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From "Lama Doctors" to "Mongolian Doctors": Regulations of Inner Mongolian Buddhist Medicine under Changing Regimes and the Crises of Modernity (1911–1976)

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Received: 28 May 2019; Accepted: 5 June 2019; Published: 7 June 2019

Abstract: This paper focuses on how Buddhist medicine in twentieth-century Inner Mongolia was defined, restricted, regulated, and transformed under different ruling political regimes since the fall of the Qing empire in 1911 to the 1980s. The paper argues that the fate of Mongolian medicine was closely linked with the fate of Mongolian Buddhism in twentieth-century Inner Mongolia. As Inner Mongolian Buddhism came to be re-defined, regulated, and coerced by various systems of governance that came to rule the region, Mongolian Buddhist medicine faced crises of modernity in which processes of secularization, exercises of biopower, practices of colonial medicine, and discourses of ethnicity and hygiene challenged the tradition to either reform and adapt to new standardizations imposed by Western biomedicine or lose relevancy in rapidly evolving eras of change.

Keywords: Inner Mongolia; Buddhist medicine; Mongolian medicine; Tibetan medicine; biopower; modernity; colonial medicine; traditional medicine; secularization

1. Introduction

Situated in a larger Eurasian network, the traditionally itinerant Mongols have historically absorbed and transmitted medical knowledge and technology from and between various cultures such as India, Tibet, and China across the continent (see Wallace 2012; Wallace 2017; Bulag and Diemberger 2007; Atwood 2004; Sneath and Kaplonski 2010; Rossabi 2014). In the thirteenth century, Buddhism became the de facto state religion of the Mongol Yuan dynasty under Qubilai Khan (see Wallace 2015; Elverskog 2006). Since then, Mongolian medicine has been primarily informed by the Tibetan medical system, which has its basis in Indian Buddhist literature and Āyurveda (see Gyatso 2015, Garrett 2008, Craig 2012). In the Qing period (17th–20th century), Mongolia, particularly Inner Mongolia, saw a boom of Buddhist monastery construction under royal patronage. These sedentary monastic sites became not only influential centers for religious education in the Tibetan Gelugpa system, but also central institutions of medical learning and practice (Charleux 2006; Humphrey and Uje 2013; Ujeed 2015). In the twentieth century, with the fall of the Qing empire, these monastic institutions in Inner Mongolia struggled for survival and relevancy under unstable circumstances of political turmoil, competing ideologies, colonialism, and modernization.

Traditional Mongolian medicine has historically been informed by Tibetan medicine, which, in turn, drew its medical knowledge from its Buddhist neighbors: India, Nepal, and China. The core theories of Tibetan medicine have always revolved around Buddhist concepts and practices, and the Tibetan medical system known as *Sowa Rigpa* (*gso ba rig pa*) has been closely tied to Buddhism. With the conversion of the Mongols to Tibetan Buddhism, Tibetan medicine became an intrinsic part of Mongolian culture, especially since the second conversion of the Mongols to Tibetan Buddhism in 1575 (Atwood 2004, p. 345). Mongolian medical practitioners in historic Mongolia mainly consisted

of Buddhist monks trained in monastic education based on the Tibetan model. Although in some instances traditional Mongolian medicine included the indigenous medical knowledge from folk and shamanic healing practices and imported certain sets of practices from Chinese traditional medicine, it has been mainly Buddhist in nature (Atwood 2004, p. 345).

In the traditional Mongolian medical model, medical practices are concerned with the overall wellbeing of individuals, including the person's physical, mental, ethical, and spiritual needs and practices. Medical treatments are designed to relieve the suffering that is understood to be part of a larger Buddhist cosmology of karmic cyclical rebirths. In this model, health is defined as a balance between three life-sustaining principles of *hii* (wind), *sar* (bile), and *badgan* (phlegm) (Yu and Amri 2016, p. 84), based on the theory of the five elements propounded in Indian Āyurveda, namely, the earth, water, fire, air, and space, which have hot (*arga)* and cold (*bilig*) attributes (Yu and Amri 2016, p. 84). Most diseases are understood to originate from an imbalance of these forces, caused by various factors, including the primary mental afflictions of delusion, aversion, and attachment, and which are diagnosed through observation, palpation, urine analysis, and questioning of the patient.

