to these monastic learning centers; healing traditions also abounded in tantric circles, and oracle mediums were involved with healing as well. But even for the medicine fostered by the monastic schools, we know little of the sociology of practice, regarding, for example, what percentage of practicing physicians were actually trained in those schools, what the lay-monastic breakdown was, what the rate of literacy was among physicians, to what extent physicians actually used medical writings, let alone all the questions one might raise about the economics and daily practice of medicine. Moreover, there is every reason to expect that the answers to such questions would vary widely from area to area and period to period. For the moment, we are stuck mostly with generalities. We can only venture, for example, that the degree of professionalization for Tibetan medicine, even during its

apogee around the seventeenth century, probably does not approach that achieved in Chinese medicine, due to the centralized bureaucratization there of qualifying examinations for physicians, and, by the Song dynasty, regulations that physicians keep standardized case records. (2004: 85)

Following Gyatso, we must take note of the fact that there is little historical data available concerning the social, political, and economic conditions of medical practitioners. This lack of data carries well into the mid-twentieth century, especially concerning the practice of Tibetan medicine in rural areas like Spiti. To thereby examine the changes of medical practice means to rely heavily on accounts given by contemporary practitioners; naturally, these can effectively only cover fairly recent history. This recent information can then only be compared to the ‘idealized theory’ displayed in the ancient scriptures, a methodology I chart in Chapters 2 and 3.

We now turn back to the chronology of institutionalization so that we can follow the evolution of Tibetan medicine. At the beginning of the twentieth century, the concentration of medical knowledge and education was once again strengthened at the center. Thupten Gyatso (Tib. *thub bstan rgya mtsho*), the thirteenth Dalai Lama, initiated the creation of the Medical and Astrology Institute (*Men-Tsee-Khang*; Tib. *smān rtsis khang*), which was set up in Lhasa in 1916. After the processes in the seventeenth century, this period is often considered the second movement of standardization of Tibetan medical education. This drive towards modernization is considered “a result of the thirteenth Dalai Lama’s efforts to centralize political power and authority” (Janes 1995: 7). Men-Tsee-Khang survived the invasion of the Chinese in 1959 and today remains the central institute of Sowa Rigpa in Tibet.<sup>77</sup> Tibetan medicine has been subsequently been subordinated under the Chinese national health system. The following fundamental transformations of its practice have been subject of extensive research (e.g., Adams 1998b, 2001a, 2001b, 2002c, forthcoming; Janes 1995, 1999a, 2001).<sup>78</sup>

Following the Chinese repression, only a few Tibetan medical scholars remained that were able to preserve the tradition of Sowa Rigpa. Some fled to South Asia, and

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<sup>77</sup> However, Chagpori as a monastic institution was destroyed.

<sup>78</sup> Taking my cue from these authors, I subsequently call this Lhasa institute Mentsikhang, in order to differentiate between the one in Dharamshala named Men-Tsee-Khang.

after some years, started Sowa Rigpa's revitalization while in exile.<sup>79</sup> It was the Dalai Lama's advice that led to the set-up of a small dispensary for the exile community in Dharamshala in 1961. It was successively enlarged and six years later, the medical institute and the astrological school were united under the new Men-Tsee-Khang.<sup>80</sup> It was established as the first Tibetan hospital, providing fifteen beds at its start (Meyer 1995a). In the beginning, Yeshe Dhonden was in charge of the medical guidance of the center, and began teaching the students. Further successive "Chief Medical Officers" of the medical department included Trogawa Rinpoche and Lobsang Dolma Khangkar (see Chapter 2.3), to name but two of them (Yonten 1989: 48). The first class of students graduated from the school in 1974. Today, more than fifty students attend the training, which consists of a five year course and two further practical years (Meyer 1992: 2; Prost 2003: 129). Since the 1980s, Men-Tsee-Khang has increasingly expanded, and today houses not only a research department, but also sections for development, publishing, and sales. The medicine department (which also includes the training college) contains a dispensary, a surgical ward, and an in-patient ward, all while operating approximately forty-two branch clinics in India and Nepal (Men-Tsee-Khang 2005). I have only begun to touch upon the subject of Men-Tsee-Khang's modernization, and further investigate this in Chapters 3.1.2 and 5.2.

Outside of Men-Tsee-Khang, there are few other institutionalized opportunities to study Tibetan medicine in India. At the *Tibetan Medical School of the Central Institute of Higher Tibetan Studies* in Sarnath (Varanasi), a seven-year course has been offered since 1993 (TibetMed 2005). In Darjeeling in 1992, Trogawa Rinpoche re-established the *Chagpori Tibetan Medical Institute*, as he was the Chagpori lineage holder. It runs a training course that is closely connected to Men-Tsee-Khang Dharamshala (Dharmananda 1999; Meyer 1995a). Both of these institutes are of little importance to my study because they are too far away from Spiti and offer equivalent courses at Men-Tsee-Khang, which is closer by. A viable alternative for Spiti-pa to study Tibetan medicine opened up last century at an institute in Manali founded by Amchi Sundar Singh. For several reasons, it is of special importance for the Spiti amchi, and will be dealt with in Chapter 2.3.

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<sup>79</sup> The lines of transmission have remained unbroken in the Indian and Nepali border regions and Bhutan, but in no other place was the formal medical education ever as elaborate as in pre-1959 Tibet.

<sup>80</sup> Today, it is officially called "Men-Tsee-Khang – Tibetan Medical and Astrological Institute of H. H. the Dalai Lama", see Men-Tsee-Khang (2005).

This historical outline confirms the proposal that Tibetan medicine has developed in a syncretistic way and can be considered part of the scholarly medical traditions of Asia (Bates 1995: 17; Meyer 1995a: 14). As previously mentioned, the centering of the standardization of learning and practicing Tibetan medicine around an authoritative corpus has long been established. However, Tibetan medical knowledge is not only transmitted in colleges, but also simultaneously from generation to generation by smaller schools and lineages of scholars and families. And despite the authority of the *Rgyud bzhi*, a certain degree of heterogeneity has entered the medical practice, due to spatial and ideological variations and differences. This is displayed, for example, through Janes' categories of professional physicians<sup>81</sup> in pre-1959 Tibet (1995: 12f):

1. Lineage physicians: teach relatives and apprentices.
2. Well-known physicians: teach students at private (secular) academies.
3. Monk-physicians: train at monastic institutes, focusing on ritual practices.
4. Government-employed physicians (since the seventeenth century).

Through this list, Janes emphasizes the multiplicity of traditions resulting from distinct genealogies and local transmissions of ecological and geographic particularities.<sup>82</sup> Meyer further adds that “[a]lthough they [the different practitioners] claimed to be of the same medical tradition, they never, until recently, formed a homogenous socio-professional group” (1995a: 15). I am emphasizing this heterogeneity here in order to point out the historicity of local particularities of Spiti amchi medicine – which although probable, is not verifiable.

The question we should ask now concerns the introduction and transmission of medical knowledge in Spiti. None of the literal sources I had access to could give any information regarding how or when Tibetan medicine was introduced to Spiti.<sup>83</sup> When asked such questions, Spiti amchi answered by referring to Rinchen Zangpo. They declared that during his extensive travels, he also came to Spiti (which is probable, see Chapter 1.1) and brought with him the knowledge and written manuscripts of “all the

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<sup>81</sup> The complete health sector of Tibet contains an even greater variety of practitioners. Especially in the field of ritual healing, other specialists (such as diviners, Tantric practitioners, and mediums) have been included. An introduction to their working modes will be given in Chapter 3.1.3.

<sup>82</sup> His aim in this article is to portray the great variety once within the medical system, which came to an abrupt end because of the Chinese invasion and implementation of a state health system.

<sup>83</sup> A few authors refer to the existence of a “western system of Tibetan medicine”, which might have been created through the influence of the Galenic and/or Bön traditions (Drungtso 2004: 20; Yonten 1989: 33). However, nothing more specific than that has been expressed.

*rig pa.*” Such a parallel dispersion of religious and medical teachings seems very likely, due to their close connectedness.

Two accounts regarding the transmission of Tibetan medicine in Spiti (given by Lyall 1874 and Mamgain 1975) report of an exclusive hereditary transmission, at least during the nineteenth and twentieth centuries. All my informants agreed with these reports, saying that Sowa Rigpa has been (until recently) practiced without exception by members of family lineages or practitioners who have been trained by one of those *rgyud-pa* amchi. Thus, on the list of Tibetan medical practitioners, Spiti amchi fit exclusively into Janes’ first category: lineage physicians. There is no evidence that any of the other three kinds of practitioners have existed in the history of Spiti. This can easily be explained when one acknowledges that in pre-modern Tibet, lineages had less importance for the transmission of medical knowledge the closer one got to the famous institutes of medical training (in central and eastern Tibet). Conversely, lineages have probably had a greater relevance for health care and the preservation of Sowa Rigpa in the marginal regions – as for instance in the western areas. Congruently, no Spiti-pa I asked was able to recall someone who had gone to Tibet for learning, or had come from there to teach in Spiti. Reconsidering the issue of marginality (Chapter 1.2), it is likely that Spiti has been a marginal region in regard to Tibetan medicine education and practice. It is important to keep in mind that when we speak of Spiti amchi, we refer to a group that, until very recently, had entirely transferred its knowledge through lineages. The attendance of schools and colleges (outside Spiti) is a new development and, in the context of professionalization, constitutes an important aspect of my investigation (Chapters 2.3 and 5).

These introductory remarks emphasize the heterogeneity of Tibetan medicine, notwithstanding its movements towards standardization from the seventeenth century onwards. It was necessary to first explore its different roots and paths so that one can then better understand this modern drive towards rationalization and its local particularities. I explore this modernization, which has been picking up speed in Tibet and India, further in Chapter 5. This issue then opens up the focal point of interest in my research: in Spiti, amchi medicine was largely neglected by these developments almost entirely until the 1980s. This thesis explores how the project of modernizing the work of the amchi has been taken up in regard to medical education (Chapter 2), social

integration (Chapter 3), economic viability (Chapter 4), and professionalization and rationalization in both national and international contexts (Chapter 5).

## 2. AMCHI ON THE ROAD

How does one become an amchi? A useful illustrative comparison is to visualize a road that crosses the Himalayan high plateaus: the way is long, almost never ending, and very troublesome. This image also serves for imagining past and present amchi students, who undertake journeys that lead far away from home in order to study Sowa Rigpa but ultimately come back to their villages as trained amchi.

A brief introduction of the different modes of pre-1959 Tibetan medical education was presented in Chapter 1.3. During the last century, the two famous colleges of Chagpori and Men-Tsee-Khang have offered the most sophisticated Sowa Rigpa training courses. The colleges' establishment with the teaching boards and classes marks the achievement of an institutionalized and fully standardized curriculum in Tibetan medicine (Meyer 1992: 4). Before the Chinese invasion, Chagpori and Men-Tsee-Khang were the historical, political, educational, and epistemological centers of Sowa Rigpa. Their practitioners represented the elite, in contrast to the practitioners who received medical education through other modes. Throughout southern and central Asia, the most common types of traditional medical education were family lineages and master-disciple relationships.<sup>84</sup> In Spiti, as mentioned earlier, Sowa Rigpa was handed down exclusively through these two methods. The foremost transmission of medical knowledge was placed within the amchi *rgyud-pa*: the family lineages. The *guru-śiṣya* relationship was less frequent, but still present, with some medical apprentices traveling to nearby or distant villages to study with a well-known amchi for some years.

Chapter 2.1 provides a detailed explanation of these two methods of medical education, since they continue to be the predominant form of transmission of medical knowledge among Spiti amchi. The establishment of centers of Tibetan medicine in India – especially Men-Tsee-Khang in Dharamshala – brought about a fundamental shift in medical education in the culturally-Tibetan regions in northwest India. Chapter 2.3 illustrates how this has led to ‘new ways of education’ in Spiti, and what exactly these ways are. Finally, this chapter ends by answering the question of what is needed to become or be ‘a good amchi’.

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<sup>84</sup> In southern Asia, the latter were called *guru-śiṣya parampara*, i.e. a teacher-disciple lineage (see Langford 2002, Gerke and Jacobson 1996).

## 2.1 Traditional Education

In order to give a thorough analysis of the content of medical education in Spiti, I begin here with a long ethnographic presentation of one of my main informants. I will repeatedly return to him throughout the thesis, as the description of his career provides an outstanding example of the important steps of amchi training, as well as sheds light on the different paths an amchi's life can take today.

I first met Amchi Chullim in October of 2003, sitting behind his desk in the Amchi Clinic<sup>85</sup> in Kaza, treating two patients. He is in his sixties, with a furrowed face lined by the weather and his age and darkened by the sun. Later on when we are outside, I'll notice his fascinating, sparkling eyes: brown, with a light blue circle around his pupils. But for now, even inside, I perceive how deep-set and alert his eyes are. His long gray hair is tied in the back with a thin red string, which I find out later is his preferred style. Like most other Spiti men his age, he is usually dressed in trousers and a shirt. As for his disposition, Amchi Chullim doesn't speak much, and when he does, he speaks very softly. When I first enter the office, he is just finishing with his first patient, and turning to the second. He takes her arm, poised and focused in order to concentrate fully on reading her pulse. He notes the diagnosis in his patient book, collects the appropriate medicine from the shelf, and explains to both patients how to take them. When they leave, I introduce myself and ask if we could talk. He suggests that we take two chairs outside, as the sun is out and it's therefore much more pleasant than in the little clinic. Sitting outside, he counts the beads of an old *mālā* and continues to do so even as our conversation becomes rather long. The amchi always looks directly at whomever he is speaking to, and I feel a bit flustered from his purposeful attention. He appears a bit reserved, but he is also very friendly. His Hindi is clear and articulate, and he always uses the polite forms.<sup>86</sup> Actually, Amchi Chullim's whole way of speaking is quite remarkable – not only because of his Hindi, but because he speaks very frankly. Ordinarily, communication in Spiti is rather restrained. However, whenever I ask Amchi Cullim a question – in the in-depth interviews as well – he responds directly and without hesitation, always stating his mind and rarely holding back his opinion. He doesn't change his words based on what others (or I) might think, but rather simply

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<sup>85</sup> It is the clinic of the association of the Spiti amchi, which is the object of detailed examination in Chapter 5.1.

<sup>86</sup> Using the polite forms is not very common because the native Spiti dialect is quite coarse and people there are used to that kind of social communication.

candidly reports his ideas. During our talk, Amchi Chullim becomes more and more interested in my research and finally – surprising me – invites me to his home village of Manne the next weekend. He explains that he now works in the Amchi Clinic all week long and only goes back to Manne for the weekend.

Manne can seem rather isolated, positioned in the lower Sham region of Spiti and situated on the southern side of Spiti River with no close road to another village (see map 1). However, people can reach the villages in Pin, lower Spiti, and even Kinnaur rather quickly by foot. From the main Spiti valley, one cannot see the actual village, but one can see a road built over the Spiti River that climbs a few hundred meters up a steep mountain. At the top of this road, Manne is seen directly on the other side, almost underfoot. The village has two parts: Manne Gongma and Manne Yongma. The former can be reached by the road, but the latter is another thirty minute walk, passing a plateau with a forest, and then through a gorge on the other side.

Amchi Chullim is at least the fourth or fifth generation of amchi in his family. It is, therefore, a quite old amchi *rgyud-pa* of Manne Gongma. Today, there is also another younger amchi that lives in Manne Yongma. He is a member of Amchi Chullim's extended family, and learned Sowa Rigpa from his father. However, the young amchi is also the head of his household, and he therefore has to work additional different occupations in order to make a good living for his family. His amchi work suffers because of this, but in the absence of the older amchi he serves the villagers as best as he can. Amchi Chullim's house is located in the middle of Manne Gongma and is big enough for a large family to live there. Presently, they have some extra space because Amchi Chullim's four oldest children (all female) are married and live in their husbands' houses. He has three boys with his second wife, the second boy currently a novice at Dhankar *dgon-pa*. The other two still attend school. Thus, Amchi Chullim is somehow waiting for the next generation to come and live in his family house. He owns quite a few fields and about thirty animals, which his wife takes care of in cooperation with the other villagers. His family also grows cash crops (peas, cauliflower, potatoes, and red beans) like other villagers. His family's wealth and respected position in the village derives not only from the amchi *rgyud-pa*, but also from a rich heritage of knowledge of different kinds of religious work passed on for generations. Some of his forefathers' skills have been passed onto Amchi Chullim, which he continues to practice. For instance, he occasionally produces the ritual offering cakes called *gtor ma*, little wooden *mchod rten* (stūpa) for altars, and larger stone *mchod rten* for the villagers.

Being a *khang chen*, the family house also contains a temple called *chos khang*. Theirs is quite big, with cushions in two parallel lines in order that lama can sit face-to-face and carry out *pūjā*. A rich altar with a few golden statues stands in the front, and old *thang ka* (hanging scroll paintings) hang on the walls. The *chos khang* is also Amchi Chullim's medicine making place. Plastic bags full of raw materials hang from the ceiling, and flowers and plants lie out to dry on some of the tables (figure 11). Opposite the altar in one corner stands a shelf with dozens of filled glasses containing fully prepared medicines, as well as more raw materials. I roughly calculate about one hundred different effective medicinal substances there. On the floor in front of the shelf lies a stone for grinding medicine powders. Although many Spiti amchi possess places like this to prepare their medicine, this is definitely one of the most extensive collections of medicine I have ever seen.

Another very important room for Amchi Chullim and his family is the small meditation room on top of the house. The *sgom khang* (a chamber for tantric meditation and rituals) looks almost exactly like an old hermit cave in the Himalayas. A small bed stands cramped next to the sitting place which is lined with thick woolen blankets and furs. On a small shelf are a few prayer and ritual utensils, as well as a small *dpe cha* – the old, longish block prints (sometimes even handwritten) containing the ancient religious scriptures. This is the place of daily prayers but also of the *mtshams*,<sup>87</sup> the months of meditation a trained practitioner undertakes in order to gain insight and strength through solitary contemplation. Amchi are supposed to undergo *mtshams* regularly.<sup>88</sup> The *chos khang* and the *sgom khang* are the most visible signs of the family's religious character. While presenting the rooms to me, Amchi Chullim explains that most of the *dpe cha* (of which he owns a good collection of bigger and smaller ones) were hand-made by his forefathers. They were talented enough to carve the wooden printing blocks to produce the prints, and Amchi Chullim is obviously very proud and happy to show off that his forefathers have signed the work themselves. There were probably not many people in Spiti who were able to create *dpe cha*, and it is therefore quite an achievement.

Recalling his education, Amchi Chullim narrates to me that his mother was very religious and sent him to Chango (upper Kinnaur) as a boy. There, he was taught how to

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<sup>87</sup> It is literally translated as “border, boundary, seclusion, retreat, intermediate space, limitation” (Nitartha 2005). In this context it is always used as a synonym for a meditation retreat.

<sup>88</sup> This practice is explained closer in Chapter 3.1.3.

read and write Tibetan, and was introduced into the philosophy and the Tantric practices of Vajrāyāna Buddhism from a *sngags-pa rinpoche*<sup>89</sup> until he was fourteen years old. He was further fortunate to have received teachings from Dudjom Rinpoche<sup>90</sup> in Pin valley. After returning from Chango, his successive education had sufficiently prepared him to become a chowa. Although this wasn't part of his family tradition, Amchi Chullim nevertheless found he had a "natural" talent for this. The old Manne chowa taught him together with another apprentice, who is today a chowa in Manne and Kaza. Only after this did Amchi Chullim begin to be specifically trained by his father to become an amchi. Because of his earlier received education, he was already very well-prepared by having learned Tibetan and the religious and philosophical fundamentals of Sowa Rigpa. It was probably relatively easy for him to acquire the additional medical knowledge, but unfortunately his father died soon after. Therefore in his early twenties, he stayed in Kyuling for three years to further learn amchi medicine from the old village amchi, who was a close relative.

Now having served Manne's health care matters for almost forty years, Amchi Chullim is beginning to think about retiring. However, he says there is still a lot of work for him, and his son is still attending classes to finish school with a "10 plus 2" exam, and therefore not yet able to become his successor.<sup>91</sup> So far, Amchi Chullim has only taught him the scriptures, no medical practice yet. The amchi says that his son will definitely take over the *khang chen* and the appropriate conjoined estate, but the decision to further learn Sowa Rigpa is left up to the son himself. It is difficult today to acquire full amchi training, and it is much more important to rather safeguard the family's economic security.<sup>92</sup>

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<sup>89</sup> Rinpoche (lit. "most precious one") is a title for someone identified as the reincarnation of an earlier accomplished lama or practitioner. A *sngags-pa* is an initiated practitioner of Tantra, also called a Mantrika, or, more popularly, an exorcist. Samuel explains that they are "lineages of hereditary lamas" and "being born into a *ngagpa* family carries the implication of inherited spiritual power" (1993: 289; emphasis in the original).

<sup>90</sup> Dudjom Rinpoche was one of the most well-known Tibetan teachers of the *Nyingma-pa* sect in the last century.

<sup>91</sup> It means ten years of school followed by two years of higher education, with a specialization in either the science or arts. The two year extension cannot be completed in Spiti; rather, young people have to attend school in the Indian plains. This exam is a prerequisite for applying to colleges or for mid-level positions in government administration.

<sup>92</sup> This conflict between household head duties and amchi work is analyzed in Chapter 4.

*Family Background*

Amchi Chullim received an exceptional education in regard to medicine and religious practices. It is fair to assume that despite being the eldest son of his family, at a young age he was considered talented, or “god gifted,” as Spiti people say. Nevertheless, we can clearly outline the main characteristics of traditional amchi education in Spiti by drawing from Amchi Chullim’s career. There are recurrent characteristics common not only to most Spiti amchi, but also to family traditions throughout the Tibetan Buddhist Himalayas. For example, the level of education varies according to the individual capabilities of the lineage holder. Meyer explains:

Traditionally, medical practice was not, in fact, regulated by any official recognition which would have required a certain standard of theoretical knowledge or practical expertise. [...] Even though all Tibetan doctors [...] pay reference to the same fundamental text, the *Four Tantras*, they represent nevertheless a broad diversity in levels of education and practice. (1992: 2; emphasis in the original)

In the past, the road to becoming an amchi in pre-modern Spiti (with only a few exceptions) consisted of being a part of the hereditary line of medical practitioners. According to male primogeniture, the first-born son of a family would receive knowledge (Tib. *nyams myong*<sup>93</sup>), skills of crafts and/or arts, and the science of healing through his father’s transmission of his expertise.<sup>94</sup> The second option open to learning amchi medicine was to join with a teacher, but this was restricted only to the boys or men of the *chahzang rigs*.<sup>95</sup> Additionally, they were also generally descendents of *khang chen* households. As their families were economically better-off, their sons were more independent and could follow a more time-intensive training (cf. Mamgain 1975: 246). Favorably, an amchi apprentice (descending from a lineage or not) would have already gained some knowledge of the Tibetan script beforehand. The opportunity for this was best when the apprentice was a lama, or in households with a strong religious tradition, such as amchi or chowa families. Often, their families owned the *dpe cha* (the

<sup>93</sup> In the upcoming paragraphs, the notion of ‘knowledge’ is elaborated.

<sup>94</sup> As mentioned in Chapter 1, the case of a woman practicing medicine through family tradition is not reported in Spiti, though it was not per se forbidden that a daughter could receive the family’s transmission. In the case of no male successor, an amchi would have tried to educate one of his daughters. This practice is quite common throughout the Buddhist Himalayas: see for instance the famous Lobsang Dolma Khangkar (Chapter 2.3).

<sup>95</sup> Descendants of the lower strata were usually not allowed to enter the amchi training (see as well Janes 1995: 34; Kuhn 1988: 41).

religious books), which their children then had easy access to. Amchi Chullim and Amchi Thupten Thapke (who is introduced in Chapter 2.3) are two such examples of this early childhood training. Boys like these two learned Tibetan, and had perhaps shown interest in medicine or had a favorable attitude or capability. The family might have believed that their child had received some kind of ‘natural or innate gift’ for the art of healing. The son of an amchi would have thus started his amchi career quite early. Other boys might have also been introduced to an abbot or a chowa, who then decided to send them to a well-known amchi for training. I found in my research that in these cases, apprentices were quite often then sent to an amchi who was related by family. Presumably this is not a coincidence, as it is probably easier to accommodate someone who belongs to the extended family for economic and social reasons. Furthermore, people seem to think that a relative of a good amchi (see Chapter 2.4) is more likely to be talented, and might have better access to the lineage knowledge (see below).

If a boy or young man came to stay and train in an amchi’s house, he didn’t only learn medicine but also served the family as a helper in the house and in the fields. In Spiti, each family member from young age on was addition to their labor force. If a family had only a few working members, children thus became more important. A son who could leave to become an amchi was therefore sometimes not permitted to do so, as he would have been indispensable to his family’s work force. Therefore in many cases, it was arranged that the students would stay at home during the summer and only come to the amchi’s residence for the less work-intensive months of the winter. It was also not unusual that a well-known amchi had two or more students at the same time (for example his son and another young man from a village), as an amchi household could then also have the benefit of more helpers in the household.

### Principle Lines of Training

Most, if not all, of the amchi families I visited preserve – like Amchi Chullim in Manne – a collection of medical *dpe cha*, as well as some religious *dpe cha*. The books are made by block prints, rarely hand-written, on longish paper enclosed by two wooden lids. Usually, they are rolled up in a woolen or silk cloth that helps conserve the book. The *dpe cha* can be ‘pocket-sized’ (about thirty centimeters long), or very large (up to one meter long and about thirty centimeters thick). They are preserved with pride in a special place of the house. Most of the prints have been made in Spiti or the surrounding valleys, and only a very few have been brought from central Tibet some generations

ago. If a family possesses one or two *dpe cha* from Tibet, they are considered a special treasure.

These visible signs of the family heritage are part of the amchi's first-born son's inheritance. He also inherits the responsibility for the continuation of the medical knowledge, accompanied by the duty to serve the village. I recognized that a boy's future – as envisioned by his parents and neighbors – is suggested in the day-to-day reality from the very beginning of his life. For instance, a second-born son might be called “lama” at the young age of two years, thereby affirming what the boy's determination ‘ought to be.’ This habit is common even when the parents emphasize that their children are free to learn whatever they like. A first-born son of an amchi *rgyud-pa* is treated just like an imminent amchi. Whenever possible, the father shows the young boy where to find plants or how to make medicine.<sup>96</sup> Naturally, the child is also usually around when patients come to visit the amchi in his house, and through this the boy is continuously in contact with the medical practice. The real training, however, starts with the learning of Tibetan script, or in other cases, the memorization of the first verses of the *Rgyud bzhi*, the medicine book.<sup>97</sup> There is no fixed age when these events should take place. Learning the script usually starts when about six to seven years old, while the memorization starts a few years later. The time of theoretical learning is, for the above reasons of seasonality, preferably in the winter (although not restricted to this time). Boys of an amchi *rgyud-pa* and those being pre-educated in the Tibetan script have a distinct advantage as compared to others. Meyer (1992: 3) and Lobsang Dolma (1990a: 13ff) agree in their statements that a medical education in Tibet includes studies of various medical works and commentaries, as well as religious, ritual, and poetic literature.<sup>98</sup> In the family and teaching lineages, the intensity and breadth of the training varies according to the extensiveness of the studies and the teacher's knowledge. Insight

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<sup>96</sup> This is supported by the fact that children of an age between two to five years accompany their fathers as frequently as their mothers. Only as long as they are breast-fed are children are mainly with their mothers.

<sup>97</sup> Pordié (2003: 6) states that although all Ladakhi amchi know parts of the Tibetan classical scriptures by heart, they do not necessarily know the Tibetan script. This assumption applies for Spiti as well, though all amchi I worked with knew the Tibetan script.

<sup>98</sup> Lobsang Dolma has portrayed in a lecture an ideal form of a medical training (ibid.: 7ff). She says that Tibetan calligraphy, grammar, and poetry should all be studied preceding any actual medical training. She emphasizes further that “the psychological atmosphere of the doctor-student relationship is auspicious and free from negative thoughts and attitudes” (ibid.: 8). Therefore when teaching, the teacher should visualize the classroom as a “Buddha field”, himself as a Medicine Buddha, and the students as gods and goddesses. In the next paragraphs, I sometimes refer to her idealized representation to display the disparity within the common Spiti way of education.

is gained through studying books and by personal transmission. Thus, a student can (for the time being) gain as much knowledge as his teacher has. The breadth of knowledge is therefore, more or less, reproduced over generations. Related differences among the family lineages are recognizable and sometimes quite considerable.

It was mentioned in Chapter 1.3 that anywhere the *Rgyud bzhi* is studied, it remains today *the* fundament of the training necessary to become a practitioner of Tibetan medicine. In Spiti, parts of the Four Tantras have to be memorized verse by verse, be it through the reading of the scriptures<sup>99</sup> or through the repetition of the amchi's words. The *man ngag rgyud*, the Third Tantra, with its ninety-two chapters is considered almost everywhere to be too extensive to be memorized. According to most of my informants, the first and the fourth Tantra of the *Rgyud bzhi* are obligatory for each student to learn, with some having also memorized the second Tantra.<sup>100</sup> In any case, it is commonly agreed that throughout their career, amchi must repeatedly work with these texts to improve their knowledge and look up unfamiliar diagnoses and medicines. Because of the *Rgyud bzhi*'s metaphorical style, it is necessary to have commentaries and further discussion with a teacher who can explain the words and meanings. An initiated amchi (see below) is believed to be especially able to reveal the underlying knowledge within it. In addition to their surrounding conditions (such as other work or family demands), the period of memorization depends on the capability and dedication of the student, lasting up to three years. Only when the apprentice amchi has reached a satisfactory level of theoretical knowledge – determined by his teacher – does he start the next phase. Lobsang Dolma points out that in Tibet, the students have to undergo a series of written and oral examinations after one year of studying (1986: 17f). In Spiti, tests do not take place in such a formalized way, but instead consist of oral exams which are the teacher's responsibility. Amchi Chullim recounts: "After learning the books, which is *all* the theory, my father questioned me in order to prove if I had learned properly." The studies following these tests take an additional four to seven years.

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<sup>99</sup> According to Gerke and Jacobsen (1996), the prerequisite for students to study the text on their own is that the teacher must read it to them first.

<sup>100</sup> This is the general convention throughout Tibet and India, as observed by other authors (Janes 2002: 275; Kuhn 1988: 41; Pordié forthcoming a). The curriculum of Tibetan medicine at Men-Tsee-Khang can be found on the internet (Men-Tsee-Khang 2005).

Knowledge from medical texts is then deepened and combined with practical instructions.<sup>101</sup> This training does not follow any set curriculum; instead, it follows the year's cycle (in summer – the collection of plants; in winter – intensive studies), patient cases, and the student's own forthcoming. The qualitative and quantitative contents of transmission depend on the father's knowledge, i.e., the wealth of the lineage. Astrology, Buddhist philosophy, and the medical ethic (see Chapter 3.2.1) are also part of the studies. In addition to this, the collection of plants and minerals (when and where to find and identify them, and how to plug and pre-prepare them), the knowledge of them (their usage and taste, the effectiveness of the different parts), the way of therapy, and eventually Tantric practices of healing (see Chapter 3.1.3) are also all transmitted down. A proper understanding of the basics of Sowa Rigpa is a pre-requisite for most of the essential parts of amchi work. Towards the end of the training, the practical aspects of diagnosis (see Chapter 3.1.1) and the preparation of medicine (see Chapter 3.1.2) comes increasingly to the fore. These two aspects are taught to a student only when he has proved that he is able to keep up with the long course of training (i.e., having the needed staying-power and the will to become an amchi). Pulse diagnosis is the most important 'tool' of the amchi, and so it is especially heeded that a student has a sufficient level of experience and proficiency for it. However, an amchi student is not expected to be perfect in this art. Lobsang Dolma points out: "If the student is able to achieve 80% accuracy in pulse diagnosis, he will be considered as eligible for medical practice" (1990a: 27). Amchi Chullim says that he learned pulse diagnosis especially from his guru (Kyuling-amchi) while they visited patients. Having some experience, he then had to read someone's pulse without knowing what his teacher thought, and explain to his guru his diagnosis. Amchi Chullim's ability to read pulses was finally tested in a special examination. Having passed it, his teacher then gave him permission to join him in the mountains and gain more insight into plants and medicine making.

In Spiti, a final exam is obligatory in order to finish one's studies. Depending on the mode of education (where and from whom they learn), amchi students undergo different kinds of examinations. It is considered advantageous to be tested by a well-known amchi, but not one's own father or teacher. One amchi, for example, told me that after being trained by his father, he went to the well-respected and old amchi from Dhankar to undergo the exam. Afterwards, he stayed another month with the old amchi

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<sup>101</sup> Lobsang Dolma states that the theoretical training takes seven years, and after that the practical training begins (1990a: 26).

in order to receive further lectures that introduced deeper understandings of amchi medicine. At the end of such training, students can also undergo a ritual empowerment (Tib. *dbang*<sup>102</sup>). It serves a twofold purpose: first, it gives power to the amchi and his medicine, and secondly makes him a full member of the amchi community. Pordié explains the latter point in Ladakh:

This ceremony, called *dbang lung*, the meaning of which covers both empowerment (initiation) and reading transmission, is occasionally conducted in Ladakh and represents an important phase in the medical life of the *amchi*. It is a *rite de passage* that qualifies entry into the group of initiated *amchi*, that is to say, those who have received original teachings according to the principle of “successive transmission”. (2003: 17; emphasis in the original)<sup>103</sup>

Empowerments are conducted by lama and rinpoche, and allow an amchi to receive afterwards the teachings of the secret oral instructions (Tib. *man ngag*). Their content is not meant to be given to anyone else and is therefore bound to this restriction. Certain parts of these initiations and instructions are open to some students, but other instructions that are considered very precious are given by the amchi to only one student. In a family lineage, this would preferably be the coming lineage holder, but it can be also someone else who is thought to be worthy.<sup>104</sup> Some amchi even prefer not to transmit the secrets at all if they cannot find a capable student. Unfortunately, this knowledge is then lost.

### Knowledge and Experience

By now, it is understood that becoming an amchi takes about ten to twelve years altogether.<sup>105</sup> Considering this, two questions are raised: what is emphasized in the amchi training, and what makes up the potential of an amchi?. People often answer that

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<sup>102</sup> *Dbang* is explained by Drungtso and Drungtso as “empowerment or conferment of spiritual power. It is just like a passport to enter the classic medical and astro. texts and the kingdom of Enlightenment and the permission to go through those texts. It is given by ones teacher” (1999: 192).

<sup>103</sup> The ceremony is conducted in Ladakh and has taken place three times during the last five years (ibid.). I have not heard of any similar event in Spiti during the last years. The number of amchi students is so small that this initiation must be conducted very rarely.

<sup>104</sup> “This [...] depended heavily on the personal relationship between teacher and student, and the demonstrated ability to lead a balanced and aware life was a prerequisite to it” (Gerke and Jacobsen 1996).

<sup>105</sup> This amount of training is a general consideration, regardless of institutionalized or informal amchi training (see Clark 1995: 11, Finckh 1975: 26, Lafitte 1990: 46).

the oral transmission from teacher to disciple, and the lineage, are of highest importance.<sup>106</sup> Furthermore, an amchi's individual capabilities and his will to intently learn his studies also make up his expertise. But, if reduced, the answers can be mostly given in two key words: *knowledge* and *experience*. In this context, Amchi Chullim points out, "The knowledge of an amchi comes largely from how much he studied himself. The teacher can give him [only] a little bit of what he knows." Another amchi says on the topic of processing of medicine:

This personal knowledge [of making medicine] amchi don't teach anybody. [...] You should not teach your personal knowledge to anybody. To give this exceptional knowledge to a student, he needs to be a dedicated and proper student. If your son is not capable to receive this knowledge, you would not give it to him, because then it would be wasted. This special knowledge should not be wasted.

To examine closer what exactly kind of 'knowledge' and 'experience' is meant, we first need some theoretical elaboration on these themes. Don Bates has made a distinction within Asian medical systems between a local gnostic tradition (China) – in which knowledge is embodied in personal, particular bodies – and a classical gnostic tradition (India) – in which knowledge is "embodied in the body or bodies of transcendent authorities" (1995: 20). Reconsidering the debate over the origin of Tibetan medicine, its ultimate reference goes back to the Buddha. Although a historical person, he is viewed by the Spiti-pa as a transcendent authority, which makes his 'words' ideologically determining. This is one reason why the *Rgyud bzhi* has continually remained the decisive authority in theory.<sup>107</sup> In the actual training and practice, however, emphasis is mainly laid on the personal teacher and the respective lineage. Over generations, locally specific information is gathered within a family lineage and transmitted in combination with the general body of Sowa Rigpa.<sup>108</sup> Through practical learning, participation, and the teacher's expertise, a student comes to embody medical knowledge (cf. Farquhar 1995: 274). This builds on the understanding of knowledge as

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<sup>106</sup> Gyatso states that the emphasis of these two aspects even occurs in a nineteenth century *nyams yig* text (2004: 86).

<sup>107</sup> Gyatso reflects that in Tibet, any authority is treated with loyalty, and criticism is expressed only gradually (2004: 90).

<sup>108</sup> For further aspects of the transmission in family lineages, see below, as well as the next chapter.

“situated practices,” which are historically constituted and adapted to the particular present circumstances (Hobart 1993). Knowledge is thus understood as an embodied experience being transmitted by parents and society. Concerning amchi medical knowledge, this must be modified, in that it is taught by the lineage holder as a composition of systematic – and Sowa Rigpa is highly systematic – and embodied knowledge, gained by successive experience. Gyatso explains, in other words, that this experience “had to do with the special kind of knowledge that is acquired only in practice, guided by a teacher, and involving daily immersion in the particularities and idiosyncrasies of individual patients”<sup>109</sup> (2004: 84). The long time-period of amchi training takes into consideration that knowledge and experience have to be acquired in succession. The day that the teacher assesses that the student’s knowledge is sufficient to treat patients independently, and knows the student is able to apply his knowledge to particular patients, he then becomes an amchi, receiving the “licence to perform” (Hobart 1993: 19).

Knowledge and experience were especially focused on here because they form an important base in the discourse of the development of amchi medicine, and these themes will come up as subjects again in Chapters 2.4 and 3.2.1. Following this theoretical excursus, the amchi lineages as the core of amchi education are next examined in detail, before finally coming to the next chapter on the occurring changes in the medical training parameters.

### *The Special Status of the Lineages*

Inevitably, a focus on the importance of amchi lineages inevitably includes a notion of the change that has occurred in the recent past. In this chapter, I thus briefly mention these transformations, but only what is necessary and useful for our understanding of amchi lineages without conjecturing too much at this time. This theme is further embedded in the context of the general decline of local transmission in Chapter 2.2. The underlying causes are then closely examined in Chapters 3.2 and 4. But first, we now turn to the special qualities ascribed to the lineages.

In pre-1960 Spiti, we have seen that the family lineages were the strongholds of amchi medicine. There was simply no other possibility to learn medicine other than from the learned masters in the villages. Students were usually their first-born son,

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<sup>109</sup> Actually, in this passage she distinguishes between two kinds of ‘experience,’ the second kind dealing with the empirical acquisition of knowledge by a medical researcher.

and/or another boy, of whom, many were relatives. Thus, despite a few exceptions, medical training remained inside the families. Through securing the health care of a village over generations, this created a close relationship between an amchi family and their communities, also reflected by a socio-economic interdependency.<sup>110</sup> As mentioned in the introduction, the amchi were rewarded the second-highest position in the village social system, just below the monastic clergy. This position was made visible at village meetings or at particular occasions during which the amchi were asked to take the honorable seat next to the lamas.

If one asks a *rgyud-pa* amchi about the special quality and status of the lineages, he usually denies anything extraordinary about it. However, after talking to other Spiti-pa, this remark can easily be interpreted as a modest understatement. Everyone speaks in a very respectful manner and with great appreciation when talking about the *rgyud-pa* amchi. Yet, there is more to it than just respect. For instance, an old man referring to the lineage amchi of his village told me: “[I]n his house, there have been many amchi [before him]. If you have a minor disease, you just go to the lineage amchi and only by his touch you will already feel better.” What this man is referring to is that though a particular amchi might have charisma, a lineage can also carry certain charismatic effects. Another example serves to deepen our understanding of the matter: Dr. Dorje is a biomedical physician working in one of the primary health centers (PHC) in Spiti. He stems from a former (now broken) amchi family. Having received his entire school and college education in the Indian plains, he speaks English and Hindi fluently and uses scientific terminology, but he is still familiar with the Spiti socio-ethical understandings. In a conversation with me, Dr. Dorje referred to two amchi of the same village. One of them, Amchi Sonam Paljor,<sup>111</sup> is a *rgyud-pa* amchi, the other one is Amchi Thinley Lodoe, who married into his wife’s house, having come originally from another region.

Amchi Thinley Lodoe has more experience because he is older and Amchi Sonam Paljor has to gain this experience. But he has the amchi in his blood! This is his advantage. Having the amchi in his blood he just has to receive full training then he would be the perfect amchi.

Dr. Dorje explains that lineage transmission is an advantage for an amchi that would normally be quite difficult for a non-lineage amchi to attain. Blood is, in his

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<sup>110</sup> This is examined in detail in Chapters 3.2 and 4.

<sup>111</sup> The names of the two amchi here have been anonymized.

understanding, the transport medium that connects relatives. It carries the power of the lineage and transfers it from one generation to the next. Some authors as well emphasize ‘blood’ by referring to the authority of the medical scriptures:

According to the medical literature within the Tibetan tradition, it is very important for the lineage of doctors to remain unbroken. Because it has the root blood of the descendant, it has much effect. (Lafitte 1990: 45f)

While explaining the succession of the Khangkar amchi lineage (Lobsang Dolma), Tsering and Dhondup translate a sentence of the thirty-first chapter of the *Rgyud bzhi* as piece of documentary evidence:

[A] doctor who does not belong to a hereditary family of doctors, maintaining an unbroken blood-lineage of medical learning, experiences and skill, is like a fox who occupies the throne of the lion and pretends to be the king of the animals. Such a doctor will not attain unanimous acclaim and recognition as no animals will take the fox as their king. (1990b: 57)

“Maintaining an unbroken blood-lineage of medical learning, experiences and skill” is the personal insertion by the two authors. The original emphasizes the amchi’s family and (authentic) lineage (Tib. *rigs rgyud med pa’i sman pa*; cf. Clark 1995: 229; Parfionovitch et al. 1992: 245). However, the transfer of qualities by blood seems to be a common understanding. Dr. Dorje found it as well “natural” that healing power is given from father to son by blood, equating it to a “gift.” This statement leads us directly into a closely related religious discourse that is common among the people of Spiti. They understand someone’s talent or special quality as a result of that person’s *karma*: the consequence of the actions of his or her former life. But the consequence of this belief is that talent is not a personal success. Rather, it is uncoupled from the self, and people are grateful for this received “god gift.” This term is regularly used in daily life to explain an individual’s particular fortune. In the case of an amchi lineage, the “god gift” explains the exceptional quality that is ascribed to that family. An amchi lineage inherits a certain healing power independent of the individual amchi because it is given ‘naturally.’ The individual amchi can use the “gift” to extend the inherent quality, but if he does not care for it, the transmitted power has little effect.

So what exactly defines this healing power? A full transmission of the patrimony includes the religious heritage of the family, centered on the main household deity (*lha*;

see Chapter 3.1.3). To preserve the prosperity of the persons living in the house, the family head has to worship the *lha* continually, usually daily. In the case of an amchi family, the *lha* of the house does not have to necessarily have medical attributes, but a part of the house altar and of the daily prayers is always dedicated to Sengye Menla, or an emanation of the Medicine Buddha. The well-being and stability of the medical family tradition depends on the continuous ‘interaction’ between the amchi and Medicine Buddha. The amchi, also usually the family head, has thus a double responsibility in the daily ritual practice. The ritual initiation mentioned in the last chapter enables the amchi to carry out his particular duties concerning Sengye Menla, while the worshipping of the residential *lha* is taught from the family head to his successor, independent from being an amchi. This ritualistic knowledge constitutes in part the individual and special knowledge of a specific amchi lineage. This is part of what a distinct lineage’s reputation is grounded on. There is another religious belief that resonates here, too: Spiti people believe that a continuous and successive worship of the *lha* and the Medicine Buddha establishes a certain kind of strength.<sup>112</sup> It then grows with each amchi who is practicing according to the *dharma*. This is why it is so important to keep an unbroken lineage (see Chapter 2.2). A lineage holder profits from his predecessors and their accumulated healing energy.<sup>113</sup> This power is the cause behind the ability of a lineage amchi to be able to heal by touch only, as mentioned by the old man in the beginning of this chapter.<sup>114</sup> A young amchi put it in these words:

We are a family lineage, and others are chowa. When we or lama do the rituals that chowa usually carry out – the tantras – then they have less effect than when a chowa would do them. Like chowa, the amchi have their own god who is called Menla, Sengye Menla, and we have [worshipped] him through all generations. When someone of this lineage gives medicine to patients then they get well. [...] Because we are lineage amchi (H. *khāndhānī*) patients visit us more [than other amchi]. [...] From childhood we learn all these things by looking only. When my father made medicine I watched him. For which disease [it is used], we experience. We give medicine and the patients get well, that’s it.

<sup>112</sup> I deliberately restrict the analysis here concerning the concept of lineage. Continuing aspects and practical consequences are elaborated in Chapter 3.1.3.

<sup>113</sup> Kuhn has described the same concept in Ladakh (1988: 44).

<sup>114</sup> It should be noted that power, as well as reputation, counts stronger in people’s perception the closer the generation of a well-known or famous former amchi is to the present.

In the second part of his statement, the amchi points to the remark made in the last chapter, saying that the successive practice and experience since childhood gives a lineage amchi a distinct advantage. Experience and medical knowledge is thought of as imbibed by an amchi's son with the mother's milk. Healing power then is a natural element of lineage transmission. Both experience and power are gifts a *rgyud-pa* amchi has to cultivate in order to benefit from and justify his lineage's reputation being transferred onto him.

The upcoming short introduction of a prominent Spiti amchi should serve for further insights: Amchi Urgen Tsering of Silling village in Pin valley is the prime example of a highly respected non-lineage amchi. His family has a long tradition of well-known Nyingma-pa lama. This heritage is continued today by two of his four sons: one being a reincarnated rinpoche in Taiwan, and the other one a lama in Nepal. Amchi Urgen Tsering himself was his parent's first son and was assumed to become a lama. He explains that he learned the reading and writing of Tibetan script and studied the religious texts for twenty years at home.<sup>115</sup> His grandfather, himself a well-known lama,<sup>116</sup> decided finally that Amchi Urgen Tsering should become an amchi instead. He recounts that at first he was not very keen on learning the *Rgyud bzhi*, but when his family bought the respective *dpe cha* from Lhasa, he became very enthusiastic over the prospect. At that time, the old lineage amchi of Silling lived just next to his parents' home, so he could very easily receive instructions from him. The old amchi had a high reputation throughout Pin valley. The young apprentice spent ten years learning the amchi methods and pharmacopoeia. Compared with the average time, not only in Spiti, this is exceptionally long, especially as he knew the scriptures before. Today, Amchi Urgen Tsering is more than sixty years old and has been attending to his patients for about thirty years. Patients come not only from Pin, but from all over Spiti (even from Kinnaur) to consult him. He is considered one of the best-versed amchi of Spiti because of his family descent, his age, his intensive studies and knowledge in the medical and the religious fields, and his vast experience obtained throughout the years. In 2002, two old lineage amchi (both with an equally high standing) died, and so Amchi Urgen

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<sup>115</sup> Exact figures, especially the number of years, are sometimes difficult to attain from Spiti informants. A high number, as is the case here, may just signify a very long time.

<sup>116</sup> The lama of this sect used to not to live in monasteries, and were allowed to marry.

Tsering is now the unofficial head<sup>117</sup> of the Pin amchi. Throughout Spiti, he is highly respected and enjoys an excellent reputation<sup>118</sup>.

Amchi Urgen Tsering's example shows that reputation isn't a monopoly or even exclusive to the lineages. What distinguishes Amchi Urgen Tsering from other non-lineage amchi is that he derives from a family with strong religious roots. They could be called a 'religious lineage' because the knowledge as well as the power of important lamas seems to be transmitted from one generation to the next. Furthermore, Amchi Urgen Tsering was prepared to become a lama as a boy, and it was because his grandfather observed that he was gifted with healing qualities that he realized that Amchi Urgen Tsering was better-suited to becoming an amchi. This is proof of the closeness and interrelatedness of the local concepts of religion and medicine (cf. Pordié 2003). Amchi Urgen Tsering's family's rich religious heritage gives him the power to heal.<sup>119</sup> In this way, Amchi Urgen Tsering serves as an example that both confirms and invalidates 'the rule' of the lineage concept: that powerful qualities of a lineage are transmitted through blood. He shows that it need not be only an amchi lineage that can receive strength derived from the connection with the *dharma*.

The healing power of medical lineages has both an individual component (the present amchi) and a collective component (the former generations of amchi). The natural ability, and the learned ability to heal (i.e., experience) are accumulated partially in parallel ways. Both abilities take root in the amchi's forefathers' lives and have to be perpetuated and nourished in the present, but have different weights. For an amchi, the experience and knowledge of the father/teacher is of fundamental importance, but must also be further developed with one's individual skills.<sup>120</sup> This practice of adapting traditional skills to modern situations is necessary for amchi lineage continuation, and is parallel to the definition of knowledge as situated practices (see above). This is because the lineage of an amchi is deeply rooted in the past, but also undeniably linked to the present. Referring to a lineage asserts the continuity of power, but is not the 'be-all end-all' of amchi healing power. Power continuity requires development from the present

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<sup>117</sup> There is no such official position in the amchi community, though there is some change currently going on because of the establishment of amchi associations (see Chapter 5.1).

<sup>118</sup> This is further demonstrated in Chapter 3.2.2.

<sup>119</sup> The example of another amchi given in Chapter 2.3 supports this view.

<sup>120</sup> It should be noted that lineage amchi have sometimes also joined with amchi other than their family for their further training.

amchi in order to have a future (cf. Craig forthcoming). Lobsang Dolma emphasized this in a lecture on “the training of a Tibetan doctor”:

While the school of Tibetan medicine [...] is open to all students from all walks of life, there is a definite and undeniable bias in Tibetan medical training towards the hereditary students whose family has medical ancestry. Therefore, Tibetans generally favour to place faith in doctors who are born and not made. [...] While it is true that lineage students have the medical stars in their favour, often a dedicated, good-hearted and selfless student can become an expert and excellent doctor starting his or her medical lineage (1990a: 13).

Despite the ‘advantages’ of the *rgyud-pa* amchi, a non-lineage amchi is also able to attain a similar status and reputation if he has equally good skills and qualities (see Chapter 2.4). This is especially documented with the almost legendary esteem ascribed to the exiled Tibetan Men-Tsee-Khang amchi. Amchi Chullim expressed this to me in an attempt of understatement:

The quality doesn’t come from the lineage; it comes because of your hard work and the remembrance of the books. [...] There are lots of Tibetan amchi who are not lineage. They have studied in the Tibetan amchi school, and they are better than the lineage amchi. This is because of their knowledge.

The perception of the exile-Tibetan practitioners is further discussed in Chapter 5.2. The amchi’s statement above proves the importance of training and experience.

To summarize, we have seen that the high reputation of amchi lineages is founded on social circumstances and religious beliefs. However, an amchi’s social status has never been solely reserved to only lineage amchi, but also favorably given to a person whose family is rooted in the locality through tradition, society, and religion – the residential *lha*. In modern times, the amchi lineages in Spiti now face several conditions stemming from the consequences of arising modernity, which are described further in Chapter 2.2, but even so, it remains that their value and prestige has not changed significantly.

## 2.2 The Decline of the Local Transmission

There is no institutionalized frame of amchi education that exists in Spiti today. The large majority of Spiti amchi have been taught in Spiti, by Spiti amchi, in the way I described in the last chapter. It has also been mentioned that there were probably no Spiti-pa leaving the valley in order to seek medical education in a school-like system until the 1960s. Since then, about thirteen individuals<sup>121</sup> have gone to the Indian plains (specifically, Dharamshala and Manali) to study Tibetan medicine. Upon returning home, their gained experiences have played an important role in the alteration and modernization of amchi medicine in Spiti. The reasons and developments that influenced these thirteen students in making the decision that an ‘external’ education promised a ‘better future’ than staying in Spiti are analyzed in the following chapter. I explore the factors currently leading people to seek ‘traditional’ medical knowledge outside of Spiti, and those who are causing a shift in the understanding of the local amchi education system.<sup>122</sup>

### *The Weight of Modern Education*

The introduction of primary schools in the 1960s altered the lives of children and youths considerably. Before, a child of an amchi family was at some point confronted with his parents’ wish that he should learn the Tibetan script, or memorize the first verses of the medical treatises. The government schools were initially often viewed with suspicion for many reasons: their benefit was doubtful, the teachers were Indian, and children were needed to stay in the house to help with the work.<sup>123</sup> Additionally, the school curriculum was directed by the government and did not include the teaching of Bodhi, but instead Hindi and English. Nevertheless, after some years school education became a matter of course. Children were then occupied with the acquisition of two entirely new languages and several other new subjects.<sup>124</sup> Attending a secondary school, or even higher education, often included the departure from one’s home village in exchange for

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<sup>121</sup> During my research I was not able to get into contact with all amchi of the region, so it was therefore not possible to know the exact number of persons leaving (see below). Cross-referencing materials and sources, however, makes this number the most likely.

<sup>122</sup> Some of the factors can only be touched upon briefly here because they require a wider analysis. I mention this to refer the reader to the relevant chapters.

<sup>123</sup> For a further, more localized, examination of these reasons, see the description of the Pin amchi below.

<sup>124</sup> School schedules go usually from morning (nine or ten a.m.) to late afternoon (three or four p.m.), shifting in the summer and winter. All government schools are closed in the winter for a few months and then run for the entire summer.

a boarding school in another village or in the Indian plains. This could also become a matter of economic considerations for a family, as part of the labor force was then missing in the house and field work. There was also another dilemma for amchi families concerning the transmission of Bodhi and medical knowledge: by attending school, the child who was singled out to become an amchi didn't have any extra time to learn any material other than what was covered in school. In this way, the lineage system competed with the school system. Thus, 'modern' education came to take the place of 'traditional' education.

Over the years, new openings in the private and government job market has increasingly demanded school education as a prerequisite. Spiti-pa realized that a school education was good, and needed for future economic security. As mentioned in Chapter 1.1, the amchi families owned the *khang chen*, and often larger properties as well. Frequently, they were economically well-off, based on agricultural/pastoral work. This means that they were often able to send their children to better education and/or higher education, such as the schools and colleges in the cities of the state of Himachal Pradesh (Manali, Dehra Dhun, and Shimla).<sup>125</sup> But with changes taking place in modern times, many amchi families have been concerned about the future of their household and traditions. Some amchi families have decided to simply add a cash crop to their land, and continue with the full amchi tradition and training of their first-born son. Yet some decide instead to send their first-born to the plains and receive higher education. By living outside of Spiti for up to a decade, these young men are no longer considered able to become amchi, but are able to get a well-paid job.<sup>126</sup>

I recognized Tashi Dorje<sup>127</sup> as an example of the above situation. He is a well-educated man working in a government office in Kaza. He originally comes from another village where his grandfather was the *rgyud-pa* amchi there. When it came down to the decision over his father's future, the family opted for an education that would make a proper job more likely. When Tashi Dorje was young, his father decided

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<sup>125</sup> Although the number and quality of schools in Spiti increased significantly in the 1980s and 1990s, certain Indian schools still have a much better reputation. Those families who can afford the fees (the least of which is room and board, plus various other fees) to send their children to these schools do. Most children then move back to Spiti after graduation, because they have good chances to gain employment in Spiti. According to my informants, the exodus of people remaining in the Indian plains after their education is relatively low in Spiti, as compared to other remote areas (Ladakh, Lahaul).

<sup>126</sup> In Chapter 1.1, I mentioned that especially the *khang chung* families took the opportunity of school education in order to gain new occupations. Overall, this is true. Nevertheless, wealthy *khang chen* families might have taken the opportunity to secure their safe outcome and send their first son or more children to their favorite schools in the plains. Decisions might have been taken very individually.

<sup>127</sup> This name has been anonymized.

that he shouldn't become an amchi, as it was not a good enough job to secure future economic safety. So he was sent to the Indian plains where he received an education that has enabled him to have the occupation he works in today. He appreciates his good job, but he is nevertheless wistful that he does not continue on his family's amchi heritage. In his house, he keeps a good collection of old *dpe cha*. Today, he would like to study Sowa Rigpa, but his job doesn't allow him the time to do so. He hopes that perhaps he can later start learning some of the aspects of amchi medicine. Tashi Dorje tells me that his first son will also receive an education at Indian schools, but he will try to push his second son into becoming an amchi.<sup>128</sup> However, he is still too young, and today children are also asked for their preference.

The opposition between traditional amchi education and modern school education creates a distinct, divided dilemma for reasons of time and capacity. Either one goes to school and neglects amchi training, or one learns amchi medicine and neglects secondary school education. Behind this exclusionary decision lies many ambiguities and opposing considerations, mostly centered on the question of whether to keep up with modern times, or to preserve tradition. The heritage transferred by primogeniture demands the continuation of the lineage, as well as the safety of the family. Disconcertion grows among amchi, who are concerned for the future of their child and for the future of their family lineage. For the head of a family, which most amchi are, economic security is often more important than the keeping-up of family tradition. The growing cultivation of cash crops in the 1980s opened up another option for amchi families, as one could then also make a living being a farmer. Thus, some amchi families then wanted their first-born son to receive basic school education and afterwards continue farming, eventually learning the medical practice. Others decided primarily for a modern education, accepting the possible loss of amchi knowledge and the breaking-off of the lineage.<sup>129</sup> Actually, among the young Spiti amchi I met, no one has this higher education. Rather, most of them accepted a compromise and received primary education, after which they learned amchi medicine. However, despite not completing secondary education, they still have (as compared to the traditional amchi education) less medical training.

<sup>128</sup> Note that this man dissociates the amchi transmission with the traditional order of heredity. I have not heard this repeated a second time, but is nonetheless a sign of modern considerations.

<sup>129</sup> In later chapters we see that breaking the family lineage is a difficult step because the lineage is tightly bound by the family *lha* to their home, and therefore to its inhabitants. Further, the amchi families usually have a long-standing social bond of responsibility with their community.

One of such young Spiti amchi is Amchi Sonam Namgyal, from a village in Pin valley. He is nearly thirty years old and stems from a well-known amchi *rgyud-pa*. People continue to speak of his father, who died in 2002, with great admiration. Amchi Sonam Namgyal keeps the family's *khang chen* and learned amchi medicine from his father. In spite of this, his school education and later on the need to work in the fields hindered him in his studies.<sup>130</sup> Also, he says that he lacked the right incentive:

I was not interested to work full-time as an amchi. I do not love it, and it's too much work. [...] People don't pay, and some of the medicines we have to collect in the mountains means a sacrifice of one's own work. If you buy medicine from the market, it's quite expensive. [...] Considering that, having medicine means having no food for the family.<sup>131</sup>

Resignation was clear in his face. Amchi Sonam Namgyal presents here a central theme for the amchi: they have come into an economic conflict. Economic pressure is one of the major reasons for the current changes in amchi medicine overall. It is therefore discussed in detail in Chapter 4. Here, we simply recognize this factor as an effect on amchi training. Economic concern is of foremost consideration when deciding between government school education and amchi education. It is not the epistemological or scientific content of the government school system that opposes the 'traditional' knowledge. Rather, it is the structural circumstances that block Spiti-pa until their late teens (at least) from studying Sowa Rigpa. In this way, government education has already inescapably jeopardized the transmission of medical knowledge through the family lineages.

Two other examples help clarify the ambiguities these young men now find themselves in. The first is Dr. Dorje, the doctor of a village PHC, whom I introduced in Chapter 1. He is in his late twenties but nevertheless spent only his second winter in Spiti, in 2003-2004. All these years he has been living and studying in the plains. Being the first doctor from Spiti, Dr. Dorje is a great hope for the people there because he speaks the local language and knows the culture from within. Still, he wishes to study amchi medicine so as to follow his family tradition and supplement his biomedical knowledge and skills.<sup>132</sup> He went to a well-known amchi to ask him about his

<sup>130</sup> These facts also cause apprentices to not join other amchi for training. As mentioned, this happened regularly in the past, but today is seen only rarely.

<sup>131</sup> See Craig (forthcoming) for similar perceptions among young Nepali amchi.

<sup>132</sup> Further aspects of his goals come to the fore in Chapter 3.1.1.

possibilities to study Tibetan medicine. The amchi agreed to teach him because he knew Dr. Dorje's grandfather but asked Dr. Dorje to first to learn Bodhi. Dr. Dorje is fluent in Spiti language, Hindi, and English, but he doesn't know the Tibetan script. Now, it is very difficult to study another script, and he does not find the proper time and commitment due to the constraints of his job. "Still," he says, "one day I want to learn amchi medicine!" This is the dilemma the young lineage amchi describe as well.

The second example is Tsewang,<sup>133</sup> who is the same age as Dr. Dorje, and the son of a well-reputed amchi from Tud. Tsewang was educated in the plains and came back to Spiti recently, and now works as a civil engineer in an office in Kaza. He is very interested in learning amchi knowledge and tries to involve himself in his father's activities. But unfortunately, his village is a two to three hour drive from Kaza, so he only goes there during the weekends, if at all. Tsewang brought back some amchi books from his father's home, in order to study by himself in Kaza. However, since he is in a government job he doesn't have the time to learn properly, which means that he has difficulty even with the primary levels of amchi education.

Both of the young men, after years of college and employment, still hold fast to the idea of becoming an amchi. In the past, men their age had finished the amchi apprenticeship and had already started practicing. Today, the new ideal is to have a well-paying job, and then do amchi work or education parallel to this, but the daily reality does not correspond this wish. Sowa Rigpa is a complex science which cannot be learned simply on the side. It requires full-time training of five or more years, even more so when we consider that these young men have internalized the value of standardized training with a diploma. To gain a college education or a government job and then complete further additional amchi training remains only wishful thinking for many.

The young men mentioned here all grew up in amchi families, concerned with the ambiguities of how to preserve their forefathers' heritage. When I spoke with them, as well as with other people, about the possibility of the breaking of this tradition, I realized that amchi lineages are still extremely valued. People feel tremendous regret if the family knowledge is lost. Tashi Dorje, for example, appreciates his safe job and income, but he also recognizes the disadvantages of breaking the tradition. His family's heritage is important for him and – though he knows that his grandfather's knowledge is

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<sup>133</sup> This name has been anonymized.

lost – he would like to preserve the amchi tradition. He feels that he has the responsibility to preserve the medicinal knowledge of Spiti.<sup>134</sup> He favors the beginning local revivalism that has begun to take shape with some initiatives in Spiti.<sup>135</sup> Tashi Dorje claims that the *rgyud-pa* families are responsible to keep up with modernity but additionally to resist the disappearance of their medicinal knowledge.

If it happens in an amchi family that one generation has skipped the amchi education, sometimes a young boy of the next generation will receive training from his grandfather. Not uncommonly, the lineage holder will then regrettably pass away too early to give a complete training to the young amchi apprentice. He would then join another amchi for further medical education. At the end of his studies, when he is officially finally an amchi, people would consider him as the legitimate successor of his lineage. Still, it would be recognized that he did not receive the full transmission of his *rgyud-pa*, which includes not only the medical, but also the religious knowledge of his ancestors. In this case of one generation abandoning amchi tradition, one can usually note a decline of medical knowledge. However, the ritual succession of the *khang chen* centered around the residential *lha* can be continued by the head of the household. On the contrary, a full break of the amchi lineage is a loss of the complete medical ritualistic tradition of that lineage. This knowledge is included in the medical and religious transmission that is only given to an amchi student (see Chapter 3.1.3).

### Particularities within Pin Valley

For a theme that is closely related to the important aspects of this chapter, I now briefly turn away from the topic of amchi *rgyud-pa*. This new subject takes into account a locally-defined and large group of amchi who work medically, though only occasionally.<sup>136</sup> When I came to Pin in 2001, I was surprised to record about twenty-eight amchi living in this single valley, which has about sixteen villages (the bigger ones with approximately sixty households). Not only is this an uncommonly high average for the amchi/population ratio, but a quick survey surprised me with the discovery that some villages had no amchi at all, while others had up to six amchi. Returning in 2003, I wanted to get to the bottom of this discrepancy and discovered that

<sup>134</sup> See Chapter 3.1.3 and 3.2.1 for further connotations of this responsibility.

<sup>135</sup> Some groups have been formed that are engaged in learning Bodhi, preserving the traditional dances, and other such activities.

<sup>136</sup> This case study has been subject of an earlier analysis presented at the tenth seminar of the International Association for Tibetan Studies (Oxford, Sept. 10, 2003) and will be published soon (Besch forthcoming).

the cause for this is closely linked to the changes that took place in the 1970s. Within a few years after that decade, approximately twenty young men decided to learn amchi medicine (although none of them descended from an amchi lineage). This simultaneous and unusual occurrence was absent in other areas of Spiti.

After conducting some research among some of these amchi, I was able to extract four key reasons behind the decision of these young men in becoming amchi. As mentioned earlier in the course of this chapter, new schools initially caused suspicion among parents. In the early 1970s, the first government school opened up in Pin, and people were asked to send their children there. But some parents hesitated because they did not trust this new institution. An interviewee stated that his parents thought the government was trying to take away their children. Plus, older children and young adults were needed as labor force and, thus, if parents wanted to educate them, they preferred to do it in a ‘traditional’ trade. The second issue was the respect and high social status a village amchi holds. Among the possible ‘jobs’ to undertake, a medical practitioner was the most desirable. Parents wanted to give their sons the opportunity to raise their social positions in the village. The third benefit was much more practical and concerned the entire family: By having a medical practitioner among them, they were secured health care, especially during the long and harsh winters. Here, one must consider the special conditions in Pin valley. Before the building of the main road, the valley was exceedingly remote, and quite isolated from Spiti during winter. Even today, the road is still often blocked during winter. Moreover, getting from one village to another is often quite difficult in Pin. Though distances are not too far, the mountain slopes and the Pin River make some paths exceptionally dangerous or impassable. Through having an amchi already in the household, a family would be appreciative of the immediate connection to receiving quick health care. However, the foremost reason that parents decided their sons should learn Sowa Rigpa was because they thought an amchi would make a secure living. At that time, the village system of reciprocity offset the amchi’s time-intensive work and guaranteed his family a solid livelihood (see Chapter 4.1). In the 1970s, families seem to have already been considering their life situations and seen the social changes taking place, and so decided that being an amchi is a positive investment in the future. The exceptionality of this occurrence is supported by studies from Ladakh. Alice Kuhn found that reasons for non-*rgyud-pa* amchi in undertaking medical training were caused through a parental wish or advice, a meeting with a *sngags-pa*, or an extraordinary experience (1988: 45). Pordié discovered a strong

urban-rural opposition during his surveys among amchi students in Ladakh (2003: 44ff). The urban students usually stated status and employment as their motivation to receive amchi medical education, whereas their rural counterparts commonly displayed compassion as their main motive. From these three differing surveys, a strong local reference is the only conclusion that can be drawn. Pin amchi seem to have had economic considerations and material motives leading their choice of occupation, rather than altruistic or religious motivations.

Most of the young men of Pin first joined one of the renowned local lineage amchi to study the *Rgyud bzhi* and later the amchi practice. But, contrary to tradition, they did not stay in the amchi's house for years. Their missing labor force could not be compensated for by their families as they were needed in their own households. Therefore some lived occasionally with the amchi and others only during winter when most of the work was paused. The declared full-time period of training of about seven to ten years (see Chapter 2.1) was thus not reached by the large majority of these young men. Rather, most of them only studied for two to four years, and even then, these limited years of learning were reduced when restricted only to the winters. As a result, when these amchi started practicing on their own, they were poorly trained and lacked the proper knowledge of where to find many of the different medicinal plants and how to process them into various medicines. The setting of amchi medicine in Pin accordingly changed drastically within a few years due to many villages containing now two, three, or even up to six amchi. This oversupply of amchi has had considerable consequences that are displayed in Chapter 4.1. Here, the previous description should hold for a particular example of non-lineage amchi and their difficulties in receiving proper amchi training. Amchi Urgen Tsering, who was introduced in Chapter 2.1, is a strong counter example to this. However, his personal preconditions were exceptional and different to the other amchi presented. At the end of Chapter 2.3, I will present some general survey data concerning the Spiti amchi, as well as particular data about the Pin amchi.

### *A Few Further Considerations*

The following considerations apply to all amchi regardless of their lineage/non-lineage descent. First of all, as a direct consequence of attending school, an apprentice's training is delayed and postponed to later years, much like the examples given at the beginning of this chapter. After having a family and a job, the available time for

learning becomes even shorter. It was briefly mentioned that in the past, amchi work was balanced by a reciprocal exchange system between amchi and villagers. This secured the medical practitioner's livelihood. A detailed analysis of this system is included in Chapter 4, but it should be noted here that reciprocity broke down as a result of the changing circumstances since the 1960s. In the past, the time-consuming amchi work was reciprocated by the villager's mutual commitment, but today this has dissolved and so the amchi have a multiple burden, income-wise. As all Spiti-pa today, an amchi has to either gain sustainable income from farming (cash crop cultivation), or he must have an additional job to secure his family's living. Both such modes of work are largely responsible for a reduction of time spent on amchi matters (cf. Besch and Guérin forthcoming), be it the training of an apprentice or the ongoing (re-)learning of medical contents by an amchi. As Amchi Urgen Tsering says, "In the past, amchi were fully concentrated on their amchi work, but today they have several jobs, so their knowledge is fading."<sup>137</sup>

An increasing mobility and individualization in the second part of the twentieth century has fostered changes in all kinds of training. The establishment of exile-Tibetan institutions in northern and southern India – monasteries, schools, hospitals, and the like – opened up streams of children and young people, both male and female, seeking education in the Tibetan Buddhist (atmo)sphere. With Spiti becoming ever closer to the new centers of Tibetan medicine in India, the perceived high quality of these training institutes made some individuals reconsider the option to learn there rather than from a Spiti amchi. Especially Dharamshala has displayed the opportunity to study in the environment of the most well-known Tibetan medical college. Joining one of the different Tibetan medical institutes (see Chapter 2.3) can be assumed to be the best option in making a living solely as an amchi. This perspective is supported by another social change: the absence of a formalized amchi school system and a standardized authority in Spiti used to reflect the foundation of an amchi's status by the "informal consensus of the local community", as Meyer states, concerning a more general context (1992: 2). Because of the rising accessibility to Dharamshala, Spiti patients are slowly starting to value the well-respected Tibetan amchi. This has created a surrounding that questions the qualification of the village amchi, thus also their legitimation. Therefore,

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<sup>137</sup> It is a common narrative by amchi (especially given to Westerners) that in the past they were "full-time amchi." This omits the fact that amchi medicine was typically practiced alongside farming, and only points towards the just explained shift as the cause of less spare time for their medical work.

training in a formalized medical institute became if not favored, at least acknowledged. Almost imperceptibly, young people have been pressured to leave Spiti when undergoing amchi training, in order to later create further legitimation for their community.<sup>138</sup> The following chapter provides some examples concerning this new way of amchi medicine training.

With all its variety, the knowledge of the lineages remains the stronghold of what we could call ‘the indigenous medical culture’ of Spiti. The several short biographies and statements of young amchi given in this chapter, however, have revealed that this knowledge is being jeopardized. Economic concern, the modern education system, changes in the social system, and the rise of mobility have all contributed to a irretrievable loss of part of the old, strongly localized knowledge within the amchi lineages. Both patients and amchi now perceive shortcomings in the medical expertise of the new amchi generation. A conglomeration of factors concerning the various faces of Spiti’s modernity is mainly rooted in the interventions of the Indian state. These factors have made the amchi reconsider their modes of education. The transmission of local medicinal knowledge, and thus the family lineage, remains – still – the irreplaceable base of the amchi work. Nevertheless, the amchi recognize that the requirements of their communities have changed (see Chapter 3.2), and the requirements of the state have become increasingly important in continuing the local medical tradition (see Chapters 4.3 and 5.2). Referring to the region of Tibetan culture where amchi medicine is practiced “in family lineages without any formal teaching institutions”, Meyer states that in “the last few years these local practitioners have tended to group themselves into professional organizations for formal training under the guidance and teaching of Tibetan refugee physicians” (1995c: 143). While it is shown later that the first tendency (the setting up of an association) is in fact the case in Spiti; the second (the training given by an exile-Tibetan amchi) proves not to be the case in Spiti. Though a few Spiti amchi wish and hope that one day this might happen, contemporary modes of education in amchi medicine are formed differently. Understanding now the traditional way to becoming an amchi, which is still in use, we now look at how the new ways are being realized in the next chapter.

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<sup>138</sup> The question of legitimation is heterogeneous in Spiti, depending on several local factors, which will be examined further in Chapters 5. Compare Pordié (2003: 29) for a discussion on the legitimation and identification among the rural and elitist amchi of Ladakh.

### 2.3 New Ways of Education

In Chapter 1.3, it was outlined that Tibetan medicine's standardized education history dates back to the seventeenth century. The central teaching institutions in Lhasa had constantly increased their authority, which was then transferred (after 1959) to Men-Tsee-Khang in Dharamshala. Presently, Spiti-pa regard that particular college with the highest reputation in the field of medical education. In the eyes of the exile-Tibetan medical community, the five-year curriculum of the college sets the general standard for medical education.<sup>139</sup> Other schools (such as the Chagpori Institute in Darjeeling) collaborate, for instance, with Men-Tsee-Khang in terms of examinations to receive recognition and a tangible diploma for their students. Thus far, there have only been two people from Spiti that have passed the Men-Tsee-Khang college entrance requirement examination. One student was accepted in the 1970s and the other in the 1980s. For young Spiti-pa, attending Men-Tsee-Khang is not really a viable option, as they perceived it as an elite institution beyond their reach. It becomes evident that despite the shift of the center of Tibetan medical training, hardly anything has changed regarding the marginality of amchi education in Spiti. So then what are the options chosen by Spiti-pa if they want to receive amchi training outside of Spiti? As far as I learned, only two further Spiti-pa (apart from the two who studied at Men-Tsee-Khang) went to Dharamshala to receive training in a private setting. About nine other young people from Spiti have moved to Manali to be trained by Amchi Sundar Singh or his successors between the 1960s and the present. These two options are described in the course of this chapter after the following explanations regarding the two Spiti-pa Men-Tsee-Khang graduates.

#### *Graduates from Men-Tsee-Khang*

I do not have sufficient or profound information on the first Spiti-pa to study at Men-Tsee-Khang, except for little more than the very basic facts. He came there as a lama, which suggests that he was sent to study Sowa Rigpa by his monastery, which then supported his attendance at the college. Later, however, he returned his robe and settled near Dharamshala in order to open a small private clinic there. He was Amchi Tsering Dorje's teacher, as mentioned in the prologue, and continues to have some connections

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<sup>139</sup> This was, for instance, clearly expressed at the Sowa Rigpa Conference 2003 in Delhi (see Chapter 5.2) and at the inauguration of the Men-Tsee-Khang branch in Leh in 2003. See as well Prost (2003).

to Spiti. Some Spiti-pa receive medicine from him or consult him when they are in Dharamshala.

