WIENER STUDIEN ZUR TIBETOLOGIE UND BUDDHISMUSKUNDE
HEFT 57

STEPHAN KLOOS

TIBETAN MEDICINE AMONG THE BUDDHIST DARDS OF LADAKH

ARBEITSKREIS FÜR TIBETISCHE UND BUDDHISTISCHE STUDIEN UNIVERSITÄT WIEN
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ERNST STEINKELLNER

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Foreword

This book is based on my M.A. thesis written in three months from March to May 2002, using the results of four months field research in summer and autumn 2001. The data gathered during these four months in Ladakh were organised and prepared in February 2002 and only a part of them found its way into this book. Other parts, but by far not all, have been presented in form of a report for Nomad RSI, the organisation I was cooperating with. The present publication is meant to provide comprehensive information on the social and medical situation, and its historical background, of the Buddhist Dard community in Hanu, Ladakh (India). Other articles (Kloos 2004a, b) that have been written on the same subject after the completion of this thesis go to deeper analytic levels and use different perspectives, but rely on the information presented in this book as their basis.

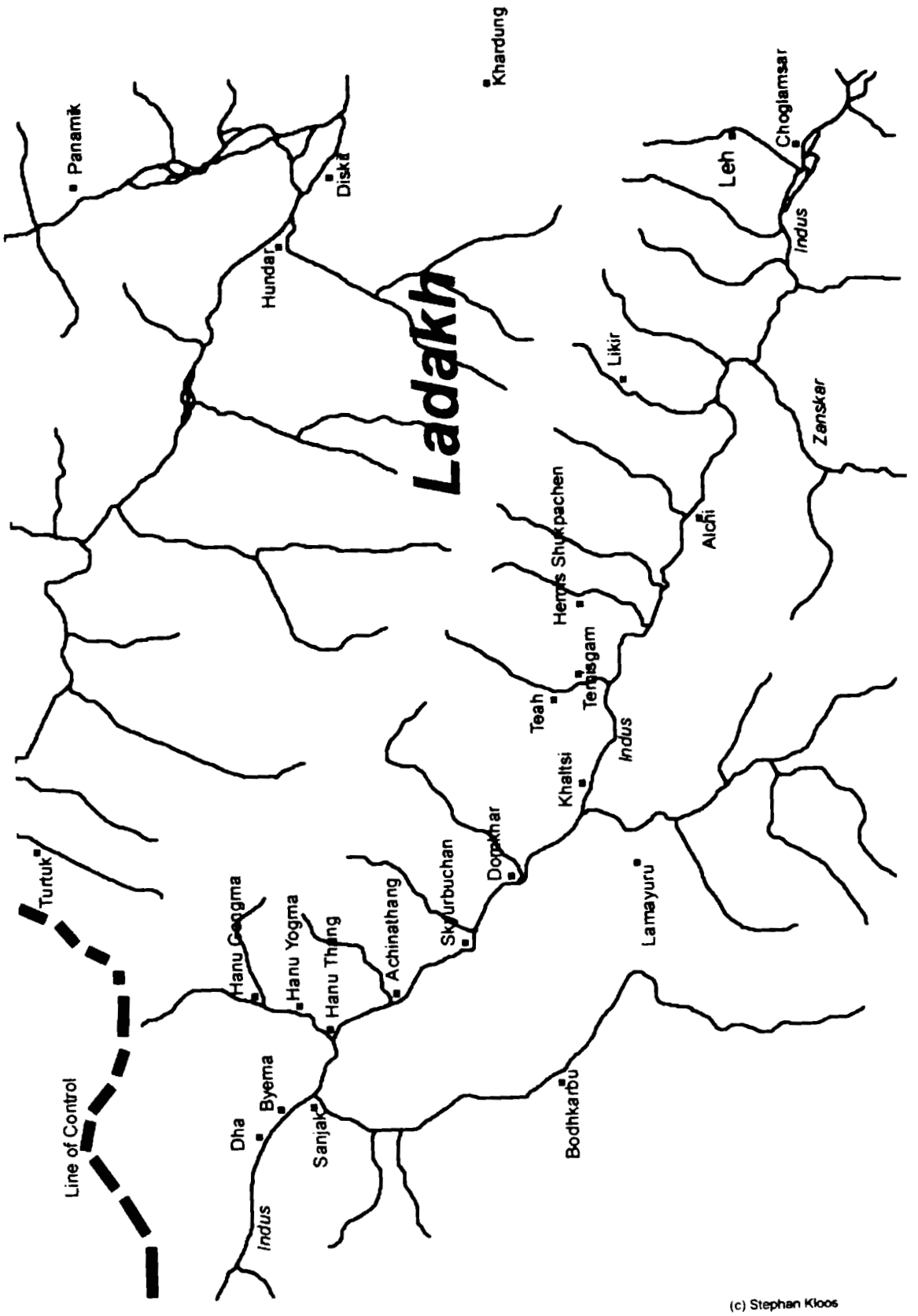
The relatively short time this study took in writing and researching is mainly due to the various kinds of much appreciated support I have received from many sides. Thanks goes to my parents for their continuous moral and financial support, to Laurent Pordié and all Nomad-pa who were a great team in Ladakh, to Andre Gingrich for his academic support, to Guntram Hazod for his spontaneous help and suggestions, to Chief *Amchi* Tsering Phuntsog in Leh for his selfless cooperation, to Dawa Tsering Malikpa for his invaluable bureaucratic and organisatory help, to Marco Vismara and Sonam Phuntsog Achinapa for sharing their knowledge, to my research assistant Tsering Thundup Skyabapa who contributed substantially to

the success of research, and, last but not least, to *Ashang* Tashi Bulu, the main character of this study, for his hospitality, patience, and jokes. I am also indebted to all Ladakhi and Hanupa who shared their hospitality and cheerfulness, and to the Indian army in Khaltsi Block, which not only gave me many a free meal, free rides, and a minimum of trouble, but also impressed me with its discipline and friendliness. I have also learned and benefited from many others, my gratitude to whom is there, even if their names are not.

Finally, I am grateful for the research grants received from the University of Vienna and from Land Steiermark. This publication was made possible by Ernst Steinkellner, and financially supported by funds from the Wittgensteinpreis 2000 bestowed on Andre Gingrich by the Austrian Fonds zur Förderung der wissenschaftlicher Forschung.

A Note on Spelling and Terminology

Wherever possible, I have used the Wylie system for the transliteration of Classical Tibetan words. Otherwise, Ladakhi words have been transcribed either in accordance to Helena Norberg-Hodge and Gyelong Thupstan Paldan's Ladakhi-English, English-Ladakhi dictionary (1991), or transcribed as they are spoken in Hanu. Please note, too, that words like "*amchi*", "Ladakhi", or "Hanupa" remain the same in both singular and plural forms.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Skyurbuchan
Achinathang
Hanu Gongma
Hanu Yogma
Hanu Thang
Turtuk
Line of Control
Dha
Byema
Sanjak
Indus
Bodhkarbu
Lamayuru
(c) Stephan Klooss

1. Introduction

Around Christmas 2000, I received an e-mail by Laurent Pordié, a good friend of mine who is also founder and coordinator of the international non-governmental organisation (NGO) Nomad RSI (2002). We had met in 1998 in Dha-Hanu, an ethnically peculiar area in lower Ladakh (see map) close to the Indo-Pakistan cease-fire line, where he and co-founder Muriel Hernandez were busy interviewing *amchi*, the local practitioners of Tibetan medicine, in their first efforts to organise what is today one of the most active and well-reputed NGOs in Ladakh. I had accompanied them for a few days, interested in their work as a young and – regarding international aid and NGO's – quite critical anthropologist, and we vaguely agreed to work together some time in the future. Now, two years later and just when I was starting to think about a subject for my MA thesis, I received the offer to conduct research in Ladakh on the social role of *amchi*, as a research fellow of Nomad RSI. The NGO was thinking about setting up an *amchi* health centre in Hanu, in order to support *amchi* medicine and improve health care in this remote area, and was, following its approach of integrating serious scientific research with supportive action (Pordié 2001), interested in in-depth social information on the *amchi* there. For me, the offer was perfect, since it meant being able to do field research with professional support and a practical perspective, without, however, compromising its scientific value, as the functions of researcher and project-planner were strictly segregated in the organisation. So, I agreed.

1.1. Aim of research

The research was to focus on one particular *amchi*, Tashi Bulu from Hanu Gongma, who had already previously worked together with Nomad RSI and was not only the most experienced, but also the most open-minded and interesting *amchi* of his area. The aim was an ethnographic documentation and analysis of his social, that is non-medical role in the village, including an array of related objectives.

1) An examination of the social importance of Tashi Bulu, but also the other local *amchi*, for the area. Special emphasis was to be given on the possible non-medical ways of the *amchi*'s contributing to the well-being and social equilibrium of Hanu.
2) Gaining an in-depth understanding of the *amchi*'s and *amchi* medicine's problems, the factors leading to them, and the *amchi*'s strategies of dealing with them from a social perspective.
3) The study of Tashi Bulu's role in the village's adaptation to outside influences and modernity.

Since apart from Alice Kuhn's (1988) descriptive work there existed no scientific evaluation of any of these topics, a more general aim of the study is also to provide the scientific community as well as national and international health organisations with an ethnographic case study and an in-depth analysis of the effects of socio-economic changes on the social dimensions of traditional health care.

1.2. Scientific context

The present study is located at the interface between classical social anthropology and medical anthropology. It takes the case of a traditional medical practitioner as the starting point for an ethnographic analysis of social change in a small community, but then leads back to the medical field by discussing its implications for the local delivery of health care. While a large part of the literature used in this book is medical anthropological, the traditional issues of this academic field, such as the cultural construction of sickness and healing, the social meanings and performance of ill-health, or a sociocultural perspective on medical practice and epidemiology (Joralemon 1999), are not dealt with here.

The investigation of social change and its influence on traditional medicine is not new. Already Ronald Frankenberg (1980, 1981) and Jean Comaroff (1981, 1982) have pointed out that outside factors influence local patterns of resort, arguing that the arrival of modernity usually leads to a demise of traditional medical practices, to the benefit of 'cosmopolitan' medicine (Dunn 1976). While this argument receives some support and ethnographic exploration in this book – the latter of which has been lacking so far according to Vincanne Adams (1988: 505f) – it has been rightly criticised (ibid.) as problematic, due to its overlooking local factors in favour of structural ones. Frankenberg and Comaroff, as well as many other critical medical anthropologists, can therefore be seen as shooting over the goal set by John Janzen (1978), who argued for a shift of (medical) anthropological focus from the study of "*roles, statuses, and patterns of relations [...] – i.e. a social system*" (p. 121) to

what he called 'macro-analysis' in order to account for changes of and in this social system. In line with Adams (1988), however, I argue that any study of social change, of outside influences on local social and medical structures, must first examine the local ethnographic context, that is, engage in micro-analysis, before taking the next – and undoubtedly crucial – step of examining larger structural factors. The present study builds on this argument by combining micro- and macro-analysis, and indeed the term 'integrated approach' takes a central position in its theoretical design.

Another central theme in this present work is that of power. The connected problematic, and indeed the orientation of this study, bears considerable resemblance to Maurice Godelier's (1986) work on the "big men" and the "great men" in the context of Melanesia. Not only will we notice some striking similarities between Tashi Bulu and the Melanesian "big men" (see also Sahlins 1970), but also Godelier's dilemma (p. xiii) of what to tell and what not to tell about certain practices and knowledge of his informants is found here. However, the differences should not be overlooked. To apply the theoretical concept of the "big man" to Tashi Bulu in analysis, or even to call him a "big man", would be dangerous and out of place in the Himalayan, non-tribal setting of Hanu, wherefore only careful comparison will be attempted at the appropriate places. In regard to the anthropologist's dilemma of how much to divulge of his information, the difference is that while among the Baruya certain knowledge is considered secret to other members of society (e.g. women), the information I present in this book is well known, albeit mostly not expressed openly, by all Hanupa.

While the larger interest of this study is therefore by no means new, there are also some fresh aspects to it, and it can thus be seen as an exception in three regards.

1) The study's setting: Despite Hanu being the only ethnically non-Tibetan region where Tibetan medicine is practiced in a traditional way, and despite its exceptional history and culture, it has never before been the site of in-depth social research. Much of the information on Hanu included in this study is therefore unique, and will, due to the area's inaccessibility, probably remain so in the foreseeable future.

2) The focus of analysis: In spite of the current trend to investigate the practice of Tibetan medicine rather than its somewhat better-explored scholarly and textual body of knowledge, the social role of Tibetan medical practitioners in their society has not been explicitly studied before, so that this publication provides the first case study of this kind.

3) The analytic approach: Contrary to most of medical anthropological literature, which tends to approach similar topics from the patients' or laity's perspective, this study looks at the problematic of socio-economic change through the perspective of a medical practitioner.

The subject matter of the present work is therefore very interesting, and I hope that the effort of research and writing, which was for the most part (except: see chapter 5.1.) an enjoyable one, offers a contribution not only to the study of Tibetan medicine and Ladakhi society, but also to practical efforts made in the support of *amchi* medicine in Ladakh.

1.3. Outline and framework

The study is comprised of three major parts, of which the first outlines and discusses the theoretical approach used in the later analysis. In the second part, the research process and its setting, Hanu Gongma, will be described, including a short history of the Buddhist Dards in Ladakh and especially Hanu. The third part, building on the first two, consists of the analysis of the *amchi*'s social role proper, and it is this part, together with the oral history sections of the second, that makes use of the empirical data gathered in the field. The first and part of the second section, obviously, are based on written sources.

2. Social Role and Status: An Overview

2.1. Definition and theory

The concepts of social role and social status, while being of implicit importance in social anthropology, have been coined and theorised mainly by sociologists. Thus it was Ralph Linton (1945) who first defined "social status" as the position of an individual in society, and "social role" as not only the individual behaviour, but also the expectations about appropriate behaviour of an individual with certain status in his or her community. Every status is connected with a specific role, but the two are not the same. This basic definition was elaborated by Robert K. Merton (1957), who extended it by two more concepts: the "role-set" and the "status-set". In contrast to Linton he argues that each social status entails not only one, but a whole set of social roles, that is a "role-set". A role-set therefore is a combination of role-relations in which a person is involved due to his or her social status (ibid. 260). A status-set, on the other hand, describes the multiple positions that each individual occupies in society, like that of father, doctor, and club-member, to give just one possible example. In order for a society to function properly, the composition of role-sets has to be coordinated, so that role conflicts are avoided as far as possible. Merton was especially concerned with the mechanisms and processes in society that have positive and harmonizing effects on role-sets. Linton, also thinking about role-stress, remarked that with increased mobility and technology of modern times, old systems of status and reciprocity are rendered obsolete, giving rise to tensions and conflicts. This basic

observation certainly holds true in the context of Hanu, and is analysed in detail below.

The theoretical discussion of social roles in sociology was carried further by Erving Goffman (1969), who, by using the example of theatre, emphasized the people's expectations and the possibility of sanction as constituting social roles, rather than – like Linton and Merton – taking society, status, and roles as *a priori* realities which individuals are subjected to. This approach was also used by William J. Goode (1960), who pointed out that roles and their inherent expectations, rights, and duties are negotiated, and differ from person to person. The more recent work of Birgit Dechmann and Christiane Ryffel (1997) also defines the social role as the sum of all expectations by groups and individuals that influence individuals (ibid. 99). These expectations, they argue, are based on social consent, which regulates who can expect or demand what, and from whom. This definition summarises what has been said so far about social roles, and serves as a useful basis for the less theoretical-sociological, but empirical-anthropological account that is to follow.

2.2. The social role of healers: Medical anthropological approaches

In medical anthropological discourse, traditional medicine and its practitioners have continued to be the subject of research and scientific enquiry, parallel to an increasing interest in the social and cultural aspects and implications of biomedicine. This interest in traditional medical practitioners reached its height in the 1980s, following the WHO's and UNICEF's 1978 Alma Ata Declaration, aiming

at "*health for all by the year 2000*" by using all available human resources, including traditional healers. Attention was focussed on primary health care delivery in less developed countries, and the possible role traditional healers could play in it (e.g. Oswald 1983; Shrestha & Lediard 1980; WHO 1991; Young 1983). Even though these studies were concerned with the roles of these practitioners, they were usually limited to directly health-related aspects, so that there hardly exists any medical anthropological work on the social role of healers *per se*, in its wider social context. However, just as health and illness cannot be studied in isolation from the socio-cultural context they take place in (Helman 2000; Kleinman 1980), so the medical role of a practitioner has by implication strong social aspects. These have, in different circumstances, been examined by authors starting from William H. R. Rivers, who first declared that "the practice of medicine is a social process" (1999/1924: 55), Edward E. Evans-Pritchard (1937) examining the all-pervading concept of witchcraft in Zande society, Victor Turner (1968) dealing with the social functions of (healing) rituals, and Michel Foucault (1973) portraying medical practitioners as agents of social control, up to the multitude of modern medical anthropological writers. Thus one finds, mostly implicitly or, less frequently, explicitly a series of observations or assumptions about the social roles of healers that transcend the medical sphere, allowing us to identify a common base of conceptualisations in that regard.

There are, however, some inherent dangers in using especially the implicit assumptions, but also the well-argued, valid observations found in the plethora of (medical) anthropological literature. Sev-

eral authors have pointed out the dangers and difficulties of implicitly regarding the category of "traditional healers" as a homogenous entity (Kloos 2000; Young 1983), as happened in the Alma Ata declaration, which has partly also due to that reason failed to achieve its self-set goal (Janes 2001: 197). Indeed, the social roles of practitioners as diverse as bone-setters, traditional birth attendants, shamans, oracles, astrologers, faith healers, herbalists, and institutionalised or non-institutionalised practitioners of classical medical traditions like Ayurveda, Unani, Traditional Chinese Medicine, or Tibetan Medicine, by necessity differ. Some of them are located on the lowest hierarchical ranks in their communities, playing only a marginal social role beyond their medical practice (e.g. Indian traditional birth attendants), while others have considerable status (e.g. practitioners of the above-mentioned classical medical systems) and may even be located at the centre stage of society, as we will see is the case in Hanu Gongma.

Another danger consists of naïve but all-too-frequent views, which project onto traditional medical practitioners all that biomedicine is accused *not* to include, such as harmonious and caring practitioner-patient interactions, in which enough time is given to the patient to express his suffering, which in turn presumably enables the traditional healer to give holistic treatment not only curing the disease, but also solving the sufferer's psychological and social problems. As Kaja Finkler (1980, 1994) has shown in her case studies, (faith-) healers may spend less time with their patients than their biomedical counterparts, they may show less interest in the patients' point of view and their social situation, and they may enact similar power

inequalities that biomedical practitioners are frequently accused of. Indeed, the question of power in medical practice as in society is a central one, and will be addressed below.

However, keeping in mind the caveats just mentioned, the more or less implicit conceptualisations of traditional medical practitioners' social roles do have validity. We can generally take as a fact that traditional healers play an important role in their communities, since for a majority of the world's population they are, for one reason or the other, the only available providers of medical care (Helman 2000). Often, functioning biomedical facilities may not be available at all in rural or remote areas; often, too, such facilities are available, but cannot be afforded by most except those belonging to the upper social strata. Even where there are affordable biomedical facilities, people continue to resort – sometimes overwhelmingly so – to traditional healers. This phenomenon has been extensively dealt with in medical anthropologists' work on medical pluralism (e.g. Helman 2000; Kleinman 1980; Minocha 1980; Young 1983). It is mostly in these studies that we find clues about practitioners' social roles. Usually, one or more of the following theses are offered as explanations for the continued popularity of traditional medical practitioners, not only in rural, but also and as much in urban areas.

(1) Traditional healers are integral members and part of the community in which they practice, which practitioners of biomedicine often are not. Their roles in society have been shaped and defined historically, and may be religiously or spiritually legitimised.

(2) Traditional healers operate with locally meaningful and accepted concepts of health, sickness, and healing (Worsley 1982), and frequently treat also problems not considered as sickness by biomedicine. Because of this, they are often able to successfully treat so-called culture-bound syndromes (Hahn 1985; Helman 2000), or solve social conflicts. Indeed, many authors have characterised traditional healers as cultural psychotherapists (Csordas & Kleinman 1990: 21; Eigner 2001; Finkler 1980; Kirmayer 1993: 161; Kleinman & Sung 1979), referring especially to shamans, oracles, and faith healers.

(3) Traditional healers are often seen as complimentary to biomedical care, either as a last resort when biomedicine does not produce the desired treatment outcomes, or simultaneously to treat the non-physical causes of the sickness.

Clearly these theses cannot be applied to all kinds of traditional healers in every context, and their validity for the Indian context has been criticised by Aneeta Minocha (1980). They do, however, provide the widest possible frame to account for their general medical as well as social roles in societies around the world. We can see here that their social roles are commonly interpreted as upholding or at least contributing to social stability and the prevention of, or effective dealing with, conflicts, be it through direct social interventions as in the case of shamans and oracles (e.g. Blustain 1976; Kleinman & Sung 1979; Lambert 1992; Stone 1976), or indirectly through other kinds of socio-culturally meaningful treatment, even if based on pharmacological agents (e.g. Adams 1992; Janes 2001; Nichter 1981; Obeyesekere 1992). Also Foucault's (1973) argu-

ments can be taken in this light, in the sense that social order is maintained through the social control enacted by medical practitioners. However, a theoretical focus on power already hints at what is often overlooked in more superficial or general accounts of medical practitioners' social roles: Far from contributing to social harmony and stability in a positive sense, they may, in direct proportion to their medical powers and social position, take part in potentially problematic power relations. This study, after giving a theoretical overview over that central aspect of medical practice and society in general, will provide an interesting example of this possibility.

3. Tibetan Medicine and *Amchi*

3.1. Tibetan Medicine

Before coming to the social role of *amchi*, the practitioners of Tibetan medicine, it is helpful to remember the history and the most important concepts of Tibetan medicine, which constitute the basis not only for the *amchi*'s medical practice, but also for their social positions both in theory and in practice.

3.1.1. Short history of Tibetan medicine

The history of Tibetan medicine is closely linked to that of Buddhism in Tibet, even though its roots date back much further. In line with the purpose and subject of this work, only a short historical overview is given here. For a detailed historical account of Tibetan medicine, refer to Rechung Rinpoche (1976) and Terry Clifford (1994: 47-63), while its mythological history is described by Tom Dummer (1988) and Clifford (ibid.). Tibetan medical knowledge is based on Ayurveda as well as various Buddhist and tantric medical practices, which were originally imported with Buddhism from India from the fifth century CE onwards, a process culminating in the formal introduction of Buddhism in Tibet by King Srongtsen Gampo (629-650 CE). The same king is said to have convened the first "international medical conference" in Asia, inviting eminent scholars from India, China and Persia, laying the foundations for transcultural influences on Tibetan medicine. Not only did it come to preserve the Ayurvedic knowledge partly lost in India with the Muslim invasions that were already underway at that

time, but it also integrated pulse diagnosis, tongue-inspection, and acupuncture from the Chinese, and aspects of the Persian medical system, which itself incorporated ancient Greek medical knowledge. Urine analysis was added as the major indigenous contribution (Clifford 1994: 52). Tibet became renowned for its medical expertise and medicinal resources, and was called "*country of medicine*" and "*land of medicine plants*" (ibid. 4). In the 17th century the Fifth Dalai Lama built Tibet's first medical school in Lhasa, the *Chagpori*, which marked the beginning of the institutionalisation of Tibetan medicine, and of 'public health' in Tibet. In 1916, a second medical college, the *sman rtsis khang* (hereafter referred to as 'Mentsikhang' in Lhasa, and 'Men-Tsee-Khang' in Dharamsala), was built in Lhasa, further strengthening the institutionalisation and centralisation of Tibetan medicine (ibid. 61-63) in the course of the 13th Dalai Lama's efforts to strengthen and centralise state-power and authority generally. Craig Janes' (1995) excellent account of Tibetan medicine in the 20th century shows how, immediately prior to as well as after the Chinese occupation, the Tibetan medical system reflected the ongoing political developments, all the while consolidating its position in the new health bureaucracy of Chinese hegemony. Today, in the Tibet Autonomous Region (TAR), it constitutes the only remaining and flourishing aspect – and indeed symbol – of Tibetan culture (Adams 2001; Janes 2001), albeit in a changed form and struggling to adapt to modernity and new economic policies of Chinese authorities. In India, the Men-Tsee-Khang in Dharamsala with its branches all over the subcontinent, has developed into a major health resource and economical force for the Tibetan exile community, and although not subjected to po-

litical restraints like its counterpart in Lhasa, it has also adapted to global forces of modernity, and continues to do so (Pordié 2002).

3.1.2. Theoretical foundations of Tibetan medicine

In contrast to writings on the social aspects and the actual practice of Tibetan medicine, which are, despite the recent work of Janes (1995, 1999, 2001), Vincanne Adams (1988, 1992, 2001), Geoffrey Samuel (2001), and Laurent Pordié (2002) still few in number, there is a good amount of literature on its medical theory. The following outline makes use, unless otherwise stated, of the works of Yeshi Donden (1997), Clifford (1994), Dummer (1988), Fernand Meyer (1981), Elisabeth Finckh (1985), and Rechung Rinpoche (1976).

