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EDITORIAL

In her editorial the editor of the former IASTAM Newsletter, Madhulika Banerjee, proposes to start a discussion on the widening of IASTAM's base. Banerjee argues that because of the rising popularity of Asian medical traditions the need of the day is to tell the world about the researches done by the scholars who up to now have been the backbone of our organization that was established in the 1970s by A.L. Basham (The Wonder that Was India; A Cultural History of India) and Charles Leslie the editor of two influential volumes on Asia's medical traditions (Asian Medical Systems, Paths to Asian Medical Knowledge). Both scholars analyzed medicine as a cultural activity and argued that our understanding of Asian medicines would benefit from a analysis of the historical, cultural, social and epistemological context by which they are shaped. Indeed all forms of medicine, as well as any other knowledge system, are informed by specific social relations, ontologies and epistemologies. Banerjee rightly argues that the time has come to seek a wider audience for the scholarly findings of over thirty years of research done by philologists, social-historians and anthropologists. She suggests that with the proliferation of goods and services related to medical entities such as Traditional Chinese Medicine (TCM), Ayurveda and Tibetan Medicine - the three traditions that have been the most successful in exporting their commodities and knowledges - the time has come to seek collaboration with other players in fields such as public health policy, regulatory bodies, non-government organizations like those of consumers, practitioners, educators and manufacturers. The first issue of IASTAM's forthcoming magazine, Asian Medicine-Tradition and Modernity, is a concrete example of this strife to enlarge IASTAM's base. The periodical which will appear twice a year tries to get practitioners of the different streams of Asian medicine interested in IASTAM and its activities among which the organization's international and regional conferences hold a prominent place. The sixth International Conference on Traditional Asian Medicine (ICTAM 6) will be held in April 2006 in the USA (for information on this conference and on IASTAM's new magazine see further onwards in this Newsletter.)

When we succeed in drawing the interest of a wider range of stakeholders to IASTAM and its activities questions such as who and what does IASTAM represent and what are the organization's objectives, will become more acute. We all have to address these questions. A related issue is to see if we can agree upon at least some common ground on which we built research, policies and practices. If not we will end up with a 'epistemological carnival' (Cohen 1995) making transparent communication and presentation difficult. In the meanwhile the IASTAM Newsletter will continue offering a platform for informing each other on our research work and related activities such as the organization of conferences and symposia. In this issue Simon McGarvie tells us about the practices of North Indian hakims, physicians who get their legitimization from a common Greek-Islamic-Indian legacy. McGarvie's contribution is interesting because of two reasons. Firstly he draws our attention to a Asian medical tradition which has been underexposed. Secondly, McGarvie mainly writes about practitioners belonging to what is aptly called the non-codified stream of Indian medicine which consists of practitioners having gained their knowledge through apprenticeship. The article is followed by the usual items that make up our newsletter such as conference announcements and reports, descriptions of work in progress and book reviews.

Maarten Bode
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Hakims of Far North-West India

Simon McGarvie

Late in 1998 I traveled through several regions of far north-west India in search of alternative medical practitioners. I hoped simply to learn something of them and their medical ideas and practices. The response to my interest was overwhelming, both from local laypeople and academics who provided information and leads, and from the medicos themselves. More than once I was told, 'You are our messenger to the world!' In the regions of Ladakh, Kashmir, Jammu, the Punjab and Himachal Pradesh I interviewed dozens of vaids, hakims, homeopaths, bonesetters, pirs, gurus and snake healers. The following excerpt focuses on hakims and comes from the much longer complete article at f2.pg.briefcase.yahoo.com/simonmcgarvie
With an emphasis on those without formal qualifications, especially older practitioners, the descriptions below provide glimpses of hakims among the great variety of medicos practicing in north-west India on the eve of the twenty-first century.

