BRILL

Asian Medicine 6 (2010–11) 175–216

brill.nl/asme

Women and Gender in Tibetan Medicine

Heidi Fjeld and Theresia Hofer
University of Oslo

The current issue of Asian Medicine emerges from the presentations made and discussions held during the panel 'Women and Gender in Medicine and Healing Across Asia' at the *Asian Medicine: Cultivating Traditions and the Challenges of Globalisation* conference in Bhutan, September 2009 (organised by IASTAM, the International Association for Traditional Medicine in collaboration with the Institute for Traditional Medicine Services, Thimphu). The original papers given at that panel spanned topics such as female medical practitioners in the history of Korean medicine, reproduction in late imperial and contemporary China, Islamic embryology, and women and gender in Tibetan medicine. While this issue focuses on the Tibetan medical contributions alone, it draws on insights gained from the wider discussions at the panel. It also includes other articles from scholars whose research is particularly relevant to the topic. The intention of this special issue is to present current research focusing on women and gender within the field of Tibetan medical and cultural practices. It presents articles that explore social, cultural, economic and medical aspects of women's health, as well as historical and contemporary roles and perspectives of female doctors and patients found within the medical landscape of a broadly defined Tibet. These contributions serve as points of reflection for this introductory essay, in which we review past and ongoing activities, explore analytical trajectories and innovative approaches in interdisciplinary research on women, gender and medicine in Tibet.

Outline

This introduction has three parts: the first reviews gendered productions, transmissions and practices of Tibetan medicine; the second part discusses the representation of women in medical literature and illustrations, while the

DOI: 10.1163/15734218-12341234

third and last part addresses Tibetan medicine and reproductive health. So far, in the history of Tibetan medicine, called Sowa Rigpa (the 'science of healing', *gso ba rig pa*), most of its practitioners and authors have been men. Both the learning and practice of Sowa Rigpa and its associated texts have been closely connected to monastic institutions. This however, is only part of the (his)story. Sowa Rigpa was also learnt outside monasteries, within medical lineages, where knowledge and practice was often transmitted from father to son, uncle to nephew, and, as we shall see, from father to daughter, uncle to niece, and mother to daughter and son. Here we find the concept of the 'house' that derives from anthropological kinship theory a useful and encompassing tool for analysing the transmission and practice of Tibetan medicine outside lay and monastic institutions, for it draws out the relations between what in Tibetan are termed medical lineages (*sman gyi rgyud*) and medical houses (*sman grong*). We discuss whether, as has been suggested in earlier work by Janet Gyatso and Hanna Havnevik, Tibetan medicine has posed a relatively open field for women and, if so, how women's status in medicine compares to their position in other domains of Tibetan socio-cultural life and Buddhist institutions. The following two sections discuss overlaps and often paradoxical views of the female body and of women's achievements in Tibetan societies, as reflected in bodies of Buddhist and medical texts, practices and experiences. Lastly, before the conclusion we discuss the relatively limited role played by Sowa Rigpa in the field of reproductive health, and examine the ways in which gender representations, derived from classical medical texts and illustration, survive in contemporary writing on women's disorders.

Sowa Rigpa: the science of healing across regions

Sowa Rigpa has long been studied and practiced in socio-culturally, economically and geographically diverse contexts across the Himalayas, the Tibetan plateau and even Mongolia, Buryatia and Kalmykia. Taking the long history and these vast expansions into account, this review cannot be exhaustive.[1] Samuel, for one, states that just as other medical traditions of knowledge and practice, biomedicine included, Tibetan medicine 'was not a uniform craft practiced precisely in the same way by all its practitioners'.[2] Across this regional and geographical diversity of Sowa Rigpa we witness the common phenomenon of a move away in its transmission and practice from predominantly

[1] In the following, we rely largely on data from Central Tibet, where the authors have carried out most of their research, but also take into account works on other regions where Sowa Rigpa is practiced.

[2] Samuel 2008, p. 253.

Buddhist epistemological and socio-cultural frameworks. Historically, we have also seen little actual regulation and standardisation of the range of Sowa Rigpa practitioners and their work within and across regions, even if attempts to that effect were made as early as the seventeenth century, for instance, by the Fifth Dalai Lama's regent, Desi Sangye Gyatso. Nowadays, medical practices, pharmaceutical production and medical knowledge transmission throughout the transnational ethnoscapes and technoscapes[3] of Sowa Rigpa are brought increasingly into the fold of national (or regional) governmental regulations and professional organisations. At the same time Sowa Rigpa is more often passed on and practiced in secular institutions.

These changes are also reflected in the very terminology used to denote the medical system. Perhaps as a result of the contact between practitioners of Tibetan Medicine and practitioners of various forms of biomedicine, in the context of colonialism, Communism and exile, what in the Tibetan language used to be, and in some instances continues to be called Sowa Rigpa—i.e. one of the ten branches of the Tibetan Buddhist arts and sciences or *rig gnas bcu*—is now more commonly referred to as 'Tibetan medicine' (*bod sman*), and in English, 'traditional Tibetan medicine'. Before the twentieth century, there was little need to identify the diverse bodies of Sowa Rigpa knowledge, practice and experience as either Tibetan or 'traditional'; they were simply referred to by Tibetans as 'medicine' (*sman*) or as Sowa Rigpa.[4]

The shift from Sowa Rigpa to 'Tibetan medicine' denotes, at least in the context of the People's Republic of China (PRC), much more fundamental transformations: from a Sowa Rigpa predominantly studied, developed and practiced within a Tibetan Buddhist framework, towards a set of practices that are increasingly located in the realms of what may be referred to as 'science', but defined primarily by biomedical models.[5] In the Tibetan areas of the PRC, this reconfiguration of Tibetan medicine has partly been led by the powerful party state, requiring practitioners at many points to consciously and ambiguously separate 'medicine' (*sman*) from 'religion' (*chos*) and 'superstition' (*rmongs dad*).[6] This process has taken different forms in Tibetan exile and amchi

[3] Appadurai 1996.

[4] Cf. McKay 2007. Similarly, there has been an emphasis in Mongolia to refer to Sowa Rigpa as 'Mongolian medicine' (ITTM 2002), or in Bhutan as 'traditional Bhutanese medicine' (McKay and Wangchuk 2005). In contrast in India, the name Sowa Rigpa has been promoted by the Central Council of Tibetan Medicine in the context of its (now successful) lobbying to include Tibetan medicine as an 'Indian system of medicine' under India's state administration for traditional medicines AYUSH (Kloos 2011).

[5] Adams 2001a, Janes 1995.

[6] Janes 1995, Adams 2001b, Hofer 2011a, Saxer 2010.

(*a mchi*) communities in India and Nepal,[7] and with Tibetan medicine entering the global arena of 'complementary and alternative medicine' (CAM).[8] Common to these changes on both sides of the Himalayas is the concurrent influence of the day-to-day practice and agency of practitioners and patients, embracing ideas of 'science' and 'modernity' in various ways. Notably, the turn towards institutionalisation and secularisation has not only led to new syllabi and training modalities, but also to an increase in the numbers of female doctors, and more recently, female medical authors.

While recent publications have used Sowa Rigpa to refer to the diverse styles and schools across the regions,[9] and 'Tibetan medicine' to refer mainly to a more standardised and institutionalised practice, we hold that this distinction might depict a forced difference not shared by many practitioners. Hence, we follow practitioners' perspectives as much as we can, and otherwise use 'Sowa Rigpa' and 'Tibetan medicine' interchangeably.[10]

Sowa Rigpa as gendered medicine

What in the literature on practitioners and patients of Sowa Rigpa can assist us in gendering Tibetan medicine and Tibetan medical texts? We begin with a review of the two main contexts in which Sowa Rigpa was practiced and transmitted up until the middle of the twentieth century—monasteries and medical colleges on the one hand and kin-based lineages on the other—exploring how these shaped and gendered the constituency of doctors (*a mchi* or *sman pa*) and their work. Important to the transmission of Tibetan medical knowledge is the concept of 'lineage' (*rgyud*) in general, and 'medical lineages' (*sman gyi rgyud*) in particular. Through medical lineages, shared either among relatives or among religious teachers and their disciples, medical knowledge was passed on in written and oral forms. Teachers and apprentices in the medical lineages in monasteries, medical colleges and families, were most often, albeit not always, men.[11]

Major historical trajectories of medical knowledge are found within Tibetan monasteries and medical institutions connected with them, as well as dedicated medical colleges and, more recently, in state-funded schools.[12] The traditional

---

[7] Craig (forthcoming), Kloos 2010, Prost 2008.
[8] Adams and Craig 2008.
[9] Cf. Adams, Craig and Schrempf 2010.
[10] For a more detailed discussion of terminology, see Hofer (in press).
[11] Cf. Taube 1981, Hofer 2007 and in press, Schrempf 2007.
[12] Bolsokhoyeva 2007, Meyer 1995, pp. 116–120, Gerl and Aschoff 2005, TIN 2004.

medical colleges, such as those at Labrang or Kumbum, were housed within large monasteries and had particular entry requirements. They followed a more or less set curriculum and only admitted monks.[13] Even in those monasteries, large or small, without dedicated medical colleges, medicine was often practiced and taught as one of the ten Buddhist sciences.[14] Monastic libraries held texts from all branches of Buddhism, often including the fundamental medical text *Four Tantras (rgyud bzhi)*.[15] Hence, monasteries often provided the space and facilities for the transmission of medical knowledge from a teacher to a student, or to a group of students. Even in cases where no teacher was present, it was not uncommon for monks to learn through self-study and short-term apprenticeship.

Medical knowledge transfer between a religious teacher and his disciples could be found both inside and outside of the formal medical colleges that began to emerge as integral establishments of some important large Gelugpa monasteries after the seventeenth century. In the Nyingmapa traditions and in smaller monasteries, knowledge was commonly passed on from a religious teacher to his disciples. Although sometimes teacher and student were also related through kinship, this was not usually the case. Lineages were therefore produced by various ritualistic elements, such as empowerments (*dbang*), initiations (*rlung*) and orally transmitted tantric practices (*man ngag*). They might have included overtly Buddhist teachings for doctors.[16]

Despite the apparent dominance of monk amchi and teachers, we should neither assume that every monastery in Tibet had a resident doctor, nor suppose that a resident doctor would also treat the laity.[17] From our studies of medical practices in rural areas, we believe that the role and presence of monastic doctors might have been overestimated in the accounts of some western writers.[18] At the same time, the monk doctors represented the elite

---

[13] Gyatso and Buffetrille 1987, Gerl and Aschoff 2005.

[14] Schaeffer 2003.

[15] The standardised translation of *rgyud bzhi* is *Four Tantras*. However, as tantra here should not be understood as the esoteric Buddhist scriptures of Vajrayana Buddhism as such, some authors, such as Janet Gyatso and Jenny Bright in this volume, choose to use *Four Treatises*, as *rgyud* also translates simply as text in general.

[16] Cf. Garrett 2009.

[17] For example, Hofer found that the largest Gelugpa Monastery in Ngamring (Ngam ring Chos sde dgon), with approximately 400 monks living there before 1959, did not have a resident doctor in the 1940s and 1950s, but rather depended on ritual healing, prayers or lay medical doctors who came to treat the monks with Tibetan medicine.

[18] For instance, MacDonald proclaimed that "every doctor in Tibet is a Lama" (MacDonald 1929). Hofer has argued elsewhere that British colonial representations of Tibetan medicine as primarily a domain of Tibetan Buddhism, were attempts to establish British superiority and 'science' over indigenous 'belief', Hofer 2011b.

of Sowa Rigpa knowledge and practice, and this remains to some extent the case today.

Much less is known about the situation of medical study and practice in Tibetan nunneries. So far no nunnery has been reported to have housed a formal medical college. Yet through the groundbreaking work of Tashi Tsering, we now know of some Tibetan nuns who were knowledgeable and skilled in medicine.[19] The biographies of these, as well as of other nun amchi discovered since then—including Ani Ngawang (c. 1930–2006, Nyemo) and Ani Pema Lhamo (c. 1922–2005, Ngamring)[20]—remain to be explored.

The establishment of the Mentsikhang in Lhasa by the Thirteenth Dalai Lama in 1916 created a new context for the study and practice of medicine. While sharing substantial Buddhist features in its layout, curriculum and practice, the new school also opened its door to lay male students. This model of teaching both monks and lay students was later adopted by the Tashilunpo Labrang in Shigatse after establishing 'Kyikyinaka (*skid skyid nad ka*) Medical College', operative from 1954 to 1958.[21] Following the escape of the Dalai Lama and thousands of Tibetans into exile in India, one of the first cultural institutions established by the exile government was the Men-Tsee-Khang in Dharamsala. Together with the Mentsikhang in Lhasa as well as the Tibetan Medical Colleges in Lhasa and Xining (established in the 1980s–90s), they represent the main new Tibetan medical teaching institutions open to the laity in which men study alongside women. Gender diversity (if not always equity) has also been the case in most privately initiated and/or NGO sponsored small Tibetan medical schools in Nepal and Tibet, such as at the Lho Kunphen school in Lo Manthang (Mustang), and the Tibetan medical schools in Lhundrup (Lhasa Prefecture) and Darchen (Ngari Prefecture).[22] Before we turn to the new kinds of female practitioners graduating from these institutions, we return to the second trajectory of medical knowledge production and learning, the medical lineages outside of monastic and medical college contexts. According to currently available scholarship, in this mode of transmission, female practitioners were more prominent than in the monastic sphere.

---

[19] Tashi Tsering 2005.

[20] Hofer 2011a, pp. 86–7.

[21] On this school and medical activities at Tashilunpo, see Hofer 2011a.

[22] There is one notable exception, namely Pelshung Tibetan medicine school, which operated near Shigatse from 1999 to 2006 and did not train any female amchi, as its director considered it a deviation from Tibetan medical tradition.

Female doctors and 'medical houses'

Most of the female doctors who practised before 1980 and who we know about, have gained their skills through kinship relations. The common practice, however, was to pass on medical knowledge to a male heir; this is still explained by Tibetans in terms of kinship ideology in general and patrilineal descent in particular. Tibetan ideas of patrilineal kinship are grounded in theories of procreation and medical theories of the body's formation and constitution, in which the two substances of *rus* (bones) and *sha* (flesh, i.e. blood (*khrag*) in medical texts) are fundamental. *Rus* is transferred via the white reproductive substance (*khu ba*) of the father to the bones of a conceived child, while *sha* is transferred via the red reproductive substance of the mother (*khu ba, khrag*) to constitute the flesh. Of these, the bones form the matrix of the body, i.e. they constitute the fundament for the person's physical and mental abilities.[23] The flesh, on the other hand, has only limited implications for the constitution of personhood. While the bone lineage (*rus rgyud*) is a direct and continuous line, the flesh lineage (*sha rgyud*) cannot continue for more than two generations. This is because the woman's red reproductive substances result indirectly from her father's bones (white substance) rather than directly from her mother's flesh (red substance), and therefore from her patrilineage, rather than from her matrilineage.

This theory of procreation and formation of the body has implications for gender patterns in the transmission of medical knowledge within families. In our conversations in Central Tibet, lay medical practitioners often expressed the view that a medical lineage would persist more strongly and therefore benefit the family and society in a more lasting manner when passed on to a son rather than to a daughter. In fact the possibility of a daughter inheriting a medical lineage was often ridiculed. The positive evaluation of a continuous patrilineage obviously supports the usual choice to teach medicine to a male heir. This is also strengthened by a normative virilocal residence pattern, through which the sons remain in their natal household following marriage, while the daughters move to their husband's household.

In such patri-dominated social organisation, we would expect little or no female presence in the medical field. This has, however, not always been the case. There are by now many known examples, as most recently reported by Tashi Tsering,[24] of female doctors who were trained by a male relative. Some of these were daughters in a family with no sons, such as Khandro Yangga

[23] Diemberger 1993, Garrett 2008, Levine 1981.
[24] Tashi Tsering 2005.

(Kham Riwoche), Lobsang Dolma (Kyirong) and Dröla (Sakya).[25] Others were wives of medical doctors and worked as amchi in their own right.[26] Yet others were trained alongside their brothers.[27] How can we explain these cases? Are they merely exceptions to the rule?

In dealing with the ever-present exceptions in descent organisations we have been inspired by discussions in the anthropology of kinship.[28] By exploring medical lineages as 'medical houses', we hope to open new spaces to appreciate and analyse, historically and ethnographically, why women who were in the household of a doctor could be taught medicine despite the dominant 'bone' lineage paradigm. Lévi-Strauss defines the house as a 'moral person' in this way:

> [A] corporate body holding an estate made up of both material and immaterial wealth, which perpetuates itself through the transmission of its name, its goods, and its titles down a real or imaginary line, considered legitimate of kinship or of affinity and, most often, of both.[29]

While material wealth is often emphasised in the studies of 'houses', we see medical knowledge as immaterial wealth (together with the house name, its reputation and social standing). Nevertheless, we identify medical text collections, medicine making equipment and medical substances as important (and valuable) material parts of 'medical houses'. Together these are transferred through a real or imaginary line and importantly, legitimized through the language of patrilineal descent. This, we should emphasise, seems most relevant in Central Tibet, and less so in Amdo (Northeastern Tibet) where patrilineal descent remains more important in a number of ways not found elsewhere in the Tibetan cultural area.[30]

The anthropological house perspective sheds new light on what have been termed 'medical lineages' in Tibet. These lineages of medical knowledge were in fact often found in what were in some cases called *sman* (medicine) *grong* (house). Well known examples in the literature include the 'Sakya Mentrong'

---

[25] On the latter see Hofer 2011a, pp. 90–92.

[26] For instance Amchi Ku Dawa's wife in Chu'og District, Ngamring County. How she studied medicine is still unknown to us.

[27] In Derge area, we were told by Thubten Phuntsog about Purpa Drolma (Phur-pa sGrol-ma) who was taught by her father and alongside her brother called Tsering Dorje (Tshe-ring rDo-rje). Her father was usually referred to as 'Dramang Lhaje', after Dramang Monastery that he was affiliated with, but his full name was Jamyang Sangpo ('Jam-dbyangs bZang-po). Personal communication, Hofer with Thubten Phuntsog, Beijing, 2007.

[28] Lévi-Strauss 1987, 1991, Carsten and Hugh-Jones 1995, Hsu 1998, Fjeld 2007.

[29] Lévi-Strauss 1987, p. 174.

[30] See Schrempf, this volume, and Makley 2007.

and the 'Lhunding Mentrong'.[31] Membership into these 'medical houses' is gained through filiation (independent of sex) and marriage (or in some cases adoption), i.e. both sons and daughters acquire full membership upon birth. Furthermore, in the next generation, the children of house members gain membership through filiation as well. In this way, both sons and daughters (as well as in-marrying husbands, or *mag pa*) become potential apprentices to the knowledge of 'medical houses'. In addition, 'medical houses' were also found at the so-called *labrang* (*bla brang*), or corporate property holding houses of incarnate lamas (*sprul sku*).

Analysing medical lineages as 'medical houses' enables interpretations that are more open to gender variations. Female practitioners are not merely exceptions, but become a nexus around which an estate of immaterial wealth (knowledge, social capital and merit) and material wealth (texts, medicines and equipment) can accumulate.

Why is it then, in practice, that the majority of apprentices in these 'houses' are sons or nephews? We suggest the reasons are two-fold: on the one hand, the bias reflects broader gender models and expectations in Tibetan societies and, on the other hand, it reflects perceptions of the female and male body and mind. Both of these issues will be returned to below. But first, looking back in history, who were the few women we know of who practiced medicine, and how and from whom did they learn?

Exceptional Women?

So far only two female Tibetan medical doctors, whose life and work spans the early to the middle of the twentieth century, have attracted serious scholarship: Khandro Yangga (mKha'-'gro dByangs-dga') originally from Kham, and 'Lady Doctor' Lobsang Dolma (bLo-bzang sGrol-ma) from U-Tsang. Their biographies and Lobsang Dolma's own writings provide insights into their life and work, and not least their specialisation within Sowa Rigpa.[32]

According to Tashi Tsering's and Jampa Trinley's work, Khandro Yangga was born in 1907, and was a brilliant child. Following her early knowledge of Tibetan language and poetry, and possibly given that she was the only child, her father started to teach her medicine. Being an influential doctor himself, he negotiated his daughter's entrance into the Mentsikhang in Lhasa, where

[31] Sa-skya sMan-grong and lHun-sdings sMan-grong. Cf. Hofer 2007 and in press.

[32] Byams'-pa 'Phrin-las 2000, pp. 458–463, bKra-shis Tshe-ring 1994, Khangkar 1998, Hofer 2011b, Josayma and Dhondup 1990, Tashi Tsering 2005, Nor-bu Chos-'phel and bKra-shis Tshe-ring 2008.

she was taught 'opening of the eyes' (*mig 'byed*), i.e. cataract surgery. From adolescence Khandro Yangga excelled in surgical skills, earning fame and respect in Tibet and beyond.[33] Following the political turmoil of China's invasion and subsequent power transfer in Lhasa, she remained at the Mentsikhang, practising surgery and general treatments, until 1962. In that year the new leadership identified her as a specialist in women's and children's medicine, and she was asked to serve as the first director of the newly established 'Women's and Children's Department'. This ended her surgical practice, which had by that time become regarded as the professional domain of newly arrived Chinese biomedical eye specialists at another hospital in Lhasa. During the Cultural Revolution (1966–1976) Khandro Yangga was severely punished. Today, her son continues to practice medicine in Lhasa, indicating, as we have argued, that 'medical houses' continue independent of a broken patrilineage.

Born almost 30 years after Khandro Yangga, Lobsang Dolma's story shares similarities with her predecessor, but also differs in significant ways. The daughter in an influential family with no sons, Lobsang Dolma was offered educational opportunities with high-ranking lamas of Kyirong, where she grew up.[34] As with Khandro Yangga, she proved to be a remarkable student of Tibetan language and was given the opportunity to continue with studies in astrology and later medicine. In 1961, she fled to India, where she initially worked as a foster mother and with road construction, and later started what became an enormously popular private medical clinic in Dalhousie. Only in 1972, she was invited to work at the Dharamsala Men-Tsee-Khang, after having tried to enter the institution ten years earlier, and failed on account of being a woman.[35] In 1978, she was asked to resign from the institute, and then set up and ran another very successful private clinic. Lobsang Dolma was one of the first Tibetan doctors to travel to western countries and to teach and treat patients there. Before she passed away in 1989 she had become a central figure in the exile community, famous for her treatments and pharmaceutical skills. She had taught her two daughters, Pasang Gyalmo and Tsewang Dolkar Khangkar, who also attended the Men-Tsee-Khang College. While Pasang Gyalmo continues to work at the clinic in Dharamsala, Tsewang Dolkar

[33] Hofer 2011b.

[34] Tashi Tsering describes her father, Dingpon Tsering Wangdu, as the holder of three unbroken lineages: 'a lineage of *lding-dpon* (ruling family of one of the territorial nine sections of Kyirong); a lineage of *grong-sngags* or *dbon-po* (lay tantric practitioner); a lineage of *sman-pa* ('doctors')' 2005, p. 177. See also Aufschnaiter's diary entry on Lobsang Dolma's father, 'Traba Angdi', reprinted in Brauen 2002, pp. 42–3.

[35] Cf. Kloos 2008.

Khangkar is now based in Delhi and is perceived to be the holder of this 'medical house'.[36]

Thinley Dolkar (1931–1956) and Tinley Paldon (b. 1939) are two other well-known female doctors. Their father, Rinzin Lhundrup Paljor Nyerongshag, trained them alongside their brothers. Tinley Paldon's own daughter, Dekyi Pedron Nyerongshag, also works as a Tibetan medical physician and is now based in the US.[37]

Tashi Tsering presents a list of more than ten female amchi who practiced in Tibetan areas before the Chinese invasion. Based on fieldwork in U-Tsang, Theresia Hofer has begun to collect stories of other female doctors, most often nuns.[38] One such account is that of Ani Pema Lhamo (*c.* 1922–2005), a nun from Dewachen Nunnery, who practised in the area of Ngamring, and later around Lhasa.[39] She was chosen as the single heir to her (male) teacher's medical lineage, receiving his texts and medical equipment. Moreover, there are stories from Ngamring from the 1940s and 1950s describing a number of nuns who learned medicine from a Nyingmapa lama from Kham who practised in the area. Among them was Ani Ngawang, who later became the abbess of Chiu Gonpa Tekchoeling nunnery in Nyemo, where she taught Tibetan medicine to both monks and nuns (See Figure 1).

Kyungtrul Rinpoche (Khyung-sprul 'Jig-med Nam-mkha'i rDo-rje, 1897–1955), the famous Bon Lama and medical doctor who travelled and worked in the Changthang areas of Nagchu as well as Ngamring and later Ngari, is also known to have taught medicine to several nuns, including a now 84-year-old nun and resident of Gurukyam monastery, Western Tibet.[40] The kinship connections of these female amchi and their teachers are not clear. Some were related to their teachers, but others were not.

Historically, there seem to have been only few areas of medicine that were unavailable to female doctors. One of the taboos for women amchi was the making of *tsho thal*—purified mercury used in numerous precious pills (*rin chen ril bu*).[41] Blood-letting was mentioned to us as improper conduct for female amchi, but this claim needs further investigation. These prohibitions can be contrasted with examples of female amchi who are in fact skilled and well-known for making *tsho thal.* One of them, the aforementioned nun amchi,

---

[36] Cf. Khangkar and Lamothe 1997.

[37] She is co-author of Brown, Farwell and Nyerongsha 1997.

[38] The reason often given for higher prevalence of nuns as amchi was that they were usually more literate than lay women, and literacy was an undisputed requirement for the study of Sowa Rigpa.

[39] Cf. Hofer 2011a, p. 86.

[40] Millard 2011.

[41] Da-wa Ri-bdag 2003 and fieldnotes 2007, Hofer.

Fig. 1. Ani Ngawang in old age at her nunnery in Nyemo.

Ani Ngawang in Nyemo, was highly regarded for an eye medicine she compounded, which contained selfmade *tsho thal*. Moreover, she had passed on this skill of mercury purification (and its associated knowledge) to several of her students, both nuns and monks, who continue to make *tsho thal* and her eye medicine today.[42] Another nunnery reported to make *tsho thal* is Tragkar Rikhö (Brag-dkar Ri-khod) in Kardze in Kham, where a medicine containing their locally made *tsho thal* is even referred to as *dge ma* [*btso bkru*] *zla shel* ('nun's [purified mercury] mirror of moon'-pill).[43]

Havnevik and Gyatso suggest that the activities of Khandro Yangga, Lobsang Dolma and others could indicate that the medical field enjoyed a relative freedom from the rigid gender hierarchies prevalent in the main institutions of Tibetan society, and through that, gave room to talented female practitioners. Therefore, medicine with its 'relatively swift verifiability of its efficacy',[44] might have presented a comparatively 'open' field of knowledge

[42] Chiu Gonpa Tekchoeling, Nyemo County. Personal Communication, Dawa Norbu, Lhasa, 2007.

[43] Personal communication with Thubten Phuntsog, Beijing, 2007.

[44] Gyatso and Havnevik 1995, p. 13.

and practice for those who could demonstrate positive results, including talented women.

Despite these observations, we find female doctors seriously under-represented in almost all traditional writings on Tibetan (medical) history. This also holds true for modern writings, we contend.[45] In our attempts to go beyond the constraints and male biases of textual records by conducting oral history and ethnographic research, the lack of female doctors' voices and accounts is still apparent.

Yet, since the beginning of the 1980s, in many urban and some rural areas, there has been a considerable growth in the numbers of female Tibetan medicine practitioners. This is a phenomenon occurring in almost all the areas where Sowa Rigpa is practiced: in Tibetan areas of the PRC, the Tibetan exile community, Bhutan, Ladakh, Nepal Himalayas, as well as in Buryatia, Kalmykia and Mongolia. The extent of this increase is difficult to pinpoint, but as an indication Byams-pa 'Phrin-las in 2000 reported that 42 per cent of all Mentsikhang staff in Lhasa were women,[46] and in 2007, the director of the Tibetan Medical College in Lhasa told us that 50 per cent of the approximately 300 college students were women that year. Tashi Tsering provides the names of all female students at the Dharamsala Men-Tsee-Khang between 1969 and 2001, who ranged between five and ten per batch. We were told that, currently, more than half of the students are female (See Figure 2).[47]

So far, we know little about how these increasing numbers of female amchi and female students have come about, or the challenges and opportunities this growth has fostered for the practitioners and their patients.[48] Mona Schrempf, in her article in this volume, found both gender and ethnicity to be crucial to the building of the essential trust within doctor-patient relations particular to reproductive medicine in Amdo. This indicates a need for further studies of gendered practices in other medical fields. A significant increase in female practitioners is also found in the neighbouring medicines of Ayurveda and TCM.[49] Cameron's study of female practitioners of Ayurveda in Nepal shows the correlation of what she calls the 'feminisation of Ayurveda' and the marginalisation of Ayurvedic practitioners in the public health care system, suggesting not a causal relation, but at least parallel processes. In some Tibetan

[45] This is seen for instance in Byams-pa 'Phrin-las collection of 155 biographies of famous Tibetan doctors, of which only one is a woman (Khandro Yangga), Byams-pa 'Phrin-las 2000.

[46] Byams-pa 'Phrin-las 2000, p. 463.

[47] Personal communication with Stephan Kloos.

[48] Hofer's forthcoming post-doctoral fellowship at the University of Oslo will tackle this topic through her project: 'Women Doctors in Tibetan Medicine and the Modernisation of Health Care'.

[49] Cameron 2010, Mei Zhan 2009.

Fig. 2. Students at the Dharamsala Men-Tsee-Khang College in 2008.

areas of the PRC, we see similar processes of marginalisation of Sowa Rigpa in the rural areas, at least within the governmental rural health care system, occurring at the same time as the ongoing increase in the number of female doctors trained in both government and private schools. The ways in which the presence of more female doctors has been reconfiguring Tibetan medicine, if at all, remain to be explored. Taking the lead from Cameron,[50] we believe that further studies of female healers in professional non-western medical traditions will be a fruitful addition to existing anthropological studies of midwives, mothers and spiritual healers, and the significant 'production of health by women'.[51]

Female authorship

Related to the question of female practitioners is the matter of female authorship of medical texts. As the monasteries were the traditional nucleus of textual production in all science fields, it appears that all writers of Tibetan medical works were men, and often monks. At the same time, medical authorship was not solely tied to monastic contexts and to the more expensive and elaborate

[50] Cameron 2010, pp. 46–7.
[51] Inhorn 2006, pp. 358–9.

printing culture. In fact many medical texts and medical notes were written and copied by hand, providing a potential opening for female authorship beyond the male monastic sphere. As a large proportion of these manuscripts were destroyed during the Cultural Revolution, and many have not been copied widely, we still know little about these traditions.[52] However, we should be cautious to presuppose that authorship in manuscript traditions was equally dominated by men as in the printed text cultures. Looking for gender in both printed text and manuscript traditions, we might be surprised by the presence of women, perhaps not as authors, but as sources of knowledge.

We found one of these 'surprises' in Khenrab Norbu's text *Mirror of the Moon: Methods for Giving Birth Helpful to All*.[53] The roots for the knowledge conveyed in this text are attributed to the Medicine Buddha and the *Four Tantras*, but are also referred to as what we could broadly call 'wise women's knowledge'. The origin of knowledge about certain aspects of childbirth, such as kneeling on all fours on a bed, is here named as 'the good idea of women who have experienced childbirth', and more generally the text and its direct instructions for pregnant women (*sbrum ma*) are said to have been inspired by the complications that the 'young aristocratic woman' (*lcam chung*) Namgyal Drolkar from Shelkar experienced during the birth of twins at the end of her first pregnancy.[54]

More Tibetological work is required in order to provide a fuller overview of the gendered nature of Tibetan medical text production and practice. In other formalised Asian medicines and particularly in Chinese medicine, the genre of case stories has proved to be a rich source for scholars to study differential treatment of male and female patients.[55] Our endeavours to provide a 'herstory'[56] of Tibetan medical history is certainly disadvantaged by the absence of this genre, especially until the twentieth century. In more recent times, case records and case histories in Tibetan medicine do exist, and these too have proven to be reliable sources of information about differential treatment.[57]

With the recent increase of female doctors, it will be especially interesting to follow new developments in the writings and practices of 'women's medicine'. This is a field that has, as we will discuss below, always been one of the branches of medicine but which has had little practical relevance among male

---

[52] A large number of manuscripts, which have been collected from all over Tibet after the Cultural Revolution, are now held at the Mentsikhang's library in Lhasa. See sMan-rtsis-khang 2006.

[53] *Byis pa btsa' thabs kun phan zla ba'i me long zhes bya ba bzhugs so*.

[54] Hofer 2011c for a translation and critical discussion of the text.

[55] Cf. Furth 1999, 2007, Farquhar 1991.

[56] Scott 1988.

[57] Hofer 2011a.

doctors. As in the case of Khandro Yangga, there seems to have been an expectation of female doctors specialising in women's medicine. One could therefore expect that an increase in the number of female doctors might lead to a growth in female authorship in general, and the production of medical literature on women's diseases and treatment in particular.

Summary

While before the mid-twentieth century Tibetan medicine may have been an exceptional field in terms of fostering female expertise in comparison with other Tibetan cultural institutions, we still know very little about female and male doctors' lives and work. Existing biographies of women usually show that female doctors received their medical education due to unusual circumstances, such as the lack of a male offspring in their families, close kinship ties with male doctors, or because they were simply out of the ordinary religious practitioners or nuns.

In the introduction to their volume on women in Tibet, Gyatso and Havnevik suggest that outstanding women in Tibetan societies were related to great men. This is clearly the case in many of the known stories of female doctors, but also often simply used as a method of identifying these women, in lists such as: 'Tashi Paldon… niece of Terchen Barwe Dorje; Rinzin Wangmo, daughter of Dru Jamyang Drakpa…, Phurbu Dolma, the daughter of the great physician of Derge Gonchen monastery'.[58] We want to question these forms of relatedness by pointing more broadly to social hierarchies, naming practices, and access to knowledge in traditional Tibetan societies. With hereditary rank being so fundamental to social position and possibilities,[59] many of these female doctors belonged to the upper social strata, which would indicate a relationship to other well-known men. Moreover, due to the limited use of family names in Tibetan communities, a person is often described with reference to their place of origin and social connections. Therefore, in the description of female doctors, what is more crucial: their relationship to a particular man, or their belonging to a certain high ranked family? Might there be a tendency to highlight the relationship of outstanding women to their male relatives in our own descriptions only, when perhaps these relations were not as important in their gaining access to knowledge and realising their potential? How, then, should we represent the social belonging of these female practitioners? We suggest adopting a broader social perspective on the back-

[58] Tashi Tsering 2005, p. 173.
[59] Goldstein 1971, 1989, Fjeld 2005, 2008.

ground of outstanding women, which might bring forth a more nuanced picture of kinship relations, social status and access to knowledge. We have found that various amchi are continuing their mother's 'medical house' (*sman grong*), that is they practice medicine, transmit the medical text and manuscript collections and instruments. The break in the patrilineage is inconsequential, as the immaterial wealth—i.e. medical knowledge and practice etc.—continues, and at times also the medical house's material wealth.

Even with the increase of female students and doctors very few women publish in the field of medicine. If they do so, 'women's diseases', childbirth and children's medicine are the usual domains. Although medical texts were and still are usually written by male authors, this volume also shows that the knowledge on which they based their writings may indeed have come from Tibetan women.

Women in Tibetan societies: ambiguity and lower birth

Turning now to the second part, we look at the limited presence of women in the Tibetan medical field through the broader perspective of the position of women in Tibetan societies, and describe the medical and religious ways of understanding the female body. Historically, access to education and formalised knowledge was limited for Tibetan women, with the exception of a very few high ranked members of the aristocracy,[60] and possibly certain nuns. This is also reflected in the low numbers of known female medical practitioners. As already discussed, medical training in nunneries or membership of a 'medical house' tended to be the main trajectories open to women who wanted to pursue a medical line of work, however it seems that before the twentieth century very few did. This can be explained sociologically in the expected roles for men and women, but should also be seen in relation to fundamental evaluation of the female body and mind, i.e. of the female rebirth. These perceptions are grounded in both medicine and religion.

Early Western sources depicted Tibetan women as outgoing, actively participating in public life and showing little shyness compared to women in India and Nepal.[61] These reports were often based on contact with women of the aristocracy, who also in their autobiographies presented themselves in a similar way.[62] Starting in the beginning of 1980s, however, critical sociological studies of the roles of women in Tibetan societies presented a more refined

[60] Fjeld 2005, Yuthok 1990, Taring 1970.
[61] See for instance Bell 1924:129ff, see also Acharya and Bennet 1981.
[62] Taring 1970, and other works by Yuthok 1990 and Sakya and Emery 1990.

picture, pointing to general subordination, and especially a negative evaluation of the female rebirth.[63] In our ethnographic studies in rural and urban Central Tibet, we have found very similar shared assumptions of female rebirth as being inferior. In conversations with female interlocutors, we often got the impression that women felt sorry for themselves for being born into a female body, pointing to what were for them obvious disadvantages of being a woman, such as a weaker body, childbirth, more sickness, and also an emotional mind. This interconnectedness of suffering and the female body itself is also alluded to in the autobiographies of female religious experts, such as the Dolpo nun Orgyen Chökyi (O-rgyan Chos-skyid)[64] and the Golog treasure revealer Sera Khandro (Se-ra mKa'-'gro).[65] Moreover, as Schrempf shows in this volume, in patriarchal Amdo, girls are less valued than boys and viewed as a burden to their families.

When trying to explain why women experience a harder life than men, the Tibetan language itself is very often used as evidence. Indeed, the most common word for woman (as well as wife) itself, *skye dman* translates as 'low birth',[66] a point made explicit by many of our Tibetan interlocutors. We have spoken with women in Lhasa who have explicitly said they avoid using the word *skyes dman* and have asked their husbands and family to abandon that term, replacing it for instance with '*Aji*' (*A ce*), meaning both wife and woman. We were also told it is a term consciously avoided by the Dalai Lama. Similarly, as Janet Gyatso has shown,[67] another word commonly used for woman is *bud med* (the politically correct feminist term for a woman). However this term is easily interchangeable with *bu med*, meaning 'not boy'. In addition to these etymological points, there are numerous Tibetan proverbs describing women as being born into a lower rebirth, and therefore subordinate to men.[68] One well-known saying reported also by Gutschow is that women are seven lifetimes behind men, and following on from this that women must accumu-

[63] Aziz 1987.

[64] Schaeffer 2004.

[65] Jacoby 2007.

[66] After strong pressure from Tibetan women's organisations in India, the exile government in Dharamsala has now suggested a new spelling for 'woman', '*kyeme*', where *kye* is still spelled *skye* (birth) but where *me* is spelled *sman* meaning medicine (instead of *dman* for 'low'), thus giving '*kyeme*' a new etymological meaning, 'birth medicine' (Namgyal Tsomo, personal communication with Fjeld). Rumour has it that it was a Western ordained Tibetan Buddhist nun in Dharamsala who initiated this rewriting. We have not, as yet, been able to confirm this.

[67] Gyatso 2008.

[68] 'If one wants a teacher, one makes a son a monk, and if one wants a servant, one makes a daughter a nun', Lopez 1998, p. 211.

late the merit of seven additional lifetimes before they can be reborn as men.[69] However, one way of compensating for the low merit leading to a female rebirth is, as reported by Schrempf, by giving birth to a son.[70]

Tibetans clearly connect gender models and negative evaluation of female rebirth to Buddhism. If we look at Buddhism, we see an ambiguity distributed across the different historical phases, from early Buddhism up to the different schools of Tibetan Buddhism active today.[71] Sponberg described how early Buddhist literature on women featured a range of co-existing attitudes towards them, from expressing a liberation path open to all, to outright misogyny, portraying women as weaker human beings and, in some cases, as 'active agents of distraction and ruin'.[72] In the sixth or seventh century, however, an additional attitude emerged within the Mahayana tradition that involved a 'dramatic revalorization of the feminine… [as well as] a re-evaluation of all those qualities and expectations culturally ascribed to male and female'.[73] The feminine and the masculine were then perceived to be—at least in some contexts—dialectically and mutually complementary on the path to enlightenment. Such a dialectic perspective is most clearly expressed in later Tibetan Buddhism and manifests in the quintessential pair of 'wisdom' (feminine) and 'skilful means', or 'method' (masculine); where the latter refers to compassion in action. The assertion that enlightenment cannot be reached without the conjoining of wisdom and compassion, like the two wings needed for the bird to fly, is a most basic religious knowledge to Tibetans today. This mutual dependency has also been discursively mobilised in an attempt to achieve a better position for women.[74] Gyatso has summed up the ambiguity of gender models and attitudes towards women as a continuous 'misogyny of Buddhist traditions, on the one hand, and the deification of a female principle in Buddhism, on the other'.[75] The growing body of literature on women and Tibetan Buddhism, i.e. female practitioners for the most part, indicates that

[69] Gutschow 2004, p. 16. She points out that there is a rather dubious logic to such a system, for if it always takes seven more rebirths, how can a woman ever be reborn as a man?

[70] Schrempf, this volume.

[71] These differing textual attitudes could perhaps been seen to reflect the point often made by more recent gender theorists about the multiplicity of gender discourses in most communities, cf. Moore 1994, Howell 1996.

[72] Sponberg 1992, p. 19.

[73] Sponberg 1992, p. 25.

[74] Palden Trinley, in Adams 2001a.

[75] Gyatso 2003, p. 89.

the deification of the feminine principle has not, however, had a liberating effect on the social position of women—lay or ordained.[76]

The female body in Tibetan medical literature and medical illustrations

How then is the ambiguity of Buddhist attitudes towards women reflected in the medical literature and its illustrations? Are there elements of both misogyny and deification of the female principle in Tibetan medicine? In what ways do the intertwined nature of Buddhism and Sowa Rigpa manifest in the perceptions and descriptions of the female body?

Wind and desire

As Mingji Cuomu's article in this volume illustrates, classical Tibetan medicine is closely related to Tibetan Buddhist philosophy. This is also evident in the descriptions of the sexual differentiation of male and female bodies.[77] The *Four Tantras* mention several reasons for the birth of a male or female child; among them, the day of conception and the relative amount of the mother's or father's reproductive substance.[78] It also states that even though any body (male or female) arises from the *nyes pa gsum* (the three humours: wind, bile, phlegm), the *'byung ba bzhi* (the four elements: earth, water, fire, wind), and the powers of previous karma and desire, a female body is the result of 'less merit'.[79] This assertion is often uncritically repeated in the classical commentarial literature on the *Four Tantras*, and as Janet Gyatso's and Rae Dachille-Hey's articles in this volume show, it is made even more explicit in the medical paintings. Only more recently are such patriarchal definitions less often repeated, as we will discuss towards the end.

Even if not outright misogynistic, Tibetan medical texts such as the *Four Tantras* clearly describe the female body in terms of its difference from the normative male body, and as a body of extra suffering: 'since she is of lower birth, the female (*bud med*) body has extra (illnesses)'.[80] These are the oft-cited additional 32 'particular' (*gtso bo*) women's disorders (*mo nad*), discussed in

---

[76] Havnevik 1989, 1999, Gyatso 1989, 1999, 2003, Diemberger 2007, Makley 2005, Gutschow 2004, Schaeffer 2004, Jacoby 2007.

[77] Cf. Garrett 2008 and Young 2011.

[78] Clark 1995, pp. 48–9.

[79] '*Bso nams dman pas za ma mo lus thob*', g.Yu-thog 1984, p. 393. On the term *za ma mo*, see Gyatso 2003.

[80] g.Yu-thog 1984, p. 393.

Chapters 74 and 75 of the third volume of the *Four Tantras*.[81] A further eight disorders, although called 'common' (*phal pa'i nad*) but in fact associated with pregnancy and obstetric complications, are discussed in Chapter 76 of the same volume.[82]

These chapters provide substantial information on the causes (*rgyu rkyen*), classification (*dbye ba*), symptoms (*rtags*) and cure (*bcos thabs*) of women's diseases (*mo nad*), and have been copied and discussed in existing commentarial literature, even though its authors were scholarly men, usually monks.[83] In the medical paintings from the seventeenth century, however, the causes and types of diseases described in these chapters on *mo nad* are not depicted, as discussed by Gyatso in this volume. Instead more widely held negative ideas about women are reproduced by linking them—repeatedly and in visually effective ways—to the three poisons.[84] In other places in the medical illustrations, women are not only connected to the three poisons, but often appear in relation to discussions of the wind humour and its root cause of desire, represented by the colour blue. In her article in this volume, Dachille-Hey's article shows how, in the parts of Chapters 2–5 on wind, bile and phlegm disorders (*'dus nad*), a strong connection is made between desire, wind (*rlung*) and women. This point can be seen in relation to Adams and Dovchin's argument that the moral and religious foundations of Tibetan medicine come forth strongly in the diagnosis and treatment of female disorders. They also hold wind to occupy a special position in terms of female disorders, and show how the qualities associated with it—emotions and desire, often grasping for sexual satisfaction—are regarded as harmful for women's health.[85] Although, as Gyatso points out, it is difficult to identify with certainty male and female figures in the medical illustrations it does appear that female forms make a more frequent appearance in the section on wind disorders, as compared to the sections on bile and phlegm disorders.

---

[81] The 32 particular disorders in the *Four Tantras* (g.Yu-thog 1984, p. 393) are subdivided into five uterine disorders, sixteen 'channel disorders' (*rtsa nad*, subdivided into *khrag tshabs* and *rlung tshabs*), nine uterine tumours (*skran nad*), and two kinds of (*'srin bu'i nad*) or 'micro-worm' disorders (today commonly translated as 'infections').

[82] These are ailments associated with pregnancy (*mtshan ma'i nad*), abortion and protracted labour (*bu ma phyin pa*), haemorrhaging (*khrag ma chod pa*), post-natal ailments (*nad gzhug las pa*), 'post-natal infections' (*dug dab*), g.Yu-thog 1984, p. 400.

[83] E.g. in Desi Sangye Gyatso's *Blue Beryl*, Sangs-rgyas rGya-mtsho 2005, pp. 1090–1109.

[84] It is a general pattern that the rich content of the *Third Tantra* is left out from the *Blue Beryl* illustrations. While for other chapters they present at least causes and types of diseases in a brief manner, by contrast the chapters of *mo nad* are left out all together.

[85] Adams and Dovchin 2001, p. 440.

While Chapters 42 and 43 of the third volume of the *Four Tantras* feature a relatively equal discussion of disorders common to the male and female genitalia, the last two chapters on fertility/virility (*ro tsa*)[86] again clearly feature a structural subordination of women within the text: male sexuality and fertility are subjects of the primary (*gtso bo*) topic, and female reproductive function is but an auxiliary (*yan lag*) matter.[87]

As we can see, almost all of the disorders of women specifically mentioned in the *Four Tantras* are in one way or another related to women's reproductive or sexual functions and roles. Thus the female body, whenever it does become a topic of medical interest, is largely viewed as a 'reproductive body' and, often a 'body of wind and desire'.

The exceptional female body

Based on her in-depth study in this volume of the seventeenth century illustrations to the *Blue Beryl*, Gyatso analyses how the Tibetan medical body is represented as a default male body, especially in its anatomical and physiological depictions.[88] At the same time, the female body becomes characterised by 'extras' (*lhag*)—the extra amounts of flesh and fluids, or the extra number of orifices.[89] Following Gyatso, we argue that disease and diagnosis in the *Four Tantras* are also explained above all in terms of a male body. For example, even when the *Four Tantras* state that the twelve organ pulses of a patient need to be taken differently for women and for men, the exemplary patient is male. How the organ pulses of a female patient should be read deserves no further explanation there. Rather, as a reason the tip of the female heart being tilted towards the right, and vice-versa with men, is stated.[90] Although this anatomical distinction has aroused scholarly interest later, it is not mentioned in the respective places on the anatomical and physiological paintings. In the anatomical paintings, Gyatso argues, both androcentric gender bias and gender parity are present in a more obvious and stronger way than in the *Four Tantras* and the commentaries.

How, then does this reality of the 'default' male body in Tibetan medical literature and visual culture, and of women's 'extra' suffering due to the pronounced 'inferiority' of the body, relate to our earlier exploration of the

---

[86] Chapter 91 and 92, cf. Gyatso 2008.

[87] Gyatso 2008, p. 83.

[88] Cf. Young 2011: 209.

[89] More women are found in the later paintings of the set, where however, they are, according to Gyatso, still shown almost always in gender-specific roles and never taken to illuminate a gender-neutral condition.

[90] Rechung 1973, p. 94.

sociology of medical practitioners and authors? This default male body norm was established by male monastic medical writers and usually male medical lineage holders and, given the historical and cultural context in which they worked, the topic of women and 'women's diseases' would have been unlikely to bring prestige and respect. More probably, it would instead have raised suspicions. With women being reduced largely to their reproductive and sexual roles this may not be surprising.

Female medical deities

Having established more fully how misogynistic and patriarchal structures influenced Tibetan medical ideas of the female body, we ask, in contrast, has there been anywhere in the medical writings and in visual depictions, a deification of women? While all scholars and practitioners of medicine, as well as patients and lay Buddhists, are well aware of the blue beryl-coloured Medicine Buddha, or Sangye Mengyi-la (Sangs-rgyas sMan-gyi Lha),[91] female medical deities have been given a less prominent role, although they are mentioned occasionally in the medical literature and iconography. The most prominent female medical deity is commonly referred to as 'Mengyi Lhamo' (Sman-gyi Lha-mo), Dutsi Lhamo (bDud-rtsi Lha-mo) or Yidro Lhamo (Yid-'phrog Lha-mo). In the legendary biography of the 8th century figure Yuthog 'the Elder' (whose 12th name-sake Yuthog 'the Younger' is known to be the author of the *Four Tantras*), his ancestry is traced back on his mother's side to a human incarnation of Dutsi Lhamo, the inn-keeper's daughter, (Kyepa) Yidro Lhamo (Yid-'phrog Lha-mo), who is cast as a beautiful and charming woman with supernatural powers. Yidro Lhamo is described as taking on a particularly important role in the spread and propagation of medical plants and trees in India, Khotan, China, Nepal and Tibet, and is reported to have offered the panacea *arura* to the Buddha in India.[92]

Mengyi Lhamo's strong connection with the plants used in Tibetan medicine probably earned her the iconographic depiction as a female deity holding an *Arura Chebula* plant in her hand (see Figures 3 and 4).[93]

She is still revered for the propagation and protection of medical plants, and for her blessings to enhance the potency of plant medicines, by contemporary medical practitioners we spoke to in Central Tibet and in exile.[94] As the Medicine Buddha presides over a group of eight Medicine Buddhas, so

[91] Birnbaum 1989.
[92] Rechung 1973.
[93] Second medical *thanka*, top row, sixth figure from the left.
[94] Personal communications, 2006, 2011.

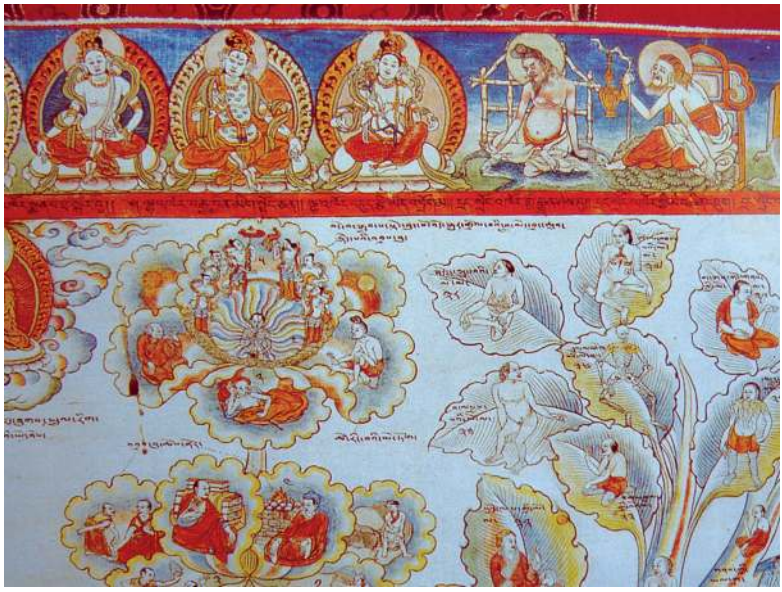

Fig. 3. Yidro Lhamo' (lHa-'god bDud-rtsi Yid-'phrog ma) with Tibetan medical panacea *Arura* on the middle of top register of the second medical thanka, Lhasa set (Byams-pa 'Phrin-las and Tshe-brtan 'Jig-med 2006).

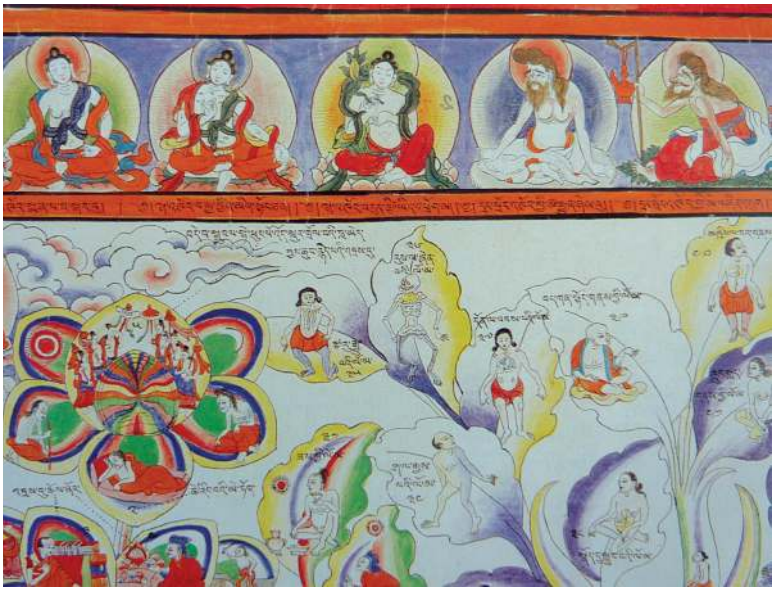

Fig. 4. Yidro Lhamo (lHa-'god bDud-rtsi Yid-'phrog-ma) depicted with the Tibetan medical panacea *Arura* on the mid-top register of the second medical thanka (Parfionovitch, Dorje and Meyer 1992, p. 20).

does Mengyi Lhamo preside over a group of eight Medicine Goddesses. We have yet to find iconographic depictions of this group of Medicine Goddesses. Although Dutsi Lhamo's wrathful form, Dorje Phagmo, is seen as the female tantric consort of the wrathful emanation of the Medicine Buddha, Tamdrin,[95] this union of (medical) 'wisdom' and 'skilful means' seems rarely visually represented. Moreover, Mengyi Lhamo and her group of eight Medicine Goddesses play a less pivotal role in prayers and as a main resource for healing powers for doctors, patients or Buddhist practitioners.

To conclude, Tibetan medical literature and its illustrations portray the male body as the default human, while largely casting women as exceptions and in relation to their reproductive roles and sexuality at the same time. While misogynistic attitudes prevail in the medical literature, hence posing a continuation of some of Buddhism's legacy, the deification of women or the 'female principle' is not as pronounced in medicine as it is in Vajrayāna Buddhism. In comparison with the main Tibetan medical deity, the blue beryl-coloured Medicine Buddha, or Sangye Mengyi-la, female medical deities such as Mengyi Lhamo and the group of eight Medicine Goddesses are mentioned much less frequently in the texts. As Jenny Bright also points out in her translation of Tsultrim Gyatso's work in this volume, religious practices to invoke deities such as the Medicine Goddess of Bright Light (sNam-kyi Lha-mo 'Od-chang-ma) are recommended to help a woman gain more merit. However, this group of deities takes equally marginal positions in iconographic depictions, as well as in medical and lay practitioners' and patients' prayers. The presence of female divinities, as in Tibetan Buddhism, has proven to have only limited effect on the opportunities open to female doctors (and patients).

Tibetan medicine and reproductive health

Building on our recognition of the common association of women and Tibetan medicine through sexuality and reproduction, in this third part we turn to a prominent issue in studies of health and medicine in Tibetan communities, namely reproductive health.[96] Several of the articles in this volume, i.e. Schrempf, Bright, and Cuomu, focus on issues related to women's reproductive capacities, and their social and medical understandings. As seen above, women's diseases, as well as gestation and childbirth, are inherent parts

[95] Cf. Clifford 1984, pp. 50–51.

[96] Adams 2001a, 2005, 2007, Adams *et al.* 2005a, Adams and Dovchin 2001, Chertow 2007, 2008, Craig 2009, Garrett 2008, Gutchow 2011, Hancart-Petitet and Pordié in press, Schrempf 2008.

of Tibetan medical theory. However, in practice amchi have remained only marginal in events such as childbirth. Furthermore, Tibetan communities are among the few in the world without a traditional institution of birth attendants or midwives, leaving women's reproductive experiences particularly vulnerable. How can we explain the relatively low presence of Tibetan medicine in the field of reproductive health?

Childbirth and Tibetan medicine

To date, only those chapters in the *Four Tantras* relating to paediatrics have been translated into French and German,[97] but the chapters on gynaecology await translation into European languages other than Russian.[98] While there are few translations of the classical gynaecological texts, Bright's article on menstruation in this issue presents the first translation of contemporary Tibetan studies of the subject. Reproductive health has primarily been analysed through contemporary ethnographies, and increasingly so since the 1990s. This new emphasis on reproductive health must be seen in relation to the worryingly high maternal mortality ratios that were reported for the Tibetan areas of the PRC in the 1990s, and led to a number of both research and applied health initiatives attempting to improve the situation.[99] The total maternal mortality rates for these Tibetan areas are not available, however reports from some regions in the Tibet Autonomous Region (TAR) show figures as high as 400–500 deaths per 100,000, ranking it among the highest in the world.[100] These numbers are also significantly higher than those found in both adjacent countries (Nepal: 290/100,000) and other areas of the PRC (45/100,000 (on average)).[101] There are many reasons for this situation in the TAR, lack of access to adequate health services and cultural preferences for home births being two important factors. In Shigatse prefecture for instance, NGOs have reported that in the beginning of 2000, as many as 90 per cent of women delivered at home, 94 per cent doing so without any trained birth assistants, which made them vulnerable to potentially lethal problems, including post-partum haemorrhage, eclampsia (toxaemia of

[97] Filliozat 1937, Jäger 1999.

[98] Dashiyev 2001.

[99] ONE Heart, Terma foundation, Burnett Institute, among others. Several of the anthropologists active in Tibetan medicine studies were involved in these initiatives, among them, Vincanne Adams, Sienna Craig, Mingji Cuomu, Jennifer Chertow and Theresia Hofer. These international NGO-initiatives were, however, partly or fully closed down following the 2008 uprising in Tibet.

[100] Adams *et al.* 2005a, TIN 2002.

[101] Craig 2009 p. 150.

pregnancy), and obstructed labour.[102] Mapping cultural practices of childbirth has therefore been an important contribution made by anthropologists involved in both research and health programmes in Tibet.

Tibetan childbirth practices have been described in different types of publications, including clinical studies,[103] socio-cultural analyses,[104] as well as in popular writings.[105] These studies have shown that, although outside the sphere of Tibetan medical professionals, Tibetan women perform a variety of practices to enhance the chances of a safe delivery. Adams *et al.* describe how these relate to five key categories: 'fear of attack by spirits/demons and negative health effects of meeting strangers; fear of and taboos against pollution/defilement (*grib*); injunctions to silence and secrecy; various beliefs about diet and behaviour; various social and economic obstacles to receiving hospital care'.[106] To tackle these challenges, women utilise a number of methods, including religious and dietary practices. As mentioned, amchi are also approached for specific Tibetan medicines associated with aiding and speeding up delivery.[107] Although amchi provide these pills for expectant mothers, amchi themselves are seldom present during the labour. Even in urban areas, most Tibetan women give birth at home, with the help of female relatives or their husband. Despite state efforts to promote use of birthing facilities in the county (biomedical) hospitals, the results seem to have been limited so far.[108]

Despite the vast knowledge of embryology, including gestation and childbirth, in Tibetan medical expertise, this knowledge has only marginally benefitted women in vulnerable health situations. One of the reasons for this,[109] is found in Frances Garrett's work on embryology in Tibetan literature. Garrett asserts that the description of embryology, or what is often called 'the formation of the body' (*grub pa lus*) has two forms and purposes in Tibetan medical and Buddhist writings: first, to address and educate doctors and religious

---

[102] TIN 2002, p. 67.

[103] Adams *et al.* 2005a, Adams *et al.* 2005b, Miller *et al.* 2007.

[104] Crook and Osmaston 1994, Rozario and Samuel 2002, Vorndran 1999, Ortner 1973, Childs 2004, Craig 2009.

[105] Brown *et al.* 1997, Sangay 1984.

[106] Adams *et al.* 2005a, p. 826.

[107] The following medicines were commonly used by *amchi* in Tsang, to help during birth or in complicated deliveries: *zhi bye 6* and *zhi bye 11* to ease childbirth and the delivery of the placenta, *gur gum 8* to stop excessive bleeding in childbirth, and *zhi bye 6* and *chi nar 6*, to stop vomiting during pregnancy and childbirth.

[108] In a recent study from Rebgong in Amdo (Qinghai province) sNying-dkhar-rgyal argues that following the implementation of the New Cooperative Medical Scheme in 2003, through which patients are secured reimbursement of significant portions of hospitalization costs, birth practices are changing towards more use of the county hospital (sNying-dkhar-rgyal 2011).

[109] See also Craig 2009, p. 153

practitioners about the nature of conception, foetal growth, pregnancy and birth; and second, to use embryology as a case to discuss the inherent morality of the Buddhist path.[110] Further, she points out that in the literature describing the growth of the embryo, the female body disappears from the text, signifying that the main focus is not on women's health, but rather on the nature of human rebirth within a Buddhist philosophical framework. In their contributions to this volume, Cuomu and Bright posit another possible reason for the scarcity of works on women's medicine and childbirth in the Tibetan medical literature, namely the centrality of monasteries to medical knowledge production and practice. Cuomu adds Tibetan women's shyness in talking about health problems relating to the 'secret parts' of their bodies might be an additional causal factor.

Modernising reproductive health

Despite the peripheral position of gynaecology and paediatrics to Tibetan medicine, attempts by the Tibetan government and central medical experts in Lhasa were made at the beginning of the twentieth century to develop a children's health care programme (*byis pa nyer spyod*). In this volume, Stacey Van Vleet describes the endeavour of the thirteenth Dalai Lama to implement a plan based on the manual *On Childcare: Treasure of the Heart Benefitting Beings* (*byis pa nyer spyod 'gro phan snying nor*), written by his personal physician, Jampa Tupwang (Byams-pa Thub-dbang). The programme comprised three main elements: the distribution of eight compounded medicines to parents of newborns, advice for rituals and care during the first year, and the efforts to calculate the natal astrology chart for all newborns. Notwithstanding contact with biomedicine in his various periods in exile, the Dalai Lama and his physician chose to base the childcare programme entirely within the formal structures of Tibetan medicine. This proved an early progressive attempt to develop Sowa Rigpa into a medical apparatus available for all social backgrounds within his own reign. However, the Dalai Lama's programme was discontinued in the 1920s, due to the turbulent political situation of the time.

In more recent history, political turmoil, caused by the Chinese invasion, has again left Tibetan medicine and its practitioners on the margins in relation to one of the most controversial reproductive health issues in contemporary Tibet, namely birth control. Amidst claims that it was a part of a policy of 'genocide' of the Tibetan people on the one hand, and to aid Tibetans to

[110] Garrett 2008, see also Craig 2009.

transform themselves into modern families on the other,[111] state birth control has proved one of the most difficult issues to research in Tibet. A decade ago, Goldstein *et al.* published findings from the TAR showing no coercive implementation of birth control in their particular area of study.[112] As Schrempf notes in her article in this volume, there seem to be vast discrepancies not only in attempts to control reproduction in Tibetan areas of the PRC, but also in the ways in which women have been subject to birth control and contraceptive use. In this first study mapping women's experiences of family planning policies Schrempf shows that Tibetan women in Amdo endured forced sterilisation and abortion campaigns throughout the 1980s and 1990s, and that the surgeries carried out on them during these years have left the women describing feelings of pain, loss of strength, and an increasing social pressure in these male-dominated communities.[113] Changes are happening in this field; Schrempf notes that younger women in the urban centres are more comfortable with the use of contraception, and often embrace the idea promoted by birth control campaigns that such measures allow the modern family to exist beyond a subsistence economy.[114]

Given the state's explicit involvement in women's reproductive health, in which ways do Tibetan medicine and the State-promoted biomedicine integrate? And who are the Tibetan participants and voices in this new field of integrated women's medicine? Birth control technology used in Tibet comes exclusively from biomedicine, and includes IUDs, abortion, and tubal litigation. Not surprisingly, Sowa Rigpa, through its long-standing emphasis on the connections between fertility and virility, has traditionally focused on enhancing fertility, rather than controlling it.[115] Fertility control today therefore represents a medical field completely dominated by biomedicine, when compared to the pattern in general reproductive health, which is characterised by integration of biomedicine and Tibetan medicine. This integration involves, however, biomedicalisation. In her extensive scholarship on contemporary practices of Tibetan medicine, Vincanne Adams has discussed the various ways in which Tibetan medicine, including women's medicine, is undergoing processes of modernisation and scientification through which biomedical technology and understanding come to form a central part of Tibetan medical

---

[111] Tibetan Women Association 1995, see discussion in Schrempf, this volume.

[112] Their sites of study were rural areas of Shigatse and Lhasa Municipality Prefectures, Goldstein *et al.* 2002, Goldstein and Beall 1991.

[113] Schrempf, this volume. Cf. Mueggler 2001 for descriptions of loss and pain following birth control campaigns among Lòlop'ò (officially classified as Yi) in Southwestern China.

[114] See also Childs *et al.* 2005.

[115] Gyatso 2008. See for instance Fjeld 2009 on the use of Tibetan medicine for fertility enhancing purposes in contemporary Lhasa.

practices.[116] These powerful, state-initiated modernisation processes are clearly part of the reason why Tibetan medicine is marginal to current reproductive health practices, as through these, traditional medical knowledge is placed lower in the hierarchy of 'science' and thus at the periphery of decision making.[117] At the same time, similar processes of biomedicalisation are seen at the Men-Tsee-Khang in Dharamsala, outside of the Chinese state's modernisation project. This leads to the question of the power of 'science' and commercialization in more general terms—beyond the reach of a particular state. Despite the fundamental differences of the political context of Tibetan medicine in India and the Prc, there are also some pronounced similarities in the processes of transformation, particularly seen in its incorporation of biomedically-defined anatomy and technology.[118]

Women's (reproductive) health has been one way of discussing the subject of Tibetan modernities. Schrempf has argued elsewhere that family planning, for instance, is a field in which Tibetan women struggle to find a 'Tibetan figuration of modernity in which . . . [they] must negotiate their own subjectivity in relation to the greater forces of socio-cultural, economic and political transformations in China'.[119] Chertow has also pointed to the role of Tibetan women in the Chinese project of modernising Tibet through state-sanctioned health projects, suggesting that through these projects, Tibetan women are constructed as a 'newly gendered, classed and racialised subject-citizen' within the Chinese state.[120] From the Chinese government's side too, the efforts to improve maternal and child health through the establishment of biomedical clinics and hospitals are indeed promoted as part of the modernisation of the Tibetan society. However, as Van Vleet's article in this volume shows, public health was not foreign to the Tibetan government in Lhasa before the Chinese invasion. She argues that the childcare programme launched in 1916 was one of many campaigns to educate women about childbirth and care, taking place not only in Tibet and neighbouring countries, but globally, initiated by both colonial rule and nation states. These campaigns were formed within discourses that linked public health care with ideas of 'benevolent rule, state sovereignty and civil society'.[121] The Tibetan childcare programme was designed to educate parents, not only mothers, independent of social standing.

---

[116] Adams 2001a, 2001b, 2002, Adams *et al.* 2005a, Adams and Dovchin 2001, Adams and Li 2008.

[117] See also Janes 1995.

[118] Prost 2006.

[119] Schrempf 2008, p. 121.

[120] Chertow 2008, p. 151.

[121] Van Vleet, this volume.

As a political project, the programme aimed to 'cultivate a sense of Tibetan subjecthood'[122] in relation to the delineated territorial nation state, which, Van Vleet points out, happened well before the thirteenth Dalai Lama had initiated his better known reforms of the tax system, the army, the postal system and more. It seems that also in the beginning of the previous century women's and children's health represented a rationalisation of the Tibetan bureaucracy, and as such it 'was an early, important, and perhaps more politic priority'.[123]

Contemporary medical writing and gender models

While Tibetan modernisation of medicine was firmly grounded in the idea of Sowa Rigpa as the 'definitive methods of analysis', as Van Vleet also found from the beginning of the twentieth century, the Chinese state's modernisation of health and medicine is conducted along biomedical lines. Although also expressed by practitioners as a process involving 'loss' of traditional knowledge, and particularly religious elements of medicine, Adams argues that biomedicine is also used by Tibetan doctors as a source of 'scientific legitimization' of Tibetan medicine in its institutional form.[124] Likewise, in her study of contemporary medical literature, Bright describes hybrid accounts of menstruation (or 'monthly mark', *zla mtshan*) in which Tibetan medical concepts of digestion and formation of the 'red element' (*khams dmar*), and biomedical concepts of hormones are intertwined in unorthodox ways so that hormones provide an explanatory model for digestion and menstruation. In line with Adams, she argues that integration with biomedicine is used to 'substantiate and bolster the validity of Tibetan medical claims', [125] rather than to dispute Tibetan medical theories. Underlying these arguments is the notion of agency and participation of Tibetan actors in the medical field, a point we find important to underline here.[126]

In which ways do cultural and religious perceptions of gender translate into these contemporary writings of a hybrid women's medicine? Has the integration of biomedicine influenced traditional notions of the inferior female body found in medical and religious theories? The texts on menstruation analysed

[122] Van Vleet, this volume.
[123] Van Vleet, this volume.
[124] Adams 2001b:225
[125] Bright, this volume.
[126] Similarly, Makley in her recent work on the Ethnic Park in Beijing, argues that Tibetan participants in the park are not just passive receivers of state cultural policies, they have proved to be capable of diverting 'meaning and values along alternative lines, even as they cope with the often crushing weight of shifting state and market pressures' Makley 2010, p. 129.

by Bright provide an indication that gender perceptions from the foundational texts, such as the *Four Tantras*, are maintained in contemporary writing. Just as people today writing about hormones, i.e. biomedical entities, do not contest Tibetan theories of digestion and the formation of menstruation, we can see similar processes of integration with other religious ideas of conception, including karmic explanations of female rebirth. Continuities in gender perception can also be found in these contemporary texts in the area of connections between women's disorders and sexuality. In most of these male-authored texts on gynaecology, sexual advice for men is also included.[127] Bright explains this continuity of gender perceptions through the characteristic form of text production employed. In this, the writer structures his or her texts as commentaries on the authoritative texts, and hence does not challenge fundamental theories and concepts.

At the same time, contemporary authors express sympathy towards women. This is seen for example in the avoidance of the infamous line, 'by having less merit [one] obtains the female body'.[128] In one of his books on women's disorders, which has been analyzed by Adams,[129] Palden Trinley, a doctor at Lhasa Mentsikhang, writes at great length about gender discrimination of what he calls the 'feudal system', i.e. pre-1950 Tibetan society, explaining it in social and cultural rather than medical terms. In fact, most of the writers examined by Bright explain women's low social status in Tibet in ways that go beyond medicine and religion. Explanations of the fundamental differences of the female and male body in terms of low merit are not prominent in contemporary medical literature, and Bright argues that in an integrated women's medicine of today sex differences are regarded as 'innate "chemical-like" features of the body',[130] much in the same ways as hormones have been sexed in biomedical theories.

Despite the increased volume of female medical expertise, it seems that authorship of medical texts remains predominately male. So far, it would appear that today's women practitioners produce few medical texts themselves. One important exception is Mingji Cuomu, who is represented with an article in this volume. Educated as a Tibetan medical doctor in Lhasa and later in Public Health and Medical Anthropology in England and Germany, she represents an exceptional and new kind of female medical practitioner, combining clinical work, research and medical writing. Conducting research on

---

[127] dPal-bzang rGya-mtsho 2010, p. 33, quoted in Bright, this volume.

[128] Bright, this volume.

[129] Adams 2001, pp. 226–227. Palden Trinley (also spelled Palden Thinley) is also the author of one of the texts analyzed by Bright.

[130] Bright, this volume.

broad topics such as public health, clinical trials and knowledge transmission in Tibetan medicine,[131] her focus in Tibetan language publications has nevertheless been on gynaecology and obstetrics.[132] Beyond confirming gender stereotypes in Tibetan medicine, the pattern of increasing numbers of female doctors publishing primarily on reproductive health indicates a future development whereby Tibetan medicine is more strongly incorporated within maternal and child healthcare.