As already mentioned, Tibetan medical knowledge is based on Ayurveda, Chinese medicine, Persian-Galenic influences, and some indigenous contributions. Its theoretical foundations are essentially those of Tibetan Buddhism, and the same concepts that Buddhist religion uses on the path to the eradication of existential suffering are applied by Tibetan medicine on the more mundane level of physical and mental illness. Thus, the root cause of all suffering, including sickness, is identified as ignorance (Tibetan: *ma-rig-pa*), that is, ignorance of the ultimate truth. It follows that in theory every non-enlightened being is regarded as sick, which is indeed one of the many medical analogies used in Buddhism. Out of ignorance, we continue to produce the three 'poisons' (Sanskrit: *klesha*, Tibetan: *nyon-mongs*) of confusion, greed/attachment, and aversion/hatred, with their corresponding humours (Tib.: *nyes-pa*) of

phlegm (*bad-kan*), wind (*rlung*), and bile (*mkhris-pa*) respectively. Each of these humours, in turn, is made up of one or a combination of the five cosmo-physical elements (Pordié 2002) wind (*rlung*), fire (*me*), earth (*sa*), water (*chu*), and space (*nam-kha*), which are the basic units of both macro- and microcosm. Not only the human physiology is explained in terms of this humoral theory, but also mental and emotional states correspond to the three humours and five elements. Health, on a mundane level, is regarded as the humours' proper balance (although, in practice: see Samuel 2001), sickness as the excess or deficiency of one humour. Treatment and healing is possible by restoring the balance by means of manipulating the patient's elementary (meaning the five aforementioned elements) condition through behavioural and dietary changes, *materia medica*, or other techniques, including rituals and prayers. Since every food, plant, or indeed every object, as well as weather, season, time, and related behaviour are made of – or classified through – the five elements, treatment techniques are varied, and astrology often plays an important role as well. In the words of Clifford (1994: 123), "*All things can be used to rebalance and reharmonize the imbalance of illness.*" Tibetan aetiology also recognizes factors of medium range, lying between the root cause of ignorance and the immediate cause of humoral imbalance: results of past actions (karma), or the negative influence of spirits and demons. Here, the syncretistic character of Tibetan Buddhism as well as Tibetan medicine, containing both Buddhist and shamanic concepts, becomes obvious.

The main treatise of Tibetan medicine is the *rGyud-bzhi* (also called "the four roots", or "the four [medical] tantras"), and contains the medical theory, ethics, and practical instructions, to be studied and partly memorised by *amchi*-students. In addition to that, there are three main commentaries (the most important being the Blue Lapis Lazuli, or *Vaidurya sngon-po* by Sangye Gyatso, regent of the Fifth Dalai Lama), as well as a number of sub-commentaries. The traditional and oldest mode of knowledge transfer in Tibetan medicine was that of personal apprenticeship (*guru-chela* relationship) under an experienced *amchi* (Janes 1995: 12), which usually took five to ten years, and ended with a formal public exam. This was until very recently the common practice in Ladakh, and remains to be in the remoter areas of that region. In institutional settings like the Men-Tsee-Khang or the Nomad *Dusrapa* school in Leh, the first degree of Tibetan medicine (*dus-ra-pa*), which covers the *rGyud-bzhi*, is obtained after three years of theoretical study and one to two years of practical apprenticeship.

3.1.3. *Amchi* medicine in Ladakh

Tibetan medicine is believed to have been introduced in Ladakh by the Tibetan translator and philosopher Rinchen Zangpo in the tenth century CE (Norboo & Morup 1997: 206). In its early years in Ladakh it has been practiced mainly by monks who received their education, as was common then, in Tibet, a custom that continued until the Chinese suppression of the Tibetan revolt in 1959 (Rizvi 1998: 185). Over the years, (lay-) *amchi* lineages developed, and locally specific medical knowledge, including that of plants, hot

springs, or minerals, has evolved. While Tibetan medicine as practiced in Ladakh does not fundamentally differ from Tibetan medicine practiced elsewhere, it has locally come to be seen as a distinct expression of Ladakhi identity and culture. Therefore, and also due to the somewhat ambivalent relations between Ladakhi and Tibetans, Ladakhi nowadays prefer to use the expression "*amchi* medicine" instead of "Tibetan medicine". Respecting this, I will use "*amchi* medicine" whenever I speak of the Ladakhi context, only referring to "Tibetan medicine" when speaking about the (exile-) Tibetan one.

With the arrival of modernity in Ladakh mainly through the Indian army and tourism from 1976 onwards, there has been a steady decline in numbers of *amchi* as well as a growth of problems the remaining *amchi* were faced with (Rizvi 1998: 124; see below). Several international non-governmental organisations (NGOs) have supported *amchi* in Ladakh, starting with the Leh Nutrition Project some decades ago (ibid. 185ff), to the Ladakh Society for Traditional Medicine (LSTM; formerly Nomad RSI) which is today the major NGO on that field. Also the Indian government runs a support programme for rural *amchi* in Ladakh, with the objective to guarantee a basic level of primary health care also in those villages with no biomedical facilities (Tondup 1997). In this project, 40 *amchi* with the status of "government *amchi*" are currently paid a nominal salary of 300 Rs. per month plus a yearly allowance of 1500 Rs. for medicines. The largely problematic effects of this government support will be described in chapter 9.3.1. However, mainly due to the efforts of NGOs and an increased public aware-

ness also among foreigners about *amchi* medicine, the negative trend of the last decades has recently turned into a fragile positive one again. It remains to be seen how Ladakhi *amchi* cope with new challenges like over-harvesting of medicinal plants, or the competition of a Tibetan Men-Tsee-Khang branch hospital in Leh.

3.2. The social role and status of *amchi*: A literary overview

3.2.1. Theory

The role and status of an *amchi* is well defined in Tibetan scriptures like the second tantra of the *rGyud-bzhi* (in Rechung 1976: 91-92), or the biography of the healer-saint *gYu-thog Yon-tan mGon-po* (in Rechung 1976: 282-284), which have also been referred to by Kuhn (1988: 47f) and, implicitly, Clifford (1994: 61-63, 121-123). The four *amchi* vows mentioned by Finckh (1985), and the six qualities and eleven vows of a good *amchi* described by Rechung Rinpoche (Rechung 1976: 91) are examples of the ethical code that *amchi* were, and are, expected to follow.

Both the ideal role and status are defined and legitimised along Buddhist moral concepts of compassion, mindfulness, and saving life. Thus the *amchi* was seen as "*a representative of the Medicine Buddha*" (Rechung 1976: 92; see also Birnbaum 1979), and regarded as the "*king of gods*" (*lharje*), as the "*all knowing one*" – a title normally used only for Bodhisattvas (Clifford 1994: 61). The extraordinarily high status of *amchi* in society, as well as their social role, is implicated here, and, as Clifford (ibid.) observes, there

is "*no separation of healing skill from Dharma.*" The *amchi* derives his medical power from the Medicine Buddha, and his practice, starting from the gathering of plants to the prescription of medicine, is supposed to follow the Buddhist ideal. An *amchi* has to be compassionate, pure-minded, and mindful to be able to heal, which also means – the other way round – that any *amchi* who *can* heal, by implication must have these qualities to some extent. Kuhn (1988: 47-48) mentions the ideal qualities of *amchi* in more detail.

"[E]in Amchi muß reine, klare Gedanken (ethisch) haben und die zehn buddhistischen Untugenden vermeiden. [...] Er soll fleißig und zielstrebig sein. [...] Ein Amchi muß mit Menschen aller Schichten kommunizieren können. [...] Selbst unter Lebensgefahr soll ein Amchi dem Kranken eine Behandlung nicht verweigern. Allen Kranken soll mit Mitgefühl begegnet werden. Unabhängig von der finanziellen Situation des Patienten bzw. der persönlichen Beziehungen zwischen Patient und Amchi soll gleiche Behandlung und Medizingabe erfolgen. [...] Benötigt ein Kranker teure Medizin, kann sie aber nicht bezahlen, soll sie ihm trotzdem gegeben werden, und der Amchi soll darüber weder Kummer noch Ärger verspüren."

She goes on (ibid. 48) to say that also the patients' behaviour towards the *amchi* is strictly prescribed (Finckh 1985), making critique or a failure to follow the *amchi*'s advice a definite breach of etiquette. In this way the social status and role of an *amchi*, as well as his relations with patients and laity in general, is defined. One notes an emphasis on the *amchi*'s moral qualities, his duty to treat everyone (and everyone as equal), and the importance of remaining

aloof of financial considerations. We will see how this ideal picture of an *amchi* continues to define the *amchi*'s social role, but creates conflicting obligations within the *amchi*'s role-set, and leads to social disharmony in the changed setting of modernity today.

3.2.2. Tradition

From what is known and recorded about *amchi* before the onset of modernity, that is in Tibet the Chinese occupation, and in Ladakh India's independence from the British Empire, their social status more or less corresponded to the theory described above. Thus A. Reeve and Kathleen M. Heber (Heber & Heber 1976/1923), who were Moravian missionaries in Ladakh in the beginning of the 20th century, mentioned that *amchi* were among the most respected people in the villages. Pordié (2002) describes how *amchi* were granted lands and one of the highest social positions, in addition to being exempted from communal work. Kuhn (1988: 49) adds that until independence, Ladakhi *amchi* also did not have to pay taxes, nor were they forced to host visiting government officials, as was the common obligation. In my own conversations with Ladakhi *amchi*, stories about the high status and respect they or their fathers received until some decades ago were frequently told with nostalgia. Always, the descriptions of high status and respect had material benefits at their core: Horses would have been provided especially for the *amchi* to travel on, a whole *dzo* (crossbreed between yak and cow) would have been given in return for cure, special carpets and *choktse* (Ladakhi table) would have been prepared for them to sit and dine on. Then, usually the unfavourable comparison

with today's conditions followed – no more horses and *dzo*, no more special carpets for the *amchi* – which are interpreted as signs of less status and respect. Still, however, *amchi* see themselves as equal in status to monks or biomedical doctors, above normal laity but below *rimpoche* (reincarnate monks, ascribed with special powers) and tantric practitioners (Kuhn 1988: 48; this research).

To come back to the 'old times', however, several factors affecting the *amchi*'s social role and status can be distinguished. On the one hand, the *amchi*'s position was defined by their monopoly on medicine-giving, and thereby on a large and, it seems, the most important sector of health care in old Ladakh and Tibet. As is the subject of a multitude of legends, and as is also reflected by the aforementioned appellations like "*king of gods*", even rulers (and, according to these legends, also the gods) were dependent on their skills and service. On the other hand, Clifford (1994: 63) tells us that the overall length of studying medicine in Tibet under the Fifth Dalai Lama was 30 years, including the study of classical Tibetan which was necessary for medical studies. Even if, as was probably more common (also in Ladakh) than the idealistic first number, the study of medicine *per se* took only six years (ibid.), this still implies heavy demands on the intelligence of the student, a high degree of specialisation, and an esoteric body of knowledge, with all respective implications for the power, role, and status of *amchi* in society. Special mention should be made in this respect to the issue of scripturalism, especially in largely non-literate societies, as was the case of Ladakh and Tibet, and its social consequences (see e.g. Gingrich 1996: 240ff; Goody 1986, 1990). Furthermore, only reasonably

wealthy families could afford to send a son to study medicine, so that *amchi* usually built on an already favourable social background. Lastly, the above-mentioned religious legitimation of *amchi* greatly contributed to their status and, as explained, shaped their roles. Usually, and especially in the Ladakhi context, *amchi* were – and often still are – the only ones besides monks to be literate in classical Tibetan, enabling them to read and ritually recite prayers and religious texts, which alone would have been enough to socially position them above laity.

However, this does not necessarily mean that all *amchi* were indiscriminately revered and respected. People did make distinctions between 'good' and 'bad' *amchi*, that is, between more or less medically powerful ones (Kuhn 1988: 48), and were aware of the individual *amchi*'s socio-economical backgrounds (Janes 1995: 12), all of which determined the *amchi*'s status. As Janes (ibid.) and Kuhn (p. 43ff) point out, much also depended on the precise medical – and therefore social – role the *amchi* occupied: There were *rgyud-pa* (lineage) and non-*rgyud-pa amchi*, *lama* (Tibetan & Ladakhi: teacher; in Ladakh commonly used for any monk) *amchi*, itinerant herbalists, those who were in the service of a royal family, or those who practiced medicine only as a sideline to other occupations, like farming.

3.2.3. Practice today

As already mentioned, no research has been done specifically about the social role of *amchi* today. However, there has been a shift of focus from research on the more or less static theoretical aspects of

Tibetan medicine to its actual practice in modern times (e.g. Samuel 2001), and an analysis of writings on the latter gives us some information on the present subject of this study. These recent studies (Adams 1988, 2001; Janes 1995, 1999, 2001; Kuhn 1988; Pordié 2002) have laid special emphasis on the effects of modernity on the practice of Tibetan medicine, highlighting change in a variety of contexts.

Four main themes concerning the social role of *amchi* can be distinguished there: They are (1) the professionalization of Tibetan medicine, (2) a trend towards a de-socialisation of the *amchi*, (3) their increasing involvement, voluntarily or not, in market economy, which is closely related to the first two trends, and (4) their new role of being symbol and means of expression of ethnic and cultural identity. These themes are, albeit sometimes in different forms and with different meanings, investigated in three local contexts, namely the TAR (Adams 2001; Janes 1995, 1999, 2001), the Khumbu region of Nepal (Adams 1988), and Ladakh (Kuhn 1988; Pordié 2002). Interestingly, no recent studies exist about the practice of Tibetan medicine in Dharamsala, which is, like Lhasa but in completely different (political) circumstances, the setting most affected by modern trends today.

In the Tibetan context (Lhasa), Janes sees two divergent forces bearing on the practice and role of *amchi*. On the one hand, with the Chinese prohibition of virtually all other traditional Tibetan healers, the *amchi* now find themselves under pressure of the laity to fulfil the role previously played by these other healers (shamans, oracles), who specialised – in contrast to the *amchi* – in socio-cen-

tric modes of healing (Janes 1995). On the other hand, new neo-liberal economic policies of the Chinese government and the resulting cuts in state-funding of public health care, force *amchi* to involve themselves more and more in capitalist market economy (Janes 1999). An increased accumulation of *amchi* in towns and cities where business opportunities are better follows, which not only leaves rural areas under-supplied, but also, inherent to the *amchi*'s relocation from familiar settings into unfamiliar, urban ones, has de-socialising effects. Furthermore, in its quest to maintain its status in a modern environment, Tibetan medicine in the TAR is constantly modernising itself, with obvious effects on its social structure and cultural content (Janes 1995). Thus Janes (ibid. 24-25) concludes that the social relations of healing are transformed and disembedded from local contexts, and that Tibetan medicine and thereby the *amchi* are becoming part of a centralised, bureaucratic system, putting emphasis on professionalism, contributing to power asymmetries, and reifying the patient (see also Taussig 1980). However, somewhat alleviating this pessimistic diagnosis, he also points out (Janes 2001) that the *amchi* play an important role in being a means and channel to express – and deal with – the social suffering involved in the Tibetans' loss of cultural identity, conflicts brought by the rapid modernisation, and ethnic discrimination. Indeed, *amchi* and Tibetan medicine today serve as a means to safely express ethnic consciousness and identity. Adams (2001) also shines a more optimistic light on contemporary Tibetan medicine in the TAR. She argues that while not being explicitly mentioned in practitioner-patient interactions, the discursive framework of Tibetan medicine still takes place on a social and moral level (ibid.

237). Considering these diverse and divergent factors influencing the *amchi*'s social role in today's TAR, a study directly focussing on that subject, instead of giving these insights as by-products of other theoretical and empirical interests, would be highly interesting.

Similar to the TAR, the social role of Sherpa *amchi* in Khumbu today seems to be considerably shaped by their involvement in market economy, and by being used as an expression of culture and identity (Adams 1988). However, Adams neither notes a trend towards professionalization, nor de-socialisation. While she concedes that normally the influence of capitalism proves harmful to the practice of traditional medicine, she argues that in this case *amchi* profit from it. They are used, in the context of Buddhism, as a means for laity to make merits and improve personal karma by presenting them – as representatives of religion (see chapter 3.2.1.) – with large amounts of money. In this way the *amchi* do not only heal, but transform the money earned by the laity in tourism business into religious merit and thereby social status, thus encouraging participation in the market economy and contributing to social harmony. Furthermore, *amchi* are seen as a symbol of Sherpa ethnic identity, which, as the Sherpa have realized, besides everything else is a tourist attraction and therefore to be supported out of economic reasoning.

In Ladakh, again we find similar trends with differing effects. Kuhn (1988), Janet Rizvi (1998), and Pordié (2002) all mention the problematic effects of market economy – in Ladakh brought by the Indian army and tourism – on the practice of *amchi* medicine and the

social role of *amchi*. Especially Pordié's (ibid.) paper contains a clear, albeit very concise, analysis of this mechanism, which corresponds with my own findings presented at length later in this study. He argues that market economy has changed the traditional system of remuneration for the *amchi*, and that with the modernisation of most aspects of life, social links on which the *amchi* depend are loosened. Thus, *amchi* medicine has become a loss of money for Ladakhi practitioners (see also Kuhn 1988), putting them in the difficult situation of being unable – but still expected – to give medicine, with the obvious problematic social implications.

4. Power

It is clear that the concept of power is of central importance in the analysis or even description of society, be it in form of modern, complex state-societies, or in form of non-literate, small communities with a higher degree of homogeneity. This is certainly the case in the present study of the *amchi*'s social role in Hanu, where, during field-work, the overwhelming role of problematic power relations involving the *amchi* became obvious very quickly. Therefore, before using a concept of power in the analysis of the empirical data, that concept has to be clearly defined and to be set in context with the ongoing theoretical discourse on power in the social sciences.

4.1. Concepts of power

The theoretical discourse on the subject of power abounds of diverging definitions. The most that these definitions seem to agree on is that power is "*concerned with the bringing about of consequences.*" (Philp 1999: 657) Apart from the possibility to emphasize different bases, different forms, and different uses of power, and apart from the different theoretical biases arising from this, the concept of power itself is messy. In an excellent effort to bring some clarity into the confusion of the social sciences' theoretical debate over the concept, Mark Philp (ibid. 657-661) distinguishes two elements – intentionality and significance of effects – underlying all differences, and uses them to work out four main perspectives on power. As he points out (ibid. 660), each of the four per-

spectives has its own advantages and disadvantages, and each allows different conclusions and produces different results. This chapter, therefore, is concerned with identifying the concept(s) of power most suited to the context and demands of the present study. Since Philp's framework serves as a useful basis for that endeavour, a short outline will be given, incorporating other sources as well.

The first perspective "*makes no distinction between A's intended and unintended effects on B, nor does it restrict the term of power to a particular set of effects which A has on B.*" (ibid. 660) This is, essentially, Foucault's view, who conceptualized power as "*the medium through which the social world is produced and reproduced, and where power is not simply a repressive force, but is also productive.*" (ibid. quoting Foucault 1980) Foucault's intention, it should be noted, was not to provide a generally applicable and universally valid theory of power, but rather to use it as a concept, linked to a certain field or object of enquiry (Foucault 1990). To him, power was but a name given to a complex strategic situation (Foucault 1978), and in that sense it can be taken as the central and all-encompassing aspect of social reality itself (ibid.). It is, he emphasizes (Foucault 1990), a net of interrelated forces and factors determining social relations from the most insignificant to large-scale structural ones, and not something in possession of individuals or groups, as in Max Weber's (1956: 151ff) sense. Power, therefore, is better seen – and indeed used – as an analytic tool and perspective, not an explanation, and thus concerned with causal nets instead of single, specific causes for a given phenomenon (Foucault 1990). Although it can be argued that Foucault's concept of power

as used in his later works (1977, 1978) implicitly continued to build on the old Nietzschean dualism that Foucault thought he had overcome (Fink-Eitel 1992: 93f), its wide applicability and usefulness in social analysis has been proved repeatedly. Another advantage is its neutral stance on an otherwise often morally and ideologically charged subject, which makes it ideal for the present study, as we will see below.

In the second perspective, again intentionality does not matter, but a set of significant effects of A's exercise of power over B is defined, namely such effects that are contrary to B's interests. Here, it does not matter if A intended to exercise power over B, and there is even the possibility of A not foreseeing any effects of his actions on B, whereby the concept of agency is eliminated. This is a view taken up by Marxism in the social sciences (e.g. Baer, Singer et al. 1986; Poulantzas 1973; Singer 1989; Taussig 1980), which sees power as "*the capacity of a social class to realize its specific objective interests*", which depends on "*the structures of a social formation, in so far as they delimit the field of class practices*" (Poulantzas 1973). This concept has the advantage of explaining cases where B's options and interests are curtailed by others, be it intentionally or unintentionally. Collective, and often unintentional, exercise of power by social 'classes' or groups becomes understandable also on a global level, transcending borders of nations and boundaries of culture. Its disadvantage, however, is a moral dilemma: The possibility of unintentional exercise of power throws up the tricky question if the group in power can be held responsible for the suffering it inflicts on others (Philp 1999: 659). In scientific

practice, this dilemma is usually circumnavigated by blaming systems rather than people, like capitalism, free trade, or – most recently – globalization. In medical anthropology this perspective on power is represented by the sub-branch of critical medical anthropology, which has not only produced important critique on certain theoretical assumptions and the almost exclusive focus on micro-analyses up to the early 1980s (e.g. Baer, Singer et al. 1986; Scheper-Hughes & Lock 1987; Singer 1989), but also demonstrated its practical value in several important case studies. Thus, to give only a few examples, this structural focus on power was used by Michael Taussig (1980) in his classic study of the reification of patients and their illnesses in American hospitals, by Aihwa Ong (1988) in her analysis of spirit possession among factory workers in Malaysia, and by Paul Farmer in his examinations of AIDS (1992), structural violence (1996), and social suffering (ibid.) in Haiti.

The third view is the opposite of the second: Intentionality has to be there in order to attribute the concept of power, but not significant effects, which means that it does not matter if the effects are against the interests of B or not, as long as they are in the interest of A. Identifying the victims of power, as is the main effect of the second perspective, gives way to identifying the agents of power. Thus, power is seen as "*die Chance, innerhalb einer sozialen Beziehung den eigenen Willen auch*" – but not only – "*gegen Widerstreben durchzusetzen, gleichviel worauf diese Chance beruht.*" (Weber 1980/1921) Power, according to this definition, is an individual's, group's, or society's ability to impose its will on someone else, and can derive from personal, physical, or psychological superiority,

from charisma, knowledge, possession of wealth or rare goods, or from a better organisatory talent (ibid.). The focus on A's intention in this perspective has the advantage of making A's actions understandable and, to some extent, also predictable. Furthermore, by not placing any restrictions on the manner in which A exercises power, critical examination of different means of securing compliance becomes possible, as has been done, for example, by Godelier in his study of the Baruya (1986). Philp (p. 659), however, also points out the danger of analyses which understand all action in this sense of power, where an actor's behaviour is merely seen as a strategic scheme designed to meet his or her own ends. In medical anthropology, this perspective on mostly micro-level factors is often used to account for problems and difficulties in the delivery of primary health care in less developed countries. Thus, Judith Justice (1983) identifies the strategies of biomedical practitioners in Nepal to secure their positions, careers, and wealth as detrimental to adequate health care delivery in rural areas, and Mark Nichter (Nichter & Nichter 1996) repeatedly describes struggles, strategies, and intrigues for power in the primary health care sector in India and Sri Lanka (Nichter 1996). However, also case studies dealing with illness, patterns of resort, and their social meanings essentially look at power from this perspective. There, illness is often seen as a means – often as the *only* means – to express and resist social inequalities (e.g. Good 1977; Janes 2001; Nichter 1981), thereby becoming a strategy of power and resistance. Of course, illness as a strategy to exert power is not an exclusive domain of lay people: As shown in this study of Hanu Gongma, it may also be used by medical practitioners for transforming their medical powers into social ones.

The fourth perspective uses the last possible combination of the two elements: Here, power is defined both in terms of intentional action and significant effects. This concept "*concentrates on cases where A gets B to do something A wants which B would not otherwise do*" (Philp 1999: 659), because it is against B's interests. While this perspective, with its sharp boundaries, may be promising for building abstract theories, it is clearly too narrow to account for many phenomena, such as, to mention only one example, the potential – or possession – of power, without power actually being exercised (Barry 1976). As Philp (p. 660) remarks, "*Wealth, status, and so on, are not forms of power, but they are resources which can be used by A to secure B's compliance. An adequate understanding of power in a given society will include an account of any systematic inequalities and monopolies of such resources, whether they are being used [...] or not.*"

The examination of this framework reveals a movement from a perspective that could be called 'meta-structural' (Foucault's concept), to one that is classically referred to when speaking of 'structural' or 'macro-analysis' (used in Marxist approaches and critical medical anthropology), followed then by a view of power most commonly used in so called 'micro-analyses', and finally a theoretical definition of power that is too narrow to be widely used in empiric studies. This is a similar movement from macro- to micro-level that also Eric Wolf (1994: 218ff) used in his own framework of "*four modes of power*", which is however by far not as cogent as Philp's, so that I will not deal with it in more detail. What also becomes clear is that most empirical studies in the social sciences, and in so-

cial anthropology in particular, are located either on the second or the third level in this framework, and can usually be divided into the two categories of micro- and macro-level analyses. Various scholars (e.g. Scheper-Hughes & Lock 1987; Wolf 1994: 219) have rightly called for an integration of these two levels, but it seems that this is more easily demanded than accomplished.

