

In search of trust and efficacy

Tibetan medicine in multiethnic Rebgong, Qinghai, China

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Abstract

This article describes how Tibetan medicine, traditionally an ethnomedicine indigenous to Tibetan areas, travels across cultural boundaries in a multiethnic region, presenting empirical findings from Rebgong (Ch. Tongren) in Qinghai province, People's Republic of China. Focusing on Muslim Hui and Han Chinese citizens, we describe how these patients smoothly engage with Tibetan medicine. This, we argue, is enabled by a strong sense of trust in distinguished Tibetan doctors, or 'lineage doctors', and their privately produced Tibetan medicines, and by shared understandings of the patient role. Contemporary medical pluralism in Rebgong invites us to revisit classic themes in medical anthropology as it brings the study of ethnomedicine into the context of a reconfigured instrumentalized public health system and ethnic relations, in which trust is a rare and treasured quality.

Keywords

Tibetan medicine, ethnomedicine, trust, multiethnicity, Amdo, China

Introduction

Tibetan medicine, also called 'Sowa Rigpa',¹ has in the last two decades developed into a flourishing industry not only in China, but also in India, Bhutan, and Mongolia (see Craig

¹ Sowa Rigpa translates as the 'science' or 'art' (*rig pa*) of healing (*gso ba*). See the special section by Craig and Gerke (2016) in *MAT* on the politics of naming Tibetan medicine across Himalaya and the

2012; Saxer 2013; Kloos 2017). Supported and encouraged by these national governments, and in varying ways included in the public health system, Tibetan medicine has become a modern traditional medicine employed alongside biomedicine and other medicines. Walking through the ever-wider streets in Rongwo town, the capital of Rebgong county in what Tibetans call ‘Amdo’ and People’s Republic of China (PRC) administrators call ‘Qinghai province’, one cannot avoid noticing a strong presence of Tibetan medicine. In between the old houses, the new high-rise buildings, hotels, a new massive museum, and the continuous construction sites, numerous private clinics and pharmacies make themselves known with Tibetan door hangings and signs written in Tibetan and Chinese indicating ‘Clinic for Tibetan medicine treatment’. The central part of town hosts the large Malho Prefecture Tibetan Hospital (hereafter the ‘Prefecture Tibetan Hospital’), a central medical institution in Amdo since 1983. It currently has two hundred employees and seven specialized medical departments, and is a highly professionalized hospital (Nianggajia 2015). The noticeable presence of Tibetan medical institutions is not a coincidence. Tibetan medical knowledge and practice in Rebgong is connected with the Rongwo monastery,² which for centuries has hosted and trained outstanding physicians.³ Rongwo monastery also played an instrumental role in reviving Tibetan medicine in the aftermath of the Cultural Revolution. In addition, Rebgong has long been famous for its numerous ‘lineage doctors’, who use techniques unique to their teachers, as taught by family members, in their private clinics. As such, Rebgong has a long history as a hub for Tibetan medicine. The contemporary therapeutic landscape in Rebgong is not, however, simply a continuation of past practices; it is a new configuration of national health ideologies and policies, public health services (and their

Tibetan areas in China. While ‘Sowa Rigpa’ increasingly has become a globalized brand that is preferred also by many practitioners outside the PRC, Tibetan medicine (*pö me*) remains the preferred term in Amdo, from where the material of this article is produced.

When unmarked, vernaculars are Tibetan terms. ‘Ch.’ indicates Chinese *pinyin*. For clarity we use phonetic representation of Tibetan terms, and include Wylie (1959) spelling on first occurrence.

- 2 Traditionally there were two main ways of learning Tibetan medicine: in monastic institutions or through family lineages. In 1916, the first secular medical school, Mentsikhang, was established in Lhasa. In contemporary times, Tibetan medicine is taught in universities, as well as through apprenticeship in monasteries of medical family houses. See Fjeld and Hofer 2011 for a description of forms of medical training and authority in Tibet.
- 3 Many senior practitioners of Tibetan medicine working in private clinics and at public medical institutes today in the Amdo area are students of former monk-physicians from Rongwo and its affiliated monasteries. In 1962, several former monk-physicians from local monasteries had already set up the forerunner of the Prefecture Tibetan Hospital. Hence, they continued to play an important role in the new health system under development in Rebgong (Nianggajia 2015).

limitations), local and regional medical entrepreneurs, pharmaceutical industries, and local ethnic relations.

In urban and semiurban centers in Tibetan areas, Tibetan medicine offers treatments both in private clinics and in larger public hospitals to all residents, Tibetans and others.⁴ Observing such strong physical presence in Rebgong and the ongoing rapid economic development of a transnational Sowa Rigpa industry that Kloos (2017) calls the ‘Tibetan pharmaceutical assemblage’, raises questions about the users of all these services and medicines. While Tibetan medicine is an integrated part of most Tibetans’ therapeutic practices, it seems unlikely that their use of such services alone could account for the renewed growth. Preliminary observations by the authors and by colleagues⁵ have indicated that part of this expansive growth is due to the broadening of patient groups: Tibetan medicine is used not only by Tibetans but also by people with otherwise limited connection to, and knowledge of, Tibetan culture and language (see also Craig and Adams 2008; Craig 2012; Millard 2008). The growing literature on Sowa Rigpa in the last two decades has given little attention to patients and their motivations and experiences (with the exception of Schrempf 2011; Craig 2012; Bassini 2013), and, so far, no studies have focused on non-Tibetan patients. In this article, we therefore explore what motivates people of Han Chinese and Hui Muslim ethnic background in Rebgong to use Tibetan medical services and medicines and how they make sense of their therapeutic experiences. We take these findings to discuss the role of so-called traditional medicine in the current public health system in this western corner of China, showing how trust is a rare and treasured quality in the contemporary healing landscape of Rebgong. Contemporary medical pluralism in Rebgong invites us to revisit classic themes in medical anthropology as it brings the study of ethnomedicine into a context of both reconfigured public health systems and ethnic relations – where health care is instrumentalized and commodified and ethnic relations politicized – a context that differs much from what dominated the 1970s and ’80s, the heyday of ethnomedicine as a subject in anthropology.

Traditional medicine is often described as the ethnomedical system indigenous to a group of people or a geographical area. This is also the case with Asian medicines, such as Ayurveda, Unani, traditional Chinese medicine, and Tibetan medicine. Gradually occupying a more marginal position in medical anthropology throughout the 1990s and 2000s – losing ground to emerging topics such as bioethics and biopolitics – traditional medicines and their

4 The medical landscape is different in rural areas, with limited access to both biomedical and Tibetan medical health care (Hofer 2008; see also Adams et al. 2005).