What is a Hakim?
Mohan Singh Vaid, the nineteenth-century Sikh poet, writer and social reformer who established the family medical practice Mohan Singh Vaid and Sons, learned his art from a medical practitioner he met by chance on a morning walk in the Punjabi village of Pedi, a few kilometres from Tarn Taran. The young, recently qualified vaid Dr Avilochan Singh described his great-grandfather's teacher as a hakim. That a vaid so highly regarded in the region's history could be said to have learned his art from a hakim was an indication of the variety of meanings accorded the two titles. Many of those interviewed maintained that the distinction between vaid and hakim was purely linguistic. Som Nath Vaid, an 85-year-old who worked from a dispensary located in the Shalimar area of the Old City of Jammu, said that Urdu speakers - in general India's Muslims, estimated to be approximately a quarter of the country's population -

would tend to use the title hakim, whereas Hindi speakers would use the term vaid to describe the same medical practitioner. Pandit Puranjan Sharma, a long-serving vaid in the village of Mera, in the Jammu region, who had gained his complete knowledge of medicinal herbs in just one and a half months from an educated saint, also saw the use of either vaid or hakim simply as linguistic convention.

The word hakim could also be simply a caste name. Kashmiris said there were whole villages where most inhabitants were named Hakim, even if few of the villagers would be considered medical practitioners. Throughout Kashmir villagers popularly regarded any old man with a long, white beard as a hakim, someone who by virtue of his long life was thought to have acquired the necessary wisdom and knowledge, both medical and spiritual, to treat illness. Expressing another common view, a senior allopath in Jammu insisted that a hakim was strictly a herbalist. For the highly qualified hakims practicing at Kashmir's premier Unani outpatients department at the Regional Research Institute of Unani Medicine in Srinagar, a real hakim held the five-year BUMS degree, the Bachelor of Unani Medicine and Surgery. A student studying for this degree in the city said that she would have no hesitation in applying the theory and practice of both the allopathic and Unani medical systems after she had graduated.

Andrew Dalgleish, the young Scottish adventurer and trader who traveled extensively in the western Himalayas in the nineteenth century, was called hakim by local people because he carried medicines, allopathic in this case, which he distributed to the communities he visited. Likewise, the Scottish medical missionary Elmslie, who in each of three consecutive years in the mid-1860s travelled via the villages en route from Lahore to Srinagar, was announced as a hakim even though he practised as an allopath.

The wide variation in qualifications and approach among those practising as hakims both in earlier times and today reflects a similar variation seen among vaids. But while such variation has allowed medical practitioners to create innovative approaches to healing adapted specifically to local conditions, such individualism is believed to be one factor hindering the development of traditional medical systems.

In Unani the ideal of a real hakim was - and, for some, continues to be - a court-based man of great wisdom, as much philosopher as physician, who had learned his art apprenticed to his father or another male member of the extended family. At the end of the nineteenth century the revered Hakim Ajmal Khan took steps to replace this traditional familial system of apprenticeship with a system of formal, standardised education for hakims. His father and older brother had already founded the Madrasah Tibbya in 1883, officially inaugurated in 1889, which offered a formal three-year degree course. By 1900, 65 students had completed their studies and were awarded degrees.

In the mid-1800s a British administrator by the name of Mercer trained Punjabi village hakims in the basics of allopathic medicine so as to provide more widespread medical care in the region. But no matter how well intentioned his programme, it was never designed to promote hakims as practitioners of Unani medicine, for he envisaged that they would gradually be converted to the exclusive practice of allopathic medicine. In the face of opposition from professional allopaths in the Punjab the hakim programme was brought to a close by 1880.

The Mongols centuries ago, the British in more recent times and nowadays quacks are all said to have hindered development in traditional medical systems. But Jammu and Kashmir's first qualified hakim in independent India, Hakim Tahir Mufti, a former state director of health and now the principal of Srinagar's Tibbya College, said that Indians had never tried to understand their own medical systems. Until 1947, vaids and hakims had a common cause in fighting the allopathic orientation of medical policy under the imperial British administration. But even Hakim Ajmal Khan's attempts to unite vaids and hakims as a force in medical practice had ended in disagreement.

In an echo of the declaration by a Gujar settled on Jammu's Tawi Island, that there are no real vaids left, some Indians, such as a senior Kashmiri journalist in Srinagar, said that there are no real hakims left.

In academic circles today a hakim is commonly defined as a medical practitioner who practices Unani, while a vaid practises Ayurveda. But in north-west India there was a whole spectrum of physicians of sharply differing qualifications and practices who called themselves hakim and who were recognised and consulted as such by the local population, as the following select examples illustrate.