4.2. An integrated approach

So what about this study? What concept – or combination of concepts – of power can explain the *amchi*'s social role with all its implications in Hanu Gongma best? To answer this question – and it should be clear that there are more than one valid answers possible – we have to look at the specific demands and interests of this book. There are four of them.

1) The concept should be capable of explaining the social phenomena observed during field-research.

2) Both micro- as well as medium- and macro-level factors impinging on the local situation in Hanu should be accounted for.

3) It should, furthermore, provide the possibility for predicting future developments and making prognoses about the social effects of supportive interventions on the local health sector. This requirement derives from my cooperation with the international NGO Nomad RSI during and after the research, and is developed more fully in another article (Kloos 2004b).

4) In view of the particular role of *amchi* Tashi Bulu in his community (see below), the concept should not imply moral judgements, and rather help in understanding the why and how.

Clearly there is no single concept meeting all these demands, and an integrated approach using more than one definition of power is advisable. Already in the outline of Philp's framework above the relative usefulness or applicability of the four perspectives on power for this study has been hinted at. Thus the first perspective, that is, Foucault's concept of power, is very promising in several respects, and comes as close to being singularly useful as seems possible. Firstly, it allows an encompassing analytic view of the situation including both small-scale local, as well as large-scale structural factors. Secondly, its neutral use of power simply as an analytic tool for the analysis of complex strategic situations fits the structure of this study well, since power will indeed be the main analytic axis, owing to its central role also in emic perceptions of the Hanupa. Thirdly, by virtue of this neutrality, it is a welcome tool to avoid moral judgement on certain of Tashi Bulu's strategies and actions. However, while this perspective provides an excellent framework for analysis in this study, it is less well suited to account for immediate personal motivations of the main actors in Hanu Gongma, which are, without a doubt, as valid and important in order to understand what is happening 'on the ground'. Therefore, I will make use of the less abstract, more immediate explanatory qualities of the third perspective as well, which focuses on the agent of power (i.e. Tashi Bulu), his interests, and his means to achieve these interests.

It is clear that the application of both these perspectives in the same analysis brings with it an interesting combination between two fundamentally different conceptions, one of which sees power as an abstract medium, a name for social processes, and the other as an attribute possessed by individuals or groups. I do not think, however, that the two are mutually exclusive; in the contrary, Foucault's concept is wide enough to accommodate another one, especially if that other one is concerned only with the micro-level. Indeed, they may mutually supplement each other: the dangers of the latter are defused by the former, which also provides the otherwise missing larger perspective. Conversely, the micro-perspective focusing on the agent of power provides the practicable tools for analysis that are under-developed in Foucault's concept, which monistically proclaims power as the one and only analytic means.

Regarding the remaining two perspectives of Philp's framework, only the second, structural-Marxist one is of interest. As we will see, capitalist modes of production do play an important role in the social change happening in Hanu, and scientific models explaining it are welcome. However, I do not regard the situation in Hanu as one of structural oppression or exploitation, however unsettling the effects of capitalism on the social structure may be. Capitalism, therefore, will find its due place in the explanatory framework, but will not be mistaken as the single cause to blame for every evil. As I said, the approach outlined here is certainly only one among a number of possible ways, but it will serve its purpose in the analysis below.

4.3. Medical power

It is still necessary to define the concept of power used in this study further, since at a later stage the concept of 'medical power' is used as distinct from 'social power'. Obviously, what has just been said about power refers to social power, since power in itself is essentially, as we have seen, a social function. Medical power, in contrast to that, is a more straightforward concept, and easily defined as the intrinsic attribute of every healer, which enables him or her to treat and heal sickness. It can derive from whatever source, and usually the source is multilayered. In the case of *amchi*, medical power derives, on a supernatural plane, from *Sangs rGyas sMan bLa*, the "Buddha Master of Remedies"; on a religious, but already personal level, from moral conduct and a mind of compassion; and on the mundane level from factors like the study of medicine. In terms of the above framework, medical power assumes a special position, in which its exercise is, at least theoretically, both in the interest of the agent and the person being objected to it. Indeed, a positive outcome is its defining and essential quality, and, again at least theoretically, it is exercised not for A's, but for B's benefit (Turner 1995: 131). Also Weber (Weber 1980/1921) pointed out that a (medical) professional is neither motivated by personal interests nor simply by the desire for economic rewards. Of course, if health becomes, under the impact of capitalism, a commodity to be bought on the market place, so to speak, this ideal of the medical profession (see chapter 3.2.1.) becomes obsolete, and profit and efficiency become important (Turner 1995: 167), as indeed happens in Hanu. But this is going beyond the field of pure medical power,

into terrain the next paragraph will shortly outline. In any case, we can say that medical power most closely fits into the third perspective, both in respect to being conceptualized as a person's possession, as well as in the sense that this perspective does not posit that the exercise of power necessarily has to affect others in a negative way.

The most interesting aspect of medical power, which is otherwise more the subject of micro-studies in the field of ethnomedicine, is its dialectic with social power. Medical power frequently translates into social power, but not always. How is the one kind of power transformed into the other, a process which can work in both ways? Why is it that this process sometimes does not happen, and what consequences, if any, does this have for the existing medical power? In this study, which examines both cases, namely where medical power is and is not transformed into social power, some tentative answers to these questions are sought.

5. The Research

5.1. Research situation and difficulties

After considerable theoretical preparation in the subject of medical anthropology at Brunel University in London, and more specific preparations on the subjects of the above two chapters in Vienna, I felt excited and confident about finally entering the field and starting the empirical part of research. Thus, when I arrived in Leh – the main town and administrative headquarters of Ladakh, which I had visited already three years before – in mid-July, I planned to quickly find a translator, meet some important people in order to get letters of recommendation, buy food and other provisions necessary to be more or less self-sufficient in the village, and begin the research. All of this, acclimatisation to the thin air at 3500 metres included, should have taken two weeks according to my calculations. Alas, the calculations were European, and the reality was Asian: things and people took their time, translators were, at the peak of the tourist season and at the salary we offered, hard to find, and the main character of my research, *amchi* Tashi Bulu, suddenly turned up in Leh announcing his plans to gather medicinal plants in the mountains of Zanskar for two weeks, instead of remaining in his village to be observed by me. Quickly I changed plans and arranged to accompany him on his trip, anticipating a good and interesting time camping in the mountains with a group of *amchi* students of my age, whom Tashi Bulu was planning to join. At the same time I could also act as the representative of Nomad RSI who sponsored the trip as part of its three-year *Dusrapa* degree course

for young rural *amchi*-to-be. One day before the trip started, though, Chief *Amchi* Tsering Phuntsog came to hear about the situation and forbade Tashi Bulu to join the trip, and instead help me with my research in his village, which obviously did not constitute a good basis for Tashi Bulu's relation and cooperation with me. After clearing the misunderstanding with the Chief Amchi and obtaining a letter from him ordering Tashi Bulu now to join the plant gathering trip, however, Tashi Bulu had already gone back to Hanu. In the end, on a chase by public bus, my translator – whom I managed to find only the night before – and I caught up with the *amchi* and, with much apology, coaxing and showing the letter, persuaded him to do what he actually wanted to do.

This was only the start. In Zanskar I quickly found out another phenomenon of field-research: All the theoretical wisdom I had laboriously acquired in my years of study, all the good ideas of my research proposal vanished like a cloud in face of banal reality. Luckily Tashi Bulu and I got along very well, for he liked to talk, and I liked to listen, and for making – mostly dirty, as seems the norm in Ladakh – jokes and exchanging small stories neither of us embarrassed the other with an all-too-good Hindi. After the two weeks some of my confidence was restored, as I had a few exercise books full of notes, and a good working- and joking-relationship with Tashi Bulu, which seemed a sound basis for the actual study in Hanu Gongma.

Back in Leh, I went to the army headquarters to ask for a letter authorising me to stay in Hanu for longer than a week, as usually permitted for tourists. What I thought a mere formality, however,

provoked a laugh from one of the top-generals there, and the question "Anything else you want?" "No, sir, that's all", I said, to which he replied that he was very sorry, but even to go there for one hour was totally out of question for a foreigner. Since the Kargil conflict 1999, which had taken place also in Hanu, the area has been declared strictly off-limits for outsiders, so that even non-Ladakhi Indians needed a special permission to go there. I needed a day or two to digest that, but the Hindi proverb "Bharat men sab chalta hai" (In India everything goes), and the fact that Tashi Bulu still had my jacket, without which I could not even think about spending the autumn – let alone winter – in Ladakh, prevented me from giving up. However, it took me another three weeks in Leh to arrange a permit through the backdoor and another translator before I decided to try my luck and go.

I was lucky indeed, and the soldiers at the two army check-posts before Hanu did not seem to notice me. I settled into the glass room (Ladakhi: *shel-khang*) of Tashi Bulu's house, and thought about my research strategy. The original plan was according to the books (e.g. Bernard 1994: 136ff): "Hang out" (ibid. 151) and participate as much as possible in village life – it was harvesting and threshing time – in order to make contacts and establish trust, and only then, after two weeks or so, start asking questions more directly. Now, however, I was lucky to be there at all, and there was no knowing how long it would take until the army threw me, in the better case, out again, or, in the worse case, into prison. So I decided to make the best of whatever time I had there, and straight away started interviewing people, trusting on the introduction by Tashi Bulu,

whose advice, according to what he had told me in Zanskar, everybody followed anyway.

The peace of mind for full concentration on the task at hand, however, remained elusive. On the next day, an agent of the Indian Intelligence came to see my permit, and the day after, four tall, bearded, and turbaned Sikh soldiers with semi-automatic guns and grim faces came to arrest me. They led me to the next check-post a one and a half hours' walk down the valley, where I was told that my permit had to be checked with the upper military hierarchies. After several phone calls and a two hour wait, in which I managed both to amaze myself with the amount of Hindi that I could suddenly speak, and to convince myself that my next destination was prison, a smiling officer came to apologize and tell me I could go up to Hanu again. From then on I was better friends with the Sikh soldiers of that check-post than I ever became with the villagers of Hanu Gongma. The uncertainty about how long I could stay in Hanu, however, remained. The Indian Intelligence still did not want me there, and my permits were only valid for seven days each, the new ones to be sent to me every week by public bus.

Other problems arose, as if to demonstrate book chapters such as "*Hazards and punishments of field work*" (Pelto & Pelto 1978: 184ff). Tashi Bulu somehow seemed much less enthusiastic to help and talk than in Zanskar, usually disappeared in the morning with his goats only to return tired in the evening, and did not introduce me to anyone. My translator did not get on with the Hanupa, did not translate properly, and had no social skills whatsoever, so that the interviews were boring and frustrating both for the Hanupa and

me. Spradley's (1979) guide to ethnographic interviews only helped in telling me what exactly went wrong: everything. The Hanupa themselves had, at that time of the year, a lot of work in the fields, so that even if the interviews would have been less boring, they would have had no time for them. Besides, they lived up to their reputation in Ladakh as being suspicious and cunning so much that I could never be sure if they told me the truth. Most of all, I sensed that of all topics, the *amchi* and especially Tashi Bulu was the one they wanted to talk about least and lied the most, and I could not, at first, find out why. After four weeks I had enough of all that and decided to go back to Leh again, after arranging another, more capable translator from a neighbouring village for my return.

After two weeks among friends in Leh, during which I also worked on the data I had acquired so far and – not surprised at all – noted their insufficiency, I felt it was time to go to Hanu Gongma again and get the data still needed to make sense of what was going on around the *amchi* there. This time, the Indian Intelligence finally managed to have me deported from Hanu, but that was only after ten days of intense research activity on my part, during which I managed to get most of the data I had hoped for. Thundup, my translator and research assistant at that time was the opposite of his predecessor in every respect, and contributed much to the final outcome of the research.

5.2. Research methods

The difficulties described above naturally had their impact on the research methods that I used. When I came to Hanu, I unwittingly

entered the stage of social conflict in which the *amchi*, and especially Tashi Bulu, played a central role. Any information the locals were willing to give me, whether true or not, was thus dependent on this complex social reality and my own role in it. As it were, I was well aware of my role in that setting from the beginning, since I consciously cultivated it to legitimise my research activity, and indeed presence in Hanu, in regard not only to the locals, but also and especially to the Indian army and Intelligence. Obviously, my role of being employed by a foreign NGO to gather the necessary information for building an *amchi* health centre, brought with it certain interests both the *amchi* and the lay Hanupa had in me, determining the answers I would get to my questions. To the extent I realised this with my – in the beginning very limited – knowledge of the local situation, I posed the questions accordingly: Rather than asking direct questions expecting my informants to tell the truth, I expected – and indeed got – untruths, which, however, often turned out to give more valid information than the truth. This method could be described as 'observant interviewing', which means using interviews not so much to produce true statements, but to expose the intricacies of social reality which nobody would, or indeed could, articulate or openly talk about. Of course, this method is the more effective the more one already knows about a given society, and so in the beginning it mainly served to alert me to the fact that there *was* conflict going on involving the *amchi* at all. Only towards the end of my stay in Hanu, that is, in the last ten days there, I could gain some insight into the processes at play in this conflict, the same processes that had impeded my work and yet revealed so much in impeding it, as subsequent analysis showed.

As mentioned, what I planned was classical ethnographic field research, relying on participant observation (Malinowski 1922: 2-25) and qualitative interviews. Due to the circumstances, however, in practice there was a definite emphasis on un- and semi-structured qualitative interviews covering the three kinds of questions outlined by Pertti and Gretel Pelto (1990: 295) in regard to medical anthropology: descriptive questions, analytic questions, and – only to a small extent – intervention-oriented questions. The method of 'observant interviewing' described above blended into this pattern well and could be used with all three types. The selection of informants, apart from those specifically needed (the *amchi*, the biomedical health workers, and the village *sarpanch*), happened at random in the early stages of the research, while later on I specifically interviewed people who had given particularly interesting interviews before, or selected the informants from families that either had not been interviewed before, or were especially involved in the social happenings I was interested in. While I did not make a special effort to select informants according to gender, the distribution was roughly equal, and there were no distinct differences in the kind of information I received. Age-wise I tried, in the beginning, to achieve some variation among my informants, but as it turned out, young and especially unmarried people – men as well as women – were too shy, and most of my best informants were above the age of 40.

Generally, I made liberal use of different methods of gaining data (e.g. Helman 2000: 265ff), not only because this was my first chance to try them in practice, but also because I was aware that

any data on Hanu would be unique. Thus, I recorded narratives like the biography of Tashi Bulu (see chapter 8.2.1.), documented local oral history and religious beliefs (only partly included in this book), and made the effort to draw and cross-check the genealogies of 21 of the 27 *de facto* existing families in Hanu Gongma (not included in this book), thus shedding light on the history of *amchi* medicine in Hanu (see chapter 8.1.). Furthermore, I copied various written sources in Hanu Gongma, like Tashi Bulu's and the biomedical sub centre's "patient register books", which provide the basis of some interesting statistical information about patterns of resort (see chapter 8.3.), and the village census, which was, together with the genealogies, very helpful in socially orienting myself in the village.

5.3. Research statistics

The research was conducted in mainly two places, that is, in Zanskar and in Hanu, with preparatory activities, data-processing, and some interviews done in Leh. As mentioned above, Tashi Bulu joined the Nomad *Dusrapa* Summer Camp to collect medicinal plants in Rangdum and Padum (both in Zanskar) from 3rd to 20th August 2001 (more than two weeks), where I accompanied, established contact, and conducted preliminary interviews with him. After that I stayed in his house in Hanu Gongma, which was the base for the rest – and main part – of the research, during the periods from 14th September to 10th October 2001 (four weeks), and from 29th October to 8th November 2001 (ten days).

In Hanu Gongma I conducted extensive interviews both with Tashi Bulu and all other local *amchi* as well as with other Hanupa, at

least one from almost every family there. Thus a total number of 100 interviews were conducted with 65 people (incl. five *amchi*), 26 of them with Tashi Bulu, seven with the other *amchi*, two with local biomedical health workers, one with my translator Tsering Thundup Skyabapa from Dha, and one with Sonam Phuntsog Achinapa, a scholar from Achinathang. This leaves 63 interviews with the remaining 56 informants, all of them Hanupa.

6. The Setting: History

6.1. The Dardic migration and settlement of Dha-Hanu

The elders in Dha say that their Brokpa ancestors originally came from Europe, and settled in the Pur valley east of Gilgit. Then Duthamelo Sanaleph, the grandson of Angutheno, moved to Gilgit, and had three sons there: They were Galo, Melo, and Dulo. As they grew up, one brother became a very good hunter, one brother a good businessman, and one brother a good shepherd, and by joining their skills they became rich. They had a good friend there, who was a musician. At that time in Gilgit musicians were not a low-status social class like today in Ladakh. The hunting-brother used to provide him with meat, the business-brother used to give him money, and the shepherd-brother provided him with butter and curd.

The three brothers frequently went hunting together. Once they were hunting and exploring the mountains near today's village of Dha, when they came to a place that is now known as *Nirdah*. As it was already late in the day, they decided to spend a night there, and when they took off their shoes to sleep, some grains from the barley used for insulation fell out on the ground.

As the years passed on, the Gilgit people became jealous about this family's success, and they made a plot to kill them on a party. The brothers' musician friend, who was playing on that party, however, knew about the plot, and warned his friends with a special tune or rhythm. The brothers understood: One of them gestured while dancing, "Oh, today we will die", and another brother signalled, "Today our life is finished", while the third brother said, "We es-

cape". Thus during a dance called *nimaskor brasal* they escaped by dancing very rowdily – in that way making space around them. They fled Gilgit and went through some villages, after which they came to Ganoks valley, where again they stayed for some time. There each brother had one son: Galo's son was Gapomaro, Melo's was Thapomaro, and Dulo had Gil Singhe.

Staying in Ganoks again they went hunting, came to Nirdah a second time, and found barley growing there, as a result from the few grains that had fallen out of their shoes years before. The place where they found the barley growing in Nirdah is called *Malmalkutu*. When they saw the barley, they liked the place. They also went to the Hanu valley for hunting, and a competition between two brothers took place there. One said, "I can kill an ibex by using another ibex, which is still alive, for supporting my bow." The other brother said, "I can eat 18 feet of *shibris*." (Shibris is like a sausage: meat stuffed into guts.) "After that, in one night, I will make a field 18 feet square all alone." The third brother did not participate in the competition.

On the same day the first brother killed the ibex just like he said before, and out of its meat they made the *shibris*. Then the second brother ate 18 feet of it. Night came, and while the other two slept, he ploughed the field. He had brought some barley grains from Nirdah, and when he had finished, he planted these seeds in the field, because they also liked this place. The next morning they left again for Ganoks.

When their sons were older, Galo, Melo and Dulo took them on their hunting trips, and came again to Nirdah and Hanu, where they

now found a lot of barley growing, and a clear spring at Malmalkutu. They named the field in Hanu *Hangdangsmin*, which is still today the uppermost hamlet in the Hanu valley, and the site of a large army camp. Since they really liked these places, one brother said, half seriously, "I will settle in Hangdangsmin", and another brother said, "I will settle in Nirdah", and the third one said, "I will stay in Ganoks." Then they laughed and all three of them agreed that they would stay together. Thus they spent, together with their sons and wives, some time in Ganoks, and after that some time in Nirdah, and some time in Hangdangsmin.

After a while, though, Galo grew fond of Hangdangsmin so much that he settled there permanently. Melo liked Nirdah and settled there, and Dulo liked Ganoks most and stayed there. However, Melo's son Thapomaro stayed with Dulo in Ganoks, and Dulo's son Gil Singhe with Melo in Nirdah, because they liked the place of the other better. Then they decided to have a yearly festival rotating between Ganoks, Nirdah, and Hangdangsmin. In each place they had a *dühiya* (a place for *lha*; Ladakhi: deity, spirit) where they killed an ibex or goats for the festival. This was the origin of the Bononah festival.

After years, when Gil Singhe was 40 or 50 years old, he decided that he wanted an orchard. He was a lucky man and always got what he wanted, so he said, "I shoot my arrow (*dah*), and wherever my arrow lands, this will be my orchard, and I will call that place *Dah*" He shot and went to check where the arrow went, and at that place (*Dhaphangsa*) he dug an irrigation channel and planted apricot trees. Today there is still a hole at this place, where the men of

Dha put special grasses and juniper, and where women are not allowed to go.

6.2. Historic sources about the Dards

What has just been recounted is the core of the Buddhist Dards' oral history, which plays an important role in the maintenance of a common Buddhist Dard identity. The next chapter will attempt to give a chronological rendering of what is known, mainly from written sources but also including – where mentioned – oral sources, about the early history of the Dards and the more recent one of Hanu, starting from the immigration referred to in the legend above. The general history of Ladakh will not be dealt with here, except where it is of immediate relevance for Hanu. However, Ladakh's history has been written about sufficiently by other authors, among them A.H. Francke (Francke 1999/1907), Luciano Petech (1977), H.N. and Shridhar Kaul (1992), and to some extent also Janet Rizvi (1998).

As historic research (Francke 1999/1907; Petech 1977; Vohra 1989a, 1989b) has shown, the Dards in Ladakh can be traced for about two millennia. However, the more particular the information should be, the less reliable and clear the existing historic accounts become. Thus, apart from a few references and glimpses (Phuntsog 1999, 2000; Vohra 1989a, 1989b), the local history of Hanu has so far not been written about. The reasons for this are an almost total absence of written sources by the Dards themselves, the tendency of Ladakhi historians past and present to deal with such outlying regions only when they gain temporary importance through, say, a

war, and a local oral history which is, because of its variety and discrepancies, often more confusing than helpful. Another reason which applies especially to the Hanupa is the loss of their original language (a dialect of Shina, today called 'Brog-skad' and still spoken in Dha and Garkun) at one point in history (see below), which went together with a loss of mythical lore and an already established oral tradition in the old language, which today can still be found, to some extent, in the villages of Dha and Garkun. Finally, it may be assumed that life in the small villages of Hanu was rather uneventful for most of the time, so that what is remembered today by the locals are only the most outstanding and unusual events, which have shaped the life of the Hanupa until today.

The oral history collected by me in Hanu and in discussion with Sonam Phuntsog (see also Phuntsog 2000) can give an interesting insight into local traditions, social life, and change as perceived by the Hanupa themselves. It is usually linked to places and families, and remembered because of its value in legitimising property and social status. Mostly these stories involve a Ladakhi king, whose identity is unfortunately in no case remembered, so that it is sometimes difficult to determine if two of the stories may relate to the same king or not. One of my informants, the elder Tsewang Rabstan Dompa (80) from Hanu Yogma, however, provided me with a relative order of these stories, which fits to the written sources and therefore seems plausible.

For this study, whose purpose is not historical, a mere description of the written sources and some of the oral traditions is sufficient; and yet, this chapter is the first attempt ever of putting together, al-

beit in a superficial way, the known bits and pieces of history concerning Hanu. What is more, it follows Evans-Pritchard's (1949) argument in this regard, who was one of the first social anthropologists to point out the importance of including history in the study of society, and Edmund Leach's (1954) observation that no society can be perfectly stable finds another example here. This chapter also serves to emphasise the fact that Hanu, like the rest of Ladakh and Tibet in general, has "*been in a process of continuous change for as far back as we can trace.*" (Samuel 1993: 41) Considering the argument of the present book, where a lot is said about *recent* changes affecting the social structure and practice of *amchi* medicine, such a historical context will be useful.

6.3. The history of Hanu

6.3.1. Early migrations and settlement of Ladakh

It is generally agreed today that the first settled inhabitants of Ladakh were Indo-Aryan people, and that the Dards, moving in from Gilgit, soon gained the upper hand over other groups coming from Kashmir (Francke 1999/1907: 19) and colonised Ladakh, which was – until then – almost empty except for some nomads from the Tibetan plateau. This happened around 200 BCE or not long after (Francke 1999/1907: 19ff; Kaul 1992: 38; Phuntsog 1999: 379), and old rock inscriptions and ruins of Dard castles dating from that time onwards can still be seen today in various places of Ladakh. Rohit Vohra (1989a: 6ff) deals in some detail with classical Greek and Sanskrit sources such as the Mahabharata, where the

"Daradas" were already mentioned as a warlike people, inhabiting the areas of Baltistan and Ladakh. Some mentions have also been made by the early Chinese traveller Huei-ch'ao and in various later Islamic sources.