5 Schrempf and Craig, personal communication 2012, 2013; see also Craig and Adams 2008.

ongoing standardization, commodification, and pharmaceuticalization remained a strong undercurrent, particularly in Asian contexts (Farquhar 1996; Scheid 2002; Wujastyk and Smith 2008). Recently, in a special piece on Tibetan Medicine in *MAT*, Vincanne Adams (2016, 12) argued for the value of a renewed focus on ethnomedicines, reminding us that: ‘at the heart of much of what we do in medical anthropology is a fundamental set of concerns about how people attempt to heal, how they define disease and health, how they make claims about the legitimacy of their culture in and through medicine, and how medical systems reflect basic cultural claims (even about nature and the body)’. She suggests that, for these aims, contemporary Tibet is possibly ‘one of [the] more interesting sites in the world today’ (ibid., 13). In Tibetan areas within China, Tibetan medicine (*pö me, bod sman*) is the dominant nonbiomedical option available to residents, making up a varied and professionalized medical landscape. While more recent medical anthropological themes, such as biopolitics and bioethics, are also relevant in the Tibetan and Chinese context, we take this opportunity to put emphasis on how, for many people, health and illness are about a struggle to access affordable, quality treatments.

Although the opening of the market in China in the 1980s substantially raised living standards, also in urban Tibetan areas, the economic reforms also led to the privatization of the health system and a drastic decline in health insurance coverage, which resulted in both medical poverty and limited access to primary and specialized health care. This was especially true for the minority areas in the western parts of China (Hsiao 2007; Foggin et al. 2009). In more recent times, insurance coverage has significantly improved, but the challenges from privatization remained. The World Bank (2013) characterized the Chinese health system (of 2009) as a ‘dysfunctional system that was plagued by high cost and poor quality of care’, facing serious problems of overprescription and overtreatment. The 2009 health reforms sought to reduce price escalation in the hospital sector, and while these have had positive effects in many places, substantial challenges remain, also in the primary health sector. An editorial in *The Lancet* (2017, 226) lists some of the major challenges in China: ‘an under developed primary care system; maldistribution of health resources; inadequate quality of care’. It is within this context of limited or partial access, fear of overtreatment, poor quality of treatments, and the ongoing development of a functioning health system that a renewed focus on ethnomedicines and medical pluralism is particularly meaningful, in Tibetan areas in China and beyond.

Ethnomedicines, once seen as closely connected to a particular ethnic group, are also rapidly changing, and can no longer be viewed simply as bounded medical systems. Medical ideas and practices to an increasing degree travel and intermix with other local, regional, and global approaches to health and healing, including biomedicine. At the same time, traditional medicines are contested in global health policy and development circles, often due to the

difficulties of testing efficacy within the dominant randomized clinical trial methodology (see for instance Adams 2016b). Yet, in 2005 WHO estimated that ‘60–80% of the people in the Global South rely primarily or exclusively on traditional medicines’ (Kloos 2017). These numbers indicate that we need to take seriously how people engage with nonbiomedical medicines, not only as traditions that need cultural protection and preservation, or as potential burgeoning industries (Adams 2016a; Kloos 2017), but also as available pathways to better health, experienced as safe and efficacious in an increasingly commodified and instrumentalized health care system.

Tibetan medicine in the health system in Rebgong

Rebgong (Reb gong; Ch. Tongren)⁶ is both a county and the administrative seat of Malho (Rma lho; Ch. Huangnan) Tibetan Autonomous Prefecture. The county is located approximately 180 kilometers south of Ziling (Zi ling; Ch. Xining), the capital city of Tshongon (Mtsho sngyon; Ch. Qinghai) province.⁷ The 2015 census reports the total population in Rebgong county to be 89,654, with an ethnic distribution as follows: Tibetans: 72.94 percent, Monguor: 11.8 percent, Han Chinese: 8.83 percent, Muslim Hui: 3.86 percent, Salar: 1.68 percent, Baoan: 0.5 percent, Mongolian: 0.18 percent, and other: 0.21 percent.⁸

Rongwo (Rong bo; Ch. Longwu) town was the historical center of power when Rebgong was ruled by a Tibetan administration, before the 1950s. Today, it is both the county town and the administrative center of Malho Prefecture, and a place currently undergoing rapid urbanization, attracting a continuous influx of regional and transregional migrants. In line with the region’s economic development and modernization, the availability of medical services and commodities has also increased. Biomedicine – expressed in Tibetan as ‘*gyermen*’ (*rgya sman*), literally ‘Chinese medicine’ – was introduced to Rebgong in the 1950s. However, as Schrempf (2011) shows, biomedicine has not displaced local medical practices, and today the therapeutic landscape in Rebgong consists of different, and also, hybrid types of medical

⁶ All place names in the Tibetan areas of the PRC have both Tibetan and official Chinese names. For the administrative levels and province level we use the Tibetan place names and provide the Chinese names in parentheses on first occurrence.

⁷ Historically, Rebgong was considerably larger than current county boundaries that were redrawn with the establishment of the PRC (Dhondup 2011; Nianggajia 2015).

⁸ From the seventh census of Rebgong county conducted in 2015 (prepublication data personally conveyed to the first author, 2016). The Bureau of Statistics of Tongren County has not yet formally published the full results of the 2015 census.

traditions, including biomedicine, Tibetan medicine, traditional Chinese medicine, and elaborate ritual healing options.⁹

Tibetan medicine has been the ‘traditional’ medicine indigenous to the Himalayas and the Tibetan Plateau since at least the seventh century (Meyer 1997). With the compilation of its foundational treatise the *Gyüshi* (*rGyud bzhi*, Four Tantras) in the twelfth century by Yuthok Yönten Gönpo (*g.Yu thog yon tan mgon po*, 1126–1202) and the numerous commentaries produced in the centuries that followed, Tibetan medicine became an important part of Tibetan cultural and intellectual history (Gyatso 2015). Although there have been reforms and centralization processes of Tibetan medical ideas and practices from the seventeenth century onwards (Hofer 2008), there has also been a relatively strong continuity in the transmission of knowledge from teacher to student over these centuries. At the same time, Tibetan medicine is characterized by heterogeneity across regions, classes, and countries (Craig 2012; Adams et al. 2010; Soktsang and Millard 2013). The last five decades have brought massive changes not only to how Tibetan medicine is applied but also by and on whom. Following the Chinese revolution in 1949, Tibet was incorporated into the new PRC, leading to immense restructuring of Tibetan communities. This included powerful efforts to secularize Tibetan medicine, which was at the time an integrated part of Buddhist monastic institutions and was associated with Buddhist epistemology also in the lay medical family and house lineages.¹⁰

Since Deng Xiaoping’s economic reforms of the early 1980s, and the government’s post-Alma Ata policies of including traditional medicines in primary health care, Tibetan medicine in Rebgong has witnessed a gradual increase in the number of hospitals and clinics (both secular and monastic), as well as of licensed and unlicensed private practitioners. According to the Tongren Country Health Bureau (2014), there were sixteen registered private Tibetan medical clinics in Rebgong in 2014. This number does not include unregistered practitioners based in their homes, of which we observed many. Moreover, they reported eight registered private clinics of biomedicine and two of traditional Chinese medicine.