Practising Hakims

Hakim Sardari Lal Sajgotra, practicing in the heart of Jammu city at Koda Hai's, a clinic named after his recently deceased father, was a traditionally trained hakim. A slim and fit man for his forty-seven years, he was dressed in a pale-brown, lightweight two-piece suit and wore a closely trimmed greying beard. He was the seventh generation of a family tradition started when his ancestors had begun acquiring medical skills from other men in their village. At the time of Partition his family had migrated from Sialkot, now in Pakistan. He was training his son to carry on the same medical tradition in Jammu. Although not formally qualified, he owned several old, hand-written books. Written by his predecessors in Sanskrit, Hindi, Urdu or Arabic, the name of each disease appeared in red script, the diagnosis and treatment in black. Despite the various languages used, he confirmed that the books were strictly Unani medical texts. They included images of medical implements such as knives and syringes. (In one of the books there were also several loose cards bearing images that might have been from the Kama Sutra. It was suggested, a little tongue in cheek, that they might be used for marriage counselling.) In 1996 he was awarded 20,000 rupees by the Government of India for the books' preservation.

After many years' practice he seldom used them, the knowledge now second nature. He also said that he was not a teacher and hence was not in a position to teach young people studying Unani in colleges today. He treated mostly skin diseases and sometimes jaundice. After diagnosis he usually gave his patients medicines he had prepared himself and mixed with a dairy product, typically butter. Many of his medicines he created by trial and error. He mixed them from raw ingredients bought in

local markets or Delhi, or gathered in the nearby forests, grinding them with mortar and pestle. One of his great successes had been to create a remedy for skin allergies that began to appear in the 1970s when foreign grasses were planted in the area. He didn't trust commercially produced medicines, concerned as he was about the property-changing effects of high-speed machinery used in production.There were few restrictions in Unani, he said. He tended only to caution patients against excessive intake of fat and salt. He also treated sciatica, abscesses, anal fistulas, piles and carbuncles. For sciatica, for example, he would cut the patient's leg with a very old pocket knife stamped with the date 1886, before inserting a paste and covering the wound with a bandage. He did not attempt to treat cancer, heart disease or orthopaedic conditions, referring such cases to an allopath. Allopaths also referred patients to him. His charges were nominal.

In the Punjab, Hakim Abdul Shakoor was the first in his family to be a hakim. A hakim, he said, was a practitioner of Unani, while a vaid practised Ayurveda. A short, lean man dressed in a khan suit and a white Muslim cap, he was originally from Uttar Pradesh. As a young man, he became interested in Unani while watching hakims treat patients, and decided that he too wanted to help people. He thought that a college education was necessary today, and owned several textbooks himself, but he had learned the rudiments of Unani from his father. He had no apprentice. To diagnose a condition he established the patient's history and performed an external examination. He would check the pulse, abdomen, chest and heart, just like a modern doctor, he said. He would also look at the colour of the person's urine and eyes. If he was unable to diagnose a problem on this basis he would send the patient's stools for modern scientific analysis. Working from within a pharmacy in the busy pharmaceuticals trading quarter in Amritsar, he used both Unani and Ayurvedic herbal remedies, often those produced by the huge Unani medicine manufacturer Hamdard. While he charged for medicines, consultations were free. He did not perform surgery of any kind. He believed allopathy and some of its medicines could produce undesirable side effects and were not effective in treating some diseases, such as diabetes. In addition, although believing money rather than the desire to help people motivated most allopaths, he referred patients he could not treat to practitioners of allopathy. As modern life was becoming increasingly fast-paced, he explained, patients sought the immediate recovery offered by allopathic cures. As a consequence, he typically treated older people suffering from catarrh, colds and rheumatism, and those with chronic conditions an allopath was unable to treat. A great many of his patients suffered from sexually transmitted diseases. In the final analysis, he wished to offer patients both medical treatment and, as he termed it, God's blessing.

