

## “The Birth of a Clinic”? The IMS Dispensary in Gyantse (Tibet), 1904–1910

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### Introduction

The establishment in 1904 of a British hospital at Gyantse, in southwestern Tibet, marked the formal introduction of biomedicine into that Himalayan state. In the ensuing decades, officers of the Indian Medical Service (IMS)<sup>1</sup> offered treatment to Tibetans from their Gyantse base as a part of the British imperial relationship with the Tibetan state.

Given that Gyantse was a small town of little political or economic importance, the medical impact of the IMS dispensary on Tibet as a whole was insignificant. But it provided a base from which in 1936–37 the British expanded their medical services to establish a hospital in Lhasa, the Tibetan capital. In the 1940s the Republican, and later the Communist Chinese governments also established biomedical hospitals in Lhasa, and while the indigenous medical system(s) of Tibet survived, the urban centres of central Tibet have had access to biomedicine since that time. Thus the history of the first permanent biomedical position in Tibet is a part of the medical history of both the British imperial government in South Asia and of Tibet itself.

We are fortunate in that this pioneering imperial medical endeavour was of such political importance at the time that it produced a considerable amount of official correspondence, which was preserved in the imperial archives. These sources not only provide evidence for the scope of, and the processes surrounding, the British imperial medical project in early twentieth-century South Asia but also give indications of the indigenous reactions to this initiative.<sup>2</sup>

In this paper I discuss the establishment of the Gyantse hospital and locate in a wider context the issues that arose there during the first five years of its existence down to 1910. Within that brief period, the principal features of the biomedical encounter with Tibet

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The terms “Tibetan medicine” and “biomedicine” are both problematic. The former embraces a wide variety of practices and understandings and, while including

an élite textual tradition, should not be taken as implying a unified system (although the British tended to see it in such terms). “Biomedicine” is used rather than the more popular term “Western medicine” in order to emphasize the basis of the system following the scientific advances of the later nineteenth century.

<sup>1</sup>The Indian Medical Service was formed in 1896 from the amalgamation of the Bengal, Madras and Bombay Medical Services. It was originally a purely European cadre whose officers were required to be qualified medical practitioners.

<sup>2</sup>A study of the Tibetan sources on this process, which are now becoming available to European scholarship, is obviously needed for a more balanced understanding of those reactions.

emerged, with a selective Tibetan uptake of elements of the new system at the same time as resistance to other aspects of biomedicine became evident. As with the political encounter between Tibet and the imperial Government of India, initial British optimism gave way to a more realistic understanding of the requirements of a long-term encounter.

### The Birth of a Clinic

Diplomatic relations between the British imperial Government of India and its northern neighbour were established in 1904, after the “Younghusband mission” had invaded Tibet and fought its way to Lhasa. The Tibetans had previously sought to isolate themselves from the British, perceptively fearing that contacts with the imperial power would undermine their socio-political religious system. But the imperial Government sought to extend British influence across the Himalayan watershed, both to open Tibet to Indian trade and to protect the Indian empire against any threat of Russian influence from the north. Thus, when the Tibetans had rejected all British diplomatic overtures, the Viceroy of India, Lord Curzon, despatched the armed mission under the diplomatic command of the Indian Political Officer, Francis Younghusband, which forced the Tibetans to sign a treaty opening their state to British trade and diplomatic overtures.

A permanent British–Indian diplomatic presence was then established in Tibet as Younghusband’s forces withdrew in September 1904. A so-called “Trade Agency” was opened, which was in fact a diplomatic mission staffed by, and under the control of, imperial India’s diplomatic service, the Foreign and Political Department. The Trade Agency came under the direct control of a British Political Officer stationed in the Sikkimese capital of Gangtok, who was also responsible for British India’s relations with Sikkim and Bhutan, which were, in effect, “Princely States” ruled by indigenous élites under ultimate British authority.

In deference to Tibetan desires for isolation, however, the imperial Agency was established not in the Tibetan capital of Lhasa, but in Gyantse, 120 miles south-west of the capital. The first British agent to be posted there was Younghusband’s Intelligence Officer and “right-hand man” on the mission to Lhasa, Captain (later Lieutenant-Colonel) W F O’Connor. An astute, Tibetan-speaking officer, O’Connor already had a decade’s experience of intelligence gathering on India’s northern frontiers.<sup>3</sup>

The duty of a Political Officer under the imperial government system was to establish friendly personal relations with the indigenous state authorities and thus to influence them to follow policies advantageous to British imperial interests. O’Connor thus set out to befriend the Tibetan élites, using a variety of means to demonstrate British goodwill in the aftermath of the conflicts arising from the Younghusband mission.

Experience elsewhere in the Indian empire meant the British recognized that one simple and economic, yet highly effective means of developing good relations with the Tibetans was by providing them with free medical treatment. Western medical knowledge had enjoyed some repute amongst Tibetans since at least the early eighteenth century, when Capuchin missionaries had opened a medical clinic in Lhasa. The Tibetans subsequently barred missionaries from entering their territory, but during the nineteenth

<sup>3</sup>Regarding the establishment and history of the British positions in Tibet, see Alex McKay, *Tibet and the British Raj: the frontier cadre 1904–1947*, Richmond (UK), Curzon, 1997.

century a chain of Christian mission stations was established around the frontier, where medical services were offered as a (largely unsuccessful) means of attracting Tibetans to Christianity.<sup>4</sup>

In addition to the missionaries, a number of Europeans who travelled in or around Tibet offered medical services as a means of ingratiating themselves with their hosts, and there are indications that political and commercial interests were promoting Western pharmaceutical products in Tibet by at least the last quarter of the nineteenth century.<sup>5</sup> Russian influence was also a factor. The Russian Buddhist republics were an avenue for the penetration of European medical knowledge into Tibet as well as being the main route for the well-known traffic in medical knowledge from Tibet to Russia, where Tibetan medicine was much in vogue by the early twentieth century.<sup>6</sup>

Tibetans themselves encountered institutional biomedicine as they travelled to places such as Peking and Calcutta for trade and pilgrimage. In addition, individual Tibetan medical practitioners may already have begun incorporating aspects of biomedical knowledge and practices into their own understanding. Certainly a demand existed within Tibet for items such as smallpox vaccine.<sup>7</sup>

During the Younghusband mission, imperial medical staff had treated Tibetans wounded in the fighting against them and had offered free medical services to any Tibetans wanting them. These actions do seem to have created a great impression among the local people, both because battlefield casualties in that region were traditionally at best ignored and at worst slaughtered, and because Tibet at that time lacked any civil or military medical service in the European sense.

While the natural environment of Tibet was a healthy one, in which the extreme cold meant an absence of malarial infection and of many of the water-borne diseases that

<sup>4</sup> A comprehensive account of these missionary activities is a lacuna in the field, but there are a number of studies of particular missions; in the English language, see for example, Fulgentius Vannini, *The Bell of Lhasa*, New Delhi, 1976; John Bray, 'Christian missions and the politics of Tibet, 1850–1950', in W Wagner (ed.), *Kolonien und Missionen*, Bremen (Universität), 1993, pp. 180–95. The classic study of the Capuchins is Luciano Petech, *I missionari italiani nel Tibet e nel Nepal* (II Nuovo Ramusio II), 7 vols, Rome, ISMEO, 1952–1956.

<sup>5</sup> According to Jürgen Aschoff's comprehensive *Annotated bibliography of Tibetan medicine (1789–1995)*, Dietikon, Garuda Verlag, 1996, entry 1559, E E Uktomsky's Russian language work 'From the field of Lamaism. On the campaign of the British to Tibet', St Petersburg, 1904, p. 66, describes Dr Campbell, appointed imperial Superintendent of Darjeeling in 1839, as "responsible for sanitary imports" into Tibet. See also note 6.

<sup>6</sup> Samjamitab Tsybiktarov (1877–1921), the first Buriat trained in biomedicine, for example, was attached to the Russian consulate in Urga (Mongolia), which had close ties with Tibet. I am indebted to Dr Alex Andreyev (St Petersburg) for this information, taken from a biographical sketch of Tsybiktarov by Sh. B Chimitdorjiev. On the institution of Tibetan

medicine in Russia in this period, see John Snelling, *Buddhism in Russia: the story of Agvan Dorzhiev, Lhasa's emissary to the Tsar*, Shaftsbury (UK), Element Books, 1993, pp. 85–9.

