Exploring the Cross-cultural Journey of Tibetan Medicine in Modern China:

A Case Study in Rebgong

NIANGGAJIA is a lecturer at Qinghai Minzu University, No. 3 Bayizhong Road, Chengdong District, Xining City, Qinghai Province, 810007, China (qinghaigyalpo@yahoo.com).

ABSTRACT: Tibetan medicine, also known as Sowa Rigpa (the science of healing) is the traditional medicine indigenous to Tibetan peoples across the Himalayas and the Tibetan plateau. Historically, its aetiology, nosology, treatments, and training have been closely connected to Tibetan Buddhism, language, and environments. The last three or four decades of standardisation and commercialisation in China and beyond have brought Tibetan medicine, ideas, experts, and institutions to new patient groups and new markets. This study investigates the ways in which Tibetan medicine has moved out of Tibetan communities to transcend cultural and ethnic boundaries in the People's Republic of China (PRC) today. Focusing on users of Tibetan medicine in Rebgong, a multiethnic border area known to Tibetans as Amdo and located in the PRC's Qinghai Province, the study explores and analyses how Tibetan medicine is perceived and used by diverse groups. Based on ethnographic fieldwork that combines formal and informal interviews with Tibetan doctors and both Tibetan and non-Tibetan patients (including Hui Muslims and Han Chinese), it investigates the motivations and experiences of users, their perceptions and assessments of its efficacy, and the nature of clinical encounters.

KEYWORDS: Rebgong, Tibetan medicine, clinical encounter, medical pluralism, ethnic boundary.

Introduction

In this paper, I explore how Tibetan medicine, also known as Sowa Rigpa གསོ་བ་རིག་པ། (the science of healing), is perceived and used by non-Tibetans in the contemporary People's Republic of China (PRC). Sowa Rigpa is the traditional medicine indigenous to Tibetan and related peoples across the Himalayas and the Tibetan plateau. My aim is to investigate in what ways these medical ideas, diagnoses, and treatments are transcending ethnic boundaries in the PRC today. In the history of medical anthropology, so-called ethnomedicines have been strongly associated with particular ethnic groups in terms of their culture, religion, language, and history (Mahapatra et al. 2019). Yet, with modernisation and more recently globalisation, ethnomedicines are being standardised, commercialised, and commodified in new ways, and many have transformed into assemblages of practices and materialities that travel more easily, reaching new patients and users and reshaping relations between patients, practitioners, and medicines. For many Asian medicines, such as Ayurveda in India, these transformations began early in the twentieth century (Langford 1995; Alter 2005; Zhu 2018). For Tibetan medicine, however, these changes are more recent. In the last four decades, Tibetan medicine has undergone many transformations worldwide. Within the PRC alone, Tibetan doctors, hospitals, and large pharmaceutical companies increasingly offer a wider range of innovative treatments and medicines to Tibetan and non-Tibetan patients (Janes 2001; Kloos 2008). Observing these transformations and new developments in the province of Qinghai and, more specifically, in Rebgong (known as Tongren County in the Chinese administrative system), the centre of the multiethnic Tibetan autonomous prefecture of Malho (Huangnan Tibetan Autonomous Prefecture), I became interested in investigating the motivations and reasons of non-Tibetans' engagement with Tibetan medicine: how did they become interested and gain access to these medical practices, for which ailments did they seek them, and what characterises their interactions with Tibetan medical doctors? Moreover, as Sowa Rigpa is a medical system influenced by Buddhist philosophy (Ozawa-

De Silva and Ozawa De Silva 2011; Gerke 2013), I wanted to understand how non-Buddhists make sense of the aetiologies and treatments offered.

Multicultural and multiethnic Rebgong in Qinghai Province is a relevant place to investigate how Tibetan medicine is used across ethnic and cultural boundaries, given that the area is a historic and contemporary hub for Tibetan medicine and a long-term ethnically diverse community, as well as my hometown where I possess an extensive social network. Previous studies of Tibetan medicine have dealt with theoretical and historical aspects and the recent processes of secularisation, industrialisation, commercialisation, and globalisation as well as the development of the Tibetan pharmaceutical industry (Pordié 2008; Saxer 2013; Kloos and Blaike 2022). Despite the massive commercial transformations, Tibetan medicine in the still rather peri-rural area of Rebgong is a healing practice deeply rooted in the cultural, social, ethnic, and interpersonal networks and relations of this particular locality. Once virtually the only healthcare available in the area, it has regained its clinical preeminence and is today a relevant and important healthcare option, not only for Tibetans, but also for Hui Muslims and, to a lesser extent, for Han Chinese residents in Rebgong.[1] This study shows health-seeking behaviour as pragmatic and to a large degree dependent on personal relations, which is consistent with classical studies in medical pluralism (Janzen 1978; Leslie 1980). I argue that specific medical theories have only limited relevance to patients' choice of treatment, even in cases of potentially contradictory explanations, and I show that ethnic groups in Rebgong – with Tibetans, Hui, and Han as examples – come to share local epistemologies in ways that form health perceptions, illness experiences, and therapeutic behaviour in similar yet distinct ways.

This study also extends a related previous study (Nianggajia and Fjeld 2017) by investigating the use of Tibetan medicine among non-Tibetans and non-Buddhists in contemporary Rebgong. Nianggajia and Fjeld (ibid.) indeed explored the intricate web of affiliations that this medical tradition shares with various aspects of Tibetan life. Their article paints a picture of the symbiotic relationship between Tibetan medicine, Tibetan Buddhism, the Tibetan culture, and the indigenous environment. It elucidates how these elements are interwoven with the practice of Tibetan medicine, shaping not only its theoretical foundations but also its practical applications. It delves into the motivations that drive individuals to seek out Tibetan medical treatment and explores the perceived experiences they undergo during the process. This scrutiny encompasses a wide spectrum of factors, from the patient's trust in the therapeutic efficacy of Tibetan medicine to the intricacies of their clinical encounters with Tibetan medical practitioners. By shedding light on these diverse dimensions of patient experiences, this study enhances our comprehension of the patient-centric outlook that is integral to Tibetan medicine. It showcases how patients, regardless of their ethnic backgrounds, place their faith in this ancient healing tradition. The in-depth examination of these elements demonstrates the impact Tibetan medicine has had on the healthcare choices of individuals and how it transcends cultural and ethnic boundaries.

In the present paper, I present a deeper exploration which thereby contributes to a more holistic and nuanced understanding of this unique healing tradition sought after by patients of different ethnic backgrounds. The main questions I aim to answer in the paper are: In what ways does Tibetan medicine travel across ethnic boundaries? Who consults Tibetan doctors and uses Tibetan medicine in Rebgong and for what purposes? What distinguishes non-Tibetan patients' use of Tibetan medicine and their interactions with Tibetan medical doctors?

Research site

Rebgong is situated approximately 180 kilometres southeast of Xining, the capital city of Qinghai Province, China. Rongwo Town serves as both an administrative and religious centre, featuring the significant local Gélukpa Monastery of Rongwo, one of the largest monasteries in Amdo. The Nyingma and Bön traditions are also prominent in this area. The county has a total population of 102,300, with Tibetans being the predominant ethnic group at 74.3%, followed by the Han at 9.77%, the Tu at 8.99%, the Hui at 4.42%, the Salar at 1.27%, and the Mongols at 0.6%.[2] Other groups constitute the remaining 0.62%. Rebgong is renowned for its multiethnic landscape and Buddhist art, attracting numerous domestic and international researchers from various fields. Less well-known is its status as a significant centre of Tibetan medical knowledge and practice in Amdo, historically linked with Rongwo Monastery and generations of lineage physicians. Rebgong also played a pivotal role in the renaissance of Tibetan medicine in Amdo following the Cultural Revolution.