Vohra (1989a: 18, 22) emphasizes that this early migration was only the first of many over the centuries, the last one having taken place, according to him, as late as the 15th or 16th century. The Dards living now in Dha-Hanu have probably migrated 1000 to 800 years ago, and legends like the one above about Galo, Melo, and Dulo (henceforth "GMD") relate to that time. At that time there already lived some people called Minaro (Vohra 1989b: 14) in the Dha-Hanu area, who were probably also Dards/Daradas, but from an older migration. According to Vohra (1989a: 32), fighting between the two groups took place, but then they intermarried. A critical examination of the information existing about the migratory route that GMD are said to have taken (not included in the version given above), and hymn Nr. 5 (Vohra 1989b: 81ff) of the triennial Bononah festival in Dha, reveals some discrepancies (Marco Vismara, personal communication 2001) that are, however, not easily solved and will therefore only be mentioned here. It is clear that the Bononah hymns are of Minaro origin (Vohra 1989b: 77), who, according to the legend about GMD, already lived in Dha and Hanu before the three brothers migrated from Gilgit. However, the names of the different places along the migratory routes of both the Bononah hymn Nr. 5 and the story of GMD are identical, which means that either GMD must have been Minaro and not Dards in today's sense, thus belonging to a much earlier migratory wave, or some

mixing and blending of oral traditions has happened, adding to the already prevailing confusion.

Over most of the first millennium CE Dard settlements spread in Ladakh and organized themselves in small chieftainships, relatively untouched by influences from Tibet. This changed, however, sometime between 935 and 945 CE (Petech 1997: 232), when the central Tibetan king Nyima-gon conquered Ladakh, and the Dards were assimilated to Tibetan culture through intermarriage, or pushed back westwards (see also Francke 1999/1907: 50ff). The area of Dha-Hanu however was not directly affected by this.

While it is not sure when exactly Dha-Hanu became part of the Ladakhi kingdom (the local Dards seemed to retain their independence for some time by siding with either Baltistan or Ladakh, whatever was opportune; Vohra 1989a: 34), by the time of the Ladakhi king Tsewang Namgyal (1532-1555) at the latest, the area belonged to Ladakh. This king conquered Shigar and Kharko in Baltistan, and had a road built up the Hanu valley over the Chorbat La to Baltistan (Francke 1999/1907: 86; Kaul 1992: 48). This is the first time specific reference is made to Hanu, owing to its strategic location as the main route from Ladakh to Baltistan.

Sonam Phuntsog (1999: 380, pers. comm. 2001) believes that it was the same king, Tsewang Namgyal, who makes an appearance in the story of Tho Shali, an oral tradition of Hanu which still today is remembered every autumn in the festival of Tho Shali, and which has also been written about by Francke (p.29-30) and Vohra (Vohra 1989a: 2). Since this is a central story of Hanu folklore, I will deal with it in some more detail.

6.3.2. The story of Tho Shali

Once a Ladakhi king demanded forced labour (Ladakhi: *thal*) from the Hanupa. However, there was one man, Apo Tho Shali, who refused in the name of all Hanupa, and was subsequently caught by the king and immured in the foundation of a bridge. The ruins of the foundations can still be seen today on the banks of the Indus, a little upstream from where the side valley leads up to Hanu (Phuntsog: pers. comm. 2001). On a rock nearby there is an inscription saying (Phuntsog 1999: 380): "*Tho-shali was killed because of his resistance.*" Also the words of Tho Shali himself are still known today, in form of the proverb, "*Like a dog does not wear a saddle, a Brog-pa [Buddhist Dard] does not do forced labour.*" (Ladakhi: *Khi'a rgal met, Brog-pa thal met.*) Already half immured, Tho Shali was asked again if he would give labour, and again and again he refused, until only a finger was sticking out of the walls, which still waggled "No!" Because of the martyrdom of Tho Shali the Hanupa were exempted from all taxes and forced labour until 1842, when Ladakh lost its independence. The festival is celebrated to express the combined joy and sorrow over the exemption from taxes and the death of that man.

This story can be set into historical context easily. Both Francke (p. 86f) and Kaul (p. 48) note that Tsewang Namgyal demanded forced labour and tributes, and Vohra (Vohra 1989a: 2) also substantiates Sonam Phuntsog's assumption about the king's identity, by noting that the story must have happened in the 16th or 17th century, which overlaps the time when Tsewang Namgyal ruled (1532-1555).

6.3.3. Language change 'agreement' in Hanu

The single most important event in the history of Hanu, because of its consequences for the Hanupa, is at the same time also the most important for this study. It is the rule by a Ladakhi king to the effect that the Hanupa were forbidden to speak their own language, made to speak Ladakhi, and in return were granted the distinction of being officially "Ladakhi" instead of looked-down-upon Brog-pa. Due to this turn of events, the Hanupa not only lost a lot of the Brog-pa mythic lore, but over time came in contact with *amchi* medicine, which is the reason why they are today the only non-Tibetan ethnic group practicing Tibetan medicine in a traditional way.

Sonam Phuntsog (pers. comm. 2001) stated that this rule was issued by the same king, Tsewang Namgyal, two years after he immured Tho Shali. The argument is logical, and obviously based on Francke's remark (p. 86) that Tsewang Namgyal "*wished to keep the goodwill of the people*", especially in strategic areas like Hanu. According to Sonam Phuntsog the king was worried that after the Tho Shali incident, the Hanupa might out of grudge support Baltistan. This concern was based on the more general idea to ensure the support of a population known to be on good terms with the enemy, and living strategically along the main route between the two kingdoms. That they spoke a language that the Ladakhi could not understand made them all the more suspect, and so, in addition to freeing them from tax right after Tho Shali, the 'agreement' was aimed at these two points. Its effects can still be seen today: The Hanupa speak Ladakhi as their mother tongue, they practice *amchi* medicine, and they deem it an insult to be called Brog-pa.

6.3.4. The Ganglunduppa family

There is an oral tradition in Hanu Gongma that refers, according to my informant Tsewang Rabstan Dompa, to the time shortly after Tho Shali and the language change, and therefore again to the same king, Tsewang Namgyal. It is exemplary for the way status and wealth are legitimized by history and the reference to old kings' orders, wherefore I will recount it shortly, as it was told to me by Tsering Norbu Ganglunduppa (73).

One day the Leh *rGyalpo* (Ladakhi: king, ruler) came to Hanu with 18 men. (It is interesting to note here that Pascale Dollfus (1996: 10) mentions that reference is made to 18 archers in connection with special status also in Hemis Shukpachen, and it is likely that both references have the same source.) At that time the Ganglunduppa were the richest family of Hanu Gongma, and provided the king and his men with food for one whole day. The second day all other families together gave him food. As a reward for the Ganglunduppa's generosity, the king gave the family all the land of a ravine above Khaskhas, called Khaskhas *lungpa* (Ladakhi: valley), which is still owned by them. At that time the land of the Ganglunduppa was even slightly bigger than all of nearby Sanjak village today. Because they were so rich, they got special respect from the villagers, which manifested in the tradition of the *lharngargu* (a special rhythm) being first played in their house at Losar, the Ladakhi new year. As a return, the Ganglunduppa gave food and *chang* (Ladakhi: local barley beer) to all the musicians who played for them.

Not long after, again the king came to Hanu, this time with seven men, and this time they went straight to the Ganglunduppa house.

The seven men cooked nine goats' heads in a pot, but while cooking, they broke the *skea* (Ladakhi: wooden stick used for cooking). When the king saw this, he ordered them to throw all the food down the toilet. However, one of the seven men held a bowl under the toilet and caught the food, which they secretly ate somewhere else. The king also told the Ganglunduppa not to eat this meat, because they, too, were *rus-chen* (Ladakhi: of noble lineage). His order meant that any time a wooden stick used in making or eating food broke, all the food in that pot or bowl had to be thrown away. From that time onward the Ganglunduppa were called *Geshingpa* (Ladakhi: *gal [=ge] tches*: to break, *shing* = wood), i.e. "the broken wood people", and had the status of *rus-chen*, of noble lineage. At that time, also the Sakyipa *phaspun* (Ladakhi: group of families, believed to have common ancestors) was *rus-chen*. In time, the Ganglunduppa family split, so that today the resulting *phaspun* is called Geshingpa, and of it also the two other families Malikpa and Nagdapa have the rule of the broken wood, and are *rus-chen*. This rule is still followed today, even though one suspects that there are not many occasions to actually prove it.

Tsering Norbu also told me that the family still has documents written by that king in possession (in a sealed tea-making tube), but I could not see them personally.

6.3.5. The introduction of Tibetan Buddhism to Hanu

At the time of the first Dardic migrations, which happened during the Indian Gupta period, Buddhism had already spread to the north-eastern regions including Kashmir and Gilgit. This means that the

earliest Dards already must have been exposed to Buddhist ideas. However, whatever influences of Buddhism there were among the old Dards, over the centuries they got lost, so that Tibetan Buddhism, when it made its way to Hanu, was an entirely new religion in comparison to the old animistic beliefs and ritual practices of the Hanupa. It should be noted that even today animistic beliefs play a large role in Hanu society, where despite the presence of Buddhism animal sacrifices are still carried out to appease the *yul-lha* (Ladakhi: village deity), to mention only one of many examples.

Sonam Phuntsog (1999: 381) describes the introduction of Tibetan Buddhism to Hanu in some detail, mostly, it seems, based on oral history. In short, three monks from Spiti came to Hanu in 1779, converting some Hanupa, while the majority became 'Buddhists' (outwardly, at least) after the visit of Konchok Wangpo from Skyurbuchan. This hermit built a monastery in Hanu in 1825. With only a short interruption of seven years early in the 20th century, the Hanupa have, until today, been associated with the Digungpa sect of Phyang and Lamayuru monasteries.

6.3.6. The conquest of Zorawar Singh

After the completion of the road by Tsewang Namgyal and the language change of the Hanupa, we can assume that Hanu, lying on the most important route to Baltistan, was constantly subjected to influence from the outside, for better or worse. At the same time, the more enterprising of the Ladakhi kings seemed interested in the loyalty of the Brog-pa (including the 'non-Brog-pa' in Hanu), like

Singhe Namgyal, who helped the Dha-pa rebuild their fortress (Vohra 1989a: 32).

The next time we hear of Hanu in the literature is at the occasion of the military expedition into Baltistan in February 1839 (Kaul 1992: 75) or 1941 (Francke 1999/1907: 154) of Wazir Zorawar Singh, who was military commander of the Maharaja of Jammu, ruler of the Dogra empire. A full account of Zorawar Singh's conquest of Ladakh and Baltistan can be found in Kaul (pp. 64-88). On his way to Baltistan, Zorawar Singh divided his troops, and sent the Ladakhi half up the Hanu valley over Chorbat La, while he and his Dogra troops took the route along the Indus, where the Garkunpa helped them secure a victory over the Balti forces by building a bridge over the Indus. The passing through of Zorawar Singh's Ladakhi soldiers is still remembered by the Hanupa today, who recount that a Garbapa man prophesied them victory, who, after the 'prophecy' (it was actually more an encouraging shout) had came true, was given the land of today's village of Kanyungtse in the Indus valley as a reward.

6.3.7. Dogra rule until independence: socio-economic developments

While there are plenty of historical accounts about Ladakh from 1841 until today (among them the most concise is Kaul 1992), there were no more written sources concerning Hanu after Zorawar Singh's soldiers had passed through available to me. Sonam Phuntsog (pers. comm. 2001) mentioned to me some written reports by a Dogra official responsible for Hanu, who complained about the bad

character of the Hanupa, but I could not see them personally. Besides, any written sources that may be available, for example in the Leh archives, would inevitably be in Urdu script (the newer ones), or in *bodyig*, the Tibetan script (the older ones).

However, we know that the tax exemption of the Hanupa (the result of Tho Shali's martyrdom) lasted until Ladakh lost its independence and became part of the Dogra empire following Zorawar Singh's conquests. Later, shortly after independence, taxes were again abolished – this time for all Ladakhi – due to the efforts of Bakula Rimpoche (Kaul 1992: 207ff). In the little more than 100 years in between, also the Hanupa had to pay tax, both in form of barley and labour. Oral history in Hanu concerning this time is less patchy and confused, and provides a glimpse of the socio-economic situation then.

Thus, according to one of my informants, Sonam Rinchen Ganglunduppa (59), 21 families of Hanu Gongma as well as 42 families of Hanu Yogma had to go to Lamayuru each year after Losar, to bring barley and to work there for 30 days. It seems that there was a representative of the Maharaja, called *Khazar*, who collected the taxes and oversaw the work. There is still a valley near Lamayuru called Hanupa *lungpa* (Ladakhi: Hanupa valley), where they used to keep their animals, which they brought for carrying the barley. Work was divided between the 21 families from Hanu Gongma and the 42 families from Hanu Yogma: Batches of seven families from Hanu Gongma and 14 families from Hanu Yogma worked for ten days, then the second batch would come, and after another ten days

the third batch took over. In that way the Hanupa worked for 30 days, while ensuring that the villages were never completely empty.

At that time, the wealth of a family depended on the land they owned: the more land, the better. Those whose land was not enough to supply them with enough food for winter were forced to borrow from the rich families, who had a surplus of barley, at high interest rates (25% p.a.). If it was impossible for a family to pay back the grain the next year, they had to give labour instead, and if the debt became too high, the lending family threatened to take part of the borrowing family's land. As it can be seen, this system created a static situation of dependency, and there was little chance of a poor family becoming rich. In between the rich and the poor families, there were also a few who had enough land so they could sustain themselves without borrowing, but did not have enough to lend. The rich families were the lDanpa, Ganglunduppa, Garbapa, Gangchungpa, and Kulikapa. The poor families, among them the Manupa, Pheyapa, and Doangpa, however, were the majority.

Since under the Dogra rule the animosities between Ladakh and Baltistan ceased, a lively trade between the two regions developed, most of which went through Hanu, and in which the Hanupa actively took part. A popular trading route for the Hanupa was to go to Sakti to exchange their barley, of which they had plenty, for salt from the Changpa (nomads from Changthang and Rupshu). Then they took the salt to Baltistan to exchange it for dried apricots, which in turn they brought to Leh to sell for money or goods. Generally, at that time the Hanupa had closer relations with Baltistan than with Leh and Ladakh proper. While Baltistan was only one

day's journey away, it took six days to travel from Hanu to Leh. Thus, the old Hanupa had many friends in Baltistan, and the Balti often came to work on the fields in Hanu, for which they were paid with barley. At the same time, the English first explored this area. Old people still remember the English survey expeditions that came three times a year, who forced the locals to work for them as porters.

6.3.8. The Kargil conflict

While Hanu was affected by the two wars between India and Pakistan in 1965 and 1971, the most recent, so-called Kargil conflict (April to July 1999) had the furthest-reaching effects on life in Hanu. The road up to Hanu Gongma and Chopodok/Hangdangsmin has been completed by the army within a year in 2000, a feat that the government could not accomplish in the previous ten years, when the roadwork was officially started. With the road, transport of people as well as goods has become easy, making life much simpler for the Hanupa. Gas cylinders, kerosene, threshing machines, food rations, and building materials now easily find their way up to Hanu Gongma, and Leh, with its business opportunities, educational and medical facilities, can be reached within one day.

While it is not readily visible in Hanu itself, also the bank accounts of the Hanupa are in a good shape since the war. Following a similar strategy like already king Tsewang Namgyal in the 16th century, the Indian army tries to secure the loyalty of locals in strategic border areas by "bribing" them in form of extremely high wages, heavily subsidized consumer goods, and free apples and chocolates for

the children. Thus, at the time of the war, when local porters and cooperation were needed most, the Hanupa got paid for their labour with wages higher than even army officers could dream of. Now the demand as well as the wages have gone down, but still remain sufficiently high to provide lucrative income for the Hanupa.

The more immediate and unpleasant effects of the war were the fear in which the Hanupa had to live for four months, and a few days camping up a side valley which was secure from the shelling of the Pakistani soldiers. However, no civilian died or even got hurt, and no building was damaged during the conflict. One local soldier, Angchuk Dorje Manupa was killed in battle, and the big prayer wheel at the side of the road as one enters Hanu Gongma was erected in his memory.

7. The Setting: Hanu Gongma

7.1. General Information

Ladakh, of which Hanu is geographically, politically, historically and culturally part, is located in the east of the Indian state of Jammu and Kashmir, nestled between the great mountain ranges of the Himalaya and the Karakorum. It traditionally had strong ties with Lhasa and the Tibetan regime, which have only been severed by the Chinese occupation of Tibet and the subsequent setting up of an embattled international border between China and the newly independent India. There are several excellent publications, both of general and anthropological character, on Ladakh (Beek, Bertelsen et al. 1999; Crook & Osmaston 1994; Dollfus 1989; Kaul 1992; Osmaston & Denwood 1995; Osmaston & Tsering 1997), so that I will straight away deal with the actual research setting, Hanu.

Hanu is a side valley to the north of the Indus River just before Dha-Byema (see map), consisting of the three main villages Hanu Thang, Hanu Yogma (Ladakhi: Lower Hanu), and Hanu Gongma (Ladakhi: Upper Hanu), the latter being the highest at about 3200m altitude. Starting in Hanu Thang in the Indus valley, which has lush apricot orchards, the valley quickly turns into a narrow gorge, and the road literally had to be blasted out of the sheer rock face some 50 metres above the stream. Before reaching the next village, Hanu Yogma, it passes two army check-posts, of which the first, but not the second one, can be avoided by walking the old footpath. Hanu Yogma with its old cluster of stone buildings, most of which are two or three stories high, gives a good impression of traditional

Dardic village life, and is a striking reminder of the cultural difference between Dards and Tibetan Ladakhi. A clear stream flows through the meadows seamed with willows just below the village, and the blue- or green-eyed children, some with dark brown, some with fair hair, usually in blue and red school uniforms, surprise the Western visitor by not asking for "One Rupee, one chocolate". The valley between Hanu Yogma and Hanu Gongma is, in summer, green with barley fields, among which some newer houses are dotted, and the road is less dangerous now so that one can actually enjoy the scenery. Some four kilometres above Hanu Yogma, the terraced fields of Hanu Gongma come into sight, long before one notices that just above them, so as not to waste any arable ground, the houses of the village are built.

Hanu Gongma consists of two parts: Khaskhas (Ladakhi: staircase) to the left of the road coming up from the Indus valley, and Pharol (Ladakhi: the other side) across the stream on the right side of the road. The houses here are smaller than in Hanu Yogma, the poorer of them being more a roofed hole in the slope than a building. Narrow little footpaths, often not much wider than one metre, lead between the houses, of which only the toilets – separate little towers – are whitewashed. At Hanu Gongma, the valley splits into two, the left arm going up via the hamlet of Chopodok (= Chopobroks = Hangdangsmin), where there is also a big army camp, to the Chorbat La, which earlier was the main pass between Ladakh and Baltistan, and which today marks the Line of Control (LoC) between India and Pakistan. The right arm leads up via a few small groups

of houses to high pastures, a glacier, and another pass to Turtuk in the Nubra valley.

Of the Hanupa, only a few men still have the traditional long hair woven into a pigtail, or wear large buttons in their ears as was the norm until some decades ago. The women, however, still wear the traditional caps adorned with fresh flowers and silver ornaments, have silver necklaces around their necks, and plait their hair in four tails on each side and six on the back, as a sign of a married woman. All Hanupa are Buddhist, but while Hanu Gongma and Hanu Yogma have, with the exception of migrant Nepali labourers who are Hindu, an exclusively Buddhist population, in Hanu Thang there also live some Muslims. Generally, Muslims – even those living in Hanu Thang – are not seen as Hanupa but as Balti, and are regarded with a mixture of contempt, suspicion, and fear by the Hanupa of the upper two villages, which is partly due to widespread bad memories about the behaviour of Pakistani soldiers during the short occupation of Hanu in the first Indo-Pakistan war.

Hanu Gongma, where the main focus of the research is placed, had at the last census (2000) 478 inhabitants living in 77 households and belonging to 29 families, including five families who were originally not of Dardic origin: The two *rgyud-pa* (Ladakhi: lineage) *amchi* families Sponpa, who came originally from Zanskar, and Abapa from Hemis Shukpachen (lineage broken); the Chunpapa from Pacherik, and the Monpa (originally from Skyurbuchan) and Garba. Apart from the Monpa and Garba families, who don't have a *phaspun*, there are six *phaspuns* in Hanu Gongma (Table 1). The average age of Hanu Gongma's population is 27.5 years.

The social organisation of the Hanupa is outwardly the same as elsewhere in Ladakh (see Dollfus 1989), with the household of an extended family as the smallest social unit above the individual. Every family (except for the Monpa and Garba), which usually consists of more than one household, belongs to a *phaspun*, a group of families coming into function for birth-, wedding-, and death-ceremonies, who trace themselves back to one common, known or unknown, real or invented ancestor (Crook 1994). As a special feature of Dardic social organisation, Vohra (1989a) repeatedly mentions the importance given to a household's independence and self-sufficiency, and the resulting decision-making system where the heads (usually not the elders but the strong, young men in their reproductive age) of each household meet and discuss matters of common interest. However, today this tradition has not much practical relevance anymore, due to the historic assimilation to Ladakhi social organisation, and the recent extension of Indian political systems to Hanu. As in Ladakh, a *goba* (village headman) is elected by the household heads and has the responsibility of maintaining social and legal order in the village. *Goba* are nowadays elected on a rotation basis, whereas until recently they remained in their function for as long as the villagers approved of their work.

Table 1. Families, *phaspuns*, and households in Hanu Gongma
(HY = Hanu Yogma; HG = Hanu Gongma; No. = number of houses – not necessarily households – in possession of the family)

Phaspun	Family	Village	No.	Remarks
Geshingpa	Ganglunduppa	Pharol	6	original family
	Malikpa	Pharol	2	split from Ganglunduppa
	Nagdapa	Pharol	1	split from Ganglunduppa
	Skidsonampa	Pharol	2	
	Byaphopa	Pharol	2	
	Sponpa	Pharol	1	from Zanskar
	Dakchenpa	Pharol	1	
Ganjapa	Gangchungpa	Pharol, Khaskhas,	10	
		& Hanu Thang		
	Magolpa	Pharol	2	
	Namgopa	Khaskhas	1	
	Pheyapa	Khaskhas	5	
	Pheldruppa	Hanu Yogma	0	live in HY but have land in HG
	Batopa	pastures	1	
	Chunpapa	Khaskhas	1	from Pacherik
Sakyipa	Yuryogpa	Pharol	5	Labdag-phaspun
	Doangpa	Pharol	2	
	Garbapa	Pharol & Khaskhas	4	also in Kanyungtse
	IDanpa	Pharol	1	
	Gochaypa	Pharol	1	only old man left who lives with in-laws in HY

Table 1. continued

Phaspun	Family	Village	No.	Remarks
Galopa	Kulikapa	Khaskhas	4	
	Manupa	Khaskhas	4	
	Dorepa	Khaskhas	1	
	Chombopa	Khaskhas	2	
Zugzugpa	Konchokzurpa	Khaskhas	4	
	Changbearpa	Khaskhas	1	since recently; before Ladruppa HY
no name	Gonpapa	Khaskhas	1	earlier, phaspun was the village
	Abapa	Khaskhas	2	from Hemis Shukpachen
	Monpa	Pharol & Khaskhas	5	no phaspun
	Garba	Pharol & Khaskhas	6	no phaspun

A few years ago, the Indian political unit of the *panchayat*, consisting of one or more villages, with a locally elected *sarpanch* at its head, was introduced to Hanu, and the larger area (including Dha-Byema and Achinathang) has now also a representative in the Ladakh Autonomous Hill Development Council in Leh, thus further extending the political organisation of the area.

Although there are two primary schools in Hanu Gongma (one each in Pharol and Khaskhas), and a high school in Hanu Yogma (up to class 10), the educational level of the Hanupa is very low, there be-

ing only a handful of educated men – no women – from Hanu, none of whom actually live there anymore.

All residents of Hanu Gongma are farmers, and indeed Hanu can, with some reservations due to the non-Tibetan background of the Hanupa, be classified as a "*remote agricultural community*" (Samuel 1993: 115, 126-131), due to its weak political centralization and social stratification, an absent estate system, and a kinship system laying emphasis on lineage, as visible in the *phaspuns*. Wherever there is a surplus of labour-force or spare time, people work for the army which has a heavy presence in Hanu since the recent Kargil-conflict, either as porters (men) or as road workers (mainly women) on the road up to Chopodok. Considering the extremely high wages the army pays, this is a very lucrative occupation and indeed the main source of cash-income. Tourism is completely absent from Hanu: As mentioned, the whole valley is off-limits to foreigners and non-Ladakhi Indians since the Kargil conflict 1999 (with a short interruption, it seems, in summer 2000), but even before that only few foreigners – like Laurent Pordié, Muriel Hernandez, and me in 1998 – ventured above Hanu Thang, and stayed maximally one night. There were and are no facilities for tourists whatsoever.

There is still, apart from often broken solar cells, no electricity in Hanu. However, communications have much improved due to the presence of the Indian army and the construction of the road up to Chopodok in 2000. There is a daily bus service between Hanu Gongma, Hanu Thang, and Byema, Fridays a direct bus from Leh to Hanu Gongma, which returns on Saturday, and Sundays a direct

bus from Hanu Gongma to Khaltsi and back. Besides that, army vehicles usually pick up civil passengers, and once down in Hanu Thang, there is a daily bus service between Byema and Khaltsi/Leh. Private vehicles are not allowed above Hanu Thang. The nearest telephone service is an STD booth run by the army in Achinathang, and another one exists in Byema.

