FIELDWORK conducted within five weeks in Kathmandu, Nepal amongst a population of Western trained Nepali nurses showed that their patterns of behavior were similar to other populations studied within medically pluralistic contexts and within Nepal in particular. They engaged in concurrent treatment. Their medical belief systems incorporated ideas and concepts from several different medical systems. Their treatment choices were a result of their beliefs regarding the nature of their illness as well as their perceived needs and finally, their attitudes and beliefs reflected larger social processes in Nepal.

They also exhibited distinct behaviors that were unique to them as a population and unique to their locale. They were more comfortable with Western medicine than other populations have been previously, and they used Western medicine in conjunction with the practice of self-medication. If a disease was physical or biological in nature they used Western medicine as their therapy of choice and if their illness was emotional or mental in nature they consulted with an astrologer. Ultimately, this thesis was exploratory and limited in nature, but it can be used both to support previous work done in Nepal and it can be used a guideline for further research into the nature of medical pluralism in Nepal, especially within an urban context, and amongst a population trained in Western medicine.
The “West” in the Nepali “East”: A Perspective on Nepali Medical Pluralism

by
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DEDICATION

I dedicate this thesis to my mother. Without her help none of this would have been possible.
BIOGRAPHY

The author of this work is a twenty three year old woman from Cary, North Carolina. She is an avid lover of anthropology, history, and all other aspects of art and culture. She received her undergraduate degree in physical anthropology and cultural history with a specialization in primatology from Peace College in Raleigh North Carolina and she also possesses a Master’s degree in cultural anthropology with a focus on medical anthropology from North Carolina State University. She has traveled to Nepal, Japan, Qatar, and Mexico and would like to continue exploring the world and its people in the future.
ACKNOWLEDGEMENTS

I would like to thank my committee members for their help and guidance; my informants in Nepal for their invaluable contribution to this work; my family for their support; and my friends and boyfriend for their encouragement.
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CHAPTER ONE

NEPAL AND MEDICAL PLURALISM:

AN INTRODUCTION

While there have been extensive studies done on medicine and medical systems in Nepal, less research has been done on medical pluralism as it is expressed in an urban context and amongst a population trained in Western medicine. In 2010, I conducted fieldwork in Nepal’s capital city, Kathmandu among a population of Nepali women who were or were training to become Western nurses. The focus of my research was to explore how these individuals understood medicine within this urban and medically pluralistic context. I also sought to describe how their Western medical training might influence their beliefs and attitudes concerning medicine and their personal medical choices.

Most general anthropological research conducted in Nepal has focused on a wide array of topics and has dealt with different themes within both anthropological theory and discourse. Some of the most prevalent themes include identity studies as can been seen in Guneratne’s (2002) ethnography exploring the creation of Tharu identity and its use as a political vehicle. Cameron’s (1998) and McHugh’s (2002) studies concerning women and their identities as defined by both caste and gender. Symbolism and ritual as explored in Holmberg’s (1989) ethnography upon myth and ritual exchange amongst the Tamang and Desjarlais’s (1992) study exploring symbolism, the concept of pain, and the aesthetics of
illness and ritual amongst the Yolmo people. Finally, Ortner (1978, 1989, and 1999) has also done extensive work in Nepal with the Sherpa people, which have focused largely upon their role in Nepali politics, and their role in trekking and tourism within the country.

The sub-field of medical anthropology has also been one of the most thoroughly explored topics within Nepal and Nepali culture. Adam’s (1998) research which was conducted upon Western trained Nepali doctors shows how they used their status as Western trained medical professionals to further their political agendas during the Nepali civil war. Burghart (1996) explored communication and miscommunication between Western trained Nepali medical providers and their rural patients. Gellner (1994) focused on shamans in Kathmandu, exploring both the ideological and social context of this medical system within the city. Kohrt and Harper (2008) conducted a multidisciplinary study concerning psychiatry and the stigmatization of mental illness within Nepal and compared the results they found to the way mental disease is understood in Western medicine; and Pigg (2001) studied HIV/AIDS in Nepal focusing on governmentally supported preventative and educational programs created in response to the epidemic.

Medical pluralism is another anthropological and medical topic that has been extensively explored within Nepal and it is the focus of my own research. Medical pluralism is a theoretical model that has been proven to represent most of the world’s medical systems (Burghart 1996; Colson 1971; Durkin-Longley 1984; Good 1994; Hare 1993; Kleinman
1980; Pigg 1995, 1996; Press 1978; Rashid 2008; Stoner 1986; Subedi 1992; Waxler 1984, 1988; Weller et al 1997), a prominent theory, it suggests that most cultures are host to several different medical systems operating and existing in tandem. This is in contrast to earlier theories that suggest that only one medical system is truly operating in any given context (Good 1994). Within this thesis I not only support that medical pluralism exists in Kathmandu Nepal, but I also support one of the most prominent theories in anthropology regarding medical pluralism; that all medical systems, including those within a pluralistic context, are comprised of concepts and are in fact concepts themselves (Burghart 1996; Good 1994; Hare 1993; Kleinman 1980; Pigg 1995, 1996; Rashid 2008; Subedi 1992; Waxler 1984, 1988; Weller et al 1997). Medical systems are therefore comprised of ideas, values, and behaviors that are created by individuals within a culture and are institutionalized into real practice. Within a medically pluralistic context this would mean that the concepts within the different medical systems become more readily intertwined; the people operating within these systems create their own medical concepts and these concepts are frequently a unique mix of the different medical systems inherent within their cultural context (Burghart 1996; Hare 1993; Pigg 1992, 1995; Rashid 2008; Weller et al 1997).

In order to explore medical pluralism in Nepal, and how the medical systems therein are social and mental concepts, I decided to investigate how my informants, a population of Western trained Nepali nurses and nursing students, beliefs and behaviors may or may not be influenced by the pluralistic nature of their medical system. Thus, the central focus of my
thesis was to explore and describe how my informants understood and utilized Western medicine within a pluralistic context. Ultimately, what I found is that my informants did reconstruct Western medical knowledge. They had become trained in the field and they frequently utilized Western medicine. However, their use and understanding of Western medicine was unique. This means that I was witness to the expression of a selection process; my informants appropriated and rejected certain parts of the Western medical model and they did this both consciously and unconsciously. I believe that by examining what they chose to accept and what they chose to reject I was able to see that these decisions were a result of both their cultural context and their preexisting beliefs and knowledge regarding the nature of illness and disease.
Figure 1. An image of a Nepali child; courtesy of photographer Aayoush Onta
CHAPTER TWO

NEPAL, A CONFLICTED COUNTRY

Nepal is a landlocked country located in the region of South Asia. It is also a country currently in the middle of a major demographic transition, with a population of about 27 million people living within an area of 147,181 square kilometers. Even though there has been an increase in contraceptive prevalence in the country (41%), the growth rate of the country is still very large, especially compared with other countries in the region, and its growth rate reached a startling 2.25% as of 2011. It is considered to be one of the least developed countries in the world by UN standards. The UN Conference of Trade and Development state that Nepal, along with several other countries is, “highly disadvantaged in their development process and facing more than other countries the risk of failing to come out of poverty” (UN Conference of Trade and Development 2011). This is due to several factors including: low overall income; weak human assets; and economic vulnerability (UN Conference of Trade and Development 2011). The country is also largely underdeveloped in terms of industrialization and urbanization and the majority of the population, 84%, still lives in rural communities and practice agriculture which is the country’s main economic resource. Nepal is also one of the world’s poorest nations with a GDP per capita of only US$294. (WHO Country Cooperation Strategy May 2010).
Nepal’s developmental instability is also largely due to its recent political instability and a civil war known as the “People’s War”. This war has been a political and ideological movement within the country during the past two decades and the factors involved have been both a result of the country’s poor quality of life and a further contribution to these problems. The War began in February 1996 as a manifestation of insurgent activity by the Communist Party of Nepal (Maoists) and was ultimately violent. This violence was originally aimed at rural landowners and police officers and it was not until after 2001 that the Maoists gained more power and support throughout the country and within the urban center of Kathmandu. When this occurred the monarchy was forced to abdicate and dissolve in 2006 and the recreation of the country into a federal republic in 2007-2008. The Nepalese government is now currently in a deadlock, with intensive negotiations between the Maoists and other leading political parties affecting the country’s ability to move forward developmentally and economically.

Not only is Nepal a country facing developmental, economic, and political problems, but it is also a country that faces a great deal of problems concerning human development, quality of life, and availability of health care. The civil war and the new government have yet to make any substantial changes within this arena, as can been seen in the following UN report:

Nepal features among the poorest countries in the world in terms of human development (UNDP, 2003). Nepal’s human development indicators remain well below the average for the South Asia region:
more than 40% of the Nepali population live below the national poverty line, nearly half of all the children below 5 years are underweight and nearly 60% of all adults are illiterate. Additionally, women traditionally have a lower status than men and gender inequality is deeply rooted. Nepal is one of the few countries worldwide in which men live longer than women. More boys than girls receive any form of education. Women generally work longer hours than men. Men have better access to services including health (United Nations Office on Drugs and Crime, 2005).

These larger economic and social factors also play a key role in health and medical issues in Nepal and the country’s population faces a great deal of social and health care problems. The country has a large disease burden consisting of both communicable and non-communicable diseases with vector borne diseases such as malaria and Japanese encephalitis being a major problem as well as those of heart disease, HIV/AIDS, tuberculosis and diabetes (WHO Nepal: Health Profile accessed 2011). Other health related issues such as high infant mortality rates, poor nutrition, and susceptibility to natural disasters are also problems and a major concern both for the people of Nepal and their government (WHO Nepal: Health Profile accessed 2011). As a result of these concerns there have been mass political movements and state sponsored development projects that emphasize the creation and improvement of health services (Marasini, 2003; Subedi; 1989; WHO accessed 2011).

Western medicine is a relatively new development in Nepal. It was introduced to the region by religious missionaries in the sixteenth century and later by British colonialists during the latter part of the seventeenth century. This exposure was very limited and was
isolated to the specific regions and locales in which these individuals lived and worked. Western medicine became an official institution in Nepal in 1947 when Prime Minister Bir Shamsher had the first Western hospital built in Kathmandu. Several other hospitals were built in the same year in the regions of Teku, Birganj, Jaleshwar, Hanuman Nagar, Taibhawa, and Nepalganj (Marasini, 2003).