Conclusion

Beyond this special issue's concerns with women as Sowa Rigpa practitioners and with Tibetan medical views of the female body as such, the scholarship represented within this volume also aims to disturb the usual perspectives in studies of Tibetan medicine featuring largely male authors, practitioners and patients. It reveals how human bodies and minds in Sowa Rigpa have largely been defined based on a normative and default male body and mind, a state of affairs that has been articulated and illustrated (with few exceptions) through men.

Compared to other domains of Tibetan social and cultural life, Tibetan medicine may have been an area with more room for female manoeuvre and performance beyond normative gender roles. Nevertheless, we question women's exceptional status as a social group, in the sense that we would argue for a constant negotiation and adjustment of ideals, through human or other agency, whether these ideals are outlined in texts or propagated in the context of social and moral orderings and disciplines. Hence the co-existence of seeming paradoxes should not be surprising, such as finding a woman doctor, with nuns and monks as her disciples, purifying mercury for locally produced precious pills in a rural Tibetan nunnery, yet at the same time noting that the Lhasa Mentsikhang does not allow any females, whether human or animal, near the one and a half month-long mercury purification at its production site outside of the city. Despite social constraints, structural limitations and cultural perceptions of the female rebirth as a disadvantage, there are accounts of women with great accomplishments and influence throughout Tibetan history.[133] In medicine there are well-known female doctors such as Khandro Yangga and Lady Doctor Lobsang Dolma, but also less well-represented

[131] See Craig, forthcoming.

[132] sMin-skyid mTsho-mo 2009, Byams-pa sGrol-dkar *et al.* 2004.

[133] See Diemberger 2007, Havnevik 1999, Jacoby 2007, Schaeffer 2004, as well as Uebach 2005.

women amchi, who nevertheless at times were holders of prestigious medical houses.

In addition to the well-known Tibetan category of medical lineages (*sman gyi rgyud*), we have pointed to the fact that some of these are also referred to as 'medical houses' (*sman grong*). Importantly we suggest that an emphasis on 'medical houses', as a new analytical perspective on the transmission of Tibetan medical knowledge, might be a fruitful way to account for women and understand better how they, whether lay or ordained, in different places, have learnt and practised medicine.

In terms of the female body in mainstream Tibetan medical literature and visual culture, leaving the vast extant manuscript and non-elite visual culture aside for the time being, the articles in this volume present the female body as represented and perceived predominantly as a 'body reproductive', a 'body/mind of desire', and a 'body of extras'.

As anthropologists, feminists and women, both having studied and lived in Tibet and having worked with exiled Tibetans for a number of years, we are curious to learn and to see what is changing in Tibetan medical notions of humanity, gendered discourses, personal experiences and broader healing and cultural practices of women and men. These are timely considerations, not least because almost half of the medical student population at most Tibetan medical institution—in large Chinese state colleges, exile institutions and in small private schools—is female. What will be the implications of this for the proclaimed notion of the inferiority of the female body in medicine and religion? Or, what will be the implications for the doctor-patient encounters in rural and urban Tibetan communities? What forces foster new ideas in this domain and in which ways will they be articulated?

It is only in recent decades that we can find published Tibetan medical texts by female authors, one of which is represented in this volume. We have discovered that these women do not reproduce the oft-held negative ideas about women (nor do some of their male contemporaries), yet they do tend to publish in the fields of *mo nad*, pregnancy and child birth.[134] That female amchis' expertise seems more comfortably cast in this domain was, as we have seen, already an issue for Khandro Yangga, chosen to head the newly established department for women and children's health at the Mentsikhang in 1962. Could it be that the domain of women's diseases, pregnancy and childbirth has been a field of medical expertise of Tibetan women all along, but existed outside of what has been defined as 'medical' in Tibetan medicine or biomedicine? How will the boundaries within Sowa Rigpa and other knowledge

[134] dPal-ldan 'Phrin-las 1996, Lha-mo sKyid 2007, sMin-skyid mTsho-mo 2009.

systems be redrawn, redefined and crossed with more women entering professional medical work, where traditional medicine is also beginning to take a more central position than in the past? And how will this take place in dialogue and in discussion with biomedical ideas and its global assemblages of biopower, science and technologies? By bringing these articles together, it has been our aim to start engaging with these questions.

These contestations of traditional gender roles and the creation of new subjectivities, within and outside of medicine, are taking place at interesting times. The use of the term 'low birth' *skye dman* for 'woman' is self-consciously debunked by many urban Tibetan women in favour of *bud med* or *a ce*. While the oppositional unity of 'wisdom' and 'method' may be used as a liberating force for religious women, it remains to be seen how feminist literature is navigating its path across and between the Communist Party and other lines. Almost twenty years have passed since Samuel wrote that 'Tibetanists have generally ignored the issues raised by feminist thought'.[135] We hope that scholars of Tibetan studies and the anthropology of Tibet alike will be more attuned to listen to and represent women's voices, and that the disciplines will not need to be critiqued, again, for its lack of subaltern movements and engagement with gender studies.

Acknowledgements

We would like to thank the Nansenfoundation and the Norwegian Research Council for their project grant made available to Hofer and Fjeld, without which this joint writing and editing project would not have been possible. Equally, heartfelt thanks to the Section for Medical Anthropology and Medical History, Institute for Health and Society for facilitating Theresia Hofer's stay as a guest researcher. Many thanks also to our reviewers, as well as our colleagues who closely read and commented on the introduction, in particular Barbara Gerke and Sienna Craig. We gratefully acknowledge support from the Trace Foundation for funding conference travel of Tibetan participants to the panel in Bhutan and for covering the costs of translation of Cuomu's article included here, as well as the Austrian Ministry of Education and Research and the Norwegian Research Council for funding conference travel. Finally, we wish to thank our copy editors Liz Hudson, Ruth Biddes and Thea Vidnes, and translator Katia Holmes for their excellent work and collaboration.

[135] Samuel 1994, p. 696.

References

Tibetan Language

bKra-shis Tshe-ring 1994, 'Bod du grags can mi sna'i gras bud med kyi bod lugs sman pa'i lo rgyus rags tsam gleng ba yid gdung sel ba'i sman mchog' in *g.Yu-mtsho*, 2, 1, pp. 48–84.

Byams-pa 'Phrin-las 2000, *Gangs ljongs gso rig bstan pa'i nyin byed rim byong gyi rnam thar phyogs bsrigs*. ('Biographies of Famous Sorig Doctors in the Snowland'). Beijing: Mi rigs dpe skrun khang.

Byams-pa 'Phrin-las and Tshe-brtan 'Jig-med 2006, Tshe-brtan 'Jig-med, *Gso rig rgyud bzhi'i sman thang brgydu cu'i dkar 'grel bai DU+rya a'i od sman shel bya ba bzhugs so*. Lha sa: Mi rigs dpe skrung khang.

Byams-pa sGrol-dkar, sMin-skyid mTsho-mo, Gongs-mi, Nor-dbyangs, Tshe-dbyangs sGrol-dkar 2004, *Mo nad gso ba*. Lha sa: Mi rigs dpe skrung khang.

sMin-skyid mTsho-mo 2009, *Mo nad phal pa'i nad la zhib 'jug dang gso bcos bays pa'i nyams yig* ('Clinical Experience in Treating Obstetric Conditions'). Lha sa: Bod ljongs mi dmangs dpe skrun khang.

Da-wa Ri-bdag 2003, *Bod kyi gso ba rig pa lass man rdzas sbyor bzo'I lag len gsang sgo 'byed pa'I lte mig*. Delhi: Rig Drag Publications.

dPal-ldan 'Phrin-las 1996, *Bod lugs gso rig gi rgyun mthong mo nad 'gog bcos bya thabs*, Lhasa: Bod-ljongs mi dmangs dpe skrun khang.

g.Yu-thog Yon-tan mgon po 1984, *Bdud rtsi snying po yan lag brgyad pa gsang ba man ngag gi rgyud ces bya ba*. Dharamsala: Tibetan Medical & Astro Institute.

Lha-mo sKyid 2007, 'Zla mtshan gyi rnam par dpyad blo chung byis pa'i mgul rgyun' in *Krung go'i bod kyi gso rig*, vol. 1, 103–11.

Nor-bu Chos-'phel and bKra-shis Tshe-ring 2008, *Mnga' ris smad yul skyid grong rgya dgu'i lo rgyus dang brel ba'i skyid grong grwa khang dkar ba'i sman pa mkhas grags can blo bzang sgrol ma'i nang mi'i lo rgyus nor bu'i me long.* ('A Brief Account of the Famous Tibetan Lady Doctor Lobsang Dolma Khangkar (1935–1989) and her Family, Including Historical Materials on Kyirong, South West Tibet'). Dharamsala: Amnye Machen Institute.

mKhyen-rab Nor-bu (alias Dra-kya ma-ni), *Byis pa btsa' thabs kun phan zla ba'i me long zhes bya ba.* ('Mirror of the Moon: Methods for Giving Birth Helpful to All.') Lhasa Mentsikhang, n.d. (On Folio 8a it is stated that the text was written on an auspicious date in the 'year of Mars' (*mig dmar lo*), however we are not sure which year this may correspond to).

Thub-bstan Sangs-rgyas 1975, *Bod kyi sngar srol byis pa skye gso bya tshul po thra la yi them skas zhes bya ba.* ('Stairs to Potala—The Traditional Tibetan Art of Delivery and Childcare'). Dharamsala: Library of Tibetan works and Archives.

Sangs-rgyas rGya-mTsho 2005, *Gso ba rig pa'i bstan bcos sman bla'i dgong rgyan rgyud bzhi'i gsal byed Vaid urya sngon po'i ma li ka* ('The Blue Lapis Lazuli' or 'Blue Beryl'). Lha sa: Bod ljong mi dmang dpe skrun khang, 2005 [1687–88].

sMan-rtsis-khang, Bod-rang sKyong-ljongs 2006, *Bod lugs gso rig dpe rnying dkar chag* (Tibetan–Chinese–English Catalogue of the Tibetan Traditional Medicine Books). Lha sa: Mi rigs dpe skrun khang, 2006.

European Languages

Acharya, Meena and Lynn Bennett 1981, 'The rural women of Nepal: An aggregate analysis and summary of eight villages studies,' *Status for Women in Nepal*, vol. 2, part 9. Kathmandu: Centre for Economic Development and Administration, Tribhuvan University.

Adams, Vincanne 1998, 'Suffering the Winds of Lhasa: Politicized Bodies, Human Rights, Cultural Difference, and Humanism in Tibet', *Medical Anthropology Quarterly*, 12.1: 74–102.

—— 2001a, 'Particularizing Modernity: Tibetan Medical Theorizing of Women's Health in Lhasa, Tibet', in L.H. Connor and G. Samuel (eds), *Healing Powers and Modernity. Traditional Medicine, Shamanism and Science in Asian Societies*, Westport, CT: Bergin & Harvey, 222–46.

—— 2001b, 'The Sacred in the Scientific: Ambiguous Practices of Sciences in Tibetan Medicine', *Cultural Anthropology*, 16.4: 542–575.

—— 2002, 'Establishing Proof: Translating "Science" and the State in Tibetan Medicine', in M. Nichter and M. Lock (eds), *New Horizons in Medical Anthropology. Essays in honour of Charles Leslie*, London and New York: Routledge, 200–220.

—— 2005, 'Saving Tibet? An Inquiry into Modernity, Lies, Truths, and Beliefs', *Medical Anthropology*, 24: 71–110.

Adams, Vincanne and Dashima Dovchin 2001, 'Women's health in Tibetan Medicine and Tibet's "first" female doctor', in E.B. Findly (ed), *Women's Buddhism. Buddhism's women. Tradition, Revision, Renewal*, Boston: Wisdom Publications, 433–50.

Adams, Vincanne *et al.* 2005a, 'Having a "Safe Delivery": Conflicting Views from Tibet', *Health care for Women International* 26.10: 821–51.

Adams, Vincanne *et al.* 2005b, 'The challenge of cross-cultural clinical trials research: case report from the Tibet autonomous region, People's Republic of China'. *Medical Anthropology Quarterly*, 19.3: 267–289.

Adams, Vincanne and Sienna R. Craig 2008, 'Global Pharma in the Land of Snows: Tibetan Medicines and Identity Across Nations', *Asian Medicine: Tradition and Modernity*, 2.1:1–28.

Adams, Vincanne and Fei Fei Li 2008, 'Integration or Erasure? Modernizing Medicine at Lhasa's Mentsikhang', in Laurent Pordié (ed), *Exploring Tibetan Medicine in Contemporary Context: Perspectives in Social Sciences*, London: Routledge, 105–31.

Adams, Vincanne, Sienna R. Craig and Mona Schrempf 2010, *Between science and religion. Explorations on Tibetan grounds*, New York: Berghahn.

Appadurai, Arjun 1996, *Modernity at Large: Cultural Dimensions of Globalisation*. Minneapolis and London: University of Minnesota Press.

Aziz, Barbara 1987, 'Moving towards a sociology of Tibet', in J.D. Willis (ed) *Feminine Ground: Essays on Women and Tibet*, Ithaca, NY Snow Lion Publications, 77–95.

—— 1988, 'Women in Tibetan Society and Tibetology', in H. Uebach and Panglung (eds), *Tibetan Studies, PIATS Munich 1985*, 25–34.

Bell, Charles 1924, *Tibet: Past and Present*, Oxford: Clarendon Press.

Birnbaum, Raul 1989, *The Healing Buddha*, Boulder: Shambhala.

Bolsokhoyeva, Nathalia 2007, 'Tibetan Medical Schools of the Aga Area (Chita Region)', *Asian Medicine: Tradition and Modernity*, 3.2: 334–46.

Brauen, Martin 2002, *Peter Aufschnaiter's Eight Years in Tibet*, Bangkok: White Orchid Press.

Brown, Anne Maiden, Edie Farwell and Dickey Nyerongsha 1997, *The Tibetan Art of Parenting, From Before Conception Through Early Childhood*, Boston: Wisdom Publications.

Cameron, Mary 2010, 'Feminization and Marginalization? Women Ayurvedic Doctors and Modernizing Health Care in Nepal', *Medical Anthropology Quarterly*, 24.1: 42–63.

Carsten, Janet and Stephen Hugh-Jones 1995, *About the House. Lévi-Strauss and Beyond*, Cambridge: Cambridge University Press.

Chertow, Jennifer M. 2007, *Gender, Power, Space: Transnational bodies and the cultures of health in contemporary Tibet*, PhD Dissertation, Department of Anthropology, Stanford.

—— 2008, 'Embodying the nation. Childbirth in Contemporary Tibet', in: R. Barnett and R. Schwartz (eds), *Tibetan Modernities, PIATS Oxford 2003*, Leiden: Brill, 75–99.

Childs, Geoff 2004, *Tibetan Diary: From Birth to Death and Beyond in a Himalayan valley of Nepal*, Berkeley, CA: University of California Press.

Childs, Geoff *et al.* 2005, 'Tibetan Fertility Transitions in China and South Asia'. *Population and Development Review*, 31.2: 337–349.
Clark, Barry 1995, *The Quintessence Tantras of Tibetan Medicine*, Ithaca: Snow Lion.
Cliffort, Terry 1984, *Tibetan Buddhist Medicine and Psychiatry*, New York: Samuel Weiser.
Craig, Sienna R. 2009, 'Pregnancy and Childbirth in Tibet: Knowledge, Perspectives, and Practices', in H. Selin (ed), *Childbirth Across Cultures*, New York: Springer, 145–60.
—— Forthcoming, *Healing Elements: Efficacy and the Social Ecologies of Tibetan Medicine,* Berkeley: University of California Press.
Crook, John and Henry Osmaston 1994, *Himalayan Buddhist villages: Environment, resources, society and religious life in Zanskar, Ladakh*, Bristol: University of Bristol Press.
Dashiyev, Dandar 2001, *Dzhud-shi: Kanon Tibetskoj Meditsiny [Gyushi: Canon of Tibetan Medicine],* Biblioteka tibetskoi meditsiny, Moscow: Vostochnaya literature.
Diemberger, Hildegard 1993, 'Blood, sperm, soul and the mountain. Gender relations, kinship and cosmovision among the Khumbo (N.E. Nepal)', in T. del Valle (ed) *Gendered Anthropology*, London: Routledge, 88–127.
—— 2007, *When a Woman Becomes a Religious Dynasty*, New York: Columbia University Press.
Farquhar, Judith 1991, 'Objects, Processes, and Female Infertility in Chinese Medicine', *Medical Anthropology Quarterly*, 5.4: 370–399.
Filliozat, Jean 1937, *Étude de Démomologie Indienne. Le Kumara-tantra de Ravana et les Textes Parallèlles Indiens, Tibétains, Chinois, Cambodgien et Arabe*, Series: Cahiers de la Société asiatique. 1: IV, Paris: Imprimerie Nationale.
Fjeld, Heidi 2005, *Commoners and Nobles: Hereditary Divisions in Tibet*, Copenhagen: NIAS Press.
—— 2007, *The Rise of the Polyandrous House: Marriage, Kinship and Social Mobility in Rural Tsang, Tibet*, PhD thesis, Faculty of Social Sciences, Oslo: University of Oslo.
—— 2008, 'Pollution and Social Networks in Contemporary Rural Tibet', in R. Barnett and R. Schwartz (eds), *Tibetan Modernities, PIATS Oxford 2003*, Leiden: Brill, 113–37.
—— 2009, 'Dealing with infertility in Lhasa. Past and Present', Paper presented at ICTAM VII, 7–11th September 2009, Thimphu, Bhutan.
Furth, Charlotte 1999, *A Flourishing Yin: Gender in China's Medical History, 960–1665*, Berkeley: University of California Press.
—— 2007, *Thinking with Cases: Specialist Knowledge in Chinese Cultural History*, Honolulu: University of Hawai'i Press.
Garrett, Frances 2008, *Religion, Medicine and the Human Embryo in Tibet*, London and New York: Routledge.
—— 2009, 'The Alchemy of Accomplishing Medicine (*sman sgrub*): Situating the Yuthok Heart Essence (G.yu thog snying thig) in Literature and History', *Journal for Indian Philosophy*, 37: 207–230.
Gerl, Robert and Jürgen Aschoff 2005, *Die Medizinhochschule Tschagpori (lCag-po-ri) auf dem Eisenberg in Lhasa—Geschichte, Fakten, Zeitzeugen.* Ulm: Fabri.
Goldstein, Melyvn 1971, 'Stratification, Polyandry, and Family Structure in Central Tibet', *Southwestern* Journal of Anthropology, 27: 64–74.
—— 1989, *A History of Modern Tibet 1913–1951: The Demise of the Lamaist State*, Berkeley: California University Press.
Goldstein, Melvyn *et al.* 2002, 'Fertility and Family Planning in Rural Tibet', *The China Journal*, 47: 19–39.
Goldstein, Melvyn and Cynthia Beall 1991, 'China's Birth Control Policy in the Tibet Autonomous Region: Myths and Realities', *Asian Survey*, 31.3: 285–303.
Gutschow, Kim I. 2004, *Being a Buddhist Nun: The Struggle for Enlightenment in the Himalayas*, Cambridge, Mass.: Harvard University Press.

—— 2011, 'From Home to Hospital; the Extension of Obstetrics in Ladakh', in V. Adams, M. Schrempf, and S.R. Craig (eds) *Medicine between science and Religion—Explorations on Tibetan Grounds*, New York and Oxford: Berghahn Books, 185–213.

Gyatso, Janet 1989, 'Down with the Demoness: Reflections on Feminine Ground in Tibet', in J. Willis (ed), *Feminine Ground. Essays on Women and Tibet*, Ithaca: Snow Lion, 33–51.

—— 2003, 'One Plus One Makes Three: Buddhist Gender Conceptions and the Law of the Non-Excluded Middle', *History of Religions*, 43.2: 89–115.

—— 2008, 'Spelling Mistakes, Philology, and Feminist Criticism: Women and Boys in Tibetan Medicine', *Revue d'Etudes Tibétaines*, 14, 81–98.

Gyatso, Janet and Hanna Havnevik 2005, *Women in Tibet*, London: Hurst and Company.

Gyatso, Yontan and Katia Buffetrille 1987, 'The medical college of Labrang', *Newsletter of the International Association for the Study of Traditional Asian Medicine*, 7–10.

Hancart-Petitet, Pascale and Laurent Pordié (in press), 'Birth in Shun Shade: Notes on Role of the Amchi Regarding Childbirth', in L. Pordié (ed.) *Healing at the Periphery: Ethnographies of Tibetan Medicine in India*, Durham and London: Duke University Press.

Havnevik, Hanna 1989, *Tibetan Buddhist Nuns: History, cultural norms and social reality*, Oslo: Norwegian University Press.

—— 1999, *The Life of Jetsun Lochen Rinpoche (1865–1951) as Told in Her Autobiography*, PhD thesis, Faculty of Arts, University of Oslo.

Hofer, Theresia 2007, 'Preliminary Investigations into New Oral and Textual Sources on *Byang lugs*—the "Northern School" of Tibetan Medicine' in M. Schrempf (ed), *Soundings in Tibetan Medicine—Anthropological and Historical Perspectives, PIATS Oxford 2003*, Leiden: Brill Academic Publishers, 373–410.

—— 2011a, *Tibetan Medicine on the Margins: Twentieth Century Transformations and the Traditions of Sowa Rigpa in Central Tibet*, PhD thesis, University College London.

—— 2011b, 'Changing Representations of the Tibetan Woman Doctor Khandro Yangkar (1907–1973)', in A. McKay and A. Balicki-Dengjongpa (eds), *Buddhist Himalayas: Studies in Religion, History and Culture. Proceedings of the Golden Jubilee Conference of the Namgyal Institute of Tibetology Gangtok, 2008, I: Tibet and the Himalaya*, Gangtok: Namgyal Institute of Tibetology, 99–122.

—— 2011c, 'The Mirror of the Moon—Khenrab Norbu's text on Tibetan medical methods for giving birth', talk given at the UCL Wellcome Trust Centre for the History of Medicine, London, 10th May (Medical Texts in Translation Series).

—— In press, *The Inheritance of Change—Transmission and Practice of Tibetan Medicine in Ngamring*, Vienna: Wiener Studien zur Tibetologie und Buddhismuskunde (Vol. 76).

Howell, Signe L. 1996, 'Many contexts, many meanings? Gendered values among the Lio moral system', *Journal of the Royal Anthropological Institute*, 2.2: 253–269.

Hsu, Elisabeth 1998, 'Moso and Naxi: The House', in M. Oppitz and E. Hsu (eds), *Naxi and Moso Ethnography. Kin, Rites, Pictographs*, Zurich: Völkerkundemuseum, 67–99.

Inhorn, Marcia C. 2006, 'Defining Women's Health: A Dozen Messages from More than 150 Ethnographies', *Medical Anthropology Quarterly*, 20.3: 345–378.

ITTM (International Trust for Traditional Medicine) 2002, 'Traditional Mongolian Medicine', Special issue of *Ayur Vijnana*, 8.

Jacoby, Sarah H. 2007, ' "This inferior female body": Reflections on life as a Tibetan visionary through the autobiographical eyes of Se ra mka' 'gro (Bde ba'i rdo rje, 1892–1940)', *Journal of the International Association of Buddhist Studies*, 32.1–2:115–150.

Josayma, Tashi Tsering and K. Dhondup 1990, *Dolma and Dolkar: Mother and Daughter of Tibetan Medicine*, Delhi: Yarlung Publications.

Janes, C. 1995, 'The Transformation of Tibetan Medicine', *Medical Anthropology Quarterly*, 9.1: 6–39.

Jäger, Karin 1999, '*Nektar der Unsterblichkeit' Zwei Kapitel aus der Tibetischen Kinderheilkunde*, Egelsbach: Verlag Dr. Hänsel-Hoherhausen.

Khangkar, Lobsang Dolma 1998, *Lectures on Tibetan Medicine*, Dharamsala: Library of Tibetan Works and Archives.

Khangkar, Docteur Dolkar and Marie-José Lamothe 1997, *Médicin du toit du monde*, Monaco: Editions du Rocher.

Kloos, Stephan 2008, 'The History and Development of Tibetan Medicine in Exile'. *Tibet Journal*, 33.3: 15–49.

—— 2010, *Tibetan Medicine in Exile: The Ethics, Politics, and Science of Cultural Survival*, PhD thesis, University of California, Berkeley.

—— 2011, 'Making a "Medical System": Tibetan Medicine in Exile', paper given at the 'Contemporary Issues in the Anthropology of Tibetan Medicine' workshop, 21st–22nd of January, Cardiff University.

Levine, Nancy 1981, 'The theory of *rü* kinship, descent and status in a Tibetan society', in C. Fürer-Haimendorf (ed), *Asian Highland Societies. In anthropological perspective*, New Delhi: Sterling Publishers Private, 52–78.

Lévi-Strauss, Claude 1987 [1983], *The Way of the Masks*, London: Jonathan Cape.

—— 1991, 'Maison', in P. Bonte and M. Izard (eds), *Dictionnaire de l'ethnologie et de l'anthropologie*, Paris: Presses de Universitaires de France.

Lopez, Donald S. 1998, *Prisoners of Shangri-la. Tibetan Buddhism and the West*, Chicago and London: Chicago University Press.

MacDonald, David 1929, *Land of the Lama*, London: Imprint. 1929.

Makley, Charlene 2005, 'The Body of a Nun—Nunhood and Gender in Contemporary Amdo', in J. Gyatso and H. Havnevik (eds), *Women in Tibet*, London: Hurst and Company, 259–84.

—— 2007, *The Violence of Liberation: Gender and Tibetan Buddhist Revival in post-Mao China*, Berkeley: University of California Press.

—— 2010 'Minzu, Market and the Mandala. National exhibitionism and Tibetan Buddhist Survival in Post-Mao China', in T. Oakes and D.S. Sutton (eds), *Faiths on Display*, Plymouth: Rowman & Littlefield Publishers, 127–156.

McKay, Alex 2007, *Their Footprints Remain. Biomedical Beginnings Across the Indo-Tibetan Frontier*, Amsterdam: Amsterdam University Press.

McKay, Alex and Dorji Wangchuk 2005, 'Traditional Medicine in Bhutan', *Asian Medicine: Tradition and Modernity*, 1.1: 204–18.

Meyer, Fernand 1995, 'Theory and Practice of Tibetan Medicine', in J. van Alphen and A. Aris (eds), *Oriental medicine. An illustrated guide to the Asian arts of healing*, London: Serindia, 109–41.

Millard, Colin 2011, 'Between Science, Bon and Buddhism: multiple values in Tibetan medical education', paper given at the 'Contemporary Issues in the Anthropology of Tibetan Medicine' workshop, 21st–22nd January, Cardiff University.

Miller, Suellen, C. Tudor, Nyima, V.R. Thorsten, Sonam, Droyoung, S. Craig, P. Le, L.L. Wright, M.W. Varner 2007, 'Maternal and neonatal outcomes of hospital vaginal deliveries in Tibet', *International Journal of Gynecology and Obstetrics*, 98: 217–21.

Moore, Henrietta 1994, *A Passion for Difference: Essays in Anthropology and Gender*, Oxford: Polity Press.

Mueggler, Eric 2001, *The Age of Wild Ghosts—Memory, Violence, and Place in Southwest China*, Berkeley: University of California Press.

sNying-dkhar-rgyal 2011, *Local health seeking strategies and the New Cooperative Medical Scheme in contemporary Phyed ri village, Amdo*, MA thesis, University of Oslo.

Ortner, Sherry B. 1973, 'Sherpa purity', *American Anthropologist* (*N.S.*), 75, 1: 49–63.

Parfionovitch, Yuri, Gyurme Dorje and Fernand Meyer (eds), 1992, *Tibetan Medical Paintings: Illustrations to the Blue Beryl Treatise of Sangye Gyamtso (1653–1705)*, 2 vols., London: Serindia Publications.

Prost, Audrey 2006, 'Gained in translation: Tibetan science between Dharamsala and Lhasa', in T. Hermans (ed), *Translating Others (Volume 1)*, Manchester: St. Jerome Publishing, 132–144.

—— 2008, *Precious Pills. Medicine and Social Change among Tibetan Refugees in India*, Oxford, Berghahn.

Rechung, Rinpoche 1973, *Tibetan Medicine—Illustrated in Original Texts*, London: Wellcome Institute of the History of Medicine.

Rozario, Santi and Geoffrey Samuel 2002, 'Tibetan and Indian Ideas of Birth Pollution: Similarities and Contrasts', in S. Rozario and G. Samuel (eds), *Daughters of Hariti: Childbirth and Female healers in South and Southeast Asia*, London, New York: Routledge, 182–208.

Sakya, Jamyang and Julie Emery 1990, *Princess in the Land of Snows: the Life of Jamyang Sakya in Tibet*, Boston: Shambhala.

Samuel, Geoffrey 1994, 'Tibet and the Southeast Asian Highlands: Rethinking the Intellectual Context of Tibetan Studies', in P. Kvaerne (ed), *Tibetan Studies: Proceedings of the 6th Seminar of the International Association for Tibetan Studies, PIATS Fagernes 1992*, Oslo: Institute for Comparative Research in Human Culture, 696–710.

—— 2008, 'The Politics of Tibetan Medicine and the Constitution of an Object of Study', in L. Pordié (ed.), *Tibetan Medicine in the Contemporary World—Global Politics of Medical Knowledge and Practice*, London and New York: Routledge, 251–63.

Sangay, Thubten 1984, 'Tibetan traditions of Childbirth and Childcare', *Gso rig: Tibetan Medicine*, 7: 3–24.

Saxer, Martin 2010, *Manufacturing Good Practice—GMP and shifting notions of quality in Tibetan medicine*, Institute of Social and Cultural Anthropology. PhD thesis. Oxford, University of Oxford.

Schaeffer, Kurtis R. 2003, 'Textual Scholarship, Medical Tradition, and Mahayana Buddhist Ideals in Tibet', *Journal of Indian Philosophy*, 31: 621–641.

—— 2004, *Himalayan Hermitess*, Oxford: Oxford University Press.

Scott, Joan Wallach 1988, *Gender and the Politics of History*, New York: Columbia University Press.

Schrempf, Mona 2007, 'Bon Lineage Doctors and the Local Transmission of Knowing Medical Practice in Nagchu' in M. Schrempf (ed), *Soundings in Tibetan Medicine—Anthropological and Historical Perspectives*), Leiden: Brill, 91–126.

—— 2008, 'Planning the Modern Tibetan Family', in V. Houben and M. Schrempf (eds), *Figurations of Modernity—Global and Local Representations in Comparative Perspective*, Frankfurt: Campus Verlag, 121–151.

Sponberg, Alan 1992, 'Attitudes toward Women and the Feminine in Early Buddhism', in J.I. Cabezón (ed), *Buddhism, Sexuality, and Gender*, Albany: State University of New York Press, 3–36.

Tashi Tsering 2005, 'Outstanding Women in Tibetan Medicine', in J. Gyatso and H. Havnevik (eds), *Women in Tibet*, London: Hurst & Company, 169–94.

Taube, Manfred 1981, *Beiträge zur Geschichte der medizinischen Literatur Tibets*, St. Augustin Verlag.

Taring, Rinchen Dolma 1970, *Daughter of Tibet*, London: John Murray.

Tibet Women Association 1995, *Tears of Silence: Tibetan Women and Population Control Policies*, Dharamsala: TWA.

TIN (Tibet Information Network) 2002, *Delivery and Deficiency: Health and Heath Care in Tibet I*, London: TIN.

—— 2004, *Tibetan medicine in Contemporary Tibet: Health and Health Care in Tibet II*, London: TIN.

Uebach, Helga 2005, 'Ladies of the Tibetan Empire (Seventh to ninth Centuries CE)', in J. Gyatso and H. Havnevik (eds), *Women in Tibet*, London: Hurst & Company, 29–48.

Vorndran, Eika 1999, *Good to be Human: Coming into Existence in a Tibetan Bon Exile Community*, MA thesis. Vienna.

Young, Serenity 2011, 'The Buddhist Discourse on Gender in Tibetan Medical Iconography', in E.F. Lo Bue (ed), *Art in Tibet—Issues in Traditional Tibetan Art from the Seventh to the Twentieth Century*, Leiden: Brill, 203–212.

Yuthok, Dorje Yudon 1990, *House of the Turquoise Roof*, Ithaca, NY: Snow Lion Publications.

Zhan, Mei 2009, *Other-Worldly: Making Chinese Medicine through Transnational Frames*, Durham and London: Duke Publishers.

BRILL

Asian Medicine 6 (2010–11) 217–292

brill.nl/asme

Looking for Gender in the Medical Paintings of Desi Sangye Gyatso, Regent of the Tibetan Buddhist State

Janet Gyatso

Abstract

This essay studies the representation of women and gender in the unprecedented, elaborately detailed medical paintings created by Desi Sangye Gyatso at the end of the seventeenth century in Lhasa, Tibet. It compares the textual version of the information rendered in the paintings with their visual translation. The study discovers a rather complex and mixed picture. It finds that the more systematic portrayals of human anatomy betray a deep androcentrism, with images of female bodies either marginalised or entirely absent. However, other less standard parts of the set that depict a wide swathe of daily life on the Tibetan plateau show much more diversity in gender conception. A far greater number of females are depicted there. Women are still shown almost exclusively in gender-specific roles and are virtually never deployed to stand for a gender-neutral medical condition, which is always represented either by a default male figure or a gender-ambiguous one. And yet some of these less standard depictions show either gender egalitarianism, or indeed show little gender differentiation at all, even with respect to attire and bodily features such as breasts and hair. Some images even suggest that gender differentiation was not an important issue, at least some of the time. Yet still other portions of the less standard vignettes do display strict gender distinction and also indicate the greater importance of male medical issues and the inferior status of the female body. In sum, the medical paintings suggest that a wide range of gender conceptions operated not only in Tibetan medicine but also across society more broadly, and these were neither consistent nor fixed.

Keywords

Tibetan medicine, visual representation, medical iconography, Lhasa, sex, gender, androcentrism

Introduction

The spectacular set of 79 medical paintings, produced at the height of the Tibetan Buddhist state by the regent sDe-srid Sangs-rgyas rGya-mtsho ('Desi Sangye Gyatso', 1603–1705), provides many images of men and women, in all walks of life, in a wide assortment of everyday activities, as they relate to human flourishing—and malady. The set provides an unmatched opportunity to study a Tibetan visual representation of Tibetan society. Among the many

DOI: 10.1163/15734218-12341235

issues on which it affords some window are questions about gender difference and gender status in Tibetan history, about which we have precious little information elsewhere.

This essay will explore the Desi's medical paintings for their representation of female sex and gender.[1] How rigorously was gender difference defined, and what were the implications of such difference? Was there a distinction between the ways gender identity and difference were represented textually and the way they might have been depicted visually? More broadly, what cultural significance could the depiction of the bodies of men and women convey? To what degree could female images—like male ones—serve to represent the general human predicament? How important was gender identity in the depiction of medical knowledge at all?

Such questions appear relatively straightforward, and yet they entail some hoary issues for historians. Not the least of these is a recurring, and fundamental, question for feminist historiography: to what extent must gender conception and related social practices inform cultural production? Is any portrayal of women, for example, necessarily infused with gender politics? (This writer would almost always say yes, but we still need to provide the specifics of how and why and to resist hasty generalisations).

These basic issues will be complicated by a second kind of question that the topic of this essay raises. The paintings in question purport to reproduce the knowledge in a written text. The latter is the magisterial *Blue Beryl* commentary, authored by the Desi himself, on the famous twelfth-century Tibetan medical work *rGyud bzhi* (*Four Treatises*).[2] Paying attention to the ways in which the painted images of gender differ from the corresponding textual references to gender may allow us to glimpse the inner workings of a key moment of artistic production in Tibetan history. It might suggest what decisions were made in the studio and what liberties in the representation of gender that the artists—or their director the Desi, or indeed the other scholarly informants who seem to have been present in the painting studio—were able

[1] In this essay I will mostly use the term 'gender' to refer both to biological differences between the sexes and to second-order symbolic and cultural formations based on such differences. While in other publications I have pursued the distinction between sexual identity and gender as they relate to Tibetan discourse and practice, I will here follow the lead of feminist theorists such as Judith Butler who have pointed out how much even anatomical specification is a cultural construction.

[2] There is a close relation between the painting set and the Desi's commentary *Blue Beryl*, but most primarily the paintings are keyed to the *Four Treatises* itself, as evidenced in the fact that interlinear marks that correspond to elements of the painting plates were added to the blockprint of the latter but not the former. See nn. 8, 9 and 26 below.

to take. And, like the question about gender politics, this second angle of vision also opens up an interesting theoretical issue regarding cultural production, now about representation as such, not to mention the sociological and cultural differences between the scene of writing and the scene of painting. What differing opportunities—and limitations—did each contribute to the production of knowledge?

For its part, this second question about the differences between image and text opens up a third, even more intricate issue about kinds of representation. There is a distinction to be discerned between those images in the painting set that carefully present detailed medical knowledge and those that more loosely depict the plethora of human figures and situations surrounding medical practice. In other words, the questions we have posed for this essay means we will also be led to ponder whether there is a difference between painting gender according to academic system and painting gender in the context of the everyday. Indeed, the very fact that we can discern in the paintings a difference between what I have just called academic system and the everyday in turn raises some fundamental questions about medical knowledge in Tibet. Most of all, these pertain to the very relation between Buddhist scholasticism and science in Tibetan history.

While we will not be able to spend time on that last large question here, there is yet a fourth theoretical issue that needs flagging at the outset too. While this one is on a different register than the others, it affects all of the questions I am raising. The issue regards our ability to read images for their cultural message. In particular, how do we read gender? This is a thorny question for any observer, but all the more so when one is separated by time and space from the objects in question and relatively ignorant about the details of gender codes in clothing, ways of holding the body, demeanour, personal ornamentation and hairstyles, not to mention gender-differentiated work patterns and gender-coded domestic spaces. Yet neither is it the case that the scholar can simply ask native Tibetans to read the gender of the painted images, since the conventions at work today have not remained the same over the past 300 years, even inside pre-1950s Tibet. Add to that the strong possibility, pursued in this essay, that sometimes the gender of the figures is in fact ambiguous, be that deliberate or not. My own experience on showing these images to several learned Tibetan colleagues has indicated that many of the figures whose gender seemed ambiguous to me were ambiguous to these viewers as well.

In what follows we will try to resist the tendency to project our own, rarely examined assumptions about gender and body type, dress, social function and so on. But even in trying to stick to what we can say for sure about gender

markers in the paintings, and who is a male and who is a female, such distinctions will already trade on a slew of assumptions that confound the whole question of the relation of anatomical sex to the conventions of gender. Again, these are issues that are far too big to resolve here, but at least they will be kept marginally in view.

The Desi's medical painting set

Luckily, the medium through which these recondite matters will be pursued is itself delightful and lucid. No matter how many times, it seems, you gaze at these detailed and expressive images, you never get over the pleasure. A big part of that reaction has to do with the brilliance of the set's execution. The brainchild of the Desi, the powerful regent to the Fifth Dalai Lama during the apogee of the Tibetan Buddhist state, this encyclopaedia of medical illustration, begun in 1687 and completed by 1703, is the product of a broad collaboration between the learned Desi himself, a host of medical scholars and practitioners with whom he consulted and a group of painters, all operating at what is arguably the height of Tibetan artistic virtuosity, at the centre of Tibetan culture in Lhasa.[3]

The exquisiteness of the detail alone—from didactic illustrations on the medical anatomy and *materia medica* to a huge variety of depictions of life on the Tibetan plateau—is enough to draw in the viewer. And that is not to mention the inventiveness and palpable high spirits in which these multiple scenes were conceived and carried out. While the set went on to be copied many times, including a late-twentieth-century rendition created by a Nepalese painter for an American museum, it seems the original iconography was so expressive that the various copies continue to retain a freshness and human liveliness that approaches that which exudes from the earliest versions.[4]

---

[3] Gyatso (forthcoming) discusses the dates when the paintings were begun and completed; see also Byams-pa 'Phrin-las 1996a and Meyer's Introduction to Parfionovitch *et al.* (1992), vol. 1, pp. 5–8.

[4] We are not certain of the disposition of the originals, but it is possible that the plates reproduced in Wangle and Byams-pa-'Phrin-las (2004) contain some from the original set. They were apparently assembled out of a larger number of extant plates in the early twentieth century and kept at the Mentsikhang in Lhasa; another set was also assembled and held at the Norbu Lingka in Lhasa. For a history of the paintings and various copies, see Byams-pa-'Phrin-las (1996a), Wangle and Byams-pa 'Phrin-las (2004, pp. 2–3), Parfionovitch *et al.* (1992), Bolsokhoyeva (2007) and Williamson and Young (2009). The following essay focuses on the images from the plates of Parfionovitch *et al.* (1992). All plate numbers refer to that version, which only includes 77 plates.

There appears to be very little precedent for medical illustration in Tibetan art history of any kind, let alone a project of such an ambitious nature and scale as this one.[5] Moreover, unlike the several counterparts that we can find among Chinese medical illustration sets, such as the somewhat later *Yuzuan yizong jinjian* (*Imperially Commissioned Golden Mirror of Medical Learning*) of 1742, the Tibetan set had few readily identifiable painting traditions from other fields to draw upon—that is, beyond the Buddhist visual arts, which offered some models—that would compare with the many resources in Chinese popular visual culture such as illustrated biographies and decorated material objects.[6] While Tibetan Buddhist narrative paintings, donor portraits and decorated coffins, furniture and other objects produced since around the eleventh century did portray vignette scenes of everyday life and people, these provided only some of the models for the many pathological states, zoological specimens, and range of ordinary human activities and dispositions portrayed in such detail in the medical paintings.[7]

In short, the Desi's medical set constitutes a watershed for Tibetan painting. The plethora of topics in secular life referenced by medical science offered an unprecedented opportunity for artists, normally confined to Buddhist topics and the occasional everyday background scene, to render quotidian Tibetan people and things never before depicted in painting. Of course we cannot read these images as transparent and objective representations of what life was like and what people looked like on the ground. Even the original images executed in the Desi's studio—like the texts to which they are connected—are framed

---

[5] Some evidence of earlier medical drawing is mentioned by Byams-pa 'Phrin-las (1996a, pp. 370–1), who lists earlier works that seem to have included instructions for illustrations. See also Meyer, introduction to Parfionovitch *et al.* (1992, vol. I, pp. 10–11), discussing the only other extant medical illustration from Tibetan sources, a diagram of moxibustion points found at Dunhuang and kept in the Bibliothèque nationale de France: P.t. 1058. There seems also to have been likely influences from Graeco-Arabic medical tradition. None of these indications demonstrate any direct connection, however, and are still speculative.

[6] Wu 2008.

[7] Early examples of narrative painting in Tibet include the murals of the life of the Buddha and the story of Sudhana from the *Gaṇḍavyūhasūtra* at Tabo: see Klimburg-Salter (1990), for example Figs. 120–32. There are early fourteenth-century murals of the life of the Buddha at Zhwa lu monastery and the Jonang stupa: see Vitali (1990). An important early instance in portraying the life of the Milarepa in painting is from the late fifteenth century: see Pal (1990, Plate 19). Another striking case of an illustrated narrative text is the marvellous autobiography executed by Yol-mo bsTan-'dzin Nor-bu during the late 1630s; the manuscript, kept in the Tibetan Library of Works and Archives in Dharamsala, is being studied and published by Benjamin Bogin (pers. comm., 2010). On the early Dulan coffins, see Xu (2006), Luo (2006), Xu and Liu (2003) and Heller (forthcoming). For early donor portraits from Tabo see Klimburg-Salter (1990: Figs. 2–5, 48–50, 139–42, 151).

and clothed in ways that reflect any number of intellectual and social agendas at work.

There are indeed several layers of textual representation behind these images, their arrangement and the entire question of what was chosen to be portrayed and what was not. The painting set is ostensibly a visual rendering of the information in the Desi's four-volume medical commentary *Bai sngon* (*Blue Beryl*).[8] This work by the regent actually reproduces verbatim large portions of an earlier sixteenth-century commentary, *Mes po'i zhal lung* by Zur-mkhar-ba bLo-gros rGyal-po. Both are part of a series of commentaries on the twelfth-century 'root' medical text, the *Four Treatises*, which were produced periodically ever since the root work's composition.[9] The *Four Treatises* in fact stands as the primary 'text' upon which the paintings are based. That seminal work in turn inherits a slew of cultural conceptions and prejudices about gender, among many other things, not only from classical Indian Ayurveda but also from a wide range of medical works from both East and West Asia on which it draws.[10] All this means that the framings and agendas in question actually span a long period, starting from the early centuries BCE. In particular, they reflect a complex history of medicine in Tibet from at least the twelfth through the seventeenth century, one which was rife with various controversies about medical knowledge, including the nature of gender and the female body.[11]

In exploring gender representation in the medical paintings we also need to take into account the influence of Buddhist conceptions and values on the *Four Treatises* and its commentaries. We see there in fact a direct appropriation of the Buddhist commonplace that to be a woman indicates one's inferior store of merit. Just as much, however, we are picking up in the medical treatise echoes of more general Tibetan cultural notions about women in the paintings: that they are weaker, more prone to emotional and ethical flaws and less capable of learning and discipline.[12] Such social conceptions impacted medicine broadly. As in other fields of learning and status, there seem to have

---

[8] The Chakpori xylograph of the *Blue Beryl* was published as sDe-srid (1973). For this essay I am citing sDe-srid (1994); all page references to this publication refer to the Arabic page numbers, not the Tibetan ones. Only a portion of the material in *Blue Beryl* or the *Four Treatises* is represented by the paintings, although every chapter is included. The precise relation between the text and images has yet to be studied systematically, although Katherina Sabernig of the Medical University of Vienna offered initial data in a paper on the medical murals at Labrang Monastery, delivered at the 12th seminar of the International Association of Tibetan Studies held in Vancouver in August 2010. See n. 3 above.

[9] In this paper I am citing [gYu-thog] 1992. For full information on the available editions of the *Four Treatises*, see Gyatso 2009b.

[10] See Ga 2010.

[11] Gyatso (forthcoming) details these controversies.

[12] One survey of relevant mythology regarding women in Tibet is Gyatso 1987.

been few—if any—academically trained female physicians in Tibet prior to the twentieth century.[13] Certainly no female physician is pictured in the painting set. This should not necessarily lead us to conclude that knowledge about women's bodies was wanting. Quite the contrary: both classical Indic Ayurvedic works and the Tibetan *Four Treatises* provide very detailed information about the female reproductive system and also frequently take into account general differences between male and female bodies. Nor did there appear to be reticence to represent the female genitalia overtly; this is evident in a variety of explicit illustrations in the painting set. Despite the pervasive androcentrism and frequent patriarchy and misogyny in both medical contexts and society at large, medicine took the care of female bodies seriously. Even Buddhist sources, especially on monastic discipline, included considerable detail about genital anatomy due to certain regulations regarding ordination and vows of celibacy.[14]

In any case, this essay is not investigating the quality or accuracy of medical knowledge about females as such. Rather, my main question concerns the degree to which gender prejudice was—or was not—incorporated into the medical representation of women. In particular, this essay looks at such representation in the paintings and explores what distinguishes their visual semiotics from the texts that they represent. This is a complex question that requires close examination and comparisons. Given the lack of precedent for the painting set's iconography, as well as the mix of conceptions that fed into its formulation, we should not assume that the visual images simply reproduce already established system or doctrine. In fact, the history of gender representation in the texts already shows many inconsistencies; in what follows we will find further fluctuation and ambiguity in the paintings. Some of this might have to do with the idiosyncratic proclivities if not whims of the painters themselves. Unfortunately, although we have the names of the two leading artists employed by the Desi—Lho-brag Nor-bu rGya-mtsho, who drew many of the outlines, and Lhas-pa dGe-bsnyen, who applied the colour[15]—we know little about them, except that they would have been highly regarded craftsmen in their day.[16] At least we can say that the director of the paintings himself, the Desi, was not a monk but rather a very learned and powerful layman. The paintings he masterminded were sponsored by the State, in a moment when

[13] Tsering 2005.

[14] Gyatso 2003.

[15] sDe-srid 1994, p. 1474. This comment refers to the set at an initial stage when it only included 60 plates.

[16] On the former, see Jackson 1996, pp. 53, 316 n. 702 and 345; see also pp. 206–14 on the Desi's patronage of artists more generally.

the Dalai Lama's government was coming into its own and reaching a new level of cosmopolitanism and scientific aspiration.[17] Another side of the project's interests concerns whether the new circumstance in which medicine was achieving some autonomy from Buddhist scholastic pressures served to loosen up gender conception, especially when that was being expressed in a new medium.

The following study will focus its questions upon the visual representations themselves: what their renderings, placement and comparison with other images say about the status of women in medicine and related medico-social notions that we usually group under the heading of gender. This will include a look at how the paintings change or add to what can be traced in the corresponding texts—i.e. the *Four Treatises* and the Desi's commentary, *Blue Beryl*.[18] In what follows I will be using the plates of the meticulously rendered version of the medical paintings now housed in Ulan Ude. I will also compare the probably older set of examples held at the Mentsikhang (sMan rtsis khang) in Lhasa, in the few cases where there are differences of any import.[19] The Ulan Ude copy seems to have been executed in Lhasa around the beginning of the twentieth century. It was then taken to Buryatia and eventually to the History Museum of Buryatia where it is now preserved.[20] I have chosen this version because of its beauty and clarity and because of the kind consent of Serindia, the publisher of its reproduction in book form, to include images from that book here.

Part I: Anatomical androcentrism

In our first look for gender representation in the paintings we are immediately drawn to the anatomical plates. These show the human body in great detail and systematic precision. The anatomical illustrations comprise Plates 7–15, 38, 39, 47, 48, 49, 50 70, 71, 72 and 73.[21] These lucid images, indicating the

---

[17] Meyer 2003.

[18] In general, the Tibetan painting set follows the medical texts far more closely than does the Chinese case of the *Golden Mirror* which shows considerable disjuncture between textual and visual depictions of gender, the former being far more prone to androgyny: Wu 2008, pp. 353–4.

[19] The latter is reproduced in Wangle and Byams-pa 'Phrin-las 2004. Unless noted otherwise, there are no significant differences between the Ulan Ude set and the paintings at the Mentsikhang in the examples considered here.

[20] Parfinovitch *et al.* 1992, Bolsokhoyeva 2007. See also n. 4 above.

[21] Other anatomical paintings were executed under the Desi's direction as well, two of which, representing the systems of arteries according to the interpretation of the scholar Lhun-sdings rNam-rgyal rDo-rje, are included as Plates 6 and 7 in Wangle and Byams-pa 'Phrin-las 2004.

location of organs, nervous and cardiovascular systems, bones and other anatomical details central to medical practice are likely the core of the set, along with the equally precise section of plates on medical plants which will not be discussed here. These two sections of the work were used the most in the teaching of medicine and were occasionally reproduced in various combinations on their own.[22]

Our feminist eye notices immediately that in every case where genitals are depicted in the large anatomical images the figure has the male organ. We easily jump to the conclusion that when the human body is displayed for its normative anatomy, part of that includes being marked as male. None of the large anatomical images are shown with female genitalia. In this respect the set's androcentrism has much in common with the *Golden Mirror*, not to mention many cases worldwide.[23]

In short, the female gender is never used to represent adult human anatomy in the Desi's medical paintings. While we do find a few small female images that are vaguely anatomical, these provide information about the female body alone. Never is a general anatomical point, one that would apply to both males and females, made by an image of a body marked as female.

Looking closer, we can distinguish between cases where the anatomy being represented has nothing to do with the male organ and those where the male organ is intrinsic to the anatomical system being portrayed. In other words, we can ask in each case if the male genitals are there to denote the whole person whose body is being used to illustrate some segment of medical knowledge, or whether the male organ merely represents one of the parts of the particular system that is the topic of the plate. Both would reflect kinds of androcentrism, but the former has a more weighty impact, especially when the medium of representation is visual.

Raising the question of what system is being represented by the paintings means we need to consult the text to which the images refer. And once we do that, we find that in many cases the male organ is indeed intrinsic to the nervous, muscular or skeletal system being portrayed. In other words, the male organ in these images frequently is not gratuitous; it is there for a reason—a reason having to do with the particular medical system laid out in the text.

---

[22] See Lange 1964. The Field Museum in Chicago and the Thomas Pritzker Collection both contain smaller sets of anatomical plates that are closely based on the Desi's full set.

[23] Regarding the *Golden Mirror* Wu writes, 'In particular, male figures are used to depict the body's basic structures: circulation channels, location of bones, and almost all acupoints. Similarly, the figures used to illustrate how different diseases manifest themselves on the body are almost all male. In contrast to this wide use of male bodies as the standard human body, female figures are used to illustrate medical problems that are defined as being unique to or more common in women.' Wu 2008, p. 458. For studies of the figuration of the female and European medical androcentrism see Laqueur 1990 and Park 2006.

Before looking at some examples, a few further words are in order about what I mean by the text behind the images. I already indicated something of the genealogy of *Blue Beryl*, the Desi's commentary on the *Four Treatises*. But the aetiology of the painted images is more complicated yet. For one thing, the Desi himself reports that he was drawing on many auxiliary sources, some of them textual[24] and some of them oral in the form of information from his colleagues in the medical world.[25] We also do not know the exact timing and relation between when the images were finalised and when *Blue Beryl* was finalised. It is not impossible that ideas generated out of the experience of rendering the anatomy imagistically, for example, contributed to the writing of *Blue Beryl*, in addition to the other way around.

Finally, we also have to pay attention to the variety of textual elements that are included on the painting plates themselves. These are careful and work well but appear to be *ad hoc*, itself a sign of the newness and total lack of precedent for such a medical illustration project in Tibet. The text found on the paintings is of at least four kinds:

1. captions under or next to elements of the anatomy as well as for virtually all of the individual vignettes;
2. captions in yellow boxes at the top of the registers that indicate which chapter or topic in the *Four Treatises* is being illustrated in the next several images;
3. numerals and alphabetic letters inserted on the anatomical drawings that map onto interlinear numerals in the pages of the *Four Treatises*;[26]
4. a more general colophon at the bottom of each plate that describes the topics of the plate and also refers to parts of the illustrations on that plate by means of letters of the alphabet, which have been inserted onto the images as well.

---

[24] For example, the colophon of Plate 12 (which I assume was written by the Desi although the colophons are not signed) cites information from the *Mes po zhal lung*; Plate 13 cites the Zur-mkhar-ba tradition. Another work frequently mentioned in the plates' colophons is *Aṣṭāṅgahṛdayasaṃhitā* or its commentary *Padārthacandrikāprabhāsa* (Tib. *Zla zer*).

[25] See especially sDe-srid 1994, vol. II, pp. 1468–74.

[26] For these marks in the sDe-dge edition of the *Four Treatises*, see [gYu-thog] 1773. As one example, the interlinear marks on f. 7b show the count of the orifices in the body and correspond to the images of those orifices on Plates 14 and 15 of the paintings (see discussion below). The same interlinear marks have been reproduced in the modern version of the sDe-dge *rGyud bzhi* ([gYu-thog] 1992). While we don't currently have access to the original Potala version edited and published by the Desi, the sDe-dge edition is based upon it. The referents of some of the interlinear marks are still obscure to me; for example, Chapter 72 of the *Man ngag rgyud* contains interlinear numbers, but none are visible in the corresponding plate (45) of the painting sets available to us.

In the anatomical paintings sometimes several minute systems of signification are juxtaposed on the same image, making it difficult to identify all of the cross-referencing between image and these several topoi of text. What is more, the anatomical illustrations do not always strictly follow the order of the *Four Treatises*, since sometimes several elements of the anatomy are portrayed together on the same illustrated body. Nonetheless we can still detect many ways in which gender in the texts and gender in the paintings triangulate. Given the complex layers packed into each of the images, just a few examples will have to suffice.

Female as exception

The androcentrism of the text of the *Four Treatises* is visible on many fronts. An obvious example is in Chapter 4 of the second of the *Four Treatises*, the 'Explanatory Treatise' (*bShad rgyud*), which introduces much of the human anatomy on which the rest of the work depends.[27] One section of this chapter concerns the measurements of parts of the body. After going through the amount of humoral substances, flesh, fat and blood, etc., in the body—a list that includes the amount of semen[28]—the text notes that 'women have 20 extra handfuls [of flesh, on account of her] thigh flesh and breasts'.[29] The Desi's *Blue Beryl* adds that she also has extra fluids in comparison to the male: a double cupped fistful (*snyim*) of breastmilk and four double cupped fistfuls of menstrual fluid (*zla mtshan*).[30]

The same chapter also introduces a second anatomical specification where female difference is singled out, namely, the number of orifices of the body. The *Four Treatises* counts nine standard orifices on the body. It is only when specifying, a few pages later, the openings that serve as passageways into the body (*rgyu lam bu ga*) that the text remembers that the female has three extra ones, that is, an opening into the uterus and two at the two breasts.[31] (In

[27] There are also many further anatomical specifications in the *Man ngag rgyud* portion of the work.

[28] [gYu-thog] (1992, p. 21) lists *khu ba* among other bodily substances that are being measured but never mentions the female analogue of *khu ba* which would usually be *zla mtshan*, or in some contexts *khrag*. Occasionally *khu ba* can include in its meaning female seminal substance (see nn. 95 and 96 below) but since the commentaries specify *skyes pa'i khu ba* and add a measurement for *zla mtshan* (see n. 30) that is not the case here.

[29] [gYu-thog] 1992, p. 21, *bud med b[r]la dang nu ma nyi shus lhag*.

[30] Zur-mkhar-ba (1989, vol. I, pp. 146–7) cites *Aṣṭāṅgahṛdaya* to make the point that she also has extra fluids in comparison to the male. This is duly repeated by sDe-srid (1994, vol. I, p. 95).

[31] [gYu-thog] (1992, p. 22) '*bu ga sgo dgu yod*' and p. 25 '*phyi yi bu ga mgor bdun gsang bar gnyis / bud med mngal sgo nu ma gnyis kyis lhag*'. The embryology also counts nine orifices in the

general, Tibetan medicine recognises that the male has breasts too, but when body orifices are counted the nipples are only counted for women, as pathways for milk to leave the body.)[32]

These statements show attention to the specificities of female anatomy. What stands out for our purposes is the word 'extra' (*lhag*) in both cases. That usage says that there is a norm and then there are bodies that diverge from that norm—by virtue of having something extra. It makes the female amounts of flesh, fluids and orifices anomalies: they are extras, over and above what has thereby been established as the rule, the normal or usual amounts. These specifications constitute clear examples of androcentrism in the medical text.

Can we discern anything different about the androcentrism in the images that represent these passages, or are they just visual reiterations of the text? Let me defer the measurement of bodily substances until later in this essay. I want to turn first to the depiction of the orifices. Here we will see that the answer to the question just posed is that the paintings exacerbate further the sidelining of women.

Actually the extra orifices of the female body are represented twice in the painting set. In each case the female is a very small figure at the side of much larger and more carefully rendered male or sex-neutral figures. This alone sparks some irony: the female has 'extra' openings, more than men, but does that make her size extra big, perhaps to accommodate the illustration of the extra orifices? No, quite the contrary: she is smaller, much smaller. We might recall here how female consorts in Tantric Buddhist iconography in Tibetan art are also very frequently portrayed smaller than the male figure. But there is a difference. In that case, the presumption would seem to be that this female figure—be she Yeshe Tsogyal or a female deity—is in fact smaller in size than her male partner. In contrast, in the case of the medical paintings at hand, her tiny girth and height are wildly disproportionate to actual gender-based size differences. Instead, the smallness, as well as the relative roughness of the rendering and lack of precise detail, shows that the female body's importance or interest was deemed negligible and marginal.

We can also note that the normative nine orifices of the (male) body do not receive the same spotlight in these images: there is no parallel image dedicated

---

embryo which constitutes another reference to the normative male: '*dbang po sgo dgu'i bu ga rnam par bye*' ([gYu-thog] 1992, p. 19).

[32] Examples of anatomical features around the breasts on the human body which would include males may be seen in the discussion of the various channels of the body in sDe-srid (1994, vol. I, pp. 106 and 116). Zur-mkhar-ba (1989, vol. I, p. 185) records an objection that men have apertures at the breasts too but merely cites the *Aṣṭāṅgahṛdayasaṃhitā* as the ultimate authority that women have three extra orifices.

to the orifices of the body of the male. The orifices are indeed represented, but on images of the male body that also carefully display many other features of the anatomy at the same time.

The first of the two occasions where the extra female orifices are pictured spans Plates 7 and 8 (see Figure 1).

Plates 7 and 8 map many parts of the body: the solid and hollow organs, the bones, pores and more. They deploy a complex system of denotation using numbers, letters, ink colour and other devices, all referenced in the bottom colophons of Plates 7 and 8 taken together. The nine main orifices are indicated on the main images of the two plates by numbers in dark ink: eight are visible on the main (male) figure of Plate 7 and the final one, the anus, is indicated on the main figure of Plate 8. According to the colophon, these numbers are enclosed in a red bracket, and also, at least on one occasion, by the letter *pha* which signals the system of the nine orifices. But it is hard to spot these marks in the cacophony of other marks and abbreviations overlaid on the two figures. The number of openings is but one of many features of the standard anatomy.

Only the count of openings on the female, as a remarkable anomaly differing from the norm, are singled out, and yet this figure is small, and on the side, seemingly not very important and added as an afterthought (see Figure 2).[33] A double whammy: the specifically female body is at the same time a remarkable aberration, and an insignificant one. Indeed, neither of the colophons where the female orifices are depicted, i.e., on Plates 7–8 and Plate 14, mention the female figure at all. What's more, in both cases the female image only has labels for the three extra openings, not the other nine ones that she shares with other human beings. However, we do see pictured in this first case a large red feature of her body, presumably the uterus, likely coloured red because of the widespread association of the female element with the colour red, not to mention with the blood of the menses. This is a thoroughly adventitious addition by the artists, perhaps to visually reiterate some of her distinctive (or anomalous) femaleness.

We are further struck by the fact that the corresponding portion of the *Four Treatises* text, where the rest of the information represented on Plates 7–8 is provided, does not even mention the female extra orifices; it only mentions the normative nine orifices.[34] It turns out that the Desi himself, here departing from previous commentarial tradition, briefly notes that women actually

[33] In fact, the same plate in the set in Wangle and Byams-pa-'Phrin-las (see p. 5) fit in this female figure at a different spot on the plate, one of the very few notable differences in layout between the two sets.

[34] [gYu-thog] 1992, p. 22.

Fig. 1. Plates 7 and 8.

Fig. 2. Plate 8, detail. The female is at the bottom left portion of Plate 8.

have 12 orifices in his comment on this statement in the *Four Treatises*.[35] This modification on the root text is what is mirrored in the paintings. While we cannot know which came first—if the paintings merely take the lead from the Desi's commentary, or if the task of executing Plates 7–8, which included highlighting the nine orifices of the human body, elicited the sense that the extra openings of the female, known from another textual context, should also be pictured, and which then was duly noted in *Blue Beryl* as well. In either event, we see some concern here on the Desi's part to set the record straight with respect to female anatomy. Women may be grateful for the attention; and yet the visual insult with which it is bestowed cannot be ignored either.

The second occasion on which the extra orifices of the female are illustrated is Plate 14 (Figure 3). In this case, the corresponding text of the *Four Treatises* does indeed mention the female anomaly. Following a discussion of the vulnerable points of the body, the *Four Treatises* mentions the orifices in the body again, and now it adds for the first time that the female has three extra openings.[36] In

[35] sDe-srid 1994, vol. I, p. 97. In this he may have been original, as neither Zur-mkhar-ba nor sKyem-pa Tshe-dbang, another earlier commentator, make this move. Zur-mkhar-ba (1989, vol. I, p. 149) curiously gives no comment on the root text's first mention of nine orifices at all, only discussing them on the second occasion, on pp. 184–5, albeit in more detail that the Desi provides. See also sDe-srid 1994, vol. I, p. 119.

[36] [gYu-thog] 1992, p. 25.

Plate 14, as in Plates 7–8, the main nine openings are mapped onto the larger figure, this time indicated by the letters *ka* through *ta* (eight are seen on the main figure of Plate 14, and one more, the anus, is indicated by the letter *nya* on Plate 15, not pictured here).[37] Again, the female image is at the bottom of the plate, much smaller than the other figures (Figure 4).

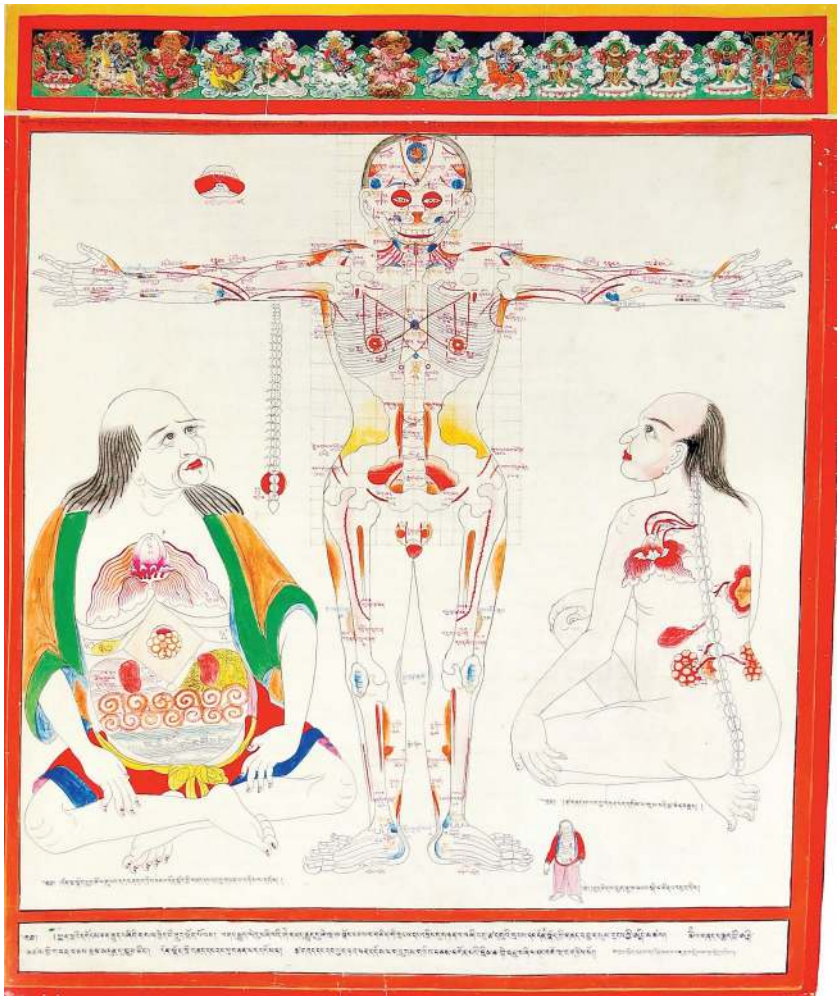

Fig. 3. Plate 14.

[37] These letters are not indicated in the painting colophon but rather in the interlinear spaces in the text of the *Four Treatises*; see n. 26 above.

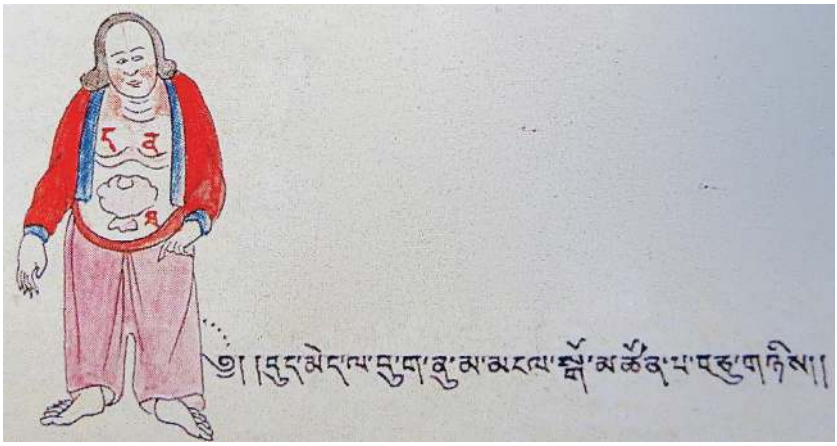

Fig. 4. Detail from Plate 14.

The caption for this second image of the extra female orifices is almost identical with the one on Plate 8, but the image differs in that here her extra orifice at the vagina is demurely covered. Once again what is probably the uterus is represented, again without any label and now just in outline. But the letter indicating the third orifice is placed next to it, suggesting that the uterus is standing for the twelfth orifice, the vagina (or cervix; actually it is not exactly clear to what the term 'door to the womb' [*mngal sgo*] refers).

The forgoing is a first example where textual androcentrism is not transparently translated into image. While we find a solid foundation for the paintings' androcentrism in the root text, the imagistic renderings make certain shifts that send a mixed message. The images clearly aggravate the female anomaly by using diminutive size and reduced detail and precision. More complicated to explain is the unnecessary repetition of this anomaly. Indeed, the fact that her extra openings both are represented twice and are singled out on both occasions with a separate image calls attention directly to the female body. We can add that it also draws attention to the count of orifices on the body altogether, which otherwise is a small point that is far from revelatory; it is covered in just a line or two and never comes up again, that is, *qua* count. But this only confirms my suspicion that representing the female extra orifices so prominently serves to highlight female anomaly as such.

The female is represented as having extra features on several other occasions as well. But these other cases—each with considerable interest of its own—come up in a second kind of image found in the painting set, namely the smaller vignettes. We will return to these after making several other observations about the anatomical paintings.

Male as anatomical norm

We have been distracted by the small female figures at the side of two of the anatomical plates. Let us now return to the striking observation that other than these two marginalised images, practically all of the human bodies in the various anatomical illustrations have male genitals. This certainly gives the viewer the impression that human anatomy is normatively conceived as a male body. When we study some individual examples closely, however, we discover several distinctions in what we are calling androcentrism.

Plate 9 (see Figure 5) begins a section that continues through to Plate 14, on the various channels of the body. The *Four Treatises* describes four main types of channel, but these overlap in certain ways and are often illustrated together in various combinations.[38]

Why do both frontal figures have male genitalia? Consider first the left-side figure (Figure 6). It is labelled as illustrating the front view of the 90 bloodletting vessels. In fact, all of the 90 are not shown here; other bloodletting vessels are pictured in the succeeding plates. What's more, the *Four Treatises*' statement reads that there are 77 bloodletting vessels.[39] The Desi's commentary takes up a long-standing debate and presents several versions leading up to the view in his time that there are really 90.[40] We are hardly in a position to follow this very detailed matter here. Suffice it to demonstrate that some of the bloodletting vessels were already located in the male genitalia in works such as the *sdom tshig* of the Zur-mkhar-ba tradition cited by the Desi.[41] Those points are also duly counted in the Desi's contemporary list of bloodletting sites.[42] Thus there is nothing odd in the fact that the plate adds two close-ups of the tongue and the male genitals: these are both sites in various known systems of bloodletting, and perhaps their delicacy called for more detail. Nor is it an artistic intervention for the figure as a whole to be portrayed with the male organ; the latter is part of the system being represented. Indeed, the small numbers on the testicles in the large figure are repeated with a further specification of a third vessel in the side detail. What is notable is only that the

[38] On these channels see Gyatso 2004.

[39] [gYu-thog] 1992, p. 22.17. One segment of the system of 77 bloodletting channels is illustrated at the upper part of Plate 9.

[40] His main discussion of this issue begins at sDe-srid (1994, vol. I, p. 98); for the particular matter of the number of bloodletting vessels see 103.18–106.1; he justifies the more contemporary (*deng sang*) count on p. 105.

[41] sDe-srid 1994, vol. I, pp. 103–4.

[42] sDe-srid 1994, vol. I, p. 105.20.