The second student who graduated from Men-Tsee-Khang is Amchi Norbu Gyaltzen, from Kaza. He studied in Dharamshala from 1980 to 1987, following the advice of the late Rinpoche of Tanyud *dgon-pa* in Kaza.<sup>140</sup> He holds the state-registered degree of a “Bachelor of Traditional Tibetan Medicine and Surgery (B.T.M.S.)”, which is, in Tibetan terms, a *kachupa* diploma.<sup>141</sup> After his studies, he went to Calcutta and Delhi to practice but later returned to Spiti. In Spiti, he opened up a hotel and a shop in Kaza, which usually occupies most of his time. Also, he travels frequently to the plains and often stays during winter in Dehra Dhun. A colleague and good friend owns a clinic there, but also practices in Europe for a few months each year. Amchi Norbu Gyaltzen belongs to the small Kaza bourgeoisie, owning several cars and houses. People sometimes allege that he is not an amchi anymore but rather a “businessman.” But this doesn’t accurately depict his own views. He explains that he continues to treat patients, and that he is eager to work with his amchi colleague in Europe. For now, he uses the financial support – received annually from a Westerner – to buy large stocks of ready-made medicine from Dharamshala and Dehra Dhun. The total amount spent on obtaining the medicine is, according to himself, the largest amount any Spiti amchi has at his disposal (in 2003). In 2005, Amchi Norbu Gyaltzen also set up the *Tibetan Medical Clinic* in the backyard of his hotel. It is based on an association founded on H.P. state registration (*The Spiti Sorig Preservation Institute*). Nevertheless, he continues to be absent from Spiti repeatedly.<sup>142</sup>

Both of these Men-Tsee-Khang graduates share somehow ambivalent relations with the amchi community and the Spiti people.<sup>143</sup> They are referred to with some pride and admiration because these two were able to pass the exam and are therefore the only ones with a registered diploma. In a way – though not in every regard (see Chapter 2.4) – it makes them the best trained Spiti amchi. Yet, somehow unfortunately, both of them are not considered fully as part of the amchi community; one due to spatial distance, the other because of social distance. They distance themselves, go their individual ways,

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<sup>140</sup> I met and interviewed Amchi Norbu Gyaltzen mainly in 2003.

<sup>141</sup> At Men-Tsee-Khang, five years of training and one year internship leads to the acquisition of a *kachupa* degree (Tib. *ka chu pa*).

<sup>142</sup> For further examinations on his situation see Chapters 3.2.2 and 4.2.

<sup>143</sup> I draw here from the statements of my informants. These two amchi were not the central focus of my study, therefore information is limited by my pool of informants.

and are consulted for treatment by only a small number of Spiti-pa. Thus far, the Men-Tsee-Khang education is neither a realistic option for most Spiti amchi students, nor does it have positive effects in terms of medical resources for Spiti patients.

*Becoming a Modern Amchi*

Two Spiti amchi, on their separate roads to learning amchi medicine, joined teachers in Dharamshala not organized with a teaching institution. One of the students was Amchi Tsering Dorje, whom I introduced in the prologue. The following, more extensive, description is devoted to the second amchi, who is as well one of my main informants and additionally a key character in the amchi community.

Amchi Thupten Thapke was the first Spiti amchi I met during my initial field stay in Spiti, in the summer of 1999. I have to admit that I was at first a little disturbed by his appearance because he did not match my expectations – the one a first-time field researcher might imagine – of a “traditional healer.” Being in his early forties, he is tall and powerfully built. That day he wore jeans, a tee-shirt, and a modern down vest. I would later come to recognize this outfit as the usual dress/style for him. With sunglasses and a beard (cut in the “French style,” as the Indians call it), he looked more like a ‘cool guy’ rather than a respected, learned practitioner of medicine. Nevertheless, many laugh lines showed on his dark burnt face and made him appear likeable. Indeed he was likeable, and pretty quickly I overcame my original expectations and prejudices of how an amchi ‘should’ look or be like. Although our first conversation was difficult – my Hindi was not yet reliable, and he spoke only very few words of English – we were able to communicate and exchange some information, while enjoying each other’s company. Over the years, Amchi Thupten Thapke remains my primary and most personal contact in Spiti. Whenever I arrive to Kaza, his place of residence and work, my first intent is always to visit with him.

When people speak of Amchi Thupten Thapke, they usually refer to him as “amchi-lama”, and sometimes in direct conversations they even say “lama-ji.”<sup>144</sup> Although amchi and lama are not rare, many Spiti-pa all over the valley know exactly who is meant by the name “amchi-lama”.<sup>145</sup> This name hints at his past and present, as

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<sup>144</sup> In Spiti, it is common for men to have nicknames by which they are known to everybody. These often arise through the person’s position, social status, profession, or the like. Usually, persons are called by their given names, consisting of two names. In a family context, someone might be called by only one of the two names, or by the respective kinship term.

<sup>145</sup> This also illustrates that at the moment in Spiti there is no other lama who is also an amchi.

we see later. Amchi Thupten Thapke was born in the village of Dhankar in 1960. This place is famous for its *dgon-pa*, which is breathtakingly situated on top of a large, cliff-like rock. About twenty kilometers east of Kaza along the Spiti River, one can spot the village and *dgon-pa* a few hundred meters up the northern mountainside. Amchi Thupten Thapke was born as the second son into a family descending from amchi and *chowa*. It is not a successive lineage, and therefore cannot be called an amchi rgyud or *chowa rgyud-pa*. Amchi Thupten Thapke's great-grandfather was an amchi; his grandfather a famous *chowa*. Amchi Thupten Thapke's father learned neither trade and rather kept the family house, with his younger brother becoming a monk and later a *chowa*. When Amchi Thupten Thapke was fifteen years old, his parents moved to Lidang, a small village located between Kaza and Dhankar and close to the Spiti River.<sup>146</sup> At that time, Amchi Thupten Thapke entered the monastic life at the Gelug-pa *dgon-pa* of Dhankar. A monk from that order told me that the abbot had found the boy to be talented, and so sent him on to Mundgod (Karnataka<sup>147</sup>) to study the Tibetan script and later on Tibetan medicine.<sup>148</sup> Amchi Thupten Thapke himself states that when he was a lama he “felt that in order to help people in a better way, it is more useful to become an amchi.” He emphasizes that it was his own interest and decision to enter amchi training, and was not a consequence of his family tradition. Pointing to the individuality of his decision, he makes it clear that in the same way as he did, his sons are free to decide if they want to become an amchi, a *chowa*, or neither of these. In 1978, Amchi Thupten Thapke started his studies of Sowa Rigpa in Dharamshala. He studied at the private clinic that had been founded by Lobsang Dolma Khangkar.<sup>149</sup>

<sup>146</sup> His father still lives there. Amchi Thupten Thapke and his family officially belong to Lidang, although they have never lived there.

<sup>147</sup> Mundgod is the great enclave of the exile-Tibetans in South India with several big monasteries. It is considered to offer the best possibility of receiving a Tibetan education in the diaspora.

<sup>148</sup> His government school education is therefore very limited. The monastic education and environment made him speak Tibetan, and less Hindi, with the typical accent of the Tibetan community.

<sup>149</sup> I give here a brief overview of her not only because she is Amchi Thupten Thapke's teacher, but because throughout my thesis she is quoted: Lobsang Dolma (1935 – 1989), often called Ama (mother) Lobsang, was one of the most well-known Tibetan doctors of the twentieth century. She was born into the old lineage of Khangkar amchi in western Tibet, taught later by her father. She received extensive training not only in medicine, but also in philosophy, poetry, and astrology. Finally, her father made her the thirteenth Khangkar lineage holder. Escaping the Chinese invasion of Tibet, she fled to India, where she slowly started practicing medicine again. From 1972 to 1978, she was the Chief Medical Officer and head of Men-Tsee-Khang Dharamshala, succeeding the famous doctors Yeshe Dhonden and Trogawa Rinpoche. As part of the position, she toured all over the western world and India to give lectures and attend conferences. She became internationally famous for her work on contraception and cancer (specifically, the development of medicine and treatment) and opened the way for more Tibetan women to become amchi. Her two daughters (Pasang Gyalmo and Tsewang Dolkar) studied at Men-

After having been a lama for four years, he gave back the monk's robe and became a 'layman' again.<sup>150</sup> When he left Spiti, his family had not been able to give him little more than pocket money, and he was therefore quite destitute. Lobsang Dolma offered him a place to stay in her house with her family. Having entered the house, he then took responsibility for the housework and learned from this well-known amchi in a private atmosphere for about ten years. According to tradition, he first learned the *Rgyud bzhi* as a theoretical fundament, and later practiced assisting Lobsang Dolma at her clinic.<sup>151</sup> In addition, he learned about processing medicine and gave out prescribed medicines from the clinic dispensary to the patients.<sup>152</sup> At that time, the clinic was flourishing because of Lobsang Dolma's national and international fame. Amchi Thupten Thapke mentions that because of this way of learning, he saw "hundreds of patients per day"<sup>153</sup> and learned many kinds of different diseases, also many that are usually unknown or unheard of in Spiti.

Amchi Thupten Thapke learned Sowa Rigpa in a very special and unique way. He was not taught in the tradition of his family lineage, but instead in the close environment of one of the most well-known lineages of Tibet. He had the exceptional opportunity to learn with this famous teacher in a homelike atmosphere, which was almost the same situation as in a traditional *guru-siṣya* relationship.<sup>154</sup> Nevertheless, most of the training took place in the setting of a modern Tibetan clinic, especially influenced by Lobsang Dolma's travels to the west, as well as her international patients.

After more than eight years at Dharamshala, Lobsang Dolma sent Amchi Thupten Thapke to Kinnaur, a north-eastern province of H.P., with borders to Spiti and Tibet. She planned for him to do two practical years each in Kinnaur, Spiti, and Ladakh, similar to an internship under her guidance. The two had talked about the possibilities of Amchi Thupten Thapke going afterwards to Europe and working as a Tibetan doctor there. But things turned out much differently. In Kinnaur, Amchi Thupten Thapke set up a medical camp near Rekong Peo and, in his own words, "had up to two hundred

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Tsee-Khang and today practice respectively in Delhi and Dharamshala (cf., Dharmananda 1999; Sisodia 2005; Tsering and Dhondup 1990a-c).

<sup>150</sup> Most probably, this was a disappointment to the Dhankar *dgon-pa* because the monasteries typically send their monks to southern India to study, and then want them back to benefit the monastic life.

<sup>151</sup> Today, it is called the "Dr. Lobsang Dolma Khangkar Memorial Clinic" and is situated at the heart of McLeod Ganj (Upper Dharamshala).

<sup>152</sup> He says that Lobsang Dolma also taught him acupuncture, but I never saw him practicing it.

<sup>153</sup> This is supported by a statement from Lobsang Dolma herself: "Everyday, if I am not tired then I examine from one to two hundred patients" (1990b: 42).

<sup>154</sup> I didn't have the opportunity to interview a family member to find out more about this relation.

patients per day.” No resident Tibetan practitioner was present in the valley anymore, and so people greatly appreciated Amchi Thupten Thapke’s service.<sup>155</sup> Lobsang Dolma provided all medicine he needed so that he could give it for free to the patients. When Amchi Thupten Thapke was ready to leave Kinnaur, people pleaded with him to stay. He recalls that even the Indian officers asked him to continue his service. During these years, Amchi Thupten Thapke had also met Bhuti, a woman from Kinnaur. After falling in love, they married shortly afterwards and planned their life together. Unfortunately, Lobsang Dolma died in 1989. Amchi Thupten Thapke mourned for her not only as a person and an amchi, but as his now-lost guru and advisor. This incident had a dramatic consequence on his budding career. She had wanted to give him a medical diploma after his “internship,” but now he had no diploma to show for his work.<sup>156</sup> Amchi Thupten Thapke saw this as his ‘life pitch’. Considering everything, he and his wife believed their only option was to start a life in Kaza. The family needed an income, as their first son Nawang had just been born.<sup>157</sup> Kaza didn’t have an amchi in those days,<sup>158</sup> and so it seemed to be a promising future, also because it was developing as the center of Spiti. It had just started to flourish as the main market of Spiti. Hence, all possibly needed commodities were available because the Spiti people preferred to buy items here rather than crossing the passes and going to the Indian plains. Amchi Thupten Thapke opened a shop in the market to sell clothes, shoes, and different items, like nuts and apricots from Kinnaur. From his time in the Indian plains, he knew exactly where to obtain the merchandise to resell, and so business went quite well for the first years. After some years, the family then built a house on some land located in a quarter which could be called one of the ‘new housing estates’ of Kaza, although it is on the eastern side of the *nālā*, thus in “Old Kaza.”

Amchi Thupten Thapke is very ambitious concerning his amchi work in Kaza. He has seen a lot of progress among the Tibetan medical sphere in Dharamshala. As a consequence of strong western interest and support, the two clinics (Men-Tsee-Khang and Lobsang Dolma’s) have especially flourished. He wants to implement similar

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<sup>155</sup> Although I was not able to prove the existence of Tibetan practitioners in Kinnaur, it is a very likely scenario since other Spiti amchi told me that they move to Kinnaur in the summer for some months in order to make some profit from amchi work.

<sup>156</sup> Lobsang Dolma had not established a recognized school which could reward an official diploma. But, a written certificate of his achievement by Lobsang Dolma would have certainly opened many doors for Amchi Thupten Thapke.

<sup>157</sup> In 1999, his second son, Sonam, was born.

<sup>158</sup> Amchi Norbu Gyaltzen (described above) returned only a few years later to Kaza.

modern institutions in Spiti, with the aim of developing the local medical system there. In his own words, Amchi Thupten Thapke works towards this goal with the intention “to benefit the Spiti people.” Although being a ‘modern man’ in his outlook, his ideas and concerns are still motivated by a strong Buddhist belief and the Mahāyāna ideal of an altruistic life. In the same way, his understanding of being an amchi is based on the traditional ideals of practice and help for the sake of others. Amchi Thupten Thapke summarizes these views as follows:

In this region, amchi are not developed. One hundred years<sup>159</sup> ago, people depended totally on the amchi because there was no English medicine and no āyurvedic medicine. People had only the amchi’s medicine and treatment. Today, this is changing. The government gives money and has opened a hospital. There is no value of the amchi, although we have practiced from our childhood. [...] Nowadays, if people are seriously [ill] they go directly to the hospital instead. Our elders were interested in these things, which is why we are still doing this [amchi] job, to respect them and the culture. [...] When we become a good amchi, we don’t think about making money. We work because we think it is good for our future and our next life (laughing).

He tries to combine the core principles of traditional amchi practice with modern forms of organization to meet the changing requirements of people in a modern Spiti world. Over the years, he has become the leading force of the revitalization of amchi medicine in Spiti. In 1998, he founded along with other amchi an association of local medical practitioners named the *Spiti Board of Amchi Sangh* (SBAS). They organize amchi meetings and seminars, and in 2002, they set up the Amchi Clinic in Kaza.<sup>160</sup>

In the beginning, however, Amchi Thupten Thapke had yet to establish his work as an amchi and so had to make a living selling items from his shop. His way of working followed – and continues to follow today – the traditional pattern of daily amchi work. Health care is given when the need arises. Patients know where to find ‘their’ amchi. In the morning, the evening, and at night he is at home. Mornings and evenings are the best times to consult an amchi. During the daytime, Amchi Thupten

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<sup>159</sup> Amchi Thupten Thapke’s figure here does not relate to the actual number of years but is just meant as a term for the past.

<sup>160</sup> These projects are closer examined in Chapter 5.1.

Thapke performs a profitable job, while in a village this time might be spent in the fields or somewhere in the jungle up on the mountains. Amchi Thupten Thapke is much easier to find: at his shop, in the middle of the Kaza market. If it's urgent, people can pick him up there and then take him to the patient. The neighboring shopkeeper, Amchi Thupten Thapke's best friend, then tends the shop for him. In other cases, patients just pass by the shop and ask him for help. Without delay, he takes their pulse and questions them. If necessary, Amchi Thupten Thapke then asks the patient to follow him to his home where he stores the medicine. There begins a procedure that is the same in all the amchi households I have observed up until Ladakh. The patient is invited into the house and kitchen. *Chāy* (and later *gsol ja*) will be served by the amchi's wife or, if she is out, by the amchi himself. If food has recently been prepared, the guest will then be asked to take some. Depending on how close the relationship between the patient and amchi's family is, this procedure (as well as the following talk) takes a longer or shorter amount of time. After the patient's initial explanation of his problems, the amchi takes the pulse.<sup>161</sup> Within a few minutes, he asks for further symptoms and constitutions to help finally detect the correct diagnose. Amchi Thupten Thapke might have already completed the first parts (pulse reading, interviewing) at the shop. Now, the only thing left is to give the patient their medicine and explain to him or her how to take it. Having received the medicine, a small 'ritual' starts between the patient and (usually) the amchi's wife: she will ask him to stay to have some more tea, while the patient tries to leave the amchi's house as fast as possible, so not to disturb them anymore. This might go on for some time, until the patient finally leaves.

Some days Amchi Thupten Thapke – as is quite common among Spiti practitioners – has no patients consulting him, while other days, nine, ten, or more patients come seeking help. The time spent on treatment is, as well, extremely variable, depending on the seriousness of the disease and the complexity of treatment. It is imaginable that sometimes Amchi Thupten Thapke needs only five minutes to diagnose someone and give them the correct medicine from his stock. However, it's also conceivable that in other cases, he will stay for the whole night at someone's house to help diagnose and/or heal a patient. Thus, depending on the number of patients and the time-intensiveness of their treatment, amchi work can be quite strenuous and demanding. It can even keep an amchi away from his income-producing occupation. As

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<sup>161</sup> The performance of pulse diagnosis is examined in detail in Chapter 3.1.1.

a result of the economic changes of the last decade, Amchi Thupten Thapke's main concern today relates to the difficulties in supporting his family, while at the same time serving his patients and forcing his amchi goals into reality. Without going too deep into this matter, which is the focus of Chapters 4 and 5, it should be noted here that Amchi Thupten Thapke faces various obstacles in his personal and institutional amchi work on local, regional, and national levels. Trying to navigate through all his connected wishes and requirements, Amchi Thupten Thapke feels often alone on this road, but nevertheless keeps producing new ideas to accomplish his goal of an amchi practice that benefits the Spiti people.<sup>162</sup>

### *Considering an Amchi Career*

This thorough presentation on Amchi Thupten Thapke's career and amchi work, though unique and exceptional, provides several intersections concerning amchi education that can also be used to illustrate generalities for other amchi. Furthermore, throughout this thesis, his example and statements serve for many insights pertaining to encounters with present-day amchi themes. But first, the different motivations and possibilities of starting amchi training outside Spiti should be examined theoretically. Previously, certain structural factors were observed that are direct consequences of the developments during the last decades, such as the government school system, new infrastructure, and new occupation possibilities. Shaping Spiti modernity, they have all influenced choices leading to differences from the traditional education system. The three presented case studies of Amchi Thupten Thapke, Amchi Norbu Gyaltsen, and Amchi Tsering Dorje have offered further reasons. Their decisions were quite individual (though could be similarly taken by others), differing from either following a rinpoche's advice or personally wishing to help people, to yearning to be prepared for present requirements which are not met by the lineage. These three amchi did their training in Dharamshala, which has the atmosphere of the undisputed center of Tibetan medicine. Another option for learning amchi education (which is much more accessible for Spiti-pa) has opened up in Manali, a city about two hundred kilometers away (or today, a ten hour bus ride) from Kaza. It's the western port to the Indian plains and presents the first center of consumption to Spiti.

Amchi Sundar Singh settled in Manali when he came back from Tibet in the 1960s. He was the most famous practitioner of Tibetan medicine throughout Lahaul and

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<sup>162</sup> His social integration in Kaza and a further examination of his life follows in Chapter 3.2.2.

Spiti in the twentieth century. Born in Lahaul, he stayed in Tibet for about fourteen years studying Sowa Rigpa.<sup>163</sup> Most probably in the 1950s, he graduated from Men-Tsee-Khang Lhasa. Settling in Manali, Amchi Sundar Singh established an amchi clinic and school that is today officially called the *Research and Education Institute (Himalaya Both Ayurvedic Indigenous Herbal Treatment)*. For better recognition, I from hereon out call it the *Tibetan Medicine Institute Manali*. Amchi Sundar Singh enjoyed an exceptional reputation grounded on his countless successful (and sometimes magical-appearing) treatments. Young men from the surroundings came to him to be taught Tibetan medicine. After his death, two of them – Amchi Tashi Gunpo and Amchi Karma – became his successors and are the ones who today run the school and clinic.<sup>164</sup> Amchi Karma is originally from Lahaul, and Amchi Tashi Gunpo is from Losar village in Spiti. They reported that Amchi Sundar Singh's graduation diploma from Men-Tsee-Khang was, in addition to the authorization by the former Tibetan government, later recognized also by the Indian government. This was the basis for the institute's state registration in H.P., as well as its support by government funding. The budget – half of which is from the central government, and half from the state – enables them to run the clinic and the school. It also includes a small salary for the amchi, enough for the complete production of medicine,<sup>165</sup> and the school expenses. The latter even enables them to pay for the student's lodging and give them some small pocket money. Amchi Tashi Gunpo and Amchi Karma explain<sup>166</sup> that in the past hardly any student came to study there. But some years ago an amchi in Lahaul received a job within the bounds of a government scheme.<sup>167</sup> The prospect that in the future, amchi work could eventually be rewarded and paid by the government encouraged young people from Kullu, Spiti, and Lahaul to start training at the Tibetan Medicine Institute Manali. In 2003, they even had to refer some students to Dharamshala instead because the present class had already started. The institute runs only one class at a time, each lasting a period of five years. Students learn verse by verse three of the four Tantras of the *Rgyud bzhi* (excluding the third Tantra, see Chapter 2.1). The curriculum follows the contents of the medical

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<sup>163</sup> Concerning Amchi Sundar Singh, I completely rely on the references made by the two Manali amchi (see below) and on Spiti peoples' testimonials. I could not find any written record about him.

<sup>164</sup> One informant told me that Amchi Sundar Singh had a son, but he did not learn amchi medicine and therefore could not become his successor.

<sup>165</sup> Patients in the clinic are treated free of charge, although I observed that most of them freely give a small donation of twenty to thirty rupees.

<sup>166</sup> I met the two amchi for several interviews in spring of 2004.

<sup>167</sup> For more details on this scheme, see Chapter 4.3.

scriptures but is not fixed. According to the seasons, occasions, and matching times for theoretical and practical training, students learn all the parts of the medical practice, including medicine-making. At the very end of the teachings, the students then learn pulse reading.

The H.P. government strongly recommends the school to award certificates to their graduates. These can usually allow the new amchi to practice officially within the state (although it's not definite). Amchi Tashi Gunpo and Amchi Karma are accordingly registered by the state government. They explain that the government has asked them to admit only those students who have finished the "10 plus 2" in medical science (see Chapter 2.1). However, this is a large impediment because, as Amchi Karma says, the amchi school's own requirement is fluency in Bodhi writing and reading. A "10 plus 2" degree can only be attained at a government English or Hindi school, both of which do not teach Bodhi. Therefore, the two requirements almost cancel out each other. At the time of application for the last class at the institute, however, they did not insist on the "10 plus 2" degree. The two amchi are now happy to teach a batch of eleven students originating from Kullu,<sup>168</sup> Lahaul, a student from Bhutan, and five from Spiti. Some of them have school degrees, others even have a Bachelor of Arts (B.A.). Contrary to the past, a couple of young women even make up a share among the students.<sup>169</sup>

Apparently, the Tibetan Medicine Institute Manali fills the gap between the possibilities of amchi education at Dharamshala and the transmission of the local lineages. It offers qualities that meet the expectations and needs of young Spiti-pa in their changing socio-economic environment. Amchi Karma told me that young people are not yet interested in amchi medicine because it has not received recognition in India so far.<sup>170</sup> But it seems that the recognition of the amchi school diploma in H.P. is already being appreciated by the students. They have hopes that in the future the government will offer further schemes and amchi positions with a (secure) government salary. This also shapes Spiti-pa's attraction towards the Tibetan Medicine Institute Manali. Having graduated from government school, many young people look for a job

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<sup>168</sup> During the last half century, many Tibetan-Buddhist people from Ladakh, Lahaul, Spiti, and Tibet have settled in Kullu, alongside the large Hindu population.

<sup>169</sup> Though at least a survey of these students would have been of use for my study, for several technical reasons I was not able to carry out interviews at the school.

<sup>170</sup> My interviews with the two amchi took place just a few days ahead of a Sowa Rigpa Conference in Delhi, at which 'recognition' was the most important topic. Both of the amchi wanted to attain it, so it became a central topic in our talks. The interaction between the state and the amchi are closely examined in Chapter 5.2.

options back in Spiti valley. The Tibetan Medicine Institute Manali thereby provides an option that combines people's hopes of meeting their economic needs with their wish to learn a traditional art. Another motivation for some Spiti-pa is to learn from someone of their own culture. For example, Amchi Tsering Dorje chose his guru in Dharamshala partly because he was a relative. It does not necessarily have to be a relative, but Spiti-pa feel more closely connected with a teacher from Spiti – like Amchi Tashi Gunpo. The Tibetan Medicine Institute Manali is, thus, socially and geographically nearby.

In the following paragraph, some comparisons between traditional amchi learning versus Men-Tsee-Khang and Dharamshala must be mentioned in order to complete the understanding on the subject of modern education. Because this anticipates the analysis in Chapter 5.2, I strive to present only the facts that are strictly necessary here. At Men-Tsee-Khang, medical students are generally not taught about the processing of medicine; instead, this field has been made a specialization (Gerke and Jacobsen 1996). The theoretical aspects of medicine making are part of the curriculum (Men-Tsee-Khang 2005), but the production is left to the factory-like unit of Men-Tsee-Khang. Spiti-pa view this as a shortcoming and obstacle in practicing amchi medicine properly in Spiti, notwithstanding the outstanding theoretical quality of Men-Tsee-Khang amchi. Additionally, knowledge of local plants and their usage is strongly emphasized in Spiti (see Chapter 3.1.2) and cannot be taught comparably at Dharamshala. Further, it has already been touched upon, and is elaborated later in Chapter 3.1.3, that the amchi medical practice is, in certain regards, interwoven with Tantric aspects of Tibetan Buddhism and the local belief system. Spiti-pa claim, and some scholars have found as well (Gerke and Jacobsen 1996; Pordié 2003) that elaborate institutes, such as Men-Tsee-Khang, separate religious practices from the medical practice and training. While these are – in brief – the perceived shortcomings of Men-Tsee-Khang, Spiti-pa today do also recognize the shortcomings of training by Spiti amchi as well (see Chapter 2.2). Since Spiti amchi obtain their qualities through practical applications referring to the local culture, their lineage knowledge and education might not have the capacity of the full theoretical course of Tibetan medicine. Amchi Tsering Dorje even perceived his father's transmission to be limited. On the other hand, the Dharamshala and Manali schools are generally considered to have a complete transmission. Accordingly, some generalizing statements of Spiti people are understandable when they say “local amchi have little knowledge, because they learned only from their fathers.” Nevertheless, the close relation between teacher and disciple is

an important basis for amchi work. Correspondingly, Amchi Thupten Thapke and Amchi Tsering Dorje both emphasize their close and personal relations to their gurus in Dharamshala. Regarding the Tibetan Medicine Institute Manali, the school system replaces the traditional educational setting in a family (atmosphere). But it does not necessarily replace the transmission of local knowledge because Amchi Tashi Gunpo is able to teach it. Additionally, he is the successor of the most famous amchi of the region, whom he received his oral instructions from. The small school in Manali is not an amchi *rgyud-pa*, but it can still reproduce the *guru-śiṣya* relationship. It is close enough to an esteemed home locality that it has become a favored option for young Spiti-pa searching for an amchi medicine education. As compared to the lineage education, its distinct advantage is its image and status as an institution. The Tibetan Medicine Institute Manali does not provide the same formal value of a degree like Men-Tsee-Khang. But its provisions – including having a classroom, fixed timings, exams, diplomas, a registered graduation, and a name recognized by the public and the government – make it an educational institution with an official touch. Young Spiti-pa, who are today used to the requirements of administrative modernity, appreciate the signs of this modernity.

To conclude, the new way of amchi education in Spiti means leaving the valley for at least some years for (further) studies, preferably in a modern institutional setting that Spiti has not offered until now. However, being trained at Men-Tsee-Khang, which is ultimately the most elaborate Tibetan medical college (in India), is, in the eyes of the Spiti people, not to be equated with the complete course of medical training needed to practice properly in Spiti. Additional requirements can only be taught by an amchi of Spiti origin who has received the knowledge of his forefathers or predecessors – the knowledge of the locality. This importance of the locality lies less in the theoretical medical knowledge but rather in practical applications. Often, the example of local pharmacopoeia is brought forward to exemplify the value of the local heritage. But this is also done to give an easily comprehensible and superficial example of the value of local knowledge/heritage (see Chapter 3.1.2). Other parts of emphasized local knowledge are mainly found in the field of Tantric healing (see Chapter 3.1.3). The interdependency of ancestors, deities, the community, and the residence is incorporated in the amchi *rgyud-pa* and defines its power. Emphasizing the lineage is an obvious

expression of local identity, which is a constantly recurring theme throughout Chapter 3.1 and returns in Chapter 5.

In this current analysis, the Spiti-pa's differentiating and selective dealing with forceful, external discourses on education has been observed. Being in the margin doesn't only enforce an evaluation of the superior institutions at the center, but also of the local tradition and its (remaining) knowledge. In the general context of Tibetan medicine, modern education is closely associated with Men-Tsee-Khang. In Spiti, an amchi student follows a modern way of training if he or she can find the balance between 'outside' training (more important for the theoretical aspects) and local training (more important for certain practical aspects). The three presented practitioners – Amchi Tashi Gunpo, Amchi Thupten Thapke and Amchi Tsering Dorje – are prime examples of amchi who have taken new roads in education. Their training kept the essential traditional characteristics while being received in a modern surrounding. Today, this trend is seemingly becoming more specified, with a shift towards emphasizing government recognition of teaching institutions. Presently, the Tibetan Medicine Institute Manali is best at uniting these different aspects and has, consequently, become the preferred place of training for young Spiti-pa. Considering the number of Spiti amchi students in Manali (five) opposed to current students in Spiti (zero; see below), we observe a beginning shift here from education through lineages to education through schools. A consequence of this is a significant growth in the proportion of non-lineage amchi to *rgyud-pa* amchi.

#### General Survey Data on the Amchi Community

After examining the different modes of education, it now makes sense to present a survey that provides statistical data on the Spiti amchi community. These figures are useful in creating further insights about the group's composition. During my stays in the valley, I tried to collect as much data as possible about amchi with whom I could not meet. Nevertheless, as the total numbers of villages, households, or populations are difficult to detect, it is also difficult to get the correct figures for the number of amchi, or some of their basic data. The following figures<sup>171</sup> are therefore approximate, and to be seen as grounds for an analysis but not as definite. For reasons of structure within the amchi community (and its later analysis), I follow a triple division of Spiti on a

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<sup>171</sup> All of them refer to 2003-2004.

geographical basis that counts the regions of Bhar and Sham together into one unit of analysis, while the other two are kept distinct as the geographical regions of Tud and Pin valley.

My calculations resulted in a total number of about sixty villages and hamlets in Spiti. Six of the villages belonged to Tud, sixteen to Pin, and the remaining thirty-eight to Bhar and Sham. In 2003-2004, I tallied a number of at least fifty Spiti amchi. Two of them lived permanently outside Spiti.<sup>172</sup> Out of the fifty-four amchi, about fifteen belonged to a family lineage (two pairs of which were father and son), which was almost one third (28%) of the total. Seven amchi trained at either Dharamshala (two at Men-Tsee-Khang,<sup>173</sup> two privately) or at Manali (three at the Tibetan Medicine Institute). Interestingly, all of the amchi (whom I knew) who had received training outside of Spiti came from Tud or Bhar. This seems to indicate a geographical dimension in the decision. I have not followed up this question, but a possible reason could be that both of today's locations of external education (Manali and Dharamshala) are situated east of Spiti. Potentially, the contact to these places is stronger in upper and middle Spiti. But, turning back to the modes of training, it arises that more than thirty amchi, though not belonging to a lineage, learned from a Spiti amchi. This high figure is, to a considerable extent, caused by the occurrences in Pin valley explained in Chapter 2.2.

I counted twenty-eight amchi staying in Pin (which is more than half of the Spiti total) but only five of them were lineage amchi. Compared to the overall Spiti average, this is consequently a low share (18%). The twenty-eight amchi are further spread over twelve Pin villages, of which, five have only a single amchi. That means the remaining seven villages contain twenty-three amchi, an average of more than three per village. These figures highlight the extraordinary situation found in the valley and its notable emergence, which is elaborated in Chapter 4.1.<sup>174</sup>

In Tud, the second region, probably four amchi live and practice there today. The two well-educated amchi, who do not permanently stay in Spiti, originate from here. This is especially unfortunate for the inhabitants because the entire region is 3,600

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<sup>172</sup> They have already been mentioned in the course of this chapter. To recap, they live in Manali and near Dharamshala, and both of them have been trained outside Spiti.

<sup>173</sup> One is mentioned in the concluding footnote, and as said, the second does not continuously stay in Spiti.

<sup>174</sup> Certainly, the extraordinariness of Pin valley in this, as in other regards (geological, botanical, religious, cultural), would justify any long-term research in Pin valley.

meters altitude and is cut off from the rest of the valley and the outside world for at least five months of the year. However, one of the most well-known Spiti lineage amchi practices in Tud. Moreover, the only female amchi in Spiti lives here.

In the approximately thirty-eight villages of middle and lower Spiti, about twenty amchi practice there. In at least five villages (Kibber, Kaza, Dhankar, Demul, and Manne), there live two amchi each, of whom the Dhankar and Demul village amchi are father and son. This means that fifteen villages accommodate at least one amchi, of whom, no less than nine are *rgyud-pa* amchi.<sup>175</sup> Compared with the other regions, the ratio of amchi to villages is quite low, but their share of lineage amchi is quite high. This might indicate that some lineages are broken already (I know of one), and that only very few amchi of non-lineage descent underwent amchi training here.

If we want to extract the contemporary state of amchi medicine from this survey data, the figures of lineages and young amchi (and students) are of particular interest. First of all, excluding the five students in Manali, I know of no amchi student undergoing training at least half- or full-time in Spiti. Among the fifteen lineage amchi I met, not one has a child or young adult under consequent training right now. There are a few children of lineage amchi who would like to learn or do so occasionally, but none of them spends sufficient time seriously learning.<sup>176</sup> Though no data exists on the number of lineages from earlier times, we can gather from narrations that they have since declined. These present facts give further rise to the assumption that if there are no considerable changes, the traditional stronghold of amchi medicine will continue to decline. However, the younger (between twenty-five and thirty years of age) amchi among the contemporary practitioners – four in number – all descend from a lineage. Though they are already practicing, Spiti-pa view them to be in a continuous process of acquiring further knowledge and experience (see Chapter 2.1). That means that presently, amchi medical education in Spiti takes place without exception within the lineages because they carry the demand of the maintenance of their personal tradition. The second mode of education, the Manali school, seems to be especially popular right now. We are witnessing, therefore, the continuity of the amchi lineages *and* a shift among students towards seeking institutional training, non-existing in pre-modern Spiti.

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<sup>175</sup> My survey is especially incomplete concerning the villages east of Tabo, where I did not conduct any research. These villages are quite far away from the center of Kaza and contact is much more difficult.

<sup>176</sup> Additionally, some of the amchi's children are too young.

As mentioned earlier, this data is not meant to be definitive and so rash conclusions should not be assumed. Any conclusions from the data need to be evaluated in the light of the further ethnographic data. But, it is a help in giving a closer idea of what we mean when we refer to “the Spiti amchi.” In particular, this data corrects publications of authors who draw images of the Spiti amchi that are probably supposed to serve particular purposes. Among such authors are Ham and Stirn, who speak of the Hansa amchi as the last medical practitioner of Spiti (“letzter Naturarzt des Landes”; 1998: 140), or the website of the Austrian NGO *Spiti-Help* that vaguely mentions four amchi in an undefined area of Spiti who are in need of support (Spiti-Help 2006). Images created by Westerners of the last amchi practitioner(s) are as well questionable, as are the images created of the amchi community as a homogenous group with approximately fifty proper members. Rather, this data reveals a heterogeneous group stretched between quite distinctive poles in terms of training and descent. However, the amchi community does share some common crucial ideas and perspectives about medical theory and practice. In their marginality, Spiti amchi are distinguishable from other practitioners of Tibetan medicine. This establishes the ground for common challenges concerning their present and future, especially in social, political, and economical respects. To reveal the similarities and differences between the Spiti amchi (and within the whole community of practitioners of Sowa Rigpa) is one of the tasks of this thesis. Although Spiti amchi demonstrate in some aspects a homogenous group, this should nevertheless not deceive anyone to their plurality of voices and various designs of life among them.

## 2.4 What Makes a “Good Amchi”?

By putting the question, “what makes a good amchi?” at the end of the chapter on medical education, we are now led to the question of the qualities and characteristics ideally ascribed to amchi and how they shape the demands made by the patients and amchi themselves. What role does medical education play in this, and do the described changes in training have an influence on the expected demands? Or, is the description of someone as a “good amchi” independent of his mode of education? This section constitutes an important aspect of my thesis because it presents an ideal theory of an amchi’s attitude, as well as its discursive representations in several contexts. Chapters 3

and 4 then show the discrepancies of the ideal social practice and the arising ambiguities in amchi work. In this way, we prepare the foundation for later concluding analyses on the actual amchi practice.

In the thirty-first chapter of the Explanatory Tantra of the *Rgyud bzhi*, a detailed description is given on the qualities and requirements of a Tibetan physician. Amchi and amchi students memorize these verses and reflect on them. In discussions, amchi claim that their internal demands for themselves are directed along the lines presented in this scripture.<sup>177</sup> I therefore present here the contents of this piece, so that we can delve into the inner motivations of an amchi. A large part of this chapter also concerns the medico-technical capabilities a practitioner ought to have, such as diagnostic methods, experience, knowledge of diet and conduct, etc. In a metaphoric style, the negative consequences brought about by physicians who do not have these qualities are then shown. Mental attitude and behaviors are explained thoroughly, especially at the beginning and the end of the chapter. Among the three “types” (Tib. *dbye ba*) of physicians, the “ordinary physician” (Tib. *phal ba'i sman pa*) is considered to be the most common.<sup>178</sup> The first statement, concerning the “ordinary physician”, regards the significance of lineage descent, as mentioned in Chapter 2.1. Moreover, a physician is further distinguished by “intelligence” (Tib. *blo ldan*), “virtuous thinking” (Tib. *bsam pa dkar ba*), “compassion” (Tib. *snying rje*), and “gentleness” (Tib. *byam po*). He or she should have a good expertise (Tib. *bya ba la brtson*) of the medical scriptures and be experienced in the medical and religious practices (Tib. *mi chos mkhas*). It is emphasized that a physician must show good performance on all three levels of the body, speech and mind. The resulting benefits (Tib. *'bras bu*) for an excellent physician are happiness (Tib. *skyid pa*), and finally, the entering of buddhahood (Tib. *sangs rgyas sa la bkod pa*). This means that a physician performing in the appropriate ways benefits socially and mentally in this life and positively affects his karma for the next life.

Turning to various authors on this subject, whose publications are mainly meant for a Western audience, one finds that the religious attitudes of the practitioners are often accentuated in their works. Translating a part of the *bshad rgyud*, Rechung Rinpoche says, generally, that a physician should “not be lazy,” have “a sympathetic

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<sup>177</sup> See Kloos (forthcoming), who quotes a Ladakhi amchi as saying, “If an *amchi* knows the scriptures, he knows how to act well.”

<sup>178</sup> The two other types are the “insurpassable” and “special” physicians. The first is the Buddha, and the latter are the unique physicians of the past (Parfionovitch et al. 1992: 89).

mind, [...] treat all alike,” and should have “practical experience” (2001: 91f). However, translating the same section, Clark interprets that a Tibetan doctor should have a state of mind that is “altruistic, compassionate and happy.” He emphasizes that a practitioner should behave according to the Mahāyānic ideal of the “*Bodhisattva*”<sup>179</sup> (1995: 224). Lobsang Dolma has also expressed her highly idealized understanding of this same *bshad rgyud* section:

A Tibetan doctor, after contemplating on the difficulty and rarity of obtaining this human body which has all the opportunities of attaining liberation, will consider and be convinced that because these opportunities are so rare that it is a unique opportunity that she has got this human body in which she is a doctor at this particular time. Then she thinks, if I am not going to use this body to help others who are suffering, who are sick and need medicine to be cured, then I will die. I will lose this body, I will probably never get the opportunity to help other being[s] in this way. That means, this is the way a Tibetan doctor thinks, the way she sets her aims and intention. [...]

When a Tibetan doctor is facing the patient, she thinks that in many lifetimes this person has been my mother or father and therefore has shown me kindness. [...] Then she treats the patient, that kind of therapy will be done through love and care. (1990b: 38f)

Whether it is the more general words of Lobsang Dolma, or the explicit Buddhist terminology used by Clark, the intention of both is to tie the attitude of a physician closely to the behavioral ideals of the Mahāyāna Buddhist tradition. This motive corresponds to the expectations of a Western audience that values Tibetan medicine as holistic and spiritual (Janes 2002; Samuel 1999, 2001a). Whatever these motives are, the core of the ancient medical scripture points out that an amchi’s character should be strongly oriented towards compassion, generosity, and equanimity – all key concepts of Buddhist commitment. The particular authority of the *Rgyud bzhi* (see Chapter 1.3) causes Tibetan medical practitioners – including Lobsang Dolma, Rechung Rinpoche, and Spiti amchi alike – to adopt these demands, at least as ideal concepts. Some authors

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<sup>179</sup> A *Bodhisattva* (lit. enlightened being) is understood to be someone who accomplished Enlightenment but vows not to enter nirvāṇa until all sentient beings are saved from suffering (cf. Bechert and Gombrich 1989; Kapferer 1997: 92; Schumann 1995: 181ff). Striving for this ideal means to orientate one’s life towards selflessness and compassion.

also mention corresponding vows taken by some Tibetan physicians (Rechung 2001: 91; Drungtso 2004: xxvi).

The high standard of the Buddhist ideal is transferred to representations expressed by amchi and their patients. Examinations from Ladakh show processes similar to Spiti's and help us in furthering our analysis. Laurent Pordié presents the local discourse among Ladakhi amchi concerning their idealizations in his treatise called, *The Expression of Religion in Tibetan Medicine* (2003). He comes to the following conclusion:

Ideal religious behaviour represents the path to liberation, not only for the *amchi*, but for all who observe the same practices. What characterizes the *amchi* is that they are at the centre of a particular application, *viz.* medicine, of the teachings of the Buddha. The discourse of the *amchi* can be interpreted as an emic theory, that is to say, as a set of representations of the theoretically ideal qualities of the practitioners and of the related behaviour. [...] The *amchi* of Ladakh have an ideal of their practice that is reproduced not only in their discourse, but also in number of their daily actions. (ibid.: 21; italics in the original)

In the course of a survey conducted by Pordié, most amchi state that medical practice depends on (and can be improved by) a practitioner who is compassionate, honest, generous, and altruistic (ibid.: 18).<sup>180</sup> Additionally interviewed Ladakhi amchi students also name compassion as their main motivation in studying Sowa Rigpa (ibid.: 45). Kloos investigated the social role of an amchi in Hanu (Northern Ladakh) and found that the ideals ascribed to the amchi shape their social incorporation into the village community (forthcoming). Both Kloos and Pordié spotted partial correspondence between the ideal concepts and the actual social practice among amchi. In the case of Hanu, the remoteness of the village, as well as the health care monopoly of amchi medicine in the past, has made the villagers strongly dependent on the amchi's services. This dependency<sup>181</sup> was then somehow balanced out by the ethical and moral codex ascribed to the amchi. The public's expectation, grounded on the medical scriptures and local tradition, forced the amchi's implementation of his practice – including, for

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<sup>180</sup> Kuhn's investigations support these statements (1988: 47).

<sup>181</sup> Kloos extends his analysis far further into the questions of power, legitimation, and their changes in modern times. These aspects, and their parallels in Spiti, will be objects of detailed analysis in Chapters 3 and 4.

instance, the duty to treat everybody at anytime and not to expect remuneration for amchi work. Kloos reveals in his study two further factors that make a “good amchi” in the eyes of the Ladakhi: a proper medical knowledge and the provision of good medicine. These observations from Ladakh accompany us as we now turn to Spiti.

The discourse among the Spiti amchi on what Tibetan medical practitioners should be like, and what exactly makes a “good amchi” exists especially when referring to questions on the contemporary state of amchi medicine. To differentiate themselves from other amchi or amchi medicine belonging to other medical systems, most of my informants insisted on the importance of *experience* and *knowledge*. Both were already subjects of examination in the context of education and lineage (Chapter 2.1), which further indicates their essentiality for the medical practice. A short interview sequence with Amchi Urgen Tsering supports this:

FB: What makes a “good amchi”?

UT (after smiling silently): To become a good amchi you have to have good knowledge about [the theoretical aspects of] Sowa Rigpa and about the *kham s lnga*.<sup>182</sup> This is the basis. If you don’t have good knowledge about these then you can not diagnose well. [...]

FB: What makes some people very good amchi, like, for instance, Amchi Sundar Singh?

UT: He became very popular because he had very good knowledge of these basic things and the diagnosing. These skills make a perfect amchi.

*Knowledge* is usually a synonym for the theoretical comprehension of the classical scriptures and/or the practical accomplishments of medical application, among this, especially the pulse diagnosing (Chapter 3.1.1). Thus, knowledge depends on the amount and quality of education received. The number of years spent training, the lineage and the good name of the teacher,<sup>183</sup> and the knowledge and medical skills demonstrated at amchi gatherings or through patient cases all count when determining the expertise of a “good amchi.”

It was pointed out earlier that *experience* has a strong temporal component, in that it has to be gained successively. As indicated in Chapter 2.1, referring to Gyatso

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<sup>182</sup> These are the five properties or elements: *sa* (earth), *chu* (water), *me* (fire), *rlung* (wind), *nam mkha'* (space).

<sup>183</sup> Another amchi stated that what an amchi’s guru says about his disciple plays an important role in people’s considerations of the amchi.

(2004), the acquisition of experience needs to be completed during practice, and in the best case scenario, under the guidance of a teacher. The number and variability of patients is a further factor influencing and increasing the process. It is, therefore, important that an amchi has ‘enough’ patients consulting with him. Though experience cannot really be a measurable substance, it is indicated through the number of patients and their reports and stories of successful healing in difficult cases. In this way, an amchi therefore depends (to a certain degree) on the patients who visit him. The broken monopoly of the amchi in the villages has, as one consequence, led to a decline in the patient-load for many amchi. It has, thus, become more difficult today to gain considerable experience (cf. Kloos forthcoming). In an interview, one amchi pointed out the coherence between the amchi-patient relationship and knowledge/experience:

An amchi becomes good if he has a good mind and works hard. While practicing, you have to read the [medical] books again, so that you get experience and better knowledge. If you learn well, you are a better amchi. [...] If you are always in touch with your patients, then you get good experience. And if patients come a second time, you don’t even have to take their pulse because you know them already. You have to be a hard worker. To become a popular amchi, like Sundar Singh, you don’t need special things, there is no difference between me and a popular amchi, you [just] have to be in touch with the patients with an ‘honest heart’ [H. *sacce dil se*].

The amchi indirectly expresses here a perception commonly agreed on in Spiti: proper medical knowledge is important, but by itself it cannot make a good amchi. Another amchi said, “Lots of amchi know the books, but they don’t know how to diagnose, they do not have a long or good practice”. This basis of experience is found in the amchi-patient relationship, in which the amchi formulated in Hindi as “*sacce dil se*.” This term is meant as a translation of the Tibetan concept of having a “good heart” (Tib. *sems bzang*; see Kloos forthcoming; Pordié 2003: 18). My observations in Spiti correspond to the observations of these two authors from Ladakh. The amchi’s “good heart” and his moral and ethical virtues are strongly linked to the social and medical reality (further examined in Chapter 3.2). The amchi-patient relationship and the efficacy of the treatment depend on both the amchi’s and the patient’s states of mind (see Chapter 3.1.2). Amchi Thupten Thapke outlined this in the following way:

An amchi needs a good education, a school. Some [of his] comprehension is a god-gift resulting from the last life, it is natural to him. [...] If one wants to become a good amchi, then he shows interest, he reads, and looks at the books daily. He examines the patients, loves the patients, then the understanding will come, then he will become a good amchi. [...] Actually, what an amchi needs is medicine. Just diagnosing someone does not cure them. To become a good amchi you need medicine. Among the Tibetan doctors<sup>184</sup> are *lakhs* of good doctors, like for instance, the Dalai Lama's personal doctor. Some of these doctors are not so well-known; others are well-known because they have some natural gift from their last life. Like lady Dr. [Lobsang] Dolma, she was very well-known throughout the whole world. [...] Some amchi are naturally well-known because they came as a Medicine Buddha, Sengye Menla. [...] For [all diseases] we make medicine. The most important thing, though, is that the one who takes the medicine does so with respect, and the one who makes the medicine should not have money on his mind. This is how to make a good medicine. If the amchi thinks: 'I will earn good money from the patient,' then the medicine will not cure the patient. That's why some amchi are well-known and some are not.

He indicates that having medicine – which means having a large stock that's also known for its effectiveness – contributes greatly to the reputation and efficacy of an amchi. This aspect as well leads to the inner qualities of an amchi, since the effectiveness of the medicine comes in part from the amchi's positive and selfless ambitions.<sup>185</sup> Further, Amchi Thupten Thapke explains that while the patient has to be respectful towards the amchi and his medicine, the amchi has to have a "good heart". This personal quality can hardly be cultivated, as it is given as a "god-gift." Based on a "good heart," the power to heal emerges. This is inevitably connected to an amchi's charisma. For Spiti-pa, it's visible in one who is restrained, humble, and helpful – qualities that we witnessed during my introduction of the amchi in this chapter and in the prologue. In the piece of interview above, Amchi Thupten Thapke describes a further characteristic in reference to one of the most dominant themes of today's life:

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<sup>184</sup> "Tibetan doctors" is meant here literally.

<sup>185</sup> Kloos states that the "good heart" is a prerequisite for a strong inner connection between Sengye Menla and the amchi (Tib. *dam tshig*), which is again important for the efficacy of treatment (forthcoming).

money. Not being concerned about one's financial outcome, or being generous (as the scriptures say) is an important aspect of the quality of contact with patients today. This has a strong impact on the prescribed medicine and on successful healing processes. Medical knowledge and skills are important for an amchi, but are essentially merely necessary prerequisites. They mark the amchi's abilities. However, his quality is largely formed through his moral and social virtues, which are derived on theoretical grounds from the *dharma*, the Buddhist doctrine. Today, the villagers' perceptions of the moral and social qualities of their amchi are often shaped by the amchi's way of making a living and the question of the financial remuneration of amchi services (this is further discussed in detail in Chapter 4).

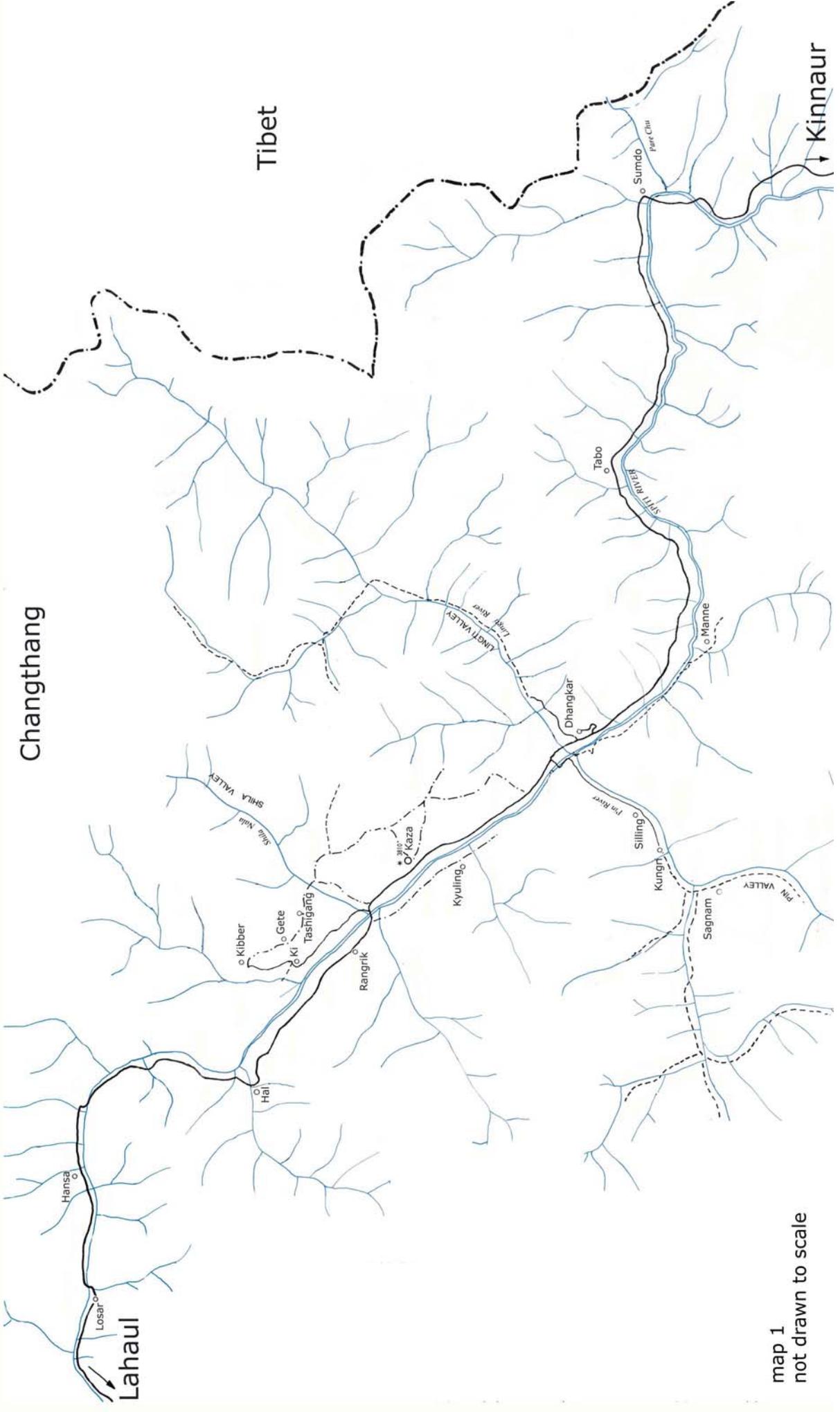
The amchi ideal – perpetuated in the Buddhist *bodhisattva* ideal – though aspired, is never presented as a reality. No one would ever present him or herself as matching the ideal. Neither do the villagers think that their amchi is, or has to be, infallible. Nevertheless, there are some former Spiti amchi that have been idealized retroactively, and Amchi Sundar Singh is today presented as the 'perfect amchi' (cf. Pordié 2003: 21). His visualization unites all the aspects that make up an exceptional amchi: an elaborate education leading to the appropriate knowledge, exceptional skills (especially in pulse reading), the experience of a successful and demanded healer, charisma, and the appropriate mental attitude. Contemporary amchi are not expected to have all of these ultimate qualities, and they are certainly not expected to necessarily have the good qualities as defined through their names or lineages (cf. *ibid.*: 19). As in Ladakh, Spiti amchi are – since the rise of medical pluralism offered by biomedical institutions and mobility – exposed to increasing comparison and judgment by their villagers (Kuhn 1988: 45). This decline of dependency has opened up a discerning quest among villagers who now able to compare the qualities of their amchi to others. Amchi are tested in this way in terms of their inner and outer qualities. For example, in the past, having been to Tibet for training was a sign of excellent medical quality – one of the reasons for the fame of Amchi Sundar Singh. Today, by means of comparison with the government medical system and the Tibetan medical education in Dharamshala, people increasingly value institutionalized medical education for amchi. A diploma as a sign of quality is becoming progressively more important, as the real quality of a certain education or school is difficult to measure. In Ladakh, at least in the urban setting of Leh, Pordié found that “the holding of diplomas and the extent of the political network

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of which one avails take precedence over the moral qualities of a given person” (2003: 52f). To the contrary, diplomas in Spiti have gained importance but have not yet replaced other favorable characteristics, such as the lineage. To have studied at one of the Tibetan medical colleges definitely promotes a well-established basis of knowledge. But it does not necessarily include all the medical subjects which are required for being a “good amchi,” and it does not automatically mean a student has learned everything. To become a “good amchi” in the eyes of Spiti-pa depends not only on the kind of education a student received, but also on his or her intensity during studying, and afterwards (as a matter of time) the gained experience culminating in good medical skills.<sup>186</sup> This corresponds to the concept of “embodied medicine” (Farquhar 1995: 274). To be considered a “good amchi” is further influenced by a variety of factors, located in the domain of inner qualities – such as the power of the lineage, the natural gift or talent, and charisma formed by the amchi’s “good heart.”

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<sup>186</sup> Experience seems to be valued higher than mere knowledge, as Gyatso has pointed out in the context of the *nyams-yig* medical genre (2004: 86).



map 1  
not drawn to scale



Figure 1: The road to Spiti, near Rothang Pass



Figure 2: Spiti in winter, near Ki



Figure 3: Spiti River and the road to Tabo

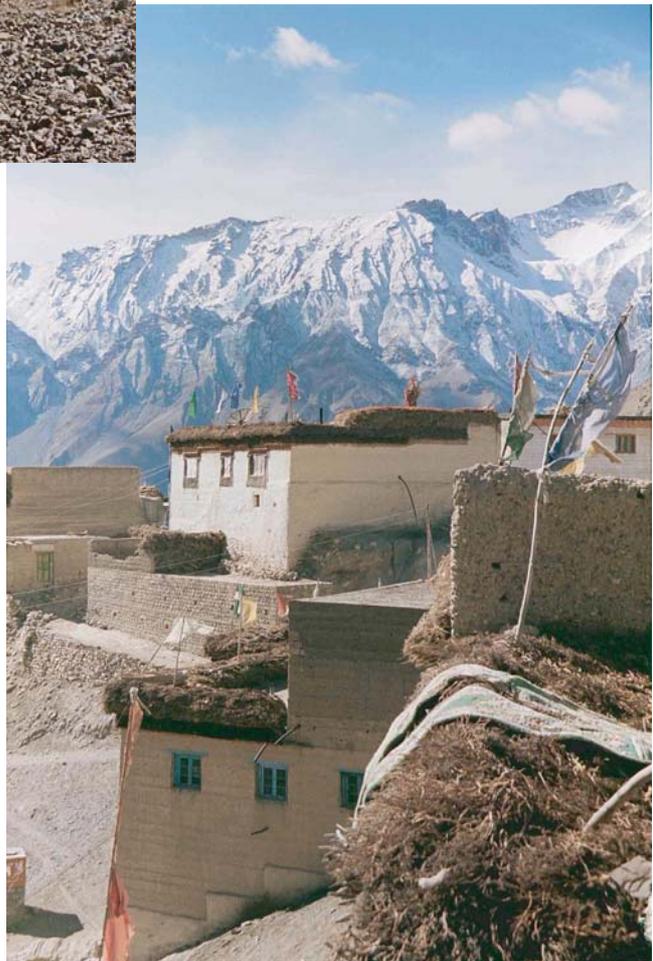


Figure 4: Kibber village



Figure 5: Kibber village



Figure 6: Kibber village



Figure 7: View of Kaza 2003



Figure 8: View of Kaza 2005



Figure 9: Kaza market



Figure 10: Shopping complex at kaza market



Figure 11: An amchi in his medicine making room

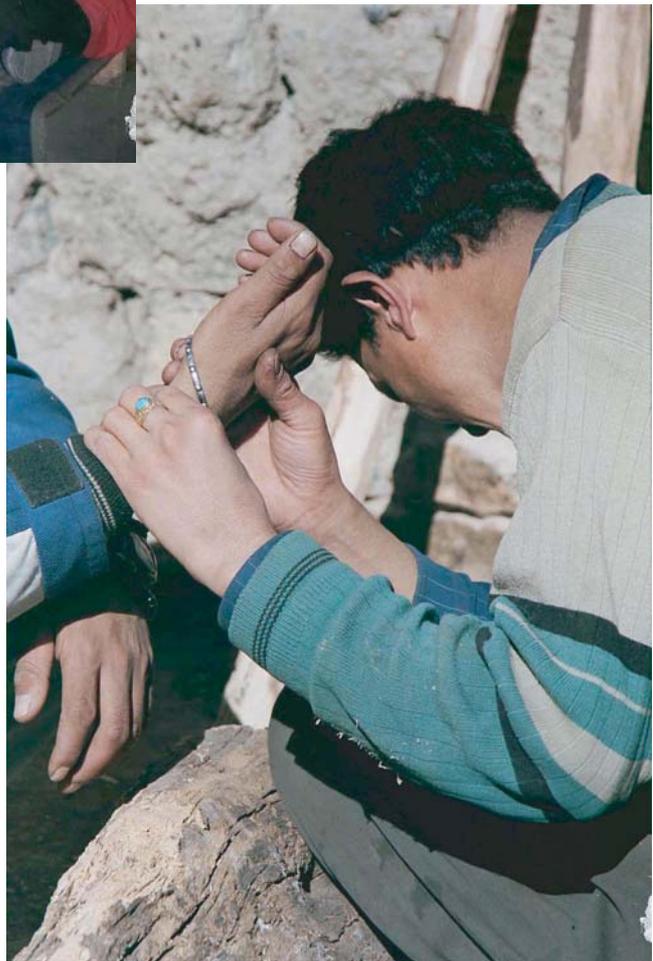


Figure 12: An amchi reading a pulse

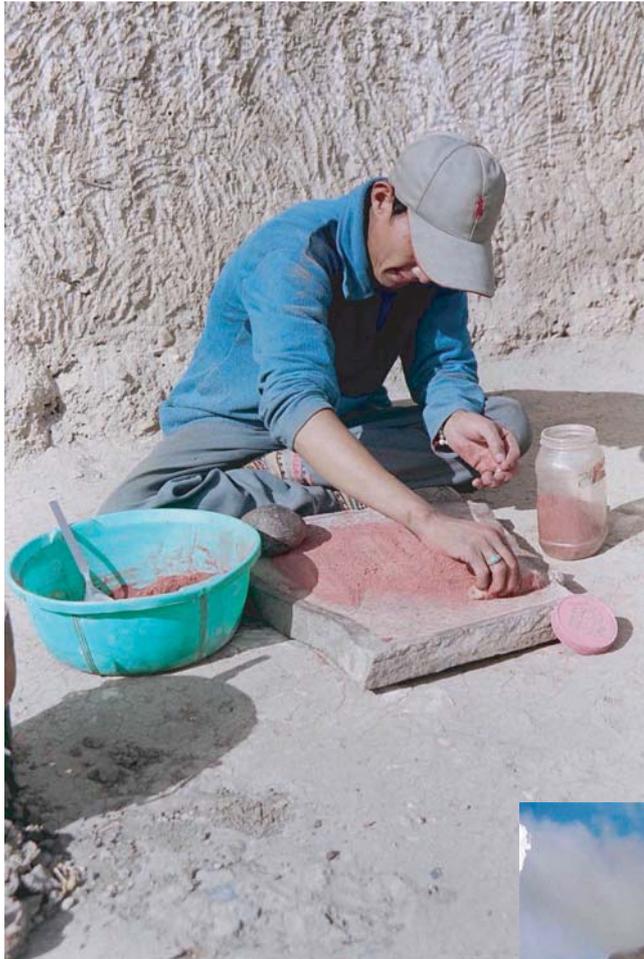


Figure 13: An amchi making medicine

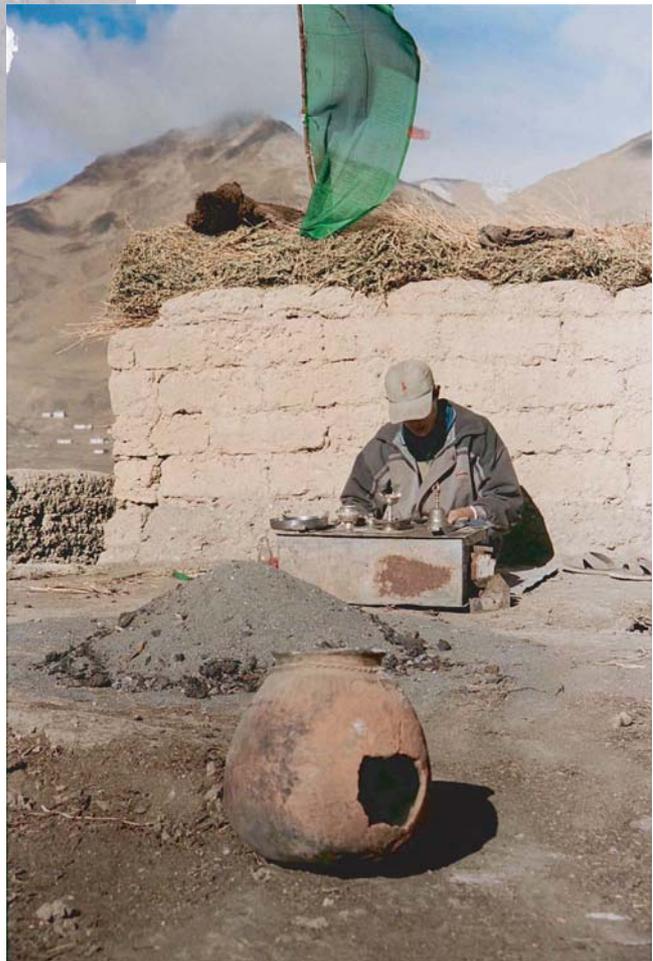


Figure 14: An amchi performing a puja



Figure 15: Ki monastery

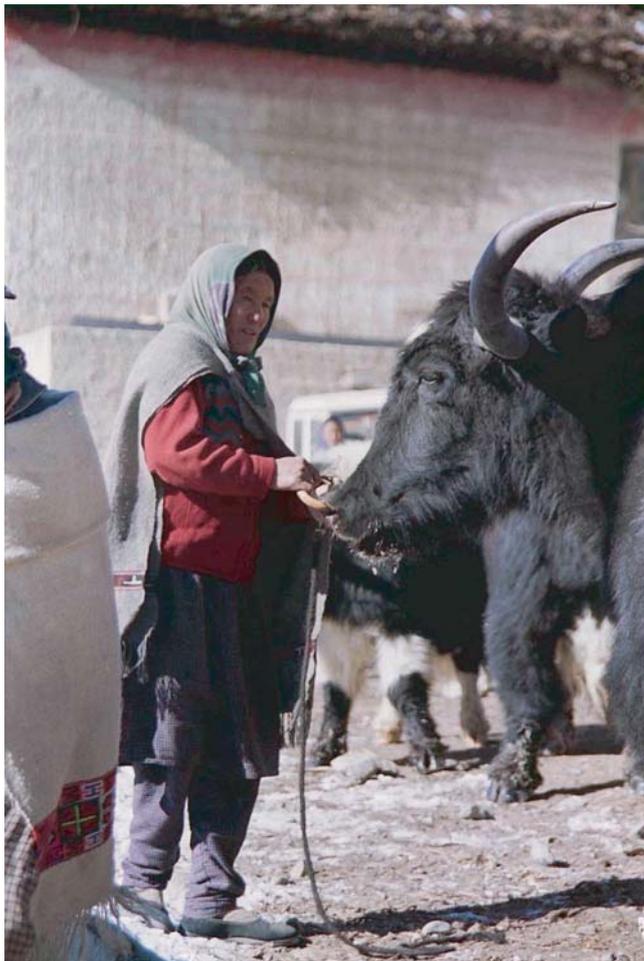


Figure 16: Woman with yak



Figure 17: Men dancing at marriage festivities in Kaza



Figure 18: Men performing the sword dance



Figure 19: Spiti Board Amchi Sangh Clinic



Figure 20: An amchi in the SBAS Clinic



Figure 21: Researcher and assistant



Figure 22: The new medicine room in the SBAS office in Kaza



Figure 23: An amchi in the new medicine room



Figure 24: An amchi in the SBAS office

### **3. AMCHI AT HOME**

Following their training, amchi subsequently get involved in the daily work of their villages. In this chapter, we turn to the application of their knowledge and the appropriation of their experience in a social milieu. In other words, we now observe the practice of amchi medicine as it is currently situated.

This chapter is the central part of this dissertation – but not because it is in the middle, or by far the longest chapter. It is rather the pivotal chapter because it contains the richest parts of my ethnography, displaying what an amchi’s life today is all about. This chapter contains two large sections, each of which could have easily made up its own chapter, but I decided to keep them under this one heading because both parts are about the ‘amchi at home’. The first section is concerned with aspects that visually characterize the daily practice of the medical practitioners. It is focused on the work as a craft, presenting the amchi in his solitary work and individual interactions with the patient. The second section of this chapter draws the first section to a close, focusing on how amchi are embedded within their communities. It introduces the changes of the socio-political dimension and thereby reveals the foundations for the central present dilemma of the amchi. At the start of each sub-chapter, I further introduce the specific points and contents under discussion.

Let us now turn then to the topics on diagnosis and treatment, which are naturally substantial parts of amchi work.

#### **3.1 Aspects of Healing**

Healing is the primary focus of each medical practitioner, and the differences between the practitioner’s ideology and actual practice are most evident at this point. The following sub-chapters are, thus, the most explicit (in comparison with the other chapters) in regard to the issue of the differences between theory (Tibetan medicine as it is ideally described and presented) and practice (amchi medicine as carried out and socially embedded in Spiti). The chapters are organized accordingly, which I introduce here in order to create better transparency and understanding: The reader is first led

from theoretical explanations to interpretations of the observed practice, while the actual (and longer) ethnographical accounts are given either at the beginning or in-between these two parts. The theoretical part usually includes particular excerpts from the *Rgyud bzhi*, the authoritative treatise, as well as statements from contemporary authors on Tibetan medicine.<sup>187</sup> These explanations are then afterwards supported or opposed through representative statements given by Spiti amchi. Finally, these theoretical accounts are confronted with the interpretations of the actual ethnographical observations and drawn to a conclusion concerning any discrepancies existing between theory and practice.

Throughout this chapter, I am mainly concerned with the three particular aspects of healing that, considered from a socio-political point of view, form the center of contemporary amchi practice: pulse reading (Chapter 3.1.1), the making and administering of medicine (Chapter 3.1.2), and religious healing following Tantric Buddhism (Chapter 3.1.3).<sup>188</sup> The first aspect – pulse reading – is not only the amchi's main method of diagnosis but is also an outstanding (and to some degree, technical) marker that identifies and indicates skilled amchi. The second aspect, concerning the production of medicine, is the most time-consuming element in amchi practice and has thereby secured a critical position in our modern, rapid times. On several levels, the colloquial statement – ‘where there is no medicine, there is also no amchi’ – is elaborated upon. And finally, the third aspect, concerning religious healing, deals with certain practices that include mantras and ritual ceremonies. Although they are not performed very often, Tantric practices bring amchi and patients in contact with the local deities of their place.

All three of these aspects are intertwined with the central topics concerning the modernization of amchi medicine, such as social embeddedness, commercialization, and identity. Issues of identity are especially repeatedly raised because pulse reading and the administering of medicine are the most visible and public aspects of amchi medicine, while ritual practices strongly link locality and culture. These themes already indicate

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<sup>187</sup> These works must be differentiated: Some authors have mainly given translations of the first two Tantras of the *Rgyud bzhi* or only parts of it (e.g., Clark 1995; Dhonden 1977; Finckh 1975; Parfionovitch et al. 1992). Others have stuck close to that text and gave additional explanations (e.g., Dhonden 1986; Finckh 1980, 1988b; Rechung 2001). And a third group orients alongside the *Rgyud bzhi* but summarizes the Tibetan anatomy and physiology in order to put their emphasis on the key fields of interest for the Western reader who is generally assumed to have some layman medical interest and a spiritual background (e.g., Birnbaum 1990; Clifford 1984, 1996; Dummer 1998).

<sup>188</sup> The reader is reminded here that – as pointed out in length in Chapter 1 – I do not describe the detailed medical background through which healing is achieved in Tibetan medicine.

the analysis concerned with the amchi's interaction with the nation-state and the central institution of Tibetan medicine. Within these three aspects of healing, therefore, some issues of transformation are raised that lead into the later chapters concerning socio-economic change (Chapters 3.2 and 4) or professionalization (Chapter 5.1).

### 3.1.1 Pulse Reading

Pulse reading is a form of diagnosis that can be carried out anywhere, and in fact amchi do practice pulse diagnosis wherever it is necessary – be it in the middle of the village (as in the prologue), on some lonesome track in the mountains, or at home. As such, pulse reading can be publicly practiced and thereby has become the most visible sign of an amchi. Besides being a visual marker (and its obviously medical function in making a diagnosis), it also serves as an important 'tool' in the amchi-patient relationship. Fernand Meyer explains accordingly:

For the sick person and for those around him, as well as for many healers, diagnosis – in other words, the application of explanatory models to the signs manifested by a particular pathological event in order to interpret their cause and/or to define them as a given nosological entity – must satisfy a quest for meaning rather a need for knowledge as such. What makes a diagnosis meaningful is not so much its scientific or even empirical accuracy, but its coherence with the sick person's subjective experience and with his conception of his relation with others and the world. (1995a: 12)

In this chapter, I do not merely follow the path regarding the subjective side of the patient as laid out here by Meyer, but rather question the issues he raises. I examine this topic in a slightly different way, exploring the meaning of pulse reading as connected to the village-based relationship between patient and amchi in this contemporary period of change.

My analysis starts with an introduction of the general modes of diagnosis in Tibetan medicine, and follows with an explanation of the actual manual technique involved in pulse reading. These two points are necessary in order to give one an understanding how diagnosis in Tibetan medicine works. Afterwards, closer examination of the potentials of pulse reading (again, besides mere diagnosing) is then

possible. This finally culminates with a discussion on the above-mentioned question of social relations.

### The Technique of Diagnosis

Before receiving lessons on diagnosis, a student of Tibetan medicine must prove his qualification through stamina and knowledge. After years of learning the basics of Sowa Rigpa and having proved the completion of the studies of the medicine books (see Chapter 2.1), only then is a student taught the techniques of diagnosis (of which, pulse reading is the most emphasized). This arrangement seems to be the same everywhere, whether in the lineages in Spiti or in the curricula of the Tibetan Medicine Institute Manali and the Men-Tsee-Khang in Dharamshala (Men-Tsee-Khang 2005; Samuel 2001a: 257). This shows us that pulse diagnosis is given an exceptional position among the different contents of amchi training.

