

Positioning Sowa Rigpa in India

Coalition and antagonism in the quest for recognition

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Abstract

The years leading up to the recognition of Sowa Rigpa (Tibetan medicine) by the Government of India in 2010 saw unprecedented interaction between various branches of the tradition and the state apparatus. These interactions grew particularly intense during March 2008, when two conferences focusing on related issues took place. The first referred to ‘Tibetan medicine’ and was organised by Tibetan exile institutions, while the second spoke of ‘Sowa Rigpa’ and was hosted by a coalition of Himalayan Indian associations. Through detailed ethnography of these events, this article examines the way in which a medical system was discursively constructed and positioned on the brink of state enfranchisement. It shows how ‘discourse coalitions’ and antagonisms formed during these events, and enquires as to the implications of these for the balance of power in Sowa Rigpa and for its positioning in relation to the Indian state, technoscience, and the growing market for traditional medicines.

Keywords

Sowa Rigpa, Tibetan medicine, recognition, discourse coalitions, policy process

Introduction

The medical tradition known as Sowa Rigpa (*gso ba rig pa*), or Tibetan medicine, has provided an important source of healing across the Tibetan plateau, the Himalayan region, and beyond

for many centuries (Gerke 2004; Janes and Hilliard 2008; Meyer 1981; Saijirahu 2008; McKay and Wangchuk 2005; Norboo and Morup 1997). Although it has been supported by the state for several decades in China, Mongolia, and Bhutan, the tradition was not granted official recognition by the Government of India until 2010. The years leading up to this momentous decision saw unprecedented interaction between Himalayan Indian and Tibetan exile branches of the tradition, representatives of Ayurveda, the Indian state apparatus, and the medical research industry. These interactions grew particularly intense in the spring of 2008, when an expert committee report into the potential for recognition was being finalised for the Indian Parliament, and two national conferences concerning this medical tradition took place back-to-back. The first of these referred to ‘Tibetan medicine’ and was organised by two leading Tibetan exile institutions: the Men-Tsee-Khang (MTK) and Central Council for Tibetan Medicine (CCTM).¹ The second spoke of ‘Sowa Rigpa’ and was hosted by a coalition of Himalayan Indian organisations, notably the Himalayan Buddhist Cultural Association (HBCA) and Sowa Rigpa Research Centre (SRRC).² Through detailed ethnography of these twin events, this article examines the way in which a medical system was discursively constructed, represented, and positioned as it stood on the brink of state enfranchisement.

The two conferences mirrored each other in many respects, with numerous presentations addressing identical themes. However, the different names chosen to refer to the tradition in question reflected deep-seated controversies (see Craig and Gerke, this issue), and the style, content, and audience of the events also differed significantly, revealing much about the social, political, and institutional dynamics at play. These events were sites of concentrated interaction between actors holding a range of viewpoints and agendas. They allowed for carefully rehearsed public discourses to be performed, while also demanding face-to-face debate, individual improvisation, and interpersonal exchange. Although I do not suggest that these interactions led in any direct way to the Government of India’s decision to recognise Sowa Rigpa two years later, I argue that they contributed significantly to the realization that recognition was a real possibility, to the public representation of the tradition, and to shaping the social relations and policy frameworks into which it would subsequently be inserted.

¹ Established in the early 1960s by Tibetan refugees, the Men-Tsee-Khang is the largest and best-known Tibetan medical college and institute in India. The Central Council for Tibetan Medicine was founded in 2004 as the official body charged with regulating Tibetan medicine in exile and representing it on the political stage. For further details, see Kloos 2013 and 2011.

² The Himalayan Buddhist Cultural Association lobbies for greater linguistic, cultural, and political rights for Buddhist Himalayans in India. The Ladakh-based Sowa Rigpa Research Centre – now the National Research Institute for Sowa Rigpa – is the only government-funded research institute focusing on this medical tradition.

Discourse coalitions and policy processes

The rival 2008 conferences, and the activities taking place around them, displayed many features of a policy process. Various groups of actors were striving to achieve a major policy decision – recognition – while at the same time seeking to influence the terms under which it would take place, the regulatory frameworks within which it would be set, and the balance of power that might pertain within those frameworks. Because recognition had not yet been granted, however, the policies in question were tentative and aspirational rather than definitive and binding.

Recent literature has moved away from mechanistic, linear models of policy processes towards seeing them as ongoing, contingent, performative, and contested (DeLeon and Martell 2006; Shore and Wright 2003). They are part of the way institutions, public bodies, private companies and individuals conceptualise reality and symbolise social relations, and their analysis enables us ‘to observe the way fragments of culture and society are brought into new alignments with each other to create new social and semantic terrains’ (Shore, Wright, and Pero 2011, 2). My analysis focuses on the deployment of discourses within the contested and pre-emptive policy process leading up to Sowa Rigpa’s recognition. I use the term ‘discourse’ to refer to ensembles of ideas, categories and ways of talking that assign meaning to aspects of the physical and social world. They are never neutral reflections on objective facts, social processes, or relations, but play active roles in creating and shaping these phenomena (Jørgensen and Phillips 2002). Discourses are also produced within, and actively reproduce, institutional and social fields of practice (Hajer 2005).

My approach has theoretical roots in the recent reworking of Foucault, Marx, Althusser, Laclau, and Mouffe by Stuart Hall and others (see Morley and Chen 1996), as well as in the critical discourse analysis of Fairclough (1995, 1989). I share with these analysts a view of social processes as complex and indeterminate, occurring on multiple levels that interlock through webs of correspondence and contradiction. I am also interested in how ideological elements and political objectives cohere into discursive formations, in the linkages between them, and in the compromises and impasses that emerge when competing sets of interests are furthered or held back in relation to one another. My work does not, however, seek to conform to any of the main schools of discourse analysis (see Jørgensen and Phillips 2002), and my interests diverge from these theorists in several ways. For example, I do not seek to explain these processes at the level of ‘society’ or ‘culture’, but retain a tight focus on one medical system. Furthermore, although I pay close attention to the words that are used, their ordering, and various levels of meaning, I privilege ethnographic observational methods over

the textually focused approach favoured by the main proponents, most notably the systematic linguistic analysis of Fairclough.

Following several groundbreaking publications on the topic, I understand conferences and public meetings as increasingly important sites of social interaction, politics, and policy making, and hence for ethnographic research (see Blaikie et al. 2015; Brosius and Campbell 2010; Cohen 1995; MacDonald 2010; Riles 2001). The way discourse is orchestrated at such events – who is invited, how topics are selected, how the programme is structured, and who is allowed to speak to whom and for whom – appears just as analytically important as the content of the spoken and written texts themselves, further distinguishing my approach from the text-oriented work of the major discourse analysts.

A concept that has proved particularly useful for this analytical approach is that of ‘discourse coalitions’, which grew out of the study of environmental policymaking and has since been applied in other fields (Bingham 2010; Hajer and Wagenaar 2003; Stevens 2007). Discourse coalitions emerge among actors who converge around a particular way of seeing a policy problematic, who utter the same story lines or are oriented towards the same way of arguing, even if they might disagree on other issues. The empirically observable shared discourse is the starting point: ‘the vocabularies, story lines and generative metaphors, the implicated division of labour and the various “positionings” of the actors’ (Hajer and Wagenaar 2003, 103). As coalitions form, one can discern both the shared and divergent interests pertaining to the various actors and analyse the institutional practices through which discourses are adapted, reproduced, and disseminated (Hajer 1995).

I employ this approach to order empirically observed discourse (written, spoken, or otherwise signalled) and to locate narrative currents that formed during the 2008 conferences. Examining discursive antagonism as well as coalition allows for a dynamic picture of the shifting boundaries of consensus and conflict from which institutional practices emerge,³ and through which a medical system is discursively cast, contested, and recast. Following brief ethnographic accounts of the conferences, which establish their contexts and introduce some of their main themes, I examine several fields of discursive convergence and divergence which, when understood in relation to one another, offer glimpses of the larger processes involved in the making of a medical system and the formation of policy concerning it.

³ For details of the rivalries and conflicts that often accompany the development of *amchi* associations see: Craig 2008; Craig and Bista 2005; Pordié 2008a.

