TRADITIONAL MEDICINE IN BHUTAN

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Abstract

The Himalayan kingdom of Bhutan is an independent state situated between China and India. It emerged as a unified polity in the early 17th century under the rule of an exiled Tibetan religious leader and much of its elite culture, including its medical traditions, were brought from Tibet during this period. The Bhutanese Traditional Medical system subsequently evolved distinct characteristics that enable it to be viewed as a separate part of the Himalayan tradition of Sowa Rigpa ('the science of healing'), which includes what is now known as Tibetan Medicine. After coming under the influence of the British imperial Government of India at the beginning of the 20th century, Bhutan was occasionally visited by British Medical Officers from the Indian Medical Service, who accompanied British Political Officers on diplomatic missions there. But when the British withdrew from South Asia in 1947 there were no permanent biomedical structures or even fully qualified Bhutanese biomedical doctors in Bhutan. Since 1947, Bhutan has evolved a state medical system in which their Traditional Medicine is an integral part and patients have the choice of treatment under traditional or biomedical practitioners. With particular reference to the role of The Institute of Traditional Medicine Services in Thimphu this paper discusses the history, structures and practices of traditional medicine in Bhutan, including its interaction with biomedicine.

Despite growing interest in the indigenous medical systems of Asia the medical traditions of Bhutan remain largely unknown in the West.[1] Although the Bhutanese traditions share historical developments, practices and understandings with the medical traditions of

[1] In 2002, The Institute of Traditional Medical Services in the Bhutanese capital, Thimphu, in an effort to counter the lack of sources in this field, printed a guide to the Institute entitled *The Institute at a Glance*. This article draws principally on that publication and on an interview and discussions with the Institute director and other health practitioners in Bhutan in July 2004. One interesting source is an article by Subhuti Dharmananda entitled 'Traditional Medicine of Bhutan', which appears (as of 1 September 2004) at the website www.itmonline.org/arts/bhutan.htm. This article includes relevant excerpts from Bhutanese media articles on the subject. I am indebted to Olaf Oczaja for this reference.

their northern neighbour, Tibet, there are distinct elements to the Bhutanese tradition and to its reactions to modernity. Indigenous medicine is very much a living tradition, which has now been integrated into the Bhutanese public health structures to a remarkable degree. State health services offer the patient a choice of biomedical or indigenous treatment, usually under the same roof, and both practices in this country are funded by the Royal Government. In the wider context this approach is part of an explicit Bhutanese search for an alternative model of development, something that deserves wider attention than can be given here. Aspects of the extensive *pharmacopoeia* and the treatment of chronic conditions in the Bhutanese system may also prove of particular interest in the West. To provide a basis for future scholarship, this essay will outline the historical development of Bhutanese traditional medicine and discuss the distinct elements of that tradition.

Historical background

Bhutan, a small Himalayan Buddhist state with a population of around 750,000 people, lies between the Tibetan Autonomous Region of China to the north and the West Bengal and Assam regions of India to the south. Today Bhutan is a developing country, but it is also one that explicitly questions the models of development applied elsewhere in Asia during recent decades.[2] This is most notably articulated in the King's assertion that he is more concerned with 'Gross National Happiness' than with Gross National Product as a measure of development.[3] Having observed the social, cultural and environmental degradation consequent on the encounter with modernity in places such as Kathmandhu and Gangtok, Bhutan seeks an alternative model, one in tune with the country's Buddhist principles.

The emergence of a unified Bhutanese state as a distinct entity is generally credited to the arrival from Tibet in 1616 of Shabdrung Ngawang Namgyal (1594–1651), a leading figure of the Drukpa

[2] These models result in statistics that place Bhutan among the world's poorest nations, despite an absence there of malnutrition, homelessness, beggars, rampant corruption and other symbols of poverty and want such as oppression, war and epidemic diseases, all of which are common in Bhutan's neighbouring regions.

