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Feminization and Marginalization?

Women Ayurvedic Doctors and Modernizing Health Care in Nepal

The important diversity of indigenous medical systems around the world suggests that gender issues, well understood for Western science, may differ in significant ways for non-Western science practices and are an important component in understanding how social dimensions of women's health care are being transformed by global biomedicine. Based on ethnographic research conducted with formally trained women Ayurvedic doctors in Nepal, I identify important features of medical knowledge and practice beneficial to women patients, and I discuss these features as potentially transformed by modernizing health care development. The article explores the indirect link between Ayurveda's feminization and its marginalization, in relation to modern biomedicine, which may evolve to become more direct and consequential for women's health in the country.

Keywords: [Ayurveda, gender, Nepal, indigenous medicine, South Asia]

Gender and Medical Transformation

The diversity of indigenous medical systems around the world suggests that gender issues, well understood for Western science, may differ in significant ways for non-Western science practices and are an important dimension of how women's health care is transformed by medical modernization. In the context of plural medicine, which is familiar to women and their families in many parts of the world, we might ask if biomedical modernity compresses indigenous medical plurality in a manner that bears on people's gendered experiences of medicine. Indeed, women's health care prospects may significantly depend on how gender relations in health and medicine are transformed through biomedically influenced health care modernization, particularly at the crossroads of indigenous medicine and biomedicine. Understanding the complexities of gender and indigenous medical relationships is one step toward minimizing negative outcomes of sociomedical change for women. This article takes up the question of gender and medical transformation in Nepal through the experiences of women Ayurvedic doctors who achieve high professional status in a patriarchal society and who increasingly encounter biomedicine within the country. Relying on seven years of ethnographic research with formally trained women Ayurvedic doctors, I explore the issue of

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indigenous medical transformation and gender within the three main contexts of medical education and women training to become doctors, their unique capability to heal women patients, and the ways they enculturate medicoscience practices. In so doing I attempt to identify gendered features of medical knowledge and practice that can potentially change from biomedical influence. The women's experiences and perceptions about being professional healers in a modernizing health care context allow us to think more broadly about the connections between social (gender) and medical transformation, as these coevolving realms might impact health care policy and delivery in gender-differentiated ways in societies with strong traditional healing systems.

There are four main points I wish to develop here regarding medical transformation and gender. First, in addition to inherent paradigm differences between Ayurveda and biomedicine, the social and cultural features of women's professional practice indicate contradictory paradigms in which medical authority contravenes women's social subservience. Women patients' strong preference for female healers is the most evident example of a gender order that stratifies, on the one hand, and empowers, on the other hand, as the women doctors enjoy high social status and patient demand for their medical services in an otherwise male dominant society. Still, while their professional status may minimize their gender-based cultural and social inferiority, it creates a new kind of social marginalization found in some women's unorthodox marriages and other family arrangements. This gender-based social paradox is further complicated by how Ayurveda is ideologically rendered in the wake of biomedical health care development.

That takes us to the second point. The field of feminist studies has long called us to look closely at the connection between the secondary status of women and the kinds of work women perform in society today and in the past. In Nepal, more young women are choosing Ayurvedic medical education from among an array of possible careers in medicine. This trend is growing in spite of the official governmental view of Ayurveda as secondary to biomedicine, a view that in fact belies Ayurveda's enormous popularity in rural areas and pockets of urban communities. We are led to ask, then, if women's participation is contributing to Ayurveda's official marginalization, or, vice versa, that Ayurveda's lesser official status somehow makes it easier for women to apply to Ayurvedic medical colleges than to biomedical programs. Put another way, does a growing feminization of Ayurveda lead to its diminished status or does its diminished status—it receives far fewer resources from the Nepali government and international donors—lead to its feminization? Both sides of this formulation may play a part in explaining the Nepali case of gender and sociomedical change, but the ethnographic data nonetheless provide persuasive other reasons for women's enhanced role in Ayurveda on the one hand, and Ayurveda's official marginalization on the other hand. For example, the personal satisfaction and social power women doctors derive from caring for the health care needs of women, and their strong belief in the efficacy of Ayurveda, are important motivations for women's professional choice. Additionally, higher education for women is more acceptable and encouraged now in Nepal than it was 50 years ago, and women's presence is growing in all fields, including Ayurvedic medicine. Finally, Ayurveda's official decline is very much the ideological product of the political economy of contemporary health care development: international donors favor biomedicine's

development. And yet, gendered features of another kind may, indeed, contribute to Ayurveda's official decline, bringing us to the third point.

The very qualities that render Ayurveda officially inferior to biomedicine are those that bring women healers and women patients together and include noninvasive and low-technology diagnostic techniques, minimal cost, and clinical interactions that encourage culturally relevant medical knowledge exchange. Thus, many of the reasons why Ayurveda is popular among female would-be doctors and patients also make it "weaker" than biomedicine, as it is judged to be less objective and less scientific by health care administrators and officials. Although such conclusions are hotly debated in Nepali medical communities on both sides, the diagnostic techniques such as pulse reading, humoral evaluation, and use of plants as medicines are considered essential characteristics of Ayurveda (although clearly subject to historical and regional variation themselves) that are not inherently gendered. Indeed, such clinical techniques and cultural relevance are vulnerable to alteration by the influence of biomedicine, and thus, to the degree that women patients are familiar with and prefer them, their loss may negatively impact women's health care in the future. This brings us to the final and fourth point I would like to make. Potential sites of medical and social transformation related to the gendered dimensions of health care suggest areas that should receive attention by those advocating plural medical systems that benefit women's health. This larger issue of gender and medical modernization is taken up in the three main sections that follow on women becoming doctors, healing women patients, and the enculturation of medicoscience practice.

The ethnographic details provide the context for discussing social and medical implications of health care modernization on nonbiomedical practices in general and their particular implications for women. The research on which the analysis relies was undertaken in urban and rural Nepal from 1998 to 2005, and the focus here on women is part of a larger study examining modernizing Ayurveda in Nepal. I observed and interviewed female and male practitioners, health administrators, and patients and their families in a variety of medical and nonmedical contexts, including Ayurvedic hospitals, clinics, health posts, classrooms, and pharmacies, primarily in the three cities of Kathmandu Valley (Kathmandu, Bhaktapur, and Patan), in Dang District, and in rural communities in far western Bajhang District. The main features of women's medical practice that make them unique as healers for women within the Ayurvedic tradition have been distilled here from my work with seven women, five of whom are presented in this article and three of whose names have been changed to protect their confidentiality.