<sup>7</sup> In the early 1880s, the Bengali headmaster and imperial intelligence agent Sarat Chandra Das took smallpox vaccine to Tibet at the request of the Panchen Lama; for an examination of this initiative in its wider context, see Alex McKay, 'The drowning of Lama Sengchen Kyabying: a preliminary enquiry from British sources', in H Blezer (gen. ed.), *Tibet Past and Present: Tibetan Studies I. Proceedings of the 9th International Seminar for Tibetan Studies*, Leiden, Brill, 2000, pp. 263–80, esp. pp. 266–7. For an example of an individual Tibetan medical practitioner acquiring biomedical knowledge in India, see Vincanne Adams and Dashima Dovchin, 'Women's health in Tibetan medicine and Tibet's "first" female doctor', in E B Findly (ed.), *Women's Buddhism, Buddhism's women: tradition, revision, renewal*, Boston, Wisdom Publications, 2000, pp. 433–59, esp. p. 446; I am indebted to an anonymous *Medical History* referee for this reference. While it relates to a later period (1940s?), relevant Tibetan sources (esp. *gnam tars*: religious biographies), are only now beginning to appear in European languages.

ravaged India, the country was still subject to smallpox epidemics, child-mortality was extremely high, and treatment of wounds was rudimentary. Contemporary medical services in Tibet appear to have been provided by a variety of practitioners from domestic and “village level” healers to monastic practitioners of the élite Tibetan medical system. An important role was also played by both oracular or shamanic healers and by *amchis*, lay practitioners who had studied the traditions of a particular lineage of medical teachings. Treatment could thus be from the Tibetan pharmacopoeia and/or within the context of “magico-religious” healing, generally within a Buddhist rhetorical framework.<sup>8</sup>

The élite medical tradition of Tibet—that commonly known today as “Tibetan medicine”—drew on a number of elements both indigenous and foreign. Its canonical heart was the Gyü Shi (the “Four Medical Tantras”), a text regarded as a revelation of the Medicine Buddha. Understood as being of Indian origin, it is more probably a Tibetan compilation from the twelfth century drawing on a Sanskrit original. It includes, however, Persian and Chinese as well as indigenous elements, testifying to the cosmopolitan nature of earlier Tibetan medical understandings.<sup>9</sup>

This élite tradition was preserved within the medical institutions of the Tibetan socio-religious system, in particular the Chakpori medical college, situated on a rock outcrop opposite the Potala Palace in Lhasa. Established in 1696, its graduates were posted to major monasteries throughout Tibet where they practised and taught the élite traditions.<sup>10</sup> There was, however, no public health system in the European understanding of the term and, while there are accounts of the isolation of smallpox victims,<sup>11</sup> it is uncertain whether any permanent systems of disease control existed in practice.

Scientific medical advances in the West, such as germ theory, were entirely unknown in Tibet at that time and, without entering into the question of the efficacy of Tibetan medical practices, it is safe to say that there was an enormous potential appeal for biomedicine

<sup>8</sup>The non-élite medical traditions of Tibet have not been subject to critical historical study, as far as I am aware. Two significant anthropological studies that might form a basis for such work are: Craig Janes, ‘The transformations of Tibetan medicine’, *Med. Anthropol. Q.*, 1995, 9 (1): 6–39; and Vincanne Adams, ‘Modes of production and medicine: an examination of the theory in light of Sherpa medical traditionalism’, *Soc. Sci. Med.*, 1988, 27: 505–13.

<sup>9</sup>Galenic medicine had reached Tibet in an even earlier period; see Christopher Beckwith, ‘The Introduction of Greek medicine into Tibet in the seventh and eighth centuries’, *J. Am. Orient. Soc.*, 1979, 99: 297–313.

<sup>10</sup>On the élite medical culture of Tibet, see, for example, Rechung Rinpoche, *Tibetan Medicine; illustrated in original texts*, London, Wellcome Trust, 1973. The “official” view of Tibetan medicine today is concisely contained on the website of the Tibetan Government-in-exile ([www.tibet.com](http://www.tibet.com)). Critical studies of the subject are rare; see however, Samten Karmay, ‘Vairocana and the rGyud-bzhi’, *Tibetan medicine*, series 12, 1989, Dharamsala (India), pp. 19–31.

<sup>11</sup>For example, William Rockhill, *Tibet: a geographical, ethnographical and historical sketch, derived from Chinese sources*, London, 1891, p. 235, quoting from the *Hsi Ts'ang fu*, p. 28, states that “In 1794, the Talé [Dalai] lama, under orders from the Emperor, erected special hospitals for small-pox patients, in which they were supplied with food and every necessary, and which were under the care of a special officer”. Rockhill’s *Land of the lamas*, London, Longmans, Green, 1891, p. 242, however, states that these fell into disuse.

The grave lack of critical studies impairs our ability to present a realistic picture of the Tibetan medical system(s) in the pre-1950 period; European observers provide valuable observations, but aside from the question of bias, their investigations were far from systematic. Most modern Western accounts of Tibetan medical practice at best relate the idealized Tibetan Buddhist sources and while there is no reason to doubt the compassionate and humanitarian motives of medical practitioners highlighted in these sources, they surely represent only one element of the system.

there, particularly if those services were offered free of charge, as British biomedical treatment was.

By 1905, the principal contours of modern biomedical understanding had been established; the role of bacteria was known and the need for antiseptic conditions in surgery accepted. Anaesthetics were available, as well as vaccines against typhoid, plague and smallpox, and the physicians' use of stethoscopes, thermometers and microscopes was standard. The doctors posted to Gyantse in this period were recent graduates in touch with the rapid advances in science and biomedicine. But many of those advances would have been of little relevance to a remote dispensary such as Gyantse, which had no laboratory or x-ray facilities, and the doctors' training in tropical medicine would have been of little relevance on the Tibetan plateau.<sup>12</sup>

The practice of biomedicine at Gyantse between 1905 and 1910 was thus “rough and ready”, although in line with the “generalist” ideal of the IMS officers and their frontier setting. Only in surgical performance might a doctor there really distinguish himself in the medical sense and the unsanitary conditions made even basic surgery problematic. But the IMS officers were in no doubt that even their rudimentary biomedical services were superior to the indigenous offerings, and that the free provision of medical services would be greatly appreciated by the Tibetans.

Yet, aside from issues of efficacy, even the question of “free medicine” in the Tibetan understanding is problematic. While Tibetan religious biographies do contain references to physicians who gave free treatment to the needy,<sup>13</sup> it appears that in Tibet (as in the West) it was the accepted custom to pay for medical treatment. Certainly European accounts suggest that, as the eighteenth-century Jesuit Ippolito Desideri described, “Medicine is the only profession which has qualified members . . . The professors are well paid and generally stipulate what their fee is to be before undertaking a cure”. But Desideri goes on to note that while the Capuchins did not charge fees, they did accept “any present which is offered”.<sup>14</sup> The British doctors were also offered (and accepted) “presents”, generally in the form of foodstuffs, and given the virtual absence of a cash economy this may very well have been understood by Tibetans as payment for medical services.

The British do not appear to have considered this perspective, however, for they had little knowledge of, or interest in, the Tibetan medical system(s) and no consequent understanding of such matters.<sup>15</sup> The viceroyalty of Lord Curzon marked the high tide of the British Indian empire and the IMS officers reflected the self-assurance of that empire, operating in complete confidence in the superiority of their own medical system and its efficacy in comparison with indigenous Asian systems.

<sup>12</sup> W F Bynum, *Science and the practice of medicine in the nineteenth century*, Cambridge University Press, 1994, esp., pp. 100–1, 121–3, 137–9, 161, 173; Christopher Lawrence, *Medicine in the making of modern Britain 1700–1920*, London and New York, Routledge, 1994, esp., pp. 64–7, 73.

<sup>13</sup> See, for example, Adams and Dovchin, op. cit., note 7 above, p. 446; see also Rechung Rinpoche, op. cit., note 10 above, p. 25, on free medical services at the Men-se Khang (*sMan-rtsis-khang*). Both references relate, however, to a later period.

<sup>14</sup> F de Filippi (ed.), *An account of Tibet: the travels of Ippolito Desideri of Pistoia, S.J., 1712–1727*, London, Routledge, 1932, pp. 186–87.

<sup>15</sup> None of the British Medical Officers who served in Tibet, or even Sikkim and Darjeeling, appear to have published any studies of Tibetan medicine, nor does there appear to have been a standard work on the system available to them. A few comments by travellers such as Sarat Chandra Das probably comprised the sum total of their knowledge of the subject in this early period.