[3] See for example, Sonam Kinga, *et al.*

Kargyu school of Tibetan Buddhism.[4] He became the first religious and secular head of modern Bhutan, which has maintained an independent identity and national existence since that time.[5]

During the eighteenth and nineteenth centuries, Bhutan was increasingly drawn into contact, and conflict, with the growing power of the British colonial state. From 1905 onwards Bhutan's defence and foreign policy were under British imperial control, and British authority was represented in the person of the Political Officer for Sikkim, Bhutan and Tibet, who was stationed in the Sikkimese capital, Gangtok. In practice, these imperial officials were primarily concerned with events in Tibet and made only occasional visits to Bhutan. There were no permanent European residents in Bhutan during the colonial period and there was very little imperial interference in internal affairs and customs there.

In consequence, the traditional medical structures and practices of Bhutan remained largely unchanged during the colonial period. There was no public health system and while an elite medical tradition existed, the majority of the population relied on local and village level healers. Elsewhere in Britain's South Asian empire biomedicine (allopathic, or 'Western medicine') was deliberately used as a means of obtaining the goodwill of the indigenous peoples. In British India, biomedical structures were established at state level, and in regions bordering British India (such as the Indian Princely States, Tibet and Nepal) the British stationed medical officers who provided free health care to all classes of the indigenous peoples. These initiatives and the promotion of biomedical techniques and advances in scientific knowledge had an enormous impact on traditional medical systems. They paved the way for the indigenisation of biomedicine in South Asia, with indigenous training institutes producing local biomedically trained health professionals who inherited the state medical systems in the late 1940s after the British withdrawal from regional Empire.

Bhutan in contrast received only around a dozen visits during the 1905–1947 period from imperial medical officers who accompanied Sikkim political officers, and no permanent biomedical structures

[4] *Shabdrung* is a title that may be translated as 'at whose feet one submits'.

[5] The *Shabdrung* is credited with having 'enacted the first-ever ban on smoking in public when he outlawed the use of tobacco in government buildings' in the 1640s. See McKay, forthcoming.

were created in consequence of their visits.[6] Although both the Bhutanese monarchy and the British political officers were keen to expand biomedicine in Bhutan, no financial resources were made available to implement health care structures similar to those existing in British India. As Christian missionaries were prohibited from entering Bhutan, medical services such as those established by them in neighbouring Darjeeling-Kalimpong, for example, were not available either. As a result, when India became independent in 1947 and inherited the British role there, Bhutan did not have a public health system and indigenous biomedical developments had just begun.

It was not until 1953 that a proposal for a medical school was put forward in the newly founded National Assembly of Bhutan.[7] However, throughout the 1950s and early 1960s state medical institutions were still heavily reliant on Indian and other foreign biomedical practitioners. As the Bhutanese government took increasing responsibility for health services, Bhutanese people began to be sent to India and other countries for training from the late 1960s onwards. At the same time state support for traditional medicine was instituted, more slowly at first, but with increasing enthusiasm following Bhutanese participation in the 1978 World Health Organisation (WHO) conference at Alma Ata, where traditional medical systems (notably the Chinese model of 'barefoot doctors'), found considerable ideological support.[8]

Current structures

Health services in Bhutan are a government monopoly and private medical practice is not permitted.[9] All forms of medical treatment are free to Bhutanese citizens, including the provision of around 328 essential biomedical drugs and 103 essential traditional medicines.

[6] See McKay 2004, pp. 137–59.

[7] *Proceedings and Resolutions. . . .*, Vol. 1, 1953, p. 21.

[8] Interview with Dr Samdrup: retired physician, Thimphu, 23 July 2004.

[9] This is justified on the grounds that better quality control of medical services is possible under state monopoly, while centralised surveillance and reporting systems are able to produce a better health picture and to respond more rapidly to it. In addition, a wide range of tests can be done that many could not afford with private practice.