In the twenty-fourth chapter of the Explanatory Tantra of the *Rgyud bzhi*, we find a brief introduction relating to the matter of diagnosis.<sup>189</sup> Accordingly, there are the three methods to examine and diagnose a patient: interview (Tib. *dri ba*), touch (Tib. *reg pa*), and observation (Tib. *blta*), which correspond respectively to the three senses of hearing, touching, and sight.<sup>190</sup> The first method – questioning – is when the amchi gets to know about the complaints, symptoms, environmental influences, and dietary habits that might indicate the underlying disease. Secondly, the touching of the patient’s body gives further clues to the amchi, but the most important and primarily practiced kind of touch in this sphere is the feeling of the pulse (Tib. *rtsa*).<sup>191</sup> The third method of examination – sight – includes all signs that are visually detectable. The amchi then concludes the patient’s general and specific constitution from the visible symptoms from the patient’s body. Even deeper insights can be gained from a visual examination of the urine and tongue.

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<sup>189</sup> An even shorter introduction can be found in the fourth chapter of the first Tantra of the *Rgyud bzhi*, which has been translated by Finckh (1988a: 31f).

<sup>190</sup> Meyer explains that most parts of the diagnosis in Tibetan medicine are derived from āyurveda, while sphygmology especially stems from classical Chinese pulse diagnosis (1995b: 132ff).

<sup>191</sup> *Rtsa* has more various meanings, as for instance: (subtle) channel, vein, artery, intestine, or bowls (Das 1902; Drungtso and Drungtso 1999; Nitārtha 2005). In Spiti, people use different languages and connotations for the pulse and its reading: the Hindi expressions “*nād*” and “*nabz dekhnā*” (to observe/examine the pulse) or the Bodhi expression “*sa(za) nyukche*” (to feel – taste, read – the pulse).

In the first chapter of the Subsequent Tantra of the *Rgyud bzhi*, a very detailed description of pulse diagnosis is laid out.<sup>192</sup> This includes significant details, such as the best time of day to take a pulse, the exact technique on how and where the fingers are placed when reading the pulse, and even pre-examination dietary and behavioral guidelines for the amchi and patient. A main recommendation regarding preparation is that the pulse should be taken in the early morning so to secure that the patient has an empty stomach and so both the amchi and patient are relaxed. The actual technique of taking the pulse is carried out with the index, middle, and ring fingers of both the amchi's hands. The right hand fingers are put on the radial artery of the patient's left wrist, and vice versa. The fingers are placed in a straight line and exert pressure in varying degrees. The patient's number of pulse beats per respiratory cycle of the amchi is measured, as well as the functional status of each organ, diagnosed through the assignment of two organs to each fingertip (divided into two parts lengthwise). The period of examination varies according to the difficulty of diagnosis, but Finckh describes it as taking a general length of five to ten minutes (1988a: 48).

Spiti amchi use all of the previously described methods of diagnosis when examining patients. A general examination, however, includes only the verbal inquiry and the pulse diagnosis. Similarly, Meyer states, "In practice however, diagnosis is based largely on pulse examination, usually preceded by a brief interrogation, which is favored over all other techniques" (1995b: 132). During the initial contact of a consultation, a patient communicates his or her complaint(s) while talking with the amchi. Spiti amchi attach great importance to this interrogation. This has even more importance in the context of the village because there they know their patients very well and sometimes do not even need to perform the pulse diagnosis. Rather, they can give medicine just by listening about the symptoms.<sup>193</sup> However, in a typical consultation (after the short interview period), the patient holds out his or her wrist for the amchi, or the amchi himself will ask for the patient's arm. I observed that the pulse taking technique carried out by all Spiti amchi corresponds to the above given description (figure 12). If asked how they do the pulse reading, the amchi explain this procedure exactly, with the correlation of

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<sup>192</sup> For detailed English explanations, see e.g., Clark 1995; Dhonden 1986; Drungtso 2004; Dummer 1998; Finckh 1988a, 1988b; Meyer 1995b; Samuel 2001a.

<sup>193</sup> This also has the advantage that a patient who is not able to visit the amchi can send a relative to get some medicine.

fingertips and organs as it is written in the *Rgyud bzhi*. However, differences do occur in regard to the recommendations for preparation: these are kept in mind but rarely followed, as the pulse is taken only when needed (cf. Samuel 2001a: 260). A diagnosis is generally taken when an amchi and patient have time outside of work (usually in the morning or evening), or whenever it's an emergency. A further discrepancy (compared to Finckh's findings) concerns the time period of pulse taking, which usually does not last more than two minutes.<sup>194</sup> I noticed that at various Tibetan clinics in North India, the same approximate amount of time was taken. However, when an amchi carries out the act of pulse reading, he does so in full concentration, as we witnessed with Amchi Tsering Dorje (in the prologue) and Amchi Chullim (in Chapter 2.1). It is a moment of silence, a pause in the conversation between amchi and patient. The amchi turns inward, intensely listening to what the patient's pulse 'tells' him. Most patients are very calm in this moment. After the pulse diagnosis, even more questioning takes place, and usually by this point the amchi knows the diagnosis. Only rarely will he ask to see the tongue, and even more seldom will he want to examine the urine.<sup>195</sup>

#### *The Potentials of Pulse Diagnosis*

As indicated in the beginning of this chapter, the question I am interested in here is not the actual technique of pulse reading, but rather pulse reading as a socio-cultural object (as considered by the Spiti people). Therefore I examine, in concrete terms, what significance it holds in the amchi-patient relationship, and if it serves a purpose other than its aim in detecting the cause of an illness. How are the issues of identity, power, and touch involved in pulse reading, and what do they all mean? To dismantle the answer to these questions, I start at this exact point: the aims and potentials of pulse reading.

It is a controversial topic among authors (as well as with the general physicians and patients presented in the ethnographies) as to what and how much can actually be detected through pulse reading. Finckh states that "pulse diagnose is seen as the most important method of diagnosis because of the information obtained in this way about the functions of the organs" (1988a: 47). But Dummer explains that it is difficult "to

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<sup>194</sup> Amchi take more time to read the pulse when they are not completely certain about the diagnosis.

<sup>195</sup> Actually, I have never seen them carry out a urine diagnosis, but most amchi claim that they will do so if necessary. My observations here concerning the practice of diagnosis match with Samuel's – in two Tibetan refugee settlements in North India (2001a: 253); Gutschow's – in Zangskar (forthcoming); as well as Janes – in China (2002: 277f). This seems to suggest a broad coherence in the performance of diagnosis in the Tibetan world.

relate pulse findings to organic causes and conditions,” as the pulse only reflects symptoms (1998: 78).<sup>196</sup> In her monograph, *Fluent Bodies*, Jean Langford dedicates a full chapter on *nāḍī parikṣan* (H. pulse examination) in the tradition and modernity of āyurveda (2002). She thereby portrays different opinions from advocates and opponents on the exceptionality of pulse diagnosis. Some physicians claim that nowadays, for a patient’s proper examination, more than just this traditional method is needed. They deny that vaidya (āyurvedic practitioners) can give correct diagnoses by the pulse only, and assert that those who do give full diagnoses are merely quacks and not real āyurvedic doctors.

Nonetheless, a practitioner’s ability to diagnose a patient’s illness simply by feeling his or her pulse is often taken as the quintessential sign of “traditional” Ayurveda. The powerful mystique of this diagnosis is pervasive among rural and metropolitan Indians and foreigners alike. (ibid.: 191)

Accounts presented by Meyer (1995b) and Finckh (1988a) also indicate that Tibetan practitioners who are able to diagnose a patient exceptionally through pulse reading are considered to have accomplished the highest state of this art. Therefore, it seems to be generally accepted in Tibetan culture that it is possible to give a complete diagnosis by pulse reading alone.

In Spiti, people do not doubt the potential of pulse diagnosis at all. It is commonly understood that it can reveal not only the patient’s basic constitution, dietary habits, and full range of his or her symptoms, but also the underlying causes of his or her general constitution as well as the actual diseases on the level of the body and mind resulting from various distinct origins (such as diet, climate, or actions/deeds of former lives).<sup>197</sup> But Spiti people do evaluate an amchi’s pulse reading abilities in various ways. After all, according to popular knowledge there, the value of pulse reading relies fundamentally on the training and experience of the person who is taking the pulse.

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<sup>196</sup> Elisabeth Hsu has completed extensive research on pulse reading in traditional Chinese medicine (2000, 2005) and points to the complexity of the tactile experience. Here, I stick to the Tibetan context and only later on refer to Hsu in the context of the importance of ‘touch’.

<sup>197</sup> These are, according to Parfionovitch et al., classified into four groups – each consisting of one hundred and one diseases: (1) diseases caused by actions of previous lives (karma), which might not be curable; (2) minor diseases that are self-curing, and treatment might speed recovery; (3) diseases caused by spirits and the like, to be treated by *pūjā*; and (4) diseases that respond to the correct treatment (1992: 165ff; see Chapter 3.1.3 as well).

Therefore, the patient's former experiences with a particular amchi and the amchi's reputation both play undeniable roles in the patient's estimation. On a deeper level, it is also important how much trust and faith the patient has in the pulse reader's capabilities. Fully comprehensive pulse taking (in the sense of being able to give a full diagnosis) is definitely viewed as a long and difficult skill to achieve requiring much training. It takes at least a few years of training and guidance by an experienced practitioner to fully learn it (cf. Dummer 1998: 78), while mastery in this art (taken as the highest stages of diagnosis with miracle-like abilities) is rare.<sup>198</sup> In the popular mind, such mastery requires several factors beyond extensive training, such as lineage transmission or an individual's karmic pre-condition (see Chapter 2.3). In this context, some patients view an amchi's talent as a natural "god gift" (see Chapter 2.4).

Regarding the training for pulse reading, in Spiti an amchi student accompanies his teacher for years visiting patients. The student then tries to read the pulse and compare his result with that of his teacher. While visiting patients, he must practice and develop a feeling for the pulse.<sup>199</sup> Although the Tibetan scriptures have many picturesque words for the different rhythms of the pulse, it seems to be very difficult to find exact verbal explanations.<sup>200</sup> Amchi say that neither the *Rgyud bzhi* nor the teacher can explain exactly how the pulse feels in this case or that case. As classified by Tibetan medical scriptures, pulse reading belongs to the 'sphere of touch' (see above). Correspondingly, one of Langford's informants (an āyurvedic practitioner) told her it was "a science of feeling" (2002: 196).<sup>201</sup> The skill of reading pulses is learned through practice. The variety of pulses must be experienced, and only then the ability to *read* them can be developed. Consequently, it is a matter of time to get to the point when a student's skill of pulse reading is tested by his teacher, perhaps to confirm that the young amchi is good enough to diagnose independently. Later on, continuous self-training through daily practice is necessary and the only way to make him a 'good pulse reader'. Urban practitioners that have a private clinic or Tibetan doctors at a clinic in Dharamshala thus have the advantage of frequent and continuous practice at expanding their skill. On the other hand, a Spiti village amchi does not have as many patients.

<sup>198</sup> If Spiti-pa are asked for an example of someone having mastered pulse reading, they mostly refer to a couple of miraculous stories of Amchi Sundar Singh (see Chapter 2.4).

<sup>199</sup> See also Amchi Chullim's explanation in Chapter 2.1

<sup>200</sup> See Hsu for explanation on this, as well for one on Chinese medicine (2005: 20f).

<sup>201</sup> The fact that pulse reading is based on *feeling* makes it, in the eyes of some observers, a matter of uncontrollable arbitrariness and unscientific rigor (Langford 2002). See here as well Hsu discussing the notion of the "science of touch" (2005).

Slowly, over many years he gains the necessary experience. But this accumulated knowledge will always be limited as compared to a practitioner in the physical centers of Tibetan medicine. This limitation stems from the restricted variety and number of ‘cases’ he usually sees – the usually common complaints of Spiti people. Through increasing contact to Indians and Westerners, the local medical horizon is exponentially enlarging. Changing dietary habits, different clothing styles, imported diseases, and the treatment of tourists all are contributing to a widening of the local context. Increasingly, Spiti amchi are therefore confronted with diseases or patients that inevitably question the extent of their ability to diagnose. While for instance the amchi who trained in Dharamshala had the chance to see up to hundreds of patients per day from all over the world, Spiti village amchi usually cannot gain this kind of expertise. In modern-day Spiti, medical experience that’s gained only in the local context might not be enough to satisfy the new expectations of patients.

Thus, it is clear why *experience* is such a central term in amchi’s discourses on their work. In the larger context of Spiti society, seniority is an important basic principle of the hierarchical structure. This concept – which has not yet been subject to great change – builds not only on tradition but also on respect as a result of experience and knowledge. It is, for instance, reflected in the social hierarchy within groups, such as the amchi community. Among amchi, the general value of experience is also a result of the long process of learning pulse reading. A young amchi can be technically good at reading pulses and detecting the ‘right’ diseases, but only time can give him the needed amount of experience to be regarded as a respected amchi. When people talk about a young amchi, they might regularly state that he is a good amchi, but has much more to learn. Amchi Chullim puts it like this:

If we do not know anything about the patient, then we have to ask him questions, read the pulse, and test the urine. Later on, when we have worked for some years as an amchi, we will know at first sight approximately what kind of disease the patient has. There is a saying: ‘A painter must have great longing; a lama must have great blessing; and an amchi must have great experience.’ It means that if you have experience, then you know the diagnosis [easily].

Therefore, we can conclude that a great deal of experience in pulse reading is fundamentally important for amchi practice, as it constitutes (and affects) so many various parts within their work.

Finally, in this section I give two further remarks concerning the local perception of the quality of pulse reading. Amchi Thupten Thapke contributes to this topic:

The best tool is the pulse [e]<sup>202</sup>. [...] Why should we research [e] the whole body? We see it by the pulse, by using three and three – six – fingers. These six fingers are the ones that tell us what is happening in the body...The amchi's work is to only read the pulse, to differentiate.

What the amchi clarifies here is the fact that he and his colleagues understand pulse reading as a technical tool and consequently place it parallel to biomedicine. For Amchi Thupten Thapke, the English word “research” is an equivalent term for the extensive diagnostic techniques of biomedicine. He marks here a difference between the complexity of an elaborate instrument of medicine and the ‘simplicity’ of putting six fingers on the patient’s wrists. Furthermore, he emphasizes the accuracy of pulse reading, stating that it ‘shows’ the amchi the direct cause of the illness.

To my surprise, the biomedical doctors in Spiti sometimes hold similar views on this. The disposition of instruments is very limited in Spiti<sup>203</sup> so the physicians often lack most of the fundamental diagnostic techniques with which they learned to work with while in the Indian plains. But nevertheless, the doctors sometimes envy the amchi for their ‘simple’ diagnostic method that gains the patient’s trust at the same time. I met several people who claimed that they would like to learn amchi medicine, and by saying so, actually meant that they wanted to learn pulse reading. For example, Dr. Dorje, whom I introduced in Chapter 2.2, is a committed physician but would like to learn amchi medicine additionally. He says:

We lack diagnostic tools. I almost never know if my diagnosis is correct, I’m just assuming so. I’m trained for differential diagnosis but have no lab, no microscope, no X-ray, or anything. I examine the patients according to their symptoms and do an outer examination. If further examination is needed, I send them to Kaza. Alternatively, the amchi take the pulse and can

<sup>202</sup> English words used by my informants in interviews are, if relevant, marked directly after the word with [e].

<sup>203</sup> In Kaza, the hospital contains only an X-ray machine and a laboratory, and often there is no electricity to use the instruments.

tell you the diagnosis exactly. They are absolutely sure of it and nothing further is needed. I would never get this result here. That's also why I'd like to learn pulse reading.

Differential diagnosing in Tibetan medicine consists of pulse reading and cognitive work to identify the pulse rhythm with a diagnosis. Spiti-pa think the potential for this diagnosis technique is nearly limitless, however, the actual quality of a diagnosis still depends entirely on the amchi. Therefore, we now turn our attention to the interactive part of this process.

### *By First Touch*

Inside the boundaries of a village, an amchi 'proves' his medical ability through two things: his accurate diagnosis, and the effectiveness of his medicines. Both of these factors work to establish a secure relationship between the villagers and the amchi. In an individual relationship between an amchi and a patient, the diagnosis is essential because it is part of the initial contact between them. Think back to the old man in Chapter 2.1, who said about the lineage amchi: "only by touching, you will feel already better." Trust can be, and is, achieved by the first touch. With the establishment of trust and the patient's faith (Tib. *dad pa*), the healing process itself has already started<sup>204</sup> (cf. Kloos forthcoming, Langford 2002: 225; Pigg 1996: 185). If an amchi is able to correctly describe to his patient his symptoms (without prior knowledge), or is able to accurately describe more than just what the patient has told the amchi, then the trust is increased. The more precisely the amchi diagnoses, the more confidence is established. The amchi's initial touch, combined with his words of diagnosis, is the decisive moment that can generate closeness. Many amchi told me that trust is actually more important than giving the right kind of medicine. One amchi even said that it would be more effective if a patient gets the wrong medicine but trusts the amchi, than if he or she gets the correct medicine but does not trust the amchi (cf. Kloos forthcoming).

The following two brief examples illustrate the importance of confidence and pulse reading. First, I have stated above that in the village context, amchi often do not need to take the pulse because they know the diagnosis only through an explanation of the symptoms and through their familiarity with the person. Nevertheless, they usually do take the pulse, and so I conclude that they do so for matters of confidence and to get

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<sup>204</sup> This is of importance again when discussing medicines and ritual healing, which is discussed in the next two sub-chapters and intensively elaborated in Chapter 3.2.1.

*in touch* with their patient. Secondly, the reading of a baby's pulse can be observed to be physically very difficult (see the prologue). Some amchi consider it not useful at all, and state that there is not much to detect anyway. However, I observed repeatedly that amchi do take babies' pulses, and it soon became clear that they actually do so in order to calm the parents down. This goes even a step further than what Hsu explains (in the context of Chinese medicine), that "the brief period of taking the pulse can calm down a patient" (2005: 20). Therefore, pulse reading is not only the basic diagnostic tool of the amchi but also an important tool that can inspire the patient's confidence. I would therefore support Hsu's following assumption, and hold it true for amchi medicine as well, that pulse reading has "therapeutic effects" (ibid.).<sup>205</sup>

An amchi's ability is perceived as extraordinary if he is able to give a full diagnosis through pulse reading only. There are stories of amchi who were able to do so, and they have the highest reputations of all. Amchi Chullim explains, "For example, if a patient comes to me, and I read his pulse and can tell him his exact disease without having asked him one question, then the patient knows that I am a very good amchi." This seems to be a general expression for the significance of pulse reading in the amchi-patient relationship in Tibetan culture. "In the eyes of Tibetans, the most prestigious physicians are those reputed to establish their diagnosis on pulse examination alone, without having to ask the patient a single question" (Meyer 1995b: 132).<sup>206</sup>

This leads us to the fact that pulse reading is also connected to authority. If we consider the need to *feel* the pulse and get the experience of it through feeling, then it becomes obvious that pulse diagnosis (though it is built on a rational and structural system of the body), is fundamentally situated in the sensory sphere. Unfolding this sphere, the amchi holds the position of the one who has the knowledge and therefore the patient relies on him. This also has a connotation of dominance on the side of the amchi. Hsu points out, "A doctor who touches the patient at the wrist puts the patient into a passive position. By his demonstratively active intrusion into the patient's more intimate sphere, he asserts his authority over the patient (this would seem to be the case in any cultural setting)" (2005: 20).

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<sup>205</sup> This conclusion is supported by drawing a parallel to a study on the meaning and efficacy of biomedicine, in which the author states that, "diagnosing someone is a form of medical treatment which might have an effect" (Moerman 2002: 25).

<sup>206</sup> Even Finckh points out what an extraordinary practitioner Yeshe Dhonden is because he "was able to arrive at an extremely accurate diagnosis without asking patients any questions" (1988a: 41).

A Spiti-pa once compared pulse reading to the chowa's religious practice called "mo"<sup>207</sup>. Both practices are able to detect the spiritual causes of, for instance, diseases. By comparing the amchi's practice of pulse reading to the chowa's *mo* illustrates that pulse reading is, in part, popularly regarded as a "magical power" (cf. Langford 2002). It highlights the fact that ordinary people have difficulties comprehending the way in which an amchi receives his knowledge. The amchi can identify the 'right' disease, whereas it was hidden from the patient himself. "Magic" seems to be a layman's description for understanding that part of pulse reading. However, it is also connected to the divine sphere, which becomes clear when we recall the ascription of an extraordinary capability (like pulse reading) as a "god gift". The ability to 'read' the cause of the patient's illness can therefore strongly contribute to the amchi's charisma, reputation, and authority. Besides being the fundamental tool and a visible marker, pulse reading is also an important symbol of the amchi.

#### Changing the Meaning of Diagnosing

Amchi notice the contemporary social changes taking place and their consequences on the amchi-patient relationships at the singular moment of taking a patient's pulse. Amchi Thupten Thapke explains:

The main change in modern relationships with the patients is that earlier, they had respect and confidence. Now, there are different people around, but some of them still respect the amchi. But it's a different kind of trust because in former times, people just whole-heartedly trusted the amchi and his work. Today, because of the influence of the hospital, patients say: 'Take my pulse, and if you diagnose the correct disease, then I will trust you!'

Nowadays, patients generally seek health care from both available medical systems<sup>208</sup> and try to make the best use from this rivalry.<sup>209</sup> Now able to compare two diagnoses with each other, patients meet with the amchi and demand the 'right' diagnosis. If the

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<sup>207</sup> A *mo* is a divinatory practice carried out in answer to a client's questions, or to identify auspicious days for ceremonies, traveling, etc. For further explanations, please see Chapter 3.1.3.

<sup>208</sup> Especially in summer, patients visit the hospital first because they hope for fast relief through the biomedical treatment. Some only visit amchi in the case of severe diseases, or if the biomedical treatment did not help. In winter, the order in which people seek health treatments reverses, for reasons of access (see Chapter 3.2.1).

<sup>209</sup> In the past, there might have been concurrence among amchi of neighboring villages. But, as Chapters 3.2.1 and 4 show, the medical pluralism of the state health system has had strong social and economic implications on the amchi.

patient comes in with the idea that he or she already knows what the diagnosis is, then the pulse reading becomes a kind of test. The amchi has to prove his ability (in relation to the given biomedical diagnosis<sup>210</sup>) to deserve the patient's confidence. Patients no longer depend on the amchi's diagnosis. The dominant position the amchi held over the patient in the past is dissolving; we even see later on that it is the patients who now hold the dominant position, as a consequence of further changes. Scepticism and competition have entered the sphere of pulse reading.

As a final point in this discussion, I introduce the matter of 'proof', that is, an aspect of the interactions between the amchi and the state. This is analyzed in detail in Chapter 5, but it is useful to insert an initial point here that brings together amchi medicine and biomedicine analytically, as well as examines the relationships between the amchi, patient, and the state. Vincanne Adams has analyzed the production of evidence extensively in the context of clinical Tibetan medicine in the Tibetan Autonomous Region in China (2002b). She shows how Tibetan doctors in the Lhasa Mentsikhang use biomedical techniques, such as ultrasound, to underline the more relevant results of the pulse diagnosis. The accuracy of Tibetan diagnosis (as well as the efficacy of Tibetan medicine) is thus contested by the direct comparison with biomedicine. "Proof, in this sense, becomes not just a question of epistemology [...] but rather a question of the way epistemology is made to speak for politics, history, and free markets in a changing world" (ibid.: 217). Tibetan doctors feel the need to position their own methods of diagnosis against the hegemony of state-supported biomedicine, which is especially expressed in scientific terminology. In Spiti, Tibetan medicine and biomedicine have not yet been put together in one institution or health system. State policy has favored (without exception until the 1990s) biomedical health care facilities. However, there is now a political debate starting to take place between the amchi and the state. This debate is of a structural character, concerning the physical control of services; it has not yet evolved into the epistemological debate concerning proof as is the case right now in Tibet. This theme is further discussed in Chapter 5. However, a debate on proof between biomedicine and amchi medicine that occurs on the local level (though not in the immediacy of one institution) is mediated via the patients. It is centered on the amchi themselves and their practice. State administered medical pluralism has created the ramification that the amchi now have to prove their healing

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<sup>210</sup> For the patients, the two medical systems are just one field of reference and they do not care for etymological differences.

abilities and diagnoses in direct comparison with biomedicine. Proof is not yet scientifically produced, but rather subjectively.

The main point of this chapter is that pulse reading is more than just a form of diagnosis but also a core element that can produce confidence in the amchi-patient relationship. Despite remaining a determiner of trust and a prominent visual marker of being an amchi, the significance of pulse reading has been altered. It not only has to establish proof of the diagnosis, but nowadays, additionally of amchi medicine as a whole. The amchi aptly perceive this as a fundamental change in the relationships with their patients. This chapter has, therefore, given another clue regarding the transformations of amchi medicine that find further expression in the next chapter on the actual medicines and their production.

### 3.1.2 The Making of Medicine

Moving on from diagnosing, the next logical subject regarding treatment is medicine. Tibetan medicine consists of three therapy options, which are described here in ascending order with respect to the seriousness of the disease. The first option is when an amchi gives advice concerning proper diet and behavior. The second is when he prescribes medicinal remedies. And the last option is when the amchi applies mechanical or ‘external’ treatment (such as acupuncture or moxibustion<sup>211</sup>). Janes has remarked in this context that from the Tibetan patient’s perspective, “the ‘content’ of Tibetan medicine lies primarily with its considerable *materia medica* [...] [and] the goal of nearly all treatment [...] is to gain access to these medicines” (2002: 267; italic in the original). This chapter thus concentrates on the production of medicine and its administration to the patient. As it’s a crucial dimension of amchi medicine, this chapter extends quite far and touches some of the aspects of change within the medical system. Therefore, I present here a brief introduction to the chapter’s general structure.

The first section presents an ethnography of the making of medicine as typically done in Spiti, with subsequent explanations that highlight and explain the ethnographical account. This section is meant to explain the conditions under which medicine is produced and to illustrate exactly how it is produced. The second section broaches the theme from a theoretical and global perspective, emphasizing the change

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<sup>211</sup> In Chapter 3.1.3, a case of moxibustion is described.

of Tibetan medicine, especially at Men-Tsee-Khang Dharamshala, towards “herbalism”. Further global impacts are then revealed in the section called *Competing Resources*, which concerns itself with environmental changes. Then, I return to ethnographical material in the form of a large excerpt from an interview that deals with the question of *The Efficacy of Medicine*. This interview touches many relevant aspects that are elaborated successively throughout this chapter. The analysis then merges the global influences with local perspectives, thereby revealing the reasons for the contemporary limited state of the production of medicine. Through analysis of a discourse on *Powder versus Pill*, we then see how Spiti amchi react to such influences, and finally, how they implement some of their *Visions*.

Now we return to the beginning to observe how an amchi makes medicine.

### Producing Medicine

One day during my stay at Kibber village, Amchi Tsering Dorje invited me over to watch how to make medicine (Tib. *sman*) and to probably also help him a bit with the work itself. He carries a bowl (measuring one meter in diameter) up onto the top of his house into the sun where we prepare the work site (figure 13). In the bowl, I identify more than ten different kinds of raw materials (medicinal herbs, Tib. *sngo sman*), including plants, woods, nuts, and roots. He wants to make *skyu ru nyer lnga*, which means that there are (all together) twenty-five ingredients needed, using *skyu ru*<sup>212</sup> as its main component. The amchi explains to me that he uses the medicine for various kinds of pain. In a broad plastic bottle, there is a pre-prepared a mixture of the remaining ingredients, which looks like white powder, and is made from ground stones and minerals (medicinal stones, Tib. *rdo sman*).

As described in Chapter 1.3, Tibetan medicine is a conglomeration of different influences, mainly from India and China, combined with the particular streams of local knowledge. These different origins have a significant influence on the inserted *materia medica*: quite a few medical materials are therefore not indigenous to the Tibetan Himalayas, but rather found in bordering areas including regions as far as south India.<sup>213</sup>

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<sup>212</sup> The identification of the Tibetan pharmacopoeia to the Latin botanical equivalents is quite difficult (cf. Finckh 1988a: 58). *Skyu ru (ra)* is colloquially called the Indian gooseberry, or Emblic Myrobalan, while the botanical name is *Emblica officinalis* (cf. Clark 1995: 149). It is a medicinal sour fruit which has a wide usage (Drungtso and Drungtso 1999; Rechung 2001).

<sup>213</sup> The Tibetan literature on pharmacology is vast. In the *Rgyud bzhi*, the following chapters are dedicated to it: the Second Tantra, chapters nineteen to twenty-one (for a translation, see Clark 1995: 125-195),

A *materia medica* can be regionally specified, as in the present case of Spiti valley, or it can be even further specified down to the level of a particular village or precise spot somewhere in the mountains. Spiti amchi, by and large, share a good deal of knowledge amongst themselves about the medicinal materials that can be found in Spiti. There is a basic and well-known ‘general’ set of flora, herbal, and aromatic plants which one can find in and around most villages. But because the inhabited areas begin at 3,000 meters altitude, and plants can grow up to an elevation of 4,200 meters, the diversity within Spiti is vast. It was mentioned in Chapter 1.1 that cultivation differences result from the valley’s ascent from east to west (totaling an altitude difference of about 1,000 meters). But flora diversity and differences not only occur along the east-west axis, but also occur due to the valley’s narrowness, even between villages that are actually neighboring each other. Though they lie close to each other (measured as the crow flies), there might be a steep ascent of several hundred meters in-between them. Divergences can thus be striking, even within half an hour or a few minutes of walking. The causes of this are numerous and diverse. Though the altitude and different climatic conditions play vital and limiting roles that influence the particular vegetation of the region, other factors, such as the existence of bodies of water, solar irradiation, wind, and the varying compositions of soil are all also of extreme importance and also impact local plant life. Besides the actual and specific occurrence in one location, the time of growth is also of importance for the amchi (and as well as for the farmers). Thus, a Spiti amchi has to know not only his village and surroundings, but he has to know the distinct qualities of many places all over Spiti.<sup>214</sup> He must be able to answer questions such as these: where exactly can one find each specific plant or earth material? And at what time, or even on which particular day (varying according to the conditions of every year and the local lunar calendar) does one have to harvest a certain plant? Which part of the plant does one need for a certain medicine, and when is the right time to get it? How do the qualities of a certain area influence the effectiveness of the material and therefore the created medicine? Gerke and Jacobson explain this mass of considerations further in the direction of psycho-spiritual, extra-human and basic elementary conditions:

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and the Fourth Tantra, chapters three to nine. For a textual introduction into the Tibetan pharmacology, see Finckh 1988a.

<sup>214</sup> All the knowledge surrounding the collection of medicinal raw materials is an essential part of the personal resources of an amchi and therefore of his education as well (see Chapter 2.1). Depending on the extent and quality of the educational transmission, an amchi’s resource pool will vary.

A given medicinal plant has to be picked at a certain time of the year at which the configuration of the five elements and three humoral principles in the environment maximizes its medicinal value. Other factors to be considered in gathering medicinal plants include the compass direction of the slope on which they are found, the position of lunar and planetary constellations at the time of gathering, the time of the day, the signs of specific birds and animals in the natural surroundings as well as the state of mind of the person collecting the plant. [...] All of these factors are understood to affect the medicinal power of the final drug. (1996)

These multiple considerations mean that amchi have to plan ahead when producing their stock of medicines and collecting raw materials. Some medicines are produced only as needed, while others are produced in larger amounts and stockpiled. Since some ingredients are only available once a year and/or only in a specific place, the collection of raw materials is carefully planned in advance. Every year, most of the plants have to be plucked or harvested fresh to guarantee their medical potency. From experience, the amchi know which amount of various ingredients they will need to get through the year. Some plants can be obtained near the village, close by, or in the fields. Others can be found within walking distance of the village. However, the amchi must plan ‘collection tours’ for certain places with a broad variety (containing particular plants with special qualities and/or with rare species), or, for instance, to places with deposits of certain minerals or earth materials also needed. These ‘tours’ might take anywhere from two days, even up to two weeks. Other raw materials must be obtained from far-away places, as illustrated by a statement of Amchi Karma of the Tibetan Medical Institute Manali.<sup>215</sup> When I visited him in his office one day, he showed me a bottle of medicine pills and read through the description of the contents of that medicine in an old *dpe cha*. “To make this one medicine, thirty-five ingredients are needed. This one an amchi can find only in Kinnaur, this one only in Nepal, and the next ingredient only in Changthang,” he says. Other hard-to-get ingredients can be found around Manali and some near Mandi or Riwalser (both are places in H.P.). However, I have never heard of any practitioner going all the way to Nepal to collect plants or the like, as most of these ingredients can usually be obtained at the Indian markets. Yet, Spiti amchi do not frequently go to the Indian plains either, in contrast to those practitioners who live in the

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<sup>215</sup> The institute has been introduced in Chapter 2.3.

plains and therefore have easier access to the markets. In any case, every aspect in the gathering of medicinal materials is a time-intensive matter and must be balanced with the other duties of work and family life.

Turning back to making medicine on the roof with Amchi Tsering Dorje, he explains to me that he collects most of the raw materials from the surrounding mountains because his village is close to one of the richest spots for medicinal plants in Spiti. Other materials are brought to him by friends from the villages Lalung and Rangrik.<sup>216</sup> Because Amchi Tsering Dorje lived for some years near Dharamshala, he is familiar with the conditions in the Indian plains and is able every now and then to replenish his stock of long-lasting materials that formerly belonged to his father.

Before we actually start the production of *skyu ru nyer lnga*, Amchi Tsering Dorje brings out a shovel filled with glowing coal and incense. Murmuring the Medicine Buddha mantra,<sup>217</sup> he surrounds our working place and creates a circle of smoke around the raw materials and grinding tools, thereby purifying everything. Usually, the first step is to crush the raw materials with a pestle and mortar.<sup>218</sup> To finally be able to pulverize the mixture with the grinding stone, it must first be minced in the mortar. This procedure takes quite some time and is extremely exhausting. At the moment, Amchi Tsering Dorje is only crushing minerals (including salt crystals), hard woods, and nuts in his mortar. He has a metal hand-mincer that a friend bought for him in the plains. This tool is not common in Spiti, and most amchi still use a regular pestle and mortar. By increasingly setting finer adjustments to the mincer, the medicinal material is slowly – through several repetitions – refined. Although the mincer is definitely easier work than the mortar, it is still a strenuous effort. We were quite happy to be able to take a break from this job by alternating with each other every so often. After the initial grinding of the raw materials, Amchi Tsering Dorje added two spoonfuls of the white mineral powder he had prepared earlier. When parts of the material became powder-like, we started separating it from the thicker remaining material with a sieve. The leftovers from this return to the mincer to be further refined, while the powder is then ground as fine as possible. Using a small stone moved with

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<sup>216</sup> Two villages with different climatic settings compared to Kibber. Rangrik lies down in the main valley, close to Spiti River, but with comparably less sun because of its shadowy position. Lalung is a remote village, the last one in the northward region of Lingti valley.

<sup>217</sup> A mantra is a track of spiritually significant sounds created by an arrangement of syllables or words.

<sup>218</sup> For a theoretical introduction into the compounding of medicines according to the *Rgyud bzhi*, see Clark 1995: 184ff.

both hands in rhythmic movement, the powder is further grated on a flat, rough stone plate (figure 13). These two grinding stones are customarily passed from father to son within the family. By now, none of the ingredients retain any of their former structure or color. The powder acquires a consistency almost as fine as machine-cut stone dust, and takes on the color of its predominant ingredient, in this case, dark red. Finally, the powder's consistency is tested once more, proving correct when shaken through an even finer sieve. Later in an interview, Amchi Tsering Dorje explains the procedure in a very comprehensible way:

Our elders said, if you make medicine on the stone, it has a better effect than if you make it with a machine [e]. The reason for this is: the finer the powder, the more effective it is for the patient and the faster it works. If you make it very fine, then the powder is dissolved faster in the body. That's why I use the mincer and still rub the medicine on the stone to make it very fine.

I ask Amchi Tsering Dorje if and how he measures the quantities of the ingredients, and he says that today he can do this very easily by hand. This kind of measurement usually fits well because what the amchi actually needs is the correct proportion of ingredients, and not necessarily exactly measured amounts. The proportional relation between the ingredients is of utmost importance. Minute variances in weight do not change the efficacy of the medicine, but a larger disproportion, or even the full omission of one ingredient, would definitely matter and change its effect. Amchi Tsering Dorje explains that towards the end of the preparation, amchi taste the final product in order to prove its accuracy. By dissolving a fingertip of medicine on their tongues, they judge if it's correct. This is also the same way in which they test the quality of a plant or mineral when they collect them in the mountains. Its appearance in color, structure, etc., is one factor, but the final and decisive judgment is ultimately done by taste.<sup>219</sup> Gerke and Jacobson state:

Once gathered, the medicinal value of a plant is assessed by taste. A skilled traditional physician can determine the proportions of five elements and the

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<sup>219</sup> The high importance of *taste* in Tibetan medicine is reflected by its prominence not only in the production of medicine but also in its use in diagnosis and treatment. For instance, a medicine's taste gives a hint as to which contra-indication of a disease (which is also characterized by a certain taste) it can be used. For further explanation, see e.g., Clark 1995; Dhonden 1986; Drungtso 2004; Finckh 1988a; Rechung 2001.

three humoral principles present in a plant in this way. The ability to do this accurately depends on the assessor's personal state of health and mental clarity. (1996)

As in the case of pulse reading, we see that a crucial aspect of medicine making is situated in the sensory sphere. Measured by their bodily senses, Spiti amchi decide if the medicine is made exactly the way they want it to be in order to be beneficial for their patients. Back to our present case, Amchi Tsering Dorje is making a general stock of *skyu ru nyer lnga*, a medicine he knows very well because he prescribes it regularly. This is why he is treating the production of it generally, composed according to the overall formula and not according to a specific condition of one patient. This, and certain other medicines, can be produced in larger quantities and kept in-stock due to its level of potency. Several amchi have told me that they usually make such kinds of medicines that are usable for several patients. If a patient's disease is severe (meaning the best and most effective medicine is needed), or if a disease or pulse pattern is very rare, an amchi will differentiate and adapt the composition when making the medicine so that it is tailored especially for this person. To do this, they vary the original formula slightly from the books, according to the particular patient's pulse pattern (i.e., his or her special personal constitution) that they had recognized (cf. Finckh 1988a: 58). This kind of individual medication is of great importance regarding discourse among amchi on the application of rational principles for modern large-scale medicine production (this topic is discussed below and in Chapter 5.2).

When we have nearly finished the production of *skyu ru nyer lnga*, Amchi Tsering Dorje does as mentioned before, and proves the powder's effectiveness by tasting it. To my surprise, he immediately realizes that something is definitely missing. He thinks about it and tries to figure out the missing ingredient but unfortunately has no idea. He leaves and brings back his notebook, in which he has written the composition of several medicines during his studies in Dharamshala. For the ingredient list of *skyu ru nyer lnga*, he finds that the missing component is coriander (H. *dhaniyā*). We then had to find and grind up some green coriander and mix it into the prepared red-colored medicine powder. Finally, we have produced a whole plastic bottle full of medicine. What has taken both of us two hours to prepare sometimes takes Amchi Tsering Dorje two to three days.

*Global and Local Changes Regarding Medicine*

This ethnographical account illustrates the complexity of making medicine, especially in regard to its demand for knowledge, resources, and time. As can be imagined, these parameters underlie various considerable influences caused by this contemporary period of change. Before delving into explanations concerning the various aspects of medicine making and administering, we first need to digress into the global developments of Tibetan medicine that have particular influence on the local level in Spiti. Therefore, I further expound on the ramifications of some of contemporary changes that were first generally explored in Chapter 1, and more specifically in Chapter 2 (concerning education).

In these previous chapters, some clarification was brought to the socio-political and economic transformations currently underway in Spiti. These transformations can be viewed and understood as results of the extension of infrastructure and mobility, the rise of a market economy and government subsidization, and finally, the arise of the education system and a job market. All these aspects and their further consequences have varying weights attached to their respective impacts on the production of medicine and its perceived perception. The globalization of Tibetan medicine, pushed forward by Men-Tsee-Khang Dharamshala, is very closely related to these factors.<sup>220</sup> Contrary to the current coverage of Tibetan medicine in China, its globalization in reference to India has not yet been the singular object of an investigation or publication, having been only briefly touched upon in various texts.<sup>221</sup> Therefore, I had to collect information from several sources and combine them with my observations of Spiti. Considered from a Spiti perspective, Men-Tsee-Khang emerged in the second part of the twentieth century as the first institute of Tibetan medicine providing the full medical extent of the Tibetan pharmacopoeia. The concentration on practicing Tibetan medicine mainly as a herbal medicine has a long history oriented along pragmatic and standardized means (see Chapter 1.3), as its preference against other modes of treatment seems to have been prevalent also in Tibet. Says Janes, “The narrow focus on medicines may, however, predate sustained contact with biomedicine, and be related to efforts made by the 13<sup>th</sup>

<sup>220</sup> I deliberately narrow the following examination to the context of Tibetan medicine and leave out the wider analysis of rationalization and professionalization of traditional medicines, as this is dealt with in Chapter 5.

<sup>221</sup> In the Chinese context, Adams (2001a, 2001b, 2002b) and Janes (1995, 1999b, 2001, 2002) have intensively researched this topic. Samuel (2001a) has worked on it in the Indian context, but rather in the periphery and not in its center, Men-Tsee-Khang. Cantwell (1995) and Prost (2003) have also worked in Dharamshala and provide some aspects concerning this topic.

Dalai Lama to develop a secularised state-sponsored medicine” (2002: 279). In exile, this development intensified through a trend towards biomedical standards. Research at Men-Tsee-Khang is, through competition with biomedicine, focused on finding out one effective substance out of the multi-substance-based compositions of the traditional scriptures.<sup>222</sup> Nourished by the Tibetan (see above) and Western demand for herbal medication, treatment is developing towards the use of a particular effective medicine for a particular disease (Meyer 1995b; Pordié 2002, 2003; Samuel 2001a).<sup>223</sup> Observing Tibetan medicine in the Chinese context, Janes concludes:

This de-personalisation of medical care fits quite well with processes of commodification, where in this case the subject becomes the object, and the object is placed into a category to which is affixed an array of material treatments. In this sense, modern Tibetan medicine tends toward the objectification processes that have been identified as hallmarks of biomedicine. (2002: 280)

Adjustment to the Indian and Western pharmaceutical markets has made further standardizations of medicine necessary (Prost 2003: 142). Increasing its orientation towards national and global sales markets has led to large-scale machine-based manufacturing based on rationalizing principles. Considerations of traditional importance (such as astrological advice concerning harvesting and producing times, etc.) are reduced under these conditions.<sup>224</sup> Ritual consecration, having been common practice earlier, is today limited to a few so-called “precious” medicines (Cantwell 1995: 181).<sup>225</sup> This distinctive development of Tibetan medicine, tending towards a commodified herbalism, is unmistakable.

Access to Tibetan medicine, as practiced by the exiled-Tibetans, has been increasingly simplified for Spiti-pa in the last two decades. Traveling to the Indian plains and visiting Tibetan medicine clinics in Manali, Dehra Dhun, and Dharamshala has become

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<sup>222</sup> According to Prost, the research unit concentrates on “fields of cancer treatment, hypertension, and the alleviation of non-insulin-independent diabetes mellitus” (2003: 129), which highlights its focus towards biomedicine and the international market.

<sup>223</sup> It also includes the attempt to eliminate animal ingredients in medical compositions (Samuel 1999: 93).

<sup>224</sup> Prost reports that for certain pills needing a ritual preparation (like *ma ni ril bu*), the manufacturing process is sped up for market purposes (2003: 117).

<sup>225</sup> This evidently runs contrary to the manifold presentations of Tibetan medicine for a Western audience as holistic and spiritual (Samuel 1999: 93). Although the target group is similar, manufacturing needs to take into account the market pressures of time and demand.

more affordable and less time-consuming.<sup>226</sup> By means of public attention and publicity, the variety of herbal treatments and their potencies are now deliberately displayed and contemplated by the amchi as well as the patients. Expectations and imaginations are raised, which especially applies to the amchi who lived for a significant period of time in Dharamshala (Chapter 2.3). But these expectations are applied as well to the patients, who then transfer them onto their village amchi. Increasingly, Spiti amchi find themselves in a differentiating competition with the clinics in the plains, and especially with Men-Tsee-Khang. The variety and quality of Men-Tsee-Khang medicine has come to be regarded – not only on a local, but also on a regional and national level – as the general standard of Tibetan medicine.<sup>227</sup>

The link between Men-Tsee-Khang's standards and government implementations is explored in Chapter 5. However, it is interesting to remind one that the government holds influence over the amchi, and regularly refers to Men-Tsee-Khang for standards on such matters. This connection is, besides the Spiti-pa themselves, a second gateway through which amchi are confronted with the standards of a modern Tibetan medicine.

### Competing Resources

A second field of supra-regional and global influences that concerns the production of medicinal materials is explored in this section. This is specifically related to climatic and environmental issues within the Spiti valley. Spiti-pa have observed – especially throughout the last years – an environmental change. It started with the building of roads in the 1960s, done because the workers in remote areas needed fuel and so cut most of the local timber down. As a result, erosion has become a major problem for many villages in the lower main valley. Today, one of the most important environmental tasks is the re-forestation projects taken up by the Forest Department. A second impact on the local flora, as Spiti-pa have recorded, is the continuous climatic change that is reflected, in average, through less snowfall and coldness in winter, and more rainfall and warmth in summer. So far, however, there has been no recorded environmental impact caused by an increase of the local population. Nor have there

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<sup>226</sup> Modern infrastructure makes it possible to receive treatment once from an amchi, say in Dharamshala, and afterwards, in case of successful efficacy and needed continuation of treatment, call the amchi's clinic and get the medicine by mail.

<sup>227</sup> This applies as well on an international level. In this context however, this does not play a role. The impacts of globalization are discussed in Chapter 5.3.

been any alterations due to tourism just yet, as has been the case in Ladakh (Pordié 2002); but is mostly because significant amounts of business-oriented trekking tourism have only started very recently, in 2004.

However, because of the environmental changes, the amchi say that the natural plant fields have altered. Plant populations and their qualities in Spiti and its border regions have noticeably declined. A second, equally strong impact could be caused by the arrival and actions of plant collectors from outside of Spiti. Spiti-pa could not identify most of these people, though they did suspiciously observe their activities. Some Spiti-pa have recognized collectors from Men-Tsee-Khang, visiting since 2003 to collect plants from some of the best spots in Spiti. A villager says, “Sixteen people from Men-Tsee-Khang came here and went above the village to the areas rich in plants. They plucked several sacks of plants, and their pick-up car was full when they left.” Though amchi and villagers have become increasingly aware of this issue, they don’t know what to do about it (partly because the responsible government offices seem to not care about it). This trend of over-exploiting natural resources by professional collectors in the north-western Indian Himalayas has been observed elsewhere as well (Thinley 1997).

Within the last decade, the Indian pharmaceutical and cosmetic industries have discovered the national and global economic potentials of ‘natural products’ and remedies of alternative medicines. While the Indian state has laid down strong restrictions for international companies to follow (largely excluding their access to India), Indian companies seem to have unrestricted access to all natural resources.<sup>228</sup> In the case of Men-Tsee-Khang, one could assume that the reason for their recent appearance in Spiti might be due to the current increasing global demand for its products. As large-scale cultivations of medicinal plants haven’t been very successful

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<sup>228</sup> An example demonstrating this practice is the Indian NGO Pragma: it runs several projects all over the Indian cold desert areas to cultivate medicinal and aromatic plants and to save them from extinction. For their approach and work, they have won two international awards and gained financial support from the Indian state, Indian industrial funds, and the European Community. Pragma teams regularly come to Spiti for their different projects, some of them concerning plants. Pragma has official permission from the relevant government authorities, including those of Spiti, for these projects. Spiti-pa, and among them amchi, are recruited in order to help show them the plants and explain the local herbs. Talking with many of their informants, I learned that for the most part Spiti-pa have no idea why the NGO is doing this. The NGO-projects extract local knowledge and sometimes local resources in return for small salaries. The locals are left behind satisfied with the salary but suspicious over the motives of the NGO. In the local perception, the conservation projects which have been started – publicly marked by big billboards– haven’t, up until now, been of any considerable benefit for the Spiti people.

yet,<sup>229</sup> Men-Tsee-Khang might cover its demand by making more wide-spread and larger harvesting tours. The situation in Spiti now proves what Kloos – again in the case of Ladakh – concluded, namely, that “the capitalist market economy itself encourages the increased exploitation of these delicate natural resources” (forthcoming). The increasing global demand for Tibetan medicine subsequently severely affects the natural environment of habitats that have been described not only as remote, but also as extremely sensitive and delicate. Naturally, these effects on the environment concern the Spiti population as well. In particular, the amchi sense the increasing scarcity of naturally abundant plants. It thereby increases the pressure on the amchi to obtain raw materials from places other than their valley. Therefore, they have to spend money to purchase the needed materials at the Indian markets. The decline of local resources strikes the amchi in their personal budgets, which is explored in further detail in Chapter 4.

This last assessment has opened up the issue of global and supra-regional transformations impacting Spiti’s situation. As we return now to the exploration of the production of medicine on the local level, it is useful to keep these revelations in mind.

#### *The Efficacy of Medicine*

Taking up again the thread of the introductory ethnographical account, I continue here with a bigger excerpt of an interview with Amchi Tsering Dorje. It served to bring some central topics on the question of medicine to the fore. I prefer to present this interview unedited in order to demonstrate the density and ramification of the themes. The explanations following the interview make it clear that for several reasons, medicines (and especially their efficacy) are at the very core of the modernization of the work of the amchi. The new topics introduced thereby expand quite a bit. These refer to the transformations just introduced, and also anticipate themes that are fully elaborated later in the course of the dissertation. The reader is thus asked to keep in mind that the analysis of this interview is drawn out over the entire chapter, and even brought up throughout the thesis as I refer back to it for some cases.

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<sup>229</sup> There are some projects under way right now that attempt to cultivate Tibetan medical plants (see for instance, Men-Tsee-Khang 2005, or the homepage of Pragya – [www.pragya.org](http://www.pragya.org)), but as far as I know none have had a sufficient outcome to be used intensively for medicine manufacturing. Also, it seems that people generally regard cultivated plants to be less effective than naturally grown ones (Prost 2003:142).

During an in-depth interview, Amchi Tsering Dorje expounds upon the question of what he learned from his father, and what he learned from his teacher:

Learning from my father or my guru-ji, if we do not have a good [mutual] understanding, he won't give me the [transmission of] knowledge that he earlier intended to do. In the Men-Tsee-Khang, nobody teaches the students about *jari-buti* [H. medical plants]. But my guru-ji taught me everything about *jari-buti*, he did not even leave out one [thing]. While I stayed with him, he taught me everything, how to use the plants and so on. When I learned from my father, he taught me how to stay in *msthams* and how to use the mantras. What my father taught me – the mantras – is very special, and he would not have taught this to anyone else. [...]

FB: Is there a difference between the hand-made fresh medicine you make and the ready-made medicine from Men-Tsee-Khang?

TD: Actually, both are the same. But, the way Men-Tsee-Khang produces the medicine, it looks better because they can make them into pills. But [concerning the ingredients] they are the same. Even I am able to make pills, but not here and now [he does not have the machine to do so<sup>230</sup>]. When I get in a better [financial] position then I will make them. Actually, both [types of medicine] are the same but when you give pills to the patients, they appreciate it more than the powder. Because the powder looks bad in comparison to the pills. [...] I can even compose *rin chen ril bu*, but if I give it to the patients telling them that it is *rin chen ril bu* in powder form then they do not trust me. If I buy the machine and the cloth<sup>231</sup> for *rin chen ril bu* and give it that way to them, then they would appreciate it and feel better. If a patient suffers from a disease and gets it checked out by different amchi, then he will be cured by that particular amchi whom he trusts with his heart. Even if the amchi gives a different medicine [than what might be required] it will suit the patient because he trusts the amchi. It is the same with *rin chen ril bu*. If it has the cloth around it, then the patient trusts it more and it therefore has a better effect on him.

<sup>230</sup> Though rolling the medicinal pills could be even done by hand, I have never seen someone doing so, as it is also quite time-intensive.

<sup>231</sup> *Rin chen ril bu* are special medicine compositions that are ritually empowered (cf. Samuel 1999: 95). The precious pills produced by Men-Tsee-Khang are wrapped in a silk cloth and tied up to protect it from sunlight.

FB: Do they speak mantras at Men-Tsee-Khang when they manufacture medicine by machines?

TD: I do not know if they use mantras. It is a big institute; I cannot say anything about it. But, the mantras are very necessary for making medicine. We are small workers here and we make one or two kilos [of medicine] at most. It does not matter how much medicine we produce, we have always enough time to speak the mantras. But they [Men-Tsee-Khang] manufacture large amounts and I do not know if they use mantras then. [...]

FB: If someone does not use mantras during the production process, does it make a difference to the final medicine?

TD: There will be some difference. But the way they [Men-Tsee-Khang] make it, the people just feel better. If you feel better about something, it does not matter how big the amount [of money] you spend on it because you do not feel sad about it.

FB: Do medicines produced without mantras have less effect?

TD: Yes, there is less effect. But [in Dharamshala] they have the great lamas' blessings, like the Dalai Lama's blessing. Because of that, it goes well. Maybe, because of this, the medicine's effects are good. Anyway, we are the small workers. So, we don't care how much time it takes to make the medicine.<sup>232</sup> They receive orders in quintals<sup>233</sup> and they try to produce them as fast as possible. At the moment, we are small workers, but if we get large orders then probably we would make it the same way. We would try to make them as fast as possible, and we would also leave out the mantras and try to get the money [laughing].

FB: If you use local raw medicinal materials for a patient who is ill here, do they have another effect than materials from another place?

TD: Once [in Dharamshala] we focused not on all the raw materials [of a medicine] but only on one ingredient. This one plant grows in the plains [...] like a plant, but in our mountains, it grows like grass. We took one of the latter to the plains, made medicine out of it and gave it to patients. It had

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<sup>232</sup> He does not mean here that he has plenty of time to make medicine but that compared with professional productions, he is not under pressure to produce large amounts of medicine as fast as possible.

<sup>233</sup> One quintal is a unit referring to one hundred kilograms.

less effect on them. The people of the plains are living in a hot place, and the plant from their own region has more effect on them. If you give that medicine to our patients then it does not have a good effect on them. Because it is from a hot place and we stay here in a cold place.

In this section of the interview, the amchi has broadly given us the key points which – in the local perception – influence the effectiveness of medicines. I would like to summarize these points before going further into detail regarding this topic. Besides the pharmacological potency, the things affecting the efficacy of medicine are as follows: the recipient's confidence, the knowledge of the maker, the sacred powers of religious practices, the external appearance of the final medicinal product, and finally, the place of origin in which the medicinal ingredients are in relation to the patient's place of residence. The first three points are discussed hereafter in succession, while the latter two points follow towards the end of this chapter.

During this interview, Amchi Tsering Dorje referred repeatedly to the importance of the recipient's trust in the amchi and his medicine, which was also introduced in the last chapter regarding pulse reading. This theme is emphasized in Chapter 3.2.1 but also deserves a remark made here on this notable frequent accentuation of the patient's trust in the amchi. The amchi seem to make the mutual understanding of healer and patient very central to their medicine, which is something that has been found central to the healing process in biomedical contexts as well (Moerman 2002). The reasons for its prominence by Spiti amchi is gradually explored additionally in the next chapters.

Concerning an amchi's expertise, Chapter 2 gave extensive commentary on the importance of the transmission of knowledge and its reference to locality. Amchi Tsering Dorje emphasizes these two connected points here from a slightly different angle. Following his statements, we are brought via the knowledge of medicine making to its contemporary economic concerns. Following the repercussions of these aspects of change in amchi medicine, we turn back to the topic of the efficacy of medicines. Amchi Tsering Dorje is happy to have received a broad education concerning the production of medicine because he enjoyed two lines of transmission: one from his father and one from his teacher. The latter was able to introduce him to a large variety of *jari-but*i and their processing, even including the making of *rin chen ril bu*. He emphasizes that at this point, his father's knowledge didn't seem to be sufficient for

him. Several other amchi also state that the general transmission of this part of amchi knowledge in Spiti lacks breadth and detail. It is said that many Spiti amchi might actually have only a relatively small pool of medicine-making experience to draw from (perhaps being able to make only between twenty to thirty medicines, compared to the considerably larger number of actual recipes in the *Rgyud bzhi*).<sup>234</sup> Though there is some substantial evidence to this claim, I want to emphasize here that I have also visited several amchi who have a large stock of raw materials (in part derived from their fathers), and who definitely produce larger numbers of medicines. In contrast, Meyer mentions that Tibetan medicine includes several pharmacopoeias with about “two thousand two hundred drugs and their sub-varieties [but] only one hundred or one hundred and fifty among these are commonly used” (1995b: 137).

In Spiti, several causes have contributed to this state of medicine that does not reach as high as this number: Firstly, breaks in the (full) transmission of the family lineages have led to a decline of knowledge, which was sufficiently explained in Chapter 2.2. Secondly, at the beginning of this chapter, I pointed out that in regard to the medical materials available in Spiti, an amchi’s plant harvesting trips can be extremely time-consuming. Despite the small distances involved, hikes into the mountains over steep slopes, debris, boulders, and the like can cause an amchi to take a couple of days to fully collect their needed range of plants and stone materials. In winter, there is no possibility and no point of making these trips, and in summer, amchi find it increasingly difficult to find spare time partly because of their daily work and jobs (cf. Craig forthcoming). Even an absence of only a few days might raise serious financial considerations – most commonly the loss of working hours in the cash crop cultivation or job (creating a struggle between making money and making non-paid medicine). Spiti people commonly perceive an increasing bustle (in new modes of work) that results in cutting back time for work that was previously more important – a common phenomenon of the new capitalist market economy. The time-intensiveness of the collection and production of medicine has thus, for many amchi, become a fundamental problem of their practice.

The third reason for the limitation of medicine is the decline of available native medicinal materials, which have accordingly reduced the diversity of medicines. This is connected to the fourth point, which requires a lengthy discussion: the difficulty of

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<sup>234</sup> A limited number of produced medicines or used ingredients are known as well from other remote areas, as for instance Zangskar (Gutschow forthcoming).

getting or buying non-native ingredients. If we consider the remoteness of Spiti in pre-modern times, this difficulty can be regarded as nothing new. Before the building of roads, the access to raw materials that could be imported from India or Tibet was quite limited for reasons of distance and marginality of trade routes. It can be assumed that a shortage of raw materials has thus been more or less the normal case in the past, as it is in some regards in the present as well. But what has changed today is the connected connotation. Today, access to the Indian market is a matter of only a one- or two-day bus ride. Nevertheless, an amchi needs the temporal resources to go there, not to mention the additional financial resources for the trip and raw materials. Concerning the latter, prices have generally increased during the last years, due to the decrease of regionally available plants (Pordié 2002; see also Nichter 1996: 293). Amchi need more and more money to buy the needed ingredients for their medicines. Here, I fall back on some statements made in the first and second chapters where I introduced that, albeit the general economic advancement in Spiti, the breakdown of the reciprocal exchange system between amchi and patients has created pressure on the amchi regarding their medical work.<sup>235</sup> One amchi says, “Most Spiti amchi prepare about twenty to thirty medicines from plants and raw material. Actually, they have the knowledge to make more, but they cannot buy the expensive ingredients and therefore cannot produce more.” Some ingredients are cheap, and all amchi can afford them. But, there are very few amchi who are able to buy the expensive raw materials needed for a sufficient stock of medicine.

These are the complex reasons lying behind the limitation of availability of medicine among amchi. This is, however, not only an actual problem, but it is also a matter of perception and presentation. It was mentioned earlier that patients view a large stock of medicine as a sign indicating a “good amchi” (Chapter 2.4). Very likely, the patients’ estimation relates to the observations of unlimited stocks of medicine in Dharamshala and the exile-Tibetan settlements. A large stock of medicine has become an important symbol of amchi medicine, as well as a sign to be able to treat patients sufficiently. Thus, Spiti amchi feel the urge to present larger stocks of medicine to their patients and the public in order to appear competitive. But only few of them actually have the resources and the knowledge to produce such an extensive stock. The comparison with modern Tibetan medicine has made the amchi’s own limitations

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<sup>235</sup> Here, I extend this analysis slightly to the production of medicine. The full examination, however, is given in an extra section (Chapter 4) of this thesis.

painfully visible and has brought this deficiency even more to the fore than in the past. The consequence taken because of this was, since the late-1990s, to make the fact of their limited medicine a matter of the entire amchi community. They started to present the lack of medicine as their central dilemma, and derived from it the need for financial support (see Chapter 5).

### *Reducing Medicine*

Having clarified the factors that contribute to a limitation of raw materials as well as medicines, we can now proceed to analyze the dilemma the amchi find themselves in and some conclusions they have drawn individually. In the following interview, a Spiti-pa who is familiar with amchi work explains how these economic difficulties can arise and what the consequences might be:

An amchi depends largely on his farming, and therefore he acts in his amchi work according to it. If, for instance, one year we have had little snow, and following it he has a poor pea harvest, then the amchi has considerable less income. He will be able to spend only a little money on his supply of [medical] raw materials. If he then has to make a medicine which consists partly of a precious or an expensive ingredient, he might reduce the quantity of this ingredient. He will not leave it out, but might put it in less quantity than needed. Or he might just make less medicine overall. Then, if a patient needs this medicine, he will give him a smaller course of it or will reduce the dosage. Because an amchi would never give no medicine at all, so he will try to keep enough for the next patient.

Considered from a solely economic point of view, this villager fans out the possibilities an amchi might have in front of him. But, starting from a primary topic, this interviewee has brought up (besides the lack of financial means) another core aspect: the amchi's code of conduct. His last sentence points out that an amchi feels morally compelled to treat each patient that comes to him for help. This can be further illustrated by the following continuation of Amchi Karma's interview as presented above. He had been talking about the collection of thirty-five different medicinal ingredients from far-away places. Then Amchi Karma continues:

You see, only for this one medicine an amchi has to go to quite far places and might spend 10,000 rupees to make it. When a patient comes and needs

this medicine, the amchi has to spend a large amount of money. The patient might give him some money in return, but maybe only 1,000 rupees or, in exceptional cases, he might even give 5,000 rupees. But this is still much less than what the actual cost is to produce this medicine. You know, people also never give something additional for the amchi's knowledge or the hard work he has carried out.<sup>236</sup>

He points out emphatically that he “has to go” and get the needed ingredients to make the medicine. In his (represented) understanding, there is no question of the duty to make a medicine if it's needed for a patient. The same is expressed by the Spiti amchi: there should be no distance too far and no price too high to help a patient in need. This representation requires intensive investigation, which takes place in Chapter 4. However, this assumption is very much at the core of the economic and problematic situation at hand and the conclusions the amchi above draws from it. But what is of importance here is that the amchi feel morally obligated to administer medicine. This is naturally tied to the social environment of a village, in which an amchi is in constant interaction with his neighbors as patients. Taking into consideration the above explained economic problems, it follows that an amchi might acknowledge that he cannot or does not want to spend time and money on medicine making, thus finding himself additionally in a socio-moral dilemma.<sup>237</sup>

Although the penultimate interviewee put together the ‘solutions’ to this dilemma as being the different forms of reduction, expensive ingredients, total quantity of medicine, or prescribed dosage, he excluded the possibility of a total omission of an expensive or unavailable ingredient. However, one can presume that this could indeed be a possibility in some places, even in Spiti. One amchi told me that some amchi skip ingredients deliberately, even knowing that fact that “if one ingredient of a medicine compound is missing the whole medicine can have a bad effect.” Let us then discuss further the possible ‘solutions’ for this issue, including even the exclusion of ingredients. Pordié, in his study on “La pharmacopée comme expression de société” (2002) in Ladakh, points out that in contrast, ceremonies can substitute a missing ingredient (see below). Nevertheless, I found no evidence of this actually being

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<sup>236</sup> The amounts of donations mentioned here by the Manali amchi do not reflect the common Spiti reality, see Chapter 4.

<sup>237</sup> The moral and social dimensions that come here to daylight are especially investigated in Chapter 3.2.1.

practiced in Spiti. But, one could also argue that, according to the amchi's understanding presented earlier, the patient's trust could as well 'compensate' for the incompleteness of composition. Replacement of an ingredient seems to be a similar 'solution', however, one that is not very favored, and only slightly preferred to skipping it altogether. But practical matters arising from the social and moral pressures seem to make substitution more of a reality. The following account illustrates this:

One winter day, I see a gallbladder, *mkhris pa*, hung up recently in an amchi's kitchen. I ask the amchi about it, and he says that he will use it for medicine. He explains that the formula for this medicine dictates the use of a *mkhris pa* of a black bear, but it would be very difficult to get this and even if he could, then it would be very expensive. But the *mkhris pa* of a black yak is a good substitute. The animal has to be entirely black, and one has to take just a little more of the yak *mkhris pa* than of that of the black bear. The medicine would then have the same effect, he concludes.

Spiti amchi often find themselves exposed to the expectations and demands of their patients regarding their medications and behavioral or dietary advice (remember Janes' citation at the start of this chapter).<sup>238</sup> Medicine production (and therefore treatment) becomes, thus, a matter of compromise and reduction.

This issue is continued later on in this chapter, but first we need to clarify how religion interacts with medicine.

### *Ritual Empowerment*

In the last section, ritual empowerment as a possible means of balancing a missing ingredient of medicine was mentioned. This indicates that rituals are considered able to increase the efficacy of medicine, as also declared by Amchi Tsering Dorje in the long previous interview. The ethnographic account at the beginning of this chapter further showed the necessity of starting the processing of medicine with a ritual purification. We therefore consider here the religious aspects of the production of medicine, albeit

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<sup>238</sup> Pordié concludes, in the Ladakh context, that expensive raw materials might be substituted by cheaper ones (look-alikes or relatives) because meeting patients without being able to treat them might cause accusations of laziness and undermine their reputation and practice (2002). The moral dimension of this is further examined in Chapter 3.2.1.

shortly, as the next chapter is entirely devoted to the various modes of inclusion of Buddhist and ceremonial practices into amchi medicine.<sup>239</sup>

All Spiti amchi agree that Buddhist religious practices do have a positive stimulating effect on medicines, and even more so in that medicines rituals are definitely necessary, at least for some, in order to empower them. The *Rgyud bzhi* determines the need to purify certain substances and empower certain medicines. However, among Spiti amchi it seems to be not only a theoretical claim but also conviction based on practical experience.

For this analysis, it's necessary to distinguish between the more 'ordinary' practices, like speaking mantras, and the more elaborate practices derived from Tantric Buddhism. How regularly and how many of the different practices are carried out in praxis depends on their complexity, and the individual amchi: his depth of training, his ability, and his conviction. As Pordié explains, "not all *amchi* in Ladakh practise this type of tantric technique, but they all recognize the importance" (2003: 26). Some religious practices we can attribute as 'ordinary', a common routine that an amchi (who regards himself as a serious practitioner) carries out frequently, if not daily. Such 'ordinary' practices include: the recitation of mantras when collecting medicinal materials or making medicine; (textually arranged) prayers invoking deities (Dolma,<sup>240</sup> Sengye Menla) concerned with medical topics; or, the meditation/visualization of the Medicine Buddha (and his emanations) in the early morning (cf. *ibid.*: 24). The respective mantras and ceremonial texts belong to a common reference pool which is either read by the amchi or known by heart.

Other practices of a more specialized knowledge are given from father to son, or from guru to disciple. These practices are more complex and can include ceremonial activities. They are implemented in cases of external treatments, such as moxibustion (Tib. *me btsa*'), diseases caused by spirits or gods,<sup>241</sup> or other special occasions, like the ritual empowerment of *rin chen ril bu*, the precious medicinal pills. Samuel explains, in his study based on the northern Indian Tibetan settlements, that in the layman's perception, *rin chen ril bu* and *byin rten* (sacred substances empowered by lamas or Buddhist deities) "have at least some association with the powerful realm of Buddhist

<sup>239</sup> Also, this theme is naturally closely connected to the rationalization process going on in Men-Tsee-Khang, but we save this as well for the next chapter.

<sup>240</sup> Dolma (Tib *sgrol ma*, Skr. *tārā*) is a female Tantric deity, her white emanation associated with health and healing. For a further, closer examination, see Samuel (2001b).

<sup>241</sup> For more explanations on external treatments and spirit-caused diseases, see Chapter 3.1.3.

Tantric ritual” (1999: 96). This observation is congruent with what Spiti people presented when talking about *rin chen ril bu*. However, although I never noticed anyone producing the precious pills in Spiti, the other two aspects of ceremonial healing did take place while I was there, and are discussed in the next chapter.

The religious practices in Spiti that surround the regular production of medicine and its efficacy belong primarily to the first mentioned group of an ordinary nature. These practices are mainly performed and carried out by the amchi themselves in Spiti. Less common are the elaborate rituals performed by lamas.<sup>242</sup> As mentioned above, not all amchi apply the mantras, prayers, and meditation techniques daily or continuously. But the speaking or murmuring of mantras is supposed to create an especially potent effect on the amchi’s medicine when it is carried out during the collection of plants, the production of medicine, and the interaction with the patient (cf. Pordié 2003: 24f). The more often and steadily they are practiced, the more effect they are supposed to have. Dhonden – a well-respected Tibetan physician – describes that the imagination of the Medicine Buddha, including mantras and “meditative stabilization,” turns “medicine in highly potentialized medicine” (1986: 217).<sup>243</sup> Furthermore, some amchi go into a meditative and ceremonial retreat (*mtshams*) once a year, while others perform it only once a lifetime. This is explained in detail in Chapter 3.1.3, but it should be noted here that it is believed that going through a *mtshams* allows an amchi to receive additional internal and spiritual strength that enables him to increase the efficacy of his medicine.

It has become evident, “that the religious approach of the practitioner is considered in all cases as an additional ingredient in the remedy provided” (Pordié 2003: 26f). Amchi who are religious or consider religion an important aspect of their work consequently carry out prayers and/or meditation every day. Usually, one or two texts are recited in the morning, visualizations of themselves as Sengye Menla are

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<sup>242</sup> Some authors have given examples of special religious practices that are carried out by high lamas and are comparably rare occasions. Samuel, for instance, explains that in the context of life-initiations (Tib. *tshé dbang*), mantras and visualizations of lamas and participants can be “used to ‘empower’ material substances (liquids and medicinal pills)” (2001b: 80). Gerke and Jacobson (1996) add that, “When it comes to processing the raw materials into medicines, specific spiritual practices, such as consecrations through the recitation of mantra, and the admixture of materials carrying the blessings of great saints, are often seen as essential contributions.” The effect of these special treatments on the medicinal materials is a power that intensifies the natural healing capacity of the ingredients and can create further potencies beyond that. The medicine might then not only carry the power to cure the intended disease but to also “protect the body of the patient from harmful influences that can also shorten his life” (Dolma 1990b: 43).

<sup>243</sup> Spiti amchi explain this effect as well. We should keep in mind, however, that Dhonden writes especially for Western audiences and emphasizes the spiritual aspects of Tibetan medicine in order to claim its extraordinariness.

practiced, and offerings are performed in the front altar of the house, *chos khang*. All of these ceremonial acts are considered to have a direct impact on amchi work and intensify the essentially pharmacological potency of a medicine.

*Powder versus Pill – Debating Efficacy*

Continuing in the line of different topics that influence the efficacy of medicines, Amchi Tsering Dorje mentioned in the above interview another matter that is treated as a fact among Spiti-pa: the relation of the place of origin of the medical ingredient to the patient's place of residence. He described at the end of the interview, saying that he and his teacher had observed the properties and effectiveness of a single plant. He explains that a plant species has a general potency, which is then slightly altered according to differing habitats and specific characteristics. In the same way, it is believed in amchi medicine that human beings have different constitutions depending on their place of residence. An individual's body constitution is, among other things, shaped by time (including the time of the day and year, and one's position in the life-cycle) and place (not just the actual place of the exam, but the place of residence and the place of origin/birth). This also gives a local climate a special position among the factors of a disease occurrence. Amchi Tsering Dorje's explanations prove a lively paradigm among Spiti-pa, saying that the medical potency of a plant is most effective if its place of origin corresponds to the living place of the patient, i.e., where he got the disease. From this conviction, Spiti-pa derive the importance of locality for their medical system and its efficacy.

The matter of efficacy and locality are further merged in a discourse over the external appearance of the final medical product. This discourse often takes place among Spiti-pa and refers to the patient's preconceptions about amchi and their medicines, as well as to Men-Tsee-Khang. The issue of the appearance of medicine is not only a matter of preference over the one that looks nicer, but also a medico-political and ideological discourse concerning the difference between medicine powders and pills. This matter has come into being recently because the medical offerings from the plains are, by a majority, pills. To the contrary, most Spiti amchi produce without exception powders, except the two Kaza amchi who prescribe pills bought from Dharamshala. Additionally, the Amchi Clinic in Kaza (set up in 2002) administers pills

as well.<sup>244</sup> The confrontation between the two methods appears frequently when talking with various people. For instance, when I once asked an amchi about the structural changes in Tibetan medicine, he misunderstood my question and applied it instead to the remedies used, insisting that there are no changes: medicines will always be produced according to the scriptures, these formulas cannot be altered. This is a common dogmatic representation about the origin of Tibetan medicine and the medical recipes going back to the Buddha. As I have outlined above, medical formulas in Spiti have probably always been altered to encompass the lack of ingredients and the scarce economical and time resources. Another reason for slightly changing the formulas has been explained as to perfectly reflect the patient's constitution. One amchi pointed this out to me when asked if a medicine is exactly the same when two different amchi process it:

If amchi make medicine by reading the books, then they will use the same quantity of all raw materials. [But,] if an amchi reads [a patient's] pulse, then he knows how to treat the patient properly and which imbalance is the most important to treat. If he makes the medicine, then he will use different [to those prescribed in the scriptures] quantities of the raw materials according to the patient's disease. In the Tibetan medicine [in Dharamshala], they [the exile-Tibetan doctors] use ready-made pills or powders. Therefore a medicine for fever has fifteen ingredients, each raw material in the same quantity [as prescribed]. But, by observing the pulse, an amchi [from Spiti] sets the quantity of raw materials according to the patient's disease. That's the difference, and that's why we don't like the ready-made pills.

This amchi clearly refers to the rationalized, calculating medicine manufacture in Dharamshala, as it is described above. However, instead of analyzing the relation between Spiti amchi and Men-Tsee-Khang here (which instead happens in Chapter 5.2), I am more concerned here with the link between the 'originally prescribed formula' and the 'individually produced medicine.' As indicated, it is not at all common procedure to produce each medicine individually for a particular patient's illness. Though the amchi do so sometimes, they also keep a stock of pre-prepared medicine that is more often

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<sup>244</sup> I leave out further explanations here about the Amchi Clinic (its funding, structure, etc.), because it is thoroughly described in Chapter 5.1 and is not really relevant here.

used for treatment. This quote is thus merely a representation of an idealized state. The amchi emphasizes the individual potency of his treatment to actively differentiate it from the ready-made remedies. The changes in Dharamshala towards the standardization of Tibetan medical formulas and their systematic prescription for standardized diseases are lively in the amchi's image of such medicine. The opposition of freshly-made, individualized medicine versus ready-made medicine is a common debate among amchi. Deriving the supremacy of 'medicine made in Spiti' from this narrow antagonism is, to a large extent, realistically unfounded. The 'individual medicine' is not the rule, and the amchi frequently produce 'ready-made medicine' by themselves – a ready stock if nothing else. Often, this antagonism is expressed figuratively in the competition-like statements of 'powder versus pill.' It can be therefore assumed that this ideological discourse serves a particular end, which we now pursue and examine in the following paragraphs.