Tibetan medicine in Dharamsala

The first morning of the national conference-cum-workshop on Tibetan Medicine saw lively scenes at the sprawling Men-Tsee-Khang compound. Several hundred people were greeting one another in the spring sunshine, including distinguished figures from the Tibetan government in exile, leaders of the MTK, CCTM, and the Central University of Tibetan Studies (CUTS), practitioners working across India and overseas, and students from the Tibetan-run medical colleges. The meeting hall was buzzing with activity as participants took their seats and video cameras were set up.⁴ The Tibetan⁵ elite were accompanied on the dais by Indian Ayurvedic and biomedical practitioners, scholars, researchers, and activists, including several members of the expert committee who were at that time preparing their report for Parliament. The total absence of senior Himalayan *amchi* (practitioners of Sowa Rigpa/Tibetan medicine)⁶ on the stage, in the crowd, or the conference programme was striking.

Following short welcome addresses, the CCTM chairman, Dr Dorjee Rabten, gave an eloquent opening speech. He established that this was the first conference to be jointly organised by the MTK and CCTM, and the first time that representatives of Tibetan medicine, Ayurveda, and biomedicine had ‘joined together on an equal platform’. The following excerpt introduces several discursive elements that became central as the event unfolded:

We have inherited the Tibetan medical system from our ancestors and consider it complete in terms of medical literature, *materia medica*, and pharmacological matters. But now the time has come when we are seriously thinking that we need to do something more to preserve and promote this unique science of healing. . . . Over the last two decades there has been an exponential growth in the demand for Tibetan medicines and because of this the international community, in India and abroad, has started to feel the competitiveness of Tibetan medicine. There are now a lot of legal

⁴ This footage was later released for sale as a boxed set of fourteen DVDs.

⁵ Henceforth, all references to Tibetans refer to Tibetan exiles, unless otherwise stated.

⁶ I use the term ‘Himalayan amchi’ throughout this article to refer to practitioners with Indian citizenship hailing primarily from Ladakh, but also from Himachal Pradesh, Sikkim, and Arunachal Pradesh.

issues and policy issues that have started coming up. . . . The main thrust of this conference is to bring together doctors of Tibetan medicine from India and abroad to discuss how best to resolve these legal and policy matters. Ayurvedic and allopathic doctors have been invited here to see how we can collaborate on these common interests. We seek their help in our ongoing efforts to gain legal recognition for Tibetan medicine from the Government of India, as a first step towards getting recognition in Europe and the USA. . . . We need to go beyond the current levels and limitations of practice, to establish ourselves as legally entitled, qualified medical practitioners. We need to focus on the legal and practical questions, so that we can reach out to people in Europe and the USA. We cannot ignore the right of these people to take Tibetan medicines or to practice Tibetan medicine, but because of the legal issues, which are being supported by big pharmaceutical companies, this is not possible at the present moment.

This speech presented the pressing need of the moment as overcoming mounting legal and policy obstacles, but without sacrificing distinctiveness or accepting subordinate status. The 'equal platform' between medical systems was to become one of the main leitmotifs of the conference. Recognition within India was proposed as a stepping-stone to increased global acceptance and market opportunity, rather than as an end in itself. Instead of downplaying economic imperatives, as Ladakhi *amchi* are apt to do, Dr Rabten acknowledged them as key drivers of the quest for recognition. The couching of these goals within a discourse of rights – to practice, produce, transact, and consume Tibetan medicine – gave political bite and broad appeal to his argument. Claiming that pharmaceutical companies were actively trying to deny these rights offered a strong appeal for unity in the face of powerful – though ill-defined – common foes.

Many of the ensuing presentations took great care to present Tibetan medicine and Ayurveda as rational medical sciences intimately related to one another, yet clearly distinct. For example, Dr Pema Dorjee stressed the indigenous Tibetan origins of the system that existed well before the compilation of the *Gyushi* (*rgyud bzhi*, the foundational texts of this medical tradition). He politely challenged Dr Naresh Sharma to identify Ayurvedic therapies that were not found in Tibetan medicine, and by highlighting differences – notably the continuing importance of pulse diagnosis in Tibetan medicine – presented it as a sophisticated contemporary of Ayurveda rather than its denuded descendent. Although there were murmurs of debate from the assembled Indian scholars, assertions of the independent and essentially Tibetan identity of the tradition went unchallenged.

A scholarly atmosphere pervaded the remainder of the event, with presentations focused tightly on theoretical, technical, and clinical issues. This approach was epitomised in the workshop style of the latter three days, which saw pedagogic sessions in the Tibetan

language led by senior experts and aimed at college students. Policy-focused papers were largely avoided and although the question of recognition hovered in the background throughout, it was rarely addressed head-on.

The closing ceremony saw the conference's keynotes reprised. The importance of gaining recognition as a step towards greater global acceptance was underscored, as was the need for collaboration on an equal footing with other medical systems. Several speeches alluded to the tensions between the various Tibetan groups, and heralded the conference as a major step towards overcoming them. Dr Rabten spoke again about the pivotal role of the CCTM and called for a clearer mandate from the Tibetan government in exile. While reiterating the importance of recognition, he advised caution lest 'AYUSH⁷ claim Tibetan medicine as part of their own medicine'. He was referring to what the Tibetans saw as the less favourable option of recognition under the existing act of Parliament, the pursuit of which explained the Himalayan faction's ongoing – and highly contested – assertion of similarity between Ayurveda and Tibetan medicine. Dr Rabten also painted Ayurveda's recent success as being largely driven by its commercial and public health potential, bringing the relationship between ethics, health care provision, industry, and profit firmly into the picture.

Finally, the assembled representatives unanimously adopted a set of resolutions. These largely paraphrased the mission statement of the CCTM as laid out in its landmark document (CCTM 2008, 1), thereby publicly restating its claim as the representative and regulatory authority for Tibetan medicine in India. There was little debate over these resolutions here, but some of their controversial implications were to emerge in New Delhi over the days that followed. Two additional targets were also proposed: gaining recognition and collaborating on an equal footing with other medical systems. As discussed below, although less problematic for Himalayan and AYUSH representatives than the CCTM's claim to regulatory authority, these aims carried different meanings according to one's institutional and discursive positioning.

I left the Dharamsala conference with a sense that matters of great import had been addressed, but in an indirect and carefully choreographed manner. Major policy issues were raised, but always through filters of technical and scholarly discussion. For me, this approach reflected the confidence that these well-established and highly organised institutions had built up over recent decades, as well as their relative technical advancement and specialization compared to their Himalayan counterparts, who were notable mainly by their

⁷ The Department for Ayurveda, Yoga, Unani, Siddha, and Homeopathy (AYUSH) is the government body responsible for traditional medicine in India. It was upgraded to the status of a ministry in 2014.

absence. There were also signs, however, of growing insecurity about the direction the system was heading, and concern that recognition under the existing act of Parliament might reduce the Tibetans' control, pushing it into the hands of the Himalayans and the AYUSH Department.

Sowa Rigpa in New Delhi

Immediately after the closing ceremony in Dharamsala, I jumped onto an overnight bus to New Delhi as the rival conference was due to start the next morning. Arriving in the bustling capital twelve hours later, I managed to meet up with twenty Himalayan *amchi* just as they were leaving for the conference venue. I shared a rickshaw with the 'chief *amchi*' of Leh District Health Department, Tsering Phuntsog, who peppered me with a series of questions about the Dharamsala event: How many *amchi*, Indian scholars, and government officials attended? Was recognition discussed? Which of the Tibetans were planning to come today? Foremost in his mind was the scale, audience, and political clout of the recently concluded event, and the bearing it might have upon the current one. After my short debriefing, Amchi Phuntsog explained that this was not actually the first day of the Delhi workshop. Most Himalayan representatives had gathered the previous day in order to finish organising the conference and to draft proposed resolutions. This information had not been shared with the Tibetan delegates. As we approached our destination, another Ladakhi *amchi* joked about the 'Sowa Rigpa vs. Tibetan medicine' nomenclature issue, humorously pre-empting the imminent resumption of this long-running debate (see Craig and Gerke, this issue; Kloos, this issue).

At the grand gates of the Constitution Club in New Delhi's administrative district, old friends and new faces came together from across Himalayan India. Most of the Ladakhi *amchi* elite were present, alongside representatives from Sikkim, Arunachal Pradesh, and Himachal Pradesh. When the Tibetan contingent arrived direct from their overnight drive, most of the Himalayans greeted them warmly, although exchanges with certain others were noticeably brisker and less comfortable. Beneath these subtle differences lay complex histories of professional and personal interaction, rivalry, and friendship, as well as tensions concerning the way the current event would unfold.