Standards of practice are generally higher than in neighbouring countries, as is indicated by a tendency for foreigners to enter Bhutan for medical care. However, patients with conditions that require advanced treatments (such as hip replacements and kidney transplants) are sent out of the country for treatment.

Traditional medicine officially co-exists with biomedicine in Bhutan and the two systems are fully integrated under the National Health Care System. Each of the twenty districts of Bhutan has a traditional medicine section in the local health centre, thus offering patients the choice of systems under one roof. The only exception is the capital, Thimphu, where the hospital at the Institute of Traditional Medicine Services provides traditional treatment, while the Jigme Dorji Wangchuk National Referral Hospital is the biomedical centre.

The Institute of Traditional Medicine Services in Thimphu comes under the authority of the Medical Services Department of the Bhutanese Ministry of Health.[10] Its stated aims are, in summary, to promote and preserve the traditional medical systems that are based on a rich cultural experience, and to complement biomedicine. The Institute began as the Indigenous Medicine Unit, a dispensary staffed by two *drungtsho*s (doctors), Pema Dorji and Sherub Jorden, both of whom trained in Tibet.[11] The Unit was formally recognised by the Royal Government in 1967 and its development as a modernised system within the Bhutanese public health system began. In 1971 it commenced training *menpas* (compounders) in pharmacy techniques and formal training of *drungtsho*s was instituted in 1978. In 1979 the Unit was upgraded to become the National Institute of Traditional Medicine Services (NITM), and it was equipped with a new hospital and training centre.[12] Over 50,000 patients are now treated annually at the ITMS's Thimphu hospital.[13]

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[10] Anon, 2002, p. 3.

[11] Anon, 2002, p. 1. *Drungtsho* Pema Dorji, who became the first director of the institute, was from a medical family, the grandson of a practitioner who had treated the royal family. He trained at Chakpori medical college in Lhasa from 1946–53 and on return practiced for 9 years in Trongsa Dzong under his physician uncle; Drungtsho Sherab Jorden trained at the Mentsekhang in Lhasa, as did Ladakh Amchi (another early practitioner at the Institute who became the Traditional Medicine royal physician); 'Bhutan Health Services Report on the Introduction and Status of Traditional Medicine', (included within) 'Traditional Medicine . . .' at www.itmonline.org/arts/bhutan.htm

[12] In 1979 it was reported that 'Separate institution for study of indigenous medicine had been established and graduates to be attached to the Basic Health Units set up in the rural areas'; *Proceedings and Resolutions* . . ., vol. 3, 1979, p. 32.

[13] Anon. 2002, p. 15.

Since 1998 the NITM has been upgraded as the Institute of Traditional Medicine Service (ITMS) and organised into three sections: the national traditional medicine hospital (NTMH), the national institute of traditional medicine (NITM), and the pharmaceutical and research unit (PRU). To train as a *drungtsho* requires five years of study and six months of practical work, to obtain the Bachelor's degree in Traditional Medicine, and there is also a three-year, three-month internship programme for a Diploma in Traditional Medicine, both degrees being recognised by the Royal Civil Service Commission. By 2002 the training programme had produced 36 qualified physicians and 34 compounders nationwide, along with 11 research assistants and 12 pharmacy technicians. In 2004 the student body numbered 29.

Traditional medicine in Bhutan has benefited from foreign aid programmes, including WHO funding of drug production and European Union support for a pharmaceutical research unit established in 1998.

Bhutanese pharmacopoeia

Bhutan is referred to in early Tibetan sources as 'Lhojong Menjong'—the 'Southern Valleys of Medicinal Herbs'. As in the Tibetan pharmacopoeia, Bhutanese medicines are largely herb-based, with some use of animal and mineral products. Around 265 different raw materials in total are used, and from this around 100 medicines are currently produced at the ITMS centre in Thimphu under WHO manufacturing guidelines. Production is fully mechanised and around five tons of traditional medicines are produced annually for supply to all 20 districts of Bhutan.[14] One factor inhibiting research into these medicines is that they contain multiple ingredients, a minimum of five up to a maximum of 35. Bhutanese medicines thus face the same problems as those of other Asian systems in terms of biomedical testing regimes.