Generally, it is stated that the medical scriptures dictate some formulas to be produced in pill form and others in powder, while for most formulas it is not a fixed matter. The reality in Spiti is that most amchi produce almost only powders, and have some ready-made pills bought from Dharamshala. Among the ready-made pills, most amchi possess especially the imported *rin chen ril bu*, mostly because no one else produces them. But most other medicines bought from Dharamshala are also in pill-form, and only very rarely did I see some special medicinal tea powder.

I need to insert here a further brief consideration that concerns the distinction between 'fresh-made' and 'ready-made'. The ethnographical account in the beginning involved an amchi making a medicine for his stock purposes. The practice to pre-fabricate and store is probably nothing new or modern in Spiti. According to the amchi's understanding, a certain habitat, diet, and lifestyle 'produce' a patient's specific and, therefore prevailing, imbalances, health problems, and diseases. Thus, the corresponding region's amchi often keep ready the best remedies to treat these region-specific ailments. This applies not only for Spiti valley, but can also be broken down to each village. It is assumed that on the local level, the prevalence of certain remedies corresponds to the conditions of the place which affects its inhabitants.<sup>245</sup> If we consider

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<sup>245</sup> Climate, diets, living habits, medicinal plants, and diseases underlie a constant alteration throughout history. Nevertheless, the prevalence of these traits changes slowly and they form part of generation-crossing amchi knowledge. A village amchi, thus, usually has a long experience with the effectiveness of certain potencies and the frequency of its needed use for his particular village.

further all the factors that theoretically have an impact on the potency of each ingredient and the complete medicine, it becomes very likely that medicine production has always been a creation of the best possible. It is therefore consistent and pragmatic for an amchi to keep some generalizing potent medicine in stock. ‘Ready-made’ medicine in the sense of pre-fabricated is thus very common among Spiti amchi. But today, ‘ready-made’ medicine is only associated with the pills that come from Men-Tsee-Khang. This is where Spiti-pa draw the difference.

Pertaining to the forceful distinction of ‘powder versus pill,’ the amchi give some simple facts: firstly, medicine in pills can be kept longer in stock. This is an important consideration for a Spiti amchi who might travel only every other year to Dharamshala. On the contrary, powder medicine can only be stored for about a year. Afterwards, it does not have a ‘bad’ quality but its efficacy reduces increasingly as time passes. But, as Spiti amchi only produce medicines in small quantities anyway, the ‘expiration dates’ of the powders are usually not reached. Additionally, because of the small amounts needed, pill production does not really make sense as it is too lavish. Secondly, Spiti-pa see a definite advantage in freshly produced medicine from local ingredients, as explained above. Some further facts of minor importance are stated such as that the elders have said that powder works better and that patients who can watch the amchi making the medicine have more trust in his treatment. However, my inquiries revealed that patients often have personal preferences: some prefer the appearance of powders while others prefer the appearance of pills. The only main unanimous preference is made in regard to *rin chen ril bu*, which nearly everyone expects to have a nice appearance (being wrapped in silk cloth) and produced by Men-Tsee-Khang.<sup>246</sup>

A qualitative difference between powders and pills doesn’t seem to be really crucial in this discourse. Rather, this confrontation is more a vehicle to express the deeper concerns regarding the rationalization of Tibetan medicine taking place in Dharamshala: the local ‘competition’ finds this new dynamic as trying to challenge their amchi medicine status. In Chapter 5, we explore the fact that Spiti amchi have taken on the portrayal of Tibetan medicine consisting of natural herbal remedies (as introduced above). Although they have in fact adopted such methods, this and the next chapter

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<sup>246</sup> The cloth has a simple medical reason: the medicine should not have any contact with light. Nevertheless, the shiny colors of the silk increase the positive image of the *rin chen ril bu* as being blessed as empowered medicine. This package definitely supports a specific image and might even have an effect on the efficacy itself (Moerman 2002).

show that the local medical practice in Spiti contains much more than pure herbalism. Therefore, we can conclude from all this that in the case of amchi medicine, contrary to Tibetan medicine, it is merely a matter of a represented herbalism. This representation serves for the amchi's desired end. Presenting amchi medicine as an herbal medicine enables the amchi to emphasize the locality in several ways: the wealth of the local flora, the knowledge of the local flora, and the local transmission of this knowledge. This is in clear opposition to the supremacy of Men-Tsee-Khang (Chapter 5). The second aim of this 'strategy' is to point out the fundamental dilemma the amchi perceive presently: the need for medicine, which is further outlined in the section after next.

### *One Step Beyond – Visions*

Now that we have completed the discussion on efficacy, modern changes, and the ideologies concerning the practice of medicine, I continue here with observations that first struck me when I came back to Spiti in 2005 for a short visit. I observed a clear break from the past, with new conditions and circumstances regarding the medicine production and supply in Spiti.

About a year after I finished my dissertation fieldwork, I arrived in Spiti again and wanted to meet with Amchi Thupten Thapke, the practitioner of Kaza. On the way to his private house, I saw a new metal sign – “Spiti Board of Amchi Sangh” – pointing the way to the office (see Chapter 2.3). At his house, construction work was taking place to set up a second floor. After welcoming me in, the amchi was keen to start explaining his recent activities. The lower floor of his house, he said, is going to be used by the Amchi Sangh, while his family will live on the upper floor. As we enter the ground floor of the house, Amchi Thupten Thapke proudly shows me his preparation for a second room for the SBAS, besides the office (which had been there since 2003) next door. There were multiple sacks of raw materials he had bought – I estimated more than one hundred kilograms – and masses of different herbs collected from the local hills placed on the floor (figures 22-23). In the middle of the room stood two grinding stones and two hand machines for making medicine pills. About twenty-five big metal boxes lined the wall, most of them full with powder medicine.

I was astonished by the changes that I saw. Just a year before, Amchi Thupten Thapke had expressed to me that for lack of time and facilities, the self-production of medicines in Spiti was not feasible or practical. He had said that the limited number of

medicines produced by most village amchi would not be sufficient in order to properly practice Tibetan medicine. Therefore, he had preferred to buy ready-made pills from Dharamshala for keeping up his stock, as well as for the Amchi Clinic's. Now, everything has changed. Amchi Thupten Thapke explained to me that in 2004, he was able to strengthen his contact with the new Additional Deputy Commissioner (ADC) of Kaza, who is the highest administrative authority of Spiti. This man then supported the idea of a SBAS project Amchi Thupten Thapke had proposed to him. In this way, the SBAS received a special budget from the Ayurvedic Department in Shimla (H.P.) for the purchase of raw materials and for the investment of time and labor. Some amchi belonging to the SBAS then produced dozens of new medicines over the wintertime. However, these were not to be sold in the Amchi Clinic in Kaza but rather benefit the Spiti people. In spring of 2005, they took the new medicine and set up "medical camps" in several villages, mainly the upper ones in the Bhar region. In autumn of 2005, several more visits were planned, resulting in a total of more than ten "medical camps". With these "camps", two amchi from the SBAS (as well as the respective village's amchi) would diagnose and treat villagers for an entire day, moving from village to village. All treatments were given free of cost, provided by the SBAS – though ultimately financially maintained by government resources. Amchi Thupten Thapke summarizes that the campaign was a full success because many patients visited them.

Being able to buy raw materials in this way is something completely new in Spiti.<sup>247</sup> To my knowledge, no one has ever had the resources or support that would have enabled him to do so before. Beyond that, the state funds also enabled the SBAS to buy hand-driven machines to produce pills and even offer payment for the transport, working time, and especially processing time. This amount of funding would have been more than sufficient to significantly enlarge the existing Amchi Clinic stocks of ready-made medicine. But that was not the intended final vision. At first glance, it seems contradictory that the Spiti amchi did not choose to buy ready-made medicine from Dharamshala, which is supposedly the best quality. This choice, one might think, would have been logical in terms of providing good health care to the Spiti people and taking part in the modern developments of Tibetan medicine. However, the amchi's vision was

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<sup>247</sup> This account unfolds with even more depth when put into the larger context of the development of the SBAS, given in Chapter 5. There are also further explanations on the interactions between amchi and government institutions. Concerning the increasing state support reported here, however, I cannot provide an account from the government administration's side because I did not have the opportunity to contact them during my stay in 2005.

molded and influenced by other considerations as well. They wanted to be able to provide the Spiti people with good health care by self-made medicine and not just rely on ready-made medicine. This new financial leeway enabled them to complete intensive plant harvesting tours far into the mountains, which resulted in medicine that is locally regarded as the most effective. The additionally needed raw materials could then be bought in large quantity, resulting in a more than sufficient supply of ingredients. The amchi of the SBAS can now make most of the medicines they want, as well as be able to provide their patients with the best possible quality ingredients. Having such a variety of ingredients now, and being able to process medicines they weren't able to make before, has had a beneficial learning effect on all the amchi involved, whether through first- or second-hand experience. The amchi responsible for this in the SBAS had this positive outcome in mind when choosing in favor of the 'self-made option'. In 2003, Amchi Thupten Thapke told me that he wanted to enable the Spiti amchi by increasing their knowledge and resources to make use of "all ingredients". Now that they possess a sufficient stock of medicine, this must have a positive psychological effect for the amchi involved. I can only imagine the extent of it by the proud shine in Amchi Thupten Thapke's eyes, and through recalling the discomfort which many amchi had earlier presented to me when talking of their limited medical possibilities. I suppose that instead of being slightly embarrassed of those previous limits, that these involved SBAS amchi now enjoy being able to practice from another point of view, and can show off their new proficiency. Vested with medicine, they can help everyone in the upper villages with personal economic sacrifice – what a radical change!

We can imagine that this consolidation of work endows the amchi with a new self-assurance in their practice. Instead of merely waiting anxiously for patients, in this case they can even go out – without being called – to offer medical care. Moreover, in terms of processing techniques, the amounts of medicines, and the type of supplies, this SBAS project is concretely a step beyond anything the state amchi medicine has had before. Though it does not mean a change for every amchi (to have sufficient medicine), but it nevertheless opens up a distinctly local way to herbal medicine. My analysis therefore proceeds directly into the processes of modernization, which is intensively elaborated in Chapter 5, but needs to be brought to a close at this point.

*The Essential Dilemma: An Amchi Needs Medicine*

This extensive chapter is finally drawn to a conclusion by extracting the crucial aspects of medicine. The production and administration of medicine is hardly noticed in modern Tibetan medical literature and is only in certain regards covered by the present anthropological literature on Tibetan medicine (the exception being Pordié 2002). For the first genre, the topic seems to be of no interest to (Western) audiences, as they rely on manufactured medicine. The second genre has, until now, concentrated largely on questions concerning the global pharmaceutical market (Janes 1999b and 2002) and intellectual property rights (Pordié 2004). Contrary to these approaches, a picture drawn of the Spiti amchi's reality has a completely different focus. Self-made medicine is essential for the amchi, and its production is a fundamental part of their work. Amchi Thupten Thapke put it concisely (in an interview already presented in Chapter 2.4): "Actually, what an amchi needs is medicine. Just diagnosing someone does not cure them." From this statement, it can easily be concluded that where there is no medicine, there are also no amchi. The actual medicine is the most work-intensive and resource-consuming part of the amchi's work. Both of these aspects (work/time and resources) are, in modern times, measured in rupees. From this shift emerges the strong emphasis to the need for financial support, which comes especially to the fore in Chapters 4 and 5.

However, the subsequent question here regarded the strong accentuation of herbal medicine by the amchi. Medicinal plants have elsewhere been acknowledged as a carrier of cultural identity because they are an interface of tradition and modernity (Pordié 2002). We have found this endorsed here, in the opposition of ready-made pills from Men-Tsee-Khang. Competition with this institute has cultivated an emphasis on local identity.

Furthermore, the topic of treatment has again stressed the centrality of the mutual understanding of amchi and patient<sup>248</sup> and the patient's trust in the healing process. Spiti-pa point out that as long as a patient trusts the practitioner – who might give him pills or powder, Tibetan or biomedical remedies – the medicine will help cure him, and the more he trusts the amchi, the more effective it will be. Kloos, in his study of the social role of an amchi in Hanu (Ladakh), was led by his informants to the conclusion that "the medicine's efficacy is only determined by the patient's faith"

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<sup>248</sup> The agreement between a physician and patient has been found to generally be a key factor for successful healing (Moerman 2002: 40).

(forthcoming). This thread of the amchi-patient relationship has been continued on from Chapter 2.4, in which I outlined that the amchi are expected to have a “good heart” and be morally indisputable. In this chapter, the other side of the mutual relation came up: the patient’s confidence in the amchi and his medicine. The following chapter now adds to the religious dimension of this, before all the threads are finally taken together and the amchi-patient relationship is fully illuminated in Chapter 3.2.1.

### 3.1.3 Tantric Healing

This third aspect of healing that is introduced and discussed in this section – Tantric healing – has already been touched upon in previous chapters. This suggests that religion and medicine, despite being distinct separate theoretical spheres, share a deeply intertwined interface that values prominently throughout other aspects of amchi practice as well. To further define its importance and meaning for the amchi, I first introduce it theoretically and afterwards turn (with the help of ethnographical material) to some of its aspects that help finally illuminate the issues of its relevance today.

First, I briefly outline some concepts that highlight the theoretical and historical separation of medicine and religion. The overlapping of these two spheres is then broached by an introduction into the variety of practitioners involved in ritual healing. Two ethnographical examples are then presented in order to illustrate how an amchi can be involved in Tantric healing. The religious practices carried out by most amchi, as well as those performed by only a few of them, are afterwards analyzed. This analysis especially includes the *mtshams*, the extensive retreat amchi undergo periodically. Evaluating these practices leads us to the central themes that finalize this chapter in dealing with the amchi and his community, as well as with his status and the question of local identity.

#### Separating Medicine and Religion

From the conceptual point of view regarding Tibetan science (*rig gnas che ba lnga*), religion and medicine are deliberately separated, making them two distinct entities (*nang don rig pa* and *gso ba rig pa*) not to be mixed up (Pordié 2003).<sup>249</sup> The conception of Tibetan medicine, nevertheless, is firmly structured on Mahāyāna

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<sup>249</sup> This was explained historically in Chapter 1.3.

Buddhism, particularly in its philosophical and ethical fundamentals. Religion thereby determines such basic concepts as the five elements, the humors,<sup>250</sup> human mental concepts, and the attitudes recommended for amchi and patients. Regarding one's health, the Buddhist dharma views any suffering (or illness) as ultimately caused by the one of the three mental poisons (Tib. *dug gsum*): desire, hatred, and ignorance. Reversed, this consequently means that illnesses can ultimately be healed through (religious) behavior (cf. Pordié 2003: 20). “Nevertheless, the basic Tibetan ideas about health, illness and fate are not really Buddhist derived. They include a range of concepts [...] all referring to various kinds of energy, vitality, life-force or good fortune, and other range of concepts, such as *drip*, *dön*, *nöpa*, *barch'é* referring to obstacles, spirit-affliction and the like” (Samuel 1999: 90). Conceptions of health and healing thus have a strong local reference additionally grounded in folk religion. We come such across practices corresponding to both religious spheres (that are practically inseparable) throughout the course of this chapter.

When we dealt with religious practices in the previous chapters, we saw that they are rooted in everyday Spiti life as well as the everyday work of the amchi. We have additionally witnessed that religion can be a factor in an amchi's self-preparation – whether annually in *mtshams*, or through daily prayer and worship – in setting a diagnosis and producing medicine. While these previously mentioned public religious aspects seem to form an obvious, visible relationship with medicine, in this chapter I mainly deal with the religious practices that are less observable to outsiders. However, despite their veiled position in regard to outsiders, they constitute an important facet of Spiti amchi medicine. The aspects of amchi practice I refer to here deal with diseases which are spirit-caused, or necessarily need religious practices to be fully treated. Though the *Rgyud bzhi* clearly emphasizes the technical-medical aspects, and not the spiritual side of medicine (Pordié 2003; Samuel 2001a: 262), both of these practices are dealt with in the Four Tantras. They are therefore inherent to Sowa Rigpa – the Tibetan science of healing as composed in the ancient scriptures – and do not constitute something entirely specific to Spiti. Despite the contemporary attempts to pigeonhole Tibetan medicine as an herbal medicine, and its public representation (by Tibetan doctors and amchi) as herbal medicine (see Chapter 3.1.2), amchi often perform religious practices based on the *Rgyud bzhi* as part of their medical work.

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<sup>250</sup> These medical concepts and their religious foundations are outlined in the respective literature on Tibetan medicine referred to at the beginning of Chapter 3.1.

To examine the historical development of the distinct working spheres of medical and religious practitioners, we must look back to the earliest times of Tibetan culture, including a short historical excursion into Tibetan religion. Samuel traces the beginnings of religious practices dealing with spirits and deities back to the risings of a ‘folk religion’<sup>251</sup> in Tibet, associated with shamanic practices<sup>252</sup> (1993: 8). Tibetan people’s dependency on the harsh Himalayan environment and climate is reflected through their close involvement with the gods and goddesses of nature, and especially of the mountains. Cults of such deities were a means to deal with an array of different spirits – perceived of being a minor order, or of lower power than deities – which could take up a negative or even destructive impact on people. Protection from, or the exorcising of spirits could be done by spirit-mediums, who had contact with the deities by traveling through trance to their realms. Later, more elaborate religious practices in the early Bön-religion (see Chapter 1.3) included “techniques of divination and medical diagnosis,” “rituals for placating or overcoming local deities,” “techniques for destroying enemies (i.e., sorcery),” and “funerary rituals” (ibid.: 177). This ‘early Bön’ is clearly distinguished from the Tibetan ‘folk religion’ due to its prominent marker of using mediums. Some cults of both religions continue to have members and still practice today. As Samuel states, referring to Snellgrove (1967), “all Tibetans believe [...] that it is necessary to keep on good terms with the local gods to secure good fortune in the world of everyday life” (1993: 179). It is important to note that in Tibet, the shamanic tradition was not uprooted and eliminated, but rather parts of it were incorporated into clerical Buddhism, as it is well illustrated in the stories of Padmasambhava (Tib. *gu ru rin po che*), who tamed nature and spirits on his way to introduce Buddhism in Tibet. A clear separation of these spheres in the rituals and religious practices of both ‘folk religion’ and clerical Buddhism is not possible (cf. Adams 2002a: 398).

So, for purposes of clarification in the following analysis, it is therefore useful to now briefly introduce Samuel’s scheme of the three orientations<sup>253</sup> of religious activities in Tibetan culture (1993: 5ff). The “*bodhi* orientation,” which is constituted by a small number of outstanding spiritual practitioners who pursue Enlightenment, is reflected in

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<sup>251</sup> For lack of a better phrase, Samuel adopts here the one used by Tucci (1980) and I follow his precedence.

<sup>252</sup> Someone performing shamanic practices enters alternate states of consciousness to get in contact with the realm of spirits and deities with the intent to make changes in the human sphere (ibid.).

<sup>253</sup> This term nicely describes the openness and non-conformity of the three parts.

the overall aim of Vajrayāna Buddhism. Practices of the “*karma* orientation” are mainly performed by the monastic order that equates past and future lives and the according rite de passages as the basic principle in Buddhism, being the law of cause and effect (Skr. *karma*). The third field of religious activities – “*pragmatic orientation*” – contains the broad spectrum of interactions with gods and spirits aimed at the “realm of this-worldly concerns” (basically, health and prosperity) conducted mainly by laymen practitioners.<sup>254</sup> Every level includes shamanic practices. According to this scheme, we can now later more easily categorize the various practitioners involved in healing.

#### *A Pluralism of Religious Practitioners*

Keeping these general remarks in mind, we now explore the variety of practitioners involved in ritual healing. We turn back briefly, therefore, to medicine and its historical development. In pre-Buddhist times, the medical and religious spheres were not separated. However, with the introduction of Buddhism in Tibet it seems that a division of specialization for spiritual or ritual healing and for “pragmatic” (Samuel 2001a: 262) or “technical” (Pordié 2002 and 2003) healing increasingly opened up. The distinction among such practices was deepened when Sowa Rigpa, as a practice of technical medicine (amchi), became a taught profession in institutionalized settings and then intensified throughout the centuries (see Chapter 1.3). The move to develop distinct religious and medical horizons was favored by medical practitioners as well as by the Tibetan government, which had successively aimed at a rationalizing modernization of medicine in the medical institutions. Medicine, therefore, developed as “a lay rather than a monastic profession” (Samuel 1999: 89). Its rationalization was further consolidated in the beginning of the twentieth century by emulating the British health care standards (Samuel 2001a: 262). While this had particular implications for the medical practice of the professional elite in the centers, it certainly also influenced the non-institutional, usually rural, practitioners as well. Probably, these changes were more noticeable the closer one got to the institutions in central and eastern Tibet (cf. Samuel 1993). While the ‘rationalization’ of Tibetan medicine is further elaborated in Chapter 5, I introduce briefly in the upcoming paragraphs the various practitioners engaged in any kind of healing techniques. Here, we can conclude that healing techniques in Tibet

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<sup>254</sup> Samuel notes that Tantric teachers (in Tibet also called lama, see Chapter 1.1) are considered to be the foremost of these practitioners. The lay community looks to them for religious performances in the pragmatic orientation (Samuel 1993: 31).

were practiced over the last centuries in both institutionalized (usually urban or geographically central) and non-institutionalized (usually rural) settings, and that the technical medicine was rather carried out by lay practitioners, while religious healing was mainly practiced by religious practitioners, both monastic and lay.

Let us turn now to observations concerning the practitioners in the field of religious healing. In Tibetan culture, the Buddhist clergy holds the authority over the dharma. This means that monks are the most sophisticated religious practitioners, and therefore the ones who conduct the most elaborate rituals, including those which are done for curing purposes or empowering medicine. In their rituals, shamanic influences of the pre-Buddhist period are combined with Tantric practices.<sup>255</sup> Besides these monks, there are additional religious specialists whose practices are incorporated into the Buddhist realm as well, though it is strongly derived from the Tibetan ‘folk religion’. Concerning Samuel’s categorization, they belong to the sphere of ‘*pragmatic orientation*’, though they can also belong to the laity or the monastic order. These are the spirit-mediums or, as they have often been called by scholars, oracles (Tib. *lha ba* or *lha mo*<sup>256</sup>), who conduct their services mainly in villages.<sup>257</sup> These mediums, their spirit-afflictions, and their trances (their distinguishing feature) have been the frequent subject of research (Berglie 1977, 1992; Crook 1998; Day 1990; Kalweit and Schenk 1995; Melches 1997; Schenk 1990, 1993, 1994; Schüttler 1971; Yamada 1993<sup>258</sup>). Concerning their role in healing, the *lha ba/lha mo* are usually asked for by patients if an amchi has requested he or she do so, or if former treatments have not had a satisfying effect. The health problems then often have extra-human causes, which have to be first diagnosed exactly. To find out who or what caused the disease, the medium goes consciously into trance and enters the supra-human realm of the gods. Answers concerning the cause of the illness are gained from the gods, spoken in unknown

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<sup>255</sup> Samuel explains that Tibet never had a strong political centralization, which is responsible for the fact that Tibetan monasticism is more shamanic compared to the Buddhist clergy in other societies (1993: 550f).

<sup>256</sup> The word *lha* is, especially in lay Tibetan terminology, quite blurred, meaning mainly god or spirit, but, according to Samuel, has to be further subdivided into local gods, heavenly gods and Tantric gods (1993: 165ff). The suffix *-ba* marks the male respectively, and *-mo* the female practitioner, engaged with those gods.

<sup>257</sup> Mediums often do not belong to the monastic order, though they might be associated with a particular monastery and taught by their monks. Monks usually do not fall into trance, as we can also collaborate from Samuel’s scheme. But there are exceptions (called *sung ma* or *chos skyong*), as for instance the ‘Nechung-oracle,’ who is the spirit-medium of the Nechung monastery and the so-called “state oracle,” who gives advice to the Dalai Lamas (Nebesky-Wojkowitz 1948, 1956; Prince Peter 1978).

<sup>258</sup> The works are of extremely varying quality.

dialects. From thereon out, the *lha ba/lha mo* is able to give advice as to how the problem can be solved, for instance, by religious activities by the patients.<sup>259</sup> Often, the medium also takes steps to cure the patient by asking the spirit or god (who attacked the patient in the first place) to leave, or even tries to drive it out, sucking the cause out of the patient's body.<sup>260</sup>

Finally, astrologers (in Tibetan called *rtsis pa*) are also involved in the healing. In Spiti they are called chowa (Chapter 2.1), though Spiti-pa who translate the word and their work into an English equivalent usually refer to them as "Tantric". This shows that their way of working and their descent from a lineage are considered to be mystical and ritualistic. They are consulted for various reasons, providing answers and/or solutions to questions or problems that touch or lie outside the visible or human sphere. With the help of astrological scriptures and a *mālā*, they find the best beneficial dates for marriages and certain ceremonies. By divination (Tib. *mo*), they give answers to psychological or practical problems, or problems that might be caused by spirits or gods and then advice (often religious acts) on how to deal with it. Furthermore, they are also called for ceremonies that clean the human environment or protect people from various influences, such as spirits, gods and other harmful energies. Chowa or lamas who work with Tantric practices and mantra are said to cure by "*tana-mana*" (cf. Dietrich 1998: 29).

Healing is, thus, a pluralistic field in which not only practitioners with a technical-medical approach – amchi – are involved, but also various practitioners with a more spiritual approach – lama, *lha ba/lha mo*, or chowa. Presumably, all the variously specialized practitioners form a "contested site for both meaning and agency," in the field of ritual healing, as Gutschow declares for the same context in Zangskar (forthcoming).<sup>261</sup>

After having declared and examined the pluralism of healers, we continue now analyzing their work, especially the rituals performed by the amchi. I start here from a conceptual point of view and then carry on with practical observations. According to

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<sup>259</sup> These can vary from the hanging up of *rlung rta*, to individual *pūjā*, or ceremonies carried out by chowa or lamas.

<sup>260</sup> All these possibilities are described at length in the respective literature.

<sup>261</sup> This is in contrast to the monopoly the amchi hold in the technical-medical sphere, but does not contest the amchi's monopolistic position. Connor et al. have assumed that in ethnic Tibetan communities (including Spiti), mediums and oracles are more popular than amchi (1996: 115). From my fieldwork alone, I negate this estimation regarding Spiti.

Samuel's above presented schematization, the working field of ritual practitioners is the "*pragmatic*" sphere of "this-worldly concerns" dealing with local gods and spirits. Tom Dummer differentiates between four sets of practices in this field: 1) mantra and ceremonial rites, 2) burning incense, 3) exorcism, and 4) dharma teaching (1998: 103). In the course of this chapter, two of these categories are the objects of investigation (the first and third), as these are the practices I was able to observe among amchi.

As mentioned before, in Tibet 'pragmatic' medical practice is separated from religion. Consequently, amchi are not considered religious specialists. Samuel's 'double' terminology of "*pragmatic* medical practice" and "*pragmatic* religious activities" is in this sense no coincidence but rather specifically indicates an intersection of the spheres. At least in Spiti, a sharp distinction between the two working spheres does not exist in the practical reality. Samuel's categorization can, thus, only be understood as a working tool, as we see in later examples as well.

Concerning amchi, I noted earlier that the religious practice of various amchi is quite heterogeneous. Some amchi do not consider them very useful and rather not use them; some irregularly pray concerning their medical work; while others practice religious acts every day. However, some Spiti amchi are (mostly through family transmission – *rgyud-pa*) versed in the religious activities of the '*pragmatic* orientation'. Depending on the elaborateness of their capabilities, these few can be considered as specialists for ritual healing as well. Patients, therefore, also have the opportunity to choose one of these particular amchi if they are seeking help in the field of ritual healing.

How does such a healing process usually proceed? The work of a religious specialist either takes place instead of, or very often before, the main (technical) amchi work. Imagine a case where a patient has come to the conclusion that his illness has an extra-human cause because no one could help him, or because an amchi told him so by taking his pulse. Often, the amchi can find out that a spirit or god is the cause but can't say which one exactly. Well-versed religious specialists can then narrow down and specify the diagnosis. The collaboration with the patient then always involves some sort of small religious activities, in addition to trying to eliminate the root cause of the illness or instructing the patient the way to help eliminate this cause (for instance, a visit to a particular healer). Therefore, the religious specialists with their different aids are mainly concerned with diagnosis in the farthest sense, i.e. detecting the root cause of an illness, and eliminating this cause. Only afterwards can an amchi go on to give

treatment for an eventual secondary problem, maybe headache, fever, or pain. Often these ‘secondary’ problems are the reason why the patient originally consulted the amchi.

Collaboration between the different specialists comes into play if there is a case which is external of the purely medical sphere and cannot be entirely solved by technical-medical means (cf. Gutschow forthcoming). Amchi Chullim – who is an amchi and a chowa (see Chapter 2.1) – is especially knowledgeable at providing information on this intersection and attachment between the religious and medical practice spheres. In a related interview he says:

FB: How is the relation between your chowa and your amchi work?

C: The chowa treats with mantra, and giving medicine is the amchi’s work. If someone has an evil spirit then what could an amchi do? With only medicine, the evil spirit will not leave. [...] A bad sight can be treated only by lama or chowa. [...] In the cases of evil spirits or bad sights, a chowa will do [the treatment] and when they have left, then an amchi will give medicine for the symptoms and disease and the patient will be cured.

FB: Some amchi say that they can recognize a bad sight by pulse reading...?

C: Yes, we can recognize that. The [pulse] beat is different. Then we identify it and will tell you that you have some *gnod pa*,<sup>262</sup> and ask a lama [for help], because the medicine cannot have an effect until the evil spirit has left.

FB: What other causes of diseases does a chowa have to treat?

C: Mostly, chowa and lama have to treat those causes, like evil spirits and bad sights. Diseases are only treated by medicines. [...]

FB: Earlier we talked about diseases caused by former lives...?

C: These are also treated by chowa and lama. Our *dpe cha* mention four hundred and four diseases: one hundred and one are called *sngon nad*, which chowa and lama can try to cure with a *ser khyim*.<sup>263</sup> [...] Another one hundred and one are *thal nad*, which can be cured by itself. If you take

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<sup>262</sup> *Gnod pa* seems to be a term only used in Spiti, as I could not find it anywhere else in the literature. The word *gnod* means harm, injury, evil. *Gnod pa* is therefore something that causes harm. According to Drungtso (1999) and the Nitartha dictionary (2005), *gnod sbyin* are the *yakṣas* or mountain spirits. Several of my informants used the term *gnod pa* in a more broad sense, as the above direct translation suggests, saying that it can come from another person or *gshin 'dre* (see below).

<sup>263</sup> A *ser khyim* is a Tantric ceremony to persuade gods.

medicine it will be cured faster, if not, it will still go away. A further one hundred and one are called *gdon nad*, which cannot be cured without lama and chowa. The final one hundred and one are the *yongs grub tshe nad* which can be cured by the amchi.<sup>264</sup>

Amchi Chullim makes an effort here to neatly split up the treatment spheres of amchi and those of other practitioners. In his last answer, he presents the list of disease categories in Tibetan medicine (see Chapter 3.1.1) and the respective specialists for each category. Amchi Chullim remains here on the theoretical level of the theme, nicely showing differences and overlapped areas. Keeping this as an illustration of the theoretical ideas, I now come to the actual practice of religious healing in Spiti.

While the techniques of the religious practitioners are described for many cases (see above), the religious part of the amchi's work – despite its theoretical representation – has not been considered much until now. Pordié (2003) presents an excellent study on *The Expression of Religion in Tibetan Medicine* that focuses especially on the political use of religion in the medical sphere in Ladakh. Therefore, I frequently refer to this study later on. However, the Tantric healing practices I am interested in here are not part of Pordié's investigation. Only Kim Gutschow has presented corresponding observations and analyses where a parallel to my own examinations can be drawn. Gutschow offers two studies on *rlung* disorder in Zangskar (1997, forthcoming) that examine, in detail, the various diagnosis forms and (religious) treatments by different religious and medical practitioners.<sup>265</sup> In her later study, Gutschow emphasizes that although several amchi are indeed competent and able to carry out certain religious practices, they still rely on the help of ritual specialists to give a complete treatment. She thereby supports the differentiation of the religious and medical spheres, which is referred to later on in my discussion. The following

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<sup>264</sup> Amchi Chullim gives here a typical illness classification, which is identical or close to the classification given in Chapter 3.1.1: The first category of *sngon nad* (Tib. *gzhan dbang sngon nad*) is caused by karma of former lives, which might not be curable, but sometimes is tried to cure by a *pūjā*. The second category, which Amchi Chullim called *thal nad*, is that of the minor diseases. The *gdon nad* (Tib. *kun brtags gdon nad*) are diseases caused by spirits which require a *pūjā* performance. The final category – *yongs grub tshe nad* – are of this life and can be cured by the correct treatment.

<sup>265</sup> The study of *rlung* disorders is quite prominent, especially in the context of suffering from suppression in Tibet (Janes 1999a; Adams 2002a). However, these studies focus on embodied distress in clinical settings that seem to clearly differ in terms of therapy from the observations in Zangskar and Spiti. It remains that in contrast to those studies (Gutschow, Janes, Adams), I have not focused on *rlung* diseases during my fieldwork but rather apply my observations here for means of clarification in the distinction of religion and medicine and secondly for the clarification of socio-political issues of status and identity.

ethnography, however, sheds additional light on the above presented theoretical accounts and looks deeper into the matter of socio-political relevance of religious practices for the Spiti amchi.

In the section below, after giving two ethnographical examples, I further extend the previous analysis of this aspect of amchi medicine to discuss the argument of differentiation and explain the special position of religious practices in the constitution of Spiti amchi identity.

### *Mental Illness and Evil Spirits*

One autumn day, Amchi Tenzin Tashi<sup>266</sup> took us for a walk to a neighboring village. He had already been talking for some days about a relative whom he has been called to, and he wanted us to join him, although he had not shared with us the particular medical problem. The amchi had to postpone the visit several times, but today he is free to make the trip. When we reach the village, we go over to one of the houses near the stream. A tiny room downstairs serves as kitchen and living room, with the main space being occupied by a bed in which the patient was lying. When we greet him and sit down next to the oven, he looks a little distraught. Now, in the late morning, the oven is cold and Amchi Tenzin Tashi immediately lights it again. The patient's wife, a relative from the amchi's mother's side, comes in, and the two talk while she makes *chāy* and serves us some eggs. The wife explains that they had wanted to call Amchi Tenzin Tashi two weeks ago, but they knew that because of the harvest the amchi was very busy at that time. The amchi, nevertheless, became informed of the patient's problems which, although not acute, had been ongoing since the summer. Amchi Tenzin Tashi explains that the man is "half-mind" [e], meaning he has some mental disturbances. His symptoms include not understanding correctly what people are talking about, and then thinking that they are talking poorly of him. He turns everything negative and has become quite depressed. He doesn't have control over his feelings and thinks about jumping into the river or hanging himself. Sometimes, when he feels quite well, his thoughts tell him that he is too weak and that he should eat a lot. Then he will eat up to ten bowls of *thug pa*. But at other times he does not eat at all. Because of these dietary habits, he believes himself to be physically ill and is scared that he is going to die.

One day, a few weeks before our visit, an old amchi from another part of Spiti came and visited him on his way through the village. As he is one of the most respected

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<sup>266</sup> This amchi's name has been anonymized.

and well-known amchi of Spiti, the family naturally asked him to visit and take a look at the patient. The amchi diagnosed him by pulse reading and found his body to be healthy, but that the root cause of the mental problems is a *gshin 'dre*, an evil spirit, or more exactly, a wandering dead soul. The amchi saw the seriousness of this problem and stayed at the house for two days. He conducted one day of *pūjā*,<sup>267</sup> and the next day a fire treatment called *rdo me* (lit. stone-fire). This treatment contains a *pūjā* and mantra murmuring and the heating of the top of a copper or iron instrument, the top being less than a centimeter in diameter. The red-hot end is put on certain points of the body, according to the respective problem to be solved. In this case, the patient shows us the mark on his chest, a little to the left of his sternum, just where one could imagine the heart beneath. The wife tells us that the old amchi is supposed to come again and do a second treatment on his back as well. Amchi Tenzin Tashi explains that the fire treatment was done exactly at that spot because it should “control the heart”, thereby controlling his feelings.

The day that we visit him the patient looks quite weak, his body lean and skinny. He timidly watches us, his eyes looking disturbed and a little scared. I think that it could be because a foreigner has just come in and sat next to his bed, but Amchi Tenzin Tashi has deliberately brought me with him and seems to know what he is doing. Instead, I realize that the man's look is probably an expression of his problem, his insecurity of what people must think about him. His wife explains that the fire treatment has helped a lot and that he feels much better now and has even starting eating again. But for now, he does not talk a lot and stays in bed the whole time. Still, he is able to answer all the amchi's questions and give short comments. While we eat the eggs, he eats two cups of *thug pa*. Afterwards, Amchi Tenzin Tashi sits down at the end of the patient's bed and takes his pulse. He confirms that the man is completely physically healthy, reassuring him of this fact. The amchi then gives him some medicine which he has brought with him, which is supposed to have two effects: if he feels like not eating when he should, the medicine will make him feel hungry and eat more. In addition, if he eats too much or has digestion difficulties, the medicine will then help in digesting and controlling these urges. When taking the medicine, he should also do some “*mane*”, which is the abbreviation for continually repeating the mantra “*oṃ maṇi padme hūṃ*”. Amchi Tenzin Tashi suggests that he should also repeat this mantra when he feels alone, or if

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<sup>267</sup> In a later interview, the amchi called this *pūjā* a *ser khyim* (see above).

difficult thoughts come to his mind. He explains to the patient that because the former treatment had a positive effect on him, the first amchi would suit him better as his treating amchi. It would be a very good continued treatment if the same amchi comes again to do the second fire treatment. In fact, Amchi Tenzin Tashi will ask him to visit again as soon as he can. But, in the event he cannot come, Amchi Tenzin Tashi can do this treatment as well, and they should not hesitate to call for him. The amchi continues to sit by the patient's side while talking to him about other things. He assures him not to worry about his daughter's time at school, and not to worry about various other things. Again and again, he directly addresses the patient and tries to surround him with a positive atmosphere. He looks openly into his eyes, and all of his gestures are meant to make the patient more comfortable. Often, he is also touching his knee. At the beginning of our visit, the amchi talked exclusively with the woman, but now he is fully concentrated on the patient. This habit is definitely an exceptional case because Amchi Tenzin Tashi, as well as most of his colleagues, is usually not intimate with his patients. Amchi address them but rarely do so as intensively as Amch Tenzin Tashi does now, and they almost never touch them except for the diagnosis. In this case, it seems that he is focused on giving the patient some relief from his mental tensions.

Without going into any kind of narrative on the illness itself, the clinical picture, or pathology analysis, it should be briefly pointed out here what made the use of mantra and *pūjā* necessary. This patient was diagnosed by both amchi as physically healthy but suffering from depression, suicidal tendencies, and food irregularities.<sup>268</sup> Amchi Tenzin Tashi summarizes these problems as not being able to control his feelings. According to Tibetan concepts of the body, emotions are closely related to the consciousness, whose main seat lies in the heart. The root cause of this illness then sits in the heart, but is not of a human-physical nature. It is traced back by the old amchi to a separate entity, a *gshin 'dre*.<sup>269</sup> Dead souls that have not been able to pass through the *bar do* – the

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<sup>268</sup> In the Tibetan medical conception, body and mind constitute no dualism, but the psyche and body are an interconnected continuum (cf. Adams 2002a: 396; Dummer 1998: 87; also Gutschow forthcoming). Nevertheless, the amchi explains the problem here with these terms.

<sup>269</sup> According to Tibetan medicine, most psychological instabilities and mental diseases are disturbances of *rlung* (wind), one of the three humors. The *srog rlung*, life-wind, is, in its subtle form, the main carrier of the consciousness and has its seat in the heart, or, in Tantra, the heart-chakra (cf. Adams 2002a: 396; Clifford 1986: 175ff; Janes 1999a: 394f; Rapgay 1985: 20). Emotions and demons or spirits (Tib. *gdon*, see below) use the same channels to get to the heart and influence the consciousness (Tib. *rnam shes*). If the consciousness is besieged, then mental disturbances are the consequences. The five causes that can be responsible for such mental diseases: *karma*, negative emotion (like worry or

intermediate state after death and before the next life – roam around in that *bar do* realm and are able to interfere with the living until their next rebirth.<sup>270</sup> A *gshin 'dre* is such a wandering soul with a negative impact on people. It belongs to the class of evil spirits, the *gdon*<sup>271</sup> (H. *bhūt pret*<sup>272</sup>).

Having caused offense to the gods is thought of as a kind of pollution, *drib* [Tib. *sgrib*]. *Drib* is the prime cause of misfortune in everyday life, and has to be remedied by appropriate ritual action to the gods. In addition, *drib* makes the individual vulnerable to attack by malevolent spirits of various kinds. Some degree of *drib* is almost unavoidable in everyday life and the attacks of offended deities and of malevolent spirits have to be ritually combated on a regular basis. (Samuel 1993: 161).

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grief), humoral imbalances, poison, or spirits. These factors can also come together, as it is, for instance, the weakness of a human body that allows a spirit to enter it. However, spirits are classically considered the main causes for mental illness, and therefore it is comprehensible that the classification of spirits corresponds partly to the classification of mental illnesses. In this way, it makes sense that five chapters of the *Rgyud bzhi* deal exceptionally with the various spirits (Clifford 1986: 175-197). For a much deeper analysis of *rlung*, read the excellent studies done on *rlung* imbalances and their present socio-political causation in the context of Tibetan oppression in China by Adams (on the embodiment of political distress, 2002a) and Janes (on the cultural conceptualizations of *rlung* disorders, 1999a).

<sup>270</sup> The concept of a soul in a Western understanding, as brought up with Christianity, does strictly not exist in the Buddhist ideology (especially that of the Madhyamaka school). As nothing has an inherent existence and everything is ultimately *śūnya* (empty), there can be accordingly no self-conceptualization. The question of reincarnation and human rebirth is solved by a series of phenomena that move, caused by conditional origin, from existence to existence without being bound to any self (cf. Bechert and Gombrich 1989: 49). Nevertheless, the general understanding – maybe also following the pre-Buddhist ‘folk religion’ belief system – postulates that from the everyday experience of rebirth, a human soul can be reborn or get stuck in the *bar do*.

<sup>271</sup> The generic term and category for all evil spirits in Tibetan is *gdon*, which actually means forces or creatures that radiate negative effects. It is translated as demon or spirit, and Spiti-pa sometimes acknowledge a *gdon* as a deity, as well. They emerge according to the philosophical level of Buddhist doctrine from the three illusions or poisons (Chapter 1.3), and could be therefore called “embodied emotional affect or projections,” (according to Gutschow, forthcoming). While this view regards *gdon* more as a force or energy, most view them as real existing entities. Such spirits are classified into three groups: one of the higher realms; one of the lower realms, the serpent spirits (Skr. *nāga*, Tib. *klu'i gdon*); and the last of the middle realm of our world. Furthermore, they can be divided into eighteen great *gdon* (Tib. *gdon chen*) and countless minor *gdon* (Tib. *gdon phran*). The spirits have differing qualities, such as *rgyal po* (the king spirit), *btsan* (spirit living in rocks, ghosts of hunting, as well), *bdud* (Mara, god of hell, as Spiti-pa call it). Clifford states that the *rgyal po* is the most often occurring cause for mental illnesses (1986: 207). As introduced earlier, in Tibetan medicine, there exists the category for one hundred and one diseases which are caused by evil spirits (Tib. *kun brtags gdon nad*, cf. Yamada 1993: 216). They can be (theoretically) diagnosed by the amchi, following a particular behavior and appearance in the patient, through questioning and a special pulse (Tib. *gdon rtsa*). Read Clifford 1984 and 1986 for a detailed introduction into this matter.

<sup>272</sup> Spiti-pa used *bhūt pret* as the Hindi equivalent to *gdon*. It is a literal doubling, as *bhūt* itself has the meaning of (evil) spirit and *pret* is also an evil spirit, but with a connotation of a spirit from someone who died. In Newar Tantrism, *bhūt-pret* is a restless spirit of someone who died an unnatural or violent death, and these are very frequently sighted (Dietrich 1998: 45f).

Spiti people are concerned by *sgrib* in everyday life. Preservation and treatment of “attacks” are a frequent activity. A confrontation with evil spirits or bad sights can have many different forms. The ‘bad sight’ – in Spiti mostly called by the Hindi words *burī nazar* – is a second category of disease-causing agents beside the *gdon*. A *burī nazar* is sent by someone or something for reasons of envy, revenge, a quarrel, or the like.<sup>273</sup> This concept could derive from folk beliefs or might even be induced from Hindu conceptions.<sup>274</sup> A very prominent agent in causing a bad sight is what the Spiti-pa call “one’s own god”, who is the deity of the household (see Chapter 1.1). Especially larger houses with a long tradition have special shrines or prayer rooms in which a particular deity is daily worshipped. If this ceremony missed, it can have immediate negative consequences for the household members. However, the effectiveness, diagnosis, and exorcism of both a bad sight and an evil spirit are the same. If a *gdon* or *burī nazar* enters someone, it always takes the ‘port,’ which a person’s most vulnerable point. Depending on one’s karma and personal constitution, this can be very different points. Accordingly, the secondary set of symptoms will then develop. One particular patient might have back pain, while another might get a fever. In the above reported particular case I witnessed with Amchi Tenzin Tashi, the *gshin ’dre* had disturbed the heart function of the patient and so he was not able to regulate his emotions anymore. The spirit made him lose control over himself, causing depression and suicidal tendencies.

To diagnose exactly which evil spirit or deity is responsible for an illness is not an easy task, but crucial for the counter-ritual. The forms of diagnosis carried out by the amchi are, as usual, mainly the visual and verbal examination and the pulse diagnosis. Besides a visual observation of conspicuous behavior, the reading of the pulse is given a high priority.<sup>275</sup> Amchi Tenzin Tashi later tells me that he is only able to figure out if it

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<sup>273</sup> The study of Kapferer (1997) about sorcery among Sinhalese Buddhists serves as an interesting comparison here. In that context, he states that talk and thought can cause harm, and therefore can be considered sorcery (ibid.: 38). Though ‘sorcery’ is not a concept I have heard of in Spiti, a person might be able to direct negative energy – ‘a bad sight’ – against someone else and a ritual is needed to exorcise it. In Zangskar, Gutschow (forthcoming) calls this phenomena “witchcraft” and states that the witch is usually a woman. Witches and demons would often be considered to be acting “involuntarily or unintentionally.”

<sup>274</sup> Such a Hindu import seems to be unlikely, regarding the fact that very few such explicitly Hinduist concepts are found in the Spiti religion, but the frequent usage of the Hindi terminology could give rise to this assumption.

<sup>275</sup> The priority of pulse diagnosis seems to contradict Samuel’s observations when he stated that *gdon* “are generally diagnosed through the nature of affliction. Not through pulse or urine [...]” (2001a: 260). Gutschow (forthcoming) mentions that the Zangskari amchi emphasize the verbal questioning of the patient’s family and personal relations as well, in order to get a clear picture of the social background.

is a *gdon*, and if so, whether it is a great or a minor one. His father taught him this diagnosis of *gdon*, with some mantra and *pūjā* also learned for treatment. Only amchi with very good training and experience are able to exactly determine which spirit is causing the illness. Generally, amchi have to send such a patient to a *lha ba/lha mo* or *chowa* for exact specification. Another amchi explains this type of situation:

An amchi does not know how to do the *mo*, he finds out by reading the pulse, and even then he can only say if it is a *gdon* or a *gnod pa*, [either] from the *dgon-pa*,<sup>276</sup> or a *gnod pa* from the *rgyal po* or a *gnod pa* from *gshin 'dre* [...]. If an amchi does know [how to treat it] then he will do it himself, but if he does not know it, he will call a Tantric.

In the above described case I had attended, the (first) old amchi had given the exact diagnosis. He stems from a family with a rich religious tradition and is well-versed in medical and ritual work, and could therefore, according to Samuel, be called a *ser khyim pa* (1993: 259, 289). Amchi Tenzin Tashi relied on his knowledge and experience, knowing that he is one of the few Spiti amchi who are able to make this kind of diagnosis.

Medicines have no influence on diseases caused by evil spirits, besides helping only with any secondary problems the attack of the evil spirit has caused, and only after primary religious treatment has been completed.<sup>277</sup> Amchi Tenzin Tashi was only able to give the patient some medicine to help support his digestive function. But with a *gshin 'dre*, one must deal with it differently. The old amchi had conducted a spiritual act in combination with a physical treatment. Both of which being Tantric medicine require a specially trained and experienced amchi. The *ser khyim* was intended to pacify the *gshin 'dre* and make him stop having this negative impact on the patient. The fire treatment, *rdo me*, accompanied by further rituals, was meant to have a beneficial

<sup>276</sup> A very common pattern of mutual negotiation exists for Spiti-pa in relation to the *dgon-pa* of their place of birth and/or to which their family (lineage) belongs. At least once a year, offerings should be brought there and prayers completed. If someone offends the *dgon-pa* by missing this worship, and therefore renewing the relationship, then an evil spirit or bad sight of the *dgon-pa* might bother a family member to remind them of the duty (cf. Crook 1998: 35). This amchi explains: "If I have done a good *pūjā* to the *dgon-pa* today but do not do it in general, or this year I have done one but the next year I don't do one, then the *dgon-pa* might give a *gnod pa*. Why? In order to make us realize the Buddhist dharma."

<sup>277</sup> A *rlung* imbalance can have varying causes and, if not caused by a spirit or god, can be treated with medication and sometimes moxibustion. Janes also notes that a *rlung* illness is treated as any other disease, but he does not report on spirit-caused diseases (1999a: 395). In the understanding of the Spiti amchi, when there is a *gdon*, one has to proceed by firstly exorcizing the *gdon* and then treating the humoral imbalance with medicine.

physical impact on the heart.<sup>278</sup> As Amchi Tenzin Tashi formulated, it should “control the heart” and give the patient back his ability to regulate his feelings. As there are considerably less ‘violent’ methods of exorcism – such as the releasing by effigies (Tib. *glud*), *pūjā*, or the thread-cross ritual (Tib. *mdos*) – with which spirits and deities can be satisfied (Clifford 1986: 218), it can be assumed that this patient was considered to be very seriously ill. Only the strongest Tantric therapies were thought to be helpful. The first set of treatments was successful in that the patient felt better, as his wife claims. Seemingly, the treatment suited the patient well, as did the amchi who conducted the treatment, whose relationship to the patient, as noted earlier, is of great importance for the cure. A continuation of the treatment with the same treating practitioner would have been most appropriate, but the latter might not have been possible for various individual and infrastructural reasons. Therefore, Amchi Tenzin Tashi offered his help, though he is not able to diagnose the *gshin ’dre*. Nevertheless, he would be able to conduct the ceremony needed to do the *rdo me* if necessary.

#### The Musician’s Illness

To extend the analysis towards the various uses and special importance of mantra, collectivity, and identity, I give here a second ethnographical example that sheds light on the link between religion and the community.

One winter morning, Amchi Tsering Dorje called me to come to visit a patient in a musician’s household in Kibber. As explained in Chapter 1.1, the persons belonging to the *beda rigs* are, in average, rather poor and hold the lowest status among the Spiti people. The hierarchical organization of the local society is not only a historical fact but is constituted by the daily reality. Especially in autumn and wintertime, several occasions can be observed that confirm the musician’s separation from the rest of the society. In this village, however, quite a number of families<sup>279</sup> are also musicians, and together, they exclusively form the lower class. Besides their specific task to call the

<sup>278</sup> This kind of treatment uses a hot iron and in Tibetan medicine is subsumed under moxibustion as part of the external therapies. Moxibustion is used to burn certain points that have a negative effect on spirits and *rlung* illnesses (cf. Drungtso 2004: 468; Dummer 1998: 101ff; Meyer 1995b: 138). Clifford notes that this practice is a Mongolian derivative (1986: 86). ‘Burning’ is considered one of the advanced possibilities among the stages of treatment. The first ‘gentle’ stages are the lighting of incense and giving of medicine; the next step is more ‘coarse’ and includes venesection and moxibustion. Cauterization and surgery represent the last and most ‘violent’ stages of the healing methods.

<sup>279</sup> In this village, more than ten families are counted as *beda* though not all are able to play music. Among a total of eighty households, this ratio is high as compared to other villages where there are only one or two such families.

village together for religious activities with their drums,<sup>280</sup> they also play music<sup>281</sup> at several occasions, such as weddings and rituals. While they do play a vital role in these activities, thus positioned for example, quite centrally during a wedding, this is an exception, and they are normally treated completely different, as for instance during the rituals in a household. Although they are necessarily needed for the ritual itself, the musicians are then placed off to the side and near the entrance. They receive food and beverages, but afterwards their cups are generally not used anymore.<sup>282</sup> A very obvious reason for their low standing and ambiguous position is their participation in slaughtering the animals. From October onwards, sheep and goat are needed for all the different festivities. In December, the people will then collect their stock of yak and *mdzo* meat to last for the winter. In former times, there wasn't much food variety, and meat was a staple item in Spiti, so it continues today to be the most preferred food of Spiti-pa. In wintertime, yak meat is eagerly awaited, and people pay proper sums to get a share after the slaughtering.<sup>283</sup> However, as Buddhists, they are not allowed to kill living things, and so people who do so regularly or professionally are considered to be impure. In a place like Ladakh – with a partly non-Buddhist population – this kind of work can be taken over by Muslims, and today, the professional butchers in Kaza are Hindus from the Indian plains. But in former times and even today in the upper and smaller villages of Spiti valley, there are no non-Buddhists. Therefore the lowest strata must carry out this job, and in Kibber these are the musicians.

That morning, the amchi and I entered the musician's household. For Spiti-pa of the *sa ma 'brog* rank, as are the amchi, this is rather improper and unusual conduct. After having been in the musician's home, I was once even asked by someone, frowning, if I had really done this, who then commented that hopefully I had not drunk or eaten anything. But Amchi Tsering Dorje does not care about these kinds of habits and the possible talk amongst people. The patient we were to see is the head of his household, and just a few days before I had seen him in Kaza, quite drunk. This seemed

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<sup>280</sup> At least once a month for the full moon, each family is called on to participate in prayers and circumambulations of the local *lha khang*. Usually, the women do this, and view it as a possibility to meet with one another.

<sup>281</sup> They usually appear with one or two drums and a wind instrument similar to an oboe.

<sup>282</sup> Jahoda discusses briefly the low status of the musicians but does not go deeper into the matter (2003: 267). In Ladakh, Erdmann has noted the rigid avoidance of contact with the lower *rigs*, as well. He traces it back to a notion of "impurity/pollution" (1983: 151). Though I could not detect a respective terminology in Spiti, the habit here indicates a notion of "impure" directed at the musicians, corresponding as well to behavior observable as a consequence of the Hindu caste system.

<sup>283</sup> The price for a yak went up strongly in the last ten years and in 2003, one animal could obtain a price up to 19,000 rupees. People pay about 1,200 rupees for ten kilograms of raw meat in Kibber.

to confirm a prejudice against musicians drinking too much alcohol, but I would not verify this notion in general. However, marked by his facial and eye color, this man seemed to me to perhaps be an alcoholic, although he was not drunk as we entered his room. He was suffering from strong pains, especially in one hand. It was very swollen, and the small finger was thick and yellow around the joint, seemingly filled with pus. On the back of both hands, there were closed wounds, around which was swollen as well. Later the day, the amchi confirms to me that the wounds are actually already a year old. The man's hands are shaking, but I cannot say if it is from pain or from not having alcohol. Before we receive the *chāy*, Amchi Tsering Dorje examines his patient's hands and expresses some serious concerns. It looks really bad. To me, it seems as if the patient has had this problem for quite some time, and now the inner inflammation could already be moving up his wrist. Blood poisoning could be one possibility. Amchi Tsering Dorje takes the man's pulse and then orders the daughter to fetch some gauze and a stone "needle", which turns out to be a thin splinter ending in a sharp tip. The amchi starts to repeat a mantra while cleaning the needle. He then he asks the man to look off to the side. He positions the needle on top of the yellow spot of the patient's pinky finger and then opens up hole, one to two millimeters wide. Continually reciting the mantra, he tries to squeeze out the fluid from inside. The man shows that he is in strong pain. The oven shovel is full of ash, and is laid beneath in order to catch whatever comes out of the wound. However, not much fluid is released and Amchi Tsering Dorje stops squeezing. The amchi then throws the needle in the ash, and the man's daughter hastens to bring everything outside the house. Amchi Tsering Dorje wraps some yak hair into the gauze and tapes the finger in a professional manner. While drinking the *chāy*, he promises to bring some medicine for him in the evening. When we leave the house, Amchi Tsering Dorje appears to be very concerned and says that the patient definitely needs to take some medicine because the problem has to be treated from the inside as well.

Later that same day in the afternoon, Amchi Tsering Dorje takes me back to the musician's house. He explains to me that last week, blood spots had appeared on the back of the patient's hands. He tried to open them, but they became inflamed. When we enter the room for the second time this day, the family has prepared for a small *pūjā*.<sup>284</sup> We sit down next to the oven, and Amchi Tsering Dorje takes two packets of medicine

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<sup>284</sup> For an image of a comparable *pūjā* see figure 14.

out of his pocket. One is a piece of *silajit*,<sup>285</sup> and the second one is prepared from several medicinal plants. He mixes both medicines with water in a small bowl and puts it on the oven. Family members bring a plate with small bowls of butter and rice, an empty small butter lamp, and a bottle of *arak*, which are all put directly in front of the amchi. Amchi Tsering Dorje prepares the lamp by putting three small pieces of butter on its edge. Reciting from memory a ritual text, he then alternately pours grains of rice and drops of *arak* into the butter lamp. He repeats the procedure until the *arak* overflows and pours down onto the small plate underneath. When the ceremony is finished, the patient's daughter takes the plate and throws the contents outside the house, as she did this morning. Amchi Tsering Dorje then asks the patient to sit next to him. He has unwrapped his bandage in preparation for the first fluid part of medicine mixture, which has been standing in the bowl on the oven. The patient then swallows the liquid (made black from the *silajit*). The amchi then spreads the thick medicine paste on the different spots of the hand. He tapes the hand up again with cotton and gauze. Afterwards, we leave.

During a later interview, Amchi Tsering Dorje explained the reasons for the practices he performed:

The reason we did the *pūjā* today was because of an evil sight from their own god. They [the patient's family] do not believe in these things. We went there in the morning, and the patient told me that this and that [concerning the disease] had happened. But when I read his pulse there was nothing of what he had told me, but I detected a *burī nazar*. Then I said [to him]: 'For your peace of mind I will perform a *pūjā* and mantra. It will help you to sleep better as well.' [...] The mantra [I had spoken earlier] in the morning was for curing the disease. For that, we use the mantra of our god, Sengye Menla. The *pūjā* we did just now was a *ser khyim*.

He explains that the reason behind the inflammation was actually twofold, caused by the *burī nazar* of their own family deity and by his karma from a former life.

### Creating Tantric Power

Entering the analysis of these two ethnographical examples, let me first recall Dummer, who categorizes three kinds of treatments for evil spirits (and the like): 1) "magico-

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<sup>285</sup> *Silajit* is mineral pitch (Bot. asphaltum).

religious exorcisms (through Tantra and yoga);” 2) “organic (through medicine and somatic treatments);” and 3) “psychological (through the dharma)” (1998: 89, cf. similarly Dolma 1990c: 75). In the ethnographical examples, the amchi is witnessed carrying out practices on all of these three levels. I go deeper into the analysis here, however, only based on the explanation of the *pūjā* performed, and afterwards I further explore in some length the meaning of mantra in general.

Referring to the second ethnographic example, a form of *pūjā* is described there that is regularly practiced by this amchi (and any others who are able) for medical purposes. This *ser khyim* uses ritual activities that form components of most of the larger Tantric rituals conducted by lamas and monks as well. Rice, butter and *arak* – in monasteries usually non-alcoholic blessed fluids are used – are here symbolically displayed to attract the spirits or evil forces, in this case, the *burī nazar* of the deity. By satisfying its desires, the impure and negative energies are bound to the ritual objects (Tib. *glud*) and are thrown out of the house (cf. Gutschow forthcoming). The further power of the *ser khyim* is created through the ritual texts that lead into the murmuring of mantra, what we deal now.

My two preceding ethnographical accounts have shown that mantra can be used for various purposes based on the assumption that it owns an inherent power that can be transferred onto subjects and objects. Everyone can use mantra and prayers to unfold their power for particular aims. Samuel explains that simple everyday problems concerning deities and spirits can be handled individually by a layman himself, while for a more serious problem, religious practitioners have to be consulted (1993: 174). Conceptually, there are two categories of diseases that need the application of a specialist’s Tantric practice: the ones caused by spirits and the ones caused by the patient’s last life’s *karma*. Mantras are a fundamental element of these practices, so essential that an amchi states: “A disease which is related to the last life cannot be cured by medicine but only by mantra. [That’s why] mantras are very necessary for the amchi work.” In the last chapter, I outlined their accepted utilization as agents in empowering medicine and reinforcing their natural capacity. This is the first type of mantra, directly related to Sengye Menla, the Medicine Buddha. It is the special mantra of the amchi and supports him in any kind of medical work, from medicine making to the diagnosis and healing practices. Amchi often request Sengye Menla’s help in normal situations, but especially in situations of greater difficulty (cf. Pordié 2003: 26). The potential powers of Sengye Menla and the appropriate mantra to help cure a disease are interrelated and

can not be distinguished from one another. Considering neither as an objectified status – not Sengye Menla as a person or Buddha, and the mantra not as a text – they consist of the same energy which the amchi makes use of. In certain cases, this energy is considered to have the potency to cure a disease directly without any other further needs.<sup>286</sup> In the first example of this present chapter, this is confirmed further when the amchi asked the patient to speak the mantra (Tib. *mani sbnyen pa*<sup>287</sup>) himself. The Menla-mantra spoken by a patient can thereby self-evidently unfold its power as well (cf. Dolkar 1990: 42). Besides, this advice had two further goals, which are both connected. If the patient speaks the mantra at the same time that he takes the medicine, in the local understanding this thereby reinforces the efficacy of the treatment.<sup>288</sup> At the same time, the praying reassures the patient of the efficacy of the treatment and calls upon the powerful support of the Buddha.

The mantra serves, besides its inherent capacity, also on a psychological level, giving the patient the feeling of security. Giving a patient a useful task during the healing process gives him an active part in the cure and safeguards his engagement. Adding religious practices – that both the amchi and patient consider to be powerful – further increases a certainty about the healing capacity of the treatment. Besides the effective power of the mantra, its murmuring and its connected confidence enables the patient to relax his mind, as the constant repetition of a spiritual formula is in itself already considered to have a calming effect. In the case of a depressed patient, this is of very obvious importance in helping to support his mental state. It is as well the reason why Amchi Tenzin Tashi advised the musician to say prayers when he would start feeling insecure or get into a bad mood. In the case of the patient himself speaking a mantra is an acute help in diverting attention from his pains and giving him strength.

Additional to the psychological level, certain mantras are also considered to work directly on a more, so to say, physical level. This second type of mantra is connected to the *ser khyim* and, for instance, helps in persuading spirits and gods. These

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<sup>286</sup> Amchi also mention that doing the mantra is initially a means to accumulate merit which is good for their karma.

<sup>287</sup> The most common recitation (*bsnyen pa*) in this case is the mantra “*om mani padme hūm*”. This mantra especially traverses the everyday life of Tibetan people. This and other mantra are often used for gaining merit (Tib. *bsod nams*), praying for the Buddhas’ protection over them, and keeping good relations with the local deities.

<sup>288</sup> There is other advice that also engages the patient in his healing process, such as prostrations (Tib. *phyag byed pa*), which is, in Spiti, briefly called *chag bum*. Looking at the distinctness of religious and medical sphere, Pordié comments that the amchi’s “recommendations follow medical logic, but they borrow elements external to medicine strictly speaking” (2003: 28).

kinds of mantras serve as agents of protection. Before cutting into a human body or, in this case, opening an abscess, ritual support is needed, and the tool used for cutting (the stone needle) needs to be ‘cleaned’ by the mantra.<sup>289</sup> Furthermore, the pus is considered to be infectious and impure, so when it was pressed out, the surrounding area has to be protected by speaking a mantra as well. These observations have shown that the power of mantra can actually be passed on, giving energy to something or someone else. During a *ser khyim*, however, another more absorbing effect of prayers and mantra is assumed. They force the evil energies or entities to leave the place of their negative actions by accumulating them in the butter lamp that is to be thrown out of the house. Mantra spiritually supports the attraction that is built up on a material level through the symbols of rice and *arak*. In summarization, mantra and ritual prayers work for ‘disinfection’, material and spiritual protection, and the patient’s psychological reassurance.

Some amchi are able to perform such *ser khyim* as the one presented above. They have usually learned these ritual performances as part of their family transmission. These religious activities carry part of their family identity and are part of the conception of their personal self. To highlight this fact, I begin with the practice of *mtshams*, which was introduced in Chapter 2.1. The *mtshams* is a prerequisite to being able to perform a *ser khyim*.

During a *mtshams*, the practitioner isolates himself from all social and family life and retreats for a time (anywhere from a few weeks to a couple of months<sup>290</sup>) in a small chamber. Two to three times a day, usually in the morning and in the evening, the amchi performs a *ser khyim*, recites mantra, and reads ritual texts to worship and invoke the Medicine Buddha. This includes meditation in the form of a detailed imagination of Sengye Menla merging into a visualization of oneself as the deity. This Tantric practice<sup>291</sup> is accompanied by prostrations and ultimately empowers the amchi. Besides the assumed benefits in a next life, the practitioner also strengthens his mental and spiritual capacities. During the *mtshams* days, the amchi further reads and works on

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<sup>289</sup> I observed a similar procedure in a case of tooth extraction. The amchi spoke a mantra over the top of a pair of pliers and then blew these words at it before entering the mouth.

<sup>290</sup> One amchi has told me that he, being a *buzhens* (a special kind of Nyingma-pa lama) at that time, has even done a long *mtshams* of three years, three months, and three days. Pordié reports this also of a monk amchi in Ladakh (2003: 26).

<sup>291</sup> See Samuel (2001b) on the visualization in context of healing.

medical texts, thereby enlarging and expanding his medical knowledge. Practically, he has thus an outcome that doubly influences the efficacy of his amchi work. If an amchi was asked to pinpoint the effects of a *mtshams*, he might give an example, for instance, such as that for curing pimples, they just have to speak mantra over hot water and spit in it and the patient will be cured by drinking it. Another example was mentioned earlier, when Amchi Tsering Dorje spoke a mantra and blew it over the stone needle or a pair of pliers. One amchi has even reported that sometimes, when he enters a house to visit a patient who has been attacked by a *gson 'dre* (a goblin or demon of a living soul) or the like, this demon will disappear from the patient in just the moment he arrives. These are all examples through which the accumulated spiritual power of an amchi (by their good karma and religious merits) is demonstrated. The daily prayers and meditation, which, of the general opinion in Spiti should be carried out by each amchi, are one such type of vehicle to gain this end. Of a great more value and effect are *mtshams*. The invocation of Sengye Menla transfers his power onto the amchi and empowers his healing abilities. All of the amchi's tools and activities gain more strength, starting from the production of medicine, leading through his diagnosis via his mental and spiritual capacities, all the way to his treatments (cf. Pordié 2003: 24).

Having just explained the possibilities and 'tools' needed to invoke Tantric power, we can now turn back to the practitioners themselves and reflect on their activities. On a related subject, Lobsang Dolma states that

Certain lamas have the power of curing a patient by their recitation of a mantra. [...] since the lama is always in meditation and has a realisation of his true being, then by the physical contact a great number of diseases and harmful external influences are cleared just by that touch (1990b: 42).

I assume that a similar, though limited, ability is also attainable for amchi. This might especially be possible in the case of an amchi who had previously been a monk (like Amchi Thupten Thapke), derived from a family with a strong religious tradition (like Amchi Urgen Tsering), or have done training as a chowa (like Amchi Chullim). The appropriate building blocks to reach this end seem to be as follows: an appropriate karma, an appropriate education, and the implementation of one long or repeated shorter *mtshams*. Obviously, Amchi Tsering Dorje is also an amchi that is counted within this group of those capable of Tantric practices. This should be obvious, in hindsight, from

the prologue's account of my day with him. His special ability came to the fore when we passed the village where a family was going to hang up a new *rlung rta*; they were happy that he was there to do this because they considered him well-versed by his religious experiences and Tantric capabilities.

It can be concluded here that many Spiti amchi are able to perform small *pūjā* that go beyond the lay community's ordinary religious practices and secure good health. Only some Spiti amchi, however, can perform more extended Tantric rituals for healing, and be considered as specialized in ritual performances, though not as elaborate as the religious specialists. Consequently, lama and other religious practitioners remain considered the actual specialists. But if none of them are at hand, an amchi can serve well instead to perform the necessary rites.

This brings us back to the point of considering the separation of religious and medical practices, but we have now more knowledge of the practices in Spiti. We now understand that the Tantric practices of a more elaborate nature – the exorcisms – are actually separated from and precede the medical activities. Thus, it can be stressed that in general (as indicated at the beginning), a conceptual and practical detachment of the medical treatment from the religious sphere exists. This can be further illustrated by a report given by Amchi Tsering Dorje about a woman who has had back pains:

That was also a *burī nazar*. I have treated it with mantra and still afterwards she was not cured. So, then we made a *glud* out of *pag*.<sup>292</sup> After that, she was cured. Before that, the medicine did not work on her but afterwards it did. Today she is fine.

The medical work and the medical specialists appear to the cases of need, only after the dharmic work of the religious practitioners has been done, as is also outlined by Pordié (2003, forthcoming a) and Gutschow (forthcoming). Ritual is generally the preliminary stage of healing, to be followed with other treatment, but only when ritual doesn't actually cure it fully by itself (cf. Dietrich 1998: 167). Spiti amchi who are capable of performing Tantric ritual always proceed in the same order – first exorcism, then medication – and therefore reinforce the differentiation of the ideologically divided separate spheres of medicine and religion. This differentiation corresponds with amchi's self-conception of themselves, and the Spiti-pa's conceptions of amchi medicine: an

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<sup>292</sup> *Pag* is barley dough. They created a statue, *torma*-like, from this and thereby attracted the spirit to then exorcise it.

amchi is not a religious specialist like a chowa or lama, he is a technical-medical specialist. Pordié emphasizes the strictly medical role of the amchi by stating:

Both the great preponderance of what is contained in medical texts and the daily actions of the practitioners are of a medical, technical and a-religious nature. The religious dimension is a supplementary component that is favourably viewed by the practitioner and his community, but this does not preclude the practice of medicine in the absence of religion. Medicine and religion are distinct and independent. (2003: 15)

This distinction of the two spheres is historically and ideologically manifested and, as we have seen, implemented on a practical level and very much still intact in Spiti. Some amchi, however, are capable of elaborate religious work and can carry out religious and medical practices at the same occasion. They still separate the two spheres theoretically, but nevertheless, they are both embodied in one person. My assumption is, therefore, that the “medical-religious bipartition” pointed out by Pordié (ibid.: 46) has become a permeable barrier, especially in a remote village context among elaborate practitioners.

#### *Status and Identity*

After having clarified the power considered inherent in Tantric practices, we turn now to the impact Tantric practices have on the social status of an amchi. Chapter 2.1 highlighted the importance of the lineages regarding the skills and the anticipated reputation of an amchi stemming from the fame of his direct forefathers. Family identity is made up in part by the family transmission (its occupation), its karma, and the household deity, all together constituting most part of the social status of the family in the village. If an amchi is well-known for his religiousness and his capabilities for ritual healing, people expect him to transfer his knowledge and some of his powers – inherent in the family deity – to his son (or legitimate successor). The son should thus honor this family transmission (which can, indeed, also be a burden) and strive for an appropriate continuation of the tradition. If, at some point, he is able to show the ‘successful’ application of the appropriate rituals and prayers, his forefather’s reputation ‘melts’ into his own and the continuation of the social status is possible. Says Samuel,

In shamanic Buddhism, a practitioner can relate directly to the sources of power and authority, by contacting the Tantric ‘deities’ and other central ‘culture-heroes.’ Once a practitioner becomes a lama, this direct contact

with power legitimates a social role that can easily extend into the political sphere as into the religious. (1993: 34)

Though amchi cannot gain the status of lama, I draw here from Samuel's statement when I state that if an amchi is considered a religious specialist (or at least in part a religious specialist) he then gains additional social reputation. Samuel also states (in another context) that an effective ritual reconstitutes people's faith in the ritual practitioner (2001b: 81). Though he applies this to monks, the same principle applies to the amchi as well. Whenever an amchi performs a healing ritual, his credibility and reputation are at stake. If, however, his Tantric abilities prove to be effective, it then enhances his standing. Having a high social status in the village anyway, an amchi can be further socially empowered by his religious capacities.

However, this is not only a matter of gaining status, but also of religion as making up a large portion of the individual identity of an amchi. Amchi Tsering Dorje has expressed many thoughts on this point to me while giving remarks on the specific skills he gained during his education at home and in Dharamshala (Chapter 2.3). By saying that in Dharamshala he could learn "everything," he referred to the clinical-technical part of medicine, synonymous with the rationalized form of Tibetan medicine. But, in Spiti more than just this is required to meet the needs of the local population. Medical training in Dharamshala lacks the religious dimension of amchi medicine. In order to understanding these interactions with local deities and spirits, diagnose the illnesses caused by them, treat these illnesses with rituals, and learn to do *pūjā* and mantra, Amchi Tsering Dorje had to be taught all of this by his father. No one else could have taught him because his father was the only amchi in the village.<sup>293</sup> Through this example, we can comprehend the close connection between the tradition of the family, the lineage transmission, and the residential *lha* (Chapter 1.1) that is united in the present amchi. It is evident from this situation that the capability to perform *pūjā* for healing purposes constitutes an essential part to the identity of an amchi in his local region, where religion is still the primary constituent of social life.<sup>294</sup>

The identity issue is, however, not just limited to the self or the lineage of an amchi, but also has a regional dimension. Just as we observed with the topic of local

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<sup>293</sup> The second amchi of the village had moved there from Ladakh and was not able to perform these locally specific rituals.

