

# Introduction

## Orienting to Place and Practices

People all over the world fall ill and, in response, seek healing. Our experiences of illness in the context of healing practices, or our quest to find them, are a part of what it means to be human. This book is about what happens to people when sickness takes over their lives, inviting a complex set of understandings, reactions and experiences. It looks at these processes of suffering and healing in the context of Bhutan, a small landlocked country nestled in the Himalayan steppes, and the healthcare practices that are available throughout this country.

Bhutan is known as Druk Yül ('brug yul), Land of the Thunder Dragon. It is positioned between China and India, with Nepal to its west, from which it is separated by the Indian state of Sikkim. Its population of approximately 750,000 (World Bank 2015) live in the 38,394 square kilometres of valleys and steep slopes of the Himalayan Mountains, which descend from northern high altitudes to the southern low-lying planes of India (Ministry of Agriculture and Forests, MoAF 2013: 16). Over 70 percent of this land is covered in nationally protected forests (MoAF 2013: 16), a testament to Bhutan's progressive policies of wildlife and environmental conservation (see Kuyakanon Knapp 2015; RGoB 1995; Siebert and Belsky 2007; Buch-Hansen 1997). On the edges of these deep forests and steep mountain slopes, subsistence agriculturalists grow rice, chillies, potatoes and other vegetables, as well as keep a small amount of livestock. The agricultural labour force amounts to over 60 percent of the working population (Ministry of Labour and Human Resources, MLHR 2012: 20). The other 40 percent of the workforce are engaged in sectors like private business (19 percent, MLHR 2012: 20) and government (14 percent, MLHR 2012: 20), and live in the growing urban clusters, with Thimphu (thim phu), the capital, drawing the largest population (approximately eighty thousand, National Statistics Bureau, NSB 2005: 9).

Although significant gains were made in the past decade, Bhutan's economy remains one of the smallest in the world, with a 2012 GDP of USD\$1.780 billion (World Bank 2015). Hydropower, collected and sold to India from a growing network of major dam projects, underpins the Bhutanese economy and offers a steady revenue stream for government administration.<sup>1</sup> While hydropower

investment is intended to offer Bhutan greater economic self-sufficiency in the next ten to twenty years, the country's development projects have thus far received most of their financial support from international governments and institutions. These international revenue streams are channelled primarily into government-centralized projects, helping the state to build health, transport and hydropower infrastructure as well as to support other national development projects that have caused massive changes to the lives of Bhutanese citizens (Ura 2009c).

National development and poverty reduction have made remarkable progress in the last decade. Literacy rates climbing to 63 percent mark the growth in education and schools (NSB 2013c). Poverty rates below 12 percent that were over 23 percent in 2007 (NSB 2013a: 12) demonstrate household level changes, especially in rural areas that saw the most dramatic drop (30.9 percent in 2007 to 16.7 percent in 2012: 12).<sup>2</sup> Infant mortality rates have dropped from 102.9 in 1984 (Ministry of Health, MoH 2000a: 12) to 40.1 in 2010 (MoH 2010a: iii), highlighting progress in healthcare provision. Such gains have been framed by the government's dedication to its strategy of Gross National Happiness (GNH) – the pursuit of sustainable development, preservation of cultural values, conservation of the environment and good governance (Gross National Happiness Commission 2013: 5; Ura 2009a and 2009b). Commitment to GNH has led many Bhutanese officials to claim that while Bhutan has expedited its development over the last decade, it hasn't lost sight of its spiritual, environmental and social values, derived from Mahayana Buddhism, the predominant and guiding religion (see e.g. Al Jazeera 2010). Alongside such gains, Bhutan has developed into a democratic country, relatively stable and peaceful when compared with neighbours such as Pakistan or Myanmar. However, Bhutan is not without its political, social and economic problems, both past and present. There continue to be challenges facing the leaders and peoples of Bhutan; GNH simply offers a guiding policy for the decision-making process (see e.g. Wangyal 2001 and Brooks 2013).

One of the leading priorities of GNH and the development goals of Bhutan's governments and monarchs was the founding and proliferation of a national healthcare service that could offer free healthcare to patients nationwide. This effort began in the early 1900s thanks to the first king Ugyen Wangchuck (1907 to 1926), who hosted international doctors. Health services were then institutionalized as the Ministry of Health (MoH 2013b) in the 1960s and are still heavily under development today (C. Dorji 2009). The advent of health services has changed in dramatic ways the experiences of illness and suffering for all of Bhutan's population. There are still generations of elderly Bhutanese who remember the days when such services were not available and when sickness imposed a greater risk to life than it does today. One elderly patient answered my question about what happened when he fell ill as a young man: 'If you got sick, you got better. If not, you died.' Combined with other historical accounts of patient conditions (Melgaard and Dorji 2012: 72–74) and early reports of

morbidity and life expectancy (MoH 1986: 17–20), we can assert that the success rates for curative practices in the early 1900s and before were not good, resulting in this man's matter-of-fact attitude towards illness, healing and death. Times have changed, but only recently. The last decade has seen a dramatic improvement in access to and quality of healthcare practices in both urban and rural locations. Patients now have diagnostic and treatment options. They are 'citizens' with the 'right' to 'services', all terms that are themselves the products of state-institution agendas. Learning to use these services is changing patients' relationships with health, illness and their own bodies.

The backdrop to these changes in healthcare and patient experiences was the emergence of a Bhutanese nation-state, including but not limited to more than a century of monarchical rule (1907 to 2008) and the more recent transition to a democratically elected government starting in 2008. Sonam Kinga's (2009) *Polity, Kingship and Democracy: A Biography of the Bhutanese State* offers one of the best narratives for the state's development. It describes in detail the consolidation and then de-centralization of state power by the succession of Bhutan's five kings. They were responsible for many of the state-building endeavours, such as taxation reform (2009: 255–57), the founding of a National Assembly and legislation (2009: 226–42; see also Whitecross 2004), the creation of a standing army (2009: 242–45), the formation of government ministries and institutions (2009: 283–87), the systematization of five-year development plans and the introduction of GNH as a replacement for GDP to guide development. Kinga argues that the 2008 abdication of King Jigme Khesar Namgyel Wangchuck and subsequent transition to a parliamentary democracy was a slow and intentional process of de-centralization of power away from a single monarch, 'empowering local communities in self-governance' (2009: 273) as well as the newly formed democratic government (2009: 320–23). Through the past century, Bhutan has entered a new era in which people have emerged as citizens of the Bhutan state. These citizens have been presented with a growing number of state services, authorized, operated and provided by state institutions. The Ministry of Health and the provision of free healthcare services were two of the most visible signs of state development, offering new horizons to clinical care and survival possibilities. As a result, sick persons now have a two-option healthcare system to choose from.