Two centres for the collection of medicinal plants have been established in Bhutan. High altitude (from above 8000 feet) plants are gathered in June to August and collected at a centre in Lingshi, a sub-district of Thimphu, which is four days' walk from nearest road.

[14] But nearly 30 per cent of ingredients are imported. Anon. 2002, p. 11. 'Traditional Medicine . . .' at www.itmonline.org/arts/bhutan.htm states in error 35 tons.

There is a small drying unit at Lingshi, and the collection centre buys raw material from the local community before the dried plants are taken by horseback to Paro or Thimphu road heads. There is a similar drying centre at Langthel in Trongsa district for low altitude plants (which are collected from December to January).

While there is currently an abundance of wild medicinal plants available, wild plants are a challenge to search for and to find, as they often grow in remote and dangerous locations that also provide habitat for wild animals. In the long term, sustainability is essential and farmers are now being encouraged to engage in the sustainable collection and cultivation of herbs. The aim is to induce farmers to grow herbs as a cash crop in the same manner as fruit and vegetables. A ready market already exists in India and other countries for any produce in excess of Bhutan's own needs.

In addition to these projects, small-scale income-generating initiatives have also been taken. The Menjong Sorig Pharmaceuticals unit of the ITMS markets a tea called 'Tsheringma' (named after the Goddess of Longevity), which is advertised as enhancing health and long life. Containing safflower (*Carthamus tinctorius*), considered a cardiac, liver and nerve tonic, and the bark of *Cinnamomum tamala*, considered a digestive, the tea is now beginning to find an export market in countries such as Singapore after initial sales to the local market.

Relationship with Tibetan medicine

The traditional understanding of the Bhutanese medical system is that it ultimately derives from the words of the historical Buddha, whose followers believe him to have given medical teachings 2500 years ago. Some of these teachings are understood to have been preserved in texts known as the *Gyu shi* ('Four Medical Tantras'). These are regarded as Tibetan translations of the original Sanskrit texts, brought to Tibet in the era of the Indian Tantric master Padmasambhava during the eighth century.[15] Their transmission and promulgation in Bhutan is attributed to Tenzing Drugyal, the personal physician of Shabdrung Ngawang Namgyal.

[15] The *Gyu shi* is considered by Western scholarship to date to around the 14th century.

Bhutanese medicine is thus accepted as an offshoot of Tibetan medicine. Its textual basis is the Dzongkha language version of the *Gyu shi.* As in Tibetan medicine, understanding of illness is based on humoral concepts, and diagnosis generally involves pulse reading and urine examination. However, although individual Bhutanese medical practitioners did travel to Tibet to study medicine, the Bhutanese medical tradition has developed independently from that of Tibet. There are variations of practice, belief and culture, and their systems are not thought of as 'Tibetan medicine' by the Bhutanese. Their system also remains an open rather than a bounded tradition: recently two popular practices—herbal baths and steam treatments—have been introduced in response to demand, although so far only at Thimphu hospital.[16]

One notable structural difference between the Tibetan and Bhutanese medical systems is that medicine was not necessarily a monastic practice in Bhutan. Family lineages of doctors seem to have constituted the bulk of the elite practitioners, and while monks might on occasion have made offerings to the Medicine Buddha, they did not normally practice medicine.[17] At the level of practice, Bhutanese doctors point to differences in techniques from those used in the Tibetan system. In the case of acupressure, for example, the Bhutanese practitioners do not puncture the skin and they use gold and silver rather than the iron needles used in Tibetan practice.[18]

The distinctions between Tibetan and Bhutanese medical systems continue to persist. There is no formal contact between the Bhutanese traditional medical practitioners and the traditional Tibetan medical institutions preserved under the auspices of the Tibetan Government-in-exile in Dharamsala (north India), although some personal links exist and individual Bhutanese may train there. Consequently, while, as we have noted, biomedical patients may be sent to India or even Europe for advanced treatment, patients under traditional treatment are not referred outside of Bhutan.