<sup>294</sup> Amchi Tsering Dorje mentioned accordingly that these religious practices are not "necessary" in Dharamshala. Cantwell substantiates this estimation saying that among Tibetan refugees, practices derived from folk religion and exorcisms have declined (1995: 173).

flora, Spiti amchi are the specialists regarding the influences the (spiritual) environment of their habitat has on the health of its people. Every house, village, stream, and mountain has a specific spiritual dimension, addressed in the form of gods and spirits. Amchi – along with the other Spiti religious specialists – are uniquely qualified to deal with health problems that arise from this particular local dimension. Thus, they have a residential focus that is sharply different to that of the neighboring areas, especially compared to the Indian plains. Today, the amchi construct differences to the Indian plains as a type of opposition against the rationalized modernity of India, and even more so of Tibetan medicine in Dharamshala, explored further in Chapter 5. However, a religious understanding of the local environment makes up a specific part of local health care, rooted deep in the amchi lineages. To demarcate their tradition and skills from that of other Tibetan medical practitioners Spiti amchi especially emphasize the religious dimension of their work. For amchi who are not capable of Tantric healing, this accentuation is lucrative in constituting a specific identity. For amchi capable of Tantric healing, this skill additionally contains the chance to enhance and consolidate their status.<sup>295</sup>

#### *The Collective and the Individual*

Finally, this analysis needs to be continued in this current socio-political direction by next considering the village context and within that, the special position of the musicians. To properly examine the dynamics involved with the social standing of the musicians and the above presented patient's illness – the collective and the individual – it is useful to draw now from Vincanne Adams' extrapolation on the Tibetan concept of a "collective subjectivity" from her study on *rlung* disorders in Lhasa (2002a). She says:

The *sems* (sentient mind) is the physical expression of a collection of various persons who are present at once in the living being. These beings – who were not flesh, bone, blood, the same as "you" – are now present in you in the sense that it was their actions that produced your physical existence. Their lives make up your life. Collectively, they are the physical foundation of the self. The most subtle mind is thus inseparable from the body and it is a collectivity of *bodies*. This most subtle mind must be seen

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<sup>295</sup> As evident from the last two sentences, amchi identity is not a homogenous construct, but rather multiple. See Beek (1997 and 2001) for discussions on identity and the political usage of this category, and especially reference Pordié (2003), who discusses the interference of science and religion in creating distinct identity discourses.

as the expression of the accumulated *karma* that derives from these body forms in the past lives. [...]

Evidence of a collective subjectivity among Tibetans comes from patients who describe their health problems in terms of the actions of both karma and spirit beings. Many Tibetans believe that one's person is constituted by a collection of a variety of gods: from one's place of birth (*ziptak*), lineage (*gyurpa lha*), and past lives (*gyaptak*). (ibid.: 397, emphasis in the original)

Adams continues to explain that certain parts of a person can consequently be shared by the whole community of one locale. Offending the god of your place of birth or lineage, or a *dgon-pa*, may have an effect and cause on the person or community. In the Spiti village where the musician lived, I found this matter proven through the following explanation. Some years back, the villagers had a quarrel with the local *lha ba*. The medium of the village god was a man from a musician family, and people suspected him of being greedy and selfish. Earlier, the god had been worshipped and the *lha ba* was called for many occasions for divinations and exorcisms. Now, the villagers refused the *lha ba* and with it, further obedience to the god. The villagers who led this decision were the powerful and influential characters of the village. The lower *rigs*, like the musicians, do not usually interfere with such decision processes, though they do take part in village meetings. Villagers told me that nowadays the mutual cooperation between them is not as good as it used to be. Individualization and economic changes have given rise to splits in the society, especially concerning tensions between the *sa ma 'brog* and the *beda*. Since the offending of the *lha ba*, the village has sometimes been afflicted by the god at night, making people afraid. Amchi Tsering Dorje reports as well that people have gotten sick by the god's actions. The god of the locale has been offended, and the community now is affected by the consequences. But certain people were hit harder and more often from this than others. In fact, all the cases caused by *gdon* or *burī nazar* (what I had witnessed) were patients from musician families.

As Amchi Tsering Dorje explains below, the cause for this lies, perhaps surprisingly, in economic differences:

If you are wealthy and it [the god] attacks you, then you can do lots of things because you are rich. You can call the doctor, you can call the chowa for the reading of mantras, you can do lots of things. But if I am poor, then I

cannot go anywhere [to ask for support]. So, it mainly attacks the poor people.

After harvest time (but before the snow starts) and around *lo gsar*, the new year, lots of ritual activities go on in Spiti. Many households invite lamas of the respective *dgon-pa* (and sometimes chowa) to carry out *pūjā* for general and particular purposes. The most common and an important reason to ask for a *pūjā* is to request the blessing of the house and family (including the pacification of their wrong-doings) from the gods, and ask for their protection throughout the coming year. These ceremonies may take less than a day or up to a few days, and are carried out by one chowa or a few (up to ten) lamas; the household supplies the full offerings and all the food. The extent of such an occasion depends partly on the reason for the *pūjā* but fundamentally on the financial resources of the family. Each lama receives a donation of 100-300 rupees per day, while head lamas and the like receive double. Food, supplies, and *pūjā* items for making the *gtorma* also have to be provided, which, totaled, can make a considerable sum. Based on the average contemporary good-income situation (Chapter 1.1), many Spiti-pa are very willing and able to invest some money in the ritual protection of their household at least once a year and, if need be, more often. Adams reports in her studies among Sherpa communities in Nepal of similar ceremonies of a preventive or curing nature, which is quite expensive for the implementing household (1988: 507).

Samuel's conclusion – that in Tibetan culture, spirits are considered to be “a constant threat to life and prosperity” and need ritual counteraction (1993: 189) – is thus proved to be very much still alive today in Spiti and has even gained some renewal as a consequence of economic advancement. However, less wealthy households have less ability to care for their ritual protection and good fortune. The musician families, overall, do not have a good income. Often, they do not own land and cannot participate in the contemporary main income source of cash crop cultivation. Unprotected, they become vulnerable for all kinds of *gdon* and *burī nazar*. The village repudiation of the local god, taken as a decision by the wealthier households,<sup>296</sup> mainly has consequences only for the poorer households. The economic situation in this village has created a two-class society concerning the access to ritual protection. The socio-economic situation thereby has created a greater threat of illness through evil forces for the lower strata of

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<sup>296</sup> Households of high status and influence are not necessarily to be equated with being rich, but they usually have at least a proper outcome.

the community.<sup>297</sup> Generally, when someone becomes ill for karmic or spiritual reasons, several options regarding treatment are open if he or she can afford them. The choices are, as explained earlier: amchi, chowa, and lama, whether in Spiti, at the plains, or even in Dharamshala. However, the musician families, not engaged in prevention (for economic reasons), basically rely on the village amchi and the *lha ba* to cure their illnesses. The amchi gives treatment and performs the rites he is capable of for free. He therefore represents a cheap alternative to the expensive ‘preventive care’ of the lamas. Concerning the differentiation between the two strata in this village, behavior regarding seeking health care has become a matter of purchasing power.

It must be noted however, that Spiti-pa view these social and economic inequalities not only as a matter simply belonging to the present. An inequality has most likely been caused by actions from former lives, from individuals and communities. Everyone in the village is connected by karma to each other and has therefore his or her ‘karmically’ justified present place in the society. This does not mean one is set or in a paused position, but rather gives a proper explanation for one’s current position and promotes selflessness, as one can never entirely be self-responsible for one’s own fortune, wealth, etc. And one’s situation can – to a certain extent – be worked on. That’s why, in the described case of the musician, Amchi Tsering Dorje demands that the family changes their habits. A proportional cause of the illness has been because of a disregard of the family deity and an omission of its worship. To better their state of mind and health, they are requested to engage in small religious activities, which can be performed by anyone, in order to receive protection by their deity. On the other hand, under these circumstances of social inequalities, we must also consider the amchi’s performance of ritual healing for the musicians as a political act. It counter-acts the socio-economic imbalance in the village that leaves the musicians at the mercy of unprotected spirit-influences. In this situation, the amchi can be considered a social agent closing the gap that the socio-economic transformations have opened up.

However, to change the basic situation that caused the repudiation of the local god, the village – as “the collectivity of *bodies*” – needs to find a joint social way. People often remark that only the unity of the village, including the *lha ba* and the recommencing of worship could pacify the god so that he would stop afflicting the

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<sup>297</sup> I have been told that in addition to this group, Spiti women are also generally more prone to spirit attacks. For more on this female subordination, see Gutschow’s report from Zangskar (forthcoming), Yamada on Ladakh (1993: 218), and Samuel on South Asia (2001b: 82), as a more general case.

villagers. This solution is, as far as I can assess, nowhere in sight. Rather, economic advancements are often accompanied by a tendency towards individualism, which becomes clearer throughout this thesis. Here, the ceremonies per each household promote individualization, an effect that Adams has observed among the Sherpa as well, although under different conditions (1988: 511). A family carrying out a proper *pūjā* is protected and does not rely so much on the social embeddedness anymore. We can therefore assume that capitalist logic has entered the religious sphere and has thus increased the habitual tendency of Spiti people to calculate for their individual safety and success. How far this plays a role in amchi work is examined in Chapters 4 and 5.

The examination of some of the aspects of healing (Chapter 3.1) comes to an end here. It has been revealed that pulse reading, medicine making, and Tantric healing are special markers of amchi medicine and underlie ongoing contemporary transformations. These transformations result in a re-evaluation of different aspects, leading to an accentuation on issues of identity and power. These issues have now been opened up and illuminated to a certain extent. We now carry them with us through the next chapters, until the final analysis in Chapter 5. Henceforth, however, this thesis continues with the analysis of the socio-political embeddedness of amchi medicine in the next section, Chapter 3.2.

### **3.2 The Socio-Political Dimension of Amchi Medicine**

In the beginning of October 2003, one of the largest Spiti weddings in years took place in Kaza. It is through the following concise description of this event that I am able to provide a useful illustration of some of the recent societal changes that have been ongoing in Spiti, and provide an example concerning the traditional social status of the amchi. This marriage was arranged between two of the wealthiest families of Kaza for their respective offspring. Both of the families were ready to display their social positions by presenting a splendid three-day ceremony in traditional Spiti style. Years before, it had been fashionable to marry ‘Indian style,’ through adopting Indian dressing fashions and ceremonial aspects from Hinduist India. Now, a revitalization favoring traditional local expression has taken place. Hundreds of guests were invited from all over Himachal Pradesh, Ladakh, and even Delhi, including a considerable number of

officials and notable persons from the Indian administration and Spiti bourgeoisie. The event of interest to this thesis happened on the first day of the wedding festivities. The afternoon consisted of a dancing and singing ‘competition’ between the male relatives and friends of both parties. Each party had gathered more than twenty men who wore newly made silk dresses, hats, and their family ornamentation of necklaces with precious stones and big silver amulets containing small Buddha statues or Dalai Lama pictures. The groom’s friends and relatives started the festivities by giving a dancing performance at the bus stand (a large square in Kaza; figure 17). Beda played music during this, and the men that made up the core of the groom’s family sat off to the side, receiving gifts of bottles of *arak* and white silk scarfs, *kha btags*. Afterwards, the party went in a procession to another square to meet the bride’s party there. All the men were equally beautifully clothed and each now carried with him a ritual sword. Entering the square, each party formed a line and moved rhythmically into separate circles to start the dancing. In that moment, I recognized Amchi Urgen Tsering. This well-respected man from Pin valley was led as a relative of the bride’s party (figure 18), his status being honored with this position. After some time of dancing, the performances were continued with an antiphonal chant, during which the parties gathered around a ritual stone pillar and alternately sang, with one party answering the other, and each party alternating with their leading singer. The singing was competitively raised until at last one party was supposedly victorious over the other by having the ‘last word.’ This ‘victory,’ I was told, had been previously fixed. Jointly singing, the parties then left the square walking in a close group and thereby knocked over the big stone pillar and dozens of more small white, black, blue, and red stone pillars. These had been erected in a make-shift field to symbolize the couple’s future obstacles, which were now eliminated. The celebration continued into the evening and way into the night at the bride’s family house.

I come back to this ethnographic piece in the course of the following chapter, and so now outline the structure for this. After the last chapters elaborated the essential aspects of healing, the following chapters are now concerned with how amchi are embedded in their communities. This brings up socio-political aspects, including the amchi-patient relationship and recent social changes that have shaped the interactions between amchi and their communities. Chapter 3.2.1 reveals the foundations for the central present dilemma of the amchi, and therefore their reasons for the start of their own

modernization project. By examining the special case of Amchi Thupten Thapke in Kaza (Chapter 3.2.2), we learn further insights and become able to answer the question of how amchi work in Spiti has changed in the context of the village (the ‘doorstep’ to the modern Indian world). The chapter concludes with the description of the “amchi at home,” showing how current social transformations impact the amchi’s life.

### 3.2.1 Social Change and the Amchi-Patient Relationship

Villages in Spiti are – with the exception of Kaza – quite small and easily surveyed. In most of the smallest, hamlet-like villages of only a few houses, an amchi, or an amchi lineage, does not usually dwell there. But middle-sized villages are often home to an amchi *rgyud-pa*, or at least a family that once had been an amchi lineage. These amchi feel responsible for the people of their locale, and for the surrounding villages or hamlets lacking their own amchi. Additionally, most amchi have regular patients from all over Spiti, sometimes even from Kinnaur, who visit them because they feel well-treated by this particular amchi. Therefore, an amchi usually knows his clients very well and is bound to them through the social networks of extended family or village relations. The latter, and the parameters of an amchi-patient relationship, are contemporarily being altered by changes caused by Spiti modernity, which is the object of investigation in this chapter.

Spiti’s environmental and climatic conditions influence the arrangement and closeness of an amchi’s relationship with his patients. The degree of separation between an amchi and his patient is obviously a key factor in their relationship, and harsh geographical conditions or bad weather only exacerbates the distance (meaning it could up to a day for an amchi to travel and see a patient). In connection to this, time constraints are also a major factor influencing the relationship. Independent of one’s job – whether one is a farmer or does other business – during the summer months (starting from mid-April and lasting to mid-October), everyone is very busy working from sunrise to sunset. This situation applies to amchi, as well as to lama or normal villagers. Therefore it’s obvious that regarding one’s own interest and the amchi’s interest, medical advice is sought either in the early morning or at the end of the day. Only in very acute and serious cases would an amchi be called away from his work during the day for a patient. This custom – as do many others – completely changes during the winter months. Because of the severe cold and not-compelling work, things that take

place outside the house only are done when the sun is out (usually a period of only six hours), and evenings are very long, spent at home in front of the oven.<sup>298</sup> Therefore during winter, an amchi is usually called on during the day, and sometimes in the early evening. In the case of the patient living in another village, the round-trip visit might take longer than the sunny period of just one day, and possibly even several days with the amchi walking through knee-deep snow. The farther an amchi is away from the patient's house, the more difficult it becomes in winter to transport a patient, or contact the amchi to have him come to the patient. This fact was witnessed in the prologue, where I described Amchi Tsering Dorje's visit to Tashigang, during which several patients took that chance to consult him. The experience of isolation as a result of the cold and snow has made people acknowledge their dependency on the local amchi.<sup>299</sup> The value of, and need for, a medical practitioner in the surrounding peripheral range becomes very comprehensible and individuals as well as whole villages have taken this into account.

#### *The Dissolution of the Amchi's Monopoly*

These special conditions have shaped the relationship of villagers and amchi for centuries. To secure health care in this remote area, joint socio-economical arrangements were arranged, something I touched upon earlier in earlier chapters. Before beginning to analyze the social circumstances here in detail, I first clarify some of the transformations within the last decades in Spiti, initially introduced in Chapter 1.1.

Compared to the period prior to the 1990s, two major infrastructural innovations are now greatly influencing Spiti-pa's perceptions of their dependency and geographic-climatic inclusion, thereby altering and deepening the aforementioned seasonally distinct behavior. One of these innovations is the continuous improvement of the road network throughout Spiti. Though the first road construction projects were implemented in the late 1960s, decisive improvements weren't visible until the 1990s. Link roads built to almost all the villages go through the rough desert landscape and have enabled regular connections between the villages by bus or jeep. Spiti-pa have thusly become

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<sup>298</sup> Because of the narrowness of Spiti's valleys, in winter the sun comes up in many villages only at 9:30a.m. or later, and sets at 4:00p.m. This varies also according to the particular location of a village in relation to the surrounding mountains. Temperature drops with the setting sun and can drop ten degrees or more within mere minutes.

<sup>299</sup> This issue beginning to take shape here has also been described as well in Ladakh (Besch and Guérin forthcoming; Kloos forthcoming).

increasingly mobile inside Spiti and in north-west India (at least, during the summer months). Especially in spring and autumn, when farming and construction work aren't at their peak periods, people use this time to travel for social contacts or gatherings, pilgrimages, or just doing business in the plains. These special intermediate times do not have a consequence on amchi work but what really makes a difference is the wintertime. From the first day of snowfall, most traffic comes to a standstill and is shelved for the next four to six months. Only a very few roads, like the one from Kibber to Kaza or the central road from Kaza eastwards to Kinnaur, are re-opened after a few days – depending on the amount of snowfall – only to be closed again with the next snow. Villages that do not lie on these roads (like those in western Spiti, Lingti valley, Pin valley, and at the higher plateaus) remain closed all winter. Getting in and out is largely restricted to walking by foot, if possible and non-life-threatening.<sup>300</sup>

Spiti-pa's newly gained and well-enjoyed mobility is thus clearly restricted to a certain time of the year. Road connections have then enabled Spiti villagers to access health care institutions beyond that of their local amchi. Within just a few years during the 1990s, one could suddenly seek treatment from another accessible amchi only a few hours drive away or even from other Tibetan practitioners within one day of driving (in Manali and Kullu). Down in the pre-alpine regions, the first biomedical institutions also started to become available.<sup>301</sup> Since the late 1950s, a public dispensary has existed in Kaza.<sup>302</sup> But only the establishment of the 'Community Health Center' in Kaza in 1994 brought reliable biomedical facilities to Spiti. This can therefore be considered the second major infrastructural innovation. Public health care has been subsequently enlarged so that in 2004, five doctors were stationed in Kaza and in the Primary Health Centers in Sagnam and Tabo, as well as in the civil dispensaries in Kibber, Hansa, and Losar.<sup>303</sup> Moreover, several trained health workers work in smaller dispensaries all over

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<sup>300</sup> Every year, reports are heard that people right after the first snow try to cross the Kunzum-la between Lahaul and Spiti, or try to cross the snow fields in higher western Spiti to get to Kaza because they misjudged the timing and need to return home and then get in serious trouble.

<sup>301</sup> I doubt that Spiti-pa purposefully traveled to the plains for biomedical care. Mamgain reports that since the mid-nineteenth century, the Moravian Missionaries ran a dispensary at Keylong (Lahaul) and that in 1929, a civil dispensary was opened (1975: 247). I suppose that these as well were not viable health care options for Spiti-pa either.

<sup>302</sup> An Indian administrative official pointed out his view on the medical facilities in Spiti by saying, "Similarly the Spiti area of the district, prior to the opening of a dispensary at Kaza in 1958, had nothing to offer to the sick but primitive medicine, magic, necromancy, witch craft and sorcery" (Mamgain 1975: 247).

<sup>303</sup> One of the latter two village dispensaries does not have a full-time doctor there.

Spiti.<sup>304</sup> In Spiti (being a tribal area of H.P.), biomedical consultation and treatment are free, including only a registration fee of 25 paisa<sup>305</sup> per visit. The dispensaries and Primary Health Centers in the villages do not usually consist of more than a single building or room, in which basic drugs (like pain killers, antibiotics, anti-worm cures, contraceptives, and first-aid materials) are available. They also serve as stations for the regular vaccination campaigns conducted under the management of the medical department. The Community Health Center, known all over Spiti just as “the hospital,” has an in-patient ward of twenty beds, a laboratory for basic analysis, an X-ray machine, an ultrasound, a bureau for family planning, a dispensary, and usually one or two doctors on duty. The staff reports that their supply of drugs is extremely good compared to the Indian plains because of their tribal status and the large amounts of free state resources they have access to. Despite the considerable amount of cultural and linguistic misunderstandings that take place between the doctors and patients – which both sides readily confirmed – at the biomedical institutions, the hospital has become the first place of health care that all Spiti-pa in the surrounding region seek, at least in the summertime. Despite its limited equipment, no one wants to miss out on its services.

These two large improvements – considered as such not only by the developers but also the Spiti-pa as well – have had a considerable impact on amchi work and the amchi-patient relationship. The monopolistic position many amchi have held in their villages in regard to non-religious healing has dissolved in not just one, but several regards. In many villages, a biomedical health post has been established as a second health care option. Other biomedical institutions are available in Kaza and Manali (both private and public) and big hospitals have been built in Chandigarh and Shimla. Private Tibetan medical practitioners, as well as those of the Men-Tsee-Khang, are located in

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<sup>304</sup> The number of staff has gradually increased over the years. Health workers from Spiti first had to be trained and needed sufficient school education to apply for a position. The pool of local people considered for these jobs is today much higher than twenty years ago, as the quality of the school system is much better now and more accepted among the people. In 2003, four of the five doctors came from places all over India, and only one was a young doctor originally from Spiti (see Chapter 3.1.1). Young doctors who are still training are usually appointed to a position. Although a posting in a remote tribal area, such as Spiti, includes a drastic increase in salary, the strenuous, harsh, and simple living conditions are not really the ideal for an Indian doctor. Combined with further factors, such as below-average working conditions (little technical equipment, frequent power outages) and their cultural foreignness to the Buddhist Himalayas, this affects the doctors' motivations and therefore influences their performance and length of stay. This phenomenon, which is similarly observed with school teachers, became worse in the 1990s, but the personal effort and understanding for the local circumstances by the Block Medical Officer in Kaza, who has posted there now almost a decade, has improved the situation considerably.

<sup>305</sup> In 2003, 100 paisa = 1 rupee; 55 rupees = 1 euro.

Manali, Riwalser, Dehra Dhun, Dharamshala, and Delhi (the latter three are reachable within a two day long drive). Health care in Spiti has become a radically enlarged and increasingly contested field with an increased number of participants and provisions that go far beyond the valley's boundaries. According to these increased and diverse offers, people's demands have accordingly expanded with their means, especially with the boom of individual financial resources at the end of the 1990s (Chapters 1.1 and 4). The more financial resources at hand one has then the wider the possibilities of health care. Spiti-pa's health care seeking behavior has changed in a pragmatic way. Similar to Samuel's descriptions of the Tibetans' health care seeking behavior in India (1999), or Janes' in China (2002: 279), Spiti people have typically just used the medical options they had been provided with, not ideologically bound to any one system.

#### *Health Care Seeking Behavior*

Before examining the impact of the new medical pluralism taking place regarding amchi, we first investigate the health care seeking behavior more closely here, beginning with an ethnographical account to illuminate the key issues at hand. In one of the upper villages, I met a well-settled Spiti-pa, who had a government job and ran a business with his family. He told me the following narrative:

One time, my granddaughter had a cold that just got worse and worse. We brought her, after some time, to the Kaza hospital where she was diagnosed with tuberculosis. My family and I were not convinced of this diagnosis and we went to a private hospital in Manali. There, they had an x-ray done and diagnosed the white clouds between her skin and ribs as pus or water. My granddaughter stayed there for seven days and received treatment which should have made the 'clouds' disappear. Then they gave her another medicine for ten more days, but after all this she was still not cured and her problems remained. Nevertheless, the private clinic released her to go back home, and when we were back in Spiti, we went again to the Kaza hospital. There, the doctors were very engaged with her treatment but could not successfully treat it either. One day, one of the most famous Spiti amchi, who is also our relative, came to our village to collect some medicinal plants. Visiting our house, he became aware of my granddaughter's problems and, hearing the story, he asked us to give him a chance of seven days to help her. We were not convinced because we were just about to

bring her to the big hospital in Chandigarh, and did not want any further risks or postponements of her treatment. But the amchi went up to the mountains, found and prepared the needed medicinal plant, and again asked us to let him have a try at helping her. After some discussion, though I was still skeptical, I agreed to this. My granddaughter went back with him to his village, stayed there for seven days and received the treatment he prepared for her. When she came back, we were overjoyed because she was fully cured.

Spiti people generally present a paradigm for the comparison between the two medical systems, the Tibetan and the “English.”<sup>306</sup> This situation is very typical and found in many other parts of Asia: the indigenous system is considered to be “soft, natural, slower in its effectiveness, but cures the core problem” and biomedicine is “strong, might have side effects and is fast in effect” (cf. Janes 2002: 278; Kuhn 1994: 71; Nichter 1996: 294; Samuel 1999: 94; Pigg 1995, 1996). Though these characteristics are competitive with one another, Spiti-pa are basically exclusively pragmatic in dealing with these systems. I have met no one refusing the option of one of the offers and, for instance, in most amchi households I even saw biomedical drugs being used. Most amchi do not only use biomedical drugs for themselves (which does happen in special cases) but I have also frequently observed them giving advice for a patient to go to a “doctor” because that treatment would be more effective or at least faster. From this level, there seems to be no competitive behavior on the amchi’s side.<sup>307</sup>

It also seems that amchi traditionally have a habit of transferring patients among each other in cases of difficult diagnoses or lack of medicine. In such cases, a competition between practitioners was clearly not in place.<sup>308</sup> In case of illnesses, especially long lasting ones, patients often use biomedicine and Tibetan medicine, switching between the systems and between practitioners and institutions in each

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<sup>306</sup> Biomedicine is often commonly called “English medicine,” probably a consequence of their use of the Hindi language.

<sup>307</sup> It is interesting to note that most biomedical practitioners posted in Spiti acknowledge the local healing system as well. They do not transfer patients to amchi, but this is largely a matter of non-information about the capabilities of Tibetan medicine. Most doctors had nothing negative to say about amchi and perceived amchi work more as a distant phenomenon not really of interest concerning their own practice. The Block Medical Officer, however, being in Spiti for a long time now, has tried to support the local amchi in an administrative way (see Chapter 5).

<sup>308</sup> If a village was home to two amchi (or even more than two, as with recent trends in certain regions of Spiti, see Chapter 2.2), they were not rivals because the patients were just shared according to existing relationships and networks. For more on these collaborative and non-rivalrous relationships among amchi, see also Kuhn from Ladakh (1988: 51) and Gutschow from Zangskar (forthcoming).

system. The longer an illness lasts, the more the patients generally re-consider using the indigenous patterns of diagnosing and explaining illnesses.<sup>309</sup> This is connected to the understanding that if medicine does not work for a disease, the reasons behind this must be searched for in the karmic and religious spheres. Thus, indigenous and religious practitioners become the more favored option at this stage of an illness. However, these descriptions of health care seeking behavior have so far remained on a somewhat superficial level, so what is interesting for my analysis is reflected in the people's presented pragmatism in their behavior. As mentioned earlier, Spiti-pa are extremely busy with their work in the summer. Many are rushing and hurried, though this image might be difficult to imagine sometimes. Naturally, this attitude is definitely more prevalent in Kaza and in villages of big cash crop cultivation. For reasons of saving time, most patients favor biomedical drugs, in particular pain killers, in these summer months.<sup>310</sup> Even if they know that their illness might not be cured by this drug, they rather prefer to be back at work as soon as possible. Being fully cured is then postponed until the winter when one has more available and free time. Time is thus a strong consideration and connected with the paradigmatic opinion of amchi medicine as slower but fully curing the core problem. In this way, apparently, amchi medicine thus subjectively contains more advantages in the winter, with biomedicine more so in the summer. Additionally, many villages are cut off from access to the hospital in winter<sup>311</sup> and are forced to evaluate between the remaining available resources in their region – a simply equipped health post (if at all) and/or amchi. During the last decade, health care seeking behavior has become strongly determined by seasonality, with biomedicine dominating in the summer and amchi medicine in winter.

Elsewhere, other accounts of perception on the relation between biomedicine and 'traditional medicine' have often revealed the notions that indigenous healing practices are blamed for their dangerous treatments; their users and practitioners are marked as 'backward,' and that 'modern man' uses biomedicine (e.g., Jeffery 1988; Langford 2002, Pigg 1995, 1996). In contrast, the perspectives of biomedical doctors

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<sup>309</sup> I have not delved deeper into the analysis on explanatory models of patients of healers (cf. Kleinman 1980 or Janes 2002: 277) but rather stuck to the structural and emotional sides of the doctor-patient interactions. Nevertheless, it seems to me that patients and amchi follow quite similar paths as illness explanatory models.

<sup>310</sup> Compare Pordié (2002), who has examined in Ladakh the comparison with biomedicine leading to a desire for fast healing among the patients, and thereby undermined the traditional medical practice that favors progressive steps in treatment. As a consequence, the importance of herbal medicine was raised.

<sup>311</sup> The hospital maintains in the peak winter months of January and February often only minimal service, as some of the doctors escape the strong winter to have a holiday with their families in the plains.

seem to believe that amchi medicine is not perceived as life-endangering to the patients because it is practiced as a by and large herbal medicine (see Chapters 3.1.2 and 5.3). Furthermore, Indians are very familiar with medical pluralism and the use of non-allopathic, mainly herbal drugs, following the diversified Indian medical system that includes, besides biomedicine, āyurveda, unani, siddha, and homeopathy as well. Therefore it is not such a surprise that biomedical doctors support a juxtaposition of the two medical systems.

I did not detect any stereotypes regarding the dichotomy of one system as ‘modern’ and the other as ‘backward’ from any patients. Overall, there are three factors for Spiti-pa that contribute a ‘traditional’ sense to amchi medicine without any negative connotations. The first of these factors is the support and supervision of Tibetan medicine by their highest religious authority, the Dalai Lama. The second factor involves the reviving and blossoming of Tibetan medicine in Dharamshala and elsewhere. And finally, the third is the significant amount of interest shown in the medical tradition of Tibet (and Spiti) by Westerners. Well-situated Spiti-pa even can be observed investing in gaining access to Tibetan medicine.<sup>312</sup> They might travel to the plains or Dharamshala and seek medical treatment of one of the well-known Tibetan physicians there. And as portrayed in the wedding ceremony at the start of this section, a revitalization process of local culture has begun, and medicine is part of this. However, it is recognized below that amchi medicine is not that strongly involved in this process. Thus, if one wants to state something about ‘being modern’ in this context, then we can say that ‘modern’ Spiti men and women use both biomedicine and Tibetan medicine for their health care matters.

To conclude this section on health care seeking behavior, it can be summarized that Spiti people do use the (new) medical offers and actively alter their health care seeking behavior regarding pragmatic concerns. Consequently, the individual village amchi suffers from a loss of the villagers’ demand. Only in wintertime do villagers ‘suddenly’ remember the importance of local practitioners for their health. It must now be shown how the amchi-patient relationship has actually developed as a consequence of these changes. Why was such a basic principle of organized society – mutuality – given up? And furthermore, how has this affected the amchi themselves?

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<sup>312</sup> The fact that wealthier Spiti-pa use a variety of health care resources supports Adams’ critique of previous anthropologists who thought that capitalist economy participation by the upper classes increased commitment to biomedicine (1988: 505).

*Breaking-Away from Mutuality*

I want to first start this theme with a general remark on how Spiti-pa assess these modern times. According to the Buddhist calendar (and common understanding in Spiti), this is the contemporary era called the *kāliyuga*. It is marked by a maximum of degeneration and mankind is afflicted very strongly by the three mental delusions. Spiti people refer to this epoch ‘label’ when they try to explain the societal changes that have a negative impact, for instance, when recalling earlier times when “everyone has been peaceful,” “people did not strive for money,” “today everyone works for himself,” or “earlier doors were just left open, no locks were needed.” Frequently, one can hear people (particularly the mid-generation Kaza-pa involved in business activities) complain about the present times and lament the ‘good old times’. During an interview, an amchi answered my question concerning the amchi-patient relationship as such:

The attitudes of the patients towards the amchi have changed. They have less respect, not like before, in the earlier age. Today, we have the *kāliyuga* and people have bad thoughts. Before, they had good thoughts and knew the importance of the amchi. [For example,] I once treated a truck driver from Spiti. After a successful healing, he wanted to give me money, but I told him to keep it. Instead, I asked him to take people and give them a lift with his truck whenever they needed help on a road. The driver promised to do so. One year later, I was with some people on the road from Manali and needed to go to Spiti. We had not been able to get a vehicle until this same truck driver came by. He did not recognize me and shouted at us that he is not a saint and wouldn’t take anyone with him.

Being aware of the ‘circumstances’ the *kāliyuga* brings with it, Spiti-pa treat contemporary changes and their presumably unpleasant outcomes intellectually as if they were part of a natural process. Practically, they try to adapt and deal with the changes that have infiltrated everybody’s lives in Spiti. I noted earlier that even though people complain sometimes about “the new things and the decline of the old way of life,” they get along with it quite well: consuming, incorporating and altering it for their own benefit – roughly speaking. Discrepancies, ambiguities and problems nevertheless have emerged from the social, political, and economic transformations taking place during the last one or two decades, and they are revealed now by the upcoming examples of amchi medicine.

In earlier chapters, the breakdown of reciprocal exchange in Spiti society and the consequences of this on the amchi has been broached several times, like for instance the reduction of time spent on amchi work and training. Though the social and economic spheres of this subject are closely connected, I separate them in order to give the economic dimension in this thesis a particular significance (in Chapter 4). In this way, we can fully concentrate (as much as possible) in this chapter only on the social sphere and its transformations.

As an unusual introduction to this topic, it is interesting to note that in Tibetan medicine theory, the social dimension is hardly considered at all (cf. Cantwell 1995: 175). Social factors are never presented as a possible cause of illness,<sup>313</sup> nor are the relationships between the amchi and patients ever emphasized. Though the *Rgyud bzhi* does give advice as to how the patient and the amchi should behave with each other (see below), it does not elaborate on the social interaction between the two. It seems as well a non-existing theme in the modern Tibetan literature. On the other hand, in this thesis it becomes more and more clear that the relationship between an amchi and patient is central to the process of healing, as well as for amchi medicine overall, which is further elaborated upon now.

Social organization of the villages is based on a threefold stratification and reciprocal exchange system, as introduced in Chapter 1.1. Though particular situations and conditions of a village might be gradually distinct in different villages, common lines can be recognized in all. Amchi were traditionally closely integrated in the community system and organization but were also provided a special position. They have usually said to have belonged to the *chahzang rigs* and inhabit the *khang chen* of a family, both of these honors granting them a high social status. Mutual aid networks existed in-between the *khang chen* and *khang chung* of one family, and in-between households of distinct families. These networks were configured as such to owe social preference to the *khang chen* (family level), *chahzang rigs*, and especially to the amchi (both on village level). The major changes I've been describing (road infrastructure, biomedical health care system, school systems, cash crop cultivation, wage labor, and

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<sup>313</sup> That is, unless one believes interactions with spirits to be considered social factors. Some people do believe they are factors, but for the purposes here we stick with a more narrow focus on social factors limited to the mortal realm, excluding spirits and deities.

the growing dependency on such factors) support a growing individualization and displacement of these once-customary networks.

The social consequences from these changes can be observed in two subjects: the organization of the networks, and social status. Concerning the amchi, they have felt more consequences occur in the collective organization of neighborly assistance than in the subject of status. Therefore the theme of networks must be dealt with before we can examine status changes. With the introduction of cash crop cultivation, villagers have generally found themselves to be extremely busy in their fields, which is now additional work in order to persist in their subsistence economy. Spare time has become meager, but as a result, cash resources have become available, enabling people to hire laborers. The need for mutual aid networks has decreased because of this and joint rotational village works were repealed. While some of these joint works are still in use today, others have been omitted. Amchi were not immune from this and it can be concluded that the former social collectivism (from which the amchi had benefited and enabled them to spend a sufficient amount of time on their medical occupation) declined.

For reasons outlined throughout the course of this chapter, amchi never actively complained about this decline of village support. Most Spiti amchi were definitely affected by these changes, but coping was easier for some than others. Only very few amchi continue to enjoy the former state of mutual village aid.<sup>314</sup> These amchi insisted in conversations with me that it is a matter of keeping good relations with their villages. It should be added that these amchi in particular were well-established old lineages in their villages. This means they derived from the local amchi *rgyud-pa*, thus had personally served their people for already two decades or more, and were therefore quite respected in their communities. This most likely was a different case in villages where a break of the continuous amchi practice had taken place, usually caused by the death of the old amchi. Villagers' attitudes and an amchi's established reputation were not simply handed down to the amchi's successor. Amchi who are young in age (belonging to a lineage or not) and new amchi (from other villages or the surrounding valleys) usually need to work hard to gain their respective social standing. My surveys conducted in several villages revealed that the changes in the traditional social system had been subtly developed and were gradually established without the public even being

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<sup>314</sup> Pirie reports similarly from Ladakh that depending on the local circumstances, the reciprocal system was retained in some villages, while in other villages it was dissolved (forthcoming).

aware of such changes. Consequently, the question of whether this development included a loss of the amchi's social status is therefore raised.

### Social Status

In Tibetan village communities, religious and medical practitioners are typically regarded the highest social status, just below that of the Buddhist clergy (Besch and Guérin forthcoming; Craig forthcoming; Kloos 2005, forthcoming; Pirie 2001, forthcoming; Pordié 2002). The ability of performing dharmic practices and of lecturing on Tibetan religious texts has a decisive influence on this status (Kloos forthcoming; Pirie forthcoming). As both of these skills are part of the work astrologers do, and not necessarily work of an amchi, the astrologers thus have a higher status than the amchi in a village. In Spiti, most villages do not have a *dgon pa*<sup>315</sup> and, in the absence of a chowa,<sup>316</sup> the amchi thus hold the highest social position in an actual village context. Publicly, this is displayed and confirmed at gatherings and festivities, in which a fixed seating line (Tib. *gral mgo*) provides the 'top' seat to the most honored guest. In Ladakh, the establishment of this seating line is of great importance, and often merges into a playful performance or ritual. For example, if a guest visits someone's house and is given the honorable seat, the guest will then demand a lower seat. Following this, the host and guest will then argue back and forth, sometimes even lightheartedly physically pulling each other to the respective seat. This demonstrates one's humility and modesty, though often resulting in the original arrangement anyway (seating orders are quite fixed at times) (cf. Pirie forthcoming). In Spiti, the seating line is also established at many occasions, but is not displayed as seriously and explicitly, in order to show respect and humility.<sup>317</sup> Spiti-pa know their respective position and do not usually try to play modest, but rather just assume the proper seat. I even attended village gatherings in which the seating order was not taken into account at all. Spiti-pa also consider themselves to be more rough and direct in their behavior (as well as in their language) compared to the Ladakhi. I have been told that this perception is nothing new and that people see this as a typical characteristic of themselves and their region. Today, the *gral mgo* and the 'traditional' hierarchy of social status continue to be considered, though

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<sup>315</sup> An exception to this is Pin valley, where the Nyingma-pa lama did not live in monasteries but in the villages, so they kept their highest positions.

<sup>316</sup> Chowa are, at least today, less numerous than amchi.

<sup>317</sup> But take care to remember the example of Amchi Tsering Dorje's modesty when visiting Tashigang, presented in the prologue.

new powers have emerged. School, college education, and recently accomplished wealth can all contribute to a person's increasing influence in a village, but nevertheless will not displace a long-standing position of a family.

The granting of status to an amchi, thus, is built on tradition, long relationships between amchi families and villages, and their individual capabilities (literacy in Tibetan, religious practices, etc.). Status is therefore a combination of collectively granted traits (ones standing generally for all amchi, and ones for all amchi of a particular lineage) and of individually granted characteristics. Concerning the first aspect on collective traits, it can be stated that the traditionally granted status of the amchi continues on to the lineage amchi into the present. This is proved by the undiminished continuation of giving amchi one of the highest seats in the *gral mgo*. It is as well illustrated in the previous description of the marriage in Kaza, at which the amchi led the line of dancing men. Jahoda supports this observation through his study in Tabo (2003). He states that, in general, the status of amchi and chowa have remained the same, and just the reputations of the family lines have declined and the social privileges were then dissolved if the occupation was not practiced anymore (ibid.: 267 and 279). This brings us to the second point: individually granted reputations. In earlier chapters it was mentioned that among the amchi exists a diverse set of characteristics regarding literacy/knowledge, as well as training in religious practices. We also came across several further factors that contribute to the social reputation and power of an individual amchi. In the course of Chapters 2 and 3, most of these determinants were identified and each one explored. Here, they are reiterated in order to put together a complete picture. From the discussion of 'traditional' amchi education and the importance of lineage transmission (Chapter 2.1), *knowledge* and *experience* emerged as 'soft skills'<sup>318</sup> that are especially valued by patients. The examination of the *pulse diagnosis* (Chapter 3.1.1) revealed the ambiguity of dependency and the intimacy of the amchi-patient relationship at first touch. The magic of pulse reading resulting in the 'right' diagnosis was determined to help constitute the amchi's authority. From there, the elaboration of medicine (Chapter 3.1.2) and ritual (Chapter 3.1.3) then diverted the – by then, quite evident – significance of the *efficacy* of the amchi's treatment. Success from a treatment was fundamentally grounded in the patient's *trust* in the amchi's capabilities and effectiveness of his medicine.

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<sup>318</sup> Generally understood as skills that are not really measurable, but rather depend on the amchi's appearance and the patient's estimation of him.

From this comprehensive list of parameters that make up an amchi's reputation, we can conclude that the parameters themselves have not changed under the influence of modern times. Rather, their particular importance in making up the amchi's status has probably gradually changed, as shown below concerning the emphasis on trust. Furthermore, in Chapter 2.3 we touched upon the fact that modern education is becoming increasingly valued, evidenced by the high number of current students at the Tibetan Medicine Institute Manali. However, this factor instead concerns further political questions dealt with in the upcoming Chapters 5.2 and 5.3, which explore the issue of legitimation. Instead, for now we turn back to the issue of trust, which still needs further elaboration.

All amchi with whom I discussed this with stated that no healing is possible without the patient's trust and confidence.<sup>319</sup> The establishment of confidence in the amchi-patient relationship<sup>320</sup> is an interactive process between the amchi and patient, created through the interplay of all the previously mentioned factors throughout time – deriving not only from the present amchi, but from his predecessors as well. However, maintaining the prominent position among the various factors in gaining confidence are the moral virtues that are ascribed to the amchi, as explained in Chapter 2.4. Examining his inner qualities, the emphasis remains that the amchi should have a “good heart” (Tib. *sems bzang*). Having a “good heart” is a demand adopted by patients and amchi and derived from the dharma and the Tibetan medical scriptures, at least in their representations. An amchi is thereby expected to strive for the perfection of the Bodhisattva ideal in his thoughts, words, and actions. In a village context, the amchi's morality and ethical code of conduct, which are oriented on religious lines, constitute a large part of the respect and the reputation shown to him (cf. Pordié 2003: 51). Both qualities form the basis of the amchi's medical power, as well as the effectiveness of his treatment. Visible to the patient is however, the amchi's charisma, as shown through his altruistic, compassionate and humble behavior.<sup>321</sup> By referring to the Buddhist dharma,

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<sup>319</sup> Various authors have underlined the outstanding importance of trust and confidence in a doctor-patient relationship regarding the healing process (e.g., Kloos forthcoming; Langford 2002: 225; Moerman 2002; Pigg 1996: 185; Pordié 2003).

<sup>320</sup> Kleinman's model and examination of patient-healer interactions (1980) do not serve for my purpose here as they are not dealing with social change or the power applied to the relationship by either side (cf. Pappas 1990). Neither is his central theme (the translation between doctor and patient) an object of my consideration.

<sup>321</sup> This is as well the reason why one will never hear an amchi complaining about the decline of village support.

amchi usually claim to hope they can collect enough merit for a “good rebirth” in the next life.

At the core of the amchi-patient relationship we thus find the socio-religious concepts of morality and conduct on the amchi’s side, and respect and confidence on the patient’s side. Each of these factors is expected from the respective side, and, in cases of fulfillment, believed to make up the decisive part of healing. In view of this analysis, it becomes evident why Spiti-pa emphasize that an amchi “suits” a patient if a treatment has been successful (Chapter 3.1.3). However equally valid these principles of interaction have been in past and present, a question is nonetheless raised now in connection with the long interview presented with Amchi Tsering Dorje in Chapter 3.1.2. This question was, namely, why amchi emphasize trust so often in these present times. Despite its obvious and proved relevance for the healing process, one could argue that the accentuation of trust is a consequence of the dissolved dependency situation. As patients do not have to regularly visit a single particular amchi anymore, it has left a gap in the amchi-patient relationship. The amchi seem to demand that this gap now be filled with trust, because the patients who consult them ‘must’ therefore have confidence in their healing capacities.

### Village Politics

Before giving an ethnographical example of an amchi involved in village politics, I make here a general statement on the subject of the special circumstances of being an amchi. Especially among younger amchi, I witnessed a kind of ambiguity resulting from inconsistent interests and social demands. They are positioned in-between being young men, heads of their households, laborers (farmers, self-employed businessmen, or employees), members of a community, and being an amchi, the last of from whom high moral virtuousness is expected. It therefore can not be that surprising that amchi are sometimes caught by an accusation of immorality when they do something that is not so virtuous. Even though many amchi represent the high integrity of being an amchi, they often explain that they are as well ‘just human beings’ with human wishes and needs – especially when it comes to the duty of caring for their family.

The sensitivity of political issues in connection with amchi medicine was broached during my stay in Kibber. The village was seriously split according to political party lines corresponding to family lines. Quite often, quarrels paralyzed community matters. The former amchi – he had died a few years back – was reported to have been

clever and taken a neutral position in these politics, even though his family clearly belonged to one of the sides. This was taken as a sign of his moral virtue. I was told by the villagers that his son, Amchi Tsering Dorje, had not been so clever and had actively supported one of the three parties during an election campaign. People did not understand why he did not follow his father's example in this matter. His attitude was considered inadequate and decreased his good reputation. Politics in this village were a sensitive issue, and the young amchi squandered his reputation, which was not that high anyway, as he was young and had little experience.

In Kibber, many activities can be quickly acted upon as a political issue or discussed along the various social fissures. During my stay, the amchi behaved according to the villagers' general expectations. I attended several village meetings, some of which concerned directly or indirectly amchi matters.<sup>322</sup> The amchi surprised me with his absence at these meetings that directly addressed amchi objectives, or through his strict restraint. If he was present, he didn't speak a word but rather looked down, though he did carefully listen to the ongoing discussion. I do not know if this behavior was a consequence of the above mentioned previous incorrect behavior assigned to him, but it was definitely the attitude expected from him as a young man not holding a public position, like for example in the local youth association (of which he was an ordinary member).

In Chapter 3.1.3, it was mentioned that Amchi Tsering Dorje stood out from most of his villagers in his show of respect to the people in the *beda rigs*. In cases of illness, especially if it is presumed that a spirit affliction is the cause, he is their first reference and option of health care for them. He obviously enters their houses, and his house is open to them, at least, in so far that they do not hesitate to go there and stay for some time, and perhaps drink some tea. The amchi's well-known duty to treat everyone who comes to him is not merely an obligation to him, but rather also a chance to justify his sometimes unconventional convictions, actions and beliefs. However, his duty to treat everyone regardless of prejudice or peculiarity is clearly estimated as morally higher and more important than the viewed social marginality of certain people. This is agreed upon by all the people, and gives the amchi freedom to act socio-politically. As mentioned earlier, the socially and economically marginalized *beda* are limited in their possibilities in protecting themselves from the consequences of the villagers' offences

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<sup>322</sup> Some of them dealt with the watershed problems or environmental care, others with the protection of medicinal plants or financial support to the amchi.

to the local deity. Their exposure to those powerful forces has made them rely on the amchi on treating the effects of this. Amchi Tsering Dorje, by treating these illnesses, has cured a consequence of the social and economic inequality in the village. In this sense, he rebalanced a social disparity. This fine line between health care and political action is thus further blurred, reflected also by the fact that people told me that the amchi then uses his connection to the musicians for political ends, though I could not verify this accusation. However, the amchi has become a major subject in the contested field of village politics. A medical action performed can bring him personal problems, but he can also use it as a conscious socio-political act. Yet whatever an amchi's intentions, this particular example has shown that the norms and values of a community restrict the expansion of an amchi's social power based on his medical power.

This investigation of the socio-political role of the amchi is supported by three authors who have all worked in Ladakh. Pordié has produced evidence of normative structures of village societies that ensure that the practitioner of Tibetan medicine does not apply his power for his individual socio-political ends but solely for the medical field (forthcoming a). Pirie extracted the same separation between the medical and political spheres from her ethnographical account on politics in a western Ladakhi village (forthcoming). However, Kloos closely explored the establishment of social power by an amchi in a northern Ladakhi village that obviously yielded him a controversial and discordant reputation, which he is only able to conquer by having a large stock of medicines (forthcoming). Even so, social tensions remained and Kloos detected that the amchi's non-conformity to social standards ultimately undermined the villagers' trust in him and thereby the perceived efficacy of his medicine.

It can be concluded from the parallelism of Ladakh and Spiti that the village practitioners of Tibetan medicine are strongly bound to the consensus of their communities (cf. Meyer 1992: 2) established by their normative structures. Amchi are embedded in their societies by the ambivalence of a social reciprocity that grants them a high social status but also restricts the application of their power in the social arena. Both the representation of and orientation towards the amchi's high morality serve in this way to affect his status and social restrictions. The example of Amchi Tsering Dorje is no exception to this; he remains in the medical field, and when (if at all) he uses his work in accordance with his duty, it's to rebalance a socio-economic inequality but without any gain of personal benefit.

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*Individual Amchi-Patient Interactions*

It is now time to have a final and more personal look at the amchi-patient relationship. Generally, it can be stated that the relationship between an amchi and individual patient is very personal and sometimes intimate, although one could object this by stating that a doctor-patient relationship must necessarily be like that, which is certainly correct. However, the particular relevance to this point is that the medical interactions between the two always take place in either the patient's house or the amchi's house. Typically, the kitchen is used for this purpose, being the central location of social interaction in Spiti households. Thus it happens that a patient will then often explain his or her problems in front of the entire amchi family, and family members then sometimes participate in the conversation, even offering advice at times. Further closeness is then fostered by the fact that in emergency cases, patients can (and do) call their amchi at any time of the day or night. An amchi might then stay with the patient for hours, or even the whole night if the illness and patient's condition is seriously bad. All this presupposes that fact that the patient has trust in the amchi and his family, and that the relationship between them is a personal one. Depending on the actual health problems and the understanding between an amchi and patient, their relationship can become intimate as well, although obviously this term has a different meaning in Spiti than in western cultures. The amchi's examination is to a great extent – with the exception of the pulse diagnosis – non-tactile. Though the importance of this special *touch* has been investigated, and we have seen that in special cases a mentally ill person is often touched in order to reinforce certainty and reassurance, it is very rare that an amchi will touch a part of a patient's body to feel the consistence and composition of the tissue. Touching is usually done over the clothes because only an exceptional situation would ever involve the partial undressing of a patient. Intimacy is therefore a term solely concerning the level of knowledge about the patient's inner condition and the connected emotions. Empathy and charisma seem to be the two characteristics of greatest importance.

Concerning manners regarding interaction, the amchi and his family usually behave especially courteously towards the patients. Working on this topic in Spiti, as well as in Ladakh, I found it surprising that patients (especially because of these manners) sometimes felt uncomfortable and then hesitated to visit the amchi at home. Such reluctances have increased since people have become increasingly aware of everyone's busy-ness, time restraints, the rising of individualization, and the partial

dissolution of the reciprocal exchange system.<sup>323</sup> One example was reported in Chapter 3.1.3 when the wife of the mentally ill patient said that she had not called the amchi because she knew he was busy. These changes in the society of the last decade have not stopped just in front of the amchi's doorstep, but have made it inside, having an impact on the personal relationship between amchi and patient. What people perceive and name as *kāliyuga* has natural consequences on the personal level, and so the amchi as well as the patients have to readjust themselves and their relation to each other in this new light.

The central cause for this change in the amchi-patient relationship is the increased medical pluralism, i.e., the dissolution of the amchi's monopoly and the patient's newfound variety of health care choices. In biomedical institutions in Spiti, the relationship between the doctor and patient is of rather little importance. Here, classical patterns of cultural misunderstandings and translation difficulties can be observed (cf. Kleinman 1980). But concerning Tibetan medicine, one can also detect a positive consequence of the change: reduced by seasonal adversities, many patients are now in the position to choose the practitioner of Tibetan medicine whom they trust the most and whom they believe will restore them best to health. Similar to the above recounted narrative of the family trying out several biomedical institutions and a Spiti amchi to find the best successful cure for their granddaughter, Spiti-pa today use the opportunities of the new modern infrastructure and consult several practitioners of Tibetan medicine in Spiti and in the Indian plains when confronted with illness. Well-known Spiti amchi might be the first points of reference, but practitioners in Manali, Dehra Dhun, Riwalser, Dharamshala, and Delhi are frequently visited as well. Traveling to these places for religious, business or other purposes can be combined with seeking treatment, in a case of a long-continuing or chronic illness. Sometimes, people travel especially just to visit a particular amchi. The new infrastructure makes this travel only last a half-day (Manali), one day (Riwalser), or two days (Dehra Dhun, Dharamshala and Delhi); even successive treatment is easily possible by ordering the needed medicine by telephone and getting it sent via the mail.

The new pluralism among practitioners of Tibetan medicine has two sides for the Spiti amchi. First, amchi medicine has become an increasingly contested arena, in which an amchi must somehow stand comparison to the elaborate practitioners of the famous Tibetan colleges (past or present). Some amchi might even perceive a patient

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<sup>323</sup> These facts are deepened regarding the context of money in the amchi-patient relationship described in Chapter 4.

drain. On the other side, many patients – except when factoring in the conditions of winter and financial scarcity – are able to consult the amchi they prefer. Thus, an amchi can be relatively sure that a patient who is visiting him for treatment has confidence in him. It has become less a matter of need than one of will in seeking treatment from a particular amchi. This then supports the fundamental factor behind a successful cure – confidence in the amchi and the treatment. This can definitely be perceived as a benefit.

Chapters 2.2.1 and 3.1.2 pointed out the various reasons that result in a general loss of the time an amchi can dedicate to his education, the decline of lineage transmissions, and the reduction of average medical knowledge and medicines in use. In combination with the analysis above, it can be generally stated that the amchi's reputation and social acknowledgements have decreased over the last decade. In line with Kloos' observation (in Ladakh) that an amchi's popularity is strongly determined by his medical skills and stock of medicines (forthcoming), the diminution of both of these features has contributed to a loss of popularity in amchi medicine concerning many amchi in Spiti. However, there remain a few Spiti amchi who enjoy undiminished popularity in their villages and all across Spiti. Others are still a popular refuge for health care within their villages. Amchi who enjoy good reputations also benefit from a higher number of patients, which then multiplies their experience and possible skills, further helping their reputation. Yet others do not benefit from this positive multiplication process and remain with their lower social and medical reputations.

In the next chapter, a closer examination of one particular amchi in Kaza (the most 'modern' setting in Spiti) highlights the amchi's role in this particular social milieu and further inquires into the development of amchi medicine. In the 1990s, the entire amchi community had recognized the consequences of current social change and tried to cope. Chapter 4 further elaborates their economic dilemma and some of the measures amchi have taken to conquer it. Chapter 5 then deals with the way in which amchi are trying to develop a structural adjustment to the crisis.

### **3.2.2 Alienated in Kaza**

After the general overview that's been given so far on the amchi's social position and their interactions with their patients and respective villages, this chapter now provides an actual example of these issues with one particular amchi in Kaza: Amchi Thupten

Thapke. Kaza is not only the biggest village, but also the administrative, infrastructural and geographical center of Spiti. It is home to numerous facilities and a growing number of Indian government officials, business men and the like. Modern communication and transportation facilities (including television, telephone, internet, bus lines, taxis, etc.) are all started here and combine to form the main ‘port’ to the outside world. Kaza is by far the most adapted and visibly integrated village in Spiti, and the quickest in acclimatizing itself to the rapid social and economic changes still taking place. Through examining the situation of an amchi in this extreme village, I hope to familiarize the reader with such complex issues as the being of an amchi in this modern environment, and whether or not the new structures of organization have an impact on their social status. These important matters are exceptionally relevant to my thesis as a whole, and so I now begin by telling more about Amchi Thupten Thapke and how his story reflects certain aspects of the situation for other amchi today.

#### *Being an Amchi in Kaza*

Amchi Thupten Thapke was introduced in Chapter 2.2 concerning his religious and medical career that made him finally settle in Kaza with his family, open a merchandise shop, and practice as an amchi there. Amchi Thupten Thapke has now practiced in Kaza for more than ten years. Nevertheless, he is neither considered ‘the’ amchi of Kaza nor does he have the social status normally given to a village amchi. Why is this so? To begin with, he does not belong to the amchi *rgyud-pa* of Kaza, and he has been away from Spiti for quite some time. Furthermore, he is more a son of Lidang rather than of Kaza. This somehow corresponds to his own sentiments as well, which is demonstrated in the following explanation of amchi practice that I must briefly introduce here: when an amchi is called to come to a patient, he will usually go wherever he is called. Nevertheless, this normally counts only for his own village, and possibly the surrounding villages that lack their own amchi. Additionally, amchi are sometimes called upon to help relatives, friends, or close patients from other villages. This happened to Amchi Thupten Thapke once in 2002, when his father was ill. Naturally, he then went to Lidang for several days and treated his father. The following winter, he was then called upon by other patients also from Lidang because there was no resident amchi in the village or nearby. Because of Amchi Thupten Thapke’s connection to the village, they called for him and he thus looked after them. At that time, the five kilometer long road to Lidang was covered by snow. He then had to stay overnight at

Lidang and, getting no transportation back, had to walk all the way back the following day as well. It took him hours to hike the harsh the snowed road. All the same, he feels quite attached to the village. He could have postponed the patient's visit (and for good reason), yet in this way, though having never lived in Lidang, he shows himself to be more a Lidang-pa than a Kaza-pa.<sup>324</sup>

The question of his social status takes an even more unusual shape if we also consider the following situation: In Chapter 3.2, I presented a description of part of a wedding in Kaza in 2003, which was arranged by the new upper-class. In the recounting of this event, I pointed to the extraordinary position Amchi Urgen Tsering had been given in the festivities, as well as to the fact that at marriages and celebrations the village amchi is usually provided one of the first seats in the *gral mgo*, thus showing his top rank in the community. The main part of this Kaza wedding took place in a big tent at the husband's house. It was obviously different from the usual common marriages in Spiti because many guests had arrived from all over, including Delhi, Manali, Lahaul, and Kinnaur. Seated upon the top side of throne-like armchairs were the highest ranking guests: the Ven. Lochen Tulku (the reincarnation of Rinchen Zangpo), and Sonam Angdus (the former king of Spiti, with his wife). Below and in front of them followed the highest representatives from the Indian administration in Spiti, as well as further special guests. Next in the seating order were some dozens of men mixed from the new Kaza bourgeoisie, the highest traditional Spiti stratum, and the most important relatives from the two families. All these guests were dressed in newly made silk Spiti dresses. From thereon out to the end of the tent sat the rest of the guests, ordinary women and men spread out on blankets and carpets.<sup>325</sup> To the side of this in a separate side wing was the house's ground-level balustrade, where mainly young men and foreign tourists gathered, anyone who probably felt better to be a little separate from the rest. It was there Amchi Thupten Thapke sat with some of his best friends. Obviously, he was neither considered 'the' village amchi, nor socially important or honorable enough to be seated somewhere else. Even more, regarding this virtual 'who's who' in Spiti, not only

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<sup>324</sup> In Kaza, the concept of belonging to the members of the village, like being a Kaza-pa, is dissolving at the moment because many Spiti-pa from other villages and Indians settle there for reasons of occupation. Today, the majority of Kaza citizens are not original Kaza-pa. According to this modern structure, a new social system is evolving to include the ones who are newly settled there. This is visible in everyday life and also during celebrations. Nevertheless, there is still a noticeable line that distinguishes the original Kaza-pa, as they have built a core group referring to the "traditional" social system. Amchi Thupten Thapke, therefore, is definitely not a foreigner in Kaza, but also does not belong to the core group of native Kaza-pa.

<sup>325</sup> Party politics are of no relevance in this context.

did no one consider him to be a part of the society, he felt the same! For sure, Amchi Thupten Thapke doesn't want to belong to this new bourgeoisie<sup>326</sup> and it is not his goal to do so. Nevertheless, another amchi, Amchi Urgen Tsering from Pin valley, sat among the traditionally dressed, important local community members. He had been rewarded that special position during the dancing and the celebrations, but not just as a result of being an amchi or relative. Rather, he has descended from one of the most important religious families of Pin valley, locally famous, both in past and present. Furthermore, Amchi Urgen Tsering himself is a very traditional figure, educated in the old time-honored way and was one of the eldest men at the party. It was thus for all these reasons that he had received this honorable position, though being an amchi was also an important factor. However, in the social hierarchy of the new bourgeoisie, there is no place for an amchi like Amchi Thupten Thapke – an amchi without a strong family tradition or the best modern or traditional education (at least, in the bourgeoisies' eyes).<sup>327</sup>

Drawing from this example then, there exists no identification with the public to the amchi who work among them in Kaza. Why does this mode of thinking apply to the general population as well as to the bourgeoisie? Concerning the new bourgeoisie of Spiti, one could possibly imagine that it is an anti-tradition oriented group that supports modern developments in any regard. While it is reported that similar groups of populations do often prefer biomedicine in terms of health care (Comaroff 1981; Frankenberg 1981), this can at least in part be rejected regarding Spiti. This is because currently (as this extremely 'traditional' bourgeoisie wedding shows), the local elite especially support a revival of local culture. On one side, they support traditional ways by investing into visits to far-away amchi or the Tibetan medical practitioners in the

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<sup>326</sup> This group is distinguished not only by wealth derived from several kinds of businesses, but also by a certain appearance which displays their wealth to the public and gives them an elitist appearance. In this context, someone once called them "the extravaganza", which perhaps even represents it better.

<sup>327</sup> Both modern and traditional educations are valued in this group of people. But, as mentioned in Chapter 2.2, Amchi Thupten Thapke belongs to the generation which did not receive a proper school education because when he was young, schools were just being set-up in Spiti, and his parents were not able to send him to an institution in the Indian plains. Instead, he became a monk and learned classical Tibetan. Through staying in a monastery in south India, he is able to speak modern Tibetan as well. But he did not learn proper Hindi among the Tibetans. Hindi is today considered central for recognition of a good education in Spiti. Therefore, he is not considered to have a modern education – which people even sometimes equate with "illiteracy" – and, although he knows Tibetan, he did not receive this knowledge from a family lineage and does not belong to the monastic order anymore.

Indian plains.<sup>328</sup> However, on the flip side, this group also demands special treatment by the practitioner they consult. The amchi they consult should definitely have had the best possible education, whether in the modern or the traditional way. This includes practitioners of Tibetan medicine qualified from Men-Tsee-Khang as well as amchi deriving from a well-known Tibetan or Spiti amchi *rgyud-pa*, who have finished the full course of studies with their predecessors.

Amchi Thupten Thapke belongs to neither one nor the other group of amchi as described above. One could speculate that an official diploma and the support of Lobsang Dolma, his famous teacher, would have counted positively towards his reputation in Spiti. But, as always, there are more facts to be considered. Using another example, Amchi Norbu Gyaltsen, for instance, belongs to the Kaza bourgeoisie and has a diploma from Men-Tsee-Khang (see Chapter 2.2). Nevertheless, he is no real point of reference when it comes to amchi consultations in Spiti. This is because of his long absence from Spiti when he received his education, as well as his continuous frequent absences for several months at a time. Although he is actively working medically and owns a good stock of ready-made medicine, due to his engagement in several kinds of businesses he has, until now, not been qualified in the eyes of Spiti-pa to be regarded a proper amchi.<sup>329</sup> Amchi Thupten Thapke, however, is not reproached for being a “businessman” because his is a small business that obviously does not show a big profit, in contrast to Amchi Norbu Gyaltsen’s.

However, what counts more in the issue of relationship between the community and its amchi is the amchi’s absence from Spiti. Both of the above amchi have been away for long periods of time, which thus makes it hard for local people to identify with them. Amchi Tsering Dorje in Kibber was in the plains for some years as well, but only a few, and a major difference is that he belongs to the amchi *rgyud-pa* inherited to the village. Amchi Thupten Thapke and Amchi Norbu Gyaltsen are both not from the Kaza amchi lineage. As amchi, they are therefore not rooted in the village. They miss this legitimation and so people do not strongly identify with them, a feeling which applies to the bourgeoisie as well as for all Kaza-pa. Amchi Thupten Thapke’s position at the

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<sup>328</sup> Transportation by bus within Spiti is very cheap, so journeys in the valley are affordable for everyone. Visiting the plains becomes more expensive because of the travel expenses and the accommodation needed for several days.

<sup>329</sup> Additionally, factors offered in previous chapters play a role in this, as for instance the fact that he is not considered to have the full transmission of knowledge needed for Spiti, and therefore not able to make medicine from local ingredients.

wedding<sup>330</sup> is therefore more understandable, as well as for his overall low status in Kaza.

Additionally, as a result of Kaza's central location, it is made easier for patients there to have access to amchi all over Spiti and beyond. In Kaza, a pluralism of medical practitioners is given all year long. Furthermore, the new settlers in Kaza stemming from all over Spiti still identify themselves with their home villages and the corresponding amchi, when there is still close relationship there.<sup>331</sup> Kaza is thus fundamentally heterogeneous, but not only for this reason. A close relationship between Amchi Thupten Thapke (more a Lidang-pa than a Kaza-pa) and the Kaza population has, until now, not been developed. But this does not mean that he is not frequently visited by Kaza-pa health care seekers. However, the dependent relationship that is traditional in the villages between amchi and villagers has never existed between Amchi Thupten Thapke and the Kaza-pa, as there is no foundation for such a bond. Even if Amchi Thupten Thapke is a fundamental help for the well-being of many, it is of no relevance to the community as a whole. Amchi Thupten Thapke had known this when he originally settled in the village some ten years earlier.

#### *Drawing Status from NGO Activity?*

From the beginning, Amchi Thupten Thapke's long-term plan to actively practice amchi medicine had always been something different than just becoming a village practitioner. In Chapter 2.2, I introduced his pioneer work for the establishment of an amchi organization, the Spiti Board of Amchi Sangh (SBAS), and its Amchi Clinic in Kaza. The motives and background behind these steps of institutionalization and further development is further investigated in Chapter 5.1. Here, drawing from Pordié's findings in Ladakh, where amchi have regained status in the modern adjusted society by being part of the development and of NGO institutions (2003: 59), the obvious question arises of whether Amchi Thupten Thapke's engagement in the SBAS had any influence on his social status in Kaza.

With regard to 'development industry' implementation, Spiti cannot be currently compared with Ladakh, whose first development projects started back in the mid-1970s. In Ladakh, such projects started as a consequence of increasing tourism, which then

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<sup>330</sup> If comparing these two latter amchi, one might ask about Amchi Norbu Gyaltzen and his attendance at the wedding. Unfortunately, he was not there, so nothing can be directly compared in this regard.

<sup>331</sup> Though modern infrastructure contributes to a growing division between amchi and their communities (see Chapter 3.2.1), relationships between amchi and patients remain intact.

brought over Westerners who took an interest in development for the local people. As tourism and thus its consequences were delayed in Spiti due to its remote position (see Chapter 1.1), the first development initiatives only began in Spiti in the 1990s.<sup>332</sup> Though the engagement of international, national and local NGOs have increased since then, it is still quite limited. However, large fields and a network of various organizations that bring about strong social and economic impact on the local population – as has happened in Ladakh or Nepal – is not yet the case in Spiti. Some NGOs have naturally had an influence on Spiti, but not to the same large degree as they have elsewhere. This is because NGOs are still in their beginning phase in Spiti, being few in number and limited in scope. Most existing NGOs in Spiti are currently active in preserving natural and cultural heritage and building up education, not in economic and social developments. A further reason NGOs have not yet had a significant economic impact is due to their methods: only a very few Spiti locals are employed with an NGO, and even then, usually on a very temporary basis (such as hiring an amchi for a day to learn about the local plants). In this way, the NGOs are anything but a direct economic or social stimulant.<sup>333</sup> Nevertheless, Spiti-pa generally appreciate the ongoing development work done by NGOs, such as an organized school with a high teaching level or the projects encouraging various skills (learning Bodhi, traditional dances, etc.). They also view a position within an NGO as a desirable goal, as NGO's become increasingly respectable institutions with visible results; yet I never found a change in anyone's social status or reputation by working for an NGO, as the case in Ladakh (Pordié 2003: 59), and I believe this will hold true for Spiti in the future as NGOs expand.

The SBAS and the Amchi Clinic have been recognized by the population. The Amchi Clinic has an increasing number of visitors but still does not have a famous or even well-known status.<sup>334</sup> The SBAS has been perceived until now (in 2004) as a group trying to benefit the amchi community.<sup>335</sup> However, as an overall benefit for the Spiti population has not yet been perceived, there is presumably no social relevance for

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<sup>332</sup> One of the first projects set up in Spiti was the Munsel-ling school, by the *Rinchen Zangpo Society for Spiti Development*, established in 1993 in Rangrik.

<sup>333</sup> The contemporary development scene – if it can be called that at all – is quite diverse and overlapping, but networking is not underway. Spiti-pa are still not very confident about their work and wait to become further engaged with it until (in their perception) the first positive results emerge.

<sup>334</sup> For more details and information on the perception of the Amchi Clinic, see Chapter 4.2.

<sup>335</sup> See Chapters 4 and 5 for a report on the changes taking place in 2004-2005. I did not have the opportunity to figure out if any consequences have emerged from these activities.

the community. Concerning Amchi Thupten Thapke, his modern activities have not yet contributed to a more positive reputation in the village. Being an amchi who adjusts his life to the changing circumstances of Spiti modernity and his ideas of a future concept for Tibetan medicine in Spiti neither offers reputation on the ground of the ‘traditional’ value system nor on the ground of the ‘modern’, economy-based society of Kaza.

Chapters 2.2 and 2.3 contained the analysis that young men (and women) who want to become amchi in Spiti today are forced to go outside the valley to receive another medical education than the one available from the remaining Spiti amchi. A modern education is a good basis for becoming what is thought to be a “good amchi” and for slowly gaining a positive reputation. But we have also seen that in itself, this is by far not enough. Furthermore, by training and living away from the community for several years, this can leave noticeable negative differences for the future relationship between amchi and community. In the same way, being a new amchi in a village demands the (re)constitution of relations. The personal relationship between the amchi and patient has to be established in its own unique way, as shown in the last chapter. The relationship between the amchi and community, however, continues to be best grounded through lineage. This relationship is representative of the amchi’s social status in the village. For instance, being perceived as a “good amchi” is not equated with having a high social status. Status is bound to the tradition of lineage and community, and a village amchi has to be well integrated in his community to receive it.

### *Political and Institutional Engagement*

After approaching the question of deriving status by modern means from the community perspective, we now turn to the interactions with government offices. The ‘traditionally’ shaped status formation continues to play a vital role in any social interactions in Spiti, including communication with government offices, if these positions are indeed filled by Spiti-pa.<sup>336</sup> These positions sometimes increasingly display the superiority of ‘modern’ education, which is naturally connected to wealth and status. The result of these facts is namely that the first families who could afford to send their children to the plains for school education were the wealthier families of the

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<sup>336</sup> The relation to Hindu Indians transferred to office positions in Spiti depends very much on their individual attitude and behavior. Some of them act respectfully and engage in the local matters, while others are irritated at being posted in this high altitude periphery and so do little work and behave in a disapproving manner.

upper strata, the *nono* and *chahzang*.<sup>337</sup> Though presently this situation is changing and people applying for government jobs in administration are derived now from a broader social spectrum,<sup>338</sup> the fact remains that proper Hindi and English language skills are the main carriers of social superiority. Today, there is a correlation – though definitely not an absolute one – between social status, economic family wealth, and government positions, which is extended through modern education.

It is not surprising then, that I was repeatedly told that Amchi Thupten Thapke's "illiteracy" – used as a synonym for not being fluent in Hindi and English – limited his successful engagement in amchi matters. He himself even stated that his language skills were sometimes a problem for applications and other things. But, in my observation, his restrictive communication with Spiti-pa in government positions was a matter of social status as well. The amchi's low status caused him to be reserved in any interaction with a person of higher social rank. Communications are therefore sometimes difficult, and I have noticed Amchi Thupten Thapke trying to bypass Spiti-pa in offices, preferring the direct interaction with the Indian officers on the local, state (Shimla) and national (Delhi) levels. He frequently reported to me that though he cannot speak good Hindi, these officers appreciate his ideas and work concerning the development of amchi medicine in Spiti.<sup>339</sup> It is obvious through his explanations that he feels much freer to act in the political setting when he is not bound to the social parameters of Spiti interactions.

Continuing with political issues, I now depict a parallel between the political engagements of the amchi in Kibber (Chapter 3.2.1) and the politics in Kaza. Concerning party politics, there is a totally different atmosphere and relevance of parties in Kaza than is observed in Kibber. The heterogeneity of the Kaza citizens and the youth of the contemporary society have buried many old family rivalries or the like, and such animosities are now of little importance to political life. Nevertheless, during the election campaign of 2003, many men<sup>340</sup> were involved and active in this campaign for

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<sup>337</sup> Because of the former socio-economic system in the past, high status and economic wealth were more closely tied together than they are today.

<sup>338</sup> One has to keep in mind that someone who received an education in the plains and continued to go to college (which is the aim of sending a child to an Indian school) will return only after some ten years. In this regard, the changes that have occurred in Spiti (for instance, concerning the availability of financial investments) are followed by changes in other fields (such as the availability of Spiti teachers, doctors or officers) but with a decade's delay.

<sup>339</sup> The improvement of the SBAS work displayed in Chapter 5 proves this and extends the analysis.

<sup>340</sup> Women do not engage publicly in party politics.

a period of two to three weeks.<sup>341</sup> In contrast to villages like Kibber, elections in Kaza do not simply serve as reasons for animosities or social splits. Men of different parties continue to meet and talk with each other. Instead, despite Spiti-pa's very limited influence on the state parliament, the engagement in such election campaigns serves a very typical Indian purpose: the contact to, and possible benefit from, the support of a certain candidate for the parliament. If the candidate is elected, he has access to government decisions, positions, and resources and so his voters and supporters expect him to consider them in such decisions. The prospect of benefiting from this makes people active, even curiously visiting all the villages with jeeps, waving flags and banners and giving talks, canvassing for their candidate. However, while in Kibber election campaigns intensify social tensions, in Kaza they seem more like a playful activity. In Kaza, supporting one of the candidates cannot bring an amchi into trouble, unlike the difficulties that emerged for the politically-oriented amchi in Kibber. In Kibber it has been shown that morality is an issue in the social as well as in the political field. To the contrary, morality does not serve as a tool in a modernized environment, when concerning the relationship between an amchi and community that has neither strong historical ties nor strong present social ties.

One brief remark should be mentioned here before turning to the conclusion of this chapter, continuing on the morality theme: the last chapters have already indicated the contemporary emphasis given on amchi regarding moral issues. The connection of morality and economic ascents (respectively, money), is suggested by anthropological literature and therefore receives a large recognition in my analysis in Chapter 4. Being engaged in an association, such as the SBAS, that tries to secure government funds will always be involved with confrontations tinged with envy and suspicion. For the amchi of the SBAS, in particular Amchi Thupten Thapke, this is a sensitive issue because of the moral virtuousness expected from them.