With treatments, the emphasis has been often on balancing the humors through the patient's diet and behavior, various natural therapies, and medicines derived from decoctions, powders, pills, and ointments made from plant, animal, and mineral products (Yu and Amri 2016, pp. 84–85). The efficacy of the treatment is believed to also depend on blessings and empowering medicines through rituals and mantra recitations (Yu and Amri 2016, p. 85). Buddhist services such as healing rituals, mantra chanting, and astrological readings have been traditionally considered to be the essential parts of a complete treatment regimen and have been performed by monastic physicians themselves.

During the Qing period (1644–1912), there were as many as 1800 Buddhist monasteries and temples in the Inner Mongolian region, as well as more than 150,000 monks (Delege 1998, p. 452). Major Buddhist monastic centers in Inner Mongolia have functioned historically not only as key institutions for monastic education, but also as vital hubs for political, social, economic, and cultural activities on the vast steppes. These monasteries not only housed practitioners from the local communities, but they also served as key connecting points on transregional networks of religious exchanges. Buddhist scholars and highly revered lamas from Amdo, Central Tibet, and China often stayed at these monasteries in Inner Mongolia to disseminate religious teachings and medical knowledge.

A critical function of the monastic centers was medical education and the provision of medicine and healthcare. Ever since the second transmission period of Tibetan Buddhism into Mongolia in the sixteenth century, monastic education in the Inner Mongolian monasteries has based its curriculum on the Tibetan treatises dealing with the "five major and five minor fields of knowledge"; and education in the monastic medical colleges (*sman pa grwa tshang*) focused on medicinal sciences based on the *Four Medical Tantras* (*Rgyud bzhi*). Since the initial translation of the *Four Medical Tantras* from Tibetan to Mongolian in the eighteenth century, the *Tantras* and their commentaries became a significant resource for the development of Mongolian Buddhist medicine. Most medical colleges in the major Inner Mongolian monasteries taught the *Four Medical Tantras* in both Tibetan and Mongolian and carried out their medical practices in the Mongolian language (Delege 1998, p. 239). Medical colleges of the Inner Mongolian monasteries also functioned as the dominant if not the only providers of health care in their communities.

It is not clear how many Buddhist monasteries in Inner Mongolia were equipped with a medical college, as well as how many Buddhist medical practitioners provided medical services, especially since these traditional Buddhist medical practitioners were just as itinerant as their nomadic patients. However, it seems that at least one or two monk-physicians were often stationed at most monasteries and temples in Inner Mongolia. In a study done by the Good Neighbors Association (*Zenrin kyōkai* 善隣協会), a semi-official humanitarian organization affiliated with the Japanese military in 1935, at least one or two "lama doctors" could be found at any local Buddhist monastery in the Inner Mongolian territories (Zenrin kyōkai chōsabu 1935, p. 258). These "lama doctors" provided medical services and healthcare for their immediate communities and were greatly trusted by the locals (Zenrin kyōkai

chōsabu 1935, p. 258). In another study published in 1937 sponsored by the New Asia Association (*Xin yaxiya xuehui* 新亞細亞學會), researchers of the Nationalist Republican government of China reported that there were two to six "lama doctors" in each banner region of Inner Mongolia (Xu 1937, p. 154).

One example of a prominent Buddhist monastery that provided medical services is the Gegeen Süme (Gaiqamsiga jokiragulogci süme, also known as Ruiyingsi 瑞應寺 in Chinese), situated in today's Fuxin Inner Mongolian Autonomous County in the Liaoning province of China. The medical college at Gegeen Süme was established in 1702 and served as at one of the key institutions for medical training in Buddhist Inner Mongolia. Medical degrees such as *manrampa* (Tib. *Sman rams pa*) were issued there to qualified monastic students who have completed not only seven to eight years of medical training, but also three to five years of residency practice (Delege 1998, p. 719). At its height, the Gegeen Süme had more than 3000 lamas living and studying there, who would later go on to be stationed at various other monasteries of Inner Mongolia (Delege 1998, p. 723).

2. Biopower and the Transformations of Inner Mongolian Buddhist Medicine in the 20th Century

With the collapse of the Qing empire in 1911, the contours and nature of Mongolia and Mongolian Buddhism were open to redefinition. From the second half of the nineteenth century to the first half of the twentieth, the post-Qing Mongol lands became the object of territorial contests between the Mongols, Republican China, imperialist Japan, and Soviet Russia. The northern lands of the Mongols—Outer Mongolia—declared independence in 1911 and subsequently came under Soviet control as Mongolian People's Republic in 1924. As a result, the southern and eastern Mongol lands—Inner Mongolia—became part of the Chinese Republic that later fell under Japanese occupation and influence in the 1930s and 1940s. As the geopolitics of Inner Asia grew more complex at the turn of the twentieth century, Inner Mongolian medicine, which was closely linked to the fate of the Buddhist monastic institutions, came to be regulated under different post-imperium regimes. During this shift from the collapse of sovereign power to the formation of nation-states, attempts were made to redefine and re-regulate traditional Inner Mongolian healthcare, turning monastic physicians and patients from imperial subjects into general population. Buddhist medicine in Inner Mongolia thus became a location for the exercise of biopower in these post-imperium transformations from sovereign power into state power.