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[16] Unlike the Tibetans and Sikkimese, while the Bhutanese do recognise medical pilgrimages in the sense of 'seeking refuge' as a medical practice at any sacred location, they apparently do not have any specifically medical pilgrimages or curing places.

[17] The extent to which medicine was primarily a monastic practice in pre-1950s Tibet is, however, a topic requiring further research.

[18] We may note, however, that the tradition of veterinary care as part of the physicians' role is an aspect of the early Tibetan medical tradition that has been lost from Bhutanese medicine; as our informant wryly remarked, in today's world that is the Department of Agriculture's territory!

Religious aspects

The ITMS is keen to emphasise the religious aspects of traditional medicine. When medicines are produced, the first sample of produce is offered to the Medicine Buddha before it is released for use. There is also a Medicine Buddha temple in the hospital, and a monthly *puja* to 'Sangye Menla' (the Medicine Buddha) is held at the Institute on the eighth day of the lunar calendar. These practices are considered as the 'sacred dimension of Traditional Medicine'. However, the secular nature of the professional guild is illustrated by the fact that the recitation and chanting, offerings and prayers are conducted by the ITMS physicians themselves rather than by monks.

The religious affinities need to be understood within a wider context. Both traditional and biomedical practice is seen by Bhutanese as 'good action', a Buddhist practice benefiting others. This gives medical practitioners high social status, although not without attendant responsibilities. Several (biomedical) physicians interviewed by the authors mentioned that they rarely visited (or needed to visit) temples to pray because their performance of their medical duties was a religious offering that equated with prayer. It is felt that doctors are 'fortunate to be in a position where they can help people—and therefore they should help people'.[19] As a result of this culture, both biomedical and traditional Bhutanese doctors, even after retirement, are never really 'off-duty'. They are often telephoned at home, or patients may stop them in the street or market for advice, and they are expected to respond in their professional capacity. As patients' expectations and demands are rising in the wake of the accelerated pace of medical developments, doctors are beginning to feel pressured for time.

Although biomedically-trained professionals do generally occupy the leading positions within the government health structures, the prevailing ideology within the Bhutanese Health Department is to stress the need to maintain and develop the ethical and social ideals that can be seen to derive from the tradition of 'Bhutanese doctoring'. The Officiating Secretary of the Health Department expressed

[19] Interview with Dr Tobgye Wangchuk: Acting Superintendent, Jigme Dorji Wangchuk Hospital, Thimphu, 23 July 2004.

this by acknowledging that while technical knowledge is important, the doctor's 'kindness, compassion, and politeness' are crucial—visiting a doctor 'should be like a visit to a good friend'.[20] No doctor has ever been sued for malpractice in Bhutan [!], however, given the current absence of legal codes of medical practice (which are being developed), a socio-ethical framework such as the one suggested by the health department official is seen as particularly important. What is more, this ideology may be located within the wider Bhutanese quest for a more culturally-appropriate model on which the country may develop.

Thus deliberate efforts are made to align the practice of biomedicine as it commonly functions in the West with Bhutanese traditions. For example, one recent practical measure has been to attach on a permanent basis (and paid for by government), one or two monks to each of the regional biomedical hospitals. They pray and offer incense in the wards every morning and provide spiritual care to the patients. Their work provides psychological benefit to the patients and they are particularly valuable in interventions such as limb amputation where the local belief is that those losing a limb will be reincarnated without one in their next life. The monks are able to negotiate such issues and assist in translating biomedical concepts to patients, relating, for example, germs to 'demons', or the biomedical concept of blood pressure to the indigenous understanding of 'pulse'. They also remain with the dying and carry out the rituals that prepare patients for death.[21]

The religious sentiments of Bhutan can create certain tensions in the medical sphere. Malaria control, for example, can be seen as contrary to Buddhist practice in that it involves killing living creatures. But equally it may be justified on the grounds that those disease-causing creatures are not compassionate beings. Abortion is a similarly complex issue. In situations where biomedical understandings and practices are hegemonic, efforts are made by public health workers to articulate these issues in terms compatible with traditional models of understanding.