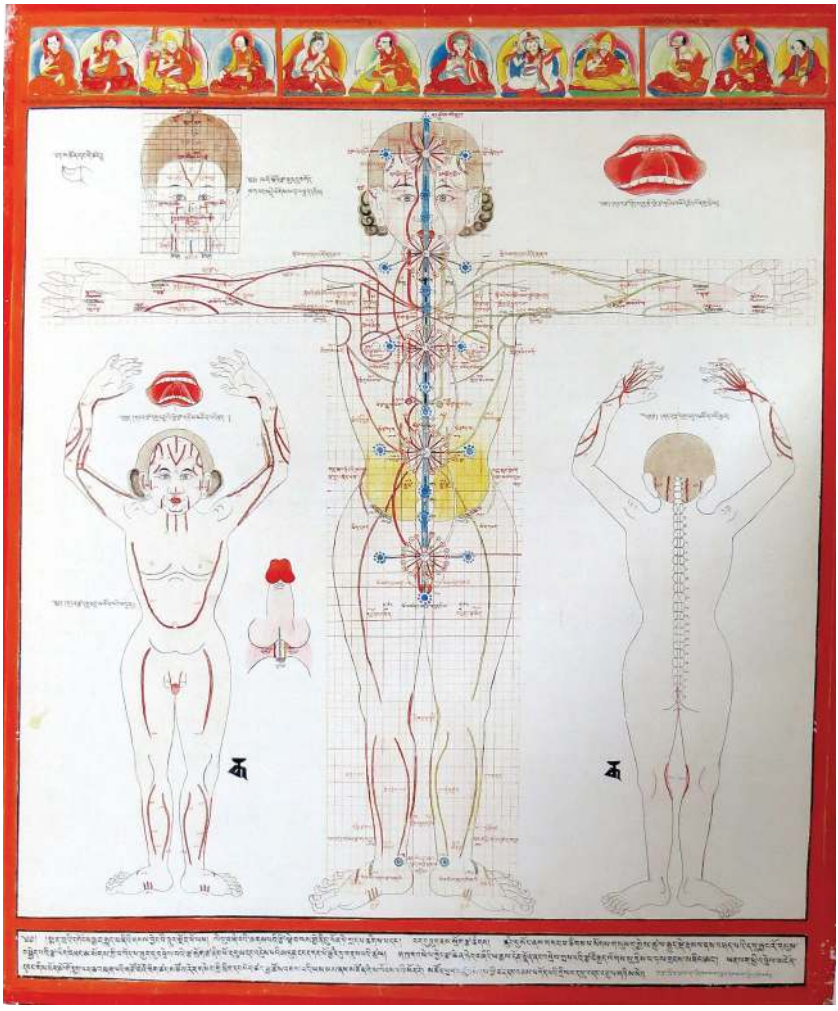

Fig. 5. Plate 9.

medical tradition had identified no such therapeutic bloodletting vessels around the female sexual organ.

The other image of the male organ on Plate 9 (Figure 7) illustrates a similar situation, but this time the image represents two medical systems, one of which references male and female genitalia equally, while the other only specifies the male organ.

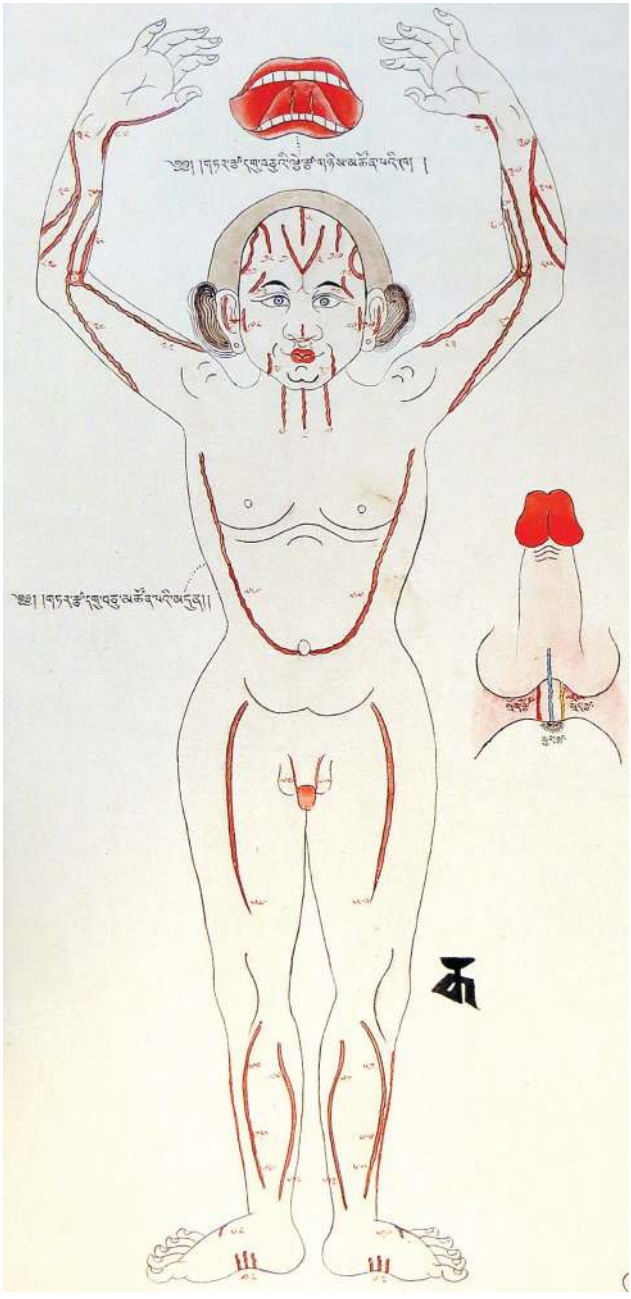

Fig. 6. Detail from Plate 9.

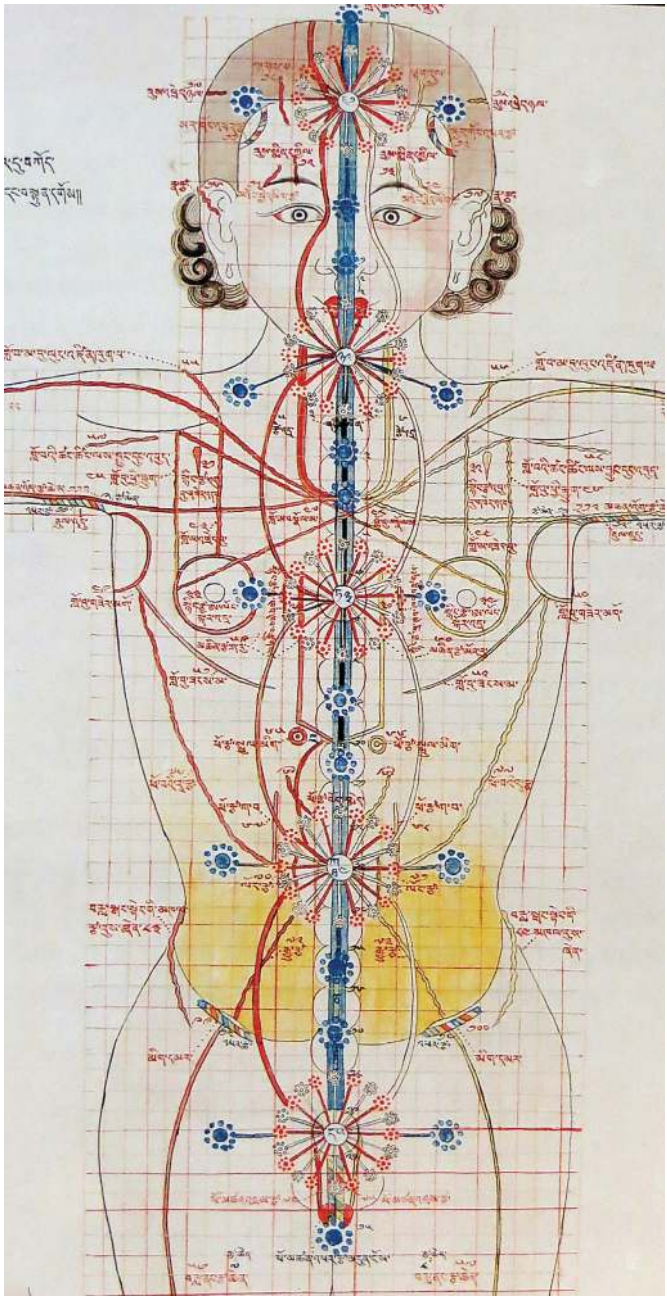

Fig. 7. Detail of central figure from Plate 9.

This figure combines some of the 'vulnerable points' (*gnyan pa'i gnad*) with the system of the 'channels of existence' (*srid pa'i rtsa*). The latter are the second of the four kinds of channels described in the *Four Treatises* and refer to matrices of channels in the brain, heart, navel and the sexual organs; they govern, respectively, perception, memory, growth of the embryo and reproduction.[43] (The Desi, in line with commentarial tradition before him, has added a fifth, at the throat.)[44] The matrix of the sexual organ is the bottommost main circle with spokes. It is labelled with Tibetan characters as '*da*-5'. That abbreviation is unpacked in the colophon on Plate 10, where it is glossed by the term 'secret' (*gsang*), a common but vague euphemism for the reproductive organs and genitals. This 'secret' matrix of channels is thought to exist in the genital area of both males and females, a point that is explicitly mentioned by the Desi in his commentary.[45]

Yet due to the fact that a system of vulnerable points is mapped onto the same image and that quite different system includes information on the male but not the female genitals, the occasion of illustrating that second system means that the whole figure is rendered male. These bloodletting and vulnerable points are only briefly referred to in the *Four Treatises*.[46] But they are discussed in detail by the Desi, in turn depending on a variety of commentarial traditions. We find several textual identifications of the same *pho mtshan 'gram rtsa*, 'channels next to the male organ', pictured here.[47] The plate itself contributes the additional specification that it is picturing these vessels next to the penis from the front (see Figure 8).[48] Here the impact of visual translation is especially clear. One textual system that is not androcentric is nonetheless overdetermined as masculine by virtue of another one that is. Both systems share the larger imagistic arena, but the androcentric one visually wins the day.

---

[43] [gYu-thog] 1992, p. 22. Gyatso (forthcoming) deals with the larger question of the various kinds of channels discussed in the *Four Treatises* and debates around their location.

[44] sDe-srid 1994, vol. I, pp. 101–2. The five are portrayed here on Plate 9, and there is also a further illustration of the heart centre in the right large figure on Plate 10 (mistakenly identified by Parfionovitch *et al.* [1992, vol. II, p. 191] as being on Plate 8).

[45] sDe-srid (1994, vol. I, p. 101) refers to the bases of these channels as the male or female organ (*pho mo dbang po rnams*) and refers to the matrix in the genital region on p. 102 with the gender-neutral term *mtshan ma.*

[46] [gYu-thog] 1992, pp. 22–5.

[47] sDe-srid (1994, vol. I, pp. 104 and 105), the first referencing *Zur mkhar ba'i sdom tshig.*

[48] The paintings also add an image of this same vessel in the penis from the back view, visible on the main image of Plate 10.

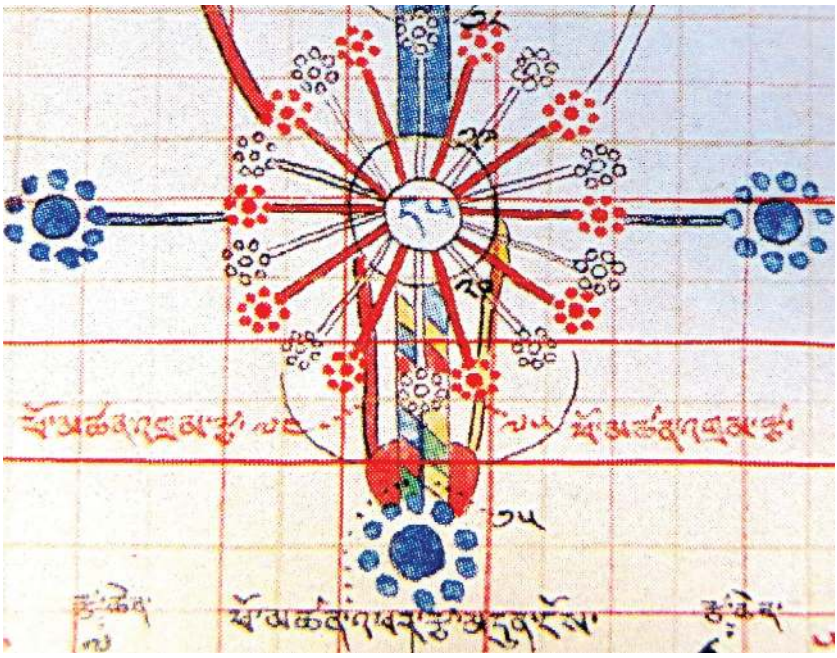

Fig. 8. Detail of main figure from Plate 9.

Yet another example of textual androcentrism translated into image is the central figure of Plate 14 (Figure 9), which we already studied for its depiction of orifices. This figure also shows the vulnerable points. The vulnerable point at the so-labelled testicles (*rlig 'bras*) is exactly mentioned in the text of Desi's medical commentary.[49] Hence again there is no surprise that the entire figure has been rendered male as a result.

These examples call to mind the suitability of the term 'mark' for genitals in both Tibetan and Sanskrit (*mtshan; linga*). The inclusion of the genitals on a body 'marks' the rest of the figure as being male—or female—in a logic of *pars pro toto*. Thus, whenever a system being represented on a medical plate contains, among much other specification, information about the male organ, the visual image becomes a male, tout court. What might merely have been one among a list of many elements in the text gains far greater saliency in its visual translation. Here we can see how the visual representation of medical

[49] sDe-srid 1994, vol. I, p. 114. The image also labels the testicles with the numbers 74 (?) and 75; it is not clear where these numbers are coming from, although they might represent the unspecified numbers for channels added in the Desi's time to the *Four Treatises*, as seen in the sDe dge edition (cf. [gYu-thog] 1992, p. 24.)

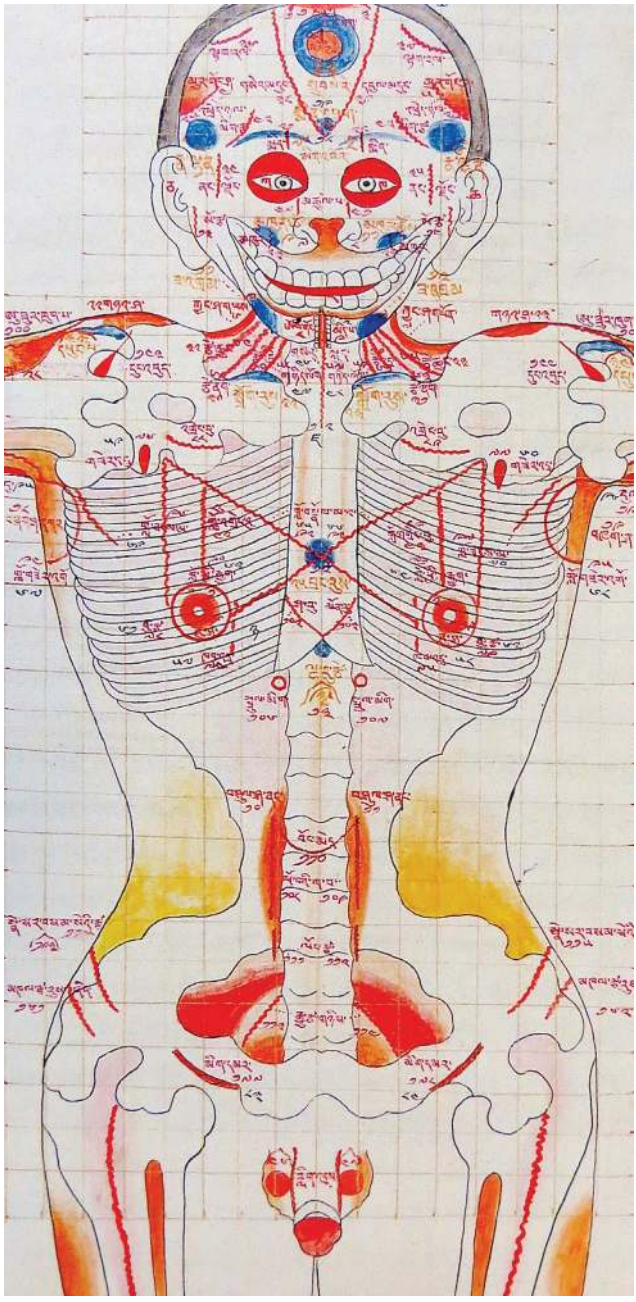

Fig. 9. Detail of central figure from Plate 14.

system can yield, by virtue of metonymy, a pervasive impression of androcentrism far exceeding that produced by the text.

While we cannot go through all of the cases where the male organ is pictured, we can venture this general rule. Those male organs that are labelled with a number, letter or textual caption are there because of the text; they represent a pre-existing anatomical system that specifies aspects of the male genitalia but not the female ones.

What would follow would be that male genitalia with no label at all might be a gratuitous addition on the part of the painters, serving to gender the image male even while what is being portrayed has nothing whatever to do with the genitals or sexual identity. That would be a clear example of an additional layer of androcentrism added on the occasion of painting. Now we have to be careful to look for small labels, such as the single number below the male organ on Plate 7 (see Figure 11, a detail from Figure 10): according to the very arcane semiological system described in the plate's colophon, it marks the urethra in the penis as one of the nine orifices of the body.

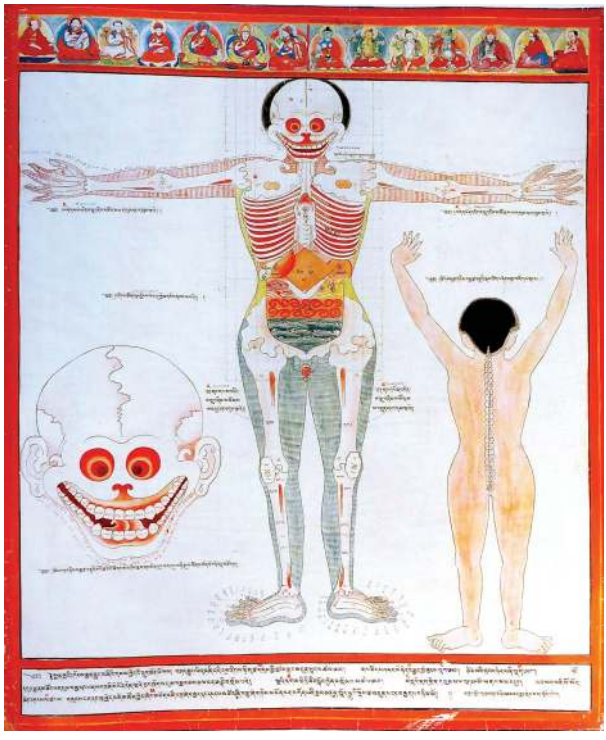

Fig. 10. Plate 7.

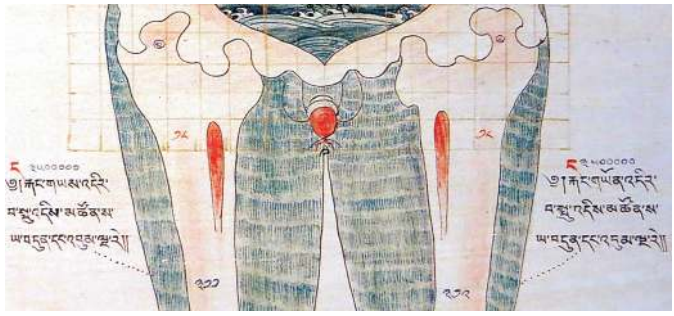

Fig. 11. Detail of main figure from Plate 7.

But, going further into the plates, it is really no surprise to find figures where the male organ is indeed portrayed with no label whatsoever and does therefore turn out to be a gratuitous masculinisation of human anatomy on the part of the painting studio. Consider Plate 10 (Figure 12), which continues the channels begun in Plate 9 and illustrates further anatomical features, largely concerning certain blood vessels as well as a few channels in the body connected with states of consciousness and emotion.

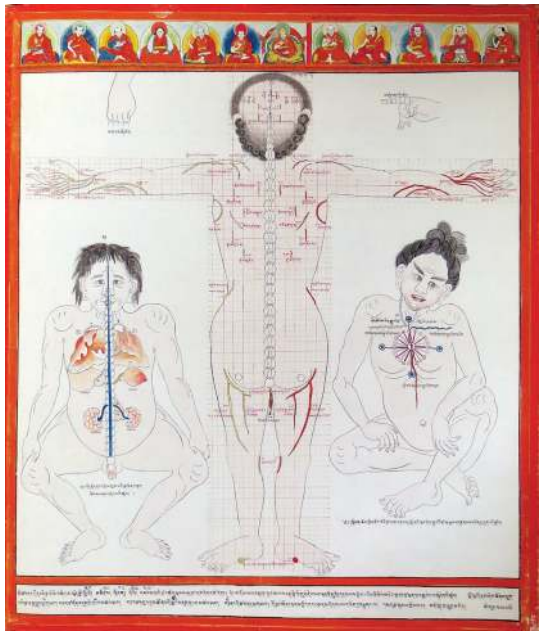

Fig. 12. Plate 10.

The figure on the left (see Figure 13) illustrates a set of eight main channels that connect covertly to the interior of the solid and hollow organs.[50]

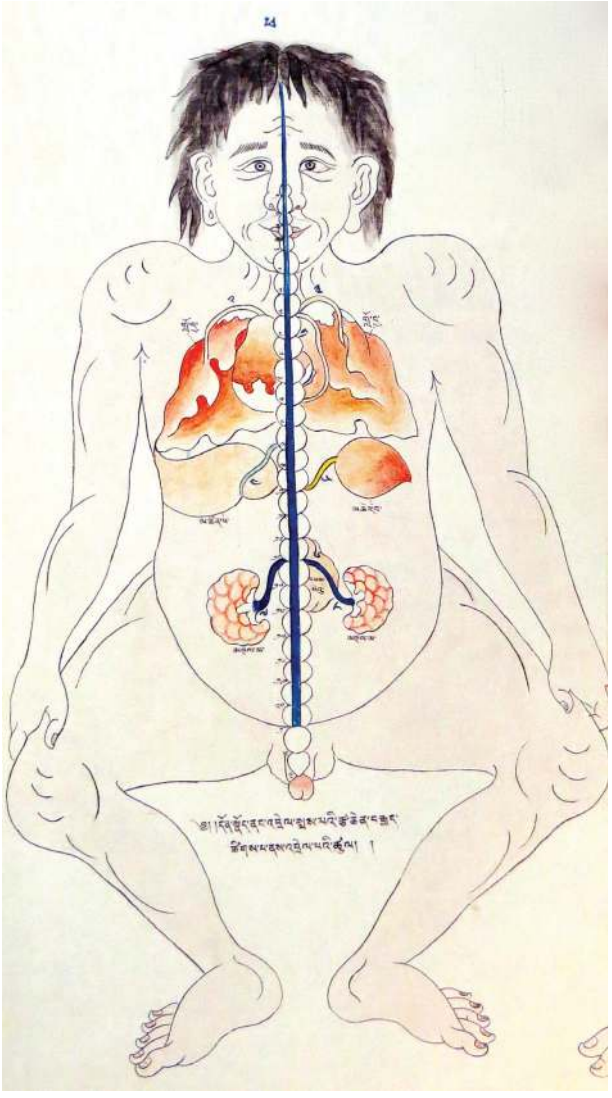

Fig. 13. Detail from Plate 10.

[50] [gYu-thog] 1992, p. 22: *don snod nang 'brel sbas pa'i rtsa chen brgyad.*

Here the male organ is pictured at the end of the series of digits in the spine. The latter is relevant to the topic of the so-called 'covert channels', since the particular digit from which each of these channels emanates is specified in the medical texts. But the penis and scrotum are entirely irrelevant to this topic of illustration. They are not mentioned either in the *Four Treatises* when the subject comes up nor in the section of *Blue Beryl* where the Desi unpacks its details.[51] And they are given no label at all in the image.

Another example of a gratuitous male figuration of human anatomy on the part of the artists is the right side figure from Plate 13 (Figure 14) that pictures a set of nerves and tendons (lit. 'water channels', *chu rtsa*). There is no mention of the male organ at all in this system.[52]

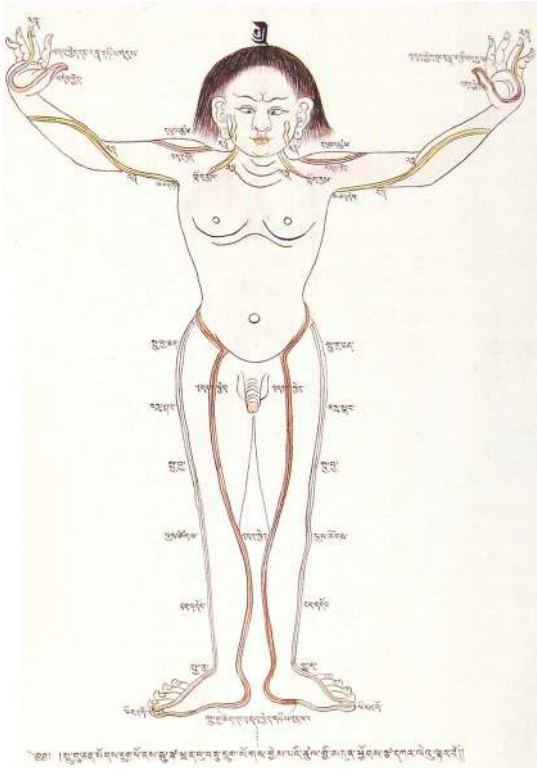

Fig. 14. Detail from Plate 13.

[51] sDe-srid 1994, vol. I, pp. 103.9–14.

[52] sDe-srid 1994, vol. I, pp. 108–9, although the *bsam se'u* is mentioned once, albeit not pictured here.

Here, as elsewhere, a choice has been made to render the figure male. Perhaps the mere occasion to portray a frontal view of the body, which would entail the visibility of the sexual organ, frequently elicited a decision to represent this body as male. Or perhaps it was not much of a decision at all but rather a reflex action. Perhaps the already-existing androcentrism of the medical system—and the adjacency in the painting set of many other figures that were required by virtue of that system to render the human anatomical figure male—made for a habit, or an unexamined assumption: the default human body is male.

And while we will see below that some frontal views decline to portray the genitals at all, never are the female genitals depicted when an anatomical image references the human body in general. Either such an image is male, or it is gender-neutral. Indeed, one image from Plate 14 (Figure 15), showing a set of vulnerable points associated with the solid and hollow organs (*don snod*), has as part of its textual background one tradition that adds the uterus to the list.[53] But evidently a decision was made not to represent that system for this painting. This would be a case where the general human image could have been rendered female by virtue of the addition of the uterus, but it didn't happen. In fact, this image did not simply remain gender-neutral due to its lack of reproductive organs, it was made more pointedly male than most by virtue of its bald head and moustache.

Before leaving the anatomical illustrations it behoves us to look at one of a very few exceptions that undercuts our picture of complete anatomical androcentrism, be that textual, imagistic, or both. While a number of the anatomical illustrations lack gender specification because the figure's position is such that the genital region is not visible, the two figures in Plate 8 (Figure 16) are portrayed head-on and yet still decline to portray the genitals at all. They picture the proportions of the body of a person 'in the world' (*'dzam gling*), along with those of a 'bad body' (*gzugs ngan*). For a change we can say that their (lack of) gender information is entirely appropriate and egalitarian. Textually, the specifications about body size and proportion have nothing to do with sexual identity.[54] Nor did the moment of painting become an opportunity to assert the normativity of the male body. Nor do any of the other possible gender markers in these images, such as hair or breasts, signify male or female. These figures could be either. It is difficult to say why this is the case. Perhaps the decision to add the image of certain specificities about the female on this same plate, as we can recall from above, reminded the paintings' creators that

[53] sDe-srid 1994, vol. I, p. 115.
[54] [gYu-thog] 1992, p. 22.

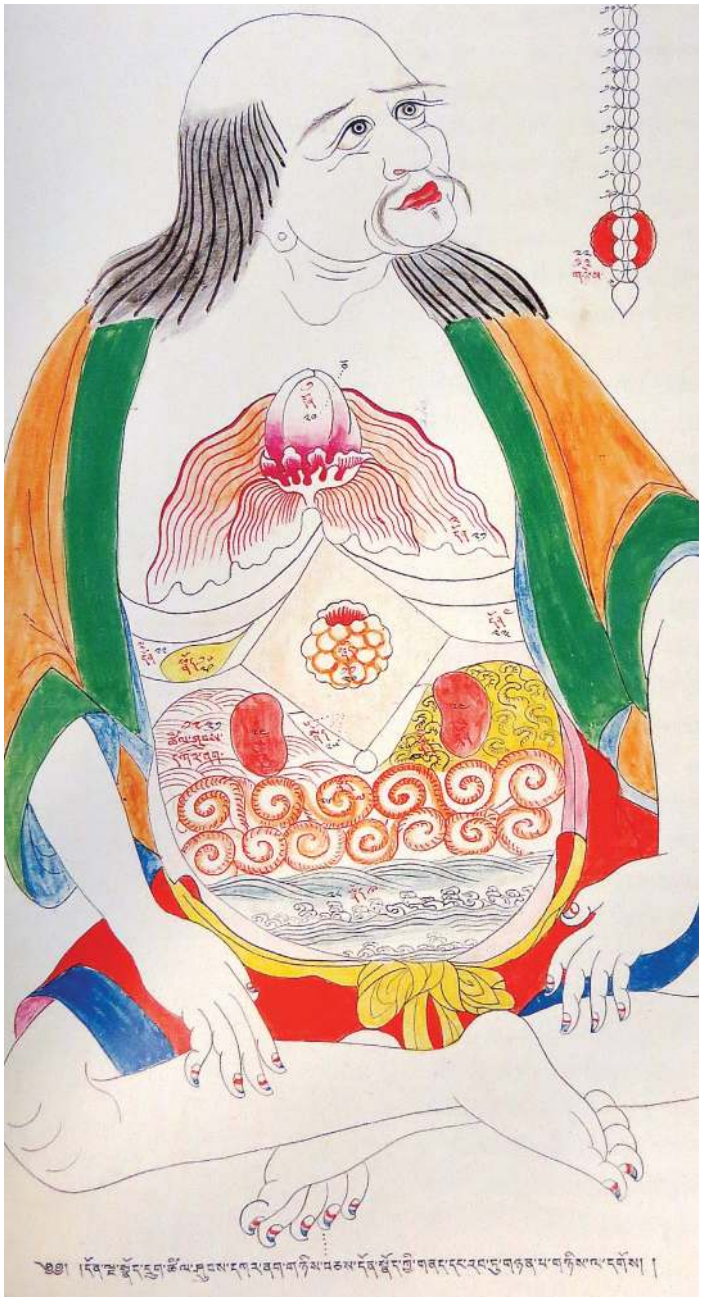

Fig. 15. Side figure from Plate 14.

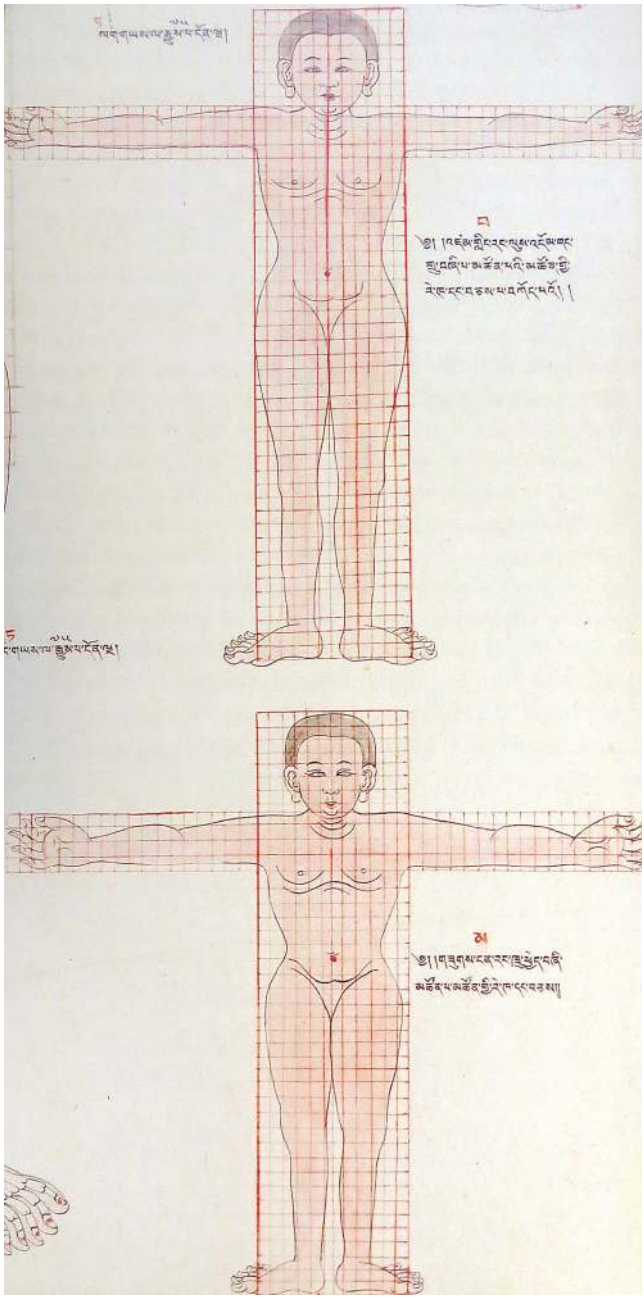

Fig. 16. Side images from Plate 8.

indeed there is more than one sexual identity among humans, impelling them to represent generic figures of human anatomy in this plate as gender-neutral. We could also say that the painters or directors for this particular set of images might simply have been participating in a larger, gender-neutral vision of human life.

Actually, once the medical plates move from anatomical diagrams to other topics, we seem to see far less androcentrism or even sexual specification at all. This is not to say there is none, for there is, including some overt misogyny. But we have to wonder about the palpable overall difference in representation style, for when scenes of life and illness are depicted outside of the strict specifications of anatomy there seems to be much more vagary around gender.

Part II: The vignettes

Both first glance and closer inspection of the almost entirely male figuration in the anatomical paintings spell a quite pervasive androcentrism. We have seen that these visual representations frequently go even a step further than the already-codified textual focus on the male body. It is thus a surprise to find, on scrutinising the rest of the medical plates, that the picture changes significantly. While there are still numerous examples of the male representing common human conditions in the smaller vignettes, there are also many cases where gender is either ambiguous or impossible to determine. And in the many other instances where gender is indeed marked the spirit is often quite egalitarian.

The small vignettes are the preponderant kind of image in the set. With the exception of the anatomical illustrations, most of the plates consist in many miniature paintings arrayed along horizontal registers.[55] The variety of their content distinguishes the set's structure from the comparable Chinese example, where the images divide easily into two main kinds: general anatomy and specific illness.[56] In the Desi's set, once the illustration departs from anatomy, the subject matter opens up exponentially. Many of the smaller images are, like the anatomical plates, obviously didactic, picturing in great detail the species of the medical botany, pharmacopoeia, zoology and instruments, as well as a series of expressive renditions of diagnostically significant pulse and urine. But by far the largest number of plates in the set consist of much less systematic representations of a wide variety of situations in which humans

[55] There are a few exceptions, such as the mnemonic 'tree' plates at the beginning of the set, a few scenes of Buddhist realms and several larger tableaus with Buddhas.

[56] Wu 2009, p. 456.

find themselves. These too correlate directly to the medical information in the *Four Treatises*. But they are less comprehensive, often skipping important medical data in the text. What the vignettes do show are the human aspects of medicine: people being examined, treated, convalescing, dying, resting, working, experiencing medically significant symptoms, dreaming, and engaging in a slew of activities that are either harmful or helpful for health. In many cases the illustrations just represent in visual form a small point in the text, without providing any medical knowledge on their own.[57] That does not mean that there are not any number of other connotations of these images, medical and otherwise, and certainly there is pictured a plethora of kinds of persons and cultural activities. Far more than in the anatomical illustrations, there are many images of females here. And while these remain greatly outnumbered by males, there still are a lot of them.

Sex/gender parity

One way in which the vignettes depart from the anatomical androcentrism is with several cheerful renderings of gender parity. Some of these occur even where the text being represented is quite androcentric if not downright misogynist and patriarchal. One example that comes up early and that really catches the eye is found in the embryology, the topic of Plate 5 (Figure 17).

The plate contains much detail about the female *qua* mother, including birthing scenes in the bottom register with mostly female assistants attending. But nowhere do we have a more stunning foregrounding of human gender difference than in the pair of images portraying the basic marks of sexual identity, said to emerge on the foetus in the third week of gestation (Figure 18).

The marks are unmistakable: the two classic genitals of male and female, here pictured on two examples of a foetal mass in the earliest moments of its development, along with numerals indicating on which days of the menstrual cycle a woman will conceive a boy and on which a girl.[58] The two embryos are pictured side by side; they are on the same register, the same size. The only possible hint that a male child may be favoured is that the male comes first (as the male usually does). Otherwise it seems like a value-free alternative: either the foetus is a male, conceived on days 1, 3, 5, 7 or 9; or a female, conceived on days 2, 4, 6 or 8. This is actually just what the text tells us. And despite the striking fact that the text goes on to provide a ritual to change the sex of the

[57] This phenomenon is explored in Gyatso (2009a) and Gyatso (forthcoming).

[58] A variety of issues regarding this older Ayurvedic idea of days of the cycle and the sex of the child are discussed in Gyatso (forthcoming), including the possibility that the child might be of the third sex, a *ma ning*.

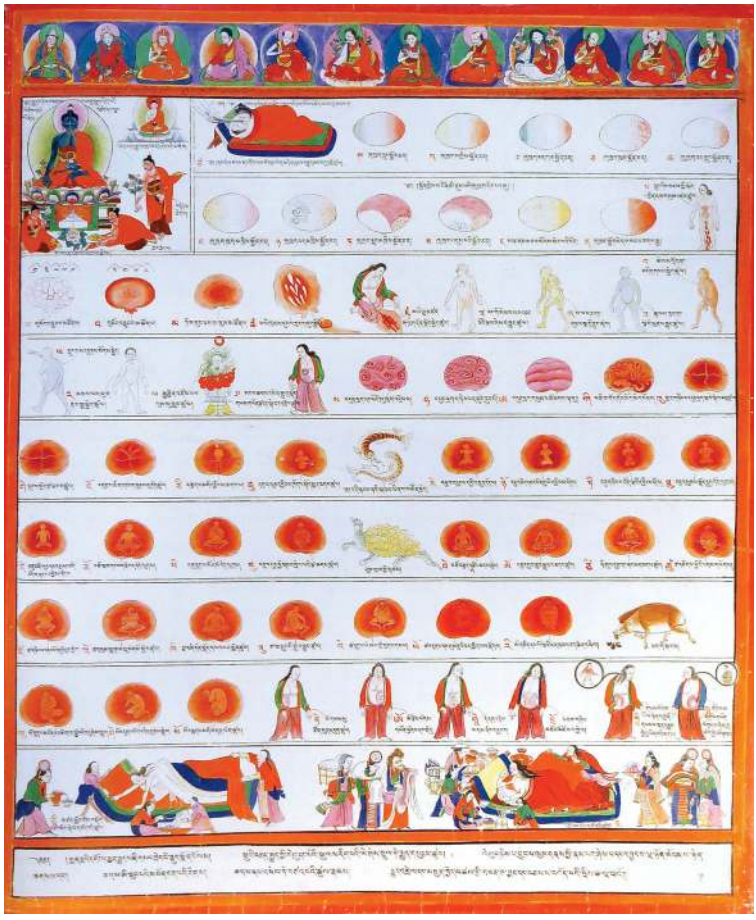

Fig. 17. Plate 5.

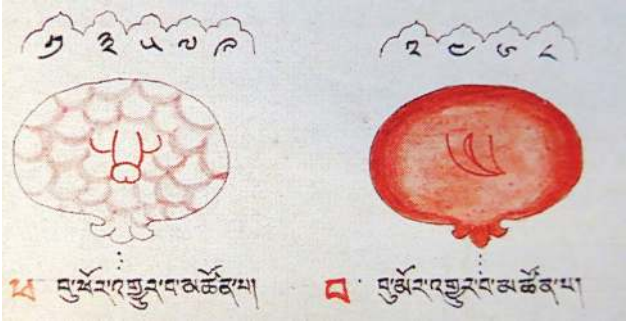

Fig. 18. Detail from Plate 5.

child into a boy up to the end of the third week of pregnancy, indicating an unmistakable preference for boys, that highly androcentric and patriarchal orientation does not infect this illustration of the all-important moment when sex is first determined.[59]

Many other vignettes display robust gender parity where the text is not androcentric either. Engaging examples can be seen in the large section on pulse diagnosis, the basic system of categorization for which is described in terms of gender, this time comprising three genders.[60] Most of the illustrations depict only male and female; that is because much of the pulse lore concerns the close connection between the pulse compatibility of husband and wife and the sex of their offspring (see Figure 19). These images of heterosexual couples, along with expressive indications of their pulse rhythms, allow us to compare the portrayal of women to their male counterparts where indeed the entire topic is about gender difference.

Fig. 19 a–c: Details from Plate 54.

[59] [gYu-thog] 1992, pp. 17–18. In not providing a ritual for the opposite case, the Tibetan text departs from its Indic source, which indicates the ritual for changing boys into girls too, should the parents so desire. This was known to Tibetan medical tradition: cf. the relevant quote cited by Zur-mkhar-ba (1989, p. 127.5).

[60] Gyatso 2003, pp. 100–6.

Note that the depiction of the couples themselves does not directly express their gendered pulse types; they rather are relatively random pictures, simply of sample human couples. It is clear that the artists found here an opportunity to exercise their talents of portrayal, rendering each image unique and idiosyncratic—as indeed human beings are, and couples are. This exuberant human idiosyncrasy is one of the most delightful features of the images throughout the set. Notice the parity between man and woman: equal level of detail, equal feeling, equal human expressiveness and variation. Yes the males are slightly larger, perhaps. But there is no hint of subservience or hierarchy; more to the point, here are two parents, along with a schematic representation of what each will bring to their child's form.

Similar kinds of gender parity, arrayed on what we can only call an even playing field, is evident on many other plates too. Even this line-up of the possible sexes of a human being—which goes from male, to female, to a slew of examples of the third sex (I only included the first one of these below)—is positioned along an axis where each person is portrayed with equal care and specificity. Visually, at least, there is no sign that any one of these sexes is more or less favoured than another.[61]

Fig. 20. Detail from Plate 16.

Some of what we are seeing may reflect social practice. The painting set provides many examples of male–female cooperation, apparently drawn from everyday practice, such as the pairs working together in various food-preparation tasks in Figure 21. Note that the text only discusses the substances being prepared (in both cases, kinds of milk-based foods); the human preparers are entirely extrinsic to the discussion and constitute original additions on the part of the

[61] Nor is there textually: this is a striking feature of the Tibetan description of the sexes. See Gyatso 2003.

painting studio.[62] Actually, the first substance consists in a mixture of water and milk: nicely represented by two people contributing the two liquids, but with a flourish of cross-gender cooperation to boot.

Fig. 21 a–b. Two details from Plate 22.

Androcentrism too

Our reading of these last images does beg the question of how we know that the pairs portrayed are indeed a male and a female. Their gender identity is not 100-per-cent definite, although it is a very good guess based on the clothes and hats. In many other vignettes, however, the gender of the figures is ambiguous, and this raises some further questions that we should address.

But before getting to that, we need to modify what was said just above about gender parity. Let us stay for another moment with those cases where gender identity is definite, either because of the caption or topic being portrayed, or because of unambiguous primary or secondary sex-related marks on the image itself. Despite the frequent parity, there are virtually no instances where an explicitly identifiable woman represents a common human medical condition. In contrast, there are numerous examples where an overtly male figure represents a condition that is common to all humans. Like with the anatomical diagrams, the vignettes too portray the male as the normative human being—certainly not as regularly as in the anatomical plates, but often enough to prevent us from jumping to any simple conclusion that the vignettes are more egalitarian than the anatomical diagrams.

Again, some of the androcentric vignettes replicate pre-existing textual androcentrism, such as Figure 22, an illustration of the 'two lower passages' of the body, analogised in the *Four Treatises* to drainage pipes on a building.[63] Thinking in terms of two lower passages instead of three, as with the number

[62] See sDe-srid 1994, vol. I, p. 227.

[63] [gYu-thog] 1992, p. 21: *'og sgo gnyis ni chu khung bzhag pa 'dra.*

of orifices in the body, is yet another instance where the text forgets about females. The male body represents an imputed general point about the drainage of the human body.

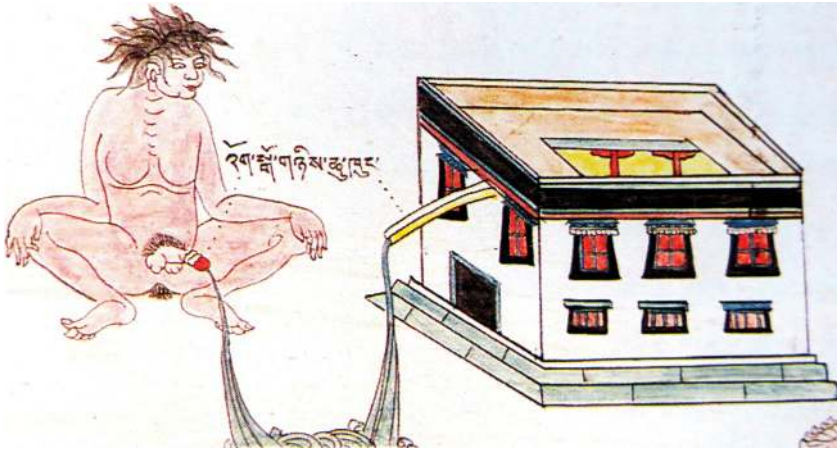

Fig. 22. Detail from Plate 6.

But more germane to the questions of this essay would be cases where the images add gender to textual passages that are themselves not gender-specific. Figure 23 shows three examples where such medical points have been rendered male only by the painters. The first shows a male (his sexual organ is visible) with a kind of worm (*srin*) in the lower section of the trunk, one of several indications that an enema should be administered; it is not a gender-specific condition.[64] The second figure shows someone undergoing purging, one of the causes of a type of fever; we know the image is male because of his bald head.[65] The third is an illustration of a person with indigestion, one of the causes of dropsy (*dmu chu*). Again, the condition is illustrated by someone who is definitely a male since he has a beard, while the topic itself is gender-neutral: dropsy affects both males and females.[66]

[64] sDe-srid 1994, vol. II, p. 1338. The rest of the list ranges across the sexes, including the stopping of semen (*khu ba*) and diffuse menses (*zla mtshan*) so it is clear that the list as a whole refers to the human condition.

[65] Mentioned by sDe-srid (1994, vol. I, p. 610), with no gender reference.

[66] sDe-srid 1994, vol. I, p. 532.

Fig. 23 a–c. Details from Plate 68, Plate 42 and Plate 41.

There are many such examples where the male figuration seems to be quite arbitrary, except to say that the male is the default human being. However, another subset of the images that use a male to represent humanity do so not entirely arbitrarily but rather for cultural reasons that we can readily surmise.

In the first case pictured (Figure 24a), the male figure illustrates one of the results of drinking alcohol: a lack of shame and restraint. We might speculate that more men got very drunk in Tibetan society than did women; and yet we certainly can assume that women did too. Still, the quite detailed discussion of what happens to people when they get drunk in the text gives no indication of gender.[67] The second figure (Figure 24b) is part of a list of omens that a patient will recover: it shows a person whose meritorious practice matches that

[67] sDe-srid 1994, vol. I, p. 235.

Fig. 24 a–b. Details from Plates 22 and 16.

of a monk. If you see such a person, it is a good sign. We only know this one is male because of the facial hair, but, in theory at least, it could just as well have been illustrated by a female. But it was not. Again, there likely are gender-specific stereotypes operating: perhaps men were thought more apt to be engaged in meritorious practice than women (and, indeed, while in the text this auspicious figure is not gendered, the following lines list one of the ominous signs as seeing a woman).[68] But that only proves our point: wide-ranging cultural gender bias informed the painters' choices in many of the vignettes, resulting in further elaborations of androcentrism beyond what was already represented in the written tradition.

Social conception feeding painterly choice is particularly evident in the renderings of childrearing techniques. In Figure 25, three out of the four children's genitals are visible, and they are all male; these children are marked as sons.[69] And while the *Four Treatises* in other respects displays a clear preference for male offspring,[70] the section on childrearing is presented entirely in gender-neutral terms.[71] Only the illustrations represent the generic offspring as a male.

---

[68] sDe-srid (1994, vol. I, p. 136), discussing kinds of religious practitioners in Tibet who are like renunciates but are not ordained; the lines give no explicit indication of gender.

[69] The Mentsikhang version is less explicit, only marking one of the children for gender. See n. 84 below.

[70] Gyatso 2009b, p. 87.

[71] [gYu-thog] (1992, pp. 362–3) speaks of either *byis pa* or *bu*; the latter in this context is a general term that refers to both male and female, but we can of course note the larger linguistic

Fig. 25. Detail from Plate 45.

The visual depiction of physicians is another area that is entirely androcentric, albeit informed again by social reality rather than any textual norm. We have no evidence of an express principle that prevented women from serving as physicians. And yet we know of no cases of female physicians in Tibet prior to the twentieth century.[72] This fact on the ground is reflected by the painters, as in this group of physicians reading pulses (Figure 26). Again, the reason we know for sure that they are all males is that they either have facial hair or are bald. At least two also appear to be monks—many, but not all Tibetan physicians were.

Fig. 26. Detail from Plate 59.

But now, despite such obvious examples, we have to be careful in what we are expecting and how that affects the way we read these paintings. While the *Four Treatises* and its commentaries often suggest a general androcentrism in Tibetan medicine, the textual record itself is mixed, and other passages indicate a range of ideas about gender, some of which are not only inclusive but may favour the female or indeed the third sex.[73] Even our widespread assumption about the androcentrism and patriarchy of Tibetan society more broadly is

androcentrism, similar to the use of the term 'man' in English to refer to humanity. sDe-srid (1994, vol. II, p. 821) also uses the term *khye'u*, which is also gender-neutral.

[72] Tsering 2005.

[73] Gyatso 2003 and Gyatso (forthcoming).

very much a generalisation, and the field is only in the beginning stage of figuring out a history of gender relations in Tibetan history.[74] So, just because we have seen some tendencies in the medical paintings to use the male to represent otherwise non-gendered human conditions does not mean that it will be true for all of the images in the set.

The three patients depicted in Figure 26 are a case in point. One may be tempted to revert to a default assumption that these three patients, illustrating problematic congenital pulse patterns, are all males, but in fact that is not for sure. None of the three patients have any recognisable gender mark. And while that observation may well be due to our own ignorance regarding what males and females looked like in eighteenth- to twentieth-century central Tibet, careful study of the vignettes across the set can yield some reliable principles. For example, when an explicitly labelled male and an explicitly labelled female have the same hairstyle, we have to conclude that that hairstyle is gender-neutral. When we begin to study the images in this way, we find that short of some well-known gender markers in dress (such as certain aprons or head dress for women), many of the human figures are portrayed in simple attire and disposition common to both men and women. Not only does that mean that we cannot say across the board that it is always a male who represents a general human condition. More radically, it appears that the painters were frequently comfortable portraying human beings whose gender specification is not really an issue. And that is quite noteworthy, in an environment where there was still a vociferous androcentric if not misogynistic orientation in play.

Gender ambiguities

Hair is a good place to start. Both recent practice and the artistic record indicate that prior to the late twentieth century both male and female laypeople usually had long hair. Both male and female renunciates had short hair. Does this mean that hair length is not a reliable guide to identifying the gender of a figure in the paintings? The answer in most cases is yes.[75]

Among the women who are portrayed with their hair down, their locks often seem to be twisted once around the nape of the neck. The woman on the left in Figure 27a, which pictures two metaphorical queens' attendants (the symbolize the large and small intestine), displays this hairstyle.

---

[74] Diemberger (2007), Schaeffer (2004) and Havnevik (1999) all provide a complicated picture with regard to the status of women in traditional Tibet.

[75] The following general points hold true both for the Ulan Ude set and the Mentsikhang set; a few minor variations in hairstyle between the two sets have not been noted here.

Fig. 27 a–b. Details from Plates 6 and 46.

But for the other woman on the right, whether the twist is there or not is not so clear. Moreover, not all women with their hair down have the twist at all; the female in Figure 27b, illustrating a woman with breasts filled with 'white element', is a case in point, and there are numerous others. And that introduces an opening for a major ambiguity. Men portrayed in the medical paintings wear their hair down their backs too (see Figure 28).

Fig. 28 a–b. Details from Plates 43 and 44.

Figure 28a, from Plate 43, is labelled a condition of the male genitals. Figure 28b, from Plate 44, shows a symptom that would be gender-neutral but, due to the genitalia, we know it is male. Figure 28c, from Plate 43, illustrates a person with excessive wind; the facial hair says that it is a male. And, finally, Figure 29, a lively image of someone, probably a husband, giving the wrong medicine to his wife, shows a male—again, identifiable by virtue of his beard—with an thick mane of hair hanging down his back.[76]

[76] This entire section of the first chapter of *Phyi ma rygyud* concerns ways in which husbands and wives affect each other's health and pulse, which also means that the physician can examine the healthy spouse's pulse in order to diagnose the sick one.

Fig. 29. Detail from Plate 59.

The other frequent hairdo to be seen on females in the medical paintings is a bun at the nape of the neck, like in Figure 30:

Fig. 30. Detail from Plate 44.

But the same buns are often seen on males as well, as in the group in Figure 31, illustrating a variety of causes and conditions of infectious diseases, at least one of which, the middle figure on the bottom register, has a male organ. Plate 42 for some reason shows a preponderance of figures with buns; it is doubtful that that has anything to do with gender. In fact they are probably all meant, if anything, to be males. My point is only to say that it is not sure imagistically.

Fig. 31. Detail from Plate 42.

More than hairstyle, one would expect clothing and headgear to be reliable gender markers. In Figure 32, a set of women with whom relations are to be avoided (because of being married, unattractive, pregnant, or weak) show a kind of pleated overskirt frequently seen on women in the painting set.

Fig. 32. Detail from Plate 20.

Similar garments are visible in the set of childrearing women in Figure 25, but there it is already evident that these overskirts can have various forms, blurring into cases where it is not clear whether there is an overskirt or not. Figure 33a is gender-specific: it shows a prince and two princesses (metaphors for the lobes of the lung), and it illustrates how close the dress of males and females can be. Figure 33b, of two people giving alms to a beggar, does not specify who they are, but I assume it is meant to portray a husband and wife; if I am right it shows that a man can have what looks like an overskirt too.

Fig. 33 a–b. Details from Plates 6 and 20.

In fact, there are many cases where men are wearing over-robes with another robe underneath. There is even what looks like the pleated overskirt that we are identifying as female dress on a urinating male (see Figure 34).

Fig. 34. Detail from Plate 16.

And so, while there are certain patterns in the dress of many female figures, lacking other evidence we cannot absolutely identify a figure as female just because it has an overskirt. We certainly cannot say that a figure that lacks an overskirt is not a female, for there are many people, explicitly identified as female, who have no overskirt. Some examples were already seen in Figure 19 in the images of the pulse combinations of couples. Lack of overskirt or robe obtains especially when women are pictured as patients, or in repose at home, when they would not be wearing their full costumes in any case. Figures 35a and 35b, one illustrating womb blood and the other showing a woman having her pulse read, serve as typical examples.

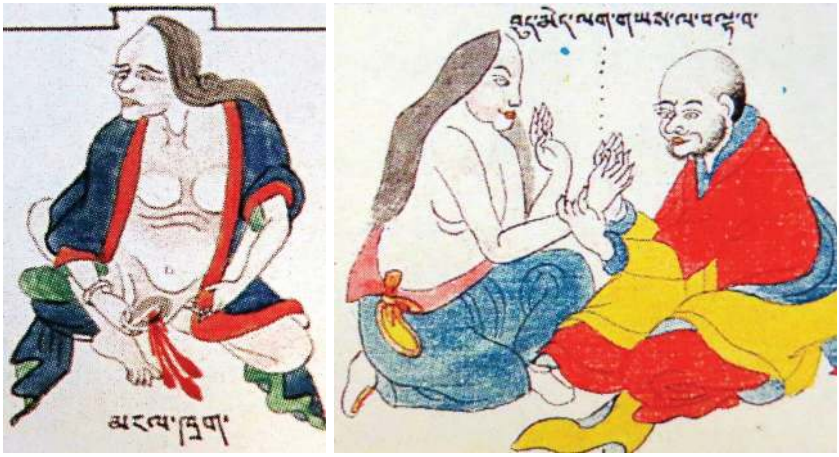

Fig. 35 a–b. Details from Plates 28 and 54.

Depictions of people in medical paintings would in any case tend often to lack gender-markers in dress and hairstyles, since people of both sexes who are ill or who are simply at home in bed would tend to have their hair down and be wearing simple robes. And yet that does not alone explain the frequent inability to recognise gender in these images.

More interesting is the variation and ambiguity of gender specificity on the body itself. For example, sometimes chest hair does indicate a male, but in most cases none is in evidence. Especially noteworthy is how little breasts can serve as reliable gender markers.[77] Yes, on occasion they contribute to a certain

[77] Some of the following cases display some very minor differences between the Mentsikhang and Ulan Ude rendering of breasts, but the overall range in breast size for both men and women, as discussed here, is the same in both sets.

confidence that a figure is a female, as in a lovely example (Figure 36) of someone administering a massage to a physician—probably his wife.[78]

Fig. 36. Detail from Plate 16.

But the more we look the more uncertain it becomes. In Figure 37, one might want to say that female breasts may be distinguished from those of the male next to her (she illustrates the red reproductive substances [*khams*] in the body while he illustrates the white) on the grounds that she has nipples while he does not. But note how round his breasts are, similar to hers.

Frequently women don't have nipples indicated either, such as the female we have already seen who illustrates a woman with breasts filled with white element (see Figure 38a). Figure 38b, from the same plate, is labelled a lama and has a small goatee; we know he is a male but can we identify a definitive gendered difference between the depiction of his breasts and hers?

Figure 39a and 39b show two nude figures where an explicitly male figure has nipples and an explicitly female one (she is illustrating a dream of re-entering one's mother's womb) does not; in fact her breasts are barely represented at all.

[78] The caption for the next vignette indicates this topic is drawn from *Zla zer*.

Fig. 37. Detail from Plate 30.

Fig. 38 a–b. Details from Plate 46.

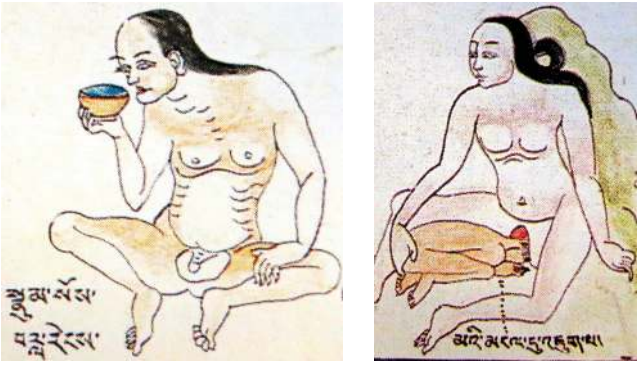

Fig. 39 a–b. Details from Plates 36 and 17.

If deities are thought to represent cultural ideals, then the following examples show a possible range of breast size for male and female more strikingly yet. Figure 40 shows the god Paraśurāma, with round breasts and nipples.

Fig. 40. Detail from Plate 1.

Figure 41 depicts three demons whose range of breast size quite judiciously parallels that found in the population of human females.

Fig. 41. Detail from Plate 45.

Even the painting set's plethora of couples having sex are hard to read for gender. We never see the genitals, and while we might suspect it is usually the man on top we really can't be sure. Figure 42 is one of the more finely rendered ones.

Fig. 42. Detail from Plate 41.

It would certainly seem that it is the male on top, and the image matches our gender expectations about the size and strength of the head and perhaps a round breast below him. Note too his bun—if that is the male. But we really can't be sure. In the following pair of images of two kinds of wrong sex (during the day and with someone other than your own wife; see Figure 43), it is certainly not clear who is above and who is below. And in the couple on the right, if it is the other man's wife who is on the bottom, note that she has a bigger head than him.

Fig. 43. Detail from Plate 20.

Most indicative of a lack of care for gender identity are the images where the genitals could be depicted and are not. The supine naked person in Figure 44, who illustrates someone who has had a stroke, can stand as one example where the painters apparently were making no effort to specify the sexual identity of the unfortunate patient.

Fig. 44. Detail from Plate 46.

Actually, most of the vignettes of individual patients are clothed, at least around the lower body. Many of the cases where the genital area is exposed and the sexual organ is visually articulated are illustrating medical conditions that involve those orifices of the body. Of the several scores of nude bodies that do not need to be nude in order to make a medical point, most of them are in positions that end up blocking a direct view of the genitals. But among the several scores of other cases where the area is exposed and the genitals are irrelevant to the medical condition that is being illustrated, I estimate that they are split between portraying the male organ (three examples of which were provided above) and roughly an equal number of frontal nudes with no genitals depicted.[79] Contrast the anatomy plates, which provide approximately three instances of a frontal nude that demurs from any gender specificity, out

[79] Examples can be seen on Plates 62.97, 67.73, 68.49, 68.86, 69.73, 69.95, 74.60 and 75.54.

of a total of roughly 25 anatomical figures with genital areas exposed, the rest of whom are male.[80]

Androgyny?

While there are many instances of readily recognisable sexual identity, there are many others where it is not. Can we say for sure that the patient being examined in Figure 45 is a male?

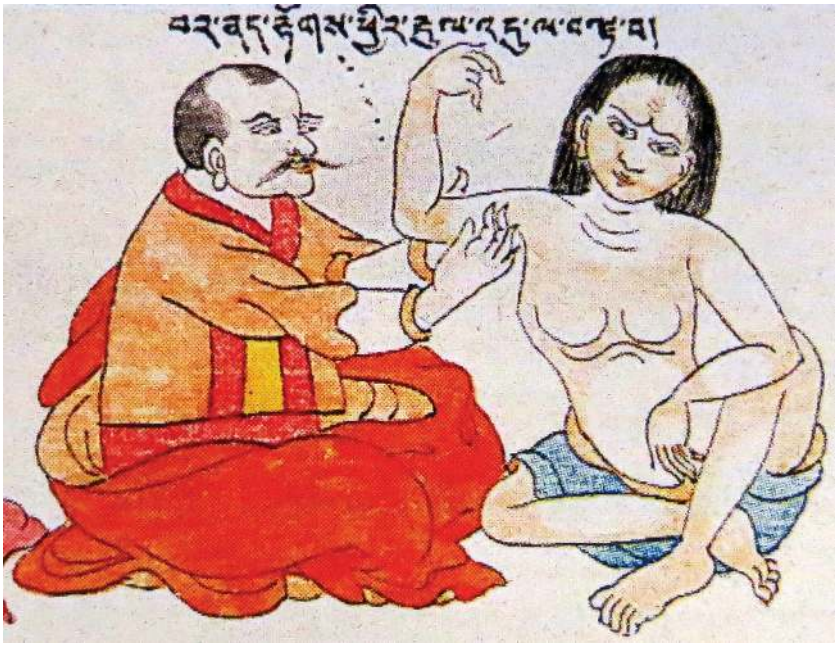

Fig. 45. Detail from Plate 54.

What about the group of patients (Figure 46) whose disease is caused by a variety of kinds of disturbances? Are they male or female? We only can say that the doctor at the end of the row is male because of his baldness.[81]

[80] It is difficult to provide a precise count for a variety or reasons, including the fact that some of the anatomical nudes are positioned in ways that partially or fully block views of the genital area. Plates 49 and 50 provide a few other examples of frontal anatomies that seem to lack sexual organs, in addition to the side figures of Plate 8 studied above.

[81] In the Mentsikhang set, the hair on these figures is different, but the first figure on the left could still possibly be female. Wangle and Byams-pa 'Phrin-las 2004, p. 295.

Fig. 46. Detail from Plate 42.

The people in Figure 47 could be female—or not. Figure 47a illustrates the heaviness and inactivity that ensues after eating 'cold' foods; Figure 47b shows a person whose pulse portends suffering.

Fig. 47 a–b. Details from Plates 40 and 55.

And what about the clothed persons in Figure 48? One is offering a scarf to a physician (Figure 48a); it looks female to my 2011 American eyes, but is that right? The middle one is having a second meal after a first one that is not yet digested (Figure 48b), but is this person wearing an under-robe or is there a female overskirt? And what sex is the third person, who is consuming salt (Figure 48c)?

Figure 49 shows a group of people who have been poisoned but who will be cured by a doctor. Are any of them women? I could see the middle one and the last one as female, and yet men wear their hair in top-knots too. The yogi-looking person could also be a female . . . but probably is not. What about the one with the big cape? A stocky matron?

Fig. 48 a–c. Details from Plates 35, 40 and 41.

Fig. 49. Detail from Plate 31.

Is the yogi pictured in Figure 50a, meditating on the 'vital channel', definitely a male? Probably, but not necessarily; it would be plausible to read the image as a female too. And what about the grey-haired person in Figure 50b, making *bezoar*, a kind of medical concoction? That could conceivably be a woman too, even if, again, it is probably a man.

Finally, what about the three people shown in Figure 51 illustrating exceptional sleeping habits—are they women or men?

Our residue expectation of androcentrism predisposes us to say they are men.[82] And maybe that is what they were meant to be. But the foregoing analysis has suggested a range of possibilities in reading figures such as these. One is that indeed maleness was so overwhelmingly assumed to be the coin of the realm, so to speak, that it was not even necessary to add an explicit gender marker.

[82] In the Mentsikhang set the hair differs significantly on the last two figures, where it is short, but the figures still can plausibly be read as females, i.e. as nuns: Wangle and Byams-pa 'Phrin-las 2004, p. 158.

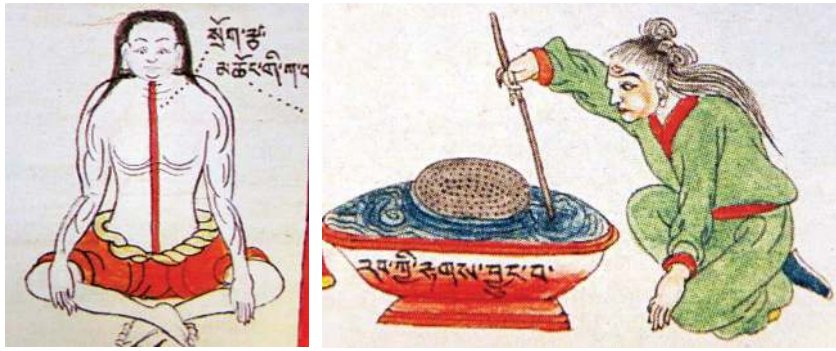

Fig. 50 a–b. Details from Plates 6 and 31.

Fig. 51. Detail from Plate 20.

But it might also have been frequently the case that gender was not on anyone's mind in portraying activities such as sleeping (and surely both men and women sleep at odd times when they are not well!) and making food or medicine, such that what was portrayed was merely a generic human being.

Certainly in many cases gender-specific markers are portrayed in depictions of such activities, as in the image of couples cooperating in the preparation of foods in Figure 21, or here in Figure 52, showing single cooks.

Fig. 52. Detail from Plate 22.

The first is certainly a woman by virtue of the head-dress; I guess the second is a male, although as has now been shown that is not for sure; it could also be an older woman cooking at home. But lacking any evidence that radish is typically prepared by women (or that garlic, the content of the second stew, is typically prepared by men) we have to say that the painters are simply portraying human diversity—and perhaps even gender diversity—in quotidian occupations. Such a scenario would be a variation on the cases that appear to display gender neutrality: both no gender and random gender variation work to undercut strong notions of gender, if in different ways.

In the end, there are several ways of reading cases such as these cooks, and the gender-uncertain people sleeping and the other gender-ambiguous illustrations. Perhaps all such figures are indeed marked for gender, in ways that I have missed. Or perhaps—and this is a significant alternative—the operative codes of gender identity in hair and dress during the period and among the groups in question provided certain possibilities for gender-neutral self-presentation. (For example, as already ventured, perhaps when at home and in bed men and women dressed similarly.) If that was indeed the case—at least in certain kinds of everyday circumstances and practices—it would be another 'social reality' that provided the occasion for gender-neutral representation as well.

This is not necessarily to propose that such neutrality was intentional on the part of the artists, as if to say, 'this figure can either be a male or a female, and indeed the situation here represented is experienced by both men and women.' It might rather be a case of simply portraying a human condition, many opportunities for which present themselves in the set. Sometimes, perhaps rather randomly, the choice is made to render the generic human condition as male. One place to glimpse such gender randomness is in occasional differences between the Mentsikhang and Ulan Ude versions in the exact way they render breasts, or the degree to which baldness is evident or not. A good example can be seen in the case of the individuals represented in Figure 53, illustrating people who have eaten too much, and too little. The artists for the Ulan Ude set that we have been tracking in this essay provide no sexual organs at all.

But in the set currently housed in the Mentsikhang, the same two figures in the same position have about half their male organ visible, peeking out above their crossed legs.[83] (And lest it be thought that one atelier of artists was more circumspect than the other, we can note that for the illustration of child-raising techniques shown in Figure 25, the situation is reversed: the Mentsikhang set only indicates the male organ, very vaguely, on one of the children, in contrast to the much more visible maleness of the children from

[83] Wangle and Byams-pa 'Phrin-las 2004, p. 354.

Fig. 53. Detail from Plate 54.

the Ulan Ude set.[84] In most cases, the sets are identical in what they indicate, or not, of gender identity.)

This last example does not 'prove' that the figures are indeed 'really' male. Rather, we can say that frequently gender is sufficiently off the table that the addition of gender indicators is an afterthought. Such an attitude does leave open the possibility that gender was sometimes left out precisely because the artist realised it is not needed, since indeed a generic human is being represented. All in all perhaps the situation is not unlike the use of certain stick figures in modern signage: sometimes (on public bathrooms, for example) gender is part of the message; in other cases, residual androcentrism makes a figure on a sign male anyway; and finally, sometimes simple lines for head, torso and limbs will suffice to indicate a generic, genderless human activity. If the latter, deliberately liberatory gender-neutral signification is less intentional in the Tibetan medical set than it has become in modern practice, it still remains the case that the generic kind of representation germane to medical illustration opened the door for such a path to be taken.

[84] Wangle and Byams-pa 'Phrin-las 2004, p. 316.

Women representing humanity?

Despite the gender neutrality that we have been able to discern in the medical paintings, our initial suspicion that a general human condition is virtually never represented by a female appears to be correct. Almost always, a gender-neutral medical condition is either explicitly represented by a male, or it is represented by a figure whose gender is not specified.

Still, our study has opened up the possibility that a figure whose gender seems ambiguous might have actually been meant to portray a female. I have found a few vignettes where it looks possible that a female is representing a generic human condition. For example, the person shown in Figure 54, in a series of images of human vices to avoid, may be a female, judging from the overskirt.

Fig. 54. Plate 20.

Unfortunately for feminist purposes, this female representation, if I am right, is overdetermined by negative gender stereotypes; the vice being portrayed, 'foolish chatter', is in many cultures deemed to be the special purview of women, even if it is a vice in which, in the end, all of humanity participate. On the other hand, it is not entirely clear it is a female—and it may be that the

ambiguity in this case is intentional, serving precisely to represent the situation in less than sure terms—and yet tipping in a certain direction nonetheless.

Figure 55 is another instance where a gender-neutral condition might be represented by a female: it is an image of a person to whom riches may come. Whether there are gender stereotypes associated with such a situation is hard to say; it is something that happens to both men and women in Tibet, patrimonial practice notwithstanding.

Fig. 55. Detail from Plate 55.

Figure 56 is one last case, but now I am disregarding the uncertainties I have taken pains to uncover above. The rendering of the hair and breasts makes this patient look like a woman. The image shows a physician examining someone who has a type of halting pulse (*nad sdod*), in this case indicative of a brain, spinal-cord or marrow disorder. If this patient is indeed a female—and how would we ever know for sure?—it would be a revelation, since indeed the condition is not necessarily female.[85] It could even be for the painters

[85] The various kinds of halting pulses are discussed in sDe-srid (1994, vol. II, p. 1209). As is frequently the case, pulse is checked on opposite arms in men and women, as for example indicated on p. 1210, but that distinction is not always illustrated in the paintings and in any event

a mini-effort—like our current widespread endeavour in English occasionally to use the feminine pronoun to refer to a human condition. We do so in order to even out the playing field or just to indicate the varying ways of being human.

Fig. 56. Detail from Plate 61.

Textual androcentrism dropped

The last section showed how rarely we can identify for sure a female figure who is used in a context other than one that is specifically marked female. Far more encouraging is our other finding, that frequently gender is either ambiguous or sufficiently underemphasised as to be relatively unarticulated.

One further finding that is mildly encouraging is that the painters and their directors had enough oblivion to gender bias—at least on occasion—to produce several illustrations that desist from the clear gender bias of the textual passage they were actually representing. One good example is another instance, mentioned at the start of this essay, where the text dubs features of the female

---

both arms are eventually involved, so this illustration does not indicate gender by virtue of which arm of the patient the doctor is holding. Gyatso (forthcoming) will provide some discussion of the complicated practice to reverse left and right arms in the examination of men and women.

anatomy with the androcentric moniker 'extra'.[86] This is the passage from the *Four Treatises* that characterises the measurements of the substances in the body. Unlike the anatomical images of her extra orifices, the vignettes illustrating the bodily substance measurements fail to render the anomalousness of the female features visually (see Figure 57).

Fig. 57. Detail from Plate 6.

Actually, the painters made several adjustments to the text in terms of gender here. The first concerns the measure of flesh on the adult human. While the text makes no gender-specific statement about this quantity, the painters chose to represent this measure with three human figures.[87] The first two depict a man and a woman (their attire leaves little room for doubt). There is also a third figure, and it is hard to know what it represents, but it is possible that it depicts a third-sexed person (*ma ning*). In any case, the caption seems to go with all three figures (see Figure 58).[88]

Fig. 58. Detail from Plate 6.