In the early years of the British period in India Political Officers travelling or stationed in remote areas were normally accompanied by a medical practitioner whose primary task was to ensure the good health of the Political Officer. By the twentieth century the goodwill obtained by the provision of biomedical services to the indigenous peoples, both élites and non-élites, was widely recognized by the imperial policy-makers as beneficial to the diplomatic success of the Political Officer's missions.<sup>16</sup> Thus the Medical Officers accompanying Political Officers devoted most of their time to treating the local peoples. They were entitled to charge fees for private consultations with the local élites,<sup>17</sup> but gave their services gratis to the general populace at clinics attached to political agencies, or in camps set up while travelling.

It was, therefore, standard practice when in October 1904 after O'Connor was left in Gyantse as the British diplomatic representative, a large house near the bazaar was rented for use as a hospital and a Medical Officer, Captain Robert Steen, was stationed there.<sup>18</sup> The son of a landowner, Steen was born in Ulster in 1874 and educated at Queen's College Belfast, before taking his medical degree at the Royal University of Ireland. Steen, who eventually retired with the rank of Lieutenant-Colonel, presumably impressed O'Connor while serving on the Younghusband mission, and during his two years in Tibet worked closely with his fellow Ulsterman.<sup>19</sup>

The friendly relationship between O'Connor and Steen was important because there were several issues of authority that could threaten the relationship between the political agent and the Medical Officer. The first was that although the political role of the hospital was the reason for the appointment of a European Medical Officer, the hospital had originally been established as a military post. This meant that the Medical Officer there was technically charged only with serving the fifty soldiers of the Indian Army who acted as the Trade Agent's escort. While praising Steen's willingness to act in the additional political role, O'Connor noted that another officer succeeding Steen would be within his rights to refuse to undertake non-military duties. O'Connor thus proposed bringing the hospital under Political Department authority, as was the case in British political agencies elsewhere.<sup>20</sup> When the proposal was accepted, and the Gyantse position continued on a new administrative basis, Steen carried on there, having transferred from military to civil employment with a reference from O'Connor that stated that he [Steen] was "wonderfully popular with all classes of natives".<sup>21</sup>

<sup>16</sup> "It is a well known principle that medical officers are attached to our Consulates and Agencies in remote localities primarily on account of political considerations". National Archives of India (New Delhi) [hereafter, NAI], Foreign Department [hereafter, FD] External A, Sept. 1906, 40–46. File note by "R.S.B. & R.W.S.", 29 May 1906.

<sup>17</sup> The differing facilities offered to local élites were justified on the grounds that "The better class of people naturally dislike mingling with the poorer classes in hospital". Oriental and India Office Collection (London) [hereafter OIOC] L/P&S/7/229–923, Dispensary report attached to

Gyantse Annual Report [hereafter GAR], 1 April 1908–31 March 1909.

<sup>18</sup> The house was subsequently described as "a very unsuitable building, impossible to keep clean, dark and ill-ventilated". OIOC L/P&S/7/241–1058, GAR, 1 April 1909–31 March 1910.

<sup>19</sup> Dirom Crawford, *The Roll of the Indian Medical Service 1615–1930*, London, W Thacker, 1930, p. 509; NAI FD, 1912 Establishment B, Jan. 38, application for employment by Captain Steen.

<sup>20</sup> NAI FD, External A, Sept. 1906, 40–46, WFO'Connor to Government of India, 29 March 1906.

<sup>21</sup> NAI FD, 1912 Establishment B, Jan. 38, application for employment by Captain Steen.

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Steen's popularity was an important consideration. His political superiors considered that while the efficacy of biomedicine and its free provision themselves enhanced the British reputation, "the right type" of doctor could do "a tremendous lot for British prestige".<sup>22</sup> One characteristic of the "right type" of officer was his ability to befriend the local people, for that personal relationship was regarded as the basis from which to enhance British diplomatic relations with the local state.

Thus, while Steen was stationed in Gyantse as a Medical Officer, his primary role there was actually a political one.<sup>23</sup> This close relationship between the medical and political roles of the European officers in Tibet was most clearly demonstrated by the career of Lieutenant (later Lieutenant-Colonel) Robert Kennedy, who served as Medical Officer in Gyantse from October 1907 to March 1910. By that time Tibet had ceased to be an important issue in British Indian diplomacy, which meant that ambitious Political Officers did not want to be posted there. From June to December 1909, in the absence of a suitable diplomatic candidate for the position as Gyantse Trade Agent, Lieutenant Kennedy combined the political role with his medical duties.<sup>24</sup>

The political nature of the Gyantse post was clearly understood by all parties involved in the British endeavour. Francis Younghusband had supported the establishment of a Gyantse dispensary precisely because it was "extremely desirable on political grounds"<sup>25</sup> and as O'Connor explained:

Although the medical officer at Gyantse originally received his orders from the military authorities and is still nominally in [medical] charge only of a small detachment of native troops at Gyantse, it was from the first considered desirable that a medical officer should remain at Gyantse more from political than for military reasons. Ordinarily no medical officer would be required with so small a detachment as 50 men . . . but as it was clear that Gyantse was being occupied entirely for a political purpose and not as a military post, and as the Foreign Department was establishing a British Officer in civil employment as their Trade Agent at that place, and as the ministrations of a medical officer were known to have a high political value, it seemed only right that an officer of the medical service should be left at Gyantse to carry on the work . . . with an eye far more to the political than the military exigencies of the case.<sup>26</sup>

The political goodwill obtained by Steen's services was described by O'Connor in the following fashion:

Our experience in Tibet throughout the [Younghusband] Mission and since has proved conclusively the valuable political effect produced by the medical treatment of the natives of the country by our doctors. It is a revelation to a backward ignorant race like the Tibetans to find that their conquerors carry humanity to such an extent as to provide them with free medical attendance, and that such marvellous cures can be effected (as for instance of cataract, etc) in the cases of diseases and disfigurements which they regarded as incurable and permanent.<sup>27</sup>

<sup>22</sup>NAI FD, 1904 Secret E, Feb., 1398–1445, file note by Francis Younghusband, 4 Nov. 1904.

<sup>23</sup>The term "political" is used here in the British Indian sense, as pertaining to relations with states bordering the territory of the Government of India. It thus equates to the term "diplomatic".

<sup>24</sup>Kennedy left Tibet in March 1910, being succeeded as Gyantse Medical Officer by

Captain D M C Church, who remained there until June 1911.

<sup>25</sup>NAI FD, External B, March 1906, 19–31, file note by Francis Younghusband, 4 Nov. 1904 [*sic*].

<sup>26</sup>NAI FD, External A, Sept. 1906, 40–46, W F O'Connor to Government of India, Foreign Department, 25 March 1906.

<sup>27</sup>*Ibid.*

So the British were satisfied that the Tibetans appreciated both the efficacy of biomedicine and the generosity of those offering it to all who asked. They judged that this resulted in the Tibetans taking a positive view of the British, and thus that the Tibetans were likely ultimately to prove more co-operative in the political and diplomatic sphere as a result of the British medical initiatives. That individual Tibetans appreciated the provision of free biomedical services cannot be in doubt, but the question of whether this resulted in British success in the diplomatic sphere is a complex one that must be located in the wider context of the Tibetan encounter with modernity. Anglo-Tibetan diplomatic relations did improve after the expulsion of the Chinese in 1912, but in the 1920s the Tibetan leadership rejected virtually all aspects of Western modernity in an unsuccessful attempt to preserve their religio-social system. That development virtually ended any British hopes of an indigenous biomedical tradition developing in Tibet.<sup>28</sup>

### The Establishment

The medical establishment at Gyantse in the 1905–10 period consisted of a British officer of the Indian Medical Service, a Hospital Assistant, a Compounder [of medicines], and a *khalassi* (dresser), along with a sweeper and a coolie. The status of the British officer was clearly expressed in financial terms. He received an annual basic salary of 7,200 rupees per annum, while the indigenous employees received 1,400 rupees between them.<sup>29</sup> Medicines were supplied to Gyantse by the Government of India, but financial considerations were always paramount in its administration of the posts in Tibet, which meant that there could be large discrepancies between the equipment and medicines requisitioned by the Gyantse Medical Officers and the actual supplies received. In 1907, for example, a precise and detailed list of sixty required specialist surgical items was submitted from Gyantse, but a greatly simplified and considerably more economical list of fifteen items was actually sanctioned.<sup>30</sup> Such economies must have impacted on the efficacy of biomedical practice at Gyantse.