The first major healthcare route available for patients is the biomedical<sup>3</sup> services offered nationwide by the Ministry of Health and its clinical hospitals, Basic Health Units (BHU) and outreach clinics. Also called 'modern', 'Western' or 'allopathic' medicine, these services are the only biomedical diagnosis and treatment options for ill persons, with private practices currently disallowed by the Royal Government of Bhutan. Therefore, the network of care offered in biomedical treatment centres is the single largest centralized and funded healing source in Bhutan, with the ministry reporting a total of 1,990,958 cases accessing its nationwide services in 2012 (MoHa 2013: 66). The largest biomedical hospital, the Jigme Dorji Wangchuk National Referral Hospital, is



**Illustration 0.2** Awaiting the King and Queen, *Thimphu*. On October 13, 2011, King Jigme Khesar Namgyel Wangchuck was married to Jetsun Pema, a twenty-one-year-old student. After the wedding ceremony in Punakha, the married couple returned to Thimphu and walked its streets, lined by throngs of celebrating onlookers. Celebrations continued for many weeks across Bhutan.

based in Thimphu, while the eastern regions of Bhutan are served by the second largest, Mongar Eastern Regional Referral Hospital.

The second option for sick persons is the traditional-medicine services offered within the Ministry of Health's institutionalized healthcare structure. As a part of an integrative two-option healthcare strategy started by the third king when he founded the Ministry of Health in the 1960s, these traditional services were developed alongside and complementary to the biomedical services, albeit with a much smaller budget and slower rate of growth. They are offered under the same roof as biomedical services in hospitals and BHUs, an infrastructural development that underpins the Ministry of Health's policies of medical integration. As a result, at hospital reception desks across Bhutan, visiting sick persons are offered the choice to see a traditional or biomedical doctor. In Thimphu, traditional medicine is offered in the stand-alone National Traditional Medicine Hospital (NTMH), which is also the service's training, administrative and clinical headquarters. Patient use of the traditional services has grown over the past decade, with 131,692 cases counted in 2011 reported by the National Traditional Medicine Hospital's nationwide clinics (MoH 2013a: 99).

The medicine offered in this traditional service is an iteration of *sowa rigpa* (*gso ba rig pa*), often translated as the 'art and science of Buddhist healing'.<sup>4</sup> This

popular Buddhist practice has spread across the world, with many variants of private and nationalized clinics and practitioners using its methodology and cosmology, most notably in Tibet where it has received the common name, ‘Tibetan medicine’.<sup>5</sup> Its most popular name in Bhutan was ‘traditional medicine’, known in Dzongkha as *nang pé men* (*nang pa’i sman*), where *nang pé* literally translates as ‘Buddhist’ and *men* as ‘medicine’.

Along with the state-run biomedical and traditional institutionalized forms of care, people are seeking out a wide range of other healing sources, which I call ‘alternative practices’. The practices in this third category are known in Bhutan as ‘local’ or ‘traditional’ (said in English, sometimes in the middle of Dzongkha sentences), or by specific practice names in Dzongkha, Sharshop or other Bhutanese languages.<sup>6</sup> Alternative practices may include shamanistic rituals, bone-setting, religious ceremonies, oracle use, spirit possession, dietary behaviours and familial care (among many others), all of which take specific forms given the socio-cultural contexts of the communities in which they are practiced. I call practitioners of these curative methods ‘alternative healers’.

My use of the term ‘alternative’ here does not derive from its common use in the West to describe an amorphous range of ‘new-age’ practices. ‘New-age’ practices have a small presence in Bhutan, but they are not popular and were seldom referenced by patients, healers or healthcare staff. ‘Alternative’ rather points to an ethnographic distinction of ‘local’ practices from the state institutions of healthcare that take a dominant and powerful position in the politics, ethics, and patient narratives of modern-day healthcare in Bhutan. This division of institutional from non-institutional was recognized by my informants in the language they used to discuss alternative practices. The terms ‘local’ and ‘traditional’ were very much set against the institutional practices. Therefore my use of the term ‘alternative’ was intentionally selected to tease out this ethnographic occurrence of ‘otherness’ embedded in practice identities. However, most of the alternative practices engaged by Bhutanese healthcare-seekers do show similarity to those from other Himalayan societies as described in an extensive literature, by Samuel (1993) or Diemberger (2005) for example, the spirit mediums called *pawo* (*dpa’ bo*) and *pamo* (*dpa’ mo*),<sup>7</sup> male and female, respectively. While regional cross-referencing is both possible and necessary for an analysis of these alternative practices, some of them also appear to be unique to Bhutan, for example the *ja né* (*rgya nad*) healers discussed in chapter 4. In the discussion of alternative practices, I will draw upon sources that describe this regional similitude while also offering clear definition to those practices, or parts of practices, that appear to be unique to the ethnographic context of my fieldsites.

Finally, it’s important to note that a main distinguishing factor between alternative practices and those of biomedical and traditional services is that they are non-institutionalized and, in most cases, non-centralized, professionalized or standardized. Alternative healers treat patients in their homes and community spaces, often for a small remittance. They operate within communi-

ties, referred by word of mouth or from religious practitioners who forward ailing persons who have sought a religious solution to their illnesses. As will be fleshed out in the following chapters, the government and its institutions of healthcare are often in contention with these healers, deeming them to be either dangerous in their own right or distractions to patients from the timely and effective use of institutionalized biomedical or traditional treatment. Although the unmonitored and unauthorized use of these practitioners frustrates public health officials, they are very much a part of the healthcare-seeking narrative of the Bhutanese, who will often use them in conjunction with the institutionalized practices without notifying the biomedical or traditional doctors.

### **A Brief History of Healing Practices in Bhutan**

To understand where these practices fit within contemporary ideas of health in Bhutan, it is necessary to look first at some of the epochal moments in Bhutan's history that still affect patients today. Before doing so, it's relevant to note that Bhutan's written histories are arrangements of past events that form particular historiographies, narrative versions that often have agency within present political, academic or institutional contexts. In writing such a brief introduction to Bhutan's history I have selected historiographic narratives that link directly to the birth of the Bhutanese state and contemporary healthcare practices. There are omitted events, persons and texts that could provide additional historical perspectives. For example, Bhutan was and still is inextricably tied to Tibet, China, India and other Himalayan regions; the histories of these countries and regions are incredibly vast, with libraries of texts offering overlapping details and perspectives that could add to a narrative of Bhutan's history. I have selected specific events that are important to understanding Bhutan's contemporary medical context, but there are always more sources, known and unknown, from which to draw different versions of history. I will attempt to show where I draw my historical sources from so that the particular agenda of my historiography – to explain how modern-day biomedical, traditional and alternative healthcare practices came to prominence – is clearly signposted in the vast historiographic landscape in which it resides.

