Chemist's/Druggist in Chamba, also selling ammunition.

Alex McKay

The Introduction of Biomedicine into the Indo-Tibetan Himalayas

Research > Central Asia

While a modest academic literature exists on the introduction of biomedicine (popularly known as 'Western' medicine) into the metropolitan centres of India and China in the late nineteenth and early to mid-twentieth centuries, little or no attention has been paid to the same historical process in the Himalayan lands.

By Alex McKay

Designed to fill this lacuna in our field, my current research is guided by the proposition that there were four main agents behind the spread of biomedicine in the Himalayan region: medical missionaries, private travellers, commercial representatives, and the colonial state – the British Imperial Government of India. Records of missionaries, travellers, and the colonial state are both abundant and revealing. Commercial records are, however, less easy to access, with pharmaceutical companies reluctant to open their archives to potential critics. Therefore, I would be pleased to hear from anyone with knowledge of the activities of Indian and other companies with commercial interests in the spread of biomedicine.

In the early years of the British presence in South Asia, European and indigenous medical systems were not necessarily incompatible. In the latter part of the nineteenth century, however, European medicine underwent something of a revolution: developments such as germ theory, the discovery of anaesthetics and systematic vaccination led to a radical departure from earlier understandings. This transformation was accompanied by an increasing sense of superiority among practitioners of biomedicine, with the consequent loss of interest in indigenous systems and remedies for disease.

The transmission of biomedicine to the peoples of the Himalayas began in the last decades of the nineteenth century. Missionaries began to place increasing emphasis on the use of medicine as a means to encourage conversion; colonial travellers and officials, in their efforts to discover and map the remotest corners of the region, introduced, incidentally, knowledge of at least the basic features of the Western biomedical system. There were political imperatives: the need to attract indigenous supporters to the imperial system. On top of this, belief in the 'White Man's Burden' and his 'Christian duty' coalesced with the belief that scientific principles were universally applicable, and knowledge could – to both political and moral benefit – be transferred from the metropolis to the farthest reaches of the empire, and indeed the world.

There was an almost total absence of state public health structures in the Himalayan region at the beginning of the twentieth century. Indigenous medicine consisted of several strands of belief and practice, with elite textual, shamanic, 'village-level' and household practitioners providing medical treatment, generally within a religious theoretical framework. Medicine, however, lacked state and professional organization and a system of verification. While not without efficacy, particularly for conditions that included psychological aspects, the Himalayan world was largely defenceless against epidemics, child mortality was high, and certain serious conditions were virtually endemic.

Biomedicine in its early twentieth-century form offered a variety of treatments that were to radically alter the Himalayan medical landscape, not the least of which were surgery (particularly for cataracts) and vaccination against smallpox. As was the case elsewhere, the new medical system did not meet with immediate acceptance. Nor did it, while eventually becoming hegemonic at state and local elite levels, entirely displace indigenous systems of medical practice. Elements of biomedicine were adopted at various speeds: some were adapted for use within local systems, while others were resisted. The subject demands, therefore, consideration of the process of adoption and interaction with indigenous systems and practices.

Within its general survey of the process by which biomedicine came to predominate in the Indo-Tibetan Himalayas, this project focuses on five particular regions: Tibet, Sikkim, Bhutan, Darjeeling and district, and Chamba district in the western Himalayas. Each of these regions existed in a slightly different constitutional relationship to the Government of India, and by analysing them separately, the effects of the different relationships with the Indian state on the development of medical systems can be discerned.

Imperial stepping stones

In Chamba district, for example, missionaries were the prime agents in introducing biomedicine and in establishing its predominance. Christian missionaries were forbidden to enter Tibet, where the Imperial government's Indian Medical Service officers were the primary agents in spreading biomedical practices. In both cases, the project succeeded by obtaining the consent and support of indigenous elite classes. By persuading elites of the benefits of biomedicine, the new system was made available to all classes within indigenous society; indeed the lower classes may well have benefited disproportionately.

Particularly in the Tibetan Buddhist world, the religious framework of indigenous medical practice translated into manifestations of cultural resistance. Political resistance, of the type noted in India, was largely absent due to the lack of national consciousness among Himalayan Buddhists, as was resistance based on notions of purity and pollution. The greatest resistance seems to have been to modernity in general, with biomedicine being an aspect of that modernity. Resistance to biomedicine was thus an active policy based on a specific world view, and while its use spread among indigenous elites over time, in 1950 there were still no indigenous practitioners of biomedicine in Tibet or Bhutan and only a handful in Sikkim.

In the postcolonial era, Chamba and Darjeeling districts, old stepping stones for the imperial project of introducing biomedicine into the Himalayas, came under full control of the newly independent Indian government; their medical services became part of those of the new state. Whereas Sikkim was brought into the new system in the 1970s after the Indian take-over, Bhutan, retaining its independence, formulated a different model for developing its medical system. Bhutan granted concessions to indigenous medical systems, for example clinics offering local and biomedical treatments under the same roof.

Biomedicine in exile

Of particular interest is the history of the interaction between Tibetan medicine and biomedicine in the period after 1959, when the Dalai Lama and approximately 100,000 of his followers went into exile in India. Biomedical treatment was made available to the exile community under the Indian state, and by the 1970s biomedical facilities were established within the Tibetan exile community, initially under private philanthropic initiatives and subsequently under exile government control. Tibetan medicine, patronized and promoted by the exile government, was made available alongside biomedical treatment.

The preservation and promotion of Tibetan medicine has been part of the wider political project of preserving Tibetan culture in exile. Exposed to the wider world, however, the problematic elements of the project can be discerned. One obvious difficulty, which may, of course, be applied to all such terms, is defining 'Tibetan medicine'. Historically, numerous medical practices existed within Tibet's regions; as these were not systemized under central authority, they varied considerably in form and practice. The form chosen for preservation and promotion has been Tibetan Buddhist culture's elite textually based system, and not, for example, women's' knowledge of local cures.

Alongside practical problems such as guaranteeing the supply of traditional herbs in Indian exile, difficulties remain in the promotion of Tibetan medicine as a scientific system. The identity of Tibetan medicine is also challenged by the extent of its interaction with biomedicine; as it enjoys considerable popularity among westerners, Indians, and Chinese, its survival as a separate system may well depend on outside patronage. Among the exile community, the resort to biomedicine is common, while practitioners of Tibetan medicine, incorporating aspects of biomedical practice (such as the taking of blood pressure), place less emphasis on both 'traditional' practices (such as pulse-taking) and on religious aspects that once provided a clear framework to their medical initiatives.

Many patients resort to both systems, often simultaneously. Numerous factors affect their choice, including ease of access, cost, ideas of efficacy, and issues of personal and ethnic identity. The modern construction of Tibetan medicine as a state authorized system is an ongoing process, subject to negotiation, and affected by global political and economic factors; its final status remains unknown. It is, however, important to study both the history and the ongoing issues of medical interaction, not only in Asia's capitals and centres, but among all its peoples. By examining the process through which biomedicine was introduced into the Indo-Tibetan Himalayas, we may shed light on both colonial and postcolonial political structures and social processes. <

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