Health care in Rebgong, as elsewhere in the Tibetan areas, is structured in a four-tiered system, with biomedical facilities at prefecture, county, township, and village levels. While biomedicine dominates the public health system, Tibetan medicine also functions as an

⁹ Various folk and religious healing practices, such as divinations and consultations with lamas or *ngagpa* (*sngags pa*, ‘lay tantric specialists’) or trance mediums, supplement the medical services provided by doctors of different medical systems.

¹⁰ See Fjeld and Hofer 2011 for an overview of lay and monastic medical institutions before 1950.

integral part. In fact, Tibetan medicine in Rebgong was partly integrated into the structures of the public health system as early as 1962, and was from 1971 officially a legitimate part of the state-run health care system (Nianggajia 2015). Subsequent to the establishment of the Prefecture Tibetan Hospital in 1983, Tibetan medicine has gradually been deployed to the county, township, and village levels, although with varying quality of care, particularly at the lower administrative levels.

On 21 April 2009, China's State Council issued a document called 'Opinions on Supporting and Promoting the Development of Traditional Chinese Medicine',¹¹ declaring that Western and traditional Chinese medicine (Ch. *Zhongxiyi bingzhong*) should be recognized as equally important components of the national health policy and primary health care. This document reaffirmed traditional medicine as an indispensable element of the goal of 'health for all'. Favorable policies toward traditional Chinese medicine over last few decades have provided a positive framework under which Tibetan medicine, as well as other ethnic minority medicines (Ch. *minzu yiyao*), could develop and prosper. On 26 August 2009, the Qinghai provincial government issued a follow-up document entitled 'Implementing Opinions on Supporting and Promoting the Development of Traditional Chinese Medicine and Traditional Tibetan Medicine',¹² stating that Tibetan medicine (Ch. *zang yiyao*) is equally important as biomedicine. In this text, one of the noted aims was to enhance the inclusion of Tibetan medicine in health insurance programs, making prescribed drugs reimbursable and thereby improving access to Tibetan medical services down to the village level. The basic health insurance in Rebgong consists of three major components: urban employees' basic medical insurance (UEBMI) launched in 1998, a rural cooperative medical scheme (RCMS) for rural populations launched in 2003, and urban residents' basic medical insurance (URBMI) launched in 2007. These insurance systems cover mostly in-patient services. The reimbursement rates of the RCMS and URBMI vary, with 90 percent of the expenses reimbursed for patients hospitalized at township level, 80 percent in hospitals at prefecture level, and 70 percent in hospitals at the provincial level. Insured patients can choose their hospital, whether specialized in Tibetan medicine or biomedicine, and – if approved by the local Medical Insurance Bureau – purchase remedies at designated public and private hospitals, clinics, and pharmacies. More often than not, there is no fixed price for treatment or medicines prescribed by private doctors. Prices of privately produced medicine are normally slightly lower than these of the same medicines in the public hospitals. In general, the integration of Tibetan medicine into the public health system allows for easy access to Tibetan medicine, at a relatively low cost.

11 Ch. Fuchi he cujin zhong yiyao shiyi fazhan de ruogan yijian.

12 Ch. Fuchi he cujin zhongzang yiyao shiyi fazhan de shishi yijian.

At the same time, Tibetan pharmaceuticals and practices in the PRC today are commercialized and commodified (Janes 1995; Adams, Schrempf, and Craig 2010; Saxer 2013; Kloos 2017).¹³ Not only a defined minority medicine and thus part of the government's development plan, Tibetan medicine has become a lucrative business. Already in 2003, Saxer (2013, 6) found the estimated annual output value of Tibetan medicine to be one billion RMB, and there are no reasons to believe that these numbers have decreased in the last decade. At the same time, Tibetan medicine remains closely connected to Tibetan culture: in education and clinical practice Tibetan is the language of instruction, its theories remain fundamentally associated with Tibetan Buddhism, and the main actors – so far – are Tibetans.

The articles in the 2016 special section on Tibetan medicine in *MAT* showed very well 'what is at stake as "traditional" medicines and their underlying knowledge systems get commercialized while they are simultaneously being "protected" – but only under certain circumstances, when different interests (states, markets, local communities, etc.) can be aligned' (Adams 2016a, 13). In this article, we explore an aspect that has so far been left unexamined: how, in the process of commercialization and cultural protection, Tibetan medicine is being utilized by people who do not identify as Tibetans and who have limited or no connection to Tibetan culture. How does Tibetan medicine travel beyond cultural and ethnic boundaries in contemporary Rebgong?

Methodology

Conducted in Rebgong (Ch. Tongren) county, in the southeast of Qinghai province, or what Tibetans think of as part of the Amdo region,¹⁴ the study was designed to investigate what motivates patients with limited connection to Tibetan culture and language to use Tibetan medicine. An important multicultural hub for Tibetan medicine, Rebgong is an interesting place for an ethnographic study of its contemporary use.¹⁵ We were particularly interested in

¹³ A similar process of transformation into a commercial standardized medicine is also found in Tibetan communities in India, a development that could be interpreted as part of modernization and pharmaceuticalization (Kloos 2013, 2016; Blaike 2016).

¹⁴ Amdo, one of the three traditional Tibetan regions (Ü-Tsang, Amdo, Kham: cho kha sum), is located in the northeast corner of the Tibetan Plateau, and currently belongs to Qinghai, with smaller parts to Gansu and Sichuan provinces.

¹⁵ Rebgong was also a convenient place to conduct fieldwork for this study. Nianggajia, the first author, is a Tibetan native to the area, fluent in both Tibetan and Chinese, and could easily recruit

how people engage with its elements, including professionals, institutions, theories, diagnostic methods, medicines, and treatments.