Another growth in the accessibility of Western Health care occurred during the years of 1951-1963 when the Nepali government relinquished some of their control over Western health care development and allowed private sectors, foreign interest groups, and non governmental agencies to be able to provide health services and create and build Western medical facilities (Marasini 2003). Training facilities for Western medical professionals also began to be established during this period of time. Previously, most of the doctors, nurses, and other specialists that worked in the country were foreigners and largely from India (Marasini, 2003). “As of 1963 there were 32 hospitals and 104 health centers in the public sector” within Nepal and the figures have been growing since. For example, some of the country’s major hospitals have been only recently built. Tribhuvan University Teaching hospital was built in 1986; Nepal Medical College Teaching Hospital was built in 1997; Bharatpur Medical College Teaching Hospital, and Kathmandu Medical College Teaching Hospital where I conducted most of my own research were built in 2002 (Marasini 2003).
However, due to the political climate as well as the instability of these programs, Western medical development has still been relatively limited. Western health care is almost nonexistent within many rural areas in Nepal and has only really been implemented within urban regions (Desjarlais, 1992; Pigg, 1995; Steele 2011; Whelpton, 2005). However, Western health care is readily available within the nation’s capital city, Kathmandu and the city is where most of the country’s hospitals and western health care services are centered and located (Marasini 2003). Nepal is also host to a large number of indigenous and traditional forms of health care and alternative medical systems. These include: Ayurvedic medicine, Shamanism, Unani, homeopathic healing, Buddhist/Hindu healing rituals, and Vedic astrology which are the attributing factors to the country’s medically pluralistic structure (Pigg, 1992 1995; Subedi 1989; Gewali 2008).

Western medicine therefore is only one of many medical models in Nepal and within the greater Nepali context it is arguably one of the less important and pervasive ones. However, within the Kathmandu context it does hold some power because of its availability and its association with governmental and nongovernmental development programs, but it still has to compete and negotiate within the medically pluralistic structure of the city.
CHAPTER THREE

NEPAL’S OTHER MEDICAL SYSTEMS

Western medicine is not the only medical system inherent within Nepal’s medical structure and in fact it is only one of many. Nepal is host to a wide array of other medical systems, many of which are more indigenous to the region and have longer histories of practice within the country’s culture and amongst its people. These different medical systems include: Ayurveda, Homeopathy, Unani, Shamanism, Vedic Astrology, and other forms of faith and spiritual healing. The following information is a general overview of these other medical systems. They are in no way complete or representative of all the expressions of these systems that may be in existence throughout the country. There is also a figure, or chart, provided at the end of the chapter that further describes and generalizes these systems.

Ayurveda is one of the most important indigenous medical systems in Nepal. It is similar to Western medicine in that it is also well established and sophisticated and possesses a large body of knowledge, both oral and written. Ayurveda is also one of the world’s oldest medical systems with its origins dating back to ca. 1,500-900 BC (Gewali, 2008). According to the Ayurvedic tradition, which has its roots in the Hindu tradition, all things within the universe are comprised of five elements. These elements are: prithivi (earth), jala (water), agni (fire), vay (air), and akasa (ether) (Gewali, 2008). Ayurvedic medical knowledge also states that the human body is comprised of these elements, but that its functions are comprised of only three of the elements; air, fire, and water which are called doshas. The
body is also comprised of seven different types of tissue and waste products. The body functions as a result of the balance between these different elements and a healthy individual will have a standard amount of these different elements. Disease therefore is caused when someone has too little or too much of one or all of these different tissues, elements, or wastes and this is what Ayurvedic practitioners seek to treat (Gewali, 2008).

There are two types of practicing Ayurvedic practitioners in Nepal. Vaidya are those who are trained professionally in colleges and universities and kaviraj are those who have been informally trained by gurus or their families. There are eight different types of therapy groups in the Ayurvedic tradition and they deal with different ailments, including general imbalances, infertility, infection etc. Therapies may include: herbal remedies and tonics, minor surgeries and procedures, and life style changes. Psychiatric problems are perceived as spiritual ailments caused by the gods and are treated with blessings and animal sacrifices (Gewali, 2008).

Homeopathy is also a traditional medical system currently active in Nepal and it too is recognized by the Nepali government and institutionalized in hospitals and clinics throughout the country (Gewali, 2008). The homeopathic medical tradition in Nepal was originally founded by a German physician named Samuel Hahnemann during the eighteenth century and is based upon concepts concerning balance and imbalance within the body (Gewali, 2008). However, the most important part of the homeopathic regimen is the
“remedies” that are produced by its practitioners. According to the homeopathic tradition, in order to treat an illness a homeopathic practitioner must create a diluted solution for the patient to take based on the “law of similars,” this means that any remedy made must be out of a substance that produces the same symptoms as the actual illness (Gewali, 2008). For example, if a patient was experiencing food poisoning, a homeopathic practitioner would make a remedy for the patient made out of herbs and other substances that would induce the same symptoms as the food poisoning, except the solution would be diluted several times through a process called “succussion,” in which the homeopathic healer would further dilute the solution by shaking it vigorously by striking it against an elastic body ten times (Gewali, 2008).

Unani is also an officially recognized medical system in Nepal. Originally created in Greece, it is a medical system that was later altered and expanded upon by other Arabic cultures. According to Unani, “disease is a natural phenomenon and symptoms are created in the body in response to the disease” (Gewali, 2008). Unani also posits that the body must be in balance, but rather than having forces or elements the body possesses four humors. These four humors are: dam (blood), belgham (phlegm), safra (yellow bile), and sauda (black bile). Diseases are diagnosed in Unani through the practice of pulse reading and also through the examination of urine and stool samples. Therapies that are offered by Unani can be placed into four therapies: regimental, diet, pharmacotherapy, and surgery (Gewali, 2008).
The previous three medical systems: Ayurveda, Unani, and Homeopathy are all medical systems that have been officially established in Nepal. Like Western medicine they have their own educational institutions and medical care centers, such as hospitals and clinics. This is extremely different from the following medical system, that of shamanism, which is considered to be both a traditional medical system in Nepal as well an unofficial, but paradoxically popular one (Desjarlais, 1992; Pigg, 1995; Gewali, 2008). Shamanism, like all medical systems is subject to individual variation, but the system itself and the therapies the shaman provides are largely based upon faith healing. Shamanism is practiced throughout the country, but it is one of the most popular therapies largely within the rural areas of the country. The concept of illness within shamanistic practice in Nepal is largely perceived as being spiritual in nature and illness is often the result of evil forces. These forces can be the result of witches and evil spirits or can be caused by unintentional ill will. Therefore, the shaman will often conduct healing in one of two ways; they will either attempt to prevent illness by disbursing evil powers through the use of protective amulets and incantations, or they will cure existing illnesses through exorcism or healing rights (Desjarlais, 1992; Gellner, 1994; Gewali, 2008). Exorcism is usually achieved through the intervention of more powerful benevolent spirits or gods, who are asked to enter the shaman and work through him. This is usually achieved through trance which can be achieved through the use of drums or rhythmic chants (Desjarlais, 1992; Gewali, 2008). Buddhist and Hindu priests, or Lamas and Pudits respectively, are also considered to be folk healers much like Shamans. Unlike
shamans they are considered to be strictly religious and ceremonial healers and they treat illness through the use of prayers and rituals (Gewali, 2008).

Finally, *Jyotish*, or astrologers are healers and medical practitioners who have studied and practiced Vedic astrology. According to Vedic astrology, illness is caused by karma and the will of the gods. Illnesses can be diagnosed through astrological readings which are based upon planetary forces and movements and these can be determined through horoscope readings and palm and forehead readings. After an astrologer has determined the problem they must determine what will help the patient in question (Gewali, 2008). There are several ways in which a person can “cure” their illness. They can give to the poor, engage in selfless acts, wear special amulets, fast, perform Vedic prayers, wearing gem stones, and carrying out fire rituals (Gewali, 2008).
Figure 3. Hindu religious ritual and blessing, courtesy of Aayoush Onta

Table 1.
<table>
<thead>
<tr>
<th>State Recognized Medical Systems</th>
<th>Description of Medical System</th>
<th>Therapies Offered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ayurveda</td>
<td>Body is comprised of a certain amount of tissues, elements, and wastes. These must be kept in balance for a person to be considered healthy.</td>
<td>Life style changes, herbal remedies and supplements, nutritional changes, yoga, meditation, hygiene, and minor to major surgical procedures</td>
</tr>
<tr>
<td>Homeopathy</td>
<td>Illness must be treated through the use of “remedies.” Remedies are based on the “law of similars.” This means that an illness must be treated with a diluted solution that causes the same symptoms as the illness.</td>
<td>Diluted solutions in the form of tonics or homeopathic pills upon which a drop from a remedy solution is placed.</td>
</tr>
<tr>
<td>Unani</td>
<td>Based on the concepts of the four humors: phlegm, blood, black bile, and yellow bile. Illness is caused by an imbalance of these substances.</td>
<td>Four types of therapy: regimental, diet, pharmacotherapy, and surgery</td>
</tr>
<tr>
<td>Traditional or “Folk” Medical Systems</td>
<td>Description of Medical System</td>
<td>Therapies Offered</td>
</tr>
<tr>
<td>Shamanism</td>
<td>Illness is caused by malevolent forces, jealousy, the evil eye, and spirit possession</td>
<td>They will prevent illness through the use of amulets or incantations and they will heal illness through the use of exorcism and other rites</td>
</tr>
<tr>
<td>Religious Healers (Hindu or Buddhist)</td>
<td>The origin of illness is spiritual and a result of the cosmic forces of each respective religion.</td>
<td>Healing will accomplished through prayers, blessings, and offerings</td>
</tr>
<tr>
<td>Vedic Astrologer</td>
<td>Illness is karmic or destined and an astrologer can learn about your illness through your astrological chart.</td>
<td>One can do one or any of the following depending on the illness: performing fire rituals, charitable acts, fasting, giving to the poor, or wearing special amulets.</td>
</tr>
</tbody>
</table>
KATHMANDU METROPOLITAN CITY

Kathmandu Metropolitan city is both Nepal’s capital and its largest city. Located within the Kathmandu valley at an altitude of 1,350 m above sea level, the city lies within the foothills of Nepal’s Himalayan region. Kathmandu shares the valley with two other cities, Patan, or Lalitpur, and Bhaktapur. Kathmandu is the largest of these cities with a population of 949,486 people living within an area of 5,067 hectares (Bahadur et al. 2007). The city contains 62.43% of the entire country’s urban population. The city also has a long and colorful history dating back 2,000 years. Originally the seat of power for the Newari Kingdom the city has served throughout time as a cultural and political center as well as an important trade route between India and Tibet (Kathmandu Metropolitan City Office). The city is also home to a vast assortment of architectural treasures and important religious sites which have made it both the nation’s tourist center, but also a UNESCO world heritage site (Kathmandu Metropolitan City Office).

