‘Seeing’ the patient

The uses and responsibilities of pharmacies in Kathmandu

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The Uses and Responsibilities of Pharmacies in Urban Kathmandu.

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Abstract

There is a worldwide increase in the reliance of medicines when it comes to treating illness. In many developing countries, pharmaceuticals can easily be procured at the local medicine shop or pharmacy. In Nepal, most medications can be bought over the counter though there are government regulations regarding some types of medication. In medically pluralistic societies, like Nepal, there is a multitude of medical traditions and treatments to choose from when one falls ill. For many locals the neighborhood pharmacy is often the initial point of contact with the health care system in Kathmandu, and is for many preferred above other options such as physicians.

Based on a 6-month participant fieldwork among allopathic and ayurvedic pharmacies in the heart of Kathmandu, the thesis explores the essential role pharmacies and their staff have as purveyors of medicine, filling the knowledge gaps that occur between the patient and the physician, and also acting as sources of rudimentary health education. The pharmacists offer a wide range of services including, but not limited to, dispensing medication, health education, counseling and recommendations regarding further treatment, and being an integrated part of the local community they reside in they are an essential part of the local health care system of Kathmandu. When there are so many different healing options to choose from in Kathmandu, why have pharmacies become a frequent go-to place for people after home remedies fail to treat an illness? This study therefore attempts to document what other roles and functions the pharmacy has in the community in an effort to uncover *why* they have become such a popular curative option.

Keywords: Health, illness, medical pluralism, pharmacy, healing, allopathy, ayurveda, home remedy, treatment.

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Introduction

From the moment my plane landed in Kathmandu at Tribhuvan Airport, and I sat in the back of the small, white Suzuki taxi maneuvering through the streets of Kathmandu, on its way out to Lalitpur, I couldn't help but notice the number and variety of health care facilities located in the city. Passing large white buildings, standing out from the grey and dusty surroundings, marked with large crosses indicating that the building was a hospital, I had never seen such a miscellany of health care facilities. As I got to know my local neighborhood in Lalitpur, and then later on returning to the energetic city of Kathmandu, I continued to be amazed by the sheer density of health care options available. Allopathic and ayurvedic pharmacies, herbal shops, private allopathic clinics, ayurvedic clinics, specialized clinics and hospitals dealing with specific health problems such as eyes, diabetes, cardiac issues, thyroid problems etc., public hospitals, private allopathic hospitals, private ayurvedic hospitals and Government health posts, in addition to less familiar providers such as numerologists, traditional healers, spiritual healers, crystal healers and astrologists, just to name a sample of the selection. Though the health care system in Kathmandu is a pluralistic one, I will throughout this thesis focus exclusively on the traditions of ayurveda and allopathy[1] as the two were the most commonly used by people I met, and they were by far most accessible in the urban scenery being Government approved, professionalized medical traditions in Nepal.

In many developing countries, pharmaceutical regulation is lacking, deficient or not enforced by government authorities. Thus, many regulated drugs can be purchased over-the-counter without a prescription from a physician, and the local pharmacy functions not only as an outlet for unregulated distribution of medication but also as a place to seek advice regarding treatment and general health (Kamat & Nichter, 1998). Although the World Health Organization (WHO) have pointed out several problematic issues associated with this practice such as negligent prescribing and over-prescribing, and in particular misuse of antibiotics leading to resistance (I have myself observed instances where these issues have been of my concern as well), the WHO has recognized that pharmacists can become a beneficial resource in spreading information and promoting safe use of medication to the local population (WHO, 1988). Although the cited

[1] Also known as biomedicine, evidence based medicine or western medicine. I will give a more thorough explanation for my preference of using the term allopathic medicine later on in this chapter.

WHO report was published in 1988, the issues it raises with respect to the practices of pharmacies and pharmacists within the health care system are no less relevant today.

Though the allopathic medical tradition has only really been available for the general population[1] since the 1950s, compared to ayurveda and other herbal remedies having been present for a substantial longer period, the use of allopathic medication was wide spread in Kathmandu. Most of the people I encountered used the two traditions interchangeably depending on the illness and their own personal beliefs regarding illness and healing. As time went by, and I settled down in the Kathmandu Valley I saw how people, and even physicians, would in many instances rely on treatments and medication from both traditions in trying to cure a specific illness or addressing a more general health concern. What the treatment consisted of or the specific order of curative resorts (trying ayurveda first and then allopathy, vice versa or all at once) would vary depending on the illness and the opinions available to the patient or his/her family, or the prescribing physician. Whereas the public health care options offer free general services to the population, the private ones charge the patients several hundreds rupees or more for a single consultation with a physician, depending on the specialty of the physician and the reason for the consultation. There were plenty of options in a variety of price categories to say the least, even in the small town in Lalitpur, which was significantly smaller in both size and population compared to Kathmandu.

Seeing that the ever-present pharmacies seemed to be people's first encounter with the professionalized part of the health care system, I chose those locations as my own entry point when trying to unravel how ayurveda and allopathy were practiced in a professionalized setting and how the professionals (the physicians and pharmacists) treated their patients. Going to the physician could be a time consuming ordeal, especially public alternatives, and if one opted for a private provider in order to save time it would most certainly be far more expensive. The pharmacies were easily accessible to most people and offered a wide range of treatments (both allopathic and ayurvedic) as well as advice for most common health problems. Though it would be interesting to delve deeper into people's illness beliefs and their reasons for choosing different curative resorts, I will not speculate on *why* or *how* people make these choices[2]. Only that the people seeking a cure for an illness, be it home remedy or public health care, felt the need to do so based on their own assessment of their own health.

[1] When I say 'the general population' I do not mean that all of Nepal had access from this point, because they didn't (and some still don't), but rather that it became available for non-royalty with government hospitals being built.
[2] My reason for this will be further discussed in chapter two, Methodology.

With ayurveda and allopathy as a foundation (being two of the more frequently used medical traditions in Nepal) this thesis will examine how illness is treated within the home and family and, if home remedies fail to provide a satisfactory outcome, why have pharmacies become a common option for seeking treatment? What do the pharmacies offer the patient that the physician does not or cannot offer? I will attempt to shed light on the pharmacy's role in the health care system, the diversity of functions and responsibilities found at the local pharmacy, and how some of them are a the preferred starting point for those seeking help – even before consulting a physician.

Having clarified my objective for this thesis and its research question it will be necessary for me to also clarify some of the key concepts that will be used repeatedly throughout this thesis.

Clarifying key concepts

Throughout this thesis I will rely on some basic concepts when referring to my ethnographic material. Since this conceptual framework not only serves as a foundation for the analysis of my own observations and thinking, but also allows comparison and contrast with previous research within the same region and/or on the same or related topics, a clarification of what I mean when I refer to central concepts is called for. Furthermore, some of them may have an unclear meaning in themselves or be contested in their meaning depending on ones professional affiliation or theoretical persuasion. So, in the hopes of making my ethnographic material and further discussion and analysis as clear as possible, I devote the following space to clarification so that, when turning the last page, the reader is not left with an uncertainty as to *my* understanding or use of the following concepts.

Illness, disease and sickness

Concepts describing what constitutes less than perfect or poor health obviously have a strong presence in medical anthropology. In *Patients and Healers in the Context of Culture* Arthur Kleinman states that the concept of *disease* refers to the biological or psychological malfunction of the affected persons body, while *illness* refers to the meaning and psychosocial experience of the disease (Kleinman, 1980, p. 72). Disease and illness are two aspects of sickness, where *disease* refers to the biological dimensions of the ailment, without any cultural or social connotations, and *illness* is the social, personal and cultural response to disease. Whereas disease normally will only affect one individual, illness can have significant impacts on a person's family and social

network as well. It is worth noting that these are "explanatory concepts" and can only fully be understood within the social and cultural context surrounding them. What constitutes illness or associated risk factors in Nepal will not necessarily be the same in Norway. Since my focus for this thesis lies primarily on the readily observable manifestations of disease/illness (rather than its biological roots or experiential dimensions) in that I focus on the relationship between ayurveda and allopathy, in addition to the social interaction within the pharmacies as a part of the treatment, disease and illness will not be key components of my analytical framework. Thus, given the focus of my observational data, I have deliberately excluded further elucidation of these two intertwined concepts. Rather, I focus on the observable and more accessible side of the healing process (the treatments) and the reasoning that lies behind curative options on the part of physicians, specialists and pharmacists. I have not taken into account the deep, underlying motivation or reasoning for the patients' visit to the pharmacy or clinic, nor had I the chance, time and skills to do justice to such an endeavor, however enlightening it might have been. My point of departure is therefore an individual with a felt the need for external help and consultation for what he/she perceives to be a health-related problem. For this reason I will consistently use the term 'illness' when referring to any sort of ailment observed in the pharmacies and elsewhere.

Allopathy and ayurveda

When referring to the medical traditions which constitute the foundation for this thesis, I will use the term 'allopathy' rather than other, commonly used terms such as 'biomedicine' when describing the more western style of medicine that is favored in Europe and USA. This is because I find it more suitable in the case of Nepal. Though the medicines used in allopathy can be found in western countries as well and are based on the same medical tradition, I believe the use and the practice of dispensing is different from that of the West, so by calling it 'western medicine' one risks understating essential differences as well as loosing sight of similarities. Therefor I will consistently refer to these pharmacies and their main medical tradition as allopathy to avoid the connotations stated above and to clearly separate them from both ayurveda *and* from the medical tradition practiced in 'the West'.

The ayurvedic tradition and the way it is being practiced in Nepal is extremely diverse and cannot be rigidly categorized. Among the different practitioners or specialists I spoke to, all had their own opinion of what was best regarding the production and preparation of medicines linked to the underlying way of thinking that sits as the foundation of ayurvedic healing. That

being said, for the purposes of this thesis and to simplify somewhat, I will make a rough distinction between what I will refer to as *traditional ayurveda* and *contemporary ayurveda*. By traditional ayurveda I am referring to ayurveda that is taken directly from the ancient texts of the Vedic scripts. The common denominators for this type of ayurveda are that all the medicinal recipes are from the original recipes found in the scripts, they are made from herbs, oils and other organic material (usually by the ayurvedic specialist themselves), the production is very simple and the medicines themselves come in the form of powders, hand rolled pills and oils for the most part.

The other 'type' of ayurveda that I will focus on is contemporary ayurveda, a term also used by Jean Langford in her book *Fluent bodies: Ayurvedic Remedies for Postcolonial Imbalance* (Langford, 2002) to describe a form of reinvented ayurveda that serves as a medical tradition alongside that of allopathic medicine. While many of the medications and treatments found in these pharmacies and clinics are based on the recipes from the Vedic scripts, they have in most cases been altered or further refined. The most visible difference between the traditional ayurveda and the contemporary is the mode of production and the forming of the medication. In contemporary ayurveda, from what I could read from the packaging, a substantial amount of the medication is mass-produced by larger, either Nepali or Indian, companies specializing in herbal remedies.

My reasoning for dividing ayurveda into these two categories can be debated, as the division is a simplification made for the purposes of this thesis. The two directions do not fit neatly into each separate category as both directions incorporate elements from the other, and even from allopathic medicine. This discussion can further be applied to the allopathic medicine practiced in Kathmandu where ayurvedic medicines are regularly prescribed for patients. As the focus of this thesis will lie more on the utilization of the different healing options available within a highly pluralistic setting, and not on medical systems as such or the patients reasoning for choosing one over the other I will uphold this distinction though I am aware of its underlying complexity.

Patient

I will throughout this thesis use the term 'patient' when describing those who come to the pharmacy and clinics. I generally refrain from using 'customer' or 'client' though some might argue that these terms show that the patients have an agency in the situation and that they are not just passive recipients of the physician's directives. Given that the people I observed in the pharmacies and clinics came to those places to deal with a health issue, and sought professional

or specialized help in dealing with these issues, I will refer to them as patients unless otherwise specified. Some non-patients who frequented the pharmacy and clinics could be the friends or neighbors of the pharmacists, physicians who came by just to chat or catch up on day-to-day life, or the pharmaceutical representatives who proved to be an ever-present group of people visiting the pharmacy on a regular basis. Since I am focusing on the role of the pharmacists and the interaction between them and the people using the pharmacies as places for healing in specific cases of illness, rather than the sick role of the individual, I find that the term 'patient' is appropriate for my purposes.

Pharmacy and pharmacist

'Medical shop', 'medical hall', 'pharmacy' or 'medicine market' are descriptive terms that can all be used to describe a place where medicine is sold. As in many other developing countries there are both formal and informal outlets when buying medication, the formal being operated by or authorized by the government, and the informal are those that lack this authorization. I have chosen to define pharmacies in a broad way, not focusing the government's requirements for running a pharmacy, but rather the fact that they administered medication to people coming in from the street and as directed by physicians carrying prescriptions to be filled. They function in the same way that one would expect a pharmacy to function, regardless of the training of the person who operates it. I might have chosen to distinguish between different types of pharmacies differentiated by the personnel's training or authorization, but - from what I could tell - most of the pharmacists (or at least the main person responsible) in the pharmacies had attended different types of courses, education programs or had university degrees within their field of medicine. That, in combination with my modest sample size of different pharmacies[1], made it difficult to divide the different pharmacies into additional sub-categories.

To be certified as a drug retailer one needs Department of Drug Administration (D.D.A.) approved training and experience to be able to market and sell medication. There is said to be over 20,000[2] pharmacy outlets in Nepal, the majority of these staffed by untrained personnel (Harper, Brhlikova, Subedi, & Bhattarai, 2007, p. 16). While this seemed to be general knowledge amongst the people I spoke to, no one would admit to knowing specifically which pharmacies conformed to government regulations and which did not, especially not the pharmacists I spoke to. They all said they had their papers and training in order with the proper education, though

[1] Two allopathic and two ayurvedic. See a further explanation and distinction in chapter 2.
[2] This number include shops that distribute allopathic, ayurvedic, unani, homeopathy or veterinary medicines. Since the focus in this thesis lies on allopathy and ayurveda, the number would be smaller.

this was difficult for me to confirm this, so I am aware of the possibility that they were not entirely truthful about their background.

I will use the term 'pharmacist' consistently throughout my thesis to describe the people who worked in the pharmacies I frequented. I could use a more general term, such as drug retailer or dispenser, as it might be more accurate in regards to the educational background of the people working in the pharmacies. I prefer this term as the pharmacists I came to know referred to themselves with that term, and they gave the impression of having gone through an extensive amount of training to claim that title. There were other employees in some of the pharmacies that lacked the complete training to claim such titles, but they were always secondary in command at the pharmacy and seldom provided definitive advice regarding health issues without the pharmacist's guidance and approval.

Having made clear my objectives and discussed relevant terminology that will be central throughout this thesis, I now see the need to contextualize my fieldwork before proceeding. Because Nepal is a vastly diverse country (both physical and culturally) with a somewhat turbulent political legacy (historically and in recent times), I will step back and briefly examine the historical and ethnographic backdrop that may help the reader better understand the current situation in Nepal's health care system.

1: Ethnographic and historical backdrop

In *Patients and Healers in the Context of Culture* (1980) Kleinman describes the sectors of a health care system – the popular sector, the folk sector and the professional sector (pp. 50-60). The professional sector comprises the professionalized and organized professions (those with formal training/education). The folk sector consists of the non-professionals like those who practice traditional folk medicine such as herbalists and shamanism. The popular sector comprises treatments given, or received, by oneself, the family, social network or the local community. While these sectors seem to be segregated and neatly separated, it is not always that separated. I truth, the different sectors overlap and merge and it can sometimes be difficult to place a specialist or a healer firmly within one of the sectors and not another. Therefore I would like to introduce another way of looking at the health care system – as an ecological system. Inspired by Sienna Craig (Craig, 2012), and my own academic past in biology, I find this approach applicable in trying to describe the plethora of healing options and the variety among them.

As I will show in this thesis, there are variations between the different medical traditions, but also substantial variation between the options within the same tradition. All physicians do not treat their patients the same, and all allopathic pharmacies offer the same type of services. Thinking in terms of a social ecological approach makes it, in my opinion, easier to understand the degree of medical pluralism that I saw in Aushadhi Chowk and easier to see why people would choose different curative options depending on their complaints. The approach takes into account the political, historical and social environment and the challenges that follow, in giving illness and choice of treatment a wider context than that of a single street.

Aushadhi Chowk

Walking down almost any street in Kathmandu one is never far away from some kind of pharmacy, private clinic or hospital. Through a series of fortunate coincidences and some conscious decisions[1] I found four pharmacies within a single, densely populated street that became the center for my ethnographic material during my months in Kathmandu. I decided to

[1] This will be further addressed and discussed in chapter 2 where I describe my methodology.

name it *Aushadhi Chowk* ('Medicine Street' in Nepali) mostly for my own amusement, but it stuck with me and will be a consistently used pseudonym throughout this thesis. Aushadhi Chowk was no different from the other streets, if anything it was the epitome of my first impression of health care in Kathmandu – overflowing with options. The street measured about 200m in length and after a rough count I discovered that it contained over 25 allopathic pharmacies (some with adjoining clinics), roughly 15 pharmaceutical supply shops and distributors situated towards the upper end of the street, and around 20 ayurvedic pharmacies in the lower half. Located on the street was an NGO-funded hospital offering a range of different paid services for the local community, but also offering free services to those who couldn't afford to pay. Within walking distance there were at least four other hospitals, one of them a large Government hospital. Clearly, people in the neighborhood had several different pharmacies and physicians from a variety of medical traditions to choose from, and these were only the most visible health care providers, not taking into account all the other non-professionalized options such as local herbalists or shamans providing services out of their own homes. With around 2,5 million inhabitants, Kathmandu Valley[1] is densely populated, but even so, I had a hard time understanding why there were so many pharmacies available and how they all managed to attract a sufficient number of customers to stay afloat, considering the extreme concentration of hospitals and clinics within the city. Scattered along the street, in-between all the various pharmacies lay the four pharmacies that will be the main center for this thesis.

The allopathic pharmacy owned and run by Kaylan, a young man with a pharmaceutical degree from one of the local universities in Kathmandu. Together with a private allopathic clinic, his pharmacy shared a space on the first floor of an old, crooked building. The pharmacy held open throughout the day, but it was especially hectic in the morning and evenings when the private clinic in the back of the locale was open and filled with various physicians. The clinic also had a fully functioning laboratory. Further down the road lay one of the many allopathic hospitals in the area, and within the courtyard there lay a small allopathic pharmacy. Binod, the owner, took care of the daily operation along with his sister, his son and his wife, and his nephew. The pharmacies opening hours were the same as the hospital as almost all their patients came from consultations with the resident physicians there. Mahendra ran one of the few traditional ayurvedic clinics in Aushadhi Chowk. He came from a long line of practitioners and owned two clinics and a small-scale factory producing his own ayurvedic remedies, which he sold in the clinic. At the end of the street lay a large, open spaced ayurvedic pharmacy. Unlike Mahendra's

[1] Kathmandu Valley consists of the three districts Kathmandu, Lalitpur and Bhaktapur,

clinic, which specialized in traditional ayurveda, Sagar's pharmacy only stocked contemporary ayurvedic remedies. Sagar had worked in pharmacies his entire adult life, and had owned his own in Aushadhi Chowk for the last 15 years. Just as with Kaylan's pharmacy, Sagar was also linked with a private clinic though this was an ayurvedic clinic. Dr. Ravindra was an elderly, ayurvedic physician who was specialized in contemporary ayurveda. He was well known in the area and there was always a line of patients waiting for him when he arrived in the afternoon.

Medical pluralism

Nepal is an ethnically pluralistic country, shaped by divergent influences from neighboring countries China (mainly Tibet) and India, in addition to Nepali ethnic communities spread across the country, from the Lopas and Sherpas in the mountainous northern regions, the Newars and Gurungs in the Himalayan foothills and valleys, to the Tharus and Rajbansis in the lowland Terai-region, each with their own native language although Nepali is the official language of Nepal. In the 2011 Nepali government census, 125 different caste/ethnic groups and 123 different spoken languages were registered, Nepali being spoken by less than half (44,6%) of the population (*National Population and Housing Census 2011 (National Report)*, 2011, p. 4). This gives room for a large variation in cultural traits and modes of living, and thus variation in local healing traditions across the country. Seeing as more and more people migrate to more densely populated urban areas such as Kathmandu[1], the variation and availability of different modes of healing is highly diverse in the larger cities, something that becomes apparent when walking around the congested streets of Kathmandu.