2.1. Limiting Monasticism: The Rise of Biomedicine in the Republican Era (1912–1949 CE)

On 16 December 1911, the northern part of Mongolia declared independence and the Eighth Jetsundampa Khutugtu (Ngag dbang blo bzang chos rje nyi ma bstan 'dzin dbang phyug rJe btsun dam pa, 1870–1924) became the theocratic ruler of the state. While many Mongol lords also pushed for political independence from the failing Qing government, some remained observant of the new waves of political movements. In order to appease the Mongol lords in Inner Mongolia, the self-declared president of the Republic of China, Yuan Shikai passed the "Regulations for the Treatment of Mongols" in 1912 based on Qing policies that protected the rights and power of the Mongol lords and influential lamas of the Buddhist communities. These regulations retained the same privileges that the Mongol lords and lamas of late Qing had enjoyed, and further elevated their statuses (Boyan 1962, p. 80). Titles of lamas and names of monasteries that were given by the Qing rulers were renamed and reissued by president Yuan (Delege 1998, p. 180). In March 1912, Yuan Shikai abolished the Office of Territorial Affairs (*lifan yuan* 理藩院), as established by the Qing rulers, and founded the Office of Mongolian and Tibetan Affairs (*Mengzang yuan* 蒙藏院), which managed minority ethnic relationships and their religious matters (Delege 1998, p. 181).

In 1924, the Office of Mongolian and Tibetan Affairs proposed and passed the "Legislation for Limiting Mongols on Becoming Lamas" (*Xianzhi mengren chongdang lama an* 限制蒙人充當喇嘛案). The content of the document suggested this:

1. The only child of a family shall not become a lama;
2. The sole living heir of a family shall not become a lama;

3. The parents of those who do not wish to join the monastic order cannot force them to become lamas;
4. The parents of those who have not reached the legal age of adulthood (eighteen years old) cannot force them to become lamas;
5. Those who wish to join the monastic order must report to the respective banner officials, and they cannot become a lama if the banner has found violations of any of the above;
6. These regulations will become effective after the approval of the ruling lords (*wanggong* 王公) in Beijing.

(Delege 1998, p. 182)

This proposal was approved and became effective in all the leagues and banners of Inner Mongolia. This was a clear policy to limit the monastic population in Inner Mongolia, many of whom were the sole providers of healthcare. By limiting the population of monastics, the policy indirectly limited the practice of Buddhist medicine in Inner Mongolia, without having the need to establish separate regulations for medical practitioners. This laid the foundation for the elimination of potential competitive medical service providers for the new modern nation-state.

In 1928, with the creation of the Nanking government under Chiang Kai Shek, the outdated Office of Mongolian and Tibetan Affairs was replaced by the Mongolian and Tibetan Affairs Commission (*Mengzang weiyuanhui* 蒙藏委員會) (Huang 1938, vol. 1, p. 217). Their policies towards handling the Mongolian Buddhist communities again was very much based on the Qing model; however, new regulations were inserted to further restrict Buddhist monasticism in Inner Mongolia. The practice of keeping *shabinar*, or a monastery's personal subjects, was abolished, along with the tradition of accepting children under eighteen years of age to join the monastic order (Huang 1938, vol. 1, p. 338). The relinquishing of the monastic robes was strongly encouraged by the Nanking government under the logic that the monastic population was becoming a strain on economic development. On the other hand, the Nanking government also set up supplementary schools in the monasteries for teaching young monks literary skills in Mongolian and Chinese, along with knowledge about the Kuomintang Party beliefs (Huang 1938, vol. 1, p. 338). This signaled the installation of a new phase of policies that were aimed not only at restricting monasticism, but also at re-educating the monastic population.

