



Global Pharma in the Land of Snows: Tibetan Medicines, SARS, and Identity Politics Across Nations¹

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Abstract

This article takes as its starting point the outbreak of the SARS epidemic in 2002–2003 in the People's Republic of China (PRC) to ask pertinent questions about the politics of identity in the Tibet Autonomous Region (TAR), and to connect these issues to the circulation of, as well as the social and economic value placed on, Tibetan medicines within China and abroad. We aim to connect the global pharmaceutical industry—including the ways it shapes science, disseminates knowledge, increases market demand, and influences clinical and social practice—to the production of Tibetan identities. We discuss dramatic increases in the production and sale of Tibetan medicinal products, specifically protective amulets, 'precious pills', and incense, during a particularly traumatic and widely publicised public health crisis in the PRC. These products clearly demand that we rethink the category 'medicine'. The popularity of these products during the SARS epidemic also points to the complicated positions of Tibetans and Tibetan cultural forms within contemporary China. What was it about these products that gave rise to the perception among Chinese and Tibetans alike they could 'save' or 'protect' people from contracting SARS. In more general terms, we ask if this exponential growth of the Tibetan medical industry in China—heightened during the SARS epidemic, but continuing apace since then—is allowing for cultural expression that highlights Tibetan uniqueness difference within otherwise contested social and political arenas. Or, is the global pharmaceutical industry in China in the process of encompassing and reformulating Tibetan medicine? Finally, we explore connections and distinctions between the rise in highly marketed Tibetan medicinals in China and their availability and appeal in the West.

Keywords

Global Pharma, Tibetan medicine, identity politics, precious pills, SARS, China

¹ This article is based on ethnographic data collected in the TAR (primarily Lhasa Prefecture) during and immediately after the SARS epidemic started, likely in Guangdong Province, China, in November 2002. The article is further informed by research that both authors have conducted, independently and collaboratively, between 2000–5 in the TAR and Qinghai Province, China, on epistemological and pragmatic exchanges between biomedicine and Tibetan medicine, and the translation of 'science' across cultural and geographic divides. The authors would like to thank the editors of *Asian Medicine: Tradition and Modernity*, Theresia Hofer, Martin Saxer, and two anonymous reviewers for their comments and constructive criticisms on earlier drafts of this article.

Introduction

The outbreak of Sudden Acute Respiratory Syndrome (SARS) coronavirus first in the People's Republic of China (PRC) and then globally between November 2002–July 2003 directly affected more than 8,000 people worldwide and caused 774 deaths.² This epidemic prompted an array of responses among China's citizens, from official government efforts at explaining, containing, and curtailing this public health catastrophe to more personal, informal reactions.³ At a time when national and international biomedical public health and epidemiology establishments were mystified and overwhelmed by SARS, many of China's citizens—from governmental employees and army cadres to private entrepreneurs and peasants—turned toward non-biomedical therapies as a source of protection from, and prevention of, this new virus. Many people relied on Traditional Chinese Medicine (TCM, *zhongyi*) for building up resistance to the disease, strengthening the immune system, preventing transmission, and even helping to treat the disease.⁴ Others embraced one of China's minority nationality (*minzu*) medicines: *Gso ba rig pa*,⁵ Tibet's 'science of healing'.⁶

The onset of SARS in the PRC marked an unprecedented increase in the domestic sale—and fame—of Tibetan medicinal products, specifically amulets, incense and *rin chen ril bu*⁷ or 'precious pills'. As evidenced by popular press reports during spring 2003, especially March–May,⁸ as well as one of the

² For a complete listing of WHO statistics for the SARS epidemic, see http://www.who.int/csr/sars/country/table2004_04_21/en/index.html

³ Kleinman and Watson (eds) 2005; Zhan 2005.

⁴ See 'Traditional Chinese Medicine Proves Effective Against SARS', People's Daily, 7 June 2003 http://english.people.com.cn/200306/07/eng20030607_117823.shtml and Dharmananda 2003 for overviews of the role of TCM in addressing the SARS epidemic.

⁵ Throughout this article, we follow the Wylie (1959) system for transliteration of Tibetan terms.; *Gso ba rig pa*, the science / knowledge of healing, *rin chen ril bu* precious / jewel pills, and *Sman rtsis khang*, Medicine and Astrology Institute. Chinese terms are transliterated in *Pinyin*.

⁶ The association of the term *Gso ba rig pa* with 'Tibetan medicine' is at once commonplace and something of an oversimplification. Practices and medical traditions that are identified by scholars and practitioners as iterations of *Gso ba rig pa* exist throughout the greater Himalayan ranges (Ladakh, Himachal Pradesh, Sikkim, and Arunachal Pradesh, India; northern Nepal; Bhutan), across the Tibet–Qinghai Plateau (Tibet Autonomous Region, Sichuan, Yunnan, Gansu, and Qinghai Provinces, China), in Mongolia and Buryatia, and in urban Chinese centres such as Beijing, Shanghai, and Hong Kong, as well as in increasing western locales. For a useful discussion of Tibetan medical plurality, see Pordicé 2008, pp. 4–5.

⁷ Aschoff and Tashigang 2001 provide a general introduction to precious pills. Hofer (this volume) discusses precious pills as an avenue into the larger question: 'Who has access to Tibetan medical health care in the TAR?'

⁸ See Radio Free Asia 2003; Saunders 2003; Associated Press 2003.

author's (Craig) ethnographic observations in Lhasa during this time, ethnically Han and Hui Chinese living in Lhasa began to purchase increasing numbers of these commodities. Lhasa informants asked to remember the event reported that 'The post offices in Lhasa were crowded with people—ethnic Tibetans and Chinese alike—sending packages of these products to friends and relatives in other parts of China.' In addition, Tibetan pharmaceutical companies' exports of these products to mainland China reached unprecedented proportions; in some cases sales increased to three times the normal level depleting supplies of otherwise plentiful products, particularly incense.⁹

The 'fame' of these medicinal commodities, which are often blessed or ritually empowered by Tibetan Buddhist teachers, is partly due to the fact that they are thought to confer protective qualities on those who consume or use them. As is the case with other Tibetan therapeutic practices, their potency is attributed not only to the perceived efficacy of the ingredients, but also to the fact that they are ritually imbued with *mantra*.¹⁰ As we will discuss in more detail below, one particular *rin chen ril bu* formulation was connected in popular discourse and Tibetan medical texts to the prevention of epidemics among Tibetan communities at other moments in history.¹¹ It is worth noting at the outset that the bounds around what *Gso ba rig pa* considers 'medicinal' includes therapies and practices that might be read as 'spiritual' or 'religious' in other cultural contexts (such as amulets and ritually empowered pills), as well as 'external therapies' like the use of incense to purify contaminated environments and address other health imbalances in individuals. As such, these particular types of products make us explore and expand the category 'medicine' with reference to Global Pharma. Global Pharma, in this chapter, refers to the pharmaceutical production, marketing and consumption of medicinal products, which in the case of Tibetan medicine, includes such varied things as amulets and incense as well as herbal-based compounds. Our inquiry is aimed at interrogating the culturally-complex intersection of the global pharmaceutical trade with local medicinal production, marketing and consumption. Global Pharma, in our usage and following its usage in other literature (Petryna, Lakoff and Kleinman 2006) refers to both the industry and the medicinal products themselves.

It is significant that many of the products that generated high demand by Tibetans and non-Tibetans alike during the SARS outbreak were being

⁹ Associated Press 2003.