Pandit Manoharlal, short in stature and dressed simply in grey slacks, white shirt and rubber slippers, was a 75-year-old who for half a century had dispensed herbal remedies to his customers. For the last twenty years he had done so from the roadside opposite Khalsa College on the Grand Trunk Road in Amritsar. Born in Lahore, he came to India in 1947. As his formal education had finished with primary school, he had learned his trade from his grandfather. His dispensary of sorts consisted simply of two wooden benches and two wooden boxes stacked with glass bottles labelled in Urdu. He also owned a book about Ayurveda, written in Urdu and published in 1962. Calling himself a hakim, he believed there was no difference between Unani and Ayurveda. The conditions he treated included indigestion, sex diseases (including impotency and leakage of semen with urine), skin diseases, which he believed to be a manifestation of all illness, respiratory complaints such as asthma and coughs, and diabetes. Whatever the ailment, his treatments took time.

In Kashmir, Gulam Kadir Rishi, a slim sixty-year-old wearing a flowing brown gown, a long white beard and the simple white Muslim cap, practised in a large room in his house in the village of Dhara Sadpur. In the corner furthest from the door he sat cross-legged on the only furniture, a small square wooden platform on legs raising it a short distance above the floor. From the age of fifteen he had squeezed beside his father on the same platform to learn the methods he now applied in his clinic. He was the third generation in his family to be a hakim, his grandfather having learned the art from a holy man visiting from Kabul. He was now training his own son. He was an expert in snake bites. He estimated he had treated more than five thousand of them in an area extending to a radius of one hundred kilometres from Dhara. Many of his snake bite patients were soldiers serving with the Indian army. On Sundays the spacious room was filled to capacity with patients suffering from jaundice, another of the hakim's specialities. (He also visited jaundice patients in Srinagar's hospital once a week.) Three-quarters of his patients suffered back complaints. He attributed this to both the inadequate warmth provided by concrete housing during the cold winters and, in the case of women, wearing high heels. Treating one young girl for scabs and infection where her upper arm rested against the skin below her armpit, the hakim produced a large fold-out knife and waved the blade back and forth above the injury, blowing regularly on the affected area. When sick, many Kashmiri villagers blow intermittently on a glass of water while reading the Koran before drinking the water to cure themselves of an ailment. They also wear amulets bearing inscriptions from the holy book of Islam, and sometimes eat similarly inscribed paper amulets soaked in water. Gulam Kadir Rishi's materia medica consisted of natural substances alone, mostly herbs gathered in the surrounding forest rather than bought at a market. He prescribed no other kinds of treatment, such as visiting curative springs - which exist in Kashmir - nor did he, in spite of his knife, perform surgery or use implements of any kind on the body. He was to a large extent a faith-healer. As a hakim, he said he worked through religiously inspired medical means. As a pir, he solved medical problems by religious means alone. He used no text books, his knowledge acquired entirely in the clinic from his father. When asked how he performs diagnosis his response was immediate: 'The face is the index of a man'. And although his patients were exclusively Muslim, a patient's particular faith was not a factor determining the success or failure of a treatment. Paraphrasing the most basic tenet of Islam, he said there is only one God, that 'God is one'. Gujars, who constitute an estimated one quarter of

Jammu and Kashmir's population, spend the hottest months high in the mountains in the north of the state. With the approach of colder weather in September they drive their buffalo, goats and sheep down into the Himalayan foothills or, in a development in more recent years, onto the fringes of the plains. During the migration they resort to several sources of medical care. Gujars just arrived in Purmandal - after a two-month journey on foot with a group of more than a thousand and their combined livestock from land around Panikhar, near Kargil, in Ladakh - said that en route south to Kishtwar and then south-west via Udhampur they visited small dispensaries for medical problems. For minor ailments such as headache and diarrhoea they bought medicines from shopkeepers along the way. Gujar hakims, whom they also referred to by the Muslim religious title of mulvi, travelled among them, treating many ailments. Like Gulam Kadir Rishi and many other Muslims, the Gujar hakims would blow on the affected area of a patient's body, the holy exhalations thought to have curative properties. Gujars also wore protective amulets and chanted hymns from the Koran to ward off illness. Gujars also resorted to bonesetters for breaks, sprains and dislocations. They described an instance where a Gujar bonesetter had reset an Englishman's shoulder, dislocated while the visitor played the physical game of kawadi with them. Where possible, though, especially when settled near more modern facilities such as the government's public health centre in Purmandal, they would consult what they called an Angrezi or private doctor, a practitioner of allopathic medicine.