Kathmandu is also a culturally and religiously diverse city and has demographics comprised of many of Nepal’s different ethnic groups, with the most represented groups being those of the Newars, Brahmins, and the Kshetris. In more recent years, due to economic opportunities, improved amenities and facilities, and the uneven distribution of wealth and development opportunities throughout other parts of the country, mass migrations to Kathmandu from other locales has risen substantially (Bahadur et al. 2007). This has
further changed the heterogeneous population of the city. Now other groups such as the Tamang, as well as people from the Terai region have become a strong force within the city. Many different languages and dialects are spoken within Kathmandu as a result of these migratory movements, with the most prominent languages being Nepali and Nepal Bhasa. The city is also a crossroads for religion and religious activities with Buddhism and Hinduism being the two most prominent religions (Bahadur et al. 2007).
Quality of life in the city is greatly impeded by pollution, and other public health issues. Emissions from traffic and industry, coupled with meteorological patterns that are a result of the valley’s geographic shape, has made air pollution one of the worst problems in the city. Water quality and availability are also a problem (Bahadur et al. 2007). The city’s water comes mainly from surface water and ground water, both of which are frequently polluted and contaminated. City officials have recognized these problems and their affects on public health and have launched a community basic health program in the city and as a result have created 21 community urban health centers (www.kathmandu.gov).

These centers are only a small portion of the health care facilities available in Kathmandu. As mentioned previously, the Nepali government has seen health care development, especially the development of Western health care, as one of its main priorities. Kathmandu is where most of these developments have occurred (www.kathmandu.gov, Bahadur et al., Whelpton, 2005). The city is the country’s leading center for Western medical research and most of the nation’s Western hospitals and Western medical training facilities are located there (Marasini 2003). Some of these facilities include Bir hospital, the first hospital in Kathmandu and the country, which remains the busiest and largest facility and other hospitals such as Tribhuvan, Patan, B&B hospital, and Norvic hospital. Kathmandu is also host to all of the other medical systems in Nepal, and the city is the site for health care
facilities and hospitals that support Ayurvedic, Unani, and Homeopathic medicine (Marasini 2003). The “folk” medical traditions are also represented throughout the city. Tourists can see shamans performing spirit possession on the streets and temples and astrology shops abound (Gellner, 1994; Steele 2011; Subedi 1989, 1992).

Kathmandu is a diverse locale with a heterogeneous and culturally complex population making it a rich location for anthropological research. Kathmandu is also an area in which all of the medical traditions of Nepal are mixed, and it is the one place in the country where Western medicine has become a major force within the already existing medical structure. It is, therefore, one of the best places within Nepal to study the phenomenon of Medical Pluralism
Figure 4.2. Street in Thamel, Kathmandu; were the researcher lived during her fieldwork
CHAPTER FIVE

MEDICAL PLURALISM: THEORY AND LITERATURE

Medical pluralism first appeared as a major topic of discussion within the anthropological discourse in the 1970’s (Leslie 1976; Press 1978). Considered to be a new approach for the investigation and explanation of medical systems cross-culturally, the pluralistic model suggested that the norm for most cultures was the existence of several different models, all operating within the same context. Previously, medical systems had been perceived as being mutually exclusive. With one system in particular possessing a monopoly on legitimate practice and that specific medical systems etiology being uniformly accepted amongst both practitioner and patient alike (Leslie, 1976). This is not the case and as extensive research upon this topic has shown, the medically pluralistic model is the norm throughout the world (Burghart 1996; Colson 1971; Durkin-Longley 1984; Good 1994; Hare 1993; Kleinman 1980; Pigg 1995, 1996; Press 1978; Rashid 2008; Stoner 1986; Subedi 1992; Waxler 1984, 1988; Weller et al 1997).

According to these studies (Burghart 1996; Colson 1971; Durkin-Longley 1984; Good 1994; Hare 1993; Kleinman 1980; Pigg 1995, 1996; Press 1978; Rashid 2008; Stoner 1986; Subedi 1992; Waxler 1984, 1988; Weller et al 1997) the medically pluralistic structure supports not only the existence of several different, and even competing medical systems, but it also supports the mixing and blending of these systems in both practice and within the beliefs and behaviors of the people who operate within them. Patients within medically
pluralistic systems will frequently use several different therapies in regards to illness and
disease (Burghart 1996; Colson 1971; Durkin-Longley 1984; Good 1994; Hare 1993; 
Waxler 1984, 1988; Weller et al 1997). This concurrent treatment involves the use of 
therapies that are often representative of different medical systems. For example, an 
individual experiencing chronic joint pain may decide to consult with a Western physician, 
an astrologer, and a shaman, all for the same illness as well as use several different therapies 
in tandem.

While most researchers agree as to the nature of medical pluralism and that it 
ce ncourages and supports the use of different medical structures, there is some debate as to 
what ultimately controls patient behavior. Some research (Beals, 1976; Kleinman, 1980; 
Subedi, 1989, 1992; Young 1983) suggests that patients within medically pluralistic systems 
will make their personal health care choices based upon the type of illness perceived by the 
patient. They will choose what healers to consult and which therapies to use based upon the 
nature of their illness and what they perceive to be the problem. Their personal beliefs and 
the meanings they attribute to their illness will determine both how they understand and how 
they will seek to treat it. Rashid (2008) and others (Pigg 1995, 1996) suggest that medical 
pluralism is a result of and effected by larger social processes and that these processes and 
their results is what ultimately dictates patient behavior. Factors such as poverty, educational 
level, governmental development projects, and larger cultural values all play a role in how an
individual defines, understands, and treats illness as well as how medical systems are expressed within a pluralistic arena.

These factors are all relevant within the Nepali context. Pigg (1995, 1996) and Subedi’s (1989, 1992), research also focuses on urban populations and the utilization of Western medicine within Nepal. In Subedi’s (1989) survey his population consulted with several different types of healers and used several different therapies during the course of their illness episodes. Also according to Subedi’s (1989) results, most individuals followed a specific pattern of behavior. When one of his informants was experiencing an illness or a health problem, they would first consult with their families and friends and they would attempt to self medicate, usually with home or herbal remedies. If their health problem persisted they would consult with indigenous or local healers such as a shaman or a Buddhist lama. If his informants still continued to experience problems they would consult with a Western trained medical professional, but this would have been only as a last resort. Pigg (1995, 1996) also discusses the role of Western medicine amongst her informants. Unlike in Subedi’s survey, Pigg’s population was using Western medicine with increasing frequency. According to her results, Pigg’s informants associated Western medicine with development, education, and modernity. The perceived efficacy of Western medicine also appealed to them. This caused many of her informants to actively question the legitimacy of more traditional, indigenous forms of healing.
All of these studies are very important in terms of my own research and I found similar results during my fieldwork conducted in Kathmandu. Kathmandu was indeed a context that possessed a distinctly pluralistic medical structure. Not only were there many different types of medical systems present and available in the city, but also there was mixing between these different systems within the minds and practices of my informants. Even though my population was unique from some populations studied previously, my informants displayed similar types of behavior as well as possessed similar attitudes and beliefs regarding medicine as those found amongst other populations. The women in my population relied mainly on self-medication; they relied on different medical systems based upon what they perceived their needs to be; and larger social processes active in Nepal also influenced their beliefs. My population was also distinct. Unlike some of the other populations studied, they were more comfortable using Western medicine and ultimately they relied on Western medicine more than any other medical system, which may be a direct result of their medical training and background.
CHAPTER SIX

POPULATION AND METHODS

Even though I spoke to and observed a wide array of people from varying backgrounds during my fieldwork in Nepal, the focus of this thesis is upon one specific population that of Western trained nurses. My population consisted of 23 female nurses, nursing instructors, and nursing students who work at or attend school at Kathmandu Medical College and Teaching Hospital located in Kathmandu, Nepal. All of my informants were originally from Nepal and many of them were from villages and regions outside of the city. They were of varying ages and levels of medical training. Snowball sampling and networking were used in order to recruit the women included in my study population.

The methods I used in this study were participant observation, structured and semi-structured interviewing, free listing, and pile sorting. For the data I present in this thesis I relied most heavily upon semi structured interviewing and pile sorting. I decided to use a pile sort method as a way in which to produce both quantitative and qualitative data and it proved to be an excellent way for me to establish rapport with my informants. The pile sort technique also gave me an avenue in which to begin and guide my interviews. The pile sort itself was comprised of a stack of laminated cards with 33 different physical ailments and illnesses written upon them in both English and Nepali. I had had chosen the 33 illnesses as a result of free lists I had gathered previously using Nepali citizens living in the U.S. I had asked 15 of these individuals to make a list of any illnesses and diseases that they knew of.
After this was completed I took these lists and combined them into one, choosing the illnesses and diseases that appeared most frequently within all of the free lists. The final list that I used in the pile sorts can be seen in Appendix A.