[86] See nn. 29–31 above.

[87] [gYu-thog] 1992, p. 21, sDe-srid 1994, vol. I, p. 95.5.

[88] The version seen in Wangle and Byams-pa 'Phrin-las (2004, p. 97) explicitly connects the caption to the last two figures with dotted lines, but clearly the first also belongs to this topic.

Here the paintings' creators seem to be going out of their way to illustrate the fact that this measure for the amount of flesh—500 *spar* —is the same for all genders. The choice to represent two (or perhaps three) people for this point is a case of the painting studio weighing in. The paintings bring the lack of gender specificity in this measurement to the fore, precisely by providing individual images of all known genders. Note too that the figures are of equal size and detail.

The final portion of the textual passage on bodily measurements is represented by four females, so labelled (Figure 59). This is the portion that refers to the 'extra' (*lhag*) female substances, namely, 10 extra *spar* measurements of breast flesh, 10 extra *spar* of thigh flesh, a *snyim pa mdo* of breast milk and four *snyim pa* of menses. Actually the first two specifications modify the gender-neutral measurement given just before, that all adult bodies have 500 *spar* of flesh: in addition to this standard amount, women actually have 20 extra *spar* of flesh, and then they also have two kinds of liquid in their bodies which are not present for males.[89]

Fig. 59. Detail from Plate 6.

In any event, all of this male-centred specification is from the texts. The visual representation of the figures gives no inkling that the female measurements have an anomalous status. These women are situated on the same register and rendered with the same amount of care, wit, detail, interest and idiosyncrasy as the male figures, here and elsewhere. This careful attention to female specificity poses a stark contrast with the way in which the anatomical renderings relegated the female body with her 'extra' orifices, where she was a small, vague and inconsequential aside.

[89] See n. 30 above.

Textual androcentrism retained and the male gaze

But does artistic care and attention to the female figure always mean egalitarianism? The attention bestowed in another major representation of the female provides delightful and variegated renderings but probably spells the exact opposite.

In this case, the textual source is unmistakably and extremely androcentric—as well as being explicitly patriarchal, if not misogynistic. The source is the *ro-tsa* section of the *Four Treatises*, which concerns sexual virility and fertility. It is examined in Chapters 91 and 92 of the *Man ngag rgyud* (*Instructional Treatise*) portion of the work. The text makes it crystal-clear that the male is the principal (*gtso bo*) subject of this branch of medical knowledge, while the female is but an ancillary (*yan lag*). One of the reasons for this is that sexual performance, according to this text, depends solely on the male. The text also asserts that family lines go through males rather than through females, here providing an important textual confirmation of the patriliny long observed in many Tibetan groups.[90] And while it provides detailed information on how to facilitate male arousal and virility it says nothing about female sexual experience. In fact, the entire discussion of sexual arousal and performance is limited to Chapter 91, which is about the male. Chapter 92 then takes up the 'ancillary' topic, that of the female, but its content is devoted entirely to a brief survey of problems in the female reproductive system.[91]

In the painting set, the two *ro-tsa* chapters are portrayed along one line in Plate 53 (see Figure 60). It is worthwhile looking at them together. The main portion constitutes one of the largest single tableaux among the vignettes. It actually integrates the content of the entire Chapter 91 into one scene. The final small panel on the register, spotlighting three female figures, illustrates the material in Chapter 92.

The difference between the figuration of the female in the two sections is telling. The first portrays five women, not counting the one locked in embrace with the male protagonist at the right end of the tableau. They are depicted in full costume, in varying styles and poses, and illustrate attractive women with the qualities that the male should seek in a sexual partner (see Figure 61).

---

[90] [gYu-thog] 1992, p. 551: '*skyes pas 'dod pa spyod par ma nus na / bud me brgya yis bskor yang don mi'grub / skyes pa'i khu ba skyon med 'phel gyur na / bud med bu tsha 'phil ba btsal du rung / de phyir ro tsa' gtso bo skyes pa yin / . . . pha yi rabs brgyud bu mos mi zin pas / gtso bor mi 'gyur.*' See Gyatso (2009b) on the fact that elsewhere in this section it is clear that reproduction depends on the sexual fluids of both the mother and father.

[91] Gyatso 2009b.

Fig. 60. Detail from Plate 53.

Fig. 61. Detail from Plate 53, showing 'the beautiful and laughing adult woman'.

Fig. 62. Detail from Plate 53.

Figure 62 shows the various female activities that the text describes as serving to arouse the male, including gazing into the eyes, singing, conversation, smiling, kissing and embracing. Note that the male in this and the detail illustrated before it lack captions; he is merely the subject of the scene and is so naturalised that he does not even need labelling.[92] The women in this vignette, in contrast, are prime examples of what is commonly referred to in modern feminist studies as 'objects of the male gaze'. We should also note that, in line with a tendency also seen elsewhere in the vignettes, only a very few of the medical substances and none of the procedures recommended in the chapter are illustrated. The entire scene rather focuses on a sweetly painted rendition of the beautiful place suitable for romantic pursuits, which is duly described in the text, and the alluring consorts themselves, along with their appreciative male suitors and finally the culmination of their efforts in bed.

In stark contrast, the final panel of the *ro tsa* section depicts three sickly women to stand for Chapter 92 (Figure 63). They are exhibiting the three main categories of pathologies of the menses, each caused by an imbalance of one of the three humours. Like the woman's overall label in the *ro tsa* textual

[92] The caption visible here under the man, *zas ka ra* ('sugar'), refers to one of the aphrodisiac substances pictured to his right.

passages as 'auxiliary', this final panel presents itself visually as an addendum to the preceding grand scene of male pleasure and performance. What that grand scene of Chapter 91 does have in common with this representation of Chapter 92, however, is that, again, the focus is upon the female figure. As a matter of fact, the *ro tsa* text exhibits a systematic ambivalence whereby the title to its second chapter, 'Attending to [a Cure to the Reproductive Pathologies in the] Woman' can also be read to say 'Looking for [Another] Woman'.[93] The idea seems to be that if the woman fails to reproduce (and perhaps to please), the patriarch can feel justified in seeking a new partner. This implication is reflected in the visual representation of the chapter (Figure 63). These three unattractive women, displayed in their invalid condition, suggest exactly that option—especially if the eye were to compare them to the lovely ladies of the main *ro tsa* tableau.

Fig. 63. Detail from Plate 53.

[93] Gyatso 2009b.

Misogyny

The androcentrism of the *ro tsa* section is perhaps to be expected, given the special buzz—in so many cultures world-wide—around male sexual performance and entitlement. But one more section of the medical vignettes is indeed remarkable for how far it goes beyond the already androcentric and misogynistic text, and deserves our attention. It shows that even the vignettes that portray the central medical data of the *Four Treatises* are subject to extreme gender prejudice. This is the set of illustrations for the three gynaecological chapters of the medical treatise. Once again, the illustrations are indebted in their gender prejudices to the text itself (see Figure 64).

Fig. 64. Detail from Plate 46.

These two registers plus one image illustrate the entire gynaecological section of the medical treatise—Chapters 74–6 in the *Instructional Treatise*. The first register is trained on depicting the first few lines of the text of Chapter 74. Those read,

> The body, made from the three poisons and the four elements, appears as male or female through the force of previous karma and desire. Through low merit one attains the deficient female [*za ma mo*] body.[94] Breasts, womb and the monthly cycle are her special extras. The ultimate bodily essence [*lus zungs*] is the two fluids [*khu ba*], the white and the red.[95] [As for the] red, menses [*zla mtshan*] drip after

[94] For *za ma*, see Gyatso (2003, nn. 75 and 76).

[95] Here is a case where *khu ba* names both the male and female reproductive fluids. In the next line (see n. 96) the text refers to her fluid as *zla mtshan*. That term in turn can denote either the menstrual cycle or the actual fluids produced each month. Note too that in the next line the term *khu ba* would seem to refer to the male sexual substance, which I have translated as 'semen'.

> she has reached 12. She holds the semen [*khu ba*] inside the womb, and the fleshly body [of the fetus] develops. [As for the] white, it spreads in the breasts and comes to nourish [the baby].
>
> In that, as a result of the conditions of previous karma, eating, behaviour, and ghosts, there are the five womb illnesses, 16 channel illnesses, nine tumour illnesses and the two types of worms illnesses. The principal female illnesses are 32. Along with the eight common illnesses there are 40 altogether. Since she is a lower birth the female [*bud med*] body has extra [illnesses].[96]

Here, rather than androcentrism, we are looking at misogyny. The *Four Treatises* made an important contribution in gathering female pathology and therapeutics into a separate section devoted to women's conditions. But perhaps to compensate for this thrown bone, the text makes sure to remind women at the outset that they are still inferior beings. This involves yet another reference to the 'extras' entailed in being female. But now, in addition to having breasts, a womb and the monthly cycle, it also means being subject to extra illnesses, in addition to the eight that are common to both genders. Most of all, now these 'extras' on the female body are explicitly attributed to her low merit.

But the illustrations are even more vociferous than the text. First of all, we have again a sin of omission. The paintings illustrate none of the detailed information on gynaecological medicine contained in the three textual chapters, regarding menstruation, gynaecological symptoms, treatments for various imbalances, tumours or obstetric conditions—far more than what was provided in brief in the female *ro tsa* chapter. This in itself might not be particularly significant since a number of the chapters in this section of the *Four Treatises* are not fully illustrated in the painting set; perhaps the painters were running out of steam (or funding!). Still, the way in which the content of the gynaecological chapters is abbreviated visually is telling. The illustrations are taken up almost entirely with misogynistic generalities about the reasons one is born a woman and what it means to be a woman, along with a depiction of a few general causes of gynaecological problems (such as humour imbalance, deity possession, bad diet and bathing in the wrong time or place). The only other images are four very general depictions of women (see Figure 65).

---

[96] [gYu-thog] (1992 p. 375): '*dug gsum 'byung ba bzhi las grub pa'i lus / sngon las 'dod chags dbang gis pho mor snang / bsod nams dman pas za mo mo lus thob / nu ma mngal dang zla mtshan khyad par lhag / lus zungs phyi ma khu ba dkar dmar gnyis / zla mtshan dmar po bcu gnyis lon nas 'dzag / mgnal nang khu ba 'dzin zhing sha lus skyed / dkar po nu ma la rgyas gsos su 'gyur / de las sngon las zas spyod gdon rkyen gyis / mngal nad lnga dang rtsa nad bcu drug dang / skran nad dgu dang srin bu'i nad rigs gnyis / mo nad gtso bo sum cu rtsa gnyis dang / phal pa'i nad brgyad bzhi bcu tham par 'gyur / skye ba dman phyir bud med lus la lhag'.*

Fig. 65 a–b. Details from Plate 46.

The first on the right in Figure 65a represents a woman with a 'female disorder', which simply stands for the entire announced topic of Chapter 74. The second is a woman consumed by an array of imbalances, followed by another general image of a woman with a 'particular female disorder', which together stand for the entire content of Chapter 75. Finally, Figure 65b, a woman with a 'common female disorder', represents in summary the entire content of Chapter 76. Apparently the depiction of generic women sitting on their sickbeds was enough to portray the gynaecological knowledge and treatments of three substantial medical chapters.

Adding insult to injury in their representation of the textual passage just translated, the images ignore the text's association of 'the three poisons' (represented by the cock, the snake and the pig) with both male and female as translated above.[97] They offer no images of males here, making it seem in the visual rendition of the passage that the poisons only contribute to becoming a woman. Worst of all, the painters quite gratuitously provided a second repre-

[97] sDe-srid (1994, vol. II, p. 839) makes that point even clearer, adding the third sex *ma ning* to the list of kinds of bodies one can get as a result of the coming together of the poisons and elements.

sentation of the three poisons for Chapter 76, even though the poisons are not mentioned there in the text at all.[98] But in the paintings' version, Chapter 76 starts with yet another generic woman—perhaps having tea?—facing, again, the cock, pig and snake (Figure 66).[99]

Fig. 66. Detail from Plate 46.

This completely unnecessary image seems simply to be reminding everyone once more, 'Here is woman: the three poisons.'

Conclusions

Among the several challenges this paper has faced, one has been the task of performing feminist criticism on an object about which our cultural knowledge is woefully incomplete. That alone guarantees that any generalisations we can offer about the gender representation in the medical paintings will have to be provisional. But there are also more basic—and historically significant—reasons why our findings in the foregoing are mixed and often ambivalent, quite apart from the epistemic distance of a twenty-first-century analyst. The very object at hand has turned out, on its own terms, to be inconclusive about the meaning and marks of gender. Stridently exclusionary gender rhetoric can be found right alongside gestures and practices that serve to balance gender difference, or even to render it non-existent. Much the same, of course, could ultimately be said of the modern, supposedly post-Sexual Revolution world. In fact, I believe that there is something germane to the entire issue of gender that makes it intrinsically chimerical, ever shifting, inconsistent and often restrictive and liberative at once. In the present context, I have been curious to

[98] [gYu-thog] 1992, p. 382.

[99] The Ulan Ude set dropped the caption visible in the plate from the Mentsikhanag seen in Wangle and Byams-pa 'Phrin-las (2004, p. 320), which simply reads *bud med*, 'woman'.

discover if gender fares differently in the culture of Tibetan medicine than it does in religion, with its systematic ideologies and highly disciplined practices, on the one hand, or in general social practice, with its more instinctual and unregulated quality, on the other. Once again this is far too large a question to answer, and it might even be quite wrongly conceived. There is much variation regarding gender conception and prejudice in medicine, religion and society alike. So let me just point out more narrowly what we have seen in this study, namely that while many threads of patriarchy, androcentrism and misogyny are certainly inherited by Tibetan medicine, we also do see several corners where gender difference is either equalised or rendered largely irrelevant. Exactly how those variations unfold in a few examples is one of the main interests of this article.

The foregoing study has focused in particular on gender representation in a visual medium. While a fair amount of fluctuation on gender definition and status can already be recognised in the medical texts, this study has revealed further variability in the paintings. In short, we have seen androcentric gender bias, gender parity and even absence of gender markers altogether in the painterly representation of the human subjects of medicine. We have found all three phenomena in the images that directly reproduce the medical texts as well as in those that display artistic improvisation.

Overall, the first impression from a quick scan of the medical paintings has been sustained: there are significantly more males represented than females. Both the anatomy plates and the plates of small vignettes virtually always render the normative human male. And yet frequent deviations have been noted, and general rules are hard to extrapolate. While it would appear that where systematic medical knowledge is being represented, it is more likely that the images will be androcentric, the sections covering the minute systems of pulse diagnosis—which is one of the most comprehensively represented portions of the text, with plate after plate of vignettes—shows considerable gender parity. That might be because of the nature of the pulse concept altogether, which not only invoked but also valorised the third sex, let alone the second.[100] It also seems to have something to do with the fact that the pulse plates were painted vignette-style.

In most cases, the vignettes appear to be much more spontaneous than the systematic anatomical plates and far less bent on gender prejudice. We have seen ways in which, visually at least, many of the female vignette figures betray an empathy for female experience. We have found a significant number that seem to be oblivious of gender difference altogether, far more than in the

[100] Gyatso 2003.

anatomical diagrams. But still, even in the vignettes, a general human condition is virtually never represented by a female. A gender-neutral condition is either represented by a male or by a gender-neutral figure. And we have also seen sections of vignettes that are even more vociferous than their already androcentric or misogynistic textual counterparts. That means that the vignette renderings are subject to gender politics too—especially, it seems, where matters of sex and reproduction are involved.

Among the most interesting findings for me in the anatomical plates is the way in which the visual translation of androcentrism achieves far greater salience and impact than in its textual representation. While the male organ can appear somewhat unobtrusively among a textual list of elements in an anatomical or physiological system, when it is pictured visually on the body a powerful metonymy makes the gender of the entire body noticeable and even dominant. The resulting visual impression of male normativity then creates an environment where other figurations of the anatomy, which have nothing to do with the sexual organ, also often come to be rendered male, by either contagion or default.

As for the vignettes, most significant for me is that gender marking sometimes seems to be either an afterthought or in fact irrelevant. Even while other vignette figures are decidedly male or female with much ideological baggage attached, there is a certain casualness about many of the figures, and these give the impression that outside of those realms where gender really seems to matter (and I have yet to come up with any system to distinguish exactly what those are), there are many realms where it doesn't. Whether that has anything to do with the very non-standardised nature of the iconography of the vignettes is a matter of speculation. I have also had reason to speculate above that the casualness in fact reflects portions of social practice on the ground in Tibet, including frequent sharing of labour in animal husbandry and farming contexts among Tibetan groups, as well as aspects of domestic and social life in which gender difference was less than critical.

In the end it is safe to say that gender representation in both the medical texts and paintings was overdetermined by a whole world of patriarchal and sometimes egalitarian proclivities, quite apart from anything coming from medicine as such. Given the huge array of social practices that the medical paintings depict, it would be hard to identify all of the factors that contributed to the formulation of the medical paintings' iconography. Most of all, it is important in this kind of analysis not to assume consistency or that an operative value or concept in one case also operates in another. For example, just because we might know that notions of 'bone' (*rus*) in some Tibetan groups define patriliny does not mean that those precise notions are at play

per se in a medical image that indicates, say, a preference for sons. In the still uncharted waters of gender conception in Tibetan history, it is important to study each example on its own terms as much as possible and certainly without assuming a single, bounded and governing cultural system.

It behoves us in closing to underline the fact that it was medicine that made for such a massive and extensive visual representation of quotidian social practice as is seen in the Desi's painting set. This achievement far exceeds that known from any other scholastic tradition in Tibet. Its broad social representation served important cultural and political purposes in the life of the Desi himself, evident when he made a show of offering the medical paintings in their entirety to the newly enthroned Sixth Dalai Lama.[101] In this the set is not unlike its Chinese counterpart mentioned at the beginning of this article. That cultural production too served as a model for empire and mirrored the aspirations of the Manchu Emperor to serve as patron of medical learning, much as the Fifth Dalai Lama had already done.[102] It is a happy consequence of such grand aspirations, actually seen in many parts of the seventeenth- and eighteenth-century world, that we have preserved for our perusal this rich archive of images of daily life in early modern Tibet. Once the Desi's artists were given licence to portray that life, the explosion of idiosyncratic variety that ensued included a slew of images of women too, exigencies of gender-coding notwithstanding.

** The author would like to thank Elizabeth Angowski for her assistance in the preparation of the images featured in this essay.*

References

Tibetan Language

Byams-pa 'Phrin-las 1996a, 'Bod kyi gso rig rgyud bzhi'i nang don mtshon pa'i sman thang bris cha'i skor la rags tsam dpyad pa', in *Byams pa 'phrin las kyi gsung rtsom*, Beijing: Krung go'i bod kyi shes rig dpe skrun khang, pp. 370–81.

—— 1996b, 'sDe srid sangs rgyas rgya mtsho'i 'khrungs rabs dang mdzad rjes dad brgya'i padma rnam par bshad pa'i phreng ba', in *Byams pa 'phrin las kyi gsung rtsom*, Beijing: Krung go'i bod kyi shes rig dpe skrun khang, pp. 402–42.

gYu-thog Yon-tan-mgon-po 1992, *Bdud rtsi snying po yan lag brgyad pa gsang ba man ngag gi rgyud*, Lhasa: Bod ljongs mi dmangs dpe skrun khang. (Modern edition based on the Sde dge version.)

---

[101] sDe-srid nd., f. 203b. In fact the set was later expanded; when the Desi offered them to the Dalai Lama there were only 62 plates.

[102] Wu 2008. P. 455, citing also Hanson 2003.

—— 1773, *bDud rtsi snying po yan lag brgyad pa gsang ba man ngag gi rgyud* (sDe-dge blocks), TBRC work W00EGS1016257, see http://www.tbrc.org.ezp-prod1.hul.harvard.edu/#library_work_Object-W00EGS1016257 (accessed December 19, 2011).

sDe-srid Sangs-rgyas rGya-mtsho 1973, *Bai DUr+ya sngon po*, 4 vols., Leh: T. Y. Tashigangpa.

—— 1994, *gSo ba rig pa'i bstan bcos sman bla'i dgongs rgyan rgyud bzhi'i gsal byed bai DUr+ya sngon po'i malli ka*, 2 vols., Dharamsala: Bod gzhung sman rtsis khang.

sDe-srid Sangs-rgyas rGya-mtsho n.d., *Thams cad mkhyen pa drug pa blo bzang rin chen tshangs dbyangs rgya mtsho'i thun mong phyi'i rnam par thar pa du kū la'i 'phro 'thud rab gsal gser gyi snye ma*, Lhasa blockprint; TBRC work W2CZ7844, see http://www.tbrc.org.ezp-prod1.hul.harvard.edu/#library_work_Object-W2CZ7844 (accessed December 19, 2011).

Wangle and Byams-pa 'Phrin-las, 2004, *Bod lugs gso rig rgyud bzhi'i nang don bris cha ngo mtshar mthong ba don ldan*, Lhasa: Bod ljongs mi dmangs spe skrun khang.

Zur-mkhar-ba Blo-gros rGyal-po and Dar-mo sMan-rams-pa, 1989, *rGyud bzhi'i 'grel pa mes po'i zhal lung*, 2 vols., Beijing: Krung-go'i Bod-kyi-shes-rig-dpe-skrun-khang.

European Languages

Bolsokhoyeva, Natalia, 2007, 'Tibetan Medical Illustrations from the History Museum of Buryatia, Ulan Ude', *Asian Medicine*, 3: 347–67.

Diemberger, Hildegard, 2007, *When a Woman Becomes a Religious Dynasty: The Samding Dorje Phagmo of Tibet*, New York: Columbia University Press.

Ga, Yang, 2010, 'The Sources for the Writing of the *Rgyud bzhi*, Tibetan Medical Classic', doctoral dissertation, Harvard University, Cambridge, Mass.

Gyatso, Janet, 1987, 'Down with the Demoness: Reflections on a Feminine Ground in Tibet', *Tibet Journal*, 12 (4): 34–46.

—— 2003, 'One Plus One Makes Three: Buddhist Gender Conception and the Law of the Non-Excluded Middle', *History of Religions*, 43 (2): 89–115.

—— 2004, 'The Authority of Empiricism and the Empiricism of Authority: Tibetan Medicine and Religion on the Eve of Modernity', *Comparative Studies of South Asia, Africa, and the Middle East*, 24 (2): 83–96.

—— 2009a, 'Introduction', in Laila Williams and Serenity Young (eds), *Body and Spirit: Tibetan Medical Paintings*, Seattle, Wash.: American Museum of Natural History in association with University of Washington Press, pp. 3–13.

—— 2009b, 'Spelling Mistakes, Philology, and Feminist Criticism: Women and Boys in Tibetan Medicine', in Françoise Pommaret and Jean-Luc Achard (eds), *Tibetan Studies in Honor of Samten Karmay*, Dharamsala: Amnye Machen Institute, pp. 81–98.

—— forthcoming, *Being Human in a Buddhist World: An Intellectual History of Medicine in Early Modern Tibet*. New York: Columbia University Press.

Hanson, Marta (2003) 'The Golden Mirror in the Imperial Court of the Qianlong Emperor', *Early Science and Medicine*, Special Issue: Science and State Patronage in Early Modern East Asia, 8 (2): 111–47.

Havnevik, Hanna, 1999, 'The Life of Jetsun Lochen Rinpoche (1865–1951) as Told in Her Autobiography', Ph.D. dissertation, University of Oslo.

—— forthcoming, 'Preliminary Remarks on Painted Wooden Panels from Tibetan Tombs', in Brandon Dotson (ed.), *Scribes, Texts, and Rituals in Early Tibet and Dunhuang*.

Jackson, David, 1996, *A History of Tibetan Painting*, Vienna: Österreichische Akademie der Wissenschaften.

Klimburg-Salter, Deborah E., 1997, *Tabo: A Lamp for the Kingdom—Early Indo-Tibetan Buddhist Art in the Western Himalaya*, Milan: Skira.

Lange, Kristina, 1964, 'Eine Anatomische Tafel zur Lamaistischen Heilkunde', *Annals of the Naprstek Museum*, 3: 65–85.

Laqueur, Thomas, 1990, *Making Sex: Body and Gender from the Greeks to Freud*, Cambridge, Mass.: Harvard University Press.

Luo Shiping, 2006, 'A Research About the Drawing on the Coffin Board of Tubo Located at Guolimu, Haixi, Qinghai Province', *Wenwu*, 7: 68–82.

Meyer, Fernand, 2003, 'The Golden Century of Tibetan Medicine', in Françoise Pommaret (ed.), *Lhasa in the Seventeenth Century: The Capital of the Dalai Lamas*, trans. Howard Solverson, Leiden: E. J. Brill, pp. 99–117.

Pal, Pratipaditya, 1990, *Art of Tibet*, Los Angeles, Calif.: Los Angeles County Museum of Art and University of California Press.

Parfionovitch, Yuri, Gyurme Dorje and Fernand Meyer (eds), 1992, *Tibetan Medical Paintings: Illustrations to the Blue Beryl Treatise of Sangye Gyamtso (1653–1705)*, 2 vols., London: Serindia Publications.

Park, Katherine, 2006, *Secrets of Women: Gender, Generation, and the Origins of Human Dissection*, New York: Zone Books.

Schaeffer, Kurtis, 2004, *Himalayan Hermitess: The Life of a Tibetan Buddhist Nun*, Oxford: Oxford University Press.

Tsering, Tashi, 2005, 'Outstanding Women in Tibetan Medicine', in Janet Gyatso and Hanna Havnevik (eds), *Women of Tibet*, London: Hurst & Co. and New York: Columbia University Press, pp. 169–94.

Vitali, Roberto, 1990, *Early Temples of Central Tibet*, London: Serindia.

Williams, Laila and Serenity Young (eds), 2009, *Body and Spirit: Tibetan Medical Paintings*, Seattle, Wash.: American Museum of Natural History in association with University of Washington Press.

Wu Yi-Li, 2008, 'The Gendered Medical Iconography of the Golden Mirror (Yuzuan yizong jinjian, 1742)', *Asian Medicine*, 4: 452–91.

Xu Xingguo, 2006, *Western China and the Eastern and Western Civilisations*, Beijing: Yanshan.

Xu Xinguo and Liu Xiahe, 2003, 'Colorful Paintings Found in Tubo Tombs', *China's Tibet* 1: 30–1.

BRILL

Asian Medicine 6 (2010–11) 293–320

brill.nl/asme

The Case of the Disappearing Blue Women: Understanding how Meaning is made in Desi Sangye Gyatso's *Blue Beryl* paintings

Rae Erin Dachille-Hey

Abstract
This article dives into the idiosyncrasies of the life of the body in the world and the physician's encounter with it. It asks the reader to patiently probe the images found within a set of seventeenth-century medical paintings, to seek the clues they provide to better understand the variable conditions of different bodies and, finally, to reflect upon how the details of the paintings themselves train the viewer to see the body in a very specific way. The paintings employ particular modes of expression, referred to here as 'modes of representation', to generate meaning. In reflecting upon the relationship between image and meaning in these paintings, it will become clear that it is the manner in which the idiosyncrasies of the body are depicted, the ways in which they are framed and patterned and the ways in which the viewer learns to make sense of them, that are ultimately meaningful.

Keywords
female body, Tibetan medical paintings, representation

Introduction

This article is about modes of representation in a set of seventeenth-century Tibetan medical paintings and the specific ways in which they create meaning. By 'modes of representation' I mean the paths and devices by which meaning is made.[1] I am distinguishing them from representation itself, the product of

[1] Swiss art critic Heinrich Wölfflin (1864–1945) introduced the term 'mode of representation' within art-historical parlance in his *Principles of Art History*, a comparison of ways of seeing in the sixteenth and seventeenth centuries, as embodied in the classical and baroque movements in Europe. Melville (2009, pp. 271–316) provides an overview of Wölfflin's contributions to the study of the role of representation in the 'history of vision'. Melville (2009, pp. 279–80) observes: 'two levels of linguistic analogy are run constantly together in this text, thus tangling together problems of translation and representation. Such terms as "one's own language" or "mode of representation as such" introduce a deep complication to notions of medium, genre, and relation within art history…all of them, I suggest, work to maintain a constant reference to reading

DOI: 10.1163/15734218-12341236

these modes. I identify and analyse one of these modes of representation in a series of medical illustrations commissioned by Desi Sangye Gyatso [sDe-srid Sangs-rgyas rGya-mtsho, 1653–1705), Regent to the Fifth Dalai Lama, to accompany his commentarial text, the *Blue Beryl* (*Vaidurya sngon po*). In closely examining the details of the paintings, noting the repetition and transformation of these details over the course of the series, we begin to see how they train the viewer to see in a particular way, namely, with the physician's eye.

In focusing upon the repetition of one detail in particular, the blue human body, we will see how the proliferation and repetition of that detail reveals an underlying colour-coding of human bodies within the images. This system of colour-coding is one way in which the idiosyncrasies of the diseased human body, the body in which the humours are out of balance, is represented.[2] We will then see the emergence of a pattern of blue female bodies and observe the idiosyncrasies of the female body in particular as connected with psychophysical and moral qualities suggested through association with the colour blue. Next we will reconsider how the repetition of the colour blue in different contexts throughout the paintings encourages the reader to establish and anticipate such connections. Finally, we will observe how the disappearance of the detail of blueness of some of the blue female bodies in a contemporary set of these paintings denies the viewer the opportunity to make such connections and thereby obstructs the workings of one particular mode of representation within the set of paintings.

The *Blue Beryl* paintings

The paintings we will consider in this article are associated with the *Blue Beryl* (*Vaidurya sngon po*),[3] a four-volume commentary composed by Desi Sangye Gyatso (1653–1705) on the *rGyud bzhi* (*Four Tantras*), the central authoritative text within the Tibetan medical canon. The structure of the *Blue Beryl*

---

within the field of the history of vision, and to maintain it as at once fleeting and natural, something like a metaphor—but a metaphor without which one cannot manage, a catechresis then.'

[2] The colour-coding of the humours, elements and poisons (to be overcome) extends beyond the world of the *Blue Beryl* paintings to other symbolic systems within Tibetan visual culture such as that of the mandala. While such connections are significant, their scope extends beyond the purview of this article.

[3] I have consulted two publications of Desi Sangye Gyatso's text: the first was reproduced from the 1888–92 blocks preserved in the Lha-sa Lcag-po-ri rig-byed 'gro-phan-gling (Leh: S. W. Tashigangpa, 1973); the second is a 2007 publication of the text by the Men-Tsee-Khang, the Tibetan Medical and Astrological Institute of His Holiness the Dalai Lama in Dharamsala.

commentary mirrors that of the *rGyud bzhi* itself and is therefore divided into four sections:

1. the *Root Tantra* (*rTsa rgyud*)
2. the *Explanatory Tantra* (*bShad rgyud*)
3. the *Instructional Tantra* (*Man ngag rgyud*)
4. the *Subsequent Tantra* (*Phyi rgyud*)

The contents of the *rGyud bzhi* can be generally organised as follows. The 'Root Tantra' provides a comprehensive framework for understanding the Tibetan medical system as a whole through an elaborate schema of roots and branches that describe the various aspects of physical health, the causes of disease, their diagnosis and their treatment. The 'Explanatory Tantra' lays the groundwork in anatomy and physiology while the 'Instructional Tantra' is clearly oriented towards clinical practice. Finally, the 'Subsequent Tantra' tackles the intricacies of diagnosis and treatment.[4] The three latter portions of the text explain how to recognise the causes and symptoms of disease as well as how to treat illness.

Desi Sangye Gyatso began composing the commentary in 1685 and in the same year commissioned a series of paintings to accompany the text. While the *Blue Beryl* commentary itself was completed within a year, the massive illustration project, resulting in 79 paintings in total, was not finished until 18 years later, in 1703.[5]

Through modes of representation, the *Blue Beryl* paintings generate meaning independently of the discursive commentary by Desi Sangye Gyatso. Moreover, through the work of these modes of representation, a viewer becomes capable of both distinguishing the visual as offering something 'more' than the text and also acknowledging ways in which this 'more' enriches a viewer's understanding of that text. Through careful attention to this complex interplay of viewer, image and text, this article will bring to light a practice of cross-referencing which the paintings themselves play upon and that they encourage a conscientious viewer to apply in making sense of them.

On the one hand, this article demonstrates how this practice of cross-referencing mirrors the diagnostic experience and techniques of the physician in significant ways. On the other, it showcases the integrity of the paintings themselves through observing the way in which they generate meaning through a process that reinforces their identity as a set, rather than as isolated works.

---

[4] Parfionovitch *et al.*

[5] Meyer 2003, p. 109. Note that Parfionovitch *et al.* 1992 proposed 1687 as the date of the project's inception.

Current locations of the *Blue Beryl* paintings

We do not have the original 'set' of paintings, by which I mean we do not have a complete numbered series of paintings which can be definitively tied to the seventeenth-century illustration project. Moreover, since the paintings gradually began to be collected by European and American travellers to China and Tibet in the early twentieth century, there has historically been a great deal of confusion as to the relationship of individual paintings which appear to belong to the *Blue Beryl* series to complete coherent numbered sets.[6]

There are currently at least two existing sets of the *Blue Beryl* paintings within Tibet itself, those at the Lhasa Men-Tsee-Khang, a portion of which were on display during my visit in 2006, and those of the Norbulingka Palace, which are now under the purview of the Commission for Cultural Relics of the Autonomous Region of Tibet. While stylistic elements and evidence of wear imply that the first set is actually an amalgamation of two distinct series, the second appears coherent but distinctly contemporary.[7]

I have chosen to use the set of paintings from the Buryat Historical Museum in Ulan-Ude as reproduced by Parfionovitch *et al.* as the basis for the current study.[8] This 1992 publication provided the largest reproductions of the paintings to date, significantly larger than those included in the 1986 Tibetan-Chinese collection by Wang Lei and Byams-pa 'Phrin-las or the 1988 Tibetan-English version by Byams-pa 'Phrin las, Wang Lei and Cai Jingfeng. These paintings were likely produced early in the twentieth century as a copy of a series in Lhasa.[9] Fernand Meyer states that this set was commissioned either by the Buryat monk Sonoyev, who studied in Lhasa for several years, or by the Buryat lama Agvan Dorjiev (1840–1938), but he finds the evidence to be inconclusive. In 1936, this series, along with another set of copies based upon it, were delivered to the museum in Ulan-Ude after the destruction of the monastery in which they had been housed.[10]

---

[6] For a more detailed discussion of individual paintings acquired by collectors in the USA and Europe, see Parfionovitch *et al.* 1992, p. 5.

[7] Parfionovitch *et al.* 1992, pp. 7–8. During my term of research at the Dharamsala Men-Tsee-Khang in 2008, I had the privilege of observing the creation of a set of paintings for display in the Men-Tsee-Khang's own museum. I will reserve my remarks on what that set tells us about the contemporary creation of medical paintings for a future study.

[8] Parfionovitch *et al.* 1992.

[9] Parfionovitch *et al.* 1992.

[10] Parfionovitch *et al.* 1992. Three paintings are missing from this set. Based upon the numbering system included in the lower part of each painting, Meyer has concluded that two of the missing paintings were never commissioned to be copied as they were 'addenda' images illustrating moxibustion points not derived from the *rGyud bzhi.* The third missing painting seems to have simply been lost. See Parfionovitch *et al.* 1992. This raises obvious questions about the

There is also a modern set in the collection of the American Museum of Natural History in New York City; the set was executed by Romio Shrestha and his atelier and published in a recent catalogue.[11] Here, this set of paintings will provide a test case for seeing how the elimination of a single detail signals the elimination of a mode of representation discussed within this article and, ultimately, alters the level of meaning conveyed by the paintings.

Challenging the 'illustration model': the logic of images

In his 1992 study of the relationship between art and text exhibited in the cave murals from Dunhuang, art historian Wu Hung challenged the dominance of the 'illustration model' as the primary approach to understanding how images work to produce meaning within a work of art. Wu Hung proposed that images may instead possess a 'visual logic' of their own, independent of written and oral linguistic expression.[12] In part, this article applies Wu Hung's theory of a 'visual logic' to the *Blue Beryl* paintings. On another level, it complicates this model by introducing questions about the relationship of these images to the mnemonic aspects of medical learning. But perhaps most importantly it extends the boundaries of this 'visual logic' to ask how the visual evokes a wider range of sensory experiences, producing a kind of phenomenology of the physician. In other words, the paintings under consideration here describe the physician's experience of the diagnostic process, a process that demands the use of multiple sensorial faculties.

So, while the experience of the paintings may be a primarily visual one, we would be well served to remain open to the possibility that they were intended to evoke a multi-sensorial experience and to instruct the viewer in a multi-sensorial diagnostic process. This process was itself heavily reliant upon the physician's or medical student's mnemonic prowess, their ability to recollect and quickly reference the medical canon, committed to memory through oral recitation during a traditional medical education. The paintings may have provided more than a supplementary mnemonic tool, enlisting visual cues to supplement the aural. The paintings may also have helped to bridge the gap between the textual world of the medical canon and the domain in which they prepared the student to operate, the multi-sensorial domain of the clinic. This

---

paintings and their status as commentarial illustrations and alerts us to existing tensions between reproducing tradition and innovation. For a more thorough account of such tensions in the climate of seventeenth-century Tibet, see Gyatso 2004, p. 86.

[11] Williamson and Young 2009.

[12] Wu Hung 1992, especially pp. 137 and 139.

was a domain that demanded the physician seek invisible clues by using all of the senses to apprehend the symptoms of illness, to 'read' the patient's body through such techniques as observing the colour of the skin and tongue, tasting the urine, feeling the pulses and speaking with the patient about his or her symptoms. The physician would likewise locate those symptoms within the broader context of the patient's dietary and even moral behaviour. These are techniques upon which the physician is trained to rely to locate the causes and conditions of illness and to assign a suitable treatment.

If the paintings discussed in this article were mere 'illustrations', we would expect them to lay bare the hidden recesses of the body and to spell out dysfunction in a straightforward way, reliant upon the textual treatise of *Blue Beryl.* There are of course paintings from the set which in some ways may be said to do just that. However, these are the minority and are not the primary focus of this article. Here we will focus upon paintings from among a selection of 47 within the set of 79. These 47 paintings share a similar layout in which registers of multiple images are accompanied by captions that correspond sequentially to chapters from the text of the *Blue Beryl*.[13] This visual format departs from the arboreal framework of the paintings of the 'Root Tantra' as well as from the iconometric layout of anatomical and physiological illustrations interspersed throughout the three remaining sections. Many of these paintings describe the diseased body rather than the ideal or normative body. The idiosyncratic nature of the diseased body is well exemplified by the contrast between the images found within these 47 paintings, rows of loosely rendered, almost cartoon-like men and women, engaging in various activities, suffering from illness and receiving treatments and their iconometrically harmonious counterparts.

'Repetition with a difference'

At its root, this article asks the reader to cultivate attentiveness to the mediations occurring primarily between image and meaning and between image and viewer on the one hand and between image and text on the other hand. These mediations themselves provide the basis for a close reading of images directed towards recognising the moments in which meaning is reinvented. The mode of representation to be introduced here is characterised by the

[13] I will use the term 'register' to refer to the horizontal rows of images employed in this genre of *Blue Beryl* illustrations, intended to be read, if only in theory, from left to right. In providing numbers for these registers, I do not include the smaller upper cartouche which appears in some paintings to represent a lineage of transmission of medical learning.

repeated use of the same images in new ways. I refer to this mode as 'repetition with a difference'.[14] This term was created by John Felstiner to describe the ways in which twentieth-century poet and translator Paul Celan utilised repetition in meaningful ways that work by 'asking again how language goes on.'[15] Celan's techniques of translation transform and expand the interpretive range of a single word by using it to make meaning in different ways. Felstiner tells us that by engaging with language in this way Celan's words are 'holding up something—both displaying and delaying it—for our attention. They anticipate an act of renaming.'[16]

I will use Felstiner's term, generated in reliance upon Celan, to name a mode of representation occurring in the visual, rather than the textual, medium but which likewise uses repetition to set the conditions for 'acts of renaming'. The repetition of particular images draws viewers' attention to details, making them pause to consider both the precedented and unprecedented meanings of these details. We will see how the modes of representation in the *Blue Beryl* paintings produce such pauses, bringing attention to subtle details that might at first glance seem incidental and provoking the reader to consider how these details might possess a meaning of their own.

Through a series of comparisons of the multiple contexts in which an image appears, we will begin to see how the paintings employ the mode of 'repetition with a difference' to create a sense of anticipation in a viewer. This expectation inspires a viewer to cultivate an attunement to alterations made to the form of a seemingly familiar image as a means of understanding both how it accounts for and departs from other contexts in which the image appears. In generating such a sense of anticipation for a viewer, this mode of representation suggests another dimension of the 'more' offered by the visual, beyond what is found in the comparison of text and image.

In learning to see 'repetition with a difference' at work, we turn to the blue woman appearing at the beginning of the second register of Figure 1 (see Figure 1b). According to the identification on the lower right border, the painting as a whole (Figure 1) refers to Chapters 74–82 of the *Instructional Tantra* (*man ngag rgyud*) and may thus be referred to the 'Women's Diseases [*mo nad*] through General Wounds [*rma phyi*]' painting. A valuable point in this identification is that it specifies that the topics addressed by this chapter range are depicted, 'together with the causes and conditions' (*rgyu rkyen bcas pa*). Yellow rectangles contain captions that demarcate the individual chapters of the commentary referenced within the registers of the paintings and thereby

[14] Felstiner 2001, p. 211.
[15] Felstiner 2001, p. 211.
[16] ibid.

help to parse the visual field for the viewer. All of these captions appear to specify that it is the 'causes and conditions' (*rgyu rkyen*) of the respective illnesses that are depicted therein. What is interesting is that the actual chapter titles of the commentary as well as of the root text do not showcase these 'causes and conditions' but rather the treatment (*bcos pa*) or healing (*gso ba*) of the diseases. Therefore, on an explicit level, the paintings appear to be primarily concerned with conveying the details of aetiology rather than of symptoms and treatment.

To review, in approaching the blue woman at the beginning of register 2 of the 'Women's Disease through General Wounds' painting (Figure 1), we see that she is associated with Chapter 74 of the commentary. The chapter reference specifies that the causes and conditions of illness are the object of attention. Furthermore, the female figure herself bears a label which can be translated as '[a patient] afflicted by women's disease' (*mo nad gyis na ba*) (Figure 1b). The caption tells a viewer that this blue woman is diseased; however, aside from her pallor and her nudity, this female body, partially shrouded in a red and blue blanket, does not reveal any specific information with regard to her illness or how it might be remedied. It seems that over half of Chapter 74 is represented through this single image.

A mechanical comparison of the content of text and image founded in the illustration model, in other words, with the expectation of a one-to-one equivalence between text and image would, in this case, lead the viewer to assume that the content of the text exceeds the content of the image. Following the general structure of the *rGyud gzhi,* the text of the *Blue Beryl* treatise is ordered by a fourfold structure: (1) the causes and (2) conditions of illness (*rgyu rkyen*), (3) the symptoms of illness (*rtags*) and (4) the method of treatment (*bcos pa'i thabs*). The latter, the method of treatment, consumes over half of the chapter's text, making it relatively proportional to the topic distribution of the chapter from the root text, the *rGyud gzhi.* Chapter 74 of the portion of the *Blue Beryl* commentary related to the 'Instructional Tantra' (*man ngag rgyud*) provides a detailed account of symptoms and treatment of women's diseasees that the images, in this instance, do not.

The first register of images in Figure 1 correlates roughly with the corresponding text on the causes and conditions of illness, outlining how the three poisons of desire, hatred and aversion as represented by the cock, the snake and the pig, together with the four elements, contribute to birth in a female body and how its ripening together with previous karma as well as more current factors of diet and behaviour result in women's disease.[17] Note that these

[17] See Janet Gyatso's translation in this volume of this particular portion of Chapter 74.

Fig. 1. Painting from the *Blue Beryl* Series in the Buryiat Historical Museum illustrating Chapters 74–82 of the 'Instructional Tantra' portion of Desi Sangye Gyatso's *Blue Beryl* commentary (Plate 46 in Parfionovitch *et al.* 1992). Image courtesy of Serindia Publications. See also Figures 1a–1f.

Fig. 1a. Registers 1–3.

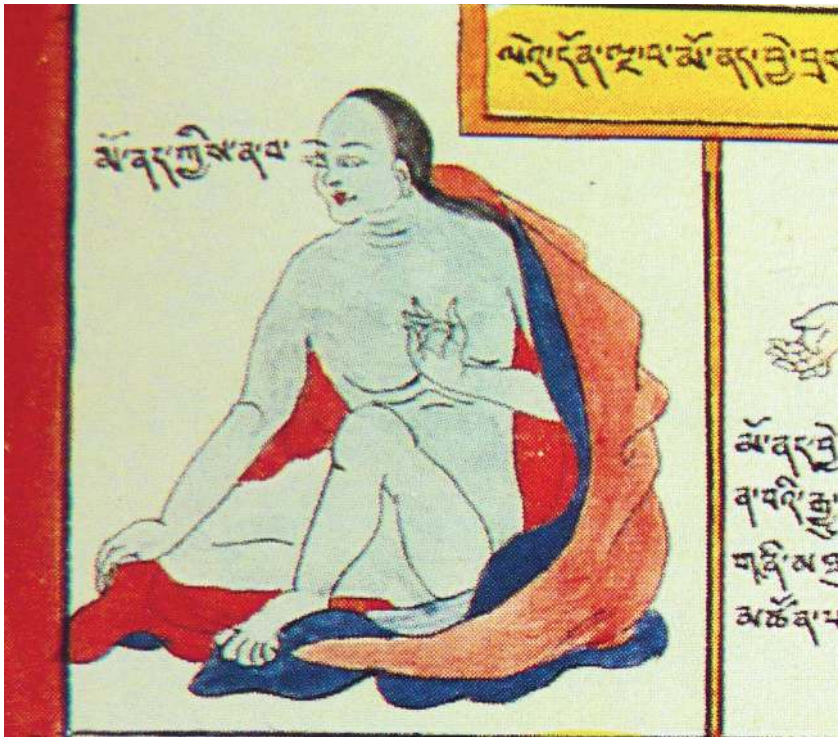

Fig. 1b. Detail from Register 2.

causes and conditions spell out a sequence of cause and effect not necessarily apparent to the naked eye.[18] The images associated with Chapter 74 emphasise a relatively short portion of the text, the causes and conditions of illness. This point of emphasis is one way in which we might interpret the 'more' of the visual. However, if we are to see modes of representation at work, it will be necessary to move beyond the illustration model to consider other, perhaps less explicit mechanisms of meaning-making operating through the repetition and variation of subtle details.

The symptom of blueness: *rlung* and the vulnerability of the female body

Only the final image of the blue woman appearing at the beginning of the second register represents the content conveyed in the second half of Chapter 74 (Figure 1[b]). This blue female form is the tangible surface and the visible sign which the physician learns to read through clinical training and practice. Two comparable images of the female body appear as the last images in the series depicting Chapter 75 and 76, in Registers 2 and 3 respectively (Figure 1c and 1d). Inscriptions identify these latter two bodies as '(the affliction) of particular women's disease' (*mo nad bye brag na ba*) and '(the patient) afflicted by common women's disease' (*mo nad phal bas na ba*). The yellow rectangles parse the topics of these images as referring to the causes and conditions of particular and common women's disease as found in Chapters 75 and 76 respectively. These female bodies are, however, not blue. Their presence and identity suggest that images of this kind may be acting as 'place-holders' of sorts, symbolising the existence of information from the text chronologically without elaborating upon it. In examples such as these, images function to represent the content of the text in only the barest sense.

Taking a closer look at the concrete particulars of these images of the diseased female body, differences emerge. There are of course variations in gesture and facial expression, differences that commonly distinguish many of the figures within the series of paintings in a general way. Accounting for a range of distinctions and then making self-conscious choices to determine which differences in detail are significant is part of what is involved in recognising a mode of representation at work. We will now begin to see how 'repetition with a difference' provides clues for the viewer as to which distinctions to

[18] See Garrett 2008 for a thorough account of the ways in which the logic of causality is presented within the Tibetan medical accounts of embryological development and the ways in which these accounts compare with Buddhist representations of the role of karma in generating corporeal embodiment.

Fig. 1c. Detail from Register 2.

focus on and also encourages the viewer to anticipate ways in which this aspect of the 'more' of the visual produces an 'act of renaming'.

Through comparison of these three female bodies (Figures 1b, Figure 1c and Figure 1d), which seemed to be functioning as mere 'place-holders', referring a viewer to the text for further detail on the symptoms and treatment of women's diseasees, we are led to ask 'Why is this first woman blue?' In searching for other instances of a blue woman within the same painting, a viewer finds an image of a menstruating female in the centre of the first register, labelled 'endowed with breasts, womb and menstrual blood' (*nu ma mngal dang bla mtshan ldan pa*) that exhibits the same blue pallor (see Figure 1[f]). Although the caption of this figure leads a viewer to expect the manifestations of all three qualities of the female body, the image itself disappoints, explicitly revealing only the latter, menstrual blood. So a viewer might be led to conclude that blue skin tone has something to do with the phenomenon of menstruation.

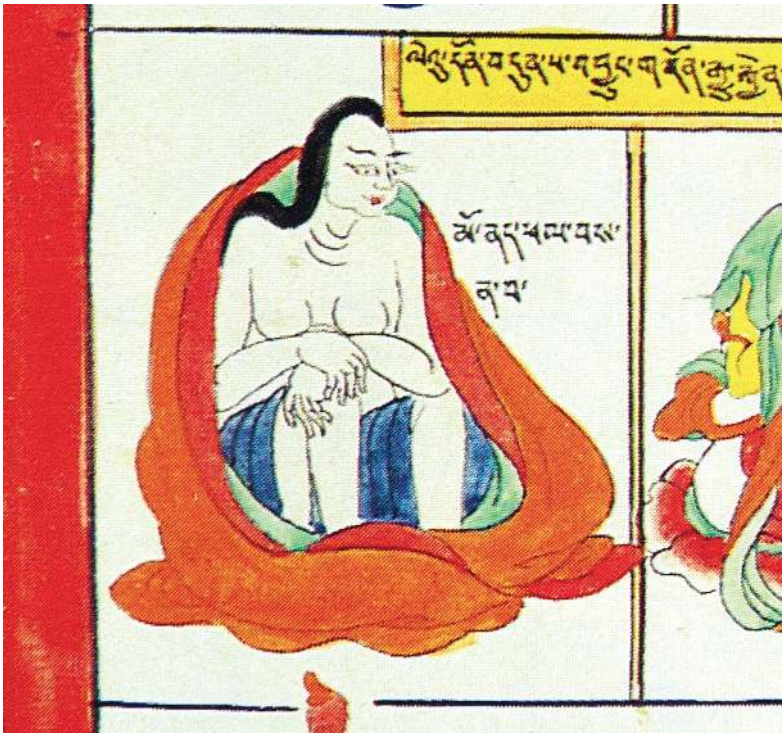

Fig. 1d. Detail from Register 3.

Fig. 1e. Detail from Register 1.

Fig. 1f. Detail from Register 1.

In order to test this hypothesis, a viewer might cross-reference the 'blue' women from Figures 1, 1b and 1f with four blue women depicted in the first two registers of another painting. This painting depicts Chapters 2–7 of the 'Instructional Tantra' and may be referred to as 'Wind [*rlung*] diseases through Tumors [*skran*] diseases' painting (Figure 2). Having already invested some time in contemplating another painting in which three animals (the cock, snake and pig) representing the three poisons (*dug gsum*) of desire, hatred and ignorance played a prominent role (for example Figure 1[e]), we quickly recognise the animals appearing under the yellow chapter captions on Registers 1, 3 and 6 of Figure 2. The captions alert us to the fact that these portions of the painting reference Chapters 2, 3 and 4 of the 'Instructional Tantra' and depict the 'causes and conditions' of *rlung, mkhris pa* and *bad kan* illnesses, often translated as the diseases of the 'three humours' or 'faults' (*nyes pa gsum*): wind, bile and phlegm.

The workings of 'repetition with a difference' in the *Blue Beryl* paintings bring the negative connotations of the *nyes pa gsum* to the surface. Through the consistent repetition of the details of the three animals as the three poisons and their explicit connection with illnesses of the three humours, the paintings render the invisible causes at the root of illness visible. They show a deeper connection of the downfall of humans on a moral level as represented by the poisons to the manifestation of disease in humoral imbalance. Through the repetition of a set of details often reinforced through colour-coding, the relationship of physical vulnerability to moral vulnerability is exposed.

The moral and environmental dimensions of *rlung* illness

Searching for clues as to how the repetition of the detail of blueness might aid us in uncovering how meaning is generated in the *Blue Beryl* paintings, we

Fig. 2. Painting from the *Blue Beryl* Series in the Buryiat Historical Museum illustrating Chapters 2–7 of the 'Instructional Tantra' portion of Desi Sangye Gyatso's *Blue Beryl* commentary (Plate 40 in Parfionovitch 1992). Image courtesy of Serindia Publications. See also Figures 2a–2e.

encounter at least four comparable instances of female 'blueness' in the context of *rlung* illness in Registers 1 and 2 of the same painting (see Figure 2[a]). In fact, while the majority of bodies depicted in this section on *rlung* illness (from Register 1 to midway through Register 3) display a blue tone, thereby solidifying the connection of *rlung* with the colour blue within the paintings, not all of them are distinctly gendered (as through the exposure of breasts or the vaginal opening).[19] As we are following the repetition of the detail of blueness in conjunction with femaleness in the case of the blue woman, we will therefore focus upon four bodies which are more distinctly female.[20]

The first is a supine female near the beginning of Register 1 labelled as 'from ignorance there is the manifestation of desire' [*ma rigs las byung ba'i 'dod chags pa*]. This portion of the register progresses from the blue and green bird (with some variations in colour and form from the other examples we have examined) expressing the concept of desire as poison to the exemplification of consequent moral downfall by two people running into a house hand in hand.[21] This couple likely implies impending sexual indulgence or misconduct of some sort.[22] A large prostrate female body appears in a pose akin to illustrations of the supine naked wrathful goddess subjugated in the construction of monasteries and temples in early Tibet. This figure is elaborately clad complete with head ornaments and moves her dress aside to expose her red vaginal aperture both to a viewer as well as to the large labelled *rlung* icon beside her.

It is crucial to note that while this figure is one of at least four distinctly female bodies represented in the three registers on *rlung* disease, no distinctly female forms appear within the registers devoted to bile and phlegm. The demographics of female representation in connection with humoral imbalance therefore insist that there is something particularly charged about

---

[19] See Janet Gyatso's article in this volume for a comprehensive presentation of gender ambiguity in the *Blue Beryl* paintings.

[20] These four more 'distinctly' female figures featured in the first two registers of the three devoted to *rlung* disease are the prostrate woman (Figure 2b), the female member of the copulating couple (Figure 2c), the naked menstruating female (Figure 2d) and the woman who appears to be bathing and subsumed in water and *rlung* (Figure 2e).

[21] We can likely, but of course not absolutely, assume at least one of the two figures entering the house hand in hand at the beginning of Register 1 to be female.

[22] A similar technique of visually translating the abstract concept of a poison into an example of misconduct in everyday life can be found in the representation of the poisons in the arboreal framework of the painting illustrating Chapters 2 and 3 of the 'Root Tantra' portion of the *Blue Beryl* commentary. See Parfionovitch *et al.* 1992, Plate 2.

Fig. 2a. Registers 1–3.

Fig. 2b. Detail from Register 1.

Fig. 2c. Detail from Register 1.

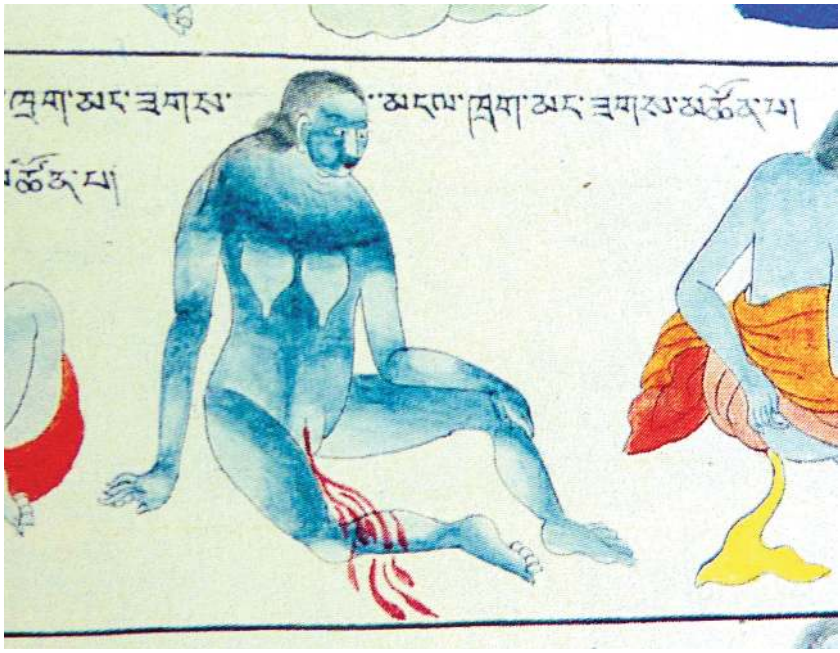

Fig. 2d. Detail from Register 2.

the relationship of women to *rlung*. Furthermore, the iconic format that connects this blue female to the symbol of *rlung* compounds the demographic component and supports the conclusion that the mode of representation at work in the repeated appearance of the female body as blue establishes a meaningful link to *rlung* and, by extension, to the poisonous influence of desire.

This layering of meaning-making is strengthened by the appearance of the next blue woman in the same register, as a member of a blue copulating couple who together bear the caption 'The Illustration of Warming because of Desire' (*chags pas dugs pa mtshon byed*) (Figure 2c).[23] We can therefore observe simultaneous acts of 'renaming' at work in which through 'repetition with a difference', images appear in conjunction with one another in ways that establish relationships between these images and in turn make new meanings avail-

[23] While this figure's genitalia are not clearly displayed, the repetition of this image of the copulating couple in the context of the *thangka* describing the causes and conditions of embryological formation makes a strong case for assigning a female gender to this body. See Parfionovitch *et al.* 1992, Plate 5.

Fig. 2e. Detail from Register 2.

able to a viewer. Such connections can be observed even on the more basic level of the concrete particulars of the images themselves without recourse to the captions or the text, for that matter. For example, the blue and green bird at the beginning of the first register introduces a colour scheme repeatedly reiterated in the blue bodies as well as in the greenish *rlung* icons appearing throughout the first three registers of this painting. Similar icons were associated with *rlung* in the 'Women's Disease through General Wounds' painting (Figure 1) on both the elemental level and the humoral level as found in Registers 1 and 2 respectively of that painting.

Proceeding to the second register of the 'Wind [*rLung*] Diseases through Tumour Diseases' painting (Figure 2), a viewer finds a blue menstruating female (Figure 2d) comparable to the one found in the first register of Figure 1 (Compare with Figure 1[f]). This image is accompanied by a caption that reads, 'Illustrating the Descent of Much Blood from the Womb' (*mngal khrags mang zags mtshon pa*). However, this female body exhibits fully formed breasts, a detail absent from the representation of the menstruating blue woman in that painting. Within the same register, another blue female (Figure 2e) huddles in water encircled by the icon symbolising *rlung*, an icon

familiar from the first register as well as from other paintings in the set. The caption reads 'Affliction Due to Cold Wind' (*bser bus bus pa*). This depiction of the female body exhibits a penetrability by the elements, a porous boundary between the humoral balance of the human body and that of its environment.[24] Moreover, the predominance of blue and green reiterates the link to the initial image of the bird, symbolising the concept of desire. Therefore, through the repetition of details of colour within a single painting and the cross-referencing of the appearance of these details within other contexts within the set, 'repetition with a difference' leads the viewer to perceive vital truths about the status of the human body in the world and the aetiology of illness in all of its environmental and moral dimensions.

Cross-referentiality: reflecting on the viewer's meaning-making process

Having retraced our steps in order to better understand the connections we have made between the diseased female body in the 'Women's Disease through General Wounds' painting and the colour blue, we can observe the fruits of close reading focused upon similarities and differences in concrete particulars in the repetition of images. We have developed disciplined practices for comparing details such as the blue-green colour scheme, the bird and the *rlung* icon within a single painting as well as of cross-referencing these details with other images in other paintings and have arrived at insights into the way 'repetition with a difference' functions. In other words, we are able to recognise this mode of representation as a tool that helps to make viewers more self-conscious of the connections they are making in the viewing process, i.e. connections between the blue female body, menstruation, *rlung* imbalance and desire.

In contemplating the connections that appear on the surface while simultaneously pursuing a deeper reading of the images and such connections, viewers utilise modes of representation to facilitate multiple acts of interpretation at once, requiring them to remain open to the possibility that many if not all of them are meaningful. This self-consciousness of one's own process of deduction of the causes and conditions of illness, of recognition of the symptoms from reading the surface of the body of the patient and synthesis of the environmental and the moral-behavioural aspects of the body in the

[24] See Adams 1998 for a study of the Tibetan medical understandings of the role of political and environmental factors in the increase of *rlung*-related ailments among patients in contemporary Lhasa.

world are precisely the methods of the physician in the clinic. The acts of cross-referencing performed by viewers in tracing the repetition of a single detail through different contexts within the paintings mirrors the mnemonic processes of physicians, recollecting the content of the medical canon committed to memory as well as of clinical experience to diagnose and treat patients, diseased bodies marked by their own idiosyncrasies, within the present moment.

The relationship of text and image in the Blue Beryl paintings: cross-referencing and the 'more' of the visual

At this point, it is appropriate to return to the relationship of text and image and to ask what might be suggested by this blue woman at the beginning of the second register of the 'Women's Disease through General Wounds' painting (Figure 1[b]). Thus far we have considered what this image tells us about the practices of meaning-making observed above through attention to 'repetition with a difference' in the images and their relationship to the text of the *Blue Beryl* on a very general level. Likewise, we have considered what the images convey about perceived idiosyncrasies of the female body in particular.

The flow of *rlung* and blood is fundamental to the way in which the female body and its disorders are described in the medical texts and depicted in the images. However, the extended connection of *rlung* and blood to the poison of desire appears far more explicitly in the images than in the corresponding chapters of the *Blue Beryl* text. As also pointed out by Gyatso in her article within this volume, at key moments the *Blue Beryl* text and images identify the female body as 'excessive' (*lhag*) in being a composite of excess orifices, the product of residual negative karma and a container of excess blood. Bearing in mind the connection of the physical and moral well-being of the human body discussed above, we will pause to focus upon the ways in which the female body is defined by its relation to blood. In doing so, we come to see how the relation to blood and the relation to *rlung*, both substantiated within the two paintings discussed above, play a key role in Chapter 74 of the text.

Picking up after the portion on the causes and conditions of female embodiment translated in Gyatso's article and the enumeration of the number and classes of women's diseasees of the general (*phyi*), the particular (*bye brag*) and the common (*phal ba*) variety, the *Blue Beryl* commentary continues:

> Moreover, from the three, the general, the particular and the common, the particular and the common will be explained later on in [their own] individual chapters. In this [current] chapter, the explanation of the general women's diseases is

> taught based upon the aspects of the classification, the cause of that, the symptoms and the method of treatment. In making these classification[s], they are described as [being] two: severe blood [*khrag tshabs*] and severe wind [*rlung tshabs*]. The reason for that [way of classifying illness] is that it arises as a result of the descent of menstrual blood, called the 'monthly sign' [*zla mtshan*]. In the early stages [the illness] is called 'severe blood' [*khrag tshabs*]. If the illness becomes chronic, lasting a long time, it is called 'severe wind' [*rlung tshabs*] because it forges an alliance with wind.
>
> As for the individual symptoms for recognising these two, the general characteristics of severe blood are as follows. There is a painful hot sensation in the bones of the back and lower genital region, and there is a prickly burning sensation in the lower abdomen, and there is pain in the upper back and diaphragm. There are hot flashes in the channels [*rtsa*], and abscesses and small sores may appear, and if womb blood is discharged, it will accumulate and turn to pus.
>
> As for 'severe wind', [the general characteristics are]: a boiling sensation in the bones, mental unrest, dizziness and a chill in the bones of the head,[25] cold sensation throughout the body and pain between the flesh and skin. There is also bloating in the muscles which appears to be swelling, [as well as] numbness, cataracts, insanity, fainting, loss of memory, a squeezing sensation in the genital area and lower abdomen and so forth, and in the descent of discharge, the monthly sign is unceasing and flows continuously…[26]

The remainder of the chapter (pp. 117.5–120.21) addresses the treatment of women's disease. This excerpt conveys the connection of women's disease to menstruation and blood and, on another level, to *rlung.* There is no mention of the colour blue in the text, and, as we see, the connection with the poison of desire is missing from this section of the chapter. The images, on the other hand, use the repetition of details to show further aspects of the causes and conditions of illness and to depict connections between the female, menstruation, *rlung* imbalance and desire simultaneously versus chronologically.

The case of the disappearing blue woman

Turning to the paintings from the contemporary series created for the collection of the American Museum of Natural History in New York and illustrated in the 2009 catalogue entitled *Body and Spirit: Tibetan Medical Paintings*, we see that in the chapters that correspond with the portions of

---

[25] *mGo'i rus* could perhaps also be translated as 'upper part', meaning the upper body.

[26] sDe-srid Sangs-rgyas rGya-mtsho 2007, vol. II, pp. 116.12–117.5. Special thanks to Amchi Pema Dorje at the Men-Tsee-Khang in Dharamsala for his guidance in producing this translation. Any and all errors are my own.

the paintings discussed above none of the female bodies depicted are blue.[27] The blue woman has disappeared. (Compare Figure 1a with the first three registers of Figure 3 and Figure 2a with the first two registers of Figure 4). In comparing details of colour in this contemporary set of paintings with those found within the paintings from the collection of the Buryat Historical Museum discussed above, we find that the rich production of meaning observed both in terms of the patterning and framing of the images themselves as well as in the viewer's methods of making sense of them has been diminished. Not only did the use of the colour blue in the mode of 'repetition with a difference' establish a coherent symbolic system within the paintings and train the viewer to look for implicit and explicit clues to the causes of illness, but also this mode of representation helped us to see more about the text of the *Blue Beryl* itself. It helped us to see how the text, like the paintings, must be read cross-referentially in order to ascertain the full range of connections necessary to read the signs of the body of the patient.

The use of colour in building a symbolic system also brings to light key aspects of the role of vision in clinical practice and the phenomenology of the physician more generally. Not only do the images within the paintings cross-reference one another in a manner similar to the way in which the physician must recall the details of the texts he/she has committed to memory in relation to one another, but also they reveal something about what the physician actually sees. Not only does the use of colour in the images help the viewer to make meaning in the context of viewing the paintings, but it also communicates a quality of the body itself. The body provides clues through colour that allow the physician to read its surface, corresponding to the quality that Shigehisa Kuriyama has described as 'the expressiveness of the body'.[28]

In his comparison of Greek and Chinese medical accounts of the human body, Kuriyama denaturalises the primacy of autopsy as the ideal source of medical knowledge within Western medical history. The assumption of a boundary between the exterior and interior of the body that must be transgressed by piercing the skin was not inherent in the Chinese system and therefore, he argues, should not be assumed as a universal framework for reading the human body.

In fact, many clues linger on the surface of bodies. Kuriyama shows how Greek and Chinese physicians had techniques of reading the colours of the body. As in the case of the Tibetan medical system, the body held clues to

[27] Williamson and Young 2009.

[28] Kuriyama 1999, especially pp. 153–92.

Fig. 3. Painting from the contemporary set of *Blue Beryl* paintings completed by Romio Shrestha and Atelier, illustrating Chapters 74-82 of the *Instructional Tantra* portion of Desi Sangye Gyatso's *Blue Beryl* commentary (Plate 46 in Williamson and Young 2009). Image courtesy of the Division of Anthropology, American Museum of Natural History, New York (Accession number: 70.3/5509).

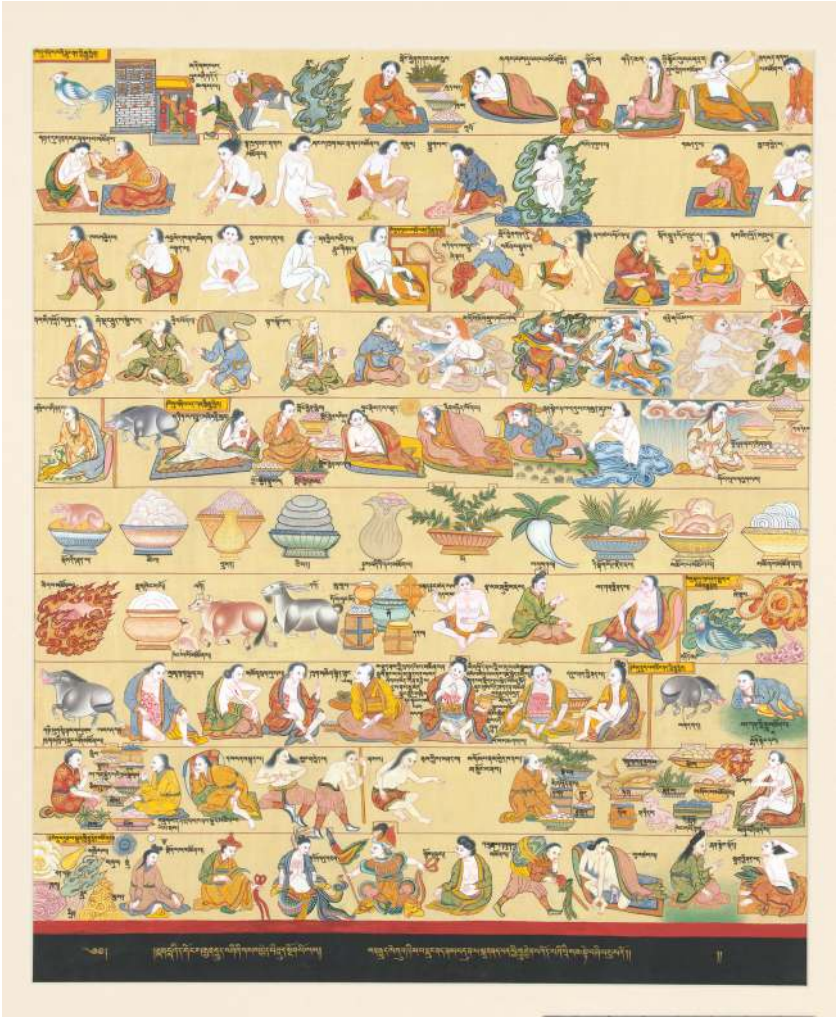

Fig. 4. Painting from the contemporary set of *Blue Beryl* paintings completed by Romio Shrestha and Atelier, illustrating Chapters 2–7 of the *Instructional Tantra* portion of Desi Sangye Gyatso's *Blue Beryl* commentary (Plate 40 in Williamson and Young 2009). Image courtesy of the Division of Anthropology, American Museum of Natural History, New York (Accession number: 70.3/5503).

both physical and moral character that could be read by a trained expert. Modes of representation at work in the *Blue Beryl* paintings train the viewer to see with just this sort of expert eye.

In fact, there are numerous instances in the text of the *Blue Beryl* as well in which colour is meaningful for the diagnostic process as the pallor of different areas of patients' bodies such as the tongue, the skin or the eyes clues the doctor in to the kind of ailment from which they are suffering. While other symptoms may be read through touch or through listening to the very visceral account of the patient (we before have encountered symptoms such as 'boiling sensations in the bones'), colour is a sign that is accessed visually, making it an ideal way of conveying meaning in image form.

The way in which these paintings tap into the phenomenology of the physician accords with the transformation of ways of knowing discussed by Janet Gyatso in her 2004 article on the role of empiricism in seventeenth-century Tibetan medical literature.[29] Gyatso shows how empirical observation became validated as an alternative to the textual, allowing for innovations in medical writing exemplified by a new genre of experiential literature known as *nyams yig* together with the practice of autopsy by the court physicians of the Fifth Dalai Lama, in particular by Darmo Menrapa (Dar-mo sMan-rams-pa).[30] The new technology of autopsy coexisted with this literary genre of clinical experience, exhibiting a diversity of techniques for reading the body that thrived during the very time in which Desi Sangye Gyatso commissioned the *Blue Beryl* paintings.

Concluding reflections

The text of the *Blue Beryl* confirms the ways in which the images are connected to it through the association of blue, menstruation and *rlung* imbalance. However, it also draws attention to the ways in which the mode of 'repetition with a difference' functions to make meaning independently to produce a correlation between blue, menstruation, *rlung* and desire, a correlation not made explicit in the text. This is not to say that the images contradict the text but rather that they depart from it in meaningful ways, often employing the same image with significant differences to produce acts of 'renaming'.

By using techniques of close reading to view the *Blue Beryl* paintings, we observed how modes of representation deflect meaning-making from the

[29] Gyatso 2004, pp. 83–96.
[30] Gyatso 2004, p. 83.

image as source to the path by which the image travels. This process requires an enduring willingness to cross-reference images within the series and to form comparisons that attend to both similarities and differences. This process requires a viewer to explore connections between images within a single painting and to understand ways in which they make meaning both in reliance upon one another as well as independently.