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Announcements

'Asian Medicine Tradition and Modernity', IASTAM Regional Conference, London 2nd December 2004

This conference is being held to celebrate the new journal of the society of IASTAM (The International Society for the study of Asian Medicine). It will also coincide with the exhibition of Asian medical manuscripts from the Wellcome Library: **ASIA: MIND, BODY, SPIRIT at SOAS Brunei gallery [13 October - 12 December].**

Members of the IASTAM board and other scholars from a range of different backgrounds will give lectures on historical, anthropological, sociological and iconographic dimensions of Asian medicine as well as practice reports from practitioners working in the field.

Places are limited, so to avoid disappointment, please apply as soon as possible. Please See Page ?? for futher details.

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Notifications

'Hybrids and Partnerships: Comparing the Histories of Indigenous Medicine in Southern Africa and South Asia', UK Conference, 15 & 16 September 2005.

(For more information contact the email address mentioned at the end of the announcement.)
Cross-fertilisation of knowledge and practice between southern and eastern Africa and South Asia has for centuries linked the geographic, economic and cultural region around the Indian Ocean. Bringing together new researchers and established scholars, this conference will explore the dynamics of this association through the medium of medicine. We will examine historical interactions among healers and bodies of healing knowledge in Africa and South Asia to achieve a greater understanding of situations in which medicines blend, practices hybridise and practitioners form partnerships across diversity and division. We will also examine cases where the reverse happens, where boundaries are affirmed or created, leading to plural and/or hierarchical systems marked by rivalry and the dominance or suppression of healers and healing knowledge.
The historical links between Africa and Asia have long been recognized. From antiquity this has included the spread of humoural medicine from the Mediterranean to South Asia and eastern and southern Africa. The long-term evolution of Swahili medicine as an Asian/African hybrid; the Tantric and alchemical traditions of India, which had interacted with Tibetan traditions; the spread of Portuguese Catholic ideas about the body and healing from the coasts to the hinterlands of southern Africa and South Asia and the diaspora of African ngoma healing in the Old and New Worlds are the result of similar migrations. Today, significant exchanges take place between

Africa and South Asia in the realm of pharmaceutical development, production and marketing, as well as in the education and migration of practitioners, in both biomedicine and indigenous medicine. Concerning more recent trends, we must also pay attention to nationalism, development plans and national health care programmes, which have often determined the nature of patronage for particular traditions, as well as the essentialisation of some traditions as 'alternatives'.

The conference will focus on the ways that local knowledge travels, both geographically and epistemologically. We will attempt to uncover the globalising aspects of indigenous medical systems and their ability to absorb and transform other healing traditions, other sciences, other practitioners and other bodies of expertise, even those of Western science and medicine. This will usefully displace biomedicine from its centrality in our accounts, encouraging a shift of perspective towards histories that put other forms of healing practice centre stage. We hope this will lead to ways of telling history through dramas of illness and recovery, disease and death that are meaningful in other cultures and societies.

The conference will focus attention on types of indigenous medicine and on geographical areas previously underrepresented in the literature on medicine and healing, while not neglecting lesser-known partnerships and hybrids between so-called modern and traditional forms of Asian, African and Western healing. This is the third in a series of ground-breaking conferences on indigenous healing to be held in Oxford. The Wellcome Trust has played a pivotal role in promoting studies of Western and indigenous medicine and their interactions in Africa and South Asia. Previous conferences sponsored by the Trust and the Journal of Southern African Studies have helped to develop this emerging field of research.

Themes: Formal and informal economies, trends in development and democratisation and their effects on the emergence of new forms of indigenous healing and their relationships with other forms of healing; Humoural medicine, Swahili medicine, Portuguese Catholic medicine - early influences on indigenous forms of medicine in Africa and Asia; Healing and 'locality': globalisation of indigenous healing expertise versus localisation of 'global' forms of scientific, alternative and 'exotic' medicine; Alternative forms of history, healers' histories, African and Asian patients' narratives; Making and unmaking medical territories and boundaries; South Asian and African Medical Diasporas; Medical Pluralisms; Issues of Gender and Childbirth; Ritual, Religion, Medicine and Sorcery: Blurred Boundaries, Deadly Rivalries; Urban/ Rural Practice; Music and Medicine; Colonialism and Independence; The Evolving Nature of Indigenous Medicine; Patents and Prescriptions, Rands and Rupees; Healing and Hybrid Identities: National, International and Personal; Healers and Markets: Informal and Formal, Local, National and International; Alternative Medical Tourism.