Although predominantly the home to Tibetan farmers, seminomads, and nomads, Rebgong is located in the Sino-Tibetan borderlands and has been inhabited by peoples of various ethnic belonging for many centuries (Hille et al. 2015; Yangdon Dondrup 2011; Huber 2002). We decided to include participants from three main ethnic groups, namely Tibetan, Han Chinese, and Muslim Hui, and in this article, we focus primarily on Han and Hui, while comparing briefly with Tibetans.¹⁶ A combination of quantitative and ethnographic methods was employed for data collection in 2014 and 2015 respectively. We developed a Tibetan and Chinese language questionnaire and distributed this to 240 respondents who self-identified as Tibetan, Hui, or Han Chinese, with eighty respondents from each ethnic group. We chose a purposeful sampling strategy, aiming for maximum variation within each ethnic category. We recruited respondents with experience using Tibetan medicine, either currently or in the past, through personal connections, snowballing, and networks in clinics and hospitals. The first author distributed the questionnaires in Tibetan and Chinese to the respondents and conducted the interviews in their language of choice.¹⁷ The questionnaires were followed up by in-depth interviews with ten respondents from each ethnic group; they were strategically selected aiming for information-rich cases, for a total of thirty people. In addition, Nianggajia interviewed ten local Tibetan medical practitioners, and had numerous informal conversations with patients and practitioners. Lastly, he also observed clinical encounters in private clinics and in the hospital. The questionnaire sought to investigate patients' treatment choices and their preferred Tibetan medical institutions or physicians, and to gain a general overview of the ailments for which Tibetan medicine is used among patients of the three different ethnic categories. The in-depth interviews sought to further explore patients' perceptions of, and experiences with, Tibetan medicine, and physicians' experiences with treating an ethnically heterogeneous patient group. Upon the completion of data collection and entry, we came together to discuss, organize, and analyze the data.

respondents from different ethnic backgrounds, something that would be difficult to undertake in other locations.

¹⁶ The study does not include Monguors, officially classified as Tu, despite the relatively large size of this category, because, apart from language, they share many common values and cultural attributes with Tibetan communities in Rebgong. Monguors are Tibetan Buddhists. They have their own spoken language, but do not have written form. They also speak fluent Tibetan as their second language (see, for example, Blo bzang snyan grags 2015).

¹⁷ These questionnaires were explained orally in both Tibetan and Chinese to those who were illiterate.

Therapeutic choices

Patterns of resort and health-seeking behavior – ‘the process whereby people seek medical assistance and select health care practitioners’ (Brown et al. 1998, 15) – are fundamentally based on an individual and social understanding of health and healing, and hence intimately linked to culture. Numerous studies have shown how people experiencing ill health adopt a pluralistic approach to treatment, moving back and forth between healing options (see, for instance, Kleinman 1980; Langwick 2011; Penkala-Gawęcka and Rajtar 2016; for among Tibetans, see Samuel 2001; Gerke 2010). We know from these studies of medical pluralism that when people experience ill health their selection of possible treatments is pragmatic, including when, as Hsu (2008, 316) writes, they ‘have mutually incompatible explanations for the disorder’ (see also Janzen 1978; Last [1979] 2007; and more recently Langwick 2011). These studies employ, to varying degrees, an analytical focus on individual choices. However, these therapeutic choices depend on various factors, listed by Oberhelman (2013, 1) as: ‘economic means, accessibility of medical practitioners, the form of illness, the healer’s past success or his reputation for dealing with specific ailments, and previous experiences of patient and her family and friends’. In order to address these factors first, we start by presenting the forms of illness for which the respondents reported trying Tibetan medicine, and second, from where they learned about Tibetan medicine.

Forms of illness

In Rebgong, Tibetan medicine is employed for broad range of conditions, but both heart and stomach problems were among the most frequently reported ailments among the respondents. During a conversation in her home, a Hui woman in her mid-thirties told the following story:

Ten years ago, I took Tibetan medicine for the first time to cure my heart problem. I was about twenty years old then. My hands and body had begun to shiver somewhat. Then I also noticed that I had some difficulty breathing. When I explained this to my parents, they presumed that they could be indications of *xin zang bing* [heart disease]. Since I was an ill-tempered person, at first I believed my problem occurred as a result of *pi qi* [temper tantrums]. As the days rolled by, my condition continued to deteriorate. My father then took me from the prefectural-level to provincial-level biomedical hospital to have an electrocardiogram to screen for potential heart disease. Much to our surprise, the results showed no evidence of any abnormalities. However, the symptoms did not decrease in any degree. I was then taken to the prefecture Tibetan hospital because my father was well acquainted with the head of this hospital. It was this Tibetan doctor who confirmed my parents’ presumption that I had a heart

problem by reading my pulse. From then on, I began to take Tibetan medicines of all sorts. Although the effect of Tibetan medicine was slow, it was indeed effective. I also used Tibetan medicine for *man xing wei yan* [chronic stomach inflammation]. I had taken biomedicine for chronic stomach inflammation, but they had not helped at all. Now I still take Tibetan medicine when my stomach hurts.

This narration is a typical example of how Hui patients described the conditions under which they had taken Tibetan medicine. Her story not only points to the common heart and stomach problems but also illustrates the often-told experience of failed biomedical consultation or treatment, to which we will return. When asked in the questionnaire for which conditions they had taken Tibetan medicine, Hui and Han reported 84 and 85 ailments respectively. In comparison, the Tibetan respondents reported 72 types of conditions (in addition to eight Tibetan respondents reporting that they used Tibetan medicine for all forms of illnesses).¹⁸ There was a clear pattern among respondents from all three ethnic categories: the most often reported ailment for which they used Tibetan medicine was stomach problems. This corresponds to findings from previous research among Tibetans in India and Amdo (Samuel 2001, 255; Schrempf 2011, 161; Bassini 2013; Nianggajia 2015, 229). In our study, 45 percent (n=38) of Hui and 52 percent (n=44) of Han respondents reported having tried to treat some form of stomach problems with Tibetan medicine. These conditions included both chronic and more acute conditions, such as chronic stomach inflammation (Ch. *man xing wei yan*), peptic ulcer (Ch. *wei kui yang*), indigestion (Ch. *xiao hua bu liang*), and diarrhea (Ch. *fu xie*) (see Nianggajia 2015 for details).¹⁹

Despite only Tibetan respondents reporting having used Tibetan medicine for ‘all conditions’, it is clear that also Hui and Han participants choose Tibetan medicine for a broad range of conditions. These correspond, in general, to the conditions mentioned by Tibetans as well, although reported in Tibetan language terms.²⁰ With the massive growth in

18 The reason why the number of conditions reported by the Hui and the Han exceed the number of respondents was that some reported two or three conditions.

19 Other conditions reported were problems related to the gallbladder, lungs and respiratory system, joints, kidney and liver, as well as blood pressure and insomnia.

20 To report ailments, most of the Tibetan respondents used both Tibetan and Chinese terms, both vernacular and biomedical. Typical examples of Tibetan vernacular terms include ‘*kanglak nawa*’ (*rkang lag na ba*, literally painful limbs), ‘*pona*’ (stomach), and ‘*khokpa shelwa*’ (*khok pa bshal ba*, frequent stools), while Chinese vernacular terms include ‘*fu ke*’ (women’s diseases) and ‘*jing zhuo bing*’ (cervical vertebra disease). Tibetan medical terms include ‘*drumbu*’ (*grum bu*, a type of disease in Tibetan medicine related to rheumatic and rheumatoid arthritis), ‘*drip*’ (*grib*, pollution or spirit-caused disorders often treated by a combination of rituals and medicines), ‘*trangzhi*’ and ‘*traktri*’ (*khrag mkbris*,

the Tibetan pharmaceutical industry, it could be expected that certain commercially promoted medicines would easily connect with established patterns of resort, including among non-Tibetan patients. This is certainly the case with stomach problems, where certain medicines are frequently used (see Nianggajia 2015). However, commercialized pharma alone cannot explain the very broad range of conditions reported.