Reliable sources for historical perspectives specifically relating to healthcare are scarce, yet a few good works help knit together an evolving narrative. Melgaard and Dorji (2012) have co-researched one of the most rounded accounts of the *Medical History of Bhutan*. Their work charts the first-century introduction of Buddhism to the Himalayan region, including the introduction of *sowa rigpa*. After these early periods, they trace the growth of 'modern' medicine (what I call biomedicine), including a detailed account of the growth of the Ministry of Health's institutionalized services. Such a historical narrative on the foundation of biomedicine in Bhutan helps to form a discursive continuum between eras

of healthcare practice that were very different from one another. Alex McKay (2004 and 2007; McKay and Wangchuk 2005) offers another well-evidenced argument for the early beginnings of these biomedical practices through the presentation of medical and field reports from various British-Indian Medical Service officers that accompanied missions to Bhutan. He argues for the importance of the adopted English education model in offering a springboard for the sustained growth of biomedical knowledge amongst wider populations. These authors present the most comprehensive medical histories available of Bhutan, but other smaller texts offer additional insight. For example, Trashi (2010a and b) writes about ‘The Chagpori Healers’, the name given to the few healers who served the royal elite in the nineteenth and early twentieth century, trained in the Chagpori Medical College in Lhasa.<sup>8</sup> Such works published in Bhutanese newspapers and by health institutions are often the only sources of Bhutan’s history of medicine and healing that are widely read by the country’s patients and practitioners.

While these works attempt a medical history, many other authors, both from Bhutan and further afield, have discussed other subjects of Bhutanese history, such as the nation-state (Kinga 2009; Aris 1979, 1994b, 1986; Ardussi 2004, 2000, 1999; Dogra 1990; Ramphel 1999a–c; White 1984; White and Meyer 2005; Collister 1987; Rennie 1866; and Pain 2004), culture and development (Ura 1994; Ura and Kinga 2004; Pommaret and Ardussi 2007; Ardussi 2008; Hutt 1994; Aris 1994a; Aris et al. 1994), state institutions (Gallenkamp 2011), literature (Ardussi and Tobgay 2008), religion (Aris 1987) and linguistics (C. T. Dorji 1997; Driem et al. 1998; Bodt 2012). The sources of these histories remain scarce, and they have drawn heavily from records from British-Indian expeditions. However, new sources are emerging. C. T. Dorji in his compilation *Sources of Bhutanese History* provides a detailed bibliography of texts in alternative languages. Although he acknowledges the ‘lack of definite historical material’ (2004: 15), he lists alternative sources of historical knowledge including: Buddhist texts, religious and devotional literature, biographical epics and legends, archaeological evidence, state papers and official records (16). He calls for scholars to draw upon these types of knowledge sets and diversify sources of data. However, the limitation of texts in Dzongkha, Chökey and other regional languages, as well as problems of access to translation resources means that these alternative histories often escape studies based on the English archives in India (e.g. Collister 1987 and Kohli 1982). The most recent historiographical edition is Karma Phuntsho’s (2013) seminal work *The History of Bhutan*, which offers a sweeping yet comprehensive view of the changing economics, geographies, politics, state and cultures of Bhutan, making use of some of these alternative sources.

Unfortunately, Phuntsho’s work, like many of the others, explains little about the healing practices of the pre-1900s, offering only a cursory introduction to ‘traditional medicine’ (2013: 6–7). The reason for this omission is that there are hardly any written records concerning healthcare practices in Bhutan before

the 1900s.<sup>9</sup> Only a few literary traces exist – for example, Phuntsho’s description of the stealing of ancient Bhutanese king Sindharāja’s *la* (*bla*), often translated as ‘life force’, and his subsequent illness. In the context of this king’s mal-relationships with local spirits and the saving powers of Padmasambhava, the eighth-century transmitter of Vajrayāna Buddhism to Tibetan-Bhutan regions, Phuntsho notes how *la* is a ‘pre-Buddhist concept of quasi-psychological property of life or constituent of a person in addition to the well-known psychosomatic components’ (2013: 94). From such ‘pre-Buddhist’ cosmological insights and their roles in the causation of illness, as well as the histories carved from the earlier cited works, we can make a few educated guesses about what health-care and health were like in pre-1900s Bhutan.

Melgaard and Dorji (2009) identify three broad historical phases of health-care in Bhutan, each marked by a significant event that was likely to have shaped patient-practice activities and relations. While broad, these are helpful in understanding what types of healing are practiced today and what notions of health are prevalent among patients. Again, there are many other versions of history involving the spread of Buddhism and other political entities in the Himalayan region that could be included here. It’s important to note that Melgaard and Dorji’s historical narrative is linked to the dominant Tibetan traditional periodization of history, emphasizing the spread of Buddhism (Tb: *nga dar*) during the imperial period and the later extension of Buddhism (Tb: *phyi dar*) after the ninth- and tenth-century civil war.

The first historic phase begins in 746 AD when Guru Padmasambhava and Tibetan king Trisong Deutsen (718 to 785 AD) introduced the religious practices of Buddhism to the regions and peoples of Tibet and the then-unnamed and non-unified Bhutan region.<sup>10</sup> As a part of this religious expansion in Tibet continued by a patronage of descendants, *sowa rigpa*, the central medical practice of Tibetan Buddhism, increased in popularity.<sup>11</sup> The Tibetan king’s personal physician, Yuthog Yonten Gonpo, is often credited with writing the original text of *sowa rigpa*, the *gyü zhi* (Dz and Tb: *rgyud bzhi*, Bolsokhoeva 1993; translations include Rechung Rinpoche 1973 and Clifford 1984 among others), translating and implementing various medical treatises, and establishing Tibet’s first traditional-medicine college, Tanadug, in Kongpo Menlung in southern Tibet (Micozzi 2013: 131; Tsarong 1981: 95). The placement of the first *sowa rigpa* institute in the southern Himalaya was no accident; the region offered a vast pharmacopeia of medicinal plants. The lands further south of Tibet were not yet called Bhutan. One of the names of this region was Lho Menjong (lho sman ljongs), ‘The Southern Land of Medicinal Herbs’, still used today. This region offered a wider variety of plants than some Tibetan areas given the range between its high and low altitudes (Phuntsho 2013: 6).