Medical pluralism has long been viewed as the rule, and not the exception, all over the world when it comes to medical systems (Stoner, 1986). Pluralism occurs in that there is often more than one option to choose from, and people will have a preferred 'route' for seeking curative options within these alternatives. In societies characterized by pronounced medical pluralism such as Nepal, there will be a hierarchy of options influenced by things such as "class, cast, religion, regional, ethnic and gender distinctions" (Baer, Singer, & Susser, 2003, p. 11). The specific route an ill person chooses when seeking care is dependent on several overlying factors such as physical availability (what options are within a reachable proximity), what explanatory model does the person have for his illness (what does he or she see as the cause and what is a reasonable approach in treating the illness), does close family have a say in the choice of treatment (do they hold other explanatory models), are the different option within economical

reach etc. These are all factors influencing the health seeking behavior of a person. This preferred route is highly subjective, though others may share the same preferences, and an individual may hold different preferred routes depending on their illness and what they perceive to be the best possible solution in seeking treatment.

Traditional folk medicine in Nepal is largely based on herbal medicine, somewhat similar to ayurveda in that they both rely on natural herbal remedies, though there are local variations depending on where in the country one is situated. Such regional differences can in no small part be attributed to Nepal's extreme variation in topography and floral ecologies that determine which medicinal plants are available locally (Gewali, 2008). The ayurvedic medical tradition, with its concepts of illness and prevention to ensure health and well being, is several thousand years old and has its roots in India. The tradition has influenced beliefs and practices surrounding health, illness and nutrition, as well as conceptualizations of the body and how it functions not only in India, but also neighboring countries such as Nepal and Bangladesh[1]. Though none of the traditional healing systems in Nepal have been professionalized to the same extent that ayurveda has been, a number of ayurvedic and allopathic drugs derived from indigenous knowledge regarding medicinal plants have been developed and marketed worldwide.

My reason for briefly raising the issue of folk medicine in relation to ayurveda is not only because of their similarities, but also because my Nepali host family made no distinction between the folk medicine they had been taught in their native village and the ayurveda they spoke of in conversation with me. When they spoke of *any* type of herbal remedy, they referred to it as ayurveda. I therefore became uncertain if the local population, especially in Kathmandu, distinguished or were aware of the differences between folk remedies and ayurveda, or if they (for lack of a better term, lack of specific medical knowledge or merely for convenience) grouped all herbal remedies together into one category. The issue reemerged during my period in the pharmacies where everything from specially produced 'authentic' ayurvedic remedies to mass-produced, European brand cough drops would be referred to as ayurveda by both those who used them as well as the pharmacists and physicians. I therefore concluded that the two could be regarded as overlapping traditions where ayurveda - in popular usage - is a collective term for herbal remedies. Thus, I use the term ayurveda when referring to such remedies with no further distinction regarding their origin or 'authenticity'.

[1] In recent years, ayurveda (and other forms of Asian medicine) has become an item of export and a health-trend. Oil massages, cleanses, singing bowl healing, crystals etc. are being customized and sold to tourists in upscale spas and in luxury hotels. I even saw a poster that advertised treatments preformed by a "real shaman".

Alongside herbal-based folk medicine there are also spiritual and faith healers[1]. In Aushadhi Chowk there was at least one faith healer – a *phukne* (blower), and while I had no contact with this type of traditional healer, in previously done research they are described as specializing in curing patients through blowing, exorcising harmful spirits, ghosts and shades that would cling to sick people (Pigg, 1995, p. 23). The *phukne* in Aushadhi Chowk now worked as a vegetable vender due to diminishing demand for his healing skills and would only supplement his primary income with an occasional patient. I was told by a pharmacist acquainted with his methods who had, in fact, referred some of his patients to the *phukne* when his remedies proved insufficient, that the *phukne* would use smoke and chants to 'blow' evil spirits and ghosts out of the afflicted patient. Due to the reported lack of demand for these alternative curative approaches, the general ignorance surrounding practitioners and practices or possibly a reluctance to discuss such practices with me, I chose not to invest my limited time moving in this direction, though it would have been highly interesting seeing how these practitioners – irrespective of the demand for their services in Kathmandu - fit into the urban healing ecology.

Ayurveda and allopathy

While ayurveda and folk medicine have a long standing history in Nepal, it was the Christian missionaries who brought allopathic medicine to Nepal between 879-1768 AD (Teijlingen, Simkhada, & Wasti, 2015, p. 4). It was not until the Bir Hospital[2] was established during the late 1800's that allopathic treatment became available to the general population, however. Before that time, ayurveda was, in addition to folk, non-professionalized traditions, the most commonly relied upon home treatment regime and was commonly provided by the family. The first ayurvedic hospital for the common man and woman was established in the 1600s (Marasini, 2003). Today ayurveda is still acknowledged (by the Government of Nepal as well as the general population) as an effectual healing option along side the tradition of allopathy, and has evolved into a professionalized traditional medical system. Among all the different medical traditions with roots in traditional healing systems, I have chosen to focus on ayurveda as it is one of the more easily accessible and commonly used of the traditional healing systems in Kathmandu.

[1] Spiritual and faith healers is a composit category consisting of healers who deal with the spiritual, commonly dealing with illnesses caused by devine powers or sorcery operating out of churces, temples and small shops (Helman, 2007, p. 84). Faith healers retrieve lost souls, expell ghosts or spirits through ritualistic practices of prayer and gestures.

[2] Bir Hospital is still one of the largest public hospitals in Kathmandu situated in the heart of the city.

The responsibility of an ayurvedic healer is to find a person's current state of imbalance and then take measures to reestablish equilibrium. The wellbeing of a person is dependent of a balance between the humors of the body (*vatta*, *pitta* and *kapha*), mind and environment. By feeling the patients pulse at the wrists, observing their general state of health and asking detailed questions regarding their current life and history, healer arrive at a diagnosis and treatment tailored to the specific requirements of each individual patient. He explained, "The treatment is not directed at the disease[1]. It is directed at the patient and the affected areas of the body, trying to bring it into balance again. When there is balance, the disease will disappear." This makes an accurate diagnosis essential for the curing of the patient and it requires a skilled specialist. If the treatment is tailored to the patient and his/her perfect state of equilibrium, any disease should be curable according to ayurveda as the disease will loose its hold as soon at the body's equilibrium has been restored. As a result it is crucial to terminate the treatment as soon as the symptoms disappear and the patient feels better, thereafter focusing on preventative measures such as managing diet and adhering to a healthy lifestyle.

In some respects, this patient-centered, individualized approach to treatment differs from the allopathic curative process, which is more directed at the presenting symptoms, and in most cases treatment regimes are relatively 'standardized'. The foundation for allopathic treatment is the prevailing biological model of the underlying process, in great part dependent on measuring the state of internal, biological processes (such as blood pressure, weight, glucose level, temperature, testing for bacterial or viral infections, etc.) and other objective data, rather than the patient's subjective experience of the relevant disease. "Compared with other medical traditions biomedical explanations are, […], reductionistic, and focused primarily on the detection of named entities such as viruses, genes, biomarkers, or other signs internal to the body […]" (Lock & Nguyen, 2010, p. 61). The diagnosis determines the treatment with little regard to the patient's surrounding environment, upbringing or emotional state as factors potentially affecting the patient's health. After spending time in several pharmacies and clinics associated with one or the other medical paradigm, it became increasingly clear to me that, although - on the surface - there may have been some overlap in diagnostic procedures and treatment, the underlying models differed markedly.

The politics of health

[1] I do not believe that Mahendra distinguished between the analytical concepts of illness, disease and sickness, and that his use of the word 'disease' was just the English word he knew and could relate to.

Nepal has seen a major change in the social and political situation over the past decades, going from a monarchy and one party congress to a multiparty system and democracy. In *Doctors for Democracy: Health Professionals in the Nepal Revolution* (1998) Vincanne Adams addresses how health professionals got involved in the revolution and medical practice became highly politicized during, and after, the revolution in 1990. While the people of Nepal lived on rationed goods and rudimentary commodities, the elite and well-connected continued to use luxury cars with private chauffeurs, little concerned with the shortage of petrol, traveling abroad for medical checkups (Adams, pp. 82-84). This evident difference between the privileged and the ordinary created even more pressure for a change. The physicians involved in the revolution promoted objectivity as the one found in the medical science as a foundation for social change and developing a democracy fit for Nepal and its traditions. By addressing the state of health in the country and its inhabitants, the discourse changed and became a point of politics as the availability of health across the country, or the lack of, said something on a larger scale of how the country was being governed by the current leaders.

Adams recounts of how, before the revolution and the establishing of democracy, it was normal to rely on loyalty, social networks and familial connections to secure a high paying position. These social ties result in various benefits depending on who one is connected to - everything from receiving favors at the local pharmacy (as I will discuss further on) to being offered attractive jobs or access to mutually beneficial connections within those jobs. The benefits resulting from such relationships would naturally be of greater significant for the elite as they socialize with others in the elite, while it would be near to impossible for a local, working class man to climb the social ladder into government jobs and so on.

After the instatement of democracy these types of social connections came to be seen as corruption. Even though Adams' book is based on history from before the revolution and fieldwork carried out during 1993, I could still see some signs of this culture among my own informants. Not to the same extents as what Adams describes in that it was not about climbing the social ladder (although it is generally positive if one is connected to high status people) or being offered high paying jobs or influential positions, but rather a way of creating stability in their own lives. People I spoke to and got to know relied heavily on their extended social networks, if not to make ends meet, then at least to enhance their lives and the welfare of their families, creating stability in the unpredictability of everyday life.

There have been countless accusations of corruption within the health care system in Nepal, and most of the non-professionals I spoke to about this (patients, my family and friends) stated that corruption was, unfortunately, a part of the system and had been for quite some time. "*Ke garne?*" (What to do?) they would often say in a joking tone, but I could sense their concern and resignation. Even Kaylan, the pharmacists at the allopathic pharmacy would just shake his head telling me he would just have to wait until a fit government came into power. "Maybe not in my time, but maybe my daughter will get to see a good government taking responsibility". This has lead to people generally be suspicious and distrustful of the government and public health care offers.

The shortcomings described above can be attributed to a number of physical factors, such as climate, challenging topography, lack of roads and poorly constructed roads or a lack of appropriate vehicles that hinder the delivery of health care, but some are harsher in their assignment of blame: "There has been poor governance, frequent transfers of government staff and weak law and order, and the outcome has affected the programs implemented and prevented people from obtaining services" (Teijlingen et al., 2015).

To reiterate, although my focus in the following will be Kathmandu and a subset of all available treatment options (for reasons discussed earlier), I would be remiss if I did not stress that my observations and conclusions are not representative for the nation as a whole. This is not to say that the major issues regarding health care and the government's distribution of funds only affects the rural areas. There were accusations of corruption not only within the Nepali government, but also in the medical schools (both for physicians, nurses and pharmacists), maintaining that a medical degree could be bought and secured by anyone with the right connections and financial means. During the spring of 2014 this type of corruption received much publicity in the media due to a renowned and well-liked physician, Dr. Govinda KC, went on a hunger strike protesting against political interference at the Institute of Medicine at Tribhuvan University[1]. He saw the government's involvement in a less than positive light, believing (and not without reason) it would lead to further corruption and commercialization of the medical sector in Nepal[2], suggesting that an increased amount of affiliated teaching hospitals would increase the corruption in that it would be easier for corrupt hospital administrators to

[1] The hunger strike was followed daily over an extended period of time by the media. There would be daily updates in the evening news and the newspapers would give daily updates on Dr. KC's general state of health, and the progress of his fight against government involvement.
[2] http://nepalitimes.com/article/nation/corruption-and-greed-in-nepali-health-sector,1075

sneak in unqualified students who had paid for their position in the program. If medical degrees and exams can be bought, and the government does not check the quality and standard of affiliating medical schools, then how can one trust that the physician, nurse or pharmacist treating you is qualified to do so?

These issues, among others, continue to lie as a backdrop for how people perceive the government, and comprehend and deal with the public health sector, and to what degree they can or will trust the physician (or other health care personnel) as well as how the pharmacists convey relevant information to their customers.

2: Methodology

There is only so much one is able to anticipate when planning fieldwork in an unfamiliar setting. Before leaving for Nepal I had a loosely developed plan regarding my methodology for how I would go about collecting data once I arrived in Kathmandu. Prior to my departure I read scholarly publications including articles, books, reports etc.. but once I arrived I mostly improvised, relying on traditional anthropological method, following the course of daily life and grasping the opportunities that arose - mostly through providence, chance encounters or coincidence. I found, not surprisingly, that it was easier to plan in theory than to execute it in real life. If I were to do it all again there is certainly a lot I would have done differently. There was a steep learning curve and it is only in hindsight that I have come to fully realize the benefits and shortcomings of my chosen approaches, which I will discuss her.

Language

A certain level of language comprehension was essential in order to capture at least the essence of the patient/practitioner dialog. Therefore, even before I began fieldwork, I knew I wanted to at least try to familiarize myself with the basics of the local language, Nepali. While staying in Lalitpur, I embarked on an intensive two-month period of individualized language training with a local private instructor. Daily Sarita tutored me in conversational Nepali but also more specialized words and phrasings that could become relevant later on in the pharmacies and clinics. She would also tell me about Nepali customs and traditions, as well as her own life and family, and how they would relate to different subjects such as health, family and work. She taught me the name of general symptoms and how one would describe physical sensations like feeling pain, headache, being nauseous, e.g. *malaai jwaro laagyo* (I have a fever), but also how I should present myself when I first met with a pharmacist or physician. As the verbs are conjugated depending on the status of the person one is speaking to, it was crucial to get it right so I wouldn't offend the people I spoke to. This became extremely helpful when I listened in on patient-pharmacist/physician conversations in the pharmacies and clinics.

I believe I went into the field naively assuming that I would be able to learn the language while simultaneously doing fieldwork, which I came to realize was a full time job. On the other hand it proved almost impossible to start the language training before I went to Nepal, as language

courses in Nepali were not available in Oslo. I tried out a selection of audio instruction courses, but without a practice partner it was difficult to achieve desired conversational fluency. This had implications for my data gathering by limiting the direct interaction I would have with patients and others who were not proficient in English. Thus, pharmacies and clinics became my focus as pharmacists and physicians are educated beyond secondary school and can be expected to be more proficient in English than the man on the street. After a consultation I would always ask the physician or pharmacist if I had heard correctly or have them explain what had just taken place. I had greater difficulties in forming coherent sentences than understanding what they said. This would have made informed consent a problematic issue and, regrettably, made me more dependent on people who spoke English than I wished to be. I could manage a basic conversation in Nepali, but the likelihood of misunderstanding was great and I was not willing to risk misinterpreting what people said in relation to my research objectives. By knowing some basic language, however, I was able to introduce my research and myself, and more information became available to me through listening in on conversations between the physician, pharmacist and the patient or customer. Even though the rest of the conversation that would follow would be in English I believe that it helped me gain access and a certain degree of rapport by demonstrating that I was a serious student/researcher who had made an effort to master Nepali. I do believe that by making an effort to speak some Nepali I gained acceptance more rapidly, even though it might, in large part, have been because they were charmed by my limited vocabulary and slow speech (I was sometimes compared to elderly people).

Finding 'the field'

I had a clear research proposal when I came to Nepal, though it changed considerably along the way, being molded by the amount of access I got and the opportunities that emerged along the way. When I arrived in Kathmandu I started out in a peri-urban town about 6 km south of Kathmandu, in the district of Lalitpur. The town had a small center with a wide network of roads leading out into the rice and cornfields with larger private homes. I had in advance, with help from the Norway-Nepal Association, made arrangements to stay with a local family for the entire duration of my fieldwork. I initially made this choice hoping to get a better comprehension of what it's like to live in the Kathmandu valley for a Nepalese family while acquiring some basic language skills as time was a limited resource in my case. What were their daily routines, food habits, challenges, and, above all, how they treated illness? The family's hospitality in allowing me to take part in their lives and willingness to share their beliefs regarding health and illness, and impressions (including their perceptions of me as an 'outsider',

including my incidental health issues) proved to be a valuable source of insight that I would not have had if I lived by myself or with non-Nepalese. It would certainly have taken me considerably longer to gain the same level of knowledge regarding local perceptions of health and treatment practices within the framework of family life had I not lived with my informants the way I did. I am very grateful for that opportunity.

I stayed with a family of four, a husband and wife – Aadi and Indira both in their 40ies, with two children at the ages of 12 and 19. The youngest attended a local private school and the eldest was just about to begin higher education and medical school. They were Hindu, middle class Brahmins, but, with the exception of morning prayers, religious rituals and activities did not appear to be significant facets of their everyday lives. They lived in an area of mostly middle class homes, but families of higher and lower classes were also living in the neighborhood. Outside of my bedroom window there was a family who lived in an abandoned chicken shed in the back yard of one of wealthier families in the area. Aadi worked long hours, six days a week, while Indira took care of the household while the children were in school. Aadi had two jobs and worked long hours, six days a week while Indira took care of the household, and as a result I would spend a lot of time with her during the day when Aadi was at work and the children had left for school. In retrospect she, Indira, was the one who treated me more as a family member and not as a researcher, which made me closer to her than to any of the other family members, probably because we often were the only ones in the house at daytime. The children rarely spoke to me even though they both spoke fluent English. This might have been a result of shyness (from both our ends), but me being a foreign researcher who lived with them probably had an affect on our relationship.

I early on began to seek out typical health related localities such as the local hospital, the private clinics situated along the main street and the many allopathic and ayurvedic pharmacies spread all over town. From the outset I was set on keeping my focus on the allopathic options available, but the more I observed and the more I learned from my family I soon realized that ayurveda was equally or perhaps even more important in the treatment repertoire of the local population. I was therefor compelled to broaden my research focus in order to gain a more complete understanding of their health related practices. Out of all the options, ayurveda seemed to be the most common and most accessible, supported by the observation that there were as many ayurvedic pharmacies as there were allopathic ones. I made a conscious effort to observe the different clinics and pharmacies at different times during the day to see the variation in patient

flow and the patients themselves, a practice I continued when I eventually was able to observe in specific pharmacies in Kathmandu.

Although I planned on spending six months with my host family, I ended up only staying four months before relocating to downtown Kathmandu. Gaining access to clinics and pharmacies in Lalitpur proved to be less straightforward than anticipated and the journey into Kathmandu on public transportation was both time-consuming and in many respects quite challenging, so when an acquaintance said he could assist me in getting in touch with the right people in the city I didn't hesitate to say yes. I must admit, I waited far too long before I made the move, but as a novice anthropologist it was difficult to admit defeat, to make the move without knowing what was waiting for me in Kathmandu and if my research was already way past the point of salvaging.

When I moved in with the family I thought it would be a good opportunity to get acquainted with the neighborhood and that I might be introduced to the people at the nearby pharmacy and health post. This proved difficult because Aadi, who had the most extensive social network, had long hours at work. I believe this lack of help was not intentional, but rather a misunderstanding where I had not been clear enough about what I needed help with during my stay. The family as a whole seemed to take it for granted that I would have an easy time making friends, and would on several occasions tell me to go into town and not come back until I had made some friends. As a result most of my empirical material on home life and illness treatment it based on observations and experiences within this single family setting. I am aware that this does not capture the extent of variation in illness treatment as people's explanatory models and curative resorts are highly individual. Regardless, I did gain valuable insights regarding events and challenges associated with daily life in a peri-urban town. Issues regarding infrastructure, predictability (or the lack of) and health seeking behavior in the event of illness became an important backdrop for my further understanding of options in health care. But since illness is unpredictable and difficult to study in a relatively healthy family where I seemed to be the only one falling ill (not that I wished my family any illness or hardships), I needed to relocate and gain access to a location where I would encounter a greater volume and variety of health issues, a location where I could observe health care practices, the variety of curative options, patients and treatment in action, something I had not managed during my four months in the small town.