Dr Dorjee Rabten, the CCTM Chairman, explained to me the circumstances of his arrival. Neither he nor his colleagues had been officially invited by letter, as etiquette would normally demand, but had rather been 'summoned' by telephone a few days earlier. They had been given no programme documents and had no idea of what was expected of them. Behind his cheerfully resolute demeanour was more than a trace of affront, but I also sensed

a grudging acceptance of the strategic logic of these manoeuvres, which put the Tibetan contingent on the back foot from the outset.

Called to the opening ceremony we filed into the large modernist meeting hall, in the centre of which sat a garland-strewn dais with a large banner above it reading:

National Seminar and Workshop on Sowa Rigpa (Science of Healing)
(Amchi System of Medicine)
30th–31st March 2008, New Delhi
Organised by the Himalayan Buddhist Cultural Association,
in collaboration with Trans-Himalayan Parliamentary Forum,
supported by National Medicinal Plants Board,
Ministry of Health and Family Welfare, Government of India

Even this seemingly innocuous and functional text made strong statements. ‘Tibetan medicine’ was conspicuous in its absence, while both ‘Sowa Rigpa’ and ‘Amchi System of Medicine’ had come to evoke Indian claims over the system in recent years. Furthermore, the support of several branches of the Indian government was clear, demonstrating a high degree of political connectedness and further underscoring the citizenship of the organisers.

Directly beneath this banner and alongside several high-ranking monks sat the Venerable Lama Chosphele Zotpa, Chairman of the Organising Committee and President of the HBCA. A charismatic monk from Ladakh, Lama Zotpa has held a number of civil service posts, including membership of the National Commission for Minorities, and has used these offices to pursue cultural and political rights for Buddhist Himalayans. Next to him sat the imposing figure of Dr Bhagwan Dash, a renowned Ayurvedic scholar and author who has published several books on Sowa Rigpa (1988, 1997), and a prominent member of the parliamentary committee on Sowa Rigpa. The Director of the Central Council for Research in Ayurvedic Sciences, Dr Lavekar, was also prominently seated, beside the three senior-most Ladakhi *amchi*. Dr Padma Gurmet, the young director of the Ladakh-based SRRC, sat to one side next to Maling Gombu, the dynamic conference-organising secretary. The dais formed a mosaic of political and monastic powers, renowned scholars, and AYUSH officials, as well as established figures and rising stars of Himalayan Sowa Rigpa.

Waiting for the opening ceremony to begin, I scanned the smartly presented and largely trilingual (English-Tibetan-Hindi) ‘souvenir programme’ (HBCA 2008). Lama Zotpa’s introductory piece placed the conference within a broader aim ‘to preserve and promote the ancient traditional cultural practices of the Himalayan region’ (HBCA 2008, 3). By claiming Sowa Rigpa as part of ‘Himalayan culture’, this statement foreshadowed one of the principal

discourses of the entire event. Lama Zotpa concluded with a statement of unequivocal intent: 'I am sure that the workshop will be successful in achieving the desired goals and move towards developing Sowa Rigpa as a full-fledged profession under Indian Systems of Medicine' (ibid).

Reading the programme further, I was astonished by the high number and rank of political figures either attending or offering their written approval. The president and vice president of India, the minister of health, secretary of AYUSH and two chief ministers had all contributed letters of support. These texts offered telling snapshots of the extensive political networking at play, and of the discursive positioning of Sowa Rigpa recognition in different governmental spaces. Although obviously based on a template circulated by the workshop organisers, nuances in the form and voracity of support emerged from the personal touches unique to each letter. Those at the very top were cautious, calling for further support, research, and development but not explicitly for recognition. However, direct requests were made by several lower-ranking figures, including the chief minister of Himachal Pradesh, who bluntly stated: 'The system should be formally recognised under the Indian medical system at the Government of India level' (HBCA 2008, 8). Although their tone and volume varied, these were the voices of heavyweight political figures that rendered the overarching aim of the event crystal clear.

Amazingly, only one Tibetan was named among the thirty-four speakers in the conference programme. Listed simply as 'Pema Dorjee, Dharamsala, Himachal Pradesh', the details of his title, affiliation, and role were missing. With no prior warning, he was being asked to contribute two papers, one focused on history and the other on research. As he later pointed out, these were subjects that he was not the best placed among his colleagues to address, and he had been given very little time indeed to prepare. Despite a major panel being convened to discuss training requirements and syllabus improvements, Dr Dawa, the director of MTK, the largest Tibetan medical institute and college in India, was not asked to contribute anything. Furthermore, no representatives from CUTS even attended the event, despite its status as the only central government-approved university offering training in the tradition. Even more glaringly, Dr Rabten was not mentioned at all, despite being chairman of the CCTM and thus the official spokesperson for Tibetan medicine in exile. When I later asked the organisers about these omissions, they attributed them to last-minute planning and uncertainty over who would be attending, while also mentioning that the workshop was intended 'mainly for Himalayan *amchi*'. Whatever the reasons, the Tibetans had to overcome these affronts and be persistent to get their voices heard at all.

Before the seminar presentations had even begun, several sharp contrasts with the Dharamsala event were becoming evident. The strategic planning, invitation list, programme structure, orientation of papers, and accompanying literature here were all aimed squarely

towards the pursuit of recognition under the existing act of Parliament. As the first day of the conference progressed, I noticed that in place of the scholarly atmosphere, technical papers, and ‘equal platform’ of the earlier meeting were a set of direct, policy-oriented speeches, largely presented by Himalayan *amchi* and aimed at an audience of well-placed Indian political figures, to whom the *amchi* positioned themselves as subordinate. The target audience not only reciprocated with encouraging words, but also collectively assembled a formula for how Sowa Rigpa could reach its goal. This normative, programmatic approach was evident in speeches by the AYUSH secretary and three other high-ranking government officials.

Although the matter of recognition hovered in the background from the beginning, it was not until the morning of the second day that it was tackled head-on in a session entitled ‘Policy and Recognition’. Senior AYUSH representatives spoke of recognition as if it were imminent and gave their recommendations for how it could best be achieved. They then listened and nodded as the Himalayan coalition summed up their case. In the midst of this, a speech by Tsering Phuntsog stood out as the only contribution that was even-handed towards Himalayans and Tibetans, college graduates, and uncertified practitioners, as well as the only time that ambivalence towards recognition was expressed. His was the lone Himalayan voice praising the MTK and CCTM for their achievements, reminding participants of their shared goals, and warning of the negative outcomes that could accompany rapid modernization. While accepting professionalization as necessary and inevitable, he pleaded for educational programmes for uncertified, but socially valued, rural practitioners to be developed alongside college-based training. This message must have sounded off-key to many of those assembled – Himalayans, Tibetans, and AYUSH officials alike – but it was the clearest call for unity between the rival groupings, and the only representation made on behalf of the majority of Himalayan *amchi* who were lacking both institutional qualifications and a voice in the decisions affecting their futures.

A draft resolution was then read out for the delegates to ratify or amend. The clause attracting the most discussion concerned the formation of a national advisory body to dialogue with the government and push for recognition. This happened to also be the first clause of the resolution ratified a few days earlier in Dharamsala, although the body referred to here was not the CCTM but a new group to be decided then and there. When the list of members was read out, not a single Tibetan representative was mentioned, resulting in a moment of stunned silence. Then Dorjee Rabten spoke up, asking, ‘Where is the place for Tibetans in this body? Are we to take advisory positions, as nonmembers, or what?’ The conference’s organising secretary, Maling Gombu, fumbled for a moment and then said, ‘Members of MTK and CCTM can also be included, although the exact names need to be discussed further’. Padma Gurmet again underlined the citizenship issue: ‘This body is

advisory, not legislative, so there is no problem for Tibetans to be inside'. The Tibetans consulted one another and proposed that the MTK director and CCTM chairman should be included. After a nervous pause, no objections were raised and the official titles, but not the names of the incumbents, were added to the list.

Towards the end of this session, Dorjee Rabten made a final attempt to get an answer to his burning question: Would recognition mean that Tibetan medicine would be considered an Indian medical system? Padma Gurmet led the Himalayan response, arguing that it did not mean this exactly, as the example of homeopathy illustrated. Dr Rabten again pointed out that homeopathy was recognised under a separate act of Parliament,⁸ which is exactly what the Tibetans were calling for. Would the Himalayans also support this route, or were they committed to gaining recognition at any cost? With no response forthcoming he sat down, exasperated. When the clause on educational institutions and the formal registration of practitioners came up, however, he felt obliged to raise his voice again:

Why is there no mention of the CCTM in this section? We have already agreed that the CCTM will take the lead role in this! And also, what about the ninety-eight Himalayan *amchi* registered under CCTM? If they are not included, then they will also disappear from the recognition process.