¹⁰ Craig 2006, in Adams *et al.* (eds) forthcoming; Schrempf in Adams *et al.* (eds) forthcoming.

¹¹ This particular formulation is known as *ril bu dgu nag*, or 'nine ingredient black precious pill'. See Radio Free Asia 2003, Mazetti 2005 and TibetNet 2003, for specific references to this formulation in relation to SARS.

manufactured in the Tibet Autonomous Region (TAR), a location that has been increasingly viewed by cosmopolitan Chinese not simply as a political ‘hot spot’ or an economic ‘backwater’ in China’s otherwise growing economy, but as a place that could simultaneously fulfill Shangri La fantasies and signify Reform-era religious freedom on the ground.¹² Indeed, the SARS epidemic marked a significant break from official Chinese Communist Party rhetoric about the ‘backwards’ and ‘superstitious’ Tibetan ritual practices that had been discouraged in the scientific revival of Tibetan medicine, toward an overt embrace—at least for a time—of esoteric religious practices and ‘secret’ Tibetan formulas to protect against infection and bolster these products’ perceived efficacy. Surprisingly, this was particularly true among non-Tibetans as well as among modern, urban Tibetans—including Tibetan members of the Chinese Communist Party (CCP)—who have been resolute in their disavowal of such products or practices at other historical moments over the past 50 years.¹³

In addition to these accounts of exponential increases in the manufacture, sale, and consumption of Tibetan medicinal products to guard against SARS, as well as anecdotal accounts of these products’ efficacy among Tibetans and Chinese, another set of popular narratives coursed through the press and the streets of Lhasa during that spring of 2003. Were there SARS cases in the TAR? What measures were Chinese health authorities taking to prevent the spread of SARS to Tibetan areas? Despite official restrictions on travel into and out of the TAR, were individuals from heavily SARS-affected areas entering into Tibet? And, if so, what were they hoping to find there? Rumours circulated that they sought a high-altitude escape from the epidemic! A cure for SARS! Some wondered aloud whether or not Tibet was even susceptible to SARS. Did the region’s rarefied air, ultraviolet rays, cool temperatures, and Buddhist faith render it immune to this particularly virulent ‘Chinese’ epidemic?

Rather than read this phenomenon as a simple case of mass consumption and fear in the face of an epidemic, we ask in this essay: how might the popularity of Tibetan medicinals during the SARS outbreak be read as a map depicting the rather serious identity politics of Tibet and Tibetans within the PRC, as well as in relation to globalised pharmaceutical practices, or Global Pharma, originating in part in the United States?¹⁴ We aim to connect the

¹² As an example of this, we cite the continued increase of mainland Chinese tourists to Tibet (more than 2 million in 2007, according to the Xinhua News Agency) and the increasing popularity of Tibetan Buddhism among both mainland Chinese and Taiwanese (see Zablocki 2005).

¹³ Saunders 2003.

¹⁴ We should state at the outset that there exists a parallel and interconnected identity politics among producers and purveyors of *Gso ba rig pa* in the Tibetan exile community, specifically

global pharmaceutical industry—including the ways it shapes science, disseminates knowledge, increases market demand, and influences clinical and social practice—to the production of Tibetan identities. What was it about these products as well as the ecosocial and popular epidemiology¹⁵ of SARS containment across the Tibet-Qinghai Plateau, which gave rise to the perception that they could ‘save’ or ‘protect’ people from contracting SARS? In more general terms, we ask if this exponential growth of the Tibetan medical industry in China—heightened during the SARS epidemic, but which began before the epidemic and has continued to grow since then—is creating an avenue through which Tibetans articulate aspects of cultural difference through the idioms of medicine and science, within otherwise contested social and political arenas? Or, are Tibetan medicines being actively recast to fit within a frame that we might call Global Pharma with Chinese characteristics, and in the process further constraining Tibetan identity options in the contemporary PRC? Finally, what connections might we draw between the rise in highly marketed Tibetan pharma in China and its availability and appeal in the West? Through this portrait of Tibet and the SARS epidemic, we aim to illustrate Global Pharma’s nature and its capacities to negotiate not only ideas about efficacy and legitimacy of medicines but also social relations within and across national boundaries.

Defining Global Pharma

The presumption that we are living in a medical age dominated by what Law and others have dubbed ‘Big Pharma’ is relatively commonplace.¹⁶ From popular culture expressions, such as Michael Moore’s 2007 film ‘Sicko’ to the work of researchers/activists who advocate for global health equality around issues of access to drugs such as anti-retrovirals (ARVs), anti-malarials,

within the Men-tsee-khang, or Tibetan Medicine and Astrology Institute (TMAI) in Dharamsala, India. While it is beyond the bounds of this paper, and our own ethnographic data, to explore these connections here, we note here the relevant work of Samuel in Connor and Samuel (eds) 2001, Prost 2008, in Pordié (ed.) forthcoming and Kloos in Adams *et al.* (eds) forthcoming, as well as the current research agenda of Martin Saxer, a DPhil student in medical anthropology at Oxford studying the Tibetan pharmaceutical industry in both the TAR and India.

¹⁵ Nichter 2008, p. 3, suggests the need to widen the concept of epidemiology to more explicitly account for and study emerging and synergistic health problems, as well as new assemblages of people, social movements, and health care transitions that are shaping our understanding of ‘global health’ at conceptual level and in terms of lived experience.

¹⁶ Law 2006.

and tuberculosis treatments,¹⁷ as well as the scores of scholarly articles on the pharmaceuticalization of illness,¹⁸ we see examples of how drug production, marketing, regulation, access, and use are becoming globalised, and how they are, in turn, reshaping the ways individuals and collectivities define ‘well-being’ and understand and act on their experiences of illness.

Global Pharma is not simply about pills and profits; it is an index for biomedical scientific legitimacy, a means of invoking official sanction for the sale of medicines and the authority to make claims about what medicines can or cannot do in an international arena. Likewise global inequalities that emerge from and are reinforced by market-driven medicine present us with a ‘morass of economic and moral paradoxes’.¹⁹ Correspondingly, we take Global Pharma to be intimately connected to the industries of largely western government—and pharmaceutical company-funded research, specifically to how and under what circumstances such research is conducted and what becomes of its results.²⁰ The revolving door between industry and academy in the area of biomedical clinical trials in the global context is the first evidence of the linkage.²¹ The second has to do with the scientific discourse that flows in and around concerns about productivity and efficacy of medicines, on the one hand, and around the clinical research (and related publications) required to generate grants, salaries, laboratories, tenure, etc. on the other.²² These two spheres are often cast in such a way that they are strategically disassociated from each other; attempts are made by both academic scientists and pharmaceutical companies to keep science and commercial markets (and profits) distinct.²³ Yet Global Pharma meets academic capitalism more often than we might care to admit.

In this sense, we define Global Pharma as more than a commercial apparatus, tied to a variety of pharmaceutical companies that operate globally in the manufacture, advertising, and sale of medicines. Following Petryna and Kleinman, we see the ‘pharmaceutical nexus’ as illustrative of the ‘sheer scale and complexity of our interconnected world and its uncertain social and biological outcomes in local and national settings’.²⁴ Global Pharma operates at multiple

¹⁷ Farmer 2003; Biehl and Eskerod 2007.

¹⁸ C.f. Lakoff 2005.

¹⁹ Petryna and Kleinman 2006, p. 2.

²⁰ Petryna in Petryna *et al.* (eds) 2006; Adams *et al.* 2005.

²¹ Rasmussen 2004; Liebenau 1987; Healy 2000, 2002.

²² Wailoo 1997.