When I had settled in Kathmandu, seeing all the pharmacies located in the area around my guesthouse and given my limited time frame, I made a decision to restrict my focus to the

pharmacies as a venue for health and treatment. There were always people coming and going from the various pharmacies, and I noticed that the flow of customers would vary throughout the day and depending on the pharmacy. Some had a continuous stream of clients while others seemed deserted at certain times. Given that only 3 months of my stay in Nepal remained, accessibility and convenience were major considerations, but this location, in many respects, constituted a manageable microcosm of urban health-related service providers found in Kathmandu and indeed in other cities in Nepal that I am familiar with (e.g. Pokhara).
In the end I decided on four different locations as my primary focus: an allopathic pharmacy connected to an allopathic private clinic (hereafter referred to as allopathic pharmacy), the pharmacy of an allopathic community hospital (hereafter referred to as hospital pharmacy), the clinic of a traditional ayurvedic healer (hereafter referred to as traditional clinic), and a contemporary ayurvedic pharmacy connected to a private ayurvedic clinic (hereafter referred to as ayurvedic pharmacy). By making the choice to do participant observation at four different localities with a little under three months left, I knew it would affect the amount and the depth of the empirical material that could be gathered. Regardless, I was set on trying to capture and comprehend the variation between the pharmacies and to see the similarities and differences between the two traditions.

Participant Observation

When being outside of the family home I spent my days walking around, exploring the neighborhood and on most days I would also stroll into the heart of the town where most people in the area would go for all their shopping needs and errands. The local neighborhood around the home proved to be a microcosm of what lay downtown. People were friendly, but not very talkative or lacking in English skills. They would mostly just ask me why I was in this area and not in Kathmandu with all the other tourists. Walking downtown I got a lot of the same comments, but because more people lived and were employed downtown it was harder for me to get to know people. I rarely met the same people more than once, except the shopkeepers in my regular shopping places, and it made it difficult for me to obtain a lasting relationship with anyone I met in town (with some exceptions). I often felt I was only observing, and not interacting/participating as I struggled in my attempts to get to know people and finding localities where I could do long-term participant observations. This fortunately changed once I relocated to Kathmandu.

On a normal day in one the pharmacies in Aushadhi Chowk I would stand behind the counter, either helping out in the daily business of the pharmacy or just observing from the bench in the corner. I would intermittently and as unobtrusively as possible jot down notes on my phone when the stream of patients died down. Every pharmacy had seating arrangements for their customers. On some occasions I would sit on these just watching the pharmacist work, asking questions and listening to the pharmacists interaction with the customers. Sitting next to the waiting customers I sometimes found it amusing and informative to chat with the customers sitting on the bench next to me, waiting for their turn with the pharmacist or with the specialist in the clinic. With my limited communication skills, I believe I was primarily a source of amusement for the patients and the conversations never got to the subjects for my research. But after a while the regular customers would greet me[1] whenever they came by for either small talk with the pharmacist or for an actual consultation regarding an illness. I believe that this made me more of an integrated part in the pharmacy and after a couple of days customers had stopped asking the pharmacist who I was and why I was here, though I, on several occasions, caught people talking about me in front of me. I still stood out from the locals, generally taller than the majority of the customers and probably the most obvious distinguishing features: I was a fair skinned, blue-eyed girl sitting behind the counter at a local Nepalese pharmacy. I assume that this is not a common sight, but most people just stared. After I greeted them with a polite *Namaste!* folding my hands at my chest and slightly bowing as a sign of respect, most would smile and sometimes laugh before going about with their consultation.

I kept my focus on my research even outside of the pharmacies. Casual conversations with the local shopkeepers, or people I got to know on my time off offered a substantial amount of information (both intentional and unintentional) regarding illness beliefs and preferred treatments. While many of the specific details from these conversations have been left out of this thesis, they formed a backdrop for me in understating how people thought about and treated illness and several of their explanations and stories coincided with what I witnesses in the pharmacies and confirmed some of my suspicions. As I spent a substantial amount of time in the local cafés writing down my observations and notes for the day, it became a conversation starter in many instances when people wondered why I was sitting there writing for the fifth day in a row.

[1] I didn't get the same greeting as the pharmacists. They were normally greeted with the polite form and the customers always spoke in the polite form, while when greeting and addressing me, most customers would use a more casual form. This was not surprising as I was younger than most of the client base and the polite form is usually used when speaking to people older or higher in status than oneself, though some very few used the polite form with me as well, possibly because I was a foreigner and by definition a guest in their country.

Gaining access

Anthropology as a science can sometimes be a bit difficult to explain to others. Me 'hanging around', walking through town observing pharmacies and clinics, and learning how people prepare home remedies is actually me, the researcher, collecting data material. A casual conversation had while walking home or had around the dinner table may prove to be just as significant to me as a formalized, well-structured interview. One afternoon in February the family's 19-year-old confronted me with my progress (or lack thereof) and was wondering when I was going to begin. I explained that what I was doing now in fact was research and that just being around and experiencing life in Nepal was a major part of it (as this was fairly early on and I had not yet found any specific localities I wanted to research more thoroughly). I was met with a comment on how she understood, that anthropology was an "easy science" and not all that challenging compared to medical school, which was a "hard science". For my own part, I thought fieldwork was, and is, a very demanding and intense form of science, albeit (often) without quantifiable findings or boilerplate research design, but I fully understand that others are puzzled and fail to recognize its value and what makes it, in my view, a hard science.

Within the family, gaining access wasn't necessarily a problem as I spent a considerable amount of time with them, though I sometimes experienced that my level of 'access' would vary depending on the day or the situation in a way akin to what Briggs depicts in *Kapluna Daughter* (Briggs, 1970), I found myself alternating between being a researcher, somewhat of a daughter and a foreigner new to Nepal. This affected the amount and type of information I was given and what was expected of me as well. I had difficulty connecting with the children in the family. Aadi seemed to regard me more as a researcher (not that it was an incorrect perception - I was, after all, there to do research), but it affected the way he would talk to me. Indira, less fluent in English, was more casual and personal while her university-educated husband would be more formal and speak in general terms about what "Nepali people" would do in certain situations. Although I learned a great deal about public health, health care and perceptions of illness in Nepal, I would have liked to hear more about his personal appraisal and explanations regarding these issues rather than purely descriptive accounts, however enlightening these proved to be.

I believe I made some ill-founded decisions based on erroneous assumptions when I decided to move to Lalitpur and selected this community it as the sight surrounding my fieldwork. I initially thought that doing research in the middle of Kathmandu would prove to be more difficult as it was a larger, more densely populated area and I would thus have a hard time finding people who

would talk to me, regarding me as a burden in their otherwise hectic schedules. By choosing the small peri-urban town in Lalitpur I assumed it would be a Kathmandu in miniature, but with the potential of making myself known and being accepted in this smaller and more isolated community. This assumption proved to be wrong. I found that trying to gain access, do participant observation and making myself understood was infinitely more difficult in Lalitpur than in Kathmandu. While the town of Lalitpur was smaller, it was still much larger than anticipated and the fact that many people lived outside of the town's center made it difficult for me to get to know people and even more difficult to make myself known to others.

After I moved to downtown Kathmandu I experienced several breakthroughs. I moved into a guesthouse and through the manager I was able to get in touch with a local allopathic pharmacy where I could do observations and interact with clientele (language skills permitting) and medical staff. The area had several different pharmacies so after being introduced to the first, I started pursuing pharmacies nearby asking the pharmacists if I could see how they operated their pharmacy and treated patients and ended up with four different types. After being introduced by my contact to the first pharmacy, I couldn't rely on the same kind of assistance in gaining access to other pharmacies. In the end I approached different pharmacies along the same street, briefly explaining in Nepali what my research was all about and inquiring if I could spend some time at their pharmacy. Everyone I asked said yes, though some hesitated before consenting.

As I mentioned earlier, I gained access to the first pharmacy through an acquaintance, which I believe made it easier for me to gain acceptance and access, functioning as a 'seal of approval' or guarantor for me and my research. I had previously experienced how important social ties and networks were, and how beneficial and in many cases essential it was to know the right people, personally or through intermediaries. Compared to the other three pharmacies, the first pharmacy, the allopathic pharmacy, was the only pharmacy where I felt I had a close and more confiding relationship with the pharmacists. If this was attributable to my introduction to the pharmacy I do not know, but there was a noticeable difference when I went to visit the other pharmacies. Because of this relationship, I felt it was easier to ask questions regarding financial matters, adherence to government regulations and the treatment of patients.

The pharmacists working in the hospital pharmacy treated me as nothing more or less than a researcher. There was no small talk or no friendly conversation except for when I asked specific questions, which they obligingly answered, but misunderstandings were common and I would

more often than not have to repeat questions to get more comprehensive replies. The specialist in the traditional clinic perceived me to be a medical student from Norway, trained in ayurveda, and gave the impression that they had been (intentionally or unintentionally) misinformed when I told him I knew nothing about medicine. "Then why are you here? You should have told me!" This influenced the way the ayurvedic specialist addressed me, and how he shared knowledge about ayurveda. He initially spoke to me as a professional, and not as a layman. My previous observations paired with this type of conversation were rewarding as it gave me the possibility to test my data against other sources as pointed out by Alex Stewart in *The Ethnographer's Method* (1998, p. 26). It also gave me an opportunity to further discover if there was a discrepancy between what the pharmacists or physicians said they did and what they actually did, relative to patient treatment.

After having spent several days at these two locations where I felt I had struggled to gain access and explain my research objectives and strained to uncover relevant findings among unresponsive pharmacists, it was a relief to find the last pharmacy, the contemporary ayurvedic pharmacy with a connected private clinic. The owner was open and friendly, and more than willing to answer all my trivial questions. When the flow of customers was slow, we would sit on opposite sides of the counter and swap information regarding our own respective cultural backgrounds. There was no topic that was off limits and we could spend the whole day swapping this kind of information, though I would normally steer the conversation on to topics regarding health, illness and treatment. This form of information swapping proved to be useful, both as a tool to elicit relevant information and, equally important, a natural way of building a relationship and mutual trust. Being a relatively young woman, I believe this made access easier for me both in getting access to the pharmacies and in socializing with the patients. Had I been an older man, it is unlikely that I would have been able to act the way I did, speak as freely as I did or get the same answers.

Limitations and implications

Engaging in fieldwork is a constant process of making choices and through these choices opening some doors and accepting that others close behind you. It is virtually impossible to accomplish everything one initially sets out to do, and especially when one only has six months one has to make difficult decisions knowing that potentially valuable sources of insight will be excluded. I have mentioned limitations related to gaining access and the constraints imposed by

language and will now consider some additional limitations inherent in my fieldwork and what implications these may have had on my data material.

As a result of the language problems I faced, most of my data collected is a form of expert knowledge as most of my informants in the pharmacies and clinics were educated and experts (to varying degrees) in their respective fields. They most likely have a different view and a different way of addressing health, body and treatment than those who do not have a formal education within medicine or healing, and there might be a discrepancy between how the specialists address these issues and how the layman, the patient, think about and experiences this. Because of this my primary focus for this thesis will be on the specialists and their work and function within the health care system in Kathmandu. To supplement my understanding I am therefore forced to rely on secondary sources, i.e. research carried out in Nepal and comparable locations such as India that captures patient-practitioner relationship and behavior related to health, illness and health care.

As mentioned, I struggled to gain access to relevant resources during the first four months of my stay and looking back I would have done certain things differently during my stay outside of Kathmandu, in the peri-urban community. At the time I found it very difficult to meet people and if I met someone who was willing to speak to me, all they wanted was my number, or the more common phrase "How are you? Where you from?" in stuttering English, that contributed little to my understanding of health. I once had a 30-minute conversation with a young man who only repeated those phrases over and over again. In these situations, I believe that being a young woman hindered me somewhat in establishing trust or developing some form of relationship conducive to open information sharing. As I early on discovered, girls seldom walk alone when outside of the home. Boys, by contrast, often walked alone. There were other times when people in cars or on motorbikes would drive beside me at walking pace, only to stare at me for several minutes before driving away and maybe yell a comment regarding my female physique. My gender, age and physical appearance proved to be a greater handicap than anticipated in this community, a handicap that I, regrettably, was not able to overcome. I became a bit lethargic in regards to my own fieldwork and probably wasn't as assertive as I should have been in seeking out places where I could do observations. Luckily I regained needed assertiveness when I relocated to Kathmandu. As Okely briefly mentions in *Anthropological Practice* (Okely, 2012), the individual personality of the researcher can affect with whom and how one interacts, for better

or worse, and that one might have to overcome one's own personality traits to move forward and interrelate with informants (pp. 135-136).

As an inexperienced researcher I am naturally interested in exploring my chosen field, but I am also intrigued by the field research setting and interpersonal dynamics that produced the disparate outcomes illustrated by my experiences on Aushadhi Chwok. Much can be attributed to my lack of experience or sensitivity to local social conventions (even though I did my best to notice and abide by these conventions), but as in more "normal" and spontaneous social interaction, one does not always succeed in connecting with the people one wants (or needs) to connect with. Sometimes generating respect, understanding and trust simply takes time, time to engage, time to clear up misunderstandings – time that I did not have in this case (due to my own choices in the early stages of my fieldwork). In other cases organizational limitations, warranted and unwarranted suspicion or status/gender considerations may hinder the free flow of information. Or perhaps my less talkative respondents simply did not have a pre-defined and familiar category to place me in (e.g. patient, pharmaceutical representative, professor, tourist, government official) and were therefore uncertain about my intentions and how to relate to me. Some or all of the above may be relevant in my case, but I found it encouraging discovering that there are interpersonal strategies such as the information swapping (reciprocity or 'tit for tat') approach that facilitated understanding and trust. It just illustrates that I, as a researcher, cannot control whom I get along with and get access to. Even if I am present, no matter how much I try and want to gain acceptance, in the end it is also up to the informants themselves if they want to give me access and want to share their lives with me.

Ethics

Finally I would like to bring up some choices I have made regarding ethical concerns. All informants and locations have been anonymized to the best of my abilities, and all photos featured in this thesis are from other (but similar) locations than those referred to. This has been a conscious decision on my part as illness and the health care specialist/patient relationship are private matters, both in the family and within my primary research setting of pharmacies, the doctor's surgery and clinics. The pharmacists and physician I have encountered have been kind enough to let me take part in their everyday lives and business. I have been a witness to consultations regarding personal and family problems, unwanted pregnancies and abortion, chronic illness, financial matters, life threatening illness, and ethically 'questionable' behavior on the part of pharmacists, pharmaceutical company representatives and the physicians. Therefore I

have chosen not to disclose the identities of my informants or the names of their pharmacies, clinics or hospitals in order to maintain the privacy of the individuals who have placed their trust in me, informed me and generously allowed me to 'hang out' with them for weeks at a time.

At the same time, what about the ethics of the pharmacists who have let me witness consultations without regard for the patient's privacy, fully knowing that I could understand at least parts of the conversations carried out in front of me? The patient's health issues are of a private nature, and the fact that I was allowed - no questions asked regarding how I would use the information obtained - to sit in and listen to these private matters tells a great deal about the prevailing view on patient confidentiality or the lack of it. I witnessed several consultations carried out in the open such as across the pharmacy counter or over the table in front of the clinic with several other patients waiting for their turn and easily within earshot of the current consultation. This was a common scene, but my presence as a researcher is something completely different. In the hectic periods of the pharmacy it would have been disrupting and complicated having to explain my purpose for being at the pharmacy, what type of data I was collecting, how it would be processed and anonymized, for how long it would be securely stored, how it would eventually be disposed of, hopefully resulting in their signature on an informed consent form. Apart from disruptions of work flow in the pharmacies, if this were even possible, I would never know if the patients fully understood the implications of letting me listen to their consultation.

This can potentially reveal aspects of hierarchy, cast and rank, and the difference between the patients, and the pharmacist and physician. The issue of doctor-patient confidentiality never came up as an issue during my time in the different pharmacies. I witnessed everything from filling prescriptions and vaccinations, to conversations regarding abortion, financial problems and life long, debilitating illnesses. The patient's health problems, complications, family problems, test results etc. were never treated as a sensitive subject by neither the physician nor the pharmacist. Most of the consultations with the physicians were conducted within the walls of their surgeries and consultation room, but with the pharmacist all the consultations and conversations were carried out in front of a handful of known and unknown people, myself included. As a result, I have been very meticulous in choosing what kinds of information and empirical data I will draw upon throughout this thesis, and how I will depict the pharmacies and their patients in a way that preserves their anonymity and respects their privacy.

As a researcher I have the responsibility to treat this personal and sensitive information with the respect that it deserves, not forgetting that there are actual people behind every empirical case and not just theoretical instances. By primarily focusing on the social relations and interaction naturally occurring in and around my family and the pharmacies, as well as the work of the pharmacists, and not on the patient's specific illness or other issues regarding their private lives I feel that I am doing my best in dealing with the issues of anonymization and preserving my informants (both those aware of my presence and the unaware) identity and their health issues with the respect it deserves, and if any of them were to read this thesis I sincerely hope they would approve of my depiction.

3: Maintaining health and providing care within the family

Upon first arriving Nepal and settling in with what was to become my family for the next four months I early on got a taste of the local home remedies and the means of preventing illness within the family that I would be living with. The first night of my stay I was served heated, fresh cows milk from the neighbor's cow, prepared by the mother in my household. The father of the house, who spoke English, explained to me that since I had gone through a long journey, had experienced a whole new food culture and was bound to be missing my parents back home, I was, according to him, at risk of getting sick. The warm milk would calm my insides – both physically and mentally – and I would get a good night's sleep. Being lactose intolerant, I had my doubts that this would be beneficial and I tried to explain that if I drank milk it would have the opposite effect on me. "No, milk is calming. It will be good for you" was their response. Not wanting to offend, seeing as they had already bought and prepared the milk, I accepted the glass and emptied it. After all, this was my fieldwork and I wanted – within reason - to try the local remedies. I soon wished I had declined the offer and went to bed early. The next morning I was offered milk tea, a very sweet tea where the tealeaves are soaked directly in hot milk. Having learned from my mistake the previous night I respectfully declined and explained that I couldn't drink milk as it gave me stomach problems. This made little sense to my family since milk is generally regarded as calming and prevents the problem I had experienced. The father told me that if I had had yogurt, or curd as he referred to it, he would understand why my body had reacted the way it did. Curd should never be taken before bedtime, as it will cause problems in the circulation of the body and digestive system, he informed me. I soon learned that milk isn't just milk. Throughout my stay I was kindly offered curd, ice cream, rice pudding, milk tea and cheese, all of which I declined. Different preparations of milk had different effects on the body and trying to explain that *all* food items made with milk would make me ill proved to be very difficult. To me, milk was milk regardless of its form while in Nepal the properties of milk changed according to how it was prepared or its form (warm, cold, curd, fresh, in food, in tea etc.). This episode introduced me to the realm of beliefs surrounding illness and preventive health care in the home and how it is heavily influenced by the ayurvedic medical tradition.

Health within the home

What Kleinman describes as the popular sector of health care includes types of treatment that people use that doesn't require consulting a trained specialist. The main area of this sector is the home, where most of the treatments are made by the ill person themselves or by family members. These treatments are influenced by beliefs regarding illness, both personal and community-based, roles, relationships, availability of different treatments etc. These self-made home remedies made by the sick individual, or his or her family, are commonly the first meeting the patient has with treatment and healing. This is what Kleinman refers to as "self-treatment" (p. 51) and was an integrated part of healing in the home of my Nepali family.

Depending on the illness, the remedy and the duration of the treatment will vary from external treatments such as oil massages, and to ingestible treatments such as roots bought in the market that, alone, is taken as a remedy to more complex home made brews with several ingredients. These remedies, based on herbs, spices and other natural ingredients, are commonly viewed as less potent – though not without effect – than allopathic medicine. As the children in the family were older now, Indira would tell me how she would treat them when they got sick as babies. Giving them full body, oil massages and feeding them a specific, home made, pickled fruit that was said to keep them strong, containing essential vitamins. Later on, when I worked in the ayurvedic pharmacy I would see many mothers with young infants come to buy tonics, syrups and powders for their baby's cold, gastric problems or general fatigue. The ayurvedic pharmacist explained this by stating that ayurveda was not as "strong" as allopathic medicines, and that since babies were fragile and often weak, it was better to give them milder medicine. Mothers would bring their babies to the allopathic pharmacy on a regular basis with the same issues as seen in the ayurvedic pharmacy. There they would receive the same ayurvedic medicine as in the ayurvedic pharmacy with the rationalization that it was "clinically proven" to be the best treatment for children. Since a major part of the prevention and treatment that takes place within the home is closely linked to ayurveda, the basic principles of traditional ayurveda needs to be briefly discussed and contextualized.