Before the 1950s, healthcare services in Rebgong were primarily provided by Tibetan doctors from Rongwo Monastery and lay lineage physicians. Rongwo Monastery has historically not only functioned as a centre for Buddhist education but also played a crucial role in Tibetan medicine in Rebgong. Although the monastery did not establish a dedicated Tibetan medical college, monks pursued advanced studies at major monasteries in Utsang and Amdo, such as Kumbum and Labrang Monasteries. Upon returning to Rongwo Monastery, these monks disseminated their knowledge of Tibetan medicine through traditional apprenticeships. Known for its rigorous academic environment, Rongwo Monastery produced numerous esteemed monks who became renowned Tibetan medical practitioners.[3] Their contributions significantly advanced Tibetan medicine in Amdo, particularly in treating local populations. Their lineage of medical knowledge has remained unbroken, with successive teachers and students continuing this tradition to the present day. For instance, Drungyik Gendün Trinlé Gyatso (1804-?), a distinguished monk-doctor from Rongwo Monastery, studied under the renowned Tibetan doctor Mayang Tamdrin Kyap. His medical lineage can be traced through several notable figures, including Mayang Pandita, highlighting the continuity and evolution of Tibetan medical practices (Dorjégyal 2011). In 1962, Drungyik Gyatso (1909-1993), a lineage holder of Drungyik Gendün Trinlé Gyatso and former monk physician from Rongwo Monastery, pooled resources

1. Tongren County Chronicles Compilation Committee 同仁縣志編纂委員會, 2001, 同仁縣志 (*Tongren xianzhi*, Tongren county gazetteer), Xi'an: Sanqin chubanshe.
2. People's Government of Tongren 同仁市人民政府, "同仁市基本概況" (*Tongrenshi jiben gaikuang*, Basic overview of Tongren), 27 June 2024, www.hntongren.gov.cn/html/5793/426920.html (accessed on 27 June 2024).
3. Huangnan Tibetan Autonomous Prefecture Compilation Committee 黃南藏族自治州志編纂委員會, 1999, 黃南州志 (*Huangnan zhouzhi*, Huangnan prefecture gazetteer), Lanzhou: Gansu renmin chubanshe

to establish the Tibetan Medical Treatment Clinic, the first in Malho, marking a pivotal moment in local healthcare development. The clinic not only provided medical services but also conducted Tibetan medical training classes. Drungyik Gyatso's leadership extended to organising short-term training sessions in rural areas. This initiative significantly bolstered the training of Tibetan medical healthcare personnel across Qinghai Province. In 1979, the Tibetan Medical Treatment Clinic was upgraded to the Tongren County Tibetan Medical Hospital, later expanding in 1983 to become Malho Prefecture Tibetan Medical Hospital.[4] In 1987, the hospital invited renowned Tibetan physician Troru Tsénam (1928-2005) to teach Tibetan physicians from within and outside the province the alchemical process of refining mercury, reviving the manufacture of precious pills across Amdo.

Since the 1980s, several monasteries in Rebgong, including Rongwo, Doba, and Gartsé, have gradually reopened. These monasteries established Tibetan medical clinics to serve the healthcare needs of the local population across different ethnic communities. In recent times, the healthcare ecosystem in Rebgong has become highly diversified, including public Tibetan medicine, Western medicine, traditional Chinese medicine (TMC) hospitals, private hospitals and clinics, and local ritualistic treatments. This combination of diverse medical systems ensures that the people of Rebgong have access to a broad spectrum of healthcare options, blending modern advancements with traditional wisdom and cultural practices.

Rebgong's unique status as a multiethnic area lends it a distinctive context for my study of Tibetan medicine's dissemination beyond Tibetan communities. The area's cultural diversity allows for an exploration of how Tibetan medicine interacts with and is utilised by different ethnic groups. However, it is important to note that Rebgong's specific characteristics may not fully represent the broader landscape of Tibetan medicine's integration and acceptance in other regions of China. While Rebgong serves as a valuable case study showcasing Tibetan medicine's ability to transcend cultural and ethnic boundaries within a localised context, findings may not necessarily generalise to all regions where Tibetan medicine is practised in China, because other regions may have different dynamics influenced by varying levels of ethnic diversity, historical contexts, socioeconomic factors, and government policies regarding traditional medicine.

Figure 1. Rongwo Monastery Tibetan Medical Hospital (Rebgong).

Credit: author.

Methods

I conducted ethnographic fieldwork in Rebgong for nine months over various periods from 2014 to 2015, with follow-up data collection in the summers of 2017 and 2021. For data collection, I used a combination of in-depth interviews, informal conversations, and observations. My aim was to recruit participants identifying as Tibetan, Hui, or Han Chinese. However, with the exception of Tibetan doctors, initial recruitment efforts proved challenging due to interviewees' general lack of familiarity with social science research and discomfort with being approached by a stranger requesting personal information. Despite my native status as a Tibetan, I initially faced significant challenges in identifying suitable participants, necessitating reliance on my social network of relatives, friends, and acquaintances.

Recruiting non-Tibetan participants presented additional challenges, particularly the inclusion criterion requiring prior or current experience with Tibetan medicine. While it was assumed that all Tibetans had utilised Tibetan medicine, identifying Hui and Han Chinese participants with relevant experience was more problematic. To address these challenges and ensure eligibility, I employed convenience and respondent-driven sampling methods to identify potential informants (McCreesh et al. 2013). The recruitment process began with my immediate social circle, including family, relatives, and friends, who helped identify further candidates. This approach facilitated contact with a diverse range of non-Tibetan participants who had varying experience with Tibetan medicine. I also obtained permission from Tibetan doctors at private and public hospitals and clinics to recruit their patients. Their support, motivated by interest in my academic background and international experience, was crucial in fostering trust and cooperation among potential participants.

Fieldwork involved a strategic division of time, with mornings spent in hospitals and clinics and afternoons in various social settings where individuals of different ethnic backgrounds congregated. These settings allowed for casual conversations, often leading to the identification of potential participants. To capture a comprehensive view of Tibetan medicine use, I engaged with individuals across various professions, including grocery store and restaurant owners, farmers, nomads, government employees, and manual labourers, aiming for maximum variation in participant backgrounds. Finally, ten respondents from each ethnic group – comprising five men and five women from Tibetan, Hui, and Han backgrounds, all aged between 30 and 70 – were selected for in-depth interviews based on their willingness to share experiences and their comprehensive knowledge. Additionally, I interviewed seven private and three public Tibetan doctors at hospitals and clinics and had numerous informal conversations with practitioners.

4. Tongren County Chronicles Compilation Committee 同仁縣志編纂委員會, 2001, 同仁縣志 (*Tongren xianzhi*, Tongren county gazetteer), Xi'an: Sanqin chubanshe.