'So I just gave it a try': Social networks and flows of recommendations

Less often discussed in ethnographic studies of Tibetan medicine, but crucial for understanding health-seeking behavior and patterns of resort, is the significance of social networks, those webs of personal social relationships including family members, relatives, friends, neighbors, colleagues, and acquaintances. Often, it is through social circuits that sick people and their therapy management group, including family and caregivers, learn how to recognize and respond to health threats, and get advice on effective treatments. It is also through social networks that ethnomedicine, such as Tibetan medicine, travels across ethnic boundaries.

One of our initial questions concerned exposure to, and the sources of, information about Tibetan medicine. What role did commercials play in people's motivations to use Tibetan medicine? The survey and the interviews showed that for both Hui and Han respondents it was primarily their friends and acquaintances in adulthood that motivated them to try Tibetan medicine. Tibetans have naturalized access to information on Tibetan medicine; in other words, they know where to see medical specialists and buy medicines, and they know the names of frequently used medicines for corresponding conditions. None reported to have first learned about Tibetan medicine through commercials. Our Hui and Han respondents on the other hand, were introduced to Tibetan medicine during conversations about particular health problems, when friends, colleagues, neighbors, and family members shared their own positive experiences or described how they had witnessed others' recovery. These stories encouraged the Hui and Han respondents to try Tibetan medicine. As a typical example of this, one Hui woman told of how she was introduced to Tibetan medicine by her neighbor, a Tibetan shop owner, who had recommended a particular Tibetan stomach medicine if she experienced digestion problems. Similarly, a Han Chinese woman recounted that she had been taken to the Prefecture Tibetan Hospital by her Tibetan colleague and through that had been exposed to Tibetan medicine for the first time.

combined blood and bile disease). Chinese biomedical terms used by Tibetans are '*nao mao yan*' (meningitis), and '*gu zhi zeng sheng*' (hyperosteogeny).

Han and Hui also reported that they had received recommendations from non-Tibetans in their own networks. A Hui female shop owner in a small underground shopping mall in Rongwo told how she had heard about the *Rikar* digestion medicine (Ch. *Jiebaiwan*, Tib. *Rikar, Ril dkar*): ‘Almost every shop owner knows *Jiebaiwan* because it is more or less recommended from one person to the next in the mall’. A Chinese man in his fifties, suffering from hepatic cancer, who had already been through eight months of treatment at the Qinghai provincial biomedical hospital, said that a Han neighbor had advised him to stay at the Prefecture Tibetan Hospital. This neighbor worked at the hospital as a cashier, and when speaking to her later, at her side-line hairdresser business in town, she said she often recommended Tibetan medicine to her customers when learning of their complaints.

Observing the popularity of Tibetan physicians in their local community also triggered people’s curiosity and led them to try Tibetan medicine. Tibetan, Hui, and Han communities in Rebgong have lived side-by-side for generations. Sharing locality exposes non-Tibetans to the presence of Tibetan physicians, and enables them to observe the many patients seeking treatments at these private clinics. Private Tibetan physicians often offer clinical services from their homes, sometimes bringing a steady stream of patients into the neighborhood. Suffering from back pain, a Hui woman said that she had taken Tibetan medicine for the first time the previous year. When asked how she came to know about Tibetan medicine, she explained: ‘There is a private Tibetan clinic near where I live. A lot of Tibetans from rural areas would often line up to see this private physician. I thought this physician must be a competent physician. With hope and some curiosity, I went to see him’.

Not only does living alongside Tibetans give non-Tibetans an opportunity to become aware of distinguished local Tibetan physicians but it enables frequent and continuous contact, and for them to seek Tibetan medicine in times of need. In conducting this research, Nianggijia observed that the number of Tibetan physicians has increased over the last few years; as of 2017, there are also Tibetan clinics in or close to Hui and Han communities in Rongwo town.

Structural factors, such as the historical and contemporary dominance of Tibetan medicine in Rebgong and the inclusion of Tibetan medicine in the public health system, form an important role in how Tibetan medicine travels beyond Tibetan communities. Moreover, social interactions in which recommendations flow and observation of Tibetan physicians are possible introduce people of other-than-Tibetan background to Tibetan medicine. Hence, practical, rather than ideological or theoretical, concerns lead people to try Tibetan medicine, independent of potential conflicting notions of the body, illness, and treatment rationale. Therapeutic pragmatism in pluralistic medical landscapes has been well documented (see, for instance, Leslie 1980; Lock and Kaufert 1998; Obermeyer 2000; Scheid 2002). Similarly, in Rebgong, the choice of trying medicines is pragmatic, with little

ambivalence involved; it is an easy choice. As one Hui man put it: ‘It was recommended and it was effective. So I just gave it a try’.

Trust and the experience of efficacy

A pragmatic attitude to taking Tibetan medicine once does not, however, necessarily lead to continuous use. In fact, the bitter taste, the relatively large doses of medicines required per day, and the long-term treatment period are factors that reduce compliance, both among Hui and Han patients. ‘Tibetan medicine is just like stones and sands – hard to swallow’, commented one Hui woman in her early forties. Some Hui and Han reported to have stopped taking the medicines halfway through the course of treatment or earlier, hence reducing efficacy. However, most of the respondents did complete their treatments; they reported their meeting with skillful physicians, their personal experience of efficacy, and a lack of side effects, as well as disappointment with biomedicine. Together, these were important factors for continuous use of Tibetan medicine.

Trust in Tibetan medical physicians

Trust is a central element to doctor–patient relations in all medical traditions (Fugelli 2001). Much research has been done to identify forms and degrees of trust in biomedicine (Mechanic and Schlesinger 1996; Mechanic and Meyer 2000; Skirbekk et al. 2011; Pearson and Raeke 2000, to mention a few) and, though to a lesser extent, in Asian medicines (Kleinman 1980; Scheid 2002; Hsu 1999). In theoretical works, trust has been defined in numerous ways, often emphasizing social or individual aspects. We here lean on the *Merriam-Webster Dictionary*’s definition of trust as ‘assured reliance in the character, ability, strength, or truth of someone or something’ (2017). Trust, ‘manifested by a number of expectations by one party about the capabilities and behavior of the other’ (Davies and Rundall 2000, 612), is often built through repeated personal experiences and interactions between physicians and patients. Therapeutic trust is relational and negotiable (Skirbekk et al. 2011), and when expectations desired by patients are met, trust in physicians gradually becomes stronger. According to Pearson and Raeke (2000, 509–10), drawing upon the most commonly described dimensions of physician behavior, patients ‘base their trust on competence, compassion, privacy and confidentiality, reliability and dependability, and communication’.