I not only created a set of cards listing the diseases and ailments, but I also asked my 15 volunteers to make a free list containing both medical practitioners and medical therapies that are available in Nepal. From this list I made another set of cards this time with the kinds of terms for practitioners and therapies that I saw most frequently within the free lists. This list ultimately contained seven medical practitioners and therapies. These seven kinds of individuals also represent therapies and are as follows:

Hindu Priest or Buddhist Lama
Pharmacist
Self Medication
Shaman (jhaktris)
Western professional
Ayurvedic Doctor
Astrologer

When I administered my pile sorts, I asked my informants to lay out the cards into certain categories usually upon a flat surface or on a table. I would initially lay out the seven practitioner/therapy cards onto this surface and in a row. I would ask my informants to take each of the illness/disease cards and categorize them, placing them with the practitioner or therapy that they would consult or use first for that disease or illness. While they were doing
this I would ask them about their choices as well as ask them to express their opinions regarding the types of practitioners and therapies listed. I recorded their answers and used them as potential topics to explore in the interviews I conducted with each informant after the pile sort.

The pile sort method also had some limitations, most of which had to do with my list of practitioners and therapies. I had initially designed the list to accommodate my original research target population which was supposed to be wider and more varied than the one I actually studied. As I have mentioned previously, little research has been conducted upon urban populations in Kathmandu and thus when I created my list of health care practitioners I had favored those that I had also found described in the literature, which focused on rural contexts. Also, because of this previous research I had decided to make a category covering “self medication,” which included homemade herbal remedies and tonics which is also more prevalent in rural contexts. Thus, all of the options listed above were originally separate and distinct; however, this was not the case when it was applied to my actual study population, who were not rural dwellers had very different relationships with all of the practitioners listed.

Since my informants were trained in Western medicine they could technically diagnose themselves and utilize the pharmacy without having to consult with the pharmacist present. Thus, the categories of “pharmacist”, “Western professional”, and “self medication”
became interconnected. Each of my informants chose to deal with this ambiguity differently and many of them defined the different practitioners and therapies using their own personal opinions. Therefore, I do not intend my pile sort data to be taken as or used as concrete data or evidence. Instead I used the pile sort for the insights they provided into the Nepali medical system and a way in which to discuss Western medicine with my informants. I would also like to mention that all of the nursing personnel that I spoke to and interacted with were women. While this suggests something about the nature of gender roles and health care in Nepal, gender was not the focus of my study. Thus, even though my informants were women and this may well have played a significant role in how they understood illness and health and how they behaved, for the purpose of this thesis I chose to use my findings as an example of how health care professionals in Kathmandu and people themselves understand and assimilate conflicting information and knowledge within a pluralistic system rather than just how women do so.
Figure 6. Photo of Nursing students and professors at Tribhuvan Teaching Hospital
CHAPTER SEVEN

A VISIT TO A NURSING CLASS

Sita, one of my key informants was a middle-aged mother of two, a busy wife, and an even busier nurse. A nursing instructor at Kathmandu Medical College and Teaching Hospital, Sita was a seminal part of my fieldwork in Kathmandu and she was someone who connected me with the rest of my population, all of which were either nursing students or nursing instructors. The first time I visited the hospital I went with Sita and she took me to visit one of her undergraduate classes. Comprised of first year students in their second semester at the school, I was going to meet them during one of their presentation days. It was near the end of the semester in Nepal and the nursing students would be showcasing their semester projects; for Sita, for the other nursing instructors, and for each other. The presentations, I was told, would be focusing on cognitive development in children.

The women I saw in the classroom that day were chipper and excited. They were all of varying ages and sizes and bedecked in saris, special saris that announced their profession. Unlike the rich, colorful, and often-sparkling ones I had seen outside in the markets and on the streets, the ones worn by the women in this room were exactly the same color as uniform scrubs in the U.S. There were some muted blues and purples, but the majority of the women wore the regulated gray green that I had become so familiar with at home. Over this less fashionable and more practical attire they all wore long white lab coats. The only superficial difference in appearance between the students and their professors were that the nursing
The women were indeed excited; excited because today’s class was a special event. They would be presenting their term projects, which were set up about the room much like a project fair is at home. The colorful dioramas and poster boards were carefully and accessibly arranged along the back of the room and they were set up on gray and white metal folding tables. All the chairs in the room had been moved together into tight neat rows at the front of the room close to the board. Sita had already informed the class that I would be visiting that day and I can only hope that some of the excitement they seemed to feel was for my visit. Needless to say I felt like a rock star that day when I entered the white and bright room. The students and teachers alike came eagerly toward me as soon as I walked in with Sita. Sita, my main informant, is a nursing instructor at the hospital. She is a small and short Nepali woman who on this day had her full, black hair pulled into a clip at the back of her head. Her round glasses where perched on her beaming face and her long white lab coat was draped down over her scrub green sari. After she formally introduced me to the class, the other students and instructors came forward bowing their heads, some clasping my hands, as they all welcomed me to the teaching hospital.

After that things began to calm down as Sita took charge. It was a pleasure to watch my new neighbor and friend, an intelligent and straightforward woman, suddenly become an
orator and performer. Her presence filled the room and in English (for my benefit?) she commanded everyone to be silent and explained how we would precede with the class. First we would circulate around the room so that we could view the student exhibits and more formal presentations, also given by the students, about each one of the exhibits would be given to the class. This was one of Sita’s undergraduate classes and the focus for today’s event was to explore cognitive development in children. The students had been separated into six groups, with each group given the task of presenting information about the different child development stages. Not only were they charged with the task of making a report, but they also had to design toys and games that would be appropriate for the age groups represented by the developmental stages. It was these toys that were on display around the room.

I was encouraged to start perusing the tables first, along with the professors. Each of the tables represented a different cognitive stage of development. The students who had worked on the project for each stage were present at the corresponding table and they explained the toys they had created and explained how they would indeed be useful and amusing to a child of that age. The toys were all very ingenious and the level of creativity and care that had gone into designing and making them amazed me. My own dexterity is poor, and thus I could appreciate all the more these women’s efforts towards their projects. Once I had gone through this portion of the fair, the students were allowed to mingle and view each other’s work, and then we all drifted to our seats for the longer presentations. There were six speakers that day, one chosen from each of the eight groups consisting of four
people each and they would present detailed information about the cognitive stage they had researched. Their presentations were much longer and more detailed than those that had been given at the tables and they contained more specific information about the cognitive development of children; the stages as defined by the child development system; and how cognitive development corresponds with physical development and motor function. I did not understand all of these presentations because three of the women did not choose to speak in English, but their presentations were still punctuated with borrowed English words and official Western medical jargon that shot out at me like bullets.

The presentations were thorough and they were similar in style and structure to many presentations I had heard or given at home in the United States. Like the presentations I had done at home, the students at the teaching hospital were given a topic to conduct research upon. They wrote essays utilizing previous works and citations concerning their topics and they reformatted this material into an oral presentation showcasing the information assembled. The topic, Western medicine and cognitive development were also ones that could be commonly seen in a similar medical and educational institution in the United States. However, there were some slight and subtle differences in the presentations that can stand as allusions to medical pluralism and how it is in operation in Kathmandu, Nepal and within the educations and minds of the nursing students and professionals that I worked with there.
Figure 7.1. Image of one of cognitive development exhibits

Figure 7.2 Image of a cognitive development exhibit and several students
My class visit and the event I described above happened on the first day that I visited the Kathmandu teaching hospital and it is one that I felt was very important for its descriptive and symbolic qualities. This event is a representation of the interwoven nature of my informant’s medical reality. The members of this class are Western nursing professionals or are training to be so. Yet, their expression of Western medicine in distinct and in both ideological and mundane ways this expression is a reflection of both their status as Western medical professionals and Nepali citizens. Nepali medical pluralism, the mixing of different medical beliefs and practices, can be seen in this description. It can be seen in the saris made out of scrub material and dyed in traditional scrub colors. It can be seen in the long white lab coats that were worn over these “scrubs”.

This event also illustrates another facet of medical pluralism, that of the mixing of medical ideologies. The presentations and the exhibits that were on display that day had to do with cognitive development in children, which is a field allied both with biology and psychology. As I will discuss later in my results, psychology, psychiatry, and mental illness are not readily accepted or recognized in Nepal. All of my informants were familiar with these terms, but they were also familiar with the fact that these terms and ideas are not currently accepted in Nepal. In essence psychology does not really exist within their cultural worldview. They understand that it exists as a concept, and is one that they are taught about in school and within Western medicine, but this does not make psychology “real” for them.
Therefore it was very interesting that these nurses were not only learning about cognitive development, but that they were also comfortable with the contradiction between their training in psychology and their rejection of it.

Ultimately, I found that these nurses behaved in similar ways to populations studied in other works concerning Nepali medical pluralism. I will explore these behaviors, and how they were uniquely expressed within my own research context. I will explore these behaviors in the next section: self-medication as a first resort and the most popular form of therapy; concurrent treatment in regards to Western medicine and astrology; and opposing epistemologies within a pluralistic system.
CHAPTER EIGHT

PILE SORT RESPONSES: CONTRADICTORY EVIDENCE

As I mentioned in my methods and population section, one of the methods I used in the field was that of pile sorting. Originally, I intended this method, and the results, it produced to be a major part of my thesis and my analysis. Pile sorts have frequently been used by medical anthropologists as a way of eliciting therapy choices, patterns of resort, and cultural models concerning therapies from individuals in the field and have been used as quantitative compliments to other qualitative data concerning study populations (Weller, et al 1997). Pile sorts proved to be a helpful method in my own research, but not in the ways that I had originally intended. They allowed me to gain rapport with the nurses I interviewed and they also provided an available structure for me to create pertinent questions for my later interviews; however, the results of my pile sorts were in some ways ultimately misleading, and in fact as I later discovered in my interviews the results I gathered from them were largely based upon the structure of my pile sort test, which was created using my own conceptions of Nepali medical care and where interpreted differently by most of my informants.