In 1937, the Nanking government funded the establishment of the "Mongol Institute of Hygiene" (*Menggu weisheng yuan* 蒙古衛生院) and was under the management of the Republican government's ministry of health (Suiyuan shehui ribao 1935). The institute was made up of four departments: a disease prevention department, a wellness department, an administrative department, and a patrol department (Suiyuan shehui ribao 1935). Although under the Republican policy "Guidelines for the Management of the Mongol's Institution of Hygiene" (*Menggu weishengyuan zuzhi zhangcheng* 蒙古衛生院組織章程) the purpose of the institute was for the "provision of public healthcare and the treatment of diseases for the regions of ethnic Mongolian inhabitants," the institute did not utilize traditional Mongolian medicine and treatments nor did it hire Mongolian medical practitioners (Zhongyang ribao 1937, 7 January). Instead, the institute administered disease prevention and other medical services through Western biomedicine and modern technologies. This marked the beginning of the establishment of biomedical institutions as competitors and as an eventual replacement of traditional Mongolian medicine administered by Buddhist monk-physicians.

In 1936, shortly before the "Mongol Institute of Hygiene" was established, the document called "Policies for State Medicine" *(Guoyi tiaoli* 國醫條例) was publicized by the Nanking government. Proposed by the modernist Yu Yan, the policies prohibited all practitioners of non-modern and non-Western medicine from practicing without having passed state-sponsored examinations and holding certifications for less than three years (Husili 2007, p. 83). The examinations were mostly on subjects of Western scientific knowledge and anatomy. This prevented many practitioners of traditional medicines, such as Chinese medicine and Mongolian medicine, from treating their patients (Husili

2007, p. 83). Western biomedicine officially became the norm and the standard against which other traditional and alternative medical practices were measured.

During the Republican period, it was said that the number of Mongolian medical practitioners in Inner Mongolia decreased from around 6000 in the Qing era to less than a thousand in the 1930s (Husili 2007, p. 79). There was a general decrease in Inner Mongolian population as well. Records show that at the fall of the Qing in 1912, the population of Inner Mongolia was around 878,000; in 1947, the population dropped to 832,000 (Husili 2007, p. 83). The average life expectancy was less than 35 years in the Inner Mongolian region and only 19.5 years for ethnic Mongolians (Husili 2007, p. 79). This distressing number was probably partially caused by the drastic decrease of Mongolian medical practitioners who were also monks and whose number were limited by Republican regulations on Inner Mongolia monasteries. The reduction in the number of practicing monastic physicians (who were often the sole providers of healthcare in the nomadic regions) was worsened by the bubonic plague and the spread of brucellosis that took place between 1917 and 1947. In 1945 and 1946, the bubonic plague lasted for two years and spread to eleven banners and counties, killing 7503 out of 8604 infected persons with a death rate of 87.2% (Husili 2007, p. 84). In addition, sexually transmitted diseases were rampant: on average, 45% of the population in Inner Mongolia was infected by syphilis (Husili 2007, p. 84).

2.2. "Reforming" Inner Mongolian Buddhist Medicine: Colonial Medicine during the Japanese Occupation Era (1932–1945 CE)

On March 1st of 1932, the Japanese-controlled empire Manchukuo was created, which incorporated the eastern part of Inner Mongolia. In March 1936, Manchukuo troops occupied the Chahar Province, previously controlled by the Chinese Republican government. In 1943, these Mongolian regions were united under the "Xing'an Provinces" and were directly controlled by the Manchukuo government. As for the western part of Inner Mongolia, the Mengjiang United Autonomous Government was set up in 1939 with Prince Demchugdongrub as the chairman. The Buddhist communities in both eastern and western Inner Mongolia had to face new policies announced by these governmental bodies with regard to their religious practices.

Right after the creation of Manchukuo in 1932, the Xing'an provincial government initiated a regulation titled "On the Prohibition of Lamas' Involvement in Politics" (*Guanyu jinzhi lama ganzheng zhi jian* 關於禁止喇嘛干政之件), and it strictly disallowed any participation in political decision makings for members of the Buddhist monastic community, especially for influential high-ranking lamas such as *khutugtus* (Manshūkoku hōsei kyoku 1939, vol. 2, pp. 1–3). On 19 August 1940, the Manchukuo government further issued a document entitled "The Outline for the Reformation of Lamaism" (*Lamajiao zhengdun gangyao* 喇嘛教整頓綱要) related to the policies for Buddhism in Inner Mongolia. The document reads:

> For seven hundred years, the Mongols relied on the Lamaist religion for spiritual guidance and are still bound to the tradition today. The teachings of the religion are Mahāyāna teachings that encourage the maturation of one's self for finding a place in the world for one's self. The Mongols' belief in the Lamaist religion can be useful in avoiding the invasion of foreign religions, Euro-American powers, and especially Communism; it is an asset. However, the quality of lamas is generally low, and their population is a strain on society. This state of affairs needs to be changed if the Mongols were to prosper in livelihood and culture. The leaders of the Mongols, as well as those who are concerned about the Lamaist religion, all agree to this point and wish to see reform. For this reason, the reformation of the Lamaist religion for the better management of the Mongols has been an important issue since the founding of our state.
>
> (Shengjing shibao 1940a; 27 August)

Under the new regime, Buddhism became an "asset" to combat the "invasion of foreign religions" and "communism." The Manchukuo government called for a reformation of Buddhism in Inner Mongolia, which is an attempt to "purify" the tradition of "backwardism," as well as to "modernize" Buddhism and Mongolian medicine into productive institutions for the state and empire.

In 15 December 1940, the Manchukuo government established the "Manchuria Empire Lamaism Group" (*Manzhou diguo lama jiaozong tuan* 滿洲帝國喇嘛教宗團) to manage the religious affairs of the Xing'an, Rehe, Jinzhou, and Fengtian provinces, regions which used to be eastern Inner Mongolia (Shengjing shibao 1940b, December 6). The group was responsible for overlooking all religious affairs in the Inner Mongolian regions, and was designated to be the sole authority to issue and evoke religious titles, achievements, and certificates (Shengjing shibao 1940b, December 6). The group also administered various monastery's resources such as land, and it was responsible for conducting researches on monastery data, namely, the number of monasteries and their locations, monastic population, and resources (Shengjing shibao 1940b, December 6).

Different from the secularization efforts made under Republican China's rule, Buddhism in Inner Mongolia was manifestly promoted, albeit for political reasons, under Japanese occupation. This promotion of the Buddhist faith was more of a strategic move to gain support from religious Mongol leaders in the region, while at the same time, it was a way to utilize the productivity of the monastic population in raising awareness for modern senses of hygiene and education.

Under Japanese occupation, specific qualifications for monastic medical personnel were introduced: examinations for the lama doctors were instituted and only those who passed the examinations may be issued a certificate licensing the qualification of their medical practice (Mōkyō Shinbunsha 1941, pp. 370–73). In addition, medical training classes and medical schools were established in Inner Mongolia in order to increase the level of lama doctors' skills and knowledge (Mōkyō Shinbunsha 1941, pp. 370–73). This exemplifies yet another effort to measure and standardize traditional medical practices according to Western biomedicine, thus ultimately restricting traditional medical practices. As the only non-Western colonial power active in Asia in the early twentieth century, Japan utilized science, technology and medicine not only to place itself amongst the "enlightened" world, but also to define itself as racially different from other Asian countries in order to justify its imperialist agenda (Wittner and Brown 2015). Medicine thus was a vital instrument in the process of empire building. Under the regulations of these standardizations, opportunities were created for traditional Mongolian Buddhist medicine to "modernize" itself and "progress" in these models of colonial medicine.

2.3. Secularizing Inner Mongolian Buddhist Medicine: The Politics of Medicine in the People's Republic of China Era (1949–)

In May 1947, the Autonomous Region of Inner Mongolia was established under the leadership of the Chinese Communist Party, and it issued guidelines that defined and regulated Buddhism and related practices in Inner Mongolia. The "Policy Guidelines for the Inner Mongolia Autonomous Region Government" (*Neimenggu zizhiqu zhengfu gangling* 內蒙古自治區政府綱領) stated:

> … ethnicities such as the Inner Mongolians, Han Chinese, and Hui Muslims in the Inner Mongolia Autonomous Region are all equal … [We must] establish new ethnic relations between the various ethnicities to increase intimate cooperation, and to wipe out all segregation and discrimination. All ethnicities will respect each other and their customs, habits, histories, cultures, religions, beliefs, languages and scripts; all ethnicities are free to express their history and culture as well as their revolution traditions; all ethnicities are free to develop their own economic lifestyles to contribute to the development of a new Inner Mongolia.
>
> (Zhonggong zhongyang tongzhanbu 1991, p. 1111)

Moreover, the document encourages the participation of Buddhist monks in secular education and economic development as well as in healthcare:

> . . . institute the freedom of religion and the separation of religion from the state; protect monastic properties; encourage self-willing lamas to invest in retail, agriculture, industries, and other economic endeavors; reward self-willing lamas for enrolling in schools, participating in labor, and practicing medicine.
>
> (Zhonggong zhongyang tongzhanbu 1991, p. 1111)

Policies such as these instituted at the beginning of the young People's Republic of China are consistent with regard to their attitudes towards Buddhism in Inner Mongolia: while the freedom to practice religion is officially respected and allowed, the active secularization of Buddhist monastics into the larger productive society was encouraged and even rewarded.