7.2. The clinical situation

In comparison to a few years ago, the clinical situation in Hanu has, at least quantitatively, much improved. There are basic biomedical sub centres in all three main villages (civil) as well as in Chopodok (army), and there are five practicing *amchi* (plus two who have an *amchi* education of some kind, but don't frequently practice) in Hanu Gongma and Hanu Yogma. There is no *amchi* in Hanu Thang, but a Muslim *ackon*. Additionally there is a *lhamo* (a female oracle) in Hanu Yogma, and two *onpo* (ritual healers), one each in Hanu Gongma (Tashi Bulu's first son Skarma Stamphel) and Hanu Yogma. For more information about these kinds of traditional healers in Ladakh, refer to Kuhn (1988).

The biomedical sub centre in Hanu Gongma consists of a rented room in a private house, with a supply of roughly 50 medicines which are brought every six months from Khaltsi, where there is the nearest civil hospital. These medicines are mostly antibiotics, pain killers, cough syrups, antispasmodics, and vitamins. In addition the sub centre carries out a polio and measles immunisation campaign among the children. Each of the sub centres in Hanu is staffed with one man and one woman. In the case of Hanu Gongma,

the man is Tashi Bulu's physically disabled second son, Tashi Angdus, who holds the position of a nurse orderly, receives seven days of training twice a year, and a salary of 5000 Rs. per month. Below him in hierarchy is Phuntsog Dolma from Domkhar, who holds the temporary position of lady pharmacist. She is student at the University of Jammu, and has two years' training as a pharmacist. Her salary is 3500 Rs. per month. Phuntsog Dolma is frequently – and understandably – absent from Hanu Gongma for longer periods (compare Justice 1983, 1984; Messer 1990), especially in winter, but when she is there, she is actively performing her duties, in contrast to Tashi Angdus. A similar situation seems to be prevailing in Hanu Yogma.

The next better biomedical facilities are the army hospital in Achinathang, the civil hospital in Khaltsi, and the Sonam Norbu Memorial (SNM) Hospital in Leh. All the biomedical facilities in Hanu and Achinathang are free of cost, as are the medicines given out by them. In cases of emergency, the Hanupa told me, the army provides a vehicle as an ambulance, again free of cost, to bring the patient to an adequate facility, even if that may be Chandigarh down in the Punjab.

8. *Amchi* in Hanu

8.1. History of *amchi* medicine in Hanu

8.1.1. Introduction

The old people in Hanu still remember how *amchi* medicine came to be established in Hanu by the settlement of two *rgyud-pa amchi* families, both of them in Hanu Gongma. Before that, however, *amchi* occasionally visited Hanu, so that *amchi* medicine was known to the Hanupa even before the settlement of the two families. About these visiting *amchi*, information is much more scarce and unreliable. What is certain is that the visiting *amchi* belonged to the Abapa family of Hemis Shukpachen. The only detailed account of these visiting *amchi* comes from Rigzin Dolma Abapa, the eldest daughter of the last *amchi* of that lineage, but her claims could not be verified by me and should be treated with care.

Thus, while the history of *amchi* medicine in Hanu started with the Abapa family, whose *amchi* visited Hanu already at least four generations ago in the late 19th century, the establishment of *amchi* medicine took place later, when the grandfather of Smanla Rigzin Sponpa settled in Hanu Gongma around 1910. Some 25 years later also an Abapa *amchi* finally settled in the same village. From the time the first *amchi* settled in Hanu, Hanupa men began to learn *amchi* medicine, and thus there are today, in addition to the Sponpa *amchi*, four practicing Hanupa *amchi*, plus two old men who have also learned *amchi* medicine, but do not practice it regularly.

Any account of the history of *amchi* medicine in Hanu therefore has to start with these two families, the Abapa and the Sponpa.

8.1.2. The Abapa family from Hemis Shukpachen

The first *amchi* we know for sure to have visited Hanu was Aba Rigzin (ca. 1865-1940) from Hemis Shukpachen. People generally agree that at some point in history the Hanupa requested the Abapa to visit Hanu, but it is not clear if they requested Aba Rigzin or one of his ancestors. Given the steady contact with Ladakh and the kings of Leh since the 16th century, it is very likely that this request was made before the time of Aba Rigzin.

According to Rigzin Dolma Abapa, the Hanupa requested the Leh *rGyalpo* Singhe Namgyal (1610-1645) to send an *amchi* to their villages. The only *amchi* living in Ladakh at that time was from the Abapa family in Hemis Shukpachen. The Abapa were, according to her, the first *amchi* in Ladakh. They had orders from a king (not clear if they were given by Singhe Namgyal or a *rGyalpo* before him) to the effect that only the Abapa could give medicine, that they must never stop the *amchi* lineage, and that therefore all men in every generation of the Abapa had to learn *amchi* medicine. Singhe Namgyal ordered this Abapa *amchi* to look after Hanu, and in return the Hanupa signed a document that they would not speak badly about the *amchi* or treat him badly. The family, according to Rigzin Dolma, still has these papers today. In this way the Abapa started visiting Hanu ten generations before Tsewang Tashi, who finally bought land in Hanu Gongma, but still did not settle. So he

was given another piece of land, called the Isunkar, to make him stay.

While Rigzin Dolma's story is, at least in temporal perspective, not impossible (Singhe Namgyal did indeed rule about ten generations before Tsewang Tashi), there is no proof for it. The documents that according to her were in the possession of her brother Tsewang Smanla, do not exist to the knowledge of this brother, and at least some of the orders, like the one to the effect that only the Abapa could give medicine in all of Ladakh, seem very unlikely. Also her reference to the land called Isunkar is doubtful: It is true that the Isunkar today belongs to the Abapa, but my informants did not agree on if it was given to Tsewang Tashi for free, if he bought it, or if he just took it.

What is certain is that Aba Rigzin did a tour of villages and areas in western Ladakh a few times per year, each of which took him between 15 to 20 days to complete. The way from Hemis Shukpachen to Hanu alone took three days by horse. The tour included the villages of Garkun, Dha, Hanu, Turtuk, Teah, and Temisgam, and sometimes also villages in Baltistan, among them Thanu. He usually went alone, with three horses – one for himself, one for the medicine, and a spare one to carry the *bsod-snyoms* (Ladakhi: alms) and presents he got from the people.

Aba Rigzin had five sons, and since at that time it was customary that only the eldest son, Aba Konpan in this case, would marry and inherit the family land, two of his younger brothers shared his wife as younger husbands, while the youngest two went as *magpa* (uxo-

rilocal husband) to Turtuk. Tsewang Tashi, Aba Rigzin's youngest son, however, probably had some troubles there and left again.

We know today that all five brothers were *amchi*, and all of them travelled to other villages to give medicine. Aba Konpan and Tsewang Tashi, maybe also some of the others, came to Hanu regularly, and it was clear that the Hanupa would have liked them to settle in Hanu, since there was no local *amchi*. Thus, when Tsewang Tashi moved out of his wife's house in Turtuk, he remembered the favourable conditions of Hanu, where on earlier visits he had received more than the normal amount of presents, and the fertile land of which he liked. Besides, since the Abapa had visited Hanu for at least two (and possibly for ten) generations as the only *amchi* available, they enjoyed high status and respect. He bought the land of the Manapa family in the lower part of Khaskhas, whose only son – the heir of land and family name – had recently died, and took a wife from Achinathang. At that time, however, there lived already another *rgyud-pa amchi* family from Zanskar in Hanu Gongma, the Sponpa, who had moved there only two or three decades before.

Tsewang Tashi had one son and three daughters, and naturally wanted his son also to learn *amchi* medicine. The son, Tsewang Smanla, however, was not interested at all in becoming *amchi*, and escaped his father by joining the army training. After that he fully joined the Indian army and served as a soldier for 22 years. Then, in 1995, he retired, bought a bus, and moved to Leh-Skalzangling, where he lives now with his mother (88), his wife, and four children from his income as a bus driver and his army pension. He is

now 50 years old, and I could interview him in Leh. His elder sister, who married a *magpa* husband from Zanskar, Tsering Norbu, lives in Hanu Gongma on the old family land, where also Tsewang Smanla has a house. A further indication of the old connection between the Abapa and the Dha-Hanu area is that an aunt of Tsewang Smanla, Tsewang Tashi's sister, has married to Dha where she lives today.

Thus the *amchi* lineage in this branch of the Abapa family has stopped with the death of Tsewang Tashi in 1988. The other branch of the Abapa, who stayed in Hemis Shukpachen, has preserved the *amchi* lineage one generation longer, down to Norbu, the son of Aba Konpan. Norbu also has one son, whose name is also Tsewang Smanla, who works now as an army doctor.

8.1.3. The Sponpa family from Zanskar

As already mentioned, the first *amchi* to settle in Hanu around the year 1910 belonged to the Sponpa family. The grandfather of Smanla Rigzin, Sonam Joldan, was *thangka* painter as well as *amchi*, and this profession caused him to travel all over Ladakh. The profession as a painter is also responsible for the name of his family now: Sponpa, from Ladakhi *spon*, means painter. It seems he once was working in Skyurbuchan, a village not far from Hanu, and the Hanupa, learning that he was *amchi*, asked him to settle in Hanu Gongma. He agreed, settled, and married a Balti woman by the name of Zangsom. At that time documents were written and signed by the *goba* of Hanu Gongma for Sonam Joldan, which are today still in possession of his grandson.

Sonam Joldan and Zangsom had two sons, Sonam Dorje and Sonam Gangdup. The elder one, Sonam Dorje, married Thundup Tsomo Ganglunduppa, but had no children with her. Sonam Gangdup married Skalzang Dolma (probably Gangchungpa), but she died before they could have children. So Sonam Gangdup joined the family of his elder brother, and had three children with his elder brother's wife, before she divorced both brothers and remarried Tashi Paljor Magolpa.

The second of these three children is Smanla Rigzin, whose official father as well as teacher was Sonam Dorje, but whose biological father was, as just mentioned, Sonam Gangdup. Amchi Smanla is today 46 years old, and the only remaining *rgyud-pa amchi* in Hanu. Like his ancestors, and in contrast to most other families of Hanu, he is affiliated with Likir Gonpa (Gelugpa) instead of Lamayuru Gonpa (Digungpa), and is responsible for maintaining the Dukhang, a temple, of the same sect in Pharol. After Tashi Bulu Gangchungpa he is the second most active and respected *amchi* in Hanu Gongma, even though he states that he has lost interest in *amchi* medicine somewhat, and is mostly busy working as a kuli for the army or for other construction works. His eldest son is now eleven years old, and seems to be more interested in joining the army than carrying on the *amchi* lineage of his family.

An other lineage of the Sponpa also survives until today in Mulbekh. It seems the elder brother of Sonam Joldan, also an *amchi*, moved to Mulbekh where he settled and married. His son Smanla Tsering became *amchi*, and he in turn taught both of his sons, Nawang Stanzin and Smanla Thundup, *amchi* medicine. Nawang

Stanzin, who is Smanla Rigzin's (Hanu) second-degree cousin, has a daughter, Smanla Tsomo, who is *amchi* as well, and so is, according to Smanla Rigzin, her son Smanla Tsering.

8.1.4. The *amchi* tradition in Hanu

The beginnings of the *amchi* tradition in Hanu has already been described, as has been the settlement of the two first resident *amchi* in Hanu, Sonam Joldan Sponpa and Tsewang Tashi Abapa. Table 2 gives an historical overview of what happened at that time and after, as far and precise it could be determined by me.

It has to be noted that the Hanupa do not remember history, distant events and people by the year they happened in, but by putting them in relation to other people and events. Objective time references are very rare, and the subjective ones often contradict each other, because of mistakes or intentional misinformation. Furthermore, years in Hanu are counted by *loskor* – twelve-year cycles – and questions like "How old was *amchi* X when he died?" or "How many years ago did he die?" would invariably get an answer like "Six *loskor* and a little bit." Thus I calculated this table out of vague and relative time references, eliminating contradictions, and checking it against the few objective ones I had – a task reminiscent of logic-puzzles. While the dates, especially the ones marked with a star, are only approximate and may not be absolutely correct, they do give a reliable picture of who was *amchi* at what time in Hanu. What is more interesting than the absolute dates are the time-differences between the *amchi*, which are more precise. Through them it becomes possible to make statements about seniority, rela-

tions between the *amchi*, possible teachers, and the development of *amchi* medicine.

8.1.5. The first Hanupa *amchi*

Soon after Sonam Joldan Sponpa settled in Hanu Gongma, the first Hanupa began to learn *amchi* medicine, most probably from him. It is generally agreed in Hanu that Tseang Sandup Gochungpa from Hanu Yogma was the first of his generation to learn *amchi* medicine, and thereby became the first Hanupa *amchi*. He was, according to old stories, "speaking too much" and an "actor", but at the same time accepted to have been the best *amchi* of his time. Also Sonam Joldan earned a good reputation by successfully dealing with a tuberculosis epidemic. Even though the oldest *amchi* of that generation was Stanzin Gangchungpa, the grandfather of Tashi Bulu, he learned very late in life. He was *goba* for 18 years, which is a testimony for being very respected, but in his function as an *amchi* he must have had only minor importance. Stanzin died the same year that Tashi Bulu was born. Both Abapa *amchi*, Aba Rigzin and his son Aba Konpan, were visiting Hanu at the same time – and before – the above *amchi* were practicing. Even though Aba Konpan is a generation below Aba Rigzin, Sonam Joldan, Tseang Sandup, and Stanzin, for all practical reasons he has to be counted to the first 'batch' of *amchi* in Hanu that this study is concerned with.

8.1.6. The second generation

The senior most *amchi* of the second generation, if we do not count Aba Konpan, is his younger brother and student Tsewang Tashi, who must have started to give medicine around 1925, around the same time when also the old man Stanzin completed his education. At that time, however, Tsewang Tashi was still based in Hemis Shukpachen and Turtuk, and only visited Hanu occasionally. Around 24 years after Sonam Joldan Sponpa had settled in Hanu Gongma, his eldest son Sonam Dorje started practicing. Shortly after, Tsewang Tashi moved to Hanu Gongma to settle in 1935. At that time, still all *amchi* of the first generation were alive and practicing, even though Aba Rigzin had by then already transferred his duty to his sons. Thus in the 1930s there were five *amchi* living and practicing in Hanu, while at that time Aba Konpan must have ceased to visit Hanu since this responsibility was now fulfilled by his brother. In 1940 Stanzin died, Tashi Bulu was born, and two more *amchi* started practicing, both in Hanu Yogma, most probably both having had the same teacher, Tseang Sandup. These two *amchi* were the son of Tseang Sandup, Sonam Stobdan, and Sonam Angbopa. Most *amchi* of this generation died in the 1960s and 1970s, with the exception of Tsewang Tashi, who died in 1988. The most respected *amchi* of this generation were said to be Sonam Stobdan Gochungpa and Tsewang Tashi Abapa.

8.1.7. The break with old forms of reciprocity: *bsod-snyoms*, *amchi skalwa*

With the death of Sonam Dorje Sponpa, and even before the last *amchi* of his generation, Tsewang Tashi, passed away, the old system of reciprocity between *amchi* and village community seems to have died out. While most *amchi* of the second and third generation took *bsod-snyoms* as a return for their medicines, none of those still alive ever took it in Hanu, which marks a profound break in the economic situation of *amchi*. Today people especially remember the Abapa and Sponpa to have taken *bsod-snyoms*. These 'alms' used to be mostly barley, and were both given freely by the patients, as well as actively collected by the *amchi*. When it was collected by the *amchi*, which is the usual sense of the word, it was customary for the *amchi* to go to every house – patient or not – to collect it, until he had as much as he could carry.

Table 2a. *Amchi* in Hanu (generations)

(Dates with * are only approximate, but in correct relation to the others.
HG = Hanu Gongma; HY = Hanu Yogma; "Gen." = Generation)

1. Gen.	Family	Village	Dates	Age	*Amchi* edu.	Teacher
Stanzin	Gangchungpa	HG	1854 - 1940	86	1915-1920*	?
Sonam Joldan	Sponpa	HG	1860 - 1954	94	1870-1880*	rgyudpa
Aba Rig-zin	Abapa	visit	1865 -1940*	?	1875-1885*	rgyudpa
Tseang Sandup	Gochungpa	HY	1882 - 1960	78	1915-1920*	?
2. Gen.						
Aba Konpan	Abapa	visit	1890 -1960*	?	1900-1910*	Aba Rig-zin
Sonam	Angbopa	HY	1892 - 1976	84	1920-1930*	Tseang Sandup ?
Sonam Stobdan	Gochungpa	HY	1910 - 1970	60	1920-1930*	Tseang Sandup
Tsewang Tashi	Abapa	HG	1912 - 1972	60	1922-1930*	Aba Konpan
Sonam Dorje	Sponpa	HG	1913 - 1972	59	1920-1930*	Sonam Joldan
3. Gen.						
Thundup Tsephel	Pheyapa	HG	1930 -	71	1942-1954*	Sonam Dorje
Tashi Bulu	Gangchungpa	HG	1940 -	61	1953-1961	Skalzang Stopges
Smanla Rigzin	Sponpa	HG	1955 -	46	1960-1970*	Sonam Dorje
Tsering Thundup	Dompa	HY	1955 -	46	1964-1970	Tashi Bulu
4. Gen.						
Skarma Stamphel	Gangchungpa	HG	1963 -	38	1996-2000	Tashi Bulu

Table 2b. *Amchi* in Hanu (seniority)

(Dates with * are only approximate, but in correct relation to the others.)

Seniority according to practice		***Amchi* edu.**	
Sonam Joldan	Sponpa	1870-1880*	20*
Aba Rig-zin	Abapa	1875-1885*	20*
Tseang Sandup	Gochungpa	1895-1905*	23*
Aba Konpan	Abapa	1900-1910*	20*
Stanzin	Gangchungpa	1915-1920*	66*
Sonam	Angbopa	1920-1930*	38*
Sonam Stobdan	Gochungpa	1920-1930*	20*
Tsewang Tashi	Abapa	1922-1930*	18*
Sonam Dorje	Sponpa	1920-1930*	17*
Thundup Tsephel	Pheyapa	1942-1954*	24
Tashi Bulu	Gangchungpa	1953-1961	21
Smanla Rigzin	Sponpa	1960-1970*	15*
Tsering Thundup	Dompa	1964-1970	15
Skarma Stamphel	Gangchungpa	1996-2000	37

One informant, Tsering Samjor Yuryogpa (74), recalls, "Earlier the amchi wanted more... If the patients didn't give enough, then the next time the *amchi* would give less medicine. So the people were scared for their lives and gave a lot." An old joke in Hanu, saying that the more people were sick, the happier the *amchi* was, further underscores the point.

At Losar, the Ladakhi New Year, it was and to some extent still is the tradition in Hanu to slaughter a goat. The meat of the goat used to be shared, and while there was, according to my informants, no system of meat division, there was a special piece reserved for the Abapa *amchi*, that is, Tsewang Tashi. This was one front shoulder of the goat, and was called *amchi skalwa* (Ladakhi: share, portion). The *skalwa* of a front shoulder of a goat was only for the *lama* and the Abapa; however, if more than one goat was slaughtered, and other *amchi* were present, they would also get it. The lama and Abapa *amchi*, in contrast to other *amchi*, did not have to be present at the meat division; their part would be kept for them. Since the meat of the goat was shared between all the houses, the other *amchi* would get a share anyway, only not a front shoulder. This obviously marks the special respect that not only the *lama*, but also the Abapa *amchi* got. Undoubtedly its reason lies in them being the first *amchi* lineage to ever have come to Hanu, so that even the Sponpa, who settled first, never managed to receive the same amount of status and respect. This tradition of *amchi skalwa* stopped about 20 years ago, when Tsewang Tashi was still alive.

8.2. Today's *amchi* in Hanu: The third and fourth generation

Today, there are five practicing *amchi* in Hanu, four of them in Hanu Gongma and one in Hanu Yogma. Besides, there are two more men in Hanu Yogma who have some knowledge of *amchi* medicine, but who hardly practice at all. The four *amchi* of Hanu Gongma are Tashi Bulu, Rigzin Smanla, Thundup Tsephel, and Skarma Stamphel. In Hanu Yogma, *amchi* Tsering Thundup is practicing, and the other two men are Thundup Stanzin and Thuwa. Two *amchi* in Hanu are government *amchi*: Tashi Bulu and Tsering Thundup, who each have a certain area of responsibility, and earn 300 Rs. per month. Besides that, they also receive 1500 Rs. worth of medicinal raw materials every year. The same two *amchi* are also members of the Ladakh Amchi Sabah (LAS), which none of the others is. None of the *amchi* in Hanu charges his patients, although all of them accept money, barley, or labour to some extent in return for their medicine. In the following, a short portrait of each of the *amchi* practicing today is given, including a short biography of the main character of this study, Tashi Bulu.

8.2.1. Tashi Bulu Gangchungpa: A biography

Tashi Bulu was born in 1940 in Hanu Gongma, as the second youngest of six children, and has three brothers and two sisters. His actual name is Tsering Paljor, but when his mother was pregnant with him, she asked what name he should be given, and his elder brother, who at that time could hardly speak himself yet, said "Tashi Bulu" (Ladakhi: little Tashi), by which name he is still

called by the Hanupa. He never went to school, but learned a little *bodyig* from his father.

When he was 13, he went to his teacher, Skalzang Stopges (Lungspa), an *amchi* in Teah, because his own grandfather, who was also *amchi*, was not alive anymore. Since already his grandfather was *amchi* and his parents wanted to keep the tradition going, they insisted on him to become *amchi* (his father was an only son and therefore couldn't become an *amchi*). Besides that, he himself was eager to become *amchi*, because at that time there were no doctors and only very few *amchi* in Sham, so the health care situation was not good and it was difficult for the existing *amchi* to serve the whole area. He also thought that *amchi* get a lot of respect.

Thus, he stayed eight years with his teacher, started to give medicine at the age of 15, and passed his *amchi* exam (Ladakhi: *thit*) with 21. While studying at Teah, at first he became homesick and ran home, but then he was ashamed, went back and stayed. He "never slept for eight years", and it was "a big struggle": during the daytime he worked for his teacher and herded cattle, and at the same time he took his books and read. Then, at night, he would learn everything by heart. "I would have felt guilty if I had complained."

Still, he was homesick, and finally, after many requests, his teacher allowed him to go home for some time. It took three and a half days to walk from Teah to Hanu. Smilingly, he told me an anecdote about when he passed to Khaltsi: He bought some glasses to look fashionable, but he did not know about lenses. So he accidentally bought glasses with optical lenses, which cost 50 paise – a lot of

money then. Walking on, after a few hours he got a headache and had to vomit, but at that time he was already too far away from Khaltsi to turn back and exchange them.

Teah was much closer to Leh than Hanu, so he often had the opportunity to go there with his teacher. They also went with traders to Changthang, where they took wheat and turnip to trade it for butter and wool, which in turn they sold in Leh. These traders used to send him ahead with their animals on the way back from Changthang to Leh. Even though he "stopped at every house to drink *chang*", he still arrived before them and had to wait for a few days in Leh. During this time he saw many new things, which did not exist yet in the countryside, like glass rooms (*shel-khang*) that were excellent living rooms heated by the sun.

Not only did he work for his teacher as a return for the teaching, but when he had passed his exam in 1961, he offered him the choice between a horse, a *dzo*, and a donkey. The teacher took the donkey, which was then the most valuable animal. The animal was provided by his elder brother, Tsering Stobdan. For his exam (*thit*), which took place in Hanu Gongma, he invited his teacher, and his family had to treat him and all the villagers.

After having become a full *amchi*, he learned proper *bodyig* from Sonam Gunga, a lama who was also the teacher of a *rimpoche* and is now a respected monk in Dehradun. At that time this *lama* stayed in Skyurbuchan, and since it is the duty of *lamas* to visit the villages of their area for *pujas* (Hindi but also used in Ladakhi: rituals), he also came to Hanu Gongma sometimes. On these occasions,

and whenever Tashi Bulu had the opportunity to go to Skyurbuchan, he would learn from him; this went on for four to five years.

In 1965 – Tashi Bulu was 25 years old – he met Sonam Dolma, his wife, who was seven years younger than him, lived in Hanu Yogma, and had education up to the fifth class, which was high education for a woman then. As he remembers, he "found her beautiful and decided to marry her." Thus he went to Tsewang Rabstan, the grandfather of Tsering Thundup Dompa, who was then already the student of Tashi Bulu, and asked him to arrange things for him. Tsewang Rabstan went to her family (Khabatapa) to ask, but Sonam Dolma was just studying in the fifth class and they did not want her to marry then. So Tashi Bulu went to speak directly to her, and proposed. In Tashi Bulu's words, "Since I was a good looking, active young man, she agreed to the love marriage."

They have five children, three sons and two daughters, and only one daughter is still unmarried. His eldest son learned *amchi* medicine from him, as Tashi Bulu's second student after Tsering Thundup. One son studied at the Moravian Mission School in Leh until class 12, where he was the second best student, but after that he married, and was adopted by Tashi Bulu's elder brother who was getting old and had no son. Now this son has a temporary job as labour officer in the army. The third son, who is physically disabled, has, as mentioned above, a government job as nurse orderly in the local health centre and receives a government pension because of his disablement.