Feminist Insights on Science and Medicine: Cross-Cultural Applications

To understand the gendered features of Ayurvedic practice and how they potentially change with medical modernization, I look to insights from feminist theory and medical anthropology that address the relationship between scientific ideology and gender on the one hand, and the ways culture and society impact medicine on the other hand. In the area of science, culture, and social change, medical anthropologists have shown the variability with which indigenous healing systems are impacted by the power of modern science and globalized biomedicine in non-European

contexts (e.g., Connor and Samuel 2001). For our purposes here, I synthesize medical anthropology with feminist critiques of science to provide a framing by which to better understand the women doctors' paths to becoming professional scientists and healers, what they are uniquely able to offer women patients, the ways they enculturate medical practice to deal with modern pressures like greater social equality and biomedicine, and, more broadly, whether and how plural medicine is compressed and homogenized by the force of biomedicine in a developing country as these transformations may be of particular concern to women's health care.

Feminist scholars of Western science have greatly advanced our understanding of gender and modern scientific ideology, in particular with respect to how the historical development of the nexus of politics, culture, and science have affected women's health lives. From the philosophically grounded work of Evelyn Fox-Keller and Helen Longino (1996) on the gendered ontology of scientific language to the well-known work of Emily Martin (1987) on the language of gender embedded in medical school textbooks, the abundant findings of feminist scholars of Western science provide ample evidence of science as a gendered social practice with real consequences for women.

Social studies of science question the assumptions at the heart of Western scientific research, leading to fundamental reformulations in knowledge around human issues. The analysis provided here is greatly informed by Donna Haraway's (1989) and Sandra Harding's (1993) calls for an objectivity that is situated and embodied, and one that produces knowledge that aims for reliable accounts of things by including multiple perspectives from specialists and nonspecialists alike. We see at work in the Nepal Ayurveda case a non-Western affirmation of Harding's and Haraway's (and many others') critiques of Euro-Western scientific methodology; paralleling Western knowledge production, South Asian society that is gender, caste, and age stratified has typically marginalized knowledge from the bottom. In the wake of the rising power of allopathic medical institutions and advocates, Ayurveda is becoming officially marginalized by authorities at the top, and it isn't unreasonable to suggest that Ayurveda's feminization may gradually contribute to this. I suggest here that if that were to happen what would be lost are the benefits to society from what medical anthropologists identify as plural medicine and, what Harding calls "strong objectivity," the cumulative effect of recognizing authentic human problems from the perspectives of people experiencing them. Put another way, plural medicine that is authentically multiple in type (Ayurveda, biomedicine, shamanism, etc.) and diverse in participants (women, lower castes, lower classes) enhances medical knowledge production.

Finally, feminist theory also informs my methodology. In analyzing the apparent contradictions in the lives of women Ayurvedic doctors—for example, when they advance naturalizing explanations of female impurity over stigmatizing ones yet follow most cultural prescriptions for properly subservient female behavior—I follow the logic of "modernist" ethnography that Skeggs (1994) describes, one that concentrates on the complex formation of identity across a range of sites to produce multiple subjectivities. Multiple subjectivities, rather than discreet monolithic subjects, emerge when we consider who or what controls and defines the identity of individuals, social groups, nations, and cultures.

Scholars from anthropology, philosophy, and history have systematically identified elitist, sexist, and objectifying practices of Euro-American science and biomedical institutions. As Mary Tiles (1987) has outlined it, the lineage of such projects and the very possibility of applying this Western-based critique to a non-Western context begins with the assumption that at least one of the three Platonic premises behind conventional science is false: Every genuine question has exactly one true answer, all others being false; the method that leads to correct solutions is rational in character and identical in all fields; and solutions are true universally, for all times and for all people. For anthropologists, cultural diversity refutes at least the first of these; there are indeed a variety of ways to ask and answer genuine questions. For medical anthropologists confronted with questions of rational knowledge accumulation and efficacy—the second premise—the path can be treacherous as we try to describe and explain ethnomedical diversity, on the one hand, and are called to provide evidence of efficacy. This challenge for us, though, pales in comparison for those whose livelihoods depend on how successfully they address issues of evidence, proof, and efficacy on the other hand. The women Ayurvedic doctors discussed here frequently confront tests to the legitimacy of their profession, yet they continue to be supported by the large numbers of women who come to see them, and by the culture in general. Thus, medical modernization emerges as the broad context in which to understand gender, health, and Ayurveda in Nepal.

Becoming Doctors

In an excellent review of women's health ethnographies over the last 20 years, Marcia Inhorn (2006) notes the lack of feminist models to understand gender, culture, and health care. Here I would add to Inhorn's concerns the seeming paucity of research on women professional practitioners of non-Western medicoscience, and I suggest a way to expand our understanding of women's health globally with the specific case of women professionals of Ayurvedic medicine. Their position importantly compares with women allopathic practitioners and indigenous midwives, two groups that have received considerable research attention. Ayurvedic women doctors, too, are highly educated and skilled in a field that is medically and socially desirable for women, and yet, little researched, they remain poorly understood.

In her review, Inhorn points out the disproportionate amount of research that anthropologists have conducted on women's reproductive roles (constituting between 75 and 90 percent of the ethnographies she reviews), suggesting that, although this is a unique and important aspect of women's health care, research could be encouraged on other health care issues of concern to women. Here I take her observation to partly explain the lack of information on women professional providers, for not only have anthropologists (overly) focused on women's reproductive health, but also midwives and other informal providers of health care have been at the center of research attention by anthropologists and related others. The "production of health by women" (Inhorn 2006:358–359) is significant in its quantity and quality, taking place in the home, in the midwives' quarters, and in the sacred spaces of spiritual healers. The record, though, leaves the impression that women are not significant players in professional medicine, including non-Western

medicoscience traditions that have histories and lineages of knowledge transmission found in formal and nonformal institutions. (A recent excellent exception is Hong's preliminary analysis of Korean women doctors beginning in the Chosun Dynasty at the turn of the fifth century and continuing for 500 years [Hong 2009].) However, women have been part of indigenous Ayurvedic medicine's evolution and practice for at least the past century in South Asia, and the number of women formally trained in both Ayurveda and biomedicine has steadily increased with the acceptance of women's higher education. The production of health by women clearly also occurs in clinics and hospitals by professional practitioners of indigenous medicine, who provide for women's health and who are at the crossroads of modern medical change.