The policy guidelines established in 1947 by the Chinese Communist Party were part of the broader discourse on ethnicities and religion. It situated the Inner Mongolians as part of the diversity of fifty-six ethnicities that the new China now accommodates and regulates. In addition to the equality of all ethnicities, the "Guidelines" also clearly state: "the freedom of religion and the separation of religion and the state," it also reads, " . . . all land property rights that belonged to the feudal classes and the monasteries are abolished . . . all slave systems are abolished . . . all slaves are freed and forever liberated from any relations with slave-holders and have the rights to equal citizenship" (Neimenggu wulanfu yanjiuhui 2013, p. 72). This new policy marked a new beginning for the Buddhist tradition in Inner Mongolia. For the first time in centuries, exclusive rights and statuses that high lamas and monasteries have enjoyed even through the Chinese Republican and Japanese Occupation eras were abolished. The Buddhist monks in Inner Mongolia now became ordinary citizens.

After the establishment of the People's Republic of China in October 1949, the first meeting for the representatives of Inner Mongolian Buddhism (*Neimenggu zizhiqu lamajiao diyici daibiao huiyi* 内蒙古自治區喇嘛教第一次代表會議) was held in 1951. Around nineteen respected religious leaders in the Inner Mongolian Buddhist tradition from various leagues of the regions attended (Delege 1998, p. 740). Although a few disagreements took place with regard to the question of whether if children should be allowed to be ordained, at the end of the meeting seven articles were passed in agreement (Delege 1998, p. 740). These are as follows:

1. Support Chairman Mao, support the Chinese Communist Party, support the People's Government, support the shared policies;
2. Oppose the American Imperialists' invasions into Taiwan and Korea, oppose the American Imperialists' attempts at re-attacking Japan, participate in the War to Resist US Aggression and Aid Korea movements (*kangmei yuanchao* 抗美援朝), protect world peace;
3. Support the government in its crackdown on anti-revolutionaries, aid the government in reporting anti-revolutionaries, not listening to rumors, not spreading rumors, oppose rumors;
4. Participate in production, support labor;
5. Modernize lama medicine and technology and provide healthcare for the people of Inner Mongolia;
6. Establish schools for lamas to study their ethnic language, intensify the conviction of patriotism;
7. Not coercing underaged teens and children to become lamas.

(Delege 1998, p. 741).

It is not difficult to see that by 1951, the official attitude towards Inner Mongolian Buddhist monks and their practices, including medical services, has become more precisely and clearly in support of secularization to increase production and social immersion, as well as political allegiance.

From 1956 to 1958, through the efforts of the Inner Mongolia Autonomous Government under the leadership of Ulanhu, around 70% to 80% of Buddhist monks have been dispersed into the labor market (Wulanfu gemingshike bianyanshi 2013, pp. 169–70). According to Ulanhu's writing on his

policies toward the region during this period, he saw the urgency of incorporating monks with medical knowledge into the state enterprises as workers to "advance them and Inner Mongolia on the path towards socialism" (Wulanfu gemingshike bianyanshi 2013, pp. 169–70). In 1958, the government of the Autonomous Region of Inner Mongolia created a series of mandatory "study meetings" in the various leagues across the region and re-educated more than 500 Inner Mongolians and monks in communist and socialist ideologies (Delege 1998, p. 755). Shortly after the uprisings in Tibet in March 1959, two mandatory "lama study meetings" lasting a year and six months were created to specifically re-educate around 120 Buddhist monks in the region on socialist ideologies and the "crimes of the Dalai Lama and his group of traitors" (Delege 1998, p. 755).

These series of policy changes caused a drastic decrease in monastic population in Inner Mongolia; out of those who maintained monastic status, many were also engaged in labor and production for the communes. According to census results conducted by researchers of the new Public in 1949, there were around 1366 Buddhist monasteries and temples in the Inner Mongolian region, with a total monastic population of 60,000 (Delege 1998, p. 453). However, by 1961, there were only around 17,000 monks in Inner Mongolia who identified as such; 11,594 of them participated in labor, out of which 354 worked in state-owned mineral industries, 2330 worked in agricultural production, 6400 in husbandry, 1200 in medicine and healthcare, and 1300 in other areas of production (Delege 1998, p. 761).