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'Sense and Substance in Traditional Asian Medicine.'

The sixth International Conference on Traditional Asian Medicine, ICTAM VI, will take place April 27-30 2006 at the Texas Union on the campus of the University of Texas at Austin.

Calls for papers and panel proposals will go out in the spring of 2005. Participants can do more than only volunteer a paper like organising a session on a topic dealing with Traditional Asian medicine. Especially those new to the academic field as well as other interested parties such as practitioners, manufacturers, distributors, policy makers, governmental and non-governmental are invited to suggest a topic for a panel. It is recommended that activities for organising panels start as soon as possible-potential panel members should be approached well ahead of the start of the conference. Those who are interested can contact: **Dr. Martha Selby, queenie@uts.cc.utexas.edu**

The Knoweledge of Healing,

The first comprehensive documentary film about Tibetan medicine. Please read about the film on: http://frif.com/new2004/know.html The film will be reviewed in Asian Medicine-Tradition and Modernity.

Conference Reports

'New Research on Tibetan Medicine', 10th Seminar of the International Association for Tibetan Studies (IATS), Wolfson College, Oxford, Sept. 6-12, 2003.

In the past 20 years, quite a number of well-known Tibetologists have dealt with or even dedicated their entire research effort to Tibetan medicine. The resulting studies have been philologically oriented for the most part and we owe a lot to their ground-breaking contributions to the field. The panel held at the 10th Seminar of the IATS at Oxford during September 2003, however, constituted the first forum for interdisciplinary exchange in the study of Tibetan medicine, and included both historians and a considerable number of anthropologists. A new development was the high number of medical anthropologists presenting research on Tibetan medicine. Overall 21 presentations were given. These were organized into four main sections: traditional medicine and modernity; education and professionalization; epistemology, medical history and practice; and history of Tibetan medicine. Two papers were explicitly comparative in their outlook: one was dedicated to a comparison between Tibetan and Chinese pulse diagnostics, while the other described an interesting Tibetan history of Indian medicine. The Wellcome Trust kindly provided some of the participants' travel and accommodation expenses.

The first section on traditional medicine and modernity

was opened by Alex McKay (London), with a paper on 'Himalayan Medical Encounters: the Establishment of Western Biomedicine in Tibet.' This was followed by Audrey Prost (London), who provided an historical overview on 'Tibetan public health' as practiced in Tibetan exile communities. Vincanne Adams (San Francisco) contributed an insider-view based on many years of fieldwork concerning contemporary modernizing practices at the Tibetan hospital (Mentsikhang) in Lhasa. She stressed the overall bio-medicalization (i.e. secularization and scientization) in this allegedly 'traditional' setting. Susan Heydon (Dunedin, New Zealand) also provided an insider-view of the modern hospital established by Sir Edmund Hillary at Khunde in the Sherpa region of Khumbu. She, however, emphasized the relatively harmonious and mutual co-existence and integration of Western medicine and local beliefs-although she did not mention traditional Tibetan medical practices as being extant in this region. Colin Millard (Edinburgh) discussed his practical engagement in translating and assisting the Tibetan doctor Lobsang Donden, a practitioner at the Tara Institute of Tibetan Medicine in the UK who was also present at the panel discussions. Millard focused on what he considers to be the most significant modifications in the practice of Tibetan medicine in the West, i.e. modernizing issues in the production and sales of Tibetan medicinal pills. Tibetan doctor Tenzin Namdul (Research Department, Dharamsala Mentsikhang) reported on a double blind control study concerning the efficacy of Tibetan medicine for Diabetes Mellitus patients. Another randomised control study was reported Alejandro Chaoul (Houston) who outlined Tibetan yogic practices of the Bon tradition used in the treatment of cancer patients in the United States.