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[20] Interview with Dr Gado Tsering: Officiating Secretary of the Health Department, Thimphu, 20 July 2004.

[21] It was noted that whereas it is common for Westerners to desire to be left alone when ill, this is not the case in Bhutanese culture, where patients prefer to have company. Thus the monks are particularly welcome to patients from remote districts etc., who may not have relatives and friends present.

For example, to encourage villagers to keep the local water source pure, the idea can be expressed in terms of avoiding polluting the realm of the local water-spirit. Similarly, with the local practice of bloodletting, which in the context of HIV is problematic, there is no local taboo against sterilising the instruments used and so local healers are encouraged to do that.

In 1989 a Health and Religion project was initiated to consider such issues. This provided a forum in which the relationship between religious practices and biomedicine could be mediated. It could ensure that, for example, when a monk advised a sick person to go on a pilgrimage they would also give (biomedically sound) medical advice to the patient (e.g., to prevent dehydration).

Interaction with biomedicine[22]

Biomedicine has had a considerable impact on Bhutanese understandings of health and medicine. The elimination of smallpox, polio, and leprosy, and the great reductions in numbers of those suffering conditions such as goitre, TB, and pneumonia that the local system could not control, were key factors in establishing trust in the biomedical system there. People learned to have considerable faith in the power of antibiotics and injections, while the effect of penicillin on venereal conditions was also a big factor in the uptake of biomedicine.

In certain spheres of public health in Bhutan biomedicine is hegemonic. Emergency treatment for wounds, fractures, etc. is given solely in biomedical institutions, and all hospital referrals to outside of Bhutan are for biomedical care. There is no indigenous Bhutanese tradition of invasive surgery, and traditional medical practitioners do not generally deal with maternity cases or infectious diseases. Yet traditional medical provision continues to be significant for problems that do not fall within these areas, raising the complex question of why patients resort to one or other system. Given that all medical treatment is free, economic factors are marginal if not non-existent, and the absence of an articulated nationalist view of Bhutanese

[22] This section is largely based on a series of interviews with past and present health professionals in Bhutan.

traditional medicine that attracts patient commitment also stands in contrast to the situation for Āyurvedic and 'Tibetan medicine' traditions.

Biomedical practitioners interviewed tended to consider that their system found favour with patients for its ability to offer immediate relief of symptoms and pain. In addition they pointed out that biomedicine has the advantage of visual aids such as laboratory reports, ECG and X-ray charts, and methods of demonstrating success such as kidney stones that have been removed. This visual verification builds up patient confidence in biomedicine, particularly in a society where illiteracy is common.

Availability and easy access is another factor in patient choice. Bhutanese state support for traditional medicine has had an impact on patient choice both in material terms and in terms of the social legitimacy conferred by state authority. In simple terms the establishment of dual-system public health clinics has meant that patients had access to a medical clinic, and that the practitioners there had state medical resources to provide and embody state authority in the field of medical knowledge.

But perhaps the key factor in patients' resort to the traditional system was the recognition that biomedicine is not a certain cure for all medical conditions. Traditional Medicine is a logical strategy for conditions like hypertension, rheumatoid arthritis, sinusitis, and liver diseases such as jaundice. Ear, nose and throat conditions are another stronghold for traditional medicine, as is the treatment of psychological conditions (where the emphasis is on religious aspects such as *pujas* to the Medicine Buddha).