Coming to a close on this chapter regarding the situation in Spiti, the following can be noted. Although Kaza is still the size of a village, its structure and appearance is

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<sup>341</sup> Elections for the Himachal Pradesh parliament took place state-wide in February, but in June for Lahaul and Spiti (08.06.2003) due to special climatic conditions. The district of Lahaul and Spiti has a very low population density and therefore has only one member in the state parliament. The population of Lahaul is furthermore counted triple as much as that of Spiti, which additionally reduces Spiti-pa's influence on the state parliament to a minimum. Moreover, in 2003, the election had already revealed the high victory of the Congress Party. The campaign in Spiti was thus of no real practical relevance concerning the parliament.

developed rather like that of a small modern town, and it is indeed the most modern village in Spiti. It is no coincidence that Kaza has become the leader for future trends (for example, why the SBAS is situated there and not elsewhere). Structural changes, such as the availability of a large variety of jobs, orientation along business and money, the new infrastructure enforcing the pace of everyday life, or the progressive interactions with Indians and the Hindu Indian culture all promote an increasingly heterogeneous population that observes rising individuality and less reason to define itself as a joint group. Though Spiti-pa in Kaza form a community for the purpose of local interests, there is no shared identity because most of them ‘belong’ to other villages. Today, Kaza is strongly determined by economic departures and related structural changes that are followed by rapid new constitutions and re-constitutions of its social system. Kaza is a catalyst for the rest of Spiti, pushing forward towards the modern world.

The traditional factors that constitute the status and reputation of a village amchi (extracted in the last chapters) are valid in the modern setting of Kaza as well. However, they are undermined by the heterogeneity of the population, the striving for individualism among the populace, and the medical pluralism in place there. For Amchi Thupten Thapke, there has been no possibility to gain the common status of an amchi in his community because he has neither the traditional legitimation (the particular local lineage), nor a modern legitimation (education) for that higher status. Kloos has shown that in Hanu (Ladakh), important factors that help one gain popularity and social power included medical skills and a good stock of medicine (forthcoming). This has been supported in a village context in Spiti as well. However, the case of the two Kaza amchi explored here reveals that these two factors need to be integrated in a social system. An amchi needs to be socially embedded so that the other factors can gain importance. Though both of these amchi are well-educated and have sufficient stocks of medicine, neither have received a high community status, nor a community-wide positive reputation. The modern setting of Kaza makes the ongoing social disembedding of amchi medicine visible, including the loss of social power on the amchi’s side.

The analysis of the socio-political dimension of amchi medicine comes to an end here, after having been explored in the ‘traditional’ and ‘modern’ settings. Chapter 3.2 ascertained how the social relationship between amchi and their communities could break, which then triggered the central dilemma of the amchi: the loss of socio-

economic support. Preceding that, the elaboration of the three core aspects of the medical work of the amchi didn't only bring their craft to light, but also shed understanding on the respective part of each aspect that contributes to the complete puzzle of social embedment and, consequently, disembedment. Based on their analyses on transformations and new issues of status, the issues of legitimation and identity making up today's life of the "amchi at home" have been raised. This leads us to the examination of the changes in amchi medicine and its modernization from a solely economic viewpoint covered in the next chapter.

## 4. MAKING A MEDICAL LIVING

The topic of the economic circumstances of practicing amchi medicine in Spiti have already flared up several times in this thesis, pointing towards the central question asked by many amchi: how to keep up with their medical work and secure a living in the new conditions of these modern times? To refresh some of the situations and different threads brought up already concerning this topic: Amchi Tsering Dorje's expression from the prologue, which showed the strain and tension from working an entire day in a neighboring village without bringing home any tangible payment. In Chapters 2.3 and 3.1.2, Amchi Thupten Thapke was cited on the relation of medicine and the amchi's attitude, saying that "when we become a good amchi, we don't think about making money. We work because we think it is good for our future and our next life." Furthermore, in Chapter 2.2, the young Amchi Sonam Namgyal was introduced and presented his frank opinion, which I partially repeat here from that earlier chapter:

People don't pay, and some of the medicines we have to collect in the mountains means a sacrifice of one's own work. If you buy medicine from the market, it's quite expensive. [...] Considering that, having medicine means having no food for the family. Amchi work is only loss [e],...it is a 'loss market' [e].

His eye-catching metaphor of the "loss market" emphasizes nicely our current question of the economic future of amchi medicine. All these amchi have brought up the connected themes of community, responsibility for the family, and morality and economic constraints, all of which together form their perceived dilemma.

The fact that the decline of the reciprocal village system is tantamount to the existential crisis for the amchi has also already been touched upon in earlier chapters. But these two related dimensions are now closely examined in this chapter and combined with an analysis of the economic change in Spiti. This analysis follows a chronological order, starting with the breakdown of the exchange system (Chapter 4.1), continuing with the description of the cautious introduction of money (Chapter 4.2), and finally elaborating on the issues of the commercialization of amchi medicine and the (individual) sustainability of the amchi (Chapter 4.3). This examination follows up the question of whether a commoditization of Tibetan medicine (which has been observed

elsewhere) has already been launched in the remote locales of Spiti, and if so, how this is taking place. In this way, we arrive at one of the core themes of this analysis of modernization.

#### **4.1 The Breakdown of Exchange**

This chapter concentrates on amchi medicine's historical economic basis and its consequent breakdown in the recent present. For lack of historical data regarding Spiti, I start here briefly with a presentation on what information is available regarding the economy of Tibetan medicine from other Tibetan regions. This can then serve as a comparison for the elaboration on the traditional reciprocal exchange system surrounding amchi medicine, which is then analyzed in detail. At the center of all this stands the understanding of medicine as a gift, and therefore it must be examined how such transformations in this sphere have taken place.

##### *Some Supra-regional Historical References*

In ancient scriptures, any of the chronicles or travel accounts recorded have, to my knowledge, nothing written on the ancient and pre-modern socio-economic integration of amchi medicine into Spiti village structures. The same lack seems to apply, to a large extent, to the other rural areas of Tibetan culture as well. The Tibetan medical scriptures merely comment on the moral attitude to be ascribed to the amchi, as well as on the patient's and amchi's behaviors during the consultation (see Chapter 3.2.1).

Concerning Tibet, Nepal, and Ladakh, some scholars have recently offered various accounts on the former practices of mutual exchange, remuneration, and gifts, in part extracted from contemporary Tibetan medical practitioners' given information. All their descriptions point towards the supposition that the socio-economic integration of practitioners in villages of Tibetan culture followed similar lines of morality and exchange. In order to apply these findings to Spiti, I draw a comparison between Spiti and Ladakh. Additionally, I then draw especially from Jahoda's thesis on the socio-economic organization of Spiti villages (2003). These two sources are then merged with Spiti-pa's contemporary explanations and are later discussed with a contemporary setting in mind.

Very little has been put into writing regarding remunerations or exchange with the medical practitioners in their village (or even nomadic) contexts in Tibet. I have collected and present here the information available: Gyatso recalls that between the late-eighth and the twentieth centuries, the position of a “court physician” (Tib. *bla sman*) existed and that “medical clan lineages” were granted land and special, inherited rights (2004: 84). Janes gives a short description on how socio-economic structures were generally established:<sup>342</sup>

The first category of physicians [lineage physicians], historically of greatest antiquity, are those whose training and practice were rooted in individual contractual relationships. [...] Upon completion of their training, [...] the students would practice privately, exchanging services for goods or fees. These “lineages” of physicians were often seen as descending from one of the great historical physicians of Tibetan medicine. Privately trained and practicing doctors were primarily associated with the secular aristocracy in Tibet; that is, they were members of or attached to landed estates. There was, however, significant variation in the socioeconomic background and status of these physicians. Some were itinerant herbalists who made a regular round of villages to peddle medicine [...]. Others practiced medicine as a sideline to other occupations, even farming, and derived relatively little income from it. (1995: 12)

The rewarding of medical services in the form of “goods and fees,” thought of as an exchange, is already touched upon here. Further, Janes mentions the possibility that medical personnel might not have made enough to secure an entire living. The “lineages” he recounts here are by no means comparable with the lineages of village amchi in Spiti, but can rather be exemplarily represented by the family history of Lobsang Dolma Khangkar, who stemmed from one of the most famous lineages of Tibet (Tsering Josayma and Dhondup 1990a). Lobsang Dolma has reported how the amchi-patient relationship ought to be (which I present below), but unfortunately does not say anything on how the interaction was actually introduced in the social system.

Craig has explained that in Nepal, the Himalayan Amchi Association (HAA), which is the organization of Tibetan medical practitioners, recounts a narrative from

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<sup>342</sup> This quote concerns Janes’ categorization of professional physicians in Tibet that was introduced in Chapter 1.3. The description of the lineage physicians reveals most of what concerns our topic here.

former times that links moral principles with the remuneration of medical services (forthcoming). Accordingly, amchi were not to charge payment but rather receive anyway some goods or a little money. Adams explains that among the Sherpa, patients generally (at least in the 1980s) gave what money they could (wrapped in a *kha btags*), according to their ability for receiving treatment (1988: 507). Additionally, every now and then they also offered food or contributions. Adams also recounts that reciprocity (for labor and production) in general remained largely intact in the villages, but does not verify this specifically for the amchi.

Most accounts on the topic are available from Ladakh (Besch and Guérin forthcoming; Blaikie forthcoming; Kloos forthcoming; Kuhn 1988 and 1994; Pordié 2002). These scholars reproduce what amchi today report on the earlier privileges and on the modes of exchange in the villages. The compensations to the amchi seem to have been twofold: one coming from the governing power, and the other from the respective villagers. Pordié explains that when Ladakh was a kingdom, villages were rewarded land in the form of a “field of medicines” (Tib. *sman zhing*) whose produce was then given to the medical practitioner (2002: 190). Kuhn recounts that before Indian independence, amchi were exempt from tax revenues and obligations to pay maintenance to government officers (1988: 49). After independence, however, these privileges were withdrawn (Blaikie forthcoming; Kuhn 1988: 49; Pordié 2002).

There existed a common reciprocal commitment between the village communities and their amchi. This included, on the villagers’ side, families taking turns helping the amchi with the cultivation of the his fields during the occasions of seeding, harvesting and threshing (Besch and Guérin forthcoming, Kuhn 1988: 51, Pordié 2002). Blaikie reports that amchi were additionally excused from community obligations regarding common labor sharing and the like (forthcoming). These practices might have been slightly differently shaped in varying communities (compare with the below examples from Spiti). Additionally, amchi received individual gifts from their cured patients in forms of barley, butter or liquor. It was a common practice as well to collect gifts (Tib. *bsod snyoms*, lit. alms) for the amchi from the entire village community. Regularly, (sometimes once a year, sometimes once every two or three years) grain (usually barley) was collected from each household and given to the amchi as a form of exchange for his services (Kloos forthcoming, Kuhn 1988: 51). The amchi did not charge for their medical work and, as some authors report, no exact payments were given either. This reciprocal practice was, therefore, very important because it enabled

the practitioner to get needed medicinal ingredients and exercise the time-intensive work of an amchi, while still securing a safe living for his family.

The practice of *bsod snyoms* was intended as an act of voluntary support and understood as a parallel to the Buddhist behavior towards monks, therefore a chance for villagers to gain merit (Adams 1988: 511; Kloos forthcoming; Kuhn 1994: 71; Pordié 2003: 19). In practice, however, people seemed to have felt an obligation to do so, arising from the complete dependency on their amchi in health matters.<sup>343</sup> However, despite whether it was more a moral obligation (Kuhn 1988: 51), or, as Kloos (forthcoming) reports, more a result of “duty mixed with fear,” it doesn’t matter because the difference between them was minimal and, perhaps as well, a consequence of varying local circumstances. The matter of obligation versus gift in a Ladakhi village is also the object of an earlier analysis (Besch and Guérin forthcoming). The traditional patterns of amchi support seem to have been very similar in Ladakh and Spiti. Examining the situation in Spiti in-depth, I therefore refer to those Ladakhi examples.

#### *Reciprocal Exchange in Spiti*

Given the scarcity of literary and scientific documents, I rely instead on Jahoda (2003) for a reconstruction of the socio-economic integration of amchi in pre-modern Spiti, in addition to my ethnographic data. He collected an array of historical documents and combined their extractions with his own ethno-historical data from Tabo (lower Spiti) to reproduce the historical socio-economic development in that area. I draw from Jahoda’s conclusions in order to receive inspiration as to whether and how the amchi might have been treated and rewarded for their work.

According to Jahoda, there is no documented proof concerning the form of socio-economic (and political) organization in (lower) Spiti before the end of the tenth century (2003: 119). In that time, the valley had become part of the west Tibetan kingdom, Guge, ruled by Yeshe Ö (Chapter 1.1). The feudal and theocratic regiment of this king and his successors founded numerous monasteries and temples throughout the area and produced a system of their maintenance that was kept until the mid-nineteenth century<sup>344</sup> and can still be in part detected even today. Based on a sustainable agricultural economy, Spiti people were bound by edict to support the respective

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<sup>343</sup> The reciprocal system in Ladakh broke down, according to Kloos (forthcoming), in the Hanu region in the 1970s, but Kuhn generally states that this custom was repealed in the 1980s (1988: 52).

<sup>344</sup> As far as it is understood, Spiti remained under the rule of Guge until 1630, when it became part of the Ladakhi kingdom (Jahoda 2003: 127f).

monastery of their region and its members through specifically prescribed amounts of natural produce and labor (ibid.: 117-121).<sup>345</sup> In the nineteenth and twentieth centuries, the safeguarding of the monastic communities was guaranteed by the families and villages that were related to a particular monastery. Monks accumulated income through the performance of ceremonies and transitional rites, agricultural labor, alms, and from the yield of the so-called “lama’s field” (Tib. *grwa zhing*) that was cultivated by a monk’s family of origin. Jahoda does not go into the question of whether or not parts of this support were understood as objects of a reciprocal exchange between the villagers and clergy, but rather speaks of long-standing relationships (ibid.: 209-15). However, he repeatedly explains community relationships were built on the exchange of goods and labor, as for instance between blacksmiths and villagers (ibid.: 320) or between households of the same or different status (ibid.: 278 and 323). The exchange of goods and labor, therefore, seemed to have been a fundamental element of Spiti society. This then raises the question regarding my topic, namely, whether the patterns of support for the clergy were extended to other groups of the population, and, going further, if the patterns of exchange relationships were also in place between amchi and villagers.

For monks and other privileged people in Spiti (and other Tibetan culture areas), there seems to have been two accordingly fundamental lines of economic support: one from the governing powers and one from inside the communities. In a footnote, Jahoda refers to Lyall (1874), who stated that in the nineteenth century, amchi had the privilege of tax-free fields, which were called “fields of medicine” (2003: 277). As stated earlier, the Ladakhi kingdom pursued the same aim by granting such land to villages to be cultivated for the amchi. The ruling powers seem to have had an interest in treating the medical practitioners in a special way. Parallel to the governmental support of the monks, one can assume that the Buddhist rulers perhaps considered the amchi as a group with religious skills and wanted to treat them accordingly similar to the monks. Furthermore, health care is of central importance for any population, and no doubt the rulers would have wanted to keep their subjects as healthy as possible. I have no straightforward evidence from my own data regarding the “fields of medicine”, but some Spiti informants did declare that generations ago some villages provided their

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<sup>345</sup> Jahoda explains that it was initially needed to restructure the local economy towards these ends and secure its stable existence (2003: 121). It seems evident that in the following centuries, the Spiti people were able to stabilize their agricultural economy at a level that secured their own outcome and the existence of the monastic communities, but growth by means of natural conditions was not possible (ibid.: 128).

amchi family with sufficient land and eventually a house. However, a large gift like this from the villagers seems dubious, and more likely to be given from rulers, so perhaps my informants have simply confused the donors. In any case, the presented argument here suggests there has been longstanding superior support for the amchi in Spiti which might have included material benefit in the past.

The second structure of support from the villages has much more evidence in its favor. The above introduced exchange system was vital to Spiti society in facing and compensating for the valley's harsh and secluded environment. People were extremely dependent on each other for skills and help. The organized and permanently established exchange of labor and goods was therefore of social and economic centrality. While this can be subsumed under commodity exchange, barter was in fact the dominant and most important exchange mode with the people of the neighboring valleys.<sup>346</sup> It was the exclusive practice until the mid-nineteenth century. Jahoda has said that the monetary economy that entered Spiti arrived much later than in the surrounding valleys (ibid.: 143). It can be assumed then that amongst the Spiti-pa, reciprocal exchange continued to be their first means of transactions well into the twentieth century.

Such an exchange system was traditionally established between an amchi and his village.<sup>347</sup> The amchi's labor was considered to be adequately exchanged with labor or goods. Spiti villages agreed on a concerted system in which all households rotationally helped in the amchi's fields as well. This was designed in accordance with a general village practice that for each different cultivation period (planting, harvesting, etc.), a certain work order was kept, according to the owner's status. It would start with the fields of the monastery (if existing), then continue on to the *khang chen* fields, and finish with the *khang chung* fields (ibid.: 315). Several informants explained to me that the cultivation of the amchi's fields was typically done just after the fields of the monastery. This corresponds with the social order status (Chapter 3.2.1) and also makes sense because the amchi was usually the head of a *khang chen*. The amchi (and his property) was treated according, to the social order, as a prominent figure among the *chahzang rigs*. This system was something of a generalized practice independent of the fact whether the amchi's work was successful or not. Any further collection of goods

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<sup>346</sup> Barter and commodity exchange form two of the three modes of exchange. Gift exchange, as the third mode, is introduced below and plays a crucial role in amchi medicine (cf. Rössler 1999: 175).

<sup>347</sup> At what time or period this system originally occurred is not demonstrable. Following Jahoda's analysis, one can assume that it goes back to the tenth century.

among the villagers (whether implemented regularly or by the amchi's request) was only rarely reported to me (see below). It seems to have not been a common practice in Spiti. But naturally, patients would reward successful cures with further individual gifts (Tib. *smān yon*) like barley, butter, liquor, or the like. Their amount or frequency depended completely on the individual wish of the patient. From a religious point of view, *smān yon* were understood (as in Ladakh) as a possibility for the patient to gain merit (Tib. *dge ba*).

This derivation of the socio-historical dimension of exchange is only one side of the interaction that goes on between an amchi and patient. Contemporary representations of their relationship have a strong moral and practical component. It is difficult to trace back their historical origins because people mainly report only on the last one or two generations. This aspect, however, was examined in the context of Ladakhi (Besch and Guérin forthcoming, Kloos forthcoming, Pordié 2003). The strong parallels between Ladakh and Spiti have become evident so far and, thus, some conclusions can now be drawn from the comparison with those examinations. The complete image of reciprocal exchange in the past can be displayed through the analysis of ethnographic accounts and statements by Spiti-pa regarding the contemporary consequences of its breakdown.

*Power and Morality: The Safety of Being an Amchi*

This section deals with the fundamentals of exchange as they are found in the examination of the concepts of power and morality.<sup>348</sup> As mentioned earlier, the economic situation of amchi in pre-modern times was strongly interwoven into the village social structure. Agriculture and husbandry were the main, and usually only, sources of income for the large majority of the people,<sup>349</sup> naturally applying to the amchi as well. Besides, amchi also worked as part-time medical practitioners, so the reciprocal exchange system in place enabled them to follow their studies, collect medical plants, and make medicine, all of which better enabled them to serve their village with good health care. The actual treatment itself is not really time-intensive (Chapter 3.1.1) but it is rather the training (Chapter 2.1), and the collection and production of medicines that are the most time consuming (Chapter 3.1.2). The latter

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<sup>348</sup> Opposed to earlier chapters, this section does not move from theory to practice but instead uses the theoretical explanation at the very end in order to make the above presented practice more comprehensible.

<sup>349</sup> Exceptions were only for people engaged in trade and the lower strata of blacksmiths, musicians, etc.

often must be carried out during the high season of crop cultivation. The rewarding of land, labor and goods by the rulers and villagers was meant to create a rise of income and make the harvest yield easier for the amchi. Of greatest importance among the donors of such ‘gifts’ were the villagers. By working in the amchi’s fields, they freed his time so he could thus focus more on his medicine. To make a living as an amchi, one had to rely on the close involvement of the community.

Despite the above analyzed historical dimension, the community-based social interactions were also shaped by positions of power. In most cases, practitioners belonged to a *khang chen* with a considerable estate, which, combined with the high prestige of being an amchi, secured them a top position in the social order of the village (Chapter 3.2.1). Deriving from an amchi *rgyud-pa*, as was usually the case, brought one an even higher reputation. Furthermore, it was explained in preceding chapters that the amchi held a monopolistic position in the realm of non-religious health care (see Chapter 3.1.3). The villagers depended on this service, especially during the long and harsh winters. Yet despite the fact that this historically established health care system was essentially their ‘right’ (due to its nature of reciprocity), villagers still felt a mixture of gratitude and moral obligation towards their amchi. These feelings ensured that they would properly remunerate the medical work they’d received by working for the amchi in his fields. Certainly, these socio-emotional interactions varied individually because they relied on the particular local conditions and personal factors. These factors included, in addition to lineage and social status: individual experience and knowledge; respectability based on age, morality, and religious skills; medical skills; and the stocks of medicine. While these necessarily included the patients’ own opinion in regard to how they judged the amchi, the amchi could extract considerable power from the monopoly of treatment. Spiti patients, as well as patients from Ladakh, express that amchi were in the position to potentially give more or less effective medicines according to the perceived relationship (Kloos forthcoming, Kuhn 1988, Pordié 2002). Patients thus feared the amchi’s power of action. As much as they had to trust him and his treatments, they also feared it. Without them even knowing it, their medicine could lack a certain (for instance expensive, but effective) ingredient. Patients felt the need to nurture a good relationship with their amchi to benefit fully from his goodwill. Kloos’ analysis (forthcoming) of the social role of a contemporary amchi in Hanu (Ladakh) has examined this point:

Tsering Samjor, 74, recalls, ‘Earlier the *amchi* wanted more... If the patients didn’t give enough, then the next time the *amchi* would give less medicine. So the people were scared for their lives and gave a lot.’ Although even then this was perceived as greed and therefore a moral issue, there was not much the people could do about it except accept it as a fact of life. An old joke in Hanu, saying that the more people were sick, the happier the *amchi* was, further underscores the point. The collection of *bSod-snyoms*, therefore, served not only as the primary source of income for the *amchi*, enabling them to spend time on medicine rather than in the fields, but also as an assertion of their social power.

Phuntsok Namgyal (Meme Serku), an old man from Kibber, told me a story along the same lines:

Once there was an *amchi* in Spiti who went to the mountain with his horse packed with saddle bags to get medical plants. He reached a place close to where a bear couple was living in a cave. One of the bears had swallowed a piece of bone that stuck in his throat and gave him lots of pain. The other bear went out to look for help and found the *amchi* roaming around in the mountains. The bear approached the *amchi* and grabbed his horse. The *amchi* was very afraid because he thought the bear wanted to kill him. Nevertheless, he stayed on the back of the horse. In this way, the bear led the horse, and the *amchi* sitting on it, to his cave. The bear pointed to the other bear and made the *amchi* understand that there was something stuck in the bear’s throat. Still being scared, the *amchi* nonetheless went to the bear and was able to remove the piece of bone. In the bears’ cave laid many skulls, and the bear, happy about his partner’s recovery, took several of them outside the cave. There, he packed them into the saddle bags of the *amchi*’s horse. The skulls were filled with precious stones and golden jewelry. Coming out of the cave and seeing all this, the *amchi* kept the jewelry but threw the skulls away. Thus happy, he returned home.

As Kloos remarks, these two narrations insinuate greediness on behalf of the *amchi*. In the latter tale, the *amchi* is quite wicked, accused of not honoring the dead and only striving for wealth. How far this mental attitude has historical or general evidence is left open to speculation. But the existence of this tale and the Hanu-pa’s joke are clear

examples of the ambivalent amchi-patient relationship. An incomplete medicine compound could have the excuse of a lack of resources (Chapter 3.1.2) or could assume a malicious intention. However, I do not reduce the relationship of amchi and villagers to Kloos' phrase of "duty mixed with fear," but rather add the fact that gratitude was (and is) a common patients' sensation towards the amchi. The predominance of one emotional attitude or the other is, in my perception, very much bound to the particular relationship of individuals involved. The villagers were bound for their own good to support the amchi economically, and the amchi relied on the villagers' support. The exchange system was balanced although it contained a good deal of power on the amchi's side. What then had a great deal of weight on the amchi's side was the ethical and moral excellence expected from him.

Material greediness was and continues to be an accusation that weighs heavily in Tibetan conceptions because it is considered a facet of desire which is one of the three 'root poisons' in Buddhism. Morality and ethics as effects within amchi work were already the subjects at hand in Chapters 2.3, 3.1.2, and 3.2.1. Thus, the derivation and grounds of the ethos ascribed to the amchi need not be repeated here again. Instead, the central concept of the "good heart" gives rise to the main characteristics of a good amchi: compassion, honesty, generosity, and altruism. Following the central themes of this chapter – economy, remuneration and exchange – generosity and its opposite (greediness) become the focus here. An image of the ideal amchi is found not only in the representations given by current amchi but also by the contemporary accounts of Tibetan physicians and in the *Rgyud bzhi*. This determining ancient scripture emphasizes the importance of compassionate behavior of the practitioner of Sowa Rigpa and reminds him of the virtue of generosity (Parfionovitch et al. 1992: 89). Authors interpreting the *Rgyud bzhi* interpret this such that the practitioner shall be altruistic and not strive for material benefits (Clark 1995: 223 and 229; Rechung 2001: 86). Lobsang Dolma points out that a greedy doctor thus poisons the relationship with his patient (1990b: 40) and later illustrates what is expected from a doctor by saying:

When a patient has a very serious illness but has no money to pay, the doctor should have equal thought in diagnosing and giving the medicine. Whatever they pay the doctor should be satisfied. ... Suppose the patient is very poor and the medicine he needs is very expensive, like jewellery pills

[*rin chen ril bu*], the doctor must accept the responsibility to give freely to save the patient. (1990c: 74)

Lobsang Dolma's statement is almost verbatim the opinion also expressed by a Ladakhi amchi as quoted by Kuhn (1988: 48). The ideal of the altruistic and generous amchi is a continuum in time, emphasizing the morality of Tibetan medicine in the past and in the present. In scriptural accounts and theoretical explanations, morality occupies a prominent place, which is strengthened by highly religious ideas. At this level, the central concepts of Mahāyāna Buddhism are most clearly expressed (cf. Adams 2001a: 236f; Pordié 2003). In the practice of amchi work, religious ideals are the theoretical frame for a moralization that was socially approved. The amchi's reputation is closely tied to the patients' impression of how much he wishes to be compensated. The collection of donations by the amchi has, in my view, two socio-moral sides: the "assertion of their social power," and the peril of lost credibility. These two sides need to remain somehow in equilibrium to ensure a fruitful relationship between the amchi and his patients. However, a superiority of power – reflected in social status – lies firmly on the amchi's side.

### *Medicine as a Gift*

Having illuminated the historical and the social dimensions of exchange, the heavy moral burden of exchange is accordingly perceived on several levels. The observations above suggest a theorization of this topic along the lines of a well-known anthropological theme: the gift.<sup>350</sup>

The two common methods of giving something in return for an amchi's service in Spiti have typically been the helping of the amchi in the fields, and the individual *sman yon*. Each of the exchanged items – medicine, labor and goods – accumulates the characteristics of a gift, which, in Tibetan culture, also contains the connotation of gaining merit. In differentiation to commodity exchange or bartering, gift exchange is especially distinguished by its social dimension. Gifts initiate, reproduce, and enforce social bonds and are, thus, "concrete representations of social relations" (Osteen 2002a: 2). Leading initially into the analysis of the theme, Marcel Mauss (2002 [1954]) clarifies that gifts carry a "spirit" that forces its receiver to give something in return, which means that gifts are bound to cultural norms and laden with obligations. Despite

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<sup>350</sup> In structure and content, this and the next paragraph owe much to Isabelle Guérin who co-authored an article on the same topic based on research in Ladakh (Besch and Guérin forthcoming).

just the visible material, an exchange may also include the transfer of other non-tangible things, such as prestige, honor, humiliation, or shame (Mauss 1993 [1950]). It is, therefore, widely acknowledged that altruism from gift-giving is superficial and only comes into being through the interest of the donor, carrying with it a fairly ambiguous aura. Kapferer explains the full potential of the gift “as poisonous, as negating and separating, and as constitutive of relations and of life within the space of these relations” (1997: 199). The recipient of a gift is transformed into a debtor by its attributed obligations, and thus the donor then gains or manifests a superior position. Gift exchange promotes reciprocal relationships that are structured in a social hierarchy.<sup>351</sup> Mostly, however, it is agreed with Mauss that social power is accumulated on the donor’s side (Osteen 2002a: 7) because the receiver’s subordination is manifested by his or her inability to return the superior’s gift. Yan (2002), however, gives a counter-example to this from rural China, in which the power flows asymmetrically to the recipient, who is socially higher positioned. Thus, whichever the direction of the gift flow, the gift always reinforces the local hierarchy (Osteen 2002a:18). The gift exercises a power that establishes a relationship, and can be a “bond of life” or a “deadly embrace” at the same time (Malamoud 1988).

Returning now to the amchi-patient relationship in Spiti, the former local health care system was based on exchanges of gifts and counter-gifts, in the Maussian sense. Medicines, goods and labor were ideally viewed as freely donated objects, but were practically accompanied by moral obligations to give something in return. In the examination of a Ladakhi village, we marked the same kind of exchange practice as “an *extended* reciprocal system” (Besch and Guérin forthcoming [emphasis in the original]). This term accentuates that fact that obligation did not simply emerge from the gift, i.e., the medicine itself, but instead originated from the social system surrounding amchi medicine. Counter-gifts were located in the public sphere and involved the whole community. Gift exchange in health care in Spiti occurred between a group (a village) and an individual (their amchi), or between two individuals (the patient and amchi). This distinction can also later be observed in a practical sense when examining the transformation of exchange. On the level of an individual donation of medicine or goods, we recognize the ‘spirit’ that accompanies the gift – envisioned by Mauss as a

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<sup>351</sup> Accordingly, reciprocity can be defined as an exchange of goods driven by mutual social obligations (Rössler 1999: 172).

“total prestation” (2002 [1954]) – as an opportunity for both the amchi and patient to gain merit.

However, the relationship between a group and their amchi is decisive in social and economic terms. This particular gift exchange between them has little in common with other exchanges between two enclosed groups, and is focused on the social interactions within one community. Here, credit and debt from the reciprocal exchange create social power. For certain, the gift-giving between amchi and villagers reproduced the social bonds between them. But consisting of only one community, there were further ties and patterns that also established the social system (village organization, etc.). A characteristic of this kind of gift exchange was the consolidation of hierarchy, that is, an exercise in social power on the amchi’s side. The moral obligation on the amchi’s side (Chapter 3.2.1), meaning the same treatment for anybody at any time, acted as a slight counterbalance to the amchi’s monopoly on health care and treatment. But this monopoly also ensured that the gift of treatment reproduced the amchi’s superior status in the village. In this sense, a gift of treatment could also become “poison” (Mauss 1993 [1950]). This could happen when a villager fears that his next treatment will be insufficient because of a past unsatisfactory payment to the amchi (cf. Besch and Guérin forthcoming).

#### Contemporary Local Variations

The reciprocal village exchange system concerning amchi medicine has now been analyzed in its theoretical, historical, and social dimensions. With this foundation, we can now continue on to explore the noticeable changes in the exchange system and then try to explain them in the view of the theory provided. To begin with, here are three examples of amchi from different villages and their statements regarding today’s status quo regarding their relationship with their villages. These passages intend to show the variety within today’s representations and practices:

Example 1: This amchi is in his mid-thirties and learned amchi medicine from his father, who is still living in the village but does not practice anymore. He explains to me that when he was still single, he did not have to have a job. But to make a living for his family today, he works as a

government contractor.<sup>352</sup> Because the government does not give him a salary for his amchi work, he states that he has to buy medicine from his income, when necessary. In his father's early practicing days, the villagers worked in his family's fields, taking turns helping. Although he remarks that some today still help in the fields, most work less because of the [biomedical] dispensary that was established close by. However, another villager explained the situation, stating that some fifteen years ago the villagers did not want to work in the amchi's fields anymore. As a compensation for this, they collected *smān yon*, donations for medicine, once or twice a year, depending on the amchi's request. Whenever he needed to make medicine, he asked a respected person to go from house to house and collect donations. The people then gave whatever amount they felt to be acceptable and, the villager says, they all appreciated this system. The amchi agrees with this narrative, and adds that some years ago he collected some special donations for the Spiti Board of Amchi Sangh. His villagers expected the organization to then distribute the medicine to all amchi, somewhere in the sum of several thousand rupees. But he did not get any medicine from the organization, and now he is too shy to ask his village for further donations. That's why he has to pay for the medicines himself now. When asked about individual payments, he specifies that no one gives him anything for the treatment of common diseases. Only if he has to buy costly ingredients or medicine, then he could explain this matter to the patient and he or she would then be free to pay him whatever amount is felt necessary. Also, any outsiders from other villages who consult him would then pay, even for common treatments.

Example 2: Amchi Chullim, from Manne village, explains in an interview that today, villagers don't have to rely solely on their amchi anymore, but nevertheless their support continues if the amchi fosters "good contact" with them. When the relationship between amchi and villagers is good, then this

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<sup>352</sup> Contractors receive a contract from the government that includes a specific kind of work (like roadwork or construction) and the total amount of expected costs. The contractor then hires laborers with equipment, who do the work for him, and then he pays their salary directly.

system can still work. The amchi explains that in his village, even today, people from each family still help in his fields. Although he does not ask for it, some patients give him money as well. For instance, one patient who has a lucrative job once gave him 1000 rupees to buy new raw material. Sometimes things like this happen with a good relationship between amchi and villagers.

Example 3: In his mid-twenties, this lineage amchi comes from a remote village in Lingti valley, and is the only Tibetan medical practitioner to serve his and the surrounding villages and hamlets. During an interview, he explains that the support from the villages and patients has vanished. In the past, everyone helped with his family's fields, but today only some people do so, and on only one day of the year. He does not receive any money in return for his given treatments and his patients do not give him anything else.<sup>353</sup> The amchi attributes this to the fact that patients do not depend on amchi so much anymore because there is the hospital available in Kaza. People ask less often for amchi medicine. But, he says that economic difficulties do not arise for him because his family is quite large and is largely self-sufficient. Also, he continues to have a well-supplied stock of medicine from his forefathers, so he is able to produce medicine without much more effort. Otherwise, it would be difficult because to buy new medicine or ingredients would be very expensive.

Not only these three, but all Spiti amchi state that things have drastically changed and their economic situations in continuing the medical practice have become more difficult. Obviously, the today's social and economic interactions and interdependencies between amchi and villagers definitely vary according to the particular local conditions in each village, which can even be considered as continuums from the past. Beyond local variations, the changes of the general conditions affect the whole amchi community. Yet

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<sup>353</sup> That no one is remunerating him is unusual and relatively unlikely. This statement might be owed to the fact that he talked to a Westerner whom he might want to have represented a certain image and need. Further information manifested this estimation. Nevertheless, the direction displayed by the amchi regarding the decline of support meets the reality. Beside the various factors for this development analyzed in the course of this chapter, in his case, the amchi's young age and the break after his father's death have probably played an important role.

however positive or intact the relationship between an amchi and his village might have been (or might even be today), the former reciprocal exchange system is facing a steep decline and in many villages it has already completely collapsed. I refer back to these examples throughout the chapter to use them as exemplarily pieces of evidence for analysis purposes.

#### Consequences of the Breakdown

The reasons for the breakdown of exchange have been outlined and explained in length in the preceding chapters. In order to move onto the further analysis later, I provide here a refresher list of the keywords of change-causing factors.

The first catalyst of change has been identified as the *government interventions*, including massive program implementations and subsidizations that in turn have led to a new and rapidly expanding *infrastructure*. Roads over the mountain passes have caused the *reduction of distances* and worked as gateways for the new *education* system, state sponsored *biomedicine*, and a flourishing capitalist *market economy*. All of these factors then triggered a domino-like chain of transformation that also led to the loss of the amchi's exclusive, monopolistic position in health care. Increasingly, *medical pluralism* has extended itself to include biomedical and Tibetan medical facilities in the Indian pre-Himalayas and plains. The latter is briefly expanded here: concurrence broke through individually (for each single amchi) and systematically (for the entire amchi medical system). Economically, one could argue that the relationship between supply and demand overturned from a mono-supply to a market with multiple supplies and demands. It is important to note here that the second systematic concurrence for amchi medicine came from some degree within its own system. The accessibility of the Tibetan medicine of Men-Tsee-Khang brought up an almost equally challenging impact as biomedicine did.

A point that has not yet been considered – the monetary market economy – is now the focus here. As elsewhere (e.g., Gudeman 1986; Mauss 1993 [1950]; Pordié 2002; Taussig 1980), the dissemination of market principles has demonstrably weakened the subsistence and exchange economy in this region.<sup>354</sup> Previously, subsistence and exchange economies were the backbone of Spiti life and society

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<sup>354</sup> Processes of change forced by the introduction of the money economy have been often described in anthropological literature, giving a much more detailed account than I do here. Their analyses and interpretations however, vary (for further readings, see Akin and Robbins 1999; Bloch and Parry 1989).

(Jahoda 2003). The decrease of subsistence, and the simultaneous arising demand for new commodities, has pressured amchi (along with everyone else) to look for new income possibilities. Thus, labor (whether paid in wages or yield profit) has become the basis for living. Being “measured by time” (Gudeman 1986: 20), the switch to labor has caused the reduction of time that was formerly available for following various practices of amchi medicine. The dissolution of the village exchange system was a consequence (and is a sign) of the loosening of social ties and growing individualism. This process is multifaceted. Exemplarily, it should be mentioned again that people are moving out of their villages to work instead in Kaza, young people are learning education in the Indian plains, and new income possibilities (cash crops, employment) are altering the village structure by the (partial) dissolution of the old *khang chen/khang chung*-system. Family and social ties have been loosened because people are finding more individual ways of making a living. Missing goods can now be bought in the market and payable services can be substituted for reciprocal exchanges of labor. Reciprocity – formerly embedded in the social system to solve certain community tasks – has broken down and affected almost all parts of Spiti life (cf. Jahoda 2003). Exchange has lost its importance and has been replaced by money payments. As a consequence, money is today accepted for any kind of remuneration, and land, labor, and goods have become commodities that are commonly bought and sold.

I do not blame money as the exclusive reason behind the breakdown of the exchange system, nor do I join in on the debate on the judgment of commodity and gift exchange, as earlier scholars have done (for instance, Bohannan 1959; Gudeman 1986; Taussig 1980). In my interpretation, the development in Spiti cannot be viewed in a mono-causal way but rather must acknowledge several factors already mentioned. The active cooperation of the population in maintaining development is one of these factors. It has not been merely the power of money that has replaced exchange, but instead a whole set of infrastructural and economic changes that have contributed to the situation, enabling the local population to not need this form of economic interaction. The development in Spiti, however, shows parallels and differences to other regions. For instance, it has been noted that in Ladakh similar occurrences were enforced by two additional factors: most notably tourism, and secondly, the stationing of the Indian army

(Beek 2001; Pordié 2003: 40).<sup>355</sup> Whereas Adams, in her study of the Sherpa in the 1980s, identified tourism as the major factor changing and challenging the area. However, she concludes that its impact on amchi medicine remains minor and “the authority of traditional healers is sustained by the persistence of social relations that existed prior to tourism” (1988: 510).

Back in Spiti, the dissolution of the two exchange systems and the introduction of money as remuneration have affected the amchi system in its overall impact. The rise of medical pluralism and the general money-making of the majority have undermined the traditional exchange system. The system of counter-giving has become obsolete. Typically, throughout Spiti the villages have simply stopped supporting their amchi. The repeated rotational work done by various families on the amchi’s fields has been largely abandoned. Pordié has claimed the same for Ladakh:

Free [biomedical] drug delivery completely deletes the “contre-don” and thus contributes to destabilising the traditional social organisation and to confirming, through biomedical hegemony, the possibility to get treatments without a counter-part, which favours the process driving rural *amchi* to money difficulties. (2002: 9)

As visible in the examples one and two above, in some cases, villagers have collected community donations or have given individual money donations for received medicines. Small gifts of natural produce after a successful treatment have become less, but nevertheless are still quite common (depending on the individual situation). But, there has not been a general agreement (in Spiti overall, or in entire village communities) that amchi should receive regular donations, or that the formerly firmly established counter-gift of repeated labor support should be converted into a monetary remuneration or the like. This fact is especially challenging because other groups of society have also faced the various consequences of the declining exchange process, but, as in the case of the clergy, a system of monetary donations was installed to keep up the reciprocal relationship. This ambivalence is further elaborated in the next chapter.<sup>356</sup>

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<sup>355</sup> Contrary to Ladakh, and despite its closeness to China, the Indian army is hardly present in Spiti. Only the very east of Spiti contains significant stationing.

<sup>356</sup> Kuhn reports similarities from Ladakh where private biomedical clinics are common institutions since the 1980s: “It is considered to be normal to pay a private allopathic practitioner with money and a

The villagers' removal of labor and time support has meant that the amchi's family must deal with their subsistence work as everyone else – alone. To be sure, because of their inherited estates, most amchi families have not suffered much from this situation in terms of economic security (cf. Jahoda 2003: 267).<sup>357</sup> The *khang chen* amchi were able to use their sufficient land to gain additional income and many of the lineage amchi continue to be well-settled today. Yet even some of the amchi families who were not as well-settled, as for instance some of the ones mentioned earlier in Pin valley, probably also did not fall into economic trouble because of the general upswing. However, this general security could be cut off at any point due to the fact that the environmental situation remains so delicate, meaning that weather extremities can strongly impact the entire local economy and destroy a family's standard of living in just one season.<sup>358</sup> However, the changes to an economy market and the arising pressure of modern needs (changing food patterns and clothing fashions, housing, technical equipment, etc.) have forced amchi to try, like everyone else, to find a job, whether in government service (as forest guard, contractor, or officer), in a private enterprise, and/or in the business of cash crop cultivation. Distinct working locations even result nowadays in amchi being absent from their villages for days and weeks at a time during the summer (cf. Kuhn 1988). Today, many amchi families in Spiti valley have multiple incomes, salaried jobs, and work as farmers (including cash cropping).

Here, I return back to a point from Chapter 2.2, in which I introduced the unusual surplus of amchi in Pin valley. This extreme example of these particular amchi reflects the analysis of the last paragraphs. The sprouted dissolution of the monopoly of the village amchi has been aggravated by the glut of amchi. Because of their disproportionately high number of amchi, a Pin valley villager's dependency on one particular amchi has evaporated more intensely than in the rest of Spiti. As stated earlier, these 'new' amchi could never gain the reputation and social status their *rgyud-pa* colleagues had. Additionally, they were accused by many people to have learned amchi medicine only in pursuit of financial benefit, which is parallel to the greediness

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village Amchi with 'thank you'" (1994: 71). She notes, however, that in Leh, Ladakh's capital, amchi are also paid for their services.

<sup>357</sup> Kuhn has observed this also in Ladakh (1988: 52).

<sup>358</sup> One might remember here a portion of an interview with a Spiti-pa in Chapter 3.1.2 who pointed to this fact. A drought in 2004 had this exact impact by destroying all the crops. That season, Spiti-pa gained no income from cash crops and even had no fodder for their cattle. Another example is when a strong flood comes and destroys the roads and stops or reduces supplies, cash crop sales, and tourism access.

displayed in the above 'bear-tale.' This accusation then undermined the amchi's moral standing. Starting to study the traditional medical occupation, these amchi had hoped for a gain in respect and economic security. But when it came time to actually practice, times had changed and they gained neither. The villagers refused to fully legitimize these new practitioners.

Before settling on the final remarks on the situation in Spiti, the following paragraphs merge theoretical considerations of gift-giving with the observed transformations. In this way, the breakdown of exchange regarding amchi medicine constitutes a particularity within Spiti society, as well as forms a general comparison with that theme. It is a termination of reciprocity from one side only; remarkably, the side with less social power. Treatment is continued to be given and understood as a gift, but the communal counter-gift has been phased out. How is that possible? And furthermore, what happened to the (power) relationship between the amchi and villagers, and the moral obligations arising from such gifts?

First, we must acknowledge the power of the market: within just a few decades, money dissolved an exchange system that had previously been the primary mode of economy and social relations for (probably) centuries. Because of this new trend, the amchi system was only one practice affected among many others. The arising pluralism of health services fostered a further effect: the one-sided dissolution of the gift exchange. We must take into consideration here the distinction that developed between the more private individual gifts and the more communal gift by the community as a whole. The individual amchi-patient relationship, including small gifts for successful treatment, has often remained intact. But, the connection between helping in the amchi's fields and eventually receiving medicine was not necessarily a direct or up-to-date one, which might have contributed to the villagers shaking off further moral obligations arising from the gift of treatment. This of course would have only been with a considerable consequent break in the relationship. The reason for this break can be only understood with the substantial decrease in the amchi's authority and power. Medical pluralism has shifted the social power from the amchi to the villagers. In contrast, amchi are still bound to their traditional identity regarding the moral basis of their work, namely, giving medicine to everyone in need. Only by losing their entire identity, and

ultimately their legitimacy to work, could they shrug off the obligation to treat.<sup>359</sup> Being an amchi, and staying an amchi, means to continue giving medicine and not ask for remunerations. The moral obligations on the villagers' side, however, almost unanimously eroded, with the only exception being that they now have a guilty conscience about it (see below).

What might be surprising then is that generally, the social status of the village amchi has remained largely untouched, as was sufficiently explained in Chapter 3.2.1. Arguing from a structural and tactical point of view, this ambivalent-looking separation makes quite a bit of sense: following the course of change, one dissolves traditional bonds as far as is useful, but no further than necessary. Keeping the amchi at this point – left with status and reputation – secures that he continues his work to a great extent.

The villagers have cut the social roles of donor and recipient. According to Mauss, by not reciprocating the gift loses its 'spirit' usually associated with honor and status. The gift-debt, created by the giving of medicine that had formerly compelled the villagers to reciprocate the gift, has been dissolved. But the villagers have not had to fear consequences for they have gained additional social power. This shift of power has dissolved the previous meaning of the gift. Thereby, medicine has become a type of "free" gift, but one that is bound to a specific local history and the moral codex of the amchi.

#### *Amchi Medicine as a Loss Market*

In this final section, some remarks must be made that further illuminate the individual side of the economic issues that have led to these emotional ambiguities among patients and disillusionments among amchi.

The individual amchi-patient relationship was partly excluded from the breakdown of exchange.<sup>360</sup> Because of their medical commitments, amchi kept on trying to cure any patient who presented themselves for treatment. Earlier, the patient's individual donations of small amounts of goods were given voluntarily – in contrast to the fixed communal gifts – and the quantity and frequency of these gifts were at one's

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<sup>359</sup> It has been touched upon earlier that the practical reality could diverge from the moral ideal. Kloos gives a strong example for this in Ladakh (forthcoming). Nevertheless, a complete dissolution of the moral obligation to treat patients would be tantamount to the loss of reputation and the joint understanding of the medical occupation.

<sup>360</sup> I argue here exclusively from an economic and social point of view and leave out the consequences of economic change, like for instance mental and social health issues, which, for example, Kleinman and Kleinman examined in rural China (1999).

own discretion. Under ‘modern’ conditions, one could assume that patients would have just as soon started giving money donations to their amchi in lieu of labor, as, for instance, has been the case among the Sherpa (Adams 1988). But in Spiti this was not commonly implemented, and any cases of larger donations (like the one reported above in example two) were, and remain, rare occasions. If an amchi were to ask for money face-to-face with a patient, it would mean the breaking of the tradition of voluntarism, and therefore the amchi-patient relationship based on trust as well. The peril of this possibly lost credibility discourages the amchi from asking their patients to pay for treatment, and the villagers use this as an excuse not to pay. Frequently, people give two exceptions for this rule: patients from villages other than the amchi’s (they pay small amounts), and in case of very expensive ingredients, the amchi will ask for an unspecified donation. These dealings are further examined in the next chapter. The former accompanying obligation of medicines as a gift, however, has left an imprint on the modern amchi-patient relationship. The self-induced dissolution of reciprocity often causes a feeling of guilt among patients towards their amchi. Similar emotional consequences have been reported from Ladakh as well (Kloos 2005). Nevertheless, people have not taken any steps to solve this contradiction.

It is comprehensible now that the public and individual economic changes and the free concurrence of biomedicine have aroused some resignation among amchi. Young people repeatedly state that under these conditions, an amchi education would not be appropriate for them. Amchi Sonam Namgyal’s words relating the amchi work as a “loss market” (Chapter 4) must be assimilated in this light. The economic metaphor of a “loss market” expresses the fact that amchi medicine is nowadays competing with other jobs to make an income, and that it is typically understood at the same time as a non-profit responsibility. In these contemporary times, amchi do not only work for free, but have to also invest time and money to do so properly. If amchi present a need for financial support, then it is meant merely to meet the financial needs of a medical system which has recently been influenced by competition with state-sponsored biomedicine, and comparison among Tibetan medicines and the wide potentials of an accessible market. This also alludes to issues of individualism, such as when the amchi comes into the conflict because of securing their family’s income versus the needed raw materials, or labor against amchi work. Not a seldom occurrence, this conflict of morals against individualism comes into play on a daily basis.

Until the turn of the millennium, the socio-economic context of Spiti amchi medicine neither created a private income nor a real amchi community budget. Examples for both from Ladakh and Manali are presented in Chapters 4.3 and 5. In the contemporary terms of a society that has changed from an exchange economy to a monetary economy, amchi medicine is understood as a loss-making deal. It is time-intensive and can only be practiced through investing additional money for medicines and the like. Being an amchi in Spiti has become much less attractive to any future prospective students and has definitely become a matter of economic concern. One simply cannot make a good living solely through medical practice today.

Money is a topic with a long history of anthropological analysis, which we have just understood in the specific case of the modernization of amchi medicine. It is as well a matter of debate among the amchi, and so takes the center stage of our consideration in the next chapter.

## **4.2 Money for Medicine**

The ‘bear-tale’ in the last chapter created an image of amchi that makes them appear as people who only help when forced to, who do not show respect, and who are ultimately greedy. This image can be taken as a possible patient’s opinion which complements the argument that the amchi’s gift (his altruism) is only superficial and merely is a means for an accumulation of power. The notions of altruism and modesty are derived from the Buddhist dharma and, in contemporary Spiti amchi medicine, closely connected to ‘money.’ Today, there is no way to practice amchi medicine without some cash investment. Money is needed to buy raw materials that are not native to Spiti and to compensate for the time spent on medical work (time that could have been used for other income generating activities). Interestingly, most amchi claim that the first need is the much more compelling one, and that the latter is ‘somehow’ manageable. The reason for this estimation is explained in the course of this chapter. In Spiti society, money itself is not burdened with moral bias. However, the inclusion of money within the amchi medical system is an ambiguous issue which is also followed by structural difficulties. These issues are examined in this chapter.

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*Various Uses of Money for Health Care*

The breakdown of the exchange system, the decline of the amchi medical system, and the new qualitative and quantitative demands on the medical practitioners are all developments from the 1980s and 1990s. Today's precarious economic situation of amchi medicine seems to be at odds with the individual economic progress of the Spiti people. Currently, villagers are able to save quite large amounts of money because their income is increasing but their possibilities to actually spend the money are not very extensive. Nevertheless, people are not yet ready to extend 'fees-for-service' for the amchi or regularly collect larger sums for donations. Yet, I have been told that patients are generally very willing to pay for health services, in certain situations. As mentioned in Chapter 3.2.1, people travel to the Indian plains to seek treatment, especially in cases of severe diseases. One of the government doctors explained that patients sometimes need to bear an expense up to 20,000 rupees for minor surgical operations. Many Spiti families do actually have the ability to pay for such health care of that price, and from various accounts, I can assume they have a general willingness to invest, at least, for certain incidents. The last chapter, however, revealed that the total remaining support for the amchi (largely on an individual basis) cannot fill the requirement of sufficient or long-lasting medical care. Considering the contemporary situation with amchi, the following question arises: why do Spiti-pa, except for the very few patients once in a while giving a money donation, not invest (anymore) in their own indigenous health care system?

To approach the answer to this question, it is first useful to observe the following short ethnographical account relating to this issue. There is a Ladakhi amchi I was told about who came to Tabo a few years ago. In Tabo, a village in eastern Spiti, the amchi lineage is broken and today no one practices Sowa Rigpa there. Tabo is famous for its monastery, which was founded by the great translator Rinchen Zangpo in the tenth century. Since the Dalai Lama performed a Kālachakra ceremony there in 1996, the village has gained considerable popularity among tourists, and people have started different kinds of businesses there. Since Tabo is situated right on Spiti's main road, it seemed the perfect place for the Ladakhi amchi to open a private clinic during the summer season. He then started to provide medicine to patients in return for direct payment. Generally, Ladakhi amchi have a good reputation among the Spiti population, and I have been told that many patients consulted him. In the beginning, he charged 200 rupees or more for a one-week course of medicine. Patients honored his work, paid the

fees, and continually kept seeking advice from him. The clinic was such a success that first summer (and, apparently, better business than in Ladakh) that the amchi returned a year later. He set up the clinic again, but raised his fees up to 400 rupees. This amount, however, was too much and the patients stayed away.

In Chapters 3.2.1 and 4.1, I mentioned that some Spiti-pa spend large amounts (it can be up to 2,000 rupees) for exclusive trips to consult an amchi in Manali or Dharamshala. Though these expensive journeys are rather uncommon, the example of the Ladakhi amchi above shows that Spiti people are able and willing to pay around 200 rupees for a single treatment. This is clearly another piece of evidence supporting the fact that Spiti-pa still value Tibetan medicine. If they consider a treatment valuable or an amchi to be well-trained, patients are very willing to invest in Tibetan health care. Furthermore, this example reaffirms the argument given in Chapter 4.1 that people make a distinction between ‘their’ village amchi and an ‘outside’ amchi (cf. Kloos 2005). An ‘outside’ amchi means that they do not consider him to be part of their close community. As soon as people leave their village to seek treatment in another town or in Kaza, Kinnaur, or Kullu, they are fully ready to pay cash for medicine.

#### *Amchi Work is not Repayable*

We now revisit the accounts of two Kaza amchi introduced in Chapters 2.3 and 3.2.2 in order to gain further insight with the analysis here in this chapter. These two are the only Spiti amchi who were fully trained in Dharamshala and live today (mainly) in the valley. Though they received their education in two different institutions (at the Dr. Lobsang Dolma Khangkar Memorial Clinic and at Men-Tsee-Khang), both have extensive experience with the modern Tibetan medicine of the exiled Tibetans. The two Dharamshala clinics are professionalized especially in terms of production of medicine and orientation towards a global health market. Both institutions are points of reference for Tibetans, Indians and foreigners from all over the world. They further match in charging money for medicine<sup>361</sup> and offering consultations for free. The two Spiti amchi have thus become used to patients paying cash for medicine, as well as to foreigners ordering large amounts of medicine by mail and then paying in foreign currencies.

However, today the two amchi follow completely different approaches to practicing medicine. A brief list of their similarities and differences follows: when he is

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<sup>361</sup> The fees follow the cost of production and materials and are generally quite low, though in average higher than the fees taken in Ladakh or Spiti (see below).

present in Kaza, Amchi Norbu Gyaltsen offers medical service from his private clinic just next to his house (since it was set up in 2005). In contrast, Amchi Thupten Thapke has settled his life in Spiti and devotes his energy to the SBAS and the Amchi Clinic. Therefore, Amchi Thupten Thapke's approach can be marked as more publicly oriented, while Amchi Norbu Gyaltsen practices exclusively on a private basis. However, both of them buy ready-made medicine in Dharamshala from their respective institutions.<sup>362</sup> Yet while Amchi Norbu Gyaltsen exclusively purchases this kind of medicine, Amchi Thupten Thapke only did so until 2005, when the SBAS was able to start producing the medicine itself in larger quantities (see Chapter 3.1.2). But, until 2005, both amchi<sup>363</sup> took certain amounts of money for prescribed medicine from their patients.

Amchi Norbu Gyaltsen's patients know that he buys medicine with his personal money. He said that he usually charges 60 rupees for a one week dose of medicine. At the Amchi Clinic, payment must be organized more publicly. Because of their government support, the SBAS has to record their complete income and expenses. The amchi have been urged to write down payments received for a full course of medicine in their (carbon-copy) receipt books. The amchi thereby consider the actual cost of the medicine, as well as the patient's ability to pay when figuring out a bill. The amount for a one week course never exceeds 100 rupees, and poor people do not usually have to pay.<sup>364</sup> The patient will then give the money without being asked, but rather by reading what is written in the notebook. Usually, the whole process takes place without ever mentioning anything related to the money transfer. In both cases, public or private, the remuneration received is in average less than the cost of the purchased medicine. The matter of payments becomes more tangible when we reflect on the fact that people sometimes refer to the Amchi Clinic as "shop," or in Hindi, "*dukān*."<sup>365</sup> What Amchi Thupten Thapke does there is considered 'selling medicine.'<sup>366</sup> He is not paid for his

<sup>362</sup> Amchi Norbu Gyaltsen as well buys medicine from his colleague's clinic in Dehra Dhun.

<sup>363</sup> I do personalize the Amchi Clinic as Amchi Thupten Thapke in this paragraph because he is largely in charge of the medicine purchases and 'sales.' Nevertheless, other amchi are also involved and do treat patients in the Amchi Clinic. This personalization, however, makes the point of analysis more clear.

<sup>364</sup> Samuel reports similarities from the Men-Tsee-Khang branch clinic in Dalhousie: "The price is uniform and relatively low, though by no means negligible in terms of the average income; some patients receive medicine at a free or subsidized rate" (1999: 94). This statement gives a hint that the average income in Spiti is, compared to the rural Indian areas, relatively high.

<sup>365</sup> If we consider Kaza as the center of Spiti, this matches with a tendency observed in Ladakh, where the closer one gets to the centers, the more monetized medical institutions become (Pordié 2002).

<sup>366</sup> In no way is this comparable with medicine-selling shops or drug stores in India or China, which form a popular-culture sector. Kuhn has observed that since the 1980s, drug-sellers and "self-appointed 'doctors'" do business in Ladakh and push commercialization of health forward (1994: 70). Such shops run by medically uneducated people or unqualified personnel do not yet exist in Spiti.

work; it is only the medicine that is paid for. Many amchi told me that the differentiation between payment for medicine and payment for work is vital for them. Most of them do not agree to be paid for their actual time-consuming work by the patients.

The following section continues to deal with this topic. I present here a long excerpt of Amchi Thupten Thapke's reply to when I asked why the amchi do not charge for their work and consultations but only for the cost of the medicine. Because each paragraph of his answer contains some useful remarks to the theme, I comment directly on each of them and, finally, after the interview, I return to the analysis of this chapter. He says:

The charge [e] is not a lot. In our [medicine] books nothing [related] is fixed, in our books it is not written to take money from a patient. In the very old books, the same is written: it is the patient who wishes to give money [or not]. [Suppose,] you are a patient and I am the doctor, and I give you a medicine that costs 10,000 rupees. If you give me 10 rupees for it, that is fine. If you pay 30,000 rupees, that is also fine. It is not fixed.

Amchi Thupten Thapke refers here to the authority of the *Rgyud bzhi*, which is a very common practice among amchi when reflecting theoretically on a moral topic. The scriptures have pre-determined that a practitioner's mind should not be disturbed by thoughts about remuneration (see Chapter 3.2.1). Rather, it should be the patient who wishes to give compensation out of respect and gratitude. Through his use of a fictional (and unreal) amount of cost, the amchi wanted to show how large the gap between costs and payment can be. In this way, he subtly implies how difficult the amchi's situation is when giving an expensive treatment.

Nowadays, the world is changing, so why not the Amchi Sangh as well? Why [should we take] a fee for consultation? Just to say something? Why should we ask for money? Yes, for medicine it is okay, because this goes into our stomach. If we are greedy, we could earn 400 rupees just from one patient because they have to pay when they are sick.

Rhetorically, Amchi Thupten Thapke asks what reason there could be to charge fees over and above the simple remuneration for medicine. Paying for medicine that the amchi had to buy himself makes sense simply under the habituation of the market economy. Money used for purchasing medicine is then literally missing for buying

food. It “goes into our stomach.” The passing on of costs is much more obvious in the case of ready-made medicines than in case of self-made medicine that perhaps contains bought materials. According to this differentiation, medicine is thus sub-divided. If Amchi Thupten Thapke gives medicine to a patient from his personal stock at home, he is generally not remunerated for it. But if he takes the patient to the Amchi Clinic, he would self-evidently pay. Medicine that is obviously purchased is repayable, and medicine that might not be purchased is not necessarily remunerated. Additionally, the idea of recompensing for a consultation that takes only a few minutes is completely beyond belief. This is what all amchi emphasize.

The patient does not make a difference. [...] Some [patients] come pretending to be very sick, some come as a gentleman but have cancer [e] and others come to hospital very young. For us, all patients are the same, be they rich or poor. We are not like that, giving good medicine to the rich people and bad to the poor. If we know that a poor patient cannot pay, we still give him the medicine that he needs. And if someone comes with *lakh* [thousands] of rupees in his briefcase, he will still get the same medicine.

Amchi Thupten Thapke continues to represent the ideal depiction of an unbiased amchi, who does not give treatment on a preferential basis. He tries to challenge the previously expressed statement that patients ‘fear the amchi’s revenge.’ However, Chapters 3.1.2 and 4.1 have shown that reality can sometimes compel an amchi to leave out an ingredient if it is not affordable to them.

If I think about how to earn money, I have lots of opportunities. But, by saving money from my small shop – let’s say, 15 to 20 rupees per day – I can start to give medicine free of cost to the patients. We try to benefit the people, not earn money. [...] There are some [people/amchi] who run after money and others who just think about their next life. This [amchi] work is still going because [...] people think they will get good things after death. However, till now we have not seen [if it is like that – smiling].

The amchi modifies his remark here, adding that certainly some amchi have financial interests in what they do. The attitude of the amchi’s mind, which is the basis of amchi medicine, should not to be concerned about this life or the benefits that could be obtained in this life. Rather, an altruistic amchi has the certainty that he will have the

merit of his deeds in his next life. That is the Buddhist concept of karma – and he relativizes its confirmation.

If someone comes to my home and wants to be given, for instance, a sewing needle, then I definitely say “no.” But, if someone asks for medicine, I am always ready to give it, even if it costs 5,000 rupees. Because from childhood, I have been in touch with medicine, so I know what the patients need.

Finally, Amchi Thupten Thapke points out here the difference between his personal identity and that of his amchi identity. As a neighbor or citizen, he might not give something as a present. But medicine will always be given as a gift. That is part of the amchi education, a matter of course, and part of the conception of the amchi’s self that is transmitted by the society and his predecessors.

#### Money as *Sman Yon*

Amchi and patients draw a strict line between medicine that is bought and the actual amchi work done (including the processing of medicine and the diagnosing). It has been sufficiently explained now that the former is repaid and the latter is not. Following the mass productions in Dharamshala, in Spiti medicine has (like in the Tibetan settlements) become a commodity (cf. Kopytoff 1986). This medicine has a generalized formula that is not specified to the particular demand of one patient but instead for the demand of a particular disease (see Chapter 3.1.2). Supported by the enlarged infrastructure, medicine is now – theoretically – alienable, meaning many patients now all receive the same medicine. Medicine as a commodity is exchanged for money. Following this assumption and practice, amchi are forced to express their need of payment for treatment, i.e., give a price for a commodity. But, asking for money in a direct amchi-patient interaction arouses suspicions of greediness.<sup>367</sup> Pordié has remarked the same for Ladakh: “They [the amchi] claim that they cannot ask for money explicitly without being called a niggard or accused of breaking tradition, but they must, or should, give help to any patient to keep their medical commitments” (2002). The orthodox view still claims that the value of the amchi’s work cannot be paid back but only voluntarily returned. Based on the traditional social legitimacy, amchi are forced to keep their altruistic attitude.

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<sup>367</sup> See also the underlying notion of this in the exemplary statements of amchi in Chapter 4.1.

Money can even be included as a factor in the amchi-patient interaction by its emphasis on the traditional values and beliefs. Pordié concluded from the observation of private clinics in Leh when a patient presents individual gifts after payment:

The gratitude of the patient toward the *amchi* is noted and the reciprocal merit is upheld. This system of *gift and counter-gift* is falling into disuse in the rural area [...] as well as in the urban area, where one pays for treatment and the corresponding price is fixed. Nevertheless, the financial transaction seems, according to the urban *amchi*, to also allow of the acquisition of merit on condition that the *amchi* and the patient give and receive with the appropriate mental attitude. (2003: 19)

This confirms the natural inclusion of money in Tibetan medicine. Depending on the mental attitudes of both parties, money can be viewed as a gift and accumulate merit like any other *smān yon* as well. This is further demonstrated by Adams' account on the Sherpa that I presented in Chapter 4.1. There, the wrapping of money in a *kha btags* makes it an offering. Without much interpretation needed, we see the giving of *smān yon* is more than a superficial habit: it is rather grounded in Buddhist culture and belief. In my understanding and experience of Spiti culture, the local people do not give a gift as an ordinary habit, but attach hopes for merit to the gifts. Anything given as a *smān yon* – including money – is believed to become a merit for the giver. To gain merit, the giver naturally needs a receiver. Consequently, both are in a reciprocal relationship. Whether the *smān yon* is money or goods, the merit relation between the amchi and patient continues to exist in Spiti, as elsewhere in Tibetan culture areas.

However, money connected to an amchi that was not given as a *smān yon* can throw an amchi under deep suspicion. Accusations of greediness have become powerful instruments that the amchi try to distance themselves from as much as they can. Nevertheless, in a time of an uprising monetary economy in which every family is trying to find its way to make some income, one can quickly find oneself sucked into a disreputable position. Disapproval and jealousy are sometimes natural consequences of making any profit at all. An old Ladakhi man quoted by Kloos brings this to a point, “The people don't like it if an *amchi* is rich. But they like it if an *amchi* has a lot of medicine” (forthcoming; italic in the original). This citation succinctly displays the ambiguity of having money and having medicine. Amchi are thus in an extremely tricky dilemma, as is further evident from the ongoing analysis here.

An obvious solution to this problem is found in the installation or creation of an official association. Receiving payment by the government (as is the case in Ladakh) or by an amchi organization makes all the difference to the patients.<sup>368</sup> It removes the direct payment from the individual amchi and requires recorded money transactions, meaning they are (theoretically) publicly controllable. Suspicions of greediness and envy are then further removed, though certainly not completely dispelled. In the case of the SBAS, however, this ‘strategy’ for the removal of accusations did not really last that long. If one person alone is responsible for the acquisition of funding (whether from the government or from donors) and its distribution, he then holds a very powerful key position in the organization. Amchi Thupten Thapke is the only one in the SBAS who is capable of engaging in these matters. Although he displays no lavish forms of wealth – for instance, a big house, a car, or extensive traveling – he is repeatedly exposed to such accusations simply because of his position. People remark that in these modern times they don’t trust someone who works without tangible benefit. It is thus evident that the moral dimension here has taken on a central discourse in the relationship between amchi and his patients, as well as with his community. For the amchi, it means reflexively balancing his family’s economic needs and the demands of his work, which of late can be described as somewhat of a tight-rope walk.

The contemporary economic and monetary concerns within amchi medicine at the moment are a result of the gradual assimilation of the Tibetan medical institutional practices in Dharamshala and elsewhere. The commoditization of medicine is a consequent fact of contemporary Tibetan medicine that Spiti-pa are generally used to by now; they would even be ready to pay for purchased medicine if a clinic was based in their village. Until now, most amchi do not have the budget to buy medicine privately in large quantities. But when asked, many amchi feel very comfortable and favor the idea of extending the Kaza models of private or public clinics to their villages. On the contrary, this step to commercialization of the ‘traditional’ medical system (which would additionally mean having fixed prices for amchi consultations and services) is far from actually being set in motion.

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<sup>368</sup> This complex situation including organizations and their possibilities is further elaborated in Chapter 4.3.

*Monetizing Medicines*

Referring to commercialization, it is important to specify here the meaning of ‘money.’ Its analysis is needed to avoid the trap of simply using the Western image of money as *the* factor causing the negative implications on ‘traditional’ economies (cf. Bloch and Parry 1989: 12; Brison 1999: 152). I stated in the last chapter that this change in the amchi medicine economy has multiple factors. Money, unlike most Western prejudices, does not have a negative stigma in Spiti society. On multiple occasions it is given as a gift without any negative connotation at all. It is, for instance, a single form of gift handed over on major family occasions, like marriages and *pingri*.<sup>369</sup>

The most striking comparison example for this is the remuneration of amchi work versus monk work, which includes things like ritual performances (discussed in Chapter 3.1.3). It was further explained in Chapter 1.1 that the maintenance of the clergy was installed in the tenth century by royal legacy. The reciprocal exchange system between a monastery and their connected population thus continues to be marked today by a predominance of power on the clergy’s side. As an example, there is the recently introduced ‘fine’ instituted by most of the Spiti *dgon-pa*, charged for each second son of a family who does not enter the monastery or anyone who leaves it without a weighty reason.<sup>370</sup> The amount of this fine varied in 2003 between 10,000 to 20,000 rupees. Furthermore, as explained earlier, lamas receive amounts between 100 to 200 rupees per person and day for a performance of various protection ceremonies. These are carried out on a regular basis in most households. People view this money as remuneration for the service offered, but also hand it over in a ritualized way that transforms it into a gift. Only such a ritualized gift can have the effect of merit, which continues to be an important form in accumulating merit for the general population (cf. Jahoda 2003: 33).<sup>371</sup> This fact clarifies several things: first, money is not considered impure or to have a negative aura. Otherwise, it would not be given to monks at all. Second, money can be a gift.<sup>372</sup> Third, based on the clergy’s power, money can take on the position of a counter-gift. Fourth, lamas are not accused of greediness when

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<sup>369</sup> The closest relatives may present particular non-money gifts, like cloth for a suit or the like. Similarly, Parry has noted that in Madagascar, the money gifts are written down and proclaimed without any embarrassment during the festivity (1989: 166).

<sup>370</sup> One of these reasons could be that the elder son has died and the younger is needed to take over the family’s estate.

<sup>371</sup> It would be, in several regards, very valuable to conduct research specifically on this topic concerning the monasteries.

<sup>372</sup> Bloch and Parry conclude from ethnographical examples that in some cultures, money as a gift is possible while in others it is not (1989: 9).

receiving quite large amounts of money for extensive ceremonies. This indicates that money on its own does not (necessarily) make his receiver appear greedy. Therefore, the main point emerging from this comparison of remunerated services is the difference between monks and amchi in their varying degrees of power.

On a theoretical level on the analysis of money, it can be concluded that until now, the impact of a money economy has had a diverging effect in the society. A general individualizing tendency is noticeable, which can be attributed to the new work options which generate individual income. Spiti's example in general has proved Karen Brison's statement that "money has a powerful capacity to bring about transformation in local exchange systems and, particularly, to undermine an emphasis on communal solidarity" (1999: 163; cf. as well Bloch and Parry 1989: 3). This development has, however, not completely dissolved or irretrievably altered all aspects of gift exchange. In the remaining aspects, reciprocity continues to be an important part of social bonds, like for instance between the clergy and lay people. In some cases, money has been included in this, taking the position of a gift. In amchi medicine, however, money has entered the center of the local discourse as a symbol for morality. Morality is a two-sided coin: one side for the amchi to claim authority and the other by the patient to impose pressure on the amchi. Money is therefore embedded in the changing meanings of society. It is thus proved that "[w]hat money means is not only situationally defined but also constantly re-negotiated" (Bloch and Parry 1989: 23). The meaning of money in the context of gift exchange in Spiti is not consistent, but is instead subject to re-negotiations under particular circumstances of power.

After these narrowly focused considerations on money, we now widen our perspective to the economy as a whole again by turning to the overall examination of the development of amchi medicine as a process of commoditization. This is intertwined with a view of the future of the Spiti amchi.

### **4.3 Making a Living as an Amchi**

The last chapter served as a specific examination of the usage of money in amchi medicine. This issue is continued here and merged into the final theorization of this chapter. In this discussion, we must develop the boundaries between gift and

commodity, and the differentiation between that which remains un-repayable and that which can be paid for. This analysis includes the differentiation between the monetization and the commercialization of amchi medicine. This finally clarifies the amchi's dilemma and leads to the overall question, how to make a living as an amchi? Or, more precisely, what needs to be implemented to enable an amchi to make a living today solely based on medical work? Consequently, the second part of this chapter presents various options that open up to help solve the economic dilemma.

### *Gift and Commodity*

Overall, the reciprocal exchange of gifts, complete with the norms and obligations in regard to the public sphere of amchi medicine, has dissolved. As a consequence of the initialized development of including payment for medicine, money has now become a part of the way amchi medicine is embodied in society. Though this progressive development is by far not completed, the two spheres extracted in the last chapter both involve money as their primary means of remuneration: purchased medicine, and health care external to the native community. Therefore, money is increasingly assuming the position of the “counterpart value” (Kopytoff 1986) for medicine. By using imported medicine from outside of Spiti, patients and amchi have consequentially agreed to adopt two characteristics of the market economy: medicines have become commodities, and are monetized. Therefore, since the late 1990s, changes have been made that have altered the indigenous medical system profoundly. The contemporary status of Tibetan medicine in Spiti is, however, not at all comparable with those in Tibet, in the Tibetan settlements in India, or in Ladakh. In these regions, these related processes of change have been ongoing for thirty or more years. The commodification of medicines in the institutes in Tibet and India (but not in Ladakh) has reached a phase that is currently oriented towards the international and mass medical markets, which is closer examined in Chapter 5.2. These institutes have taken up industrialized manufacturing of medicines for market purposes. In contrast to this development, Pordié points out that the commoditizing process in Spiti and Ladakh is actually negligible (forthcoming a). But this does not mean that a process of commodification has not yet started.

The “de-personalization of medical care,” i.e., the use of standardized medicines not personally configured to the individual patient's specific constitution, is, according to Janes, a clear indication of the commodification process (2002: 280). This view is supported by Nichter when he defines it as a “tendency to treat health as a state which

one can obtain through the consumption of commodities, namely, medicine” (1996: 269). The circumstances of de-personalization – though understood as a historical necessity arising from declining supplies of raw materials – has been observed as a modern phenomenon adapted to rationalized Tibetan medicine, also in Spiti (Chapter 3.1.2). Although progress is modest so far, we can nonetheless identify a commodification of medicine in Spiti.<sup>373</sup> Mark Osteen has indicated that in the discourse on commodification, the dichotomous approach that polarizes the gift and market exchanges does not reach far enough (2002b: 229), supported by Spiti’s example. Regarding Spiti amchi medicine, the facts are quite entwined complexly with each other, especially seeing that within this one system, the analysis reveals two closely connected spheres that are nevertheless treated so differently that they make up the two extreme poles – gift and commodity. For reasons of morality and power, amchi medical work remains in the gift sphere, while medicine has become a part of commodity. The increasing commodification of amchi medicine is, therefore, restricted by the modes of social relations. This is closely related to the question of commercialization of amchi medicine, which we consider now.