The near invisibility of women professional healers in medical anthropology has limited our understanding of the gender dimensions of professional non-Western medicine and science and has confined our models of the relationship among social change, gender, and health to informal female healers in a variety of communities (Huber and Sandstrom 2001; Jeffrey et al. 1989; Jordan 1983; Kaufert and O'Neill 1993; Laderman 1983, 2001; McClain 1995), and to male professional and informal healers in South Asian medical anthropology (Burghart 1984; Desjarlais 1992; Durkin 1988; Kakar 1982; Leslie and Young 1992; Macdonald 1975; Maskarinec 1995; Nichter 1980, 1981, 2001; Nordstrom 1989; Obeyesekere 1992; Parker 1988; Stone 1976, 1986; Trawick 1992; Zysk 1991). In Nepal, where traditional medical practitioners such as shamans and midwives have been identified as bridges between the people and the state's modern messages of health care (Pigg 1992), we might ask about Ayurveda's parallel role and, in particular, its female practitioners. Women providers from such traditions stand in a unique position not only to their patients but also to the state.

Professionals are understood here to be medical practitioners who skillfully apply an organized body of knowledge that is transmitted across generations in formal and informal contexts (e.g., Hsu 1999, on Chinese medicine). They are sought by members of society for their expertise in diagnosing and curing a broad range of illnesses, and some have specialized in Ayurvedic subfields like *panchakarma* ("five actions" or therapies used for a variety of conditions) and obstetrics. In this article, I focus on professionals of indigenous or traditional medicine, and not professionals of Western, cosmopolitan, or allopathic medicine. In Nepal this group includes institutionally and lineage-trained Ayurvedic doctors, commonly called "baidya" (a word that does not necessarily distinguish educational status, which can vary from one-year certification to graduate-level medical degrees). I limit discussion to women who received formal higher education in Ayurvedic medical colleges and hold advanced degrees in medicine; I am excluding women baidya who apprenticed with relatives and others in nonformal settings, for they tend to be less integrated into the state's medical apparatus and hence are less impacted directly by the social change forces of concern here. Today in Nepal, approximately 15 percent of the Ayurvedic doctors holding the Bachelor of Ayurvedic Medicine and Medical Surgery degree are women. The number of women doctors-in-training is rising, comprising half the students in recently enrolled classes at Naradevi Ayurvedic Hospital and College, the majority of whom selected Ayurveda over biomedicine as their first choice in higher education, itself a trend reversal.

Medical Modernization

Nepal's mid-20th-century biomedical successes set the stage for much medical transformation to follow, allowing a relatively unhindered movement of people, goods, services, and ideologies into the country (Dixit 1995; Shrestha and Lediard 1980). Ayurvedic medical education and management in Nepal are products of modern health care transformation, too. First, as graduates of such institutions, professional women doctors become integrated into formal state and development structures that are funded and guided by international organizations located in Europe and the West, as well as by Asian countries interested in influencing Nepal's national development, like India and Japan. The doctors interact with powerfully influential forces like biomedicine and health care development, and even with medicinal plant conservation initiatives (Cameron 2009a), through regular bureaucratic contact with the Ministries of Health, Education, and Forestry and Soils. Their complex connection with the state distinguishes their relationship to Western biomedicine from that of their nonformally trained Ayurvedic peers.

As a result of widely circulating modern health care discourse, Ayurvedic medicine has met a powerful entrant in international donor-driven and state-supported biomedicine, and the government and development organizations frequently construct Ayurveda as less scientific than biomedicine. The dichotomy shaping health development discourse presents rational Western therapies and hygienic practices as superior to indigenous, irrational, and potentially dangerous healing systems (Pigg 1992, 1996). One example is recent legislation that seeks to regulate Ayurvedic practice. The Nepali government, following institutional biomedical management, passed the Ayurvedic Council Act of 1988, which stipulates that individuals practicing Ayurveda must register with the Department of Ayurveda. Those without institutional certification must meet strict conditions to continue treating patients and manufacturing Ayurvedic medicines. The legislation's impact on Ayurvedic practice has altered the relationship between formally and nonformally trained baidya (Cameron 2009b). Other modern influences on Ayurveda that diminish its official status include the proliferation of allopathic drugs, the government's greater support for biomedical education, the loss of medicinal plants through environmental degradation and illegal exportation, and escalating Indian influence over the export of Himalayan medicinal plants (Cameron 2009a).

I point out this array of potentially detrimental effects on Ayurvedic medicine's sustained development in Nepal to problematize the notion that greater numbers of women in the profession might be the only or the main reason for its marginalization. Other factors are at play in transforming the high status Ayurveda historically enjoyed. That said I also wish to call attention to this set of processes that may in fact negatively impact women's health care choices in the future. Put another way, the feminization of Ayurveda (more women physicians and patients) cannot be said to be contributing solely to its decline—the political economy of health care development is also at play—but Ayurveda's extension of health care to women patients may become marginalized because of its decline. Conversely, the officially lower status of Ayurveda vis-à-vis biomedicine may contribute to its feminization, but it is not the sole reason. Here a look at some Nepali women's professional paths can help explain Ayurveda's appeal to would-be women doctors. What these

examples importantly illustrate is how difficult it is to study medicine in Nepal as a woman, and the real effects of such choices on women's marriage and family life are evident for all of the doctors portrayed here.