Evidently uncomfortable, the organisers conceded and began discussing amongst themselves how to word the proposed amendment. Finally, it was agreed that the resolution would mention that the new advisory body would 'collaborate closely with' and 'work alongside' the CCTM. It was far from clear what this actually meant, however: two parallel bodies pursuing the same ends, or one subordinate to the other? This vague statement of intended collaboration, signed by representatives of Sowa Rigpa and Tibetan medicine, and witnessed by powerful figures in the AYUSH hierarchy, seemed an appropriately ambiguous note on which to draw this highly contested event to a close.

Disputed origins and nomenclature

The history of this medical tradition and the name by which it should be known were prominent fields of contestation in the spring of 2008. As numerous anthropologists and historians have noted, debates over the origins, cultural foundations, and nomenclature of medical traditions are often closely connected to broader social and political struggles, not least those relating to nationalism and postcolonial nation building, as well as being

⁸ See Hausman 2002.

important to practitioners and institutions in terms of their identity, habitus, and claims to authority (Attewell 2007; Craig and Gerke, this issue; Croizier 1968; Hardiman 2009; Kloos, this issue; Leslie 1976; Sivaramakrishnan 2006). The crucial role of narrative in ordering the social world and legitimising institutional positions within it is also widely recognised (see Bruner 1991, 1986). Narrative constructions of a medical system's origins involve processes of inclusion and exclusion that are linked to contemporary struggles over biopolitics, cultural politics, and geopolitics, or power in both pre- and post-Foucauldian senses of the word.

For these reasons, the long-running 'Sowa Rigpa vs. Tibetan medicine' debate remained hotly contested as recognition appeared increasingly attainable. This struggle was very much in evidence at the Delhi conference, despite the fact that the preceding 2004 event had concluded with a resolution signed by 107 delegates, including many Tibetans, stating that 'The nomenclature henceforth used will be Sowa Rigpa Medical System' (HBCA 2008, 13). The Himalayans referred to 'Sowa Rigpa' or '*amchi* medicine' in all documents, presentations, and discussions. Participants from AYUSH and other government bodies all followed the Himalayan lead and the few scattered references I heard to Tibetan medicine in Delhi were quickly self-corrected. For example, on both occasions when Dr S.T. Phuntsog accidentally uttered 'Tibetan medicine' while addressing the floor, he pointedly corrected himself and thus underscored the political significance of the name favoured by the Himalayans. Meanwhile, the four Tibetan exiles present consistently spoke of Tibetan medicine and made no mention of the name favoured by their hosts.

The only period of open debate on this matter came when Dorjee Rabten was invited, somewhat provocatively, to speak on the Indian contribution to the development of Sowa Rigpa. To the evident displeasure of the hosts, he instead addressed the nomenclature controversy, expressing surprise at finding '*amchi* medicine' on the banner but no mention of Tibetan medicine: 'I thought this had already been discussed and agreed in 2004 – the name will be Sowa Rigpa, so why is "*amchi* medicine" still there?' With no answer forthcoming, Dr Rabten went on to connect this issue back to the debate over origins: 'It is clear, to us at least, that this is a Tibetan medical system, not an Indian system that was spread to Tibet and practised there, but a system in its own right that radiated out from Tibet'. Echoing a key note from Dharamsala a few days earlier, he then called for 'a common platform of mutual respect between Ayurveda and Tibetan medicine, to avoid the distortion of history and to look clearly, on the basis of scholarship, into the similarities and differences so we can support each other rather than adopting a kind of stepmother to stepson relationship'.

By this point, the panel's chair was becoming visibly irate and attempted to stop Dr Rabten mid-flow, but he carried on for several minutes before finally giving up the floor. Without

deigning to respond to any of his points, the organisers moved swiftly on with their programme.

In contrast to the Delhi event, the nomenclature issue barely registered at the Dharamsala conference. The tradition was consistently referred to as ‘Tibetan medicine’, as had long been the agreed convention amongst Tibetan exiles. Although never explicitly discussed, this was widely understood as a united front of opposition to Himalayan efforts at limiting Tibetan claims over the system. This strategic choice is reflected also in English-language MTK books, journals, and promotional literature from this period (MTK 2007, 2001), and although the main CCTM publication is entitled *Sowa Rigpa: The Tibetan Medical System* (2008), this is the only place in which the former name is used and it is immediately followed by a direct statement of Tibetan ownership. Almost all the Indian delegates fell in line with this naming convention, even though several of them were members of the parliamentary expert committee and thus well aware of the official name. There was no debate over nomenclature in Dharamsala largely because there were no Himalayans present to raise a challenge. The term ‘Tibetan medicine’ thus appeared – temporarily at least – as an unproblematic ‘nodal point’ in the wider discourse: a privileged sign with a relatively stable signification, which configured the meaning of the other discursive elements in play in particular ways (see Laclau and Mouffe 1985, 112).

Similarly, although Tibetan medicine’s origins, history, and relationship to Ayurveda were discussed on the first day of the Dharamsala conference, they did not become major issues of contestation. The important influence of Ayurvedic texts was never denied by the Tibetan speakers, and had in fact been confirmed by experts from both traditions at a conference held at CUTS a year earlier (Roy 2008). However, central to the Tibetan exile discourse was the view of their medical system as a unique hybrid of Tibetan folk traditions with Ayurvedic, Chinese, and other influences. No Indian delegates questioned this and as there were no Himalayans present to challenge it more deeply, this version of the tradition’s origins and history appeared as a discursive moment, with a relatively stable meaning configured in relation to the nodal point ‘Tibetan medicine’.

In stark contrast, the purportedly Indian origins of Sowa Rigpa and its similarity to Ayurveda were major narrative currents running throughout the Delhi conference. These points were stressed in almost all of the letters of support and were frequently underscored verbally from the opening to the closing ceremonies. Written examples include the Arunachal Pradesh Chief minister’s bald statement that: ‘This traditional science of healing originated in India and spread to other parts of the world’ (HBCA 2008, 9), and Padma Gurmet’s assessment that:

Before the introduction of the present medical system, a kind of Bön (pre-Buddhism religion of Tibet) folk medicine was prevalent in Tibet, but if we give a close look, the majority of theory and practice of Sowa Rigpa are similar to the Indian medical system Ayurveda, followed by a few Chinese principles and then the prevailing Tibetan folklore. (ibid., 39)

This ordering and weighting of historical material heavily underscores Indian origins and denies the system an inherently Tibetan identity.

Such gambits were made, and challenged, throughout the early phase of the Delhi conference. Indeed, repeated claims that the origins of the tradition lay in India were made during the opening session, entitled ‘History and Practice’. Padma Gurmet and others argued that Sowa Rigpa ‘originated’ as Ayurveda and had been practiced in the Himalayan region for almost as long as in Tibet. Objections were raised from the Tibetan side, but only Pema Dorjee was permitted to speak from the stage in opposition. He pointed again to folk foundations and multiple influences, and stressed the extent to which this hybrid tradition had been formalised and enriched within Tibet, including the publication of virtually all the major texts.

The final panel of the first day comprised three papers under the highly leading title ‘Contribution of Indian Scholars in the Development and Practice of Sowa Rigpa’, which were delivered back-to-back by Ladakhi *amchi*. They completed the multipronged public claim that Sowa Rigpa originated with Ayurveda and was then modified simultaneously both in Tibet and in the region known today as Himalayan India. Politely and persistently throughout, this narrative construction was challenged by the Tibetan contingent. As the panel was being drawn to a close, Dr Dorjee grabbed the microphone and launched full-tilt into his counternarrative:

Of course Indian scholars brought many important teachings and of course Tibetan medicine’s roots in Ayurveda are strong, but everyone seems to be overlooking the fact that it flourished in Tibet much more than anywhere else, and grew there for many centuries before coming back to India. The *Gyushi* was not brought complete from India, nor is it simply what the Buddha said – it is all of these things, plus other influences which are not present at all in Ayurveda, or are there in a much less developed form. . . . There are chapters of *Gyushi* that are not found anywhere in Sanskrit. Of course the similarities are known, but what about the differences, what about helping each other out in fields the other does not know? Genuine collaboration is needed if any progress is to be made.