²³ Parascandola in Higby and Stroud (eds) 1990; Liebenau 1987; Healy in Petryna *et al.* (eds) 2006.

²⁴ Petryna and Kleinman in Petryna *et al.* (eds) 2006, p. 20.

scales and registers: political and economic, cultural and ethical. It is linked to agencies of knowledge production that operate within and between nation-states, as well as to claims about efficacy that emerge from within academic and corporate settings. Global Pharma encompasses efforts to standardise and regulate the production of drugs, as well as the biopolitics inherent in how clinical trials are designed and funded, how subjects are recruited, results are read, and ‘risks’ and ‘benefits’ are characterised in the context of research, marketing, and clinical use.²⁵ Moreover, we take Global Pharma to include, though not unproblematically, those same activities where they emerge from non-Western centres of science, such as the PRC, and also as they are articulated in relation to ‘alternative’, ‘complementary’, and ‘traditional’ medicines.²⁶ Of course, discussions about how to legitimise, sell, or gain ownership of non-biomedical pharmaceuticals in places like the PRC are intimately linked to discussions about the same issues in places like the United States, as well as through multilateral entities like the World Health Organisation (WHO), as they articulate policy for ‘traditional medicines’. Indeed, in the case of the PRC, many of the models for constructing such legitimisation, whether in the field of clinical medicine or commercial production, have come from the United States, as we shall explore in more detail below.

The scope of Global Pharma from the TAR to the FDA

Before delving into the specifics of Tibet in relation to SARS and the global imaging of Tibetan medicines to emerge in its wake, it is worth putting into perspective how and why this analysis of Tibetan pharmaceuticals has emerged for us as a site for critical inquiry. We have both had various opportunities to analyse and participate in the interaction of Global Pharma and Tibetan medicine in the context of contemporary Tibet; our involvement with a specific academic and US government agency-funded clinical research project is discussed elsewhere.²⁷ Suffice it to say that even when clinical research projects focus on Tibetan medicines that, at present, have little commercial value and are only used in clinical settings in the TAR, the challenges and appeals of Global Pharma still exist. The terms of negotiation for clinical research in the TAR and in other parts of the PRC have been set by national and international agencies and standards, from the US FDA and WHO to parallel agencies within the PRC and TAR governments. In addition, health bureaus at

²⁵ Adams *et al.* 2007; Petryna in Petryna *et al.* (eds) 2006.

²⁶ Adams 2001, in Nichter and Lock (eds) 2002; Langwick 2007.

²⁷ Adams *et al.* 2005, 2007.

national and regional levels, as well as drug registration and standardisation departments and departments of TCM—the general regulatory umbrella under which other minority medicines are placed—hold sway over how Tibetan medicines are produced and sold.²⁸ The power and influence of Global Pharma emerges every time questions arise about the ownership and rights to commercial sales for Tibetan medicine. This is particularly the case in the rare instance in which a clinical trial ‘proves’ the efficacy of the Tibetan formula in bio-scientific terms. It is equally true in the context of Tibetan medicines whose contemporary production is based on modern reformulations of ‘ancient’ recipes that are lauded by state and private commercial interests as ‘national protected traditional medicines’ but that now must conform with Good Manufacturing Practices (GMP) and the new ‘Pharmaceutical Administration Law’ of the PRC.²⁹ Only if a formula is produced to these internationally recognised manufacturing and safety standards can it enter into the Global Pharma arena. As of 2004, all Tibetan pharmaceutical factories in the PRC are required to meet these standards. Likewise, questions of ownership and intellectual property rights surface in this milieu, particularly in the domestic pursuit of drug registration numbers which allow commercial production and sale of Tibetan formulas both in China and abroad—where in some instances, such as the USA, they are marketed primarily as ‘nutritional supplements’ rather than ‘medicine’.³⁰ (In the case of the SARS outbreak in 2003, most of the *rin chen ril bu* (precious pills) and some of the incense and commercially produced amulets, were made in factories that had either already received GMP certification or were in line to receive certification by the following year.)

Discussions about which protocols to use in order to garner official national *and* international rights to such sales raise issues about the scope of Global Pharma as it intersects with the world of Complementary and Alternative Medicine (CAM) research, clinical practice, and consumerism. Whether these discussions occur in Lhasa or Beijing, Zurich, New Delhi or New York, concerns remain consistent: How to standardise quality, how to prove safety, and what constitutes a ‘robust’ research design? How large should cohort sizes be? How should control populations and randomisation procedures be determined?

²⁸ Fan and Holliday 2007; Craig 2006.

²⁹ Most of these formulas are *rin chen ril bu*. As Hofer describes in this issue, the production and manufacture of these medicines for commercial profit has increased significantly within the past decade and placed them out of the economic reach of many Tibetan consumers. See <http://www.gl-group.cn/en/aboutUS.htm> for a discussion of the production and marketing of these ‘national protected traditional medicines’ from the perspective of the Tibetan Traditional Medicine Pharmaceutical Factory in Lhasa.

³⁰ Adams 2002a; Craig 2006; TIN 2004.

What sorts of laboratory toxicity tests are acceptable (and to whom), and how many chemical and animal tests are needed to establish safety before these ‘traditional’ Tibetan formulas can be clinically tested on humans and, based on this outcome, marketed for commercial sale? Of course, this is not to mention the ways that marketing budgets—be they for biomedical compounds like Zoloft or Tibetan precious pills like *rin chen rat na bsam ’phel*—often greatly exceed, and are *expected* to exceed, the capital spent on research and development of new therapies.³¹

The Chinese standards for obtaining official sanction to register a traditional medicine are close to, but not exactly the same as, those used in the United States by the FDA and by the US National Institute of Health (NIH) and similar agencies elsewhere that fund much of the world’s CAM research. Likewise, Chinese standards closely reflect WHO regulations on the production of traditional medicines, but they still bear marks of national difference. And yet these differences still reinforce a hierarchy of knowledge, evidence and constructions of clinical efficacy that are based on biomedical standards reformulated for ‘integrated’ TCM with which China’s minority nationality medicines, including *Gso ba rig pa*, are expected to conform.³²

In the case of Global Pharma’s impact on Tibetan medicine, one of the most significant aspects of regulatory overlap between the US, China, and Tibet has to do with the introduction and enforcement of GMP, as well as and related to regulations on standardisation and ingredient sourcing. The Chinese GMP has been adapted from the US FDA regulations of the same name, as well as those stipulated by the WHO. These regulations detail how medicines should be produced, under what conditions and standards. They raise many issues about whose definitions of potency, efficacy, and safety should be adhered to—those described in Tibetan medical texts or those outlined in accordance with biomedical models of standardisation and ‘drug safety’.³³ The GMP includes specific guidelines in relation to Tibetan medicine, particularly around cleaning, drying and compounding techniques, as well as the removal of what Tibetans identify as ‘poisons’ from medicinal ingredients. These guidelines have been especially important in relation to the production of *Rin chen ril bu*, not only because of the high commercial value of these medicines, as we shall explore in more detail below, but also because they traditionally contain precious and semi-precious stones, plant and animal products derived from fauna today classified as rare endangered species, as well as purified and heavy

³¹ Lakoff in Petryna *et al.* (eds) 2006; Craig 2006.

³² Fan and Holliday 2007; Craig 2006.