Chapter 31 of the Explanatory Tantra of the *Gyüshi* points out that physicians should be adept at both medical theory and practice, and guided by compassion toward all patients indiscriminately (Schaeffer et al. 2013, 282). Schrempf (2007, 91) describes how senior Tibetan lineage physicians in the Tibetan Autonomous Region (TAR) ‘were perceived by their patients in the terms of transmission of, and trust in local medical knowledge and

practice'. It is also the case in Rebgong that patients, regardless of ethnicity, expressed trust in the diagnostic and therapeutic competence of Tibetan physicians, especially senior lineage holders.

Competence is a central component of trust in patient-physician relations in Tibetan medical encounters. One Hui respondent, a thirty-nine-year-old woman, stated:

My husband and I visited the local biomedical hospital and explained to the physician that I had been having back pain possibly from gallbladder. Without any substantive diagnosis, the physician assumed that something might be wrong with my spine and referred me for an X-ray of my back. As I had expected, the result indicated nothing abnormal and we spent more than one hundred *juan* for nothing. Later, it was the private Tibetan physician in our neighborhood who correctly diagnosed by reading my pulse that I had a gallbladder disorder.

For Tibetans, impressive diagnostic skills depend on experience, seniority, and knowledge transmission, and this was often mentioned in our discussions about patient–doctor relations with Hui and Han. Liwen, a forty-six-year-old man who suffered from diabetes, recalled his consultation with a senior physician called Shadrang Menpa (Dr. Shadrang) in this way:

I didn't tell Shadrang Menpa my conditions diagnosed at the Qinghai provincial biomedical hospital. He felt my pulse and could basically name all the conditions I have. He is a highly experienced doctor. He could diagnose that I have diabetes, high blood sugar, and a heart problem. That is why I believe in him and went to see him several times.

Shadrang Menpa – named after his village – is a well-known and popular private monk-physician that many of the Han and Hui we talked to had visited. His popularity is also partly due to the reputation of his teacher, one of the leading catalysts for the renaissance of traditional Tibetan medicine in Rebgong in the mid-twentieth century. Patients spoke highly of Shadrang Menpa's diagnostic and therapeutic skills, as the quote above illustrates. A Hui Muslim patient suffering from a heart problem said that he had for years regularly bought medicine from Shadrang Menpa and recalled that he had carried this medicine with him all the way to Mecca, adding that he probably would have died from the heart problem during his pilgrimage without that medicine.

Another monk-physician often mentioned by our respondents was Tokya Menpa. Also named after the place where he lives, Tokya Menpa was an influential physician sought after by many patients from all over Rebgong and beyond. He passed away in late 2014, but Nianggijia was able to visit his home-based clinic twice, in 2014 and after his death in 2015,

and observed that patients still come to see his nephew, who they perceive to be the rightful lineage holder of his medical tradition. Patients nicknamed his nephew ‘Tokya Mentrük’ (Tokya Menpa, the younger), indicating that he has received the expertise and all oral transmissions unique to Tokya Menpa, the senior. Some of the non-Tibetan respondents had visited Tokya Menpa regularly over the years and had developed an intimate relationship with him, notwithstanding different religious beliefs. Liu, a Hui scholar in his late forties, and his relatives have managed to retain intimate ties with another local Buddhist monk-physician. Liu recalled that his father would often invite the monk, who lived in the monastery in the vicinity, to treat his grandmother at home. When the monk passed away, Liu maintained the relationship between his family and the monk-physician’s student, who was now practicing in the area.

Lineage holders are known both for their diagnostic and therapeutic skills and their medicine production. Patients and physicians in Rebgong often expressed a worry that pharmaceutical efficacy was in decline. One Hui patient in his sixties recalled the efficacy of medicines produced by local Tibetan physicians of the past, and said ‘the efficacy of contemporary several doses is incomparable with that of one dose produced by physicians of the past’. Practically all the senior physicians interviewed reiterated the importance of following the principles of the Seven Limbs (*yenlak dun, yan lang bdun*), described in the *Gyüshi*, and sometimes called the ‘GMP²¹ for Tibetan medicine by Tibetan medicine professionals’ (Saxer 2013, 65). Senior physicians hold these traditional principles to procure desired therapeutic efficacy, and expressed disappointment in the inferior quality of Tibetan medicines produced these days by commercial enterprises.²²

When this kind of long-term relationship with a particular physician is absent, reputation is crucial. One forty-six-year-old Han respondent explained: ‘I usually don’t consult Tibetan physicians randomly, but only the ones I have known for years and have heard of from others’. Patients, regardless of ethnicity, expressed that they felt it was safe to use Tibetan medicine if the physician they consulted was known either as a lineage holder of a famous previous local physician or as having substantial experience in practicing Tibetan medicine (see also Craig 2007, 147). Hence, there is a clear preference for senior Tibetan physicians among the respondents. This resonates with Hofer’s (2008, 506) study in the TAR showing that ‘the idea of the power and trustworthiness of doctors from a medical lineage is still strong’, and that ‘Tibetans generally trust older doctors’.

21 Good Manufacturing Practice.

22 In his study of the commercial Tibetan pharmaceutical industry, Saxer (2013, 67) argues that ‘in some cases the traditional approach sets the bar higher than the contemporary drug regulations’.

Trust lies at the center of the physician–patient relationship in both the public and private health sectors, and in traditional and biomedical clinical encounters. Coming back to Pearson and Raeke’s list of core attributes shaping patients’ trust in physicians, we found competence and compassion, as well as reliability and dependability, to be the basis of trust in senior physicians. Mechanic and Schlesinger (1996, 1693) also point to the particular significance of competence: ‘The success of medical care depends most importantly on patient’s trust that their physicians are competent’. Trust based on competence is particularly important for both physicians and patients in order to offer and receive continuity of care and thus to enable the enhancement of health care quality. Patients who trust their physicians are more willing to follow through with their prescribed medical treatment.

Demonstrated diagnostic skills and therapeutic successes earn Tibetan physicians trust not only from Tibetans but also non-Tibetans with otherwise limited experience and knowledge of Tibetan culture and medicine. Trust in Tibetan physicians’ competence is based on the authority of the lineage and their experience, and is partly associated with the efficacy of their privately produced medicines. The value of trust expressed by our respondents should be understood within the context of a health system where medial institutions work hard to finance themselves and where overtreatment and overprescription is common. Trust in the biomedical pharmaceutical industry is low, and the fear of biomedical side effects high.