While the spread of Buddhism into Bhutan has been explored by many researchers (e.g. Phuntsho 2013 and Aris 1979), the introduction of *sowa rigpa* is less clear. Melgaard and Dorji assert that ‘while Bhutan supplied raw materials for the manufacture of medicines, Tibet provided the institutions for Bhu-



tanese to master the art of Tibetan medicine' (2012: 21). Without formal teaching institutions in the Bhutan region, physicians required a sponsor to study abroad. Those rare few that managed to travel to Tibet to study in institutes like Tanadug would most likely have returned to a personal physician position with their sponsor, probably a member of a ruling elite. The returning traditional physicians from Tibetan training were reserved for a small privileged section of Bhutanese society, inaccessible for most persons. Sick persons would have to find other ways of curing illness than relying on this growing system of healing. Therefore the pre-1900s practice of traditional medicine was closely tied to a patronage with Tibetan *sowa rigpa* institutes, a relationship and training that continued until Bhutan institutionalized its own training and clinical services later in the twentieth century, only then offering these traditional-medicine services to the wider populations.

Before the establishment of Buddhism, various other forms of culture and religion dictated daily political, agricultural and social life, as well as the healing activities of Bhutanese communities. The problem we have today is that we have very few reliable historical sources on this time. This absence is even more distinct when it comes to healthcare and healing practices. We simply do not have any data to accurately assess what people were doing to heal themselves before the seventeenth century.

Melgaard and Dorji problematically draw attention to a popular religion known as *bön* (Tb and Dz: *bon*) to explain these 'pre-Buddhist' cultural and religious activities, as well as a 'system of *bön* medicine' (2012: 10). Academics such as Samuel (1993) explain the risk of using *Bön* as such a definitive historiographic catchall: 'The tern *Bön* and its derivative *Bönpo* have been employed by many Tibetan and Western scholars to refer variously to all sorts of allegedly pre-Buddhist and non-Buddhist elements of Tibetan religion, often including the folk-religion cults of local deities. . . . Such usage conflates so many different things under the one label that serious analysis becomes impossible' (1993: 10–11).

Given the argument of Samuel (1993), Melgaard and Dorji's collapsing of pre- or non- Buddhist healing practice into a 'bön system' might not offer an analytically accurate historiography. Ultimately, we are left with so little written or oral evidence of medical practices at this time that we can only speculate about how people combatted illness. Nevertheless, from this complicated relationship with religious and practice identification we can conclude two points regarding healing practices from the eighth to the nineteenth century in Bhutan. First, both Tibetan medicine formally of the large medical institutions in Lhasa and southern Tibet and other forms of healing not specific to a particular institution or regional identity were most likely practiced by individual physicians and healers, with a high level of diversification between the methods and cosmologies driving their healing logic. Second, some of these practices and beliefs were different from the knowledge of *sowa rigpa*, known today in Bhutan as traditional medicine. What were some of these alternative beliefs and how do they influence contemporary patient narratives?

There are some useful principles to draw from Melgaard and Dorji's early history surrounding non-Buddhist practices to answer this question; for example, there was a strong belief that one had to protect oneself from malevolent spirits or omens that share their environments with local populations (2012: 10). In this life-world containing spirits, ghosts and magic, as well as the cosmologies that guide their power relations, protection could be achieved through mitigation techniques, typically defined by some type of exchange – for example, the performing of rituals and the offering of food or gifts. Phuntsho touched on one such example in his history of King Sindharāja and the stealing of his *la* (life force) by malevolent spirits angered by the king's desecration of his tutelary deities (2013: 94).<sup>12</sup> The loss of his *la* caused grave illness to beset the king, remedied only by a spiritual exchange performed by Padmasambhava. This grandiose story emphasizes the engagement with spiritual beings and life forces in the aid of a king's health. Unfortunately there are no stories documenting the causation and cure of a layperson's illness, requiring us to infer the use of such cosmology and practice in daily life.

It is important to note that these cosmologies and knowledges regarding spiritual beings and the healing practices deployed to mitigate their effects on health were not necessarily Buddhist practices, and may not fit into a Buddhist cosmology. Such divisions in religious and spiritual beliefs are present and exerting influence on today's patients who also learn the differences between a Buddhist deity and a village spirit, the latter often described in scholarship as a type of 'animistic' entity (e.g. Walcott 2011: 254). Such specialist knowledge dividing religious and animist cosmologies required the intervention of specific healers and religious practitioners who specified their practices to one or the other, or both. Collapsing animistic and Buddhist cosmologies is both analytically erroneous and dangerous for patients; seeking a Buddhist solution to a non-Buddhist-caused illness wouldn't cure the ailment, but it might aggravate it. Therefore, awareness of these cosmological differences is important as we trace the narratives of patients who move across philosophical discourses, as well as those of the traditional, biomedical and alternative practices.

While the division of these cosmologies must be recognized, the confluence of Buddhist and other religious or animistic beliefs from the eighth to the nineteenth century have also come to play an important role in contemporary conceptions of health. As Buddhism spread, its practices and teachings on health, illness, disease and death contested and ultimately merged with these alternative views. Over time these influences became intertwined so that at times they may be indistinguishable from one another. A fusion of animistic beliefs and Buddhism continues to emerge in the concepts of health and techniques to ameliorate suffering chosen by patients today. Many of these, including the use of different alternative healers, religious practitioners and spirit mediums, and their engagement with patients, spirits, ghosts, deities, ill luck, negative karma and fate will be explored in the coming chapters.

The next important phase in Melgaard and Dorji's historiography of medicine in Bhutan is marked by the founding of Bhutan's nation-state through the consolidation and centralization of political and religious power by Shabdrung (zhabs drung, 'at whose feet one submits') Ngawang Namgyal in 1616. For the first time in Bhutan's history, a single political entity was able to unite the regions of Bhutan under its leadership. This was achieved partly due to the consolidation and delineation of political and religious authority between two figures, the Druk Desi ('brug sde srid) and the Je Khenpo (rje mkhan po), respectively. While this period marks one of the most well-cited chapters of Bhutan's history, the birth of the nation-state (a historiography well-deployed by contemporary state-building projects; see Phuntsho 2013: xiii–xiv), it also marks the beginnings of formalizing and centralizing *sowa rigpa*. This is the period when a few traditional physicians either visited or moved permanently from Tibet to Bhutan to offer medications compounded from plants collected and prepared from the Himalayan plateau. As noted earlier, these physicians would have worked independently rather than as part of an institutional collective, with no formal traditional-medicine institutes forming until the mid-1900s. Thus the post-1960s institutionalized traditional medicine is very different to the offerings of *sowa rigpa*-trained physicians at this time. These doctors were predominantly available to the Shabdrung and his inner circle. Many rural Bhutanese at this time would not have had access to traditional physicians and would have used alternative practices in their local areas, again, something we know very little about due to lack of reliable sources.