Unconventional Marriage

Dr. Laxmi Pradhan is one of the first two women Ayurvedic doctors educated in Nepal. She began studying when she was 17 years old, passed the Acharya Degree from Naradevi Ayurvedic College in 1970, and completed clinical rotations throughout much of 1971. When I first met Dr. Pradhan, she was working as the head doctor in two clinics and as a government administrator. For the first of our interviews in 2000, I took a taxi to the Department of Ayurveda on a rainy monsoon morning and dashed inside the dark entry to her office, a branch of the Ministry of Health located in a converted Rana palace. I shook out my umbrella as she put aside papers that detailed the Ayurvedic medical supply to the nearly 300 Ayurvedic clinics in Nepal. She then gestured for me to sit down on one of two small red couches facing a wood and glass coffee table, on which an assistant soon placed a tray of square sugar cookies and sweet spiced milk tea.

Dr. Pradhan was educated during a period when King Mahendra began radically transforming Nepal's educational system, a process that was continued for several decades after his death by the eldest of his three sons, King Birendra. The traditional Sanskrit-based curriculum of Ayurvedic medical education was converted to an English- and Nepali-based curriculum that integrated biomedicine, and its administration was moved from the Ministry of Health to the Ministry of Education. This move split the regulation of clinical Ayurveda from the formal educational system, a division that continues today. The Madhyama and Shastri degrees of the Sanskrit system were replaced with the Intermediate Degree in Ayurvedic Science and the bachelor's degree in Ayurveda; the Acharya Degree (equivalent to an M.A.) was eliminated.[1]

In balancing domestic and professional life, Dr. Pradhan found the conventional patrilocal marital arrangement unsuited to her educational goals. Nepali daughters-in-law are expected to work harder in the home than other family members, and they do the majority of household work. In spite of being in college when she married, Dr. Pradhan was expected to perform the demanding role of daughter-in-law in her husband's extended family. During a March 2005 interview, she divulged to me that it had caused her many hardships.

> I finished a two-year course on Ayurvedic medicine at Naradevi and then when I was in my first year of the Shastriya course, I got married. I married at a young age and struggled hard to continue my studies. My husband was a teacher. I wasn't treated well in my husband's home. I had to cook for all the family members but I wasn't given much to eat myself. Often I had to rush to campus without taking any food. My husband is a simple gentleman who does not like to say anything on these matters. When he found out that I wasn't eating, we decided to live separately from my in-laws. He even took care of the cooking so that I could study.

In Nepali families, formal education is often discontinued or receives diminished attention once a daughter marries. Yet with a supportive husband, changes are possible for a couple. The Pradhans quietly moved to a separate flat, and Dr. Pradhan was able to continue her medical studies. Still, family life for a woman can hinder professional progress. Promotions and raises for Ayurvedic professionals require a doctor to spend several years working in remote districts of Nepal and serving the rural poor. Dr. Pradhan, however, has been unable to relocate away from Kathmandu because of family obligations. She notes that men receive merit-based raises much more often than women because they can provide such national service, and she resents the sexism in the system. Dr. Pradhan feels discouraged that she is overlooked for promotion and compensates by being actively involved in many professional functions and in mentoring new doctors who are establishing their own clinics.

The marital histories of women Ayurvedic doctors rarely fit Nepal's general marriage patterns. In her mid-forties, Dr. Sarita Shrestha recently married a widower with two children. Dr. Katambari Acharya married a man of higher caste status in a "love marriage" (as opposed to the far more conventional arranged marriage). Her husband's family never accepted her, and the couple and their three children lived with her parents who, along with a sister, provided childcare while Dr. Acharya studied medicine. Finally, Dr. Devkhola Bhandari's impending arranged marriage while she was a teenager compelled her to run away from home long enough to convince her family she was serious about her future education and her desire not to marry young. She tried a few different medical programs and finally discovered her passion in Ayurveda. Eventually, Dr. Bhandari married a fellow student in an unconventional love marriage.

Dr. Sita Bista: A Journey to Healing

Dr. Bista was born in the Indian state of Sikkim 37 years ago. She studied in Bangalore in a pure Ayurveda program, one that was not integrated with modern medicine, although she is the only doctor among those with whom I work who occasionally and unapologetically prescribes biomedical drugs. Dr. Bista began studying Ayurvedic medicine when she was 19 after securing a scholarship from the government of Sikkim and graduated at 24. Her brother, whose opinion she greatly trusts, advised her to study Ayurveda, even though there are family allopathic doctors, including her own father. In fact, Dr. Bista had not heard about Ayurveda until she went to study it and was most surprised to learn that much of the coursework was in Sanskrit, a language she did not know. In a July 2000 interview she describes the winding journey that took her to Ayurveda.

> My father is an allopathic doctor. In fact there are six or seven allopathic doctors in my family. In Sikkim we do not have a university or an Ayurvedic college. So in order to produce doctors, the Ayurvedic colleges in India established scholarship quotas for the people of Sikkim. The year I passed the I. Sc. there were two seats for Ayurveda for the first time in Sikkim. My brother is a lawyer and he tried to get me a medical seat. I even got an M.B.B.S. seat in Bihar. On that same day the health director told me that

> there was also an Ayurveda seat . . . I could try for that. My brother thought that Bihar was not a good place, so I applied for the Ayurveda seat and on the first attempt I got it. It was in Delhi but there was no women's hostel. Again I applied for any college that had a hostel. And the next seat was from Bangalore. That is where I went. Until then . . . I had no idea what Ayurveda was. I knew I wanted to become a doctor. I had scored 89 percent in I. Sc. and I was sure that I would get a medical seat. So this was how I came to Ayurveda. When I went to the college the very first class was in Sanskrit. I thought to myself "what is all this?" My classmates told me . . . that everything would be in Sanskrit. After that I started taking tuition classes . . . and I committed to finish it.

Many of the doctors with whom I work, including the informally trained village healers, chose their vocation because of an inspirational family member in Ayurveda. Still other Ayurvedic doctors have children who go on to practice biomedicine. Dr. Bista's path is unique, coming as she does from a family of biomedical doctors. She recently completed studying Ayurvedic obstetrics in India, funded through the Nepali government and the World Health Organization, and returned to fill the obstetrician's position at Naradevi Teaching Hospital.