My pile sort results, therefore, are not reliable data when presented or analyzed alone, but they are an excellent gateway into the actual data I received during my interviews and I
will use them in this chapter in just such a way; they will act as an introduction to the behaviors and patterns I will discuss later in my results section. The table showing the results of my pile sorts can be seen at the end of this chapter. The 31 illnesses and diseases I used are listed on the side and the following practitioners or therapies: Hindu priest and Buddhist Lama; pharmacist; self-medication; shaman; Western professional; Ayurvedic doctor; and astrologer are listed across the top. The numbers listed in the figure represent the number of times that particular practitioner or therapy was chosen as a first resort by the nurses and nursing students I interviewed. In order to more fully understand why this method proved to be problematic I will also state my own interpretation of these categories when I created them. Hindu Priests and Buddhist Lamas are any healers with that designation that are religious figures and who give blessings that are appropriate to their allied religion. The “pharmacist” category refers to both the trained pharmacist and the pharmacy assistants working in a pharmacy; when selecting this category I believed that my informants would be using pharmaceuticals, but that they would also be consulting with the pharmacist or pharmacy assistant. Self-Medication referred to non-pharmaceutical herbs and home remedies. The category, “shaman,” referred to faith healers operating under that title that used possession; shamanic trance; brushing, blowing or spitting techniques; or amulets when they provided healing and preventative care. Ayurvedic doctors were considered to be formally or informally trained health care practitioners that presented themselves as working solely in the Ayurvedic tradition. And, finally, the category called “astrologer” represented any practitioner of Vedic astrology who used it as form of healing and health care.
I explained these categories to my informants when I administered the pile sort, but each of my informants ultimately chose to interpret these categories as they wished. I am grateful they did so because by doing this they were actually supplying me with their own beliefs and conceptions of these categories. If they had heeded my categories they would have conformed to my erroneous assumptions and I would have failed to elicit their beliefs and expectations. What follows are the results of my pile sorts as they appear in the chart and a discussion of how my informants actually perceived these categories and how these perceptions are reflections of the behaviors and beliefs that I discuss later in this thesis.

The data as shown only through my pile sorts is as follows. For six of the illnesses/diseases listed: complications with pregnancy; broken bones; diabetes; tuberculosis; venereal diseases; and syphilis, all of my informants chose to go to a Western professional as their first resort. Chapped lips and the common cold were the only ailments in which a western professional was not cited as a first resort. Seventeen of the illnesses diseases listed had self-medication or the pharmacist as a first resort and ten had the Ayurvedic doctor listed as a possible first option for treatment. Three illnesses/diseases has the astrologer chosen as the first health care provider consulted and none of my informants chose to consult with a Hindu priest, a Buddhist lama, or a shaman as a first resort. According to these results Western medicine, as provided by a trained professional, was the therapy most chosen as a first resort and it was selected one hundred ninety four times. Consulting with a pharmacist
or using a pharmacy was the second most popular choice as a first resort, and my informants chose it as an option 60 times. Self-medication was next and it was a therapy that was chosen as a first resort thirty six times. Ayurvedic professionals and Astrologers each were chosen twelve and seven times respectively and faith healers such as Buddhist Lama’s, Hindu Priests, and shamans were not selected by any of my informants as a preferred first resort for any of the illnesses or diseases they were presented with in the pile sort. When reviewing this data it appears that Western medical professionals are the most popular first resort. It also shows that amongst my population Western medical professionals were consulted for a wide variety of illnesses and diseases. Western trained professionals also appear to be the most popular choice by a large margin. Also, pharmacists and self-medication appear to be the closest alternative options and more spiritual faith healers appear to be the least popular choice.

These were the results indicated by my pile sort; however, when I began to interview my informants in more detail, I discovered that my results were largely misleading, my informants interpreted the test in different ways and their choices and understandings of the therapies listed was not as concise and simple as I had previously thought. Basically, I had assumed that my test would be understood by my informants in the same way as I had when I had created it, instead my categories were too broad and therefore my results were too simplistic. I believe this to be largely due to the practitioners and therapies that I chose to use in the pile sort and how my informants conceptualized these categories. Most of the nurses
and nursing students who did the pile sort felt that “Western professionals,” “Pharmacists,” and “Self-Medication” were interconnected. They felt that all three of these categories could be placed under the broader category of “Western medicine”. They also considered themselves to be represented by the “Western Professional” category at the exclusion of other Western trained medical specialists. When they chose “Western professional” they were often choosing themselves as their health care provider. Self-medication was problematic because, most of the nurses interviewed did not interpret this category to mean herbal or home remedies; instead it meant relying on their own Western medical knowledge. Pharmacist was problematic for the same reason as that of Western medical professional and self-medication. Most of my informants they treated themselves (Self-medication) often with pharmaceuticals (Pharmacist) and they were acting as Western Professionals. They could not see the differences between these three categories and therefore they felt many of their answers in the pile sort were arbitrary and did not actually reflect their actual behavior. This was further complicated by the fact that some of the nurses did try to interpret the categories as I had originally intended it when I had made the pile sort design.

The pile sort method proved to be very problematic indeed, but it did shed some light upon the directions of my subsequent interviews as well as showcases some of the behaviors and beliefs that my informants would tell me about in our discourse. Ultimately, Western medicine was utilized in some form by all of the nurses for most of the illnesses and diseases they had. The most popular form of therapy was that of Self-medication. They were a
demarcation between perceived physical and emotional/mental problems and how they should be treated; and faith healers, especially the shaman, were not considered to be popular are even desired health care providers.
Table 2. Pile sort responses based upon first therapy chosen

<table>
<thead>
<tr>
<th>Illnesses/Diseases</th>
<th>Hindu Priest /Buddhist Lama</th>
<th>Pharmacist</th>
<th>Self-Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dysentery (serious)</td>
<td>6</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Fever</td>
<td>4</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Common Cold</td>
<td>5</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Gastric Problems</td>
<td>4</td>
<td>3</td>
<td></td>
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<tr>
<td>Chronic Anger</td>
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<tr>
<td>Madness</td>
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<td></td>
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<tr>
<td>Trouble breathing</td>
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<td></td>
<td>1</td>
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<tr>
<td>Arthritis</td>
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<td></td>
<td>3</td>
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<tr>
<td>Sore throat</td>
<td>1</td>
<td>4</td>
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</tr>
<tr>
<td>Insomnia</td>
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<tr>
<td>Complications (pregnancy)</td>
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<tr>
<td>Depression (chronic)</td>
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<tr>
<td>Headache</td>
<td>6</td>
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<td>Syphilis</td>
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<td>Rabies</td>
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<td>Parasites</td>
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<td>Venereal Diseases</td>
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<td>Sprains</td>
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<tr>
<td>Complications (menstruation)</td>
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<td>Chapped lips</td>
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<td>Dry skin</td>
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Table 2. Continued

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<th>Western Professional</th>
<th>Ayurvedic Doctor</th>
<th>Astrologer</th>
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<tr>
<td>Dysentery (serious)</td>
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<td>Fever</td>
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<td>Gastric Problems</td>
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<td>Chronic Anger</td>
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<tr>
<td>Madness</td>
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<td>Trouble breathing</td>
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<td>Complications (pregnancy)</td>
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<td>Depression (chronic)</td>
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<tr>
<td>Sprains</td>
<td>8</td>
<td>2</td>
<td></td>
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<tr>
<td>Complications (menstruation)</td>
<td>8</td>
<td></td>
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<tr>
<td>Chapped lips</td>
<td></td>
<td></td>
<td>1</td>
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<tr>
<td>Chronic fatigue</td>
<td>5</td>
<td>1</td>
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<tr>
<td>Dry skin</td>
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<tr>
<td><strong>Total</strong></td>
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CHAPTER NINE

SELF-MEDICATION: THE MOST POPULAR THERAPY CHOICE

Pigg’s (1995, 1996), Kohrt and Harper’s (2008) and Subedi’s (1989, 1992), research conducted in Kathmandu has shown that the people of Kathmandu behave in similar ways to other study populations living in medically pluralistic contexts (Burghart 1996; Colson 1971; Durkin-Longley 1984; Good 1994; Hare 1993; Kleinman 1980; Press 1978; Rashid 2008; Stoner 1986; Waxler 1984, 1988; Weller et al 1997). I found similar results amongst my own study population of nurses, nursing instructors, and nursing students; mainly that they, like these other research populations, relied heavily on self-medication; made medical choices based upon their perceived needs, engaged in concurrent treatment, and were also influenced by other larger social processes and the affects these had upon their values and beliefs.

Self-medication was undeniably the most popular treatment choice and therapy option amongst the nurses and nursing students I spoke with and it was the most desirable and logical therapy choice for several reasons. One of the most obvious, in their minds, was that the practice of self-medication allowed them to retain and exercise their own power: power over their illness, their diagnosis, and their treatment. This empowerment, was largely a result of their self identification as Western trained medical professionals; they were nurses and their education and their medical background made them qualified to diagnosis and treat all illnesses, especially their own. The practice of self-medication was therefore an independent and powerful response to illness that showcased their medical knowledge and
training, and perhaps, even more importantly, allowed them to avoid the advice of other medical professionals, especially Western trained physicians. These themes are inexorably tied together within the beliefs and practices of the women I spoke with and it can be seen in the following quote from one of my informants, a cardiac nurse named Ranjana:

If I am sick I will use what I have at home. If this doesn’t work I ask around. Family, friends, see what things [medications, remedies] they have. Then I will go to the pharmacy, if it is still bad. I am a nurse. I can help myself. One time I got rehydration fluids for myself. You know, for the IV. I gave it to myself, at home.

Deepika, another nursing instructor at the Teaching Hospital, was more vehement in her claim to medical authority and her refusal to see a doctor, saying:

I would go to anyone, do anything, before I would go to a doctor! I would first go to the pharmacy. I wouldn’t go to the doctor first, only then, if I had to. Even if my child was sick I wouldn’t go to the doctor! One time my baby was sick with a bad eye infection. I had been sick too and I already had antibiotics. I was on the antibiotics so I decided to use my own breast milk. I put it in her eye and it worked. I knew this because I am a nurse, but also women know this. When I was in India they did it a lot. I do not need to go to the doctor. I can take care of myself!

The nurses I spoke with practiced self-medication as an obvious and intuitive first resort when they were faced with an illness and its symptoms. The prevalence of this behavior and its application in regards to most medical problems can be seen in the quotes above; many of the nurses I spoke with frequently used pharmaceuticals and other medical care products as
they saw fit and in many cases, like the two incidents described, inventively. They did not
feel that they needed to see another medical provider because they believed that both
Western medicine and their training in it provided them with the correct knowledge to
provide the appropriate self care.