The third phase begins with the coronation of Bhutan's first king, Ugyen Wangchuk in 1907. A succession of five monarchs saw the introduction and development of biomedical practices and education throughout the country. This was the first time a healthcare practice would cast itself nationwide, conglomerating doctors and health staff, some of them Bhutanese, under one administrative and clinical practice. Melgaard and Dorji note that 'while the influence of British colonial rule in India until 1947 had a major impact on the future development of biomedical medicine in Bhutan, it did not provide the same amount of financial support as in neighbouring areas such as Sikkim, Tibet and Nepal' (2013: 5). Bhutan was never colonized, but British India engaged with Bhutan through limited dialogues by various political missions both before and after 1907 (see Eden and Pemberton 1865, Rennie 1866, and Government of Great Britain 1908 for examples of these dialogues, albeit rather one-sided narratives given Bhutan records of these exchanges do not exist). Yet their interests were with Bhutan's external rather than internal affairs (Collister 1987). When Ugyen Wangchuk signed away Bhutan's foreign office into the hands of the British, the subsidy was 'a mere 50,000 rupees until 1910' (McKay 2007: 187). Even after several doublings of that amount due to Bhutan's accordance with British India's various demands, 'the cost of supporting the state administration and monasteries left little finance available for development projects' (187). Lack of financing and a general concern from the monarchs and

British political officers that Bhutanese ‘culture’ and ‘traditions’ would be eroded by contact with Western influences, especially medical missionaries who were the most available for prolonged stays in Bhutan, kept biomedical development in Bhutan at a slow pace.

Relative international isolation continued until the third king, Jigme Dorji Wangchuck (1929 to 1972), decided Bhutan’s future rested upon a slow and responsible opening to the world. This began with simple internal changes such as officially ending feudalism and slavery<sup>13</sup> and encouraging technological advances like wheeled vehicles for agriculturalists who, up to this point, carried crops from villages to markets. These smaller developments are pitted against large-scale national infrastructure changes to government, institutions and national services. By the end of his reign, he was responsible for the foundation and growth of many of Bhutan’s government ministries that ushered in a new ‘modern’ era, including the Ministry of Health in the 1960s as well as the Ministry of Foreign Affairs. This was also a period when a rudimentary road network started to grow, a trajectory of accessibility that is still ongoing today (Fischer and Tashi 2009). It was predominantly during Jigme Dorji Wangchuck’s reign when biomedicine and traditional medicine, as formal institutions, really took root in the country, and ‘services’, including hospitals, clinics



**Illustration 0.3** Mongar Tsechu, *Mongar Dzong*. Crowds gather from all over the Mongar *dzongkhag* to come and watch or participate in the Mongar *tsechu*. Dancers leap into the air, pulling their feet all the way to their foreheads. Similar pictures are reproduced by the many tourists who attend these ‘cultural’ events, and they are often found in the large photographic books published on Bhutan.

and healthcare staff, were made available to the wider population of Bhutan. From this institutional growth, aided by foreign investment, expertise and medical schools, arose the government health services available to patients across Bhutan today.

From the mid-1950s to the early 2000s, Bhutan's slow and cautious approach to development kept many international influences at bay – for example, television was only introduced in 1999 (see Ura 1994; Aris and Hutt 1994; Ren 2007; Phuntsho 2004). However, with the 2008 abdication of the absolute monarch for the now ceremonial fifth king, Jigme Khesar Namgyel Wangchuck, a new era of democracy has brought an increasing rate of development and internal changes to the political, economic and social contexts of Bhutan.

This book is written against the backdrop of this rapid contemporary development and change, both in Thimphu and throughout the country.<sup>14</sup> Foreign influences have increased dramatically since the 1960s with the opening of trade, media, tourism, business and government channels with other countries. Increased wealth has also permitted material imports and the possibility of international travel for those lucky enough to afford it or those sent abroad on a government-sponsored trip. New influences are seen as part of a growing 'modernization', and materials, trends, objects, people, desires and bodies are often locally described as 'modern', highlighting their variance to a 'traditional' or 'old' identity. Sitting quietly in a Thimphu cafe observing the wealthy Bhutanese clientele as they sipped cappuccinos and discussed among friends, I overheard one woman ask a man sitting on an adjacent couch, 'Is that the iPad 2 you have?' The man replied, 'No, it's the Samsung Galaxy Tab.' To add to this observation, at a *tsechu* (*tshé bcu*), the colourful and expressionist dance seen as a vestige of 'traditional culture' held in the *Thimphu Dzong* (*rdzong*, ancient fortresses used for religious and state offices), one can often see iPads held high above the crowd, videotaping the performance. These are not tourists holding them but a growing number of wealthy middle-class Bhutanese living in Thimphu, who drive new cars, go out to restaurants, fly around the world or dream of doing so, frequent night clubs and engage in political debate. While the rest of the country admittedly may be far from affording such gadgetry due to the inequalities between urban and rural economies and development, the trend towards modernization is clear, with both urban and rural societies changing ever more rapidly.

In the midst of these changes, the Bhutanese have continued to fall ill and seek different healthcare opportunities. While the human constant of a fluctuating healthiness has remained, the ways in which illness is understood, experienced and treated has undergone massive changes, most of which occurred within the last sixty years. This book looks at some of these contemporary enactments of health, healthiness and healthcare as lived, suffered and experienced by many patients of modern day Bhutan.

## What This Book Is About

From the cursory introduction to Bhutan, its contemporary plural healing scenario and its history, it is immediately apparent that ill persons and their families may call upon a diverse range of knowledge and practice to respond to suffering. Having spent some time following the narratives of ill persons in Bhutan, I discovered early on that most would use more than one type of practice, sometimes one after the other or simultaneously. Such an insight is no surprise to contemporary health practitioners in Bhutan, nor does it contradict historical records; since the dawn of institutionalized services, patients have oscillated between the two, as evidenced in a report from visiting international physicians Ward and Jackson (1965: 813) in 1965:

While modern medicine is being practised increasingly in Bhutan, many of the older patients still consult local herbalists, who dispense powders and liquids extracted from plants. Sometimes the patients alternate between the ancient and modern worlds, hoping to get the best of both.