All of these women perform multiple medical functions in their communities. They work in clinics, hospitals, government service, and as medical school educators. Dr. Shrestha, for example, received her medical training at Naradevi Ayurvedic College in Kathmandu and Banaras Hindu University in India. Dr. Shrestha is the cofounder and supervising physician at the Devima Om Rural Ayurvedic Hospital for Women, located on the outskirts of Bhaktapur, a city in Kathmandu valley. She is also the supervising physician and board chair at Dhanwantari Ayurvedic Hospital, a new private hospital in a Kathmandu neighborhood. Finally, her own clinic is a collection of offices on the third floor of a building on a busy street in Patan. In addition to her work in Nepal, Dr. Shrestha annually travels to the United States to be a resident Ayurvedic practitioner in a number of health facilities. The money she earns from international work helps support the Devima Om Hospital for Women.

Healing Women

> [The female patients] covered themselves and refused to let the [male] doctor see them. Being a physician I did not feel shy or ashamed, nor do I feel it now.
>
> —Interview with Dr. Laxmi Pradhan, July 2000, describing her medical school internship

Women Ayurvedic practitioners' multiple roles as healers, wives, parents, and daughters constitute their multifaceted identities. Although a heterogeneous group, the doctors agree that because they are women they are able to provide medical care to women differently from male physicians because of the experiences their social roles shape. Although it would be incorrect to present women Ayurvedic

doctors as a definitive case study of female empowerment, their claims to being uniquely positioned to understand the social contexts of gendered morbidity are persuasive and widely shared. As practicing scientists, such women can be seen from the perspective of feminist standpoint theory as occupying heterogeneous and potentially more objective subject positions (Harding 1993), thus suggesting that Nepali women practitioners strengthen medical objectivity by enlarging the discourse of science's role in society and by extending notions of medical truth to include subjective and marginalized states.

Nepali women doctors are particularly concerned about how women's health is affected by everyday economic arrangements, gender role expectations, and family neglect of women's health needs. Dr. Laxmi Pradhan poignantly describes in a July 2000 interview how the gender organization of labor and kinship in the subsistence-farming economy exposes women to greater health risks.

> The women from the villages and remote hills hesitate to tell us about their gynecological problems. They carry heavy loads during pregnancy and immediately after delivery, and as a consequence, they develop a prolapsed uterus. But they do not know exactly what it is, and when they finally tell their mothers-in-law, they are told to keep quiet and that such a condition is not unusual. But the condition worsens and becomes chronic, yet they are still not taken to the hospital. The in-laws need the daughter-in-law at home to do the chores, and so they claim they do not have money for treatment.

The too-common condition of uterine prolapse resulting from hard physical labor during and after pregnancy is worsened by family decisions that place economic needs over medical ones, delaying medical treatment for suffering women. Dr. Pradhan's knowledge of the social basis of this painful condition helps to inform the compassionate medical care she provides to them.

Meaningful Medicine

Women patients share a number of reasons for preferring women doctors, beginning with Ayurveda's cultural salience. The "ecology" and "economy" of the body and person in Ayurvedic thought fundamentally differ from the mechanistic and compartmentalized biomedical model of the body. As it is widely practiced in South Asia, Ayurveda regards the patient's daily practices, social relationships, and environmental surroundings to be integral to diagnosis and treatment (Langford 2002; Nichter 1981, 2001; Sharma and Dash 1998; Zimmermann 1987). A humoral-based, integrated theory of the human body, nonmedicalization of the human life cycle, and noninvasive techniques of diagnosis all potentially make Ayurvedic practice less detrimental to female bodies than what feminist scholars have shown biomedical science to be. Within this broader framework of practice, specific characteristics of clinical interactions that appeal to women include the following: (1) an experience-based and reflexive understanding of the complex social and gender factors of health; (2) doctors' willingness to convey medical knowledge that involves appropriate explanation of the cause and cure for a condition; (3) skillful diagnosing of medical conditions utilizing noninvasive techniques that are familiar to women, such as

pulse examination, evaluating foods regularly eaten, and identifying recent abrupt changes in living and other "environmental" conditions that may disrupt humoral balance; (4) expressing an empathic rather than a detached objectivity toward the patient; (5) reading certain cultural practices as biological, natural, or health-related in ways that reinterpret the language of women's impurity; and (6) encouraging culturally relevant and feasible preventive medicine. Examples of these are described below.

Women medical scientists employ an empathic and engaged objectivity by focusing on patients' subjective states and family and community values even while diagnosing physical signs of aggravated *dosas*. (*Dosas* or "humors" are bio energetic substances that flow throughout the body and are formed from five ubiquitous elements found in the phenomenal world—ether or space, fire, air, water, and earth. The three *dosa* (*tridosa*) exhibit identifiable qualities and locations in the body that change with social, physico-environmental and behavioral changes.) Some of the women I have observed in clinical settings spend considerable time with patients and their accompanying family members, understanding their emotional states and family situations. At other times they act authoritarian, as I show below. Although they do not disregard the patient's feelings, they exhort them, for example, to stop eating foods that disrupt dosic balance. Such flexibility in clinical interactions makes sense when we consider them in the context of Nepali cultural values that regard persons as constituted by family and community influences that are typically hierarchical (cf. Pach et al. 1998), and from medical principles that assert the patient is nonetheless a unique dosic individual whose physical condition must be adjusted through a doctor's authority.

Women Ayurvedic doctors clearly practice female-centered therapy by the sheer numbers of women patients they see. Male doctors, aware of this preference, are hesitant to treat female patients if female doctors are conveniently available. At the hospital that Dr. Shrestha supervises, for example, women's and men's wards and massage-therapy facilities are separate. As she and I talked one morning in March 2005, a male colleague interrupted our conversation seeking advice on the "difficult" application of heat to a woman's hip. Understanding the male physician's hesitation to touch the woman's abdominal and pelvic areas, I offered to end our conversation so that Dr. Shrestha could attend to the patient. In another context four months later at the end of July, Dr. Acharya succinctly summarized how gender norms help shape medical experiences: "Female patients expect to have female doctors. They feel they can be more open to talk about their problems with female doctors than with male doctors."