Exploring Tibetan medicine's journey beyond ethnic boundaries

The findings resonate with classical studies on pragmatism and medical pluralism in medical anthropology, as exemplified by the works of Redfield (1956), Leslie (1973), Janzen (1978), and Waxler (1984). The concept of medical pluralism (describing the availability of different medical approaches, treatments, and institutions that people can use while pursuing health), criticised since its inception (Hsu 2008), has led to the proposal of new concepts such as "medical diversity" (Parkin 2013; Krause, Parkin, and Alex 2014) and "medicoscapes" (Hörbst and Wolf 2014) to address its shortcomings. Though criticised by various anthropologists (Baer 2011), the concept of medical pluralism has recently regained attention. This resurgence is due to the growing popularity of complementary and alternative medicine, the public health care funding crisis, and the intensified global exchange of people, goods, and healing practices (Penkala-Gawęcka and Rajtar 2016). In a similar vein, Cant (2020) argues that the emergence of a new variant of medical pluralism can be attributed to several factors, including the spiralling cost of biomedicine, the persistence of chronic and degenerative diseases, the reluctance of the pharmaceutical industry to invest except where profits are assured, the recognition of the iatrogenic effects of some biomedical interventions, and opportunities to (re)learn about alternatives and explore different conceptions of self and well-being. While the medicoscape was developed to emphasise the interconnected nature of medical practices across the globe, illustrating how medical knowledge and practices transcend national boundaries, my ethnographies and analyses focus on specific and localised contexts. This narrower focus allows for a detailed examination of how medical practices operate within specific communities or regions, exploring local dynamics, beliefs, practices, and health seeking behaviours that may not be fully captured by a global or transnational lens.

To better understand the plural medical landscape in Rebgong, I used Kleinman's classification system, which divides healthcare into three sectors: popular, folk, and professional (1981).[5] In countries such as China and India, traditional medicines are part of the professional sector and play a significant role in public healthcare. Tibetan medicine, a professionalised system taught in public schools and integrated into China's national healthcare system, is an example (Janes and Hilliard 2008; Luo et al. 2015). Categorising medical practices within these sectors reveals that people from different sociocultural backgrounds have varying notions of disease and health, leading them to seek different healing strategies. For instance, the following illness and treatment-seeking narrative told by Li, a 35-year-old Hui woman, illustrates how a person makes use of treatments and medicines from all three sectors as well as other medical systems:

> I have diabetes and bronchitis. My diabetes is more serious than the bronchitis. I was diagnosed with diabetes three years ago. To be honest, it had never occurred to me that I would be diagnosed with diabetes one day. Actually, I had had diabetes for some time. It's just that I did not know that I had had diabetes until three years ago. Prior to the diagnosis, I had contracted foot infections. I was only 32 years old at that time and I thought I was not old enough to get a serious disease. At the onset of the infections, my husband treated it as a common skin infection and used antiseptic skin cream for some time, but this did not improve my condition at all. Since the *Ahong* 阿訇 (imam) is my father's friend, I also visited him, and I was advised to recite *duwa* 杜瓦 (*du 'ā'*, prayers for healing sickness). Because my condition remained the same, I underwent a medical examination at Huangnan Biomedical Hospital on the advice of my elder sister. There, I was diagnosed with diabetes and admitted to the hospital for almost a month. At the hospital, I took all sorts of Western medicine and had intravenous infusions in order to reduce my glucose level. After being discharged from the hospital, I took all sorts of oral glucose-lowering medicines that I could get from friends, pharmacies, and hospitals, and medicines for diabetes-related complications like dental and heart problems. It seemed that many of these medicines did not work for me, so I decided to use insulin therapy in addition to oral medicines. Since five months ago, I have taken two small spoons of powdered *huangqi* 黄耆 (*astragalus membranaceus*) in the evening for my foot infection upon the recommendation of a Tibetan doctor from Huangnan Tibetan Medical Hospital, an old friend of my father. My foot infections have almost cleared up now. Seeing the improvement of the foot infection, my relatives advised me to take two additional spoons of powdered *huangqi* in the morning. Now, I take two spoons in the morning too. As diabetes is incurable, I think I need to take all sorts of medicines for life. (Interview, 23 August 2017)

Li's pattern of seeking care can be understood using Kleinman's classification system. She used whatever healthcare was available to her, switching between different sectors with help from family members, relatives, folk healers, and professional healthcare providers. Her narration reveals that she first sought care from family members and relatives in the popular sector, then from an *Ahong* in the folk sector, and finally from the professional sector. Her illness was diagnosed in a biomedical hospital, and she sought treatment from a Tibetan doctor whose remedy helped her recover from her foot infection. Every time she received treatment, she returned to the popular sector for evaluation and further treatment suggestions and decisions. It also shows that the popular sector is the nexus of seeking care, the base from which she entered both folk and professional sectors. Li's illness event illustrates the presence of medical pluralism in this multiethnic area and the permeability of boundaries between the three sectors.

Kleinman's (1981: 50) study in Taiwan revealed that 70% to 90% of illnesses, treatment decisions, and choices regarding whom to consult, where, and when, were managed within the popular sector. Decisions to seek treatment from folk and professional sectors are also first made within the popular sector. This resonates well with

5. The popular sector involves self-care, family support, and care within social networks; the folk sector includes healers who use alternative treatments outside of mainstream medicine; the professional sector refers to organised medical systems considered the dominant form of healthcare.

previous findings that show Hui and Han patients in Rebgong were advised to visit Tibetan medical institutions or practitioners by their family members, relatives, or friends (Nianggajia and Fjeld 2017). Hui and Han informants as well as Tibetans held that being a member of a family and a community was an important source of sharing information and knowledge for different purposes, including health-related issues.

A theme I found common to all three groups was the importance placed on individual behavioural and dietary modifications. Reflecting on her dietary changes and medical journey, a Han woman in her fifties shared:

> Back in 2017, I started having lots of vomiting, pain, and nausea after eating. Turns out, it was because I used to eat a lot of oily stuff, mainly because my father-in-law loves it. You know the "one household, one kitchen" rule – I ate what everyone else did. When I found out it was gallbladder inflammation, I decided to switch to lighter, less oily foods and started jogging to stay fit. That worked well for about two years, keeping me symptom-free. But last year, the pain came back, so I went to see Dr Tashi at the Huangnan Tibetan Medical Hospital. (Interview, 18 July 2021)

When starting to feel ill, informants, independent of ethnic background, report that they first modify their behaviour and diet and make use of home-based therapies before seeking treatments from either the folk or the professional sector if the condition remain unresolved. These methods are culturally ingrained and often the first line of defence against illness, indicating a layered approach to healthcare where traditional remedies precede formal medical intervention.

The choice of which folk healer to consult was often made in the popular sector. Although these unlicensed folk healers in Rebgong fall outside the professional sector (of biomedicine, Tibetan medicine, and TCM), they play an important role in the treatment of diseases and the decision to seek appropriate healthcare. They often exhibit religious healing techniques and skills that licensed doctors in the professional sector do not have. These techniques include a wide range of elaborate and complex rituals for averting upsetting supernatural causes or spiritual entities (Schrempf 2010; Czaja 2016). The folk sectors of the three ethnic groups also share similarities, of which the most obvious is the belief in supernatural causes of various diseases. However, I found this component to be stronger among Tibetans, followed by Hui and then Han participants. When treatments in the popular sector failed, Tibetans often sought help from a spiritual teacher (*lama* བླ་མ), a tantric practitioner (*ngakpa* སྔགས་པ), a diviner (*mopa* མོ་པ) or an astrologer (*tsipa* རྩིས་པ). A Tibetan woman in her forties recalled:

> One evening, I took some meat to my brother who had returned from a pilgrimage to Lhasa. The next day, I began to feel discomfort in my heart. As days passed, I started having difficulty breathing. My husband suggested I take *nying men* སྙིང་སྨན།.[6] Following his advice, I took *agar gyépa* ཨ་གར་བཅུད་པ།[7] for nearly two months, but it didn't help at all. In fact, I felt like my condition was getting worse. Later, my husband attributed the issue to *nöpa* གནོད་པ, a harmful influence he believed was brought on by the meat I had taken to my brother that evening. Together, we decided to consult *Alak*[8] Sönam. *Alak* Sönam not only referred us to Menpa Tenzin from the Tibetan Medical Hospital but also recommended *dokpa* ritual.[9] As *Alak* Sönam suggested, I took *sokdzin chuchik* སོག་འཛིན་བཅུ་གཅིག[10] prescribed by Menpa Tenzin and had the ritual performed by three village *ngakpa*. After three months, the discomfort in my heart was nearly gone. (Interview, 26 July 2017)

This narration is a typical scenario of the folk sector, where illness was perceived as influenced by spiritual factors alongside physical symptoms. The initial discomfort in the heart was interpreted through the lens of *nöpa*[11] given to her brother. This belief shows the folk understanding that illness can stem from spiritual or karmic disturbances, not solely physiological causes. The treatment journey reflects a blend of traditional medical practices and ritualistic interventions. The initial use of *agar gyépa* did not yield improvement, leading to a reconsideration of the diagnosis and treatment approach. Consulting *Alak* Sönam, who recommended both a specific Tibetan doctor, Menpa Tenzin, and a *dokpa* ritual to counteract perceived spiritual harm, exemplifies the integration of folk healing practices with formal medical consultation. The involvement of a village ritual specialist (*ngakpa*) in performing the ritual demonstrates the community's reliance on spiritual interventions alongside medicinal treatments. This holistic approach highlights the interconnectedness of physical health, spiritual well-being, and community support in addressing health challenges. It reflects a broader cultural understanding where illness is not merely a biological condition but a complex interplay of social, spiritual, and environmental factors, necessitating a multifaceted approach to healing.

In Rebgong, biomedicine and traditional Tibetan medicine are the main treatments in the professional sector for all ethnic groups. Biomedicine was preferred for acute diseases, but Tibetan, Hui, and Han respondents alike expressed concerns about its harmful side effects, especially with long-term use for chronic diseases – a concern which echoes Samuel's (1999) findings among Tibetans in Dalhousie. One Hui informant noted that long-term use of painkillers, immunosuppressants, and hormones for rheumatism could cause peptic ulcers, anaemia, and osteoporosis. Others reported that pain relievers for biliary colic caused gastric problems. Thus, medicine with fewer side effects was preferred for chronic conditions, including cancer, confirming earlier studies (Namdul et al. 2001; Bauer-Wu et al. 2014; Qi et al. 2018).

Studies in Western settings have explored push factors (i.e., dissatisfaction with and side effects of biomedicine) and pull factors (i.e., previous positive experiences or aspects associated with traditional medicines, and holistic and personalised treatments; see

6. Medicine for heart problems.
7. A Tibetan medicine for heart problems made from eight herbs and minerals.
8. *Alak* ཨ་ལག་པ is an honorific Amdo colloquial term for an incarnation.
9. A *dokpa* བཙོག་པ ritual is a ritual that returns harm to the sender.
10. A Tibetan medicine for mental balance and heart problems, made from 11 herbs and minerals.
11. Eating or consuming meat outdoors in the evening is believed to attract harmful evil spirits.

Sirois and Gick 2002; Bishop, Yardley, and Lewith 2010). In Rebgong, initial use of Tibetan medicine was driven by push factors such as dissatisfaction with biomedical efficacy and side effects, while pull factors include positive individual experiences and favourable reports within social networks. Bonderup Dohn (2009) emphasises that affordances are shaped by personal experiences. Likewise, Schmidt (2007) underscores that social affordances emerge from learning and past interactions. Shared understandings of health, illness, and treatment among Tibetans, Hui, and Han facilitate culturally preferred affordances, as described by Loveland (1991), which are informed by local ontologies and prior experiences. My findings indicate that the underlying motive for using Tibetan medicine for the first time among the Hui and the Han was perceived efficacy or knowledge of another person's successful treatment. When asked about the reasons for taking Tibetan medicine, Tibetan respondents reported previous experience of Tibetan medicine being effective, while Hui and Han participants referred to recommendations from family members, relatives, and friends with positive experiences. This finding is consistent with a broad range of previous studies in different medical fields on the use of traditional medicine (Alderman and Kiepfer 2003; Saini et al. 2011; Welz, Emberger-Klein, and Menrad 2018).

Kloos (2008: 131) argues that Tibetan medicine's popularity and dissemination strongly depend on its ability to show medical efficacy, "efficacy [being] the indicator of Tibetan medicine's soundness and strength." Efficacy was an important part of the discussions in social networks and contributed to the initial use of Tibetan medicine and its continued use for different ailments. Experiences of efficacy are, in turn, heavily influenced by the role of individual doctors in medical practice.

The integral role of ethical practice and trust in Tibetan medical treatment

When searching for treatment by Tibetan medicine, patients of all three groups tended to seek out particular Tibetan doctors for specific conditions rather than hospitals or clinics. Individual Tibetan doctors play a major part in the treatment of both Tibetan and non-Tibetan patients, who emphasised their diagnostic competence and the efficacy of the formulas they produce. A Hui woman in her forties described:

> After my father-in-law's funeral, I began to feel something lodged in my throat. I couldn't swallow it, nor could I spit it out. This sensation lasted for a few weeks. Soon after, I started to become impatient and irritable, followed by feelings of nausea and dizziness. The problem persisted and worsened over time. My mother accompanied me to the prefecture-level hospital for Western medicine for a CT scan, but the result showed nothing wrong. Later, a private Tibetan doctor diagnosed me with a disruption in the flow of energy (*qi* 氣, *lung* རླུང) in my heart through pulse reading. Thanks to his prescription, my symptoms gradually improved. (Interview, 23 July 2017)

This case exemplifies the diagnostic prowess of a Tibetan doctor who identified *qi*-related issues through pulse reading. The narrator's symptoms – such as throat discomfort, impatience, irritability, nausea, and dizziness – are interpreted in Tibetan medicine as disruptions in *lung* flow, often triggered by emotional or environmental factors (Deane 2019; Samuel 2019). Depression arises from *lung* imbalance in the heart, referred to as *nying lung* སྙིང་རླུང། (heart-wind). When this function is disrupted, it results in symptoms of depression. Contrary to biomedicine's emphasis on structural and biochemical abnormalities, the Tibetan doctor diagnosed disrupted *qi* in the heart using pulse reading. Her symptoms, occurring after an emotional event like a funeral, illustrate Tibetan medicine's view of emotional stress causing a heart-wind disturbance. At the hospital, a CT scan revealing no abnormalities shows biomedicine's limitations in diagnosing non-structural disorders. The narrator's gradual recovery following the Tibetan doctor's treatment regimen suggests the efficacy of traditional approaches in addressing energetic imbalances.