The British officers in Tibet and other Political Department postings filed annual reports on the establishments under their jurisdiction, most of which have survived. The reports from the hospital at Gyantse vary somewhat in regard to the details they record, but collectively they do provide a valuable resource for the analysis of health conditions in a distinct Himalayan location over a specific period of time.

The first report from Gyantse states that in the first ten months of the hospital's existence, 58 operations were carried out under general anaesthesia, with one death recorded. Respiratory and heart diseases were noted as being rare there, with much of the Medical Officer's workload consisting of treating wounds and accidents, although "boils, ulcers and various diseases of the skin" are recorded as forming 23 per cent of all cases treated, with venereal diseases forming 15 per cent of the total.<sup>31</sup> Unfortunately the report does not

<sup>28</sup> On the 1920s, see, in particular, Melvyn Goldstein, *A history of modern Tibet, 1913–1951: the demise of the lamaist state*, London, University of California, 1989, *passim*; Alastair Lamb, *Tibet, China, and India 1914–1950*, Hertingfordbury, Roxford, 1989, *passim*; K Dhondup [sic], *The water-bird and other years*, Delhi, Rangwang Publications, 1986, pp. 64–92; McKay, *op. cit.*, note 3 above, pp. 102–18.

<sup>29</sup> NAI FD, External B, March 1906, 19–31, J C White to Government of India, Foreign Department, 7 Jan. 1905.

<sup>30</sup> NAI FD, External B, Oct. 1907, 1–4, various correspondence.

<sup>31</sup> OIOC MSS Eur F157–304b, GAR, 1906 [actually from Oct. 1904 to 31 March 1906].



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provide the total number of cases treated, although Steen does record that a temporary dispensary he opened for eight days while on a visit to the larger nearby town of Shigatse, treated between 500 and 600 cases in that time.<sup>32</sup>

In his Shigatse report, Steen noted the prevalence of eye diseases, which were among a number of conditions that could be improved by British surgery.<sup>33</sup> There was an indigenous treatment for cataracts, but a later report states that “[m]any eyes are destroyed by the native method of treatment (firing)”,<sup>34</sup> and this was to be one area in which considerable success was achieved by the British. As O’Connor had suggested, the restoration of a patient’s sight had an immediate and lasting impact on local thinking, and thus was valuable propaganda for the British system.

The annual dispensary report for 1906–7 records that the Gyantse hospital treated 369 patients, of whom 34 were inpatients, with 24 operations carried out. The principal conditions treated were “general and local injuries”, which totalled 60, syphilis, with 55 persons treated, and ulcers, which totalled 32 cases.<sup>35</sup> The figures for the 1907–8 period are not available,<sup>36</sup> but the following year’s report indicates that 23 per cent of patients were suffering from venereal diseases. While these were curable, the process was then a lengthy one and the Tibetans proved unwilling to continue the treatment after the immediate symptoms had vanished.<sup>37</sup>

In the 1909–10 report a total of 3,428 patients are listed as being treated, of whom 14.6 per cent were suffering from venereal diseases. A report was then submitted for the period 1 April to 31 December 1910, after which the reports were submitted on the basis of the calendar year. That abbreviated 1910 report breaks the figures down into two categories, outpatients, of whom 40 of 444 (9 per cent) were suffering from syphilis, and inpatients, totalling 65, of whom 31 (47.7 per cent) were similarly afflicted. Two of these inpatients were removed from the hospital by relatives and are presumed to have died of the disease.<sup>38</sup>

The treatment of venereal diseases was to continue to be a mainstay of the Gyantse Medical Officers’ workload. Their reports indicate that while the Chinese soldiers then in Tibet made up a high percentage of those suffering from these conditions,<sup>39</sup> venereal diseases were endemic in the country.<sup>40</sup> But the medical issue of greatest concern to the Government of India at that time was not venereal disease but smallpox, for the

<sup>32</sup> Ibid.

<sup>33</sup> NAI FD, External B, March 1906, 19–31, R Steen to W F O’Connor, 28 Oct. 1904.

<sup>34</sup> OIOC L/P&S/7/249–1151, dispensary report for the year ending 31 Dec. 1911. No details of the “firing” technique (or other Tibetan medical techniques) are given in British sources; Dr Alexander Hamilton, who visited Tibet in the 1770s, described the Tibetans as “entirely ignorant” of the structure of the eye and the nature of cataracts, but more successful in treating them than European doctors due to superior instrumentation; see A Hamilton to G Bogle, 6 Nov. 1775, in A Lamb (ed.), *Bhutan and Tibet: the travels of George Bogle and Alexander Hamilton 1774–1777; Vol. 1, Letters, journals and memoranda*, Hertingfordbury, Roxford Books, 2002, pp. 388–9.

<sup>35</sup> OIOC L/P&S/7/203–1162, GAR, 1 April 1906–31 March 1907.

<sup>36</sup> The dispensary report for that period is not attached to the GAR contained in L/P&S/7/220–1625.

<sup>37</sup> OIOC L/P&S/7/229–923, dispensary report for the period 1 April 1908–31 March 1909.

<sup>38</sup> OIOC L/P&S/7/241–1058, dispensary report for the period 1 April 1909–31 March 1910; L/P&S/7/249–1151, dispensary report for the period ending 31 Dec. 1910.

<sup>39</sup> See, for example, OIOC L/P&S/7/249–1151, dispensary report for the year ending 31 Dec. 1911.

<sup>40</sup> That conclusion, however, may testify more to the efficacy of the biomedical treatment of venereal diseases (particularly with the introduction of Salvarsan around 1910), than actual disease rates. I hope to explore this issue in greater depth in the future.

Indo-Tibetan trade routes were also routes by which epidemics could be carried across the Himalayas by traders and pilgrims. A serious outbreak of smallpox in the year 1900–1 was known to have devastated central Tibet, with 3,000 to 5,000 monks alone reported to have died of the disease in Lhasa. The epidemic had then spread south, causing hundreds of deaths in the Gyantse region. The Government of India had responded by closing the main passes from central Tibet until arrangements were made to vaccinate all persons crossing the frontier, an action which contributed to a significant slump in the cross-border trade for that period.<sup>41</sup>

By the early years of the twentieth century, the imperial medical authorities in India had considerable experience in the implementation of smallpox vaccination campaigns.<sup>42</sup> They were acutely aware that vaccination potentially aroused cultural or other forms of resistance, but its efficacy was undoubted. The benefits of its extension across the frontier into Tibet were thus summarized by the Director-General of the Indian Medical Service: “Vaccination seems to be very desirable from a humanitarian point of view and will in some degree protect our territory from the introduction of smallpox. It is also a means of impressing the natives.”<sup>43</sup>

In this case, however, the fact that “the natives” were not citizens of British India was a significant issue. Whereas the Political Officer responsible for the imperial government’s relations with Sikkim, Bhutan and Tibet could, to a very large extent, enforce British will in the former two states, Tibet was in no way a part of British India and remained outside his authority (although the imperial frontier officers from Younghusband onwards sought to establish greater British domain there). This meant that, whereas vaccination campaigns quickly followed the introduction of British authority in Sikkim, and to a lesser extent Bhutan (where, unlike Sikkim, there were no permanent European residents), the process in Tibet was more sensitive. As a state outside British Indian authority, Tibet could not be forced, but only encouraged to vaccinate its people.

The position was also complicated by the fact that despite Tibet’s semi-independent status at that time, the Chinese claimed it as being a part of their empire, and one or two Chinese *ambans* (diplomatic representatives) were stationed in Lhasa to enforce the Emperor’s will. The British Government officially acknowledged that Chinese position, and particularly in the period up to 1912–13, when all Chinese officials were expelled by the Tibetans, the Government of India had to deal with the Chinese as the suzerain power in Tibet. This was not always easy, the Chinese were hostile to a British presence there, and sought to undermine the authority of the British agents. As a part of that campaign they argued that the British vaccination campaigns constituted impermissible interference in Tibet’s internal affairs.

The value of vaccination against smallpox was, however, becoming known to the Tibetans. During the Younghusband mission vaccination seems to have been offered to

<sup>41</sup> NAI FD, External B, May 1906, 156–158, J C White to Government of India, 5 Feb. 1906, and R Steen to W F O’Connor, 14 Dec. 1905.

<sup>42</sup> For a nuanced discussion of smallpox vaccination issues, see Sanjoy Bhattacharya, ‘Re-devising Jennerian vaccines? European technologies, Indian innovation and the control of smallpox in south

Asia, 1850–1950’, in B Pati and M Harrison (eds), *Health, medicine and empire: perspectives on colonial India*, Delhi, Orient Longman, 2001, pp. 217–69.