On the outskirts of Bhaktapur a new health facility for women employs a staff that daily provides examples of Ayurvedic medical approaches that appeal to women patients. Devima Om Hospital is a new three-story building on a footpath branching from a dirt road that eventually leads to Bhaktapur. It was inaugurated five years ago by a group of women that invested supplies and money to launch a rural hospital specializing in women's reproductive health care. The staff successfully delivered eight babies during the hospital's first two years. A large photograph of the eight mothers and their infants hangs in the overnight patients' room; the woman doctor, a new graduate of Naradevi Ayurvedic Hospital and College and

Dr. Shrestha's protégé, stands tall and proud behind the seated mothers holding their plump babies, each shining with mustard oil and gajal-lined eyes.

On a normal day, the modest hospital receives between five and six patients. In its first year it received nearly 1,000 patients. The staff is paid and the buildings are rented, but Dr. Shrestha does not receive a salary. She uses money earned while lecturing in the United States a few months each year to finance the private hospital, which has an annual budget of $8,000–$10,000. The all-female staff consists of one full-time Ayurvedic doctor, two Ayurveda community health workers (CHWs), two midwives with training in Ayurveda, and a cook and cleaner. At least two staff members stay at the facility overnight, while the others room in a house next door; the doctor stays over some nights. The midwives trained for 18 months, and the CHWs trained for six months. Dr. Shrestha is on call for emergencies, advising treatment over the phone or summoning an ambulance if the situation requires. There is an Ayurvedic pharmacy on site.

During the two hours of my first clinic observations with Dr. Shrestha, she examined six patients using an ear scope and stethoscope, and she felt patients' pulses to assess dosic and 'nerve' functions. A pregnant patient was further examined in a private room. Dr. Shrestha gave her home phone number to a male patient with an ear infection so he could contact her about his condition a day later. She spoke to each patient with authority and reassurance, explaining the source of dosic imbalance, listing foods to avoid, and insisting they follow her instructions to recover quickly. At the reception counter patients were given their medicine and bill. The minimal sliding fees were adjusted in the case of one woman who expressed an inability to pay; Dr. Shrestha told her not to worry, that payment could wait until her next visit.

The patients at Devima Ayurvedic Hospital told me they were very pleased when the hospital opened in their community to provide prenatal, delivery, and postnatal care within a medical tradition that their experiences told them was efficacious and less "harsh" than allopathic medicine. "We believe in Ayurvedic medicine," one middle-aged woman commented. Twenty-four hour medical assistance was particularly reassuring to them. Flexible fees, short waiting periods, culturally relevant advice on health and illness, and a respectful staff also contributed to a satisfying clinical experience. The women providers treat most of women's nonbirthing health problems, too, such as infection, indigestion, headaches, and painful menstruation, and in fact they regard birth as a rather ordinary event compared to other health problems. As I show below, they embrace certain essentialist ideas, such as the belief that a woman's quintessential role is child bearing, a natural and biological function that empowers women and is not overly medicalized.

Empathy and Authority

The quality and character of patient consultations reflect the doctor's authority and the patient's acceptance of it. In South Asian clinical settings one often hears an "eldering" tone in provider–patient dialogue, a culturally acceptable assertion of professional authority. Dr. Shrestha consulted with her patients as an active listener and a wise advisor, gaining the trust of her patients by examining them gently and by inquiring about family and farm. Indeed, patients agree with Dr. Acharya's

explanation that women doctors are "softer in nature and talk to the patient like a sister or a mother" (interview, April 6, 2005). But when giving medical instructions that include admonishing unhealthy behavior, Dr. Shrestha and others adopt a stern tone like a parent correcting a child, or an educated authority firmly advising an elderly patient. I observed this approach in Ayurvedic clinics many times, finding somewhat contradictory both the doctors' abrupt code switching—from active listener to strict lecturer—and the patients' willingness to accept the doctor's unyielding warnings. I realized, though, that in a complexly stratified society like Nepal such eldering is acceptable to patients. They rarely directly challenge the doctor's advice, although they always seek clarification and may sometimes complain about food restrictions. Importantly, cultural scripts like these allow professional women to exert authority regardless of their gender, and to have that authority respected. In turn, patients recognize their own power in health care. For example, they keep their own medical records, they are free to select among a variety of professional healers, and they can even damage a doctor's reputation through negative gossip.

Enculturating Medicoscience Practice

Understanding the gender issues in modernizing non-Western medicoscience can prevent the introduction of ideologies and practices associated with biomedicine that are detrimental to women and that have seen an expansion of dependence on expensive technology and therapies that drain national budgets. The biomedical framing of women's bodies in a manner that alters cultural ideas about pregnancy and birth, for example, and that introduces forms of diagnostic objectification and unfamiliar medical language can impede patient education and input in health care decisions. Certainly, indigenous models of illness and healing are not easily forced into biomedical paradigms and vice versa (Pigg 2001). Yet as indigenous systems modernize and increasingly confront and coexist with Western medicine, the impact on women and women's health care must be understood to best guide the process in positive directions for women.

All of the women providers interviewed believe that as women they are in a unique position to care for women patients because they can recognize the social factors of health and are able to educate their patients on health maintenance and illness prevention relevant to their social and economic situations. In so doing, they are staunch advocates of the Ayurvedic scientist's identity, which often means critiquing biomedicine as misused in a poor country. Still, the doctors differ in their perceptions of other aspects of gender, such as the impurity associated with female bodies and the authority of men over women. Some continue to work within a medical establishment that hinders their professional advancement, while others work independent of direct male authority. Such realities engage with broader feminist concerns that the "female subject" be understood as contextualized historically and culturally, rather than as possessing a fixed subjectivity (Skeggs 1994). Educated, high-caste professional Nepali women living in a patriarchal society are only partially empowered by their elite status for they continue to confront cultural barriers to professional advancement,[2] while at the same time the powerful institutions of biomedicine continue to challenge the legitimacy of their practice. Below are

examples of women adjusting to sociomedical modernization in culturally appropriate ways.

When she began her medical practice as a young doctor, Dr. Pradhan charged patients very little for her medical expertise. She explains this arrangement as a suitable compromise between her professional expectations as a physician and Nepali cultural constraints that discourage married women of high caste from earning outside income. The decision she initially implemented was in line with Ayurvedic professional ethics that encourage doctors to be motivated by compassion for the suffering of others, rather than by the riches one might receive.