Rather than openly debating these matters, the Himalayan panel members once again left Dr Dorjee's valid questions hanging unanswered in the humid air.

Debates over the origins and development of Sowa Rigpa brought Himalayan and AYUSH discourses into convergence. Both groups argued that ancient *Indian* medical wisdom found fertile ground in Tibet and flourished simultaneously there and along the Himalayan belt, incorporating other influences over time but retaining essentially Ayurvedic theoretical and therapeutic principles. A corresponding antagonism was all too clear in the Tibetan exile discourse, which contended that the tradition had its deepest foundations in the indigenous folk knowledge of Tibet. Although fundamental influences certainly came from India, the ensemble was adapted, refined, added to and codified in Tibet, only later spreading into the Himalayan region. This understanding of the tradition's origins and development shows it to be sufficiently distinct from Ayurveda to be a fully-fledged medical system in its own right, without any need for filial deference.

Viewed from the outside, questions about the origins of the tradition are both valid and valuable, but only if pursued dispassionately (see Czaja 2007; Emmerick 1977; Gyatso 2015; Hofer 2007; Martin 2007). However, the argument as publicly articulated at the 2008 conferences brought carefully selected pieces of historical evidence to bear in the validation of highly politicised a priori positions. These were presented as mutually exclusive and the proponents endlessly talked past one another, each unwilling to concede that the available evidence points to both arguments being partially true, and the conclusions being drawn on both sides to be largely the result of political 'spin'. From the inside, however, these discursive battles were understood to hold real implications for the recognition process itself, as well as for the cultural identity and power dynamics of the tradition in India. The Himalayans had accepted that the quickest route to recognition and future power was under the existing act of Parliament, which required convincing the government of Indian origins and close similarity to Ayurveda. Most Tibetan exiles favoured the longer path to recognition under a new act, as pioneered by Homeopathy in the 1970s (Hausman 2002). They were determined not to relinquish their strong sense of the Tibetan identity of the system, nor any future claims to authority or policy influence once recognition had been achieved.

The nomenclature debate also saw a discourse coalition emerge between the Himalayans and AYUSH. The Himalayans sought the official name 'Sowa Rigpa' in large part to reduce the strength of Tibetan claims to authority and future influence, while expediting recognition under the existing act of Parliament. The Indian government shared many of these interests, but was also considering the geopolitical dimension with regard to China. They did not wish to antagonise their powerful neighbour by using a name that appeared to endorse Tibetan nationalism, and neither did they wish to accept exclusively Tibetan origins. On the other hand, the Tibetan exiles were striving to maintain historical and contemporary claims over

the system as recognition appeared imminent. Furthermore, several exiles added an economic dimension to the debate by arguing that because ‘Tibetan medicine’ used the English language and was already the best-known term worldwide, switching to ‘Sowa Rigpa’ might damage the system’s popularity in the global market.

The names Sowa Rigpa and Tibetan medicine can be seen as competing nodal points within the ‘order of discourse’ concerning recognition. The order of discourse denotes the range of discourses that struggle in the same terrain (Fairclough 1989, 1995), and nodal points are privileged signs around which other elements in this terrain are ordered and configured (Jørgensen and Phillips 2002; Laclau and Mouffe 1985). Nodal points are often hotly contested because many other elements acquire their meanings in relation to them, and are stabilised or destabilised accordingly. Arguments over the origins, cultural identity, and historical development of the tradition, the locus of authoritative knowledge and representative rights, were thus subsumed within the nomenclature debate. Those involved understood that fixing the name by which the tradition would officially be known would alter the meaning of these other elements, with potentially far-reaching implications for the recognition process and for the policies that would shape its future trajectory within India and beyond.

Recognition and professionalisation

Tibetan and Himalayan discourses fitted together more neatly with regard to the status of their medical system and the importance of further professionalisation. Albeit in quite different styles, both parties used their 2008 conferences as platforms from which to project particular images of their medical tradition to those with policy influence and decision-making power, demonstrating its readiness for recognition. Beneath the shared elements of this discourse, however, there was considerable divergence over the impetus and degree of urgency driving these efforts, and hence the best route by which recognition should be sought. Debates also emerged surrounding the locus of authority over the registration of practitioners and the regulation of training and practice, foreshadowing struggles that are resurfacing in the present day.

At the rival conferences and in written texts from that period, the Ladakhi-run SRRC and the Tibetan-led CCTM and MTK carefully presented Sowa Rigpa as a medical science with coherent theoretical foundations, certified training courses, professionalised practice, and standardised pharmaceutical products (CCTM 2008; SRRC 2007). Rationality, homogeneity, and professionalism were thus ‘selectively accentuated’ (Pordicé 2008b), while the plurality that actually characterised the tradition on the ground was consistently obscured (see Besch 2007; Blaikie 2011; Pordicé 2002). This amounted to a strategic denial of Sowa Rigpa’s

multiplicity in order to achieve the goal of recognition. An important element in this concerned the definition of legitimate membership and enforcement of basic regulations, which are key characteristics of professional medical systems (Last 1986; Leslie 1976).

From its inception in 2004, the CCTM primarily concerned itself with the institutionally trained professional sector, within which almost all Tibetan exile *amchi* practice. However, from 2006 it sought to extend its authority beyond these ‘Qualified Medical Practitioners’ through the registration of unqualified *amchi*, mostly Himalayan Indians and Nepalis, whom it referred to as ‘Registered Medical Practitioners’ (RMPs). In spite of their important health care role in many areas (Besch 2007; Blaikie 2011; Craig 2008; Kloos 2004), these RMPs found few of their most pressing concerns – such as lack of income and medicines – reflected in CCTM directives (CCTM 2008). Many Ladakhi *amchi* accepted RMP status as a form of interim registration and a prerequisite for attending Tibetan-run training workshops. However, the Himalayan elite saw the CCTM overstepping its authority through the registration of RMPs, portraying it as a strategic attempt to grow the Tibetan power base beyond its proper constituency (in other words, those trained in exile-run institutions).

At the same time, however, Himalayan institutions were shifting their own focus away from the unqualified sector. Although the majority of the Ladakh Amchi Sabha (LAS)⁹ membership lack institutional qualifications, the interests of ‘traditional *amchi*’ became less central to LAS and SRRC policy as the quest for recognition gathered pace. In seeking to present a homogeneous and professional medical system, both elite Ladakhis and Tibetans adopted arguments – such as the urgent need for training and the regulation of medicine production – that undermined the legitimacy of unqualified practitioners, effectively placing them outside the bounds of modern acceptability and excluding them from the recognition discourse. Although some attempts were made to equivocate, notably Tsering Phuntsog’s speech in Delhi, the dominant image projected at both events denied the plurality of locally adapted ‘currents of medical tradition’ (Blaikie 2013; Scheid 2007) in favour of presenting a homogeneous and professional medical system.

From their lofty vantage point, Indian officials saw pale reflections of Ayurveda in the Himalayan snow. Numerous government delegates at the Delhi conference made it clear that although Sowa Rigpa training, research, and industry were considered primitive compared to Ayurveda, a handful of modernisation-oriented reforms could address the deficiencies and enable recognition in the near future. For peripheral actors, gaining the state’s approval requires the simplification and amalgamation of diverse currents of knowledge and practice,

⁹ Founded in 1978, Ladakh Amchi Sabha is the largest and longest-running Sowa Rigpa association in Ladakh. Only 37 of its 221 listed members have formal Sowa Rigpa qualifications.

rendering them legible to – and thus controllable by – the state-industry complex (Saxer 2013; Scott 1998). Indian visions of technoscience, capitalism, and industrial development are expressed through the state's policies and bureaucratic processes concerning traditional medicine, which are adapted and applied by elite institutions and local actors to varying degrees. As Eric Wolf consistently argued, far from simply emerging from collective experience and becoming shared motifs and practices, constructions of culture evolve as the unifying efforts of elites and ruling classes, who reify and enhance cultural texts in order to defend the borders against outsiders while deepening their social and economic power (Wolf 1999; Wolf and Silverman 2001). The mobilisation of symbols and structures by powerful interests creates homogenising forces, but also resistance and fracture, as the current example illustrates.