In the 1970s the director of the health department in Leh announced on the Leh radio station that every interested *amchi* could

come to Leh for an interview, in order to be appointed government *amchi* and receive a salary. At that time Leh and Kargil districts were still one. Tashi Bulu went, and altogether there were 30 *amchi* from all over Ladakh there for the interview. The director only spoke Hindi and English, but Dr. Smanla, the brother of *amchi* Gurmet Namgyal, translated. At that time, Tashi Bulu still had the traditional Brog-pa outfit, that is, long hair, earrings, goncha, and a hat with flowers. He still remembers how the deputy director told him, "You look strange. Come back and look smart." Even though he never saw the deputy director again, three years after that Tashi Bulu cut off his hair and changed his looks; this was a little more than 20 years ago. The interview was one by one. "They asked me only very simple questions, like how many bones and teeth there are in the body, because I came from such a remote area. I answered every question correctly." After the interview, everyone had to give an address in Leh in order to be contacted in case they were accepted. Tashi Bulu did not have an address in Leh, so he decided to stay and wait for the results, even though his teacher's son, who was also applying for the job, invited him to Teah for Losar. Three days later Tashi Bulu went to the director's office, and was told that only two *amchi* got the job: his teacher's son, and he himself. His first responsibility was for the villages Ledo, Achinathang, Byema, Dha, and Hanu.

When the Ladakh Amchi Sabah was founded, all the government *amchi* were automatically members. This, Tashi Bulu told me, brought with it some important changes in the organisation of *amchi* medicine as well as in the outlook of the *amchi* themselves. Be-

fore, the different *amchi* of Ladakh never met, and therefore each thought that he was superior to all others. With the meetings organized by the LAS, however, "we got to meet each other for the first time, and saw that we still could learn a lot from the others", for which purpose these meetings indeed provided a good opportunity.

Before Nomad RSI started to work in Ladakh and cooperate with the LAS, the Leh Nutrition Project (LNP) used to give seminars and medicinal support for/to the *amchi*, but only to those of the area south of the Indus. However, Tashi Bulu knew an LNP member very well, and so he could unofficially also get plant raw materials.

In the early 1980s Tashi Bulu finally had enough money to build his *shel-khang*, as he had planned since he saw the first ones in Leh. "Because there was no road at that time, it was very difficult to carry up so much glass from so far away", but he managed to complete it in 1985. "This was the first *shel-khang* in Hanu, and everybody came to see it." It did not take long, however, until "people got jealous and started building their own." Thus, two years later, the Yuryogpa built theirs, then the Doangpa, and finally another branch of the Yuryogpa, so that now there are four *shel-khang* in Hanu Gongma.

Around 1994/95 new land was created by a new irrigation channel in the valley above Pharol. This land – grassland to be used for fodder – should have been divided among the villagers, but the responsible *patawari* (government official) was guest in Tashi Bulu's house and a good friend of his, and so Tashi Bulu could register all the land in his own name. Asked about this, other informants in

Hanu told me that "at that time there was no road and no health centre in Hanu, so we were scared of him and did not dare to say anything."

Around the same time Tashi Bulu bought some land in Leh-Skara for 25,000 Rs. to build a small house there. Back in Hanu, he also registered more than his share of the family land in his name, annoying his elder brother Tsering Stobdan so much that since then they do not talk to each other anymore. A few years later Skarma Stamphel, the eldest son of Tashi Bulu, built a house on his wife's (Pheldruppa) land, which is adjacent to Tsering Stobdan's. Again there was a quarrel between them, as Stamphel was accused of taking some of Stobdan's land, and Tashi Bulu backed his own son.

In 1996 or 1997 Tashi Bulu divided all land and property between his two sons (the second oldest one, as we remember, was adopted by his elder brother) to avoid quarrel after his death. Now, except for some grassland and some animals (about 20 goats, two *dzo*), he has "nothing left at all. Now, I have done my duty, and am free to go travelling, and spend more time for *amchi* medicine."

Today, Tashi Bulu is without a doubt the most active and experienced *amchi* of the area, and he is also the *amchi* with the highest social status. According to his patients register book, he sees an average of 21 patients per month, which however does not include returning patients. He also told me that he sometimes forgets to make an entry, so that the actual number is probably a bit higher. He lives in Pharol with his wife and the family of his youngest son Tashi Angdus, who lives in the same house but has a separate kitchen. As a government *amchi* and member of LAS, Tashi Bulu frequently

goes to Leh for seminars or other activities. Even though the Hanupa generally acknowledge his skills and experience as an *amchi*, he is, due also to some of the above-mentioned aspects of his biography, one of the most controversial persons in Hanu Gongma, and a main object of jealousy and bad feelings. The implications of this will be dealt with further down.

8.2.2. Smanla Rigzin Sponpa

Amchi Smanla (46), the area's only remaining *rgyud-pa amchi*, on the other hand, states that his interest in *amchi* medicine has diminished, and it is not sure if his son will continue the tradition. The Sponpa family, consisting of only one household, lives in Pharol. Amchi Smanla is spending nearly all his time working as a *kuli* (Hindi but also used in Ladakhi: porter, labourer) for the army, while his wife is employed as a road worker, in order to earn money for the family. He still practices *amchi* medicine and especially astrology due to the demand of the people. In general opinion, he is a good *amchi* about whom – in contrast to Tashi Bulu – people do not have negative feelings, and the village's expert in Buddhist scriptures. The problem, however, is in public opinion mainly his large family and particularly his wife, who forces him to spend all his time working as a *kuli*, and even forbids him to give medicine to people she does not like. Another problem is certainly his rivalry with Tashi Bulu, who is arguably in a position of power. It can be estimated from his and other people's statements as well as from my observations, that he probably receives an average of 10 to 15 patients a month, which makes him the second most visited

amchi in Hanu Gongma. Amchi Smanla is trying to get a position as a government *amchi* as well, but is, for family-reasons, not interested in becoming LAS member, to travel to collect medicinal plants or attend seminars, or work outside of Hanu Gongma.

8.2.3. Thundup Tsephel Pheyapa

Thundup Tsephel (70) is one of the poorest villagers of Hanu Gongma, and lives in the lower part of Khaskhas. In spite of his age, he still works on the road occasionally, and is sometimes visited by patients for common colds or other minor ailments. Public opinion certifies him a good heart, but also regards him as poor, dirty and sometimes lazy. Besides that, it is noted disapprovingly that he smokes *beedis* (Indian-style cigarettes), all of which is not seen as befitting a good *amchi*. However, he is the *amchi* least involved in the rivalries of Hanu Gongma.

8.2.4. Skarma Stamphel Gangchungpa

Skarma Stamphel (38), the oldest son of Tashi Bulu, lives with his family just across the road from the biomedical sub centre in Hanu Gongma. He states that he considers himself still learning (from his father), from whom he also gets his medicines. Besides being the village's youngest *amchi*, he is also a fully empowered *onpo* (learned from the Wanla *onpo* Rigzin Namgyal for one year, empowered by Doldan Rimpoche). He does not, at the moment, get many patients as an *amchi*, but the numbers seem to be slowly increasing. In his function as *onpo*, on the other hand, he is in higher

demand, and this is – in contrast to *amchi* medicine – also a profitable occupation. Otherwise, Skarma Stamphel works, like most other Hanupa, on his fields and as a kuli for the army. He has also participated in the Nomad *Dusrapa* course in 2000, but left the course after a few months, due to a serious illness of his wife.

8.2.5. Tsering Thundup Dompa

Tsering Thundup (46) lives in the old part of Hanu Yogma. He learned *amchi* medicine from Tashi Bulu, and has the reputation of being a good hearted, skilled and experienced *amchi* himself today. He certainly benefited from Tashi Bulu's influence in becoming the second government *amchi* in Hanu besides Tashi Bulu, and like his teacher, he is also member of the LAS. Since he is the only really active *amchi* in his village, he is not as involved in rivalries as his colleagues in Hanu Gongma.

8.2.6. Thundup Stanzin and Thuwa

These two men are also *amchi* in Hanu Yogma, but only rarely give medicine. I could not talk to them personally, so I have to rely on information given to me by Tashi Bulu. According to him, Thundup Stanzin is a non-celibate (married) monk, who has learned medicine from an old *amchi* in Hanu Yogma. Thuwa is an ex-monk, who became *amchi* after marrying, and gets his medicine from Dharamsala, that is, he buys readymade medicine.

8.3. Clinical statistics

It is the general opinion in Hanu that the medical care provided by the sub centre is of low quality, and a majority thinks that *amchi* medicine is not only more reliable but also more efficient in most cases. Thus, 58% of my informants stated that generally *amchi* medicine is more efficient than biomedicine, while 26% were of the opposite opinion, and 16% believed that it depended on the kind of sickness. However, of the same informants, only 48% stated that they use an *amchi* as their first resort, while 36% said they used the sub centre first, and again 16% decided according to their sickness. Evaluating the patients register books of the sub centre and one *amchi* (Tashi Bulu), as well as the statements made by the other *amchi*, a further strong shift in favour of the sub centre occurs. While the sub centre sees an average of 140 patients per month, all *amchi* together receive only an average of about 60 patients per month, which is a little less than one third of the total number of practitioner-patient interactions. This is almost the opposite proportion than that of general preference stated above.

Table 3. Clinical Statistics

There is also a significant difference in the average age and the

	***amchi* medicine**	**sub centre/ biomedicine**	**depending on sickness**	***n***
General preference due to perceived efficacy	58%	26%	16%	31
Stated first resort	48%	36%	16%	31
Actual practitioner-patient interactions	30%	70%	----	200

gender of patients who either go to the sub centre or to Tashi Bulu. The average patient of the health centre is 32.6 years old, while Tashi Bulu's patients are, at an average, 47.4 years old. The sex ratio shows similarly big differences: that of the health centre is quite equally distributed at 51.5% women against 48.5% men (n: 266; period: 2 months), while that of Tashi Bulu's patients is 74.6% women against 25.4% men (n: 63; period: 3 months). Unfortunately, in the six weeks I stayed in Hanu Gongma, I was not able to find out the deeper reasons (as distinct from personal ones) for this marked female preference of Tashi Bulu, so that this may provide a research topic in the future. As can also be seen, there are more female than male patients per month in total. While this has been explained by all *amchi* in the same way, namely that due to pregnancies women are weaker and therefore get sick more easily, it would be rewarding to examine the clinical situation of Hanu in terms of gender studies (e.g. Moore 1994; Ortner 1974; Rosaldo 1974; Yanagisako & Collier 1987).

But, coming back to Table 3, how to explain this radical discrepancy between what people say they prefer and what they actually do? Why does a majority of people resort to what they see as inferior health care, in spite of the presence of publicly acknowledged medically superior alternatives, that is, the *amchi*? In order to find answers to these questions, the social situation of Hanu Gongma, with special emphasis on the social role of the *amchi*, who continue to be major actors on the social – if not medical – level, needs to be

examined. The cause for this discrepancy, as I will show in the remaining part of this study, indeed lies in the social sphere (see also Kloos 2000, 2004a, b).

9. The Social Role of *Amchi* in Hanu

The social role of *amchi* in Hanu is best described and analysed in two steps. First, in a general way applicable to all Hanupa *amchi*, and then specifically dealing with the case of Tashi Bulu, which will constitute a separate chapter (ch.10). The theoretical outline of the book's subject matter as given in the chapters 2 to 4 now becomes relevant. As mentioned above, the main analytical concept used in this study is that of power as outlined in chapter 4.2., since it has turned out to be the most relevant for the context of Hanu Gongma, and encompasses almost all other important issues concerning the social role of the *amchi*. Before coming to that, however, a short descriptive account of the situation in Hanu Gongma concerning the status and respect of the *amchi* will be helpful, since these two factors are closely interlinked with the concept of power.

9.1. Sitting order, status, and respect

Tashi Bulu clearly has not only the highest status of all *amchi* in Hanu, but also the highest social status on the village level in Hanu Gongma, due to the absence of a resident monk. After Tashi Bulu comes Thundup Tsephel in the sitting order, who is actually senior to him, then Amchi Smanla, and lastly Tashi Bulu's son Skarma Stamphel, being the youngest *amchi*. In terms of respect, however, Amchi Smanla ranks before Thundup Tsephel, on second place after Tashi Bulu. After the *amchi* sit the staff of the health centre, that is, Tashi Bulu's second son Tashi Angdus and, if present, Phuntsog

Dolma the pharmacist. Thereafter sit the school teachers, after whom the sitting order is according to seniority, with no special place for the *goba*, *sarpanch*, *kotwal* (Ladakhi: man responsible for organising and announcing meetings) or other functionaries.

Generally the high status of the *amchi* as compared to other people is explained by two factors: First, they give medicine and "save our lives", or, in other words, there exists still a sense of dependency upon the *amchi*'s services as well as a feeling of moral gratitude. Second, they know *bodyig* and perform *puja*s both together with monks as well as in their absence. Both sources of status correspond with the traditional role of *amchi* in society as explained in chapter 3.2.2., which in turn is closely linked both to the theory of the medico-religious Tibetan literature (chapter 3.2.1.) as well as to traditional socio-economic and clinical conditions.

Among *amchi* the factors for status and respect are more diverse, and indeed status as expressed in the sitting order is not the same as respect, the former corresponding less to actual social reality than the latter. For status among the *amchi* there is actually only one factor, which is seniority. For how much respect an *amchi* gets, on the other hand, there are more factors, and in extreme cases, these factors may even have an effect on an *amchi*'s status, as we have just seen in the case of Thundup Tsephel and Tashi Bulu. The two foremost factors, which are obviously interlinked, are a large stock of good medicine and wealth. They are the main reasons given for why Tashi Bulu sits in front of Thundup Tsephel in spite of the latter being senior. Connected with this are two other related issues, namely having a large number of patients, and having cured many

people, including serious cases. Other causes for respect that have been mentioned are: having passed the *amchi* exam (*thit*), being government *amchi*, travelling extensively to collect plant raw materials and gain medical knowledge, and attending social events in the village. Only few people mentioned being *rgyud-pa amchi* as a factor, which is, judging from Kuhn's (1988: 43ff) information, an interesting difference between Hanu and central Ladakh. Having a good heart is seen as essential for an *amchi*, again in accordance to the theory, however in the case of Hanu Gongma this is, as we will see, clearly not related to the status or respect of an *amchi*, but rather dependent on ties of family relations, friendship and dependency, and is acknowledged as a highly personal judgement in any case. This matter is also, in theory as in local belief, related to perceptions of an *amchi*'s medical efficacy, and will be dealt with in more depth in chapter 10.3.2.

A majority of villagers as well as all *amchi* agree that the status and respect of *amchi* has declined in comparison to 'earlier' (cf. Kuhn 1988). One reason for this is seen in the decreased dependency on the *amchi* for medical care, now that there are biomedical facilities available in Hanu, and comparatively easy access to the hospitals, doctors, and *amchi* in Leh. Another perceived reason is the increased level of education among the young and the fact that now people are 'rich' in comparison to earlier, both of which is, in general opinion (and not only limited to older informants), responsible for a decline in respect not only for the *amchi*, but for anyone. Asked more closely how this new lack of respect shows, however, it appeared that it does not show at all, except for the fact that

nowadays the *amchi* are rarely invited to patients' homes to give treatment as they used to be until some years ago, but patients prefer to visit the *amchi* in his house. The implications of that are more connected with reciprocity, since whoever is the guest in the other's house is usually served food or at least tea. Thus instead of being served food by their patients, the *amchi* is the one who is serving now. Especially in the statements of the *amchi* it becomes very clear, as we have seen already in chapter 3.2.2., that they equate status and respect with material returns for their services or medicines.

9.2. Power

I have just shown above that the causes – or factors – of status lie to a large extent in the cultural-religious sphere and correspond with the Tibetan literature, while the factors for respect are seen mainly in the socio-economic sphere of Hanu Gongma. The socio-economic reality, in turn, finds expression in the reciprocal relations between *amchi* and villagers. Respect is but a sign of social power, and was therefore used by me as a conceptual tool in the interviews, easily understood by the people, but referring directly to the more abstract concept of power. An analysis of the interviews and the data gained by participant observation reveals a causal pattern starting from the socio-economic, environmental, and the clinical situation, as well as from social and cultural factors of Hanu Gongma at any given time, leading to the social power of one or more particular *amchi*. Thus, power is used in Foucault's sense

as an analytic tool to examine complex factorial interrelations of a strictly delimited social reality, or rather, the social processes that make up the local reality in Hanu Gongma. At the same time, within this framework, power as the potential of an individual has explanatory value and is an important factor in itself. Finally, we will see the role of medical power in all that and its dialectic with social power, which will be worked out further in the conclusion.

An explanation of the causal pattern can start from any point. However, having multiple starting points which eventually all contribute to social power, it makes more sense to start from social power itself and trace its roots. Like this also the process of the research is reproduced, instead of artificially attempting to start from a conclusion rather than an observable fact.

9.2.1. Two mechanisms and immediate causes of social power

There are two immediate causes of an *amchi*'s social power in Hanu Gongma. They are, on the one hand, the ability, or power, to sanction people, and on the other the number of patients of an *amchi*. These two causes show the two fundamental mechanisms of an *amchi*'s power: The *amchi*'s ability to sanction people by not visiting them, not giving them medicine, or giving only 'bad' medicine, creates power through fear, which until recently was potentially a fear for one's life in case of sickness. However, nowadays this kind of sanctioning has become problematic for the *amchi*, as will be shown below (chapters 9.3.1. and 9.4.). A large number of patients could also contribute to the *amchi*'s ability to sanction, but apart from that it results in an *amchi*'s social power by way of popularity,

established through the gratitude of cured patients, and good reputation. As we will see later, the recent changes in Hanu's clinical and socio-economic situation also bring with them a shift of importance from the mechanism of fear to that of popularity.

9.2.2. Aspects of medical dependency

Let us use the causal chain of the mechanism of fear, deriving from the *amchi*'s power to sanction, as a starting point. This causal chain is still valid today, in spite of having become problematic for the *amchi* and losing its importance. This, and the changed circumstances around it, will be dealt with below, considering the case of Tashi Bulu.

It is clear that an *amchi* can only have the ability to sanction if the people depend on him, that is, if there is no (good) alternative to his services and medicine. There are two aspects of dependency: a material aspect, and a psychological-cultural one, each of them corresponding with a different factor for dependency.

The material aspect is obviously linked to the prevailing clinical situation in Hanu. Earlier, before the arrival of biomedicine in Hanu, the *amchi* were the only providers of medicine. They had a monopoly on medicine-giving, and therefore the dependency on them was almost total. Nowadays, this monopoly has been broken by a change in the clinical situation, and there is the alternative of the biomedical sub centre, and even of the hospitals in Khaltsi and Leh. Even so, there is still a certain amount of material dependency on the *amchi*, due to the poor equipment of the biomedical sub cen-

tre in Hanu Gongma, the frequent and often long absences of its staff, as well as the staff's poor qualification (compare Justice 1983, 1984). Because of these shortcomings of the biomedical health centre, people often still have to exclusively rely on the *amchi*, unless they decide to make the trip to Achinathang, Khaltsi, or Leh. This, however, is not always an attractive alternative, because in spite of the road and bus services, the journey is still uncomfortable and especially hard on old or sick people. Furthermore, especially in summer people cannot afford the time it takes to make the journey, which is also connected with costs, even if the treatment is free.

The psychological-cultural aspect refers to the socio-cultural factors of dependency. Culture can act as a direct cause of dependency on the *amchi*, who may be seen by the people as the only, or most, effective healer for a particular illness (cf. chapters 2.2. and 7.2.). This may concern so-called culture bound syndromes (Hahn 1985; Helman 2000), but also more common disorders like upper and lower back pain, dizziness, swollen joints, or dysentery, and different methods of diagnosis and treatment. Three of my informants, on different occasions, gave me the same example for that: "[In case of diarrhoea,] the doctor says you should drink more water. But for old people this is not good. The *amchi* says they should drink less water, so he is better." Many informants also explained their preference for an *amchi* like this: "In the hospital they don't check the pulse. They just give medicine or injections." Also social factors determine the psychological-cultural aspect of dependency: People are familiar with the *amchi* since childhood, and have the notion that the *amchi* is available night and day (even if this is, es-

pecially during the day in summer, not the case at all) in contrast to the often-closed health centre.

There are some important functions that are explicitly not performed by the health centre, but only by the *amchi*, which are indirectly connected with physical health. These functions focus on the psychological, social and spiritual health of the village. Thus, *amchi* are consulted in their role as astrologers to determine auspicious days for marriage or other festivals, and for all important days of the agricultural and pastoral year. They also perform rituals against sickness, which unfortunately I had no opportunity to observe. This seems to be done only by Hanupa *amchi*, due to the absence of monks in Hanu Gongma (Sonam Phuntsog, pers. comm. 2001). For these functions, the village's dependency on the *amchi* remains nearly unbroken. However, socio-cultural change also has its effects on this matter: Slowly, especially among young people, the beliefs on which these functions depend get weaker, thus also threatening to weaken this particular role of the *amchi*.

9.2.3. Number of patients

To account for differences in power *among* the *amchi*, that is, differences in dependency on particular *amchi*, again an *amchi*'s number of patients is important, which in turn depends on his stock of medicines as well as his skills and knowledge. Whoever of the *amchi* has, in the opinion of the people, the best medicine and skills, usually also has the most patients, and therefore a greater public reliance on him. Of course there were, and are, specialisations among *amchi*, which are also recognised by the people, like one *amchi* be-

ing a specialist for astrology, another for *me* (Ladakhi: fire; cauterisation).

However, the number of patients also depends on social factors, especially on the *amchi*'s family relations, since the Hanupa tend to resort to an *amchi* who is related to them. As an extension of this over the generations, some families have long-standing good relations with a particular *amchi*, who then becomes something like a 'family *amchi*', referred to by the family as "our own *amchi*".

9.2.4. Stock of medicine and skills

To summarise the last three chapters, we can say that an *amchi*'s social power can be established by fear of sanction, where the *amchi* derives his power to sanction from the people's medical dependency on him. Medical dependency itself depends on the prevailing clinical situation, on socio-cultural factors, and on an *amchi*'s number of patients. I also showed that the number of patients relies on socio-cultural factors and on the *amchi*'s stock of medicine, as well as his knowledge and skills, and as mentioned before, the number of patients itself can be a direct reason for an *amchi*'s social power by popularity. This partly goes in line with M.S. Larson's (1980) argument that status and power depend on a medical practitioner's ability to maintain access to patients, only that in Hanu Gongma, as we have seen, access to the patients depends on other factors than in Western society as in Larson's study.

Now we can go further, to examine the causes influencing the stock of medicines and skills. Firstly, both stock and skills depend on the

number of patients the *amchi* gets, because the more people he treats, the greater his experience and skills are bound to become. In relation with the number of patients, also a second cause is very important. It is the *amchi*'s mode of income, which traditionally came from the reciprocal relation with his patients or the villagers as a whole. As will be shown below, nowadays an *amchi*'s income does not necessarily have to correspond to his practice. It should also be noted that wealth in itself is a strong cause for power, but this fact is not limited only to *amchi*. The collection, exchange, or buying of medicines and/or raw materials requires both time and material resources, in today's case money (Pordié 2002). The more favourable the reciprocal relations are for the *amchi* (or in any case his financial situation), the easier it becomes for him to spend his time collecting medicines, travelling to seminars to improve his knowledge, and buy medicine.

9.2.5. Environmental factors

There is yet another variable for an *amchi*'s stock of medicine, which will gain importance in the near future: environmental factors. Included here is both the natural availability of medicinal raw materials in the *amchi*'s region, and the environmental degradation happening due to multiple factors in Ladakh and the Himalayas in general. The socio-economic situation both at a large (national and global) and small (local) scale, in regard to environmental factors and the *amchi*'s stock of medicine, is such that intensive harvesting of medicinal plants is becoming an increasingly lucrative source of income, but not, usually, for the *amchi*. As a result, plants get rare at the same time as demand is growing, thus pushing up the prices

for raw materials, on which the *amchi*, due to the same reasons being forced to buy them instead of collecting them, are dependent (Janes 1999; Pordié 2002).

Another factor of importance to the local situation of Hanu, is India's conflict with Pakistan, and Hanu's location at the Line of Control. Since the Kargil conflict 1999, the upper part of the valley (above Chopodok) and especially the mountain slopes have been closed even for locals, thus barring the Hanupa *amchi* from the places where earlier they collected most of their plant raw materials. Again, this forces them either to buy more raw materials than before, or to travel far to collect them. Both options are expensive and further connect local *amchi* medicine to the global forces of market economy.

9.3. Reciprocal relations and connected factors

The reciprocal relations are, in the integrated approach to power used in here, the most important issue in the study of the social role of *amchi* in Hanu. The nexus of reciprocity on the local level and the socio-economic situation on local, national, and international levels on the one hand, and that of reciprocity and dependency on the other, is of great value in the process of understanding the social situation of Hanu Gongma in today's context.

Let us first look at the situation today in Hanu Gongma. As mentioned above, now as earlier it is not common for *amchi* in Hanu to ask money from their patients. The practice of collecting *bsod-snyoms* in form of grains and tsampa from the villagers has died out

with the previous generation of *amchi*, so that now it is up to each individual patient to give the *amchi* something in return for medicine or not. This may be vegetables, barley, money, or labour, the latter being preferred by most *amchi*.