Speaking of ayurveda and illness

Several months after my encounter with the milk, during one of my conversations with a locally renowned Kathmandu-based ayurvedic physician he referred to ayurveda as "the mother of all medicine", maintaining that all medical traditions today have sprung out of the ancient ayurvedic

tradition. Dr. Ravindra's clinic hours were over, there were no more patients waiting and as the last patients bought their medication and left the pharmacy he took some time to explain to me the fundamentals of ayurveda and ayurvedic practice today. Ayurveda was the only tradition that contained all the features of the other medical traditions. "All aspects of healing, psychological, physical or medicinal, are a part of the ayurveda" he said smiling at me. He was always smiling, even though he had already finished a full day of teaching at the hospital followed by four hours in his clinic. Internal medicine, surgery, meditation, massages, control over one's feelings, herbal medicines, dietary restrictions, maintaining ones own happiness and lifestyle guidelines are all a part of traditional ayurvedic prevention and treatment.

Having worked his way up from the lower levels of ayurvedic education and all the way up to physician and now professor, he had a high position in the neighborhood and was well liked by most people. In several of our conversations he focused how ayurveda was different from most other medical traditions by treating the whole body and focusing on all aspects of life in the course of treatment. It was all about finding a healthy 'balance'. In general, ayurveda places particular emphasis on having a sound mind, a strong frame, caring speech and religious practices (reciting mantras) as the foundation for a healthy environment and balanced human being, free from the contaminations of pollution, negative thoughts and negative spiritual vibes. Instead of the Cartesian view found in allopathic medicine, where mind and body are regarded as two separate entities and each organ has its own more or less isolated functions. In ayurveda the whole body and its parts are all interconnected and dependent on each other and the body's state of health is governed by the balance among the three *doshas* (humors of the body), *vata, pitta* and *kapha*, Dr. Ravindra translated it to wind, bile and phlegm.

What I have briefly described here are the fundamentals of ayurveda as explained by Dr. Ravindra, and his view of what constitutes good health and how one can maintain it, his explanatory model. As his title accurately shows, he was a doctor, a trained specialist. He had several years of training and experience, and therefor his relationship with and understanding of this medical tradition lay on a different plane then that of an ordinary Nepalese man or woman. He had a way of addressing illness and health in a different way than for example my Nepalese family or even his own patients. Just as any professionally trained specialist within any field, and especially medicine, he addressed the topic with an 'expert language' that can be very different from how I heard ordinary non-specialist people talk about illness. In my family and in the pharmacies I never heard any talk of balance, even in the ayurvedic pharmacy and the traditional

clinic the only ones who spoke of balance were the experts – not the patients. Having a headache or a fever, feeling ill, stomach pains, throat pain or feeling tired were common statements regarding ones own health issues in my family. Dr. Ravindra spoke of a balance within the body and in-between its humors. When his patients during a consultation spoke of symptoms such as feeling warm, the body feeling heavy, congested, tired or having difficulty breathing, Dr. Ravindra would translate the symptoms back into an explanation fitted to ayurveda, even though the patients themselves didn't use those terms.

Emotions and illness

As highlighted above, traditional ayurveda places great emphasize on mental health as a factor contributing to health, wellbeing and, conversely, illness. This became very clear to me as my family reacted to the various trials and tribulations mostly I experienced during my stay with them. Keeping strong, negative emotions such as greed, jealousy, sadness, fright and worry under control is important for maintaining good health. While my family never spoke this extensively about the wide range of negative emotions, they were much more concerned with my emotions. As mentioned, my family didn't address illness and risk factors for illness in the same expert manner as Dr. Ravindra, and it is possible to think that this concern regarding emotions could a more common way of addressing illness, through emotions. This idea is not an uncommon one and several anthropologists have previously focused on emotion work in regards to illness, healing and health care and how strong (mostly negative) emotions can have a direct effect on ones own health and surrounding family (Desjarlais, 1992; Kleinman, 1980; Wikan, 1989). In my family they would address illness in the same way I would, using expressions like having fever, feeling warm, being tired or just stating that they were sick. Though I would have liked to go into a further exploration and following discussion regarding what illness means to those who suffer from it and how they express this through actions and words, I was not able to due to issues discussed in the previous chapter.

For the most part it was Indira who spent time with me since the rest of the family attended school or worked, and we would stay at home during parts of the day. She often seemed concerned about my emotional state (especially in the beginning of my stay), asking me several times throughout the day how I was feeling, is I was hungry, if I was bored etc. This might just have been common courtesy as I was a guest in their home, but I do feel that it was more than that. Indira's way of keeping me in a happy mood would mostly involve keeping me well fed and watching Bollywood movies on the TV if we had electricity. Sometimes she would eagerly come

running into my room to show me samples of the local flora and fauna, such as snakes, huge beetles or seeds she would plant in the family's garden. I thought it all to be good fun. I liked the *chaura* (beaten rice) and *aloo achar* (pickled potato) I had for lunch almost every day, and having studied biology previously I was always fascinated by the exotic surroundings just outside my bedroom window. I was constantly asked if I was hungry, wanted tea or how I felt in general, but it wasn't until my phone was stolen on a journey to Kathmandu that I fully realized the perceived effect emotions could have on health and why my family had gone to such lengths to secure my emotional wellbeing.

It was midday, early in February, when a boy walked past me, grabbed my phone and ran. I felt more angry than sad because of my carelessness handling my phone in public. When I came home that same day and told the family they were shocked. They had never heard of something like this happening in their area - in Kathmandu, yes, but not in their town. Indira dragged me along as fast as she could walk to the local district police station. Within a few minutes of arriving a small crowd had gathered around us, both police officers and random passers by, all willing to share their opinion and more or less helpful advice. The police station was poorly equipped so we were advised to take the bus into Kathmandu and visit the central police station near Kathmandu Durbar Square. Indira looked at me with a stern face and said in her modest English; *"Not tension! Ok? No worry!"* At the time I didn't understand what she meant and thought I might have misheard her, but this was the first of what was to become a repeated question, or command, over the next couple of days. The police were very helpful telling me they would find my phone and that I should not worry. Indira helped me fill out the paperwork and then we headed home. It was dark by the time we got back to the house. Over the next few days Indira kept coming into my room with tea, biscuits and fruit asking me if I took tension, and when I answered that I had no tension her face would light up and she seemed cheerful by this answer.

At the time, 'tension' was an expression I had never heard before, but later on I heard stories (told physicians and pharmacists[1]) of patients explaining that it was because of tension that they got ill, and that the patients believed this tension made their body receptive to the illness. I heard on different occasions Nepalese use the word 'tension' in their speech combined with Nepali e.g. "tension *garnu bhayo?*" (Do you have tension?), but it is difficult for me to thoroughly understand

[1] The physicians and pharmacists brought these stories up when speaking about patient's beliefs regarding illness and mainly in contexts with patients who they perceived as "uneducated" or "from the village". This description is not that different from the ones described in the article *Inventing Social Categories Through Place: Social Representations and Development in Nepal* (Pigg, 1992) where villagers beliefs are portrayed as backwards and less modern, being looked down upon by people living in the cities.

what they, and my family, meant by 'tension' in terms of emic concepts. When Indira asks me not to take tension, what kind of emotions is she asking me not to have? Though I am not quite certain what she meant explicitly, I, from my point of view, understood 'tension' more in connection with what it was not. I experienced it as she was actually expressing concern about my emotional state as a result of my encounter with the phone snatcher. Smiling, being visibly happy, having a good appetite, laughing etc. seemed to all be a part of not taking tension. If I became quiet at the dinner table, or maybe didn't emit expressions of cheerfulness enough it would be remarked upon. It came to a point where I exaggerated a more positive and happy exterior than what I felt on the inside to keep my family from worrying too much about me.

About five days after the loss of my phone I fell ill. I had a high fever, was sweating profusely and had stomach cramps that at one point convinced me I had ruptured my spleen. When I came down for breakfast the first morning I told the family that I wasn't feeling well and that I was ill. Their response took me by surprise. "We were waiting for you to get sick. We knew it would happen. You took tension!" They had been waiting for this all week, talking amongst themselves about me and my health. They told me they had done their best to keep me from worrying too much, but since I was far from home, was undoubtedly missing my family and now had lost my phone on top of it all it was inevitable. The damage was done, now I had to rest and eat well so that I would get well faster. The next couple of days consisted of bed rest, a lot of food (mostly rice), tea and fresh air on the roof terrace.

During this whole week of being sick I tried to tell my family that I wasn't too worried about my phone. It was insured and I would receive compensation so that I could buy a new one, but that didn't matter. The reason for my ill health was that I had worried too much and had taken tension, though this was not the widely shared opinion within the household. The daughter in the family, when I told her about my insurance, changed her causal explanation at once. "You wouldn't worry when you have insurance! I must have been something else then." She then resumed to eating her dinner and we never spoke about it again. I found this interesting as both her parents were certain that the cause of my illness was the emotional distress I had felt over the loss of my phone, while their daughter changed her mind immediately after I told her about my insurance. I do not know why she felt differently from her parents, or what she then believed to be the cause, but there was a definite difference between the two generations regarding this incident which I will address further on in this chapter.

Food with benefits

In a Nepalese household, a large part of health care and the maintaining of good health is based on dietary guidelines or traditions derived from knowledge about the special properties that certain types of food have. Different types of food have different effects on the body, usually measured in warm, neutral and cold properties. This is not necessarily a reference to the food's temperature (though that is also plays a part), but the nature of the food and how it affects the body, in connection with what kind of environment[1] one resides in. Though my family were quite certain of what foods were warm or cold, not all of those I spoke to later (after moving to Kathmandu) could agree on what should be classified as warm or cold, so there seemed to be room for variation. The specific preparation of food is also significant for its affect on the body. Some types of food should not be eaten cold, and must be heated properly before consumption. An American friend of mine, who I met later on also staying in Kathmandu, had fallen ill and his host family attributed this to his oat porridge being undercooked before consumption.

The crucial balance between hot and cold temperature combined with the hot and cold properties of food makes the seasons, and thus illustrating the effect the environment has for health, a central influence to what kinds of food the family eat and how it was prepared. It is not only the environment that affects the diet of the household. Many ingredients such as vegetables, spices and meats have more or less favorable effects on the body and certain types of ingredients will be used in cooking depending on the general health of the family or one of its members. The foundation and main staple of the Nepalese diet is *daal bhat* (lentil rice), which consist of lentils, rice and vegetables prepared in a variety of ways and with different spices depending on the season, availability and the curative properties of the ingredients. In the colder months the *daal* is thicker and heartier while in the warm months it is much thinner. This is because one should not eat light, easily digestible food when it's cold, while the opposite is recommended during the warmer seasons. The curative properties of *daal* were explained to me one night while sitting around the family's round plastic dining table in the kitchen. Aadi told me that the *daal* we were eating was commonly used when one suffered from kidney stones. If you were to eat this *daal* and only this *daal* for a couple of days, he explained, the stones would pass without difficulty. Though I must note that the family didn't eat this *daal* for that purpose, they made it just because they liked it, which I believe is the case for most families nowadays. The list of beneficial foods goes on. Most chilies can upset the stomach, but one certain kind would not. A kind of *aloo achar*

[1] Environment meaning geographical location, the temperature, weather conditions etc.

(pickled potato) with a special type of dried blossom would help if you were constipated, and if you had the misfortune of falling ill a large portion of rice would contribute to a speedy recovery.

Except in the traditional ayurvedic clinic which I got to know later on, I rarely came across people who right out told me they were intentionally following ayurvedic principles, or made reference to this medical tradition regarding their lifestyle, their cooking/diet and their home remedies. People, both within my family and random people I spoke to during the fieldwork, would rather refer to it as just something they had learned from their mother or grandmother, and that was just how they did it. Only when explaining their actions to me would people refer to what they were doing as ayurveda. As Aadi told me when I asked him why he never drank chilled beverages in the cold season "I do it because I have always done it this way. You shouldn't drink cold things when it's cold. I don't believe I will get sick, but this is what I have always done."

Home remedies

In spite of the preventive measures one takes to avoid illness in everyday life (not eating or drinking cold food in the cold months, keeping your head dry, not eating yoghurt before bedtime etc.), this is not always sufficient and one can, despite these approaches, fall ill. Before consulting an outside specialist such as the pharmacist or an ayurvedic or allopathic specialist, it is common to try home remedies as a first curative option.

The recipes are typically taught within the family and shared from generation to generation, but can also be shared within a social group. Different families might have different takes on and different recipes for home remedies where the curative powers have been proven across several generations. These remedies typically consist of basic household ingredients such as herbs and spices that are readily available in the kitchen cabinets or can be bought in the local market or specialized spice vendors. The go-to medicine for a cold might not be the same from one family to the next though it was not as if the recipes automatically were a secret. I discovered people were never shy in sharing their family's remedy or other helpful advice. It was not uncommon to consult family, friends or neighbors when a treatment failed to have an effect. Maybe the neighbors had experience with related health problems or same type of symptoms and they have already found an effective treatment. Sometimes you don't even have to ask for help, they just give advice unsolicited in a friendly manner. A Nepali friend of mine from Norway once told me "Nepali people are meddlesome! They will always give you advice, if you want it or not." He was

so used to the privacy surrounding health and private life in Norway that whenever he came to Nepal he would find the lack of privacy and the amount of spontaneous advice given from friends and strangers to be a bit annoying.

One evening after having dinner Indira got up from her chair, lit the gas on the countertop stove and started to prepare what appeared to be a mix of spices in her frying pan. From the bench opposite from the stove, she took out her spice box, a round, green plastic box that contained several smaller boxes, each containing a different spice. She used the accompanying plastic spoon to shovel the spices turmeric and chili into the now hot pan. She then took out some fresh garlic and ginger that she grated into the spice mix. The screaming hot pan released a fragrant scent that blotted out the smell of the already consumed dinner. She then filled the pan with water from the brass bucket on the floor, which I knew contained water from the well, and let it simmer. "Do you know what she is making?" came from across the table where her husband was sitting. I suggested a broth of some kind but I didn't know the use.

> "Whenever I feel a cold coming, headache and throat pain, I tell her to make this. Hopefully I will get better. This is ayurveda you know. Maybe I will drink this tomorrow too, and if I don't feel better I will visit the pharmacy."

After the broth had simmered for some minutes, Indira poured it into a metal cup and Aadi drank it quickly, chewing the small pieces of ginger last. This was a recipe Indira had learned from her family home and it had been used for generations. This was my Nepali family's usual first attempt at curing an oncoming cold. Indira could assemble all the ingredients within minutes, several of them were even grown in her own garden, and the remedy was ready to drink within 15 minutes. She made this concoction the next night as well as the cold symptoms were still there, but the day after that the he went to his regular pharmacy and bought antibiotics over the counter.

Some days after Aadi came down with the flue-like symptoms, Indira experienced the same signs. Whereas Aadi had become tired and a bit lethargic during this illness, Indira kept on going in her usual pace, cleaning the house, sweeping floors, doing the laundry, gardening and preparing all meals for the rest of the family. It wasn't until she confessed of being tired that I could see some signs of a less than optimal state of health. Days past, and Indira had gone from being tired and having a fever to developing a cough. By this time Aadi had begun and almost

finished his antibiotics, but to my knowledge Indira never bought the same medication as her husband. When her cough developed, she went down to the local market, to a stand where a local man sold different herbs and root beneficial for a vide range of health issues. She brought home a small, blue plastic bag filled with dried, chopped up roots that was the equivalent of chough drops, only natural. For the next three weeks she continued using these bits of root to calm her cough. One afternoon she came home, having taken a quick visit to the neighborhood kiosk, with a handful of a Western brand of chough drops. She had grown tired of her cough and was now trying something stronger (describing the drops as "stronger!"). Within the week, her cough was completely gone. This demonstrates how a person's access to treatment for an illness not only dependent on the physical availability, but also the persons position or status within the household (M. Subedi, 2008, p. 143). This status is dependent on factors such as the family member's position depends on age, marriage status, gender and income just to name a few. Since Aadi was the sole provider for the family, he may have had easier access to medication than his wife. Though in this particular household it seemed as Indira herself choose to try the herbal remedies rather than opting for antibiotics or other allopathic medicine.

Though the examples mentioned above all depict situations where the home remedy is used by itself this is not necessarily the case for all illness or for all families. Home remedies and remedies purchased outside of the home can be used separately, but are often used in combination, either in parallel or sequentially. Due to a lack in supervision by the government the pharmacists do not always adhere to the laws for the sale of pharmaceuticals. If one were to look for a certain medication, regardless of its classification[1], it wouldn't be hard to find a pharmacist who would sell it without a prescription. This leads to the possibility of people freely buying and combining medications and treatments from various traditions, without having to see a specialist for the correct combinations or dosages.

The neighbors of my family made this practice clear to me when the father had been having stomach problems (vomiting and diarrhea). He went to the local pharmacy and came home with a small packet of oral rehydration salts and a box of strong antibiotics. He had also stopped by a local woman selling vegetables and had purchased dates, one that had been chargrilled and the other was fresh. The salts were to keep him from getting dehydrated, the antibiotics to end the vomiting and the diarrhea (the symptoms), and the dates were an ayurvedic treatment that would

[1] Medications in Nepal are classified according to whether they can be sold without a prescription or if a prescription written by a qualified physician is needed.

put an end to whatever was causing this illness. While they knew very well the function of the dates, they seemed more unsure of the rehydration salts and the antibiotics and how much or for how long they would have to take them. Since they went straight for the pharmacy without seeing a physician there was no prescription with instructions to read, and the small pamphlet accompanying the antibiotic was apparently written in Spanish so it was unreadable. In the end it all came down to guesswork for dosage and duration of the treatment.

The order in which the ill person seeks care, what care he seeks out first or if he will do a combination of treatments from different traditions varies depending on the person, family, availability and situation. But one thing was clear, there was a clear difference between the different generations favored choice in care when it came to illness.

Tacit knowledge and generation gap

Being such an integrated part of Nepalese history and everyday life, ayurveda as an explanation model seems for many to be a form of incontestable, referred to by Kleinman as 'tacit knowledge' (Kleinman, 1980, p. 109). By referring to the underlying rationale for health related behaviors as 'tacit knowledge' I propose that the majority of the population may not necessarily have a conscious and formalized awareness of ayurvedic guidelines for healthy living, but, rather that these foundation principles describe how the world operates and are therefore essential elements of the socialization process. I am not implying that all Nepali people are equally proficient within the field of ayurveda as few have had formal training, but rather that most people have a certain degree of knowledge regarding the basic principles of the tradition and that it constitutes a foundation for Nepalese illness beliefs and illness understanding. This coincides with Kleinman's elaboration of an explanatory model in that a lay-person's explanatory model tend to be more flexible and changeable in that they are influenced by culture and ones own meanings and personality.

The level of ayurvedic knowledge would differ from person to person depending on certain factors such as their personal beliefs and their upbringing, in the same way that knowledge regarding allopathic medication and treatment would vary. I found that the elders usually had a more extensive knowledge of the tradition than the younger generation like students at the university who, when asked, admitted to knowing very little and, admittedly, had little interest in knowing more. This generation gap, demonstrated by the daughter of my family when my phone got stolen, was something I also witnessed later on when I spent time in the pharmacies. In

general, there would be few youths, age 15-25, who availed themselves of ayurvedic medicines or other treatments in the ayurvedic pharmacy and in the traditional clinic. Younger children would be brought by their parents or grandparents, some would be running errands for elder family members, but few youths would come by themselves. In the allopathic pharmacies the situation was different where youths would come by for consultations or just for procuring medication, but I will get back to the pharmacies later on.