A discourse coalition emerged between AYUSH and the Himalayans concerning the most appropriate mode for Sowa Rigpa's incorporation into the state apparatus. Recognition under the existing act of Parliament would be accompanied by a programme of harmonisation with the established systems and backed by concrete legislation, policy directives, and funding streams. Without recognition, AYUSH was in a position of limited direct administrative or regulatory influence, but the recognition process granted it considerable power to support or suppress the system and selected elements of it. State institutional discourse thus sought to 'enframe' Sowa Rigpa as a definite and controllable category.¹⁰ The Delhi conference showed how this enframing was adopted by the Himalayan elite and institutions, naturalised, and reflected back to those at the centres of power. The Dharamsala event, on the other hand, positioned Tibetan medicine as a relatively self-contained and progressive medical system, in need of official legitimacy in order to continue to develop not only within India but worldwide. Its leading institutions rejected state-imposed enframing by presenting themselves as well able to manage the required transition without external interference.

Both the Tibetans and Himalayans demonstrated their deep engagement in the quest for recognition at the 2008 conferences, but framed the quest differently and sought to pursue it along divergent paths: Tibetan medicine under a new act of Parliament and Sowa Rigpa under the existing act. These paths correspond to two parallel discourses of cultural survival. The exiles saw the Chinese annexation as threatening the entirety of their culture, and Tibetan medicine was held up as a shining beacon of resistance to that destruction (Kloos 2013, 2015). Against the odds, they had managed to successfully propagate their medical tradition in exile, attract students into a respected and relatively secure profession, and

¹⁰ See Langford 2002 for a sophisticated discussion of enframing processes in contemporary Ayurveda.

provide high-quality health care to their own people as well as many others across South Asia and beyond. Cultural survival in this context referred to the continued growth of the current of Tibetan medicine in exile, both in India and worldwide, as both a symbol and living expression of a broader Tibetan culture uncorrupted by Chinese influences.

Although the Himalayans also spoke of a valuable tradition under threat, the crisis they referred to was of a different order entirely. Loss of social status, competition with biomedicine, lack of income and facilities, weak institutions, and the absence of state support were the most commonly cited causes of Sowa Rigpa's decline in Ladakh and Himachal Pradesh (Besch 2007; Blaikie 2011; Kloos 2004; Kuhn 1994; Pordié 2002, 2003). Survival for Himalayan *amchi* was thus much closer to the existential, absolute meaning of the word and formed part of a very different framing narrative: reversing stagnation and decline rather than facilitating further progress and expansion.

Science, validation, and industry

One of the most clearly defined programming thrusts of the Dharamsala conference concerned the encounter between Tibetan medicine and biomedical science, in particular the challenge of validating Tibetan medicines through clinical trials. In New Delhi, clinical validation was also a prominent issue but was framed and discussed in quite a different manner, while other aspects such as the scaling-up of medicine production for public health care were brought to the fore. How these matters were resolved appeared to hold considerable import for all parties involved, both for the recognition process itself and for the policy framework structuring future pharmaceutical research, production, and marketing. The two conferences saw Tibetan, Himalayan, and AYUSH discourses cohering around several core issues in these fields, but also areas where they diverged, revealing different positionings, agendas, and levels of competency arising from distinct institutional cultures and practices.

In Tibetan areas of China, clinical trials have been shown to bring different medical epistemologies, theoretical frameworks, and socioeconomic and political interests into articulation (Adams 2002a, 2002b, 2011; Adams et al. 2005; Craig 2011, 2012). These studies show traditional medicine to be at a major disadvantage in negotiations over the definition of well-being, disease, efficacy, and proof, given the hegemonic position of biomedical discourse and methodology. Clinical studies of Tibetan medicines were very much in their infancy in India during the period covered by this article, due in large part to the absence of state recognition and the relatively small scale of the pharmaceutical manufacturing industry, which severely limited the funding available for expensive clinical trials. However, in the context of the search for recognition, greater external support, and larger markets,

engagement with these matters had become unavoidable, hence their prominence at the 2008 conferences.

In Dharamsala, a series of papers showcased clinical studies conducted by the main institutes of Tibetan medicine in exile, which aimed to prove acceptable levels of safety and efficacy to scientific observers. The speakers made clear their concern with gaining scientific validation for their treatments, but also expressed a strong sense of Tibetan medicine's effectiveness in its own terms. They tempered their presentations by subtly questioning the value of studies whose logic, methods, and parameters were largely derived from biomedicine. These concerns resonated with the new approaches to 'intercultural' modes of standardisation and clinical evaluation being pioneered in Ayurveda, including the rejection of double-blind clinical trials in favour of hybrid methodologies that assess outcomes based on 'treatment packages' rather than obsessing over the effects of single molecules on biomedically defined disease entities (Chaudhury and Chaudhury 2002; Shankar, Unnikrishnan, and Venkatasubramanian 2007). Several times, during both public talks and private discussions, senior Tibetans requested external help in addressing this thorny challenge. A very well-received talk by Darshan Shankar¹¹ encouraged direct and confident engagement with mainstream Indian scientists and government institutes, so as to open up a 'more epistemologically informed dialogue' that could move these debates beyond the current impasse. Later, following his highly problematic presentation on clinical research into Tibetan medical treatments for cancer, Dorjee Rabten sought Darshan Shankar out in order to probe him further about alternative protocols that could satisfy the authorities without compromising Tibetan understandings of disease and methods of treatment.

A series of papers then reported on studies into the treatment of arthritis, diabetes, and intestinal disorders using Tibetan medicine. Dr Tenzin Namdul from the MTK Research Department presented a celebrated clinical trial conducted in collaboration with the All India Institute of Medical Sciences, which yielded promising results in the treatment of Type 2 Diabetes (Namdul 2001). He alluded to the reticence some of the older generation felt towards clinical research, stating that it 'should not be seen to belittle the work of our ancestors', but was essential for Tibetan medicine to 'get accustomed to the present environment and situation', silence its critics, and raise its international profile. He suggested that 'compared to modern scientific research, we are not far behind in any aspect', but

¹¹ Darshan Shankar is a well-known scholar, teacher, and activist for Ayurveda and other Indian medical traditions. He was the director of the Foundation for Revitalization of Local Health Traditions for many years and is currently chair of the Indian Institute of Ayurveda and Integrative Medicine.

strongly encouraged the institutional leadership to invest more in clinical studies, so that the same diabetes study would not have to be rolled out every time anyone asked for proof of Tibetan medicine's efficacy. Dr Namdul repeatedly underscored the need to make Tibetan medicines acceptable to regulatory authorities in Europe and the United States, but barely mentioned the quest for recognition within India.

The renowned Tibetan scholar and teacher, Dr Pasang Yonten Arya, addressed several key issues in a crisp presentation summarising his research into the treatment of 'acute intestinal disorders'. He started by stressing both the importance of scientific validation and the difficulties associated with it. Next he gave a detailed account of the causes and symptoms of Crohn's disease, ulcerative colitis and irritable bowel syndrome 'from the Western medicine point of view'. He then carefully considered possible correlates in Tibetan medical literature and theory, concluding that such disorders had their origins beyond the digestive system and were linked to humoral, dietary, behavioural, and psychological factors. Next he progressively eliminated inappropriate Tibetan medical disease categories, as laid out in the core texts, until arriving at acceptable diagnostic equivalents to the biomedical disorders. He outlined the corresponding treatment regimens, drawing solely on Tibetan medicines, before reporting on the positive outcome of several case studies according to both biomedical and Tibetan indicators. Presented by a practitioner who stood outside the mainstream of Tibetan medicine in exile due to his many years spent living successfully in Europe, this neat and convincing account of complementarity was very well received by the audience, many of whom took detailed notes or photographed the PowerPoint slides.

Focusing on a set of biomedically defined, chronic health issues for which 'Western medicine has some treatments, but they are not so effective and have severe side effects', Dr Arya's presentation highlighted a niche that many Tibetans felt their medicine could occupy at the global scale. Relatively wealthy consumers dissatisfied with biomedical treatments for debilitating but nonlethal pathologies, or 'lifestyle diseases', often seek out complementary therapies that offer some relief. Such therapies do not demand the same rigorous scientific validation as those that claim to 'cure' infectious, acute, or potentially life-threatening diseases. Clinical research was presented as necessary because it would improve Tibetan medicine's reputation overseas and secure legal rights to practice worldwide, not because Tibetan medicine actually had anything to prove. Frequent linkages were made between the ability to satisfactorily demonstrate efficacy to a scientific audience and the negotiation of legal-economic issues linked to global market expansion, whereas recognition in India was only mentioned as a stepping-stone, if it was mentioned at all.