<sup>43</sup> NAI FD, External B, May 1906, 156–158, file note by G Bomford, 22 March 1906.

any Tibetan who requested it. We know that this had some influence on the Himalayan élites, for among Younghusband's party was the soon-to-be King of Bhutan, who acted as a high-level intermediary on the mission. He was impressed by his observations of the results of biomedicine in general and vaccination in particular, later requesting that these be introduced into Bhutan.<sup>44</sup> A similarly positive impression was presumably created in the minds of at least some of the Tibetan peoples.

The support of local élites was essential to the process of introducing vaccination in areas outside the direct control of the Government of India—that is, the Princely States and neighbouring regions. In both Sikkim and Bhutan the British had formed alliances with the local rulers and gained their support for vaccination programmes. Thus they sought an alliance with a similar figure of authority to promote vaccination in Tibet. Tibet's ruler, the Dalai Lama, had fled to Mongolia as Younghusband's troops advanced on Lhasa, but the British identified a suitable alternative candidate in the Panchen Lama, Tibet's second highest religious figure. The Panchen ruled over his court in Tibet's second biggest town of Shigatse, a day's ride from the British post at Gyantse, and in the immediate aftermath of the Younghusband mission, O'Connor devoted considerable effort to befriending the Panchen Lama. He spent much of his time in Shigatse rather than at Gyantse, and succeeded in persuading the Panchen to visit India for three months in 1905–6. There he sought to ensure that the Lama was treated with considerable respect while at the same time being impressed by the nature and extent of British power.<sup>45</sup>

Among those accompanying the Panchen Lama in India was Captain Steen, and he escorted the Panchen back to Shigatse on the return journey and remained there for several weeks—presumably in case the Lama manifested symptoms of any diseases acquired in India.<sup>46</sup> That was a very real danger; among the many members of the Tibetan's party who had become ill on the journey was the Panchen Lama's uncle, who died of malaria in Darjeeling. He had, however, failed to take the medicines provided by Steen, and the Gyantse diary, in headmasterly tone, claims that “The Lama and other Tibetans thoroughly understand that his death was due to his neglect to follow Captain Steen's advice, or to take European medicines”.<sup>47</sup>

The Panchen Lama and his large entourage were vaccinated against smallpox before they went to India, and on his return to Tibet Steen reported that he had held a lengthy conversation with the Panchen “chiefly about medical topics and rifles.” He noted that “In regard to the former, he expressed a wish that I might introduce vaccinations into Shigatse”.<sup>48</sup>

We need, however, to treat these British reports with some caution; it was common practice for the imperial officers to persuade indigenous rulers to agree to, or to adopt, a particular policy favoured by the imperial power, but to attribute the credit for the

<sup>44</sup> OIOC MSS Eur F157–224, Bhutan diary of R Kennedy 1909–10, entry of 9 Jan. 1910; see also Alex McKay, ‘British-Indian Medical Service Officers in Bhutan, 1905–1947: a historical outline’, in Karma Ura and Sonam Kinga (eds), *The spider and the piglet: Proceedings of the first International Seminar on Bhutan Studies*, Thimphu (Bhutan), The Centre for Bhutan Studies, 2004; also available online at [www.bhutanstudies.org.bt/publications/spdr-pglt/spdr-pglt.htm](http://www.bhutanstudies.org.bt/publications/spdr-pglt/spdr-pglt.htm).

<sup>45</sup> McKay, op. cit., note 3 above, pp. 17–39.

<sup>46</sup> NAI FD, Secret E, May 1906, 47–76, Diary of Captain Steen at Shigatse, entry of 26 Feb. 1906; see also Satis Chandra Archaryya, *The Tashi Lama's visit to India*, Calcutta, Government Printing office, 1907.

<sup>47</sup> NAI FD, Secret E, May 1906, 47–76, Gyantse diary entry of 18 Jan. 1906.

<sup>48</sup> NAI FD, Secret E, May 1906, 47–76, Diary of Captain Steen at Shigatse, entry of 26 Feb. 1906. The Panchen Lama sought British weaponry to bolster his political position.

initiative to the local ruler in order to avoid any charge of interference in internal affairs. The initiatives in fact developed from a complex interplay of personal relations, aims, ideas and circumstances.<sup>49</sup>

Steen had in any case already instituted a vaccination programme in Gyantse, nearly a year before his “discussion” with the Panchen Lama. Around 1 May 1905, local employees, servants and followers attached to the Gyantse Agency were vaccinated. Subsequently, as Steen reported:

The Jongpen [local administrator] and leading men of the town and district were then approached and the methods and value of vaccination fully explained to them. Some had heard of it, others had not, but all agreed that it would be a great blessing if such a terrible disease could be prevented. Since then these leading men have rendered great assistance by explaining the nature of vaccination to their people and encouraging them to come forward.<sup>50</sup>

Steen trained three Tibetans in vaccination and by 31 December 1905, 1,320 children had been vaccinated in Gyantse and the surrounding neighbourhood.<sup>51</sup> Vaccination in and around Gyantse continued until December 1906, when the local Chinese representative suddenly claimed that this programme constituted British interference in Tibet’s internal affairs. Although his claim rested on the objection that vaccination was compulsory,<sup>52</sup> and was only one of a number of objections to British activities in Gyantse that he raised at the time, the Government of India accepted the need to avoid any suggestion of such interference, and vaccination ceased.<sup>53</sup>

In April 1907, however, the local administrators in western Tibet requested the assistance of British Indian vaccinators to control an outbreak of smallpox there, and vaccination resumed at Gyantse late in 1907.<sup>54</sup> That the Chinese objections were part of a larger struggle to expel the British from Tibet is further indicated by the fact that in September 1908 the Chinese *amban* ordered the vaccination of all Tibetans.<sup>55</sup> In other words, the Chinese objections were not to vaccination itself but to the British sponsoring the vaccination.

When the British resumed their vaccination programme in 1907, it was carried out by two Tibetans whom they had trained (although it is unclear if these were the same men trained by Steen). In the 1909–10 year this pair carried out 389 vaccinations,<sup>56</sup> and the Gyantse Medical Officer confidently reported that the next outbreak of smallpox would demonstrate the efficacy of vaccination.<sup>57</sup> He seemed to be proved right in the following year when an outbreak of smallpox caused numerous deaths in Lhasa and

<sup>49</sup> On departing Tibet, Steen did, however, receive a personal letter from the Panchen Lama regretting his departure; OIOC L/P&S/7/203–1162, GAR, 1 April 1906–31 March 1907.

<sup>50</sup> NAI FD, External B, May 1906, 156–158, R Steen to W F O’Connor, 14 Dec. 1905.

<sup>51</sup> OIOC, MSS Eur F157–304b, GAR, 1906.

<sup>52</sup> That vaccination was compulsory was denied by the British and this was never official policy. Given that the co-operation of local élites was secured prior to vaccinating villages etc., it is, however, possible, that some degree of coercion, if only social, was involved.

<sup>53</sup> NAI FD, Secret E, Feb. 1907, 295–353, various correspondence.

<sup>54</sup> NAI FD, Secret E, June 1907, 375–389, various correspondence; FD, External B, June 1911, 289, various correspondence.

<sup>55</sup> NAI FD, External B, Oct. 1908, 194–216, Gyantse diary entry of 10 Sept. 1908. Chinese medical initiatives in this period do not appear to have been implemented in actuality, and the collapse of the Manchu dynasty after 1910 ended the official Chinese presence in Tibet.

<sup>56</sup> OIOC L/P&S/7/241–1058, GAR, 1 April 1909–31 March 1910.

<sup>57</sup> OIOC L/P&S/7/229–923, dispensary report for the period 1 April 1908–31 March 1909.