In contrast to the decrease of traditional monastic medical practitioners, there was an increase of interested future physicians of Mongolian medicine in public training facilities, which were opened by the Inner Mongolia Autonomous Region government. In 1956, the first institution for traditional Mongolian medical training and research—the Inner Mongolia Autonomous Region Institute for Chinese and Mongolian Medicine—was opened (Husili 2007, p. 89). The Institute provided eight-month training programs to educate new generations of Mongolian medical practitioners that would carry on traditional methods of diagnosis and treatments without the Buddhist healing rituals (Husili 2007, p. 89). In 1962, the Ministry of Health of the Inner Mongolia Autonomous Region issued a document, officially replacing the term "lama doctors" with "Mongolian doctors" (Husili 2007, p. 90).

By 1965, around 1800 students of Mongolian medicine were produced in Inner Mongolia (Husili 2007, p. 90). This new generation of physicians of traditional Mongolian medicine included both ethnic Inner Mongolians, as well as members of the ethnic Han Chinese community. In addition, many women were now able to be trained and certified as physicians of traditional Mongolian medicine, which used to be a role predominantly preserved for male Buddhist monastics only. By the end of the 1960s, at least officially, traditional Mongolian Buddhist medicine in Inner Mongolia was still Mongolian, but it was no longer Buddhist.

During the Great Proletarian Cultural Revolution from 1966 to 1976, Inner Mongolian Buddhists, including their medical practices, became targets of political oppression and attack. Before the Cultural Revolution, it was recorded that the Inner Mongolian region had more than 500 Buddhist monasteries and temples; after the ten years of chaos, only around 200 remains (Delege 1998, p. 777). Out of the remaining Buddhist sites, most were in dilapidated shape and were emptied out of statues, paintings, ritual implements, and texts. The medical colleges in the monasteries were also heavily destroyed. Most of these historical sites were not renovated and re-opened for education and tourism purposes until 1985.

It is worth noting that it is not clear how many monastic medical colleges remained in operation throughout these policy changes since the collapse of the Qing. It is also not clear how many Buddhist medical practitioners reacted against these secularizing regulations and how they might have continued practicing Buddhist medicine. Among those practitioners of Buddhist Mongolian medicine in Inner Mongolia who have survived the Cultural Revolution, many were practicing under the category of "Mongolian doctor," which allowed for traditional cultural practices under the new policies for ethnic minorities, but not explicitly religious practices. Since 1978, the Inner Mongolian Autonomous Region established many "Sino-Mongolian medical hospitals" (*zhongmeng yiyuan* 中蒙醫院), which delivered not only traditional healthcare services informed by traditional Buddhist Mongolian medicine, but

also treatments informed by traditional Chinese medicine. By 1985, there were 73 of such institutions spread across the Inner Mongolian region (Husili 2007, p. 92). These institutions became the only officially recognized places for the practice of traditional Mongolian medicine, as well as any other kind of medicine alternative to Western biomedicine, which became the mainstream method of state healthcare in the People's Republic of China.

3. Conclusions

The above-given discussion has traced the development of Inner Mongolian Buddhist medicine and the ways in which it has been defined, re-defined, regulated, and limited since the time of the fall of the Qing empire in 1912 to the end of the Cultural Revolution in 1976. It is clear that the fate of Inner Mongolian Buddhist medicine has been closely linked with the fate of Mongolian Buddhism in those turbulent eras. This is mainly because Mongolian medical practitioners and patients engaged in a type of healthcare that concerns itself with the physical and religious aspects of the person's life. Driven by modernization movements brought about by the Chinese Revolution in 1911, the Meiji Restoration, and the Chinese Communist Revolution that took East Asia by the storm, the Chinese Republican government, the Japanese empire, as well as the Chinese Communist government attempted to designate places for Inner Mongolian Buddhist medicine in their modern governances and to exercise coercion and power on the tradition and its people. It was a crisis of modernity. While China and Japan had to face the crises of modernity brought onto them by Western colonialism, Inner Mongolia was challenged with the instability of rapidly changing regimes backed by very different ideologies in East Asia. A few trends can be summarized in how Inner Mongolian Buddhist medicine was transformed.