During my discussion with non-Tibetan informants on the role of Tibetan doctors practising Tibetan medicine, they also highlighted (usually senior) Tibetan doctors' extensive experience in the treatment of chronic disease, their patient-centred approach, and their affective attitude towards their patients. Both Tibetan and non-Tibetan informants associated this approach and attitude with Buddhism. Since the fundamental theories of Tibetan medicine are closely tied to Buddhist concepts and practices, these qualities are often cultivated by the doctors through the regular practice of Buddhist teachings. This is illustrated by the following remark by a senior, now retired, male Tibetan doctor in his late sixties:

> I do not run this clinic for profit. I have enough monthly pension to live on for the rest of my life. Instead of staying at home all day long, as a doctor, I think treating patients in this clinic is a best way to practise dharma. Practising dharma does not mean you need to recite mantras and circumambulate temples. (Interview, 23 August 2015)

His intention to help the sick reflects the Buddhist medical ethics that a good doctor should not have a mind that covets the wealth of his patients, which is one of the 16 attributes a doctor must possess (Désі Sanggyé Gyatso 1982: 529).

As Kloos (2008: 133) describes in his study of Sowa Rigpa in India, the potency of Tibetan medicine suffers if altruism and compassion are lost to greed and corruption. Compassion is core to being a Tibetan medical doctor. This aligns with frequent discussions in China about opportunistic biomedical doctors and medicinal herb traders maximising profits unethically. My informants, especially non-Tibetans, discussed Tibetan doctors within the context of the strained doctor-patient relationships in China's public biomedical health sector, where corruption and distrust are common (Zhang and Sleebom-Faulkner 2011).

The qualities of a good doctor are described in the *Four Tantras* (*Gyüzhi* རྒྱུད་བཞི). The 31st chapter of the *Explanatory Tantra* on the healer physician attaches vital importance to the code of conduct for doctors, requiring physicians to be intelligent, compassionate, committed, dexterous, diligent, and holders of high moral values (Désі Sanggyé Gyatso 2010: 445-64). Tibetan doctors, seniors in particular, emphasised the importance of applying these medical ethics in practice and treating patients with compassion. A patient-centred approach and altruistic attitude were highly valued among my informants. Tibetan doctors I interviewed viewed the doctor-

patient relationship as *tendrel* རྟེན་འབྲེལ། (mutual dependence), where the doctor and patient work together in a doctor-patient alliance to create an individualised treatment plan. Patients voluntarily bestowed authority on the doctors in these encounters, following medical instructions based on their faith in the doctors and their medicines. This faith is vital to the diagnostic and therapeutic process. Tibetan doctors perceived this authority as part of their responsibility and saw patients' trust as a virtue that defines the value of their work. When asked about the qualities of doctors, a young Tibetan driver in his late forties mentioned two monk-physicians as examples:

> Today, doctors prescribe unnecessary medicines and give shots you don't need. Unless they're really sick, many people are reluctant to see a doctor and just don't want to go. It's hard to find doctors with strong ethics in big hospitals. You know how it is: nowadays, even a minor cold can cost you hundreds at a hospital or clinic. Doctors with good ethics naturally attract a lot of patients. Take Menpa Özer from our village and Tokya Menpa, for example. They've been practising Tibetan medicine for years, and many people go to them. They never overprescribe, and ask patients to visit again only if the prescription works. They produce medicines on their own and their medicines work really well. They're respected not just in Rebgong, but by patients from other prefectures and provinces too. Plus, they donate a portion of their annual income to monasteries. If they were in it for money, why would they donate their income to the monasteries? (Interview, 11 July 2021)

According to Pellegrino and Thomasma (1993), health service is inherently a moral enterprise, suggesting that ethical considerations should guide medical practices. This case highlights widespread opportunistic behaviours and practices within both public and private healthcare services in China. We can analyse this through the lens of moral economy and moral capital discussed in Martin Saxer's book (2013). In today's healthcare landscape, many doctors are perceived to prioritise financial gain over patient well-being, resulting in widespread distrust and reluctance among patients to seek medical help unless absolutely necessary, due to concerns about unnecessary treatments and high costs (Li et al. 2022; Gao and Zhou 2023). In contrast, Tibetan medicine practitioners such as Menpa Özer and Tokya Menpa operate within a moral economy that emphasises ethical considerations, such as avoiding overprescription and ensuring that treatments are genuinely necessary. Their high moral capital is evident in their reputation for ethical practice, which fosters trust within their community and beyond. Their altruistic actions, such as donating their income to monasteries, further enhance their moral capital, demonstrating their commitment to community well-being over personal profit. Their reputation owes much to the lineage training they underwent. This training, passed down through generations, ensures that they maintain high standards of medical practice and deep knowledge of traditional healing and pharmacological methods. Saxer (2013) argues that such actions accumulate moral capital, essential for maintaining long-term trust and respect within the community.

Figure 2. Tokya Menpa writing a prescription.

Credit: Tokya Menpa's niece.

Medical lineage also plays an important role in traditional medical practices, where the transmission of knowledge from teacher to student is essential in establishing the credibility and competence of practitioners.

> I chose not to go to the hospital because I had heard that the monk-doctor from Shadrang was highly skilled. An old Tibetan acquaintance had recommended this monk-doctor for high blood pressure and heart problems, mentioning that his teacher had a great reputation in Rebgong. I assumed the student would be equally competent, so I decided to seek him out. When I visited him, he didn't need me to explain my symptoms. He diagnosed my high blood pressure and heart problems just by reading my pulse. Currently, I am not taking his medicines because I feel better. However, I am open to taking them again if necessary. (Interview, 28 June 2017)

By choosing to consult the monk-doctor from Shadrang instead of opting for conventional hospital treatment, the 56-year-old Han man quoted above shows his trust in lineage-based knowledge. This decision, influenced by a recommendation from an old Tibetan acquaintance familiar with the esteemed reputation of the monk-doctor's teacher in Rebgong, illustrates how lineage inspired patient confidence. His trust was reinforced by the monk-doctor's proficiency in diagnosing conditions through pulse reading, a practice deeply ingrained in Tibetan medical traditions. Lineage holders are identified as the highest class of physicians. By this standard, a doctor without medical lineage is portrayed as a fox in charge of a lion's kingdom (Yutok Yönten Gönpo 1992: 99). Accordingly, the most celebrated Tibetan doctors in Rebgong, frequently sought after by many patients, are medical lineage holders.

Trust and efficacy in Tibetan medicine are closely linked to the ethical practices of the doctors. Senior lineage-trained Tibetan doctors, who often hold multiple roles as Buddhist experts, doctors, and pharmacologists, produce effective formulas due to their

adherence to traditional methods and Buddhist ethics. This trust is crucial for patient adherence to treatment plans, which is particularly important for chronic illnesses (Robinson 2016). Studies indeed show that patients with high levels of trust in their doctors are more likely to follow prescribed treatments (Thom et al. 1999). In the present study, trust between Tibetan doctors and patients was built on adherence to Buddhist and medical ethics, lineage-based expertise, and the demonstrated efficacy of treatments. This trust is essential for the full completion of treatment courses and achieving desired therapeutic outcomes.