> I don't *ask* for a fee. I hesitate to take money even when patients want to give me some. But my children tell me that I should take a fee from those who can afford to pay, saying that the money can be useful to buy daily goods like vegetables, etc. So these days I take money from those who can and are willing to pay. But for old people with little money, I don't accept anything. I give them medicines free of charge. [Interview, July 7, 2000]

I remarked how different her practice was from that of biomedical doctors, who must charge fees beyond the means of average Nepalis. She agreed, suggesting that the valuable social relationships that are the context of healing might be corrupted by the expectation of payment.

> That's correct. People say that you don't have to pay for Ayurvedic medicine. Besides, most of the people were born here and we all know each other in the neighborhood well. Some call me their sister, others call me their daughter. They don't expect me to take money from them, due to these relationships.

When I returned to Nepal in 2005, Dr. Pradhan's medical practice had changed. Dissatisfied that the Department of Ayurveda had denied her merit-based raises in the past several years, Dr. Pradhan moved one part of her practice from a room in her home to a family-operated Ayurvedic pharmacy where she has a clinic and sees patients in the late afternoons. At the entrance to her office is a sign that reads "Consultation Fee Rs. 60," or just under $1. She still does not require the poor to pay, but the fee helps compensate for what she feels the Nepali government owes her after 30 years of service.

Expanding Science, Limiting Biomedicine

> There must be a scientific understanding. Without that we cannot understand fully Ayurveda. With science, Ayurveda can understand allopathic medicine, and allopathic medicine can understand Ayurvedic medicine.
>
> —Interview with Dr. Devkhola Bhandari, March 29, 2005

In considering the rise of biomedicine in their country, women doctors distinguish between science and biomedicine in defining Ayurveda as an example of the former but fundamentally different from the latter. For them science should be

thought of in a broad way as an approach to accumulating knowledge that is both systematic and replicable. Guided by the theory of *panchamahabuta,* Ayurvedic practitioners have over the centuries sought to transmit and expand knowledge of human illness and health, notwithstanding the sometimes secretive sequestering of accumulated knowledge in family lineages. Biomedicine, however, is problematic for many Ayurvedic doctors. They are particularly concerned about biomedicine overwhelming Nepal's plural medical system, not because it is more efficacious but because it is more powerful. The doctors reject narrow scientific vocabularies of medical management that are borrowed from global biomedicine and applied to Ayurveda, for example in the form of licensing regulations and other strategies used by the Ministry of Health to manage Ayurveda. In critiquing biomedicine, the doctors point out certain ironies. Dr. Shrestha observes that nearly half the allopathic doctors she knows prescribe Ayurvedic drugs while at the same time criticizing Ayurvedic doctors for prescribing allopathic drugs. Many biomedical doctors do, indeed, use and prescribe Ayurvedic medicine for their families and their patients, including high-level administrators in the Ministry of Health.

The muted friction between Ayurveda and biomedicine is repeated in educational venues. Dr. Shrestha described a time when a group of Ayurvedic practitioners wanted to learn more about biomedicine so they could properly refer their patients, but the biomedical community strongly resisted. Dr. Acharya, a member of the Naradevi teaching staff, explained to me that when the Ayurvedic graduate curriculum became increasingly integrated with biomedical information, students protested; the college administrators, concerned that graduates were opting for biomedical positions over Ayurvedic ones, removed biomedical curricular content.

Still, the doctors differ in the degree to which they integrate Ayurvedic and biomedical practice. Dr. Bista, with several relatives who are allopathic doctors, regularly recommends allopathic medicine. Dr. Pradhan never prescribes biomedical drugs and instead refers her patients to allopathic colleagues if necessary. Dr. Bhandari, director of the Dang Regional Hospital, combines the two medical systems in ways she finds most beneficial to her patients. Dr. Shrestha expresses yet a different view on the working synergy between Ayurvedic and allopathic medicine. She will not prescribe biomedical drugs but does employ biomedically trained technicians at Dhanwantari Hospital because, as she says, "they better understand how to sterilize instruments" (interview, March 14, 2005). Like many of her colleagues, she will refer patients to biomedical providers if necessary.

Constructing Scientist Identity

Feminist scholars note that the process of symbolically 'naturalizing' what are otherwise cultural and social phenomena effectively depoliticizes gender issues by carrying the belief that such social arrangements are immutable biological facts. For example, Nancy Theriot's (1993) work on the history of locating mental illness in women's reproductive organs illustrates how this notion became embedded in the development of specializations in Western medicine. When naturalizing constructs draw from the discourse of science and medicine, they become powerful tools to obfuscate social inequalities, blocking understanding of the social determinants of health. Women Ayurvedic doctors, too, assert natural reasons behind the ancient

medical texts and society's Hindu-based beliefs about women's menstrual and other bodily impurity—and they do so with medical certitude and scientific authority. However, in this case, the natural rationalization potentially empowers women by subversively implicating social inequality. They claim, for example, that menstrual "seclusion" is beneficial to women in that it temporarily averts overtaxing the body's humoral balance brought on by heavy work. The result of naturalizing the social stigma of impurity pits medical science against religion. Still, it is not unusual to find some doctors professionally extolling natural explanations while personally following Hindu precepts that at least partly assert that women have a status lower than men. A good example of this occurred one late morning in July 2000 when I was interviewing Dr. Bista after her busy morning of seeing several pediatric patients and meeting with three Ayurvedic drug representatives.

That day, Dr. Bista was addressing my broader questions about how Ayurveda perceived women and whether it ascribed to women a different status from men. To explain the impurity of women from an Ayurvedic perspective in the contemporary period, Dr. Bista drew from a naturalizing language of rational medicine, describing the hard life of rural farming women and its toll on the physical body.