³³ Fan and Holliday 2007; Craig 2006; Adams *et al.* in Adams *et al.* (eds) forthcoming.

metals, including lead and mercury, which are subject to Tibetan alchemical detoxification processes.³⁴

Practitioners and producers of GMP-approved Tibetan medicine we have interviewed about these issues have much to say about the ways clinical research on Tibetan medicine in line with GMP standards and Global Pharma designs ought to be done. Many of our interlocutors also raise concerns about how to make sure that the research will benefit them, both in terms of their reputation as participants in a scientific conversation about medical efficacy in an international arena, and in terms of potential profits from the sales of Tibetan medicines. Many Tibetans employed in the Tibetan pharmaceutical industry have also undergone extensive training in new GMP production methods; factories have taken on significant financial burdens through the renovation of their facilities to meet these standards and the increased costs of production according to these new standards.³⁵ And, despite the numerous epistemological and ethical concerns many Tibetan medicine producers have raised about the problem of translating Tibetan formulas into GMP-compliant products, the assumption is that such effort is worth the investment. Indeed, even as Tibetan medicines are becoming more difficult for individual Tibetan physicians to produce and prescribe, and Tibetan patients to afford, Tibet is 'looking to its traditional medicine as [an] economic cure'.³⁶ This is what Global Pharma looks like at the periphery.

Today, producers, clinical practitioners, and researchers of Tibetan medicine find themselves at the cutting edge of a growing consumer market for Tibetan medicines in the global arena.³⁷ The Tibetan pharmaceutical industry has begun to boom; it is a multi-million dollar industry. Official claims delineating the value of this industry range from approximately \$32.5 million in 2004³⁸ to \$53 million in 2005³⁹ of gross output. There are now 22 medical enterprises in the TAR, and more than 50 factories within the PRC, that are GMP-compliant, and that can therefore sell Tibetan formulas commercially within China and abroad. China has invested heavily in this process of bringing Tibetan medicine to market—an estimated 200 million Yuan (US \$27 million) as of May 2008.⁴⁰ The extent of this market, and its potential for national and international growth, was revealed during the SARS epidemic of 2003.

³⁴ Aschoff and Tashigang 2001.

³⁵ Craig 2006.

³⁶ Dickie 2004.

³⁷ Janes 2002; Pordié 2008; TIN 2004.

³⁸ China Daily 2004.

³⁹ Xinhua News Agency 2005.

⁴⁰ AsiaInfo Services 2008.

In summary, Tibetan medicine pharmaceutical industries in the PRC are transforming their production and marketing practices to meet the international standards of a globalised ‘Big Pharma’ industry. Yet it is important to note that these standards have arrived in Tibet along with investment capital and expertise from both mainland China and abroad.⁴¹ These investments are often necessary due to the high costs of constructing and maintaining GMP-standard facilities and the personnel costs associated with training new GMP and quality control ‘experts’. In turn, these new investments have meant that producers of commercially viable Tibetan medicines are engaged in fundamental shifts with reference to the prices, production methods, and intended consumers of their medicines. The desire on the part of Tibetan and Chinese investors and producers to market *Gso ba rig pa* internationally prompts local concerns and debates over the ways in which Tibetans working within in this industry should accommodate, or resist, such practices. This is the first site for an analytic of the identity politics of Tibetan pharmaceuticals. Aside from issues of cost, debates over the best or most ‘authentic’ recipes, the quality of ingredients, methods of production, and even ethical and ecological concerns about over-harvesting of medicinal plants point directly toward these larger issues of Tibetan identity mediated between local and global arenas.⁴² Even packaging and marketing methods are infused with concerns over the status of Tibetans and Tibet as political and cultural entities within the Chinese nation-state and diverse sites in the West. In this analytic, pharmaceuticals are the means by which a transnational politics of culture and identity is accomplished. We explore this dynamic below.

Our objective in describing this context here is to note the ways in which Global Pharma is constructed and operates in places like Tibet, and how these trans-national regimes of power and legitimacy have an impact on local and regional patterns of medicine production and consumption, as well as on the assigning of social and economic value to certain kinds of medicines over others. In the rest of this essay, we are interested both in the ways in which medicines become a means of deciphering identity politics in Tibet, as well as the ways in which these politics are structured in part by the dynamics of Global Pharma as an industry, as a set of international regulations, and as a force in scientific knowledge production. We now turn our analytic gaze toward the types of Tibetan medicinals that were in highest demand during the SARS epidemic, and which have also forged the greatest—and most symbolic—niche in the Global Pharma marketplace; namely, specific types of *rin chen ril bu*, as

⁴¹ Adams 2002; People’s Daily 2001.

⁴² Craig 2006.

well as incense, and amulets (including pills worn around the neck instead of ingested) that were thought to protect against SARS. Those events, as well as the statistics cited above, suggest that the market for Tibetan medicines is indeed global.⁴³ Part of their global appeal lies in their ability to ‘translate’ across the terrains of clinical research and popular epidemiology the notion that these ‘ancient’ formulas, marked, as they often were, with the signs of ritual efficacy and packaged to promote a Shangri La aesthetic, could be useful in the face of ‘new’ epidemic disease.

The SARS dynamic: Pure lands, precious pills, and idioms of protection

The outbreak of SARS in the PRC prompted a flurry of news stories about Tibet in the international community. Reporters from mainstream news sources and Tibet ‘watchdog’ groups and media outlets in India and the west worried about the safety of Tibet. Was SARS there yet? Were all incoming and outgoing travellers being sprayed with chemicals and having their temperatures taken? Were Chinese quarantine measures efficient? How many travellers were actually restricted from entry, and who were they? News reports questioned the validity of statistics about the lack of SARS in the TAR coming from within the PRC, and questioned the extent to which health care services were even capable of monitoring for the presence or spread of the disease within Tibet—given both the remoteness of much of Tibet’s population and dearth of rural health care infrastructure and reporting mechanisms.

During these tense months in 2003, such concerns were matched on the streets of Lhasa with stories about busloads of Chinese being allowed passage

⁴³ This is not to say that prior to the SARS epidemic there were no Tibetan medicinals being marketed abroad. Several TAR-based medical factories have already successfully negotiated the sale and commercial distribution of Tibetan medicines to other areas of the PRC, Europe, and the US. Although the ability to export these products as ‘medicines’ as opposed to as ‘nutritional supplements’ remains a transnational regulatory issue, the markets have begun to be tested. Such is also the case in Mongolia and India. At this time, only one European company, the Switzerland-based Padma Inc., is licensed to produce Tibetan formulas in the west. Millard 2008, pp. 190–5, provides a useful case study of how Tibetan medicines, produced in China or India, but restricted in clinical settings in the west, are being reconciled with UK and European law. In China, the Gansu Province-based Cheezheng Group and the Qinghai Province-based Arura Group are both currently marketing their products abroad. Cheezheng is the largest Tibetan pharmaceutical company; it markets products in 36 countries and, in 2003, the company began to cooperate with the North American retail giant Wal-Mart (Yao 2003).

into the TAR.⁴⁴ Word on the street and in some media sources⁴⁵ included whispers about ‘potential’ or ‘suspected’ SARS cases in Lhasa hospitals, although official cases remained at zero.⁴⁶ People pondered the logic of continued flights into Lhasa’s airport from mainland Chinese cities, even as official regulations barred entry to the TAR from foreigners as of 1 May 2003, including people from neighbouring Nepal, where the official SARS numbers remained at zero.