Perceptions of efficacy

During interviews, the contrast between biomedicine and Tibetan medicine emerged starkly. The comparison between these two medical approaches reveals broader cultural and personal perspectives on healthcare choices. The preference for Tibetan medicine reflects a trust in natural remedies and traditional healing methods, where treatment decisions are guided not only by therapeutic outcomes but also by considerations of long-term wellness and the prevention of other potential harm. A 43-year-old male Hui informant shared:

> You can't take biomedicine on an empty stomach; it harms your stomach. This is particularly relevant for painkillers for my legs. I can't walk without taking them, but my stomach and back suffer if I do. Tibetan medicine doesn't have such side effects. Its efficacy is slow; it can even take days to work but it does no harm to the body. (Interview, 16 August 2021)

A Han man in his sixties also shared a similar story:

> I am now over 60 years old. I have chronic gastritis, high blood pressure, gallbladder inflammation, and kidney disorder, requiring regular medication intake. Biomedicine is my primary choice, but its long-term use causes stomach discomfort. Lately, I've experienced heart discomfort, irregular heartbeat, blurry vision, and sweating. During a recent visit to the prefecture biomedical hospital, the doctor cautioned me about the potential effects of long-term antibiotic use. As a result, I'm now cautious about biomedicine and rely more on Tibetan medicine purchased from Rongwo Monastery Tibetan Hospital. The Tibetan doctor advised against mixing Tibetan and biomedicine to maintain efficacy. Unlike Western medicine with its side effects, Tibetan medicine has been effective for me. Although it is slower to show results, it alleviates symptoms without harm. His medicines have improved my digestion and reduced gallbladder discomfort. Occasionally, I stray from my dietary restrictions, leading to discomfort, during which I turn to Western medicine for relief. So, I alternate between biomedicine and Tibetan medicine based on my health needs. (Interview, 16 August 2021)

The narration emphasises the perceived efficacy of Tibetan medicine, particularly in treating chronic conditions such as gastrointestinal and gallbladder issues. The narrator contrasts this with biomedicine, which is often seen as associated with adverse effects. This perception aligns with broader anthropological observations where traditional medicines are valued for their lower perceived risk of harm, even if their action is slower compared to the immediate but sometimes harsh effects of biomedicine. However, it's noteworthy that while Tibetan medicine is preferred for chronic conditions, biomedicine is also used, especially during acute episodes. This reflects a pragmatic approach where different medical systems are integrated based on perceived effectiveness and situational needs.

Throughout my interviews exploring the efficacy of Tibetan medicine, a recuring theme emerged: informants repeatedly attributed its effectiveness to particular medical institutions or individual doctors who formulate and administer treatments. For instance, a Han woman in her fifties stated:

> It all began four years ago when I was suffering from severe gallbladder pain. A friend of mine who also had gallbladder issues gave me pills produced by Dr Tsering, a retired physician renowned for treating gallbladder issues. Surprisingly, the pill had an effect – I felt relief after just one pill. Encouraged by this, I decided to consult Dr Tsering. I followed his prescription for four months in total. Feeling its effectiveness, I returned to him and asked for another prescription. I followed his regimen until last September, when he advised me to take a break for recovery. (Interview, 18 August 2021)

The perceived efficacy of traditional medicines is linked to the reputation and credibility of specific doctors and institutions. As shown in Nianggajia (2015), many patients, regardless of ethnic background, preferred the white pill, *rilkar* རིལ་དཀར་, produced by Gartsé Monastery, even though other medical institutions produce similar white pills with the same ingredients. According to Tibetan medical theory, the same ingredients in medicine do not necessarily produce the same efficacy. Differences in efficacy are related to the growth location of the ingredients, the manner in which they are collected, processed, and compounded, and the practitioners involved (Craig 2012; Saxer 2013). This phenomenon can be understood through the analytical lens of the social efficacy of travelling medicines (Pribilsky 2008). When medicines move across cultural and social boundaries, their efficacy is not solely determined by their pharmacological properties but also by the social and cultural contexts in which they are embedded. Dr Tsering's pills and the Gartsé Monastery's white pill exemplify this concept, as their perceived efficacy is enhanced by the monastery's historical and spiritual significance, the trust in the practitioners, personal experiences shared within the community, and the traditional methods employed in their preparation.

The Tibetan doctors I interviewed stressed the importance of applying the Seven Limbs[12] (*yenlak dün* ཡན་ལག་བདུན།) in practice to ensure efficacy as detailed in Chapter Twelve of the *Gyüzhi*'s *Subsequent Tantra* (Yutok Yönten Gönpo 1992: 605; Gerke 2013; van der Valk 2019). However, large pharmaceutical factories often fail to adhere strictly to these procedures, compromising quality in order to meet market demands (Kloos 2008). This lack of control over raw material processing results in a loss of quality and efficacy (ibid.). Traditional

12. The Seven Limbs include the natural growth, timely collection, proper drying, toxin removal, potency enhancement, and timely use of medicinal plants, as well as key compounding methods.

Tibetan doctors, guided by Buddhist ethics and respect for medicinal plants, handle them with care and reverence (Beer 1999). These ethical practices are crucial for maintaining the quality and efficacy of the medicines. However, in today's profit-driven market, these qualities are often lost, resulting in products from large factories being perceived as inferior to those produced by private senior Tibetan doctors (Kloos 2008).

Conclusion

In Rebgong, Tibetan medicine travels easily across ethnic boundaries. The people of Tibetan, Hui, and Han Chinese background sought help and treatment from (preferably senior) doctors of Tibetan medicine for a range of health problems (often perceived to have long-term implications) based on observations and recommendations from friends and acquaintances in their social networks. Their choice to use Tibetan medicine was pragmatic, and perceptions and embodied experiences of efficacy were based in the shared locality of Rebgong and trust in local (senior) medical doctors. They searched for medicines and treatments that might work for them with little concern about potentially contradictory medical explanations. Health-seeking behaviour was based on pragmatic decisions aimed at coping with health problems using available medical resources.

The findings show the multifaceted reasons why non-Tibetans engage with Tibetan medicine, revealing preferences for its perceived efficacy, holistic approach, and perceived safety compared to biomedicine. This preference was particularly evident in the treatment of chronic ailments, where patients valued the gentler impact of Tibetan remedies and the personalised care provided by Tibetan doctors. Such preferences reflect broader cultural and personal inclinations favouring natural remedies and traditional healing methods, highlighting the complex interplay between medical efficacy, cultural beliefs, and patient choice in healthcare decision-making.

Moreover, the study contributes to the literature on medical pluralism by illustrating how patients in Rebgong navigate between different healing alternatives – popular, folk, and professional – based on their perceived effectiveness and situational needs. This pragmatic approach underscores the role of social networks and trusted practitioners in guiding healthcare choices, emphasising the importance of shared local knowledge and personal experiences over theoretical medical considerations. Medical ethics and diagnostic skills emerged as a cornerstone of patient trust and therapeutic efficacy. Despite commercial pressures that sometimes compromise traditional standards, patients continue to value the ethical foundations underpinning Tibetan medical practice, viewing them as integral to maintaining treatment quality and efficacy.

From a broader anthropological perspective, this study extends our understanding of how traditional medical systems adapt and evolve in multicultural settings. By examining Tibetan medicine's continued relevance in Rebgong's diverse healthcare landscape, the study enriches discussions on cultural resilience, healthcare pluralism, and the intersection of traditional knowledge systems with contemporary healthcare practices. Finally, this study not only sheds light on the complexities of healthcare decision-making among non-Tibetan populations but also highlights the enduring significance of Tibetan medicine as a cultural heritage and a viable healthcare alternative. Future research could further explore the dynamics of patient-provider relationships, the impact of governmental policies on traditional medical practices, and the integration of traditional and biomedical approaches in pluralistic healthcare systems. Such endeavours will continue to deepen our understanding of healthcare diversity and resilience in culturally complex societies.

Acknowledgements

I would like to extend my sincere thanks to Professor Heidi Fjeld for her insightful advice during the formation of this research. I also thank the two anonymous reviewers for their constructive comments for revision.

Manuscript received on 18 October 2023. Accepted on 18 August 2024.

References

ALDERMAN, Christopher P., and Barbara KIEPFER. 2003. "Complementary Medicine Use by Psychiatry Patients of an Australian Hospital." *The Annals of Pharmacotherapy* 37(12): 1779-84.