Using Self-medication as a way to avoid allied health professionals also helped to
relieve some of my informants other health related concerns. Mainly, they were afraid that by
consulting with another professional they might potentially be wasting their time, their
money and more importantly, they might be endangering their health further. Self-
medication, therefore, was both cheaper and less evasive then visiting a hospital or a clinic to
see a doctor. Visiting a hospital or a clinic could result in extra costs, and as many of the
nurses explained to me, they ran the risk of being told what they already knew about the
nature of their illness. As the following quotes from a graduating nursing student and two of
her instructors illustrates. The student said:

    Why would I go to the doctor, he doesn’t know anything I do not. He
    will not tell me anything new; it is a waste. He will tell me what I
    already know.

One of the nursing instructors stated:

    Doctor’s think they know everything because they are doctors, but we
    have worked as nurses for just as long and we have seen everything
    they have. Why would I ask them about my sickness if I already know
    how to cure it?

The other nursing instructor agreed with her saying:
It would be silly, me going to the doctor. I would say to myself, why they were looking at me, “Prasuna, you know you have a virus; you know it is the flu. Go home. Go to the pharmacy. You know how to take care of this.”

Visiting another Western health care provider was also perceived as being potentially dangerous or problematic to one’s already altered state of health. This seemed to manifest itself in two distinct scenarios. First, many of the nurses or nursing students who had worked in hospitals in Kathmandu felt that these institutions were unsanitary and unsafe. Even though they themselves tried to keep sanitation standards high, ultimately hospitals were environments where patients could and often were easily exposed to other diseases and secondary infections. As Ranjana told me:

I work in the hospitals I know what they are like; I know how clean they are. They are not and many people, when they come, they get colds, things on top of what they already have. Staff [infection] is bad too.

Some of my informants did not share these opinions regarding Western physicians or Western health care centers. All, but one of the first year nursing students I spoke with expressed confidence in Western physicians and assured me that they would consult with one for most of their medical problems. For example, one of the nursing students I spoke with, Anchal, a nineteen year old first year nursing student, strongly assured me that she would go to a doctor first and that all of the illnesses/ diseases from the pile sort that she placed under a “Western professional,” would all be ones for which she would actually consult a physician or another Western practitioner for. As she explained, the reasons she felt this way was
because she was new to the field of nursing and she had had little previous training in Western medicine. She felt that this made her unqualified to practice self-medication for most illnesses. The other young nursing students also gave this explanation and it was cited as the reason why they did not practice self-medication as frequently as did the older, more experienced nurses. This suggests that their reliance on other Western professionals will probably change as they become more educated and experienced and, in the future, they might share some of the same opinions as the other women.

So, for what ailments would my informants actually consult a physician for, if any? According to most of the nurses, they would consult with a doctor only for illnesses and diseases that were both physical and acute in nature. A twenty three year old nursing student, named Champa, used some of the illnesses/diseases from the pile sort, as an example of the type of medical problems that would require the help of another Western professional. They were: complications during menstruation, asthma, tuberculosis, syphilis, broken bones, diabetes, sexually transmitted infections and complications during pregnancy. Champa explained that these ailments were ones that she felt she could not adequately diagnose or treat. The other women expressed many of the same opinions and two reasons for this decision became apparent from their answers. Either the nurses did not feel that they possessed the skills or knowledge necessary to deal with that particular medical problem or they felt that their symptoms and condition were to severe or problematic. Chandrika, a thirty-five year old nursing instructor at the college explained:
Yes, there are times that I would go to a doctor. Most times, no, but I cannot fix my own bones. My arm is broken; I will go to a doctor then.

Broken bones were not the only medical problems cited as requiring the expertise of another Western health care professional; severe cuts and other wounds that would need stitches were also given as reasons to visit a doctor. Severity of the illness, or its symptoms, also played a role in an individual’s decision of whether or not to go to another Western professional, and many of the nurses said that they would practice self-medication as long as the illness was not extremely acute. As soon as the illness became too acute for them to handle they would seek outside care.

Pregnancy and problems of a sexual or potentially embarrassing nature were also given as being medical issues that required outside care. In the case of pregnancy, this was unanimous amongst the nurses I spoke with, and they stressed the importance of their children’s future health and their fear that they would somehow harm their child or themselves if they attempted to practice only self care during their pregnancy. These attitudes may have been a result of the degree of responsibility the women felt for the development and health of their unborn children. This can be evidenced in this quote from Dhatri, a nursing instructor and mother of two:

My second son, when he was born he had to have a surgery. He had a problem and it was my fault. It was because I traveled when I was pregnant and I did not eat well. My husband, the Ganesh, we were in
China and I hated the spices there. I could not stand the smell, so I did not eat.

Not only did the women feel responsible for the development of their children, but they also felt that they needed to consult with a doctor during the pregnancy, as well as have a health care professional attend their birth. In fact, medically assisted births have become one of the most frequently used Western health care services in Nepal, especially in Kathmandu with 52% of the population in Kathmandu having births attended by a skilled professional in comparison to only 19% in rural areas (WHO Nepal Health Profile, accessed 2011).

Venereal diseases were also given, as reasons to see the doctor, especially if the symptoms experienced were severe. As Deepika explained:

Syphilis, if I had syphilis I would go to a doctor first. That is private and they would know what to do. Anything about private places, I would go to a doctor for that.

Many of the women I spoke with found these ailments to be embarrassing and frightening and they did not wish to practice self-medication in these situations because they were afraid they might misdiagnose themselves or not get the appropriate care in time. Another informant, Shree, a third year nursing student also expressed a fear of syphilis and the potential dangers of ignoring it:

You can treat [syphilis] if you catch it. If you think, “Oh, I am fine. My husband did not give me this, not me”, then it could be too late and syphilis is bad, really bad. Just go to the doctor, do not wait.
Therefore, my informants seemed to consult with Western physicians both as a first and a last resort, depending upon their perception of their illness, which was based both on the perceived severity of the illness and whether or not they felt personally qualified to treat it themselves. While self-medication was largely perceived as a personal choice and my informants felt that it depended upon their own personal knowledge and experience, it is important to mention that Western pharmaceuticals played an intrinsic role in my informant’s practice of self medication. Without available access to pharmaceuticals and familiarity with their appropriate use, the nurses I spoke with would have been severely restricted in their practice of self-medication.

In Nepal one does not need a prescription to get medicine from the pharmacy. This is the same in many other countries (Miles 1998; van der Geest et al. 1996) and this is the main reason why my informants were able to so easily practice self-medication as well as avoid consulting with doctors or visiting clinics and hospitals. Pharmaceuticals were so deeply intertwined within the practice of self-medication that when I myself became ill in the field I was frequently advised to go to the pharmacy.

You have a cold? Just go to the pharmacy, they can give you something. If you don’t want to take a pill, get Sancho [a Nepali vapor rub equivalent]. Then you have to drink hot fluids. No cold. No beer. Cold will make it worse. Hot will make it better.

A lack of prescriptions was not the only part of the infrastructure of pharmaceutical care in Nepal that supported the practice of self-medication. Pharmacists themselves are not trained
to assume the role of an authoritative medical expert, as can be clearly seen within this section of the Nepal Pharmacy Council’s official guidelines:

[A] Pharmacist’s fundamental concern is welfare of the patient. Patient’s responsibility to make decisions regarding his/her health must be respected at all times. Therefore, the pharmacist must help the client in making well-informed decisions about proper use of medicines and other health care medicines. Pharmacist should support the patient in making well-considered decisions with regard to self-care (Nepal Pharmacy Council, 2005).

The role of a pharmacist within Kathmandu is instead that of a guide or a counselor. This allowed the nurses I spoke with to exert their own agency in the pharmacy, utilizing their own knowledge and power rather than submitting control of their bodies to the pharmacist. The pharmacy, not only fits into my informants behavioral pattern of self-diagnosis and self-medication, but it supports and promotes it. However, many of the nurses I spoke with, while willing to use pharmaceuticals themselves, and were less supportive of other untrained individuals using them as freely. Pharmaceutical use was not perceived without some controversy and many of the nurses were aware of some of the problems associated with pharmaceutical and drug abuse in Nepal. Drug abuse is a prolific and difficult social problem in Nepal and it a major concern within governmental and developmental discourse in the country. According to a rapid assessment of drug addiction done in Nepal by the United Nations Office of Drugs and Crime, medical shops, or pharmacies, and pharmaceutical drugs are mentioned as being a large part of the drug abuse, criminal activity, and drug trafficking problem in Nepal:
The Pharmaceutical Industry in Nepal is developing fast and the absence of legislative controls on precursor chemicals is likely to be exploited by traffickers. Legitimate imports of pseudoephedrine into Nepal have also increased significantly over the years, although specific data is not available. Pharmaceutical preparations commonly smuggled out of India into Nepal contain bupremorphine and nitrazepam. In 2007, about 11,500 vials containing bupremorphine and 92,500 vials containing various benzodiazepines were seized in Nepal (INCB, 2010b). Unconfirmed reports from law enforcement officials also suggest that ATS precursors are trafficked through the land border from China into Nepal. This is a serious development in Nepal that is largely going unnoticed, as resources to address all aspects of drug use and trafficking in the country remain very limited. Treatment and rehabilitation services for drug users remain under resourced in the country (UNODC 2010).

As highlighted in the quote above, drugs and drug abuse are becoming a rapidly increasingly problem in Nepal and this situation is a result of poor legislative and governmental controls and the availability and accessibility of pharmaceutical drugs (UNODC 2010). Abusers may misuse the pharmaceuticals they procure from pharmacies for their own recreational use or the medications themselves can be used to create other more potentially harmful drugs such as heroin. Pharmaceuticals in Nepal are also shipped to other South Asian countries just for this use (UNODC 2010). The nurses I spoke with were aware of these problems and they felt that pharmacy policy and practice largely enabled drug abuse and trafficking. As a retired nursing instructor, Ojal, told me:

They [pharmacies] are a problem. People can buy whatever they want from the pharmacy. 93% of the Nepali people do not go to a doctor. Why should they when they can get it from the pharmacy? They use the shaman and then go to the pharmacy for drugs. It is a big problem.
People misuse the drugs, they get addicted. We need prescriptions here, like you have in your country.