'Repetition with a difference' redefines the 'more' of the visual as something that exceeds what is explicitly shown in images themselves by encouraging the viewer to attend specifically to changes in subtle details occurring through repetition. Such attention leads to an understanding of how meaning is made in ways that exceed the obvious and allow for a multi-faceted approach to reading the human body with all its idiosyncrasies.

Acknowledgements

This article is based upon research completed for my Masters thesis in 2007 at the University of Wisconsin-Madison under the tutelage of Professor Charles Hallisey (Dachille 2007). I am grateful to Professor Hallisey for his generosity of intellect and spirit and humbly apologise for any shortcomings this article may contain. Special thanks to the Townsend Discovery Fellowship for Interdisciplinary Studies for support for creating this article in the summer of 2011. I would also like to express my gratitude to three scholars whose work provided the inspiration for pursuing research in the study of Tibetan medicine: Professors Vincanne Adams, Frances Garrett and Janet Gyatso. I am utterly indebted to Amchi Pema Dorje of the Men-Tsee-Khang in Dharamsala for his guidance in studying the text of the *Blue Beryl* in spring 2008. Finally, I would like to thank Professor Patricia Berger of the University of California, Berkeley for enriching my understanding of how the worlds of texts and the worlds of images interact in varied and meaningful ways.

References

Tibetan-language sources

Desi Sangye Gyatso, 1973
sDe-srid Sangs-rgyas rGya-mtsho, *Vaiḍurya sngon po* (*gSo ba rig pa'i bstan bcos sman bla'i dgongs rgyan rgyud bzhi'i gsal byed bai ḍur sngon po'i ma li ka*), 4 vols. reproduced from the 1888–92 blocks preserved in the Lha-sa lCags-po-ri rig-byed-'gro-phan-gling, Leh: S. W. Tashigangpa, vol. III.

—— 2007, *Vaiḍurya sngon po* [*gSo ba rig pa'i bstan bcos sman bla'i dgongs rgyan rgyud bzhi'i gsal byed bai ḍur sngon po'i ma li ka),* Dharamsala: Tibetan Medical and Astrological Institute of His Holiness the Dalai Lama.

Unknown, 2006
bDud rtsi snying po yan lag brgyad pa gsang ba man ngag gi rgyud, Dharamsala: Sorig Literary Research Department, Tibetan Medical and Astrological Institute of His Holiness the Dalai Lama.

English-language sources

Adams, Vincanne 1998, 'Suffering the Winds of Lhasa: Human Rights, Cultural Difference, and Humanism in Tibet', *Medical Anthropology Quarterly*, 11.2: 1–28.

Dachille, Rae Erin 2007, 'Modes of Representation and Meanings in the Blue Beryl Paintings of Desi Sangye Gyatso', unpublished Masters thesis, University of Wisconsin, Madison.

Felstiner, John 2001, *Paul Celan: Poet, Survivor, Jew*, New Haven, Conn.: Yale University Press.

Garrett, Frances 2008, *Religion, Medicine and the Human Embryo in Tibet*, London and New York: Routledge.

Gyatso, Janet 2004, 'The Authority of Empiricism and the Empiricism of Authority: Medicine and Buddhism in Tibet on the Eve of Modernity', *Comparative Studies of South Asia, Africa and the Middle East*, 24.2: 83–96.

Kuriyama, Shigehisa 1999, *The Expressiveness of the Body and the Divergence of Greek and Chinese Medicine*, London and New York: Zone Books.

Melville, Stephen 2009, 'Deconstruction and the Limits of Interpretation', in D. Preziosi (ed.), *The Art of Art History: A Critical Anthology*, Oxford: Oxford University Press, 271–316.

Meyer, Fernand 2003, 'The Golden Century in Tibetan Medicine', in F. Pommaret (ed.), *Lhasa in the Seventeenth Century: The Capital of the Dalai Lamas*, trans. Howard Solverson, Leiden: E. J. Brill, 99–118.

Parfionovitch, Yuri, Gyurme Dorje and Fernand Meyer (eds) 1992, *Tibetan Medical Paintings: Illustrations to the Blue Beryl Treatise of Sangye Gyamtso (1653–1705)*, 2 vols., London: Serindia Publications.

Williamson, Laila and Serenity Young (eds) 2009, *Body and Spirit: Tibetan Medical Paintings*, New York: American Museum of Natural History in association with the University of Washington Press.

Wölfflin, Heinrich 1950, *Principles of Art History: the Problem of the Development of Style in Later Art*, trans. Marie Donald Mackie Hottinger, Mineola, NY: Dover Publications.

Wu Hung 1992, 'What is *Bianxiang* 變相? On the Relationship between Dunhuang Art and Dunhuang Literature', *Harvard Journal of Asiatic Studies*, 52.1: 111–92.

BRILL

Asian Medicine 6 (2010–11) 321–347

brill.nl/asme

Re-production at Stake: Experiences of Family Planning and Fertility among Amdo Tibetan Women

Mona Schrempf

Abstract
Biographical interviews with Tibetan women in rural Amdo (Qinghai Province, China) indicate that many women above 40 years of age experienced family planning as a threat to their reproductive health, social status and economic production. Even though family planning, implemented since 1980, was experienced differently among the targeted women, they nevertheless addressed the same social pressure of having to reconcile normative birth control administered by the Chinese state with Tibetan socio-cultural norms and values of fertility focused upon preferences for sons. Renowned female Tibetan doctors in private and public clinics and hospitals were Tibetan women's preferred and trusted addressees for voluntary birth control and reproductive health. I argue therefore, that in order to understand the effects of family planning on targeted Tibetan women, socio-cultural values of fertility need to be taken into account as they are expressed in women's narratives of their bio-psycho-social, gendered and ethnic selves.

Keywords
Tibetan women in China, family planning, experience, fertility, reproductive health

Introduction

In spite of China's uniform family planning policy, the realities of its implementation in the lives of those women targeted by it are very diverse. Family planning is intimately related to cultural, socio-political, economic, gender and reproductive health issues that are experienced by individual women in any given time, place and social location. Married, rural Tibetan women in Amdo (Qinghai Province, People's Republic of China) who are the subjects of this study have been officially targeted for family planning since the 1980s. My research results, based on women's narratives, demonstrate that the majority experienced particular difficulties with family planning measures during the first two decades of implementation. Cases of forced application of invasive birth control technologies were salient, often resulting in physical pain, long-term loss of female stamina that impaired women's essential labour power, as well as continuing social pressure to produce at least one son. These

DOI: 10.1163/15734218-12341237

issues emerged as major threatening experiences or concerns in the narratives of targeted village women, who related them not only to their individual bodies but in particular to their social relations and status. The present paper will focus on the intertwined issues of fertility, experiences of birth control, reproductive health and illness raised by my rural women informants. All are over 40 years of age and witnessed the dramatic social changes of the Cultural Revolution, the post-1978 Opening up Reforms by Deng Xiaoping, and the new implementation of family planning (or of any kind of contraceptive use). Data was gathered during nine months' fieldwork (2005–7) in Qinghai Province, using open-ended, semi-structured and biographical interviews with Tibetan women of diverse fertility ages, as well as local family planning personnel, doctors and health officials.[1] Women's narratives of their experiences are analysed by focusing on the rhetoric and tactics of their physical and social subjectivities in everyday life.[2] My approach combines Mattingly's insight into the intertwined nature between experience and narrative as ordered by remembrance and anticipation, Butler's analysis of gender as constructed and performed through a 'surface politics of the body' and Samuel's approach to Tibetan understandings of health and illness in the complex of body, mind, social and local environment.[3]

---

[1] Biographical interviews were undertaken in 82 rural Tibetan farming and nomadic households in six different townships and three county towns, primarily with women at fertility age and older and occasionally with their husbands or fathers-in-law as part of a broader perspective on rural Tibetan women's reproductive health and health-seeking behaviour and its transformation since the 1980s. A total of 21 doctors, family planning personnel and health officials were interviewed. I am particularly indebted to my local female assistants and informants for their invaluable help. Due to the political sensitivity of the topic and to protect the privacy of those who worked with me, I use pseudonyms and refrain from specifying the exact sites of my research. I thank the German Research Foundation and the Collaborative Research Centre 'Representations of Social Order and Change' for supporting my research project on family planning among Tibetans in China between July 2004 and June 2008, being part of the project 'Socialist Campaigns in Central Asia' directed by Professor Ingeborg Baldauf of the Humboldt University, Berlin. I also thank the discussants of the panel on women's health and gender in Asian medicine at the Seventh International Conference on Traditional Asian Medicine in Thimphu, Bhutan, for their valuable feedback on my presentation and the German Academic Exchange Service for financial support of my conference participation in 2009. Last but not least I am grateful to Jenny Bright, Sienna Craig, my two reviewers and Toni Huber for feedback and editorial suggestions.

[2] De Certeau, in Napolitano and Pratten 2007, p. 5.

[3] Mattingly 1998; Butler 1990, p. 336; Samuel 2006, p. 123.

Overview

China's family planning—or literally 'birth-planning' (Chinese, *jihua shengyu*)—agenda has been the object of much contestation over human and reproductive rights, both nationally and internationally. To date, however, most studies of the topic have focused on a macro-perspective based upon statistical data and have mainly considered China's majority population who are officially classified as the Han nationality (Chinese, *Han minzu*). We know, however, that among the various minorities within China the state has also been employing 'corrective' birth control surgeries for pregnancies exceeding the birth quota of villages and individual households or 'couples' for over 30 years now, while target campaigns remain secretive and undocumented.[4] We also know that in China mass campaigns for abortions and sterilisations were the main tools employed to ensure the local maintenance of specific birth quotas, in particular throughout the 1980s and 1990s, and that in some locales they are still practiced today.[5]

From a global perspective, family planning has become generally recognised as an important development strategy contributing to a number of desired outcomes in countries with high fertility. These can include poverty reduction, accelerated national economic growth and enhancement of women's gender equality and reproductive health, as well as their access to education. In China, it is rather the organisational structure, scale and methods of family planning implementation that have been revealed as a primary biopolitical tool for both population governance and China's rise to global power.[6]

Furthermore, the problem of reliable population statistics in China remains an unresolved issue for discussing family planning policy and its demographic outcomes. Goodkind generally states that official statistical data both is and remains unreliable, with births of girls most likely being underreported in

[4] After much protest, it appears that large-scale, mass sterilisation campaigns have now become rare events following some 25 years of their application. At the same time, the one-child policy for Chinese couples has been relaxed. However, the official national guideline for China's one-child policy remains: use of IUDs by mothers after the first child, the spacing of births by four years and sterilisation of mothers following the second child. The frequency and medical quality of most official target campaigns remains difficult to assess due to lack of access to data, with a major exception: the mass sterilisation campaign of 1983, at the opening of family-planning implementation, was well documented and used at the time to proudly demonstrate the nationwide 'achievement' of a total of 58 million 'birth control operations', 16 million female sterilisations and 14 million abortions (Greenhalgh 2008b, pp. 368 f.).

[5] Zhang 2002, p. 172. Zhang's interesting, rare and extensive ethnographic fieldwork on family planning experiences among rural Chinese was undertaken in a village in Hebei during 1993 (Zhang 2002).

[6] Greenhalgh 2008a,b; 2010; Greenhalgh and Winckler 2005.

census data.[7] This is not surprising given the power of the quotas to be maintained each year under threat of loss of rare government jobs by those in positions of local authority. Several qualitative ethnographies of China's ethnic-minority populations demonstrate that state-controlled family planning is a particularly salient physical, mental and socio-economic issue for rural people at the village level. As Mueggler phrased it, the Chinese state has transformed itself 'from abstract external Other to abstract internal Other'.[8] Certainly, for any minority population who live within a subsistence economy requiring sufficient amounts of land, animals and labour to both function and remain sustainable into the future, birth control poses particular and fundamental problems. In certain respects, family planning slogans emphasising an increase of the 'quality of population' (Chinese, *suzhi*)[9] and economic development through birth control and smaller families for China's progress and modernity are very apt. Together with other policies, such as those related to limiting use of farm and grassland, family planning, as the number-one modernity project of the state, makes traditionally led subsistence lives increasingly difficult to sustain and accelerates urbanisation and social change.

Few systematic, social-science studies have been undertaken on family planning in rural Tibetan areas of China. The dearth of coverage and lack of depth in available information leaves many questions open and allows for widely differing outcomes and interpretations of the issue. The few studies we do have reveal a very significant variety in the implementation of family planning practices on the ground. When compared, these examples range from a total lack of implementation to both voluntary and enforced participation in implementation, as well as a corresponding variety in how individual women experienced birth control, even at the same time and in the same local sites. For example, Goldstein and his team, using officially conducted household surveys, could not find any strictly implemented family planning practices in the Tibet Autonomous Region (TAR) at the time and place of their investigation.[10] Research by Childs revealed fertility transitions across Tibetan

---

[7] Goodkind 2004.

[8] Mueggler 2001, p. 287.

[9] Concerning 'quality of population', Sigley (2004, p. 565) argues that what marks out the 'strength' of the Chinese state has a lot to do with the image of China in the world and that it has shifted to a new 'emphasis on the physical, mental, and moral attributes of the citizen subject that are necessary to ensure national survival and revival'.

[10] Goldstein *et al.* 1991, 2002. Household surveys by Goldstein *et al.* (2002) were conducted with the help of local government officials between 1997 and 2000, in rural areas of Shigatse and Lhasa Municipal Prefectures. Their findings show that Tibetan women in rural TAR were *not* coerced to have abortions or sterilisations, even if they exceeded the limit of two or three children, but that they voluntarily limited their fertility. As Childs (2008) has shown, and in

communities in Nepal, Indian exile *and* the TAR, notably a gradual—voluntary—fertility decline since the 1970s in all these communities *without* the influence of state-controlled family planning. Childs demonstrates convincingly that even though certain culturally specific factors are shared among transnational Tibetan communities (e.g. polyandrous marriage, considerable numbers of unmarried women, in particular nuns, and so on), and these could be made responsible for a voluntary fertility decline, women in the TAR limited their fertility from the 1980s onwards specifically because of household economic constraints. These constraints included increasingly limited farm and grassland resources, changes that might be attributed in part to the newly implemented family responsibility system in 1982 and the ensuing allocation of land per capita, together with the fencing policy somewhat later.[11] Childs continues to show how, as part of China's greater Opening of the West policy, family planning in the TAR started to be seriously implemented only from 2000 onwards, supported by Chinese demographers and public media, which claimed, however, that there was population growth among Tibetans and that the more relaxed family planning policies among minorities were responsible for the economic 'backwardness' in these areas.[12]

Other implications of Tibetan fertility and demographics are not officially considered, yet they play an important role if we want to understand the impact of family planning among Tibetans. Craig, who undertook research on Tibetan maternal and child mortality, states that, despite variations, mortality among both these groups is—in common with other Tibetan Himalayan populations—high, and it is also high in comparison with other ethnic minorities in China, clearly marking them as particularly vulnerable.[13] The issue of high maternal and child morbidity in high-altitude areas of the Himalayas and Tibet could be used as another argument against a harsh implementation of family planning in these areas.[14] To turn things around, however, and claim that formerly many children died, while today—thanks to improved mother

---

contrast to urban places such as Lhasa (Adams 2005), strict implementation procedures only commenced from 2000 onwards.

[11] See Childs 2008.

[12] See Yan 2000.

[13] Craig 2009, p. 151. Economics may be a recent contributing factor. A preliminary public health report based on interviews and medical observations in a village in Yushu (Qinghai Province) connected a recent increase in maternal deaths to higher medical costs due to the privatisation of the public health sector and a decrease in access to clinics due to higher transportation costs. Another possible contributing factor was attributed to an increase of maternal workload in relation to a higher mobility among male householders. See Chin and Loy 2004.

[14] See, for example, the case study of the hazardous gestation and post-natal periods in high-altitude childbirth given in Childs (2004, pp. 38–55). Still waiting to be entirely resolved are the complex reasons behind the high prevalence of maternal and child morbidity and mortality that

and child health care and hygiene measures and increased rural public health services—a limited yet healthy number of children survive and get a good education is a convenient but short-sighted argument that was brought forward as a justification for family planning by a health official in China whom I interviewed. The implications of this argument are that only officially registered children who are born within the allowed limits of births per couple have access to health services, such as immunisation and education. This excludes and marginalises all 'unofficial' children and poor households who exceed birth limits but who cannot pay a heavy fine to buy themselves a 'golden' child (so-called because of the astronomical costs now involved) and to avoid unwanted abortion or sterilisation. When combined with the high cost of giving birth at a clinic or hospital (a minimum of 350 Yuan, or several thousand Yuan in case of birth complications, at least in 2007) as well as unsupported abortions among young unmarried women, this is, I would argue, a potentially fatal combination threatening women's and children's health, particularly among the rural poor. On the other hand, claims made by the Tibetan Women's Association (TWA) in Indian exile in the late 1980s that China had been committing 'genocide' against the Tibetans by using forced abortion and sterilisation are untenable.[15]

What has attracted little attention so far—and thus remains barely researched—are a range of questions about how women have actually experienced state-monitored birth control with their individual physical, socio-moral and political bodies. How are women's daily lives affected in already marginalised (and often sparsely populated) rural communities where life is still primarily based upon labour-intensive subsistence economies? How and why have minority women's attitudes towards family planning and ideal family size changed in recent times? What roles do better access to education, jobs outside of subsistence patterns and locally available health care play in this? How do rural Amdo Tibetan women negotiate increasingly dramatic socio-economic transformations, such as those between culturally-normative embodiments of traditional Tibetan values and their own aspirations for modern education and lifestyles, or as members of a minority whose culture and social cohesion many experience as being threatened or marginalized by

---

are also addressed by recent international NGO and public-health programmes (cf. Adams *et al.* 2005; Chertow 2008; Craig 2009; Gutschow 2010; Pordié and Hancart Petitet, in press).

[15] More recently, such untenable claims have been toned down, with the TWA stressing instead that China's family planning policy breaches fundamental human rights and impacts the 'survival' of the Tibetan population and culture as a whole (Tibetan Women's Association 1995). Human-rights issues in connection with violation of Tibetan women's reproductive rights in China have become central to the TWA's main identity (Bonnet, in press).

China's domineering state modernity as well as by some ethnic Others (whether neighbours or migrants), such as Hui ('Muslims') and 'Chinese' (Tibetan, *rgya mi*)?[16] This research addresses such questions using rural Amdo Tibetan women's own narratives of their experiences with state family planning during the first two decades of its implementation.[17]

There is no doubt that maternal and child health care, often supported by foreign NGOs, has progressed towards a more client-oriented approach in the past ten years in China, including the training of Tibetan doctors and nurses. However, while this subject received quite some scholarly attention, often the focus has been a typically 'modern' and 'biomedical' concern with training in 'hygiene' or focusing on potentially 'unsafe' Tibetan folk practices surrounding birth pollution (*skye sgrib*), while the curious absence of any traditional midwives is considered as dangerous.[18] Tibetan notions and cultural values surrounding birth, health and illness are still not being considered as relevant for women's health—a regrettable lack of knowledge in public health services that otherwise could very likely help save lives. In fact, Tibetan ideas concerning fertility, birth and the female body reflect an entirely different worldview. In the following sections, I will explain how the female body is inherently connected to the concept of karma, how having a son is related to a women's social status, how female physical strength is an important marriage factor and vital for the rural household economy based on subsistence, how health, fertility and birth can be manipulated by Tantric ritual and prayer to local gods, and how such values and practices come into play in childbirth as well as in family planning.

---

[16] The term 'Chinese' (Tibetan, *rgya mi*) also denotes 'foreigners' despite the fact that Amdo Tibetans and Chinese are neighbouring populations and trading partners for many centuries. Relations between Tibetan and Chinese populations within China are complex, varied and vexed and have mainly been looked at from macro-historical, political, nationalistic or intellectual point of views, rarely from an everyday life aspect of interaction.

[17] Family planning among Tibetan women, mainly from the TAR, is discussed in several publications by Goldstein *et al.* (e.g., 1991, 2002), Adams (2005) and Chertow (2008). On family planning policy and China's state modernity among Amdo Tibetan women, see Schrempf (2008). My forthcoming book, *Making the Modern Tibetan Family*, will articulate my extensive ethnographic data for rural Tibetan areas in Qinghai Province with available Tibetan and Chinese sources.

[18] Issues of morality (Adams 2005, 2008), gender and childbirth (Chertow 2008), maternal and child health care (Craig 2009) and family planning as an important project of modernity and social engineering (Schrempf 2008) have already been examined. While Adams points out the moral dilemmas of women giving birth or using birth control, Chertow (2008) paints a rather harmonious picture of family planning being used as a strategic tool used among rural Tibetan women in the TAR to become more modern. However, authors Adams, Chertow and Craig have all worked as part of an NGO involved in maternal and child health care, which is likely to have influenced their data.

Tibetan ideas of fertility, birth and female bodies

Fertility, health, wealth and the delicate relations between humans, animals and a land that is inhabited by local—and often ambivalent—deities are interrelated cultural and socio-moral values in Tibetan societies. Such relations are carefully maintained by offerings to these gods, seeking their protection from any harm or illness. If illness occurs, this is generally attributed to a previous low state of fortune (*rlung rta*) and power (*dbang thang*) or to an act of pollution of a local deity (*yul lha, klu* etc.). Illness can be a clear-cut 'medical' condition, but it can also turn out to be inflicted by 'demons' (*gdon*, various types of *'dre*, etc.) who might have stolen the 'soul' or 'life force' (*bla*) of the patient. In complicated or sometimes suspected cases, diviners (*mo pa*), who are usually Tantric practitioners, are asked to divine the actual causes of the illness. Sometimes, they also would refer a pregnant woman to a hospital. Far from being separate issues, medical treatments, Tantric practices and Buddhist values, such as merit and karma, can also intersect with folk religious practices, in particular in the important matters of birth, health and illness. Additionally, maintaining smooth inter-personal relations within households and villages by avoiding fights, and other social disruptions, such as illness or idleness, are crucial for balancing this delicate socio-moral cosmology, that is at the same time dependent upon the benevolence of and protection by the local deities inhabiting the place and in need of placation.[19]

In Amdo and many other culturally Tibetan areas, territorial gods (*yul lha*), indicatively also called 'birth gods' (*skye lha*), dwelling on the tops of mountains, are directly connected with the birth of any new child within their territory. An 85-year-old Tibetan village woman informant described for me her experiences of labour during three arduous days in the 1940s. In order to prevent her death and support the birthing process, her husband walked up the mountain to pray for several hours at the local shrine of the *yul lha* and to make an offering to the mountain god. At the same time, a Tantric practitioner (*sngags pa*) who had been called to help rolled his rosary (*phreng ba*) over her belly reciting a mantra. Soon after her husband returned and as a result of the ritual measures, she reassured me, her baby was born.

Even today, when women in Amdo have trouble conceiving or wish for a son, they address themselves to Tantric practitioners and visit a fertility temple. One such temple houses the Tantric goddess Dorje Phagmo. She is prayed to by women for both conception and for obtaining male children. She protects from illness those children who were conceived with her help or who

[19] See Pirie 2006.

have been given an auspicious name, usually by a lama, in front of her statue. Also, in general, when children fall ill, they are taken to the temple for blessings and better health. The local mountain god Shabo, said to have formerly been a hermit, also ensures children's good health. Newborns are brought to his shrine and given the god's name: 'Shabo'. Local Tibetans, Chinese and Monguor visit this place demonstrating both the multi-ethnic make-up of Qinghai as well as the cultural importance of local folk religious practices for health and illness while also transcending ethnic and religious identities.[20]

Hermanns described a variety of ritual practices connected with increasing fertility and, in particular, manipulating the birth of a son.[21] Having worked among rural Amdo Tibetan families for many years in the 1940s, Hermanns observed a lower fertility amongst Tibetan nomad women compared to Tibetan farming or Chinese women more generally. Furthermore, he noted that Tibetans in Amdo also had a high infant-mortality rate.[22] Neither contraception nor midwives were known in the region.

The often-cited issue of abortion, as a moral transgression of Buddhist vows connected with accumulating 'sin' (*dig pa*), did not seem to play a major role amongst my female informants, all of whom are Tibetan Buddhists. As a Buddhist principle, life starts from conception, so from an ethical point of view abortion is a form of killing. Next to conception, Buddhists also perceive (re)birth, the sex of a child and life as all being determined by karma. Furthermore, to be human is the most precious form of all six possible realms of rebirth. Human life can be manipulated throughout its course by accumulating merit, in the hope of a better rebirth. Tibetan women who had abortions had to confess the 'sin' of their terminations in encounters with their lama. To kill means to create negative karma, which will lead to a bad rebirth unless one counterbalances this by accumulating merit again. Prayers, pilgrimage to holy places and a pious life are believed to be able to remedy any breach. The absolute moral taboo amongst all my Tibetan informants, however, was female foeticide through abortion to deliberately ensure the birth of a son. This is clearly evinced in a rather balanced sex ratio among Tibetans when compared to the majority Chinese population.[23] Apart from the ubiquitous, normative statement that abortion is a 'sin', the women I interviewed were really most concerned about socio-moral dilemmas of a secular kind and not religious or Buddhist ethical concerns. For example, a situation in which a woman did not yet have a son but was forced to have a sterilisation, whereby

[20] I thank Huadan Tashi for this information.
[21] Hermanns 1959, pp. 201f.
[22] Hermanns 1959, pp. 206, 207.
[23] Childs 2008, pp. 264f.

her in-laws' patrilineage would be 'cut off' (*rgyud gcod*), was experienced as a real tragedy, a breach of the law of karma that could not be remedied.[24]

Rather than religious or ethical concerns, in our conversations women expressed fear of the use of intra-uterine devices (IUDs) or of becoming sterilised against their will, both potentially causing 'loss of strength'. Comments on women's 'strength' often appeared in casual conversations during my fieldwork. These recurring remarks made me think about the social implications of female strength, particularly in relation to the use of IUDs and sterilisation. Tibetan men would reiterate the importance of a 'tough', i.e. hard-working, strong and morally pure Tibetan wife as an asset upon which a Tibetan household economy on the High Plateau heavily depends. At the same time, this value placed upon women reiterates the classic gender division in Tibetan society identifying women with household labour and reproduction. In the patriarchal Tibetan society of Amdo, I found this gender bias to be very strong when compared with Tibetan communities elsewhere.

Women's strength was also tested in a collective ritual concerned with the fertility of the fields. The public village ritual of *chos skor*, literally 'circling [with] the [religious] law/Dharma' is indicative of how mostly young and still unmarried women publicly demonstrate their moral purity, piety and physical strength by carrying heavy volumes of Buddhist scriptures on their backs around the village fields, in order to bless them before harvest and ensure 'fertility'. When I accompanied them, walking up towards the local offering place of the most important mountain god of the area, who is responsible for the protection and fertility of the land—including its animals and people—two girls quietly complained to me about the heavy load of the books cutting into their backs and the considerable back pain that it caused them.[25] At the same time, they assured me that they would never complain about this in front of any Tibetan man, even when asked about it. Nor did one of them utter any expression of pain when, later on, a young man tried to 'test' her by hitting her on the back. Complaints about physical weakness by Tibetan women are taboo and simply not talked about.[26]

What makes a woman a particularly suitable marriage partner is her fertility. A fertile woman is described as *phentho yige* (*phan thog yag ge*), literally one who is 'useful' and 'of service'. Basically, it means that woman are expected to give birth to at least one son to ensure the continuation of the patrilineage of her husband's family in whose household she takes care of her

[24] For some examples on how abortion was differently experienced and the case of the coerced sterilisation of a woman with three daughters, see Schrempf (forthcoming).

[25] In fact, one of the girls fell sick over the following two days.

[26] See the many examples in Kleisath 2008.

parents-in-law, husband and children. The underlying expectation to ensure the continuity of patrilinearity, however, exclusively concerns a woman's fertility, which is also connected to her karma. Yet women are typically characterised in Tibetan societies as being of 'low rebirth' (*skye dman*, a traditional synonym for 'woman'). The low status of women is still testified in present Amdo Tibetan society:

> In my village, most of the people looked down upon girls and saw them as debts for their families. Most people thought that it was useless to send them to school; women do the bulk of the work, and do not have time for luxuries like education. Although they are busy the entire year, they usually do not reap the benefits of their hard labor.[27]

However, a woman can make up for her (culturally determined) social and karmic deficit by having a son, thus raising her social status. A Tibetan proverb expressing wealth (livestock) in relation to sons states: *Sgo kha rgyu yis bkang yod. Go kha bu yis bkang*: 'In front of the door, there are plenty of livestock. Around the fire pit there are many sons.' In the past, at least in practice, this meant the ability to send one son to a monastery as a monk so that he could earn merit (*bsod rnam*) and thereby increase the mother's and family's merit too, as well as having enough remaining sons to defend the home in the many incidents of conflict amongst different Amdo Tibetan tribes or other ethnic groups prior to the late 1950s. While there is no general word in colloquial Amdo Tibetan dialect for 'fertility', a woman with sons, one of whom is a monk, would be called 'a woman with merit' (*bsod rnam can*). Preference for sons is also evident in classical Tibetan medical and religious literature where, for example, we find the possibility of influencing the conception of a male foetus or of ritually transforming a foetus in its early stages into a male.[28] As Gyatso has shown, a woman's ability (or failing) in procuring a son is distinctly emphasised through the ambivalent use of the two expressions *bud med* ('woman') and *bu med* ('no son').[29] At first sight, this linguistic conflation may seem to be a spelling mistake, and is used interchangeably in the text concerned, yet it also clearly allows a man to justify his search for 'another' wife if his first does not bear him sons. In particular, a woman's failure to give birth to any sons is connected to her lack of moral virtue, lack of good karma and lack of power.

---

[27] Samtshogye (2008, p. 21). In contrast to such denigrating yet common views on and treatment of women, Samtshogye herself had been lucky and was growing up in a family where she was both most welcome as a girl and also supported in her education.

[28] See Garrett 2008.

[29] Gyatso 2008.

Right up to the present day, a Tibetan mother who does not give birth to a son fears the stigmatisation of her in-laws. A Tibetan woman usually moves to the household of her parents-in-law upon marriage and takes care of them and her husband and children. The patrilineage is 'cut off' (*gcod*) if she produces no male heir—a serious breach that goes against the grain of centuries-old traditions of inheritance and continued transmission of 'bone' (*rus*, the male medium of descent) as well as male-dominated professional or religious knowledge. The lack of a son is also considered a medical condition that can be rectified through ritual means.[30] On the other hand, karma is a flexible notion and can also function in positive ways, like an explanatory model for the socio-moral deficit of not having been able to give birth to a son.[31]

However, feelings about the family lineage being cut off are deep-seated. A village leader expressed such feelings about how his daughter-in-law, who had two daughters, became a victim of a sterilisation campaign. Her third child would have been his only chance to continue the family lineage. He was truly devastated about this injustice and blamed it on the mistake of a family-planning woman who targeted a number of women with the maximum number of two children within one small village (Chinese, *cun*) instead of distributing the quota throughout the whole township (Chinese, *xiang*), resulting in his daughter-in-law becoming a target for sterilisation. Furthermore, he was not informed prior to the event, even though it was part of his own area of responsibility; probably the local authorities anticipated that he would have objected. Another mother of three girls and wife of a government employee was forced to undergo sterilisation against her will, under threat that her husband would lose his job. With tears in her eyes she explained that she desperately wanted a son and so did her husband. These examples show that it is not just state-imposed sterilisation that puts an end to a woman's fertility but the important notion of 'cutting off the (male) lineage' that stops the continuation of a whole family lineage. Sterilisation thus breaks the law of karma, beyond matters of birth and death. This might be what some—usually elderly male—Tibetans mean when they speak of the danger of the Tibetans disappearing as a people in the vast ocean of China's majority population.

Fertility is at the heart of health, wealth and women's social status, as we have seen. It is also strongly connected to the relations between humans and the spirit world inhabiting the local environment, and in times of crisis, such as childbirth, it is of particular importance. This might be another cultural factor that has been neglected in the present scholarly endeavour to examine

[30] Garrett 2008; Gyatso 2008.
[31] Schrempf 2010, pp. 170f.

birth practices and health-seeking behaviour among Tibetans. Both pregnant woman and mother and baby in childbed are perceived as extremely vulnerable to demonic attacks and thus in need of additional protection. Such demons ride piggy-back on any 'outsider' who has not purified themselves before approaching a mother in childbed. Thus, if there is a mother in childbed in a traditional farming household, coal fires with juniper branches are burnt in front of the house and the twig of a juniper branch is hung at the door as a sign of the need to purify oneself before entering the domestic space. Such customs are taken very seriously even today and might contribute to the reluctance of leaving the safety of the house for the sterile environment of a clinic or hospital where cold draughts and potentially dangerous outsiders might harm one's unprotected body.

Insiders and outsiders, trust and mistrust

Amdo Tibetans characterise and reiterate the deep chasm between 'us' (Tibetans, and more specifically those who come from the same household and village, i.e. mostly relatives) and 'them' (anybody outside of their village, and even more so, Chinese and Hui) in the strong binary language of 'insiders' (*nang mi*) versus 'outsiders' (*phyi mi*).[32] This dichotomy is also based on either sharing the same language and culture or not, an important notion that often correlates with another important classification, i.e. trusting those who are 'true' (*ngo ma*) and mistrusting those who are 'fake' (*rdzun ma*). In particular, when it comes to culturally sensitive times of 'crisis' such as deaths and births, the 'polluting' aspect of outsiders is stressed while the 'insiders', such as female household members, husbands and then clan and village members, are asked for help and support. Thereby the issue of trust in a doctor is salient. If doctors are known as being Tibetan-speaking, empathetic and reliable by family, friends and neighbours, if they are recommended by a diviner and, when it comes to birth control, if they are of the same sex, then they are also preferred by Tibetan women for reproductive health issues. As David Parkin has shown, this kind of 'trust talk' is very important when looking at doctor–patient relationships and health-seeking behaviour in terms of medical diversity more generally.[33] On the other hand, the Chinese Government, with its imbedded surveillance apparatus and occasionally brutal family planning implementation in the past, certainly has not helped to strengthen Tibetans' trust in ethnic

[32] Colloquially I would be called a '*gya mo* (*rgya mo*)', a 'foreign woman', which indicates also that Chinese and Westerners belong to the same category of 'foreigners'.

[33] Parkin 2011.

Chinese doctors. This is certainly the case throughout rural Tibetan areas where public health services arrived rather late (after the mid 1970s), where biomedicine and its technologies were virtually unknown except for occasional vaccination programmes, and then became known all of a sudden in the 1980s in connection with family planning, where the language of doctor-patient interaction is Chinese, and where health-service facilities are generally ill-equipped and of insufficient quality.

Chinese doctors are emphatically regarded as outsiders by rural Tibetans and are hardly ever frequented, as I was able to witness, for example, in township clinics where a Tibetan doctor was also available. Yet ethnic Tibetan family planning women who live within villages are also not trusted despite the fact that, at least theoretically, they should belong to the insider category. In contrast, they are branded as the worst outsiders, i.e. as 'spies' (*myul ma*) of the Government. Their work is not only to deliver free contraception, such as the pill (*sman*), condoms and Norplant, but also to observe and report numbers of children born within a household and to inform village women about changes in family planning policies and laws. The dissemination of these measures should be supported by the village leaders, who are almost always males. Among the group of women informants over 40 years of age I interviewed, I found that hardly any useful information trickled down to them via such official channels, and anything they knew about birth control was told to them by their older female relatives or neighbours. In my research area, around 2005, village family planning women were no longer given a fixed salary but were remunerated for each reported excess child instead, apparently to increase their incentive to report. It is no wonder that they were unable to distribute their free contraceptive supplies and that village women generally avoided them if they could afford it financially.[34]

Tibetan women narrated that they very often felt mistreated, unacknowledged and misunderstood in terms of their physical, emotional and sociocultural needs due to the denigrating behaviour to which they were subjected at township governments, as well as by Chinese doctors and nurses, in particular in the context of family planning. But women of all ages also mentioned this as part of their experiences of childbirth in rural and even in urban clinics and hospitals. They felt looked down upon as Tibetans and treated as 'backward'. Some of the women interviewed had experienced much worse, in particular in unannounced 'blitz' campaigns, when they were forced to have abortions and sterilisations on the spot in ambulance vehicles. If given the chance, and if they had enough money at hand, they had to pay high fines

[34] See Schrempf 2008.

of several thousand Yuan in order to escape such surgery or to keep a child. In past decades, the Chinese doctors' original 'white labcoat' used to be a warning sign for rural Tibetan women to run and hide. Even as recently as the 1990s, a female Tibetan gynaecologist who took care of maternal and child health and who was *not* involved in family planning in any way related with exasperation that when she was visiting her township villages on routine check-ups, dressed in a professional white coat, with a representative of the Women's Federation (Chinese, *Fulian*, the pool from which family-planning personnel are usually chosen), village women would flee when they saw her approaching and would lock their doors.

Female Tibetan doctors and rural women's reproductive health

Dr Dromatsho

When a group of Tibetan nomad women came looking for Dr Dromatsho, who was dressed in a white coat at the time, they failed to recognise her as the Tibetan 'woman doctor' (*bud med sman pa*) of the township clinic. Dr Dromatsho answered their queries, quite amused, telling them in Tibetan that the *gyamo* (*rgya mo*, i.e. the 'Chinese woman' who was her colleague) was inside the clinic. After they had checked inside and couldn't find whom they were looking for, they returned to her disappointedly, saying 'Yes, but the *gyamo* is not speaking Tibetan!' Finally, she explained—speaking in Tibetan with them all along—that it was probably herself for whom they were looking. The women obviously did not 'recognise' her as a Tibetan doctor because she was not wearing the traditional Tibetan dress, a *phola*, and instead wore the typical 'Chinese' white coat identified with doctors. This little anecdote clearly demonstrates the importance to patients of doctors speaking the same language, as well as their preferred gender. Furthermore, it points to the fixed cultural identity markers of Tibetan women that play an important role in doctor–patient encounters.

Dr Dromatsho practises both Western and Tibetan medicine in a small nomadic township clinic, yet officially she is only allowed to treat patients using biomedicine from the clinic's dispensary. She is well-known for conducting careful insertion of IUDs as well as for being responsive to patients' calls at any time and by no matter whom. She is known as being kind, polite and patient, and people know that she resides close to the clinic too. Compared to the delicate and petite bodies of Chinese women, Dr Dromatsho explained, Tibetan women are built bigger and stronger, and so it is important

to carefully measure the womb and decide the right size of IUDs accordingly, i.e. it is important to include a gynaecological check-up in this procedure and to do regular check-ups afterwards. Rather funny stories—whether meant as jokes or to be taken seriously remained unclear to me—about IUDs appearing on newborn babies' heads were told again and again, possibly hinting at ineffective implementations or contesting the effectiveness of 'safe' contraceptives *per se*.[35]

IUDs, called *along* (*a long*, the word traditionally also means 'earring'), seemed to be the most commonly used form of contraception in Amdo. Several women informants, mostly over 40, complained about back pain that they attributed to their extended use, next to a general loss of their physical strength attributed to either IUD use or sterilisation. 'Inflammations are common', was Dr Dromathso's response to women's difficulties with the agreeability of IUDs. She attributed this to careless medical practice during insertion but also to irregular visits by women for check-ups. Some women I talked to had worn their IUDs for over 10 years. Another reason for the prevalence of and preference for the IUD appears to be that in the beginning of family planning implementation during the 1980s, many women became pregnant despite taking the pill. Thus, the IUD was considered the safer and better option. The pill and other contraceptives were unsafe, as women explained to me, due to their strong side effects, or because they were even less reliable than IUDs. When a woman took contraceptives voluntarily, however, or after having had her two or three permitted children, on average she complained less about problems with contraceptive use. It was astounding to me how little Tibetan women knew about contraceptives and their proper use in general. For example, a group of Tibetan village women whom I interviewed had never heard of such alternative birth control methods as vasectomies for males. When I told these women that vasectomy was also reversible, one called out, laughing, 'Who would want them to reverse?' and then added, rather bitterly, 'Men just don't care [about contraception]'.[36]

I stayed with Dr Dromatsho for several days, during which time she was called out at night several times (her home being next to the clinic). Following one of these visits, she told me how she was able to help a woman delivering a

[35] Jenny Bright confirmed having heard this rumour many times (in personal communication). See also Chertow 2008.

[36] The use of condoms was a total taboo among Tibetan men, a worrisome fact reiterated by female gynaecologists who also reported a high prevalence of sexually transmitted diseases (STDs) for which usually women came in for treatment. The increased mobility of men, together with an increase of prostitution in urban places, turns this taboo into a dangerous matter also concerning married couples.

breech birth with the baby's feet already sticking out. She was obviously experienced, trusted and in high demand, but she was also constantly tired and once told me that she was tempted to accept a recent offer for a better-paid job in a county hospital where she would also have better medical facilities to work with. Yet local people begged her to stay, so she felt obliged to do so out of compassion. While her Chinese and male Tibetan colleagues at the township clinic had time to drink tea during the day and went home in the evening, Dr Dromatsho was always on the move, personally called upon by mostly female patients. Sometimes, when patients had no money to pay for often unaffordable 'Chinese medicine' (*rgya sman*, literally 'Chinese medicine' meaning biomedical pharmaceuticals produced in China), she secretly gave them Tibetan medicine for free. She was thoroughly trained in both medical systems and convinced that Tibetan medicine could help even better than biomedicine in many cases of women's diseases. In any case, she thought it was better than sending the patients home empty-handed if they could not pay. However, she had to be careful since such actions transgressed the rules and her colleagues were already jealous of her popularity.

Despite the fact that Tibetan medicine has a long established history and practice of gynaecology and obstetrics (*mo nad*), with an emphasis on fertility enhancing treatments, its practice is completely ignored in public-health services in township clinics and even almost absent within obstetric departments of Tibetan hospitals, which in particular exclude use of any traditional medical practices surrounding birth.[37] Efforts to establish birthing facilities and obstetrics in Tibetan medical hospitals are still in their beginning.[38] An important part of the rapprochement of Tibetan medicine and biomedicine in practice concerns translations of medical terminologies between different cultural notions of health and illness, including birth and birth control, that, however, still remain a challenge for doctors and nurses working together in clinical public-health settings in Tibetan areas.[39] However, obstetric services and birth remain the exclusive terrain of state-controlled biomedicine not only because, as I argue, they are 'scientific' and 'rational', and thus are supported by both government and NGOs, but also because the number of

[37] Adams *et al.* 2005. Even though Tibetan medicine has become marginalised in present-day medical services surrounding birth and reproductive health, it used to be a traditionally strong domain; see, for example, Mingkyi Tshomo (2009), Pordié and Hancart Petitet (in press), Fjeld 2009.

[38] Personal e-mail communication with Renchen Dhondrup, 12 May 2011.

[39] A 'Tibetan–Chinese–English Biomedical Dictionary' has just been published in Xining, with about 40,000 entries. I think that if Tibetan medicine is to survive as a practice in public health, it would be very important to also produce such a comprehensive tri-lingual dictionary on Tibetan medicine.

children being born remains the important political domain of the state's vigilance surrounding issues of population size.

Dr Tashitsho

Another Tibetan female doctor, Dr Tashitsho, is a young gynaecologist in her mid-20s working in a county-level peoples' hospital. The county town is surrounded by small farming villages, with a predominantly Tibetan population of about 60 to 70 Tibetan households per village. Recently, Dr Tashitsho's formerly separate Department of Maternal and Child Health Care was moved to become part of the Disease Prevention Centre. This meant that she had many more tasks to fulfil, including epidemiological issues such as identifying and controlling tuberculosis (TB) outbreaks and immunising newborns and young children.[40] Her medical training started with a three-year study of general (bio)medicine at a prefectural health school, followed by several years of specialised training and practice in maternal and child health care in different hospitals. She also learnt some Tibetan medicine from local doctors, but pointed out that she usually does not apply it since it is not part of her medical routine. She adds that—quite in contrast to Dr Dromatsho—'translating' between 'Western' and traditional Tibetan medical terms remains 'difficult' for her since the two systems are 'actually different'.

What seemed to have caused her a 'culture shock' was her experience of an international NGO-sponsored training course on maternal health care. She felt quite alienated by some of the training sessions in which the female Tibetan doctors had to pretend to be pregnant, bleeding and lying squirming on benches 'giving birth' to baby dolls. Equally confusing for her was the fact that several Tibetan doctors from very different farming and nomadic areas, ranging from Amdo (Qinghai, Gansu), Kham (Sichuan) and central Tibet (TAR) were lumped together in that course. They were thus not able to communicate easily with each other due to their mutually unintelligible Tibetan dialects. Chinese translations of Tibetan medical terms—whether biomedical or Tibetan medical—are in any case problematic, and they did not facilitate an understanding at the time. This lack of communication was disappointing since Dr Tashitsho knew she would miss out on potentially useful information. She didn't think it was very useful to bring 'outsiders' like her into other Tibetan communities and places, whether into a big city in central Tibet or

[40] A year earlier, in 2004, the Maternal and Child Health Care Centre (Chinese *fuju bao zhen*, 'Mother Baby Protect Healthy') used to be a separate office, where she had less duties. Now, her job at the Disease Control Centre concerns next to immunising newborns and TB diagnosis and care, surveying STD and poisoning of *abra* pest animals on the grassland.

elsewhere in nomadic places, because for her 'it is like being in a foreign country'. Obviously, this feeling of foreignness was reciprocated; local patients also mistrusted 'outsiders', not just Chinese doctors but sometimes also Tibetans if they came from another county or prefecture or were somehow perceived to be connected to official family planning.

However, Dr Tashitsho did enjoy another training programme on 'safe delivery', immunisation and disease prevention co-organised by an NGO and the County Health Bureau, for which she worked as an instructor for approximately 100 township doctors from the same area. She was able to learn from their experiences, she stressed, and had the impression that this was mutual. These doctors were employed by the Government to work in township clinics and to help to deliver babies both within homes and in clinics. They also had to undergo regular training. Other training courses were planned to include 'barefoot doctors' (*rkang rjen sman pa*), who were not employed by the Government but who organised simple health care in single villages. While barefoot doctors used to help with home births and also immunisation, their tasks were recently transferred to medically well-trained personnel such as Dr Tashitsho. Yet, what she was still lacking was experience and close relationships with local women. A Tibetan-language radio programme by a Tibetan nurse, informing women about health and reproductive care, used to run for some years quite successfully, she explained. Apart from that, however, it was astonishing how little information on reproductive health was available for women in rural areas, given their still high illiteracy, at least among the older generation. No wonder they often did not know either about free health care at small township clinics or how to take care of contraception properly.

'Safe delivery' was of utmost concern in Dr Tashitsho's job, in particular since three or four women had died within her county in the previous year (2004) while in labour at home. Therefore, the need to increase women's awareness to go to hospital in time was one important health measure.[41] Doctors are indirectly made 'responsible' for maternal deaths in townships under their care. In her present work unit, Dr Tashitsho feels well established. She is taking care of a township not too far away from the county seat hospital where she is working. Together with six other female doctors, all of whom are Chinese, she is responsible for a total of seven townships in this multi-ethnic neighbourhood. In practice, this means that she makes contact with the responsible township representative of the Women's Federation first. These women are chosen by the local government because they can read and

[41] Compare with similar outcomes in Adams *et al.* (2005a), Chertow (2008), Heydon (2010), Pordié and Hancart Petitet (forthcoming) and Gutschow (2010).

write Chinese and—ideally, but not necessarily so—come from families with a medical background. Since the mid 1990s, they go to visit each village household and to spread the news about how to take care of one's body during pregnancy and how to have a 'safe delivery', directly urging women to give birth at a clinic.

Dr Tashitsho also takes care of newborns' immunisation, which is part of the 'accounting system' of registered births, something that, according to her, was 'never' properly implemented in Tibetan nomadic communities (although some children in farming areas also never received immunisation, as my inquiries had shown). Even though Dr Tashitsho does not explicitly state it, a disparaging tone pervades her statements on Tibetan nomads. She hints at the ways in which they are very 'different' from farmers, in particular when it comes to hygiene and controlling their fertility according to government laws. Interestingly, in an unrelated interview, a female Tibetan gynaecologist from a nomadic township clinic who is actually treating nomadic women directly picked up, but also corrected, such common prejudice; she explained that 'even though nomads are dirty, they are pure inside', which she connects with them having a pure heart, eating pure Tibetan food and leading a simple life and therefore being 'good people', 'real' Tibetans.

Dr Tashitsho estimates that about 60 per cent of rural farming women in the townships would give birth in a hospital. Each 'normal birth' at a township clinic or county hospital used to cost 300 Yuan before 2005, an already considerable amount for an average rural subsistence household. Many women I spoke with feared the potentially high costs involved in a 'complicated birth', such as in the case of a Caesarean section. Several informants had suffered complications when they tried to avoid going to a clinic and give birth at home and thus had jeopardised both their health and their household finances. A minimum of 3,000–4,000 Yuan is needed to pay for a Caesarean and for the ensuing in-patient stay and medical care at the hospital. Since only prefecture or provincial hospitals would have the necessary equipment for such emergency obstetric operations, higher medical costs would incur involving additional costs for transportation, and for food for the patient to be supplied by another family member. The total costs can amount to around double the average annual income of a rural farming or nomadic household. I also heard reports about women who were about to give birth, and who tried to get into a hospital, but who were not admitted since they could not pay the required 800 Yuan cash entry fee. However, if women were giving birth at the hospital 'now' (i.e. during mid-2005), Dr Tashitsho claimed, the newly implemented health insurance would cover most of the 'normal' birth costs (i.e. at township level clinics) as well as baby care and immunisation for children

until three years of age.[42] It is to be hoped that this new health-insurance system, together with better quality medical training and care, will change this situation for the better.

Dr Tashitsho explained that although family planning centres undertake cost-free insertions of IUDs—and only 'formerly' performed abortions, as she insisted—not many women availed themselves of this service. These IUDs were considered poor quality and also needed to be replaced every three to five years while the expensive ones were 'life-long' and cost about 150 Yuan. Also, something Dr Tashitsho does not mention directly, they are institutionally 'closer' to, i.e. more directly connected with, the control by family planning personnel. The County Disease Control Centre actually maintains lists of households with exact numbers of registered children, as a privately practising doctor explained to me. Families need to register their children with the government office and obtain a registration (Chinese, *hukou*) for their child, which means that immunisation will be given free and the child has the right (and duty) to go to school. On the other hand, this means that women who exceed the birth quota per couple will avoid clinics when they are pregnant and about to deliver. Also, their unregistered children fall through the net of both public health and education, which marginalises them as citizens without any rights. Most women, Dr Tashitsho states, would prefer a private clinic where there is 'less procedure' connected with contraceptives, meaning 'less paperwork' (and surveillance). In addition, private doctors do not pressure their patients to stay on, compared with admission to a hospital where patients do not know how long they must stay and how high the costs will become. Unfortunately for local Tibetans, the more expensive the health care in prefecture and provincial hospitals, the better and more reliable it is.

Dr Tashitsho admits that a certain competition exists between government hospitals and clinics and the private doctors. From her perspective as a government employee, the private doctors are out to make extra money. They implant IUDs and give a 'wellness' IV (it is not clear whether it is filled with glucose or an antibiotic) afterwards to 'comfort' the women, which will cost them much more than getting an IUD inserted at a hospital. Dr Dromatsho points out, as did Dr Tashitsho, that 'these private doctors' often would not implant

[42] At the time, the new health-insurance scheme (*nyams las sman chod*; Chinese *xinnong he*) was only in the beginning of its implementation. People were insecure about how effective it would be, having to spend 10 Yuan in advance per person and year and being reimbursed only for in-patient hospital care and according to the administrative levels of hospitals. That means the more expensive the health care, with corresponding level of quality, township hospital expenses will be covered by 70 per cent while the qualitatively better prefecture or provincial hospital expenses will be covered only by 30 per cent.

IUDs correctly because they did not know how to measure the womb properly in relation to the size of IUDs, causing uterine problems while at the same time charging more for their services. What she does not mention is that IVs are also used as part of the 'remuneration' system for women's consented abortions and that careless procedures also happen within hospitals and medical family planning service units. Dr Tashitsho claims that 'operations', i.e. sterilisations, *tse*, are 'not so common' since they 'dry out the uterus', the logic behind being that the operation might influence the ovaries rendering them incapable of nourishing the uterus. However, or nevertheless, more recently procedures of sterilisations being routinely done after the birth of the second child seem to be more common. Dr Tashitsho obviously tries to look at the positive side of family planning and states that recently the 'abortion pill' has become more popular. It is supposed to replace 'operative abortions' and make it easier for women to terminate pregnancies. The family planning centre delivers such pills for free, and as of mid-2005, women were remunerated with 20 Yuan and some food supplies if they consented to take it.

Conclusion and outlook

In this paper I have reflected upon the ways in which rural Tibetan women in Amdo experienced and negotiated family planning and related social, economic and medical pressures through their individual bodies and gendered selves. While not generally opposing the positive sides of birth control as such—most women interviewed were happy with having two or three children—birth control technologies were clearly a central health issue and often a worrying one for women. During the 1980s and 1990s, at the onset of the implementation of family planning policy in Qinghai, target campaigns were still common and family planning personnel, doctors and patients were all inexperienced. More generally, however, involuntary abortions and sterilisation left targeted women both scarred by, and scared of, the state's medical facilities associated with birth and birth control. Even when maternal and child health-care services tried positive interventions to increase women's reproductive health from the mid-1990s onwards, they were still mistrusted because of their vigilance for checking on numbers of children. Socio-cultural values of rural women's physical strength, economic productivity and fertility—central abilities for their gendered identity and social status—were experienced as being jeopardised by state family planning practices. Rural women felt caught between the opposing need to both control and to enhance their fertility. Loss of strength was a central theme in their narratives, meaning also a potential loss of social status within a rural subsistence economy that depends

heavily upon women's labour power. Women's fears or experiences of pain and loss of health were only increased by a wide range of factors:

- negative past experiences with birth control campaigns;
- problematic access to health care;
- the lack of quality in free rural public medical services surrounding reproduction and its control;
- the cost of quality health care, often located far away in prefecture towns or the provincial city, increasing related costs for transport and care by an accompanying family member;
- the State's vigilance in punishing and fining couples for excess children;
- coerced sterilisations, in particular when a woman had not yet given birth to the socially desired son.

Subsequently, women's deep-seated mistrust often results in their reluctance to submit themselves to check-ups and other forms of public health services unless they can address themselves to a trusted, preferably female, Tibetan doctor. Additionally, women expressed fear of the crippling costs involved in 'complicated' births requiring surgery and hospitalisation. Both Tibetan laywomen and medical professionals mentioned uterine inflammation and pain (especially back pain) caused by IUDs, sterilisations and abortions as recurring hazardous health problems. Medical practitioners, however, generally blamed women themselves for such problems, citing their lack of 'hygiene' and their refusal to take proper care of their bodies or to get regular check-ups.

Female Tibetan doctors who were knowledgeable about reproductive health as well as birth control became Tibetan women's most trusted sources of care. Cultural, linguistic and gender relatedness, built upon existing notions of trust among 'insiders', play an important role in Tibetan women's reproductive health choices. They constitute Tibetan women's only real alternative to a strict and unforgiving state control, one that intricately connects the physical with the social and economic through family planning, thereby limiting and jeopardising rural Tibetan women's health. Without doubt, women's bodies and their sexual, reproductive and productive powers are particularly scrutinised 'sites' of social control, as exercised by both state and local sociocultural pressures. However, whether or not they also become 'a site for resistance to' and not only 'regulation of' social change is something that remains to be explored.[43] Idioms of fear, distress and actual pain at least enable women to articulate difficulties with the system and its pressures to conform.

[43] See Makley (2005, p. 265), where she also refers to the work of Barlow (1994) and Gilmartin (1990).

Tibetan women's narratives of their experiences with birth control reflect these, while their health-seeking behaviour accounts for both their way to escape state vigilance by avoiding medical and administrative institutions connected with family planning and their efforts to find trusted doctors to deliver quality medical services for birth control. Recently, female Amdo Tibetan intellectuals have started to publicly reassert themselves as women, embracing their bodies and selves positively and expressing their views publicly.[44] Huamo (dPal mo) is one; she is also an activist for Tibetan women's reproductive health.[45]

The younger, more educated and better informed generation of rural or now recently urbanised women in their 20s and early 30s usually get along with birth control much better than their mothers did. Yet they are still vulnerable if pregnant and unmarried, being outlawed by both state and, often, their families, with free contraception, including abortion, and free childbirth in clinics being refused. I heard of at least one case in 2007 where a Tibetan girl had died while in childbirth all on her own. Research remains to be done on unmarried women and urban Tibetans in relation to other ethnic groups and on recent changes in public health via a health-insurance system. At least in urban places young Tibetan women are now more knowledgeable about the appropriate use and care of birth control technologies and also because they are less dependent on working in a subsistence economy. To become 'modern' and educated might be the best option for women. By using birth control in a constructive way that enables women to escape both hard labour in a subsistence economy and a traditional patrilocal marriage system in which they face more social pressures, they may become more self-reliant and self-determined. The trend to a voluntary one-child family among the younger generation of Tibetans has already begun. Somewhat ironically, this new trend might in fact contribute quite considerably to the State's goal for modernisation, ending a traditional way of life based on labour-intensive subsistence that is at the same time strongly connected with Tibetan cultural values and practices. Aided by other government policies, such as resettlement of nomads, fencing and the establishment of environmental zones, fertility would be successfully controlled from the State's perspective. This new relation between land, animals, human fertility and the State lies at the heart of the coming socio-cultural transformation in Tibetan areas of China.

---

[44] See Robin 2010, and in press.

[45] See www.tibetcm.com/html/news/201110163690.html. I thank Françoise Robin for this reference.

Bibliography

Adams, V. 2005, 'Moral Orgasm and Productive Sex: Tantrism Faces Fertility Control in Lhasa, Tibet (China)', in V. Adams and S. L. Pigg (eds), *Sex in Development: Science, Sexuality, and Morality in Global Perspective*, Durham, N.C., and London: Duke University Press, 207–40.

—— 2008, 'Modernity and the Problem of Secular Morality in Tibet', in V. Houben and M. Schrempf (eds), *Figurations of Modernity: Global and Local Representations in Comparative Perspective*, Frankfurt and New York: Campus Verlag, 105–20.

Adams, V., S. Miller, J. Chertow, S. Craig 2005, 'Having a "Safe Delivery": Conflicting Views from Tibet', *Health Care for Women International* 26: 821–51.

Barlow, T. 1994, 'Politics and Protocols of Funu: (Un)making National Women', in C.K. Gilmartin, G. Hershatter, L. Rofel, and T. White (eds), *Engendering China: Women, Culture, and the State*, Cambridge Mass., London: Harvard University Press, 339–59.

Bonnet, C., in press, 'Becoming Human, Becoming Women: Strategies and New Subjectivities within the Tibetan Women's Association', *Kadın/Woman 2000, Journal for Women's Studies* 13.1.

Butler, J. 1990, *Gender Trouble: Feminism and the Subversion of Identity*, London and New York: Routledge.

Chertow, J. 2008. 'Embodying the Nation: Childbirth in Contemporary Tibet', in R. Barnett and R. Schwartz (eds), *Tibetan Modernities: Notes from the Field on Cultural and Social Change*, Leiden: E. J. Brill, 75–99.

Childs, G., 2004, *Tibetan Diary. From Birth to Death and Beyond in a Himalayan Valley of Nepal*, Berkeley, Los Angeles, and London: University of California Press.

Childs, G. 2008, *Tibetan Transitions: Historical and Contemporary Perspectives on Fertility, Family Planning, and Demographic Change*, Leiden: E. J. Brill.

Chin, N. and B. Loy 2004, 'A Preliminary Site Visit Report: Ayang Monastery and Rimaa Village, Yushu County, Qinghai, China', unpublished paper.

Craig, S. 2009, 'Pregnancy and Childbirth in Tibet: Knowledge, Perspectives, Practices', in H. Selin and P.K. Stone (eds), *Childbirth Across Cultures*, (Series: *Science Across Cultures: The History of Non-Western Science 5*), Dordrecht, Heidelberg, London, New York: Springer, 145–60.

de Certeau, M. 1984, *The Practice of Everyday Life*, trans. S. Rendall, Berkeley, Los Angeles, and London: University of California Press.

Fjeld, Heidi 2009, 'Dealing with infertility in Lhasa. Past and Present', Paper presented at ICTAM VII, 7–11th September 2009, Thimphu, Bhutan.

Garrett, F., 2008, *Religion, Medicine, and the Human Embryo in Tibet*, London and New York: Routledge.

Gilmartin, C. 1990, 'Violence against Women in Contemporary China', in J. Lipman and S. Harrell (eds), *Violence in China: Essays in Culture and Counterculture*, Albany: State University of New York Press, 203–26.

Goldstein, M. and C. Beall 1991, 'China's Birth Control Policy in the Tibet Autonomous Region: Myths and Realities', *Asian Survey*, 31.3: 285–303.

Goldstein, M., B. Jiao (Benjor), C. M. Beall and P. Tsering 2002, 'Fertility and Family Planning in Rural Tibet', *The China Journal*, 47: 19–39.

Goodkind, D. M. 2004, 'China's Missing Children: The 2000 Census Underreporting Surprise', *Population Studies*, 58.3: 281–95.

Greenhalgh, S. 2008a, *Just One Child: Science and Policy in Deng's China*, Berkeley, Los Angeles, and London: University of California Press.

—— 2008b, 'Globalization and Population Governance in China', in A. Ong and S. J. Collier (eds), *Global Assemblages: Technology, Politics, and Ethics as Anthropological Problems*, Malden, Mass.: Blackwell, 354–72.

—— 2010, *Cultivating Global Citizens: Population in the Rise of China*, Cambridge, Mass.: Harvard University Press.

Greenhalgh, S. and E. A. Winckler 2005, *Governing China's Population: From Leninist to Neoliberal Biopolitics*, Palo Alto, Calif.: Stanford University Press.

Gutschow, K. 2010, 'From Home to Hospital: The Extention of Obstetrics in Ladakh', in V. Adams, M. Schrempf and S. Craig (eds), *Medicine, Science and Religion: Explorations on Tibetan Grounds*, London: Berghahn Books, 185–214.

Gyatso, J. 2008, 'Spelling Mistakes, Philology, and Feminist Criticism: Women and Boys in Tibetan Medicine', in F. Pommaret and J. L. Achard (eds), *Revue d'Études Tibétaine: Tibetan Studies in Honour of Samten Karmay*, XIV, 81–98.

Hermanns, M. 1959, *Die Familie der Amdo-Tibeter*, Freiburg and Munich: Verlag Karl Alber.

Heydon, S. 2010, ' "The greatest news": Khunde Hospital and childbirth in a Sherpa community in Nepal', in S. Craig, M. Cuomu, F. Garrett and M. Schrempf (eds), *Studies of Medical Pluralism in Tibetan History and Society*. (PIATS Bonn 2006), Andiast: International Institute for Tibetan and Buddhist Studies GmbH, 279–306.

Huber, T. 2002, *Amdo Tibetans in Transition: Society and Culture in the Post-Mao Era*, Leiden: E. J. Brill.

Kleisath, M. (ed.) 2008, *Heavy Earth, Golden Sky: Tibetan Women Speak about Their Lives*, Shem Women's Group.

Makley, C. 2005, 'The Body of a Nun: Nunhood and Gender in Contemporary Amdo', in J. Gyatso and H. Havnevik (eds), *Women in Tibet*, London: Hurst & Co., 259–84.

—— 2007, *The Violence of Liberation: Gender and Tibetan Buddhist Revival in Post-Mao China*, Berkeley, Los Angeles, and London: University of California Press.

Mattingly, C. 1998, *Healing Dramas and Clinical Plots: The Narrative Structure of Experience*, Cambridge: Cambridge University Press.

Mingkyi Tsomo (sMan skyi mTsho mo) 2009, *Mo nad phal pa'i nad la zhib 'jug dang bcos kyi nyams yig*. Lhasa: Bod ljongs mi dmangs dpe skrun khang.

Mueggler, E. 2001, *The Age of Wild Ghosts: Memory, Violence and Place in Southwest China*, Berkeley, Los Angeles, and London: University of California Press.

Napolitano, V. and D. Pratten 2007, 'Michel de Certeau: Ethnography and the Challenge of Plurality', *Social Anthropology*, 15 .1: 1–12.

Parkin, D. 2011, 'Trust Talk and Alienable Talk in Healing: A Problem of Medical Diversity', MMG Working Paper, 11–11, Göttingen: Max Planck Institute for the Study of Religious and Ethnic Diversity.

Pirie, F. 2006, 'Secular morality, village law, and Buddhism in Tibetan societies', *Journal of the Royal Anthropological Institute (N.S.)* 12: 173–190.

Pordié, L. and P. Hancart Petitet forthcoming, 'Birth in Shun Shade: Notes on the Role of the *Amchi* Regarding Childbirth', in L. Pordié (ed.), *Healing at the Periphery: Tibetan Medicine and Himalayan Societies in India*, Durham, N.C.: Duke University Press.

Robin, F. 2010, 'Des poèmes et des femmes: étude préliminaire sur vingt-cinq ans de poésie féminine au Tibet (1982–2007)', in J. Achard (ed.), *Études tibétaines en l'honneur d'Anne Chayet*, Geneva: Librairie Droz.

—— in press, 'Le corps féminin vu par les poètes tibétaines: du silence à la celebration', in S. Marchand and Esther Heboyan (eds), *La Poétique du Féminin en Asie Orientale*, Arras: Presses de l'Artois.

Samtsogye 2008, 'The Pilgrim's Journey', in M. Kleisath (ed.), *Heavy Earth, Golden Sky: Tibetan Women Speak about Their Lives*, Shem Women's Group, 19–28.

Samuel, G. 2006, 'Healing and the Mind-Body Complex', in H. Johannessen and I. Lazar (eds), *Multiple Medical Realities: Patients and Healers in Biomedical, Alternative and Traditional Medicine*, London and New York: Berghahn Books, 121–35.

Schrempf, M. 2008, 'Planning the Modern Tibetan Family', in V. Houben and M. Schrempf (eds), *Figurations of Modernity: Global and Local Representations in Comparative Perspective*, Frankfurt and New York: Campus Verlag, 121–51.

—— 2010, 'Between Mantra and Syringe: Healing and Health Seeking Behavior in Contemporary Amdo', in V. Adams, M. Schrempf and S. Craig (eds), *Medicine between Science and Religion: Explorations on Tibetan Grounds*, London and New York: Berghahn, 157–84.

—— forthcoming, 'Between a Rock and a Hard Place: Social, Moral and Other Dilemmas in Tibetan Women's Experiences with China's Family Planning', in I. Vargas and Zhou Xun (eds), *Convergence and Collisions: Disease, Religion and Healing in Asia*, Hong Kong: Centre for the Humanities and Medicine, University of Hong Kong.

Sigley, G. 2004, 'Liberal Despotism: Population Planning, Subjectivity, and Government in Contemporary China', *Alternatives*, 29: 557–75.

Tibetan Women's Association, 2005, 'Tears of Silence: Tibetan Women and Population Control', available online at: www.tibet.com/Women/tears1.html (accessed 5 May 2008).

Yan Hao 2000, 'Tibetan Population in Tibet: Myths and Facts Re-Examined', *Asian Ethnicity*, 1.1: 11–36.

Zhang Weiguo 2002, *Chinese Economic Reforms and Fertility Behaviour: A Study of a North-China Village*, London: China Library.

BRILL

Asian Medicine 6 (2010–11) 348–386

brill.nl/asme

Children's Healthcare and Astrology in the Nurturing of a Central Tibetan Nation-State, 1916–24

Stacey Van Vleet
Columbia University

My child, you are born of the heart.
May you live a hundred years and perceive one hundred teachings.
May you attain a noble long life and overcome every evil.
May you have wealth, good fortune and happiness in abundance!
From the *Four Tantras*, root text of Tibetan medicine

Let all aspire to the pure and highest motivation of benefiting others!
Through the power of all beings, high and low,
Following the small excerpt on childcare propagated here
May the glory of the highest beneficial qualities and skills be attained!
The Thirteenth Dalai Lama, in his benedictory verses to *Treasure of the Heart* (1916)

Abstract
Between 1916 and 1924, a Tibetan public healthcare programme that focused on childcare and natal astrology comprised a central aspect of the mission of the Lhasa Mentsikhang (Institute of Medicine and Astrology). Assessing previously unused Tibetan language materials—including the Thirteenth Dalai Lama's edict for implementation and an accompanying childcare manual—the programme is contextualized with regard to regional developments in British India and China. Like British 'mothercraft' education programmes of the same period, the Tibetan initiative links the health of the population (from infancy) to the health of the state and its economy. Rather than appealing to the authority of 'scientific' colonial medicine, however, this paper discusses how indigenous medical techniques and theories are put forward as effective means to prove the nascent Central Tibetan state's benevolence, legitimacy and sovereignty via intervention in the domestic sphere. Such attention to medical reform and to the domestic sphere brings light to an underappreciated effort by the Thirteenth Dalai Lama to cultivate a sense of Tibetan subjecthood and to reconfigure the relationship between his government and various segments of society. Significantly, this childcare initiative was entrusted not just to mothers, and the category of class is here more germane than the category of gender central within British programmes. Various social groups within a specifically delineated Tibetan territory are assigned tasks in the programme's implementation, illustrating the desire to incorporate each into a reorganised Tibetan state bound by a newly articulated Buddhist ideal of shared social responsibility.

DOI: 10.1163/15734218-12341238

Keywords
Early 20th century public health, childcare, Thirteenth Dalai Lama, Lhasa government, Mentsikhang

During the late nineteenth and early twentieth centuries, campaigns to professionalise obstetrics and to educate women about hygienic childbirth and postnatal care emerged around the globe. Championed within both colonialist and nationalist agendas, these initiatives formed part of a larger emerging discourse that linked the provision of public health care and the management of the domestic sphere to notions of benevolent rule, state sovereignty and civil society. Scholars have been reluctant to identify early twentieth-century social and medical developments within the Central Tibetan state led by the Thirteenth Dalai Lama Tupten Gyatso (Thub-bstan rGya-mtsho 1876–1933), with contemporaneous medical innovations and discourses of nationalism.[1] However, there has been little assessment of many Tibetan sources relevant to the most significant internal development in medicine during this period, that is the founding in 1916 of the Lhasa Mentsikhang or Institute of Medicine and Astrology.[2] In this article I will examine a critical component of the Mentsikhang's early mission, a children's health-care (*byis pa nyer spyod*) programme officially implemented between 1916 and 1924.[3] Concerns of

[1] See McKay 2007, pp. 134, 209. My research supports McKay's conclusion that the Central Tibetan state did not institute any 'systematic biomedical education'. However, in contrast to the British sources of the time that do not recognise the existence of 'public health structures' in Tibet, I aim to show that from the perspective of Lhasa, the idea of providing public health care was largely disassociated from 'biomedical' technologies and theories.

[2] The major secondary works to date regarding the Mentsikhang (*sman rtsis khang*) and its founders during this early twentieth-century period come from Jampa Trinlé (Byams-pa 'Phrin-las), student of Khyenrap Norbu (mKhyen-rab Nor-bu) and later director of the Lhasa Mentsikhang (including 1986, 1990 and undated, among others). Rechung Rinpoche 1973 gives another, albeit brief, early account. Byams-pa 'Phrin-las' works form the basis of later scholarship in both Tibetan and Western languages, notably Pa-sangs Yon-tan 1987, bLa-ma-skyabs 1997, sKal-bzang 'Phrin-las 1997, E-pa bSod-nams Rin-chen 2009 and Meyer 1992. E-pa bSod-nams Rin-chen's recent work brings to bear new material from interviews in Dharamsala and based on an undated account published in Lhasa by bsTan-'dzin bKra-shis; these two sources, along with Yinba (Tib: Yum-pa) 2008, will receive further attention in my forthcoming dissertation. Tashi Tsering (2010) has further discussed sources on Khyenrap Norbu. Alex McKay (2005a, 2005b, 2007) thoroughly details efforts to introduce the British medical system in Tibet and the Himalayas at this time, along with British perspectives on Tibetan physicians and the state of medicine in the region.