What results from this multi-practice use are complex healing narratives in which persons would encounter multiple forms of cures, conceptions of health and types of bodies in response to one or many illnesses and symptoms.

Beginning with this ethnographic insight of practice plurality, the first proposition of this book is to assert what a 'patient' is in relation to these cures (chapter 1). While the ethnographic nuances of this proposition will be fleshed out throughout this work, I start with a simple notion of what a patient is, and how one emerges from a social context, to identify the central subjects of my work: 'patients'. This is not a term always used locally, but, for the theoretical underpinning of the story I tell here, when a sick person places themselves in relation to a curative practice, they become a patient. A sick person is framed by the practices they engage and becomes a patient within the set of relations established and sustained between practice and patient. With diverse healthcare options available to the Bhutanese and their willingness to engage in them, sick persons were often becoming patients in relation to multiple practices, thus becoming different types of patients many times over. This praxis of a multiple 'relationality' between patients and various healing practices, and the not dissimilar work of Annemarie Mol on 'the body multiple' (2003), has suggested to me the term 'patient multiple'.

The second proposition is that patients are the nexus of decision-making in the healthcare-seeking process. In most cases, the agent of decision-making regarding which practice to use and when is the patient. This does not mean patients are independent or isolated agents; rather, many other social, economic and political factors and influences converge within a patient's decision-making process, feeding into the result. Family, friends, doctors, finances, geographies, topographies, advertising, public health education, healers, ethics, and many other actors could affect decision-making. Taking these influences into account,

the patient is a nexus of decision-making between all three healthcare options. As we will see, the decision-making process for choosing which healthcare practice to use and when is a challenging and complex task for patients, especially when symptoms of illness have permeated the lives of these agents. The real-life deliberation over whether to seek traditional, biomedical or alternative practices caused an ethic of healthcare-seeking behaviour, to which proponents of different practices would attribute notions of 'appropriateness' (chapter 3). When should patients visit hospital, when should they visit their village *lama* (*bla ma*), when should they seek out the village healer or when should they take traditional medicines? These are all questions asked by patients and answered by a host of opinion holders. By looking at the patient as a nexus for such questions, I am able to fan outwards into the ethnographic networks to answer some of them, exploring both the personal and wider social influences that affect patient decision-making.

With these propositions guiding the methodology in the fieldwork, this book has two aims. The first is to offer the only ethnography of patient healthcare-seeking behaviour in Bhutan. It will show some of the factors that influenced the decisions of patients and the effect of these influences on their healthcare-seeking narratives. Put in the plural medical context introduced earlier, this ethnography explores the ways in which practice multiplicity was affecting patient's experiences of suffering and healing.

The second aim of the book is to argue for an understanding of the Bhutanese patient as socially multiple, defined by a praxis of multiplicity rather than an ontological theory of single 'patient-hood'. I will show that there is potential for the effective application of such a conception of a patient in health policy and operations. Rather than looking for the integration of practices, I turn to an institutional approach which recognizes and sensitively incorporates patient multiplicity to both attract patients to services, and deliver healthcare in ways that encourage effective, meaningful and safe care.

The current textual narratives concerning healthcare, its provision and patient activities in Bhutan have thus far omitted a detailed look at patient activities and the impact of practice plurality on their decision-making processes. Work focused on healthcare in Bhutan seldom explores patient crossover between practices, thus missing this potential application of patient multiplicity. The next section explains these textual narratives and where this book aims to add to the current literature on healthcare in Bhutan.

### **Textual Trajectories: Creating New Space for Patients in Context**

Why research the ethnographic context of Bhutan's healthcare practices and argue for this theoretical conception of a patient? While many instances of medical pluralism have been documented around the world (see Cant and Sharma 1999, and Ernst 2002) or within the Himalayan region (Craig et al.

2010) by medical anthropologists as well as other disciplines, Bhutan's particular ethnographic context and healing socialities have yet to be noted in great detail. In particular, scholarship on medicine, health and illness in Tibetan societies has had a dramatic increase in attention over the past decade, with a growing number of Tibetan and foreign scholars writing on the general scope of health and healthcare through a variety of lenses, including Prost (2008) on Tibetan diasporas, Garrett (2008) on religion and embryology in Tibet, Adams et al. (2010) and Adams (2001) on science and religion, Schempf (2007) on mental health, Samuel and Cantwell (forthcoming) on long-life practices and Pordié (2012) on the social, political and identity dynamics of Tibetan medicine. All of these are primarily focused on 'Tibetan' medicine as practiced in Tibet, Nepal or India. Little to no work has been published on Bhutan, with its long practice of traditional medicine and medical pluralism being subsumed into 'Tibetology' and other neighbouring regions of study. This ethnography hopes to expand the ethnographic dimensions of Himalayan healing practices, offering Bhutan its own distinct yet connected place amongst this growing body of literature.

However, a textual lacuna is not reason enough to write about patient activities in Bhutan. More importantly, published research in this area can help healthcare providers in Bhutan better understand why patients are using different healing practices and concurrently how services might adapt to satisfy patient needs while maintaining effective care. This research is already being applied in healthcare reform, specifically aiding in the development of effective medical integration between biomedical and traditional state services, in coordination with the Ministry of Health.<sup>15</sup> Without understanding how patients are engaging with a consortium of practices, health administrators will struggle to bring effective care to a growing and demanding patient base.

Most patient narratives in the Bhutan-specific literature focus on either biomedical or alternative healing practices, with little published regarding patient activities within traditional medicine. The biomedical collection of reports are dominated by government or non-governmental-organization-funded projects interested in supporting or improving state services. Over the past six decades the Ministry of Health has hosted hundreds of biomedical research projects, exploring a vast array of health and disease patterns. I met many doctors and researchers, both national and foreign, during my stay who were engaging in biomedical research projects such as cross-border malaria (Gueye and Yangzom 2011) or nursing (Wangmo et al. 2007). These research activities and others within the biomedical practice are important to health staff for career advancement, but they also input important data into the ministry's policies and programmes. While such reports and the state-backed institutions that write them have noted the existence of other avenues of healthcare, surprisingly little has documented the crossover of patients between biomedical, traditional and alternative practices, often viewing such behaviour as detrimental to effective



care. As one biomedical doctor put it, 'They [alternative healers] should be chased out! There is no use for them in healthcare in Bhutan today.'