Yet it is not only in these areas that the traditional system is patronised. Practitioners of biomedicine admit that because of language difficulties, ease of access and religious understandings, the first resort for the majority of Bhutanese today is still to consult a local practitioner.[23] They also note that traditional medicine may be preferred in cases where a family's experience is that it works. Nevertheless, they tend to conclude that in general the educated opt for biomedicine, whereas the first resort of the uneducated is the traditional

[23] I have not sighted reliable figures in regard to nation-wide consultation figures for the two systems. Collation and collection of records is in its infancy in modern Bhutanese government.

practitioner. Attitudes to Traditional Medicine are generally tolerant and biomedical doctors in Bhutan often refer patients to traditional practitioners in cases where their own treatment has not succeeded. One biomedical doctor that we interviewed in Thimphu stated that he considered that in the case of 'non-specific chronic diseases' it didn't matter which system the patient used, while the primary concern of another was that his patients understood they could use one or other system, but that it could be dangerous to combine the two.

It was recognised that patients would tend to try one system and if that failed to provide a cure they would try the other. They had that option and would use it. Thus one biomedical doctor recalled that if he treated patients and they were not better the next day they would go to the local practitioner.[24] Often he would see evidence, such as the marks left by cupping, that they had previously tried Traditional Medicine, but he accepted that 'long-term patients would float around'.[25]

Thus the two medical systems have positive interactions and personal links that determine patterns of referral. As yet there are no formal structures for referral, but these are being developed. The ITMS tends to receive referrals from biomedical practitioners of patients suffering chronic illnesses. Conversely they mainly refer in return emergency cases and those requiring surgery, or suffering notifiable diseases. The biomedical practitioners consider it 'a healthy dialogue'. They sit with traditional practitioners in the Ministry and work out problems and encourage research into traditional medicines in an attempt to make the two systems complementary. In certain areas, biomedical practice has informed the traditional, with ITMS practitioners adopting aspects of biomedicine such as the need for sterile conditions—the wearing of white coats and gloves, etc. Biomedical practitioners, meanwhile, make numerous concessions to local customs in the application of their system; allowing, for example, non-essential surgery to be carried out at a time of the patient's religious advisor's choosing.

[24] This may be an indication of a belief, growing out of the action of drugs such as penicillin, that biomedicine worked immediately, or not at all.

[25] Interview with Dr Samdrup: retired physician, Thimphu, 23 July 2004.

Conclusion

Bhutan provides an interesting example of a public health system in which there is a genuine choice of medical systems available to the patient. The extent to which these systems may be placed in a hierachy would require analysis from a variety of perspectives, but while the structural development of traditional medicine may have lagged behind biomedicine, and the leading figures in the public health system are primarily biomedicals, there is official support for the traditional system, and considerable tolerance towards it among biomedical practitioners. While the development of the Institute of Traditional Medicine Services does represent a modern systemisation and centralisation of the traditional medical practices, it remains a living tradition, engaging with local practitioners and encouraging innovation and development rather than focussing on the selective reconstruction of elements of the past. Traditional medicine does function as a complementary system and does so explicitly within the context of Bhutanese Buddhist cultural understandings and practices. These latter aspects also define the construction of the identity of 'the doctor' in both systems in Bhutan today.

It is hoped that critical research into the contemporary medical situation in Bhutan will take into account patient's perspectives and experiences, which are lacking in this study. The encounter with modernity is, and will be, fraught with difficulty, but in the wider context the construction of a model of 'Bhutanese doctoring' within a Bhutanese model of development might come to be considered as a significant alternative to other, failed, regional models. Finally, in demonstrating a form of *Sowa Rigpa* free of narrow nationalist context, Bhutanese traditional medicine may be considered as allowing us access to a more historically accurate representation of the unbounded systems of Himalayan medical knowledge—including that of 'village' and 'local' practitioners.

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