The second section concerned education and professionalization, and opened with a report by Florian Besch (Heidelberg) based on recent fieldwork with Tibetan doctors in the Himalayan region of Spiti. He discussed the recent, socially disruptive processes of imitating modernization (rather than implementing it) and a 'monetarization' of Tibetan medicine in the region. The following two papers concerned recent developments in Tibetan medicine in Nepal. Susanne von der Heide (Kathmandu) detailed the self-organization of Tibetan amchi (doctors) into their own association, the Himalayan Amchi Association, in order to gain governmental recognition while at the same time "safe-guarding their tradition." The paper by Sienna Craig (Ithaca) investigated the changes in the curriculum of various Tibetan medical schools in Nepal due to the pressures of standardization and modernization and the impact of these changes on concepts and practice of Tibetan medicine in Nepal. Denise Glover (Seattle) followed with a paper on her research in Gyelthang in Eastern Tibet concerning more popular aspects of medical knowledge, such as ethnobotany and diet among Gyeltang Tibetan communities and their discourse of lost knowledge in the face of a growing and unprecedented professionalization in the medical sector (both traditional and biomedical).

The section on epistemology, medical history and practice was dominated by several papers focusing on spirit-inflicted illnesses. Eric Jacobson (Cambridge, Mass.) approached the subject from the perspective of cross-cultural psychiatry based upon his fieldwork among Tibetan refugees in Sikkim and Dharamsala, whereas Geoffrey Samuel (Newcastle, Australia), who has worked among Tibetan refugees in Dalhousie, North India, focused on the relationship between the textual classic of Tibetan medicine, the Gyushi (rGyud bzhi), and ethnographic accounts of spirit-inflicted illnesses. Samuel's questions concerned which kinds of illness are explained as being caused by spirits, which spirits are involved, and what the implications are for the modes of treatment used. Barbara Gerke (Oxford/Kalimpong), who administers the International Trust for Traditional Medicine in Kalimpong, presented her MSc thesis on soul (bla) rituals which engage the 'subtle body.' Kim Gutschow (Wesleyan, CT) focused on the female body in ritual and medical discourse based upon fieldwork in a Tibetan community in Zanskar, North India.

Last but not least, the panel finished with a final session by a group of historians focusing on Tibetan medical literature. A study of rare, early Tibetan medical texts which have just become available in the Lhasa archives was presented to a curious audience by Yang ga, graduate from the Lhasa Medical College (Harvard). Dan Martin (Jerusalem) presented a text-critical analysis of an interesting early Tibetan history of Indian medicine, whereas Olaf Czaja (Leipzig) investigated the earlier textual sources used to compile the famous commentary on the Gyushi, the so-called Blue Beryl, composed by the Regent of the Fifth Dalai Lama, Desi Sangye Gyatso. Frances Garrett (Toronto) focused her paper on historical understandings and usage of embryology in Tibetan medical and biographical texts. Janet Gyatso (Harvard) gave a presentation on the "Shifting fortunes of the Tantric channel system in Tibetan medical anatomy," investigating the intersections between Tibetan Buddhism and medicine. Zhen Yan (Beijing) together with Elisabeth Hsu (Oxford) presented a comparison between certain concepts and images found in Tibetan and Chinese pulse diagnostics.

The papers are forthcoming in a separate volume of the IATS proceedings, published by Brill in Leiden (2005) and edited and introduced by the panel organizer Mona Schrempf (Berlin) under the title Soundings in Tibetan Medicine. Anthropological and Historical Perspectives. Whereas five of the presenters were unable to submit their papers for publication, four other articles by authors who had not presented a paper in the panel will be included instead: two are based on very recent research on contemporary lineage doctors practicing in the Tibet Autonomous Region (Mona Schrempf, Resi Hofer-Vienna), while another focuses on the external medical practices employed at the Kumbum Monastery Hospital in Amdo (Katharina Sabernig-Vienna). Henk Blezer (Leiden) will provide an overview of desiderata in research on the history of Tibetan medicine.

It is to be hoped that this panel has set a precedent for future meetings and exchanges on Tibetan medicine, not only among Tibetologists but also among a broader and interested scholarly community working on Asian medicine in general. Research on Tibetan medicine certainly has earned its place in this arena, although it is conspicuously lacking in most works on Asian medicine, and interest in this field of study has yet to manifest itself in the form of a more direct exchange with other scholarly works on Asian medical systems.

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'Ayurvedic Identities Past and Present: The Case of Modern and Global Ayurveda'.

