This chapter attends to contemporary developments in exile Tibetan medicine and conceptions of health. In particular, it focuses on the role of the Dharamsala Men-Tsee-Khang and Tibetan medicine in addressing problems of public health in the Tibetan exile community. In the first part of this article I explore the significance of the re-emergence of the traditional Tibetan medical concepts 'bu and sрин bu (‘germs’ and ‘parasites’) in the exile context. Germane to this discussion is the idea that certain concepts in classical Tibetan medicine are now being given new salience because of their compatibility with biomedical concepts. In the second part, I examine the notion that many prevalent exile diseases are construed as diseases of place: they are seen as resulting from the physical, social and moral predicaments of exile. This leads on to the argument that traditional Tibetan medicine is particularly apt at dealing with what could be called ‘diseases of exile’ because of its emphasis on localistic aetiologies, aetiologies that link diseases

1 Here I use the concept of ‘public health’ in the broadest possible sense, not as an aggregation of health indicators such as mortality or morbidity rates, but rather, and closer perhaps to its Tibetan understanding, as inherently socially defined and produced. The interaction between traditional Tibetan medicine and biomedicine in exile in Dharamsala is far too vast and complex a topic to be tackled here, and this chapter focuses principally on traditional Tibetan medicine as practised by the Dharamsala Men-Tsee-Khang.

2 In translations of the Rgyud bzhi headings, Men-Tsee-Khang doctors gloss 'bu as micro-organism and sрин bu as parasite, although further exploration of the popular use of these terms reveal that they have more complex meanings. The compound 'bu sрин is also sometimes used to designate insects or worms. Specific species of parasites are designated by adding compound syllables to sрин bu, eg. sрин bu kwa (maggots), or sрин bu mchu ring (mosquito).

3 Inasmuch as such a label may be considered valid. In this context it refers to the theory and practice of Tibetan medicine as outlined in Rgyud bzhi.

4 On this topic, particularly the emergence of diabetes (di ya bi tis), see Gerke 1998.

5 These are aetiologies that relate bodily states to place-specific environmental factors, especially climactic and seasonal changes. Such a localistic approach is discussed by Paul Unschuld (1985) in reference to Chinese medicine.
to organisms or spirits pertaining to particular places. This ability to offer means for the identification and treatment of diseases of exile is, I argue, at the core of the Men-Tsee-Khang’s success as a healthcare provider in the community.

**COMPLEX AETIOLOGIES AND THE POLITICS OF CONTEMPORARY EXILE TIBETAN MEDICINE**

From October 2000 to September 2001 I attempted to research and map out local understandings of health in the exile community of Dharamsala (H.P., India). This meant tracing the therapeutic trajectories of patients between traditional and biomedical care, for diseases ranging from *rlung* (wind) disorders to tuberculosis (TB). It also meant finding out how the social context of exile had affected the theory and practice of both traditional Tibetan medicine and biomedicine as practised in the local hospital. With this aim I interviewed patients and doctors both in the local biomedical hospital, i.e. the Delek Hospital (Bde legs sman khang), and at the Men-Tsee-Khang in Dharamsala. Many of these conversations revealed anxiety related to the spread of ‘infectious diseases’ both in the biomedical sense, as with TB—and in the popular sense, denoting a concern with contamination generally speaking.

In both biomedical and traditional settings, practitioners and patients commonly mixed references to parasites and bacteria with more religiously orientated explanations, mostly references to *las* (karma), and, albeit more rarely, to *gdon* (‘demons’). The following table shows the results of a survey about prevalent diseases compiled through interviews with 36 patients visiting the Men-Tsee-Khang and 38 patients from Delek Hospital, in which the patients were asked what caused prevalent diseases.

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6 The patients were not interviewed after clinical consultations at either institutions, so as to avoid reiteration of the doctor’s diagnosis. Each patient interviewed was asked about explanations for the whole set of disorders, not simply of the one’s which they had experienced.

7 The format of this table was deliberately chosen to enable comparisons with a similar survey conducted by Geoffrey Samuel (2001) in Dalhousie.