[3] These dates, from Byams-pa 'Phrin-las undated, contrast to the statement of Janes 1995, p. 14, that the programme was carried out for 'about 15 years'. Only limited evidence regarding

gender, it is well established, are not peripheral to concerns of the nation; in this spirit I will argue that the dearth of attention both to medical reform and to the domestic sphere has led to some misunderstanding of early twentieth-century Central Tibetan politics. The Mentsikhang's childcare programme, while not emphasising gender as a category, represents a significant and previously unrecognised effort to cultivate a sense of Tibetan subjecthood beginning in the domestic realm as well as to reconfigure the relationship between various segments of Central Tibetan society.[4]

Uniquely, among the Thirteenth Dalai Lama's well-known early twentieth-century state-building reforms, the Mentsikhang's legacy survived the reorganisation of Tibetan governance and society after 1950 by the People's Republic of China, to be claimed proudly by succeeding institutions both inside Tibet and in exile.[5] Yet the Mentsikhang does not appear within the dominant historical narrative of this period formulated in Melvyn Goldstein's foundational *History of Modern Tibet, 1913–1951*.[6] Instead, Goldstein's treatment of the Thirteenth Dalai Lama's reforms focuses on their military and economic aspects. Motivated and funded mainly by the British, these included such technology-based and state-rationalising initiatives as the reorganisation of the army, the institution of a police force, revision of the tax code, building a telegraph connection and hydroelectric plant and conducting a mineral survey and plans for a postal service. In such a portrait, Tibetans themselves become primarily responsible for a 'failure' to create a nation-state or even a fully 'modern' society, where the idea of the modern includes certain social technologies in addition to material technologies. A stereotype also

---

the extent of the programme's dissemination and implementation is available; this will be discussed during the course of this article.

[4] Here 'Central Tibet' refers specifically to the areas administered by the Lhasa Government under the Thirteenth Dalai Lama. The exact geography of these areas, which he refers to in his childcare edict as the 'districts and estates' (*rdzong gzhis*), has been difficult to determine in contemporary scholarship with available documents. Byams-pa 'Phrin-las (1990) claims that the Mentsikhang purview extended over 96 *rdzong gzhis*, and while this figure is not found in the reprinted text of the edict (TA-la'i sKu-phreng bCu-gsum-pa 1989), it is not unlikely that it comes from his consultation of the original or a related source. See, however, Goldstein (1968) who suggests around 120 districts, all located today within the Tibet Autonomous Region.

[5] See Hofer 2011a on twentieth century medical developments in Central Tibet, Janes 1995 and the extensive body of Adams' work (Adams 2002, Adams et al. 2005, and many others) on the Lhasa Mentsikhang after the Cultural Revolution, and Kloos (2010) on medicine and the 'Men-Tsee-Khang' among Tibetan exiles in India from the 1960s to present.

[6] While Goldstein (1989, p. 510 n. 143 and p. 515 n. 157) mentions the Mentsikhang's first director, Khyenrap Norbu, he never acknowledges the Mentsikhang itself, apparently not considering it an instance of reform and state-building aspiration on a par with the others he discusses, as indeed British contemporary observers did not. See also McKay 2007, p. 156 and *passim*.

emerges of aristocratic elites, even those involved in the state reforms, as insensitive to matters of class and of the Tibetan Buddhist monastic establishment as uniformly reactionary, opposed both to reform within both their own powerful ranks and the lay sphere. The continuing dominance of this narrative has led to a more general assumption, expressed succinctly by Gray Tuttle, that:

> No real effort was made to promote an 'imagined community' or to develop a concept of citizenship. To do so would have altered the relationship between the monastic and noble elites and a populace that was more or less their subjects . . . the Tibetan leadership seemed to feel that they could become a nation-state by using international tools without changing the fundamental structure of Tibetan society.[7]

Considering the Mentsikhang's reforms along with these others, however, and in particular the institution's concern with bringing childcare and natal astrology to each Central Tibetan household, allows us to considerably complicate this conclusion.

'Mothercraft', imperialism and nationalism

At the turn of the twentieth century, the approximately 100 districts and estates under the Dalai Lama's Lhasa government lay at the cross hairs of the innocuously designated 'Great Game', a rush on the Asian continent to delineate borders, count and classify peoples and develop efficient bureaucratic states to manage populations. Although European access to Central Tibet was limited diplomatically at this time, Tibetans were nevertheless embedded in regional networks of travel, trade and the circulation of ideas and technologies (including medical ones), particularly with India, China and Mongolia. For the British Empire, the collection of increasingly sophisticated census data and statistical surveys seemed to confirm anxieties at that time over labour and military shortages both at home and in the 'jewel colony' of India.[8] As the health of the population emerged as an issue of key importance to the wealth and maintenance of Empire, the British state, along with various voluntary organisations, invested in the development of public health initiatives to combat infant mortality, to strengthen the labour force and 'imperial race' and to educate mothers in 'domestic hygiene'. 'Mothercraft' education programmes gained particular popularity for their cost-effectiveness, enlisting mothers as

[7] Tuttle 2005, p. 51.
[8] Van Hollen 2003, p. 36; Davin 1978, p. 10.

proxies of the state who could help nurture (male) infants into future soldiers, workers, traders and the administrative apparatus of Empire.[9]

In the context of colonial India, programmes to educate mothers in medicine and sanitation were charged with an added dimension of effecting fundamental social and discursive change. Just as missionaries had attempted to use medicine to demonstrate the efficacy of Christian epistemology over 'superstitious' local medical beliefs, secular public health-care programmes exhibited the Government of India's confidence in the superiority of the British medical system and, by extension, the enlightened nature of British rule. In the three decades prior to the Mentsikhang's founding, three major initiatives in health care and education for women and children were implemented on a national scale in British India.[10] From the perspective of colonial administrators, by disseminating new health behaviours and theories within the notoriously cloistered space of the Indian home, 'not only the private space but the entire nation could become *enlightened*'.[11] Indian women, considered the domestic keepers and transmitters of culture, became invaluable (potential) partners in the British mission to socialise their subjects and to enlist participation in a benevolent, 'progressive' empire.

This relationship between ostensibly secular and benevolent health-care programmes for women and doctrinaire and coercive imperial rule was not lost on (male) Indian nationalists, for whom the domestic sphere became 'the only remaining pure space unsullied by the intrusion of British rule, and a privileged site of nationalist resistance'.[12] Similar concerns took root, moreover, within semi-colonised China, where Ruth Rogaski has described how a perceived lack of Qing state involvement in matters of disease prevention became 'a powerful symbol of the deficiency of Chinese civilization', to the

---

[9] Davin 1978, p. 26.

[10] These included the 1885 Dufferin Fund, which aimed to train (mainly British) female medical workers to provide care for Indian women (Lal 1994), the 1903 Victoria Memorial Scholarship Fund, established with a special focus on training *dais* (South Asian practitioners of traditional midwifery) according to British sanitary methods (Van Hollen 2003), and the Women's Medical Service of 1914, established as a counterpart to the Indian Medical Service (largely male and military in character) as women's place in medicine and the professionalisation of obstetrics became more substantial (Lal 1994, p. 65). Of these three, the Dufferin Fund—named after its founder, then-vicereine Lady Hariot Dufferin. Within its first year branches had been established all over India, including provinces on the frontiers of Tibet and where Tibetan communities existed, such as Bengal, Burma, and the North-West Provinces. Dufferin trainees worked as doctors, nurses and midwives in new women's hospitals and dispensaries, dedicated women's wards within existing institutions and privately, entered into intimate domestic spaces and relationships with native women that remained forbidden to British men.

[11] Van Hollen 2003, p. 49, emphasis in the original.

[12] Lal 1994, p. 46.

point that even Chinese elites 'accepted a medicalised view of their country's problems and embraced a medicalised solution for the deficiencies of both the Chinese state and the Chinese body'.[13] The discourse Rogaski terms 'hygienic modernity' linked the pursuit of a sanitary and healthy society to the assertion of state legitimacy and sovereignty, as well as to building national consciousness and economic and military strength. But while many nationalists in China and British India appropriated colonial projects of hygienic modernity for their own ends, some others also designed initiatives of domestic health care and education according to their own cultural systems.[14]

Central to the allegedly universal beneficence of 'modern' public health-care programmes was their appeal to the authority of science, as a system of inquiry that foregrounded the pursuit of natural or 'physiological' knowledge over 'metaphysical' knowledge and encouraged the common enterprise of material-technological innovation while supposedly bracketing divisive moral and religious concerns.[15] Science was not only a mode of knowledge production, however, it was also a set of practices and discursive conventions, a mode of social organisation and emplacement in the world.[16] Perhaps nowhere was this more clear than within post-natal 'mothercraft' education programmes, which derived their scientific reputation not so much from reliance on material medical technologies (such as vaccination or disinfectants) as from their advice for nutrition and sanitation according to 'hygienic' standards of behaviour and the organisation of family and social life. Yet these standards of hygiene were saturated with rhetorical assumptions pertaining to gender, class, race and religion. British mothercraft literature invariably characterised the lower classes and colonial subjects as unsanitary, ignorant or superstitious and neglectful of their children, minimising the role of poverty and related unfavourable environmental factors in infant mortality and trumping notions of state, employer or wider social responsibility.[17] Underlying the design of 'mothercraft' education programmes was the idea that women, the poor and the colonised should be taught the social discipline and self-governance of efficient, 'modern' social order.

In 1916, the Thirteenth Dalai Lama issued an edict (*rtsa tshig*) to implement a post-natal health-care programme based on the medical manual *On Childcare: Treasure of the Heart Benefiting Beings* (*Byis pa nyer spyod 'gro phan*

[13] Rogaski 2004, pp. 75, 2–3.
[14] Lal 1994, p. 47; Metcalf 1990.
[15] Shapin and Schaffer 1989, p. 80.
[16] Shapin and Schaffer 1989, p. 22; Latour 1993.
[17] Davin 1978, pp. 14, 26; Van Hollen 2003, pp. 36, 52.

snying nor, hereafter *Treasure of the Heart*), written the same year by his most senior personal physician Jampa Tupwang (?–1922).[18] The programme consisted of a series of eight compound medicines to be distributed to the family of every child newly born within the Lhasa Government's jurisdiction, along with advice for rituals and childcare during the first year of life and the requirement that a natal horoscope be calculated for each infant (see Table, below). The edict also required local officials to send payment on behalf of each newborn to the Mentsikhang, which had been placed under the directorship of Jampa Tupwang's student, Khyenrap Norbu (1883–1962). Khyenrap Norbu was the author of two other texts on childbirth (written between 1910 and 1916) and on children's illnesses (written in 1921), topics he considered part of 'founding a children's care tradition' (*byis pa nyer spyod kyi srol 'byed*).[19] While the Mentsikhang children's health-care programme echoed some of the assumptions of British mothercraft literature, its authors' unique goals are underscored by those assumptions it did not adopt. In particular, while the Tibetan programme observed physiological differences between boys and girls, it did not refer to intellectual differences. The Mentsikhang programme's architects did not appropriate the dual, pseudoscientific British discourse of female gender, memorably described by Barbara Metcalf as the 'medical view' attributing physical and intellectual handicaps to women, along with the 'pedestal view' positing their unique capacity for tenderness and virtue.[20] In fact, within the Mentsikhang programme literature we shall see that the category of

[18] TA-la'i sKu-phreng bCu-gsum-pa 1989 (this reprint of the original source errs in attributing the fire-dragon year edict to the fourteenth *rab byung* cycle or 1856); Byams-pa Thub-dbang 2001.

[19] mKhyen-rab Nor-bu 2001, p. 239. These texts, *Byis pa btsa' thabs kun phan zla ba'i me long* (on childbirth; see Hofer 2011a and 2011b) and *Byis pa'i nad rigs ma lus pa bcos pa'i nyams yig* (on treatments 'from experience' for children's illnesses, with prominent reference to several variations of *glo nad* (associated with tuberculosis) and other *rims nad* (contagious diseases), were not published in woodblock form until 1924, the same year the childcare programme was officially discontinued (mKhyen-rab Nor-bu 2001). Neither the edict nor Byams-pa 'Phrin-las mentions the implementation of these two texts in the official childcare campaign, so they are not treated extensively here. Historically, although the *Four Tantras* include chapters on *byis pa nyer spyod* and *byis pa'i nad gso ba*, there is no specific chapter on *btsa' thabs* (the topic of birth is treated marginally within subsequent chapters on 'women's illnesses' or *mo nad*). The category of *btsa' thabs* as a chapter heading seems to be found first in the *Bu don ma* attributed to Yutok the Younger in the twelfth century (the *nyams yig* references the *Bu ston ma* [sic] along with 'Jam-mgon Kong-sprul (1813–1899) as sources; mKhyen-rab Nor-bu 2001, pp. 223, 233). Among the major Tibetan medical works and their Indian source texts, these three topics seem to have only been combined previously within one (relatively late, seventeenth century) major medical commentary, the *Oral Instructions and Methods* (*Man ngag lhan thabs*) by Sangyé Gyatso. Their confluence again at this twentieth-century moment seems to parallel the British preoccupation with obstetrics, post-natal care and the prevention of (especially contagious) diseases.

[20] Metcalf 1990, p. 12.

gender is not as important as the category of class and that the participation of both parents is explicitly sought in the joint enterprise of social reform and nourishing future subjects of a Central Tibetan nation-state.

Medical and social reform under the Thirteenth Dalai Lama

The three men primarily responsible for the Mentsikhang and its children's health-care programme had all previously travelled abroad, giving them opportunity to observe the latest foreign medical techniques and regimes of public health, as well as to gain exposure to priorities of colonial medicine.[21] In addition, discourses of medicine and modernity had been carried to Central Tibet's frontiers since the late nineteenth century by Christian medical missionaries and into Central Tibet itself after the Younghusband incursion into Tibet in 1904 via the British medical clinic established at Gyantsé.[22] The engagement of the Mentsikhang and its childcare programme with such discourses demonstrates, on the one hand, the embeddedness of Tibetan actors within regional contemporary social and intellectual networks. On the other hand, these developments are equally tied to the trajectories of Tibet's indigenous medical traditions. In Central Tibet the Mentsikhang's medical and social reforms had already been unfolding for quite some time. The Dalai Lama and his personal physician had both been involved in earlier, separate initiatives.

The Lhasa Government may have first displayed awareness of medical missionary efforts targeting the rural poor in the Himalayan region in 1888, when the Demo Regent, Ngawang Lopzang Trinlé, 'observing that physicians of the

[21] Especially those connected to the Dufferin Fund (see note 10), which had initially launched from the summer headquarters of the Government of India in Simla, and possibly the Peking Union Medical College founded in 1906 ('Modern Hospital' 1921, p. 186). As we shall see, the travels of the Thirteenth Dalai Lama and Jampa Tupwang to Peking in 1908, and to India between 1911 and 1912, brought them into close proximity with these efforts. Although there is no direct evidence of their knowledge of the programmes, through the course of this article I hope to argue for the familiarity with efforts *such as*, and possibly including, these. It may also be significant to the germination of the idea for the Mentsikhang that the Thirteenth Dalai Lama spent time between 1904 and 1910 in Mongolia and Peking with his Mongolian Buddhist tutor and close confidante, the Russian envoy Agvan Dorjiev, who built a medical college himself at Atsgatsky Datsan in Buryatia in 1913—three years before the Mentsikhang (see Bolsokhoyeva 1999). I am indebted to a conversation with Martin Saxer for this observation.

[22] McKay 2005a, 2007. French missionaries had also entered the eastern Tibetan region of Khams in the late 1840s. In her memoir, the aristocratic lady Tsha-rong dByangs-can sGrol-dkar mentions seeking help from Dr. James Guthrie (who was then stationed in Lhasa) for a difficult childbirth, but this was not until 1948 (2006, pp. 243–4).

field of medicine were especially excellent for people of both high and low status and especially for the sick and destitute', called for reform at the medical monastery of Chakpori.[23] Lhasa had been home for two centuries to the first and only monastery in Tibetan history to be devoted primarily to the teachings of medicine, the 'Iron Mountain (Chakpori) Blue Beryl Benefiting Beings, Wondrous to Behold Sanctuary of Knowledge',[24] founded in 1696 by the regent Sangyé Gyatso ostensibly to fulfil the aspirations of the deceased 'Great Fifth' Dalai Lama. Chakpori graduates served as personal physicians for the dalai lamas and other important figures and also built new medical colleges in Tibetan Buddhist monasteries across Tibet, Mongolia and northern China.[25] Thus, Tibetan lama physicians had precedent to regard themselves as much exporters as importers of culture, and the Lhasa establishment would have been especially attuned to the implications of proselytising through medicine. If the government of the dalai lamas and its monastics relied on Buddhist expertise for prestige and patronage, grounding their power in knowledge rather than military resources, medicine was a key component of their diplomatic arsenal. The threat posed by Christian medical missionaries—especially those on the front lines of British military and economic imperialism to the south—was a threat not just to Tibetan technologies of medicine but also to Tibet's social and political order at large.

The Thirteenth Dalai Lama, who was prone to health problems, had likewise shown interest in medicine during this period of his minority.[26] In 1893, he reviewed 'with his own erudition' the new edition of the *Four Tantras*—considered the 'root' text of the literary Tibetan medical tradition—recently prepared at Chakpori under the sponsorship of Demo Rinpoche. Finding 'some errors of omission and commission', the young hierarch flexed his developing political muscles and ordered yet another new set of blocks prepared.[27] His efforts to reform and revitalise Tibetan medicine began in earnest in 1897, however, when he first appointed Jampa Tupwang as a new personal

---

[23] Thub-bstan Tshe-ring 1986, p. 173 (Translations of this work are my own except in cases noted, where they are taken from Gerl and Aschoff 2005).

[24] *lCags ri bai durya 'gro phan lta na ngo mtshar rig byed gling* (Gyatso and Kilty 2010, p. 481).

[25] Thub-bstan Tshe-ring 1986, pp. 158–9. Also see Meyer 1992, pp. 6–7. The nature and failure of the Demo Regent's late nineteenth century medical reforms, the institutional differences between Chakpori and the Mentsikhang, and the development of this network of Tibetan medical colleges between the seventeenth and early twentieth centuries are all topics that deserve further study and that I plan to revisit during the course of my forthcoming dissertation.

[26] Dr Kennedy believed the Thirteenth Dalai Lama had a weak heart (Bell 1987, p. 441), and he is also known to have survived smallpox (Lobsang Rapgey 1977, p. 26).

[27] Thub-bstan Tshe-ring 1986, p. 174, translation from Gerl and Aschoff 2005, p. 73.

physician under 'special circumstances'.[28] The physician was entrusted with supervision of Chakpori under 'emphatic instructions' to train students carefully in the teachings and practices from various places, who would become holders of a 'new lineage' that would develop and advance Tibetan medicine.[29] We know little about this early effort except that it met with mixed results, causing some discord among the students.[30] The timing, however—only two years after he assumed political power, and predating by seven years his first travels outside Tibet—makes the Thirteenth Dalai Lama's concern with medicine one of his first attempts at enacting reform in Tibetan society, motivated from his own assessment of his polity's needs.

After the British Younghusband expedition penetrated to Lhasa in 1904, the Thirteenth Dalai Lama spent an eight-year period travelling in exile to Amdo, Mongolia, Wutaishan, Peking and, later, when the tables turned and Qing troops descended upon Lhasa in 1910, to British India. He was also thinking about medicine during this time, writing a new monastic charter (*bca' yig*) for the medical college (*sman pa grwa tshang*) at Kumbum monastery in 1908, on his return trip to Tibet from Peking. His biography mentions as well that he spent time between 1910 and 1912 studying medicine while in India, presumably with his accompanying personal physician Jampa Tupwang.[31]

Lamen Jampa Tupwang came from outside the prevailing Lhasa medical establishment of Chakpori, having sought out private training in medicine (chiefly with a lama from the eastern Tibetan region of Kham), and before meeting the Dalai Lama he already had a reputation as a progressive.[32] In the

---

[28] Bya-sbug-pa Dam-chos dPal-ldan of Shel dkar chos sde monastery in western Tibet (*stod*), holder of the unique Bya-sbug-pa family lineage of medicine that was part of the *byang lugs*, was also appointed as junior personal physician (*bla sman pa*) and asked to teach Chakpori students, but he was not involved in founding the Mentsikhang. At the time Jampa Tupwang (Byams-pa Thub-dbang) was made senior personal physician, he was also promoted to the rank of *mkhan chung* (Byams-pa 'Phrin-las 1990, p. 415; Pa-sangs Yon-tan 1987, p. 147).

[29] Thub-bstan Tshe-ring 1986, p. 175, translated in Gerl and Aschoff 2005, p. 73; Byams-pa 'Phrin-las 1990, pp. 415 and 422.

[30] Between 1897 and 1904, Jampa Tupwang taught three batches of students at Chakpori, and seven of these students gained special renown, including Khyenrap Norbu, the heart-disciple with whom he founded the Mentsikhang and who became in his own right the progenitor of a great legacy of Tibetan medical teachings. Although Jampa Tupwang shared an aristocratic background with most of his students and was also a Gelukpa monk, some did not accept him as a teacher or his ideas for reform, and he is said to have expelled 30 among them. Jampa Tupwang is quoted as regretfully telling his fellow teacher Bya-sbug-pa Dam-chos dPal-ldan, 'Your students are respectable and disciplined. Mine, even though I teach them knowledge and wisdom, all fly the coop' (Byams-pa 'Phrin-las 1990, pp. 397 and 416–17).

[31] Thub-bstan Byams-pa Tshul-khrims bsTan-'dzin 1940, ff. 95a, 102a and 108a.

[32] Jampa Tupwang is said to have been first inspired to study the theory and practice of medicine by a local doctor who had cured him of a serious illness contracted during his time

1870s, while managing his aristocratic family's estate along with his brother (with whom he shared a wife), Jampa Tupwang implemented a socio-economic reform agenda among the estate's fieldworkers (*zhing bran*) with the goal of loaning grain in times of need and increasing agricultural production.[33] Unfortunately his brother opposed these measures, and when their relationship became acrimonious, Jampa Tupwang left to become a monk at Drepung monastery and eventually a monk official. It was during this time that he contracted a serious illness and after being cured by a local physician became motivated to study medicine.

Lamen Jampa Tupwang was one of the close retinue of personal attendants with whom the Thirteenth Dalai Lama interacted on a daily basis. During their time together in exile, the two shared many experiences, and Jampa Tupwang became a trusted confidant and major adviser for Tupten Gyatso.[34] The physician contributed to many issues of politics and, along with his sovereign, seems to have gained an appreciation for the importance of symbolism in asserting statehood: it was Jampa Tupwang who created the nationalistic design for the first Tibetan paper currency.[35] Upon their return to Lhasa, the Dalai Lama appointed his physician as Chikyap Khenpo ('Chief Abbot', *spyi khyab mkhan po*), the highest monk official and head of the monastic branch of government. Four years later, in this capacity, Jampa Tupwang submitted a proposal to the (lay) Revenue and Accounting Office for the creation of a new Institute of Medicine and Astrology in Lhasa.[36] His career

---

serving as the young governor (*dzong dpon*) of Lho brag. Later, after moving to Lhasa, he continued his studies with a Khams pa lama, whose name unfortunately remains unknown at present but who evidently was an exponent of the *zur lugs* tradition (Byams-pa 'Phrin-las 1990, p. 415; Thub-bstan Tshe-ring 1986, p. 174). Pa-sangs Yon-tan (1987) also notes he could not find the name of this teacher, but Rakdho Rinpoche Lobsang Tenzin believes he came from the Nyag rong area (personal communication, 2010). According to Dr Thrinlay Trogawa, oral tradition holds that Jampa Tupwang also briefly later sought training from a mendicant female healer in Lhasa, though her name and the nature of her teaching are unfortunately unknown (personal communication, 2010).

[33] bSod-chung 2004, p. 33; the author is a descendant of Jampa Tupwang.

[34] Charles Bell describes the 'court physician' as being ever-present at his sovereign's side, a perspicacious commentator and one of the only people with whom the Dalai Lama would 'admit a lack of knowledge or a lack of power' (Bell 1987, p. 217).

[35] The currency, created in either 1911 or 1913, bore the inscription 'Ganden Podrang Choklé Namgyel' along with the images of a snow mountain and a snow lion (Shakabpa 2010, p. 763). Shakabpa also records Jampa Tupwang as being involved in sensitive diplomacy with the Jebtsundamba Qutughtu in Khalkha, as well as correspondence with the British Trade Agent at Gyantsé regarding the eventual surrender of the Qing troops (Shakabpa 2010, pp. 687 and 745).

[36] Byams-pa 'Phrin-las 1990, p. 417, and undated, p. 1; Tenzin Choedrak 1998, p. 58. The *Shod skor rtsis khang* granted the Mentsikhang the same site that the British had requested for an

defies the stereotype that monks and aristocratic regional officials exemplified conservatism in Lhasa society and acted as reactionary forces to social change.

Competing frameworks for 'definitive methods of analysis'

Tibetan and British accounts make equal and opposing claims regarding the skill and fame won by their physicians during early twentieth-century encounters, revealing palpable competition. Lamen Jampa Tupwang is supposed to have gained renown for his medical skills during his four-month stay in Peking in 1908. His student, Khyenrap Norbu, during his first trip outside Tibet as the accompanying physician for the Tibetan delegation to the 1913–14 Simla Convention, is also supposed to have overcome a potential 'great loss of face' (his initial ill-health in India was covered in the foreign press in disparaging tones emphasising its seriousness) to eventually impress his hosts.[37] Not only did Khyenrap Norbu demonstrate the efficacy of Tibetan medicine, treating foreigners so successfully for illnesses considered difficult to cure, that he was offered much praise and many gifts and 'the authorities had to deploy police guards at his place in Simla [to control the crowds]', but also he is said to have taught his medicine's theoretical underpinnings.[38] 'When foreign doctors, especially British, questioned him on the relationship between the body and the mind with regard to cardiac afflictions', a student wrote, Khyenrap Norbu 'provided extensive detail, as much on the causes as on the symptoms, and the psychic consequences related to these pathologies. His visit was a triumph.'[39]

Tibetan historical accounts never mention their physicians observing foreign medicine, just as British accounts also emphasise the reception of their own medical system over observations of Tibetan medical practice.[40] Robert Siggins Kennedy, the surgeon accompanying Sikkim Political Officer, Charles

English language school in Lhasa, a project stymied by political backlash. This land included an old building on the west side of bsTan rgyas gling monastery, which had been razed to the ground in retaliation after its monks had given quarter to Chinese troops during their invasion of 1910–12 (Goldstein 1989, pp. 63, 109). By associating this site with a medical institution, perhaps the Lhasa government was also trying to heal local political divisions.

[37] Byams-pa Thub-dbang 1990, p. 417; Shan-kha-ba, quoted in Tashi Tsering 2010, pp. 5–6.

[38] Shan-kha-ba quoted in Tashi Tsering 2010, p. 6. See also Byams-pa 'Phrin-las 1990, p. 424.

[39] Tenzin Choedrak 1998, p. 58.

[40] Khyenrap Norbu is said to have been featured in a number of photographs and newspapers while in India, but I have not yet been able to locate any of these. Neither have I come across any Tibetan record of either Lamen Jampa Tupwang or Khyenrap Norbu studying foreign medicine in depth before or after founding the Mentsikhang. As previously mentioned, the Thirteenth Dalai Lama studied medicine during his time in India, probably under the guidance of Jampa Tupwang, but there is no indication that this study incorporated anything but Tibetan texts.

Bell, on the first official British mission to Lhasa in 1920–1 (after the Mentsikhang's founding), recorded that his dispensary there received great numbers of patients and also that he demonstrated surgery and vaccination techniques for Khyenrap Norbu at the latter's request. The 'Men-tsiba Lama', Kennedy wrote, 'displayed great interest' and 'asked very pertinent questions and made copious notes'.[41] Yet while Bell knew Jampa Tupwang well in India, and both he and Kennedy later interacted with Khyenrap Norbu and visited Chakpori during their time in Lhasa, neither seemed aware of the Mentsikhang nor publicly equated its physicians and their curiosity with actual or potential projects of medical reform.[42] Bell allowed only that 'Tibetans have indeed their own doctors, many of whom hold among them a high reputation as physicians, though not as surgeons, for of surgery they are almost entirely ignorant.'[43] Literally and figuratively, surgery and the treatment of wounds stood on the front lines of the confrontation between the British and Tibetan systems of medicine.

As Khyenrap Norbu's experience in Simla indicates, not only was Buddhist epistemological order at stake, so was the social order that rested on it. While the British believed that antiseptic breakthroughs demonstrated the general superiority of their medical theory and practice, Khyenrap Norbu argued that the Tibetan tradition encompassed techniques of surgery and vaccination, 'beneficial methods from before' which were simply 'decreasing in use'.[44] The Mentsikhang director advised his students to strive (as he had himself) to learn about 'all methods of healing without ignorance' and to appreciate 'all the qualities and essences of medicine, examination and the tools of examination'.[45] Not only were new versions of these methods 'wonderful to

---

[41] Kennedy quoted in McKay 2007, pp. 134, 156.

[42] Bell claimed great friendship with both the Thirteenth Dalai Lama and his 'court physician', dating from their exile in British India. He refers to Jampa Tupwang also as the 'All-Covering Abbot' or 'Lord Chamberlain' and records him as being pro-British and pro-Russian (Bell 1987, p. 144). Although Bell's influence on the state-building reforms instituted soon after the Dalai Lama's return to Lhasa are well known, the British officer does not seem to count the Mentsikhang among these reforms. Alex McKay has remarked in personal communication (2009) that there is no mention of the idea for the Mentsikhang in Bell's papers, adding that it would be most unlike him not to accept credit where credit was due. A perusal of Kennedy's personal photo album from Lhasa, preserved at the Alkazi Foundation in Delhi, revealed photos of medical paintings from Chakpori but no photos of Tibetan physicians, their methods or the Mentsikhang. My thanks to the Alkazi Foundation and Akshaya Tankha for granting access to this collection.

[43] Bell 1992, p. 267.

[44] Byams-pa 'Phrin-las 1990, p. 430.

[45] Byams-pa 'Phrin-las 1990, p. 429. As McKay has written (2005b), smallpox vaccination seems to be one area in which the Tibetan Government displayed early interest in biomedicine. I have recently seen evidence that Khyenrap Norbu accepted serum from the British as early as

see', he wrote, they are not incompatible with the Buddhist theoretical and humoral basis of Tibetan medicine, or threatening to its integrity:

> The three roots of illness, *rlung* (wind), *mkhris pa* (bile) and *bad kan* (phlegm), are not only the cause of internal illnesses but also may cause about 400 times as many illnesses attributed to proximal external conditions, such as wounds, skin diseases, broken bones, tumours and swelling. Moreover, do not be confused by all the types of illnesses, their identification, and methods of healing them. Those who train as experts in the definitive methods of analysis, by means of their understanding in accordance with the system of the Great Country [Tibet], are like the real Medicine Buddha clearing away illness and suffering.[46]

Khyenrap Norbu thus regards techniques of surgery as applicable only to the category of 'external conditions' and argues that Tibetan physicians completely versed in the physiology and aetiology of disease according to their own tradition will be able to analyse, explain and treat (or identify new treatments for) a wide range of familiar and unfamiliar forms of suffering.

A similar faith in the flexibility of Tibetan Buddhist medical theory and techniques, along with openness to new methods and applications, underlies Lamen Jampa Tupwang's childcare text. It is immediately evident from the structure, language and references of *Treasure of the Heart* that Tibet's own textual and institutional traditions of medicine form its single greatest epistemological basis.[47] Presented as a commentary on the childcare (*byis pa nyer spyod*) chapter from the *Four Tantras, Treasure of the Heart* in fact draws most directly from the *Bai DUr+ya sngon po* (from now on referred to as *Blue Beryl*) and the *Man ngag lhan thabs* (from now on called *Oral Instructions and*

1914-1916, with the intent of vaccinating Lhasa officials and Drepung monks. He did not actually use this first batch however, writing back to David Macdonald, the British trade agent at Yatung, in a letter of receipt that it had spoilt in transit and more was needed (British Library Asia Pacific and Africa Collection, IOR Mss. F80/173, 1938; thanks to Tashi Tsering Josayma for sharing a copy of this letter with me). Between the 1920s and 1950 the Tibetan Government gradually accepted and supported more widespread vaccination efforts by the British, and between 1920–1 Khyenrap Norbu learned vaccination techniques from Dr Kennedy in Lhasa, as noted above (McKay 2005b, 2007).

[46] mKhyen-rab Nor-bu in Byams-pa 'Phrin-las 1990, pp. 429–30. These 'oral instructions' were given in 1952. Not only had Khyenrap Norbu probably been thinking through this topic since seeking foreign training in surgery himself 30 years earlier, but since the mid-1940s he had also been training students in the practice of cataract surgery according to traditional Tibetan methods (Lobsang Wangyal 2007; Hofer 2011c).

[47] Through the medicalisation of childbirth, British mothercraft programmes promised women reduction of pain through anaesthesia and reduction of maternal and infant mortality through antiseptic procedures. While *Treasure of the Heart* and Khyenrap Norbu's two texts on childbirth and children's illnesses echo similar concerns, there is no evidence that the Mentsikhang used or encouraged anesthesia or antiseptics within Tibet (McKay personal communication 2010; Tashi Yangphel Tashigang interview 2010).

Methods), two influential later commentaries by Desi Sangyé Gyatso.[48] However, the nature of Jampa Tupwang's editorial scholarship is quite different from that of the Chakpori founder. While the earlier scholar strove to expand and complete the *Four Tantras*' cryptic verses with his own more extravagant prose and to show his textual erudition by referencing Sanskrit sources, *Treasure of the Heart* displays brevity and organisational rigour.[49] Its 19 chapters are clearly marked, and its eight numbered prescriptions are said to correspond to labels on the medicines being distributed. It was clearly designed for practical use and aiding memory, resembling a doctor's handbook or even the health-care pamphlets being popularly distributed in India.[50]

In general, *Treasure of the Heart* is notable for preserving the social and ritual practices of the root texts, creating continuity between the (Central)

---

[48] *Byis pa nyer spyod* is the seventy-first chapter of the *Man ngag rgyud*, third of the *Four Tantras*. Though Jampa Tupwang does not acknowledge the debt, a close comparison shows that the main body of his text is based almost exclusively and often verbatim on the two seventeenth-century works. *Treasure of the Heart* replicates language and explication from the *Blue Beryl*, but structurally it resembles the *Oral Instructions and Methods* more closely. The latter text, like *Treasure of the Heart*, is subdivided into a series of 19 chapters (more divisions than either *Blue Beryl* or the *Four Tantras*). Jampa Tupwang also references compound medicines found in *Oral Instructions and Methods* that are not in the *Blue Beryl*. Despite the difficulty of identifying medicines in *Treasure of the Heart* conclusively, because the full recipes are not given, it is clear that the later author based his compounds on these earlier texts. Each of the few ingredients mentioned, along with Jampa Tupwang's explanations of the medicines' benefits, correspond to a compound from the *Blue Beryl* and/or *Oral Instructions and Methods*. Whether Jampa Tupwang made any changes or innovations is unknown, apart from small instances such as when he recommends mixing a medicine with sugar instead of honey (Byams-pa Thub-dbang 2001; Sangs-rgyas rGya-mtsho 1992, 2005; Tashigangpa 1978).

[49] See Schaeffer 2003 and Gyatso 2004 on Sangyé Gyatso's medical writings and their relation to the medical debates of his time. Jampa Tupwang cuts out details that Sangyé Gyatso had added to his commentaries on the *Four Tantras*, particularly explanations of rituals and the auspicious verses to recite for the child. The topic of *byis pa nyer spyod* (Sanskrit: *balopacaraniya*) is also found as a chapter within two Sanskrit texts that served as sources for the *Four Tantras*, the seventh-century *Aṣṭāṅgahṛdayasaṃhitā* by Vāgbhaṭa and its tenth-century commentary *Padārthacandrikāprabhāsa* by Candrānanda. These texts are both included in the *bstan 'gyur*, the canonical Tibetan-language collection of Buddhist commentaries. Another Tibetan medical classic of early but curious origin, the *sMan dpyad zla ba'i rgyal po*, does not include any chapters on women's illnesses (*mo nad*), children's illnesses (*byis pa'i nad* and *byis pa'i gdon nad*) or child-care (*byis pa nyer spyod*). The Bönpo *gSo rig 'bum gzhi* shows many similarities to the Indic texts and the *Four Tantras* within the *byis pa nyer spyod* chapter, but its date of origin is debated. Although *byis pa nyer spyod* subsequently appears in many general Tibetan commentaries on the *Four Tantras*, Jampa Tupwang's text seems to be the first to deal exclusively with the subject (Sangs-rgyas rGya-mtsho 2005; Ma-hA-yA-na 2006; dPyad-bu Khrid-shes 2005).

[50] Although I have not seen the original *pecha* format of this text, the Mentsikhang did publish some works, including a blockprint of the previously mentioned childbirth (*btsa' thabs*) text, in small format for easy portability (Hofer 2011a and 2011b).

Tibetan society to which the Dalai Lama and his head physician addressed themselves and some of the earliest recorded social practices of Tibetan Buddhist history and Indian precedents.[51] Jampa Tupwang's few additions and annotations take on greater significance within the tightened framework of the text, however, which is otherwise copied largely verbatim and unattributed from its earlier sources (see Table).

Jampa Tupwang's subtle but repeated references to cleanliness, purity and even vulnerability to contagion indicate a concern that runs closely parallel to, while never directly referencing, the central topic of British and colonial medical practice at the time, namely germ theory and related discourses of hygiene.[52] In particular, as discussed further below, the specific materiality of his references to purity (the pure cloth for the infant's mouth in Chapter 5, the clean bowl and purified butter for easy digestion in Chapter 16) is markedly different from the general, gendered concern with birth as a 'contaminated' act prevalent in Tibetan and South Asian cultures.[53] By far the clearest departure of *Treasure of the Heart* and the Thirteenth Dalai Lama's edict from principal earlier versions of *byis pa nyer spyod*, however, is also the one least associated with early twentieth-century medical developments, namely, a greater emphasis on astrological calculation.[54] The intent of these astrological additions will also be discussed below.

By their British contemporaries' standards, the Tibetan physicians, never fully trained within the British system, could not be recognised as true peers. Lamen Jampa Tupwang and Khyenrap Norbu, meanwhile, implicitly critiqued

---

[51] In addition to the childcare edict, the Thirteenth Dalai Lama also wrote the closing verses or *par byang smon tshig* for *Treasure of the Heart.*

[52] Nevertheless even the ancient content of *byis pa nyer spyod* dovetails in significant ways with the content of mothercraft literature. The concept of guarding the child from contagious diseases (*'go nad*) is extant in both the *Four Tantras* and Sangyé Gyatso's chapters on childcare. And like British texts, which focused primarily on pneumonia and stomach ailments as causes of infant mortality, the Tibetan texts emphasized dangers related to weather and nutrition.

[53] In Chapter 5, Jampa Tupwang suggests gently wiping out the amniotic fluid from the child's mouth with a dampened 'pure' (or 'white') cloth (*ras dkar*) just after birth, whereas Sangyé Gyatso had instead described using the right-hand index finger for this purpose. In Chapter 16, describing a broth that can be made as the child's first soft food at the sixth or seventh month, Jampa Tupwang adds a warning for parents to use a clean bowl and to melt the butter for the broth without burning in order to remove impurities and to ensure it can be digested in the infant's stomach. See Yuthok for a discussion of the concept of birth contamination among Tibetans and description of a purification ceremony (1995, p. 174).

[54] In Chapters 2, 6 and 17 respectively, Jampa Tupwang instructs parents 'in accordance with [the family's] financial circumstances' to note the date and time of childbirth for calculation of a natal horoscope, to consult a local astrologer regarding a suitable nursemaid, and (as mentioned above) to conduct a ceremony for the child's first outing on an astrologically auspicious day.

Table: Chapter outline of Jampa Tupwang's *On Childcare: Treasure of the Heart Benefiting Beings* (*Byis pa nyer spyod 'gro phan snying nor*)

Note: aspects that do not occur in either the *Blue Beryl* or the *Oral Instructions and Methods* by Desi Sangyé Gyatso are indicated in italics.

1.	Auspicious signs of a normal birth.
2.	Inauspicious or 'opposite' signs *and noting down the exact timing and details of birth for astrological calculation.*
3.	Verses to say just after birth (see epigraph).
4.	Cutting the umbilical cord, tying it off with a woollen thread and cleansing the child's body with medicine no. 1 in warm water.
5.	Cleaning out *phlegm from* the child's mouth *using a dampened, pure cloth*, applying a 'stamp' of the syllable 'hrIH' on the child's tongue using medicine no. 2 as the 'ink', then giving the child medicine no. 2 as a mixture with butter and *sugar.*
6.	Giving mother's milk for the first time. If there is no mother's milk, instructions for finding a nursemaid, including her appropriateness according to the fit of her and the child's birth years (*gives examples of harmonious astrological signs*).
7.	Methods for putting the child to sleep with the head facing the auspicious directions of north and/or east, giving up sleep for two days to watch and guard over the child, draping a warm oilcloth over the head as a hood, and giving medicine no. 3 as a topical ointment for the navel.
8.	After three days, an offering ceremony *to whatever birth deities have been recognised, in accordance with the family's economic conditions.*
9.	Other rituals including first raising victory banners on the roof and secondarily the 'life-arrow' ritual, monthly offerings, ransom rites, etc.
10.	Naming the child by consensus.
11–12.	Two days after birth in the morning, in order to engage the intellect marvellously and develop vigour and agility, administer medicine no. 4 mixed with honey, rock sugar and treacle.

Table (*cont.*)

13. On the morning of the third day, administer medicine no. 5 *combined with treacle, honey and butter*. If the child is a boy, also mix with father's urine; if a girl, mix with mother's urine. This preparation encourages long life, strength and a stable personality. The child will become invisible to ghosts and demons, *and they will obey their father and mother.*
14. Wear medicine no. 6 at the neck as a protective amulet pill, wrapped in cloth of a colour concordant with the child's elemental constitution.
15. After seven or eight months, pierce the child's ear(s), first massaging the ear flaps with thumbs (boys first from right, girls first from left) in order to open them up.
16. To eat, butter with sugar or honey *should be made as a sweet clarified broth in a clean bowl, as unpurified butter cannot be digested by their stomachs*, sometimes with small pieces of meat. Also, at the end of each week, administer a little of the preparation of medicine no. 7 mixed with boiled goat's milk, for wisdom and intelligence, good memory and expressiveness, and a pleasant voice to develop. Rely on the sweet medicinal butters from this section, which not only are life-extending but also demon-suppressing, *in proportion to the family's economic circumstances.*
17. Behaviours [to follow] *after one month* include *performing the 'child festival' and healing rituals in preparation for the child's first visit outside*;[55] keeping the child from being burned by the sun and out of the cold; keeping it from being upright too early and protecting against fire, predators, infectious diseases and from fear. If sometimes massaged or warmed an appropriate amount in the sunshine, the [child's] bodily constituents will 'unfold'.
18. Administer medicine no. 8 mixed with honey when the child's first teeth begin to come in, for 'quick growth' and 'disease/pain prevention'. If the child is born with teeth, make burnt offerings for the 'demon of children with six faces', etc.
19. When the child reaches one year, release the 'life-arrow' and make thanksgiving offerings to the gods with an auspicious feast *according to one's economy.*

[55] The wording here is 'opening the gate' (*sgo 'don*), Gendun Jamyang Gyatso of the Mentsee-khang explained this as being for the child's first outing (personal communication 2010). Yuthok also describes following such a custom, but after two months, following her first child's birth in 1933 (1995, p. 175).

the exclusive truth-claims of colonial medicine by proceeding according to their own 'definitive methods of analysis' for determining what techniques of childcare should be effective and important. Under their leadership, the Mentsikhang and its childcare programme were positioned not only as less threatening instances of reform than the Thirteenth Dalai Lama's more military-industrial projects but also as part of the social and epistemological framework for cultivating a competitive national body.

Cultivating health, strength and a civil society

The Thirteenth Dalai Lama's edict described in detail how the Mentsikhang's childcare programme should be put into practice with the help of the monastic community, local officials and parents of both high and low classes. Implementation of the childcare programme, he wrote, will be like 'the development of a new custom' and not only should everyone practise it, they should do so while cultivating as much as possible 'a sense of social responsibility' (*spyi tshogs 'khur bsam*).[56] At this historical moment the concept of a Tibetan nation had not yet been distinctly articulated, but through the children's public health-care programme the Dalai Lama formulated an aspiration for social changes with clear implications for building a sense of national identity.[57] To inculcate a sense of social responsibility amongst his subjects, he assigned a unique task in the implementation of the programme to each level and sector of Tibetan society.

---

[56] TA-la'i sKu-phreng bCu-gsum-pa 1989, p. 167.

[57] Although the childcare programme documents do not use a fixed word for 'nation', the concept does begin to emerge, particularly through use of the terms *mi rigs* and *bod khongs mi rigs* for 'the people' or 'the Tibetan people'. Here these terms expressly designate the people 'of the districts and estates' of 'the government, mandated by heaven, of all the beings, in general and in particular, of the land completely encircled by pure snow mountains' (TA-la'i sKu-phreng bCu-gsum-pa 1989, p. 164). The Thirteenth Dalai Lama also uses the common metaphor 'sprout of the family' or 'sprout of the people' (*rigs myug*) for the children who are the beneficiaries of the post-natal programme (Ibid., p. 165), evoking a concept of lineage descent in addition to territoriality that is characteristic of PRC-era usage of the term *mi rigs* to evoke ideas of race, ethnicity, and (minority) nationality (see Tuttle 2005, pp. 144, 277 ft. 57). Finally, it is striking that whereas Sangyé Gyatso, whom Jampa Tupwang otherwise largely quotes verbatim, uses the term *mi rgya* to refer to lay people and distinguishes them vis-à-vis *ban bon* (referring to clerics, Buddhist and Bönpo), the later author instead uses *mi rigs* and focuses his attention on class rather than lay-clerical distinction as the major social grouping. Jampa Tupwang also refers to the Tibetan people in general as 'everyone, high and low' (*mchog dman mtha' dag* or *mchog dman tshang ma*) and as the 'common people' (*phal pa'i skye bo* or *mi rigs phal cher*).

The childcare programme consisted of three main elements: (1) the distribution of medicines; (2) the calculation of natal horoscopes and (3) the collection of a fixed-sum payment, all of which was to be accomplished 'without difference' and with clear record-keeping for each child under the jurisdiction of the Ganden Podrang Government.[58] The edict called for the eight types of compound-medicine pills (*ril bu*) made under Lamen Jampa Tupwang's direction, as well as a stamp of the syllable *hrIH* and the text of *Treasure of the Heart*, to be dispatched by the Mentsikhang to the '96 districts and estates'.[59] There the medicines should be dispensed by each local official (*do dam*) to 'pregnant women about to give birth' and administered to infants 'without mistake or confusion'.[60] Soon after birth, the syllable *hrIH* should be stamped using medicine no. 2 as the 'ink' on each infant's tongue, 'creating auspicious connections [for the child] to have the fortunate powers of buddha-speech, wise speech, and the ability to speak'.[61] In addition, the Dalai Lama commands, 'from this day forth' the year, month, planet and time of birth should be ascertained truthfully for children 'from each level', and natal horoscopes should be calculated for each child born within the jurisdiction of the Ganden Podrang Government, 'earnestly, in detail [and] in accordance with [each] one's economic conditions'.[62] A register of these calculations should be made, with one copy of the results sent to Lhasa and one copy stored by the local official 'without mistake'. Families without an astrologer or those poor parents unable to send the calculations to the local government should instead send the child's birth date and time, etc., to the Mentsikhang, which will return the 'calculations of fortune and misfortune'.[63]

Most strikingly, the decree states that the local officials of each district or estate should distribute the medicinal materials 'regardless of [people's financial] circumstances, happy or miserable, fortunate or unfortunate', and, further, that those families with good economic conditions should supply the fees for medicines on behalf of those who cannot afford them.[64] It is absolutely not permissible, the Dalai Lama adds, to transmit to the poorer people any direct or indirect 'brutal fee that causes [financial] shock'. The price for the materials is fixed at 2 *srang* and 4 *zho* per child 'without difference', and

---

[58] TA-la'i sKu-phreng bCu-gsum-pa 1989, p. 166.

[59] Byams-pa 'Phrin-las 1990, p. 418; bSod-chung 2004, p. 35. See footnote 4 regarding the number of districts and estates.

[60] TA-la'i sKu-phreng bCu-gsum-pa 1989, p. 165.

[61] The sacred syllable *hrIH* is associated with Avalokiteshvara, bodhisattva of compassion, of whom the dalai lamas are considered to be incarnations. Byams-pa Thub-dbang 2001, p. 243.

[62] TA-la'i sKu-phreng bCu-gsum-pa 1989, p. 167.

[63] Ibid.

[64] TA-la'i sKu-phreng bCu-gsum-pa 1989, p. 166.

payments on behalf of each newborn should also be kept in a register.[65] This 'clear and truthful' register, marked with each official's authentic seal, should be sent along with the monetary offering to Lhasa every six months.

In its implementation, then, the new childcare 'custom' calls for increased efficiency in the Central Tibetan bureaucracy, instituting procedural regulations according to high standards of accounting and accountability, as well as for a major expansion of its scope. It is important to note that this edict was published four years before the Thirteenth Dalai Lama's reform of the tax system and creation of the Revenue Investigation Office, which was designed to find new ways of generating government income in order to meet the need for providing new services, particularly army maintenance and communications.[66] The childcare programme, which was hoped to be at least financially self-supporting (if not revenue-generating), was an early, important and perhaps more judicious priority.

It is unclear whether the fees collected in conjunction with childcare were to be applied to government expenses other than the maintenance of the Mentsikhang and the cost of the medicines for the programme itself, but there were other clear goals for the state in implementing the programme. First, enumeration—here, through the collection of a register of names and birth data on each child born under the Lhasa Government's jurisdiction—was the first step of population management according to the powerful new British colonial model and furthermore would have provided written recognition of the Lhasa Government's legitimate, direct rule over these households from every social strata. Significantly, this new technique of reckoning the *size* of the (children's) population by register was connected in the Tibetan programme to the indigenous technique of reckoning the *type and qualities* of those making up the population by astrological calculation, a dimension which will be discussed further below.

Second, the Thirteenth Dalai Lama envisioned ruling his subjects via a more direct, regulated and unified bureaucracy. In the edict, when he charges local officials with serving as intermediaries between the Mentsikhang and

---

[65] Ibid. Assuming the measurements remained constant from the seventeenth century, 10 silver *zho* (one-tenth of an ounce) were equal to 1 silver *srang* (1 ounce) (Ahmad 1970, p. 183 n. 54). Byams-pa 'Phrin-las records that one *Tam dkar* (or *srang*) along with a white ceremonial scarf (*kha btags*) were given as the fee for the medicines (*sman yon*), while 3 *zho* were given for calculation of the natal horoscope (*rtsis yon*) (undated, pp. 4–5). Since his figures do not match those in the edict, it is possible that later the fees were reduced; regardless, it is likely that the relative costs broke down close to these proportions.

[66] Goldstein 1989, p. 87.

local households, he refers not only to the 'real officials living in each district' but also to any assisting officials serving by appointment.[67] Often the district governor, serving by inherited right to appointment as a member of an aristocratic family, would appoint a proxy administrator to stay in the rural province while the governor himself resided in urban Lhasa. The Dalai Lama writes that assisting officials, both monastic and lay, have been appointed by the Central Government according to analysis of the needs of each locality. This situation obviously caused some friction at the local levels, as the hierarch felt the need to command that the regional officials, estate owners and assisting officials disseminate the work of medicine and astrology as much as possible to every place connected with the local government authorities 'regardless of whether there is unanimity [*gcig gyur*] or not within the district', in order to make all the localities 'appropriately in accordance [with each other; *mthun 'gyur*]'.[68]

Third, there was the matter of requiring families from good financial circumstances to cover the medical fees of children from less well off families. The Thirteenth Dalai Lama has been characterised as a reluctant and autocratic progressive, restructuring taxes at a late date mainly in order to implement economic and military reforms that would consolidate his own power.[69] Through his childcare edict not only do we see an earlier example of attempted economic reform tied to the provision of direct social services to the entire population, the ruler himself made it clear that he recognised his own limited capacity to enforce these structural changes without wider civic participation. He exhorted 'those with good economic conditions' to shoulder the cost of the programme for their less fortunate fellow subjects 'out of a devoted mind (*dad 'dun blos*)'.[70] Perhaps inspired by witnessing British aristocracy in India partner with the monarchical government and its officials to organise various social programmes through 'voluntary associations' (from women's medical funds to the Society for the Prevention of Cruelty to Animals), the Thirteenth Dalai Lama here encouraged a similar sort of voluntary progressivism in Central Tibet.[71]

This last motivation should be kept in mind when evaluating the Mentsikhang childcare programme's immediate and long-term impact—a

---

[67] TA-la'i sKu-phreng bCu-gsum-pa 1989, p. 166.
[68] TA-la'i sKu-phreng bCu-gsum-pa 1989, p. 167.
[69] Goldstein 1989, pp. 66, 85–7.
[70] TA-la'i sKu-phreng bCu-gsum-pa 1989, p. 166.
[71] Bell 1987, p. 121. Bell mentions the Thirteenth Dalai Lama being 'impressed' by the SPCA.

task made difficult because of the lack of related sources. According to Jampa Trinlé, although the programme had demonstrated 'clear accomplishments', after Lamen Jampa Tupwang's death in 1922 the provision of children's medicines and calculation of natal horoscopes gradually deteriorated, and two years later the initiative was officially discontinued.[72] Tax reforms had been instituted in 1920–1, and officials of the districts and estates began to complain about the childcare programme's fees 'behind the back' of the Dalai Lama, 'on the pretext' of the financial hardship caused for peasants.[73] The turbulent political times also undoubtedly contributed to the childcare programme's demotion as an official priority.[74]

Documentation of the childcare programme's early years is especially thin.[75] Within Khyenrap Norbu's two related texts on childbirth and children's illnesses published in 1924, however, there are references to the medicines sent out in conjunction with the *byis pa nyer spyod* programme, as well as five childbirth prescriptions (for pain, for inducing a difficult birth and to stem excessive bleeding) numbered in the same manner as in *Treasure of the Heart*, indicating that they could have also been made available for sale around this time.[76] Khyenrap Norbu writes that as early as 1910–1916, when he was serving as a physician (*sman sbyin pa*) at Drepung, Lady Namgyel Drolkar of Shelkar Ling consulted him for help with her first delivery, of twins, thus providing impetus for his research on the childbirth text.[77] Hofer has found evidence, furthermore, that this childbirth text circulated in both printed and manuscript form as far as Ngamring (near Shigatsé).[78]

---

[72] Byams-pa 'Phrin-las undated, p. 12.

[73] Byams-pa 'Phrin-las undated, p. 12. The edict had specifically stated, of course, that the fees should not be passed on to this group.

[74] Goldstein states that the Thirteenth Dalai Lama retreated from his reform programme after dismissing Tsarong Shape as Commander-in-Chief of the army in 1925 (1989, p. 138). The childcare programme's troubles do not seem directly related to the tension between the Dalai Lama and the reform-oriented clique of military elites or his suspicion of British involvement. But the ruler's attention was clearly divided and his ability to enforce the fledgling health policy initiative compromised by the general political and economic turmoil.

[75] In a 2010 interview, Dr Tashi Yangphel Tashigang, a student of Khyenrap Norbu during the 1940s, confirmed early efforts to implement the programme but said that these had probably not lasted long.

[76] mKhyen-rab Nor-bu 2001, pp. 233–9, Hofer 2011a and 2011b. However, Yuthok says that 'Tibetan doctors' had no medicine for relieving mothers' morning sickness or labour pains at the time of her delivery in 1933. With difficulty, she was able to find 'a special dried fish from the Mapham Lake' in Western Tibet for speeding delivery (1995, pp. 171–3).

[77] mKhyen-rab Nor-bu 2001, p. 239.

[78] Hofer 2011a, p. 75, and 2011b.

The most detailed account of the programme by one of its beneficiaries may be found in the memoir of Lady Dorjé Yudon from the noble Yuthok family of Lhasa. Describing her first delivery in 1933, she mentions both the text *Treasure of the Heart* and requesting its medicines from the Mentsikhang, along with a 'small wooden plate' with the stamp of the syllable *hrIH*, which her husband applied to their daughter's tongue.[79] She also corroborates that these medicines 'would be sent to all the ninety-six Dzongs or districts of Tibet; however, in Lhasa we were able to request them whenever the need arose'.[80] Even at this late date, then, the Mentsikhang continued to make the childcare materials available, though the programme's implementation was no longer said to be mandatory.[81] How many mothers and infants, particularly the non-elite and those outside Lhasa, benefitted over time from the programme nevertheless remains an open question.

Between 1924 and 1950, the Mentsikhang received only irregular continued support from the Lhasa Government. However, the entrepreneurial Khyenrap Norbu did succeed in finding benefactors among the merchant class who financed him to conduct trade across the Indian border in sheep's wool for medicines.[82] Along with the sale of calendars, this trade allowed the Mentsikhang to continue its work, including ongoing efforts to train students from many areas and to provide health care and astrology to all sectors of society. In this way, the Mentsikhang began to constitute exactly the sort of voluntary and 'productive' enterprise for communal benefit that the Thirteenth Dalai Lama had encouraged in his childcare edict. It is clear that the childcare programme's implementation never reached the systematic extent envisioned by the Thirteenth Dalai Lama. But the programme certainly contributed to the Lhasa Mentsikhang's early development, and to its lasting legacy as a powerful institutional model for reconfiguring ideas of society and social responsibility in Tibet.

---

[79] Yuthok 1995, pp. 172–3. This reference is cited in McKay 2007, pp. 168, 274 n. 112. Lady Yuthok also requested medicines from the Mentsikhang for later illnesses of her first and second children (1995, pp. 176, 183).

[80] Ibid., pp. 172–3.

[81] Yuthok says that her family 'regularly' provided their own house's servants with medicines, but she does not mention the children's medicines specifically in this regard or mention providing them to the family's tenants on their other properties (Ibid., p. 161).

[82] Byams-pa 'Phrin-las undated, pp. 6, 14.

Childcare and monastic reform

In addition to encouraging the Central Tibetan aristocracy to support those less fortunate for the development of the country, the childcare programme also included a significant undertone of monastic reform. While local officials were associated with the largely lay administrative branch of the government, the Mentsikhang was predominantly monastic in character. Mentsikhang students, who carried out the time-consuming labour of compounding medicines and calculating natal horoscopes, relegating their own studies to the evenings, were almost all young monks sent under obligation from Central Tibetan monasteries.[83] A concerted effort was made to enlist recruits from rural areas not represented at the largely aristocratic and Lhasa-centric Chakpori, and some students came from the lower classes.[84] The students' home monasteries were also required to contribute to the cost of their representatives' Mentsikhang education.[85] Director Khyenrap Norbu himself was well known for having risen from humble origins; at the time he was appointed to the dual directorship of the Mentsikhang and Chakpori he was also invested as a monk official of the fifth rank (*rtse drung las tshan pa*).[86] This title indicates as well that he was part of the Yiktsang Lekhung administration, that is, the central government office with authority over monk officials and all monastic affairs, which was independent of the lay administration and at that time under the leadership of Jampa Tupwang, as 'Chief Abbott'. According to former Mentsikhang student and director Jampa Trinlé, it was the Yiktsang Lekhung that undertook bureaucratic management of the childcare programme, processing the records and payments sent from the regional administrative

[83] Byams-pa 'Phrin-las undated, p. 5. Yuthok also mentions that the childcare medicines were made twice a year, and that Khyenrap Norbu 'together with fifty of his pupils would pray for three or four days to bless the medicinal preparations' (1995, p. 172).

[84] Byams-pa 'Phrin-las undated, p. 2; Tenzin Choedrak 1998, pp. 73–9. My thanks to Amchi Choelothar of the Men-Tsee-Khang for pointing out the class issue (personal communication, 2009). Although the Mentsikhang is also well known for admitting non-monastic students, this did not take place on a large scale until 1938 with the admission of military recruits (Byams-pa 'Phrin-las undated, p. 17). Before that year, a handful of tantric adepts and astrology students who may have been laymen attended classes (Byams-pa 'Phrin-las undated, p. 2 and *passim*). Khyenrap Norbu also famously had one female student, dByangs-can lHa-mo or 'Khandro Yangga'. She came to the Mentsikhang sometime after 1920; around 1945 she was studying cataract surgery with fellow student Lobsang Wangyal (Byams-pa 'Phrin-las 1990, p. 444; Lobsang Wangyal 2007, p. 8; Hofer 2011c).

[85] Byams-pa 'Phrin-las undated, p. 2.

[86] Byams-pa 'Phrin-las undated, p. 1; 'Who's Who in Tibet' quoted in Tashi Tsering 2010, p. 4.

officials every six months.[87] The Yiktsang Lekhung would then forward these documents and payments to the Mentsikhang, where astrologers and physicians were to draw up the horoscopes and refill the prescriptions. Immediately after producing the horoscopes, duplicate copies would be made and catalogued at the Mentsikhang before affixing a return address and sending the original documents back in a batch to the local official.

Monastic reform was thus bidirectional: as the Lhasa establishment expanded the scope of its recruitment and provision of educational opportunity, these educated medical monks assumed a responsibility to serve the greater population as physicians and astrologers. And along with broadening the monastics' service responsibility in the temporal realm, the Government also attempted to broker an expansion of the lay populace's traditional responsibility to support the monastic establishment—in connection with services rendered. The fees collected (from the wealthy) for childcare would in turn be used, according to the edict, for the sake of developing 'the hospital with the virtuous lineage' so that (in a poetic expression), the 'eye medicine may benefit the eyes'.[88]

Childcare, gender and family

From the point of view of the lay households, and setting aside analysis of the medicinal compounds from the perspective of the 'scientific' paradigm as it existed then or now, the children's public health-care programme should have provided welcome recognition of and assistance with the widespread incidence of infant mortality for mothers and families. Even today many Tibetan women, especially in poor families or rural areas, often give birth alone without many formal preparations of any kind and sometimes outdoors 'so as not

[87] Byams-pa 'Phrin-las undated, p. 5. Although the Dalai Lama himself is clearly the impetus behind the new childcare programme, the edict is signed in name by three branches of the Ganden Podrang government (*bka'* [*blon*] *mda'* [*dpon*] *rtsis* [*dpon*]). This signature associates the programme as well with the largely lay administrative apparatus: the Kalön or four ministers of the Kashak (the highest government office conducting all administrative affairs), the Dapön or army generals and the Tsipön or head minister of the Tsikhang (revenue office). Since the edict names the Tsipön, it is possible that Byams-pa 'Phrin-las is actually describing the Tsikhang's role, but it seems more likely that Jampa Tupwang as head of the ecclesiastical branch of the government and the Yiktsang Lekhung took charge of the childcare programme's administration via the Mentsikhang and worked in tandem with the local officials who reported to these other branches. As mentioned above, the exact financial arrangement is unclear, particularly whether and what percentage of the fees collected were appropriated for non-Mentsikhang or childcare-related expenses.

[88] TA-la'isKu-phreng bCu-gsum-pa 1989, p. 166.

to offend household protector deities and other spirits or pollute the hearth'.[89] Although the Mentsikhang programme resembles efforts of the Ayurvedic revitalisation movement in India seeking to expand the reach of the textual and elite (male) medical tradition into the domestic sphere, it seems that there was no formal system of female midwives being displaced in Tibet, as in the case of Indian *dais*.[90] In fact, just who should administer the medicines to the infant and perform associated rituals is left unclear, for although references were made to consulting a local physician for birth complications or an astrologer for calculations, both the edict and *Treasure of the Heart* also acknowledge the likelihood that these will not be available. Parents are given ultimate responsibility, and many daily care instructions in the childcare manual are intended directly for them.

Thus, the Mentsikhang programme is one of education rather than direct care, aiming to mobilise parents to reduce the costs of the ambitious programme. Furthermore, both the Thirteenth Dalai Lama and Jampa Tupwang addressed parents in general (*pha ma*), rather than mothers in particular, as children's caretakers. While *Treasure of the Heart* acknowledges the mother's special role in nursing through the sixth or seventh month, the only other time she is expressly referred to is in the context of Chapter 17's advice for daily care behaviours, and this advice is actually addressed to 'the mother or caretaker' (*ma'am bu rdzis*).[91] The childcare manual does not specify who should perform intimate care such as guarding over the infant in sleep, administering medicines and the first solid foods, making offerings and performing other rituals, piercing the child's ears, etc. When the child receives a name, the text specifically recommends that the family choose one by mutual consensus.[92] The religious specialists designing the programme (all monks from the Gelukpa order) also took pains to be sensitive to household autonomy in another way that mattered within the Tibetan context. Jampa Tupwang wrote that the offerings for the prescribed childcare rituals should be made 'to whatever birth deities have been recognised', which seems like an effort to remain inclusive and even ecumenical, especially in light of the

[89] Craig 2009, p. 150.

[90] Lal 1994, p. 47; Van Hollen 2003. Although this has been the general assumption about Tibet, as Hofer notes, 'Much work is needed to ascertain the role of women in healing more broadly, i.e. as mothers, midwives, other kinds of healers such as oracles, as well as *amchi*' (2011a and 2011b). Yuthok's delivery was assisted by two midwives, as well as her own maid and her mother's attendant. She also mentions first consulting a male religious expert (a 'high lama') for advice 'on what particular rituals should be done for the baby, as well as what important things I should do during the pregnancy' and for 'the safe delivery of the child' (1995, p. 171).

[91] Byams-pa Thub-dbang 2001, p. 247.

[92] Byams-pa Thub-dbang 2001, p. 244.

Thirteenth Dalai Lama's accompanying verses that pay 'constant homage to the [monastic] community irrespective of sect'.[93]

What is not explained directly in *Treasure of the Heart*, or in the earlier Tibetan medical texts it draws from, is the relationship between such ritual offering ceremonies and folk ideas about purifying the contamination of childbirth. Lady Yuthok writes that her family performed ritual offerings three days after her child's 1933 birth, much as prescribed in *Treasure of the Heart*'s Chapter 8 (see Table). In a description at pains to translate her early twentieth century experience into terms a late twentieth century English readership can understand, Yuthok calls this a 'religious purifying ceremony', explaining that 'in Tibet… [c]hildbirth itself is treated as being very impure'.[94] Furthermore, she says the ceremony for girls is performed after three days while the ceremony for boys is after two, 'because boys are regarded as being more pure than girls'.[95] In practical terms, the contamination of childbirth was considered harmful to those with weak eyesight, and caused her meals to be prepared in a separate kitchen during these first days. On the day of the ritual, all the objects in the delivery room were taken out and 'thoroughly cleaned', the room itself was purified with the contents of a bucket of milk and water mixed with cow dung (a substance considered to have 'a special quality of purification' and that 'acts as an antiseptic', in her later understanding), and finally the room was washed again while a religious specialist chanted a blessing.[96] At the end, the room was 'considered both clean and pure as before', and for the first time friends and relatives could be invited to visit.

Lady Yuthok's memoir, while it cannot stand in for the experience of all women of her time, points significantly to how the event of childbirth—along with new mothers' and infants' bodies—was considered impure or contaminated in a highly gendered way that is not directly expressed in the canonical *byis pa nyer spyod* texts. With this in mind, Jampa Tupwang's ungendered annotations referencing purity in *Treasure of the Heart* (as mentioned above, the pure cloth for wiping out the infant's mouth, and the clean bowl and purified butter for easy digestion) seem to be a particularly novel formulation.[97]

---

[93] *'Go zhing bsten pa'i lha 'am / bsgrub pa'i lha sogs skyes lha gang yin ngos bzung* (Byams-pa Thub-dbang 2001, pp. 244, 248).

[94] Yuthok 1995, p. 174.

[95] Ibid.

[96] Ibid.

[97] It can also be considered significant that none of the texts associated with the childcare programme reference ritual or medicinal measures for ensuring the birth of a male infant. Such rituals are found in the *Four Tantras* and its Indic antecedents, and have been a topic of Tibetan commentaries up to the late twentieth century (Garrett 2008, pp. 73–4).

Treasure of the Heart specifically mentions differences between boys and girls only in two physiological instances, in relation to medicine no. 5 (which establishes a relationship of obedience through ingesting the urine of your same-gendered parent) and ear-piercing (which references the difference between male and female tantric physiology in the *Four Tantras*, manifest here in girls being pierced on the left side first and boys on the right).[98] Customs such as naming practices and rituals such as that of the arrow and the spindle (Chapter 9 of the *Treasure of the Heart*, see Table) often have a gendered aspect relating to the child's ideal future social and familial role.[99] Like the purification offerings, however, these aspects are not explicitly made clear in *Treasure of the Heart*, though they may be present as an undercurrent. Nevertheless, reference to the child's future social responsibilities is made instead in conjunction with astrological calculation of the natal horoscope.

The use of astrology in social reform

As mentioned above, the childcare programme's astrological component brought together two different modes of calculation. Requiring and documenting a natal horoscope for every child involved the Tibetan state in reckoning this segment of its population, but this reckoning was more than just enumerative. Natal astrology first and foremost is about predicting the course of a child's life, including proclivities, strengths and weaknesses. Jampa Tupwang writes in *Treasure of the Heart* of the need to determine the child's destiny 'in detail, good or bad, cleric or layperson'.[100] A natal horoscope may include, in highly variegated and personal fashion, information about lifespan, character, likes and dislikes, emotional and physical type, obstacles and illnesses to avoid or treat, aptitude for future skills and predictions for future financial and family circumstances. According to an anthropological study by Childs and Walter, even today in remote areas and among the illiterate natal horoscopes may be cast whenever possible, for both boys and girls.[101] Though birthdays are generally not celebrated and many people do not bother to remember the exact year of their birth, in their family home the natal horoscope document might still be carefully stored away for future reference.[102]

---

[98] See Gyatso 2004 for discussion of Desi Sangyé Gyatso and debates over the channels and gender.

[99] See dGe-'dun 'Jam-dbyangs rGya-mtsho 2001 for further discussion of these practices.

[100] Byams-pa Thub-dbang 2001, pp. 242–3.

[101] Childs and Walter 2000. Their study was conducted with Tibetans in northern Nepal.

[102] Ibid., p. 52.

In the Thirteenth Dalai Lama's estimation, however, the children of most common people in Central Tibet had not had recorded the position of the planets and stars at the time of their birth. These children, he wrote, 'are not different in their true fundamental nature' from those who had been able, through circumstance or financial ability, to calculate a natal horoscope. He was concerned that

> Only by shooting an arrow into the darkness of [children's] worldly destiny can their capacity for enlightened activities and service be seen. How many faults arise by the power of mistaken interdependent connections, such as not knowing each one's fate and capacity for standard of living, and not attaining these, etc.?[103]

This formulation presented astrology for all children as a progressive effort to identify talent and not to ignore or mistake the potential contributions of children from humble backgrounds, while placing the Lhasa Government in control of this effort (and thus ultimately over their destinies). Several leading figures of the time might be said to have embodied such discovered potential, having risen to prominence from poor or rural circumstances during the Thirteenth Dalai Lama's reign. This includes his powerful personal attendant Kumbela, the army commander-in-chief Tsarong Shape and the Mentsikhang's own Khyenrap Norbu.[104] By giving his government the responsibility to administer a programme of natal-horoscope calculation and to keep records of the background and abilities of each child under its jurisdiction, the hierarch seems to be building a routinised capacity to identify amongst his subjects those with potential for future beneficial action (*'phrin las*) and service (*zhabs 'degs*) to the State. In this project, birth as a boy or girl, future cleric or layperson, did not matter as much as realising one's potential and, in particular, one's 'capacity for standard of living' (*lto gos kyi las thabs*).

To inspire such a sense of possibility, however, required refuting notions of fatalism in a highly stratified society. Dr Lobsang Wangyal, student of Khyenrap Norbu and personal physician to the Fourteenth Dalai Lama (b. 1935), acknowledged the tension between fatalism and the Buddhist concept of karma within a discussion of childcare:

> In Buddhism it is believed that merit and demerit, or, in another words [sic], karma that one has accumulated in previous lives, comes to fruition in this life.

---

[103] TA-la'i sKu-phreng bCu-gsum-pa 1989, p. 166.

[104] Tsarong Shape was first noticed as Jampa Tupwang's valet during their time in exile in Mongolia (Bell 1987, p. 160; Goldstein 1989, p. 66 n. 4). Kumbela's story does not start out sounding progressive, as he was brought to Lhasa in fulfilment of a serf obligation, but his rise like Tsarong's occurred because the Dalai Lama recognised and rewarded his abilities (Goldstein 1989, p. 147). Of course in addition to being capable, these men rising from humble origins would also have good reason to be loyal to the Dalai Lama.

> This would mean that events in the course of our lives are pre-determined. However, much is in our hand . . . to change the child's future. Beginning with conception, and foetal growth in the mother's womb and eventual birth, Tibetan medical tradition gives many childcare guidelines and rituals, which, when properly followed, can dispel harm, ensuring a healthy growth.[105]

Two stories recalling the impact of childcare practices on the lives of major figures in Tibetan Buddhism, told by Jampa Tupwang in *Treasure of the Heart*, illustrate the idea that worldly destiny (*'jigs rten gyi las skal*) is a mutable concept that must be fulfilled.[106] His first example is none other than the Buddha Shakyamuni, for whose birth 'the methods of many midwives and diviners were relied upon, causing these [methods] to be spread far and wide'.[107] The fact of Shakyamuni's birth into the mundane world made it necessary for his caretakers to rely on mundane methods for the recognition of his destiny and nurturing him into adulthood, which in turn enabled him to become a great being. The methods of childcare and astrology are thus partly credited for setting Shakyamuni's extraordinary human life into motion, while the Buddha reciprocally is given credit for setting the methods of childcare into motion within the wider world.