While my informants acknowledged these potential problems, none of the nurses wished to lose their privileges and their ability to access pharmaceuticals and not only this none of them admitted to abusing or misusing pharmaceutical drugs. As Ojal told me when I asked her about her own pharmaceutical use:

I am a nurse. Nurses wouldn’t do that [abuse drugs]. I know what I need and I follow the instructions, but I am a nurse. Someone else, they might misunderstand and not take a pill correctly. I am a professional. I would never use drugs or use things from the pharmacy for addiction. That would not be right.

My informant’s were aware of the social problems involved with pharmaceutical use and many of them felt that pharmaceutical policy needed to be more standardized and that pharmaceuticals needed to be both controlled and monitored. However, many of the other nurses shared Ojal’s opinion, that nurses and other medical professionals were not the problem, “other” people were. Like Ojal, some of the other nurses used vague nouns such as “they,” “them,” and “the Nepali people” when they were discussing the population most likely to be engaged in the misuse of pharmaceutical drugs. The fact that all of the nurses and nursing students used the pharmacy, and frequently, when they experienced a medical was obvious, but when I asked about drug misuse and abuse all of my informants denied any personal knowledge of such behavior unless it was to describe this unknown “other”.
Ultimately, what these data have shown is that the nurses and nursing instructors I studied and spoke with rely heavily on Western medical knowledge and practice and biomedical pharmaceuticals. It also shows that self-medication is the most popular and frequently used type of therapy and that it is often the first resort for the nurses when they experience a problem. This is because self-medication allows them to retain a sense of self-empowerment and control over their illness and the therapies they receive. Not only this, but self-medication supports their self-identification as medical authorities and it allows them to avoid going to unclean medical facilities, extra expenses, and visits to other Western medical professionals. However; there are some exceptions to this rule, the nurses would consult with a physician as a first resort if they had an acute problem that required a certain medical skill such as a broken bone, or they would consult with a doctor over a severe illness. Pregnancy and venereal diseases were also medical issues that frequently were perceived as needing the care of a Western physician. Pharmaceuticals were also an intrinsic part of their medical choices and in fact the infrastructure of pharmaceuticals in Nepal is what allowed my informants to so freely practice self-medication within the Western medical system even if this practice was perceived as being controversial in some ways. However, while all of these facets may be true for my informants, it is important to mention that all of these behaviors: a reliance on Western medicine, self-medication, and pharmaceutical use were used only for certain “types” of illnesses. The nurses I spoke with felt that illnesses and diseases largely fell into two categories: physical ailments and emotional/spiritual illnesses. The behaviors I described in this chapter were used for ailments and medical issues that were perceived as
being purely physical in nature. A whole different set of behaviors and beliefs, often
contradictory to the ones described above, were exhibited by my informants when they felt
that their illness was spiritual, emotional, or mental in nature.
CHAPTER TEN

CONCURRENT TREATMENT: WESTERN MEDICINE AND VEDIC ASTROLOGY

Western medicine was the medical system the nurses used the most extensively in their daily lives and in regards to most of their medical choices. However, the nurses did not rely solely upon Western medicine for all of their health care needs, and like other populations operating in medically pluralistic contexts (Burghart 1996; Colson 1971; Durkin-Longley 1984; Good 1994; Hare 1993; Kleinman 1980; Pigg 1995, 1996; Press 1978; Rashid 2008; Stoner 1986; Waxler 1984, 1988; Weller et al 1997) they actively engaged in concurrent treatment; choosing different medical systems, practitioners, and therapies based upon their perceived needs and the nature of their illness. This behavior usually manifested itself in one distinct way amongst my population; that is, the nurses chose to consult with a Vedic astrologer almost as frequently as they chose to use Western medicine. It also appeared that the nurses would use both systems in tandem for some illnesses, but that the majority of the time they used the two systems separately to address different types of illnesses.

According to most of the nurses I spoke with, they generally separated illnesses into two large and rather fluid categories. These two categories were based upon their perceptions concerning the nature, or origin, of their illness and this in turn influenced what needs they
had, and ultimately, which medical system or systems they would use to treat it. Illnesses that were seen as being strictly physical in nature or biological in origin were the illnesses that Western medicine and pharmaceuticals were used for. The illnesses placed in the other category were more nebulous and included illnesses where the causation of the disease was unknown or were illnesses that were chronic in nature. These illnesses were often also largely emotional or mental in nature. For example, Pushpa, a nursing instructor stated that some of the illnesses/diseases in my pile sort were good examples of ones that would fall into this “category”. They included: chronic anger, madness, insomnia, and depression. These illnesses were, she claimed, harder to diagnosis and they were harder to treat. Therefore, they were often perceived as being spiritual or karmic in nature. She also stressed that any disease that was chronic and seemingly impervious to Western medical care was also perceived in this light.

She is not the only informant I spoke with who felt this way, and in fact most of the nurses and nursing students gave me similar answers when I spoke to them about the origins of illness. As Pushpa further explained to me:

When you are sick, it is because you are supposed to be. Whenever you are sick it is because of karma. Our gods they decided ahead of time, before you are born when you will be sick, or, the illness it is because of something bad you did. You have to pay it back, so now you are sick.

This belief extended into the realm of physical ailments and Western medicine as well, but acute physical problems did not appear to merit the same degree of spiritual reflection and
self-analysis, as did those in the second category. And it is for the illnesses in this second
category that the consultation with a Vedic astrologer occurred.

According to the nurses, Astrologers are important health care providers because they
have access to and are able to understand your karmic destiny. By reading your planets, your
palm, and your forehead they can determine what kind of illnesses you will experience in this
lifetime, how long they will last, and how you can treat them. This power in terms of
diagnosis is invaluable to the astrologer’s medical authority and it is what makes them the
specialists most suited to dealing with the emotional, mental, chronic, and ambiguous health
problems placed into category two. As Sita explained, astrologers were important healers
because:

The astrologer can help you when you don’t know what else to do. They can look at your sign and your planets and they can tell when
you will be sick. Then you can change it, heal, but you need to know
your sign and the stars. I am a Leo, this ring I wear, it is our stone. The
astrologer can see I am a Leo and what else and tell me what to do.

This belief concerning the astrologer’s connection with the forces of fate and destiny can be
very powerful and an astrologer’s opinion can greatly affect a patient’s decisions and feelings
regarding their illness and the therapies they will ultimately choose to use. The power of an
astrologer’s medical opinion can be seen in one of the stories several of my informants told
me about one of their colleagues, Lakshmi a nurse of longstanding who had also been an
instructor at the teaching hospital.
Three of my informants told me that Lakshmi had recently passed away and that this had been due to an illness of ambiguous origins. As the three nurses explained to me, Lakshmi had begun to have gastric problems and abdominal pain a couple months prior to my fieldwork. She had gone to several different Western doctors, but none of them could determine the cause of her illness. Her Western physicians felt that they would need to do exploratory surgery and that this would hopefully lead to an actual diagnosis. Lakshmi was frustrated about this prognosis so she than chose to consult with a Vedic astrologer, who told her that, her illness was karmic in nature and that she was destined to die. This astrologer also told her that she could continue to consult with her Western physicians, but that they would be unable to determine the cause of her illness or treat it sufficiently. Because of this reading Lakshmi decided to stop seeing her Western physicians because she now felt that her death was imminent and unavoidable—it was her destiny. She died shortly after her visit to the astrologer. This was a very sad and emotional story, but it was also a powerful example of the validity of Vedic astrology and the legitimacy of the astrologer within my informant’s minds and their decisions. Not only did Lakshmi choose to engage in concurrent treatment with both Western medicine and Vedic astrology, but this story also cemented what my informants had been telling me, both about their beliefs regarding the karmic origins of illness and their insistence that the astrologer could help them with chronic or ambiguous illnesses.
Another important aspect of my informant’s use of Vedic astrology was that they believed that the astrologer was the healer most qualified to help people with mental and emotional disorders. These problems, such as depression and anxiety are ones that are becoming increasingly recognized in Nepali society, but are heavily stigmatized and like the individuals studied in Kohrt and Harper’s (2008) work; the nurses I spoke with seemed to exhibit similar beliefs in regards to mental disorders. They recognized their existence within Western medical thought and they treated them as possible medical ailments, but they also largely rejected them as required by their stigmatized status. Clinical psychology and mental disorders were therefore just concepts, and while the nurses recognized their existence in the “West,” all but one of my informants, whose uncle happened to be one the first accredited psychiatrists working in Nepal, stated that they did not believe in its use or application. Instead, mental and emotional problems were yet again the domain of the astrologer. As a nursing instructor named Vidya explained:

Astrologers calculate people’s pain. Emotional problems are created by karma and an astrologer can tell you more about why this is happening to you. All the Nepali people go to an astrologer for these problems. Depression is from psychology; the Nepali people do not understand psychology. We do not have psychotherapy here. If you have an emotional problem you go the astrologer.

Therefore, mental disorders and emotional problems possessed an oddly contentious place within the minds of the nurses I spoke with and may, as Kohrt and Harper (2008) suggest, be a result of the stigmatized status of mental illness in Nepal. According to their
research done in Kathmandu, Western medical professionals are hesitant to diagnosis or treat mental illness due to the burden of social stigma and instead they choose to focus largely upon strictly “physical” problems; “[Western medical professionals] address “real physical problems, rather than problems of the mind. When physicians do encounter mental illness, they may provide treatment without naming it as such” (Kohrt and Harper 2008, 478). Kohrt and Harper (2008) also suggest that there is a correlation between the perception of a mental illness and the consultation of a traditional medical system or healer; they suggest that these systems more readily allow for the creation of a meaning for an illness that makes it less identifiable as a mental disorder. When this occurs the patient is free of the stigma attached to such a diagnosis. This may be what is occurring amongst my own informants. They too are not comfortable with the concepts of mental and emotional illness; they accept that they exist as a part of their Western medical training, but they chose to not openly acknowledge them. They also choose to consult with more traditional healers, such as the Vedic astrologer, for these types of problems and they also support explanations for these illnesses that are more socially sanctioned, such as karma.
CHAPTER ELEVEN

QUESTIONING THE VALIDITY OF OTHER MEDICAL SYSTEMS: THE CONTROVERSY OVER SHAMANISM

As can be seen in the previous chapters, the nurses I studied consistently and regularly questioned and considered the medical systems at work in their medically pluralistic context and they chose certain facets of these medical systems to use and believe in while rejecting others. Another example of this phenomenon can be seen in my informant’s attitudes regarding non-Western healers in Nepal, especially shamans. As mentioned previously, shamanism is one of the most prolific and widely used medical systems in Nepal, existing and operating both in rural areas and within the urban center of Kathmandu. According to Gellner (1994), Kohrt and Harper (2008) and Subedi (1989, 1992) shamans are not only prominent figures in the medical tableau of the city, but they are also widely used by most of the city’s population, both for a variety of illnesses, but also as a first resort, often before the use of Western medical services or the consultation of a Western doctor.