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Shigatse, but few in Gyantse. The number of vaccinations carried out that year leapt to 2,131, as might be expected. But these figures conceal difficulties with the vaccinators. The two Tibetans were found to be taking bribes not to vaccinate people, and were sacked. Only one suitable candidate was found to replace them, and he died soon after in Shigatse of unspecified causes while vaccinating there.<sup>58</sup>

The British sources generally paint a bright picture of Tibetans keen to embrace vaccination. Thus in reports around the time of this outbreak we read that the

Tibetans are very appreciative of the value of vaccination; during one month representatives from villages, many of them five days journey from Gyantse, came to hospital to say that smallpox was raging with them, and asking that the vaccinator be sent out.<sup>59</sup>

But a subsequent report clarified the nature of the Tibetans' enthusiasm for vaccination. They were, it stated, "reluctant to undergo vaccination unless the disease is actually amongst them".<sup>60</sup>

Thus, amidst the confident and optimistic accounts of biomedical progress in Tibet, there are indications that, as in India, there was some indigenous resistance to the smallpox inoculation process in Tibet. The fact that the vaccinators were being bribed not to vaccinate people also lends weight to the Chinese allegation that some form of coercion was used in the process.<sup>61</sup>

Steen had felt it necessary to emphasize that:

No compulsion of any kind, it is needless to say, was resorted to. When the people saw that the application of the vaccine caused little or no discomfort and when they understood that the measure was intended to prevent smallpox the children were brought forward quite voluntarily.<sup>62</sup>

Similarly, in official correspondence, the Panchen Lama's acceptance of vaccination was frequently quoted as evidence of Tibetan acceptance, as was the request from the western Tibetan authorities in April 1907. But an obituary of Lieutenant-Colonel Kennedy (which was apparently written by a contemporary British agent in Gyantse), notes that Kennedy "also vaccinated a large number of the local inhabitants, at first *by guile and persuasion*, but later at their urgent request".<sup>63</sup>

While the British sources also describe a Tibetan reluctance to undergo hospitalization, surgery under anaesthetic, and continuing treatment for venereal disease after the elimination of immediate symptoms, no other aspect of biomedical practice appears to have encountered such active resistance as vaccination. In the absence of Tibetan sources, their perspective is difficult to analyse. Tibetans did not have the gender and caste purity concerns that affected the issue in India.<sup>64</sup> Tibetan women were not socially isolated

<sup>58</sup> OIOC L/P&S/7/249–1151, GAR, 1 April 1910–31 March 1911; OIOC L/P&S/7/241–1058 GAR, 1 April 1909–31 March 1910.

<sup>59</sup> OIOC L/P&S/7/249–1151, dispensary report for the year ending 31 Dec. 1911.

<sup>60</sup> OIOC L/P&S/10/218–2396, dispensary report for the year ending 31 Dec. 1914.

<sup>61</sup> In 1908, vaccination was made compulsory in Sikkim, where the British had a controlling influence over the local government; OIOC L/P&S/10/92–1289, Sikkim annual report, 1908–9.

<sup>62</sup> OIOC MSS Eur F157–304b, GAR, 1906.

<sup>63</sup> OIOC MSS Eur F157–224a, obituary contained in Kennedy to Bailey correspondence; presumably by F M Bailey, whose long service on the frontier included a posting as Gyantse Trade Agent, 1907–9. Emphasis added.

<sup>64</sup> Unfortunately the British medical reports do not provide any figures concerning the gender of those inoculated.

from contact with men and thus their status was not, as it was in India, threatened by contact with a male vaccinator. Nor did Tibetan society base social gradations around notions of purity and impurity in the manner of the Indian caste system, where the introduction of a cultivated serum into the high-caste body threatened loss of caste status.<sup>65</sup>

Given that Tibet was not under British imperial control, it is also difficult to locate a Tibetan parallel to the relationship between nationalism and resistance to biomedicine that developed in India. There was a clearly distinguishable Tibetan identity historically based around elements such as shared dress, diet, language, and mythologies such as the Gesar of Ling saga. But this was generally only expressed *vis-à-vis* a foreign “other” in a society where the primary identity was local or regional. Thus the Tibetans at that time lacked a sense of nationalism in the modern understanding of that term as linked to the European concept of a “nation-state”; one with fixed borders and a single political authority holding a monopoly over state use of force and relations with foreign powers. “Tibet” included enclaves under foreign authority, and a variety of political and administrative formations that contested centralizing power and carried out dealings with foreign powers without reference to Lhasa.<sup>66</sup>

Tibetan resistance to vaccination may be best located in the indigenous context of resistance to innovation, for Tibetan society at that time was overwhelmingly conservative and resistance to innovation was characteristic.<sup>67</sup> This is not to be understood in such simplistic terms as a “static” or “traditional” society but was rather an expression of an active and articulated policy deriving from a particular Buddhist world-view of Tibet as the home of Buddhism under the special protection of the Bodhisattva Avalokiteśvara, and thus as an ideal land. Resistance was therefore, not to vaccination as “foreign”, or as an expression of a colonial power relationship, but rather to altering the status quo as established by the Buddha. In that sense it was a religious objection.

Adding to the potential for resistance in the Tibetan reception of biomedicine was the fact that the main preservers of the existing social structure were the monastic powers, among whose ranks, as we have noted, were those whose income (and status) derived from their knowledge and skilful practice of the Tibetan medical system. With the influence which the monasteries enjoyed throughout Tibetan society, these monks were potential

<sup>65</sup> See David Arnold, ‘Touching the body: perspectives on the Indian plague, 1896–1900’, in *Subaltern Studies V*, ed. R Guha, New Delhi, 1987, reprinted in *Selected Subaltern Studies*, ed. R Guha and G Spivak, New York, Oxford University Press, 1988, pp. 391–427, esp. pp. 396–400. In this and works such as his *Colonizing the body: state medicine and epidemic disease in nineteenth-century India* (Berkeley, University of California Press, 1993), Arnold largely initiated analysis of the complexities of the Indian reception of British medical initiatives. See also Frédérique Marglin, ‘Smallpox in two systems of knowledge’, in Frédérique and Stephen Marglin (eds), *Dominating knowledge: development, culture, and resistance*, Oxford, Clarendon Press, 2001 (first published in 1990), pp. 102–44, where the author reads resistance to both colonial and post-colonial state vaccination campaigns as political resistance “in the

name of the goddess of smallpox” against “logocentric structures of power”. Her bizarre belief that “Smallpox need not have been eradicated; it could have been controlled” is unlikely, however, to find supporters among those who have actually witnessed, or suffered, the effects of the disease.

<sup>66</sup> For an extended discussion of the issue of Tibetan nationalism in this context, see McKay, op. cit., note 3 above, pp. 196–211. Works of note on Tibetan identity include Geoffrey Samuel, *Civilized shamans*, Washington, DC, Smithsonian Institution Press, 1993; and P Christian Klieger, *Tibetan nationalism: the role of patronage in the accomplishment of a national identity*, Berkeley, Folklore Institute, 1992.

<sup>67</sup> For the predominantly conservative nature of Tibetan society, this is best illustrated in the political context by the work of Goldstein, op. cit., note 28 above.

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leaders of opposition to biomedicine (and other aspects of modernization) and where the British sources do indicate resistance to their medical innovations, it is the monks who are blamed. The 1911 report, for example, states:

This comparatively few number of patients is explained by the opposition of the Lamas, who put obstacles in the way of people coming for treatment. The reason is not far to seek, as the dispensary interferes with the fees of the Lamas who are exorcists for all manner of ghosts and demons to whom disease and even injury are universally ascribed.<sup>68</sup>

There was a general tendency for the British to demonize the collective body known as “the monks” and to attribute all Tibetan resistance to them, rather than to acknowledge broader socio-economic concerns. In practice, the British distinguished those monks—in particular the élites such as the Panchen Lama—with whom they established good relations. But they recognized that the core of opposition to their presence came from the monastic community, whose status their modernization project threatened.<sup>69</sup>

While monastic opposition was part of a wider political problem for the British, it was also an issue of genuine medical concern to the IMS officers. They found that it was only when the monks “have experimented and failed that the patients come to the dispensary. The result is that some of the cases are very serious”.<sup>70</sup> This problem was to be common throughout the British period, but particularly in these early years it seemed that Tibetan patients, or their indigenous physicians, often—or generally—used biomedicine as a strategy of last resort.

The advice of a monastic physician, novelty, chance, or economic circumstance may all have led Tibetan patients to resort to the IMS dispensaries. But while receiving biomedical treatment, many of the patients doubtless continued with indigenous therapies, particularly in regard to the religio-medical aspects of their understanding of disease causation, and their uptake of the new system was selective. The evidence for the Tibetans’ continuing resort to indigenous practitioners suggests that we might need to read the records of treatment at biomedical facilities as indicative not of overall local health patterns, but only as a record of those conditions Tibetans regarded as best treated within the biomedical system.