I found this generation gap noteworthy as most of the remedies used within the home, according to both my own family and the students were home remedies and based on ayurveda, but still few of the younger people I spoke to neither had any interest in learning more about ayurvedic remedies or receiving healing from ayurvedic specialists. I chose to understand this as signs of how the different generations operated with different explanatory models (though there were large variations within a generation as well). For the younger generation who attended university ayurveda seemed more as a part of the tacit rather than the aware. One university student told me that his mother would try to give him home remedies when he felt ill. They were remedies she had learned from her mother when she lived in her native village. Now he and his mother had moved to Kathmandu and had allopathic pharmacies and clinics readily available so he didn't want to take the home remedy or feel the need to learn the recipe himself. He would always go to the local health post as they were *"educated professionals"* and knew what they were doing. While for the older generations, the student's parents and grandparents, ayurveda was described as a more aware choice when they would seek treatment for an illness.

Health education

One afternoon in March I decided to borrow the son in the family's social studies curriculum for the 8th grade (as almost every subject in private schools is taught in English it was easily available). Browsing through *Koselee's Social Studies Grade 8* [1], reading the section titled Health, I couldn't help but notice the amount of attention devoted to the importance of health education. Education in general was the one thing that raised man above the animals and the source to happiness, and before the year 2007BS (1951AD which would refer to the building of public hospitals mentioned above) people were not educated and therefore not aware of a "hygienic way of life." Development in Nepal, according to the textbook, was dependent on educated

[1] The book was used in private schools, approved by the Government of Nepal Curriculum Development Centre (CDC) and uses Nepal as reference material for its contents. It was first published in 1996, but the edition I was reading at the time had been revised in 2013.

workers. The book then went on informing about the importance of health and education, maintaining a dichotomy between the modern today, with its medicines and educated doctors, and the uneducated primitive past with herbal remedies, also drawing lines between the primitive and village life and the modern life of the cities.

I came across this dichotomy of the 'primitive' and the 'modern' on several other occasions and it seems to be a prevalent attitude, at least in Kathmandu, that the rural areas are seen as primitive in way of life and beliefs, and the urban areas is the place for development and modernity. People did not necessarily speak ill of the villages, but rather describing it as being a place where people were less developed and old fashioned. As Sagar, the contemporary ayurvedic pharmacists, told me regarding his patient's use of healing options other than ayurveda and allopathy, such as shamans – "They are less educated and do not think like us in the city." This dichotomy has also been documented by Stacy Lee Pigg in her article *Inventing Social Categories Through Place: Social Representations and Development in Nepal* (1992) where villages were described as more or less developed in relation to the larger cities, which were the center of development. She also studied schools curriculum and identifies what she considers to be the underlying objective: to promote basic values associated with development, such as small families, proper health care, education, etc. and emphasized how these values in turn maintain the dichotomy between the village and urban development as the villages often lack the access to proper health care and education (p. 500). If this book is a reflection of the rest of the health curriculum in schools, I saw at least one aspect of why the younger generation (those I met at the university), who would have been exposed to the same curriculum, had a different perspective on ayurveda than that of their elders.

Learning through everyday actions and watching family members treat illness and health in a certain manner is arguably the most common way children learned about health, hygiene, causes of illness and the likes. Learning about safe use of medicine is especially important for children in developing countries (Bush & Hardon, 1990). When I spoke to especially the young adults that attended university they wouldn't commit to home remedies to the same extent as their parents and would favor the pharmacy and allopathic remedies. In general, there were few public sources to health education and information, both in Lalitpur and in Kathmandu. The public allopathic hospitals and health posts would have an assortment of educational posters, both written in the form of cartoons, prominently displayed on their walls, informing people about a variety of health issues such as cataracts, the importance of hand washing and good hygiene,

vaccinations and the symptoms of different lethal diseases. They would inform the reader about underlying causes of specific illnesses, symptoms, what one should do if affected and prevention.

The allopathic pharmacies and clinics would have pamphlets (typically supplied by the pharmaceutical companies) accessible to customers with information regarding different kinds of medication, but the medical terminology in these publications made it obvious that they were intended for educated health professionals rather than the general public. Once in a while, I would stumble upon street paintings made by children, typically at primary schools, painted along the outside of the concrete walls surrounding the school yard that would portray different messages regarding health and hygiene. This type of information dissemination was infinitely more visible and comprehensible than the information posters with medical jargon hanging inside the physician's offices and hospitals.

The exposure of ayurvedic medicine in public, on the other hand, was much more visible. In the contemporary ayurvedic pharmacy there would be pamphlets from ayurvedic pharmaceutical companied (written in Nepali) explaining different ailments in an educative manner, though it was clearly commercial. While being based on ayurvedic remedies with traditional ayurvedic names, most of the explanations for each medicines treatment area would make use of non-ayurvedic diagnosis and terms more commonly found in allopathy. Terms such as prediabetics, diabetics, antioxidants, dysentery and bronchodilatory properties were often used, reflecting the main health issues people were struggling with in the big city. These commercial items would also be picture based, displaying pictures of medicinal plants and different food items that were to be taken or avoided depending on the illness, making it easier for people who were illiterate. Several of the local newspapers would on regular basis have large advertisements that promoted different ayurvedic remedies from a variety of ayurvedic pharmaceutical companies, both Nepali and Indian. On television there were channels that broadcasted events with mostly Indian swamis who instructed viewers on the principles of ayurvedic living that included preventive measures such as yoga, as well as specific recipes for treating specific health problems. There would also be regular commercials for ayurvedic medication throughout the day on several channels.

Though principles of warm and cold foods and concepts of forces that can make you ill, for example, constitute a form of tacit knowledge among many, I soon discovered that many use ayurveda only as medication and as a natural, and believed side effect-free, alternative to

allopathic medication, a topic I will revisit in the next chapter regarding the medical specialists located outside of the home. Even though ayurveda has its main focus on prevention of illness, for many it is not until one falls ill that ayurvedic remedies, or health in general, become a more conscious focus in making home remedies or visiting specialists in their clinics and pharmacies lining the busy streets. And even then, the first stop after trying ayurvedic home remedies can be an allopathic option.

I make no claims that the picture I have painted so far regarding health, illness prevention and treatment within the home is representative of all Nepali families. This is, after all, mostly one family. It is rather an attempt to show an example of how families, and individuals in the Kathmandu Valley can explain illness and how they choose to treat it. While they have a tacit knowledge regarding ayurveda, in situations where allopathy is the primary tradition being used the differences between the two traditions can create difficulties for the patients as will become apparent in the following chapters.

4: Seeking a specialist

The traditional ayurvedic clinic was different from the rest of the pharmacies I experienced, not just in outward appearance but also in practice. Every morning Mahendra would light a small paper spiral of incense and move it around in circular motions to 'cleanse' the doorways, ingredients and the medicines stacked on the fragile glass shelves, before dropping the smoking piece of paper into his office drawer, which also functioned as a cash register containing the day's proceeds. He did this every day. Afterwards he would sit down in his large office chair behind his desk and wait for customers to arrive. Compared to the other pharmacies, the small clinic was dead silent. On a good day there would be approximately 5-7 patients and most of them were regulars who came to stock up on remedies or to have a follow-up on an illness already being treated.

The clinic had just opened when an elderly man came in with a green plastic bag containing assorted documents. He greeted Mahendra amicably while completely ignoring me. He sat down on one of the stools in front of Mahendra's desk and laid out all the documents for Mahendra to see. I could see they were test results from a local allopathic hospital with dates going several months back. Ultrasound pictures and the results of blood tests were among them. The man who brought in the documents was the husband of the patient, but his wife was not present at this consultation. Mahendra compared the new results with the old, studied the picture, said everything looked fine and brought out some white, plastic containers of herbal remedy. After the man had left, Mahendra gave me a detailed history of the woman's presenting complaint. She had gone to an allopathic physician in the beginning when she felt ill. After some consultations she had been diagnosed with kidney stones, and her physician had told her that surgery was her only option. Surgeries are very expensive and can lead to complications later on, so together with her husband, they had decided that she would not go through with the course of treatment recommended by the physician, opting rather for Mahindra and his traditional ayurvedic clinic. She had now been under his care the last five months, with regular checkups and ultrasound to see if the stones had decreased in size or disappeared completely. Today, her test showed that the stones had halved in size and that Mahendra's treatment was a success. She would have to keep up with the treatment and his dietary recommendations for another 4 or 5 months before the stones would be completely gone. The treatment was gradual and costly, though cheaper and

less invasive than surgery. Mahendra confided in me that most of his customers had already tried allopathic treatments without desired results, so they came to him as a last resort.

In the following chapter I will present the various aspects of health care found in Aushadhi Chowk as means to an end in trying to understand *why* pharmacies have become such a popular option for so many people in the urban areas of Kathmandu. Often, it is not so much a question of either choosing ayurveda or allopathy, but rather using different traditions in different forms depending on the illness and the severity in trying to treat an illness. With everything from free to private allopathic physicians operating within the same area alongside a wide range of other medical traditions, first and foremost ayurveda, why would someone seek help from a pharmacist, generally recognized as under qualified and ill-equipped to carry out more advanced forms of diagnostics and treatment? Perhaps answers to the question 'Why are pharmacies so popular?' can be found by looking at the societal context and institutional relationship between patient and healer, in this case the allopathic and ayurvedic physicians and traditional ayurvedic healer.

Curative resorts

Stepping out of the home and the compound, the options for treatments quadruple in both options and in variation. Going from the family members' comparatively limited knowledge to the large number of assorted specialists located in the various streets around town, such as Aushadhi Chowk, creates an abundance of options and choices to be made. A person's preferred pattern in seeking treatment, their hierarchy of resorts, is connected to a person's explanatory model for illness and their beliefs regarding preferred treatments. These patterns vary between individuals and can also vary depending on the illness and the ill persons evaluation of the severity of the illness (Durkin-Longley, 1984). The specialist one turns to for a respiratory ailment such as a common cold is not necessarily the same as one would seek for a broken leg - be it an allopathic hospital or a traditional ayurvedic bone setter. When Aadi became ill, the first place he thought to visit after his home remedy failed to have the desired effect was the pharmacy. Although he knew of several physicians and they were located within walking distance, he still chose the local pharmacy. He knew he wanted antibiotics and he knew he would get them at this pharmacy.

Speaking with some students I met at a local university, I was told that seeing a physician was seldom the first option when they felt ill. A young man in the group told me, when I asked about

his preferred alternative when he fell ill, "Why should I go to the physician and pay when I can go to the pharmacy and get the same medication without the fee?" Another young man in the same group of friends, however, admitted to always going to the local health post near his house as he thought the pharmacists didn't have the proper education to make those kinds of decisions regarding his health. "Too many people go to the pharmacies when they should see a qualified doctor!" He came from a family of nurses and had quite well-founded opinions on this topic.

Kaylan, the allopathic pharmacist, was also very concerned over the number of patients who would seek pharmacists help, his help, as an alternative to seeing physician. "This is a big problem in Nepal. People don't want to see the doctor, so I try to make them go." He would often advise the people coming into his pharmacy to see one of the physicians. This was also a subject that was frequently mentioned in the editorial and opinion sections of the local newspapers[1], leveling accusations at Nepali people for not bothering with regular health checkups and only contacting a physician when they were seriously ill by which time it might be too late (Kafle, 2014). Being located in pharmacies I mostly experienced people who actually used the pharmacies and physicians regularly (naturally), so I have no way of knowing the extent of people's refusal to see a specialist for their health problems. By the time I saw them they had already made the decision to see a specialist.

I could tell, after spending some time with the different pharmacies and specialists, that there were variations among the patients seeking consultations in regards to what types of health issues they presented and their retelling of what kinds of treatment they had tried before seeking out the present one. The opening ethnographic case illustrates a typical scenario in Mahendra's traditional ayurvedic clinic. While some of his patients came to his clinic before seeing other specialists, most of them had already tried several other options in attempts to find a cure for their problem. The woman presented above had tried several allopathic options before coming to his clinic. Perhaps this was due to his higher prices, that in his opinion matched the quality of care given, but it was evident that people didn't come to him with a simple cough or back pain. In Sagar's ayurvedic pharmacy and in Kaylan's allopathic pharmacy on the other hand, there was a plethora of various complaints and illnesses – everything from headaches and coughs, to gastric problems, diabetes and general monitoring of high blood pressure. They seemed to be the entry point for many people struggling with health concerns and illnesses.

[1]I routinely read Republica and The Kathmandu Post every morning. Though they are both English language publications, I found that they addressed many of the same issues as the Nepali papers when I discussed articles and topics with my informants.

The pharmacy

Pharmacies in general, both in Lalitpur and in Kathmandu, would be one of the first shops to open in the early mornings and one of the last to close after nightfall. They are situated along side the street just as any other shop, with open fronts facing the heavily trafficked urban scenery outside. The pharmacies, especially the allopathic ones, would stand out thanks to their generators supplying power during loadshedding, shining like a beacon after sunset in the otherwise pitch black streets (there were no street lights). The ayurvedic pharmacies would vary more in terms of appearance. Some would be light and bright like most of the allopathic pharmacies, while others were almost like a hole in the wall with no lighting and a low ceiling. The shops specializing in traditional ayurveda were often indistinguishably similar to the small spice shops located in the area, preserving the ingredients for the remedies in various pots and pans on the floor. In the evenings there would be a line of people crowding the pharmacy counters waiting for their turn to someone behind the counter. In Aushadhi Chowk, the different pharmacies would have different opening hours and many of the shops seemed to have flexible opening hours, staying open late some nights and closing early on other nights. Given their density in both Lalitpur and in Kathmandu, the pharmacy is an easily accessible option for most people (although Aushadhi Chowk was especially dense).

The way the pharmacies are situated along the streets, the vast number of them and the physical layout of the outlets make them an open space with easy access, thereby lowering the threshold for starting up a conversation or asking for advice related to ones own or a relatives ailments. Just as people would know their local vegetable vendor in the neighborhood in Lalitpur they would be equally familiar with the person running the local pharmacy, and although the density of pharmacies was much higher in Kathmandu it seemed that people had a preferred pharmacy that they would seek out if needed. The pharmacists I met knew several of their patients by name, and would greet them regardless of whether they were coming into the pharmacy or just passing. Sagar, the contemporary ayurvedic pharmacists, would specifically bring up this as an important reason for people choosing his pharmacy above others, or seeing a physician. He said he could have opted for doors or erected a wall around his pharmacy, but he chose not to because he wanted to be visible and available to everyone. By knowing the people in the neighborhood it would be easier for them to come to him with problems, as he was no stranger.

The pharmacies associated with one specific therapeutic tradition also vary widely. Especially among the allopathic pharmacies there were large variations. All of them had as their common

denominator the distribution of medication, but there were also several who specialized in other tasks and duties in order to better serve their clientele. Some of the larger pharmacies collaborate with private clinics where physicians see patients before directing them to the 'recommended' pharmacy to fill their prescription and some have access to pathology labs that can run blood work and extensive tests that the physicians recommend. Joining together in such clusters of specialist tasks makes it easier for the patients to get the help they need all in one location or in a coordinated treatment space, and cross-referrals create financially beneficial opportunities for affiliated specialists. Kaylan's pharmacy was one of the pharmacies that offered extra services for their patients. Since the pharmacy was in the same building as a private clinic, all the patients had to pass by him in order to see one of the physicians. As the clinic had a system for booking a timeslot with the physicians, this was also something they had to see Kaylan for. He would have the whole week scheduled on a small notepad lying on the counter where he would write down the appointments for people coming in person or those who called on the landline. When the patients had seen the physician, they once again returned to Kaylan to fill the prescription they had received at the consultation.

As Kaylan's pharmacy was linked to the private clinic, which seemed to have a good reputation, many people came there specifically to see one of the physicians. Even though the physicians were easy to locate most of the patients came to see Kaylan for *his* advice and expertise. Though Kaylan didn't have a medical degree, he was a trained pharmacist with a university degree. On a regular basis he would measures blood pressure, take the temperature of people when suspecting a fever, do basic examinations and, above all, take time to listen to people as they explaining their symptoms and their duration, all for free. What came as a surprise to me was that in many situations, Kaylan would, after an initial appraisal, recommend people to see a physician to confirm or modify his diagnosis. I will elaborate further on the various tasks of the pharmacists I encountered throughout this chapter as well as in the final chapter. For now, just keep in mind that the pharmacists who have a – seemingly - monotonous job in the pharmacies may have obligations that extend beyond initial referrals and what is apparent at first glance. In the case of Kaylan and his pharmacy (which turned out to be special), his responsibility for the patients or his job didn't end as soon as the patient was referred to a physician. He was a continuous part of the equation throughout the treatment process.

Physicians and specialists

Sitting in a corner of the hospital pharmacy I had an excellent view of the allopathic hospital's courtyard with the main, inpatient building to my left and the outpatient building next to it with a long wooden bench extending along the tall metal fence enclosing the hospital compound. It was difficult to predict how long a hospital visit would take since patients would have to wait in-between consultations with doctors for results from diagnostic procedures such as x-rays and blood tests, eventually returning to the physician for the final word on treatment. To make the wait a little bit more comfortable, greenery had been planted behind the bench so there was always a cooling shade covering the area. An elderly woman was waiting in the shade with a younger man by her side. They had been waiting for almost an hour when a young woman in a lavender colored coat came with a makeshift wheelchair made from a plastic lawn chair with wheels. The elderly woman was helped into the chair and was pushed into the outpatient building to see a physician. An hour later she emerged, still in the wheelchair, and was taken across the courtyard and into the inpatient part of the hospital where she stayed for almost an hour. When she rolled out into the courtyard again, she was holding a large folder containing several x-rays. Once again she had to wait before the physician could see her, but one hour later she came out wearing a crisp white cast on her right leg, which was the reason for her seeking a physician that day.

This is not an unusual sight among the hospitals in Kathmandu, and especially the public ones. Being substantially larger and affordable services, public hospitals have a much higher number of patients coming through their doors during a typical day. In the allopathic hospital there would be people sitting on the long wooden bench out in the courtyard throughout the day, waiting for their turn with the physician or waiting in-between appointments. In addition to the bench outside, inside the hospital the different wards had seats lining the wall, normally crowded with patients and their family members. In the allopathic hospital the wait could be an hour or more, in the ayurvedic clinic it could vary from 10-30 minutes, while in the allopathic clinic it would be more variable as they had organized a queuing system. It is not the wait alone that takes time; when further testing is required and the patient has to go to either a different part of the hospital or, not uncommonly, to an external pathology lab to have these procedures performed before bringing them back to the physician, it adds to the time it takes to receive a diagnosis and treatment.

In contrast to time-consuming queuing, waiting and diagnostic procedures, the consultation in itself is a short event. A Nepali friend of mine told me she had gone to see an allopathic physician for a stomach pain that had her concerned. She said she could afford to consult with a private physician, but she didn't see herself as "any better than other people", so she opted for the local public hospital. She had to take the day of work, sit in line for almost an hour, and when her turn came the physician used under five minutes to poke and prod her both physically and with questions before he prescribed her painkillers and pills for indigestion. When she asked about the diagnosis the physician brusquely brushed her off and said if she would just take the pills everything would be fine. Leaving the physicians office with only a prescription and no explanation, she did not feel reassured that the physician had given her a proper examination and, consequently, she questioned his diagnosis. In the end it was her local pharmacist who had to explain the prescription and the dosage to her. She said that had she known before, she would have gone to the private physician her mother-in-law had recommended. She had no doubt that he would have treated her better and given her more time to address her concerns.

Given such self- or institution-imposed time constraints, it is highly unlikely that the majority of patients have been sufficiently informed about their medical condition, prognosis and its treatment. Physicians are, in theory, instructed to explain to the patient their diagnosis in a comprehensible manner, the implications it will have for their life, the different options for treatment and the potential cost of these treatments, but this seldom happens. This leaves a deeper understanding of the diagnosis and its implications as well as the effects of the prescription up to guesswork on the part of the patient, or shifts the responsibility to the pharmacist. This issue was also editorialized in the local paper, leading me to believe that it was a widespread problem rather than isolated incidents of neglect (Dhital, 2014). There appeared to be little to no room for patient-physician dialog in a typical appointment with a physician. This closely resembles Kleinman's description of the Chines-style practitioners he interviewed. The practitioners believed their patients knew little of the specifics regarding their medical tradition and instead of leaving with a further knowledge regarding their illness, the patients left with a detailed prescription (Kleinman, 1980, p. 261).