The second example is the fount of Jampa Tupwang's own Gelukpa order, the 'gentle protector and Dharma king' Tsongkhapa. As soon as the great Tsongkhapa was born, Jampa Tupwang relates, his teacher Chöjé Dondrup Rinchen had to carry out the essential aspects of childcare properly 'for the sake of many necessities in the immediate and long-term'.[108] After thus humanising these legendary historic figures, Jampa Tupwang concluded, 'It goes without saying that ordinary people should diligently rely on these methods [as well].'[109] The effect is one of placing 'ordinary people' on the same rhetorical level as the pillars of Tibetan Buddhism; their children too may fulfil their greatest 'capacity for enlightened activities', if properly recognised and cared for.

Recognising the enormity of the social and mental shifts he was trying to help set into motion, Jampa Tupwang pleaded directly to parents to put the childcare methods into practice within their own homes:

---

[105] Lobsang Wangyal 2007, p. 221.

[106] This is the term used by the Thirteenth Dalai Lama (TA-la'i sKu-phreng bCu-gsum-pa 1989, p. 166).

[107] Byams-pa Thub-dbang 2001, p. 241.

[108] Ibid., p. 241.

[109] Ibid., p. 241.

> Also, parents, ripening their identification with the compassionate qualities of the Medicine Buddha, protector of beings, need to abandon any wrong hesitation or doubts.
>
> Everyone, no matter high or low, is beseeched to exert effort to be continuously aware of the importance of the fundamental welfare of their own tender sprouts.
>
> Through listening, reflective study and meditative cultivation, mastery of these types of virtuous and great actions may be attained.[110]

Data on the extent of literacy does not exist for pre-1950 Tibet, but the physician gestures here to the alternate possibility that the text *Treasure of the Heart* could be transmitted orally to the common population. The Thirteenth Dalai Lama, meanwhile, also addressed the problem of popular reception by further appealing to parents on a practical level, asserting that through their conscientious adoption of right actions and avoidance of wrong actions with regard to post-natal care, they would be able to elicit desirable qualities in their children just as much as a physician would. He assured his subjects it was 'candidly true' that this programme of childcare would deliver the promised benefits, and that these would 'be unmistakably established through experience'.[111]

Conclusion: the benefits of childcare

The Thirteenth Dalai Lama sought to establish empirically three different levels of benefit from the implementation of methods of childcare. Above all, he promised these methods would bring 'long life without illness, intelligence, and clear sense faculties [sight, hearing, etc.]' to weak individual bodies.[112] As much as this claim was about direct benefit to real people, it was also an assertion about the efficacy of Tibetan medicine—'the system of the Great Country', in Khyenrap Norbu's words. Jampa Tupwang, physician and head of the monastic branch of government, made it clear that the strength of his people and the strength of the Buddhist medical teachings were jointly at stake:

> During this time the continuum of medical teachings has deteriorated and progressive decline in the transmission of previous experience has caused ignorance of the methods of childcare. Therefore the wits, stamina and physique of the people in general (*mi rigs phal cher*) are weak, life spans are short and illnesses many, and those with wicked natures do not listen to their parents' speech. Not being able to bear these kinds of undesirable faults and defects that have suddenly arisen, I have set down the principles from the King of the Glorious [Four]

[110] Ibid., pp. 247–8.
[111] TA-la'i sKu-phreng bCu-gsum-pa 1989, p. 166.
[112] Ibid., p. 166.

> Tantras for the methods of caring for, cherishing, and nourishing children in a series of complete steps for easy understanding.[113]

In this way, Jampa Tupwang turns the late nineteenth and early twentieth century public health ideal of 'hygienic modernity' on its head. His words stand in particular contrast to nationalist Chinese reformers, who began around this same time to link fears for the decline of the Chinese 'race' with valorisation of colonial medicine and disparagement of (what they now termed) 'traditional' Chinese medicine.[114] The Tibetan physician reaches a hybrid and novel solution, championing the approach of proving his government's beneficence in an indigenous, Buddhist idiom rather than by adopting foreign medical theories, training and institutions. Certain foreign techniques could be appreciated and incorporated without compromising the integrity of the Tibetan Buddhist medical system that had been institutionalised at Chakpori and now reconfigured at the Mentsikhang. Such integrity was vital to maintain for a state that depended on its Buddhist epistemological resources for legitimacy and leverage.

Second, the Thirteenth Dalai Lama asserted that physical and mental benefits would lead to the development of economic strength by being 'interdependently connected with prosperity and well-being if performed together without confusion'.[115] In this light, Jampa Tupwang's ambiguous concern with improving the 'wicked natures' of children who did not obey within the basic social unit of the family seems to echo British mothercraft literature, in which children with proper upbringing would become not only healthier but better behaved, leading to a more productive and engaged workforce.[116] Furthermore, as in British initiatives, the rural poor are presented especially in need of saving from their undesirable (if not unhygienic) conditions—and of including in a project of nation-building. The Dalai Lama writes that in order to reverse the 'manifestations of the five degenerations', a great effort 'in the customs and practices of caring for "young shoots" and increasing [their] intelligence' is necessary, and in his edict these degenerations are said to specifically include such 'undesirable occurrences' as dumbness (*glen lkugs*) and 'untimely death among most people living in rural conditions'.[117]

---

[113] Byams-pa Thub-dbang 2001, pp. 241–2.

[114] Rogaski 2004.

[115] TA-la'i sKu-phreng bCu-gsum-pa 1989, p. 166.

[116] Davin 1978, pp. 54–5.

[117] TA-la'i sKu-phreng bCu-gsum-pa 1989, p. 165. In Buddhism, the *snyigs* [*ma*] *lnga* refer to the five degenerations 'of lifespan [shrinking to fifty years], of mental afflictions [anger, desire, ignorance etc. becoming more prevalent], of living beings [behaviour, attitudes and wealth declining], of views [the number of non-believers in Buddhism and its precepts increasing], and

But while British programmes fostered a cult of motherhood and held individual women accountable to prevent infant mortality, the Mentsikhang literature, with its main focus on class and social roles rather than gender, presented a wider view of this responsibility. The future rested equally with the 'righteous monarch' under whose benevolent leadership the programme was instigated, members of the monastic community who were called upon to serve the greater population as physicians and astrologers, local officials who must administer the programme, aristocratic landowners who should cover fees for the poor and parents of every class (and both genders) who should implement the programme in each of their households. In this way, the entire community was called upon to assist parents in their role as proxies of the State nurturing young subjects.

Third, the hierarch directly linked the welfare of the Tibetan population and its newborns to the welfare of the Central Tibetan state, calling the work of children's medicine and astrology 'the great and profound basis of prosperity and well-being benefiting sovereign and subjects alike'.[118] Jampa Tupwang reciprocally declared that managing the health of the population was the 'root' of enlightened governance by a Buddhist monarch:

> Furthermore, the basis of realising liberation and omniscience for all beings is the precious teachings of the Victorious One and the enlightened governance activities of the righteous monarch, which should spread and remain a long time. For this, the root is obtaining the flourishing of intelligence, great effort and striving, long life, youthful vigor and happiness, etc. for excellent beings and high and low people. On the strength of these [attainments], the general welfare (*sems can spyi mthun*) as well as each individual's karma, aspirations and merit will certainly be achieved.[119]

In this Tibetan Buddhist formulation of medical benefit, enabling the physical and mental basis for 'all beings' to realise the Buddhist goals of liberation and omniscience was a sign of legitimate and benevolent rule—a particularly relevant gesture, so soon after the Dalai Lama's return from his almost ten year exile. As a method of generating revenue and reasserting his sovereignty over the districts and estates, health care for children no doubt offered a much gentler initial approach than some of his later measures.

200 years earlier through his Chakpori 'Sanctuary of Knowledge Benefiting Beings', Desi Sangyé Gyatso had also linked the state's medical work to benefit for 'all beings'. He wrote that an increase in the reach of Buddhist medical

---

of the times [epidemics, famines, wars and poor harvests becoming widespread]' (Gyatso and Kilty 2010, pp. 349, 537 ft. 723).

[118] TA-la'i sKu-phreng bCu-gsum-pa 1989, p. 167.

[119] Byams-pa Thub-dbang 2001, pp. 240–1.

teachings would benefit both the 'self', or the physician on a path to buddhahood, and 'others', or those suffering from illness, 'in every realm of the ten directions'.[120] When the Thirteenth Dalai Lama and Lamen Jampa Tupwang referred to the bodhisattva intention behind their provision of children's health care, however, they formulated it in terms that were not so open-ended. The Mentsikhang programme would nurture the achievement of individual aspirations for the 'subjects of the districts and estates, everyone of high and low stature', and likewise the welfare 'of all the beings, in general and in particular, of the government mandated by heaven, of the land completely encircled by pure snow mountains', to which the childcare edict was addressed.[121] By justifying a greatly enlarged government role within the domestic sphere, the two men constructed the childcare programme as a tool for the delineation and organisation of a territorially bound Central Tibetan state.

What is more, on the basis of shared behavioural, nutritional and ritual practices in a Tibetan Buddhist idiom, every household included—of high and low stature—would be encouraged to intimately experience themselves as part of this community and their children as 'sprouts' (*rigs myug*) of a Tibetan nation. Rather than simply borrowing similar prescriptions from a foreign context, the Thirteenth Dalai Lama and his physicians discerned from their own 'definitive methods of analysis' how, in order to realise the potential of a Tibetan nation-state, they would need to identify and cultivate the potential of its children (and encourage their elders) to contribute towards mutual well-being and prosperity. At the same time, these architects of social prosperity did not scoff at foreign technologies they deemed beneficial but began incorporating techniques such as vaccination as they became available, affordable and of demonstrated usefulness. In this way, the Mentsikhang and its childcare programme can be said to have helped set into motion both the reconfiguration of Tibetan medical practice and the imagination of a Tibetan community.

---

[120] In *Mirror of Beryl*, Sangyé Gyatso describes his motivation for founding Chakpori as twofold: to develop an authoritative, systematic field of medicine and to increase both the quantity and quality of medical providers. He expresses the latter goal through a quotation in the form of a prayer: 'In every realm of the ten directions / May there be medicine, doctors and nurses, / Suitable food, drink, and every provision' (Gyatso and Kilty 2010, p. 352).

[121] TA-la'i sKu-phreng bCu-gsum-pa 1989, pp. 164–5.

Acknowledgements

I would like to thank Tashi Tsering of the Amnye Machen Institute for his great assistance during this project and especially for bringing the text of the Thirteenth Dalai Lama's edict on childcare to my attention. Also I am indebted to Gendun Jamyang Gyatso of the Literary Research Department at the Men-Tsee-Khang, Dharamsala, for our discussions of the childcare texts, to Gray Tuttle, Alex McKay and the anonymous reviewers for their helpful comments, and to this journal's editors, especially Heidi Fjeld and Theresia Hofer. This publication was made possible by support from the Social Science Research Council's International Dissertation Research Fellowship, with funds provided by the Andrew W. Mellon Foundation.

References

Tibetan Language

bLa-ma-skyabs 1997, *Bod kyi mkhas pa rim byon gyi gso rig gsung 'bum dkar chag mu tig phreng ba*, Zi ling: Kan su'u mi rigs dpe skrun khang.

bSod-chung 2004, 'Bod kyi gso rig bstan pa'i slob dpon bkras khang byams pa thub dbang', *Krung go'i bod ljongs*, 67(3): 32–6.

Byams-pa 'Phrin-las undated, *Lha sa sman rtsis khang gi gdan rabs rang bzhin dbyangs su brjod pa skal ldan yid kyi shing rta.* [Privately published edition]. Reprinted in Byams-pa 'Phrin-las 1996, *Byams pa 'phrin las gsung rtsom phyogs bsgrigs*, Pe cin: Krung go'i bod kyi shes rig dpe skrun khang.

—— 1986, 'Sman rtsis bstan pa'i gtsug rgyan gnas lnga rig pa'i dbang phyug mkhas dbang mkhyen rab nor bu'i rtogs brjod bsdus pa skal ldan yid dbang 'phrog pa'i pho nya', in Bod rang skyong ljongs sman rtsis khang (ed.), *Bod kyi sman rtsis ched rtsom phyogs bsdus*, Lha sa: Bod ljongs mi dmangs dpe skrun khang.

—— 1990, *Gangs ljongs gso rig bstan pa'i nyin byed rim byon gyi rnam thar phyogs bsgrigs*, Pe cin: Mi rigs dpe skrun khang.

Byams-pa Thub-dbang 2001 [1916] 'Byis pa nyer spyod 'gro phan snying nor', in mKhyen-rab Nor-bu (ed.), *Lha ldan sman rtsis khang gi chos spyod*, Dharamsala: Bod gzhung sman rtsis khang, 240–9.

dGe-'dun 'Jam-dbyangs rGya-mtsho 2001, *Byis pa la nye bar spyod pa'i tshul legs par bshad pa drang srong rgan po'i 'bel gtam ma yi rna ba'i bcud len*, Dharamsala: self-published.

dPyad-bu Khrid-shes 2005,*Gso rig 'bum bzhi*, Pe cin: Mi rigs dpe skrun khang.

E-pa bSod-nams Rin-chen 2009, 'Sman rtsis bstan pa'i srog shing dge ba'i bshes gnyen chen mo mkhyen rab nor bu'i mdzad rjes rnam thar rjes su dran pa skal ldan 'tsho mdzad dgyes pa'i mchod sprin', in *Bod kyi srol rgyun sman rtsis rig pa'i dpyad yig mu tig phren mdzes* (*stod cha*), Dharamsala: Library of Tibetan Works and Archives.

Ma-hA-yA-na 2006, *Sman dpyad zla ba'i rgyal po*, Pe cin: Mi rigs dpe skrun khang.

mKhyen-rab Nor-bu 2001, Bla-sman (ed.) *Lha ldan sman rtsis khang gi chos spyod*, Dharamsala: Bod gzhung sman rtsis khang.

Pa-sangs Yon-tan, sMan-rams 1987, *Bod kyi gso ba rig pa'i lo rgyus kyi bang mdzod g.yu thog bla ma dran pa'i pho nya*, Leh: Yuthok Institute of Tibetan Medicine.

Sangs-rgyas rGya-mtsho 1992, *Man ngag lhan thabs* (*Oral Instructions and Methods*) Zi ling: Mtsho sngon mi rigs dpe skrun khang.

—— 2005, *Rgyud bzhi'i gsal byed bai DUr+ya sngon po* (*Blue Beryl*), Pe cin: Mi rigs dpe skrun khang.

sKal-bzang 'Phrin-las 1997, *Bod kyi gso rig byung 'phel gyi lo rgyus*, Pe cin: Krung go'i bod kyi shes rig dpe skrun khang.

TA-la'i sKu-phreng bCu-gsum-pa 1989 [1916], 'TA la'i sku phreng bcu gsum pas bod ljongs su byis pa nyer spyod kyi sman rtsis 'phrod bsten gong 'phel gtong dgos skor rgya khyab rdzong gzhis khag la bstsal ba'i rtsa tshig', in bKras-shis dBang-'dus (ed.), *Bod kyi lo rgyus yig tshags dang gzhung yig phyogs bsdus dwangs shel me long*, Pe cin: Mi rigs dpe skrun khang.

Tashigangpa, T. S. (ed.), 1978 [11th century], *Rgyud bzhi* (Lcags po ri par ma), Leh: T. S. Tashigangpa.

Thub-bstan Byams-pa Tshul-khrims bsTan-'dzin 1940, *Thub bstan rgya mtsho'i rnam thar*, 'Bras spungs: Dga' ldan pho brang.

Thub-bstan Tshe-ring 1986, 'Gangs ljongs sman pa'i grong khyer lcags ri 'gro phan rig byed gling gi byung rabs brjod pa gsal ba'i sgron me', in Bod rang skyong ljongs sman rtsis khang (ed.), *Bod kyi sman rtsis ched rtsom phyogs bsdus*, Lha sa: Bod ljongs mi dmangs dpe skrun khang.

Tsha-rong dByangs-can sGrol-dkar 2006, *Sde dpon mi drag gi sras mo gzhon nu ma zhig gis sge'u khung nas mthong ba'i bod kyi rgyal sa lha sa'i snang tshul mdor bsdus, Rtsom rig sgyu rtsal deb phreng 8*, edited and annotated by bKra-shis Tshe-ring, Dharamsala: Amnye Machen Institute.

European Languages

Adams, Vincanne, 2002, 'Establishing Proof: Translating "Science" and the State in Tibetan Medicine', in Margaret Lock and Mark Nichter (eds), *New Horizons in Medical Anthropology: Essays in Honour of Charles Leslie*, London: Bergin and Garvey, 200–20.

Adams, V., M. Varner, S. Miller, S. Craig, Sonam and Lhakpen, 2005, 'Having a Safe Delivery: Conflicting Views from Tibet', *Health Care for Women International*, 26 (9): 821–51.

Aḥmad, Ẓahīruddīn, 1970, *Sino-Tibetan Relations in the Seventeenth Century*, Roma: Istituto italiano per il Medio ed Estremo Oriente.

Anonymous, 1921, 'Peking Union Medical College to Be Dedicated', *Modern Hospital*, 17 (3): 186.

Bell, Charles, 1987 [1946], *Portrait of a Dalai Lama: The Life and Times of the Great Thirteenth*, London: Wisdom Publications.

—— 1992 [1927], *Tibet: Past and Present*, Delhi: Motilal Banarsidass Publ.

Bolsokhoyeva, Natalia, 1999, 'Medical Faculties of Buryat Buddhist Monasteries', *AyurVijnana*, 6 (Spring): 1–6.

Childs, Geoff and Michael Walter, 2000, 'Tibetan Natal Horoscopes', *Tibet Journal*, 25 (1): 51–62.

Craig, Sienna R., 2009, 'Pregnancy and Childbirth in Tibet: Knowledge, Perspectives, and Practices', in Helaine Selin (ed.), *Childbirth Across Cultures*, Dordrecht: Springer Netherlands, 145–60.

Davin, Anna, 1978, 'Imperialism and Motherhood', *History Workshop*, 5 (Spring): 9–65.

Garrett, Frances, 2008, *Religion, Medicine and the Human Embryo in Tibet*, London: Routledge.

Gerl, Robert and Jürgen C. Aschoff, 2005, *Die Medizinhochschule Tschagpori (lCags-po-ri) auf dem Eisenberg in Lhasa*, Ulm: Fabri Verlag.

Goldstein, Melvyn C., 1968, 'An Anthropological Study of the Tibetan Political System', Ph.D. dissertation, University of Washington.

—— 1989, *A History of Modern Tibet, 1913–1951: The Demise of the Lamaist State*, Berkeley, Calif.: University of California Press.

Gyatso, Janet, 2004, 'The Authority of Empiricism and the Empiricism of Authority: Medicine and Buddhism in Tibet on the Eve of Modernity', *Comparative Studies of South Asia, Africa and the Middle East*, 24 (2): 84–96.

Gyatso, Desi Sangyé and Gavin Kilty, 2010 [1703], *Mirror of Beryl: A Historical Introduction to Tibetan Medicine*, Somerville, Mass.: Wisdom Publications.

Hofer, Theresia, 2011a, 'Tibetan Medicine on the Margins: Twentieth Century Transformations and the Traditions of *Sowa Rigpa* in Central Tibet', Ph.D. thesis, University College London.

—— 2011b, 'The Mirror of the Moon—Khenrab Norbu's text on Tibetan medical methods for giving birth', talk given at the UCL Wellcome Trust Centre for the History of Medicine, London, 10th May (Medical Texts in Translation Series).

—— 2011c, 'Changing Representations of the Tibetan Woman Doctor Khandro Yangkar (1907–1973)', in Alex McKay and Anna Balikci-Denjongpa (eds), *Buddhist Himalaya: Studies in Religion, History and Culture*, Proceedings of the Namgyal Institute of Tibetology Jubilee Conference 2008, Gangtok: Namgyal Institute.

Jampal Kunzang Rechung Rinpoche 1976 [1973], *Tibetan Medicine, Illustrated in Original Texts*, Berkeley, Calif.: University of California Press.

Janes, Craig R., 1995, 'The Transformations of Tibetan Medicine', *Medical Anthropology Quarterly*, 9 (1): 6–39.

Kloos, Stephan, 2010, 'Tibetan Medicine in Exile: The Ethics, Politics and Science of Cultural Survival', Ph.D. thesis, University of California.

Lal, Maneesha, 1994, 'The Politics of Gender and Medicine in Colonial India: The Countess of Dufferin's Fund, 1885–1888', *Bulletin of the History of Medicine*, 68 (1): 29–66.

Latour, Bruno, 1993, *We Have Never Been Modern*, Cambridge, Mass.: Harvard University Press.

Lobsang Rapgay, 1977, 'The Thirteenth Dalai Lama', *Bulletin of Tibetology*, 13 (2): 25–30.

Lobsang Wangyal, 2007, *My Life, My Culture: Autobiography and Lectures on the Relationship Between Tibetan Medicine, Buddhist Philosophy and Tibetan Astrology and Astronomy*, Dharamsala: Dawa Ridak.

McKay, Alex, 2005a, '"The Birth of a Clinic"? The IMS Dispensary in Gyantse (Tibet), 1904–1910', *Medical History*, 49(2): 135–54.

—— 2005b, '"An Excellent Measure": The Battle Against Smallpox in Tibet, 1904–47', *Tibet Journal*, 30/31 (4/1): 121–32.

—— 2007, *Their Footprints Remain: Biomedical Beginnings Across the Indo-Tibetan Frontier*, Amsterdam: Amsterdam University Press.

Metcalf, Barbara Daly, 1990, *Perfecting Women: Maulana Ashraf Alī Thanawi's* Bihishti Zewar—*A Partial Translation with Commentary*, Berkeley, Calif.: University of California Press.

Meyer, Fernand, 1992, 'Introduction', in I. U. Parfionovich, Fernand Meyer and Gyurme Dorje (eds), *Tibetan Medical Paintings: Illustrations to the Blue Beryl Treatise of Sangye Gyamtso (1653–1705)*, New York: H. N. Abrams, Inc.

Rogaski, Ruth, 2004, *Hygienic Modernity: Meanings of Health and Disease in Treaty-Port China*, Berkeley, Calif.: University of California Press.

Schaeffer, Kurtis R., 2003, 'Textual Scholarship, Medical Tradition, and Mahayana Buddhist Ideals in Tibet', *Journal of Indian Philosophy*, 31: 621–41.

Shakabpa, W. D. and Derek F. Maher, 2010, *One Hundred Thousand Moons: An Advanced Political History of Tibet*, Leiden: E. J. Brill.

Shapin, Steven and Simon Schaffer, 1989, *Leviathan and the Air-Pump: Hobbes, Boyle, and the Experimental Life*, Princeton, NJ: Princeton University Press.

Tashi Tsering, 2010, 'Bla sman Mkhyen rab nor bu: A Biographical Note and Brief Discussion of His Works', paper presented at the 12th Seminar of the International Association for Tibetan Studies, 15–21 August 2010, University of British Columbia, Vancouver, Canada.

Tenzin Choedrak, 1998, *The Rainbow Palace*, London: Bantam Books.

Tuttle, Gray, 2005, *Tibetan Buddhists in the Making of Modern China*, New York: Columbia University Press.

Van Hollen, Cecelia, 2003, *Birth on the Threshold: Childbirth and Modernity in South India*, Berkeley, Calif.: University of California Press.

Yinba (Tib: Yum pa), 2008, *Qinre nuobu dashi yu Zangyi tianwen lisuan*, La sa: Xizang renmin chubanshe.

BRILL

Asian Medicine 6 (2010–11) 387–420

brill.nl/asme

'Female Nectar': A Study of Hybridity and Gender in Contemporary Tibetan Medical Literature on Menstruation

Jenny Bright

Abstract
This essay examines contemporary Tibetan medical literature that deals with menstruation, focusing on the relations among medical, religious and cultural perceptions of women and gender. Present-day medical writers present a hybrid account of menstruation, incorporating key aspects of Tibetan medicine, such as the refining processes of digestion and the red element, with biomedical knowledge, notably the role of hormones. The integration of biomedical thought by Tibetan writers works to substantiate and bolster the validity of Tibetan medical claims, rather than discredit them. Consequently, contemporary writers are able to articulate medical knowledge about women that is as much about Tibetan religious and cultural perceptions of gender and sexed-bodies, as it is 'scientific'.

Keywords
menstruation, hormones, gender, science, contemporary medical writers

Menstruation or 'monthly mark' (*zla mtshan*) is, according to contemporary Tibetan[1] medical literature, a defining characteristic of the female body. To explain how and why menstruation occurs, present-day medical writers examine both authoritative literature of Tibet's medical system, such as the *Four Treatises* (*rgyud bzhi*)[2] and its commentaries, as well as biomedical sources. This has led to hybrid medical theories of menstruation, wherein fundamental

[1] This article focuses on publications within the political boundaries of China and does not include those medical writings published in Tibetan areas outside of China, such as India and Nepal. A comparison of how menstruation and women are medically theorized in different geo-political areas is an important question, which unfortunately will not be taken up here, nor will how the political circumstances of Tibetans in China influence medical writing and practice on women. For detailed analysis of the ways the political, economic and social situation of present-day China drive scientific change and the 'modernisation' of Tibetan medicine, see Adams 2001a, 2001b, 2007; Janes 1999, 2001; Janes and Hilliard 2008.

[2] gYu-thog Yon-tan mGon-po 2006 [1982], *bdud rtsi snying po yan lag brgyad pa gsang ba man ngag gi rgyud ces bya ba bzhugs so*. All references to the *Four Treatises* in this article correspond to

DOI: 10.1163/15734218-12341239

notions of Tibetan medicine are augmented and bolstered by biomedical thought. As such, not only are Tibetan medical ideas about women's bodies maintained but cultural and religious perceptions of gender also remain. Moreover, biomedical assumptions of gender, such as the relation between 'sex hormones' and emotion appear to reinforce Tibetan ideas of women's physical, mental and emotional make-up. As a result, present-day medical writings on menstruation reflect a hybridity between Tibetan and biomedical ideas, both of which are as much about cultural, religious and moral perceptions of gender as they are 'scientific'.

This article discusses the ways contemporary medical writers negotiate biomedical theories of menstruation in relation to fundamental ideas of Tibetan medicine. In the first section, I describe the contemporary literary sources used in this article and how I translated these works. Next, I discuss gender and science by showing how authoritative medical works, steeped in Buddhist and cultural perceptions of gender, are used by contemporary medical writers to support the discussion of women and menstruation. In the third section, I offer extensive translations and analyses of key works that integrate Tibetan and biomedical ideas of menstruation; notably, the mechanics of the red element (*khams dmar*), digestion and hormones. 'Hormones' are variously translated as 'quintessence' (*mdangs*), 'great vital essence' (*bcud chen po*), 'female nectar' (*mo rtsi*) and 'hormones' (*ho'o mo'u*). I show how Tibetan writers incorporate biomedicine in ways that substantiate Tibetan medical knowledge, rather than discredit it. In the fourth section, I point to some of the ways that the collaboration of Tibetan medicine and biomedicine betray a 'gender politics at work',[3] particularly in the connections between women's biology, sexuality and emotional disposition.

Contemporary sources

Menstruation appears in a variety of Tibetan textual sources, including medical works and a range of Buddhist works, such as tantras and sutras[4] on sex and the vinaya, the monastic rules for monks and nuns. Among contemporary medical sources, there are generally three kinds of works: medical textbooks for doctors and students of gynaecology, theoretical works written for a

---

the Tibetan numeral paging of the Central Tibetan edition. See bibliography for details. The *Four Treatises* is comprised of four parts: the *Root Tantra* (*rTsa rgyud*), the *Explanatory Tantra* (*bShad rgyud*), the *Instructional Tantra* (*Man ngag rgyud*) and the *Subsequent Tantra* (*Phyi ma rgyud*).

[3] Gyatso 2008, p. 81.

[4] Sutras refer to Mahāyāna Buddhist works.

medical audience and practical books on menstruation and women's health-care written for a lay literate audience. The sources for this article fall under the latter two categories. Three of my principal sources are books exclusively devoted to women's health: *Means of Preventing and Curing Women's Diseases as Seen in the Treatises of Tibetan Medical science* by dPal-ldan 'Phrin-las (Palden Thinley),[5] *Common Knowledge on Protecting the Health of Women* by dPal-bzang rGya-mtsho (Palzang Gyatso)[6] and *Common Knowledge on the Health of Mother and Child*, by dBang-rgyal (Wang Gyal).[7] All three of these sources are intended for a literate lay audience and are written by a male author. These books cover a range of topics including the causes and care of menstruation and pregnancy, puberty, treatment of gynaecological problems, sexual norms, laws and positions, signs of sexual arousal in women (for the male reader), beauty tips, and advice on diet, behaviour, and personal hygiene. For the sake of comparison, I also refer to a contemporary work which does not allude to biomedicine, but is a summary of exclusively Tibetan medical knowledge, *Medical Methods of Treating Various Types of Commonly Seen Diseases* by Tshul-khrims rGya-mtsho (Tsultrim Gyatso),[8] a Buddhist monk. Among the theoretical works, one of my primary sources is a recent article published by the Arura Medical Journal, *China Tibetan Medicine: Study of Menstruation Within the Body of Tibetan Medicine*, by Lha-mo sKyid (Lhamo Kyi).[9] The other key theoretical source I refer to is *Medical Knowledge of the Body* by Thub-bstan Phun-tshogs (Thubten Phuntsok).[10]

These sources were chosen for three primary reasons: 1) except for one, they all articulate biomedical notions in relation to Tibetan medical explanations of menstruation, albeit in various ways; 2) they are all readily available in Tibetan bookstores in Xining, China, and were suggested to me by medical doctors and students; and 3) they are all recent publications—within the last 15 years—from within China. Hence, my choice of sources is meant to provide a 'snapshot' of what is available at the time of writing this article.[11] Also for this reason, I have chosen to refer only to the most recent Central Tibetan edition of the *Four Treatises*, which appears to be the most widely-used edition in Qinghai province. I do not compare editions of the *Four Treatises* or look extensively at their commentaries, although many or all of my sources engage in this sort of comparative exercise. This article, therefore, is not meant to

[5] dPal-ldan 'Phrin-las 1996, *Bod lugs gso rig gi rgyun mthong mo nad 'gog bcos bya thabs.*

[6] dPal-bzang rGya-mtsho 2010, *Bud med bde srung skor gyi rgyun shes phran bu bzhugs.*

[7] dBang-rgyal 2005, *Ma bu bde srung gu rgyun shes.*

[8] Tshul-khrims rGya-mtsho 2007, *rGyun mthong nad rigs gso thabs.*

[9] Lha-mo sKyid 2007, *Zla mtshan gyi rnam par dpyad blo chung byis pa'i mgul rgyun.*

[10] Thub-bstan Phun-tshogs 1999, *Gso bya lus kyi rnam bshad.*

[11] I was unable to obtain a copy of the newly revised edition of dPal-ldan 'Phrin-las' book in Xining at the time of writing.

be an exhaustive description of menstruation in medical literature, nor to present medical treatments of menstrual disorders. Instead, I examine how some contemporary authors articulate Tibetan and biomedical meanings of menstruation. I chose to select sources, asking myself how an educated female lay reader living in Xining could learn 'modern' and up-to-date information on menstruation.

My method of translating the material for this article, as well as my analysis, incorporates consultation with medical doctors, students and researchers in Xining, China, as well as in Toronto, Canada. In addition, between October 2010 and February 2011, as well as at the time of writing this article,[12] I have been observing medical practice in the gynaecology division of the Tibetan medical hospital in Xining under the apprenticeship of a well-known female Tibetan gynaecologist. While few of my ethnographic observations will be discussed here, much of my understanding of menstruation, and women's diseases more generally, is greatly enhanced by observing clinical practice. Moreover, I observed the 'mixing'[13] of Tibetan and biomedical practices, which were informed by theoretical knowledge contained in my literary sources. Also, doctors and students were often kind enough to answer questions I had regarding gynaecological practice and the textual sources I was reading during rare lulls in hospital activity.[14]

Commentarial writing in Tibetan medical literature

A significant feature that all of my sources have in common is the way that information is presented in a commentarial fashion. In keeping with Tibetan literary customs, contemporary medical writers typically begin their works by

---

[12] My fieldwork in Xining is ongoing and will contribute to my thesis, 'The Red Element: Contemporary Tibetan Medical Literature on Women'.

[13] The doctor I apprentice under refers to her medical practice as Tibetan and biomedicine mixed together. Hence, to make a diagnosis she relied on pulse analysis and observation of the tongue, as well as biomedical testing such as blood, urine and vaginal discharge and cell analyses. She utilised Tibetan medical categories in her prognosis, such as 'excessive blood' (*khrag tshabs*) or 'wind-bile disorder' (*rlung mkhris nad*) and dispensed Tibetan medical pharmaceuticals. She did not give prescriptions for biomedical pharmaceuticals. If she could not treat a disorder with Tibetan medicine she referred patients to biomedical doctors and treatments, although even in these cases she still gave some Tibetan medical prescription, owing to the fact that some underlying problem could still benefit from Tibetan medicine.

[14] How the textual sources inform medical practice, as well as the language used by doctors and patients, are important related issues, which unfortunately will not be addressed in depth here. Also not discussed at length is whether or not, and to what extent, Buddhist ideas, such as the tantric origins of the white and red elements, are assumed, conflated or replaced in contemporary medical practice.

referencing and often quoting sections of literature considered authoritative; that is, the 'root text and commentaries' (*gzhung 'grel*) of a given subject matter. In Tibetan culture, the citing of and deference towards authoritative literature is crucially important, largely because the content of such literature is considered valid and correct knowledge. This practice, in part, is owed to Buddhist customs and the idea that authoritative literature is so called 'Buddha-word'; it is an ultimate and correct source of knowledge because it has been conceived in the mind of omniscient being. The *Four Treatises* is considered an authoritative medical source *par excellence*, providing the basis for all contemporary works and practices dealing with menstruation. It is also considered Buddha-word, being expounded by the Medicine Buddha (*rig pa'i ye shes*)[15] in a medical paradise.[16] Moreover, Tibetan medical historians have traditionally linked the history of Tibetan medicine with Buddhist history in Tibet, and the Buddha himself.[17] Other works considered authoritative include commentaries of the *Four Treatises*.

Commentarial writing, a tradition, which I argue contemporary authors continue to use, is the normative way of both adhering to authoritative knowledge, sources and authors (buddha or human), while at the same time, opening space for new ideas via 'clarifying' the original sources. Hence, contemporary authors often tell us that their work is meant to elucidate certain points of authoritative texts, which is accomplished by: 1) an investigation and comparison (*zhib bsdur*) into 'all of the meanings' (*dgongs don rnams*) or the 'root meaning' (*rtsa ba'i don*) of authoritative medical literature; 2) an examination of 'outside' (*phyi*) medicine, which I translate as biomedicine;[18] and 3) one's own experience (*rang nyid kyi' 'char sgo* or *nyam mongs*).[19] In this way, the practice of clarifying and elaborating authoritative sources is what allows innovation in the system, enabling the integration of various 'inner'

---

[15] The human writer and/or editor of the *Four Treatises* is gYu-thog Yon-tan mGon-po, who lived in the twelfth century ce. On the historical origins and religious and social context of the *Four Treatises*, see Fenner 1996 and Desi Sangye Gyatso 2010, pp. 1–26.

[16] I am uncertain as to whether or not, or to what degree, contemporary Tibetan doctors and writers in China ascribe to the notion that the *Four Treatises* are Buddha-word.

[17] Garrett 2008, pp. 41–2. See also Schaeffer 2003 on the relation between Mahāyāna Buddhism and Tibetan medical writing.

[18] I translate 'outside medicine' as 'biomedicine' because the former term could refer to other non-biomedical systems and the authors are clearly talking about biomedicine, rather than Indian or Chinese medicine.

[19] Several authors explicitly formulate their mode of research in this way: Lha-mo sKyid 2007, p. 103; dPal-ldan 'Phrin-las 1996, preface; Thub-bstan Phun-tshogs 1999, p. 40; dBang-rgyal 2005, p. 1. dPal-bzang rGya-mtsho 2010, p. 1. tells us that he has consulted authoritative and modern texts, and they are summarized in his book, so the reader does not need to consult these sources.

and 'outer' medical theories. Moreover, the basic truth claims of Tibetan medicine are never disputed, but rather, are maintained and, in some ways, strengthened by the inclusion of biomedicine. While contemporary works intended for a lay audience follow the above format less rigidly than theoretical and academic works, all of my sources premise menstruation on the core principles and ideas found in authoritative literature, and superimpose biomedical ideas onto a Tibetan framework. Hence, religious and cultural perceptions of gender contained in authoritative medical works are also often maintained with the incorporation of biomedicine.

Gender in Tibetan medicine: religious and cultural aspects

Throughout Tibetan history, medical knowledge about the female body was formulated in discussion with Buddhist—tantric, sutric, abhidharmic,[20] and monastic—perceptions of women's bodies, minds and emotions. For the majority of pre-modern medical writers, many of whom were celibate monks, the existence of womankind is owing to 'low [karmic] merit' (*bsod nams dman pa*). Moreover, the 'special characteristics' (*khyad par lhag*) of the female body—menstruation, the uterus (*mngal*) and breasts (*nu ma*)—as well as the extra 40 disorders of women's bodies,[21] are a material result of the 'inferior birth' (*skye ba dman*) of the female body. Few of today's medical writers assert that women and their bodies are acquired by low merit or moral inferiority. More often than not, they assume a sympathetic position towards women, citing their low social, cultural and religious status. Despite this, medical postulations of women's bodies, even empathetic ones, display how the making of scientific or medical knowledge is deeply intertwined with culture and religion, among multiple other factors that make up perceptions of gender.

Tibetan Buddhist monastic and medical perceptions of women

The Buddhist orientation of the *Four Treatises* and its commentaries is not surprising given that the scholarly medical tradition[22] in Tibet was primarily

[20] Abhidharma literature originates from Indian Buddhism, and was extensively commented and elaborated upon by Tibetan Buddhist and medical thinkers. It is a voluminous corpus that deals with many topics pertaining to both the outer and inner workings of the universe and humans. In regard to humans, abhidharmic literature examines the physical, mental and emotional aggregates that make up the person, or the *atman*—the sense of 'I'. The Abhidharma also elaborates on the differences between males and females.

[21] gYu-thog Yon-tan mGon-po 2006, p. 375.

[22] Here, I am not making reference to 'lineage doctors' or other kinds of Tibetan healing

based in the monasteries, and medical science (*gso ba rig pa*) itself is one of the five major sciences (*rig gnas che ba*) of the monastic curriculum. Many authors were monk-doctors who had little or no intimate contact with women.[23] Moreover, given that one of the primary, and arguably most difficult task for a celibate monk, is to quell sexual desire, women and their bodies were often portrayed in a negative light to dissuade monks from desiring feminine charms. For example, Wilson suggests that the Buddhist practice of meditating on decomposing female corpses, a practice recorded as being taught by the Buddha himself, is a means for celibate monks and nuns to view 'women as object lessons on the folly of desire'.[24] Another means of dissuading monks from desiring sex was through degrading female body parts, such as the vagina. Garrett writes:

> while Indian medical texts such as the *Heart of Medicine* may admit the vagina to be unpleasant when diseased, it is not characterized as such by that tradition. Thus, a negative orientation to the female body may be traced to early Indian Buddhist presentations, [Kritzer] argues, not to Indic medical traditions which, although still considering the male to be the default body in most contexts, nonetheless lack the stridently derogatory language of the Buddhist text.[25]

In many places throughout Tibetan Buddhist and medical literature, women and sexuality are joined together, typically in a negative light, placing the burden of male sexual desire on the shoulders of women.[26]

The correlation of women and sexual desire appears in a few places in the *Four Treatises*. For example, some Tibetan doctors and medical students told me that they understand the following verses on the origins of womankind from the 'women's diseases' (*mo nad*) section of the *Four Treatises* to point to women's excess in desire:

> The body which is made of the three poisons and the four elements appears as male and female by the power of previous karma and [sexual] desire. By having less merit [one] obtains the female body.[27]

Because sexual desire is perceived negatively in monastic circles, it would make sense that women, being nearly synonymous with sexual desire, have 'less merit'. Modern authors, however, like Palzang Gyatso, tend to rephrase the above verses in the following way:

---

traditions. For a good overview on different types of Tibetan healing practice, see Schrempf 2007.

[23] Garrett 2008, p. 48.

[24] Wilson 1996, p. 3.

[25] Garrett 2008, p. 77.

[26] See also Faure 1998 and 2003 for more on Buddhism and sexuality.

[27] gYu-thog Yon-tan mGon-po 2006, p. 375.

> The difference between the male and female manifestation is dependent upon: the powerful force of karma of the previous life, the force of the affliction of sexual desire, one's own consciousness, and the workings of the fiver inner and outer elements, and so forth.[28]

Note that the author does not mention 'low merit' in his summary, although arguably, many Tibetan readers would know that the assertion of low merit is present in the original source. An alternative reading of the above phrases from the *Four Treatises*, offered to me by Khenpo Kunga Sherab, referring to abhidharmic literature, is that this desire relates to the 'bardo-being'[29] who, seeing its future parents copulating, forms either desire for the mother, becoming a boy, or desire towards the father, becoming a girl. The above quote from Palzang Gyatso could be interpreted in the way Khenpo Kunga Sherab suggests; one becomes male or female depending on which parent their desire is directed towards. Yet, according to the *Four Treatises* one obtains an inferior body partly because of sexual desire. Because the contemporary author omits this line, he leaves open at least two possible interpretations of his meaning—that women have either an excess in desire, or simply desire for their father. In either case, however, the being ends up with a female body, one who carries the burden of menstruation.

The proposed inferiority of the female body appears in a number of places in the *Four Treatises.* The first section of the 'women's diseases' chapter tells us that 'less merit' leads to a female body (*za ma mo*).[30] There are various explanations for this particular term for woman, *za ma mo*, literally meaning 'does not eat and/or feed herself'. One suggestion is the notion that a woman cannot feed or get food herself but eats from another. This reading implies that she depends on a male for sustenance. Khenpo Kunga Sherab informed me that this idea is present in the vinaya, where it is stated that the man hunts and the woman cooks and consumes. It has also been suggested to me by medical students that the idea that a women does not feed herself is a kind of euphemism for sex; the male needs an erection in order to engage in intercourse, whereas a female, whose vagina is always 'open', can have sex at any time,[31] but needs the male penis. In other words, a woman is 'fed' by the man. The other term for woman found in the *Four Treatises, bud med*, which is still today the primary term for women in medical and other Tibetan literature, also has

---

[28] dPal-bzang rGya-mtsho 2010, p. 3.

[29] *Bar do* is a Tibetan term referring to the intermediate state between death and life; a 'state' where the karmic stores of a sentient being wanders until finding a womb to enter. See Garrett 2008 for more on the bardo being in Tibetan embryology.

[30] *za ma* alone (without the feminine ending, *mo*) refers to a third gender. See Gyatso 2003.

[31] Tibetan medical literature, however, is clear that women should not have sex during menstruation.

various interpretations. One suggestion is that *bud med* refers to the sex organs: men are known as *skyes pa*—'one who has grown [a penis]'—and women, not having a penis, are known as *bud med*—one whose '[penis] has fallen off'.[32] Lastly, the 40 types of 'extra' disorders of the uterus and breasts are the result of an 'inferior birth' (*skye ba dman*). Again, like the earlier examples show, womankind in the *Four Treatises* is largely defined in negative opposition to mankind. In all cases, negative suffixes—*ma, med*, and *dman*—are used to define woman. Furthermore, sexual overtones are evident.

It is clear from these examples that human bodies are infused with a sense of morality, and women have less moral merit than men. This is reflective of Buddhism wherein all bodies, whether of Buddhas, deities, or humans, always carry moral value.[33] The majority of contemporary medical works on women, however, no longer explicitly assert that women are of low birth or have an inferior body. On the contrary, today's medical writers, who are variously lay male and female doctors and monk-doctors, although still mostly men, articulate a more sympathetic and supportive voice in regard to women. Most of my sources explicitly state that women's low status in Tibetan society is cultural and/or religious. For example, Palzang Gyatso writes that the differences between men and women, and between individuals, is a result not only of karma and sexual desire, like we read above, but also social opportunity (*spyi tshogs kyi bgo skal*), ideology (*'du shes 'dzin stang*), the customs of one's country (*yul gyi goms srol*), religious doctrine (*chos lugs kyi grub mtha'*), social status (*spyi stogs kyi go gnas*) and the high and low qualities of one's family (*rigs kyi khyed par rten mchog dman*).[34]

On the other hand, there are rare instances wherein contemporary writers do assert or quote verses of authoritative text that claim women's low merit. Tsultrim Gyatso, a Buddhist monk, taking his cue from the *Four Treatises*, tells us that:

> It is by the power of desire that both male and female appear separately. Through having little merit, one so gains the body of a woman. The merit which is possessed by the power of fallen virtue is what a bird acquires…[35]

---

[32] This is one interpretation I was commonly told in Xining. Gyatso (2008) gives a similar explanation of *bud med* via reference to a story on the differentiation of the male and female sex organs found in *bod gangs can pa'i gso ba rig pa'i dpal ldan rgyud bzi sogs kyi brda dang dka' gnad 'ga' zhig bkrol ba sngon byung mkhas pa'i gsung rgyun g.yu thog dgongs ryan* by dBang-'dus. See footnote 44 in Gyatso 2008.

[33] Garrett 2008, pp. 58–9.

[34] dPal-bzang rGya-mtsho 2010, pp. 3–4.

[35] Tshul-khrims rGya-mtsho 2007, p. 200.

He then goes on, however, to state that religious practices that invoke Buddhist deities, such as Medicine Goddess of Bright Light (*sman kyi lha mo 'od 'chang ma*) can help those sentient beings afflicted with a women's body gain more merit. For him, this appears to be a sympathetic reassurance that one can still find happiness despite being female.

Palden Thinley,[36] in a final section asserting the value and importance of Tibetan women, debunks such 'old expressions' as 'even though peacock feathers are beautiful, they cannot fly' and additionally 'women's hair is very long and their mind is narrow'.[37] Both expressions point to the double-edged sword of beauty and sexual desire. The latter expression refers to the notion that women are bad-tempered and easily angered. He states that such comments are completely wrong and illogical, and that cultural perceptions of women's mental, physical and karmic inferiority disrupt what should be a state of equality between men and women. He correlates 'old ways of thinking' (*bsam blo rnying pa*) with women's low social status, and conversely, modernity, technological and scientific progress with an elevated status of women. He faults culture (*rig gnas*), rather than religion, for women's low status. Curiously, to support his argument for the equality of women, Palden Thinley posits the enigmatic, controversial and, among today's young Tibetans,[38] extremely popular figure, Gedun Chöpel[39] (1905–51) as a male forerunner of women's liberation. For those familiar with stories of Gedun Chöpel, his appearance as a champion of women in gynaecological literature seems strange because he was a well-known womanizer who is believed to have had sex with many teenage girls. This belief is evidenced in his manifesto on sex, *Treatise on Passion*,[40] a work wherein the author relays his experience and knowledge of sexual pleasure. In his *Treatise*, he suggests ways that tantric-like sexual practices, such as 'churning' the penis inside the vagina,[41] can bring not only pleasure but Buddhist liberation as well.[42] Palden Thinley's choice of verses from Gendun Chöpel's work is meant to exhort the male reader to understand that,

---

[36] Adams 2001b, pp. 225–239, examines dPal-ldan 'Phrin-las' 1998 edition of this book in great detail.

[37] dPal-ldan 'Phrin-las 1996, p. 77.

[38] Many young Tibetans from the Amdo area, the birthplace of Gedun Chöpel, express particular pride and admiration of this figure and it is commonplace for young intellectuals to have read all of his works. He is considered as a kind of folk hero, as much for his intellectual abilities as his 'crazy' yogi-like behaviour, such as his penchant for drinking large amounts of alcohol and his admitted sexual encounters with multiple women.

[39] dGe-'dun Chos-'phel.

[40] *'dod pa'i bstan bcos* 1969 [1938].

[41] Shaw 1994, p. 161.

[42] See Jeffery Hopkins's analysis of Gendun Chöpel's life and *Treatise on Passion* in Chöpel 1992.

without women, men cannot do anything. Quoting from *Treatise on Passion*:

> A [woman is someone who is] a benefit to one's self and the general benefit of a country. [Whether] a king's power or the livelihood of a beggar, small or big, any activity that you do, there is not one thing you can do without a woman.[43]

Palden Thinley also argues that religion supports the idea that women and men are equal. For example, he references the 14 root samaya vows of Vajrayana Buddhism which state that if a man insults a woman he has broken his vow. He also points to the tantric notion that like the necessary unity of wisdom, symbolized by woman, and method, symbolized by man, gender equality is essential. Because women are so essential to men, Palden Thinley instructs his male readers not to insult, beat, disparage, or bully women. Instead, he says, if you 'protect them with loving-kindness, then you are in harmony with the holy dharma and the human moral system'.[44]

Despite stating in the preface that the book is intended to educate women about their bodies, it is clear that this particular argument is explicitly made for the male reader, which is not uncommon among many materials on women's health and gynaecology. Palzang Gyatso's work, a small volume with a pink cover decorated by red and pink roses, also appears to be written for a male reader. For example, on recognizing and cultivating sexual relations with a woman, he writes:

> when you find *yourself* (*rang gi*) in a close, intimate encounter [with a woman], the centre of the woman's neck and chest expands and blooms very white. The armpit possessing the three knots gently loosens. If touched, great pleasure expands under the navel and at the root between the female thighs.[45]

The fact that sexual advice explicitly directed towards men is contained in a work that also describes personal care, like properly washing sanitary napkins and the vagina every day, might strike one as strange. One might assume that such information on intimate feminine hygiene is only beneficial and interesting to a female reader, and not so much for 'the guys'. Again, a certain ambiguity persists in the literature. It appears to be assumed that the reader of the family is male, and he will pass on this information to his female partner. Yet, most of the information, as well as the book's presentation such as the pink-flowered cover, would suggest an intended female audience. While this may be subtle, it is often the case that the author does not directly or definitively

---

[43] dPal-ldan 'Phrin-las 1996, p. 79. See Adams 2001b, p. 228, for her discussion and translation of Gendun Chopel's *Treatise on Passion* in Palden Thinley's work.

[44] dPal-ldan 'Phrin-las 1996, pp. 79–80.

[45] dPal-bzang rGya-mtsho 2010, p. 33. Emphasis mine.

assume a female reader, such as 'wash *your* vagina', or '*your* body', would indicate. Instead we find 'the vagina should be washed' or 'the woman's body'. A notable exception comes by way of our female writer, Lhamo Kyi, who writes '*we* must take care to…'[46]

Tantra in Tibetan medicine

Another significant religious influence in medical literature on women, alluded to by Palden Thinley, is the presence of tantric ideas of sexuality, the female body and human physiology in general. Tantric ideas of the body and their relation to medical ideas have been a considerable point of debate throughout Tibetan history. I will not detail these debates here or the complexities of tantric ideas of the body, but it is worthwhile to mention some key terms that also appear in contemporary medical literature on menstruation.

Tantra postulates a human body made up of winds (*rlung*), channels (*rtsa*), quintessential essences (*mdangs*), 'drops' (*thig le*) and 'wheels' (*'khor lo*; skt. *chakra*). The white and red elements (*khams dkar dmar*), crucial in contemporary medical literature on menstruation, are involved in all of these terms, being the substances that are refined and manipulated in the tantric body and yogic practices. Thubten Phuntsok tells us that:

> Wind is the master of movement and for this reason, it is an indispensable part without which the foundation of the human body cannot be established. [Wind is responsible for] exhalation and inhalation, the movement of the body, the body's strength, causes the ripening of the [red and white] elements and it performs the activity which is the ability to experience the objects of each of the senses. Furthermore, through training the winds they become flexible, and many inconceivable powers, such as special qualities, the blazing of blissful warmth in the body […] will be obtained.[47]

The winds travel via the channels, of which there are three primary ones: a centre one (*dbu*), and one on its right (*ro*) and left (*rkyang*).[48] Related to the channels and winds are the wheels and drops. In Thubten Phuntsok's description, there are six wheels which run along the centre channel, ranging from the crown of the head to the genitals. The wheels, named according to their tantric letter or syllable, are said to be blocked by impurities of the white and

---

[46] Lha-mo sKyid 2007, p. 108. Emphasis mine.

[47] Thub-bstan Phun-tshogs 1999, p. 113. I am grateful to Frances Garrett for sharing her translation of Thub-bstan Phun-tshogs with me, which filled in many of the gaps of my own translation.

[48] Thub-bstan Phun-tshogs 1999, p. 109. For more on the three channels in Tibetan Medicine, see Garrett and Adams 2008.

red drops, which are the quintessence or the very refined parts of the white and red elements.[49] On the origin of the drops, Thubten Phuntsok writes:

> In general, the characteristic basis of drops… is the quintessence of the essence part of both the red and white elements or reproductive fluid, the last of the 7 bodily constituents. Furthermore, the *Explanatory Tantra* says: 'The last of the bodily constituents, reproductive fluid, the most excellent quintessence, is located at the heart and pervades the entire body, and the source of life is the brilliant resplendent quintessence'.[50]

The quintessence he describes is, in tantra, what resides in the centre channel, and is supported by winds. On the location in the central channel of the white and red drops in relation to the wheels, he writes:

> The upper tip, the nature of *Ham*, is blocked by the white part (*dkar chas*), and the lower tip, below [the navel] is blocked by the red part (*dmar chas*), the small *Ah*. Between those two, the 'great existence wind' (*srog chen po'i rlung*) supports the 'ground consciousness of all' (*kun gzhi rnam par shes pa*) [which] abides there.[51]

How the drops block the wheels, and their relation to yogic practices, is explained further by an analysis of the drops. Based on tantric thought, Thubten Phuntsok describes two drops: the unconditioned drop (*spros bral*) and the drop of confusion or ignorance (*'khrul pa ma rig pa*). The first, he tells us, quoting from the *Six Yogas of Naropa*, is the 'spontaneously born primal awareness' of one's mind. The second refers to the drop of dualistic thinking which obscures or blocks the unconditioned drop. He further elaborates that within the drop of confusion and ignorance, the two white and red essences abide and they need to be purified. Their impurity is owed to 'negative emotional and cognitive patterns [that have] become lodged in the psychic body

---

[49] This section will perhaps make more sense once one reads more on digestion and the seven bodily constituents in the following section. Briefly, once food and drink are consumed digestive heat separate the essence and refuse of that initial nutrition; the essence goes on to become other body parts and the refuse is expelled. This process goes through six stages until the seventh, which is reproductive fluid. The red and white fluids, while present in both men and women, function differently. Menstruation is the refuse of the red part of reproductive fluid. According to tantric thought, the quintessence that abides in the centre channel is the essence of reproductive fluid. In being so, it is considered the most refined and pure substance of the body.

[50] Thub-bstan Phun-tshogs 1999, p. 119.

[51] Thub-bstan Phun-tshogs 1999, p. 107. Palzang Gyatso describes a similar tantric physiology:

> According to the *Mahayoga Tantras,* of the white and red element, the essence of the white part, resides in your body's central channel (*rtsa dbu ma*), at the upper end of the blood vessel between the eyebrows. And, the essence of the red element rests four finger lengths below the navel towards the lower tip of the central channel. Parts of these two [red and white elements] pervade the entire body (dPal-bzang rGya-mtsho 2010, p. 4).

in the form of knots'.[52] To untie these 'knots', Thubten Phuntsok describes one tantric yogic practice, the bliss of 'inner heat' (*gtum mo*). According to this yoga, the practitioner causes the heat of the red element, symbolized as the sun, at the lower end of the centre channel to 'blaze' upwards, melting and causing to drip down the white element, symbolized as the moon, residing at the crown. When the two quintessences meet in the centre, this he says, quoting from the *Guhyasamaja* tantra (*gsang 'dus*), '[is] the most excellent of blisses… [and] generates the joy of innate primordial wisdom'.[53]

Although the inclusion of hormones will be addressed in the following section, it is worthwhile here to point out that Thubten Phuntsok explicitly locates 'hormones' (*ho'o mo'u*)[54] as being the same substance as or abiding in the quintessence of the essence of the reproductive fluids. He further postulates at the end of the section described above, on the tantric system of winds, channels, drops and wheels that '…the shapes of letters such as Ah and Ee at the individual locations of the channels… be examined in detail [to learn] whether they refer to "channels" (*rtsa*) or "glands" (*rmen bu*)'.[55] He then further postulates that if they, the tantric letters at the wheels in the centre channel, are to be understood as glands, then their relation to the 'Western' idea of hormones and glands should likewise be 'carefully examined' for similarities.[56]

While yogic practices, such as the one Thubten Phuntsok describes, can be done on one's own, according to some higher tantras, those of the Mahayoga, sexual yoga with a real female partner, is more effective. This idea rests, in part, as is elaborated by Gendun Chöpel in his *Treatise on Passion* and by Palden Thinley, on the idea that if woman (wisdom) and man (method) are 'unified' bliss and enlightenment follow. According to this tantric view, women should be considered equal to men, even worshipped.[57] It could be argued that tantric works, which are highly influential in Tibetan Buddhism, shed a more positive light on women and sexual desire. However, there is considerable debate on this among Western scholars.[58] Nonetheless, tantric physiology as well as sex-

---

[52] Shaw 1994, p. 147.

[53] Thub-bstan Phun-tshogs 1999, p. 119. For further discussion on 'inner heat', see Gyatso 1998, p. 194; Tsong-ka-pa 2005.

[54] Thub-bstan Phun-tshogs 1999, p. 125.

[55] Ibid. The term, *rmen bu*, roughly translated as 'glands', appears is a few places in contemporary medical literature on menstruation.

[56] Ibid.

[57] See Shaw 1994, pp. 152–59, on the tantric notion of worshipping women.

[58] Miranda Shaw (1994) and Ronald Davidson (2002) occupy the two ends of the pole in the debate of women's position in tantric circles. Shaw argues that female tantric practitioners were liberated, assertive women, equal to men in education, religious attainment and status. On the other hand, Davidson suggests female tantric practitioners, the bodily instruments of unscrupulous male ascetics, were nothing more than prostitutes with no religious inkling whatsoever. For

ual practices are highly influential in Tibetan medicine in many ways.[59] Further analysis of women's sexuality will be taken up after we have looked more carefully at how hormones are integrated into the Tibetan system.

Thus far, I have examined ways in which both authoritative and contemporary medical literature perceive gender and the female body in relation to Buddhist monastic and tantric thought. I have paid particular attention to the issue of women's 'low merit' found in the *Four Treatises*, and how such a notion is countered in present-day writings. I have also focused on women and sexual desire, highlighting how they are variously conceived in Buddhist and medical literature. The intention of these analyses is to show how medical knowledge is deeply infused with religious and cultural meanings, which communicate Tibetan ideas about women, gender and sexed bodies. In this next section, which investigates the hybridisation of Tibetan and biomedical knowledge of menstruation, I suggest that these religious and cultural ideas of women persist in modern-day medical literature. I further argue that biomedical notions of 'sex' hormones are used by Tibetan authors to augment and bolster core principles of Tibetan medicine.

Tibetan and biomedical hybrid theories of menstruation

Biomedical ideas about the relation between menstruation and hormonal processes enter Tibetan medicine largely through theories of digestion and the red element, although authors employ different terms to refer to hormones, such as 'quintessence' (*mdangs*), 'great vital essence' (*bcud chen po*), 'female nectar' (*mo rtsi*) and 'hormones' (*ho'o mo'u*). As I stated earlier, contemporary medical writers claim to be able to integrate Tibetan and biomedical knowledge by means of analysis of authoritative texts, the study of other 'outside' medical systems and by their own experience. All of the authors claim to have investigated biomedicine to some degree. Also, all of the sources argue that Tibetan and biomedicine are compatible, and a few suggest that more research is needed to investigate these links. I argue that fundamental ideas of Tibetan medicine, religion and culture are not only retained in contemporary literature, but that their authoritative status is strengthened by the inclusion of biomedical ideas of hormones.

---

an example of a contemporary Tibetan female had a male partner, see Jacoby 2007. For more on women in tantra, see Campbell 1996 and Young 2004.

[59] For example, the virility/fertility chapters of the *Four Treatises* refer to the tantric way of having sexual intercourse with a female 'friend' (*'grogs par bya*) (gYu-thog Yon-tan mGon-po. 2006, p. 553).

Lhamo Kyi on how menstruation is made

Perhaps it is useful to begin with a careful reading of Lhamo Kyi's detailed description of menstruation and the functions of digestion and the red element. In her article, Lhamo Kyi argues for an integrated Tibetan and biomedical account of menstruation by first quoting various medical commentaries of the *Four Treatises* in order to form the defining basis of menstruation. Based on authoritative texts, she writes the 'nature' (*chos nyid*)[60] of mature women is to menstruate and that once a girl begins menstruating, this is a sign that she is able to become pregnant. Then, where we will pick up, she elaborates on how menstruation comes into existence:

> Whatever food and drink which belong to the six tastes (*ro drug*), at the time when the consumed foods are coming into the stomach, the three main heats (*gtso bo'i me drod gsum*) which reside in that [stomach] gradually decompose and digest [the food], and by that, separates the refuse (*snyig ma*) from the essence (*dwangs ma*). The essences, through the secondary channels (*rtsa phran*) on the surface of the stomach and the intestines, come to reside in the liver. From there, as for the liver, by the three heats that circulate (*'khor*) [and] reside there, the essence (*dwangs ma*) of that initial food and drink, from being decomposed and digested [in the liver], the essence and the refuse are separated, [and] by the action of the colour changing bile (*mdangs sgyur mkhris pa*), that essence becomes blood.[61]

Next, by quoting from *The Eighteen Branches, A Canopy over a Precious Cloud* and *The Crystal Mirror*, she establishes how the heart pumps blood throughout the body. She then continues:

> . . . [T]he system of [how] the 'strength producing blood' spreads throughout the entire body is clearly established. From there, the three heats (*me drod*) that abide in each and every individual body part, gradually, by means of decomposition and digestion separate the essence from the refuse [and by this] system mature and develop the later parts of the body. The *Four Treatises* and authoritative commentaries very clearly explain [the digestive process], and here, although the explanation is brief, for the time being it is established [by the authoritative literature]. Like that, having gradually become totally ripened, the reproductive fluid (*khu ba*) itself, the last of the body constituents, [after] having had the essence separated from the refuse, the essence [becomes] the body's quintessence (*mdangs*), and

[60] *Chos nyid* is a Buddhist philosophical term indicating something's inherent nature. For example, fire's nature is to be hot; if there is no heat, then it is not a fire. Similarly, Lha-mo sKyid asserts a woman's nature is to menstruate; if there is no menstruation then there is either a medical problem or the individual is not a woman.

[61] Lha-mo sKyid 2007, p. 104.

> the refuse, from having gathered in the ovar[ies], becomes the cause of the seed (*sa bon*) for conception (*mngal 'dzin*).[62]

After establishing the Tibetan system of how digestion makes the body and reproductive fluids, she begins to integrate biomedical ideas. In this account, I interpret 'great vital essence' (*bcud chen po*) to indicate hormones.[63] I suggest that her wording, 'furthermore…', indicates the idea that 'authoritative Tibetan medical knowledge is further evidenced and substantiated by biomedical knowledge':

> Furthermore, as for the outer elements (*phyi'i 'byung khams*), from the sixteenth day of every calendar month up to and including the thirtieth, on these occasions the power of the sun increases [causing], the seed of the 'brain heart' (*klad snying sa bon*),[64] to reside in the 'vital essence channel' (*bcud kyi rtsa*) and that 'great vital essence' (*bcud chen po*) establishes the vital essence of the bodily constituents (*zungs bcud kyi ngo bo*), [and] those activities of the the life-sustaining wind *(srog 'dzin rlung*) and pervasive wind (*khyab byed rlung*) [cause] circulation [within] the brain's nerves [?] (*klad pa'i dbang rtsa*)[65] and the subtle blood channels (*khrag rtsa phra mo*) which plants the power to cause the red and white elements inside the ovar[ies] to gradually ripen and mature, eventually/lastly becoming the seed or red element of conception.[66]

Here she establishes that the 'great vital essence', which is the product of the digestive process, is the cause for the maturation of the red element inside the ovary. Moreover, she indicates that the 'great vital essence' that abides in the 'vital essence channel' is located somewhere in the brain. Her choice of using *bcud*, meaning 'essence', 'elixir' or 'nectar' is indicative of Tibetan religious as well as medical ideas. According to Garrett, *bcud* is related to Tibetan alchemical traditions wherein 'techniques using combined pharmacological and "mystical" realms of knowledge [are] typically [used] for the purpose of extending life span.… In Tibet, internal alchemy… [focuses] especially on yogic and contemplative manipulations of the inner body.'[67] In the *Four Treatises* chapter, 'extracting the essence to expand one's life span' (*rgas pa gso ba bcud len*) we are told that 'to expand the condition of an exhausted life span,

---

[62] Ibid.

[63] Dr Choe Lothar confirmed my interpretation to be correct.

[64] According to Dr Choelo Thar, *klad snying* refers to the centre of the brain and generally refers to the glands or 'part's of the brain that control hormonal processes, ovulation and menstruation'.

[65] *Klad pa'i dbang rtsa* is also referred to as the brain's 'nervous system', but refers generally to pathways or channels of the brain that carry 'vital essence' or, in other words, hormones.

[66] Lha-mo sKyid 2007, p. 104.

[67] Garrett 2009, p. 221.

one should learn the ritual method of extracting the essence'.[68] Lhamo Kyi's use of *bcud* appears to indicate the idea that hormones are some kind of 'essence' that are related to one's life span and life-giving potential. Similar to the biomedical notion that hormones are responsible for the growth of male and female reproductive capacities, the 'great vital essence' is responsible for the growth of the parts of the body that mature and ripen the red and white elements, suggesting that *bcud*, like hormones, are fundamental for life and reproduction. In this instance, the use of *bcud* invokes Tibetan religious and medical meanings, while suggesting new or additional meanings that integrate biomedicine.

Next, Lhamo Kyi describes how the inclusion of biomedical notions of hormones, originating from the brain and carrying messages to the ovaries, should be correctly understood. Here she is participating in the debate on how to conceive the relations among the brain, hormones and reproductive fluid:

> In regards to this, a few people say that from [their] point of view, because the two, brain (*klad pa*) and marrow (*rkang*)[69] have a common root location (*ngo bo gzhi mthun*); [and] by reference to a few sections of texts, stubbornly insist that reproductive fluid arises from the brain. If reproductive fluid becomes perceived in this way, as postulated as arising from the brain, then it would be necessary for there to be quite large/thick different male and female 'essence channels' (*rtsa cung*) that move the reproductive fluid between the brain and the ovaries.[70] [This would be] necessary given the inherent nature (*chos nyid*) of material substance[s] (*dngos po*) [require a channel to move from one place to another]. How then [does that occur when] reproductive fluid is not only inherently heavy and oily, but sticky too? These days, the trend of modern science (*gsar dar tshan rig*) is very quickly becoming familiar here [in Tibet]. If [we] use a magnifying glass, etc., to see subtle [material substances] that the physical eye does not see, then even small particles (*rdul phran*) or cells (*phra phung*) just like seeing a sour fruit in the palm of the hand, are clearly seen [and therefore] as soon as it is explained that there is, postulated like that, a pathway (*lam*) that moves the reproductive fluid, it not only disproves [that thesis] but is not in keeping with the intended meaning of the *Four Treatises*. Even if we isolate ourselves from the power of new inventions, and use common sense, [this theory] is not in agreement with the other [biomedical system].[71]

Clearly, one of Lhamo Kyi's central aims is to show how the 'underlying meaning' of both the *Four Treatises* and its commentaries—texts she quotes

---

[68] gYu-thog Yon-tan mGon-po 2006, 548. For information regarding the Tibetan Buddhist and medical ritual of 'extracting the essence', otherwise known as 'accomplishing the medicine' (*sman grub*), see Garret 2009.

[69] In Tibetan thought the substance of the brain is marrow.

[70] In Tibetan, *bsam se'u* refers to both the male and female reproductive sacs.

[71] Lha-mo sKyid 2007, p. 104.

extensively from—are completely compatible with biomedical knowledge. Part of her argument is that biomedical devices, such as microscopes, make visible Tibetan knowledge that was only known before the modern era by their effects, and not by being directly seen. In this way, Lhamo Kyi argues that biomedicine does not disprove Tibetan medical knowledge, but rather vindicates it.

Having disproved erroneous interpretations of hormones, she tells us her theory, which entirely integrates Tibetan and biomedicine:

> Therefore, I myself think that the 'successive events of the seed' (*skabs 'di'i sa bon*)[72] is the reproductive fluid residing in the 'vital essence channel'. It is inherently heavy and oily because of bile (*mkhris pa*). And, the essence that establishes the root of 'vital essence' and the 'great vital essence' which cannot be seen with the eyes, is not itself, the actual seed of conception [...].[73] If one asks why, it is thus: reproductive fluid arises by the vital essence of the seven bodily constituents, which are the ripened body parts of the essence of food and drink. As it is said [earlier] the seven bodily constituents, by more and more separations [into essence and refuse become] heavy, so the nature of the reproductive fluid is likewise heavy and oily [...]. Therefore, that great vital essence possesses the inherent nature of bile which is heaviness and oiliness, even when it stays in the upper or falls to the lower [parts of the body], its inherent self-nature is [that of bile]. The life-sustaining wind, circulating the essence of the vital essence,[74] governs the brain's 'system of channels',[75] and the 'downward-expelling wind' governs the circulation of the subtle blood channels by which [the red element] descends or is carried to the ovaries. From there, by having planted the potency (*nus pa*) to cause parts of the reproductive fluid or red element residing there [in the ovaries], [the great vital essence] does not only help but stimulates [the red element or reproductive fluid] to completely ripen. If one asks, it is not possible to identify what this channel is. There is no conflict with the meaning behind the earlier texts; there are no contradictions.[76]

Here, Lhamo Kyi suggests that the nature of the 'great vital essence'—hormones—is that of bile, one of the three humours foundational to Tibetan understandings of the very constitution of the body.[77] Additionally, note that medical and tantric notions of refining subtle essences, integrated with medical

---

[72] Here, I suggest that *skabs 'di'i sa bon*—'the successive events of the seed'—could be interpreted as a Tibetan rendering of the 'ovulary cycle'.

[73] Essentially, we are told that the 'great vital essence'—hormones—is not the 'actual' (*dngos min*) 'gross' seed, but the 'subtle' form of the red element.

[74] That is, the essence of the foods is circulated through the body via blood.

[75] Again, this is referring to the glands or the brain's chemical pathways that produce and carry hormones.

[76] Lha-mo sKyid 2007, pp. 104–5.

[77] The three humours—wind (*rlung*), bile (*mkhris pa*) and phlegm (*bad kan*)—correspond to the three afflictive emotions—desire (*'dod chags*), hatred (*zhe ldang*) and ignorance (*gti mug*).

ideas of digestion, are used to describe hormones. Now, having clearly shown that biomedicine does not contradict Tibetan medicine, Lhamo Kyi proceeds with an explanation of how conception occurs once the 'great vital essence' has ripened the red element:

> Therefore, that red element which has ripened and gathered in the ovaries at the time when the cervix opens or at the time of fertility, by the 'downward-moving wind', the element is carried from the ovaries to the inside of the uterus by the two [fallopian] tubes (*sbu gu*). At the time of such a situation [of being fertile], if both the male and female seed are flawless, and the male's white element meets with the female seed in the uterus [and] a bardo-being's (*bar do*) consciousness (*rnam par shes pa*) is mutually compatible with [both parents] then the gathering [of those conditions] apply [and] that sentient being (*sems can*) enters the mother's uterus and pregnancy is achieved.[78]

Her summary explaining how conception occurs employs a range of Tibetan religious, medical and biomedical ideas.[79] We can clearly see in the logic of her argument thus far that because biomedicine confirms Tibetan knowledge of digestion and the making of menstruation, other religious and cultural ideas of conception and embryology, such as the presence of the bardo being and karma, suggesting the Buddhist notion of rebirth, are also valid. Throughout the remainder of Lhamo Kyi's article, she moves between and harmonizes tantric ideas with Tibetan and biomedical knowledge such as her explanation of how the inner cycle of the 'winds, channels, and drops'[80] effect one's emotions, and the outer seasonal, monthly and daily cycles influence the 'great vital essence' to stimulate the menstrual cycle. For her, biomedicine does not contradict Tibetan knowledge, but confirms its truth.

Hybrid Tibetan tantric, medical and biomedical theories of menstruation

Like Lhamo Kyi, Thubten Phuntsok is interested in harmonizing Tibetan medical and tantric ideas with biomedical knowledge of menstruation. Thubten Phuntsok is the only author who refers specially to hormones as *ho'o mo'u*. In each instance, he writes the Tibetan phonetic equivalent with the English spelling in brackets. Similar to Lhamo Kyi, Thubten Phuntsok locates hormones as arising from the process of digestion and the ever-refining stages of the red element. In keeping with commentarial fashion, he begins his

[78] Lha-mo sKyid 2007, p. 105.