First, the changes in the policies and regulation towards Mongolian Buddhism and Mongolian medicine in twentieth-century Inner Mongolia under different regimes show a shift from sovereign power (exemplified by the Qing empire) to state power. The receivers of state power were no longer imperial subjects under the Manchu emperors, but a population on which biopower in the Foucauldian sense can be exercised. In *The History of Sexuality*, Michel Foucault argues that a mark of modernity was that "the old power of death that symbolized sovereign power was now carefully supplanted by the administration of bodies and the calculated management of life . . . , there was a rapid development of various disciplines—universities, secondary schools, barracks, workshops; there was also the emergence, in the field of political practices and economic observation, of the problems of birthrate, longevity, public health, housing, and migration. Hence there was an explosion of numerous and diverse techniques for achieving the subjugation of bodies and the control of populations, marking the beginning of an era of "bio-power" (Foucault 1978, pp. 139–40). Although Foucault was describing new developments in the history of the West, the observation of the emergence of new techniques to govern and subjugate populations is one that can be of insight in our case of Inner Mongolian modern history. While patients in traditional Mongolian medicine were treated as individuals in a larger Buddhist cosmology suffering from afflictions of the mind and body, the post-imperium rulers of twentieth-century Inner Mongolia see a population of a "backward" culture that is linked with "superstition," "barbarianism," and "disease" in discourses of ethnicity, hygiene, modernity, and colonialism. The regulations and policies instituted by these regimes towards Mongolian Buddhism and their medical practices hierarchized traditional Mongolian Buddhist medicine under modern Western biomedicine and would only allow or support it if it is practiced according to their standards and definitions.

Second, to follow the previous point, there was a gradual introduction of Western science and technology in twentieth-century Inner Mongolia. These new systems of knowledge and technology were introduced by ruling regimes and Inner Mongolian reformers of traditional medicine to aid the development of modern Mongolian medicine on the one hand, and to create competition with traditional Mongolian Buddhist medicine on the other. For example, the institution of examinations for Mongolian medical practitioners in an effort to standardize traditional medical practices into modern ones was more about solidifying Western biomedicine as the standard than creating opportunities for

traditional Mongolian Buddhist medicine to "progress." At the same time, new medical treatments such as vaccines and antibiotics proved to be strong competitors to the decoctions administered under Buddhist rituals in traditional Mongolian medicine, which in turn inspired many Inner Mongolians to study and administer these new medications to relieve their people of plagues and rampant sexually transmitted diseases.

Third, there was the discourse for a process of "purification" of traditional Mongolian Buddhist medicine of its religious aspects. At the same time, there was also the "hybridization" of Mongolian Buddhist medicine with Western biomedicine to meet the changing healthcare demands of the Inner Mongolian public. Under the pressure of increasingly more restrictive and limiting policies imposed on Inner Mongolian Buddhism and monasticism, traditional Mongolian medical education became gradually "purified" or separated from monastic education to state-sponsored training facilities and colleges. For example, facilities and colleges set up for the training of Mongolian medical practitioners during the Japanese Occupation period and during the rule under the People's Republic of China designed their curricula mainly from Western scientific theories and technologies, which challenged and replaced the traditionally authoritative Buddhist medical treatises such as the *Four Medical Tantras*. Mongolian medical practitioners were required to be proficient in biomedicine, but the reverse was not the case (Fan and Holliday 2007). In clinical practice, Mongolian hospitals that were established in the People's Republic of China, for example, had to equip themselves with advanced modern Western diagnostic and therapeutic facilities in order to meet the new demands of a more educated patient public and to compete with modern biomedical hospitals (Fan and Holliday 2007).

This paper has provided a short survey of the different regulations imposed on the practices of traditional Mongolian Buddhist medicine by the changing ruling regimes in twentieth-century Inner Mongolia. While these regulations show discourses of power, it is not always clear how these exercises of power were carried out. How were these regulations restricting and transforming traditional Mongolian Buddhist medical practices implemented, if they were indeed implemented? Who were the agents that executed these orders? What were the effects of these regulations after their implementations? What were the reactions of Inner Mongolians, monastic and lay alike, to these new policies? There are many questions like these that this article alone could not answer.

Interestingly, in a recent ethnographic study of healthcare options in contemporary Inner Mongolia, 48% of the 144 respondents in Inner Mongolia who were surveyed on their primary choice of medicine chose "Mongolian medicine," 42% chose "Western medicine," and the remaining 15% chose "Depending on the situation" (Bao 2015, p. 129). This is rather telling of the situation of traditional Buddhist medicine in today's Inner Mongolia. Hopefully, future ethnographic research on Inner Mongolian medicine, as well as studies that utilize alternative sources such as autobiographies, biographies, and oral histories might provide us with answers that would allow for a kind of agency for the practitioners of Inner Mongolian medicine to emerge from the crises of modernity.

Funding: This research received no external funding.

Conflicts of Interest: The author declare no conflict of interest.

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