Mahendra and Dr. Ravindra both stood out in comparison to the allopathic physicians and their treatment of their patients as depicted above. While the allopathic physicians seemed to remain seated behind the desk most of the consultation, only physically engaging with the patient to do short physical exams (such as measuring blood pressure, pulse or feeling for broken bones), the

ayurvedic specialists were more 'hands on' in accordance with ayurvedic diagnostic techniques. They would always feel the patient's wrists for blood flow, while asking several diagnostic questions. Dr. Ravindra was a calm and quiet man, taking his time listening to patients recount their symptoms and their previous attempts to deal with their ailment. The consultation concluded with a diagnosis and a thorough treatment plan, which he explained in detail, continuing to answer the patient's questions after he had concluded. While the ayurvedic specialists may, seemingly, have treated their patients more thoroughly, taking their time with each of them, one cannot overlook the fact that these were private clinics charging a higher consultation fee than public options.

The majority of doctors in Nepal are employed by the public sector, working in public hospitals, clinics or health posts, but an estimate done by the World Health Organization (WHO) states that roughly 90% of these physicians run their own private clinics on the side, and can also provide their services through other private health care facilities (WHO, 2007, p. 25). The majority of these private clinics and facilities are located in urban areas, such as Kathmandu where the general density of health care professionals is higher than in the rural areas. Not surprisingly, most of the people I spoke to about this disparity in quality between public and private health care, stated that they chose the best option they could afford at the time, sometimes borrowing money from family to cover the consultation fee. The private consultations costs substantially more, but they generally last longer and people I spoke to outside of the pharmacies and hospital were of the opinion that the treatment was better if you opted for and could afford private health care. Many had the attitude that free health care options were on average of poor quality (it had to be free for a reason?), and a general distrust in the government[1] lead people to shy away from the government's health care facilities even though there are treatments and several medications classified as 'essential' that are available for free at these facilities (WHO, 2011). Most people "knew" that high quality health care could be bought if needed, and that the private options were of better quality than the public ones as these were more lucrative for physicians, thereby – presumably - attracting more qualified doctors. But in the end, regardless which kind of physician they chose, they would leave his or her office with a prescription for medications they would have to fill at their local pharmacy.

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[1] The Government of Nepal has a history of inadequacy and poor administration when it comes to health care facilities and the implementation of health promoting projects. This is most conspicuous in the rural areas where a lack of health professionals, proper equipment and access to medication are common issues due to a favoring of the urban areas of Nepal when it comes to funding. But also health posts in the urban areas tend to lack essential resources including trained health care professionals who often migrate towards more lucrative positions in private surgeries and institutions.

Medicalizing treatment

During the months I spent at the pharmacies I gradually became aware of some perceptions and practices that characterize/differentiate these institutions. One of the most salient and crosscutting observations, especially within the allopathic pharmacies, was the overriding reliance on medication, preferably pills, by both physicians and patients. I would go as far as saying that almost every patient who entered the physician's office came out with a prescription for at least one type of medication. The medication prescribed varied. If a general practitioner was on duty the prescriptions would be more diverse, including antibiotics, pain relief gel, painkillers or fever reducing cough syrup. Unlike ayurveda, the allopathic physicians I met rarely focused on dietary and lifestyle changes for their patients, relying almost exclusively on medication though man of the patients came in with lifestyle related illnesses[1]. In the allopathic pharmacy, dietary supplements, vitamins, protein supplements etc. were a common sight among the physician's prescriptions, and high blood pressure was managed with pills alone instead of recommending diet and lifestyle changes.

There are official rules and regulations regarding allopathic drug administration (National Drug Regulation Act, 1995) stating that some drugs can only be procured via a prescription from a medical doctor, antibiotics being one of them, but due to a shortage of staff in The Department of Drug Administration there are few inspections of the pharmacies and their routines (Holloway, 2011). Despite the regulations, depending on the pharmacist and the patient, these rules can and are being easily bent and bypassed (Wachter & Joshi, 1999). As there are no regulations for the sale of ayurvedic remedies this was not an issue at either the traditional ayurvedic clinic or the pharmacy. While the pharmacists have control over a substantial amount of the medications sold over the counter, the physicians would more often than not prescribe multiple drugs for a single problem.

While being in the allopathic pharmacy, I observed that some of the patients coming in seemed to have received standard prescription combinations for the most common health complaints. One patient after another would come out from the physician's office carrying a small, pink prescription booklet, all containing the same recommendations for treatment. They often contained the exact same handwritten description of the patient's symptoms. The prescriptions and descriptions would vary according to which one of the physicians was present, but I could not free myself from the image of a conveyer belt where patients would come out at regular

[1] High blood pressure, type-2 diabetes, indigestion, obesity were among the more common complaints.

intervals with the same, standardized prescription in hand. A far cry from the patient-specific treatment Mahendra and Dr. Ravindra's patients seemed to receive, with their emphasis on treating the illness with medications as a subordinate or secondary measure alongside lifestyle changes as the primary curative (and preventative) measure.

There were clear variations with regard to dispensing of prescription medication between the multitude of pharmacies and pharmacists located in Aushadhi Chowk and Lalitpur. Some adhered to government regulations, many (like the local pharmacy Aadi used) did not, and then there were those like Kaylan, who followed some regulations but not others. This not uncommon 'lenient' approach to national drug regulation can easily be debated, and several sources have done so previously with data from Nepal and several other developing countries such as India (Das & Das, 2006; Nichter, 1996; Whyte, Geest, & Hardon, 2002). What is problematic is that many pharmacists lack required insight and training in drug prescription - some even lack a proper basic education - and they do not have the same diagnostic tools and/or training in their use that skilled physicians do. This leads to guesswork from the pharmacist based on experience, and the recommended treatment may be inaccurate, either in dosage, combination (with an additional danger of harmful multi-drug interaction effects), or simply the wrong medicine due to a wrongful diagnosis. This has gained much attention in relation to the excessive distribution of antibiotics; previous studies have found that a significant proportion of Kathmandu-based drug retailers lack a adequate understanding of antibiotics nor its uses to practice safe distribution to the local population (Wachter & Joshi, 1999).

Suffering from a common cold while working in Kaylan's allopathic pharmacy, I received a full size sample of sinus clearing nose drops from one of the many pharmaceutical representatives who came by along with an inhaler for respiratory issues and for my cough. I tried to politely decline the inhaler, but was met with little understanding from the pharmaceutical representative. Why wouldn't I use something that would make me feel better? I had no previous experience with inhalers and had no plans of making this my first, so after a long discussion with the representative I was able to give Kaylan the inhaler so he could put it up for sale. Afterwards Kaylan told me that I had done the right thing by not taking the inhaler. "People should not rely on medication to get well. They should try to live without as much as they can and live healthy lives as much as they can, no medications. Inhalers and antibiotics are not for colds". I thought this was a peculiar statement as his job was to distribute medication, and if every patient were to change his or her life and focus on non-medicinal treatment (more along the lines of the

ayurvedic tradition), then Kaylan would eventually be looking at reduced sales and income. With the competition in the area being as high as it was, it would have been difficult to get by. In hindsight, I am not certain if he truly meant what he said, or just stated it because of my presence and my interest in the field. But I genuinely think that he wanted to educate his customers and share his knowledge regarding health and prevention, though there would always be economic considerations.

Regardless of the tradition, it seemed that medications were the preferred method of treatment for most physicians as well as their patients (as I will elaborate in the final part of this chapter). This is not uncommon in developing countries, and the excessive flow of pharmaceuticals has been critiqued for medicalizing health (Ferguson, 1988), and not taking into account the local, indigenous medical practices. There are many physicians, both private and public, who prescribe a variety of medications daily, emphasizing it as the most efficient way of treatment. This makes the physicians, and to some degree the pharmacists, a prime target for the pharmaceutical companies in the hopes of convincing the physicians to choose their brand of medication over a competitor's. The competition is fierce, leading to a system of incentive arrangements that can benefit the physicians as well as the pharmacists involved.

The pharmaceutical industry

One afternoon the bench in the hospital courtyard was crowded with young women and men, all dressed in crisp, white shirts and dark suits, all carrying leather briefcases or large backpacks. Some of them were carrying helmets for their motorbikes that they had parked just outside in the crowded street next to the waiting line of rickshaws always stationed outside. They clearly stood out from the remaining crowd of patients waiting for their turn with the physician. I noticed that the line of the formally dressed diminished rapidly while the line of what I, judging by appearances, took to be 'genuine' patients remained constant. One of formally dressed, a young man, came over to the pharmacy where I sat, to speak to Binod, the pharmacists at work. The young man opened his backpack and pulled out a stack of small packages in different shapes and sizes. They were sample boxes of different medicines such as eye drops, pills against high blood pressure, and various other pills (both ayurvedic and allopathic). He shoved a small pile of assorted medicines through the metal bars on the counter accompanied by a stunningly white smile and left. Binod smiled back and proceeded to sort through the medication he had just received, placing some on the shelves behind him and stuffing the rest in the pocket of his jacket before going back to watching television.

The pharmaceutical industry and their representatives are visible in every pharmacy, hospital and clinic, both allopathic and ayurvedic. The representatives visit hospitals during the day, and the private clinics during the evenings. The representatives' main goal is to get the prescribing physician or pharmacist to make *their* brand of medication the one they prescribe, stock and recommend to patients or customers. In this highly competitive environment there are numerous options with the same active ingredients or different active ingredients targeting the same condition, produced by different manufacturers (Nepalese or Indian, mainly). Several of the manufacturers target the same health problems, such as high blood pressure, gastric problems, diabetes, vitamin deficiencies, etc., so there are many different brands available for the same conditions. This has lead to an ethically disputed problem of prescription substitution where pharmacists have, when receiving a patient's prescription, recommended another brand of medication than the one prescribed by the physician (Harper, Rawal, & Subedi, 2011). The new recommendation is generally the same, only differing in brand name and manufacturer, but a brand where the pharmacist has an agreement with the representatives and gains benefits by selling that specific product. I witnessed this practice once, in Kaylan's allopathic pharmacy, where he recommended a different brand of vitamin D supplements to an elderly lady who came in for a refill. She did not have a new prescription, but it was something she had taken before and she brought the empty pill tray for reference. The lady was quite adamant that she would only accept the pills she had taken before, and nothing else, although Kaylan tried his best to make her buy a different kind – stating all the extra benefits by switching brand.

Since the competition within the pharmaceutical industry is fierce and the differences between the various brands of medication are, in many cases, insignificant from an efficacy perspective, local pharmaceutical industry representatives need to 'convince' physicians and pharmacists to choose their brand over competing alternatives. This results in various incentive arrangements. Not surprisingly, there weren't many pharmacists or physicians who wanted to talk about these incentive arrangements, but there were articles published in the local media both during and after my stay in Kathmandu reporting on these questionable arrangements and how patients were often uninformed or lead astray (Poudel, 2015). Only Sagar, the pharmacist in the ayurvedic pharmacy, had any interest in discussing the matter. When I brought the topic up during a conversation he smiled and laughed. "Yes! I have many nice things in my home that they have paid for!" He explained to me further how the incentive system operates. If the pharmaceutical company manages to get one doctor in one hospital to make their medication his/her preferred

treatment option, several of the pharmacies nearby would have to stock this medication as the demand increased by the patients coming by with their prescriptions. The physicians' rewards could vary, but Sagar had heard stories that made claims of everything from cash bonuses to motorbikes, cars and even paying for the physician's children's education. The incentives vary depending on who the main recipient is. A physician – the prime target for pharmaceutical company representatives - has a major influence on the patient's choice of medicine, as he or she is the one who prescribes most of the medication. A pharmacist will in large part dispense medication from a physician's prescription and therefor will not be as influential as the prescribing physician.

One day a salesperson from one of the larger producers of ayurvedic treatments (specializing in mostly creams and hair care, but also herbal medication) came by the pharmacy. Sagar ordered some products from the representative and asked for some samples, stating he wanted to test these before selling them to his customers. He received a large plastic bag filled with a variety of products, mostly hair and body care items, before the representative left. Afterwards Sagar told me that if he wanted, he could sell these product samples and make a profit on them, but he usually would take them home to his wife. Regarding free medication, which he also received, he would generally sell these and pocket the revenue. A larger study of pharmaceutical distribution in Nepal, *Disputing Distribution: Ethics and pharmaceutical regulation in Nepal* (Harper et al., 2011), shows that these free samples were, for resident physicians, a common way of procuring pharmaceuticals for relatives and family, and, interestingly, the poor (p. 3). These results coincide well with my own observations both in the ayurvedic pharmacy and the allopathic hospital pharmacy where pharmacists would pocket a large amount of the samples.

When an increase in prescribing leads to a thicker wallet for those who recommend the medication, it is easy to continue treating health issues by means of medication rather than promoting preventive measures or beneficial behavior change that do not include some form of medication. This tendency of medicalization is found in the contemporary ayurvedic pharmacies as well, though one would think (given the explanatory model for illness and the beliefs regarding treatment in ayurveda) they would not rely as much on medication but rather dietary and lifestyle changes. More often than not, it was the patients themselves who requested medication as means of treatment, however, not relying on lifestyle and dietary changes alone. Thus, the incentive arrangements will not only influence physicians who in most cases rely on medication when treating their patients, but also their patients who will be conditioned to regard

ointments and oral medication (pills) as the most effective course of treatment for whatever ails them.

The patient's expectations

One evening, in the hospital pharmacy, a woman came with her prescription for an ointment. She had visited the allopathic hospital's dermatologist regarding a rash. Binod gave her the ointment but she did not seem happy. Wasn't there something else she could take for the rash - a pill, maybe? Pleading with him for something stronger. Binod tried to explain to her that she did not need any other medication and that the ointment the specialist had prescribed should help within a week. The woman refused to back down, and in the end Binod gave in. He turned around facing the floor-to-ceiling shelf filled with medication, pulled out a small tray of oval, orange and green capsules. He took a pair of scissors and cut out a single pill[1], which he gave to the woman. He told her to take the pill before she started using the ointment, and before her evening meal. The woman seemed satisfied, paid and left. Afterwards, reading the small inscription on the pill tray, I saw that it was an ordinary vitamin C capsule. When confronted with this, Binod just shook his head and said that the woman would never have left if he hadn't given her a pill. "*Ke garne*? (What to do?) Some patients are not satisfied unless they get pills." Almost regardless of what problem the patients presented, they left with one or more pills, syrups or ointments in a small plastic bag. Though it is the physicians who have the most say in what and how much medication is prescribed, this is by no means a one-sided dynamic. There are several factors that may influence the amount of pharmaceuticals prescribed by a physician or sold by pharmacists. The woman suffering from a rash "demanded" the pharmacist to sell her something more potent, in addition to the ointment. Though being reluctant in the beginning, Binod gave in and sold her a pill, telling her it would cure her rash much quicker.

This event brings up some interesting aspects of the practice of prescribing, drug dispensing, and the responsibility of the pharmacist and the physician. I could argue that this was a case of unethical practice by the pharmacist, misleading the woman in making her believe that a single vitamin C capsule would cure her rash quicker than with the ointment alone, and that this practice only exacerbates the perception of pills as being more effective in treating illness. It reinforces the popular belief (in many parts of the world) that pills indeed are more efficient, potent and better than other medicinal options. If I were to place myself in the shoes of the

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[1] This was common practice in all the pharmacies. Pills were seldom sold in their original packaging. The pharmacist would cut out the exact number of pills needed and the patient paid a set price for each pill. This spares the patient from buying an excessive amount of pills using more money than necessary.

patient, and try to see this event from a more emic perspective she could have 'known' that if she refused to accept the pharmacist's assurances regarding the prescribed remedy, and insisted on something better and 'stronger' she would receive another, more effective option. Though this is purely conjecture as I do not know how the patient reasoned or felt regarding her options, I witnessed on several occasions patients who would ask if there were stronger or better (as in more efficient) options they could try to shorten the duration of their illness. A woman complaining about her weight was recommended by Kaylan to change her diet and exercise plan, but she insisted on buying expensive weight loss pills. She was not interested in eating less or exercising more. After the woman left, Kaylan even commented on the woman's purchase and said, almost laughing, that the pills she bought were pointless. "Pills will not make you loose weight, but people are lazy! They only want the fast, easy solution."

In the ayurvedic pharmacy and the clinic this preference and demand for pills was a common occurrence as well. An elderly woman came to Mahendra seeking advice for her back, which was visibly crooked and certainly painful. She had been seeing a physical therapist on recommendation from an allopathic physician, but during the two weeks she had seen him her back had not improved. Mahendra would ask her the usual diagnostic questions from where he was sitting, how old was she, what kind of food had she eaten lately, what she did for a living etc. He told her to keep on going to the physical therapist for at least a month, and if she still had pains she could come back. The woman was reluctant to leave and asked if there was no medicine he could give her that would help, but Mahendra remained confident in his appraisal of her situation and would not sell her anything. Sagar experienced this same issue in his pharmacy, and referred to it as a problem. Too many people wanted the easy way out of a health issue. Even though both he and Dr. Ravindra would advocate changes in diet, people, he said, seldom followed these recommendations. "All these problems could have been treated with diet and exercise, but people like the quick fix."

Given the fundamentals of the ayurvedic tradition explained earlier, and how illness and treatment are conceptualized, one would think that medication became a secondary therapy next to dietary and lifestyle changes (which is, at least in theory, the preferred way of treating an illness and in the end healing it completely). This, however, was not the case. While Dr. Ravindra did emphasize the need for changes in diet and lifestyle, he would also prescribe medications to help speed up the healing process. While the prescription of multiple forms of medication for a single illness was not as frequent as I could observe in any of the allopathic pharmacies, every

single patient coming there left with some form of treatment that they would have to administer orally, such as pills, tonics and powders. I also got the impression that many of the people who came directly to Sagar for advice expected a medicinal treatment for their problem, or else they would argue or leave dissatisfied. Sagar also confirmed this:

> “Nowadays many people only use ayurveda for the medication. They do not have the patience or the will to keep up the lifestyle, and I tell them medication will only help them so far. If they don’t follow my advice and the lifestyle, they will come back.”

Many of the patients I encountered at clinics and pharmacies did not seem content with their treatment unless they left with a prescription for some form of medication. This, in combination with a prescribing culture that treats every illness with a pill, creates a high demand for pharmaceuticals. Based on personal experience (as with Aadi and his cold symptoms) people ‘know’ that health can be bought, and since the bonus system of the pharmaceutical companies is well known there is also a risk that what the physician prescribes is not actually necessary. As the competition between the various curative options escalates, the physician’s reputation and the patient’s experience will be decisive for retention of patients and a successful medical practice. If the physician is unable to meet his patients’ demands they will choose a more accommodating clinic or hospital the next time they fall ill. The fact that physicians are not - in all but the most serious and life-threatening cases - the first place people go when they are ill, opting rather for their local pharmacist, understanding the patient-physician relationship could provide us with at least a partial explanation of this preference (in addition to financial constraints).

Patient-physician relationship

Although the patient and the physician come roughly from the same cultural background they will generally have different explanatory models for illness and treatment. Judging by the aforementioned woman I described above, she perceived pills to be the most efficient treatment and was therefor disappointed when she was only prescribed an ointment. Due to the lack of time the patient spends with the allopathic physician during a typical consultation, there is little time to establish a collaborative relationship between them other than what transpires during the expedited encounter – straight down to business and no pleasantries. Sitting on facing chairs often separated by a small table, the patient and the physician had little physical contact other than the occasional physical examination, and physicians rarely spoke to patients outside of the

consulting room. If one of the patients had a question regarding their treatment or their diagnosis and their physician overheard this while standing near the counter, they would normally reply to the pharmacist and rely on the pharmacist to respond to the patient's inquiry. Or more commonly, be referred to the pharmacist for all questions as the physician himself didn't have the time (or inclination) to share this information. Only once during my stay did I observe one of the physicians speaking to a patient outside of his office. He was multitasking, writing a message on his smartphone while replying to the patient's question, not looking up a single time.

Some allopathic physicians, in my opinion, displayed a form of academic superiority, assuming that their patients were incapable of understanding their own diagnosis and treatment since they were not medical professionals, and rather viewed illness in the same way as described in the previous chapter regarding ayurveda. The physicians had, after all, attended medical school to gain their knowledge so they seldom expected the patients to possess even a miniscule portion of the same knowledge they had learned. Their job was to find out what the patient was suffering from and prescribe necessary treatment, without reference to the patient's understanding – only blind compliance seemed to be required. Accordingly, most patients appeared only to be concerned about how to take the medication they had been prescribed. Often, the physician had only told them that as long as they took their medication as planned everything would be fine, but some patients, mostly the younger ones, wanted to know more about their illness. Since some physicians fail to provide this type of information within the limited timeframe of a consultation it is up to the pharmacists, if they are available, to explain to the patient what is written on their prescription and how the medication should be taken according to the physician.