ALTER, Joseph S. (ed.). 2005. *Asian Medicine and Globalization*. Philadelphia: University of Pennsylvania Press.

BAER, Hans A. 2011. "Medical Pluralism: An Evolving and Contested Concept in Medical Anthropology." *In* Merrill SINGER, and Pamela I. ERICKSON (eds.), *A Companion to Medical Anthropology*. Hoboken: Wiley-Blackwell. 405-23.

BAUER-WU, Susan, Tenzin LHUNDU, Tawni TIDWELL, Tenzin LHADON, Chikako OZAWA DE SILVA, Jamyang DOLMA, Pema DORJEE, Dorjee RAPTEN NESHAR, Rigzin SANGMO, and Tenzin YESHI. 2014. "Tibetan Medicine for Cancer: An Overview and Review of Case Studies." *Integrative Cancer Therapies* 13(6): 502-12.

BEER, Robert. 1999. *The Encyclopedia of Tibetan Symbols and Motifs*. London: Serindia Publications.

BISHOP, Felicity L., Lucy YARDLEY, and George T. LEWITH. 2010. "Why Consumers Maintain Complementary and Alternative Medicine Use: A Qualitative Study." *The Journal of Alternative and Complementary Medicine* 16(2): 175-82.

BONDERUP DOHN, Nina. 2009. "Affordances Revisited: Articulating a Merleau-Pontian View." *International Journal of Computer-Supported Collaborative Learning* 4(2): 151-70.

CANT, Sarah. 2020. "Medical Pluralism, Mainstream Marginality or Subaltern Therapeutics? Globalisation and the Integration of 'Asian' Medicines and Biomedicine in the UK." *Society and Culture in South Asia* 6(1): 31-51.

CRAIG, Sienna R. 2012. *Healing Elements: Efficacy and the Social Ecologies of Tibetan Medicine*. Berkeley: University of California Press.

CZAJA, Olaf. 2016. "The Administration of Tibetan Precious Pills: Efficacy in Historical and Ritual Contexts." *Asian Medicine: Tradition and Modernity* 10(1-2): 36-89.

DEANE, Susannah. 2019. "rLung, Mind, and Mental Health: The Notion of 'Wind' in Tibetan Conceptions of Mind and Mental Illness." *Journal of Religion and Health* 58(3): 708-24.

DÉSI SANGGYÉ GYATSO སྡེ་སྲིད་སངས་རྒྱས་རྒྱ་མཚོ། 1982. གསོ་རིག་སྨན་གྱི་ཁོག་འབུགས། (*Gso rig sman gyi khog 'bugs*, Interior analysis of medicine). Lanzhou: Kan Su'u Mi Rigs Dpe Sgrun Khang.

——. 2010. *Mirror of Beryl: A Historical Introduction to Tibetan Medicine*. Somerville: Wisdom Publications.

DORJÉGYAL རོ་རྗེ་རྒྱལ། 2011. རྗེ་མོང་གནས་སྐོར་དེབ་ཐེར། (*Reb gong gnas skor deb ther*, Rebgong pilgrimage annals). Zi ling: Mtsho Sngon Mi Rigs Dpe Skrun Khang.

GAO, Peng 高鵬, and ZHOU Cai 周彩. 2023. "醫病關係, 健康水準與醫療經濟負擔" (*Yibing guanxi, jiankang shuizhun yu yiliao jingji fudan*, The doctor-patient relationship, health standards, and the economic burden of healthcare). *Xi'an jiaotong daxue xuebao* (西安交通大學學報) 43(1): 163-74.

GERKE, Barbara. 2013. "The Social Life of *Tsotel*: Processing Mercury in Contemporary Tibetan Medicine." *Asian Medicine: Tradition and Modernity* 8(1):120-52.

HÖRBST, Viola, and Angelika WOLF. 2014. "ARVs and ARTs: Medicoscapes and the Unequal Place-making for Biomedical Treatments in Sub-Saharan Africa." *Medical Anthropology Quarterly* 28(2): 182-202.

HSU, Elisabeth. 2008. "Medical Pluralism." *In* Kris HEGGENHOUGEN, and Stella QUAH (eds.), *International Encyclopedia of Public Health* (1st ed., vol. 4). Amsterdam: Elsevier. 316-21.

JANES, Craig R. 2001. "Tibetan Medicine at the Crossroads: Radical Modernity and the Social Organization of Traditional Medicine in the Tibet Autonomous Region, China." *In* Linda H. CONNOR, and Geoffrey SAMUEL (eds.), *Healing Powers and Modernity: Traditional Medicine, Shamanism, and Science in Asian Studies*. London: Bloomsbury Academic. 197-221.

JANES, Craig R., and Casey HILLIARD. 2008. "Inventing Tradition: Tibetan Medicine in the Post-socialist Contexts of China and Mongolia." *In* Laurent PORDIÉ (ed.), *Tibetan Medicine in the Contemporary World: Global Politics of Medical Knowledge and Practice*. London: Routledge.

JANZEN, John M. 1978. *The Quest for Therapy in Lower Zaire*. Berkeley: University of California Press.

KLEINMAN, Arthur. 1981. *Patients and Healers in the Context of Culture: An Exploration of the Borderland between Anthropology, Medicine, and Psychiatry*. Berkeley: University of California Press.

KLOOS, Stephan. 2008. "(Im-)Potent Knowledges: Preserving 'Traditional' Tibetan Medicine Through Modern Science." *In* Andreas BEER, and Gesa MACKENTHUN (eds.), *Fugitive Knowledge: The Preservation and Loss of Knowledge in Cultural Contact Zones*. Münster: Waxmann Verlag. 123-42.

KLOOS, Stephan, and Calum BLAIKIE (eds.). 2022. *Asian Medical Industries: Contemporary Perspectives on Traditional Pharmaceuticals*. London: Routledge.

KRAUSE, Kristine, David PARKIN, and Gabi ALEX. 2014. "Turning Therapies: Placing Medical Diversity." *Medical Anthropology* 33: 1-5.

LANGFORD, Jean M. 1995. "Ayurvedic Interiors: Person, Space and Episteme in Three Medical Practices." *Cultural Anthropology* 10(3): 330-66.

LESLIE, Charles. 1973. "The Professionalization Ideology of Medical Revivalism." *In* Singer MILTON (ed.), *Entrepreneurship and Modernization of Occupational Cultures in South Asia*. Durham: Duke University Press. 216-42.

LESLIE, Charles. 1980. "Medical Pluralism in World Perspective." *Social Science and Medicine* 14B(4): 190-6.

LI, Jiarui 李佳芮, YANG Feng 楊風, LI Wenfen 李文芬, BAI Hui 柏慧, LÜ Pengpeng 呂朋朋, and ZHU Junmin 朱儁敏. 2022. "關於國內外醫療機構腐敗問題的研究綜述" (*Guanyu guo neiwai yiliao jigou fubai wenti de yanjiu zongshu*, Review of the researches on corruption in medical institutions at home and abroad). *Zhongguo weisheng shiye guanli* (中國衛生事業管理) 39(4): 271-4.

LOVELAND, Katherine A. 1991. "Social Affordances and Interaction II: Autism and the Affordances of the Human Environment." *Ecological Psychology* 3(2): 99-119.

LUO, Hui, Gejia ZHONG, Lifeng YUE, Qian WANG, Lina MA, and Zhaxi LUOBU. 2015. "Traditional Tibetan Medicine in China: A Systematic Overview of Randomized Clinical Trials." *European Journal of Integrative Medicine* 7(5): 450-59.