Tibetan clinicians with whom we spoke during this time, both those trained in western biomedicine and those trained in Tibetan medicine, vacillated in their fears about the threat of SARS in Tibet, to Tibetans. Some were concerned about the potential public health havoc that could be wreaked on rural populations, should the disease follow the same course as it had in other rural areas of China. Others, however, felt confident in preliminary ‘scientific reports’ produced both within China and abroad that suggested that the virus would be unable to withstand the intense ultraviolet radiation, dry air, and extreme temperatures of the Tibetan Plateau. Those Tibetans we interviewed who were involved in the health care bureaucracy were concerned not only for their fellow Tibetans but also for their own jobs, should the SARS epidemic spread to the TAR. Emergency 24-hour hotlines were established at municipal and county levels, and health bureau directors shouldered much of the responsibility for managing news and publicity and promoting public health measures to prevent infection.

Beyond this, both lay Tibetans and medical practitioners took comfort in their sense of the power of their medicines in repelling epidemic disease. Tibetan medicinal incense flew off the racks, and was cited by lay and clinically-trained Tibetans alike for its ability to prevent airborne contamination; the run on incense was so popular, in fact, that according to several officials interviewed at the Tibetan Traditional Pharmaceutical Factory of the TAR, depleted supplies threatened to impact rituals planned during the fourth Tibetan month (*sa ga zla ba*, May–June in the western calendar), the holiest time of the year for Tibetan Buddhists.⁴⁷ Small-scale, private incense producers as well as large, commercial factories increased output to meet heightened demand.

In addition to the surgical masks that became both officially required of hotel and restaurant staff and commonplace among private citizens, most

⁴⁴ Saunders 2003.

⁴⁵ C.f. Radio Free Asia 2003.

⁴⁶ Xinhua News Agency 2003.

⁴⁷ It is considered the holiest time of the year because it is the month during which the Buddha was born and also attained enlightenment (*nirvana*).

people in Lhasa could be seen wearing varieties of amulets around their necks. Fine, hand-sewn packages of indigo, black, and sunflower coloured silk were strung up for sale at kiosks around the Barkhor, or central Tibetan marketplace in Lhasa, particularly in front of the Sman rtsis khang or Traditional Tibetan Medicine Hospital. These *srung ba*, or protection amulets, were said to help prevent SARS contamination. Some sellers asserted that ritual specialists had blessed the amulets; others did not make such claims, but did a swift business anyway. Varieties of *rin chen ril bu* flew off the shelves, even at prices that were greater than their usual expense.⁴⁸ Some Tibetan medical factories began to produce scores of one particular pill known as the ‘black’ precious pill, or *ril bu dgu nag*, which is made with nine ingredients, each of which is associated with a particular deity. Another version of this pill, produced with seven ingredients, wrapped in black cloth, and worn around the neck as an amulet, was produced in great numbers by the Men-tsee-khang in Dharamsala, India.⁴⁹ In both cases, the medicine is not meant to be eaten, but is rather worn as an amulet, and was touted by Tibetan physicians and laypeople alike as a product that would help boost immune systems and guard against acquiring SARS.⁵⁰ Among friends and family members, privately made (and ritually blessed) amulets and precious pills circulated quietly, and were rumoured to be the most efficacious, since they were prepared most authentically, outside of the bounds of commercial factories and Global Pharma regulations. The increased attention paid by lay Tibetans to the power of their medicines was remarkable, in both sociological and economic terms.⁵¹ Of course, Tibetans in the TAR were not the only people turning toward the possibility that Tibetan medicine could help prevent the spread of SARS.⁵² The overwhelming lay and official Chinese response to Tibetan medicines—particularly products such as precious pills, incense, and amulets which bore some of the most overtly ‘religious’ markers—was novel.

⁴⁸ Radio Free Asia 2003.

⁴⁹ TibetNet 2003.

⁵⁰ Radio Free Asia 2003. It is worth noting that the concept of ‘immunity’ is a recent adoption within the Tibetan medical lexicon. See Gerke 1998 and Prost in Hermans (ed.) 2006 for notes on the incorporation of biomedical concepts into Tibetan clinical practice.

⁵¹ Although not significant to the overall thrust of this article, it is worth noting that the unique Tibetan commodity *yartsa gunbu* (T. *dbyar tsha dgun 'bu*, C. *dongchong xiaocao*, L. *cordyceps sinensis*), whose commercial sale has become a cornerstone of Tibetan rural economies in recent years, was touted during the SARS epidemic as a lung remedy, based on its usage in TCM texts dating to the 17th century (TibetInfoNet 2008).

⁵² China Tibet Information Center 2003a, 2003b.

Medicines and social practice: Pharmaceuticals as a site for identity politics

In reports that circulated globally during the SARS outbreak, primarily via Internet media but also through informal networks and Radio Free Asia broadcasts, one found a familiar set of political and cultural concerns that tell us something about how medicines can ‘contain’ and augment an identity politics that exceeds temporary epidemics. Popular images of Tibetan medicine that circulate in the West identify it as a resource for the ‘sacred’, inasmuch as Tibetan medicine is connected to Tibetan religious practice, specifically Buddhism.⁵³ The notion of ‘traditional’ Tibetan medicine is invested with its perceived ability to offer a holism that extends beyond mind and body dualisms so often associated with biomedicine to include things ‘spiritual’.⁵⁴ This connection between Tibetan medicine and a sense of overall ‘health’, including spiritual well-being, is pronounced at international conferences and in guest appearances by Tibetan physicians that invariably refer to Buddhism and to the ritualistic and religious aspects of Tibet’s ‘science of healing’.⁵⁵ In the advertisements for *rin chen ril bu* and Tibetan medicinal incense geared toward Western consumers (ironically, often through Chinese online herbal pharma clearing-houses), their connections not only to an ‘ancient’ medical history, but also to ritual practice and to the Medicine Buddha, are highlighted. Products manufactured at GMP-certified factories, as well as those made at monasteries such as the Jokhang and Mindrolling, are marketed together, and the fact that these formulas have been ritually blessed is mentioned.⁵⁶

This sensibility is promoted from a different perspective in the marketing of Tibetan medicinal products marketed directly from PRC-based Tibetan pharmaceutical companies. Rather than reference Buddhism or ‘spirituality’ directly, these marketing texts highlight the ‘ancient’ nature of the knowledge on which these formulas are based, and stress that they have been made in Tibet’s ‘pure’ high altitude environment.⁵⁷ Furthermore, and as a direct illustration of the effects of Global Pharma on *Gso ba rig pa* praxis, the directions

⁵³ Adams 2001; Janes 2002.

⁵⁴ Dhonden 1986; Dorjee 2007.

⁵⁵ We note the two conferences on Tibetan medicine (2000 and 2003, Washington DC) sponsored by Pro-Cultura as examples of this. The first conference opened with a speech by His Holiness the Dalai Lama, in which he pronounced that Tibetan medicine was not a ‘religion’ but a ‘science’ and was met with responses of disbelief and contrary opinion by a panel of US MDs who are considered experts in CAM research (Adams 2002).

⁵⁶ See <http://www.essenceoftheages.com/medking/medking1.html> for several examples.