Language would often become a barrier between the physician and the patient. The allopathic physicians in the hospital and the clinic were all writing in English and often speaking in medical terms, referring to medical diagnoses when speaking to the patient. This places the burden of explaining and answering all the questions the patient may have after the consultation with the physician on the pharmacist. Sagar and Kaylan also gave the same account of the patient-physician relationship to me. Not surprisingly, I had difficulties finding physicians willing to speak to me openly on this subject, often referring to 'other physicians' who did this, but not themselves.

Mahendra and Dr. Ravindra both had an entirely different relationship with their patients. There might be several factors that explain the difference, such as a more hands-on and personal approach to diagnosis rather than compiling and processing diagnostic input from others in the hospital/clinic or that there were fewer patients so they had more time with each, but the relationship between the ayurvedic physicians and the patients was much 'closer' and more personal. Dr. Ravindra knew most of his patients by name, often whole families who all had him as their regular physician, and he always had time for small talk after his clinic hours. Due to the personal nature of the ayurvedic diagnostics he knew (and regarded as significant) many details concerning his patient's personal life and history, and he would often share details about his own. Mahendra displayed the same familiarity, though he had a substantially smaller customer base perhaps because his treatments were comparatively more expensive than the nearby ayurvedic options. Or, as he put it, most of his patients were those who had already tried everything else without a positive outcome, so there weren't as many patients as there used to be. His patients would on regular basis come to his shop just to talk or have a cup of tea as long as there were no other patients seeking a consultation. There was always time for an informal consultation and Mahendra would often do full diagnostics of a new patient without charging them. Even if it the result was that the patient required a remedy that he did not stock, he would give them the address to a pharmacy nearby that he knew stocked the right remedy.

There are more factors involved in the healing process than just receiving a remedy which one is to take in order to get well. As previously explained, a person's explanatory model not only makes the cause of the illness comprehensible, but also says something about the best course of action and what is considered an appropriate response to treatment. Specialists, in this case the physicians, have been thoroughly trained in a biomedical explanatory model accounting for pathology, while their patients may have - at best - only a rudimentary and popularized understanding of bodily functioning. Thus, what they deem to be an appropriate response and what they see as effective treatment will also differ.

Drawing on Goffman's *The Presentation of Self in Everyday Life* (1969), it would seem that both the pharmacists and the physicians are 'performing' their respective roles within a defined 'setting' (p. 32). There are regulations for how a pharmacist and a physician can behave, and how they perform their routine within their setting, namely that of the pharmacy and the clinic. This performance will also reflect and incorporate the audience's expectations and the values of the society in that it is "molded, and modified to fit into the understanding and expectations of the

society in which it is presented"(p. 44). The physician and pharmacist can in some instances accommodate the patients expectations in meeting their demands for what they, the patients, see as logical treatment. This is apparent in the manner the pharmacists treat their patients. Although Kaylan believes the weight loss medication to be ineffective, he willingly conforms to "understanding and expectation" and sells it to the woman who demanded it.

While conforming to these expectations, the pharmacists still have a business to run, and a sustainable income is a necessity for keeping their own families financially secure. This may lead to the pharmacist looking past his own beliefs regarding treatment in accommodating the patient's. The weight loss pills the woman bought from Kaylan were extremely expensive compared to most of the other medications he sold, and by specifically provisioning them for her he found a way to increase his own income. Furthermore, the physicians (and to some extent the pharmacists) have their incentive arrangements with the pharmaceutical companies that further promote the dispensing of medication. Thus, the 'medication spiral' I have described is sustained by a combination of the individual patients' (and indeed society's, if we are to believe Goffman) expectations, the pharmaceutical industry's substantial revenue in Nepal and other emerging economies and medical practitioners' understanding of "what constitutes therapy", an understanding that also contributes to the patients financial wellbeing and potentially derails national health reform. When the patient, almost regardless of whom they choose as a healer, ends up at the local pharmacy where they have to buy their treatment in the form of pills and other medication, it may seem expedient to just eliminate the intermediary and go directly to the dispensary.

5: The pharmacy

It was late evening at the allopathic pharmacy, all the physicians in the clinic had left and with them, most of the patients. Sitting on the usually crowded bench against the wall, both Kaylan and I were starring emptily into the air in front of us, the room brightly lit by a piercingly bright and naked energy-saving bulb suspended from the middle of the ceiling. It had been a hectic evening as usual, and this was the first break we had been able to take in hours. The small family of mice living in the hole in the concrete floor just behind the counter, was scurrying along the bench to and from the door, gathering food from the small piles of today's trash starting to pile up along the street. I was curious as to what *he* thought was the reason for people choosing his pharmacy and trusting him with their problems rather than choosing one of the other pharmacies or seeing a physician? He gave a short laugh, and after some thought he answered:

> "Why? We have a good reputation in this area. Everybody knows that those who run the hospital are no good, the management is bad. Here, we take the patients seriously and help them. We care about their health, not only money. I know my customers like family. I ask questions, I listen, I want what's best for them and they know. If I know my customers, I see them. If they are sick or if something bad has happened to them or the family, I see, even if they try to hide it and do not want to share with me. It is all about trust, like family. Not many pharmacies or doctors do that."

Up to this point I have tried to show how people make use of the two most dominant medical traditions available in Kathmandu and the different options available in seeking treatment for an illness. I have also covered some of, what I believe to be, the more striking aspects of public health care in Kathmandu and how the general public avail themselves of the health services. As an outside observer, initially unfamiliar with health care provisioning in Nepal and similar locations, I was struck by the role played by pharmacies. Given the circumstances portrayed in chapter 4, with physicians spending little time in consultations with their patients, neglecting to adequately inform them of their illness and treatment, in addition to the role played by the pharmaceutical industry and the incentives offered by their local representatives, how does the modest but ubiquitous pharmacy fit into the complex treatment ecology I observed in Kathmandu? As this thesis is near its end, I will now turn my attention towards the *why*. Why are

the pharmacies a popular option for so many? But before turning to the why it is important so understand *what* the pharmacies have to offer, beyond easy access to restricted medication, that makes them the first choice for people seeking treatment.

A large part of the pharmacist's job is to supply medication to patients with prescriptions provided by physicians, but seeing that self-medication is also a factor and that many are reluctant to consult a physician (for financial or other reasons), the pharmacists do more than faithfully execute the physician's directives. I will again point out that my selection of pharmacies was limited and that my findings may only be applicable to a few select pharmacies (as alluded to by Kaylan). Nevertheless, I would emphasize that there are pharmacies that are exceptions to the rule and the popular conception that there is a free flow of restricted medication and that pharmacists distribute medications with little to no regard for the repercussions of that action. It is not my intention to judge the quality or professionalism of the pharmacies I observed as I do not wish to take it upon myself to judge pharmacies by universal standards of 'good' or 'ethical' practice in this area. I would undoubtedly have applied a different set of criteria than the patients who make use of the pharmacies and their services. As I will show throughout this chapter, not all pharmacies are the same and the pharmacists working in them have different opinions as to what kind of responsibilities their job entails.

Point of entry

As described in the previous chapter, the pharmacies are commonly people's point of entry into the professional part of the health care system. A visit to the local pharmacy is free while a consultation at the physician will cost you time and money, both of which are limited resources for many. When people know that the result of a physician's consultation almost certainly will be medication, and they know that these medications are easily available in the local pharmacy, then why should they have to pay for the intermediary? The pharmacists are far more accessible than physicians. Since the follow up of drug dispensing done by pharmacists is generally ignored, self-medicating is common, but it depends on the pharmacist and their willingness to bend the rules (knowing that it is at the expense of their own income). Some pharmacists would accommodate to the patients' requests in self-medicating, others, like Kaylan, would refuse to sell certain medication as they deemed it unwarranted or unnecessary. Though the pharmacist can refuse to fulfill the patients' requests, the patients are free to ignore the advice given and follow their own sense of what they deem to be the correct treatment. but more often than not the patients took

Kaylan or Sagar's advice and made an appointment with the physician or bought their recommended medication.

When a patient would come into the pharmacy, Kaylan would do as he always did; ask about their symptoms, if they had tried anything else before coming to him and for how long they had experienced the problem. Based on the patient's complaints and answers he would also do a quick physical examination. On the basis of the results he would do an evaluation and recommend what he considered the best course of treatment. There were cases where Kaylan would do a quick examination and reach the conclusion that it would not be necessary to see a physician, and then make recommendations for treatment, mostly through medication. In many cases this would involve him insisting that the patient should see a physician, one from the private clinic in the back, and offering to schedule an appointment at the first available hour or day. The patient would often agree to this, but at other times they would refuse, in which case Kaylan would generally (though reluctantly) sell it based on his own evaluation: "I can only recommend the doctor, I can not *make* them go. But I will try, and then they might go to the physician the next time." By doing this, he was actively trying to make people see that the physician was in many situations a more qualified person to assess their health. This corresponded well with his previous statements, knowing how he felt about people relying on the pharmacies for diagnostics and self-medication.

While this practice of referrals and further recommendations seemed like an honest and reputable thing to do, there were also instances where I questioned the necessity of the extensive referral practice he operated with. One afternoon, just after school had ended, an elderly lady brought her grandchild into the pharmacy. The child had complained about a headache and the grandmother asked if Kaylan had something that would remove the pain. Kaylan continued on explaining that a headache could stem from various causes, and it was best that she saw a physician. Luckily for her, the pediatrician was present at that time and she could get an appointment that same afternoon. The grandmother willingly obliged and took her granddaughter down the hall to the clinic in the back. Thirty minutes later she came out with the familiar prescription slip, which she gave to Kaylan. It was a prescription for a single pill of paracetamol, and I wondered if it had been necessary for the grandmother to pay the 300 rupee fee to see the private physician for a pill that would cost less than 10 rupee. I can only guess at Kaylan's reasoning for referring a child with a headache to an expensive private physician. He may have been genuinely concerned or perhaps he was sticking to his mantra of trying to teach

people that the physicians were their best option. When viewed from a financial perspective, one could reasonably ask if this decision was built on a foundation of evidence-based medical practice or if he was merely exploiting the commercial side of health care for financial gain seeing as most of the treatments are medication based and people hold medication in high regards when it comes to illness. Many of the patients coming into the pharmacy were seeking genuine advice, putting their trust in Kaylan and that he would give them the best advice possible.

When the patients consult with the pharmacist, they place their faith in his skills and trust that he will provide an accurate diagnosis or beneficial health advice. By doing so, the pharmacist becomes a form of *gatekeeper*, taking on the responsibility of prescribing the best treatment option among various alternatives that the patient may or may not be familiar with (Whyte et al., 2002, p. 98). How the pharmacist chooses to handle this responsibility is up to each of them. While many pharmacists would diagnose patients themselves, or submit to the patient's requests of self-medicating, others, like Kaylan or Sagar, would give more extensive advice and refer the patients to a physician for a more thorough diagnosis.

Translating, explaining and clarifying expert language

The pharmacist is not only a gatekeeper that is consulted prior to seeing a physician. An equally important role is that of a 'translator', transforming the cryptic English/Latin terminology of the medical profession found on prescriptions and other documents into a comprehensible language. As mentioned, when the physicians write up prescriptions they often use English as the chosen language, but also rely heavily on medical terms. This applies especially to the allopathic physicians. As many patients do not understand English, or might not even be able to read in general, the prescription holds little or no meaning for the patient and only indicates that they are entitled to some form of medication. Given the general lack of verbal communication in the doctor's surgery, the (often incomprehensible) prescription thus becomes the physician's main channel of communication with the patient indicating that they have classified the patient's complaints and concluding with a diagnosis that tells the patient that it is a treatable problem (Whyte et al., 2002, p. 117).

When the patient came to the pharmacy, the pharmacists would read the prescription and then transfer the recommended dosage, drawing signs rather than letters, onto the medication label. In this way, the dosage would be easily understandable for those who couldn't read, having

different symbols for spoonful and number of pills[1]. This marking system was commonly used in all of the pharmacies and was the minimum instruction given to patients, if they wanted it or not. Their medication was marked according to the physician's or the pharmacist's own assessment. While drawing these symbols, the pharmacists gave a more or less thorough description of how and when the medication should be taken, before a meal, after a meal, with milk etc. and asking the patient if they understood what he was saying or if they had any questions.

This was one of the more time-consuming tasks of the pharmacist during a day. Many physicians are, for different reasons, reluctant in sharing crucial information with the patient regarding their own health, and it then falls upon the pharmacist to fill in the information the physician left out during the consultation. On more than one occasion while sitting behind the counter at the pharmacies, I observed patients that had seen a physician at the hospital or clinic but didn't know what the physician's conclusion or diagnosis had been. Physicians often spoke and referred to the patient's complaints using terminology incomprehensible to the patient, referring of measurements and numbers or diagnoses that were totally alien to all but the highly educated. This applied especially to the allopathic physicians who not only labeled disease and symptoms using allopathic medical terminology, but were also reluctant or lacked the time to explain these to patients, making it difficult for them to understand their own illness and the implications underlying a diagnosis. The physician's responsibility seemed to be limited to examination, diagnosis and prescribing treatment.

Subscribing to two different explanatory models, the physicians and the patients in many cases do not share a common language for referring to and understanding illness. Many of the patients subscribed to similar explanatory models, as my Nepali family, based, to varying degrees, on ayurvedic principles. The allopathic physicians, being professionals, based their understanding of illness and cure in terms of an allopathic model (though many also prescribed contemporary ayurvedic medicines). As a result the clinical dialogue and the ability to convey information between the patients and the physicians becomes exceedingly difficult, not helped along by the physician's lacking interest in sharing their knowledge as portrayed in the previous chapter. It is then the task of the pharmacist to explain and make sense of the diagnosis in terms the patient will understand and accept. What the physician has written on the prescription, what kinds of

[1] The signs they drew were distinctive and were used among all the pharmacies I got to know. O-O-O would translate to one pill, three times a day, morning, lunch and evening. *∂∂- - -∂∂* would translate to two spoonfuls twice a day, morning and evening.

medication they are they supposed to take and how, and for how long they should take it is also essential information that needs to be understood by the patient.

In contrast, this was not a typical scenario in the ayurvedic clinic operated by Mahendra and Dr. Ravindra. Since ayurveda specifies lifestyle and dietary principles that facilitate health and restore 'balance' in the face of illness, medications are only meant as a supplementary aid in the curative process. It is essential for the healing that the patient fully understands their own illness, by what means it will be treated and how this will impact their symptoms. Dr. Ravindra had several small notepads lying on his desk depicting different food items both in picture and by name. Each little notepad was adapted for different diagnoses and had different items depicted on them sorted into two columns. One for food one could eat and one for items one should abstain from eating as long as the illness persisted. This made it easy for him to cross out favorable and non-favorable foods the patient should be aware of during their treatment. Sagar would also, on occasion, use these notepads with the patients who came to the pharmacy outside of clinic hours. This, accompanied by a thorough explanation and description, seemed to sort out any initial confusion there might have been between Dr. Ravindra or Sagar and their patients regarding the cause of their illness and how it would be treated. Although Dr. Ravindra was an ayurvedic physician and mostly based his recommended treatments on ayurvedic principles, he would operate with allopathic diagnostic terms, but would always view these in relation to ayurvedic explanations of causality and cure. In this way he combined the two traditions using more familiar terms (from the patient's pre-existing repertoire of terminology and explanatory models) to explain the less familiar allopathic diagnostic system. Which, in the end, was the same as what Kaylan did in the allopathic pharmacy. Taking the physicians prescription, he elaborated and explained in terms the patient could understand and relate to.

Counseling

It was late evening a slow afternoon in the allopathic pharmacy, Kaylan and I were the only ones there waiting for the physicians to arrive, when two young teenagers, a boy and a girl, came in. Whereas most patients who came had a light-hearted appearance, with these two there seemed to be something gloomy about them. Kaylan approach them at once and started chatting in his normal, positive manner, but early on in the conversation he became gentler in his tone of voice and told them to come over to the smaller counter, which faced away from the busy street and the entrance. They spoke in low voices, Kaylan doing most of the talking, and after a while he

led them into the clinic where they disappeared into the dark hallway. Returning some minutes later he gave me a summary of what had just taken place.

The couple were newly married, she 14 and he 17 years of age, had only been married for six months and now they suspected pregnancy. The couple still lived with the boy's parents, had not passed their SLCs[1] yet and had no income to support a child. They needed a pregnancy test, which could be done in the pathology lab at the clinic, and, depending on the results, then they would need information about their possibilities. Kaylan had told them not to worry and to first take the test to see if she actually was pregnant, after the results they could talk more about options. Kaylan had asked the lab technician to hurry the results so they got them immediately. While the couple was sitting on the bench waiting for the results, Kaylan offered them water and kept chatting with them. The test came, and the girl was indeed pregnant. Once again Kaylan brought the couple over to the small counter of the pharmacy for a more private talk (or as private as it could be in the small pharmacy), fortunately there were no other customers there at the time. For the next few minutes, he spoke to them both about termination of the pregnancy, and if they elected to go through with the procedure, where she should go, what would the procedure entail, risks, consequences and what the girl could expect afterwards in terms of physical complaints. Kaylan drew up a map that would lead them to the nearest public hospital, the couple left and I never saw them again. Sitting on the sideline, I felt I took part in an extremely private moment and even though I could not always understand what the three of them were saying in detail, the mood in the pharmacy had changed.

A physician may not be the first choice when seeking help in complicated and emotionally laden situations such as unwanted pregnancies. The termination of a pregnancy, though abortion is legal in Nepal, is no easy decision to make. The pharmacist, being a familiar and trusted individual, is positioned as something more than just a dispenser of medication; he also serves as a councilor in health-related, or sometimes familial, situations where the physician's consultation is inadequate. If the young couple had made an appointment with a physician (which they probably could not afford, in any case) they would in all likelihood not have received the same level of concern and care that they got from Kaylan. During the 3-10 minutes (depending on whether it is public or private) set aside for each patient, the physician wouldn't have had the time to take a pregnancy test and go through all the options regarding the termination in the

[1]The final examination of secondary school and is completed at 10th grade. Passing of this test is crucial for further education in higher secondary level or intermediate level education. It is popularly known as 'the iron gates' as it becomes a hindering for many in pursuing further education

same thorough way that Kaylan did. I never witnessed the same kind of counseling in the ayurvedic pharmacy, nor clinic, for reasons that I am unsure of. It might have been that the patients themselves deemed such 'physical' problems as better treated by allopathy, while ayurveda took care of health issues caused by imbalance.

Different pharmacies have different functions

While most of the pharmacies I observed were relatively similar in their way of accommodating and helping patients, though with a varying degree of flexibility when it came to prescription practices and favored medical tradition, one of the pharmacies clearly stood out as being vastly different. Located within a hospital compound surrounded by brick walls rather than along a street, the hospital pharmacy was essentially the sole provider of medication for all the in-patients and many outpatients alike. On no occasion did I observe people coming in from the street to seek consultation as I had routinely observed in both the allopathic and the ayurvedic pharmacies. Every single patient who approached the counter had already seen a physician and had now come for the prescribed medication. The hospital was open all day had more physicians working longer shifts than those with their surgeries in private clinics, and as a result the stream of patients was more evenly distributed throughout the day.

Having in mind the previous chapter regarding the importance of keeping the patients satisfied and meeting their expectations in relation to treatment, this did not seem to apply to the hospital pharmacy. And seeing that the pharmacy's customer basis consisted solely of patients at the hospital that had already seen a physician, they only needed to stock the medication the physicians routinely prescribed to secure an income. The pharmacists seldom did any prescribing of their own, nor did I observed them carrying out any form of diagnostic examination of the patients, e.g. taking the patient's temperature or measuring their blood pressure. Patients were not observed coming in for this type of examination since all the patients, Binod explained, were there to see a physician. The pharmacists only had to make sure that the pharmacy was well stocked and collect payment for medication. Their sole responsibility seemed to be keeping the pharmacy running smoothly and efficiently with no need to establish any type of bond or relationship with customers beyond what was required for the transaction as they were guaranteed customers regardless of their actions. Stocking medication and supplies that other pharmacies did not have access to made them the only option in many cases, leaving the patient with no other choice but to buy from them.