The increasing attendance at the IMS dispensaries does suggest, however, that the efficacy of biomedicine at least in regard to specific conditions such as smallpox or cataract surgery gradually came to be acknowledged by the Tibetans.<sup>71</sup> Modern anthropological studies indicate that Himalayan patients may regard biomedicine as effective in the worldly sphere but continue with indigenous practices regarded as effective in the other-worldly

<sup>68</sup> OIOC L/P&S/7/241–1058, GAR, 1 April 1909–31 March 1910.

<sup>69</sup> On the wider political context of British relations with the Panchen Lama in this period, see McKay *op. cit.*, note 3 above, pp. 18–42. The British sources do not, however, provide evidence for the extent to which local politics can be seen to have configured the reception of biomedicine either in Gyantse in this period, or later in Lhasa. Individual patients or local supporters are rarely referred to.

<sup>70</sup> OIOC L/P&S/7/249–1151, GAR, 1 April 1910–31 March 1911; L/P&S/7/249–1151,

dispensary report for the year ending 31 Dec. 1911.

<sup>71</sup> Resistance to vaccination had largely vanished by the 1920s, when there were a number of examples of Tibetan state uptake of vaccination; see OIOC; L/P&S/10/218–2120 dispensary report for the year ending 31 Dec. 1922 and L/P&S/10/218–2418, dispensary report for the year ending 31 Dec. 1923. As early as 1913, a group of Nepalese vaccinators found it profitable enough to travel around vaccinating people for a small fee. OIOC, L/P&S/10/218–2684, dispensary report for the year ending 31 Dec. 1913.

sphere,<sup>72</sup> and this may well have been the case with the Tibetans at that time. The ultimate result, however, was increasing Tibetan resort to, and familiarity with, the concepts of biomedicine.

In this early period there is no evidence for the interaction between the Tibetan and biomedical systems that was to develop in the late colonial period and which has been a feature of more recent medical history. There was no official communication or interface between the systems and little in the way of private initiatives. Biomedicine was culturally foreign to the vast majority of Tibetans, and this early period saw multiple elements of resistance to that foreign system, albeit that that resistance was not expressed in terms closely equating to that arising in India. Yet whether for reasons of cost, efficacy, or as a part of the wider process of the introduction of modernity, biomedicine did slowly increase in popularity between 1905 and 1910, paving the way for further Tibetan uptake of that system in later years.

### Issues of Planning

Effective medical treatment obviously required medical staff who could communicate with their Tibetan patients. But although IMS officers were required to have learned an Indian language they were not expected to know Tibetan when they arrived there. Steen seems to have learned some Tibetan, but even he engaged a Hindi-speaking Tibetan as an interpreter, and after his successor, Lieutenant F H Stewart, reported that neither he nor his Hospital Assistant spoke any Tibetan,<sup>73</sup> the interpreter's position was made a permanent one. Although Stewart's successor, Lieutenant Robert Kennedy, did come to acquire a good knowledge of Tibetan, Kennedy also used an interpreter when he began his service in Gyantse.<sup>74</sup>

Mere competence in Tibetan and Hindi was not enough to qualify an interpreter, however; class issues were also involved. O'Connor's application for the permanent services of an interpreter for the Gyantse hospital gave one essential qualification for his medical work, that "the interpreter [be] of respectable birth, and attainments".<sup>75</sup> As Stewart explained, It is ... highly desirable for the extension of friendly relations with the people that the Medical Officer should be in a position to be consulted by the better class of Tibetans. To have to employ a man of the coolie class as interpreter in regard to their private affairs would be sufficient to entirely prohibit such consultation.<sup>76</sup>

O'Connor and Stewart went on to suggest that a suitably educated Tibetan employed as an interpreter could also be further trained in the intricacies of Tibetan official correspondence etiquette, and would thus be "fitted for other Government

<sup>72</sup> See, for example, Martin Gaenszle, 'The shaman and the doctor: conflicting systems of interpretation and diagnosis in East Nepal', in D Sich and W Gottschalk (eds), *Acculturation and domination in traditional Asian medical systems*, Stuttgart, Franz Steiner, 1994, pp. 53–60, esp. p. 56.

<sup>73</sup> NAI FD, External B, April 1907, 32–33, Lt. F H Stewart to Trade Agent Gyantse, 8 Jan. 1907.

<sup>74</sup> Major Francis Hugh Stewart, born Galasheils 1879, educated St Andrews and Edinburgh, IMS

1904–21; Lt-Col. Robert Siggins Kennedy, DSO, MC, born Ireland 1882, educated Queen's College Cork, IMS 1906–23. Kennedy later spent nearly a year in Lhasa with the Political Officer Charles Bell in 1921.

<sup>75</sup> NAI FD, External B, April 1907, 32–33, W F O'Connor to the Political Officer Sikkim, 12 Jan. 1907.

<sup>76</sup> NAI FD, External B, April 1907, 32–33, Lt. F H Stewart to Trade Agent Gyantse, 8 Jan. 1907.



employment”.<sup>77</sup> This question of locating suitable intermediaries had long been an issue that concerned the British in their dealings with Tibet. Communication between the two cultures, British and Tibetan, required the use of local intermediaries who were familiar with both cultures, and who could explain one to the other. Attempts to develop suitable intermediaries had begun as early as 1874, when the Bhutia Boarding school was established in Darjeeling to train local Tibetan-speaking youths as “interpreters, geographers and explorers, who may be useful if at any future time Tibet is opened to the British”.<sup>78</sup>

The Bhutia school project did not prove a success, however. None of the youths from the school was “found to be of any real service, either as interpreter or in any other capacity” on the Younghusband mission, and O’Connor now suggested employing suitable Tibetans at Gyantse and training them to serve the British.<sup>79</sup>

The question of education was to prove crucial. Both the modernization project and the practical needs of day-to-day operations in the Gyantse hospital required that upper-class Tibetans should take up the practice of biomedicine. In Tibet, as in Sikkim, Bhutan and elsewhere, the British frontier officers wanted to see indigenous youths trained in the dominant Western medical system. The officials understood medical science as a beneficent and universally applicable system of truths, and the modernization of Tibet, seen by the British as both inevitable and a process to be encouraged, required the indigenization of biomedicine. Local practitioners, once trained by the British, could then inaugurate the development of a Tibetan public health system, with medical education and training itself becoming indigenized.

At that time, however, Tibetan trainees were hardly likely to be of immediate value in the medical field because training in Western biomedicine essentially required a Western education. Tibetans educated in Tibet learned an entirely different world-view to that inculcated even by British education in India and at that time there were no resident Tibetans with a Western education. The usual processes by which biomedical practitioners were trained were therefore absent, and the introduction of Western education to Tibet was clearly an essential first step towards producing Tibetan biomedical practitioners. A series of rather unsuccessful initiatives in that direction were thus promoted by the British during the ensuing decades.<sup>80</sup>

Imperial government, however, was not always as enthusiastic about such grand schemes as its “men-on-the-spot”. Both financial considerations and wider global concerns acted as a brake on such plans. Thus, as early as December 1904, O’Connor suggested that four young Tibetans be trained in medical work, initially in the Gyantse clinic,

<sup>77</sup> NAI FD, External B, April 1907, 32–33, W F O’Connor to the Political Officer Sikkim, 12 Jan. 1907.

<sup>78</sup> A W Croft, Director of Public Instruction, to A C Lyall, Foreign Department, Simla, 18 April 1879; NAI FD, Proceedings, Secret, Jan. 1882, 722–25, quoted in Derek Waller, *The pundits: British exploration of Tibet and Central Asia*, Lexington, University Press of Kentucky, 1990, p. 193 note 3, p. 292.

<sup>79</sup> NAI FD, External B, April 1907, 32–33, W F O’Connor to the Political Officer in Sikkim, 12 Jan. 1907.

<sup>80</sup> Four Tibetan youths were sent to Rugby school in England in 1914; the experiment was not repeated. An English school existed in Gyantse in the period 1923–26; it was closed as part of a general Tibetan movement against modernization at that time. An English school opened in Lhasa in the 1940s but was also short-lived, although by this time some Tibetans were sending their children to Western schools in India.

and later at Darjeeling. But his government, reluctant to involve itself in Tibetan internal affairs and fearful of upsetting China, eventually replied only that “you should avail yourself of any opportunity that may occur for encouraging the Tibetan authorities to send students to India for medical training without appearing to press them to do so”.<sup>81</sup> In the event, circumstances prevented O’Connor from proceeding with this plan and the eventual failure of the Tibetans to modernize their social system meant that at the time of the Chinese invasion of Tibet in 1950 there were apparently no indigenous Tibetans qualified in the practice of biomedicine.