An alternative to biomedicine

In interviews, respondents explicitly compared Tibetan medicine with biomedical options, discussing considerations and experiences of efficacy and side effects. In Rebgong, biomedicine is deemed the better therapeutic choice in the case of acute diseases, a general observation on the different ways Tibetan and biomedicine work that was reiterated by all of the Tibetan physicians Schrempf interviewed.²³ Although our respondents have respect for diagnostic and treatment expertise of biomedicine, many expressed concern over its side effects. This concern is, not surprisingly, stronger when considering longer-term or chronic diseases and treatment prospects. Long-term reliance on biomedicine, respondents feared, could expose them to a series of adverse side effects.²⁴

²³ Schrempf, personal communication 2016.

²⁴ These perceptions about relative efficacy – being effective for chronic disease and with fewer side effects – are identical to those described in relation to Chinese medicine. In addition, patients typically mention that Chinese medicine works ‘slow’ and treats the ‘roots’ of the disease (Scheid 2002, 108).

The awareness of possible side effects was high among the respondents. Those who had regularly taken painkillers to alleviate intermittent biliary colic, for instance, held their gastric problem to most likely be a direct result of the side effect of painkillers, in addition to their lifestyle. Baiju, a licensed Chinese nurse in her forties, had *qi guan yan* (Ch. tracheal inflammation) for over ten years and experienced a relapse every year during the transition from autumn to winter. She explained: ‘Every time my chest pain recurred, I would buy anti-inflammatory drugs and cough drops from the pharmacy and have antibiotic drips when needed. However, they could only reduce the symptoms temporarily and hurt my stomach at times resulting in hyperacidity and stomach pain’. These experiences led her to try Tibetan medicine. She continued: ‘It was not until I had taken Tibetan medicine for three years in a row that I began to recuperate. Although still very fatigued and not fully recovered, I have not had a relapse for the last two years or so’. Baiju’s story is typical; she started Tibetan medicine after biomedical treatment failed, and particularly after long-term use of over-the-counter pills.

Similarly, easy access to prescription-free drugs, a culture of intervention when experiencing milder symptoms, as well as a lack of information about potential side effects of prolonged use forms the background for the story of Xiaoli, a forty-six-year-old Han woman. Twenty-two years ago, when she was recurrently afflicted by headache and nausea, she resolved to take Tibetan medicine upon the recommendation of a Tibetan colleague after having been diagnosed with gallbladder disorder; she did not relapse until two years ago. She believes she had taken too many painkillers and that these might have led to a drug-induced gastric problem. Concern over possible drug-induced diseases, such as the oft-mentioned gastric problems, seemed to be stronger among those who regularly use biomedicine to treat chronic health conditions. The majority of our respondents expressed that Tibetan medicine has no or few side effects and that they find it to work effectively for chronic diseases that are not responding to biomedicine.

Therapeutic encounters

According to the *Gyisshi*, a disease may be ‘fully understood from visual (examination), palpation and questioning’ (Clark 1995, 35); in other words, correct employment of these three diagnostic techniques thus ensures correct therapeutic treatment. It is, however, not always possible to implement these during clinical encounters, especially when the patient and the physician do not have much common language. In Rebgong, one significant difference between physicians trained in public medical schools and doctors trained through apprenticeship in their families is that the former are more proficient in the Chinese language. As such, one could expect that patients who speak Chinese would prefer doctors trained in medical schools. This, however, is not the case in Rebgong. Patients and

physicians reported that a lack of shared language and limited cultural and medical shared understanding does not influence the treatment processes in a negative way. This raises the questions of what the therapeutic encounter is and what it does, in other words, its capacity to enable trust and authoritative knowledge. This capacity, we suggest, is found in the very nature of Tibetan clinical encounters. Resonating with Waldram's (2015, 279–97) findings from Latin America, complex verbal therapeutic messages between physicians and patients seem to be less important. Indeed, Tibetan physicians are not concerned about explaining diagnostic and treatment processes, and patients do not express interest in the process or the physician's considerations; instead, they focus on defining the best treatment. Therapeutic messages are often communicated through palpation (such as pulse reading) and observation (by urinalysis and examining the tongue, eyes, and complexion), while asking only simple questions about symptoms. Pulse reading and urinalysis are the most prestigious diagnostic skills, and distinguished Tibetan physicians are expected to be able to diagnose on pulse reading alone. Moreover, senior physicians also emphasize the importance of dexterity in observation and palpation in order to make an accurate diagnosis, techniques usually acquired through years of clinical practice and reflection.

To illustrate a typical clinical encounter, we describe an interaction Nianggajia observed in a private clinic in Rongwo town. A former monk in his forties, Dr. Tseben was trained in a local public medical school and had been apprenticed to senior, well-known local physicians. His clinic, located close to the Rongwo monastery, is a small room with a stove at the center of the room. Behind the stove is the consultation desk with a stethoscope, a sphygmomanometer, two Tibetan medical books, and a stack of prescriptions. There are also a few pictures of Dr. Tseben with famous doctors, demonstrating his participation in various conferences. There are several glass shelves stocked with Tibetan medicines in the form of powder and pills, stored in transparent sealed jars (to ensure therapeutic potency), as well as prepackaged medicines. The shelves are sandwiched between a small dispensary room and shelves of different patented biomedicines. Above the shelves is a *thangka*²⁵ of the Medicine Buddha overlooking framed certificates on the opposite wall with pictures of staff next to it. This small clinic epitomizes the integration of Tibetan medicine and biomedicine now practiced by many private Tibetan doctors.

Nianggajia arrived at the clinic early in the day, to observe the morning consultations. At about 9:00 a.m. a Hui woman in her forties, accompanied by her daughter, came to see Dr. Tseben. Dr. Tseben kindly asked her to sit and enquired about her health problem, speaking in reasonably fluent Chinese, though with a heavy Tibetan accent. The woman responded, 'I

25 A painting of a sacred image or deity on cotton canvas.

have had lower abdominal pain, bloating, and diarrhea for last two days. I also vomited. I took some anti-diarrhea medicines and some other stomach medicines, but it did not help'. The doctor then continued, 'Have you eaten anything that you think might have caused your stomach problem? Or have you stayed in a damp place for a very long time?' She replied, 'I started feeling twinges in the lower part of my stomach after eating meat', and gently stroked her abdomen where it hurt. Dr. Tseben then probed further by asking the color of her stools and vomit. She explained that the stools looked partially undigested and the vomit was like rice water. He then reached out for her left hand and read her pulse with his right hand. After reading her pulse for about one minute, he felt the pulse in her right hand with his left hand also for about one minute. Finishing with her pulses, he asked if she had a kidney problem. She answered that she had been experiencing slight pain on her left side from the waist down, probably due to a kidney problem, and explained that her family owned a car wash business and the washing was done manually, which she considered to be probable cause. Dr. Tseben advised her not to have contact with cold water very often and prescribed seven different Tibetan formulas to treat both her stomach and kidney problems and told her to come back after one week for further diagnosis. The woman did not solicit any further information about her condition, nor about the treatment, and left the clinic with her daughter carrying the medicine in a small plastic bag. This example reflects a general pattern in our material, namely that clinical encounters between physicians and patients, independent of ethnic background and language skills, take relatively similar forms: they are relatively short, are based on simple questions about symptoms and a brief case story, and include palpation by pulse reading.