Having come straight from several weeks of observation at the allopathic pharmacy, I immediately sensed a distinct difference between the hospital pharmacy and the allopathic pharmacy. It was mostly in terms of how they treated their relationship with the patients, how much time they spent with them and if they offered assistance beyond dispensing medication. None of the patients stopped to talk to the pharmacists except for when they asked for instructions regarding the proper use of their prescribed medication. Binod never spoke to any of the patients in a manner that would suggest that he knew them, and when asked about it he said there were too many customers to know them by name. "I know some of the chronic patients. They come often." The hospital pharmacy was strictly business, no chitchat and centered around dispensing medication as quickly and efficiently as possible in order to make room for the next customer. What I believe to be the most significant reason for this is the lack of regular patients visiting the pharmacy. There is no need to visit the hospital for every single ailment, and because many favor self-medication, people would have visited one of the regular pharmacies first to sort out their issues, only coming to the hospital if the symptoms continued. When the patients first came to the hospital pharmacy, they had already seen a physician for their illness and thus had no need for a second consultation from the pharmacist, only requiring the pharmacist to dispense the correct medication and, if required provide an explanation of the dosage and when to take it.

I am not suggesting that this practice is deficient or inferior when compared to that of the other pharmacies, it is just another way of 'doing' the job of the pharmacist. Different types of pharmacies had different uses. This was just not one of the pharmacies patients sought out first when they required personal consultations or advice. There would always be an occasional patient who would ask the pharmacists for extra advice (like the woman who requested a stronger treatment than the ointment she was prescribed), and there would be friends of the pharmacists who would drop by for some advantageous meetings (friends of Binod would come for free medication given to him by the pharmaceutical representatives), but all in all most patients would just exchange their prescription for medication and leave. These differences made the hospital pharmacy distinct from the other locations where I carried out my observations, and indicates that this category of pharmacy falls outside of the role I have focused on in the other two categories – that of the pharmacy as initial reference point before seeing a physician, and serving as the entry point with the professional sector of the health care system. My observations in the hospital compound pharmacy shed light on the variation between pharmacy practices,

however, and illustrate that urban pharmacies occupy different positions in the treatment regime, serving different needs that called for different degrees of engagement with their customers.

Desjarlais describes how the Yolomo Sherpa do not consider shamanism and western medicine as competing traditions, but rather two traditions with different application areas - illnesses such as tuberculosis situated within the sphere of western medicine while spirit loss is allocated to the shaman's domain (Desjarlais, 1992, p. 164). This closely resembles how the neighbor in Lalitpur treated his illness with both allopathic and ayurvedic remedies to alleviate the symptoms and to remove the cause. Among the four pharmacies, I experienced that they all served different purposes and they all catered to different patients with different health concerns and illnesses. As a result, they also displayed marked differences in the relationship and interaction between pharmacist and patient/customer. The patient's presenting problem also reflected these differences. Where as the hospital would get more serious cases, such as broken bones, wounds and acute, life-threatening cases, the ayurvedic pharmacy received patients with chronic complaints such as gastric problems, high blood pressure and diabetes, along with infants with various health problems. This comes as no surprise, taking into account that ayurveda is known for being able to deal with illnesses by restoring the balance of humors in the body, and that it is a mild therapy suitable for children. In this way it seemed as though patients/customers differentiated between different categories of pharmacy, selecting the pharmacy that was most appropriate given their specific ailments, their estimation of what they needed in order to get better, financial considerations, etc. I would sometimes see the same patients in the hospital that I had earlier seen in the allopathic pharmacy, with presumably different complaints.

Familiarity

Being a part of the local neighborhood, knowing many of the local inhabitants, maintaining long-term relationships with them, and offering free consultations and services, the pharmacists hold a special position in relation to their patients, and may even be considered part of the patients' social network rather than mere 'service providers'. Physicians will generally not be included in their patients' social network as they spend most of their time behind the closed doors of their surgeries hastily examining as many patients as possible and prescribing medications for their complaints. Another factor that may influence this relationship is that physicians often come from a wealthier background than that of the majority of their patients (especially those who avail themselves of the free services in public hospitals), and are thus from a completely different social background than that of their patients. Living in different neighborhoods and wealthier

areas, the physicians may not even be a part of the local area where their hospital or clinic lies so they do not encounter their patients outside of their own surgeries.

For patients, there were benefits in knowing the local pharmacist. As described in the previous chapter, free samples or gifts the pharmacist receives from the pharmaceutical representatives often end up with family or friends. While it seemed that many pharmacists adhered loosely to the rules and regulations regarding the distribution of medications, Kaylan was very strict in that he would in most cases recommend seeing a physician before recommending any medical treatment. I witnessed several instances where people would come in from the street, ask for a specific type of medication (frequently antibiotics or pills for managing diabetes) and Kaylan refused because they didn't have a prescription and he was not aware that he had ever dispensed the medication they were requesting. Many would take his advice and make an appointment with one of the private physicians located in the back clinic, while others would walk away, seemingly annoyed, making their way to one of the other pharmacies located in the street. These situations would occur when 'strangers' came to Kaylan's pharmacy, but when longtime friends, family or acquaintances came it was a whole different matter.

A close friend of Kaylan would frequent the pharmacy often, stopping by for a chat almost every day, as he would pass the entrance on a regular basis. They had known each other for a long time and Kaylan had served both the man and his extended family in the pharmacy and made appointments for them at the private clinic. One afternoon, after the evening rush of patients, the man came in to purchase medication for managing high blood pressure. He did not have a prescription (although the package said it was required), and the medication wasn't even for himself but for his aging mother. Kaylan was pleasant and accommodating, as he always was, and sold the man three trays of pills. He later explained that he knew the man and his mother very well, that they had been to the pharmacy and the clinic several times and he knew the prescription as it was a long-term health issue and they made regular visits. This happened more than once, and with different patients, but the common denominator was that they were mature men and all seemingly good friends with Kaylan.

As there are no regulations for the sale of ayurvedic remedies this was not an issue at either the traditional ayurvedic clinic or the pharmacy. There would be times where Sagar would try to dissuade people from buying certain remedies as they came in various strengths and purchasing the wrong strength, he informed, could result in over-treating the illness. A woman came to buy

medicine for her husband's high blood pressure, but as the husband did not accompanied her and Sagar didn't know just how high his pressure was, he risked dispensing medication that would result in hypotension. While Sagar couldn't refuse her the required medication, he advised her to buy one of the milder treatments until the husband could go to a physician and receive a correct assessment of his blood pressure.

The importance of these social ties in the scenarios described above depends on the pharmacist. As previously explained there are pharmacists who do not adhere strictly to the government regulation of medications that they sell, and, in many cases, patients do not need a written prescription, only a request. In other cases, the pharmacist does the diagnosing and prescribing. Regardless, people seemed more familiar with their pharmacists than with their physician. On no occasion did I observe any sign of the same type of relationship excising between a patient and their physician. I believe this to be a result of not only the location of the pharmacy, open and exposed on the side of the street, a comparable social background and, above all, the fact that in most cases it is the pharmacist who makes the illness understandable or more clear in that they are the ones who answer questions and explain treatment.

Justice (1983) describes how, during a tour of rural health clinics in Nepal, the clinics were often lacking in staff and that there was only a peon present. As it turned out, this staff member, not trained in medical science, was often responsible for treating patients using the knowledge he had acquired by watching health care workers. The local villagers would place greater trust in the peon above other health workers since he was from the local community, knew the local families and spoke their language(p. 968). Although this study was carried out over three decades ago and in rural areas, I still believe this type of familiarity is an influencing factor in today's urban Kathmandu.

The impact of familiarity on healthcare provider preference is also illustrated in my observations at the local health post in the peri-urban town in Lalitpur. The health post was staffed by a health worker from the area (with some formal training) and a physician (with a medical degree from India), but they were present on different days. On days where the health worker was present there would be a rush of people seeking assistance, while on the days the physician was available the waiting area was virtually empty. Aadi explained that while the physician might be better qualified, education wise, he was brusque and didn't know any of the families living in the area. Although the systematic variation in patients seeking help at the health post may be partially

attributed to the doctor's uncordial demeanor, it is possible that the local community simply demonstrated a preference for a familiar local face rather than the far more qualified 'outsider' from India. I would also suggest that connectedness, inclusion in social networks and familiarity are of far greater significance in relationships that deal with sensitive issues such as health and illness where *trust* and *continuity* are essential components of the relationship. Or, to put it differently: I'll buy my vegetables from whoever gives me the best price and quality since I can usually determine both by myself, but when it comes to my health or the health of a family member there is no substitute for trust built on inclusion and familiarity. Extending this idea from peri-urban Lalitpur to urban Kathmandu, when the pharmacy is located along the side of the street and has been there for years, open for all those who are passing throughout the day, the pharmacist, unlike the physician 'excluded' behind closed doors, becomes a familiar face and part of a trusted social network for many.

'Seeing' the patient

The treatment and healing of illness has two functions. It serves as a controlling factor for the illness, but it also provides the patient with an explanatory model (J. Subedi, 1989). When the patient and the practitioner subscribe to two different models that account for the illness, it can create room for misunderstanding. As we have seen, the allopathic physicians rely on the pharmacists to translate their medical models into an understandable form, transferring responsibility for the patient's understanding of his/her illness to the pharmacist. The ayurvedic practitioners offered a more thorough explanation of the illness and cure to the patient, but they also use an explanation that is more culturally appropriate, resonating better with people's explanation model in that ayurveda is more commonly accepted among the general population.

When I asked Sagar the same question that I, some weeks earlier had asked Kaylan – what made the pharmacies more popular than physicians among many of his patients – he told me that the availability of his services was the deciding factor. The layout of his pharmacy was quite intentional. He could have closed up the front of his pharmacy with glass or similar, saving him time in not having to dry dust off of the medication several times a day - the pharmacy would be cleaner and more hygienic, but the openness and accessibility would be lost. And this openness, he believed, was why the patients would come to the pharmacies. There were no hindrances for the patient to come inside and talk to him. When wishing to see physicians in clinics or hospitals you had to make an appointment or wait in line, maybe take time off from work and then pay out of pocket for the consultation and whatever drugs they prescribed. To me, it seemed as if the

pharmacy was the drop-in equivalent to the actual physicians. He also speculated that this spatial configuration might be one of the many reasons why people came to his pharmacy in particular, and not any of the other 15 plus ayurvedic pharmacies also lining the street. His shop was one of the biggest, had high ceiling and therefor the open front was much bigger that any of the other shops in the street. But considering that every single pharmacy, be it allopathic or ayurvedic, was basically constructed in the same way, I had my doubts on it being one of the main reasons for people choosing his pharmacy above others. It did, however, confirm that pharmacist were keenly aware of the significance of this factor and not merely following convention.

Both Sagar and Kaylan would examine their patients, carrying out a general physical examination based on the presenting complaint and through questioning and listening to the patient's own description of their illness. In addition, due to their long history of running their pharmacy in that area, they would often be familiar with the patient's family's medical history and the patient's previous illnesses including what other types of medication they had been, or were, being taking. When a patient came with a presenting illness, they would sometimes have an easy solution to the problem, like recommending honey and menthol cough syrup for coughs and colds. In more serious cases such as fatigue, dizziness, long term illness or more diffuse complaints they would recommend the patient seeing physician, even if they themselves had a plausible theory of what the illness could be caused by. In this way the pharmacists became more than just drug dispensing pharmacists, they were a point of referral, a place where people could come for advice, follow-ups and explanations. They seemed, to me, to be providing services more along the lines of the GPs, the general and family practitioners, familiar in western markets, though neither Kaylan nor Sagar would agree when I shared my comparison.

Sitting in the garden of my guesthouse after finishing a long day of observations, reflecting over the difference between the physicians and the pharmacists, *The Guru and the Conjurer: Transactions in Knowledge and the Shaping of Culture in Southeast Asia and Melanesia* (Barth, 1990) immediately came to mind. Relating how the two different schools of professionals handled and shared their knowledge differently, the pharmacist in this case being roughly equivalent to Barth's description of the Guru. "The task of the Guru, […], is to instruct, clarify and educate in his relation with the audience, so that his disciples learn from him, in a personal and enduring relationship." (p. 643). While it is not a set task for all pharmacists, it was one that the pharmacists Kaylan and Sagar were committed to. They spent time and energy informing patients, friends and the people in the neighborhood, sharing their knowledge of health, prevention of illness and providing

comprehensible guidelines for the maintenance of good health. It reminded me of the small neighborhood in Lalitpur where I started my journey, and how the people living in the small group of houses would share their own knowledge and recommendations with each other in times of need. When Aadi and Indira's neighbor fell ill they would share their own experiences and how they treated similar illnesses within their own family.
In contrast, the allopathic physicians I observed had more in common with Barth's initiator. "The initiator guards treasured secrets until the climactic day when he must create a performance, a drama which transforms the novice."(p. 642). The behavior of physicians I encountered as well as the depiction given to me by both patients and pharmacists were reminiscent of Barth's characterization of the initiator, guarding his medical secrets from the uninitiated novice, in this case, the patient. The physicians did, in a manner of speaking, put on a performance for their patients. The patients could see how the physician would proceed in examining and evaluating their symptoms with strange instruments, but lacking the fundamental knowledge and reasoning that lay behind the physician's diagnosis, they were left in the dark. This does not apply to the ayurvedic physician to the same extent as they routinely shared information more in line with the pharmacists. Communicating with patients in familiar terms of hot and cold properties, explaining the cause and effect of the patient's illness, the relationship between the ayurvedic physician and his patient is built up around a shared understanding. Although the ethnography of the Guru and the initiator is meant to show knowledge transactions between the Guru and his disciples, and the initiator and the initiation of novices, I find that the comparison also captures the distinctive difference between physician and pharmacist I observed.

Backtracking to Kaylan's statement at the start of this chapter, the assertion that his customers favored his pharmacy as a result of a number of things, trust being one of them, I believe he made a valid point. When many physicians may exaggerate the need for medication as a the only way of treating a health problem, it can be difficult for the patients to know if they are truly getting the correct treatment (and sufficient treatment) for their illness or if the physician in driven by other motives such as incentive gifts from pharmaceutical companies or financial gain. As long as the allopathic physicians do not regard communication as a core competence of their profession and a responsibility vis-à-vis their patients, it is challenging for the patients to gain the basic knowledge required to make informed decisions regarding their own health. With the headlines in the media revealing lack of medicines in government health care facilities, strikes among essential health care personnel and the health authorities' general lack of governance, one

becomes reliant on ones own social network. Although I have my doubts of whether or not his patients regarded him as 'family' in any sense of the work, I do believe that both Sagar and Kaylan were more than *just* pharmacists to many of their patients and that this fundamental trust made it easier for the patients to confide in him regarding their trials and tribulations. By sharing their knowledge, standing up for what they believed to be right (like refusal to sell certain medication), explaining why and elaborating the physicians' diagnosis and prescriptions, Kaylan and Sagar both showed that they cared for those who chose their pharmacy as the place for healing. Since both the pharmacies had a good reputation that extended beyond the boundaries of Aushadhi Chowk, it became apparent that people knew of their services and valued them.

Concluding remarks

Indigenous medical traditions in Nepal are largely based on herbal remedies. A tradition that dates back several thousand years, ayurveda is widely known both in Nepal and in the surrounding countries. Coexisting with various other traditions such as faith healing, Tibetan medicine, Chinese medicine and allopathy, the healing ecology is unquestionably pluralistic. While the Government of Nepal recognizes both ayurveda and allopathy as efficient healing traditions, ayurveda has been available for far longer than allopathy and is therefor a more integrated part of the common man's explanatory model related to health and illness. When home remedies fail to produce the desired outcome people seek out specialists, experts within their tradition. For many, pharmacies rather than the physician are, for reasons described in this thesis, the first choice and entry point with professionalized medicine.

Pharmacies are located at street level just as any other shop, where most people pass daily. Since allopathic physicians generally neglect and do not recognize the importance of sharing vital information regarding health and curative options with their patients, it is often up to the pharmacists to fill the knowledge gaps that the patient might have after a consultation with their physician. By occupying an infinitely more visible, accessible and familiar location than that of the clinic or physician's surgery - generally hidden behind closed doors and available at a much higher consultation fee – the pharmacy has positioned itself as an integral part of the local community and the daily lives of its inhabitants. Former patients drop by just as they would with any other neighbor, not in need of a consultation but to ask how the family is doing, or how the pharmacist's day is going. And when the same people require his services, they depend on and confide in the pharmacist as if he were a friend or neighbor. Thus, the local pharmacist has become a part of the local community's social and not merely service provider network and the ubiquitous pharmacy has thereby positioned itself as an essential component in Kathmandu's health service ecology. While most pharmacies cater to the needs of self-prescribing and self-diagnosing patients, the pharmacist behind the counter also offer a variety of services that go beyond merely dispensing drugs. By giving free consultations, free health checkups, advice and referrals they often pass up opportunities to increase their revenue in favor of the patient's health, well-being and, importantly, their loyalty.

I would argue that given the right training and support, pharmacists can play an essential role in local health care delivery, not only by offering health education, but also by offering basic health services and bridging the gap between the physician and the patient. The role of the pharmacist is gaining more attention, and in response to the observation that many people also make use of the various secondary diagnostic and consulting services offered by the pharmacies (both the approved and the unauthorized) there seems to be a shift in the way the education of pharmacists will be structured, moving from a product-centered focus on pharmaceuticals and their use towards a more inclusive approach to patient care that also encompasses basic diagnostics. The pharmacy degree program in universities in Kathmandu is has introduced a doctor of pharmacy (PharmD), increasing focus on clinical practice, patient care and prescribing, thereby allowing qualified pharmacists to perform many of the procedures traditionally assigned to physicians. Although intended to lighten the load on physicians and provide patients with a wider range of local health care options, it remains to be seen how the established medical community (physicians) will react to this drastic restructuring of their field. Taking their time to not only explain the physician's diagnosis, its implications the prescribed treatment, but also giving advice on possible diet and lifestyle changes that would benefit the patient constitutes a much-needed supplement and indeed a shift in focus from cure to prevention – a shift that will be increasingly important as western dietary and lifestyle habits are assimilated by city dwellers in Nepal. Pharmacies are an unrecognized and underutilized resource in regional and national health campaigns. As has been seen previously, people are more inclined to seek help from people whom they are familiar with and trust (though lacking in proper training) than strangers with higher qualifications.

In the end, treating and healing an illness is much more than just prescribing medicine. While the medicine may resolve a part of the problem, there are other factors that influence the patient's experience of the healing process and their feeling of being heard. Did the woman at the hospital pharmacy feel she had been correctly diagnosed and that she had received the appropriate treatment when she was prescribed an ointment for her rash? When she then went to the hospital pharmacy to fill her prescription and was able to convince the pharmacist that she needed a more potent cure, were her expectations fulfilled? Who treated her illness? Was it the physician, the pharmacist or the pill (which turned out to be a vitamin C capsule)? In these complex ecologies of healing options, combined and intertwined, who or what is it that heals?

While the physician is responsible for the official diagnosis and ordination of treatment, it is, in many situations, the pharmacist who explains and translates the physician's diagnosis and treatment rationale and supplies the prescribed medication. When most of this healing process is managed and made comprehensible by the pharmacist, it is easy to understand why many go directly to a trusted local pharmacy rather than a physician.

The unique position of the pharmacy as gatekeeper and as being positioned somewhere in-between the professionals and the laymen, suggests that they could be potential purveyors of public health information and awareness campaigns in addition to performing basic diagnostics and supplying medication. If one were to widen the scope a bit to see the possible implications of these findings, and try to imagine how this information can benefit the local population of Kathmandu, it is possible to think that instead of relying exclusively on schools, hospitals and clinics as venues for public health education (such as the informative cartoons and pictures I observed at these locations) these types of awareness campaigns – for both physical and mental health - could be centered around the local pharmacies, where locally known purveyors of health (the pharmacists) have the reputation and trust needed change health related attitudes and behavior.

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