To establish a clear analysis, I draw a line here between monetization and commercialization, which, as I understand it, the former is established in Spiti amchi medicine but not the latter. By monetization, I refer to the process in which money takes on the opposite value of a particular item, in this case medicine. Whereas commercialization could transform the sphere of amchi medicine (and all its products and services bought and sold as commodities) and put it in the free market.<sup>374</sup> It would mean fixed prices for diagnoses and treatment, but would also cover the costs of the daily amchi work. Furthermore, amchi work would then be oriented towards the rationalized principles of calculating figures for profit. In Chapter 5, it’s explained how the government regulations foster and demand calculation and rationalization. However, though we find several characteristics of a capitalist economy in the amchi sphere, we do not find a principal economic policy of capitalism: profit maximization. A profit orientation is, as expressed earlier, simply not an option for Spiti amchi. In continuation

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<sup>373</sup> This minor status is the cause why a further analysis directed towards the Marxist notion of ‘commodity fetishism’ is misplaced here.

<sup>374</sup> I imply here that commercialization takes place on a bigger scale than monetarization, though a clear-cut separation between the processes is definitely not possible. What distinguishes the two further is that commercialization goes hand in hand with commoditization, which includes the shift from use value to exchange value. Concerning amchi medicine this shift is not yet given. For an analysis of the far-reaching accomplishments of the ‘commodification of health’ in India, see Nichter (1996).

of the complex social establishment of exchange, the monetization processes in amchi medicine are socially embedded to the same degree as their earlier exchange system, but with severe differing consequences because of their contemporary ambiguities. The change from gift exchange to monetization/commoditization is accompanied by a shift in the degree of claim for morality. In response to the monetization of medicine, the amchi emphasize a highly moralized demeanor to safeguard their reputation. One could attest that the amchi's generous and compassionate behavior is merely a representation to finally serve in their reclamation of social power, which coincides with the first stance of Mauss' argument that the altruistic character of the gift is rather a superficial one (2002 [1954]). However, in my understanding, it is not that simple. Morality is not just a superficial representation here; it is deeply rooted in the fundamental beliefs of what it means to be an amchi. And it's even more so connected with their conception of themselves and their medicine. It's thus intrinsically connected to the efficacy of medicine. This explains why the exchange sphere of amchi work resists the introduction of money and capitalist ideology.

The theoretical discussion concerning amchi economics comes to a close here. The analysis elaborated in detail the complexity of the issue, which in some situations restricts monetary payments, but in others not. We finally arrive at the point that money is generally needed to practice sufficiently as an amchi, but at present, there is no inner-societal system of remuneration installed. Instead, modern times have started to offer new opportunities for the financing of the amchi medical system. The second part of this chapter represents and establishes some financing models that have emerged, thereby leading into Chapter 5, where the contemporary mode of financing is then analyzed.

#### *Financing Models for the Future*

A young Spiti amchi told me very frankly: "If someone is working, he should have some benefit. Today everybody is working for benefit. If there is no benefit, why should I work as an amchi?" This is a perfect expression of today's practical reality. In the late 1990s, many amchi realized that the continuation of their profession depended on financial remuneration of their work. But, a sustainable payment or salary from their communities was not an attainable or realistic goal. Consequently, the amchi's intention to professionalize their work through organizations and clinics has directed this economic change at their profession in order to benefit and revitalize it (Chapter 5.1).

Though not officially claimed by the statutes of the SBAS, most amchi emphasize that they had hoped for financial support (individually and jointly) from the establishment of such an organization. The all-embracing presence of money in daily life has led to the view among the amchi that money is the ultimate solution to their problems – a common understanding of the Spiti community at large.

During the 1990s, the amchi had observed two general models for the financing of institutions. The first model was the one implemented by the Tibetan clinics in Dharamshala, which is a combination of fees-for-medicine and funding from the Tibetan government-in-exile.<sup>375</sup> Foreign patients and donors are a part of these resources and carry the image of easily accessible, large sums of support.<sup>376</sup> The daily experience of the 1990s displayed the working aspect of the second model to the amchi: the H.P. government investments that concentrated on administration and infrastructure, so as no domain of life was left out or unaffected. Government subsidization and financing became a multiple reality with this model. Both models were worth consideration in overcoming the consequences of the lost local exchange system, but the more obvious option for Spiti was to try to tap government resources. This is because at that time, international support and tourism was just starting to take off. Providing medicine for monetary payments was an economically sustainable and culturally appropriate way to reproduce the received budget (at least partially).<sup>377</sup> The development of government support since the foundation of the SBAS seems to contemporarily concede this approach to be right. The respective offices of the H.P. government seem to be willing to continue to give fundamental funding to traditional medicine in remote and tribal areas. How this can be realized, as well as an analysis of the pros and cons of a structure that is built entirely on government resources, follows in Chapter 5.2.

Two further models concerning the economic future of amchi medicine are reported from other regions. I present them here because they also play a role in the contemplation among engaged amchi.<sup>378</sup> The first model is the longest existing one,

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<sup>375</sup> Today, an increasing proportion of the budget is created through merchandising Tibetan health products all over the world.

<sup>376</sup> Spiti-pa knew this as well from Ladakh, where international NGO activities started more than twenty years earlier than in Spiti.

<sup>377</sup> Despite that, it was a condition of the government support.

<sup>378</sup> The following outline goes in part beyond pure description and analysis to also explore potential future consequences from these financing models. I present these considerations here because they might be of interest for any readers interested in applying these findings towards development.

implemented early on in Ladakh and called the “government amchi.” Pushed forward by Bakula Rinpoche,<sup>379</sup> the local amchi association, and foreign NGOs,<sup>380</sup> the state government included amchi medicine at the lowest level of available public health care. Additional to the position of a Chief Amchi subordinate to the Chief Medical Officer, fifteen amchi have held the position of a government amchi since the 1980s.<sup>381</sup> They received small monthly salaries and yearly budgets for the provisions of raw medicinal materials (Kuhn 1988: 55ff). In the late 1990s, about forty amchi held the status of a government amchi (Tondup 1997). In 2000, the H.P. government adopted this idea and opened a scheme concerning the state’s tribal areas, among which is Lahaul and Spiti’s district. Four positions were offered and any amchi with a *kachupa* diploma<sup>382</sup> and a “10 plus 2” degree in science<sup>383</sup> could apply. The government amchi positions were thought to be subordinated under the general public health system. According to my informants, one amchi from Lahaul received such a position. But from Spiti, no amchi at that time had been eligible to apply for those positions. Only Amchi Norbu Gyaltzen had had the appropriate amchi diploma, but he did not have the accompanying correct school education.<sup>384</sup> The mere announcement of these positions partly changed the public perception towards amchi medicine. One of the consequences of this was that in the following years, some young people from Spiti applied for medical training at the Tibetan Medicine Institute in Manali. This change in perception included the idea that ‘amchi’ was supposedly now a job with a continual and potentially life-time salary. It is hoped by many that the government scheme will be soon renewed again. In Ladakh, the government amchi positions were granted after investigating the candidates’ suitability, but without considering their school education. The H.P. format differs in this point and thereby excludes the older, already practicing amchi from the positions as most of them did not attend a school at all.<sup>385</sup> However, the idea of being a government amchi or an amchi who is paid by the government continues to fluctuate through the Spiti amchi’s minds. Many of them very much favor this vision and hope for its realization. The

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<sup>379</sup> He was a high clerical dignity in Ladakh and the first representative of the country at the Indian parliament in Delhi in the 1960s.

<sup>380</sup> The two most engaged NGOs at that time were the Save the Children Fund (SCF) and the International Society for Ecology and Culture/The Ladakh Project (ISEC).

<sup>381</sup> Initially, eight of them received government funding and seven received their wages from SCF (Kuhn 1988: 55).

<sup>382</sup> For a description of this diploma, see Chapter 2.3.

<sup>383</sup> For a description of this school exam, see Chapter 2.1.

<sup>384</sup> He did the “10 plus 2”-exam in 2003, especially for the purpose of applying if the plan is reenacted.

<sup>385</sup> The further implications of this scheme are discussed in Chapter 5.2.

availability of a large range of government positions throughout the valley nourishes this idea. Correspondingly, the amchi imagine a full-time job with a monthly salary and provisions for a medicine budget.

If we focus on this vision and explore it further, it emerges that the amchi's integration into a governmentally structured arena would be followed by an array of structural and medical changes (as is the general pattern world-wide, see Chapter 5.1). However, here I restrict the possible scope of changes to the theme at the heart of this chapter: free medicine versus payable medicine and/or services. Part of a government amchi position would be the supplying of medicine to patients for free. The contemporary habit of individual payments (like in the Amchi Clinic) would be omitted. Instead, a new habit would be expected, one already observed by Kloos in Hanu (forthcoming). The Hanu community perceived the amchi to be fully supported by the government and so regarded the traditional reciprocal understanding of health care as no longer valid. A further observation of Spiti-pa's biomedical treatment usage thus far suggests that free drugs have, in general, considerably less value in the patients' perception, an idea which is supported by further research as well (Etkin 1992; Messer 1990). Nevertheless, the amchi strongly envision and support the idea of government amchi. Through reviewing the ambiguity of money in the modern amchi-patient relationship, the amchi's preference here is understandable. But, a free medicine supply would, once and for all, finally put an end to reciprocity in amchi medicine. The patient's counter-gift – a symbol of respect and merit, an object that promotes the effectiveness of medicine and shapes social relations – would become a thing of the past. While today's practice in Kaza (giving money in return for medicine) still includes a reciprocal exchange, a full solution including a government amchi position would further remove this element from the amchi-patient relation. This might solve the psychological and economic problems and contradictions currently under debate, but it would also make the amchi's work more a simple service, one among other such governmental services available to the Spiti population.

This financing model could also work similarly with a substitution in the place of the funding agency; for instance, if a development organization (rather than the government) is in charge of the system. Often, these agencies have a similar approach to

the government's example systems.<sup>386</sup> A contrasting example of this, however, is a development project run by the NGO named *Ladakh Society for Traditional Medicine*, in which the previously mentioned issues of reciprocity were avoided (see Besch and Guérin forthcoming). Drawing in part from that project, a second potential future model for amchi medicine is based on the involvement of the community. Considering the recent accumulation of private cash property in Spiti, money collections for charitable ends and community tasks have become quite common. Villages could then (re-)implement community collections for their amchi, thus enabling him to concentrate fully on his work and to better the quality of his medicines.

The entirety of Chapter 4 has been devoted completely to the changing economic side of amchi medicine, while then working on a central presupposing theme of its modernization. At this point in the thesis, the stock-taking of the status quo before the actual modernization process started is now coming to a close. The work of the amchi with their social, religious, political, and economic entanglements and implications have all been presented. Furthermore, the transformations of the last decades that led to the present socio-economic dilemmas of amchi medicine have also been analyzed. The last paragraphs introduced various models challenging this dilemma, some of them having realistic potential, with the one based on governmental funding presented as the present preferred choice. It is now time to turn to an in-depth analysis of the answers that have been found by the amchi and an analysis of their (re-)actions taken.

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<sup>386</sup> There are right now one international and two Indian NGOs who engage in amchi medicine (see Chapter 5.1). As far as I know of these programs, none of them intensively considers the involvement of the community and the maintenance of reciprocal exchange.

## **5. AMCHI ON THE MOVE – A POWER STRUGGLE FOR THE FUTURE**

Spiti is today – as ever – hemmed in between mountains and external powers. ‘Towards the east’ is Tibet, with its religion and culture, and is considered a historical power and reference for imagination. ‘From the south,’ Indian policies set the political and economic frames of all the development in Spiti.<sup>387</sup> In a more abstract role, ‘the West’ influences Spiti through its global powers that enter the valley for consumption and tourism. Like other probable innumerable times in their history, the people of the valley adapt to these foreign forces by developing their own strategy.

Up until this chapter, this thesis has examined the contemporary conditions of amchi medicine in a narrow (and thus, artificial) frame, concentrating on inner-Spiti conditions and the interactions between an amchi and his community. However, as hinted at various times, these conditions and interactions simply cannot be analyzed without considering ‘external’ factors as well. This chapter widens our view now to include and consider national actors and global forces, as well as patterns of rationalization. The question to be answered here is how the amchi position themselves in this ‘modern’ world. Thus, this investigation extends into the dynamics of movement and future orientation (including space and time). First, the professionalization projects initiated by the amchi are examined in detail (Chapter 5.1). Then, merging all the different threads introduced earlier, we bring them together to examine in-depth the amchi’s interactions with state bureaucracies and national politics, Tibetan medicine of the exiled Tibetans (Chapter 5.2), and the forces of globalization (Chapter 5.3). The latter point then merges with the final analysis under the considerations of rationalization.

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<sup>387</sup> Ladakh, ‘in the north’, is considered more a ‘sister in mind’ than a power, though in some respects Spiti-pa look towards Ladakhi for guidance and example.

## 5.1 Demanding Professionalization

Some amchi were observed in Chapters 2.2 and 2.3 seeking medical training outside Spiti valley in order to conquer the loss of local knowledge in the lineages and to contest the marginality of amchi medicine. It was mentioned in Chapter 3.2.2 that their experiences (which mainly took place in Dharamshala) produced ideas and inspired imaginations which were then largely responsible for the organizational structuring of the amchi community that happened later. I call this process the professionalization of amchi medicine, though it also occurs in partial and fragmented ways. Its detailed procession and specific aspects in Spiti (such as community legitimation and the processes of bureaucratization and institutionalization) are examined closer in this chapter. But before this, some introductory and theoretical outlines of the general frame of the professionalization of traditional medical systems are needed. Thus, we leave the local focus and go even further behind the borders of South Asia, entering into the global arena.

To start with, this terminology needs elaboration. In a general (Western) understanding, a professional is someone who works as a full-time specialist, usually being a member of a legally established and exclusive body. This body sets the standards of the profession, such as its service, product or training, and holds the power of certification and licensing. The standardization of a distinct corpus of knowledge secures its authority to control the production of this knowledge, with the aim of monopolizing its knowledge and work. Formal regulations and a code of ethics restrict competition. A professional association, thus, bestows status and authority to its licensed members and creates a hierarchical relationship to non-members (Borst 1995: 2; Janes 1999b: 1810; Leslie 1968; Rosenthal and Greiner 1982; Singer and Baer 1995: 235ff). Murray Last, who applied the *Professionalization of Indigenous Healers* onto a broader agenda (1990),<sup>388</sup> defines a corresponding profession as an “extended self-conscious grouping of healers with defined criteria for membership (whether through licensing, certification, or registration), and an expertise that claims to be more than a craft and has in addition an esoteric, theoretical basis” (ibid.: 350). Following from

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<sup>388</sup> The medical anthropological analysis of professionalization finds itself on the earlier, sociological debate on medical professions in Britain and the USA, which have thus colored definitions and analyses (Borst 1995; Last 1990; Singer and Baer 1995). I use the given definition, however, as my reference point and develop it along the lines of the local picture of professionalization.

these remarks, professionalization cannot be achieved outside of modernization and rationalization, as defined in the first chapter. It follows the lines of bureaucratic organization with the aim to have effects that benefit the group. In this sense, professionalization has both moralizing and normalizing dimensions. This makes it all the more important to ask by whom professionalization is mainly driven by, or what the driving forces of such processes are. These questions need answers in several contexts, and so I first provide a general description of the professionalization processes in India after independence and in pre-modern Tibet. These two reference frames are very important concerning Spiti (see below). They then further serve as a basis for the third context: the locally specified investigation.

When examining Asian medical systems, professionalization processes have both a historical and a modern dimension. Both have been object of extended studies, especially in China and India (e.g., Croizier 1976; Farquhar 1995; Frankenberg 1981; Jeffrey 1982, 1988; Leslie 1968, 1974, 1977; Langford 2002; Porkert 1976; Rosenthal and Greiner 1982; Sidel and Sidel 1975; Unschuld 1985). Historically, the Chinese, Indian, and Tibetan medical systems show similarities in the succession of their parameters of professionalization. These parameters were detected for Tibet in Chapter 1.3, including the establishment of a corpus of authoritative texts, the standardization of education, the legitimation by qualification, and subsequent state patronage.<sup>389</sup> However, in the context of Spiti amchi medicine – and besides the development of Tibetan medicine – the only developments in colonial India of any importance have been since the nineteenth century. These are highlighted now.

Based on the modernization of medicine in Europe, practitioners of the medical scholarly traditions of Indian medicine (*āyurveda* and *unāni*) transformed their medical systems by adopting forms of institutionalization, medical and bureaucratic concepts, and modes of treatment from biomedicine (Leslie 1968, 1974). As part of the Indian national movement, a revitalization of the traditional medical systems started, which included the establishment of national associations and institutions (such as universities, colleges and research centers). The consequence of this after independence was a bipartite sphere of health care in India. On the one side, there are the professional medical institutions of biomedical practitioners and practitioners of the great Indian traditions, all recognized by the Indian state. These institutions and practitioners make

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<sup>389</sup> This parallelism, however, does not concern the temporal dimension. Tibetan medicine developed in this regard more than five hundred years later than the other two medical systems.

up the two medical sectors of public health care, mirrored, for instance, in the two departments of the Ministry of Health and Family Welfare: the “Department of Health” (which is oriented towards biomedicine) and the “Department of Ayurveda, Yoga & Naturopathy, Unani, Siddha and Homoeopathy.”<sup>390</sup> However, the various institutions of the medical scholarly traditions (associations and research councils) remained weak in organization and political power. Leslie concludes that, “though organizational instruments to professionalize indigenous medicine were created, they have failed to achieve the substance of professionalism” (1968: 570). On the other side of India’s health care system, there exists the extremely heterogeneous group of practitioners whose healing systems have not been officially recognized by the Indian state. It is a mass of semi-professional and non-professional healers of folk medicine and “learned magico-religious curing,” among others (Leslie 1974: 99; Jeffery 1988: 57).<sup>391</sup> And we already know that although Tibetan medicine belongs to the scholarly traditions of Asian medicine, the practitioners of amchi medicine are not officially registered. Legally then, they belong to the latter group, a crucial detail in their interactions with the government.

In India, therefore, the integration of traditional medicine into the public health system has already been established for some time, regarding the great medical traditions (at least, compared to other international contexts). The international development of this matter is briefly explained here, as the recent development has had overall consequences on the health sector in India. On an international level, traditional medical systems have only consistently been on the health care policy agenda since the declaration of the conference of the World Health Organization (WHO) at Alma Ata in 1978. Its overall goal was claimed as “Health for All by the Year 2000” (WHO 1978). To reach this end, it was realized that the number of biomedical practitioners was not sufficient. Thus, it demanded to integrate traditional healers into the primary health care system under certain standards and restrictions.<sup>392</sup> Afterwards, a broad range of multinational and bilateral organizations and agencies engaged in the development of health care. The Chinese public health system especially served as exemplary model for

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<sup>390</sup> Family welfare is the third pillar of the Ministry of Health and Family Welfare.

<sup>391</sup> This complex theme of the integration of traditional medicine in the Indian health care system is only touched upon briefly here. The interested reader might continue, for example, with Banerji 1981, Frankenberg 1981; Jeffery 1982, 1988; Kanbargi 1997; and Leslie 1974, 1977.

<sup>392</sup> For a closer investigation of this policy, see for instance: Koivusalo und Ollila 1997; Pigg 1995; Pillsbury 1982; Streefland und Chabot 1990; Tarimo und Webster 1995; Velimirovic 1984.

the integration of traditional medicine (Bloom 1997; Hsiao 1995; Rosenthal and Greiner 1982). In the 1980s and 1990s, the international health policy was frequently influenced and altered by the World Bank and the International Monetary Fund (IMF). These organizations orient health care programs towards efficiency, measurable (scientific) parameters, market liberalization, and privatization. The orientation in the programs of these two organizations, as well as programs of other agencies (for instance, the United Nations (UNO) institutions), has had critical outcomes regarding public health care.<sup>393</sup> At about the same time, the Indian state changed its foreign and economic policy, and opened up towards Western capitalism. The country's dependency on the World Bank and the IMF then rose continuously and caused retrospectively drastic changes in India's national health policy. The matter of traditional medicine integration into the health sector was not affected by these changes. Nonetheless, the privatization process and the reduction of the state budget for health care did affect the Indian traditional medical systems, indeed as much as biomedicine was affected. The consequences of this for public health care were assessed to be strongly negative,<sup>394</sup> resulting in insufficient health care in slums and rural areas, epidemics, and the continuous spread of malaria and tuberculosis (Banerji 1990, 1998; Ollila et al. 2000; Qadeer and Sen 1998). I mention these transformations here briefly to highlight the reasons that Spiti amchi now contemporarily strive for integration into the public health system. As part of the system, they would become objects within national and international health policies. In the course of this chapter, however, we see how far the local integration has developed and recognize that the consequences of these international developments do not yet play a role in amchi medicine.

### *Policies and Legitimations*

These rather general remarks on the context of Asian health care indicate that the answer regarding the agent of promotion for the professionalization of traditional medicine is actually an interactive process of the professional group-to-be. This group pursues certain aims and political powers, which then further influence the group. Janes is the scholar who has most intensively analyzed the transformations of Tibetan

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<sup>393</sup> For a critical examination of agendas and programs of the different organizations and their consequences on traditional medicines, see e.g., Geest et al. 1990; Green 1987, 1988; Koivusalo und Ollila 1997; Pigg 1995; Pillsbury 1982; Streefland and Chabot 1990. The latest WHO policy towards traditional medicine was adopted in 2002 (WHO 2002).

<sup>394</sup> The emphasis on family planning in government, as well as international programs and the enormous expense for administration, had additionally reduced the expenditures for health matters.

medicine emerging from modernization in the context of a nation state (in his case, socialist China) and globalization (1995, 1999a, 1999b, 2001, 2002). By transferring his excellent investigations on local particularities to general statements I provide a proper foundation for my following analysis. And not least, one approach of my thesis concerns the differences in transformation processes between the medical centers (Lhasa and Dharamshala) and Spiti.<sup>395</sup> Therefore, it is useful to draw parallels from Janes' analysis. In the following paragraphs, I summarize the forces of professionalization and state two further theoretical assumptions before finally turning to the specificities of Tibetan and amchi medicine.

A major factor in the professionalization of traditional medicine is, naturally, the health policy followed by the respective government, be it in ancient or contemporary times.<sup>396</sup> In modern times, policies go beyond the interests of a single nation state and are increasingly bound to policies of multinational organizations, such as the UNO, WHO, World Bank, or IMF (Janes 2002: 274). Their enforcements of the liberalization of the health sector have additionally promoted the second factor<sup>397</sup> in traditional medicine professionalization: the demand of the market and its capitalist economy. Ultimately in this second factor, professionalization follows the imaginations and examples from the West as a consequence of tourism and/or globalization. Traditional medical practitioners are logically subject to and object of these processes, which leads Janes to the following two statements:

The crisis of traditional medicine lies in how to navigate these complex and in some cases countervailing forces without losing the core principles, values and techniques of the traditional approach and without submitting completely to the disorienting attractions of the profit-driven health care marketplace. (Janes 1999a: 1810)

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<sup>395</sup> Basic differences are obvious when considering the totalitarian regime in China, in which Tibetan medicine has been incorporated into the public health system by being regarded as a local variation of traditional Chinese medicine.

<sup>396</sup> I am aware that when considering professionalization as part of the process of modernization, the reference to 'ancient times' sounds conflicting, but as visualized already in Chapter 1.1, and now again in this context, there is no opposition. This term therefore serves as an example that the insistence on a tradition-modern dichotomy falls short in reality.

<sup>397</sup> A third force is the so called "health transition", a term that stands for the recent epidemiological changes from infectious diseases to non-communicable diseases responsible for disability and premature death in developing countries. I do not have proper data available for Spiti, nor, I suspect, does this transition already have an expression in the area.

So, while professionalization of indigenous healers is probably necessary in order to maintain the integrity of the system, standards of professionalization must be protected from such narrow, competing interests. This will likely be one of the major challenges faced: how to manage the professionalization of native healers without submitting to standards dictated by foreign systems. (ibid.: 1817)

Viewed from a conceptual and local perspective, it seems that a distinction between external and internal forces can be drawn. External forces can be understood as the influences and regulations of a national and international character. The second can be understood as the voluntary actions taken by the practitioners. In practice, this distinction is often difficult to discern because the appearance of one without the influencing the other is hardly possible. However, Last (1990) points in the same direction when distinguishing between political and social legitimation of professional healers. On the one hand, he sees policies and rising demands by governments and multinational organizations. On the other hand, he emphasizes that healers – in their process to professionalize – always need the legitimation of the communities they live in. Last therefore asks if “politically orientated professionalization from above [is] compatible with socially sanctioned professionalization from below?” (ibid.: 362). If social legitimation from the community is given, Last continues to ask “whether they [the practitioners] really need to match the systematization achieved by other professions in medicine” (ibid.). This perspective points to a major focal point in my examination concerning the Spiti amchi. If professionalization is aimed at political and social legitimation, it must be analyzed how the amchi professionalize and what they are particularly aiming towards. This is especially a key indication to look at, as we have noted that their social support has been partially withdrawn. After this, the question is raised of how the actors involved in the introduction of such processes are encouraged, considering the fact that they know the group is of a superordinate structure, additionally entailing profound changes in social practices.

Analytically, I therefore step back for one moment to sharpen the focus on what motives are at stake during professionalization. A parallel is drawn here from the following statement by Janes, on the use of healing or medical systems and their benefits – or “secondary effects” – for the ones participating:

For healers, use brings with it economic returns of various kinds, along with various potential social rewards, including influence, legitimacy, prestige, authority, and power. For patients, health care decisions may declare a particular social identity, their positions with regard to current constructions of ethnicity, engagement with modernity as locally articulated, or assertion of political rights. (2002: 269)

The potential results on the healer's side here mentioned by Janes have already been earlier examined in the preceding chapters, and apply perfectly to the traditional health care system in Spiti. The economic and medical decline of amchi medicine and the loss of power on the amchi's side can both serve as an argument that a deliberate restructuring of the group of healers aspires for benefits of some kind in social and/or economic capital. Or, more moderately, we could ask what the motives behind professionalization of amchi medicine could be, besides any structural guidelines imposed from government adjustments. Both of these matters must be answered, however, with an emphasis on the subjective motivation, so as to reveal the uniqueness of the modernization of amchi medicine. The following examination of the professionalization of amchi medicine leads from the overall frame of Tibetan medicine to the local investigation in Spiti.

#### *Standards of Tibetan Medicine*

In Chapter 1.3, the various steps of professionalization of Tibetan medicine were introduced as historical facts. They are briefly recalled here to serve as the basis for the examination of contemporary professionalization of amchi medicine. The beginnings of a professional Tibetan medicine were traced back to the seventh century, when a distinct medical knowledge system was elaborated. Standards of training were successively developed, especially since the fourteenth century, when the *Rgyud bzhi* became the main source for knowledge accumulation. Further standardization was grounded on political efforts and the link to the powerful structures of the Buddhist clergy. The course of an elite Tibetan medicine was further entrenched in the early twentieth century by the geographical and political centralization within the two leading training colleges. While the strong transformations of Tibetan medicine under Chinese rule need

no further mention here,<sup>398</sup> some further considerations about Tibetan medicine in exile are necessary, as it is in many ways a reference point for Spiti amchi medicine.

I now apply the above given historical characteristics of professionalization to Men-Tsee-Khang and its staff, piece by piece. When completed, it serves as a comparison to Spiti amchi, and as a basis for understanding the interactions between the two. Since the 1960s, Men-Tsee-Khang has been continuously enlarged as an institute, today containing all the sections of a fully elaborated medical and pharmaceutical department. Orientated towards biomedical standards, Men-Tsee-Khang has a clinic with surgical and in-patient wards, a research department, a department of medicine, para-medical production and sales departments, and a publishing firm. The institute trains its students to become full-time working doctors with the guarantee of earning wages in one of its branch clinics that have spread all over India and Nepal. Though I have no knowledge of an association of Tibetan practitioners, students and doctors are recognized members of Men-Tsee-Khang, which has been established as an exclusive body. It is a legal social and cultural organization, as well as legal Indian charity. The exclusivity of Men-Tsee-Khang is deliberately enforced by setting high standards for the profession. Entrance to the college is bound to an exam and the prerequisite skill of considerable knowledge in classical Tibetan. Additionally, most students have accomplished the Indian “10 plus 2” school education. It was already pointed out in Chapter 2.2 that it is not easy for young people in the Indian school system to fulfill this double requirement of Tibetan language knowledge and a “10 plus 2” certificate. The admission conditions of Men-Tsee-Khang differ considerably from the traditional teacher-disciple system, which generally have apprentices start their training in childhood. Instead, Men-Tsee-Khang orients itself to a modern school system that prepares one for the job market. The entrance age of students for Tibetan medicine is thus raised and parallels training for a college or university career. It is meant to prepare one for a full-time job. This organization of training-in-exile clearly follows the Indian or modern education system. Finally, graduates are certified by Men-Tsee-Khang, with their newly acquired ‘license to practice’ constituting an ultimatum for the rest of medical practitioners, as it has become the standard among practitioners. Other Tibetan medical institutes in India try to get their students examined by Men-Tsee-Khang teachers. The institute has therefore gained – presumably, as well as a continuation of its

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<sup>398</sup> Sometimes these are comparatively applied to the following analysis. For further readings, see Adams 1998b, 2001a, 2001b, 2002a, 2002c, Adams and Li forthcoming; and Janes 1995, 1999b, 2001.

position in pre-modern Tibet – the absolute authority in the field of training and executes a monopoly on knowledge and certification for work. Prost congruently examines that Men-Tsee-Khang is “a ‘total institution’” and its “students are a closed group” with an “exclusive cognitive identity” (2003: 169f). She continues, saying that the “students jealously guard their right to the status and knowledge gained through membership of the institution” (ibid.: 176). A hierarchy is seemingly consciously established when Prost states that Men-Tsee-Khang doctors regard hereditary transmission as “‘unprofessional’, i.e. an ‘unreliable’ method for training good doctors” (ibid.: 137). Standardization and demarcation is also continued in all the other fields of medicinal activity, especially pharmaceutical research and production. Despite all these expressions of enforced professionalization, the legal position of Men-Tsee-Khang in India remains in a transitional and intermediate stage. The institution is registered as a society but not as a medical body. Tibetan doctors can practice, but not as a part of the public health care system.<sup>399</sup> The Indian state tolerates, even acknowledges them (see below), but until now has not recognized them. This situation applies as well to the amchi of Spiti.

### *Projects of the Amchi Community*

The ‘transfer’ of standards from Tibetan medicine to amchi medicine is a historical (as well as contemporary) process. We have noted that the early standards of Tibetan medicine became the formal standards of training in Spiti (such as the memorization of the *Rgyud bzhi*). The transformations of the early twentieth century in Tibet (its centralized and standardized college curricula), however, seem to have not had such a comprehensible effect on amchi medicine. But the dissolution of marginality and the rising mobility in the area enabled a direct comparison, making a ‘transfer’ more immediate. The latest standardization and modernization of Tibetan medicine does affect Spiti amchi, but especially because they are not part of that process. What are these effects being made? How does professionalization take place among Spiti amchi? Does marginality have an impact on the process, making it distinct from similar processes elsewhere? Assuming that the transformations not only have structural but also moralizing character, what effect does the process have on values and norms?

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<sup>399</sup> The indigenous practitioners of Sowa Rigpa in India have started a process of legal recognition a few years ago. The theme was especially raised at the Sowa Rigpa Conference in Delhi, in February 2003 (see Chapter 5.2). For political reasons – as India’s relationship to China is on the agenda – this goal is difficult to attain as long as ‘Tibet’ is involved.

These are the questions answered now, first by way of ethnography, and afterwards by theoretical analysis.

The actions being taken and the principles being applied to the professionalization of amchi medicine are connected to some observations from Spiti amchi from when they stayed at Dharamshala. Of the approximately twelve amchi students who left the valley for training, about five have returned and practice as amchi in Spiti, as of 2004.<sup>400</sup> Two of them had gone to Dharamshala to learn Tibetan medicine in its surroundings, at the center of Tibetan culture – though not at Men-Tsee-Khang. Both are my main informants. The individual history of the origins and variable reasons to receive such ‘new’ ways of education were highlighted in Chapter 2.3. Here, I am instead concerned with the ideas these amchi returned with, after leaving Dharamshala. And why an amchi would then settle in Spiti, knowing that the socio-economic conditions for medical practice there are precarious and possibly endangering his future perspectives?<sup>401</sup>

In Dharamshala, Spiti-pa witness various practices of Tibetan medicine (for instance, smaller or larger private clinics, or at Men-Tsee-Khang). Though the grade of organization and professionalization differ among them, their pursued course is quite similar. It is a daily realization in Dharamshala that its entire environment orients towards and depends on tourism and donor support. There, Spiti amchi become familiar with modern modes of treatment and clinic organization. Furthermore, Tibetan medicine is not only tolerated, but appreciated and strongly supported by Westerners and Tibetans alike. Thus, it is perceived as having a future while satisfying certain demands and acquiring certain elements. The transfer question Spiti amchi asked themselves was: what elements need to be applied in Spiti for a future of amchi medicine? In my understanding, it’s crucial that Spiti-pa – the two amchi, as well as other amchi and patients visiting Dharamshala only occasionally – applied the standards of Tibetan medicine in Dharamshala with regard to Spiti conditions. Imaginative visions of medical and organizational practice in Spiti could then be merged with the perceived

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<sup>400</sup> I do not count here the amchi who do not work continuously in Spiti. As mentioned before, the Tibetan Medicine Institute Manali probably has had five students from Spiti in 2004, who could start to practice in Spiti soon. Their impact and eventual change would be another interesting object of future research.

<sup>401</sup> This question does not apply to the students presently learning in Manali because their comparably large number (as opposed to the 1990s) is a clear signal in support of the assumption that amchi medicine might become worthwhile again in the future, caused by the rising of government support.

availability of government funds, resulting in a solution for the current socio-economic dilemmas of the amchi.

Many amchi have expressed that a vision of transforming their work could enable them “to help the Spiti people”. Their wish to help is partially based on the experience of winter in Spiti, when people continue to be threatened by limited health care. But, the altruistic representation also mingles with social motives. It is a vision that merges together the amchi’s ethical claims, renews their bonds with their respective places and people, and justifies their traditional responsibility. The examples of Amchi Tsering Dorje and Amchi Thupten Thapke have revealed that social connections to family, lineage and village strongly contribute to an individual decision to return to Spiti. Therefore, the importance of one’s relation to a place and people, transferred especially in the amchi lineages, comes to the fore in this discussion. This bond leads to a feeling of responsibility, as *rgyud-pa* amchi express it. These aspects are certainly very strong motives for starting a revitalization of amchi medicine. More detailed motivations are highlighted now by this ethnographical account on the processes of professionalization.

Towards the very end of the twentieth century, Spiti amchi came together to seek a way out of the financially and socially precarious situation they found themselves facing regarding their medical work. Facing a pluralistic health care system and the consequences of a rising market economy, their lack of financial resources to make or purchase medicine, as well as their missing medical and technical skills painfully became realized. At the same time, they saw how well Tibetan medicine flourished in Dharamshala, how a local initiative had set up a school project in Spiti based on government and foreign funding, and third, how large government funds were available for nearly ‘anything’ (Chapter 1.1). The Forest Department in Kaza not only encouraged them to set up an organization, but helped with the initial procedures as well. In August of 1998, the *Spiti Board of Amchi Sangh* (SBAS), the association of Spiti amchi, was founded and more than forty-five amchi signed the list of members. Membership was gained through this registration and an initial and single payment of 100 rupees. Out of a group of well-known and senior amchi, the president and the vice-president were

elected and Amchi Thupten Thapke was appointed the secretary-cum-treasurer.<sup>402</sup> With this board, the SBAS registered as an association in Kaza in the same year. Since then, they have sought registration in H.P., but this process is bureaucratically very difficult, and includes some financial budget concerns and necessary political connections. Having not yet gained this legal status on the state level, it continues to be a main obstacle for the amchi's goals. Which leads us to the questions of what exactly are these goals, officially, and what are the amchi commonly and individually hoping for?

The official aims are summarized in the *Memorandum* (SBAS 1998), formulated by the amchi as part of the SBAS foundation process. They are as follows:

- 1) Publishing literature for the safeguarding, support and progress of traditional medicine;
- 2) Protection of local medicinal plants and bio resources;
- 3) Public relations work for the support of the amchi;
- 4) Safeguarding the supply of traditional medicine for the population of Spiti valley;
- 5) Establishment of a training institute in the long term;
- 6) Establishment of a network of national and international organizations, aiming for similar ends;
- 7) Cooperation with government authorities for the protection of the unique natural and cultural heritage of Spiti.

These aims sound quite official and have a broad approach. In my personal talks with the amchi, their goals were actually more clear-cut and easily defined than the actual problems. In 1999, during my first field visit, the amchi explained to me that they wanted to use the association as a platform to discuss medical questions and problems. Their idea was to make their time-intensive work more effective by working on some tasks as a group, and dividing up other tasks individually. Amchi Thupten Thapke explained that the goal with the highest priority is the one regarding the establishment of a central amchi center that provides space for a dispensary and for the production of medicine by hand-driven machines. Government offices had bound financial support to certain prerequisites, like for instance, the establishment of an office. To set up such a place, however, continuous financial resources were required, something the SBAS did

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<sup>402</sup> Naming only one amchi is not an oversight or a slight to the others: it is merely a practicality for this thesis (only Amchi Thupten Thapke plays a reoccurring role here).

not have. Lack of money was considered the major problem of the association. At that time, the government authorities, as well as an Indian NGO,<sup>403</sup> had only promised future support. In addition, a matter of high priority as well was the establishment of an amchi school or training facilities. Both raising present amchi knowledge, as well as implementing new opportunities for the next amchi generation's education were regarded as very important goals, though not deemed executable anytime in the near future.

Despite these rather concerted ideas, the amchi also had quite definitive individual interests in the SBAS. Throughout my research, I came to talk with many amchi about these topics. The main issue they raised was that of the need for financial support to produce medicine. The amchi expected the association to become a mediator with the government and become the distributor of its funding. Even better, they thought, the SBAS would use the prospective budget to buy and produce medicine, which would then be distributed among all its members. The amchi perceived the lack of medicine as the most eminent of their problems, and the one potentially solved the easiest. "Sufficient supply of raw materials and ready-made medicines for all amchi" was the main demand derived from the daily experience of inadequacy. It was no secret that this was not only a material matter regarding physical ingredients, but also one of lacking knowledge regarding the production of variety of medicines. Accordingly, the secondary hope was for opportunities to be taught in the making of medicine. Most amchi desired "help" in order to be better at their practice. The initial set up of the Amchi Sangh was, thus, accompanied by happiness and hopefulness. These expectations were dashed when not much was achieved in the beginning, as I explain below. Many amchi had attended the first gatherings, but, because of their collective disappointment, the following meetings had rather less numbers. These meetings were held at least twice a year and were meant to coordinate the SBAS work and make decisions for future activities. The first years of the SBAS were oriented towards initiating interaction with the government offices. This initial stage was quite difficult and rather unsuccessful. The Forest Department had withdrawn its support. Other authorities to be contacted for support were the Block Medical Officer (stationed in the Kaza hospital), the Additional Deputy Commissioner (ADC; the highest Indian

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<sup>403</sup> The *Foundation for Revitalisation of Local Health Traditions* (FRLHT), based in Bangalore, was the first NGO to become active concerning amchi medicine in Spiti, but in the following years it was not an established and continuous source of support for them.

representative in Spiti), and the offices of the Department for Ayurveda of the Government of H.P. in Shimla. Interacting with such offices is often difficult for Spiti-pa, in general. Because these higher administrative positions are generally held by Indians, people sometimes hesitate to meet with them. Though most amchi do speak Hindi, most of the elder ones are not able to read or write in Hindi or English, leading to complications regarding the many forms that are needed to be filled out for the various files and applications. Additionally, many older Spiti-pa are called “illiterate” because they didn’t attend school, also contributing to their discomfort. Cultural misunderstandings then lead to insecurities, and the fact that the Indian personnel in the offices changes quite frequently creates even further setbacks. The missing standard education has thus become a major difficulty for the amchi, and made the SBAS’s beginning get off to a slow start. Additionally, it is natural that it would take some time to get a new bureaucratic process going and get the people involved feeling confident enough to deal with the application. In the beginning, SBAS’s results were hardly visible and some amchi therefore lost interest in its work. Soon, the association was relying on only a dedicated few of its members, also a consequence attributed to the difficulty of attending meetings.<sup>404</sup>

Slowly, personal contact with the government officers bore fruit. Amchi Thupten Thapke met with representatives in Kaza as well as in Shimla. The Department of Ayurveda of the H.P. government granted 30,000 rupees to SBAS in 1999, and consecutively increased the budget to 150,000 rupees in 2001, and 200,000 rupees each in 2002 and 2003. These considerable increases can be attributed to a couple of factors. First, the state and the central government are generally ready and willing to invest in traditional medicine and health care in tribal and remote areas. The H.P. government’s policy on supporting and implementing these initiatives is outlined below. Second, the Block Medical Officer, who has been in charge of the office in Kaza since the mid-1990s, has developed over the years a positive attitude towards the amchi and supports their agenda.<sup>405</sup> Third, Amchi Thupten Thapke’s efforts to convince the officials kept the process open. And finally, it appears that the conditions required by the government

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<sup>404</sup> A meeting held during snowy times of year has as little prospect of success as one held during harvest times.

<sup>405</sup> It is very unusual that someone stays in this position that long, which indicates his general good-will towards Spiti. I had met him already in 1999, and observed four years later that he had changed his opinion for the better regarding the value of amchi medicine and the importance of local practitioners of health care in the villages. This is in stark contrast to the ADCs, who change frequently and with each new ADC, the SBAS has to (re-)negotiate the matter anew.

were definitely fulfilled by the SBAS. Though the budget's use is not officially specified, the process behind it underlies the control the government offices wield. The money is paid out via the ADC and the Block Medical Officer in successive steps.<sup>406</sup> Each one must be applied for by the SBAS, and at that time they have to name an application. If the local officials agree on the aim, assess the earlier implementations as positive, and appraise the accountancy to be accurate, then they continue paying out the budget.

During the first years of SBAS, funds were used for the initial set up of the organization, for its meetings, and a seminar. During the Kālachakra ceremony in Ki in 2000, the SBAS organized a five-day seminar on Tibetan medicine and its potential developments in Spiti. It was the first time that the Amchi Sangh appeared in the public eye. Although the seminar was well-attended by interested Tibetan, Indian and Western people, and the SBAS approached the visitors, there were no long-term beneficial effects that emerged for them.

Meanwhile, the increase in financial support enabled the Amchi Sangh to finally rent a room and inaugurate the *Spiti Board Amchi Sangh Clinic* in Kaza, in October of 2002 (figures 19-20).<sup>407</sup> It is located on a side-street near the market and is designated by a big metal plate announcing its name over the entrance door. The room itself has only one small window that lets light in, making it a cold place to be in wintertime. Some photos of the inauguration and a Sengye Menla *thang ka* decorate the walls. A metal shelf in one corner contains about sixty-five jars of different kinds of medicines (mainly ready-made pills).<sup>408</sup> Without exception, they were all brought from Dharamshala. Opposite the door, a desk marks the consultation site in the office. Various record books and receipt notebooks lie on it, ready to be filled in. In the beginning, the SBAS amchi had decided that they would serve at the clinic by taking turns. But this method turned out to be unreliable and inefficient. So instead, they considered giving the duty to only one amchi. As they could only afford to pay a salary lower than the average salary in Spiti, it was difficult to persuade someone. Finally, Amchi Chullim agreed to serve at the Amchi Clinic. He was the best overall choice

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<sup>406</sup> An installment usually lasts for about half a year.

<sup>407</sup> It is hardly surprising, but should be noted that all of these implementations occurred in Kaza – the 'most modern' and 'most urban' place of Spiti.

<sup>408</sup> The amchi had brought medicines to treat the most common diseases, like digestive, respiratory and circulation problems, pains of all kinds, and additionally a few *rinchen rilbu*. Exceptional treatments still have to be separately produced or bought individually at Dharamshala.

because he is an experienced amchi, and his family situation allows him to be absent from his home and not depend on the small salary he receives from the SBAS.

Towards the end of the year, however, the SBAS budget started to run out,<sup>409</sup> and they had to stop permanent service. However, the clinic was not totally closed: since its start, Amchi Thupten Thapke, being an amchi in Kaza, had been treating patients in the Amchi Clinic as well.<sup>410</sup> So he continued his mode of work as usual (Chapter 3.2.2), but instead of just coming to his private house, most patients now went to the Amchi Clinic for treatment. As he generally worked all day at his shop in the bazaar, people knew where to find him and then accompanied him to the Amchi Clinic. Early in 2003, the SBAS was able to pay him a monthly salary again and Amchi Chullim returned to work in the Amchi Clinic. Fixed opening times were installed – 9 a.m. to 1 p.m. and 2 p.m. to 4 p.m. daily, except Sundays – to give the clinic the reliable appearance of an office. This was needed to conquer the rumors that the Amchi Clinic was never open. The first half year of inconsistent operations left traces, however, especially among the Spiti-pa from other villages who came to Kaza only irregularly. All too often, the Amchi Clinic door had appeared to be closed and not everyone personally knew Amchi Thupten Thapke or where to find him. A further reason was the urging by the Block Medical Officer to establish constant opening times. Throughout 2003, Amchi Chullim (and Amchi Thupten Thapke as well) treated patients continuously, and thereby the Amchi Clinic settled itself as an institution.

With the establishment of the Amchi Clinic, bureaucratic organization solidly entered the arena of amchi work. Their government funds were bound to some conditions, most visibly in accounting and the records of patients. Self-evidently, all expenses and payments had to be registered, thus go through a bank account and the SBAS accounting records. Once a year, the account is controlled by a commission from Shimla. Furthermore, patients' health problems are recorded, as well as their prescribed medicine.<sup>411</sup> Due to their power from funding, the Indian government controls the bureaucratic appropriateness of the amchi work. Interestingly, the record book is filled out in Bodhi (in contrast to the accounting records), which means that none of the

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<sup>409</sup> The initial costs for the interior of the Amchi Clinic and their basic stock of medicine had consumed most of the budget.

<sup>410</sup> Patients often prefer one particular amchi and continue to consult him. This is only slowly changed by the general offer at the Amchi Clinic, so that more and more patients are consulting the amchi at the Amchi Clinic without regard for who is personally attending.

<sup>411</sup> I described the procedure with an emphasis on payment in Chapter 4.2.

responsible government officers can read it. What is instead emphasized is the following of certain formal rules. This makes amchi medicine an object of state-driven rationalization. Patients also receive a paper form with the medicine names and price to be paid (Chapter 4.2). These enable the amchi and patient to rationalize these processes: when a treatment is successful but needs successive medication, the patient doesn't have to come back to the Amchi Clinic himself, but can rather send a relative to bring the form and the amchi will give medicine accordingly to him. Also, the amchi are able to recount patient-related and medical data, like the number of patients, the stock of remaining medicine, etc. That way, the SBAS and their medical work successively gains a more professional character. Another example of this trend is the use of small paper bags for prescribed medicine. These are imprinted with the respective timings for taking them (morning, lunch, evening) written in Hindi. Before this, the amchi had folded the medicine up in used paper. This innovation has built respect through the patients' aesthetics and is aimed at the rising marketability of amchi medicine.

Some data from a survey I carried out further illustrates the improvements and influences of the Amchi Clinic. Overall, the average number of patients going to the Amchi Clinic is higher than that of a single village amchi. This impression is supported by the two clinic amchi themselves and matches my own observations and survey. I evaluated the patient records of the months January, February, March, September, and October of 2003. Each month, thirty to fifty patients received treatment at the Amchi Clinic. Although at peak times up to ten patients a day would show up, the monthly average was approximately between two and three patients per work day. Both my and the amchi's impressions conclude that the Amchi Clinic is increasingly attracting more patients and slowly becoming more frequented.<sup>412</sup> Further data shows that the patient parameters of the clinic are clearly defined. Overall, most patients come from Kaza. Then about one third of the patients come from other villages, mostly from Bhar, and only occasionally patients come all the way from the lower and upper regions and Pin valley.

Obviously, the establishment of the Amchi Clinic was a major milestone in the work of the association. As for the continuing development of the SBAS, Amchi

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<sup>412</sup> The data of my survey does not prove this assumption, but does have a limited meaningfulness in this regard. Here is the following data, though it is not relevant in this context: the ratio of male and female patients is equal. Most of the patients (ca. 50%) are adults, about 40% are people over fifty years old, and only 10% are under twenty years old.

Thupten Thapke set up a further office for the SBAS in his private house in 2003 (figure 24). He furnished a spare room with a desk, some shelves and chairs. This room was meant for the accounting business and any official work of the SBAS, but also for representation reasons. Talking to the SBAS amchi again, they stated that they felt that time has accomplished something and that their visions are now slowly shifting. They repeatedly said that it is now important to have someone working in the office who knows proper English and Hindi, can work with a computer, and has organizational skills. The bureaucratic and structural work due to increased interaction with the government and some NGOs has gained more importance. The issue of these missing bureaucracy skills for dealing with applications and official correspondences is continued to be a perceived obstacle for any further developments, especially for becoming recognized.

The SBAS took the last big step of their envisioned project, so far, in 2005 when they produced a large amount of fresh medicine and distributed it at medical camps in remote villages. I already described and analyzed this in depth in the context of herbal medicine (Chapter 3.1.2), but I recall here the essential aspects of this to put them in full context. The raised government funds enabled the SBAS to produce medicine in a quantity and diversity that Spiti had probably never seen before (figures 22-23). This marks a decided shift from the purchase of ready-made medicine from Dharamshala to self-made medicine with as much local raw materials as possible. As explained in Chapter 3.1.2, the latter is considered throughout Spiti to be the most effective medicine. Amchi had long spoken of this aim to be able to do so. In addition, government officials in Spiti sometimes even urged the amchi for self-production because they expected this to have a positive learning effect on amchi who lacked knowledge on this topic. However, that fact that the SBAS started the medical camps after this is considered something as a watershed. Instead of continuing with their practice at the Amchi Clinic and taking money for medicine, they advertised and emphasized the free treatment. Their aim was twofold: promoting, and therefore revitalizing, amchi medicine in the villages, and secondly, providing good health care. The latter goal has again a double connotation, as it competes with biomedical facilities and represents the SBAS as a benefit to the people. This means the SBAS is entering a new field. Despite their daily health care activities in central Spiti, they have now promoted their own work among their own people in the region.

*Analyzing the Elements of Professionalization*

The latest achievements and activities completed by the SBAS have a very special meaning for amchi on several psychological, social, and political levels. It is, for the time being, a final step in the modernization of the work of the Spiti amchi. So, to break it down on a theoretical level, we should now analyze the elements of the professionalization of amchi medicine. What are their structural roots? What are they aiming towards?

The foundation of the SBAS was, in the beginning, mainly meant to build a jointly-operated body having contact with related offices and interested people. It was important to make it a legal body so that it could have access to financial resources and be able to speak with ‘one voice’. But, the association neither controls the standards of service, training, or products, nor does it appoint formal regulations. Not being a member of the Amchi Sangh does not have any consequence on an amchi’s individual practice. Membership is voluntarily, does not depend on qualifications (except being commonly accepted as an amchi), and does not have to be renewed. Last has categorized “organizational types” of practitioner organizations, with SBAS falling under the category of “cultural societies for like-minded practitioners” with the “least professional powers” (1990: 364).<sup>413</sup> The SBAS has not yet attained the status of an exclusive body monopolizing and restricting competition. These features would preferably be developed in the surroundings of a competing market of suppliers for resources and clients. But, this is not the case in current day Spiti. The SBAS is in the first stage of professionalization that serves as an authorized platform for amchi to interact with government offices and express their need for support. The organization’s main goal so far is the collection of funds, and so the structure of the organization is correspondingly built as such.

While the seminars that were carried out aimed at representing the SBAS and opening the public’s perspective for support, the Amchi Clinic is, first and foremost, meant to serve the people. Requested by the government and in accordance with the amchi’s own demands, the Amchi Clinic is the first achieved goal oriented towards the patient. With its central location, the SBAS hopes to serve as many people as possible. Also, the clinic was thought of as a starting point and, if successful, they wanted to continue to set up clinics in each part of Spiti. In addition to this, and even of similar

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<sup>413</sup> The other three categories are: promotional groupings, unions, and professional associations.

importance, the Amchi Clinic serves as a representation. It is a public marker demonstrating that traditional medicine still exists and is developing and keeping up with modern ways. Their entrance sign above the door is partially written in English, as is common at Indian NGOs, offices, and tourist places. However, in Kaza, it is rather new to do this. The sub-inscription (“Natural Herbal Medicines”) shows an orientation garnered towards Western public interest in alternative medicines. The SBAS seems to be trying to attract potential donors (as well as patients) among Western tourists. But, though this might be a hope for in the future, it does not seem to really reflect realistic contemporary aims at the moment.<sup>414</sup> Thus, I suppose, the sign is meant more as a demonstration to the local public, announcing the fact that Westerners are strongly interested in amchi medicine. The SBAS hopes that this representation causes further attraction among the local population. The sign is a marker that actively demonstrates their attempt of reclaiming a place in the health care system with modern means. However, the Amchi Clinic is not only directed towards the Spiti people but also towards the government. The Amchi Clinic is the reification of the Amchi Sangh, and through being financed by the government, can cautiously claim a place in the public health arena.

The Amchi Clinic, as a structure, is also in various regards ‘modern’. Through its simple existence, it removes amchi work from the private atmosphere of the amchi family house to a separate location. This is a typical move for any specialized profession. The furnishings, the records of patients, and the prescription forms (with the monogram of the SBAS) set off the clinic as a modern setting comparable to a biomedical dispensary or health center. Its appearance also demonstrates the modern styles amchi medicine has taken on. This representation is very much in line with its present revitalization and the protection of local culture and heritage that is in general favored in Spiti. However, most of these structural elements are actually requirements arising from the government support. In accordance with the guidelines of administration, the Amchi Clinic has to be bureaucratically organized, which the SBAS might embellish here and there in their own sense of ‘organized’. Applications, accounting, and records all manifest the rational principles in the daily clinical amchi

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<sup>414</sup> Without speaking Hindi, a tourist would have difficulties in basic communication. Furthermore, I have noticed that amchi rather hesitatingly treat Westerners. I have not seen a tourist in the Amchi Clinic, nor one ever recorded. Secondly, contact with potential donors is usually not created at the Amchi Clinic or on the street, but rather via personal contacts.

work. The amchi, as well as patients, are used to these principles and their appearance as belonging to modern institutions. For the amchi, it is not only something they are obliged to do, but they also appreciate it as markers of a professional medicine.

The Amchi Clinic also keeps an option open for what we called above a ‘full-time specialist’. As long as their budget is enough, Amchi Chullim is paid to do be there six hours a day, six days a week.<sup>415</sup> This we could call a full-time job. However, till now it is not paid as such, but, more or less, the amchi receives his expense allowance.<sup>416</sup> No fully responsible head of family could work for that salary in Spiti, and Amchi Chullim does not do any other occupation or side work. In fact, he is actually doing it out of good-will and conviction for the matter, but is also able to do this because his family has a secure income through other means (such as their cash crops). Someone who would necessarily need an income could therefore not do this job. Being an amchi continues to be an additional profession to a ‘real’ occupation securing a living. Working in the Amchi Clinic is not a government position, nor do people perceive it as comparable with one. The job constitutes a kind of intermediate state. On the one hand, the government finances the Amchi Clinic and therefore the amchi’s presence, but on the other hand it is not legalized as an official position. Nevertheless, Amchi Chullim is the first full-time government paid working amchi in Spiti.

### More Amchi Sangh

In this section, the internal structure of this association (and that of the entire amchi community) is explored in more detail. The following explanations on the diversity of the amchi community shed more light on the contemporary issues of the ongoing modernization. Recalling the survey presented in Chapter 2.3, it can be stated without going into too much details that there definitely exists heterogeneity among the amchi regarding several parameters, like for instance age, family origin, lineage descent, economic background, amchi training, or school education. This is naturally carried into the SBAS and combined with further aspects. Two such aspects especially contribute to its inner structure: seniority by age, and respect based on being a “good amchi”. The former, as a common principle of Spiti society, is self-explanatory and has not yet experienced any great change. The latter was sufficiently explained in Chapter 2.4 as

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<sup>415</sup> As explained in Chapter 4.3, payment is only tolerable for an amchi if it is from the government or derives from other external funding.

<sup>416</sup> In 2003, he received 2,000 rupees per month, as compared to the average ‘minimum’ salary of 3,000 rupees.

having the main building blocks of *knowledge, experience, and inner qualities*. A final aspect that contributes to a good standing in the SBAS is if someone works very actively for the organization. These listed parameters have all contributed to a hierarchy within the Amchi Sangh which, except for perhaps the very last point, very much follows indigenous traditions of group organization. Continuity of engagement in the organization and participation at the meetings is shown by only a handful of amchi,<sup>417</sup> who almost all belong completely to the senior group of influential amchi.<sup>418</sup> Therefore, the main problem of the association, as frequently cited by the amchi themselves, is the limited engagement of many of the amchi in matters for their own communities. This lack of participation is usually attributed to the fact that these amchi are primarily occupied with their income-generating work. Though employment or income is an issue for most amchi, some are accused of joining the SBAS only in times of arising (financial) benefit. In a locale rapidly developing market dynamics, ‘money’ is a versatile and extremely loaded topic, as has been observed in Chapter 4.2. ‘Money’ has thus also become the object of internal amchi politics. It was a fundamental argument in the matter of putting up of two separate amchi associations in Pin and Tud in the last few years.<sup>419</sup> The amchi of these regions do not seem to feel sufficiently considered by the SBAS. A separate association promised direct access to funding, and there is a general estimation that trickle-down funds are available. The government resources for health care have become widely known, with some Indian NGOs expressing interest in amchi medicine and the first foreign donor organizations also promising support. Both regions, Pin and Tud, attract special attention because of their exclusive location, isolation in winter, and particular structures.<sup>420</sup> The two new Amchi Sangh in operation have expressed this as their main reason for setting up their own associations. Certainly, it is a strong argument, because even communication with the Amchi Clinic in Kaza is difficult in winter, not to mention the logistics of transporting medicine. There are also a couple of further minor reasons for branching-off, including some animosities and

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<sup>417</sup> This at least applies to 2000-2004, when I could observe this myself, or an amchi told me as such.

<sup>418</sup> Throughout the years, however, the position of the president of the SBAS has changed quite frequently for various personal reasons, whereas the position of the secretary is continuously held by Amchi Thupten Thapke. This continuity shows his extraordinary position in the Amchi Sangh, being a main actor in fund raising and discussing new ideas.

<sup>419</sup> I do not consider *The Spiti Sorig Preservation Institute* of Amchi Norbu Gyaltsen in Kaza here, as it is not an association.

<sup>420</sup> The survey presented in Chapter 2.3 showed the particular differences of the regions. Very briefly summarized they are: Pin has many amchi, but most of them are not lineage amchi. Tud has only very few amchi and is totally secluded in winter. The other two regions have many amchi, most of whom are lineage amchi, but they are widespread.

personal quarrels.<sup>421</sup> But, what is of extreme interest here is the fact that the overall aspiration of the three associations is the same: getting access to financial resources. All three Amchi Sangh, thus, approach government offices to try and win the respective officers support.<sup>422</sup> Additionally, each of them (in the meantime) has had contact with NGOs and/or donor organizations.<sup>423</sup> It should not be overlooked that the associations do prioritize straightforward support. It is as well the case that each group is also led by a charismatic amchi. This combination reinforced the splits in the amchi community. Officially, no one claims a total break of all ties to one another, and in some matters, cooperation between them still works. Also, there exists an overlap of personnel between SBAS and the Pin Amchi Sangh. But overall, a unity of the amchi community is not viable at this time. In my understanding,<sup>424</sup> the emergence of several Amchi Sangh is an unambiguous expression of competition for resources on the upcoming health market, combined with rising power struggles (at least among some individuals). The pulling together of the first amchi institution in one center (located in Kaza) has raised hopes. Thus, the actors in this try to professionalize their own association. Traditional health care is developing in a contested field for available resources.

### Local Legitimation

Competition among the Amchi Sangh also demands a contest between social and political legitimation. However, this is not really the case yet because of the differentiation of the regions and, at the present, a seemingly unlimited pool of resources. I thus continue to analyze this question mainly in regard to the SBAS, as it is the one I worked most closely with. The investigation here seems in many parts quite similar to the other Amchi Sangh, although with the reservation that they are smaller, less organized, and until now, still in the process of their initial development.

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<sup>421</sup> The appearance of conflict among amchi is certainly nothing new, but now with the shrinking of distances, these conflicts are challenging because the fields of interest are more overlapping and contested than ever.

<sup>422</sup> Many different programs, offices, and departments can be approached, such as the ones that are responsible for conservation, forest, watershed, development, and health – each on local, state, and national levels. By utilizing personal contacts, the different associations can apply for funding at differing authorities.

<sup>423</sup> This field is quite diverse, ranging from personal Western sponsors to Western donor organizations especially set up for this purpose (for instance, the NGO Spiti-Help; see 2.3), or to large-scale Indian NGOs (for example, FRLHT or Pragma; see above and Chapter 3.1.2, respectively). Their developmental approaches vary considerably from charities to grassroot organizations, as well as a varying grade of involvement and investment.

<sup>424</sup> I cannot claim here a full understanding of the matter because I did not do enough research among the amchi of Tud.

Having set up the SBAS as a social and legal body with the competency of an agency, a state of institutionalization has been entered. While the organization does not use its power to change the norms of medical practices among the amchi by standardization, it is itself exposed to normative external powers. Regarding the first aspect, neither a standardized control of training nor a licensing of practitioners exists. Students undergo an exam to become an amchi, but it is a case-by-case basis and not systemized (Chapter 2.1). No institution in Spiti has the authorization to license amchi.<sup>425</sup> Certification is one of the core characteristics of a professional association; however, this applies mostly on the national level. Such a national or regional association of Tibetan medicine does not exist, and collaboration between amchi all over India is also missing. The SBAS is therefore not integrated into a larger framework of an umbrella organization or the like. It is a very localized association. At the moment, the association's interest is not in the qualitative licensing of its members. This would contradict the main aim of getting support, because today such an examination would be necessarily oriented towards Men-Tsee-Khang standards, which most amchi cannot fulfill. Licensing would thus undermine the legitimation of the SBAS as a representative of professional practitioners.<sup>426</sup> Therefore normalization by the SBAS of its members cannot be detected here.

With respect to the external aspects of legitimation, a political process has been set up that is largely driven by state conditions. The SBAS depends on government funding and must concede that the government offices execute control over them through bureaucratic requirements.<sup>427</sup> The amchi must consequently justify the structural public (but not the medical) work they do. If satisfactory, they receive their continued funding. However, this only works out this way as long as its intermediate state of legality (as described above) is kept.<sup>428</sup> At some point in the future, professional amchi medicine will have to get state recognition. Political legitimation will, thus, become increasingly important for a continuation of the local medical tradition.

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<sup>425</sup> For further statements on the licensing, see the following chapter.

<sup>426</sup> Notice the difference here to the politics of certification among Nepali amchi, described by Craig (forthcoming). The Nepali amchi strive for state legitimation by promoting their work outwardly as 'modern' and 'scientific'.

<sup>427</sup> Till now, the SBAS has not depended on non-governmental funds. However, this might be different with the other Amchi Sangh (such as the Tud Amchi Sangh, which is supported by the NGO Spiti-Help). Depending on their approach, the processes of legitimation vary depending on state controlled funds.

<sup>428</sup> The question of impacts from international and national policies is dealt with in the next chapter.

Until now, however, social legitimation by the community continues to play the more important role in the amchi practice. Especially Chapters 3.2.1 and 4 revealed that though the parameters of legitimacy have not changed very much, the changes in health care and the social system have already undermined social support. The medical requirements of the communities have altered and power relations have thus shifted.<sup>429</sup> This is the point which the medical camp projects and their goals fit into. Before, the SBAS was often perceived as a society that only benefits the amchi, an internal affair with no effect for the general Spiti population. The establishment of the Amchi Clinic has not changed this, because it is ‘out of sight’ for most people.<sup>430</sup> The SBAS aimed to alter this by actively coming to the people with loads of medicine. As I explained earlier, “an amchi needs medicine” because it’s a key indicator of their own self-assessment and identity. Being able to produce medicine themselves enables the amchi to work and secure their reputation. Though these medical camps are only there for one day in each village, the activity itself demonstrates the availability of qualitative goods. This kind of action conquers the public opinion about the amchi’s lack of medicine and their declined reputation. This, as well as the above stated promotion effect, is essentially built on a moral basis. Concerning medicines, people are today used to free biomedical drugs, used to paying for amchi medicine in the Amchi Clinic, and used to having an ambiguous and sometimes guilty conscience concerning the non-reciprocity with their village amchi (Chapter 4.1). Free amchi medicine distribution subsidized by the government has, therefore, somehow an ordinary character,<sup>431</sup> inscribing amchi medicine to the same status like biomedical drugs. The patients’ ambiguous feelings thus end. Equally important to the amchi is that they got rid of the ‘money matter’ (at least, in this case). Distributing medicine for free has an altruistic character. The logic of this project builds on traditional socio-moral categories (Chapters 3.2.1 and 4) and can, therefore, be understood as an attempt to regain social legitimation. Though the project is for the moment only of an isolated character (once in each village), it points in the direction that the SBAS wants to follow. The project further merges amchi community affairs with individual amchi affairs. In benefiting the villagers, the medical camps also give a public legitimation to the SBAS and, at the same time help spread perspective to

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<sup>429</sup> Some change has set in regarding the value of medical examinations among patients. This is elaborated in the following chapter.

<sup>430</sup> See also Chapter 3.2.2, in which the image of the Amchi Clinic was explained.

<sup>431</sup> Please note how Spiti-pa are generally used to subsidization.

the village amchi (who are always involved in the camp at his village). It therefore gives amchi, as well as their patients, a deeper perspective.

The analysis from the strong perspective of the SBAS professionalization process is finished here. Various new threads that were mentioned here are continued in the next chapters. Therefore, in summary, it can be said that initial steps of professionalization have been taken. Leading the above given definition of professionalization, it has come to attention that the SBAS is categorized along Last's definition of an "extended self-conscious grouping of healers". The amchi do not follow the 'prescribed' legal way, but pragmatically merge the guidelines required by the state legislation ("from above") with their own goals, shaped in part by economic constraints and social legitimation ("from below"). Their overall aim is to stabilize their position as to enable each amchi to practice under the modern conditions of each locale, to ultimately transform the present socio-economic circumstances of their surroundings.

## **5.2 Interacting with Centers**

So far, two main reference points for the Spiti amchi have been identified in this thesis, then further split up to three places and their respective institutions. The first, Dharamshala (or more specifically: Men-Tsee-Khang), has appeared frequently throughout this thesis as a medical and ideological fixed point for Spiti-pa. The second reference points are Shimla and Delhi, which (despite their differences in several regards) are taken in this thesis synonymously as the seats of state policy and administration. On one hand, all these reference points have very solid conditions, tangible offices, and similar such requirements. On the other hand, they are also the object of amchi's imaginations and can be considered the doorways to powerful global influences. From these perspectives, these two reference points are analyzed in this chapter as centers. From there, their contributions to the ambiguities of marginality of amchi medicine are explained. A third force, the international health market, repeatedly pops up throughout these first two but is taken up separately in the analysis in the next chapter. Finally, at the end of this chapter, a last ethnographical example is shown that impressively demonstrates the Amchi Sangh's understanding of its immediate source of progress as localized in the government. The amchi thereby present their own modern way of self-marketing.

*The Supremacy of Dharamshala*

Throughout this thesis, the supremacy of Dharamshala (respectively, Men-Tsee-Khang) has become apparent. However, it has also become apparent – considered from the other side – the perception of subordination by the Spiti amchi. This fact needs further examination here. For Spiti amchi, Men-Tsee-Khang’s authority and reputation cannot be disputed. Despite this, it does not mean they do not criticize or question certain practices, especially regarding the disappearance of practices (Chapter 3.1). This is in part a consequence of historical continuity,<sup>432</sup> in which the amchi perceive themselves in a marginal position (in medical terms). They know, however, that their education and expertise is of lower average quality compared to “Tibetan doctors.” Spiti amchi, thus, perceive their position as below these doctors. This view is additionally supported by Men-Tsee-Khang doctors themselves, who present themselves as elites and show disapproval towards rural practitioners.<sup>433</sup> They prove their higher position by way of the biomedical symbolism that is used to establish a hierarchy of practitioners. Men-Tsee-Khang graduates generally use the “Dr.” title when marking their profession. It works to mark a noticeable difference between the elite and the common practitioner; between the urban/central doctors and the rural/marginal amchi (cf. Pordié 2003: 24). The difference is transferred and manifested in normal Spiti behavior, such as when people (including amchi) distinguish between “Tibetan doctors” and “amchi”.

This consciously made and purposeful division between practitioners has a historical tradition (Chapter 1.3) which affects other aspects of this theme as well. It was earlier assumed that the present status of Men-Tsee-Khang rests in part on a continuity of authority derived from the historical institute in Lhasa. The latter’s fame among Spiti-pa doesn’t go back so far to anything in particular or a famous story, but rather builds on a general reputation and an idealized image. Its connection with the institutions of the Dalai Lama has also given Men-Tsee-Khang a general inviolability, a characteristic that has been noticed by Tibetan authorities in general (Chapter 1.3). The persistence of Men-Tsee-Khang to Dharamshala is carried on by the institute itself (to some degree by its name) and by particular persons. Today’s most famous Tibetan medical practitioners personally demonstrate the continuity of being educated in Tibet, thereby taking a leading role in the re-establishment of Men-Tsee-Khang-in-exile and

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<sup>432</sup> A reminder here on the historicity of hierarchy established in medieval times (Chapter 1.3).

<sup>433</sup> This attitude was already mentioned in various contexts of this thesis (Chapters 2.1, 3.1 and 5.1). See as well Craig (forthcoming) and Prost (2003).

being the personal physicians of the Dalai Lama. The image of Men-Tsee-Khang is today further manifested by its reputation among Westerners.<sup>434</sup> Evidence of this is constituted in part by the large numbers of foreign patients, as well as the availability of enormous funds. This is something that everyone visiting Dharamshala notices, but even more noticeably so the Spiti amchi who stay there for some years.

The incidence of the Sowa Rigpa Conference<sup>435</sup> in Delhi further displays the issues at hand. Though I mentioned it briefly in Chapters 2.3 and 5.1, I expand upon its history and purpose here for a better understanding of the current topic. Organized by the National Commission for Scheduled Castes and Scheduled Tribes of the Government of India,<sup>436</sup> the conference was intended to push ahead a political process of recognition for Sowa Rigpa. It was meant to help serve the indigenous practitioners of Sowa Rigpa in India, the amchi. As mentioned earlier, the position of the exiled-Tibetans in this process is extremely difficult for bi-national politics between India and China, and one might have expected the appearance of Men-Tsee-Khang at the conference was subdued. However, the opposite was the case: Men-Tsee-Khang doctors led the discussions and widely displayed their authority. In contrast, only few amchi from remote areas had been invited to the conference<sup>437</sup> and only one amchi from Spiti. The latter was Amchi Norbu Gyaltsen, who seems to have gained an invitation because of his Men-Tsee-Khang education, and not from being a Spiti-pa. Viewing the participants at the conference, it is not an exaggeration to state that it was a rather elitist event.<sup>438</sup> Spiti amchi are evidently continued to be regarded as a marginal group in the community of Sowa Rigpa practitioners, as well as having a marginal position in the political processes of recognition, despite being so centrally important to them.

Supremacy is, however, not only a question of perception and presentation, but also one of exclusion by way of a professional organization. Men-Tsee-Khang was observed in the last chapter as able to execute the power of an exclusive body. By setting the standards of knowledge production and training, which have since become

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<sup>434</sup> This applies not only to Men-Tsee-Khang, but to some other institutes led by famous practitioners too, like for instance the Lobsang-Dolma-Clinic or Yeshe Donden's clinic. However, I continue to focus on Men-Tsee-Khang because it is the leading institute and its developments are the most advanced.

<sup>435</sup> The full title of the conference was "Scope of Sowa-Rigpa (Science of Healing) Medical System and Medicinal Plants in Himalayan Region."

<sup>436</sup> The vice-chairman of the commission, a lama from Zangskar, was in charge of the conference as well.

<sup>437</sup> The conference illustrates the meshing together of Indian government and Men-Tsee-Khang in terms of a policy of superiority, as well as a certain degree of collaboration.

<sup>438</sup> For example, from Ladakh, mainly the amchi from Leh attended, of whom Pordié states that they form the elite in Ladakh (2003).

valid for all Tibetan medicines, the institute confronts the local lineages. The latter's heterogeneous transmissions cannot comply with Men-Tsee-Khang's standards and are, therefore, allocated an inferior status. Men-Tsee-Khang's degree of standardization and systematic licensing acts as an excluding mechanism in moral and technical terms to the ones who do not meet the norms of the institution, in this case, the Spiti amchi.

To a further extent, Men-Tsee-Khang also imposes its supremacy by increasingly implementing international standards. The institute is today a production and sales company that is strongly oriented towards the global market of alternative medicines.<sup>439</sup> Pharmaceutical products, thus, have to comply with the legal regulations of the export countries. Their production requires the highest levels of scientific and bureaucratic certification, i.e., control. Producers and production (of knowledge and products) are therefore oriented towards scientific biomedical standards. This is especially strongly expressed in research, as it is the most oriented towards acknowledgement and competition with biomedicine. Similarly, the doctors educated at Men-Tsee-Khang do not only continue to work in the branch clinics, but increasingly spread out to medical centers all over the world. There, they carry on the quality seal of the institution, in this means marketing themselves as well as marketing the product label 'Men-Tsee-Khang'. The name of the clinic has actually become a brand.

An orientation towards the global market has tangible practical, ideological, and political consequences for the local market, and respectively, the local patients. Janes gives an impressive example of a medicine factory in Lhasa in the 1990s that was originally meant to produce in the framework of primary health care for the local market (1999b: 1814). He depicts how the increasing production of Tibetan medicine for the urban and international market then pressures the production company to produce the appropriate quality and quantity, which then raises the prices for the products. While these are affordable for the new target market, the local population and rural counties cannot pay these prices and consequently suffer from a shortage in medicine. In a similar causal chain in India, Men-Tsee-Khang's alignment towards the international standards of knowledge and pharmaceutical production is variously transferred onto the local markets as well. This is because those markets and its producers (amchi) orient towards and have to compete with the leading institution of Tibetan medicine. The

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<sup>439</sup> This market is found not only in the USA and Europe, but as well in Japan and in India.

pharmaceutical research and production, as well as the medical service in the clinics set *the* standards for the local markets.