9.3.1. The factor of dependency

Generally we can observe in Hanu Gongma that the less dependency on the *amchi* exists, the less are the reciprocal relations in favour of the *amchi*. In connection with the new clinical situation of Hanu, where free biomedicine has become available, the *amchi* gradually face more and more competition ('competition', it should be noted, is – in contrast to 'power' – an etic concept and not used by the Hanupa). This decline of dependency leads to the situation where the *amchi* have to rely more on their popularity among the people, than on the people's dependency on them. This has already been mentioned in chapter 9.2.1. as power by popularity in contrast to power through fear. In this new situation it is very difficult for the *amchi* to ask for anything in return for his medicine, and indeed "*[r]ural practitioners [...] are in a dead end situation, as they distribute medicines almost for free*" (Pordié 2002).

So far the issue of dependency has been examined only from one side. However, as becomes clear in the discussion of reciprocity, dependency in Hanu is mutual, and obviously also the *amchi*, and even more so *amchi* medicine, depend on the people to some extent. We can therefore say that the *amchi*'s dependency on the people has declined as well as the people's on the *amchi*. On the one hand the *amchi*, whose income earlier depended to a large extent on their

patients and the *bsod-snyoms* they collected, are reacting to the decline of this specific mode of income and are finding, more or less successfully, alternative sources. On the other hand, however, national aid programmes aimed at helping the *amchi* in this situation, have themselves contributed to the decline of mutual dependency and reciprocity. Even though only two *amchi* in Hanu receive a minimal salary of 300 Rs./month as government *amchi*, this fact has changed the people's perception of their relationship with the *amchi*. Precisely in line with the idea behind the institution of government *amchi*, people now perceive it as the *amchi*'s *duty* to provide them with medicine. However, their own sense of duty to provide the *amchi* with the means to practice has diminished, since in their view this is now done by the government. In other words, the *amchi* now are seen as dependent on the help of outside agencies (government, NGOs), and not on the villagers anymore. In Marcel Mauss's (1950) terminology, the system of "*don et contre-don*", which is defined as a voluntary act that cannot be asked for, is thereby broken. What is more, the *amchi* are caught by traditional expectations (cf. chapter 3.2.2.) and their own ideals as found in the classical Tibetan literature like the *rGyud-bzhi* (cf. chapter 3.2.1.), so that they are unable, as mentioned above, to break the *don et contre-don* system on their part by asking for a counter-gift (cf. Pordié 2002). Adding to the dilemma, the position as government *amchi* has turned into a source of jealousy, since virtually all Hanupa believe the salary to be ten to twenty times higher than it is in reality.

9.3.2. The factor of the socio-economic situation

Let us turn from the factor of dependency to the influence of the socio-economic situation. Earlier, barley and animals were the main assets of wealth, and barley was usually given to the *amchi* in form of *bsod-snyoms* or directly in return for medicine. Sometimes, as Tashi Bulu still remembers with nostalgia, even animals (e.g. *dzo*) were presented to the *amchi*. However, the old system of subsistence economy is giving way to a locally specific kind of capitalist economy, with very different modes of production (of wealth).

Time, now, has become money, since any surplus of it, which is not needed for farm work, can be used to work for money. In contrast to earlier, when surplus time had no material value, giving free labour now is worth a lot, considering the wages paid by the army for local *kulis*, or the wages demanded by Nepali seasonal labourers. The *amchi* have realised this, and therefore prefer this kind of reciprocity, but also the villagers have, and are therefore much less willing or able to give this valuable resource.

Barley, too, has a different value nowadays. Until not long ago, and still to some extent now, the gift of grain meant for the *amchi* less necessary labour in the fields, and therefore more time to practice *amchi* medicine. With the arrival of money and shops selling heavily subsidized goods, however, barley has lost much of its value, while its production has become more expensive in regard to what has just been said about time. This is a known phenomenon and problem all over Ladakh, leading to a decline in (subsistence-) agriculture and a further dependency on national politics and global market forces. The Kargil conflict 1999 and the subsequent con-

struction of the road have finally also brought this dynamic to Hanu. During my stay there, no decline in agriculture was happening yet, but some people, among them Tashi Bulu, have already understood this change. Due to its changed value, grain has become less common as a return for medicine, and also less important for the *amchi*.

Considering these developments and the coming of capitalism, one could expect that money now would take the place of barley and labour in exchange for *amchi* medicine. In Hanu, however, this is only partially so. It has already been mentioned that money is only given sometimes, and even then usually only in amounts of 10-30 Rs., so that the *amchi* gets much less in return for his medicine than earlier. The reasons for this have already been examined and are connected with the decreased mutual dependency between *amchi* and people. There seem to be no direct economical reasons, because there is no shortage of money in Hanu.

9.3.3. Summary

To sum up the situation, therefore, it can be said that the *amchi*'s wealth does not depend directly on his patients and his medical practice anymore, and the health and life of the villagers do not only depend on the *amchi* anymore. The practice of *amchi* medicine has become a deficit undertaking for the *amchi*. Not only are the people less *willing* to give an adequate return for the medicine due to diminished dependency, but they are also less *able* to continue the old form of reciprocity with free labour and barley for the *amchi*, due to the changed economic situation. On the other hand, the *amchi* in Hanu are neither willing (due to their own ideals) nor

able (due to social pressure) to leave the old system of exchange and start charging for the medicines. Socio-cultural factors which underlie reciprocal relations by regulating them through a moral and ritual structure are also getting weaker, as we have seen in chapter 8.1.7., and as has been pointed out by Pordié (2002).

9.4. Effects on *amchi* medicine

In this chapter, the effects of the changed situation the *amchi* find themselves in will be examined. The most important aspect of the new situation has just been mentioned: *Amchi* medicine has become a deficit for the *amchi*. What does this mean for *amchi* medicine in general, and for the social role of *amchi* in particular – apart from a decrease of social power as shown in the analysis above?

There are several possible effects. The first possibility, and the most drastic, is that the *amchi* stop practicing, as it was the case with Tsewang Smanla Abapa. A second possibility, exemplified by Amchi Smanla, is that the *amchi* start looking for other sources of income. This generally means that they have less time to practice *amchi* medicine, and therefore less experience, medicine, and patients. Obviously, this undermines both the quality of *amchi* medicine as well as the *amchi*'s importance for the villagers.

A third possibility, similar to the second, is that the *amchi* looks for another source of income, but within the field of *amchi* medicine. There are two options: One option, common in Leh, is to open a clinic and start charging money for the medicine. Among the Hanupa *amchi*, Tashi Bulu also thinks about that, and even has an offer from a rich merchant in Khaltsi to open a clinic there. For the

reasons just mentioned above, however, it is clear to everyone that an *amchi* clinic opened by a local *amchi* in Hanu itself would not be possible. The result of this option would therefore be less *amchi* in Hanu, and in this case it would be precisely the *amchi* with the largest stock of medicine who leave. The other option is to look for financial support from government sources or NGOs. The negative effects of this have been discussed above (9.3.1.): the *amchi* become dependent on outside help, the local exchange system is disrupted, and, in the case of Hanu, jealousy among the *amchi* as well as from the people arises. However, there are also positive effects. The *amchi* are given an incentive to continue practicing *amchi* medicine, which reduces the possibilities that the *amchi* stop practicing or look for other sources of income. Furthermore, if the financial support is connected with meetings and seminars, the knowledge gained there not only helps the *amchi* to improve their medical practice, but also increases their respect and influence in their village. Even just *being* government *amchi*, and just having contact with authorities and members of (western) NGOs, increases their reputation and importance in the eyes of the Hanupa (cf. Justice 1983).

The last effect of *amchi* medicine having become a deficit for the *amchi* is, at least in Hanu, not only possible, but inevitable. Because the medicine is expensive for the *amchi*, and because the more they give, the bigger their deficit will be, all *amchi* in Hanu stated that they preferred fewer patients rather than more. In this sense they were also happy about the biomedical sub centres in Hanu, since far from perceiving them as a threat or competition,

they see them as a relief. Due to them, they get fewer patients, which from a financial perspective is welcome, and also their duty to care for the health of the village diminished, because it is shared now with the sub centre. In this sense, the presence of biomedicine has opened the way for the *amchi* to practice less or even stop practicing, not only because the people do not depend on them so much anymore, but also the *amchi*'s sense of duty has been weakened.

In connection with the last paragraph, some other implications met my attention in Hanu Gongma. The *amchi* not only want less patients, but also they think twice about giving medicine, especially the expensive kinds, and especially in not serious cases or in cases they are not sure about. Often enough, of course, they don't have the required medicine at all. Tsering Thundup Dompa told me, expressing the thoughts of all *amchi* in Hanu, "Imagine I give good medicine to a patient for two or three weeks, and still he is not cured. I have lost my medicine, and he lost his trust in me." In such cases the *amchi* prefer to send their patients to the sub centre, or make an excuse for not giving them medicine (e.g. that they do not have it, or that it is not necessary). This not only undermines the respect for the *amchi*, and the importance of *amchi* medicine in general, but also creates bad feelings between the people and the *amchi*. Pordié (2002) has mentioned that in Lingshed, another remote Ladakhi village, the *amchi*, in the same situation, is accused of being an idler by the villagers. In Hanu, especially people who already are not on good terms with the *amchi* interpret this as a sign of the *amchi*'s 'bad heart' (see chapter 10.3.2.), or partiality for his relatives and friends. In this way tensions on village scale arise in

Hanu Gongma, and people lose trust in the *amchi*. It may be that some such accusations against the *amchi* are true, or, on the other hand, that the *amchi* really does not have the medicine. Be it because of inability to give medicine, or because of a financially motivated reluctance, or even because of animosity (the three are interlinked anyway), the negative results are always the same in Hanu. In this situation, the *amchi*'s (earlier) power to sanction backfires, since his inability or refusal to give medicine is interpreted in this sense. With the change/decline of the reciprocal relations with the *amchi*, sanctions from an *amchi* are now not accepted as a fact of life anymore, but as the moral shortcoming that, in the eyes of the community, it had been all along. More will be said on that below, in chapter 10.3.2.

Of course, it should be noted that while the *amchi* want less patients out of financial considerations, the situation is more complex than this. The *amchi* are at the same time well aware that their social importance and power is shrinking with the number of patients. As I have shown above, the number of patients serves as a direct factor for an *amchi*'s social power. Thus, some *amchi* (e.g. Amchi Smanla) are in a paradoxical situation where they have to decide their priorities: more patients and therefore more respect but less wealth, or fewer patients, less respect, and more wealth. What makes the decision easier, however, is that also wealth itself is a very strong factor for social power, *amchi* or not. In any case, that the number of patients for the *amchi* gets less is a fact in Hanu, regardless of the *amchi*'s decision. Tashi Bulu has realised this before anyone else, and has established his power through new chan-

nels all the while remaining in the sphere of *amchi* medicine, not to his financial disadvantage, but advantage. This, however, will be dealt with below.

Summarising the above points, it is clear that the described dynamic weakens *amchi* medicine and the *amchi*'s importance (and therefore respect and power) in Hanu. It contributes to tensions and social disharmony, and potentially turns the generally positive role of the *amchi* for the social equilibrium of the village into a negative one.

10. The Case of Tashi Bulu

So far a lot has been said about the general situation of the *amchi* in Hanu: Their social roles and power, their problems, and their possible ways of reacting to them have been analysed in the context of the changing social, economic, and (infra-)structural situation of Hanu and Ladakh. It is time, now, to apply these general observations to a specific – and especially interesting – case, that of *amchi* Tashi Bulu. What is and was Tashi Bulu's role in Hanu's changing environment? How did he contribute to the changes, how is he affected by them, and what are his strategies of dealing with them? How have these strategies influenced his social role, and how does his social role affect the village, socially as well as clinically?

In order to shed light on these questions, I will first give a description of some obvious, and – even though some of them are specific to the situation of Hanu – almost 'classical' aspects of Tashi Bulu's role in Hanu, that show the interdependence between his medical and social roles. In a second chapter, the focus will be on the question of how Tashi Bulu contributed to the change that occurred in Hanu over the last few decades. The answer to this question will be further elaborated in a third chapter, which deals with Tashi Bulu's role as a "power-man", as he is locally characterised. There, the analysis of the previous chapter, pertaining to issues of power, the social and economical situation, and the connected dynamic in which the *amchi* find themselves, will be carried further to account for Tashi Bulu's case. The local concept of a 'good heart' versus a

'bad heart' will be introduced in the analysis of the interrelation between Tashi Bulu's power and his social status and role.

10.1. General Aspects of Tashi Bulu's Social Role

The general aspects of Tashi Bulu's social and medical role in Hanu Gongma are also the most obvious to an outside observer. Although the question will arise with the deeper analysis further down as to how much these aspects weigh in relation to others, nevertheless they have validity.

What a visitor to Hanu Gongma interested in *amchi* medicine notices first, is the predominance of Tashi Bulu. He is the *amchi* with the biggest stock of medicine, with the most experience and the most patients, and is government *amchi* as well as member of the LAS. Meeting him, it becomes clear that he is an intelligent, widely travelled, eloquent man, who is keenly interested in *amchi* medicine, who knows how to talk to foreigners and how to leave a good impression on them. He is also quick to point out his superiority over the other *amchi* in Hanu, and his disapproval of them except for his son Skarma Stamphel, and his other former student, Tsering Thundup Dompa in Hanu Yogma. That he had two students further shows his dominant role in the sector of *amchi* medicine in Hanu, where no other *amchi* alive has trained anyone else. Also talking to the Hanupa about their *amchi*, initially all will state that Tashi Bulu is the *amchi* with the most medicines and the most experience, and therefore the best *amchi* in the area.

Another important role performed by Tashi Bulu is that of the astrologer who is traditionally consulted by the Skidsonampa family about the auspicious days for the ceremonial first manure of the fields (*tag zum zet*), the first irrigation (*yu rang stag pa*), the repairing of the fields/terraces (*szigpa*), and the first ploughing (*phok khalchor*) (cf. Dollfus 1989). The Skidsonampa are also called the *Labdagpa* because of their function to start the new agricultural year by ceremonially performing all the above tasks, before the rest of the village can start with them. Tashi Bulu is also consulted for the auspicious day to bring the animals to the higher pastures in spring, and for when to bring them down again in autumn. Apart from these special duties, he is – much the same like Amchi Smanla – occasionally consulted for other auspicious days, like for marriages or other rites or festivals. In this way Tashi Bulu contributes to the material, physical and mental health of the village community (cf. Pugh 1983, 1984). If any of the above would be done on an inauspicious day, so the belief goes, the local deities and spirits (*lha* and *lu*) would become angry and inflict sickness on the villagers and their animals, make wolves and snow leopards kill the livestock, or would even possess individuals, turning them mad (see e.g. Blondeau & Steinkellner 1996; Dollfus 1989; Kaplanian 1995). In case a rite, like the burning of the dead, cannot be performed on an auspicious day, danger can still be averted by a special prayer (*zadak shaksbum*), in which Tashi Bulu apologizes to the *lha*. Since Tashi Bulu also explains any kind of quarrel by the anger of spirits, he could also be seen as contributing to the social harmony of the village; but the villagers tend to explain quarrels with rather more direct reasons.

The ability of Tashi Bulu (the same applies to Amchi Smanla) to read *bodyik* and therefore Buddhist prayers, as well as the *amchi*'s also religiously explained high status (see chapters 3.2.1. and 9.1.), made it possible for him to partly assume the duties, and therefore the role (however not the status), of monks, since for a long time now there has not been a residential monk in Hanu Gongma, and also visits by other monks are rare. Thus, Tashi Bulu not only performs a Buddhist *puja* every morning and evening in his kitchen for about an hour each, but also carries out various *pujas* – together with monks or also alone – for other families. Until recently there were also no *onpo* in Hanu, and so Tashi Bulu took over their role, too, with the exception of playing their instruments, for which a special initiation would be necessary. Now, Tashi Bulu's son Skarma Stamphel is *onpo* as well as *amchi*, so that Tashi Bulu has given up this function. Also in other ways Tashi Bulu is engaged religiously: He founded the "Gompa Sabah Hanu Gongma, Ladakh" in 1992 in order to organize funds for the renovation of the *gompa* in Khaskhas. He has closer-than-usual connections to Doldan Rimpoche of Phyang Gompa (the head *gompa* of the Digungpa sect in Ladakh, to which also Lamayuru Gompa belongs), who stayed as a guest in his house, and he is, in line with Doldan Rimpoche and Buddhism in general, a critic of the animal sacrifices in Hanu. In other respects, however, Tashi Bulu enacts the syncretistic nature of Ladakhi/Tibetan Buddhism, on the one hand upholding the superiority of Buddhism and its pantheon, but on the other still dealing with the old, local, non-Buddhist deities and spirits, who are still seen by most Hanupa as more immediately relevant to their lives than the Buddhist ones. The religious role Tashi

Bulu thus assumes is also a social role, not only in the sense of performing curative rituals which, as many medical anthropological studies have shown (Blustain 1976; Eigner 2001; Finkler 1980,1994; Kleinman & Sung 1979; Lambert 1992; Stone 1976) can have strong social functions and effects (unfortunately, this could not be studied by me), but also by propagating Buddhism against the old beliefs and practices, with all its social and moral implications.

All this leads to the very positive picture of Tashi Bulu's role as actively keeping the tradition of *amchi* medicine alive and well, as providing the Hanupa with health care within local concepts of health and illness, and as having positive social impact on the one hand through the practice of *amchi* medicine, and on the other by propagating a Buddhist morality at the same time as ensuring the harmony between the three worlds of humans, deities, and spirits (cf. Kaplanian 1995).

However, beneath this surface of appearances, Tashi Bulu's social role emerges in a more complex and problematic light, embedded as it is in the less-than-idyllic reality of village life with all its tensions, quests for power and wealth, and intrigues, which to no small extent have acquired new forms with the changes the socio-economic situation of Hanu has recently undergone.

10.2. The coming of change to Hanu Gongma: Tashi Bulu's role

Another aspect of Tashi Bulu's social role was, and still is to some extent, his role in the change of Hanu over the past few decades. As could already be seen in chapter 8.2.1., the biography of Tashi Bulu reveals some interesting aspects of this.

Tashi Bulu was one of the first Hanupa of his time to live and travel extensively outside of Hanu, due to his *amchi* education in Teah between 1953 and 1961. It was during this time that he was exposed to new developments in Leh, which were important not only in regard to his role as a bringer of change to Hanu, but also in regard to establishing his power. Two main influences of his time in Teah and travels around Ladakh stand out: One was his interest in getting the position of government *amchi*, and generally of getting involved with regional developments for *amchi*, later also propagated by foreign NGOs. It is likely that during his time outside of Hanu his thinking became more cosmopolitan than that of an average Hanupa, and he realized very early the benefits to be gained from such an involvement.

The other main influence was his wish to build a glass room (*shel-khang*) in Hanu Gongma, just like the ones he had seen in Leh as a student, which were new then even there, and non-existent in Hanu. Even though it took him a long time to be able to build it, his was still the first *shel-khang* in Hanu.

10.2.1. Tashi Bulu's *shel-khang*

The *shel-khang* can be seen as a kind of bridge-head for closer connections of Hanu with the rest of Ladakh, especially the administration in Leh. For the first time, there was an adequate room in Hanu for official or other important guests to stay in, without which visits were not possible, since it was too much to ask from any official to walk all the way up to Hanu Gongma – or even just Hanu Yogma – and back in one day. This gave the Hanupa the opportunity to talk to representatives of the Leh administration about local requirements and problems without having to go to Leh. Word got round in Leh, and visits by officials became more frequent, which in turn contributed to the awareness in the Leh administration about Hanu. Also high representatives of the clergy were now able to visit Hanu, such as Doldan Rimpoche. Highly respected as they are, their advices and orders – be it to renovate the *gompa* or to stop sacrificing goats – were usually followed (even if only for a short time, as in the case of the sacrifices).

A second effect of Tashi Bulu's *shel-khang* was to arouse the jealousy of the other Hanupa, and those who could afford it soon began to build their own house-improvements. Obviously, money was needed for this. In contrast to the time just before Tashi Bulu's *shel-khang*, there was now a situation where a definite use or benefit of money was perceived by the Hanupa in general, and I would argue that this partly prepared the way for the coming of capitalist modes of production. Thus Tashi Bulu's *shel-khang* can be seen as a trigger for political (visiting officials from Leh), economic (creating need for money, attracting funds through visiting officials), and

socio-cultural (visiting *rimpoche*, socio-cultural effects of economical change) change, as well as putting Tashi Bulu – as the owner of the *shel-khang* and host to all these guests – in a position of power, which again had social implications for Hanu Gongma.

10.2.2. Tashi Bulu's involvement with organisations

I include Tashi Bulu's position as a government *amchi* in this chapter. As already shown above (chapters 9.3.1. and 9.4.), the governmental aid of giving some *amchi* the position as government *amchi* with a monthly salary has had far reaching consequences on the socio-economic as well as medical situation of Hanu, especially concerning the role of the *amchi* and the status of *amchi* medicine. Besides that, as a member of the LAS, Tashi Bulu frequently travels to Leh for seminars or meetings, where, also due to the cooperation of the LAS with Nomad RSI, he comes in contact not only with Westerners, but also with a certain amount of Western values and perceptions. Even though nowadays he is by far not the only Hanupa to get exposed to new influences in Leh, he is still an exception in so far as those other Hanupa who frequently go to Leh normally have less contact with strangers, and those who do are usually permanently living in Leh now, and rarely visit Hanu anymore. Of course not all of these new influences on Tashi Bulu necessarily find their way to the social reality of Hanu, but the potential is definitely there. Some examples of this influence are mentioned in chapter 8.2.1.: the change of dress of Tashi Bulu some 20 years ago, and even now his wish to look smart by wearing sunglasses; that he perceives his duty as done now, has distributed

most of his land among his sons, and is keen on travelling the world; and also his idea of opening his own *amchi* clinic in Khaltsi, which certainly does not come from staying in Hanu all the time.

10.3. The "power man"

As shown above, all *amchi* in Hanu Gongma are respected and have a high status as visible in the sitting order. Besides Tashi Bulu, especially Amchi Smanla is acknowledged to be a good practitioner of *amchi* medicine, that is, to have medical power. However, no other *amchi* besides Tashi Bulu has social power in the sense of influence beyond the medical sphere (compare the third perspective in chapter 4.1.). The question examined in this chapter is, therefore, how did Tashi Bulu transform his medical power into social power? What was his strategy in doing this, if he consciously had one, and how is it connected to the changing situation of Hanu?

I will first attempt to reconstruct the process by which Tashi Bulu established his power in the past three to four decades, making use of his biography (chapter 8.2.1.) and data gained from interviews with other informants. This will lead to a short description of how Tashi Bulu has used his power, after which the resulting effects on Tashi Bulu's social role and the social as well as clinical reality of Hanu Gongma will be discussed.

10.3.1. Establishing his power and using it

The important factors for the establishment of Tashi Bulu's social power have already been explored in another context in chapter

10.2., save two: One was the absence of any serious competition, and the second was the then lacking political structure for dealing with officials from Leh.

Amchi Smanla was still young at the time when Tashi Bulu laid the foundations for his power, he had lost his father early, and was working as a shepherd in Stok. While the absence from Hanu was an advantage in Tashi Bulu's case, in Amchi Smanla's case it can be seen – and *is* seen in Hanu – as a disadvantage. Thundup Tsephel never was any serious competition to Tashi Bulu, because he was an illegitimate child as well as very poor, and – according to the Hanupa – also not working hard enough.

At that time, too, Hanu neither had a *panchayat* and *sarpanch*, nor a representative in Leh, so that, with the old political and social organisation having become obsolete in the new environment, there was no adequate structure for dealing with officials or important visitors.

In this favourable situation the building of the first *shel-khang* of Hanu, as well as the involvement with organisations, served as the foundations of Tashi Bulu's power to come. Both of these factors resulted in the opportunity for Tashi Bulu to establish good relations with officials and other important people, thus filling the political gap in Hanu. These contacts he used, in combination with the experience he had gained from travelling, to get most of his family members government jobs, and therefore secure the family's wealth. His wife became *anganbari* teacher for Hanu Gongma with a substantial salary of 8000 Rs./month, and in this function also receives the rations for the children to her house. His son Tsewang

Namgyal, who has been adopted by his elder brother, has a (temporary) position as labour officer in the Indian army, and Tashi Angdus works, as mentioned, as the nurse orderly in the local biomedical sub centre with a salary of 5000 Rs./month. In addition to that Tashi Angdus purportedly receives a pension because of his disablement. Tashi Bulu himself, in comparison, earns only minimally as a government *amchi*, with 300 Rs./month plus 1500 Rs. worth of medicines per year. Thus, the family income is, even excluding Tsewang Namgyal, well above 13000 Rs./month and for Indian and Ladakhi standards very high. In addition to that, as already mentioned in chapter 8.2.1., Tashi Bulu used his good contacts with the *patawari* to register some newly created communal land under his name, as well as more than his share of the family land, to the disadvantage of Tsering Stobdan, his eldest brother. Thus Tashi Bulu was able to secure his wealth in both the old (land) and the new (money, government jobs) way, just as he established his family's medical dominance in both the old (*amchi* medicine) and the new (biomedicine) systems. We can see here that Tashi Bulu had early understood the changes in process and cleverly reacted to them, using them to his own advantage. Through his involvement with organisations he also came to the benefits of medicinal support and seminars for further education (LAS, Nomad RSI). Even when he himself could not get support, like from the Leh Nutrition Project's (LNP) *amchi* support programme, which only supported *amchi* south of the Indus, he could get free medicinal raw materials through his good contacts with the right people.