The importance of demonstrating the safety and efficacy of Sowa Rigpa medicines came up frequently throughout the Delhi conference, particularly during the session entitled 'New Avenues for Research and Development to Enhance the Potentiality of the Sowa Rigpa

System'. However, it struck me that here these issues were almost always raised by representatives of AYUSH or medical research institutes, invariably focused upon the requirements for gaining recognition within India, and were rarely taken up in any depth by Himalayan delegates themselves. A good example was the paper presented by Dr Atul from the Indian Council for Medical Research. He began by suggesting that 'scientifically acceptable validation of Sowa Rigpa medicines' was a prerequisite for recognition, but that this could easily be achieved through collaboration with institutes such as his own. He reassured the audience that alternatives were evolving to overcome the disadvantages that molecular studies and double-blind clinical trials imposed on traditional medicine systems. His presentation echoed discussions in Dharamsala a few days before, and questions from the floor came mostly from Tibetans, who were clearly more familiar with this field than their Himalayan counterparts.

Dr Padhi, deputy director of the Central Council for Research in Ayurvedic Sciences, then gave a talk in the form of a checklist that the main Sowa Rigpa institutions must work through before having any chance of being officially recognised:

Sowa Rigpa must learn from the experiences of Ayurveda and Siddha, and collaborate closely with them. The system should be simplified, modernised, and reorganised to suit the twenty-first century. It should also be made accessible and visible to others in India: translate the principal texts into English and Hindi, along with a complete glossary of medical terms; standardise and reorganise textbooks to show uniformity of theory; standardise and scale-up medicine production; and demonstrate scientifically the safety and efficacy of the drugs.

While implying that there was still a lot to be done before Sowa Rigpa would be 'suitable for the twenty-first century', Dr Padhi proposed several short-cuts by which recognition could be granted sooner, under the tutelage of the more established traditional systems, such as: 'Play to your strong points: find a few drugs that work well for relatively simple or chronic diseases, prove this through clinical studies, and present these to the government as evidence of the wider efficacy of the system'.

When Padma Gurmet spoke of moving ahead with clinical and pharmacological research at the Sowa Rigpa Research Centre in Ladakh, he was mainly acknowledging the support of the Central Council for Research in Ayurvedic Sciences, while sketching out his hopes for the future. Brief references to clinical research conducted by the SRRC made no mention that it had mostly been carried out more than twenty years earlier and in a rudimentary way by what

was then known as the Amchi Research Unit.¹² This omission masked the scarcity of clinical research being conducted outside the Tibetan exile institutions, but the lack of first-hand experience among the Himalayans was nevertheless apparent throughout the session.

Although he too had been asked to speak on matters of scientific research, Pema Dorjee switched focus onto the economic, ethical, and geopolitical dimensions of pharmaceutical industrialisation. He criticised the carelessness and greed with which production was being scaled-up in Tibetan areas of China. Then, immediately after decrying this rampant commercialism he called for a collective effort within India to capture a greater share of the global market. He directly appealed for the recognition of ‘Tibetan medicine’ as a step towards global expansion, deftly underlining his case by referring not only to cost-effective health care benefits within India, but also the boost recognition would give to the country’s efforts to catch up with China in the global herbal products market. Echoing several important elements of AYUSH discourse and policy (AYUSH 2002, 2006), Dr Dorjee spoke directly to the interests of influential sections of the room. His speech was received with nods and affirmative comments from AYUSH and government officials, and ended in patchy applause.

Later I joined a Tibetan *amchi* and an Indian medical researcher in the garden for lunch. The Indian scientist was explaining how his institute was always interested in testing medicinal plants and herbal compounds in search of new treatments. The Tibetan listened eagerly and expressed his interest in collaboration. Then, unexpectedly, the conversation veered off as the Indian launched into a monologue praising the perfection of ‘Buddhist science’ and lamenting its lost greatness. He said it was unfortunate that the Western scientific paradigm was now dominant, especially given the ‘perfection of the ancient Buddhist science’. The Tibetan agreed distractedly while trying to steer the discussion back to collaboration, but the Indian would not be swayed. Finally, exasperated, the Tibetan made his getaway, leaving me alone to hear the conclusion of the scientist’s eulogy. This seemed to me a strangely appropriate way to conclude the Delhi panel on scientific research and Sowa Rigpa. The session had confirmed the centrality of scientific validation and pharmaceuticalisation to the recognition effort, while also drawing out some unexpected linkages and disconnects between individuals and the larger discursive configurations of which they supposedly formed part.

Analysis of these presentations, interventions, and interactions reveals that Tibetan exile and AYUSH discourses overlapped significantly on several key issues, while the Himalayan

¹² These studies are cited in the 2006–2007 SRRC annual report, alongside two more recent studies carried out under its current director (SRRC 2007).

position was quite different. For example, at both the Delhi and Dharamsala events the Tibetans participated actively in the discussion of clinical trials and reflected upon the development of alternative protocols using similar vocabularies to the Ayurvedic researchers, AYUSH representatives, and medical research industry actors. While expressing great faith in the safety and efficacy of their ‘time-tested’ classical formulae, Tibetan speakers accepted the importance of demonstrating this to scientific and legislative audiences, albeit in a way that did not sacrifice their medico-cultural identity and theoretical specificity (see Kloos 2011, 2015). However, the way the Tibetan discourse on validation was packaged and delivered made it clear that they were unwilling to subject themselves to external controls, to buy into the increasingly powerful Indian integrated medicine paradigm (Sujatha 2011; Sujatha and Abraham 2009), or to accept the deracination of Tibetan pharmacology from its epistemological, theoretical, therapeutic, and ethical groundings, as the dominant ‘pharmaceutical episteme’ (Banerjee 2009) demanded.

Epitomised in the speeches of Dr Namdul and Dr Arya in Dharamsala, a major strand within the Tibetan exile discourse on scientific validation concerned the need to convince authorities in the European Union and United States of safety and efficacy in order to enable expansion in the global market. Underscored by the positive reaction of Indian officials to Pema Dorjee’s speech in Delhi, this argument resonated with elements of government strategy, which aimed for economic growth through the development of a profitable knowledge-products industry and its promotion on the global market (Planning Commission 2007). Key to achieving this was the need ‘To dispel the myths and establish the credibility of AYUSH therapies at the international level’ (AYUSH 2006, 1), which is almost verbatim how Dr Namdul explained his vision for clinical studies within the MTK. Such a discourse coalition was able to emerge because the Tibetan exile institutions were well established and financed, efficiently run, and reasonably advanced in terms of clinical research, large-scale medicine production, and marketing (Kloos 2013, 2015). Such an institutional culture allowed for clear understanding of the main issues with which AYUSH had been grappling for decades, and an appreciation of what was at stake in the development of both policy and market opportunity.

The Himalayan representatives lacked the institutional strength, financial security, advanced training, and first-hand experience of their Tibetan counterparts, and consequently struggled to contribute anything of note during these discussions. Their discourse on the imperative of clinical validation was thin indeed, with little detail and no long-term vision apparent beyond securing recognition. The Himalayan participants listened to others speaking about these matters and on occasion expressed willingness to engage more actively, but this appeared as little more than wishful thinking compared to the confident and autonomous programme of engagement and innovation articulated by their Tibetan counterparts. The AYUSH and

medical research industry representatives recommended collaborating closely with them in order to test and validate Sowa Rigpa medicines scientifically, which some might interpret as having a self-interested dimension given the emergent trend towards the exploration, development, and patenting of plant-based remedies in India (see Halliburton 2011; Patwardhan and Mashelkar 2009; Sahoo, Manchikanti, and Dey 2011).