British initiatives to stimulate the development of an indigenous biomedical tradition in Tibet continued, however. In 1909 it was proposed to train two Sikkimese Bhutia youths in medicine for future employment in Tibet. The Bhutias of Sikkim were ethnically Tibetan, and the Political Officer in Sikkim, Charles Bell, reported that “there will . . . be considerable political advantage to be derived from showing the people of Tibet people of their own race doing medical work after being trained in a medical college in India”.<sup>82</sup> Two Sikkimese youths were eventually trained as Sub-Assistant Surgeons and posted to Tibet during the First World War. One of these, Bo Tsering, subsequently served in the British hospitals in Tibet for more than thirty years.<sup>83</sup>

Race was also a factor in the selection of staff for the Gyantse hospital. When Steen’s normal two-year term in Gyantse ended, there were moves to replace him with one Captain D P Goil (an Indian). But a key factor in the British understanding of the basis of their power in India was their belief in prestige as an economical weapon with which to protect their imperial possessions. They believed that if the power and honour of the empire was projected strongly enough to its subjects then the empire would be seen as invincible and resistance to it as futile. Considerable importance was thus attached to the maintenance of British prestige, with considerable time devoted to considering the effects of various actions on that prestige. One conclusion the British reached was that no matter how effective an Indian might be professionally, he could not uphold the prestige of the empire to the extent that a British officer could; only a British officer could project and maintain the prestige considered essential in a political position.<sup>84</sup> Thus it was concluded that on “political grounds it is important that the Medical Officer in a pioneer post like Gyantse should be a European”,<sup>85</sup> and in October 1906 Steen was replaced by a Scotsman, Lieutenant (later Major) Stewart.

<sup>81</sup> NAI FD, External B, May 1905, 258–59, W F O’Connor to Government of India, 18 Dec. 1904, and reply of 16 May 1905.

<sup>82</sup> NAI FD, 1909 Internal B, June 57–58, C Bell to Government of India, 6 April 1909.

<sup>83</sup> OIOC L/P&S/10/218–2593, dispensary report for the year ending 31 Dec. 1916. Bo Tsering (d. 1953) was a Gangtok Sikkimese whose father worked for the local ruler. It is interesting to note that there was a large increase in the numbers of Tibetans attending the Gyantse hospital after Bo Tsering became Gyantse Medical Officer in December 1915. (His appointment was due to wartime shortages of personnel, and he remained in the post until a European medical officer replaced him in 1922.) Tsering attributed the increase to the growing

popularity of the biomedical facility, but it may be that the Tibetans actually felt more comfortable consulting a Sikkimese medical practitioner. (The Sikkimese aristocracy is of Tibetan origin.)

<sup>84</sup> McKay, *op. cit.*, note 3 above, pp. 143–47.

<sup>85</sup> NAI FD, 1906 External A, Dec., 31–38, file note by V Gabriel, 16 July 1906. The use of Indians in any positions of responsibility in Tibet was ruled out by the Sikkim Political Officer in the following terms: “Indians are handicapped by their inability to speak Tibetan, by the difference of their religion and by their ignorance of the habits of the people”; OIOC L/P&S/7/229–923, GAR, 1 April 1908–31 March 1909, cover note by Charles Bell, 11 May 1909. The British were, of course, similarly handicapped, but

### **The Expansion of Biomedicine**

While Gyantse was the centre of British medical activities in Tibet during the period under consideration, two smaller medical establishments had also been created after the Younghusband mission. One was a clinic at Yatung, in the Chumbi valley just over the border from Sikkim, and the other a dispensary at far-off Gartok, in western Tibet, at which places the British had opened smaller Trade Agencies. In addition, a dispensary was opened at Phari, north of the Chumbi, in August 1905.<sup>86</sup> The medical establishments at these locations were generally under the charge of an Indian Hospital Assistant, although during the initial period when the Chumbi valley was still occupied by British forces an IMS officer, Captain O'Leary, was in overall charge there.

Whereas in Sikkim the initial establishment of an imperial medical centre at the capital of Gangtok had been followed by the gradual dissemination of dispensaries throughout rural centres, Phari remained the only addition to British biomedical establishments in Tibet until the 1930s. Both economic restrictions and political considerations acted against any such British medical expansion, as did competition from Chinese plans for controlling the modernization of Tibet (albeit along the Western scientific lines that China herself was taking up).

Despite its gradual increase in popularity among the population at large, there appear to have been no moves by the Tibetans to introduce any form of biomedicine at state level. Their first public health initiative came only after the expulsion of the Chinese from Tibet in 1912, with the opening of a public hospital within the Men-se-Khang college in Lhasa in 1916.<sup>87</sup> Medical services there were provided free of cost,<sup>88</sup> but treatment was solely with indigenous Tibetan medicine. While this initiative did help to establish the hospital system within Tibetan understanding,<sup>89</sup> and the institute survives in a different incarnation both in Lhasa and in the exile capital of Dharamsala (north India), no Tibetans appear to have taken up biomedical practice prior to the Chinese take-over of Tibet in 1950.

The British medical post at Gyantse was handed over to the successor Indian Government at independence in August 1947. A total of 23 medical officers served in Gyantse during the 1904–47 period, latterly including a number of Indian officers as the European component of the IMS gradually declined. After 1936–37, however, when the British established a permanent mission at the Tibetan capital, Lhasa, Gyantse's importance was diminished as the Lhasa mission became the centre of British activity in Tibet.

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assumed their superior ability to surmount these difficulties. Indians were later employed in Tibet, most notably as Medical Officers in Gyantse in the 1940s.

<sup>86</sup>NAI FD, External B, Aug. 1905, 227–228, various correspondence.

<sup>87</sup>The initiative for this hospital appears to have come from the Dalai Lama, who in a reversal of his previous flight, had gone into exile in British India in 1910 to escape Chinese domination. There he came under the authority of the Political Officer Charles Bell, who apparently influenced him to experiment with a

number of aspects of modernity on his return to Tibet in 1913. The beneficent aspect of a public hospital would naturally have appealed to Buddhist sensibilities.

<sup>88</sup>Rechung Rinpoche, *op. cit.*, note 10, p. 25.

<sup>89</sup>Geoffrey Samuel, 'Tibetan medicine in contemporary India: theory and practice', in L H Connor and G Samuel (eds), *Healing powers and modernity: traditional medicine, shamanism, and science in Asian societies*, Westport, Connecticut/London, Bergin & Garvey, 2001, pp. 261–3.

## **Conclusions**

The British medical endeavour in Tibet was very much a part of the political project there. But a reading of the sources for the entire period of the British presence in Tibet from 1904 to 1947 indicates that just as the success of the political project was limited, so too was the spirit of optimism that pervades the early British medical reports to be largely unfounded. The Tibetans only gradually took up biomedicine, and continued resistance to it by the monastic powers is recorded even in the 1940s.

Yet the 1905–10 era was, none the less, one in which significant numbers of (central) Tibetans first became acquainted with biomedicine, and came to regard certain aspects of that system as in some way efficacious. This selective uptake of specific elements of biomedicine suggests that Tibetans were carefully evaluating the worth of the new system and identifying those conditions for which resort to biomedicine was most beneficial. There was, however, a continuing faith in the indigenous system, which seems to have remained the first resort, and conservative resistance to the more bodily intrusive aspects of biomedicine.

The British efforts to promote biomedicine may have been restricted by problems of language and by the limitations on the medical services they could provide, and given that the British had invaded Tibet in 1903–4, the Tibetans' evaluation of the new system may have been affected by the political context of the encounter. But the conservative tendencies of Tibetan society in that era were probably the major factor in the slow uptake of biomedicine.

The question of whether experimentation with the new system was stimulated by its being free of cost remains problematic. But certainly the Tibetan consumer should not be understood as a passive recipient of biomedicine, or entirely under the influence of the monastic powers. Particularly among the poor, individuals may well have taken up biomedicine for economic reasons, and particularly in this period when the state authorities had so recently been swept aside by outside power, some questioning or even resistance to the traditional systems and authorities may have manifested in experiments with biomedicine.

With training in the biomedical system requiring the world-view imparted by a Western education, the medical modernization process in Tibet could not proceed in the period under consideration. Nor is there any evidence of any real interaction between the two systems at this time; that was only to emerge in the following decades. But despite a limited geographical impact, the developments in Gyantse in this period do mark the beginning of the Tibetan encounter with state biomedical systems, and the earliest systematic efforts to introduce biomedicine into Tibet.