⁵⁷ See <http://www.zy1696.com/EN/Product/01.htm> for one example of this strategy.

for use on these products are given in biomedical terms. For example, *rin chen rat na bsam 'phel* is described as an ‘ancient Tibetan preparation for cerebrovascular diseases such as sequela of apoplexy, cerebral haemorrhage, cerebral concussion, epilepsy, and hypertension’.⁵⁸ And, while it has value in the context of ritual offerings often mentioned on the packaging, Tibetan medicinal incense’s abilities to ‘purify the air, destroy harmful microorganisms, and prevent *epidemics*’ [emphasis in original] is highlighted.⁵⁹

In the United States as in China, this market for Tibetan pills, powders, incense, and amulets promises large financial rewards, especially on the nutritional supplement market, in which Global Pharma has come to play an increasingly important role. Consumers of alternative and complementary medicine are willing to pay large amounts of money, out of their own pockets, for non-conventional medicine.⁶⁰ This particularly includes those kinds of medicine that deal with individuals’ disaffection, mistrust or and disenchantment with biomedical approaches, and that speak to consumer desires for a more ‘holistic’ approach to healing. These trends, at once market driven and phenomenological, recall a desire to locate cures to the ills of modernity through what Harrington has dubbed ‘eastward journeys’.⁶¹ Until recently, fostering this image of Tibetan medicine as a holistic healing modality concerned with body, mind, and spirit has been the domain of the Men-tsee-khang in Dharamsala and related groups. Indeed, this notion that Tibetan exiles are the repositories for ‘authentic’ Tibetan identity, unpolluted by the Chinese communist regime, cuts to the core of how exile politics has been fashioned over time, and how, to a large degree, international sympathy and pledges to ‘free Tibet’ or ‘save Tibet’ have been constructed.⁶²

The ways this image of Tibetan medicine as a repository for the spiritual is negotiated and managed by the Tibetan exile community became evident in their news reporting during the SARS outbreak. The exile community placed great stock in sustaining an image of Tibet as a resource for things sacred and religious—yet available to a western audience, as well as something over which

⁵⁸ See <http://www.zy1696.com/EN/Product/01.htm>

⁵⁹ See the packaging for Jiumei Tibetan Incense, Qinghai Jiumei Tibetan Medicine Pharmaceutical Factor, Qinghai Province, PRC.

⁶⁰ Baer 2001.

⁶¹ Harrington 2008. Pharmaceutical companies are also as interested in distribution of non-Western medicines like Tibetan medicine through the nutritional supplement channels as they are in distributing through medical markets (see Adams 2001). Johnson and Johnson Company, for example, sees the potential for a market for Tibetan medicines, and had three representatives at a 2000 conference on Tibetan medicine held in Tibet (personal communication (Adams) with Johnson and Johnson representatives, Lhasa, 2000).

⁶² Kloos in Adams *et al.* (eds) forthcoming; Adams n.d.

the exile community had the spiritual patent. As one western watchdog organisation reported, during the SARS outbreak:

Tibetan traditional medicine (TTM) is inextricably linked with Tibetan Buddhism and also ancient Tibetan cultural patterns. Before the Chinese authorities took control of Tibet, Tibetan medicine schools were either monasteries or closely related to religious institutions, although there were also a number of lay TTM doctors. Following the economic reforms of the 1980s onwards, the Chinese authorities have focused on the revitalisation of this secular tradition of TTM, resulting in an emerging commercialisation of Tibetan medicine and sponsored by the state.⁶³

Wrapped up in this message was another semiotics bound up in the political cause of the exile government, as represented by international news organisations that aim to report on circumstances inside ‘occupied’ Tibet. Reports such as this reminded English-speaking readers that Tibet is a place that needs protection from the onslaught of Chinese secularism—a secularism that threatens to destroy the religious qualities of Tibet’s medicine as part of the denigration of Tibet’s cultural genius, particularly Tibetan Buddhism. This secularism is tied to the possibility of engagement with Global Pharma: commercialisation of medicines produced in Tibet, it is suggested, may cause one to question their authenticity and could limit their efficacy. However, this dynamic represents a moving target in the politics of culture. It is worth noting that such debates are also occurring *within* Tibetan areas of the PRC, and during moments when Tibetan medical practitioners from both the exile and Chinese communities have a chance to meet on ‘neutral’ territory.

The politics of producing Tibetan medicinal products that have, in both historical and contemporary terms, been tied to aspects of religious identity and ritual practice not only becomes complicated by the implementation of Good Manufacturing Practices and the like, but also because of the very modern machinations of intellectual property rights (IPRs) and patents: the general revisioning of the constructed value and material benefits of medical and pharmacological knowledge, on Global Pharma’s terms. Take, for example, the following passage in an interview with a Tibetan doctor from Dharamsala’s Men-tsee-khang that appeared at the time of the SARS outbreak:

Q. Pertaining to SARS, could you shed some light on the pill which the Institute (Men-tsee-khang) has made to protect against it?

A. We cannot divulge the full details of the pill. It has been mentioned in the scriptures that such dreadful diseases would occur in the future, and remedial measures were also suggested there. There are two options described: one is by chanting certain mantras and the other is by using a special pill that would keep

⁶³ Saunders 2003.

a person immune from these unexpected diseases. Since the success of chanting the sacred mantras is contingent on the level of one's spiritual standing, it has become difficult to apply this method during this age. We have therefore opted for the other, more feasible way of making the special pills.⁶⁴

One could read this reticence to divulge ingredients and recipes on the part of the Dharamsala Men-tsee-khang in several ways. Here, the lack of willingness to reveal ingredients must be understood within the context of the Indian state's IPR policies, the production of Indian pharmaceuticals, and the legal status of *Gso ba rig pa* in this context.⁶⁵ It might also be reflective of a sense of competition between the Men-Tsee-Khang and Tibetan pharmaceutical factories in China. With regard to IPR, however, one can note a similar dynamic among Tibetan pharmaceutical producers in China, where the quest for drug registration numbers (equivalent to patents) has become a key concern, involving intense financial and political investment.⁶⁶

In addition, the quotation above also points toward a secularisation of aspects of Tibetan medicine production that has less to do with the direct experiences of exile and Chinese occupation and more to do with the impacts of modernity, broadly conceived, on Tibetan cultural practices, be they overtly 'medical', 'spiritual' or both. Namely, do producers of Tibetan medicines have the time and resources to invest in the chanting of mantras, or would they rather consume or wear a pill?

As we can see, the efforts to sell Tibetan medicines both at a moment of epidemic and beyond in China, and as 'alternative' in ways that Western consumers desire, but with the accoutrements of drug safety and efficacy that are recognisable in Global Pharma's terms, involve a complex dance through identity politics and the socio-economic realities under which Tibetans live on both sides of the Himalaya. Marketing Tibetan medicines during a time of epidemic is also tied up with how all sorts of Tibetans conceive of their own history and culture, and the place of medicine within their politics of identity. Global pharmaceutical markets figure in the construction of Tibetan medicines here. And yet, due to WHO and FDA regulations and related regimes of scientific knowledge production, these potent formulas cannot be called 'medicines'. Here, biomedical hegemony is expressed as the potential to both capitalise on Tibetan formulas and, at times, criminalise Tibetan medical practitioners.⁶⁷ The possibility that representatives of Global Pharma might be recruited to legitimise the efficacy of these medicines in an international scientific arena

⁶⁴ TibetNet 2003.

⁶⁵ Pordié in Thomas *et al.* (eds) 2005.

⁶⁶ Craig 2006; Hofer (this volume); Tibet Justice Center 2005.

⁶⁷ Adams 2002.

remains secondary. This brings us back to the question of how such issues are negotiated in Tibet itself, and within the PRC in relation to Tibet.