Clearly, the medicinal support and the seminars helped Tashi Bulu become the most experienced and best stocked *amchi* of Hanu. However, he also made use of his wealth in that direction: He could now easily afford to hire Nepali labourers for his fields (in so far as the labour given by the villagers was not sufficient) and go away in order to collect medicinal plants in the mountains, and as easily he could buy more expensive ingredients for his medicines. Tashi Bulu's interest in *amchi* medicine becomes clearly visible here, and regarding the problematic aspects of his biography, it has to be asked what other chances of successfully practicing *amchi* medicine under the circumstances of socio-economic change there would have been.

Thus on the one hand he established his medical power and also his top position in the medical hierarchy of Hanu by monopolising the people's general dependency on *amchi* for himself. On the other hand, he also established his social power along with his medical power, not only through the process of dependency as described in chapters 9.2.1. and 9.3.1., but also because of his connections to important people (thus acting as the voice of the Hanupa to the outside world) and his wealth. By training Tsering Thundup and his own son Skarma Stamphel in *amchi* medicine, and by getting a position for his other son Tashi Angdus in the biomedical sector, he further secured his and his family's medical dominance in Hanu by producing new medical practitioners loyal to him. Thus he effectively managed to marginalise – as much as possible – the other medical practitioners, in this case Amchi Smanla and Thundup Tsephel. We can see here three interwoven developments: the rise

to medical and social power by Tashi Bulu, the polarisation of the medical sector in Hanu as a consequence, and the marginalisation of those practitioners seen by Tashi Bulu as competitors, by verbal (speaking against them), medical (achieving medical superiority), and social (producing other practitioners loyal to him) means. What we can see here, too, is the resemblance of strategy to that of "big men" as described by Godelier (1986: 163f): Big men not only need superior skills in a certain field – in this case medicine – but also, and crucially, they need the ability to amass wealth and redistribute it. Secondly, Godelier (ibid.) paraphrases Sahlins (1970), big men only arise in acephalous societies (i.e. consisting of clans or, in our case, being organised in *phaspuns*) without hereditary chiefs, which do not (yet) have permanent institutions for dealing with other – distant – social and political entities. According to the theory, big men in such situations serve as the "*provisional mediums for supralocal political relations*" (Godelier 1986: 164). Tashi Bulu indeed displayed special skills not only in medicine but also in amassing wealth, and he can indeed be seen as a provisional medium, before that function has been taken over by the *sarpanch*, for relations to the officials in Leh, even though it has to be emphasised that he never had any direct political functions. Just like big men, Tashi Bulu used his acquired wealth to further extend his power, up to the point where the instability of the 'big man principle' becomes evident, and the growing centralisation and monopolisation of power undermines his social base (cf. Godelier 1986: 163). The locally specific mechanisms behind this process will be examined in the next chapter.

In the interviews – by reading between the lines and observing reactions (see 'observant interviewing' in chapter 5.2.) – it gradually became obvious that a large part of Tashi Bulu's social power was based on the people's dependency on him, and the resultant fear. This accords, as narrative interviews have shown, to the old and traditional position of *amchi* in Hanu and, presumably, much of Ladakh. However, there were also those people who positively defended Tashi Bulu against any bad reputation, which shows that Tashi Bulu's social power is not only based on fear, but also on some amount of popularity. This he was able to achieve by curing serious sicknesses, and by never asking anything in return for his medicine. As Tsering Dolma Konchokzurpa said, "Tashi Bulu is a good man. He never refuses to give medicine, and he is very respected because he has a good heart." Tsewang Dorje Byaphopa also remarked, "Two times I was very sick and both times Tashi Bulu saved my life. He is a good man." Of course, Tashi Bulu was only able to do this because of his medical expertise and resources, acquired through his wealth and involvement with organisations. What this also shows, however, is a polarisation of the village into two factions, namely those defending and those cursing him, all of which, of course, does not happen openly, partly due to the still large amount of power Tashi Bulu has. The transformation of the meaning and effect of traditional social structures by larger changes of society becomes visible here, and is especially well demonstrated in the next chapter.

10.3.2. Effects on Tashi Bulu's social role: the 'bad heart'

As already alluded to above, the mechanism of gaining and sustaining power through fear is in the process of becoming problematic. The reason is the ongoing decrease of the people's dependency on the *amchi*, following the establishment of biomedicine in Hanu and the newly acquired wealth of the villagers in combination with the new road, which makes it possible for almost everyone now to go to Khaltsi or Leh for treatment. It has been shown in the previous chapter that Tashi Bulu monopolized, through various means, the medical dependency of the people, thus multiplying his power-by-fear. At the time of research, still a majority of people felt dependent, even if not totally anymore, on Tashi Bulu, which means that until now, his power has remained intact. However, as dependency gradually lessens, this is likely to change soon. The process becomes visible in the comparison of following two statements, made by two different informants: "People don't say bad things about Tashi Bulu, because he's powerful and they're scared. Maybe one day they get a serious disease – then they need him." (Tashi Thundup Dorepa) "Now Tashi Bulu has no power anymore, because there is the hospital and the road... Now nobody is afraid of him anymore." (Nawang Dorje Konchokzurpa) As already said, for the time being the first statement holds more truth, but even the fact that these statements were made at all, shows that Tashi Bulu's power is on the wane. The mechanism of power through fear, already being problematic for the health care situation of Hanu Gongma (see below), is therefore likely to lose its relevance for the *amchi* himself.

In this context the Ladakhi concepts of the 'good heart' and the 'bad heart' (*sems bzang* and *sems ngan* respectively) become important. A 'good heart' does not refer to a physical organ, but is used in the sense of the English expression "a good-hearted person". In theory, every *amchi* by definition has a 'good heart', because he is supposed to treat everyone equal regardless of personal sympathies, and because he does it not for his own benefit, but for the benefit of others, that is, out of compassion (cf. chapter 3.2.1.). This quality of an *amchi* Tashi Bulu calls "*dam-tshig*" (from Ladakhi: *dam-tshig tsang-ma*; lit. 'of pure vows', said of e.g. a monk who observes the code of *vinaya*). While some of my informants categorically denied the possibility of an *amchi* with a 'bad heart', most could describe 'bad hearted' *amchi*: They are greedy and miserly, therefore giving 'good medicine' only to their friends and relatives, but refusing to give any medicine, or giving only 'bad medicine', to their enemies. Even the 'good medicine', according to the Hanupa, would have little efficacy, because the efficacy of medicine depends to a large degree on the 'heart' of the *amchi* as well as that of the patient. Just as the *amchi*'s quality of *dam-tshig* is important, so is the patients' trust in the *amchi*, called "*dad-pa*" (Ladakhi: faith). Asked about the possible combinations of *dam-tshig* and *dad-pa*, all informants came to the conclusion that actually *dad-pa* was more important, in the sense that it does not matter if an *amchi* has a 'good' or a 'bad heart', the medicine's efficacy is only determined by the patient's 'heart'. If the patient has *dad-pa*, then regardless of the *amchi*'s 'heart', the medicine would be effective, while all the *amchi*'s good-heartedness will not help if the patient thinks badly of him. Thus, in principle, the Hanupa ac-

knowledge the subjectivity of the accusation against an *amchi* to have a 'bad heart', actually laying the blame on the patient. However, in practice Tashi Bulu is accused of a 'bad heart' quite categorically, and the blame is laid on him, not the patients.

This is, of course, a highly social concept, in effect linking the personal relations between *amchi* and patient to the efficacy of the medicine. It works both ways: Not only in the way just described, where the gross relations between patient and *amchi*, the *amchi*'s behaviour, or the patient's lack of trust, lead to the inefficacy of treatment, but also in the opposite direction. If a medicine does not work or causes more pain, then the *amchi* is suspected of having a 'bad heart', which serves as the empirical proof for the above-made theoretical assumption (chapter 3.2.1.) in that direction. The whole concept is as accepted among the people as among the *amchi*. Tashi Bulu brought it to a point in saying, "Whichever *amchi* the people like, they say he has a good heart. Whichever *amchi* the people don't like, they say he has a bad heart."

Now how did Tashi Bulu get this strong reputation of having a 'bad heart', and what does it mean for his social role? One reason can be seen in the backlash of his power to sanction, which, as mentioned above, is seen nowadays as a moral shortcoming. Any refusal to give medicine, be it telling the patient to come back tomorrow because right now the *amchi* is busy, or because Tashi Bulu really does not have the required medicine, or because of other reasons, is interpreted in context of his power to sanction: Tashi Bulu does not like to give medicine either because he wants more in return for it, which means that he is greedy, or because he is 'punishing' some

kind of earlier misbehaviour (identified or not) of the patient. Both greed and partiality are considered signs of a 'bad heart'. Indeed, a lot of people in Hanu secretly regard Tashi Bulu as greedy and miserly, and generally use the expression "power-man" ("*mi khar tak*") in a negative sense for him.

Apart from being the backlash of the *amchi*'s power to sanction, all this can, of course, be explained by what has already been said. Registering community land in his own name, Tashi Bulu certainly did not make friends in the village. The same applies to building a wall around his land, thereby obstructing an important footpath of the village, and to throwing stones after (other people's) animals grazing on his land. Also his attempts to socially marginalise Amchi Smanla – for example by insisting that the *lharngargu* (a special rhythm played by the Monpa as a show of respect) at the Losar festival is performed in his house instead of Amchi Smanla's house, as was the tradition – were strongly disapproved by the villagers. Due to the still considerable power through fear of Tashi Bulu, however, people never dared to protest or openly criticise him (see e.g. Tashi Thundup Dorepa's statement above). There are a few exceptions, but they are generally people who are not strongly involved in Hanu Gongma village life. Incidentally, this power also showed on one occasion when mischief was brewing against me in the absence of Tashi Bulu from the village. When we told him on his return (he was a little drunk and therefore less careful in what he said to me), he proudly said, "Now *I* am here!", implying that his presence alone would stop any evildoer. It is this kind of power of Tashi Bulu that people mean when describing him as a "power-

man". All this explains the accusation of a 'bad heart' through Tashi Bulu's own actions, that is, his own quest for, and use of, power. This represents the emic view of the Hanupa, and naturally has to be set into the analytic context of this study, using the integrated approach to power by giving equal importance to structural large-scale as well as medium and micro-level factors.

In solving one problem of *amchi*, namely that of income and decline of importance, Tashi Bulu has thus created another. However, we will see that this is less a personal problem for Tashi Bulu himself, as a problem for *amchi* medicine and medical health care in general in Hanu. As has been shown, the majority of people still feel dependent on Tashi Bulu, so while he is not well liked, he remains powerful and respected for the time being. Theoretically, the implications of an *amchi* having a 'bad heart' would be less patients going to him and therefore a loss of power and influence. However, the reality shows that this is not necessarily the case: First of all, through exactly the process which brought him the bad reputation, Tashi Bulu could secure his medical superiority in the sector of *amchi* medicine. Still, most patients who go to an *amchi* go to Tashi Bulu owing to that, thus indicating that in practice the connection between 'bad heart' and efficacy is less relevant to the people than in theory. However, it is not irrelevant altogether, because even if it does not cause people to switch to another *amchi*, it does cause them to resort increasingly to the biomedical health centre (see Table 3). This, secondly, is not perceived as a threat but a welcome relief for the *amchi*, who thus makes less deficit by giving medicine, as already explained above. Therefore, the 'bad heart' of

Tashi Bulu is not only an outcome of his attempt to make a living as an *amchi* in face of the changes in Hanu and Ladakh, but also continues in itself to benefit him financially.

Socially, as alluded to above, the 'bad heart' gives Tashi Bulu's role in the village a polarising effect. The tendency is increasingly such that only people on good terms with Tashi Bulu, that is, people who think he has a 'good heart', come to him for treatment, while those with gross relations with him either always went to another *amchi* anyway, or now go to the biomedical sub centre for medicines. Thus the common accusation, namely that Tashi Bulu only gives medicine to those he likes, comes true in an inverted way, not directly intended by him. This leads to a strengthening of relations between Tashi Bulu and those people who still come to him, and a deterioration of relations between Tashi Bulu and those who do not go to him. Furthermore, among the villagers, the factions of those who think Tashi Bulu has a 'good heart' and those who think the opposite (as already mentioned above) develop further. The same effect also lessens the general dependency on Tashi Bulu, since as a consequence of his 'bad heart' many resort to the sub centre and become used to biomedical treatment. Considering the inadequate biomedical facilities in Hanu, however, this means a deterioration of the health care situation in Hanu.

Gradually, with less dependency also Tashi Bulu's power through fear will decrease in future. Power through popularity will become more important, and in this context the reputation of having a 'bad heart' is problematic. This presents Tashi Bulu with two options for maintaining his power in future: one is to become popular and cre-

ate a reputation of having a 'good heart', and the other one is to create another kind of dependency on himself. The second option however is limited, especially because of the easier connections to Leh and the increased wealth of the Hanupa. I had the strong impression that less power in the future is not of big concern for Tashi Bulu. He has used his power to ensure his family's influence and wealth in the years to come, and also to ensure his own financial security by way of his sons, so that now there is not much need for it anymore. As he said, his "duty is done." Also the Hanupa attest him a loss of interest in matters concerning the village, and he is usually represented by his son on village meetings instead of going there himself. According to himself, now that his family is well set, his only interests are the practice of *amchi* medicine and travelling. Both of these interests require money, of course, and especially for travelling he needs more than he can ask from his sons. It is clear that he cannot use his power for his own financial advantage in the way he used to anymore. Therefore he thinks about setting up an *amchi* clinic in Khaltsi, or working in a Nomad *amchi* health centre. Doing this, he would cover two of his interests at the same time: practice *amchi* medicine, and earn money.

11. Conclusion

11.1. Summary: The study

This study has aimed to describe and analyse the social role of *amchi* in Hanu Gongma, by approaching the subject in a variety of ways. At first, the theoretical discourses in the social sciences, and particularly in medical anthropology, on the subjects of social role, social status, and power have been outlined and critically evaluated for the present purpose. More specifically, the literature on Tibetan medicine, both in form of medical-theoretical and historical sources, as well as in form of practice-oriented case studies, has been used to examine the social role of *amchi* in the various Tibetan areas, also outside of the TAR. In a next step, after a necessary description of the empirical research and its methods, the setting of the study has been investigated first historically, then in a description of the present situation of the Hanu area and the village of Hanu Gongma. Moving closer to the subject of *amchi*, the history of *amchi* medicine in Hanu has been presented in an effort to set a context for the subsequent analysis, and, in replication of the structure of the previous chapter, was followed by a general description of the contemporary practice of *amchi* medicine in Hanu, including short portraits of the currently practicing *amchi* there. With this extensive theoretical foundation and background information, the analysis of the social role of *amchi* could then be undertaken. Again, the approach used here was to move from general description and emic viewpoints to increasingly in-depth analysis and abstraction. Thus, a multi-factorial model of power was introduced

and explained in detail as the main analytic framework, which was further used in the final case study of *amchi* Tashi Bulu. This case study was to provide ethnographic substance to the theoretical as well as empirical-analytical points made so far, and served as an especially interesting example for the social dynamics (on a local scale) determined by a multitude of interrelated structural, regional, and local factors. Finally, this conclusion will at first summarize the findings and main arguments of the empirical part of the study focusing on the *amchi* of Hanu Gongma, and then, by way of concluding the book, discuss the dialectic between social and medical power, an underlying but recurrent theme of this research.

11.2. Summary: The social role of *amchi* in Hanu Gongma

Traditionally *amchi* in Ladakh have the highest social status among laypeople, due to their performing some of the most important functions in the village (healer, often with astrological competences). Medical power was automatically transformed into social power due to the *amchi*'s monopoly on giving medicine and the resulting dependency on them. This power was mainly used for ensuring income – and thereby their medical practice – by extracting *bsod-snyoms* (Ladakhi: alms) from the villagers, thus upholding a socially and religiously legitimised system of reciprocity. With the change of the economic, clinical, environmental, and socio-cultural situation, not only their social and medical powers are challenged, but also their social role has started to change (Pordié 2002).

Today the *amchi*'s social role in Hanu is shaped by their various strategies of coping with the new situation, which is mainly characterised by a loss of the *amchi*'s monopoly on giving medicine, the influx of market economy, and the connected breakdown of reciprocal relations with the villagers (Frankenberg 1980: 197). The decline of medical dependency on the *amchi* and the breakdown of old reciprocal patterns has made the practice of *amchi* medicine a deficit undertaking (Kuhn 1988: 51; Pordié 2002), forcing the *amchi* to look for other sources of income as well as to manage their resources more tightly. Here, the *amchi*'s new role as providers of free medicine, receiving outside support as government *amchi* and having to compete with the biomedical sub centre's free medicines, unfavourably overlaps with their old role, according to which they have the moral duty to give medicine to anyone regardless of sympathy or return. This composite role, in addition to the medical needs of the community, creates a pressure of public expectations on the *amchi* that they cannot fulfil, resulting in accusations of laziness (Pordié 2002), greed, or malice. In the search for other sources of income, an *amchi* may take advantage of his traditional high status and power connected to his social role, which still depends on his medical activities. This leads to competition among *amchi* for "*power, status, and turf*" (Nichter 1996: 369), in which they have to carefully equate the financial losses of their practice with its potential advantages. The *amchi*'s social role thus turns into a source of tensions among *amchi* and between *amchi* and community.

This dynamic is best represented by the case of *amchi* Tashi Bulu from Hanu Gongma. His strategy of maintaining his medical practice and establishing his wealth and power has caused his social role to emerge as multilayered and ambivalent: As the most competent local practitioner giving free medicine as well performing curative rituals, and as the most important astrologer in Hanu Gongma, he contributes substantially to the social health of the village. From the 1970s onwards, he managed to establish important social contacts by frequent visits to Leh and hosting official guests in his house in Hanu, taking advantage of his medical role. Through these contacts he gained, not always legitimately, material and financial benefits, which he used to attain medical superiority over the other *amchi*, who were marginalised in the process. Both the medical superiority and the resulting medical dependence on him, as well as his contacts to high people and the wealth that came with them, secured him the highest social power in Hanu Gongma. However, Tashi Bulu's strategy for acquiring the wealth necessary for a comparatively good stock of medicines was socially unacceptable and disturbed what social balance there was in the village. Jealousy, suspicion and accusations of greed and partiality in giving medicines are the result, which, true or not, undermine public trust in Tashi Bulu and his medicines' efficacy. On the other side of the spectrum, the other *amchi* in Hanu Gongma cannot afford more than a minimum of medicines, and thereby lose their medical relevance to the community. A situation of unequal access to *amchi* medicine arises, where only one well-stocked but controversial *amchi* remains, whose services are avoided by part of the community, and who in spite of his wealth would be unable to meet the demand

for *amchi* medicine alone anyway. Since people who do resort to Tashi Bulu naturally take sides and defend him against accusations from those who do not resort to him, the unity of the village, which the Hanupa see as fundamental for progress and social health (cf. Vohra 1989a), is damaged. It can clearly be seen how social tensions, arising from a combination of structural changes and local factors, are the main cause for the inadequate health care situation in Hanu and the peculiar situation shown in Table 3.

What becomes visible here is the central role that medicines, that is, *materia medica*, play in this array of processes. Lying at the interface of, and being dependent on, all factors outlined in the analysis of this study, they are a highly problematic object with considerable social relevance. Talking about medicinal plants, Laurent Pordié (2002) remarks that "*[t]hey mediate changes in the social world, are an expression of the culture and of the range of the challenges between tradition and modernity.*" The prevailing view among Hanupa about health care confirms the importance of medicines. According to my informants, good health care and the (medical as well as social) power and popularity of a medical practitioner generally depend on the quantity and quality of his medicines, which they see as directly linked to his moral and social virtues. While the first part of this statement is still valid, modern changes have, as we have seen, outdated the latter, so that the Hanupa are confronted with a contradiction between their theoretical, ideal conceptualization of medical authority as morally legitimated, and their perception of reality today. In the current situation of grossly unequal medical resources among the *amchi*, which has been inten-

sified by the above-mentioned demise of reciprocal relations between *amchi* and community, the factors for a good stock of medicines have been moved outside the medical sphere, where they were located until recently, and into the field of capitalist economy. The wealth of a Hanupa *amchi* determines the adequacy of his medical supplies, but is today not directly determined by his medical practice anymore. It has been shown how the struggle to obtain medicines under such circumstances, and the situation of unequal medicinal resources, lead to social tensions and unequal access to *amchi* health care in Hanu Gongma. Medical authority is still based on medicines, but not on moral legitimation anymore, if it indeed ever was. In a vicious circle, unequal access to health care is a cause in itself for social tensions, as the split of Hanu Gongma in two factions – supporting and condemning Tashi Bulu – shows.

11.3. Conclusion: The dialectic between medical and social power

The dialectic between medical and social power has actually already been described in dealing with the case of Tashi Bulu, albeit not explicitly. A short summary will therefore be given here by way of concluding this book.

It has been argued above that earlier, medical power was automatically transformed into social power through the *amchi*'s monopoly on allopathic health care and the people's dependency on them. Of course, the dialectic between the two kinds of power also took place on other levels. The religious dimension has been described in chapter 3.2.1., where the power to heal was connected with supe-

rior personal character and a communion with the Medicine Buddha, and other mechanisms like scripturalism and socio-economic developments have been dealt with in chapter 3.2.2. The collection of *bsod-snyoms* by the *amchi* in the old times not only served as an assertion, as a making-visible, of the medically derived social power, but also had the function to maintain both kinds of power by securing the necessary means to continue the *amchi*'s medical practice.

The generation of today's *amchi* in Hanu, however, lacked this means of asserting and maintaining power – and indeed their practice – from the beginning. This meant that they had to look for other sources of income for achieving this double end, with the added difficulty that any source not connected with *amchi* medicine was bound to undermine their medical power by preventing them to practice – and therefore prove – it. Tashi Bulu, as described at length, was the only one in Hanu who managed this, and he did so in a most elegant way: He actively pursued a new strategy of transforming medical into social power and *vice versa*, thus filling the gap left behind by the disappeared custom of *bsod-snyoms*, and established for himself a spiral dynamic upwards, starting from the general, theoretically and traditionally defined social role of *amchi* that he had from the time he took his *amchi*-exam (*thit*). This role enabled him to get into contact with officials who allocated resources, and through these contacts as well as his own hard work in Hanu he could achieve the wealth necessary to attain medical superiority in Hanu. Medical expertise on the one hand increased his reputation and status as an *amchi*, making more contacts with

higher officials possible, and on the other hand created medical dependency on him in Hanu Gongma. Medical dependency, as explained, is a strong and important factor for (social) power. Several observations should be made here: Firstly, we can clearly see how Tashi Bulu used medical power (at first only that inherent in his role as *amchi*) to generate social power, and then how he used the social power to increase his medical power, and again the other way round, thus giving the dialectic between the two powers the said spiral form, heading towards an ever-increasing degree of synthesis. Secondly, it has to be emphasised that this process was not, in its entirety, actively planned and carried out by Tashi Bulu. Just being an *amchi*, getting his education away from home, and being made to travel by his teacher, brought with it many of the preconditions, set into process many of the developments that lead to his present position. Indeed the situation in Ladakh and Hanu at the time of his youth can be seen as a crucial determinant for the strategies Tashi Bulu used, an analytic perspective also Godelier (1986) and Sahlins (1970) took in their study of big and great men. In this regard, the analysis offered in this book was committed to an integration of structural and micro-level ethnographic views, as reflected in the concept(s) of power used in it and its framework, thus avoiding both determinist and all-too-personal, agency-oriented extremes. Thirdly, it is interesting to observe how, while intelligently establishing the dialectic almost completely anew, on the foundations of the changed realities in Ladakh, Tashi Bulu still remained within the old framework of power through dependency and monopoly, and ultimately through fear.

Generally, we can say that once the social power of an *amchi* is established, his medical power is easily maintained, due to favourable access to the resources needed for adequate medical practice. However, Tashi Bulu's case poses a problem in this regard: By remaining in the old framework of power through fear, and by using a strategy that can be shortly characterised as 'what is not given anymore (*bsod-snyoms*) now has to be taken elsewhere', his social power can actually be seen as detrimental to his medical power (see chapter 10.3.2.). And yet, also in Hanu Gongma, pragmatism proves stronger than belief, at least in matters of health care, and good medicines prevail over 'bad hearts'.

In the end, a larger temporal perspective may set the processes described in this study into a more positive context. Tashi Bulu is getting old, and shows intention to withdraw from the struggles for power and wealth, since he has accomplished his goal. And this goal, it may well be, was not only to ensure his own medical practice, status, power, and wealth, but also to set the foundations of *amchi* medicine in Hanu for the future. The negative consequences of his social role on the health care situation in Hanu are not perpetuated by his two students, Skarma Stamphel and Tsering Thundup, who, thanks to Tashi Bulu's achievements and active help, do not need to follow new strategies to practice, or go against social norms as much as their teacher anymore. The present difficulties in Hanu, then, may – especially with skilful supportive interventions from NGO's like Nomad RSI – prove to be a passing, transitory phenomenon of *amchi* medicine's struggle to contribute its important part to the health of Ladakh.

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