> In Ayurveda there are specific ideas about menstruation. As you might have noticed, during menstruation women do not take part in any kind of work. For example, I will not touch my husband and I do not enter or go near places of worship and religious ceremonies. The classical texts in Ayurveda say that women should rest for at least three to five days when menstruating because they are weak during those times. It is also mentioned that we should not have sexual intercourse with our husbands and so we avoid them during that time. Both Sushruta and Caraka say this. It was likely carried out in earlier times since it was mentioned in such texts, but as we come to think about it now, we realize that women do need some rest during those times, and that the need to rest is more important than refraining from work because we are impure. Because we live in an urban place like Kathmandu, we work less and maybe our body might not need so much rest. But in the villages women have to wake up at four in the morning and do so much work—collect firewood and fodder, farm, etc. The pressure of the household chores is all on the women. So I think these restrictions are put on women to give them rest as their health requires it. [Interview, July 3, 2000]

Indeed, rural women welcome the rest that accompanies menstrual seclusion, as the farming and artisan women of Bajhang have told me over the years (Cameron 1998). Dr. Bista emphasizes the health benefits of menstrual seclusion over the ideology of female impurity, while following behavior restrictions herself and remaining silent on social change that would cease rendering women impure. The empathic objectification of the female body—that it needs rest from constant physical labor—minimizes the impurity stigma and makes following social norms tolerable for Dr. Bista and the other women doctors.

Dr. Pradhan, too, presents herself as an objective professional healer in her response to my question about difficulties she experienced while studying. Treating the human body objectively allowed her as an intern to administer care to all patients

regardless of gender while being particularly effective in caring for women who were fearful of male physicians causing them shame and dishonor.

> No, I didn't [have any difficulties]. In the practical lessons, in surgical and maternity works, we had to face everything. There were male doctors at Bir Hospital. The women patients from villages really had difficulty as they didn't know that the male doctors would lay them on the table and they would see everything. They used to cry, "Oh god, do not let a man touch me!" They would scream and shout, saying they would prefer to die. They covered themselves and refused to let the doctor see them. Being a physician I did not feel shy or ashamed, nor do I feel it now. [Interview, July 7, 2000]

Women in the profession of Ayurvedic medicine are trained to treat the ill regardless of gender, caste, or class, and the human body is best approached from the objective perspective of a practicing scientist. Yet as women they understand the cultural factors that negatively impact women's health and well-being, and lay women in turn feel comfortable seeking treatment from them. This interesting paradox, that objectivity empowers them professionally while their sensitivity and non-Western clinical approaches make them preferred by women patients, is less a contradiction than an example of how health care and the practice of medicine are not value free in the lives of women.

Conclusions

The modernization of indigenous medicine can exhibit distinct gendered patterns that help us better understand the relationship among social change, gender, and health care and hence better predict and prevent negative outcomes for women. For example, one set of competing ideas that can be evaluated is whether biomedical practice and ideology introduce new or different gendered ideas into indigenous medicine that may be detrimental to women, or if certain characteristics of science and medicine ultimately transcend cultural distinctions—as modern science would have us believe. Alternatively, we can ask if gender issues in indigenous medicine, such as ideas about nature or diagnostic approaches, differ so significantly from Western science and biomedicine that what have been identified by feminist scholars as important gender problems for Western science and medicine simply do not hold true for indigenous medicine.

The discussion here of Nepali women Ayurvedic doctors finds differing answers to these questions and uncovers certain paradoxes in health care modernization of concern to women doctors and their patients. Indigenous practices beneficial to women are potentially changing under the influence of modern medical regulatory standards; gender-sensitive and equitable service are impeded by state regulation of professional practice, and the government's position that Ayurveda is not a modern medical science impacts women professionals' agency. Countering this are the requests for more Ayurvedic facilities by politicians that recognize its benefits and its rising global popularity, the expanding focus on biodiversity conservation and medicinal plants, and the new communist party's support for increased biotechnology research on medicinal plants (Guo 2008). Thus, the present indirect link between

Ayurveda's feminization and its marginalization in relation to modern biomedicine may evolve to become more direct and consequential for women's health in the country.

In countries heavily dependent on foreign donors to develop health care, the state becomes one of the most powerful instruments of modernity. Ayurvedic medicine highlights an important problem in how the Nepali state advances modernity in health care development. As an organized body of knowledge about illness and health that is culturally embedded and that utilizes medicinal plants as its materia medica, it is a science accessible to the people. Although firmly rooted locally, Ayurveda is also caught up in contradictory forces: narrow claims of what constitutes modern science (by which Ayurveda is found wanting), the popularity of indigenous medicine as an alternative to allopathic medicine (by which Ayurveda is a well-lobbied alternative), and its increasing feminization. State-supported health care policy can potentially marginalize indigenous traditions like Ayurvedic medicine by altering local health knowledge and diminishing people's cultural identity. The dialectical evolution of indigenous and Western medical systems in Nepal provides an important site for asking how women doctors negotiate the transformation of cultural paradigms of the body, illness, and healing as these impact gender organization and change in indigenous learned medicine.

Women doctors must increasingly negotiate with new medical paradigms and power so as to best provide services to their patients. In Nepal, gender issues in professional indigenous medicine exist in a region that is home to one of the world's oldest medical traditions, and where some of the world's highest rates of infant, child, and maternal mortality and child morbidity lead to significantly shortened lives. Strengthening Ayurvedic medicine would encourage talented women wanting to practice this living, ancient medical science, particularly at a time when the value of dialogue across plural medical systems is increasingly recognized. As we contribute to women's health improvement globally, the work of women providers of indigenous medicine that advocate for its efficacy, local availability, low cost, and cultural value is critical. The findings presented here suggest that women's health is positively affected when more women are practicing indigenous medicines like Ayurveda.

Notes

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1. Many people believe the reforms weakened Ayurveda by integrating it with biomedicine. Currently, the new educational system requires four and one-half years post-I.A. Degree to obtain the Bachelors in Ayurveda and Modern Surgery degree; five and one-half years earns one a graduate degree. Ayurvedic education in Nepal reached a low point one year after Dr. Pradhan graduated, in 1972, when the new educational system was enacted. Higher degrees in Ayurveda were not offered in Nepal until about a decade ago.

2. Patriarchy is evident in many forms in Nepal, such as son preference, patrilineal inheritance, low literacy levels for girls and women, low social status of daughters-in-law, wives, and widows, tolerance of domestic violence, and girl trafficking.

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