The desire on the part of Chinese consumers to view Tibetan precious pills, medicinal incense, and amulets as a shield for SARS might also be read in terms of an identity politics that arises as a counterpoint or a political ‘corrective’ to the discourse about Tibet as a spiritual resource for the world and a place in need of saving, emergent within both the west and the exile community. Tibet’s reputation as resource for lost spirituality and lost culture—a narrative that draws from romantic images of Tibet generated in the US and Europe—is set against the historically dominant view put forward by the Chinese government about Tibet.⁶⁸ This view holds that Tibet in pre-‘liberation’ days was feudal, backward, and primitive, a place for the less-than-civilised. The Chinese government is quite aware of this discourse of the need to ‘save’ and ‘protect’ Tibet. In fact, in the post-Mao era, it has actively engaged this representation by trying to suggest that Tibet is, in fact, an environment that needs government protection.⁶⁹ Since the end of the Mao era and the reform and ‘opening up’ the PRC has experienced since the 1980s, efforts have been made with increasing vigour on the part of the Chinese state to reclaim Tibet’s religious and cultural heritage as a unique, precious resource not just for greater China but for the rest of the world.

Much is at stake in this counter-claim from within the PRC. In relation to medicine—particularly those formulas bound up in a discourse of ‘protection’—there is a question not only about who has access to these medicines but also who, in the political sense, ‘owns’ them and has the right to offer them to the international community as consumer products. This discussion is increasingly interwoven with deliberations about scientific efficacy in ways that are counter posed to marketing the spiritual, exotic and non-mainstream (read non-biomedical and not *exclusively* scientific) elements of these formulas and products in the west. And, here is where Global Pharma again enters into the picture, with Chinese characteristics.

Today the history of China’s socialist governance in Tibetan areas plays an important role in Tibetan negotiations for legitimacy, visibility, and market share in the field of Tibetan pharmaceuticals. Now counter discourses of Tibet as a place in need of protection, especially those emerging from Beijing, set in

⁶⁸ C.f. Lopez 1998; Dodin and Räther 2001; Brauen 2004.

⁶⁹ Examples of this political strategy include, but are limited to, the creation of wildlife and cultural preserves associated with Tibet’s unique heritage, such as cooperation in the UNESCO declaration of the Jokhang Temple and its surrounds as a World Heritage Site, the creation of ‘Shangri La’ in a Tibetan region of Yunnan Province, and the designation of the Chang Tang, Tibet’s northern plains, as a nature preserve—the second largest in the world.

motion a series of debates over the ways in which Tibetan medicine should be subjected to government policies and regulations pertaining to drug research and production. Practitioners ask how a scientifically legitimate, GMP-approved, and clinically acceptable form of these medicines can contain both the ‘ritually blessed’ and the ‘scientifically-proven’ standards that meet the demands of Global Pharma, and that would enable such products to be sold abroad as ‘medicine’. Tibetan medicine is asked to live up to both sets of standards, not just for Tibet but also for China. The SARS epidemic and the mass consumption of Tibetan medicines as prophylaxis during the SARS outbreak illustrate some of these dynamics.

Here, we turn to a more detailed discussion of Tibetan ‘precious pills’ and other anti-SARS medications: their ingredients, production methods, how they are meant to be consumed, and how they are perceived by consumers. We must examine the points at which these medicines’ places within the social history of Tibet and contemporary pharmaceutical production intersect. We must look at the points at which Buddhist morality and causality meet contemporary Chinese and Tibetan concerns with clinical efficacy and science.

Proof, potency, and a politics of efficacy

Producers and consumers of such medicines within the TAR and the PRC are actively discussing issues of potency in relation to ingredients. When Tibetans in urban Lhasa were asked to describe the kinds of medicines that were being sold *en masse* both within Tibet and to the rest of China to prevent the spread of SARS, they often began with disclosures about ingredients:

In Tibetan medicine, the *rin chen ril bu* are made from precious jewels, like turquoise and gold, and they prevent contagious diseases. In winter, one takes *grang sbyor* [one of the precious pills bought in great quantities during SARS] to prevent flu. It makes the body strong. It repels disease. It is very expensive, this medicine. Things that are expensive, that have expensive ingredients, precious ingredients, are known for their protective qualities. Tibetans wear expensive jewellery around their necks, and put gold on their teeth for the same reason. It will help prevent contracting diseases. *Grang sbyor* is made from the best quality of all ingredients: like the ‘cream’ of ingredients. It is known to give protection for diseases like this.⁷⁰

Several things are worth noting in this commentary. First, one should point out that aside from any sort of scientific ‘proof’ that such medicines are powerful repellents against epidemics like SARS, a moral certitude and

⁷⁰ Tibetan doctor D, personal communication, Lhasa.

historico-religious sense surfaces when describing these medicines. Epidemics like SARS have been prophesied within both Buddhist teachings and *Gso ba rig pa*. As indicated above, this is also a vision of Tibetan history and identity shared by Tibetans-in-exile. Second, it is significant that these medicines are expensive, and that Tibetans such as the person quoted above would associate the ability to buy protection in the form of jewellery with the purchase of protection in the form of these special pills. To eat a precious pill is not only, hopefully, to improve one's overall well-being, but also to accrue social and economic capital as well as in some ways reaffirm one's Tibetan identity. Of course, the question that often remains unanswered (and that is asked from a different point of view by Hofer, this volume), is: What if one cannot afford such protection? This same interviewee continued: The people in the rest of China wanted to buy so much Tibetan medicine. They know it is strong medicine for protection against this kind of disease. The Chinese medicine does not have this special kind of medicine, especially the medicine that has been empowered (*sman sgrub*).⁷¹

The 'empowerment' or 'accomplishment' of Tibetan medicines (*sman sgrub*) refers to the tantric ceremonies that infuse these already precious ingredients with a sense of spiritual accomplishment and power that, in turn, makes the medicine's inherent pharmacological properties even stronger. During a *sman sgrub* ceremony, powerful deities are called forth through ritual incantations (*sman sngags*) and by the reading of a particular text,⁷² the making of *gtor ma*, or ritual offering cakes, and the offering of butter, water, grain, and incense. Throughout the Tibetan cultural world, a *sman sgrub* ceremony either can be a private occurrence, sponsored by the medical practitioners who produced the medicines in the first place, or they can be collective affairs, in which this ritual blessing is not only imbued into special pills but also an experience of strengthening and purification of the entire community.⁷³

Today, many of the precious pills produced in today's increasingly technologised and mechanised GMP-standard factories in Tibet are not ritually blessed in this way.⁷⁴ Beyond this, many of these precious pills are no longer

⁷¹ See Hofer (this volume).

⁷² The text most often read is from the *Yuthog Heart Essence* (*G.yu thog snying thig*), and performers of *sman sgrub* must be in possession of empowerments (*dbang*) and oral transmission (*lung*) of this tradition. See Garrett n.d.

⁷³ Kind 2002; Craig in Adams *et al.* (eds) forthcoming; Garrett n.d.

⁷⁴ Since the late 1980s, private and government-owned factories have reinstated the practice of an annual *sman sgrub* ceremonies. However, according to interviews conducted by the authors, today's factory managers are often less inclined to believe that *sman sgrub* is important, and therefore less apt to push for the inclusion of this step in the medicine-making process if it is not politically expedient or logistically possible. In addition, while it might be assumed that precious

prepared in accordance with methods outlines in Tibetan medical texts. In the author's (Craig) interviews with producers of *rin chen ril bu* in the TAR, issues regarding the procurement of key ingredients such as semi-precious stones, problems with the use of heavy metals, and their elimination from contemporary formulations, were often discussed. Further, the lack of guarantee as to whether a mass-produced precious pill has been ritually blessed only can serve to add value (social and economic) to those pills or amulets still produced privately in Tibet.