This fact is extremely interesting when the attitudes of my informants towards these health care practitioners are considered. Shamans were not popular amongst my informants or frequently consulted with. Instead they were spoken of with disdain, skepticism, and even contempt. In fact, all of my informants said that they would never use a shaman, ever, for any
reason or in regards to any medical problem. An example of this disdain and the strength of this rejection can be seen in the following quotes, both from two nursing instructors, Deepika and Sunita. Deepika, one of the nursing instructors I cited in chapter nine stated:

I would never go to a shaman! Only uneducated people use shamans. People who live in the hills will use them in the village and they come here [Kathmandu] and they will use them here, but they are backwards, they don’t know better!

Sunita, another nursing instructor had a similar response towards the validity of shamans as legitimate healers. Like Deepika, she did not have a positive opinion of these health care practitioners and she also associated shamans and their use with another group of people, divorced and separate from herself and her experience:

Many people, especially those who live in the city feel that shamans are just hocus pocus [here she turned to the side and made spitting noises and flailed her arm like she was whipping something] Ha, ha, that is the shaman. These people, they live in the city and they are educated and they can go to the pharmacy. Rural people have to go to the shaman, but a lot of them [urban dwellers] lie, they use the shaman. They feel that to say that they are uneducated and backwards too.

Both of these quotes contain the word “backwards” which is one I heard in all almost all of the nurse’s responses to any questions I posited about these traditional healers. This phenomenon and this specific term are not new to this avenue of research in Nepal. For all of their popularity and their undeniable medical authority and presence in the country, shamans and shamanism is a contested and controversial subject in Nepali discourse. This is a result of larger social processes and development projects in Nepal that have as Kohrt an Harper (2008) suggest created a Cartesian dichotomy in Nepal, one that suggests that Western
medicine is a positive and modern force in Nepal, and it is one that is integral to the
development of the country. Shamans and other traditional healers on the other hand are seen
as being a destructive force in Nepal that promotes ignorant beliefs and practices and causes
the country to stagnate instead of moving towards progress. Kohrt and Harper (2008) state:

Through both forces of modernity and its association with Cartesian
divisions of mind-body, there are new layers of stigma placed on
traditional healing. At an ideological level, one key and overarching
discourse is that development organizations, medical professionals,
and the “educated” public frequently describe traditional healers as
“backwards,” “superstitious,” or “barriers” to seeking care; indeed
[Western] health workers may even view traditional healers as having
mental illnesses (477).

The social controversy over shamanism in Nepal and its existence as a result of development
strategies is also the focus of Pigg’s (1996) work. Pigg (1996) also suggests, like Kohrt and
Harper (2008), that shamanism is a controversial subject, especially amongst and within the
minds of Western health care providers. Pigg (1996) states:

An aim of development in Nepal is to introduce “modern medicine”
(also known as “biomedicine,” “allopathy,” “Western medicine,” and
“cosmopolitan medicine”). In the everyday logic of development
practice, “modern medicine” is positioned as the eventual replacement
for existing modes of healing. “Modern medicine” thus has to combat
healers like shamans. In Nepal, shamans perform rituals that placate
spirits or foil witches; they generally do not give medicines or
manipulate the body itself. Their association with spirits and rituals
makes them especially potent metaphors for tradition in juxtaposition
to the “science” of “modern medicine” (162).

Pigg (1996) also explores, in detail in her work an event told to her by a nurse form
Kathmandu which showcases this particular women’s opinions and beliefs concerning
shamanism which is very similar to those I found within the opinions of the nurses I spoke with. The story involves an incident she experienced when she worked as a health care provider and educator in a rural village. Ultimately her story describes how one of the members in her health team decided to impersonate a shaman; after he did this, he was able to convince the villagers to use Western pharmaceuticals and care. This man eventually told the villagers of his ruse and this combined with the efficacy of Western medicine greatly altered the beliefs of the local villagers. After this event they recognized the legitimacy of Western medicine and they also questioned the validity of shamanism and other traditional healers. Pigg (1996), of course questions the nurses perception in this story, comparing her knowledge of village populations (with whom she has done extensive work) against those of the nurse she spoke with and she concludes that the nurse’s stories and opinions are reflections of larger social discourse in Nepal and not actually representative of the nature of shamanism and its use by villagers and urban dwellers alike. Pigg (1996) states:

I consider the nurse’s story to be every bit as “Nepali” as villagers stories. Its structure, particularly the way it organizes point of view, conveys something very specific to present day Nepal. The health team are “people who understand.” They identify themselves as such merely by referring to others as “villagers.” Villagers are by definition people who have not (or at least can seem to have not) been transformed by social changes of the past decades in Nepal. They reside on the other side of the modern divide. In order for the position of “people who understand” to exist there must be a credulous other (177).

This quote further explains the reactions of my own informants to the topic of shamanism. The nurses I spoke with not only disdained and disliked the shaman, but they also found
them to be a barrier to their goal of providing Western health care. As Ojal a nursing instructor explained to me:

Shamans are a problem. People go to them before they come to us. Many times their problem, their sickness is now worse because they chose to go to the shaman first. We would have been able to help them, but they do not know better. They believe the shaman and therefore they make bad decisions.

The nurses, not only saw shamanism as being a threat to Western medicine and a problem, but like Pigg (1996) and Kohrt and Harper (2008) suggest they have created in their minds an “other,” a credulous and undereducated population that chooses to use a shaman because they have not been taught better. Not only this, but also these “others” are a bane to the proper development of Nepal into a developed and modern country. As another one of my informants expressed:

You do not have shamans in your home [the U.S.], right? See, the Nepali people want to become better, to become modern. We want our traditions too, but some ways of life are dying and they are good and then others like the shaman, they stay. This is a problem. What will other people think of us? That we are all backward villagers?
CHAPTER TWELVE

DISCUSSION

In this thesis I explore medical pluralism and how medically pluralistic structures affect the medical beliefs and practices of the individuals operating within them. As can be seen in other research (Burghart 1996; Colson 1971; Durkin-Longley 1984; Good 1994; Hare 1993; Kleinman 1980; Pigg 1995, 1996; Press 1978; Rashid 2008; Stoner 1986; Subedi 1989, 1992; Waxler 1984, 1988; Weller et al 1997) done within medically pluralistic societies, the different systems therein tend to interact with one another in constant negotiation, accord, and conflict; the end result being that the different systems meld together in certain ways; their previous autonomy and distinction lost. These processes can be seen reflected within people’s beliefs and ideas regarding medicine and their behaviors within a medically pluralistic system.

The behaviors, beliefs, and choices of the nurses, nursing instructors, and nursing students I spoke with are reflections of the medically pluralistic context in which they navigate. The existence of so many different medical systems and ideologies has afforded them the ability to construct their own concepts of disease, illness, and medicine and it has given them the ability to pick and choose what facets of each medical system they would like to incorporate into their own personal belief system as well as in their health decisions and regiments. More importantly, and perhaps more valid within the confines of this thesis, the behaviors, beliefs, and choices of the women I spoke with are similar to those that have been
witnessed and discussed in other anthropologist works, both in other contexts and within Kathmandu and Nepal. My data suggests that my study population behaved in similar ways to other individuals studied in medically pluralistic settings. First, the nurses relied heavily upon self-medication, this was not only the most popular therapy choice, but it was also the first resort my informants made when they were faced with an illness episode. Secondly, my informants engaged in concurrent treatment. This meant that they utilized several different medical systems and that this behavior was a result of their perceived needs regarding their illness. Finally, larger social processes affected my informant’s beliefs and attitudes regarding medicine and this in turn affected some of their medical behaviors.

It is also important to note that my population, while behaving in similar ways to other study populations, also behaved in unique ways that were a result of their status as Western trained medical professionals. They were more familiar with Western medicine than some of the other populations studied, and as a result of this education my informants relied on and used Western medicine more readily and more extensively than other populations have in the past (Burghart 1996; Colson 1971; Durkin-Longley 1984; Good 1994; Hare 1993; Kleinman 1980; Pigg 1995, 1996; Press 1978; Rashid 2008; Stoner 1986; Subedi 1992; Waxler 1984, 1988; Weller et al 1997). This meant that while the nurses choose to use self-medication, like other populations, they were different from them in the fact that they used Western medical knowledge and pharmaceuticals to instigate self-care rather than use herbal
and home remedies (Kohrt and Harper 2008; Subedi 1989, 1992). In fact, Western medicine was the most prevalent and popular medical system used by my informants.

My study population was also unique from other study populations because their use of concurrent treatment was more limited than those in previous works (Burghart 1996; Colson 1971; Durkin-Longley 1984; Good 1994; Hare 1993; Kleinman 1980; Pigg 1995, 1996; Press 1978; Rashid 2008; Stoner 1986; Waxler 1984, 1988; Weller et al 1997). They rarely consulted with or utilized other established medical systems in Nepal, such as Ayurveda and Unani, and they also relied almost exclusively on one type of faith healer—the Vedic astrologer. This is vastly different from other populations in Nepal who have utilized several different medical systems at once and have often mixed the use of faith healers and biomedical models together (Pigg 1995, 1996). Finally, while my informants were affected by larger social processes, in this case development discourse in Nepal, they were influenced differently than other individuals because of their status as Western medical professionals (Pigg 1995, 1996). Rather than being the focus of development rhetoric and its accusations of “uneducated” and “backwards,” as other individuals have been, my informants were the perpetuators and supporters of this discourse.

In conclusion, Kathmandu is a medically pluralistic context, containing several different medical systems within one area and within one social tableau. Not only, this, but for the nurses, nursing instructors, and nursing students living and working within such a
system it has enabled them to behave in ways both similar to and distinct from other populations living within medically pluralistic contexts.
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