[79] See Garrett 2008 for more on the relation of Tibetan religious and medical ideas on conception and embryology.

[80] Lha-mo sKyid 2007, p. 107.

discussion on menstruation by quoting from the *Four Treatises* and its commentaries, and then elaborates their underlying meanings:

> [A]ccording to Tibetan customs there are two different systems of identifying the essence and refuse of things. Some say that the central meaning of essence is the part which is hard and solid, and the refuse takes the nature of a thin liquid. Yet, it is also customarily said that the central meaning of the essence is thin and the refuse is hard and solid. For example, by churning milk after the butter has been taken out, the refuse is the milk which is a thin liquid, and the essence is identified as the butter, which is solid. Also, reproductive fluid [is compared to] the taking out the refuse of beer (*chang*), wherein the fibrous part is solid and [is considered] the refuse. And likewise, the beer which is thin, is identified as the essence. Within the customary system, then, there are two types of reproductive fluid: thick and thin. From mixing together [the reproductive fluid] with blood, the constituents take the form of thin water, and this becomes the bodily constituents, and the thick liquid trickles downwards by way of the channels from the ovaries and becomes the seed for conception in the uterus. In the modern texts of Western medicine, that which comes out from the ovaries are 'hormones', which mix with the blood to become the bodily constituents. And also, from the ovaries the seed of pregnancy is the egg; by way of the channels [fallopian tubes] it falls from the ovaries and becomes the seed for conception. This [Tibetan] explanatory system is conceived in roughly a similar manner in Western medicine.[81]

Here, like Lhamo Kyi, Thubten Phuntsok postulates that hormones are similar to, or the same substance of the quintessence of the essence of food and drink, and like these substances, mix with the blood to grow and ripen the red element and seed for conception. Hormones, then, like the elements, essence and quintessence, all have their basis in food and drink and by way of digestion become more and more refined. Also, as mentioned earlier, Thubten Phuntsok postulates that the wheels along the central channel could be conceived as the glands that regulate hormones that 'Western medicine' speaks of. Curiously though, in a diagram of the female body, which he labels 'the system of glands through which hormones (quintessence) [travel]' (*ho'o mo'u* (*mdangs*) *rgyus ba'i rmen bu'i rigs*),[82] he locates the glands throughout the body, including at the brain, pancreas, adrenal glands and the ovaries.

It appears that Thubten Phuntsok knows of biomedical theories of menstruation but is less able to fully integrate them into Tibetan medical theory in the way Lhamo Kyi does. He postulates how they could be conceived of in a similar manner, and that the two systems are compatible but admits that more investigation is needed. Similarly, Palden Thinley presents at the beginning of his book several biomedical illustrations of female anatomy with Tibetan

---

[81] Thub-bstan Phun-tshogs 1999, pp. 42–3.

[82] Thub-bstan Phun-tshogs 1999, p. 146.

language labels. Yet he does not elaborate on their meanings, suggesting that they are compatible, but we are not exactly sure how. For example, in a diagram of the uterus, he labels the stages of the egg ovulating inside the ovary, using such names as 'white shape' (*dkar gzugs*) and 'yellow shape' (*ser gzugs*). By including diagrams of ovulation he is indirectly, at least, pointing to the presence of hormones in the body, but does not explicitly speak of them in the text. Moreover, in his explanation of menstruation and women's health he does not actually refer to any of the biomedical terms of his illustrations but presents a rather 'traditional' Tibetan medical account of the female body. Therefore, it appears that he has not studied biomedicine extensively but feels inclined to include biomedical illustrations, by far the most detailed ones in my sources.

If we recall from earlier, in his final chapter on the value of women in Tibetan society, Palden Thinley equates modernity with women's elevated status, and 'old ways of thinking' with their oppression. Yet he looks to 'old' religious ideas, such as the union of wisdom and means and the tantric root vows to argue for women's equality. In its entirety, Palden Thinley's presentation of women's health is somewhat ambiguous: he both celebrates and admonishes 'old' Tibetan ways of thinking (although he is careful to point out that negative attitudes derive from culture and not from religion). He similarly presents 'modern' diagrams of women's anatomy, but then offers a Tibetan medical explanation of the female body. In addition, the preface states that his book is intended for women, but he includes arguments explicitly for a male reader. Clearly, like other present-day medical writers, he argues that Tibetan and 'modern' ideas of the female body are compatible, yet he is unable to incorporate them into a more cohesive whole. Such ambiguity may point more to political pressure to at least seemingly incorporate modern biomedicine, even if a thorough and genuine investigation has not taken place.[83]

Wang Gyal, on the other hand, presents, I argue, the most integrated explanation of Tibetan and biomedical theories of menstruation. Wang Gyal opens his book on women's health with a detailed summary of how menstruation works. Instead of focusing on the seed like Lhamo Kyi, Wang Gyal concentrates on the stages of the uterus lining, a concept not present in authoritative literature. Here I present my translation of the entire first chapter, which explains the relation between what I interpret[84] as hormones (*mo rtsi*) and the menstrual cycle (*zla mtshan dus 'khor*):

---

[83] Adams 2001b, pp. 225–239, offers an extensive examination of the politics present in dPal-ldan 'Phrin-las' work.

[84] Dr Choelo Thar confirmed my interpretation that *mo tsi* in this case refers to hormones.

That which is known as the uterus lining (*mngal skyi*) refers to the gradual systematic changes of the fine skin (*skyi mo srab mo*) on the interior of a woman's uterus. A woman is [someone who] before [reaching] the age of eleven or twelve has a very small uterus, [but afterwards that uterus] gradually becomes bigger and bigger; there are no other changes [specifically in the uterus]. When [one] reaches maturity, that uterus lining goes through a transformation (*'gyur ldog*) once during each month. That transformation is the result of many appropriate causes and conditions (*rgyu rkyen*) which arise and transform the red element. Inside the material cause (*grub cha*)[85] of the red element, cells (*phra phung*) grow and increase the red element until it ripens and comes out [as menstruation]. Yellow shapes (*ser gzugs*) grow and increase, arise and degenerate and so on. The circumstance of that transformation, [is produced by] the arising of *mo rtsi* inside the cause of the red element. The arising [and] changes in the secretions of *mo tsi* change from a little to a lot, and from a lot to a little, according to the regular nature (*chos nyid*) of one's own monthly cycle. Depending on the effects of the arising of *mo rtsi*, the lining on the interior of the uterus expands and becomes thicker and thicker.[86] Pregnancy is dependant upon the effects of *rgyu rtsi* and *mo rtsi'i thun mong*:[87] the lining on the interior of the uterus undergoes changes [that makes it able to] grasp [the seed]. Depending on the sequence of the arising of the secretion of those [two *rtsi*], the changes that occur in the lining on the interior of the uterus prepare the uterus for pregnancy. If the red element and white element do not intermingle[88] then the red element does not become mixed with the white element. The degeneration of the yellow shapes is [because] the two types of *rtsi* are becoming less and less, and, the power to continue lessens. And because of atrophy [the yellow shapes] degenerate from the root. That departing blood, made of the pieces of the inside of the uterus lining, comes out by the uterus opening, [and] is called menstruation. The pieces of the lining on the interior of the uterus take approximately between three and five days [to come out]. Afterwards, there will be a new skin on the inside slope of the uterus. New cells of the red element, once again ripen. Therefore, because those activities are cyclical, menstruation is called a 'cycle'. On average one menstrual cycle takes 28 days and according to one's bodily situation it is possible for [menstruation] to come early or late. A menstrual cycle that is regular is a sign of a woman's health. The arising of transformations that likewise

[85] According to Dr Choelo Thar, *grub cha* refers to a very tiny material 'cell' that is inside the red element. The growth and increase of the cells of the red element refers directly to the digestive process; the separating of essences and wastes. The materiality of the *grub cha*, then, is provided initially by the nutrition in food. Moreover, the *grub cha* increases and decreases depending on the cycle of *mo rtsi*.

[86] In his more succinct lay presentation of this idea, writes: 'In order to prepare for conception, the lining of blood on the interior of the uterus becomes more and more thick.' (2010, pp. 9–10).

[87] I am unsure how to translate these. Dr Choelo Thar suggested that these refer to general hormones and specifically female hormones. Or, given that different hormones are involved in the menstrual cycle, it is possible that he is referring to any of these. I assume that they refer to the hormonal interactions between the hypothalamic region of the brain, the pituitary gland and the ovaries. More investigation on this point is needed.

[88] That is, no sexual intercourse or protected sex has occurred.

> [control] the menstrual cycle—the *klad skyi*[89] and the nervous system (*dbang rtsa*), [and] the system of *lte ba*[90] and so on—make [menstruation] regular. Especially the mutual effects produced by the relations of the *klad 'bur, klad dril*[91] and the source of the red element are important parts that regulate menstruation. One's outside environment and so on affects the menstrual cycle, but this is straight forward.[92]

Wang Gyal's explanation of menstruation is the most precise of my sources in describing how different regions of the brain control and regulate menstrual cycles. Unlike Thubten Phuntsok, he does not use the term 'gland' (*rmen bu*), but like Lhamo Kyi, he refers to the 'brain' (*klad*) to indicate the location of where hormones arise. Hence, it appears that there is some debate as to how to understand from where and how hormones arise. Also noteworthy is his use of 'yellow shapes'[93] to refer to the corpus luteum[94] or in lay terms, an ovulary stage of the egg. Clearly, Wang Gyal has studied biomedical knowledge on the stages of ovulation, the uterus lining and their relation with hormonal processes, and he incorporates these rather thoroughly in his description of menstruation. Much of his explanation, therefore, is new to Tibetan medicine, yet, he still retains fundamental Tibetan ideas of menstruation, such as the red element and the process of digestion.

The sexing of hormones in Tibetan medical literature

Wang Gyal's use of *mo rtsi* to refer to hormones evokes Tibetan cultural and religious ideas. Literally translated, *mo rtsi* can mean female 'nectar', 'elixir' or 'juice'. As such, his use of this term conjures up tantric alchemical ideas of the inner body in a similar way that Lhamo Kyi's use of 'great vital essence' does. In addition, by affixing a specifically feminine particle, *mo*, Wang Gyal alludes to the biomedical notion that hormones are 'sexed', meaning that the very intrinsic nature and characteristics of a male or female body are believed to be determined by specific male and female hormones. The 'sexing' of hormones

---

[89] I am unsure how to translate *klad skyi*, literally meaning 'brain skin', but it refers to some part of the brain that controls menstruation.

[90] Dr Choelo Thar claims that the *lte ba* is like a very small seed cell.

[91] I am not able to directly translate these for certain at this time. *'Bur* and *dril* are Chinese phonetic renderings of the glands located in the brain which are responsible for the regulation of hormones. I suspect that they refer to the hypothalamic region of the brain and the pituitary gland.

[92] dBang-rgyal 2005, pp. 1–3.

[93] As mentioned earlier, dPal-ldan 'Phrin-las includes 'yellow shapes' in an illustration of the uterus.

[94] Hacker *et al*. 2010, p. 41.

has been criticized by a number of Western feminist scholars[95] of science who argue that cultural, social and religious prescriptions of gender, such as the insistence that a human being can only be male or female, has significantly contributed to the creation of 'sex hormones' rather than just 'hormones'. On the 'discovery' of the endocrine system and 'sex hormones' in the 1940s, Fausto-Sterling writes:

> As they explored hormone science [...] researchers could make hormones intelligible only in terms of the struggles around gender and race that characterized their working environments. Each choice that scientists made about how to measure and name the molecules they studied naturalized cultural ideas about gender. Each institution and persuasive community involved in hormone research brought to the table a social agenda about race and gender. Pharmaceutical companies, experimental biologists, physicians, agricultural biologists, and sex researchers intersected with feminists, advocates of homosexual rights, eugenicists, birth control advocates, psychologists and charitable foundations. Each of these groups, which I will call social worlds, were linked by people, ideas, laboratories, research materials, funding, and much more. By examining how these worlds intersected, we can see the ways in which certain molecules became part of our system of gender—how gender became chemical.[96]

I suggest that, in contemporary Tibetan medical literature, we see that women's 'nature' (*chos nyid*) is becoming more intimately associated with the activities of menstruation itself. As Lhamo Kyi asserts, the 'nature of woman' is to menstruate. Moreover, as Wang Gyal writes, the 'nature' of the timing of a women's menstrual cycle is closely correlated with the increase and decrease of hormonal secretions which, as we shall see shortly, correspond to mood changes and the arising of sexual desire. Tibetan conceptions of hormones appear to be 'sexed' in the same way biomedicine understands them, such as the term *mo rtsi* indicates. Likewise, the Tibetan notion that the red and white elements become different reproductive fluids in men and women, by being in conversation with hormones, the specific activities of the red element in women's bodies are becoming more solidified as defining womankind. Tibetan medicine has long viewed women's bodies as being fundamentally different from those of men. Previously, this was owed to 'low merit' but today, I argue, it is becoming an innate 'chemical-like' feature of the body, similar to the way that hormones define 'sex' according to biomedicine. I still maintain, however, that core Tibetan medical principles are retained, along with cultural and religious perceptions of women.

---

[95] See Fausto-Sterling 2000; Keller 1992; Roberts 2002.

[96] Fausto-Sterling 2000, p. 148.

Like Fausto-Sterling argues, I have asserted throughout this article that the incorporation of biomedicine in Tibetan medical knowledge of menstruation is inescapably intertwined with cultural and religious perceptions of gender and the female-sexed body. Contemporary medical authors present a hybrid account of menstruation, mixing Tibetan medical, tantric, monastic and cultural ideas of women with biomedical ones in a manner that does not at any point dispute the fundamental principles of Tibetan medicine. For example, the process of digestion and the production of the red element is still the basis of understanding menstruation. Moreover, contemporary authors present their arguments in keeping with Tibetan commentarial tradition insofar as they first quote or refer to authoritative medical sources and then elaborate or clarify their underlying meaning, adding new information or debating specific points.

Much of Western scholarship on Tibetan medicine is devoted to an examination of the relationship between Tibetan and biomedicine, and related to this, issues surrounding 'science' and 'religion'. Many scholars[97] have been able to point to ways that biomedical knowledge, research methods and treatments have deeply penetrated Tibetan medical rationales and practices. Of these, many scholars, particularly anthropologists, have been able to show that, despite the integration of biomedicine, Tibetan cultural, social and religious assumptions are retained in Tibetan medical categories. This is particularly from the perspective of the patient who, through social metaphors of illness, is able to air social, economic and political grievances. Therefore, most scholars appear to argue that Tibetan medicine's social, religious and moral underpinnings are beneficial for Tibetans. I alternatively suggest, however, that considering medical and Buddhist assumptions about women, such as their 'low merit' and excessive sexual desire', moral and religious meanings retained in medical language may not always be advantageous, desirable or beneficial for Tibetan women.

In this section, I have suggested ways that contemporary medical writers present a hybrid Tibetan and biomedical account of menstruation. I have shown how medical, cultural and religious ideas are augmented with biomedical knowledge in a way that evokes older meanings while at the same time taking on new meanings. Therefore, I argue that Tibetan medical writers are able to retain fundamental Tibetan ideas in addition to being innovative. In reference to Western scholarship, I have suggested that the relation of social meanings and morality underpinning Tibetan medical language are more

[97] See Adams 2001a; Adams 2002; Adams 2007; Adams, Dhondup and Le 2010; Gerke 2010; Janes 1999; Janes 2001; Janes and Hilliard 2008; Pordié 2008; Prost 2008; Schrempf 2007.

complicated for women. In this final section, I will tie some of these loose ends together, suggesting how hybrid Tibetan and biomedical assumptions of women, sex and gender play out in perceptions of the relation among menstruation, sexual desire and emotion.

Sexual desire and the mood swings of women

In both authoritative and contemporary medical literature, notions of women's sexuality, sexual arousal and emotional disposition appear alongside and are related to menstruation. Earlier, I discussed at length monastic and tantric views of women and the female body, particularly in relation to sexual desire. I suggested that monastic portrayals of women and sexual desire, and the degradation of their bodies in literature and practice, such as the meditative technique of contemplating rotting female corpses, were an indication of Buddhist monastic 'discomfort' with women and sex. I further argued that the view espoused in the *Four Treatises* that women have low merit and excessive sexual desire reflects this attitude. I also pointed to ways that tantric physiology, specifically the internal winds, channels, wheels and drops influence medical thought, particularly in regard to the red and white elements and the ideas of essence, refuse and quintessence, and their relation to reproductive fluids. Moreover, I argued that ideas of tantric sex, such as the use of sexual arousal and intercourse to 'untie the knots', make their way into contemporary literature reflecting a male perception of female sexuality in medical thought.

Women's weaknesses

To explore these themes further, I will revisit the section from the *Four Treatises* on how conception occurs and the characteristics of menstruation. The following details appear throughout contemporary sources:

> There is a lot of heavy and sweet white reproductive fluid [semen], and; menstruation is similar in colour to rabbits' blood [or] vermillion (*tshos khu*); if washed, it becomes clean; [if] flawless, conception occurs [the uterus grasps]. [For] women between the ages 12 and 15; the blood that has gathered every month from the arising of the refuse; by the two great channels, black and clear, [and] by the wind, trickles out for three days through the uterine opening. Sign[s] of that [menstruation] are weakness, an ugly face; the breasts, loins, throat, eyes and hips quiver; the sign of sexual arousal towards a man [indicates] one who possesses menstruation.[98]

[98] gYu-thog Yon-tan mGon-po. 2006, p. 17.

The notion that women are 'weak' (*nyam chung ba*) during menstruation is said to refer to physical, mental and emotional weakness. All of my sources point to this weakness and elaborate its meanings in various ways. For example, Wang Gyal writes, 'At the time of menstruation [one's] mood (*blo kha*) is not stable and great anxiety, embarrassment and fear arises.'[99] Palden Thinley writes 'signs of the pain of that [menstrual process] is a [feeling] of numbness (*nyob*) in the intestines and waist and sometimes giddiness or nausea arises. Because of desire for a man, sexual desire arises…'[100] Palsang Gyatso writes that before menstruation occurs the 'body becomes weak, more lazy, the waist and feet are painful, the breasts become bigger, etc.'[101] During the time of menstruation, he writes that a woman's 'face becomes ugly/dull, the breasts, hips/waist and throat [become bigger] and the eyes waver back and forth in (sexual) desire for a man'.[102] Lhamo Kyi provides the most extensive list of menstrual and pre-menstrual symptoms:

> Because the bodily constituents have little power or are weak, one can encounter various manifestations [such as]: the face has a dull complexion, [one feels] sluggish/disheartened, the waist and base of the intestines are sore, the urethra opening is sensitive, [one experiences] headache, insomnia, depression and [one is] easily angered… appetite for food diminishes, [one feels] disgusting, the faeces are dry or runny and the breasts and eyelids waver etc.[103]

Because of these weaknesses and related menstrual symptoms, our authors tell us that menstruating women should avoid certain things. For example, Palzang Gyatso provides an extensive list: 'every night with warm water wash the genitals' and 'sanitary napkins'. Also, the woman should only 'do light labour, and generally not exercise, do heavy labour, swim, run in a competition, or other difficult exercises'.[104] Also, because during the time of menstruation:

> the ability to prevent illness is slightly weakened, in order to prevent cold, flu and other diseases, [a woman] should be careful not to stay in water, the marshland, bluish-green grasslands, in the shade, or on soft earth […] [and] be careful not to wash the feet or hands in cold water, ride animals, or travel long distances.[105]

As for diet and behaviour, 'eating certain kinds of food such as chillies, green vegetables, onion, garlic, raw, cold or spicy foods are not suitable' and, women need to 'make the mind happy, not become angry, be peaceful and not have

---

[99] dBang-rgyal 2005, p. 6.
[100] dPal-ldan 'Phrin-las 1996, p. 1.
[101] dPal-bzang rGya-mtsho 2010, p. 15.
[102] dPal-bzang rGya-mtsho 2010, p. 16.
[103] Lha-mo sKyid 2007, pp. 108–9.
[104] dPal-bzang rGya-mtsho 2010, pp. 17–18.
[105] dPal-bzang rGya-mtsho 2010, p.19.

sex'.[106] In addition to these, Wang Gyal and Palden Thinley add that 'it is necessary to take rest'.[107] Lhamo Kyi, however, counters some of these instructions, particularly those concerning women's physical and mental capacities during menstruation. She writes, '[i]n general, if [menstrual symptoms] are not severe and there are no signs of disease, then there is no harm for women to do their daily labour or study, and [the menstrual symptoms] will dissolve on their own'.[108] Clearly, Lhamo Kyi has a different perspective of women's capabilities during menstruation.

The medical assertion that women feel sexual desire towards men during menstruation, a claim which appears in authoritative and contemporary works, is also a telling example of how social and religious perceptions enter into medical knowledge. From the contemporary literature, it appears that the time of menstruation indicates a peak in women's sexual desire. Yet this strikes me as an odd, possibly ambiguous assertion, considering women are told in the *Four Treatises* and in contemporary texts to avoid sex during menstruation because it is potentially physically harmful. It would seem as though women's supposed natural tendency is to feel sexual desire during an inappropriate time. Because of this, such desire is somehow flawed and contrary to what are 'proper' times of sexual relations, and therefore, needs to be corrected. Only one of my sources examines this issue further: our female medical writer. Following Lhamo Kyi's statement that women can work and study normally during menstruation, she writes:

> The arising of menstruation in women is a sign of the ability to produce a child by the power of sexual lust (*ro tsa*) [from within] the woman herself. Five days before the start of menstruation, [sexual] desire substantially increases and because of that, it indicates what is spoken of as great [sexual] bliss (*bde bar*). At that time, a few texts say that desire for a man is a sign of menstruation or a sign of menstruation is desire for a man; great [sexual] bliss is explained like this [quotes sections from two different commentaries regarding women's sexual desire during the time of menstruation]. However, [if I] investigate myself, [between] the two, having desire for a man is a sign of menstruation or menstruation is a sign of desiring a man there is scarcely a difference; both point out that women who menstruate have the well-ripened faculty of sexual lust, and have a great power to produce a child.[109]

---

[106] Ibid.

[107] dBang-rgyal 2005, p. 6.

[108] Lha-mo sKyid 2007, p. 109. It should be noted that Lha-mo sKyid's position is in keeping with North American biomedical advice. Hacker *et al.* write that only 'five per cent or less of women … [experience] symptoms … so severe that they seriously interfere with usual daily functioning or personal relationships'. (Hacker *et al.* 2010, p. 386).

[109] Lha-mo sKyid 2007, p. 109.

Instead of countering the *Four Treatises* and its commentaries, she clarifies that once a woman has reached maturity and menstruates, she will have sexual desire and the ability to reproduce. According to her, the underlying meaning of the authoritative works is not that *during the time* of menstruation sexual desire arises, but that once a woman has achieved the age of menstruation, sexual lust will arise. It would also appear that, according to Lhamo Kyi, menstruation, sexual lust and the ability to reproduce are together features of women's innate 'nature'.

The fact that Lhamo Kyi is the only author to investigate the claim that women feel sexual desire during menstruation, or who states that women can carry on with their normal activities while having their period, is indicative of the influence of gender on the making of medical knowledge. I argue that this is because most women *know* from experience that they can carry on with their regular activities during menstruation. In fact, exercise—walking, running and swimming—is known to be a good way to lesson menstrual cramps and other symptoms. The suggestion to not do any of these things and 'rest' instead might strike one as ridiculous and coming from someone who does not have experience of menstruation. It is also likely that most women would say that their sexual peak is not during menstruation, but like Lhamo Kyi states, a few days before. Perhaps, for lack of experience, we cannot blame our male authors for not investigating this further. We can, however, clearly see that so-called medical knowledge on women's sexuality, abilities and emotional state depend on one's perspective. It is also clear that the presence of religious ideas of women's sexuality and desire (positive and negative) in authoritative medical literature is evidently carried over into contemporary sources.

Hormones and emotions: a hybrid Tibetan-biomedical perspective

Finally, I want to consider how the integration of 'sex' hormones may contribute to our understanding of how contemporary Tibetan medical writers perceive women's emotions. Women's 'weakness' during menstruation, which the *Four Treatises* asserts, is said to include physical, emotional and mental weakness. We also know from the *Four Treatises* that another weakness of womankind, perhaps the most damning one, is her lower karmic merit. We know from anthropological scholarship of contemporary Tibetan cultures that women are generally perceived to be weaker or inferior to men, intellectually, physically and morally.[110] Without too much difficulty, we can argue that

[110] See Gutschow 2004; Havnevik 1989; Makley 2008.

women's low social and religious status is reflected in medical literature. This is further evidenced by present-day authors who attempt to counter such religious and cultural assertions of women's lower merit. Yet, contemporary authors do not counter cultural, religious or medical beliefs about women's emotions and their relation to the menstrual cycle; these remain intact.

I suggest that the numerous elaborations on women's emotions during menstruation, such as the assertion that her mind is not stable, she is depressed and easily angered, while deriving from Tibetan cultural and religious beliefs, are bolstered by similar claims made in biomedicine. It is well-known that in Western culture, women are perceived to be 'more emotional' than men. Moreover, biomedical science attributes women's fluctuating 'mood swings' to the hormonal and menstrual cycle; women's emotions are 'chemical' and therefore, the perceive innate emotionality particular to women is accounted for 'scientifically'. Similarly, Tibetan medical writers, having studied biomedical explanations of menstruation would be well aware of such biomedical claims about the relation between women and emotion, and can therefore assume a correlation between menstruation and emotion. And because biomedicine does not contradict Tibetan medicine, Tibetan writers can easily assert that such ideas are correct. If we recall, Wang Gyal refers to the hormones that cause menstruation as *mo rtsi*—female nectar—an idea that suggests a specifically female hormone that controls the very essence of what being female entails. It appears that, as in the authoritative works, the very nature of womankind is involved with processes of the red element and menstruation, and these also account for women's sexuality and emotions. In this way, I suggest that, like biomedical thinkers, Tibetan medical writers solidify the relations among the body, sex and gender through asserting scientific knowledge about the female body that is, in fact, steeped in cultural and religious perceptions about women's minds, emotions and character. Again, I argue that this suggests that Tibetan medical knowledge is bolstered by the inclusion of biomedical thought.

Conclusion

Contemporary Tibetan medical authors residing inside the political boundaries of China are under increasing pressure to both modernise and substantiate the validity of Tibetan knowledge in relation to biomedicine. Consequently, present-day medical literature is marked by a hybridity of knowledge; medical authors move between Tibetan and biomedical terms and categories, and create new neologisms to suggest how the two systems are compatible. The topic

of menstruation presents a rich hybridity of Tibetan cultural, religious and medical ideas which, I argue, reflects the still active Tibetan medical commentarial tradition of both adherence to authoritative knowledge and innovation.

Acknowledgements

I would like to thank my Tibetan interlocutors, Khenpo Kunga Sherab, Dr Choelo Thar and Dr Tso Gyi, as well as the gynaecology medical students and staff at Qinghai Tibetan Medical Hospital who made this article possible. My supervisor, Frances Garrett, directed me to several important sources and offered invaluable comments and observations on my work-in-progress. Nicholas Schonhoffer provided much appreciated editorial assistance. Finally, I owe an enormous amount of gratitude to the editors, Theresia Hofer and Heidi Fjeld, as well as the two anonymous reviewers whose insightful comments vastly improved the original submission. All translations contained in this article are my own; any mistakes are mine.

References

Tibetan Sources

dBang-rgyal 2005
dBang-rgyal, *Ma bu bde srung gu rgyun shes*, Xining: mTsho-sngon Mi-rigs Dpe-skrun Khang.

dGe-'dun Chos-'phel 1969
dGe-'dun Chos-'phel, *'Dod pa'i bstan bcos*, Delhi: T.G Dhongthod.

dPal-bzang rGya-mtsho 2010 [2003]
dpal-bzang rGya-mtsho, *Bud med bde srung skor gyi rgyun shes phran bu bzhugs*. Chengdu: Si-khron Mi-rigs Dpe-skrun Khang.

dPal-ldan 'Phrin-las 1996
dPal-ldan 'Phrin-las, *Bod lugs gso rig gi rgyun mthong mo nad 'gog bcos bya thabs*, Lhasa: Bod-ljongs mi-dMangs dPe-skrun-khang.

g.Yu-thog Yon-tan mGon-po 2006 [1982]
g.Yu-thog Yon-tan mGon-po, *bDud rtsi snying po yan lag brgyad pa gsang ba man ngag gi rgyud ces bya ba bzhugs so*, Lhasa: *Bod-ljong mi-dMangs dPe-skrun-khang*.

Lha-mo sKyid 2007
Lha-mo sKyid, 'Zla mtshan gyi rnam par dpyad blo chung byis pa'i mgul rgyun' in *Krung go'i bod kyi gso rig*, vol. 1, 103–11.

Thub-bstan Phun-tshogs 1999
Thub-bstan Phun-tshogs, *gSo bya lus kyi rnam bshad*. Beijing: Mi-rigs dPe-skrun-khang.

Tshul-khrims rGya-mtsho 2007
Tshul-khrims rGya-mtsho, *rGyun mthong nad rigs gso thabs. Gansu: Kan-su'u Mi-rigs dPe-skrun-khang*.

Secondary Sources

Adams, V. 2001a, 'The Sacred in the Scientific: Ambiguous Practices of Science in Tibetan Medicine', *Cultural Anthropology*, 16.4: 542–76.

——. 2001b, 'Particularizing Modernity: Tibetan Medical Theorizing of Women's Health in Lhasa, Tibet', in L. H. Connor and G. Samuel (eds), *Healing Powers and Modernity: Traditional Medicine, Shamanism, and Science in Asian Societies*, Westport, CT: Bergin and Garvey, 222–46.

——. 2002, 'Establishing Proof: Translating "Science" and the State in Tibetan Medicine', in M. Nichter and M.Lock (eds), *New Horizons in Medical Anthropology: Essays in Honour of Charles Leslie*, New York: Routledge, 200–20.

——. 2007, 'Integrating Abstraction: Modernising Medicine at Lhasa's Mentsikhang', in M. Schrempf (ed.), *Soundings in Tibetan Medicine: Anthropological and Historical Perspectives*, Boston: Brill, 29–44.

Adams, V., Renchen Dhondup and Phuoc Le 2010, 'A Tibetan Way of Science: Revisioning Biomedicine as Tibetan Practice', in V. Adams, M. Schrempf and S. R. Craig (eds), *Medicine Between Science and Religion: Explorations on Tibetan Grounds*, New York: Berghahn Books, 107–26.

Campbell, J. 1996, *Traveller in Space: In Search of Female Identity in Tibetan Buddhism*, London: Athlone.

Chöpel, Gedün 1992, *Tibetan Arts of Love: Sex, Orgasm and Spiritual Healing*, translated and edited by Jeffery Hopkins and Dorje Yudon Yuthok, Ithaca, NY: Snow Lion Publications.

Davidson, R. M. 2002, *Indian Esoteric Buddhism: Social History of the Tantric Movement*, New York: Columbia University Press.

Desi Sangye Gyatso 2010, 'Introduction', in *Mirror of Beryl: A Historical Introduction to Tibetan Medicine*, translated by Galvin Kilty, Boston: Wisdom Publications, pp. 1–26.

Faure, B. 1998, *The Red Thread: Buddhist Approaches to Sexuality*, Princeton: Princeton University Press.

——. 2003, *The Power of Denial: Buddhism, Purity, and Gender*, Princeton: University of Princeton Press.

Fausto-Sterling, A. 2000, *Sexing the Body: Gender Politics and the Construction of Sexuality*, New York: Basic Books.

Fenner, T. 1996, 'The Origin of the rGyud bzhi: A Tibetan Medical Tantra', in J. I. Cabezón and R. R. Jackson (eds), *Tibetan Literature: Studies in Genre*, Ithaca: Snow Lion Publications, 458–69.

Garrett, F. 2008, *Religion, Medicine and the Human Embryo in Tibet*, London and New York: Routledge.

——. 2009, 'The Alchemy of Accomplishing Medicine (*sman sgrub*): Situating the Y*uthok Heart Essence* (*G.yu thog snying thig*) in Literature and History', *Journal of Indian Philosophy*, 37.3: 207–30.

Garrett, F. and V. Adams 2008, 'The Three Channels in Tibetan Medical and Religious Texts, including a translation of Tsultrim Gyaltsen's "Treatise on the Three Channels in Tibetan Medicine"', *Traditional South Asian Medicine*, 8: 86–114.

Gerke, B. 2010, 'Correlating Biomedical and Tibetan Medical Concepts in Amchi Medical Practice', in V. Adams, M. Schrempf and S. R. Craig (eds), *Medicine Between Science and Religion: Explorations on Tibetan Grounds*, New York: Berghahn Books, 127–55.

Gutschow, K. 2004, *Being A Buddhist Nun: The Struggle for Enlightenment in the Himalayas*, Cambridge MA: Harvard University Press.

Gyatso, J. 1998, *Apparitions of the Self: The Secret Autobiographies of a Tibetan Visionary*, Princeton: Princeton University Press.

——. 2003, 'One Plus One Makes Three: Buddhist Gender Conception and the Law of the Non-Excluded Middle', *History of Religions*, 43.2: 89–115.

——. 2008, 'Spelling Mistakes, Philology and Feminist Criticism: Women and Boys in Tibetan Medicine', *Revue d'Etudes Tibétaines*, 14: 81–98.

Hacker, N. F. *et al*. (eds) 2010 [2004, 1998, 1992, 1986], *Essentials of Obstetrics and Gynaecology*, Philadelphia, PA: Saunders Elsevier.

Havnevik, H. 1989, *Tibetan Buddhist Nuns: History, Cultural Norms and Social Reality*, Oslo: Norwegian University Press.

Jacoby, S. H. 2007. 'Consorts and Revelation in Eastern Tibet: The Auto/biographical Writings of the Treasure Revealer Sera Khandro (1892–1940)', Ph.D Dissertation, University of Virginia.

Janes, C. 1999, 'The Health Transition, Global Modernity and the Crisis of Traditional Medicine: The Tibetan Case', *Social Science and Medicine*, 48: 1803–20.

——. 2001, 'Tibetan Medicine at the Crossroads: Radical Modernity and the Social Organization of Traditional Medicine in the Tibet Autonomous Region, China', in L. H. Connor and G. Samuel (eds), *Healing Powers and Modernity: Traditional Medicine, Shamanism, and Science in Asian Societies*, Westport, CT: Bergin and Garvey, 222–46.

Janes, C. and C. Hilliard 2008, 'Inventing Tradition: Tibetan Medicine in the Post-Socialist Contexts of China and Mongolia', in L. Pordié (ed.), *Tibetan Medicine in the Contemporary World: Global Politics of Medical Knowledge and Practice*, Abingdon: Routledge, 35–61.

Keller, E. F. 1992, *Secrets of Life, Secrets of Death: Essays on Language, Gender, and Science*, New York: Routledge.

Makley, C. E. 2008, *The Violence of Liberation: Gender and Tibetan Buddhist Revival in Post-Mao China*, Berkeley: University of California Press.

Pordié, L. 2008, 'Tibetan Medicine Today: Neo-Traditionalism as an Analytical Lens and Political Tool', in L. Pordié (ed.), *Tibetan Medicine in the Contemporary World: Global Politics of Medical Knowledge and Practice*, Abingdon: Routledge, 3–32.

Prost, A. 2008, *Precious Pills: Medicine and Social Change among Tibetan Refugees in India*, New York: Berghahn Books.

Roberts, C. 2002, ' "A Matter of Fact": Hormones and the History of Bodies', *Feminist Theory*, 3.1: 7–26.

Schaeffer, K. R. 2003, 'Textual Scholarship, Medical Tradition, and Mahāyāna Buddhist Ideals in Tibet', *Journal of Indian Philosophy*, 31.5–6: 621–41.

Schrempf, M. 2007, 'Introduction: Refocusing on Tibetan Medicine', in M. Schrempf (ed.), *Soundings in Tibetan Medicine: Anthropological and Historical Perspectives*, Boston: Brill, 1–8.

Shaw, M. 1994, *Passionate Enlightenment: Women in Tantric Buddhism*, Princeton: Princeton University Press.

Tsong-ka-pa 2005, *The Six Yogas of Naropa: Tsongkhapa's Commentary Entitled A Book of Three Inspirations: A Treatise on the Stages of Training in the Profound Path of Naro's Six Dharmas, Commonly Referred to as the Three Inspirations*, translated by G. H. Mullin, Ithaca: Snow Lion Publication.

Wilson, L. 1996, *Charming Cadavers: Horrific Figurations of the Feminine in Indian Buddhist Hagiographic Literature*, Chicago: University of Chicago Press.

Yeshe, Thubten 1998, *The Bliss of Inner Fire: Heart Practice of the Six Yogas of Naropa*, Boston: Wisdom Publications.

Young, S. 2004, *Courtesans and Tantric Consorts*, New York: Routledge.

BRILL

Asian Medicine 6 (2010–11) 421–432

brill.nl/asme

Sexual Differentiation in Tibetan Medical and Buddhist Perspectives

Mingji Cuomu
Partially translated by Katia Holmes

Abstract
Classical Tibetan medicine is closely related to Buddhist philosophy. This article describes how the study and meaning of sexual differentiation in Tibetan medicine is deeply rooted in Buddhist texts and philosophy. The article pays particular attention to the Buddhist theory of mutual dependence of birth and death and on the medical ways of explaining the determining of sex. While Tibetan medicine approaches sexual differentiation by examining its various determinant factors, thus aiming to improve understanding of the human body and diseases, which manifest differently in men and women, in Buddhist philosophy sexual differentiation is perceived as a fundamental, natural phenomenon of human life that forms a key in Tantric practices to comprehend the nature of mind and thence attaining the highest state of mind. The article consists of a translation of the first chapter of a Tibetan medical book on obstetrics, including a newly written introduction to the Buddhist interpretive frame employed in the chapter.

Keywords
Sexual differentiation, Tibetan medicine, Buddhist philosophy, determinant factors for sex

Prelude

What follows is largely a translation of the first chapter of a monograph on the treatment of obstetric conditions in Tibetan medicine, which I published in Tibet in 2010. This earlier work aimed at filling a gap—there being at that time only very limited obstetrics texts available in the Tibetan medical literature, a situation that had come to my attention while preparing a Tibetan medical gynaecological textbook for undergraduate students in university-based Tibetan medical courses in Tibet and China. I would argue that this lack in textual resources is linked to gender, and due to both the fact that, at least historically, the majority of physicians were men (mostly monks), as well as the point that Tibetan women tend to be reluctant to talk about health problems, especially when related to more intimate parts of the body. As obstetric conditions are health problems that occur mostly during or around the period

DOI: 10.1163/15734218-12341240

of conception or delivery of a child, I therefore dedicated the first chapter of my book to Tibetan philosophical interpretations of gestation, the nature of birth and sexual differentiation, which all relate to the themes of this current special issue and are thus offered in English for a wider audience.

Introduction

Sexual difference is crucial to the maintenance of the life cycle. In Tibetan Buddhist philosophy, the male and the female are also respectively referred to with the metaphors of 'method' (*thabs*) and 'wisdom' (*shes rab*). As such 'method' and 'wisdom' lie at the centre of Buddhist practices aimed at discovering the fundamental nature of the mind (*sems nyi kyi gdod ma'i rang bzhin*), which goes beyond concepts of sex and gender altogether. Such practices have as a goal to reach the highest state of mind, which is the state of enlightenment (*sangs rgyas pa*). There is a whole body of theory in Tibetan Buddhism that characterises the two distinct energies that the two sexes manifest through the body, for example in terms of spirit, psychology and physique. Such factors in turn influence a person's social role and their performance of gender. It is impossible to discuss all these issues in a single paper. My intention here is to present an analysis of the interdependent relationship of birth and death in Tibetan Buddhism and point to its relevance for sexual divisions in Tibetan medicine.

In order to analyse and interpret ideas surrounding the division of the sexes described in the *Four Tantras* or *Gyushi* (*rGyud bzhi*), I wish to use Buddhist logic (*tshad ma rig pa*), and particularly the theory of the four conditions (*rkyen bzhi*), as found for instance in the 'Treasure of the Abhidharma' literature (Skt. *Abhidharmakośa*, Tib. *mNgon pa mdzod*).[1] Different determining factors of the sexes are given in the *Gyushi*'s *Explanatory Tantra*.*[2] There, sexual differentiation is interpreted in relation to the specific moment of conception, as well as hereditary conditions from the parents (*lhan skyes*). In contrast, in the section on gynaecology (*mo nad*) in the *Oral Instructions Tantra**, sexual differentiation is examined more from the perspective of the emotional forces of the individual. Few explanations have so far been provided in any of the previous commentaries for the internal relationships between these factors, which in turn led to confusion or doubt about which of these factors (i.e. the hereditary conditions of the parents, the specific timing of conception, or an individual's karmic merit) were more important in determining sex. In the

[1] See for instance mKhas-grub Sangs-rgyas rGya-mtsho 2010.

[2] All words followed by an asterisk are explained in the Glossary that follows this paper.

medical literature, there are examples of the use of the four conditions of Buddhist logic (*tshad ma*) to explain medical issues. One important example is the commentary on the *Four Tantras* by fifteenth century physician Kyempa Tshewang (sKye-pa Tshe-dbang), which uses the four conditions of Buddhist logic (*tshad ma*) to explain the relationships between the three major aetiologies of disease (*rkyen gsum*)[3] (sKyem-pa Tshe-dbang, 2001). His interpretation has come to be seen as a comprehensive explanation to understand which one of the three aetiologies of disease should be considered in which context.

The question of whether the hereditary condition of the parents or the time of the conception have a stronger influence in determining the sex of a child is a much discussed matter, and it also appear frequently in examinations at Tibetan medical colleges. The varying views in the *Four Tantras* show that the differentiation of the sexes during conception is not based on a single cause, such as the condition of the parents' reproductive fluids (*khu ba*). This paper also considers the four major vessel systems of the body, as described in the *Four Tantras*, the so-called 'generating, sustaining, connecting and life vessels'. It includes also those vessels pertaining to reproduction, as this part of the bodily system is where the different sexual functions are found according to Tibetan medical theory. The aim of adding a discussion of the different vessel-based circulation systems (*rtsa 'khor*), how they are interconnected, and specifically how the reproductive system relates to the other bodily systems, is to give a broader context to issues of birth, sexual differentiation and obstetrics in Tibetan medicine. The article concludes with a discussion of the nature of birth and its conceptual limitations according to various viewpoints in Buddhist philosophy.

We now turn to the translation of the first chapter of my publication, *Clinical Experience in Treating Obstetric Diseases* (2009), which is entitled 'Analysing the Natural Pattern of Birth' (*sKye ba'i khams kyi chos nyid la dpyad pa*).[4]

Mutual dependence between arising (birth) and disintegration (death)

When the original nature of primordial purity is realised as it is, one attains peace and the precious state of the *trikāya**, but as long as it is not realised one wanders, endlessly following the patterns of birth (*skye ba*), existence and

[3] Progressive condition (*skye mched kyi rkyen*), the accumulation manifesting condition (*gsog ldang gi rkyen*) and the actual arousal condition (*slong rkyen*).

[4] Cuomu 2009, pp. 53–60. I would like to thank Katia Holmes for her assistance in translating this chapter and preparing the glossary appended to this article. Both have been further edited and amended by the author and the editors.

disintegration or death (*'jig pa*),[5] in the various states of *saṃsāra* corresponding to one's own karmic imprints*.

These 'facts' show the conventional* and the definitive* approach to the ultimate 'true nature of things' without contradicting the authentic meanings of the two truths: absolute and relative truths*. The various branches of knowledge in Tibetan Buddhism represent the different kinds of explanations suited to the mentality of the countries of individuals to be trained. Thus one of the five major branches of knowledge* is medicine, the science of healing (*gso ba rig pa*) which takes care of others. It can be defined in this way: to relieve the pains, both physical and mental, of an unlimited number of sick people, and to prolong the lifespan of human beings.

As for arising, existence and disintegration, these have to be discussed according to the particularities of each specific context. In this particular instance, let us examine birth: if we reason in terms of birth and disintegration, these occur through their mutual dependence. Considering any body, there would be no cause for its disintegration if it had not been born in the first place, and if anything ever born knew no disintegration and could live on forever, there could be no such thing as being born. Because of disintegration there is birth, and this is how the very word "universe"—*'jig rten* ('the destructible basis')—was formed.

The phenomenon of birth or arising has six types of causes* and when these are complete in all their aspects, there is a human body. As part of the possibility of existence of such a body in this universe, it can become born when all its physical constituents have been fully formed, but it will show disintegration once these physical constituents have degenerated.

As all the processes related to birth and disintegration depend on the circulation of the seven physical constituents*, the continuity of this circulation is called 'existence' or 'life'. The various tissues of the body are matured through the circulation of all these in their own network of vessels.

The determinant factors of sex in Tibetan medicine

Although all beings in the realm of existence, be they superior or inferior* and differ in the origin of their gate of birth* (*skye gnas*), they are born from the union of 'method' and 'wisdom'*. As for the mode of activity of beings that are

[5] *sKye ba* means arising, in general, and birth as a particular instance of this. Both meanings apply throughout the text. *'Jig pa* means destruction, or disintegration, and can be understood as death when used in conjunction with 'birth'.

born, they are mostly divided into masculine or feminine, and this depends on a very definite set of causes and conditions. To give an example, here is a quote from the *Oral Instructions Tantra** of the *Gyushi*, found in the chapters on women's diseases: 'the body produced by the three poisons and the four elements* appears as male or female through former deeds and by the power of desire. With weaker merit, one will get a woman's body.'[6]

Mind has been free from conceptual fabrications since beginningless time, yet incidentally, apparent impurities with a natural energy of their own, cause dualistic perception and apparent motivations of attachment, aversion, dullness and so forth. These create actions of a similar nature, which turn into all sorts of karmic manifestations. Among these are the three 'dynamics'[7] or *nyes pa gsum*, which are generated by the three negative emotional forces—desire, hatred and ignorance. Through the typical action of these three 'harm-doers', the womb-born body is made up of four elements—if we consider that space pervades them all.[8] And, depending on its former karma[9] still to be experienced, it will appear as male or female through the power of desire, part of the three poisons, and the cause of the dualistic split between perceiver and perception.

Furthermore, four conditions* apply, one of which is the causal condition, which is what makes one appear as male or female, as is stated in the *Explanatory Tantra**: 'If semen (*khu ba*) is more abundant, one will be born a boy, but if menstruation (*bzla mtshan*)[10] is more abundant, one will be born a girl.'[11] Now, to explain how they appear differently through the determining condition, the same source says: 'on the first, third, fifth, seventh, ninth [day], it will be a boy. On the second, fourth, sixth and eighth [day], it will be a girl.'[12]

---

[6] g.Yu-thog Yon-tan mGon-po, 1993, p. 375.

[7] According to Tibetan medicine, the three dynamics, or *nyes pa gsum*, are three major biological forces of all physiological functions of the human body. They are *rlung* (air), *mkhris pa* (fire) and *bad kan* (earth and water). According to *Four Tantras*, health is basically understood as the constituents of the four elements in the body as well as the 'three dynamics' being in balance and harmoniously working together. For details, see Cuomu's PhD dissertation (Cuomu 2010).

[8] The four element classification does not include space, which is considered to be omnipresent, pervading all of the other elements.

[9] Karma: the propelling energy of previous deeds; the quality of one's own past actions.

[10] Although literally, the broad meaning of the Tibetan word *zla mtshan* can be understood as menstruation, in this context, it should be understood as 'ovum', or literally as the 'red element' (*khams mar*). There are many other reversible terms like this used in *Four Tantras*, such as '*mngal*', which in some contexts can be understood as 'foetus', and in others as 'uterus'.

[11] g.Yu-thog Yon-tan mGon-po, 1993, p. 17.

[12] Ibid. the *Explanatory Tantra* indicates a correspondence between the day of intercourse and sex determination: counting the day when the menstruation begins as day one, it is said that intercourse on days one, three, five, seven, and nine will conceive a boy, and on days two, four, six, and eight, a girl (g.Yu-thog mGon-po 1993, p. 17).

The immediate condition causes a male or female manifestation, as appropriate, and the object-condition is the subtle base of focus for the motivation of the foetus in that very moment resulting from the karmic imprints of a being, life after life. To sum up, when such a body is acquired, compounded from a cause, the six-fold consciousness*, and from four conditions, it appears as either male or female.

If we wish to examine the characteristics of the four conditions in brief, the *Treasury of Abhidharma** indicates:

> For results to be generated, there have to be conditions distinct from the results, and these are said to be four… What generates a result is a germinative seed: the cause of the visual consciousness present in the *ālāya**, the ground consciousness, is like its seed or causal condition. Whatever it focuses on, the object generated as a representation of mind and its accompanying mental events*, this is the object-condition. The immediate condition is what makes way for a result as soon as a cause ceases. In the case of something distinct from these three conditions, the determining [factor] capable of producing it is a condition that can support a result similar to the previous.[13]

Like this statement, any scripture or work of Tibetan Buddhist logic corroborates the four conditions as identified above. If one considers what the *Four Tantras* teaches in its different sections about the male and female way of bodily manifestation, it does indeed speak of these as well. Yet by looking at the *Four Tantras* carefully none of what it says contradicts the logic of the six causes and the four conditions of Buddhist logic. For instance, the *Explanatory Tantra* is the part of the work that expounds the main points of medical theory. When it comments on the formation of the body, on its anatomy and so forth, it does so in terms of the determining conditions and the immediate conditions relative to the mode of manifestation of males and females.

In each of its sections or 'Eight branches'* of healing, the *Oral Instructions Tantra* teaches extensively both from a conventional and a definitive* standpoint. In the section on 'women's diseases', those diseases are deliberately dealt with as a medical specialty. Everything there is discussed in terms of the causal condition: first, the karma and merit of women, then the way in which women appear as different from men and, the biological features of woman and the classification of various gynaecological diseases and details of each. This shows that different styles of explanations are used according to each specific context of the *Four Tantras*.

[13] sLob-dpon dByig-gnyen 2010, p. 163.

Examining the pattern of birth, life and death based on the nature of vessels, 'the connectors'[14]

As is described in the *Four Tantras*: 'Generating, sustaining, connecting and life*: [these are the] four vessel systems'.[15] Regarding the nature of the vessels*, they are defined as roots that sustain the body and life of human beings.[16] It is taught how, while they are generating the body, various vessel ramifications branch out to form the body complex*: in the middle, while they are sustaining [life], these generative vessels are shown to be of different kinds, with their characteristics and function; at the end, when they disintegrate, the life-propelling energy is exhausted.[17]

Thus vessels are shown to be of three types determined by these three stages. Although the actual vessel network is one and the same at first, in the middle and at the end,[18] it is necessary to divide it into these three stages; the concept of birth, life and disintegration is closely linked to the actual physical body of beings.

Examining the limits of the notion of birth (arising) from the viewpoint of Buddhist philosophy

This section offers three different perspectives on the limits of the notion of 'birth', first, as famously expressed by Nāgārjuna[19] in the *Mūlamadhyamaka-kārikā*: 'Not from itself or from other, neither from both nor from no cause at all, whatever thing it is, nothing whatever, ever arises.'[20] This quote, to me, expresses four essential ideas, which I now discuss.

First, there is no arising from oneself. If a self already exists, it does not need to arise. When a cause has stopped, it is invisible though its result is seen. Even common minds who have not investigated (the matter) will not mistake these

---

[14] 'Connectors' or 'connections' (*'brel ba*) is a term used to qualify all vessels or channels in the body. This is because they are responsible for all kins of circulation in the body. It is also used more specifically to describe one of the four kinds of vessel systems in Tibetan medicine.

[15] g.Yu-thog Yon-tan mGon-po 1993, p. 23.

[16] It may be interesting to note the semantic kinship between the word *rtsa* for vessel and *rtsa ba* for root.

[17] Literally, the propulsive force (*'phen pa*).

[18] The four categories should not be mistaken for different anatomical entities: they serve only to highlight the various functions of the vessels or channels in the body, particularly at the different stages of formation, life and disintegration.

[19] In Tibetan: sLob-dpon kLu-sgrub.

[20] Sangs-rgyas bsKyangs 1989, p. 3.

for a single substance. Second, there is no arising from others. At the time of the cause, the 'result' entity dependent on it has not arisen and does not exist. Therefore, there can be no dependent 'other'. If we consider terminology, saying 'I have procreated a son' when one has simply sown the seed of a son (the cause) amounts to the same misunderstanding as saying 'I planted a flower' whereas one has merely sown the seed of a flower (its cause).

Third, there cannot be arising from both (self and other): If self and other individually had a generative capacity, there could be generation through the coming together of these two. But if, as explained above, neither self nor other have a procreative capacity it is logically impossible that even their coming together could create something, just as there can be no sesame oil in grains of sand.[21]

Fourth, there can be no arising from an absence of cause: Buddhapālita demonstrated that thus, 'it is a logical impossibility for things to arise in the absence of a continuous line[22] because all things always come from all things.'[23] Thus, as stated above, 'things' are beyond the 'four extremes of arising'*.

The second perspective on the limits of birth derives from the *Explanatory Tantra* of the *Four Tantras*: 'First, faultless sperm and blood* of father and mother, a consciousness stimulated by karma and defilements, the five elements* all gathered together—[such are] the causes of conception in the womb.'[24]

The third perspective is that of Sakya Gyaltsen Palsang, as found in his *Secret Explanations of the Vajra Body*:

> Looking at this in connection with the five awakenings* of the followers of the Mahāyoga Tantra: first the father's essence* emerges through the anal passage, then it stays in the vajra pathway below the navel and comes out when it is expelled. This is the awakening by means of the moon, the mirror-like wisdom. When this enters the procreative organ of the mother, the quintessential part of *rakta* is covered from the outside: this is the awakening to the sun, the wisdom of identity.[25] Suffused with innate joy, the *bardo* consciousness* remains between these two, the sun and the moon; this is the awakening to the seed—the discerning wisdom. The three mingle in the form of blissful *prana*-mind,[26] and become a

---

[21] rDza sPa'-sprul 1989, p. 473.

[22] *Rgyud*: continuum or lineage.

[23] Sangs-rgyas bsKyangs 1989, p. 134.

[24] g.Yu-thog Yon-tan mGon-po 1993, p. 16.

[25] *Rakta*, blood in Sanskrit, tends to replace the word blood in tantric texts, such as in the source quoted here. The "quintessence" (*dvangs ma*) of *rakta* designates the "red element", the female essence in its purest form (the 'ovum' is its physical counterpart, menstrual blood its residue).

[26] Sanskit *prāṇa*,Tib *rlung*. In this tantric context, the merging of the physical quintessences of father and mother with the bardo consciousness, takes the form of mind united with *rlung* or *prāṇa* (pure energy, subtlest breath) and bliss, an intrinsic quality of pure mind.

> *mer mer po*, a *nur nur po* and a *tar tar po*.[27] This is the awakening to the activity wisdom. When these solidify, a physical form is produced from which the body will gradually become complete, as a creation of the previous life—this is the awakening to complete perfection, the *dharmadhātu* wisdom.[28]

From the causes of conception of a child in the womb, as explained in these various perspectives, one can gain additional understanding of Nāgārjuna's quotation at the beginning of this section ('neither from itself nor from others / neither from both nor without cause'). Thereby one can be certain that birth and disintegration are ultimately only delusions due to ignorance. This certainty will make clear the reason why Tibetan medicine rejects ignorance, as the prime cause of illness.

Conclusion

The study and meaning of sexual difference according to Tibetan medicine is deeply rooted in Tibetan Buddhist texts and philosophy. Sexual differentiation is perceived as a fundamental, natural phenomenon of human life and is seen as a key in Tantric practices to comprehend the nature of mind and thence attaining the highest state of mind. By contrast, as shown above, Tibetan medicine approaches sexual differentiation by examining its various determinant factors, thus aiming to improve understanding of the human body and diseases, which manifest differently in men and women.

References

Tibetan-language sources

Cuomu 2009
sMin-skyid mTsho-mo, *Mo nad phal pa'i nad la zhib 'jug dang gso bcos bays pa'i nyams yig* ['Clinical Experience in Treating Obstetric Diseases'], Lhasa: Tibetan People's Publishing House.

g.Yu-thog Yon-tan mGon-po 1993
g.Yu-thog Yon-tan mGon-po, *rGyud bzhi* [*Four Tantras*] *Bdud rtsi snying po yan lag brgyad pa gsang ba man ngag gi rgyud*, (3rd edition), Lhasa: Tibetan People's Publishing House.

---

[27] *Nur nur po* ('thickened'), *ltar ltar po* ('alike') and *mer mer po* ('malleable'), are the respective names of the embryo in the second, third and fourth week of pregnancy. *Explanatory Tantra*, Point II on the Body, Part 1, Formation of the body (chap. 2), g.Yu-thog Yon-tan mGon-po 1993 p.23.

[28] Sa-skya-pa rGyal-mtshan dPal-bzang 1991, p. 13.

rDza sPa'-sprul 1989
rDza sPa'-sprul, *sNying bsdus sngon 'gro'i khrid yig kun bzang bla ma'i zhal lung*, Chengdu: Sichuan Publishing House for Nationalities.
Sa-skya-pa rGyal-mtshan dPal-bzang 1991
Sa-skya-pa rGyal-mtshan dPal-bzang, *rDo rje lus kyi sbas bshad*. In: *gSang chen thabs lam nyer mkho rnal 'byor snying bsdus*, Beijing: Publishing House for Nationalities.
mKhas-grub Sangs-rgays rGya-mtsho 2010
mKhas-grub Sangs-rgays rGya-mtsho, *Dam pa'i chos mngon pa mdzod kyi dgongs pa rab tu gsal bar byed pa'I gtan bcos lung rigs gter mdzod.* Bkras lhun gsung rab dpar khang
sKyem-pa Tshe-dbang 2001
sKyem-pa Tshe-dbang, *rGyud bzhi' rnam bshad*, Tibetan People's Publishing Company.
Sangs-rgyas bsKyangs 1989
Sangs-rgyas bsKyangs, 'Chapter one, *rkyen brtag pa*' In: *dBu ma rtsa ba'i shes rab*, Chengdu: Sichuan Publishing House for Nationalities.
sLob-dpon dByig-gnyen 2010
sLob-dpon dByig-gnyen, In: MKhas-grub Sang-rgyas rGya-mtsho, *Dam pa'i chos mngon pa mdzod kyi dgongs pa rab tu gsal bar byed pa'I gtan bcos lung rigs gter mdzod.* Bkras lhun gsung rab dpar khang

European-language sources

Cuomu, Mingji. 2010, *Social and Cultural Factors in Developing Tibetan Public Health System*, PhD dissertation, Humboldt University zu Berlin.

Glossary

Ālāya: the Yogacara school added two aspects to the six consciousnesses model (q.v). The seventh, is the tainted mind, *nyon yid.* While the eighth, *Ālāyavijñāna* (Sanskrit), *kun gzhi rnam shes* in Tibetan, defines the universal basis or ground consciousness, a sort of virtual repository where thoughts and feelings leave mental imprints, habitual tendencies and conditioning, which are the seeds of later experiences.

Arising, existence and disintegration (*skye ba, srid pa, 'jig pa*): concepts used by Nāgārjuna (the great Middle Way exponent) to demonstrate that nothing has any independent, ultimate reality. Tibetan medicine shares this view and sees human life as a compound of many elements which, due to various causes and conditions, come together at a certain point through birth, endure for a certain period of life or existence, but necessarily come apart and disintegrate at some point—death—when causes and conditions have changed.

Bardo consciousness: Tibetan medicine follows the Buddhist view that when a person dies, the elements forming the body disintegrate but as long as the consciousness is fuelled by karma (the propelling energy of previous deeds), it goes on seeking another life. The bardo ('between two') is the intermediary state between two lives during which the consciousness undergoes various experiences, at the end of which it seeks a birth corresponding to its particular karma. Conception happens when this so-called bardo consciousness meets with the father's sperm and the mother's ovum, and literally 'takes flesh' or incarnates.

Branches of knowledge: Tibetan knowledge is categorised into ten branches, out of which five are known as the five major branches of knowledge or 'the five major sciences' (see below), and others as 'five minor sciences'.

Conventional and definitive approach (*drang nges tshul*): Two ways to approach the Ultimate, the true nature of things, looking at it in the ordinary, conventional way or in absolute terms.

The conventional or expedient approach addresses what pertains to the relative truth, things as they appear to be; the definitive or absolute approach relates to the absolute truth, things as they really are. Not only are these two approaches of the Ultimate compatible but they are inseparably linked within the authentic meaning of the Two Truths—simultaneity of the absolute and the relative. (See Two Truths)

Eight branches of healing (*yan lag brgyad pa*): a mode of presentation of the third treatise which covers the same material as the 15 sections but follows the traditional eight-fold classification of Ayurveda: 1. The body (anatomy, physiology), 2. Infantile diseases (paediatrics), 3. Women's diseases (gynaecology) 4. Spirits (psychiatry) 5.Wounds, 6. Poisons, 7. Ageing (gerontology), 8. Treatment of impotence and infertility, rejuvenation.

Explanatory Tantra (*bShad rgyud*): the second volume of the *Four Tantras*, q.v.

Father's essence (Tib. *thig le*, Sanskrit *bindu*): the male energy in its purest form, also called the 'white element'. The procreative seed (sperm) is its physical counterpart, semen is its residue.

Four conditions: 1. the causal condition, *rgyu'i rkyen*; 2. the determining condition, *bdag rkyen*; 3. the immediate condition, *de ma thag pa'i rkyen*; 4. the object-condition, *dmigs pa'i rkyen*.

Five elements: the four elements (q.v.) plus space.

Five major branches of knowledge (*rig pa'i gnas lnga*): Tibetan knowledge is categorised into ten branches, out of which five are known as the five major branches or sciences: grammar, dialectics, medicine, arts and crafts, and Buddhist Dharma.

Five awakenings—(Tib.: *mngon par byang chub*, Skt.: *abhisaṃbodhi*): the main premise of tantra is that everything is already totally pure and perfect (as shown by the terms Vajra body and five primordial wisdoms). The point is to realise this innate, original purity, presently unrecognised.

Four elements: *'byung ba bzhi*, according to the traditional Indian classification: earth, water, fire, wind/air.

Four extremes or limits (*mtha' bzhi*) of arising: the four propositions on arising refuted by Nāgārjuna are extreme or limiting statements, in the sense that none of them correspond to what is actually there. The Middle Way of Nāgārjuna avoids all such extremes.

Four Tantras* or *Gyushi (*rGyud bzhi*): Short title of the fundamental work of Tibetan medicine in four volumes. It is comprised of 1. *Root Tantra*, 2. *Explanatory Tantra*, 3. *Oral Instructions Tantra* and 4. *Subsequent Tantra*.

Gates of birth, four (*skye sgo bzhi*): the four modes of birth or the four ways in which something can arise in *saṃsāra:* from a womb, from an egg, from moisture and heat, and in a 'spontaneous' or miraculous fashion.

Generating, sustaining, connecting and life: 'Generating' corresponds to the stage of formation of the nervous and vascular systems. As the names indicate, 'Life-sustaining' shows the function of these systems in terms of sustaining life, 'Connecting' evidences their linking role. 'Life' is short for 'support of the life-force'—this informs on the potential longevity of a body.

Individuals to be trained (*gdul bya*): a set phrase in Buddhism to designate beings as those who need to be trained in order to reach liberation. It applies more loosely in the sense of students, disciples, trainees.

Karmic imprints: traces left in the mind by any thought or action. See also *Ālāya*, q.v.

Mental events (*sems byung*) (Mind and its accompanying mental events): the *Abhidharma* analyses what is conventionally called a 'person' in terms of five aggregates, or five collections of various elements which make up a seeming individual whole. The fourth aggregate, *'du byed kyi phung po*, represents what is called mental factors (57), out of which 51 are 'mental events'. Most of these colour the workings of mind by their positive, negative or neutral quality; some are mere mental processes.

Nur nur po ('thickened'), ***ltar ltar po*** ('alike') and ***mer mer po*** ('malleable'): the names of the embryo in the early stages of its development (second, third and fourth week of pregnancy respectively, according to the *Explanatory Tantra*, Point II on the Body, Part 1, Formation of the body, chap. 2).

Oral Instructions Tantra (*Man ngag rgyud*): the third volume of the *Four Tantras*, q.v. The third treatise is divided into 15 Sections—the tenth of which addresses 'women's diseases' (*mo nad*).

Precious human life: literally precious human body (*mi lus rin chen*). Precious because of the six sorts of beings in samsara, humans alone are capable of seeking liberation.

Seven physical constituents (*lus zungs bdun*): the seven components of the metabolic chain which goes from the digested food all the way to the 'essence-element' which ensures the vitality of a person. These are: nutrients, blood, flesh, fat, bone, marrow, and 'regenerative fluid'. The quintessence of this regenerative substance is understood to be the 'white element' in men and the 'red element' in women, which provide vitality. The sperm and the ovum are their material vehicles for procreation.

Six causes (*rgyu drug*): 1. efficient cause (*byed pa'i rgyu*) e.g. empty space can accommodate objects and the earth can support life; 2. concurrent cause (*mtshungs par ldan pa'i rgyu*), e.g. three sticks together supporting something; 3. cause with a similar effect (*skal pa mnyam pa'i rgyu*), e.g. a good thought leads to a corresponding good action; 4. interactive cause (*lhan cig 'byung ba'i rgyu*), e.g. mental functions interact with one another; 5. all-affecting cause (*kun tu 'gro ba'i rgyu*), e.g. a wrong view affects all one's actions; 6. ripening cause (*rnam par smin pa'i rgyu*), e.g. the karma of killing a sentient being brings the killer a requital, his rebirth in hell like a ripened fruit.

Six-fold consciousness or six consciousnesses: Buddhism analyses consciousness as having six aspects: five connected to sensory perception (the visual, auditory, olfactory, gustatory and tactile consciousnesses), and the mental consciousness, which labels and conceptualises on the basis of sensory experience. Consciousness can also be analysed as eight-fold, as was done by the Yogācāra and Cittamatra schools. See *Ālāya*, q.v.

Superior or inferior: Buddhism distinguishes six types of beings in *saṃsāra*, existence conditioned by ignorance. Three of these are deemed inferior, because riddled with suffering (animals, spirits and hell-beings), three are said to be superior because they are more favourable (gods, semi-gods and human beings), but the best of all is the human condition which, alone, can serve as a basis for liberation. Birth in either of those states is determined by the quality of one's own actions (karma).

Three poisons (*dug gsum*): The primary cause of illness is found in the Tibetan Buddhist theory of the three poisons: desire, hatred and ignorance.

Treasure of the Abhidharma (Tib. *mNgon pa mdzod*, Skt. *Abhidharmakośa*): written by Vasubandhu (sLob-dpon dByig-gnyen), a famous exponent of Buddhist logic and one of the founders of the Yogācāra school (circa fourth century CE).

Trikāya: in Sanskrit, the three 'bodies' of Buddha: *dharmakāya, saṃbhogakāya, nirmāṇakāya.* In Tibetan: *chos sku, longs sku, sprul sku.* Finding peace or attaining the *trikāya* means reaching the full and perfect enlightenment of a buddha.

Two truths (*bden pa gnyis*): the absolute and the relative truths. The absolute truth accounts for the ultimately real, and the relative or expedient truth accounts for the relatively real. Though these may seem to be of a very different nature, the Middle Way teachings show that they are actually indivisible and apply simultaneously. In the absolute sense, everything is already pure and perfect but, as long as this is unrecognized, things manifest on a relative level as a result of the interdependent play of causes and conditions driven by karma.

Union of means (Tib. *thabs*, Skt. *upāya*) and wisdom (Tib. *shes rab;* Skt. *prajñā*): 'means' represents the male energy, 'wisdom' the female energy. Everything is born through the union of male and female energy.

Vessels (*rtsa*): Generic term used for veins, arteries and nerves, seen as ducts or channels through which various circulations can take place in the body. There are channels for blood to circulate through the vascular system (along with carbon dioxide in veins, and with oxygen in arteries), and for nervous impulses to travel through nerves. Veins and arteries collectively are called 'black vessels', *rtsa nag* while nerves are known as 'white vessels' or 'water vessels', *rtsa dkar* or *chu rtsa*.

BRILL

Asian Medicine 6 (2010–11) 433–435

brill.nl/asme

List of Contributors

JENNY BRIGHT is a PhD candidate at the Department for the Study of Religion and the Collaborative Programme in Women's Health at the University of Toronto, Canada. Her research interests include Tibetan religion and medicine, gender theory and theories of science and medicine.

MINGJI CUOMU is a Wellcome Trust funded postdoctoral researcher at the Institute for Social and Cultural Anthropology at the University of Oxford. Her research interests are medical anthropology, public health, Tibetan medicine, and Buddhism. She is a practitioner of Tibetan medicine as well as a researcher and has authored several articles and a monograph, and edited and co-edited several books on Tibetan medicine. One of her recent publications on issues of women's health and gender is *Clinical Experience in Treating Obstetric Diseases*, published in 2009 in the TAR.

RAE ERIN DACHILLE-HEY is a PhD candidate in the Group in Buddhist Studies at the University of California, Berkeley where she works closely with Patricia Berger, Jacob Dalton, and Alexander von Rospatt. She received a masters degrees in the History of Art (2005) and the Languages and Cultures of Asia (2007) from the University of Wisconsin-Madison. Under the auspices of the Fulbright IIE Award, Rae Erin is dedicating the 2011–2012 academic year to conducting dissertation research in Nepal with the International Buddhist Academy as her host institution. While she continues to pursue her interests in perceptions of the status of the human body in the world, her current research explores the role of the body outside of the field of Tibetan medicine in the realm of Tibetan Buddhist tantric practice.

HEIDI FJELD is a senior researcher at the Section for Medical Anthropology and Medical History at the Institute for Health and Society, University of Oslo. Based on extensive fieldwork in Lhasa and rural Shigatse, her research has focused on social and cultural change of Tibetan culture within the PRC. She gained her PhD in Anthropology with the thesis *The Rise of the Polyandrous House: Kinship, Marriage and Social Mobility in Rural Tsang, Tibet*. She is the author of *Commoners and Nobles: Hereditary Divisions in Tibet* (2005). In

DOI: 10.1163/15734218-12341241

recent years she has worked on Tibetan cultures of reproductive medicine, including treatments of infertility in Lhasa. Her ongoing research focuses on the new health insurance in China and its implications for disabled people in Amdo, Qinghai province.

JANET GYATSO is the Hershey Professor of Buddhist Studies at Harvard University Divinity School. Her field of concentration is Tibetan cultural history. Her books include *Apparitions of the Self: The Secret Autobiographies of a Tibetan Visionary* (Princeton University Press, 1996); *Women of Tibet* (Columbia University Press, 2005); and *In the Mirror of Memory: Reflections on Mindfulness and Remembrance in Indian and Tibetan Buddhism* (State University of New York Press, 1992). She is currently completing a new book entitled *Being Human in a Buddhist World: A Cultural History of Medicine in Early Modern Tibet*, which focuses upon the conjunctions and disjunctures between religious and scientific epistemologies in Tibetan medicine in the sixteenth–eighteenth centuries. Gyatso was president of the International Association of Tibetan Studies from 2000 to 2006, and co-chair of the Buddhism Section of the American Academy of Religion from 2004 to 2010.

THERESIA HOFER is a postdoctoral researcher at the Section for Medical Anthropology and Medical History, Institute for Health and Society, University of Oslo. Based on long-term fieldwork in Lhasa and rural Shigatse, her doctoral research focused on contemporary Tibetan medical practices in Tsang and practitioners' memories of Communist social and medical reforms in relation to Sowa Rigpa. Her first monograph is entitled *The Inheritance of Change—Transmission and Practice of Tibetan Medicine in Ngamring* (Wiener Studien zur Tibetologie und Buddhismuskunde, Vienna, 2012). As curator of a forthcoming exhibition on Tibetan medicine the Rubin Museum of Art, New York she is editor of the accompanying publication *The Art of Tibetan Medicine*. Hofer's postdoctoral research project at the University of Oslo is funded by the EU's Marie Curie programme and entitled 'Women doctors in Tibetan medicine and the modernisation of Health Care'.

MONA SCHREMPF is a social and cultural anthropologist with a strong research interest in medicine and health, and religion and society, working within rural Tibetan and Tibetanised communities in China and the Himalayas. She is a research fellow at the Central Asian Seminar of Humboldt University Berlin, Germany, and a freelance lecturer, having taught at universities in Germany, Switzerland, Canada, and New Zealand. Her books include *Medicine between Science and Religion. Explorations on Tibetan Grounds* (co-edited with

V. Adams and S. Craig, 2010) and *Soundings in Tibetan Medicine. Anthropological and Historical Perspectives* (PIATS; Brill, 2007).

STACEY VAN VLEET is a PhD candidate in Modern Tibetan Studies within the History-East Asia program at Columbia University. She is currently working on her dissertation, which will discuss social and intellectual developments related to the spread of Tibetan Buddhist monastic medical colleges, from Lhasa to eastern Tibet, Mongolia and Beijing, between the late seventeenth and early twentieth centuries.