Although the Himalayans had little to contribute to discussions of clinical research and the global market, on other related topics their discourse aligned itself much more closely with that of AYUSH, while the Tibetans were largely silent. For the Himalayans, recognition would enable a much expanded public health-care role for the hundreds of Sowa Rigpa practitioners already serving rural zones along the Himalayas, but lacking formal legitimacy and meaningful state assistance. Scaling-up medicine production and legitimising practitioners in order to better serve these communities was an important argument for recognition among the Himalayans, as stated many times at the Delhi conference, and this converged with core strategic goals of AYUSH (2002, 2006) and India's eleventh Five Year Plan (Planning Commission 2007). The Indian government arguably saw in this a way to gain greater control over a maverick medical system, further its mission to industrialise and standardise the traditional medicine industry, and extend biopower by providing health services to minority populations in geopolitically sensitive border areas. This discourse coalition enabled the Himalayans to further calls both for recognition and government employment for their practitioners while fostering growth in the pharmaceutical industry. These were not pressing concerns for the Tibetans, whose physicians tended to work in private or MTK-run clinics and were not desperately seeking government employment, whose drug manufacturing was already at a much larger scale, and who saw the potential for expansion lying primarily in the nonstate sector and the global market.

Various discursive positionings concerning the encounter with biomedicine, clinical research, and pharmaceutical industrialisation were clearly visible in written and spoken communications during the spring of 2008. These were largely consistent within each of the three main groupings, reflecting both their current positions and their aspirations for the future. However, there were also moments when individuals departed from their scripts, came out with off-key comments, or reached across group boundaries to form coalitions that turned discursive 'elements' into 'moments' in unexpected ways. For example, instead of a logical positivist discourse, an Indian research scientist gave a eulogy to the lost greatness of 'Buddhist science', while his Tibetan interlocutor sought only to pursue scientific validation through collaborative endeavours. When the Tibetan Pema Dorjee appealed to AYUSH representatives in Delhi for help to extend Sowa Rigpa's reach in the global market, his words were better received than those of his Indian counterparts, despite the strong coalition between the Himalayans and Indian government officials in evidence at that meeting. These moments revealed the internal inconsistencies and debates that lie beneath

the official discourses of institutions and interest groups concerning the appropriate mode of engagement with science, clinical trials, and industrialisation.

The policy theatre

Writing up field notes, transcribing interviews, and reflecting on what I had witnessed over the days that followed the conferences, I came to see them increasingly as ensemble pieces of policy theatre. A medical system had been discursively constructed and represented through a series of public performances, with the drama heightened by the contested policy process within which the performances were set. Notwithstanding the absolute seriousness of their engagement, here were skilled (and less skilled) actors performing soliloquies and sharing dialogues, launching polemics and tracing subtler metanarrative arcs through a series of part-scripted, part-improvised exchanges. Both events were carefully organised and stage managed, and were performed for quite specific audiences. Although individuals sometimes departed from their scripts, the primary discursive configurations and core aims of the three interest groups were reiterated over and over again in speech and writing, strongly underpinned by the choreography of the events themselves.

In the field of articulation collectively created during this period, Tibetan and Himalayan actors deployed particular discursive constructions in their attempts to negotiate their respective currents of medical tradition around extant and emergent obstacles, and towards imagined future opportunities. With AYUSH and other branches of government more closely involved than ever before, and the expert committee report for the Parliament in the final stages of preparation, members of both parties were striving – more or less consciously – to influence the tradition's internal power dynamics and its relationship to external structures of governance; to shape the legal and policy framework within which it might come to be set; to define acceptable and unacceptable forms of training, knowledge, and practice; and to mark out avenues of engagement with the state, science, capitalism, and the pharmaceutical and medical research industries.

Each corner of this triad comprised individuals who shared elements of identity and institutional culture, and who learned and worked within specific 'communities of practice' (Lave and Wenger 1991; Wenger 1998). However, I did not find that they constituted entirely stable groupings whose members shared identical positions and agendas. For example, tensions between different Tibetan institutions and individuals were publicly acknowledged at the start of the Dharamsala conference, and these contributed to Tibetans adopting a range of positions on certain aspects while uniting with one voice on others. Many of the individuals involved in these events had relationships and interests that cut across group boundaries, such as the prominent Himalayan *amchi* who were trained by

Tibetan exiles and who shared lineage, respect, and outlook with their teachers, and those Indian *amchi* working for, or closely with, the government. The main strength of the discourse coalition approach is precisely its ability to disentangle these threads of cooperation and conflict both within and across group boundaries. It has proved useful in the current case to illustrate how institutions and individuals clustered together around discourses that reflected their interests and aspirations in connection to particular issues, even though they antagonised one another in other ways.

The struggle over nomenclature stood out as particularly crucial and partisan. The names ‘Sowa Rigpa’ and ‘Tibetan medicine’ acted as nodal points within the order of discourse concerning recognition and the policy process surrounding it. The proponents sought to establish their preferred name as the main referent for the tradition, and in doing so to alter the meaning of a whole array of other discursive elements in play. Using ‘Tibetan medicine’ implied a particular understanding of the tradition’s origins, cultural identity, and historical development, as well as suggesting a prominent role for Tibetan exile institutions in shaping its future trajectory within India. Speaking of Sowa Rigpa, on the other hand, signified a less Tibet-centric understanding of medical history and a closer kinship with Ayurveda, while implying a dominant policy-making position for Himalayan Indians under the auspices of the government. Thus the politics of naming clearly concerns much more than the words by which a body of knowledge and practice should be known (see Craig and Gerke, this issue; Hsu 2013). Discursive battles about origins, history, identity and nomenclature merged into – and became inseparable from – struggles over authority and power, and hence over the policy process that held the potential to confer or curtail them.

At the same time, competing interpretations of other prominent terms such as tradition, profession, development, regulation, science, efficacy, validity, industry, market, progress, and (not least) recognition were also struggling for primacy within the same order of discourse. Polysemic and not yet semantically fixed, these signifiers circulated as ‘discursive elements’ in Laclau and Mouffe’s (1985) framework, while the various actors constantly attempted to turn them into ‘moments’ by fixing their meanings in relation to one another, and inscribing these newly configured webs of meaning into the policy process. Competing discourses were brought into articulation at the conferences and shaped these elements in uneven ways, thus creating new configurations that in turn fed back into the social, political, and legislative processes under way.

I argue that it is through these articulations that a heterogeneous medical tradition was collectively presented to the Indian government as a unified and professional medical system, ready for recognition, while simultaneously the internal rivalries and the divergent institutional pathways, priorities, and visions of its main proponents continuously pulled it apart. These simultaneous processes of discursive assemblage and disassemblage could only

be partially apprehended through analysing the written and verbal texts presented at the conferences. In order to understand these processes and their outcomes more fully, it was necessary to look closely at how discourses were orchestrated, staged, and performed for particular audiences, which significantly altered their effects within the order of discourse and thus the wider policy process surrounding recognition.

In terms of institutional strength and organisation, research experience, and industrial development, the Tibetan exiles appeared better placed than their Himalayan counterparts to carry the system forward according to the Indian government's vision and policy. Areas of discursive convergence between the Tibetans and AYUSH – notably concerning clinical validation and global market expansion (see Kloos, this issue) – belied certain similarities in institutional capacity and outlook, which enabled the parties to reconcile their differences to some extent. The structure, style, content, and conclusions of the Dharamsala conference reflected the confidence the Tibetan exiles felt in a position of widely acknowledged authority, financial security, and institutional advancement. This positioning resulted in a scholarly, technical conference in which Tibetan medicine spoke to the government and other medical systems from a position of equality, and official recognition in India was portrayed as an important landmark on a much longer road to global acceptance and expansion.

As recognition morphed from distant dream to real possibility towards the end of the first decade of this century, the formerly dominant Tibetan discourse began coming under pressure from a small group of Himalayan *amchi* and political actors. Although lacking the institutional infrastructure, organisation, and sophistication of the Tibetans, they had Indian citizenship and this proved to be a trump card. The political positioning this citizenship offered enabled them to develop stronger connections to various branches of the Indian state. The Delhi conference showed how, by working with the governmental apparatus and accepting a subordinate position to the medical systems already within it, the Himalayans were able to perform their medical system – as a tragedy – to those with real influence, and in doing so to swing the policy dimension of the recognition process in their favour. By presenting it as an opportunity – however illusory – to unify India's medical heritage, primordial sentiments were evoked in high places, while the chance to extend the state's influence and deepen its biopower in border areas offered strong pragmatic appeal. Despite the advantages of Indian citizenship and the more powerful crowd attending in Delhi, however, it was apparent that both conferences served in different ways to highlight the potential industrial, economic, geopolitical, and public health benefits of Sowa Rigpa's recognition to the Government of India. Both events contributed to making recognition an issue of mounting interest in the corridors of power after decades of invisibility and neglect,

and to shaping the order of discourse, policy environment, and institutional dynamics into which the tradition emerged once recognition was finally granted two years later.

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