MAHAPATRA, Ananya Das, Priyanka BHOWMIK, Anwesha BANERJEE, Apurba DAS, Durbadal OJHA, and Debprasad CHATTOPADHYAY. 2019 "Ethnomedicinal Wisdom: An Approach for Antiviral Drug Development." *In* Mohd Sajjad Ahmad KHAN, Iqbal AHMAD, and Debprasad CHATTOPADHYAY (eds.), *New Look to Phytomedicine: Advancements in Herbal Products as Novel Drug Leads*. Cambridge: Academic Press. 35-61.

McCREESH, Nicky, Matilda Nadagire TARSH, Janet SEELEY, Joseph KATONGOLE, and Richard G. WHITE. 2013. "Community Understanding of Respondent-driven Sampling in a Medical Research Setting in Uganda: Importance for the Use of RDS for Public Health Research." *International Journal of Social Research Methodology* 16(4): 269-84.

NAMDUL, Tenzin, Ajay SOOD, Lakshmy RAMAKRISHNAN, Ravindra M. PANDEY, and Denish MOORTHY. 2001. "Efficacy of Tibetan Medicine as an Adjunct in the Treatment of Type 2 Diabetes." *Diabetes Care* 24(1): 176-7.

NIANGGAJIA. 2015. "The White Pill: Perceptions and Experiences of Efficacy of a Popular Tibetan Medicine in Multiethnic Rebgong." *Asian Medicine: Tradition and Modernity* 10(1-2): 221-72.

NIANGGAJIA, and Heidi FJELD. 2017. "In Search of Trust and Efficacy: Tibetan Medicine in Multiethnic Rebgong, Qinghai, China." *Medicine Anthropology Theory* 4(5): 46-72.

OZAWA-DE SILVA, Brendan Richard, and Chikako OZAWA DE SILVA. 2011. "Mind/body Theory and Practice in Tibetan Medicine and Buddhism." *Body and Society* 17(1): 95-119.

PARKIN, David. 2013. "Medical Crises and Therapeutic Talk." *Anthropology & Medicine* 20(2): 124-41.

PENKALA-GAWĘCKA, Danuta, and Małgorzata RAJTAR. 2016. "Introduction to the Special Issue 'Medical Pluralism and Beyond.'" *Anthropology & Medicine* 23(2): 129-34.

PELLEGRINO, Edmund D., and David C. THOMASMA. 1993. *The Virtues in Medical Practice*. Oxford: Oxford University Press.

PORDIÉ, Laurent (ed.). 2008. *Tibetan Medicine in the Contemporary World: Global Politics of Medical Knowledge and Practice*. London: Routledge.

PRIBILSKY, Jason. 2008. "Sending Energías from the Andes: The Social Efficacy of Travelling Medicines." *Anthropology News* 49(5): 13-4.

LI, Qi, Hai-jiao LI, Tong XU, Huan DU, Chen-lei HUAN GANG, Gang FAN, and Yi ZHANG. 2018. "Natural Medicine Used in the Traditional Tibetan Medical System for the Treatment of Liver Diseases." *Frontiers in Pharmacology* 9(29). https://doi:10.3389/fphar.2018.00029

REDFIELD, Robert. 1956. *Peasant Society and Culture: An Anthropological Approach to Civilization*. Chicago: University of Chicago Press.

ROBINSON, Carole A. 2016. "Trust, Healthcare Relationships, and Chronic illness: A Theoretical Coalescence." *Global Qualitative Nursing Research* 3. https://doi:10.1177/2333393616664823

SAINI, Andrea, Alfredo BERRUTI, Serena CAPOGNA, Manuela NEGRO, Erica SGUAZZOTTI, Rocco Luigi PICCI, Sara CAMPAGNA, Vincenzo DONGIOVANNI, Luigi DOGLIOTTI, Pier Maria FURLAN, and Lucas OSTACOLI. 2011. "Prevalence of Complementary/Alternative Medicines (CAMs) in a Cancer Population in Northern Italy Receiving Antineoplastic Treatment and Relationship with Quality of Life and Psychometric Features." *Quality of Life Research* 20(5): 683-90.

SAMUEL, Geoffrey. 1999. "Religion, Health and Suffering among Contemporary Tibetans." *In* John R. HINNELLS, and Roy PORTER (eds.), *Religion, Health and Suffering*. London: Kegan Paul International. 85-110.

——. 2019. "Unbalanced Flows in the Subtle Body: Tibetan Understandings of Psychiatric Illness and How to Deal with It." *Journal of Religion and Health* 58(3): 770-94.

SAXER, Martin. 2013. *Manufacturing Tibetan Medicine: The Creation of an Industry and the Moral Economy of Tibetanness*. New York: Berghahn Books.

SCHMIDT, Richard C. 2007. "Scaffolds for Social Meaning." *Ecological Psychology* 19(2): 137-51.

SCHREMPF, Mona. 2010. "Between Mantra and Syringe: Healing and Health-seeking Behaviour in Contemporary Amdo." *In* Vincanne ADAMS, Mona SCHREMPF, and Sienna R. CRAIG (eds.), *Medicine between Science and Religion: Exploration on Tibetan Grounds*. New York: Berghahn Books. 157-84.

SIROIS, Fuschia M., and Mary L. GICK. 2002. "An Investigation of the Health Beliefs and Motivations of Complementary Medicine Clients." *Social Science and Medicine* 55: 1025-37.

THOM, David H., Kurt M. RIBISL, Anita L. STEWARD, and Douglas A. LUKE. 1999. "Further Validation of a Measure of Patients' Trust in Their Physician: The Trust in Physician Scale." *Medical Care* 37: 510-17.

van der VALK, Jan M. A. 2019. "Garuda 5 (khyung lnga): Ecologies of Potency and the Poison-medicine Spectrum of Sowa Rigpa's Renowned 'Black Aconite' Formula." *Himalaya* 39(1): 111-28.

WAXLER, Nancy E. 1984. "Behavioural Convergence and Institutional Separation: An Analysis of Plural Medicine in Sri Lanka." *Culture, Medicine, and Psychiatry* 8(2): 187-205.

WELZ, Alexandra N., Agnes EMBERGER-KLEIN, and Klaus MENRAD. 2018. "Why People Use Herbal Medicine: Insights from a Focus-group Study in Germany." *BMC Complementary and Alternative Medicine* 18. https://doi:10.1186/s12906-018-2160-6

YUTOK YÖNTEN GÖNPO གཡུ་རྟོག་ཡོན་ཏན་མགོན་པོ། 1992. བདུད་རྩི་སྙིང་པོ་ཡན་ལག་བརྒྱད་པ་གསང་བ་མན་ངག་རྒྱུད། (*Bdud rtsi snying po yan lag brgyad pa gsang ba man ngag gi rgyud*, The Ambrosia Heart Tantra: The secret oral teaching on the eight branches of the science of healing). Lhasa: Bod ljongs Mi Dmangs dpe Skrun Khang.

ZHANG, Xinqing, and Margaret SLEEBOOM-FAULKNER. 2011. "Tensions between Medical Professionals and Patients in Mainland China." *Cambridge Quarterly of Healthcare Ethics* 20(3): 458-65.

ZHU, Jiaping. 2018. "Through a Century: Traditional Chinese Medicine Since 1912." *Chinese Medicine and Culture* 1(1): 5-10.