Along with overlooking patient healthcare-seeking behaviour, there is a noted lack of research from the biomedical camp that engages with patient perspectives on health. Works that come close to describing patient perspectives, such as Alex McKay's chapter 'Bhutan: A Modern Development' (2007: 173–204), are upfront in noting the dearth of 'patient-based inquiries' (2007: 199). Melgaard and Tandi (2012) open their chapter entitled 'The Perception and Behaviour Related to Illness' in their extensive work *Medical History of Bhutan* by saying 'it is hard to find any information or researched literature about the perception and behaviour of individuals and communities when illness strikes them. Mostly, one has to rely on anecdotal evidence in various reports from travellers to Bhutan and on verbal memories of Bhutanese sources' (2012: 96). Two notable exceptions are Unni Wikan and Frederik Barth's (2011) anthropological study of Bhutanese children in the late 1980s, sponsored by UNICEF, which includes some details of patient attitudes to health, and a master's thesis by Amanda Duncan in 2008. While encouraging, the textual isolation of these pieces of social science research demonstrates the lack of interest from the biomedical camp to explore contemporary social changes and trends where patients are moving between multiples of practice and accompanying conceptions of health.

There is one centre of biomedical research in Bhutan that appears to be approaching patients' use of multiple medical practices, the Faculty of Nursing and Public Health (formally the Royal Institute of Health Sciences), the institution responsible for training nurses and health assistants who staff the numerous biomedical clinics throughout the country. Students are assigned research projects that directly engage issues concerning patient healthcare-seeking behaviour and the interface between the Ministry of Health's services and alternative healers. The topic is of paramount importance to these students given they will be working in rural communities, attempting to persuade patients into the BHUs without degrading community beliefs or practices. In a large darkened conference room I listened to over fifteen graduating senior health assistants present their research projects to the secretary of health, often detailing their attempts to convene a community around contemporary health issues such as domicile sanitation, sexual health or maternal care. Following a rigorous full-time course over two years, students clearly understood the government's emphasis on how to approach alternative practices: 'preserve culture and traditions, but ensure they don't hurt people.' This ethical stance was repeated to me numerous times by biomedical and traditional-medicine staff when considering patient use of alternative practices. These motivated students carry this knowledge and ethic into the field as they take on senior civil servant postings nationwide. Unfortunately not much of their diligent research leaves the conference room.

While patient use of traditional medicine has received less focus than its biomedical counterpart, other important areas of this professionalized medicine service have received growing attention with the National Institute of Traditional Medicine's (NITM, the official Royal University of Bhutan training institute for traditional doctors and health assistants, known also as the Faculty of Traditional Medicine) five-edition publication of the *Menjong Sorig Journal*, available online (NITM 2013). The articles both in Dzongkha and English cover a wide range of topics, including clinical therapies (Nidup 2009; T. Wangchuk 2009; Wangdi 2008), *sowa rigpa* diseases (Nidup 2010; D. Wangchuk 2010), raw-material collection (Tenzin 2008; P. Wangchuk 2008, 2009, 2010) and institutional structure (D. Wangchuk 2008). The latest edition extends the scope of the journal and the entire institution of traditional medicine with an article entitled 'Study of the Efficacy of Hot Compression', demonstrating a new and impactful focus on efficacy-related research. Arising from this journal is the only patient healthcare-seeking behaviour study conducted by Namgay Lhamo, a lecturer at the Faculty of Traditional Medicine, entitled 'Health-Seeking Behaviour Related to Sowa Rigpa in Bhutan' (Lhamo 2011; other versions include Lhamo and Nebel 2011 and Lhamo 2010). This study included a qualitative and quantitative appraisal of the 'awareness, treatment-seeking practices and level of trust and satisfaction' of patients (Lhamo 2011: 5) across six *dzongkhags* (*rjong khag*, administrative and judicial districts similar to counties). This is the first study of its kind, and it helped to identify and assert with academic rigour that

the knowledge and awareness of Bhutanese people on *sowa rigpa* in general is quite good. However, there are variations among people with different social and educational backgrounds. People from urban and educated backgrounds showed evidence of better knowledge as compared to those from rural and uneducated groups.

This study also noted *sowa rigpa* is quite popular not only among the ageing population of the country but also among the younger ones. This is because a significant number of people seek treatment from *sowa rigpa* and they were found to be satisfied and happy with the services received from it. Although people think that *sowa rigpa* medicines are effective and helpful to them, they still indicated the lack of complete trust and confidence on it for their healthcare. This is due to the fact that *sowa rigpa* still has to go a long way in meeting the overall health needs of the patients. Lack of modern equipment for surgery, emergency and diagnosis of internal ailments were the major concerns people expressed when discussing about its limitations. (2011: 35)

While there is still much work to do in understanding patient use of traditional services, this preliminary study serves as a fantastic springboard. One area for further research includes a requirement for greater locational specificity, given that access to services varies depending on patient location. There is also a need to study long-term service use and patient crossover between traditional and biomedical services. More ethnographic research would yield such results.

Patient use of biomedical and traditional institutionalized healthcare services has therefore received some attention. On the other side of the healthcare coin, an increasing number of articles and reports focuses on alternative non-institutionalized practices: for example, shamanic rituals, *pawo* and *pamo*, or *lama*-led rituals. Academics such as Françoise Pommaret (2009), Mona Schrempf (2015a–c), John Ardussi (Ardussi and Pommaret 2007) Tandin Dorji (2002, 2004 and 2007), Kunzang Choden (2008), Toni Huber (2013 and 2014) and Karma Pedey (2005) have done particularly extensive work to these ends, although the ethnographic context is still widely unstudied. Chapter 4 offers a closer look at these works and the practices they encompass. Alternative practices are evidently featured in academic literature focusing on ‘cultural studies’ but not in the literature produced by medical institutions such as the Ministry of Health.

The impetus for past research has generally fallen into two camps: the state service providers and those pursuing ‘cultural studies’. The former seldom deal adequately with alternative practices, the latter rarely have access to biomedical and traditional services. Lost in the divide are the complexities of how patients move between practices and how this movement affects patient experiences of illness and healing. None of the work mentioned above explores patient cross-over amongst any of the three forms of healthcare, and thus it fails to address the full scope of a Bhutanese patient’s healing narrative and their journey through a practice-plural healthcare world.