The third international DHIIR workshop took place on 12-13 December 2003 at the Faculty of Divinity, University of Cambridge. A selected group of scholars, practitioners and experts convened to present and discuss their latest research. The presentations covered a wide range of methodological points of view, examining the case of modern and global Ayurveda from historical, textual, philosophical, anthropological, socio-political, economic, biomedical and pharmacological perspectives. The workshop set the foundations for the forthcoming DHIIR conference on the same topic.

Both workshop and conference are part of a larger project, the Indic Health and Medicine Research Program (IHMRP), which was developed to explore the nature, history and practical applicability of yoga- and Ayurveda-inspired approaches to health, medicine and wellbeing in the context of modern and developed societies. The first part of the IHMRP (2000-2002) focussed on studies relating to the emergence and growth of Modern Yoga, and research is ongoing. Part II (2002-2004) is dedicated to research on the history and development of modern and global Ayurveda. "Modern Ayurveda" is here understood to start with the processes of professionalisation and institutionalisation brought about in India in the 19th and 20th centuries. "Global Ayurveda", on the other hand, refers to the more cosmopolitan and geographically widespread processes of popularisation and acculturation set in motion in the 1980s.

The format of the workshop was as follows: draft presentations were circulated prior to the workshop, so that participants could familiarise themselves with the material under discussion. Each contributor was allocated a respondent who, during the workshop, introduced the paper by way of a critical summary. This was followed by the author's response, and by general discussion. A total of fourteen papers were presented, falling roughly into five thematic categories:

1) Aspects of Ayurveda and Herbal Medicine from a Western practitioner's perspective. Peter Jackson-Main, chairman of the European Herbal Practitioners' Association, discussed legal debates on complementary medicine in the UK, including the question of statutory self-regulation. Clinical and commercial issues relating to the practice of Ayurveda in a Western setting were also discussed in this context, with examples from Germany and the UK. A. Chopra (Habichtswaldklinik Ayurveda) discussed ayurvedic clinical practice in a mainstream medical setting; Sebastian Pole's (Pukkaherbs) specialised private practice with accompanying manufacture and distribution was examined by Peter Jackson-Main.

2) Twentieth century history and politics of Ayurveda in India. Dominik Wujastyk (University College London) presented a survey of reports (1923-2002) which had been instrumental in shaping government policies on Ayurveda. He showed how such reports can often be more representative of personal opinion than of formal investigation findings. Dagmar Benner (DHIIR) traced the development of ethical codes and declarations for Ayurvedic practitioners, and examined their relationship to the professionalisation and formalisation of practice. Francis Zimmermann (Ecole des Hautes Etudes en Sciences Sociales, Paris) emphasised the ecological "embeddedness" of ayurvedic theory and practice, and warned against divorcing theoretical speculations on Ayurveda from geographical and cultural contexts. He also expressed the opinion that environmentalism is influenced by Asian concepts. Madhulika Banerjee (University of Delhi) discussed processes of pharmaceuticalisation and the politics of knowledge and identity that underpin modern formulations of Ayurveda.

3) Ayurveda and Modern Science. The Foundation for the Revitalization of Local Health Traditions (FRLHT, Bangalore) is constructing a database of medicinal plants, including their locality, use, and place in textual and oral traditions. Unnikrishnan P. (FRLHT) presented this work, covering such issues as the testing for medicinal efficacy, and the sustainable cultivation of plants that are traditionally harvested from natural habitats. Bala Manyam (Texas A&M University) discussed the development and testing of ayurvedic drugs in the treatment of Parkinson's disease.

4) Anthropological narratives of ayurvedic treatment in India. Based on the case study of an Indian practitioner's adaptations of "panchakarma" to a Western tourist clientele, the paper by Jean Langford (University of Minnesota) dealt with the consumerisation of Ayurveda in India. "Neo-ayurvedic" practices such as "marma cikitsa" and psychotherapy-inspired discourses came up for discussion in this context. These have no precedent in classical Ayurveda. Manasi Tirodkar's (University of Chicago) paper began with a critical and satirical portrait of contemporary Ayurveda conferences. It then went on to offer a fourfold schematisation of contemporary ayurvedic practice: traditional, modern, commercial and self-help.

5) Ayurvedic concepts in text, context and practice. Joseph Alter (University of Pittsburgh) examined the par-