Let us now turn to how Tibetan physicians explain their experience of treating a heterogeneous population. Many senior physicians said the language barrier alone would not impede their treatment of non-Tibetan patients because dexterous palpation and observation could compensate for their limited proficiency in the Chinese language. Despite their relatively poor Chinese language skills, most of them could at least initiate very simple daily conversation in Chinese. As one elderly private physician explained, he was able to ask non-Tibetan speaking patients enough about their symptoms to initiate examination and treatment. He went on to explain that clinical encounters usually do not necessitate intricate medical theory to explain the conditions. And even if it does, he said, none of his patients – whether Tibetan or Chinese speaking – would understand the complicated medical concepts and technical terms anyway. Therefore, correct diagnosis and ultimate outcome take precedence over detailed explanations, as is often the case in master-to-disciple knowledge transmission.

When asked how he explains conditions to his non-Tibetan speaking patients, Dr. Tseben stated that he uses simple Chinese words, for instance, for the five internal visceral organs

and the six hollow organs (such as heart problem, liver problem, kidney problem, fever, headache), and other simple Chinese biomedical terms. It was important to Dr. Tseben to remain faithful to the medical theories, rather than responding to biomedical categories sometimes suggested by non-Tibetan patients, when prescribing treatments. This, he explained, was because Tibetan medicine and biomedicine have different etiological, pathological understandings, and thus different therapeutic techniques, and terminology is not directly transferable.

Shared understanding of the patient role

The diagnostic process does not differ in any significant way from the treatment of Tibetan patients. We take this to indicate that the understanding of medical theory, the body, and treatments is of limited relevance for patients' engagement with Tibetan medicine in Rebgong. Lobsang Dhonden Soktsang and Colin Millard (2013) have described Tibetan medical doctors' interactions with non-Tibetan patients in clinics in the UK. There, they write: 'The patients usually ask many questions, sometimes questions that are not related to medicine, for example, philosophical questions about Tibetan religion' (ibid., 482). Dr. Lobsang explains that many Western patients are distrustful and skeptical of Tibetan medicine and often require a full explanation of their condition before deciding whether or not to take the medicine he prescribes. This, they write, was at first 'very strange because it was very different to what he had been accustomed to' (ibid.). Clinical observations and conversations with doctors in Rebgong revealed that the non-Tibetan patients acted in accordance with the doctors' expectations; they were obedient and compliant and did not question the doctors' decisions. The physicians emphasized the significance of compliance, pointing to chapter 26 of the Explanatory Tantra, which defines the desirable qualities of patients as being obedient, in addition to courageous, tolerant of all sorts of treatment, and able to answer questions regarding the symptoms of ailment (Yutok Yönten Gönpö 1992, 85). An important factor in this uncomplicated nature of the clinical encounters in Rebgong is, we suggest, a shared understanding of the patient role, across language and ethnicity.

Conclusion

Tibetan medicine is undergoing a transformation, from a local medicine indigenous to the Himalayan and Tibetan ethnographic region to a medicine that is traveling in the region, nationally, and globally. This is a complex process, reconfiguring not only pharmaceutical production but also physician–patient relations and the characteristics of the patients. Initiated and substantiated by pragmatism and a willingness to try what was recommended from their social networks, and further, informed by their own previous experiences of efficacy and the absence of side effects, we found that Hui and Han Chinese citizens

smoothly engage with Tibetan medicine and its practitioners, treatments, and institutions. This, we argue is enabled by a strong sense of trust in distinguished lineage doctors and their privately produced Tibetan medicines on the one hand, and enabled by shared understandings of the patient role on the other hand.

Understanding Tibetan medical theory – or body, disease, and treatment rationales – is not a precondition for its use among non-Tibetans in Rebgong. Our findings echo those of previous studies showing that patients are less concerned about knowing the detailed underlying explanations and the boundaries between medical systems available, and rather engaged with various healing modalities in an empirical and pragmatic manner (Janzen 1978; Last [1979] 2007; Langwick 2011; Samuel 2001; Gerke 2010). Similar to what Volker Scheid (2002, 107) argues in his study of contemporary practices of Chinese medicine, patients' encounters with Tibetan medicine cannot be reduced to rational choices between medical systems, but should rather be seen as 'health care practices embodied locally in individual physicians, hospitals and therapeutic regimes'. There, as in many places in the world, people empirically observe and situationally choose the healing options available, including Tibetan medicine, informed by and further shaping the complex and dynamic local therapeutic landscape in this part of Amdo.

Across the Tibetan plateau and its vicinity, we see a rapidly growing, and hugely successful, Tibetan pharmaceutical industry. Tibetan medicine is a commercially manufactured commodity, mass produced, packaged in colorful wrappings, and sold across sectors, regions, and countries. Capitalizing on romanticized stereotypes of Tibet on the one side, and the growing market for all things Tibetan among part of the Chinese middle class (Yu 2013) on the other, the Tibetan pharmaceutical industry is a powerful force in shaping the patterns of use of their products. The 'Tibetan pharmaceutical assemblage' (Kloos 2017) is indeed the dominant representation of Tibetan medicine – or Sowa Rigpa – today. What we have aimed to show is that, in Rebgong, resorting to Tibetan medicine is not grounded in this romantic idea of Shangri-la and magic, but is rather a health care choice, one made in a particular context of a public health system with many limitations and challenges, including partial access, low quality of care, and fear of the consequences of prolonged biomedical interventions. Our respondents' use of Tibetan medicine was based on trust, not in a 'medical system' with all its representations in contemporary China and beyond, but rather in skillful physicians and their lineages, and efficacious and safe medicines and treatments.

Ethnomedicines, and their practitioners, are important parts of the therapeutic repertoire in Asia, and in large parts of the world today, yet these medical practices are only recently being reintroduced to debates in the anthropology of global health. While the transformations of local medical practices into standardized, commodified knowledge systems with lucrative

pharmaceutical industries attached are indeed an important topic to analyze, we must be careful not to lose sight of the patient. Anthropological approaches to global health are excellently defined by the motto of ‘people come first’ (Biehl and Petryna 2013), and the classic themes of medical pluralism and ethnomedicines help to remind us of the fundamental questions of how people attempt to heal in health systems that often can provide only partial and low quality care.

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