Let me extract from all this the responsible mechanism behind this matter through recalling some examples already scattered throughout this thesis. Several aspects came into focus in Chapter 3.1.2 when dealing with medicinal plants. It was suspected that the recent extension of plant harvesting tours by Men-Tsee-Khang to Spiti is motivated by the world-wide rising demands for Tibetan medicine, combined with the difficulty of (and till now rather unsuccessful) cultivation of Tibetan medicinal plants. The local population is, thus, already in competition with the international users of Tibetan medicine for the respective resources.<sup>440</sup> Furthermore, the quality and quantity (the number and amount) of medicines in Dharamshala is transferred as an overall image to Spiti. That means Spiti-pa (amchi and patients) observe that there now exists medicine for ‘any disease’, that new medicine is being created (with extremely good quality because of modern production modes), and that the amount of medicine able to be produced is practically infinite. This is contrasted with the perception of their own medicine production as limited in all regards. The consequence on a local level is obvious: improvements are needed that will orient towards the state in Dharamshala, even though the actual differences are consciously perceived and retained. The mechanism here is a one-sided flow of standards and images that starts on the international level, is fleshed-out through Dharamshala, and finally leaves its impact in Spiti.<sup>441</sup>

The same mechanism, however, can also be found in some other aspects. For instance, as explained in Chapter 3.1.2, the development of Tibetan medicine under the influence of biomedicine is an herbal one, leaving its mark clearly in Spiti (as is displayed visibly on the signboard at the Amchi Clinic in Kaza, see figure 19). Various other impacts with respect to the Amchi Clinic were already described in the last chapter. Its management patterns, organizational construction, and exterior representation orient the SBAS very much towards the examples of clinics at Dharamshala, synthesizing it with state requirements. The overlapping aspects of these

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<sup>440</sup> For several unclear parameters, the future perspective of this matter is doubtful. Some plant cultivation projects are presently underway, though their outcome is not yet promising. Furthermore, contemporary legal conditions do not regulate the use of medicinal material by Indian companies. And, not least of all, the future of plant cultivation depends on development in the global market of alternative medicines and the position Tibetan medicine assumes, respectively.

<sup>441</sup> In the next chapter, I investigate how this flow is used and reshaped by the Spiti amchi.

two superior structures (the state and Men-Tsee-Khang) are discussed in the next section. In addition, any further considerations that were touched upon here (as for instance the effects on the rationalization process) are investigated in Chapter 5.3.

### *The Influence of the State*

In Spiti, the implementation of public health care facilities has, over the last twenty years or so, continually increased. Especially in the past years, new primary health care centers have opened, the number of doctor positions has increased from three to six, the supply of drugs has been very good, and all government health services continue to be practically free. Concerning Tibetan medicine, the government budget has also been considerably increased. This situation is in contrast with current developments of international and national health policies and programs aimed at reducing government investments and privatizing its services. The inevitable question then follows: why do these trends not appear in Spiti and, in particular, what is the government's motivation in supporting the amchi?

These questions must be answered on two levels, to represent the state H.P. and the local authorities in Kaza. Regarding the first, state politics and legislation were both described in Chapter 1.1, involving lots of subsidization through programs designed for Spiti. The reasons behind this lie in the country's status as a border and tribal area, the large area of land, calculation of state expenditures, and the state's emphasis on anti-desertification and re-forestation. The government interest in Spiti doesn't lie in political matters (Spiti-pa are too few in number), but perhaps partially in national-strategic matters (its border to China). More to the point, consequences arise from the fact that H.P. is by and large a mountainous state. A large share of its territory belongs to remote Himalayan areas, of which, many are recognized as tribal areas. The government seems to take the claim of 'developing' these areas quite seriously, as its multiple programs indicate (Chapter 1.1). An additional factor could also be the possibility of inserting funds into remote mountain areas not as diverse as urban areas in order to concentrate on various sectors (infrastructure, education, water, health, ecology, and electricity). As the population of Spiti is quite small, the competition for programs and applications within the valley is therefore slight.

Concerning health care coverage in H.P., large, remote areas have long had little access to state biomedical facilities and have never had a tradition of āyurveda nor āyurvedic practitioners settling there. An important goal of the state has been to first

conquer the demand for biomedicine. However, sufficient health care coverage can only be reached by the integration of traditional practitioners. The tribal areas inhabit indigenous medical traditions, which are in Shimla (by pragmatic ideology, I suppose), acknowledged as Indian. For example, the “Road Map for Health Development in Himachal Pradesh. Vision-2008” emphasizes its goal as “to synergise efforts with indigenous system of medicine to increase the outreach and extension of services” (Government of Himachal Pradesh 2006b). I further assume that budgets from the central government intended for traditional medicine are not withdrawn from these regions.<sup>442</sup> In Spiti, for instance, no āyurvedic department, clinic, or health center exists. The respective budgets at Shimla might be free, then, and inquiries from Spiti might meet these resources. In summary, one can say that on the H.P. state level, an availability of financial budgets meets a political climate that turns out to be advantageous for the amchi.

Another political topic is the integration of Sowa Rigpa into traditional Indian medicine, which is often incorporated under āyurveda. This is a process that is underway on many different levels, as we have seen already through the course of the thesis. Local amchi from the Tibetan border regions are as involved as the exiled Tibetans and national politics.<sup>443</sup> Naturally, the discourse is strongly shaped by ideological aims. While exiled-Tibetan authors often point out the uniqueness of Tibetan medicine (Drungtso 2004; Men-Tsee-Khang 2005), amchi (of Indian nationality) prefer – in their process of gaining recognition – to emphasize the similarities between Tibetan and Indian medicine. They argue that Sowa Rigpa always has been indigenous to the Indian Himalayas and that the ancient Indian tradition has strongly contributed to the Tibetan system. It was already mentioned that this is a difficult political matter for the Indian government as long as the Tibetan issue is involved. Local government representatives, however, repeatedly point out that the traditional medicine of Spiti is a part of āyurveda. Rhetorically, Sowa Rigpa is already an Indian medicine, though not recognized as such by the highest authorities. In this way, H.P. state practice seems to be a step ahead of the rest, as the government scheme for amchi demonstrated in Chapter 4.3.

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<sup>442</sup> I was not able to find exact figures on this matter. The data base for health budgets and the like is very difficult to access.

<sup>443</sup> This is neither the time nor place to provide a full overview on this issue, nor have I done extensive research on it. I concentrate therefore mainly on the local level of Spiti.

However, the attitude of the amchi not only somehow serve the ideological mainstream of ‘Indianization’,<sup>444</sup> but also serve as a subordination to dominant discourses, as shown now. In the public health system, a sub-classification as Indian medicine would be congruent with subordination under the dominancy of modern science and biomedicine. This is a twofold process that has already started. First, a direct exertion of rationalized scientific influence is detected in the example of the bureaucratization of the SBAS along state-administered guidelines (Chapter 5.1). Secondly, ‘indirect’ influences emerge through the concurrence with biomedical institutions within Spiti and the exemplary standards (oriented towards biomedicine) of Tibetan medicine in Dharamshala.

I now illustrate this mingling of influences that enforces the biomedical hegemony towards amchi medicine with the following example concerning techniques of diagnosis. In Chapter 3.1.1, it was first revealed that through the expansion of state biomedical health care into nearly every Spiti village, the mere existence of an alternative set for diagnosing withdrew part of the amchi’s authority and social standing in the villages. Secondly, by staying in Dharamshala, Spiti amchi came into contact with the use of biomedical instruments and of the epistemology of biomedicine within Tibetan medicine. Samuel observed the use of a sphygmomanometer (blood pressure meter) in two Tibetan clinics in North India. I believe that this “eclectic, pragmatic form of Tibetan medicine” (ibid. 2001a: 261) – using ‘modern’ techniques alongside the ‘traditional’ pulse examination – is being pressed forward by the institution of Men-Tsee-Khang. Coming back to Spiti, the amchi then slowly start to alter the discourse over diagnosis methods themselves.<sup>445</sup> When discussing this with SBAS amchi, they sometimes emphasized that a future goal would be the setting up of a Tibetan medicine hospital in Spiti, which, among other things, would provide the diagnostics of a sphygmomanometer. The question of whether the amchi want to replace their manual pulse diagnosis with the sphygmomanometer or if they simply want to modernize the technique of pulse reading then arises. The answer to both of these questions is a simple

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<sup>444</sup> Though a repression of the local (Tibetan Buddhist) culture in Spiti cannot be detected, the nation state continues to maintain a one-sided emphasis of a Hindu national culture in its institutions. Especially in schools, one sees how its dominance is promoted.

<sup>445</sup> In other places, like Ladakh, the integration of biomedicine and Tibetan medicine is, in some cases, practically required by foreign NGOs (including biomedical physicians), which out of goodwill demand the implementation of biomedical instruments without considering the possible effects on the socio-medical equilibrium surrounding amchi medicine. This attitude is even promoted by a published article (Lee 2001). See also the pragmatic use of biomedical techniques in Lhasa Mentsikhang (Adams 2001a, 2002b).

‘no’. Spiti amchi recognize the powerful symbolism of the sphygmomanometer for biomedicine, but feel it to be pragmatically compatible with their medical practice (although the amchi know that with their pulse reading skills they hold the power to make such an instrument superfluous). This basic biomedical instrument is a sign of modernity and, at the same time, the sign of being a “doctor”. Both seem to be aspired accomplishments on the way to modernization. But traditional pulse reading remains an important symbol of amchi medicine and must be kept the way it has been practiced for generations, as it is thought to be the most authentic way. The technique of pulse reading itself was never considered to be an object of the intended modernization. Thus, behind the practical compatibility stands a double longing: keeping one of the main symbols of being an amchi, and gaining the symbols of being a doctor (instruments and title). It is their hope to retain the ‘traditional’ while incorporating the ‘modern’ symbols of power.

The congruence and overlapping of impacts by the government and Men-Tsee-Khang has further sides, which have already taken precedence throughout this dissertation in various sections. A main point is the question of certification and their acknowledgment by government offices. It was outlined that a diploma from Men-Tsee-Khang appears as the standard requirement for governmental positions as a traditional practitioner. Men-Tsee-Khang, as well as the government, requires that an amchi have completed a school examination of “10 plus 2”.<sup>446</sup> Men-Tsee-Khang and government policies go hand-in-hand in this. The high standards of the Tibetan college are transferred through the government onto the local amchi. This is supported by the successive general change of legitimation through a normalization of proving qualification by a government authorized certificate.<sup>447</sup> This has created a move towards standardized means and scientific assessments that slowly alter the traditional forms of social legitimation. The problematic situation a young lineage amchi finds himself in is very well illustrated in this interview with Amchi Tsering Dorje. He explains why he chose not to join the Men-Tsee-Khang training, and what the consequences of this were.

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<sup>446</sup> A few words need to be said here about the Tibetan Medicine Institute Manali. The government also exposed pressure on that institute to adopt these requirements. Though the institute did not fulfill it, the two teaching amchi tried to comply with government standards. Being close to Spiti and presently the first place to go for institutional training, the Tibetan Medicine Institute Manali, thus, has as well a normalizing character for Spiti amchi, which is gradually in line with the impacts presented in this chapter, but would require a separate investigation.

<sup>447</sup> The establishment of a general school education and diplomas needed for government jobs has left their traces among Spiti-pa.

TD: I thought about getting a diploma, because, as you have seen, amchi do not earn proper money to keep their household in a good condition. But, suppose that even if I had a diploma in my hand right now, I still could not go to work outside. I'd have to stay in Kibber. If I was greedy, I would have joined Men-Tsee-Khang and gotten a diploma. With that diploma, I could then get a job. Then my life would be [much easier]. [But,] then I would have a 'duty' [somewhere else] and I could not stay here. For [the villagers] it would have become quite difficult for them. That's why I did not get a diploma and join [the amchi for training].

FB: So, you did not get a diploma?

TD: I got a diploma from [that amchi], but it is not [authorized] by the government. Some years ago, the Ayurvedic Department offered some jobs.<sup>448</sup> At that time, I was the only amchi in Kibber and had done my tenth grade examination. I went with my diploma [to apply for the job], but it was useless [in that office]. Still, I do not feel sad about that. [...] Some people thought that if I got the job, it would be good. But, I thought if I got the job, I would not stay in Kibber. I couldn't treat the patients at any time. For me it is enough, I have my own house and land. Work hard and eat relaxed, I say, and take care of the people.

This amchi was, at that moment, trapped between his personal demands. On one side, a government job would have enabled him and his family a sizeable income. On the other side, he felt responsible to keep up the family lineage and serve the people of his home village. Also, the villagers do not care very much regarding a certificate that ensures his status as an amchi. But concerning interactions with the government, a diploma given by someone who graduated from Men-Tsee-Khang (Amchi Tsering Dorje's teacher) is not enough for official recognition of medical qualities. This diploma does not have an official or legal legitimation. Indian bureaucracy requires the seal of standardization that is today closely connected to Men-Tsee-Khang. An analysis of the overlap of Men-Tsee-Khang and government reveals that these two, in some cases, grow into one powerful stream of requirements and subsequent impacts, with which the Spiti amchi are then confronted. But before we observe their strategies to deal with this, we first continue with the analysis of local government structures.

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<sup>448</sup> He talks here of the mentioned government scheme for amchi.

On the local level of authority, it seems that personal contact with decision-makers is important. In a generally benevolent political climate, an association depends on personal interactions, especially when located in a remote area. The intermediate legal status of the SBAS enforces this matter. The developments from the last years show that the local authorities are usually well-disposed towards the SBAS work. Among the persons responsible for public health, it seems that this insight was triggered by the fact that health care in Spiti is difficult to establish with biomedicine only. One reason for this is, for instance, that the number of Indian doctors who are prepared to stay in the valley for some time is as limited as the number of locals who are doctors. Additionally, as the Medical Officer rightfully commented in an interview, the amchi live in their communities and know their patients, which are important advantages for treatment.

However, the positive climate of the last years has not always been the case. A likely reason for this fact is that amchi continue to have an ambiguous feeling towards the government. Some amchi recall that some fifteen years back, Forest Officers stopped them from plucking the plants in the jungle and threatened to fine them. Today, however, the amchi say that no one takes care about it. The amchi can pluck freely, but thus anyone else can do so as well. The mood has changed, and therefore today the amchi would rather prefer more support and protection of their natural resources from the authorities. Also, in the past, the authorities tried to sentence amchi in some cases for malpractice. Being not registered as medical practitioners can create a lot of trouble when someone accuses an amchi as responsible for an unsuccessful healing process. Similar problems are also reported from other Tibetan doctors who have started to practice in India (Cantwell 1995: 177f). In this legally insecure and instable situation, amchi sometimes hesitate to even treat someone at all. Further ambiguous feelings are also continuously produced because of the previously mentioned difficulties in application processes in the offices. Overall, the relationship between Amchi Sangh and the government depends very much on personal interactions and a general political climate of goodwill.

#### *The New Strategy of Self-Marketing*

Through a final example we can see how Spiti amchi try to approach the government and conquer their difficulties in dealing with it. The amchi's main problem is their 'failure' to be able to present official pieces of documentary evidence. How can the

amchi prove themselves worth supporting without having diplomas? Besides their continued attempt to gain influence through personal communications, the SBAS gave an impressive answer by using modern tools. Amchi Thupten Thapke has taken care that their latest activities were completely documented (Chapters 3.1.2 and 5.1). They created a video-CD, entitled *A Gift of Nature*, which shows the inauguration of the new medicine room with notabilities and authorities from Kaza and Shimla, as well as the medicine production itself and the medical camps. Its commentary is in English. But how did the SBAS come up with this idea? I believe that their experience with a film project in 2002 played a significant role. I had accompanied a team producing a documentary on the work of the Spiti amchi, and it seems that the SBAS concluded that such a film could have a positive effect on their aims. Since then, the SBAS-produced video has been broadcast all throughout H.P. When I saw it for the first time, I was surprised that the video's commentary was in English, but it soon became clear to me that it had not been produced for Spiti-pa but rather a national and even international audience. The video starts with a commentary sequence that classifies the medical tradition of Spiti under the great heritage of Indian medical systems. It is labeled as part of āyurveda and derived from the early sources of the “*veds* and *upaniṣads*”. The practitioners of this local medicine are first called “*vaid*s” before they are introduced as “amchi”. Overall, the video's text presents the surroundings of amchi medicine as modern and benefiting the local population. The text is of high quality, with an undertone of international or scientific finesse. The entire production and outlook of the video has a clear aim and target group: the Indian public, and specifically, the Indian administration.

The video is an activity that has documented the large steps the SBAS took in 2004-2005. The production of this video is a definite sign of self-marketing. Before this, the association did not even have flyers, pamphlets, or similar resources representing themselves. Now, they can give a presentation that is not only modern, but has the highest potential for general circulation in India. The promotion effect could not be higher. The English commentary even includes the opportunity of reaching an international audience of donors. But, I suspect that this was not their main goal for the video. SBAS's marketing set up an initial framework for itself, which is not oriented towards the national or international markets for alternative medicines or towards the pool of donors supporting Tibetan or Himalayan matters. The content of the commentary clearly targets government authorities with the potential for funding. The

combined presentation of ‘modernity’ (public health) and ‘tradition’ (origin in the ancient vedic texts) is typical for a such project of revitalization. It fits perfectly into the mainstream (government) understanding, and uses the same processes as the legitimizing of the place of āyurveda in the modern Indian society and health care system (Alter 2005a: 8; Jeffery 1988; Leslie 1974, 1976b). The SBAS is trying to make use of and follow national discourses by showing the ‘wealth’ of their medical system, its intrinsic ‘Indianness’, and the presentation of their own activities as beneficial for the public. The video ‘proves’ this by the displayed presence and appreciation of the local and regional authorities. It is a twofold action, including on one side the approval of amchi medicine subordinated under āyurveda and biomedicine in the health care system, and on the other side the documentation for the SBAS to be a legitimate receiver of government funds.

The marketing (re-)action of the Spiti amchi indicates again what we already observed in Chapter 4.3, namely, that commoditization and orientation towards a market does not significantly exist in Spiti. Actually, the national and international markets are not within reach for the amchi, nor does their approach represent a real vision to them. Industrialization of Tibetan medicine, favored in China and by the exiled-Tibetan institutions, is no viable concept in the near future among the amchi. This is a hint of the inverse relationship with the exertion of influence by multinational policy-makers, as well as by national policies and companies. This whole complex clearly depicts the ambiguities of marginality of amchi medicine: it is in a marginal position because it is not regarded as a profitable market; it is not in the margin because Spiti amchi orient their marketing towards national ‘targets.’ We come back to this in the following chapter.

In this chapter, the interactions between the Amchi Sangh on the one side, and the government and Tibetan medicine institutions on the other side were elaborated upon, thereby showing the interconnectedness of the ‘superior’ structures and the pathways or mechanisms that connect the global and the local, and vice versa. Summarized, state interests towards the amchi are quite limited and can be reduced to the simple point of better health care coverage. As a consequence of the SBAS’s professionalization, its state control and legitimation increase at the moment, though only to a minor degree when compared nationally. On the other side, the amchi have started a process of professionalization, caused by the socio-economic shortcomings and lack of foreseeable

future. This is, in structure, oriented on the model of Men-Tsee-Khang and the demands of the state. In its center stands the SBAS, which is as an association not oriented towards market competition but rather favoring state funds to solve their contemporary problems in the easiest and most logical way. In this way, they make use of the tribal status of the valley and the intermediate legal state of the SBAS. There is no resistance to national policies (as observed elsewhere in marginal communities; cf. Arce and Long 2000c; Tsing 1993), but rather a pragmatic appreciation of the present conditions. This means that the amchi of the Amchi Sangh make use of the geographical and political marginality of their association – with respect to state institutions and the Men-Tsee-Khang in Dharamshala. The current matter at hand is further merged in the theoretical analysis of rationalization and globalization in the following chapter.

### **5.3 Rationalization and Globalization**

After displaying the contemporary socio-economic dilemmas of the amchi in Chapter 4, Chapter 5 has thus far condensed the analysis to the strategies of solving these problems. The steps of modernization taken by amchi so far have been examined and set into context with the two main external parameters. This final chapter of analysis merges their modernization project with the theoretical implications raised in this thesis. Some of these aspects, such as monetization and professionalization, have been investigated in depth already. The remaining theoretical questions are taken up here and answered. We start by elaborating on the rationalization built from the working hypothesis from Chapter 1. By furthering the investigation of marginality and globalization, we produce a far-reaching image of the creation of modern amchi medicine in Spiti.

#### *Shaping Modernization*

The outline of Spiti amchi medicine developments has so far confirmed that if medical systems move forward in modernizing within a public health care system, they become increasingly exposed to the authority of modern bureaucracy and biomedical hegemony (cf. Janes 1995: 8; Leslie 1980: 191; Lock 1990: 45). This exposure brings with it contact to the rational principles on the subject, as was observed (in case of the SBAS) in respect to the implementation of applications, accountancy, and patient recording,

including calculation and coordination matters. It is thus now the time to discuss the implementation of the professional structures by the Spiti amchi in light of the definition of rationalization I gave in the beginning.

To start, I explore how the rationalization is introduced into the sphere of amchi medicine. The set-ups of an association, a clinic, and various projects have all exposed the Spiti amchi, or more specifically, the SBAS, to government-induced bureaucratic guidelines. Though also elementary aspects of science, these guidelines are not of a medical nature but rather descend from the exercising of dominant ideologies and modes of organization by the state. Formal government requirements, until now, had not included recognition of any of evidences of scientificity or efficacy. This is attributed to the intermediate state of recognition of amchi medicine on a state level, as well as the need for an improvement of the health care situation in this remote area. However, the examples presented have illustrated the new manifestation of rational principles in the work of the amchi (in the Amchi Clinic), meant to expose state control. The government offices exercise their gained power by withholding funds and urging the SBAS to reach a certain quality of management and bureaucratization. In the absence of medical validity, support is made conditional upon tidiness, ability for calculation, and the presentation of what has been achieved. Concerning the latter, the SBAS has been pressured towards implementations that have been assessed by the respective offices in Kaza as “useful”. In this way, for instance, powdered medicine is regarded as more valuable than buying ready-made medicine. Thus, the government is executing a power that is driven towards structuralization and standardization through the principles of organization.

The SBAS, having the foremost aim of raising funds, had from the very beginning a strategy oriented on successfully approaching the government authorities. The amchi adopted an attitude that is oriented along “zweckrational” principles, especially as we can observe that the SBAS amchi are becoming increasingly better adjusted to the demands of the government and extending their successful approach. The need and urge to continue receiving governmental support makes those rational standards a daily concern of amchi who work in and for the SBAS. This especially becomes evident when these amchi state (regarding the patient records in the Amchi Clinic) that they could just as well do without records, but that they have also started to value the rationality of these work processes. This progressing development is nourished by the interplay of state and modern institutes of Tibetan medicine. The

amchi's acceptance of bureaucratic standards is a consequence of requirements and orders on the one side, and of exemplary images of modernity on the other side. The fourth 'actor' in this process – the patient – brings a challenge to the medical sphere, while the others – the amchi, state, and modern Tibetan medical institutions – are challenges more organizational in nature. Patients' subjective requirements question amchi medicine, as for instance by debating the 'proof' differences between biomedicine and amchi medicine. The same mechanism – that requirements and standards of the state or Men-Tsee-Khang are not directly imposed on the amchi, but rather indirectly transferred by patients – is also found in regard to medicinal products. The idea of the availability of 'everything' is transferred from Dharamshala to the amchi via the patients, thereby setting the amchi under the pressure of medicine provision, while also pushing them to calculate their stock and profitability. Thus, we find a complex interplay of four agents that, all together, induce changes on amchi medicine traditions, behaviors and practices. In contrast to other settings (such as in Tibet or in the Indian plains), state control and influence is much less dominant in Spiti. The reason for this is the relatively small degree to which the amchi have been integrated into the public health system.

The connection of the two large spheres of amchi medicine (namely, herbal medicine and Tantric medicine) needs more analysis that takes rationalization into account. The representation of Tibetan medicine as an herbalism has already been touched upon in the preceding chapters. Within Tibetan medicine, the increasing avoidance of the "violent" treatment methods (like cauterization and surgery) dates back a long time; thus, the preference of medicinal treatment was already developed in pre-modern times. The emphasis of a 'pure' herbal medicine, however, was explained in Chapter 3.1.2 as being a modern development of Tibetan medicine caused by a global market orientation. This process of reducing non-herbal medication can actually be reconstructed in Spiti as well, but it takes another shape than the case in Dharamshala. The usage of moxibustion, the golden needle, and ritual healing practices, in addition to the simultaneous presentation of amchi medicine as a "natural herbal medicine" can be seemingly contradictory. In actuality, the representation of herbalism is a marketing action by the SBAS, in the most modern surroundings Spiti can provide. It is a result of a flow of modern images from Dharamshala to Spiti. Non-herbal treatments are still accepted in Spiti as being fundamental to amchi practices, reflecting the present social

reality. This demonstrates a clear difference between amchi medicine and Tibetan medicine as practiced among exiled Tibetans or in Tibet. The amchi emphasize matters like this in order to mark a contrast to Men-Tsee-Khang. Religious practices have thus especially become an expression of identity, which at the moment causes opposition to certain rationalizing developments in Tibetan medicine and therefore marks an independent and separate way. The two seemingly opposing matters of emphasis – herbalism and non-herbal treatment – are thus actually founded in two different discourses. One concerns a modern audience, while the other concerns identity issues.

The following issue shows striking parallels in terms of the interface of medicine, rationalism, and the discourses on each. In the past, Spiti amchi were observed reducing and eventually replacing the ingredients of their medicine for practical reasons concerning availability. This can be called a rationalizing action in the broadest sense of the meaning. Today however, the amchi propagate an attitude that emphasizes the individual patient and local, self-made medicine in the ‘powder versus pill’-debate. These medicines are valued and based on the individual patient, the freshness of medicine, the local potency of medicine, the efficacy of inaccuracy,<sup>449</sup> and the power of the mantras. So, this is contrasting with a rationalized medicine production. The latest project of the SBAS, to the contrary, contains a ‘mass-production’ of medicine, showing the ability of giving sufficient amounts of treatment. Though this action was ultimately enforced by demands from the state, it was largely initially built on local ideas. I was not present during the production of the medicine for the campaign, but I challenge it with a statement of Amchi Tsering Dorje, presented in the long interview in Chapter 3.1.2. He said that if Spiti amchi had the chance to produce for a big market, they would probably act as Men-Tsee-Khang does. “We would try to make them [the medicine] as fast as possible, and we would also leave out the mantras and try to get the money [laughing].” He assumes, even if partially joking, that the amchi would act accordingly to a rationalized market purpose. Merging this example into the analysis again, it can consequently be said that according to context, the amchi position themselves as either opposed or conforming to a rationalized strategy.<sup>450</sup> However, this is only the case when superficially looking at the large-scale

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<sup>449</sup> What I state here is that amchi deliberately deviate from the original formula of the ancient prescriptions for producing appropriate medicine to exactly match the particular condition of a patient.

<sup>450</sup> Naturally, there are also individual differences among the amchi, as one emphasizes one side more, and another amchi the other side. But, overall, these opposing patterns are observable among the majority of them.

medicine production project. Actually, the project was also intended as a possibility for the amchi to learn about a large variety of ingredients and medicines hitherto unknown to them, as well as to prove the uniqueness of the local pharmacopoeia and medical system. This opposition to a rationalization of medicine is again thought of by the amchi as an identity-marker.

As a final aspect on the specific rationalization discussion, it has been suggested to turn to the question of secularization, which is one of Max Weber's central considerations. Several authors have discerned an increasing secularization at Men-Tsee-Khang (Cantwell 1995; Gerke and Jacobsen 1996; Samuel 2001a; Prost 2003). The concerned objects range from the reduction of religious practices (especially of folk-religious origin) and the consecration of medicines to the exclusion of spiritual aspects from training and clinical practice. If we set this in relation to the observations made in Spiti, a recent secularization of amchi medicine is not detected. Rather, the penetration of religion and amchi medicine into the use of ritual and religious activities for healing purposes is observed to continue.

When regarding the Spiti society as a whole, certain aspects of secularization in every-day life are detected, though they are opposed by a movement that goes hand-in-hand with the cultural revitalization described above. As in health care, religious activities strongly vary according to season. Fast, business-oriented routine in the summertime contrasts with the socially and religiously shaped winters. Religious activities are, since recent times, strongly affected by financial abilities. These divergent tendencies are characteristic of Spiti modernity and are reflected in the religious medical sphere as well. The amchi's statement above showed that the tendency of leaving out medicine consecration is not far from being considered a norm. Also, the use of ready-made medicine implies the acceptance of non-empowered medicine among the amchi and patients. However, in contrast to this, one aspect of importance to Spiti-pa includes the points of residence, amchi *rgyud-pa*, and *lha*. These three are connected by a bond that has been shown to have a significant impact on the medical practice, in that the amchi can improve his healing power through honoring his family tradition and worshipping his family *lha*. Though being of obvious relevance for curing, the amchi emphasize this factor beyond measure. This was mainly detected to be another identity-focused discourse, as they strive to distinguish themselves from the Men-Tsee-Khang doctors and their curriculum. Pordié points as much in the Ladakhi context:

The ideals of the *amchi* concerning religion are not anecdotic discourses, but constitute one of the fundamental paradigmatic poles of their identification. [...] The voluntary Ladakhi *amchi* negotiate their social role by a political strategy using religion as an identitarian screen. (2003: 69)

Religious practices thus do not only continue to play an important role in everyday Spiti life but are promoted through its emphasis in political disputes. Weber's thesis – that the process of “disenchantment” concerns all spheres of life by a restraining of religion and an increasing of rationalization – is thus not supported in the context of Spiti *amchi* medicine. Though it could be assumed that such tendencies are a result of the emergence of the capitalist market economy, at least two forces counter this tendency. One is the general cultural revitalization, and the second is the emphasis on identity. The first movement is at least in part a consequence of the massive economic and ideological support of Tibetan culture from the West, which radiates directly to Spiti. The second was explained in length to be a counter-movement to Dharamshala by the *amchi* to strengthen and distinguish their own profile.

The last paragraphs each presented opposing discourses and seemingly contradictory activities and expressions. One could assume from all this that the *amchi* simply indiscriminately adopt various practices in an uncoordinated and inconsistent fashion. This assumption is clearly led by a Western view and bias. A certain ‘in-coordination’ can certainly be detected, since it is an association that is still in its initial stages for setting up projects. Nevertheless, the *amchi*'s way of modernization is in itself consistent. Theirs is a highly creative process. They welcomed modernity when it entered the valley, but questioned its method. Seeing the different discourses (which are selected expressions of modernity), they negotiated their various characteristics in relation to their own situation. The *amchi*'s adaptation of each of the discourses shows their activeness in shaping these discourses and their practices. If we view this from a chronological perspective, we see that the *amchi* started off at the end of the twentieth century with a strong action: the setting-up of the SBAS. It was then followed by a few years of coming to terms with the requirements of the state. Then, in 2004, the “medical camps” expressed a strong, independent idea of how modern *amchi* in Spiti should work. This is, in my understanding, an expression of a “creative adaptation” (Gaonkar 1999: 16) to modern circumstances.

*Adapting the Margin*

Until this point, this chapter has reviewed (in the context of amchi medicine) themes that are central in Weber's work, such as the bureaucratization and rationalization of the working modes that then affect social life. The investigation of the processes of modernization regarding Spiti amchi medicine (in light of this general axis of Weber's beliefs) was emphatically suggested because the major present dilemma of the amchi is presented as a socio-economic one, and as its reasons, rationalization and capitalism instantly pop into mind. Furthermore, in Weber's view modernization is entirely shaped by the rationalized principles of a capitalist market economy (1958). He draws a very pessimistic picture of the inevitability of these processes, leaving people without much choice other than to eventually adopt its impacts. The examination of amchi medicine that was aggravated above has countered the inevitability of rationalization by revealing political and cultural aspects that negotiate such processes as well. Various anthropologists (and other scholars) have as well criticized Weber's impasse-like conclusion by demonstrating local heterogeneities and emphasizing differences as results of distinct cultural contexts (e.g., Appadurai 1996; Arce and Long 2000b; Featherstone et al. 1995). Accordingly, the examination of amchi medicine in Spiti supports the thesis of a production of particular "alternative modernities" held up by those authors. The analysis of the issue of inevitability versus difference is now carried on and extended through a further dimension designated by the keyword "marginality". Marginality implies a local setting with extraordinary conditions for modernization, conditions which I present as not being characterized by historicity and stasis, but by contemporariness and creation.

In Spiti, modernization has a special link to the interplay of marginality and globalization, visibly displayed by the shrinking of distances. This can be briefly shown through two remarks regarding the difference between marginality in the past and marginality in the present. First of all, the temporal alternating dissolution and re-establishment of Spiti's isolation has existed throughout time, but only with the rise of infrastructure and mobility have the two statuses become such extreme contrasts. Spiti's isolation in winters, however, is not to be excluded when considering the busy activity that takes place in summertime. The winters shape and structure the summers, through the extra free time for celebrations, social interactions, religious activities, and time for seeking health care; the summer activities as well shape the winter's happenings and events. In regard to medicine, this was confirmed through the examples of seasonal

health care seeking behavior and the winter *pūjā* for fortune and protection throughout the year. Secondly, in the very beginning I pointed out that Spiti marginality is continually changing and alternating its reference in regard to the centers. Since the mid-twentieth century, Spiti has few fixed referring centers left; however, its marginal status has drastically changed and is in large sections broken up, though not entirely terminated. Marginality has obtained new forms and is created by different factors, for instance, as created by the amchi themselves for certain purposes. Therefore, marginality is not static but flexible; it is lasting, created, and it is especially today highly negotiated.

To deepen the analysis here, the question is raised why Spiti-pa or Spiti amchi do not openly oppose the superiority of the present centers (see Chapter 5.2). Elsewhere, scholars have identified counter-tendencies and resistance to such exposures of hierarchy and control (e.g., Arce and Long 2000b; Tsing 1993). However, in Spiti, amchi medicine contributes special, various factors that ensure such extreme reactions do not take place. I am not able to present all of those factors here, but note that two of them already make such a reaction very plausible. Firstly, government subsidizations and programs have vast dimensions and are locally perceived as benefiting the communities. The public ‘Indianization’, especially implemented by schools and television, is also not perceived as suppression, though it certainly affects cultural identity.<sup>451</sup> Secondly, Spiti’s marginal position in relation to the Indian state is not only advantageous economically (because of acquisition of government subsidies), but the Great Himalayan Range also serves as a physical buffer offering a certain independence (at least emotional and imaginative). Coming back to amchi medicine, we have witnessed the appreciation of government support and the admiration of Men-Tsee-Khang Dharamshala, and the simultaneous dissociation from both. Berman has described this concisely (and self-reflectively) by saying, “The process of modernization, even as it exploits and torments us, brings our energies and imaginations to life, drives us to grasp and confront the world that modernization makes, and to strive to make it our own” (1982: 348). The example of the video-CD (Chapter 5.2) is a clear expression such negotiation from the amchi with their encounters of modernity: their “creative adaptation” to modernity. And as a step further (though not being resistant), this example shows that amchi create “strategies of self-representation and cultural

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<sup>451</sup> The explosiveness of this issue is for instance much more tangible in Ladakh (Beek 1998, 2000).

survival” (Appadurai 1995: 218). They have converted the idea and general use of television (consumption) for their particular ends of a political promotion. Moreover, the video-CD is an additional attempt to construct a particular image of the local situation for the world. This is not only a local production of modernity, but also a modern production of locality. The Amchi Sangh creates the locality the amchi live in as a position merging ‘tradition’ with ‘modernity’, ‘cultural identity’ with ‘Indianness,’ and ‘remoteness’ with ‘belonging.’

Spiti amchi negotiate marginality in relation to the outside world in getting funds, meaning the future of their work. Within their work, the amchi are inwardly focused. They remain amchi for their locale and do not intend to orient outwardly, as for instance Men-Tsee-Khang is doing. Their medicine is not created or produced for a global market but rather for their specific region. For this undertaking, they use the space that is given to them by marginality (the subsidies that arise from their tribal status). Being at the margin has given them this freedom. However, to continue their work they understand that they must resolve and recreate this margin, depending on the context and issue. They have to negotiate the national with the local, and whether it is useful for them to include the global as well. It is this negotiation between the different levels – each carrying specific demands and persuasions – that sometimes degenerates into a struggle for power.

As indicated at the beginning of this section, the further investigation of marginality has raised another argument supporting the particularity of the modernization of amchi medicine. It also revealed the difference that amchi are mainly focused on their own community. We have to intensively look at this social side once more as a final point while considering the outcomes of modernization among the amchi. In this thesis, the dissolution of the amchi’s social networks has been unambiguously traced back to the economic changes from the capitalist market and the rise of medical pluralism. With the exception of very few, Spiti amchi have been socio-economically disembedded from their local networks, in the sense Giddens initially defined (1990). However, this must be considered again subtly differentiated, as we have seen that the amchi’s status has largely remained the same. On one hand, a disembedding has taken place in regard to economic issues (reciprocal exchange), and on the other hand for social issues (withdrawal of power). I extend this consideration here a bit and open up the topic further by adding some comments on the rise of individualism. We witnessed individualizing tendencies in several regards thus far, such

as the process observed in connection with Tantric healing (Chapter 3.1.3), when families preferred an individual ritual protection against the village-wide protection. Adams has pointed as well to the promotion of individualism through the structuring of certain rituals benefit the individual (1988: 511), which we noted as well in Spiti. The following example emerged during the discussion on ‘herbalism’ (Chapter 3.1.2): in most settings of Tibetan medical practice, it is observed that the use of standardized medicine treats a particular ‘disease’ with a particular effective substance (Janes 1999b; Meyer 1995b; Pordié 2002; Prost 2003; Samuel 2001a). Though this matter of de-personalization has historically and ideologically been more clear-cut in Spiti (Chapter 3.1.2), we also witnessed that in Kaza, the two amchi (initially) prescribed ready-made medicines, therefore promoting this new de-personalized approach. This is explained as an aspect of the commoditization of medicine (Chapter 4.3). Here, the circle comes to a close, as we see that these examples demonstrate the partial individualization of medical care and amchi medicine’s disembedding from society as a whole. Thus, Giddens’ thesis is proven to apply to large aspects of amchi medicine, including the initially most vital one concerning economics and reciprocal exchange systems that has then led to the decline of the whole medical system. However, we witness the amchi creatively adapting through the means that Spiti modernity offers them. The “medical camps” project demonstrates the particular way the amchi have chosen. The idea to implement this project was clearly directed at opposing the tendencies of individualism and capitalism. One of its aims (see Chapter 4.3) is undoubtedly to re-embed the indigenous medical system in a new fashion in the villages.

Throughout this chapter I have referred to the Tibetan medicine of the exiled-Tibetans (or even the one practiced in the Tibetan Autonomous Region in China) in order to point to the particular modernization process of amchi medicine in Spiti. The various facets of locality have been found to be ultimately ‘responsible’ for this differentiation. These facets include the remote setting, the following funds by the Indian state (which is a special treatment I have not heard of in any other place outside H.P.), and the focus of the Spiti amchi on their people and not outside. These factors are responsible for the fact that amchi medicine has taken another road in its modernization. This road is a middle, or ‘in-between’ path: not entirely resistant to rationalized modes of work and not revolting against bureaucratic requirements, instead creating distinct visions and keeping local values. The amchi have come to create a separate modernity and

alternative Tibetan medicine other than the ones present at Dharamshala and Lhasa. In being orientated towards their communities, they draw from external forces, examples, and images in sharpening their distinct identity and being “on the move” they create a modern amchi medicine that has a bright future.

## 6. SPITI AMCHI OFF THE ROADS – CONCLUSION

The main interest of my present research is led by the idea of giving a fundamental analysis of what contemporary amchi medicine in Spiti is about. The first question asked was how the modernization of Tibetan medicine in Spiti is shaped, and to find the answer I examined the processes from a local, actor-centered perspective. My research came into being as a consequence of the reoccurring discrepancies concerning Tibetan medicine. Specifically, the image of Tibetan medicine as usually displayed in modern Western-oriented literature, as well as the analyses presented on the modernization of Tibetan medicine in its centers of Dharamshala and Lhasa, were both inconsistent with what I observed as the state and change occurring in amchi medicine in Spiti. Advantageously, my research took place at a time when the general processes of change in Spiti were picking up pace. Thus I was able to observe the core aspects of the modernization of traditional medicine (such as institutionalization and professionalization) that were just introduced by the amchi. As we've seen, this process started in Spiti several decades after comparable processes elsewhere. Consequently, the scientific approach to this thesis was led by the question of how – for reasons of globalization and special local circumstances (the various facets of marginality) – the differing factors of modernization came into being, and what their specifically local consequences are. The reasons behind the amchi starting a process of change are clearly demonstrated by their disembedding from the reciprocal networks in their communities and the arising dramatic economic conflicts leading to a decline of the indigenous medical system. This presentation offers parallel findings coordinated with the key elements of Max Weber's analysis of the loosening of spheres of value and the rise of rationalization. The analysis of my ethnographic data was therefore finally combined and discussed with these basic concepts of Weber's work in mind, leading into a critique and explanation of the rise of an alternative modernity of Tibetan medicine in Spiti.

The "road" metaphor has been used throughout these discussions as a common continual thread to tie together the whole dissertation. It began with the prologue's ethnography of an amchi's day practicing his work "off the roads," meant to introduce the reader slowly into the conditions of medical work in Spiti as well as the social

benefits, requirements, and restraints through a candid narration. In this way, one learned about the harsh environment of Spiti, the remoteness of its villages, and the health care needs of its people. The introductory narration also showed that the amchi are valued as ritual performers and that an amchi's modest attitude increases the respect people hold for him. Further on, it introduced pulse reading and administration of medicine as the key essential visible activities signaling the amchi interacting with his patients. And it finally concluded with the realization of the effects of an amchi's time-intensive work: burdening concerns arising from the many responsibilities owed to his amchi *rgyud-pa*, his village, and to his family.

Moving on, the introductory Chapter 1 laid down a broad foundation for the dissertation, in order to make the reader basically familiar with the geographical, historical, cultural, social, political, and medical dimensions of the subject of investigation. This was not only important just for the context of this thesis, but also a necessity because the general literature available on Spiti valley is rather sparse and the scientific literature is limited to a very few titles. At the same time, it was important to grasp from the very beginning the seclusion of the valley though its environmental conditions, as well as its harsh conditions for survival arising from its climate and soil. Explanations of its past revealed its roller-coaster-like history of being out-of-the-way from the important trade routes and its dependence on the continuously alternating political powers. Therefore, the status of Spiti must be called "in-between" and recognized as being characterized by historical, political and economic marginality (drawing this term from Tsing 1993). The further focus on the recent past has resulted in the explanation of the dramatic changes in the economic situation of the Spiti people. The valley's tribal status within the state Himachal Pradesh has been followed by massive contributions of government development programs and subsidies. This has caused the extensive establishment of infrastructure (roads, schools, administration offices, health care facilities, etc.). Developing largely within two decades (since the 1980s), these changes opened up a broad new market of labor and income possibilities, whether in government offices, in development programs, or the new arising cash crop cultivation. The economic ascent reflected on most of the population and thus had drastic consequences on their social systems and ways of life (especially in the summers). The introduction touched upon the fact that the former village organization that was based on the reciprocal exchange of labor and goods fell into decline, which then had a strong impact on the socio-economic situation of the amchi.

The second part of Chapter 1 was to prepare for the examination of amchi medicine by concerning itself with the history of Tibetan medicine. Here, the aspects of relevance regarding the theme were focused upon, showing that – as one of the great traditions of Asian medicine – Sowa Rigpa has been undergoing processes of standardization and professionalization since the earliest times of its beginnings. On one hand, this has led to the general standards of education (the undisputed authority of the *Rgyud bzhi* as the source of training and knowledge); while on the other hand, this has led to a contrast between such central and elitist institutions and the rural or marginal village practitioners. This ancient status of differentiation continued after the rebuilding of Tibetan medical institutions in India while in exile in the second part of the twentieth century. Considered from the viewpoint of Spiti, the shift of the medical (as well as cultural-religious) focus from its east to west is a historical incidence with far-reaching consequences. It brought about an ambiguous relationship with the main institute of Tibetan medicine (Men-Tsee-Khang) generating both admiration and competition.

The introduction of Chapter 1 revealed that today's situation regarding amchi medicine is determined in every aspect by two sites (Shimla/Delhi and Dharamshala), which have been explained throughout the thesis as reference points for the modernization processes, in addition to becoming the “gateways” for various aspects of global flows into Spiti.

Chapter 2 opened up the description and analysis of amchi medicine. It started with the question of what it means to be “on the road” to becoming an amchi. The example of Amchi Chullim illustrated the traditional ways amchi are trained from childhood onwards, preferably within the amchi *rgyud-pa*. A close relationship between the teacher and disciple was viewed as essential in safeguarding the full transmission of the teacher's expertise. Training begins by memorizing the ancient scripture, the *Rgyud bzhi*, and continues on more and more practically orientated. Knowledge and experience become successively more important as the basic skills necessary for amchi practice. However, it was also shown that to become an independent practitioner, one needs a training of at least five years. When finally an amchi, one is then responsible for his village (as a rule, each middle-sized village onwards is residence to one amchi or respectively one lineage). The medical service provided used to be embedded in a system of reciprocal exchange and social status: the amchi was obliged to treat anyone at any time, and the villagers helped taking turns on his fields during the three harvest times of the year. The patients also could reciprocate a successful treatment with little

gifts of barley or liquor (in addition to helping in the fields). This system entailed that medical power was transferred into social power, with reputation being raised if considered to be a “good amchi”. The amchi’s power was largely built upon his monopolistic position in non-religious healing matters. Nonetheless, the amchi was generally rewarded the highest status in the village (together with the chowa) below the monks, which is grounded in the customary tradition. Here, the lineages come into play, as they establish a long relationship between the locality, community and amchi family. Based on the residential *lha*, the three are bound to each other; the amchi has the responsibility of the village, but also the possibility by worshipping the *lha* in order to increase his healing power related to that place. We came finally to the conclusion that the lineages remain the strongholds of amchi practice in Spiti even in modern times.

The lineages continue to be the sites of medical knowledge condensation, despite the fact that the local transmission system is in a decline. Three major factors have contributed to this decline: the modern school system, the new medical pluralism as consequence of public health care, and the breakdown of the reciprocal exchange system between the amchi and villagers. The direct consequences of these factors are manifold. The economic prospect of being an amchi has become worse because it is not regarded or paid as a full-time job. This is in opposition to the newly emerging jobs that require proper school education. But going to school and later eventually to college leaves no spare time to learn amchi medicine, as is also the case when working in a job for extra income: it reduces the amount of time that can be spent learning medical work. Overall, the time constraints (as is a typical consequence of a rising market economy) has become the major factor in shortcomings in amchi training and work. The most time-intensive parts of amchi medicine are the initial training, the continuous refreshing of knowledge, and the medical production (collection of raw materials and their processing). These parts have consequently been disregarded. The knowledge and expertise of the working amchi shrunk, and young men deriving from amchi lineages are less willing to undergo full medical training. In consequence, lineages have broken and the number of remaining lineages has recorded a qualitative decline.

Through comparison with the modern institutions of Tibetan medicine in Dharamshala, Spiti-pa have further recognized the limitation of their local education. Young people who wanted to learn Tibetan medicine have thus started (mainly since the 1980s) considering new options for training. Though not actively pressured in this direction, the changing requirements of the Spiti-pa (such as the appreciation of a

diploma), as well as hopes for employment by the government<sup>452</sup> have demanded a respective education outside of Spiti. Three general options are available: the training at Men-Tsee-Khang, training in a private setting with a well-known or famous (Tibetan) teacher, or the Tibetan Medicine Institute Manali. Very few Spiti-pa have participated in these three options, except the latter school in Manali which has recently become the most favorable option (at the moment teaching five students from Spiti). The investigation of this issue explained some things concerning the new methods of education among Spiti amchi students. First of all, for Spiti-pa it is already difficult to apply to Men-Tsee-Khang because it requires fluency in classical Tibetan and a finished school degree of twelve years (the “10 plus 2” exam). This is practically an exclusionary practice, as schools in Spiti do not offer such a combination (Tibetan is generally not offered at all). Secondly, Spiti-pa are of the opinion that a Men-Tsee-Khang education lacks certain aspects of local transmission that are still important and needed to practice in Spiti. Furthermore, a close teacher-disciple relationship is also still valued, which is better acquired at the two other options. That brings us to another very important point, namely that the school in Manali is run today by two amchi, of whom one is originally from Spiti. He is perceived to unite all the above statements, in addition to the school providing a certain official background through its diploma, which is drawn up in cooperation with the H.P. government.

Becoming a modern amchi is thus considered as different from having a diploma from the presumably most modern and famous institute of Tibetan medicine, the Men-Tsee-Khang. This relates to the findings of the final sub-chapter of Chapter 2, where what it means to be a “good amchi” in Spiti today was reflected upon. An amchi considered as “good” needs to have elaborate technical skills combined with certain inner qualities. During training, as well as during practice, an amchi needs to build up and then continuously hold a well-established level of knowledge coupled with experience. The general mode of learning in amchi medicine, as well as this ideal form of expertise, has been identified to be an expression of an “embodied medicine” (Farquhar 1995: 274). It culminates in the healer if he has good medical skills (especially in pulse reading and making medicine). Further qualities of an amchi derive from his ancestors and his karma. Healing power is considered to be collected through generations in an amchi *rgyud-pa* and, if cultivated, can be retrieved by the present

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<sup>452</sup> As shown in Chapter 5.2, hopes for governmental amchi positions continue to be nourished but have not yet been fulfilled.

amchi. Moreover, his personal karma from former lives might have also provided him with a natural gift or innate talent for medicine. Finally, the amchi is also expected to orient himself towards the Buddhist ideal of compassion and tries to develop a “good heart.”

What constitutes the amchi practice “at home,” and how an amchi is embedded in his community (including the respective recent changes in these regards), were the contents of Chapter 3. Corresponding to these two broad themes, the chapter was divided into two large main sections. In these chapters, I have in particular formally taken into account the division of idealized theory (represented through books and interviews with amchi) and the actual practice. This enabled us to see that the idealized representation (when taken over by the amchi) serves both their social and political ends.

Pulse reading has been described as the essential diagnostic tool of the amchi, which is not only considered to be able to potentially detect any given disease, but is further surrounded around by a kind of magical aura. As such it is a visual marker of an amchi, it expresses part of his identity. Besides diagnosis pulse reading, we found that it is further important to establish trust on the patient’s side, which is essential for the amchi-patient relationship and the process of healing. Trust is accomplished by the amchi’s touch as well as by his ‘correct’ diagnosis. In recent times, through the appearance of biomedical facilities, the latter has experienced an alteration because the patients have become able to compare the results of diagnoses. Thereby, not only the diagnosing method is under external pressure, but also amchi medicine as a whole. Therefore, though pulse reading as a diagnostic tool of the amchi remains uncontested, the patients’ way of dealing with it marks a fundamental change and power-shift in the amchi-patient relationship.

The second aspect of healing that was considered here is the making of medicine. For various reasons, this theme stands as the focus of central considerations to this dissertation. This is hardly surprising, considering that fact that medicine is central to amchi work. While the actual processing of medicine in Spiti has hardly changed at all, the external conditions have radically done so. Due to environmental changes, the demand for Tibetan medicine on the global market (transferred to Spiti via Men-Tsee-Khang’s plant collection trips), and the rise of prices for raw materials on the regional markets, the ingredients of medicine are becoming competing and expensive resources. At the same time, raw material collection and the processing of medicine

constitute the most time-intensive and resource-consuming aspects of the amchi's work. These activities therefore pinch the amchi concerning his economic abilities, which is further aggravated by the comparison with the presumably infinitely higher quantity and quality of medicine offered by Dharamshala. Via the patients, amchi are compared with this standard and must increasingly take into consideration that an amchi is expected to have a large stock of medicine at all times. Concurrence with Men-Tsee-Khang has given further push to a discussion on the issue of medicine powder versus medicine pills. However, this debate is revolving less and less around the efficacy of one form or the other, and has instead become an expression of another identity issue. By emphasizing powder medicine, amchi oppose and contest the superiority of Men-Tsee-Khang. They bring forward the particularity and the efficacy of the local ingredients for the healing capacity of the final product. Though for the actual healing effect, the amchi regards the patient's confidence in the amchi to be more important than the medicine itself; medicine has become a contested matter on which the amchi express their identity. This has become especially visible in the latest project of the SBAS, the "medical camps". The production of large amounts of powder medicine (financed by the government) and its free distribution to the local population deliberately sets a counterpoint to the developments of modern Tibetan medicine and tries to regain public ground they lost earlier due to biomedicine and Tibetan medicine standards.

The third aspect of healing concerns Tantric practices. This chapter expanded to present the various religious practitioners, like the chowa and lama, who are involved in this kind of healing. Though these practitioners are considered the actual specialists for this sphere, some amchi are also familiar with certain ritual practices. The amchi's ritual work mainly encompasses three dimensions: the worshipping of the deities of the amchi family and the locale; the empowerment of the person of the amchi and his medicine; and the driving out of evil spirits that cause harm and illness. The examination of these dimensions revealed various matters of relevance at play here, of which two are taken up as significant factors. First, the practice of creating power – first and foremost, the several months of a meditation retreat called *mtshams* – do not only transfer power onto the amchi and his medicine to expand his healing efficacy, but also contribute to the amchi's social power within the village. Second, ritual practices that are connected to the deities of the locale especially express an emphasis of local identity. Both of the issues presented here again make up a matter of distinction separate from Men-Tsee-

Khang, as the processes of secularization have caused the displacement of these practices.

In the second part of Chapter 3, I highlighted the social background of the work of the amchi. In the past, the relationship between the amchi and villagers was a personal one, as a consequence of the social networks of extended family and village in addition to the (general) exclusiveness of one amchi per village (when so remote that the next amchi was not accessible). The emergence of roads and biomedical facilities has dissolved this situation. The termination of the amchi's monopolistic position, accompanied by the perceived limitations of medical skills and medicine stocks (in comparison to Dharamshala), contributed to a loss of popularity of the amchi. In contrast, Tibetan medicine in general was continued to be valued by Spiti-pa. However, the village amchi experienced a decline of social power. While the individual amchi's status and reputation remained high, social power gradually shifted from the amchi to patients, expressed by the dissolution of the reciprocal exchange system that had earlier safeguarded the amchi's time to devote for medical practice.

The example of Amchi Thupten Thapke in Kaza confronted the 'traditional' setting with this 'modern' setting. Thereby, from his example it was extracted that the central present dilemma of the amchi is extended under modern conditions. This means that the social power of the amchi has evaporated and their earlier embedment in society has reversed. The amchi have recognized that practicing amchi medicine today needs external funding sources to survive.

This realization brings us into a detailed evaluation of the economic side of this dilemma. Chapter 4 initially explained the former system of reciprocal exchange that has had a supra-regional radiation (at least in Ladakh, Zangskar, and Nepal, and probably as well in Tibet). This economic system was analyzed with the help of Marcel Mauss' theorization on the 'gift' (1993 [1950], 2002 [1954]). It was highlighted that medicine traditionally has been exchanged as a gift in return for labor (in the amchi's fields) and single goods. The medicine gift, though presented out of altruism and compassion, also contained the obligation to return it in some form. Furthermore, it possessed a poisonous character, if in the case not returned to the amchi's satisfaction, where it could take the form of less effective medicine in the patient's next case of need. Thereby, the gift cemented the social power on the amchi's side. With the described

shift of power and economic ascent in society, the situation consequently changed. In many Spiti villages, the population withdrew the counter-gift of labor from the amchi. However, a personal gift of small goods continued on an individual level. The breakdown of exchange left the amchi in a precarious situation, as amchi medicine became something in which the practitioner had to invest time and money but received nothing back.

The examination continued to discuss the possibility of a monetary compensation of the amchi work in place of the failed reciprocal system. But then a problem of amchi ethics and practice emerged, seeing as their reputation was partially build on inner qualities that by nature forbid them to ask for remunerations from their patients. Comparative examples did clarify that Spiti-pa are ready and willing to pay for health care services of any kind. But the amchi of their respective villages were made exceptions to this. The supposition that money could be culturally biased and not be given as a gift was refuted; occasionally, money is even given as a return gift for medicine (Tib. *sman yon*). As well, medicine purchased from Dharamshala (as used by the two amchi of Kaza) was naturally repaid. This proved as a fact that medicine has become a monetized commodity. However, it has been explained that a full commercialization of amchi medicine is definitely not the case. Amchi work has so far withstood the introduction of money as a counter-value. Under the changed conditions of the capitalist market economy, this fact is responsible for the fact that amchi medicine is today perceived as a loss-making deal.

The Spiti amchi have thus decided to get “on the move,” away from their precarious position. Chapter 5 examined the various steps taken by the amchi since the late-1990s to solve their dilemmas. Under the influence of the modern Tibetan medicine recognized in Dharamshala, some amchi have developed visionary imaginations of the future of amchi medicine in Spiti. At first, they set up an association (SBAS) which most Spiti amchi became members of. Its aim was, mainly, to approach the government for funding. Though an integration of Tibetan medicine into the Indian health care system has not yet taken place and despite the fact that the SBAS has not yet been recognized on state level, successive increasing government funding has been provided. Besides carrying out meetings and seminars, the SBAS was able to set up an Amchi Clinic offering purchased ready-made medicine on a fees-for-medicine basis. I analyzed this development along a definition of professionalization of traditional medicine and

came to the conclusion that the SBAS actually has a rather low degree of professionalization. This is a consequence of two facts: first, the amchi have no interest in setting up standards to exclude practitioners from their profession; second, their integration into the public health system is minimal. However, due to the increasing funds from the government, the demands of governmental guidelines and the dependency on these funds increase proportionately. Therefore, the work in the Amchi Clinic is marked by bureaucratic guidelines: the usage of patient recording books, accountancy, and applications for funds. Nevertheless, the SBAS continues to be in an intermediate state between government requirements and the requirements by the patients. Consequently, the amchi's legitimation (in the frame of the SBAS) has been split up between a political one concerning the state and a social one concerning the population.

Further examining the modernization process, we look back to the orientation towards two main reference points observed as subordination under the supremacy of Men-Tsee-Khang Dharamshala and the Indian state. The first is regarded with a historically based continuous respect and admiration by the amchi, serving as well as a springboard for their imaginations. Furthermore, the Men-Tsee-Khang elitist and thereby excluding structure gives rise to an opposing amchi identity. The state is on the amchi's side for reasons of health care coverage, yet it is increasingly demanding control in return for funds. These two centers overlap in that the government uses Men-Tsee-Khang guidelines which do not take into consideration the local conditions in Spiti. Moreover, both of these poles have been identified as serving as the ports of global influence into Spiti. Yet they remain a minor influence, as the amchi do not orient themselves towards a national or international market, but rather towards their patients and funding from the state. In the further examination of the modernization of amchi medicine, we noticed that this process is being actively shaped by the amchi themselves. Being in certain respects marginal to the two centers (for instance, in medical or political terms) and being in other respects close to the centers (as measured by distance), the amchi are negotiating their position. The amchi utilize the modern occurring ambiguities of marginality and further expand them to their aims. They use the free space available from their marginal position to participate in distinct discourses (such as a rationalized herbalism, the mass-production of medicine, or the particular identity of the locale) in order to present and foster their own way of modernization. The latest SBAS project (the "medical camps," recorded on a video-CD broadcasted on

state level) demonstrates that the amchi are creatively adapting to external influences using modern modes of self-marketing in a global perspective in order to follow their goals of bettering the health care situation of the Spiti people. This has not risen (entirely) from good-will but is definitely meant to re-embed amchi medicine in the local society.

In the final chapter of Chapter 5, the modernization of amchi medicine was especially examined in light of the processes of rationalization. Thereby aspects of Weber's rationalization theory were detected in the increasingly purposeful orientation among the amchi, the principles of efficiency and calculation within the SBAS, and within the depersonalization of medical care. However, a detailed analysis of the monetization and commoditization resulted in the insight of a distinct creation of modern amchi medicine. The amchi continue to be "on the move" but have now set the course that negotiates the external rationalized modernity. They do not resist such impacts but instead use the image of their marginality to define a particular local identity. This political move has introduced a demarcation to the Tibetan medicine of the exiled-Tibetans.

My analysis has proven that rationalization is not at an impasse or has stalemated development, but rather that it can be negotiated and people can creatively adapt to such modern circumstances. Tools, such as the spread of political issues via media technology are arising from modernity and globalization and are increasingly being used to create a particular local modernity. This applies as well to the people from the remotest and seemingly most marginal areas of the world. The example of amchi medicine has shown that exactly this marginality and its various images have been used to create change that is actually a continuation of local tradition. The perpetual renewal of society is something inherent to Spiti Buddhist belief, nothing representing a complete break with the past. Modernization as a continuous change is therefore not new or modern and in opposition to the past, but instead a present process linking the past with the future.

This presentation of the modernization of amchi medicine supports the assumption of the emergence of locally distinct various Tibetan medicines. The professionalization, rationalization, and globalization of Tibetan medicine that has been observed in Tibet, the Indian plains, and even the West have been proven to be distinct from the ongoing processes in Spiti. The Spiti amchi have purposefully set the course of

their modernization in such a way that it conforms to certain standards of Tibetan medicine while at the same time confronts other developments (for instance, secularization). This is done for the sake of a locally consistent future that is – at least currently – not oriented towards the global market but towards the health care of the Spiti-pa. While in other settings, neo-liberal market reforms undermine local health care, the specific situation in Spiti (contemporarily fostered by state support) enables the amchi to undertake steps that improve the health care system on the basis of the indigenous medical system. Modern amchi medicine in Spiti displays to the world an example of a traditional medicine whose practitioners professionalize and modernize their medical system through creatively adapting foreign and local systems alike. This has been resourcefully expressed by the “road” metaphor superimposed throughout this dissertation. The amchi are modernizing their medical system through being “off the roads.” The multi-layered struggles and ambiguities this process brings with it create the new daily experience of the Spiti amchi.

## Abbreviations

ADC – Additional Deputy Commissioner

Bot. – botanical name

H. – Hindi

H.P. – Himachal Pradesh

IMF – International Monetary Fund

Lit. – literally

NGO – Non–Governmental Organisation

SBAS – Spiti Board of Amchi Sangh

Skr. – Sanskrit

Spi. – Spiti language

Tib. – Tibetan

UNO – United Nations Organization

WHO – World Health Organization

## Remarks on Orthography and Glossary

In accordance with Spiti contemporary habit, Hindi, Tibetan, and Spiti dialect terminologies are all used in this dissertation. The words are accordingly distinguished with H., Tib., and Spi. All words can be found in the subsequent glossary in alphabetical order, which applies to the written format of the Tibetan terms as well.

Hindi terms occur according to the common Devanāgarī transliteration system.

Generally, Tibetan terms follow the Wylie transcription system (1959), with a few exceptions that are common in contemporary literature, such as lama (instead of *bla ma*), amchi (instead of *am chi*), and Gelug-pa (instead of *dge lugs pa*). Hyphens are not used in the transcriptions, with the single exception for the suffix “-pa,” indicating a single person belonging to the indicated country or village, or a group of people belonging to the corresponding noun, such as Spiti-pa (the people of Spiti or a person from Spiti). Names of literary works are capitalized, for instance *Aṣṭāṅgahrdayasamhitā*. This applies as well for the Tibetan works, like for instance, the *Rgyud bzhi*, which might be unusual for the familiar reader, but provides uniformity. Names of historical and contemporary persons are given in the familiar phonetic form, while names of places are indicated by their most common use.

The few words of the Spiti dialect that are not identical to Tibetan are given a simplified transliterated form, such as chowa or *chahzang*.

amchi/*am chi* [Tib.] – practitioner of Tibetan medicine

arak [H.] – liquor, usually from barley

āyurveda [H.] – knowledge/science of long life

*bad kan* [Tib.] – phlegm

*bar do* [Tib.] – the intermediate state after death and before next life/rebirth

*bdud* [Tib.] – evil, Māra

beda/*'be dha* [H.] – musician caste

*bhūt pret* [H.] – evil spirit, spirit of the dead

*bla sman* [Tib.] – court physician

*blo ldan* [Tib.] – wisdom, intelligence

*blta* [Tib.] – observation

*bodhi* [Skr.] – Enlightenment

*bodhisattva* [Skr.] – lit. enlightened being, a person who has taken the vow to become enlightened

Bön/*bon* [Tib.] – Bön religion

*'bras bu* [Tib.] – result, fruit, effect resulting benefits

*brgyud* [Tib.] – lineage

*bsam pa dkar ba* [Tib.] – virtuous thinking

*bshad rgyud* [Tib.] – Explanatory Tantra of the *Rgyud bzhi*

*bsnyen pa* [Tib.] – recitation

*bsod nams* [Tib.] – merit

*bsod snyoms* [Tib.] – gifts, lit. alms

*btsan* [Tib.] – spirits living in rocks, ghosts of hunting

*bstan sgyur* [Tib.] – Tanjur, collection of the explaining literature

*burī nazar* [H.] – evil sight

*buzhens* [Spi.] – married lama belonging to the Nyingma-pa order, as well performer and singer

*bya ba la brtson* [Tib.] – good expertise

*byam po* [Tib.] – gentleness

*byin rten* [Tib.] – sacred substances empowered by lama or Buddhist deities

*byis pa* [Tib.] – child

*bzo rig pa* [Tib.] – arts

*bzos pa* [Tib.] – blacksmiths

*chahzang* [Spi.] – landholders, the second stratum

*chang* [Tib.] – beer brewed from barley

*chāy* [H.] – sweet tea

*cho* [Tib.] – meaning, essence, ritual

*chos* [Tib.] – dharma, religion

*chos khang* [Tib.] – temple, chaple

*chos-pa* [Tib.] – religious practitioner, dharma practitioner

*chowa* [Spi.] – religious practitioners/astrologer

*chu* [Tib.] – water

*dad pa* [Tib.] – faith, confidence

*dam tshig* [Tib.] – inner connection between guru and disciple, commitment, vow, union

*dbang* [Tib.] – empowerment

*dbon po* [Tib.] – Bön-po lama

*dbye ba* [Tib.] – type, classification

- dge slong* [Tib.] – fully ordained monk  
*dgon-pa* [Tib.] – monastery  
*dhaniyā* [H.] – coriander  
*dharmā* [Skr.] – teaching, religion, Buddhist doctrine  
*'dod chags* [Tib.] – wind from desire, desire  
*doṣa* [H.] – humors  
*dpe cha* [Tib.] – (religious) book  
*dri ba* [Tib.] – interrogation, interview  
*dug* [Tib.] – poison  
*dug gsum* [Tib.] – three mental poisons  
*duḥkha* [Skr.] – suffering  
*dukān* [H.] – shop  
*dzong* [Tib.] – fortress
- gdon* [Tib.] – evil spirit  
*gdon nad/kun brtags gdon nad* [Tib.] – diseases caused by spirits, which require a *pūjā*  
*gdon rtsa* [Tib.] – pulse of evil spirit  
*Gelug-pa/dge lugs pa* [Tib.] – one of the orders of Tibetan Buddhism  
*glud* [Tib.] – ransom effigies  
*gnod pa* [Tib.] – (to cause) harm  
*gdon chen* [Tib.] – eighteen great *gdon*  
*gdon phran* [Tib.] – countless minor *gdon*  
*gnod sbyin* [Tib.] – *yakṣas*, mountain spirits  
*gral mgo* [Tib.] – fixed seating line  
*grwa zhing* [Tib.] – lama's field  
*gser khab* [Tib.] – golden needle  
*gshin 'dre* [Tib.] – evil spirit, wandering dead soul  
*gsol ja* [Tib.] – salted butter tea  
*gson 'dre* [Tib.] – goblin or demon of a living soul  
*gtan tshig rig pa* [Tib.] – logic  
*gti mug* [Tib.] – confusion, ignorance  
*gtor ma* [Tib.] – an offering cake  
*guru* [H.] – teacher  
*guru-siṣya parampara* [H.] – teacher-disciple relationship
- jāti* [H.] – caste  
*jari-buti/jaḍī-būṭī* [H.] – medical plants

- kachupa/ka chu pa* [Tib.] – diploma of Tibetan medicine  
*kāliiyuga* [Skr.] – the present age, age of darkness and ignorance  
*karma* [H.] – action, result of action  
*kha btags* [Tib.] – white silk scarf  
*kham lnga* [Tib.] – five properties or elements  
*khāndhānī* [H.] – family, hereditary lineage  
*khang chen* [Tib.] – big house  
*khang chung* [Tib.] – small house  
*klu'i gdon* [Tib.] – the serpent spirits, *nāga*  
*koti* [Spi.] – regional divisions of *nono* families
- lakh* [H.] – one hundred thousand  
*lama/bla ma* [Tib.] – monk  
*lha* [Tib.] – deity  
*lha ba/lha mo* [Tib.] – oracle, medium (m./f.)  
*lo gsar* [Tib.] – new year  
*lus* [Tib.] – body
- mag pa* [Tib.] – son in law, bridegroom, uxori-local marriage  
*ma ni/ma ne* [Tib.] – mantra  
*ma ni ril bu* [Tib.] – empowered medicine pills  
*ma rig pa* [Tib.] – ignorance  
 Mahāyāna – the great vehicle of Buddhism  
*mālā* [H.] – rosary  
*man ngag rgyud* [Tib.] – Oral Instruction Tantra of the *Rgyud bzhi*  
*maṭar* [H.] – pea  
*mchod rten* [Tib.] – stūpa, pagoda, funeral monument, receptacle of offerings  
*mdos* [Tib.] – thread–cross ritual  
*mdzo* [Tib.] – cross between cow and yak  
*me* [Tib.] – fire  
*me btsa'* [Tib.] – moxibustion  
*mi chos mkhas; mi chos* [Tib.] – religious practice, also: tradition, custom  
*mkhris pa* [Tib.] – gall, gallbladder, bile  
*mngon brjod* [Tib.] – etymology  
*mo* [Tib.] – divination  
*mo* [Tib.] – woman

*mtshams* [Tib.] – solitary contemplation, meditation retreat lit. border, boundary, seclusion

*mtson* [Tib.] – weapon

*nabz/nādī* [H.] – pulse

*nabz dekhñā* [H.] – to observe/ examine the pulse

*nādī parikśan* [H.] – pulse reading

*nālā* [H.] – river, stream

*nam mkha'* [Tib.] – space

*nang don rig pa* [Tib.] – ‘inner’ science of Buddha’s word

*nazar* [H.] – glance, look

*ngo bo* [Tib.] – character, nature

*nirvāṇa* [H.] – enlightenment

*no no* [Tib.] – older brother; former king of Spiti

*nyams myong* [Tib.] – experience, knowledge

*nyams yig* [Tib.] – medical genre emphasizing experience

*nyes pa* [Tib.] – three humors

*Nyingma–pa/rnying ma pa* [Tib.] – one of the orders of Tibetan Buddhism

*pag* [Tib.] – barley dough

*pha rus/pha spad* [Spi.] – patrilineal group of common descent and residence

*phal ba* [Tib.] – ordinary

*phyag byed pa* [Tib.] – prostrations, which are in Spiti briefly called *chag bum*

*phyi pa* [Tib.] – outsider

*phyi rgyal ba* [Tib.] – foreigner

*phyima rgyud* [Tib.] – Subsequent Tantra of the *Rgyud bzhi*

*pingri* [Spi.] – birthday celebration

*pūjā* [H.] – worship

*rdo me* [Tib.] – (stone-)fire treatment

*rdo sman* [Tib.] – medicinal stones

*reg pa* [Tib.] – touch

*rgas* [Tib.] – aged

*rgya thug* [Tib.] – noodle soup

*rgyal po* [Tib.] – the king spirit

*rgyud* [Tib.] – lineage, continuity, tantra, family, transmission

*Rgyud bzhi* [Tib.] – Four Tantras

*rgyud–pa* [Tib.] – lineage

- rig gnas che ba lnga* [Tib.] – five major sciences  
*rig gnas chung ba lnga* [Tib.] – five minor sciences  
*rigs* [Tib.] – family, clan, class, caste, stratum  
*rin chen ril bu* [Tib.] – precious pill  
*rin po che* [Tib.] – incarnate lama, lit. most precious one  
*rlung* [Tib.] – wind  
*rlung rta* [Tib.] – prayer flag, lit.: wind horse  
*rnam shes* [Tib.] – consciousness  
*ro tsa* [Tib.] – sexual instinct, desire  
*r̥ṣi* [Skr.] – Rishi, priest, author of the veda  
*rtsa* [Tib.] – pulse  
*rtsa rgyud* [Tib.] – Root Tantra of the *Rgyud bzhi*  
*rtsam pa* [Tib.] – flour of barley  
*rtsis pa* [Tib.] – astrologer
- sa* [Tib.] – earth  
*sa ma 'brog* [Tib.] – landholders maintaining herds  
*sacce dil se* [H.] – good heart  
*śādī* [H.] – marriage  
*Sakya-pa/sa skya pa* [Tib.] – one of the orders of Tibetan Buddhism  
*samsāra* [H.] – cyclic existence of rebirths  
*sangh* [H.] – organisation, association, assembly  
*sangs rgyas sa la bkod pa* [Tib.] – to establish in the state of buddhahood  
*sa(za) nyukche* [Spi.] – to feel (taste, read) the pulse  
*sdeb sbyor* [Tib.] – metrics/ rhetoric  
*sdug gsum* [Tib.] – three mental poisons, illusions (desire, hatred, ignorance)  
*sems bzang* [Tib.] – good heart  
*ser khyim* [Tib.] – Tantric ceremony to persuade gods  
*sgom khang* [Tib.] – meditation hall, house, retreat, hut  
*sgra rig pa* [Tib.] – grammar  
*sgrib* [Tib.] – pollution  
*shin bzos pa* [Tib.] – carpenters  
*silajit* [H.] – mineral pitch, Bot. asphaltum  
*skar rtsis* [Tib.] – astronomy/ astrology  
*skor ba* [Tib.] – circumambulate religious edifices  
*sku rims* [Tib.] – effigy ritual  
*skyid pa* [Tib.] – happiness

*skyu ru nyer lnga* [Tib.] – medicine of 25 ingredients and *Emblica officinalis*  
*sman* [Tib.] – medicine, amrita; drug, healing, herb, remedy  
*sman pa* [Tib.] – physician  
*sman yon* [Tib.] – gift for medicine  
*sman zhing* [Tib.] – field of medicine  
*sngags pa* [Tib.] – initiated practitioner of Tantra, exorcist  
*sngon nad/ gzhan dbang sngon nad* [Tib.] – diseases caused by karma of former lives  
*sngo sman* [Tib.] – medicinal herbs  
*snyan ngag* [Tib.] – poetry  
*snying rje* [Tib.] – compassion  
*Sowa Rigpa/gso ba rig pa* [Tib.] – the science of healing, Tibetan medicine  
*sprul sku* [Tib.] – reincarnated lama  
*spyi* [Spi.] – general  
*sung ma* or *chos skyong* [Tib.] – monastic oracles  
*śūnya* [Skr.] – empty

Tantrayāna – Vajrayāna, Tantric Buddhism

*thal nad* [Tib.] – minor diseases  
*thang ka* [Tib.] – Tibetan hanging scroll painting, picture  
*thug pa* [Tib.] – noodle soup  
*ti* [?] – water  
*tshe dbang* [Tib.] – empowerment/ initiation, ritual  
*tshes pa bco lnga* [Tib.] – the day of full moon

*vaidya* [H.] – doctor, āyurvedic practitioner

Vajrayāna [Skr.] – lit. the diamond vehicle, Tantric Buddhism

*yang chung* [Tib.] – smallest house, lit. still smaller  
*yongs grub tshe nad* [Tib.] – diseases of this life  
*yuga* [Skr.] – era, age

*zamīndār* [H.] – landowning peasant

*zhe sdang* [Tib.] – hatred, aversion, anger

*zho* [Tib.] – curd

*zlos gar* [Tib.] – drama

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**Erklärung**

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