In our interviews about the use of Tibetan medicines during SARS, discussions of potency were also accompanied by descriptions of efficacy and economic gain brought to Tibet during the epidemic through these medicinals. In these moments, people often invoked a different set of measures to establish potency. As one interviewee described:

Incense was used widely at this time. We believe that incense can clean the air and this helps prevent the spread of diseases. We also use amulet medicine (wrapped around the neck), called *smān nag po dgu bcu*. During the SARS, everyone used the incense *tsan den dmar po*, even more than the medicine *grang sbyor*, and the amulets. We know it provides protection because in that incense is the ingredient from the *tsan den* [sandalwood] tree. One professor from China showed how it has the ability to purify the air and prevent the spread of SARS. There was one village in Guangdong Province in which the family used this incense. Even though this village was located in the heart of the epidemic, the people in this village did not get SARS. This was reported in newspapers and on television. Suddenly, even in Tibet you could not get that incense. It was all being shipped out to the rest of China. At the Post Office, you could see day after day boxes of incense waiting to be shipped. It was very good for business here.⁷⁵

The empirical validity of claims to potency rest on ideas about scientific facts that circulate within versions of Global Pharma imported to places like Tibet, in part through regulations like the GMP. Tibetan doctors know that evidence of efficacy must be measurable in quantifiable terms. Entire villages that escaped the epidemic could be accounted for by the presence of the Tibetan medicine, so long as Chinese scientists validated the claims. In the case of SARS, such claims were backed by journalists who reported on the official version of this reading of scientific validation of traditional medicines in China:

Vice-Premier and Health Minister Wu Yi Thursday highlighted the role of traditional Chinese medicine in treating Severe Acute Respiratory Syndrome (SARS) patients and called for further recognition of the scientific value of the traditional therapy in the fight against the disease. During a symposium attended by

pills and other medicines produced in India are routinely ritually blessed, empirical evidence does not always bear this out.

⁷⁵ Tibetan doctor T, personal communication, Lhasa.

renowned traditional medicine experts in Beijing, Wu urged the active application of traditional medical resources to the anti-SARS fight and called for even greater dedication on the part of medical staff on the front line of the battle against SARS. . . . Traditional Chinese medicine experts have carried out researches on the SARS epidemic and combined traditional and Western therapies in order to develop new SARS treatment methods, said Wu, adding that the experience is of great value for further research and theoretical and technical upgrading.⁷⁶

As such, the effort to determine efficacy of Tibetan medicine in the Chinese context requires calling upon various discourses of validity. It is as important for the medicines to have been blessed—or for this possibility to exist in the minds of consumers—as it is for them to show their potency by sparing a village in the heart of the epidemic. Visions of Tibet that differentiate it from the rest of China are embedded in Tibetan perceptions that their medicines are more potent than those of other Chinese people because they have the ritual religious experts who know how to imbue these medicines with power.

Finally, we can consider the ways that estimates of validity and potency worked to express various concerns about the identity politics in and of Tibet. The place of Tibetan formulas within the SARS epidemic enabled Tibetans in the PRC to not only make claims about ownership and profitability in the sale of their medicines, but also to make political statements about Tibetan insights on China and what it means to be part of the PRC. Take the following excerpt from an interview with a Tibetan doctor in Xining:

This [the SARS epidemic] was good for Tibetan Medicine. . . . It was good for the reputation of Tibetan medicine, to show that many people can benefit from it. Also, Tibetan medicine helps explain this disease. In the *rgyud bzhi* [Four Tantras of Tibetan Medicine], it says that infectious diseases are a result of having committed bad deeds in one's life. People as a group, if they commit bad deeds, then the group will be affected by infectious diseases, like SARS. This is related to the prophecy in Tibetan scriptures of a time when all society will be in decline, when religion will be lost, and people will suffer from many diseases and bad luck. We believe that this disease affected China because of this decline.⁷⁷

From this perspective, SARS had appeared in China, because China was a place filled with suffering and bad karma, where improper ethical conduct, environmental defilement, greed, and a lack of religion ensued. Tibet remained SARS-free, such individuals noted, because Tibet was a land of the gods, a place where a fundamental adherence to the *dharmā* remained, despite decades

⁷⁶ *People's Daily* 2003b. In reading this quote in relation to *Tibetan* medicine in the PRC during SARS, it is important to remember that Tibetan pharmaceuticals generally come under the umbrella of TCM rules and regulations, and are considered one of many traditional medicine systems found within China.

⁷⁷ Tibetan Doctor from Xining, 2006.

of repression. In such conversations, popular epidemiology melded with the politics of Tibet Question in novel ways—particularly given the degree of consumer demand for Tibetan products and the immediate, if short-term, economic gains for some Tibetans in the process.

Here, we also see a dialectic of sameness and difference shaping Tibetan identity politics within the PRC. Not only were the Tibetans prepared for such an epidemic, but also their environment, their religion, their history all point to the fact that Tibet is indeed *different to* the rest of China—even as the Motherland stands to benefit from the potential for Tibetan medicine to expand into the Global Pharma arena. Add to this the fact that the TAR—a Chinese province whose budget remains heavily subsidised by the federal government in Beijing—actually donated a combined 2 million RMB worth of Tibetan medicine to Beijing, Shanghai, and Guangdong to support the fight against SARS.⁷⁸ With this act, the TAR was simultaneously able to reaffirm the value of its unique medical (read *cultural*) knowledge and promote a politically correct vision of Chinese unity and mutual support. This, too, bespeaks a particular identity politics meted out through the production and distribution of medicinals in the world of Global Pharma. Beyond this, during the SARS epidemic, Tibetans in Tibet—even those CCP chairmen and party secretaries who would otherwise disregard this aspect of their cultural identity—were given a legitimate chance to express aspects of their identity that at other historical moments would have been shunned as ‘superstitious’. Perhaps we could say that the liminality of epidemic time created an ambiguous space between the ideological bookends of ‘religion’ and ‘science’.

Conclusion

The international market for alternative and complementary medicines finds its way into this peripheral site—the Tibet Autonomous Region, China—as a complex set of demands that sets priorities for profit against scientific and national standards of safety and efficacy, and against claims to Tibetan identity and cultural capital. Herein, national guidelines for research and marketing of traditional medicines make visible the problems of Global Pharma in the alternative and complementary medicine field in and around Tibetan desires for cultural survival and economic opportunities. To sum up, Global Pharma is a complex set of networks, relations, and exchanges about the utility and efficacy of medicines as well as the ownership and rights to their profits.

⁷⁸ People’s Daily 2003a.

In the case of Tibetan medicines, it becomes clear that the dynamics of Global Pharma are negotiated in and through various cultural and social priorities, including geopolitical manoeuvres, identity politics, and ethnic relations. Medicine, as we have seen elsewhere, stands in as a useful tool in negotiating these social relationships.⁷⁹ We see how this discourse finds its way into local political posturing between Tibetans and the Motherland, as well as within a more globalised realm of Tibetan identity politics. As China tries to legitimise its indigenous medical practices, including Tibetan medicine, by way of a language of science, its citizens—in this case, Tibetans—continue to at once embrace and disrupt these efforts with claims about the sources of efficacy of these medicines. This takes place in conjunction with moral claims—couched in idioms of place and social practice—that distinguish self from other, Tibetan from Han Chinese. Moreover, the mass consumption of these medicines during a moment of epidemic becomes a useful means of reasoning through ongoing political relations between Han-centric national imaginaries and visions of China that grant a greater prominence to its minority nationalities. In the end, we suggest, it is these social and political relations that will enable ideas about efficacy and potency to be actualised as empirical facts, more so perhaps than the scientific endeavours to tabulate physical outcomes and rates of cure.

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⁷⁹ Whyte et al. 2003; Zhan 2001.

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