Many reasons for the division are found within the literature produced by cultural studies academics and state service providers. International research access in Bhutan is extremely limited, with government organizations tightly controlling the authorization and support of any research project. While this has protected the country from a host of corruptive or unproductive research projects, as well as allowing national researchers to thrive (see e.g. the *Journal of Bhutan Studies*, Centre for Bhutan Studies, CBS 2013 and the *Menjong Sorig Journal*, NITM 2013), government-authorized research often finds favour with the current agendas of the hosting institution. Critical research struggles to gain traction, as it does in any institutionally dominated context. In the specific area of healthcare-seeking behaviour, the far-reaching efforts by the health institutions of Bhutan to educate and persuade patients to use state practices (both traditional and biomedical) has meant that there has been little room for research into the myriad of alternative practices and the ways in which patients use them in tandem with the privileged state services. Emphasis is continually placed on the use of state services. Meanwhile, research inquiries into alternative practices are funnelled through an institution with a more a ‘traditional culture’ mandate. Research in such categories can struggle to make waves in policy and operations.<sup>16</sup> Thus for researchers wishing to trace patient narratives that bring both patient and researcher into hospital wards and then into the houses of alternative healers, opportunity is hard to come by. Access is typically granted for one or the other. This point of divergence is exactly where my

ethnography sits. With access to biomedical hospitals, traditional-medicine units and alternative healers, as well as the everyday life of patients, I was able to follow the multi-practice narratives that characterize healthcare-seeking behaviour in Bhutan. The following section discusses how I structured this access in fieldwork methodology.

### **Methodology of Fieldwork in the Context of Two Fieldsites**

The fieldwork spanned a two-year period and was composed of preparatory negotiations, a reconnaissance trip, remote research with institutional collaborators, a six-month ethics review process, a yearlong stay in Bhutan and ongoing contact with institutions and patients. Initial contact was made with Bhutan's Ministry of Health in March 2010, and the year of onsite fieldwork was conducted between April 2011 and May 2012. This fieldwork also fits into the wider span of my research experiences, including six months in 2006 conducting fieldwork in the Traditional Medicine Hospital of Lhasa, Tibet, six months in 2007 studying urban shamanism in Lima, Peru, and a year in 2004 spent doing health-related social work in a rural Nepali village.

To put it bluntly, gaining research access to Bhutan was hard, and it was a combination of strategic marketing, a preliminary trip, good council and sheer luck that led to my invitation to conduct the research in collaboration with the Ministry of Health and the National Traditional Medicine Hospital. The restrictions and conditions to foreign researchers are well-known to those who approach institutions with research projects. The reluctance to allow researchers into the country has preempted potential damage by research oversaturation (a country famed as the Last Shangri-la that coined and implemented GNH is particularly at risk of over-popularity), while also capping the publishing rate, in comparison with Bhutan's neighbours. However, as the new democratic government continues to grow and allow power to filter down to its institutions, more foreigners are being invited to work, study and research in Bhutan. The acceptance of this research project was a product of growing interest and commitment to research projects in general. However, tight visa controls still resulted in unavoidable adjustments to methodology.

I visited Thimphu for two weeks in late July 2010 on a reconnaissance and introductory trip. This self-funded journey was made after the Ministry of Health accepted an initial proposal, and I intended to formalize arrangements while gaining current ethnographic information to refine the research project. This was a crucial trip that influenced early changes to the project. For example, an interest in 'medical integration' between biomedical and traditional practices was rejected by my Bhutanese research counterparts – rightly so because it wasn't a particularly important factor to patients or health staff. My research collaborators at the Ministry of Health and the National Traditional Medicine Hospital helped to establish that patient crossover between biomedical, tradi-

tional and alternative practices – the ultimate focus of my research – was contemporary, important and unstudied. This trip also facilitated meeting with the minister of health, ministry officials and those affiliated both administratively and academically with the research project. The outcome was that the minister accepted the project under strict yet reasonable guidelines, including the accreditation of the Research Ethics Board of Health, which I received in conjunction with following the Association of Social Anthropologists of the UK and the Commonwealth's 'Ethical Guidelines for Good Research Practice' (2010). Another strict guideline was the maximum stay of one year in the country, a relatively long time uncommon for research projects that have no added commitment to teach or work.<sup>17</sup>

Having gained access, learnt more about the on-the-ground context, and met many healthcare administrators, my methodological plan was to spend twelve months conducting ethnographic research with patients, doctors, healthcare staff, alternative healers and patients' families. Overall I interviewed over 400 patients (formal and informal interviewing) and over 150 healthcare staff and administrative officers. I sat in on over 600 consultations in both traditional and modern medicine, as well as many other treatment and clinical sessions, including surgeries. I held three focus groups, each over a two-day period, with health assistants who work in nationwide BHUs. I also interviewed eleven alternative healers, three of whom I worked with over consecutive months. Many of these research activities were done with a research counterpart, who changed depending on my location and fieldsites. However, I would often conduct interviews and observation alone. These activities were done in two fieldsites, Thimphu and Mongar. The change in location marked two distinct phases of my research, both with well-defined ethnographic focuses.

The first phase consisted of five months based in Thimphu (population approximately eighty thousand, NSB 2005: 9), Bhutan's capital and home of the Ministry of Health, National Traditional Medicine Hospital and the Jigme Dorji Wangchuck National Referral Hospital. This is the largest and most economically and politically dominant urban centre, with all major government, monastic, business and academic institutions, and international and national non-governmental organizations, headquartered around its city centre. The usual promises of 'big city opportunities' have brought rural populations flooding in (Chupein 2010: 9), with construction projects quickly expanding the city along the Thimphu Valley. Taxis and private cars whizz round its bustling streets lined by busy office workers, students, businesspersons, shoppers, tourists, monks, nuns and stray dogs. Thimphu's development in just the last five years has been staggering. Where only five years ago rice fields grew, now shopping malls, housing blocks and busy roads have transformed the environment from rural to urban. With these recent changes comes the feeling that Thimphu is on the tipping point of a massive social, economic and infrastructural transformation, one where new trajectories of urban development are no longer new, but the norm, and with that normalcy a new era of modern city life is born.



**Illustration 0.4** Archer's Poise, *Thimphu*. An archer pulls back his bow, takes a deep breath and steadies his arm. The US-made carbon compound bow floats in front of him, ready to send the arrow whistling towards the target.

Amongst these familiar shapes of globalizing modernity are distinctive markers of 'Bhutanese-ness'. Many people still wear the national dress, a *gho* (*go*) for men and a *kira* (*dkyi ra*), or fashionable versions of it, for women. Admission to most official administrative and private offices is dependent upon this national dress, arguably helping to keep it in fashion. The nation's favourite dish, *ema datshi* (*e ma dar tshil*), a potently spicy mixture of melted cheese and chillies, still earns centre stage on dinner tables. The main attraction for Bhutan's recreational male is the city centre archery ground where arrows whistle through the air, propelled by expensive carbon compound-bows, echoing bygone battles with Tibetan invaders. Cinemas, *dzongs* and tourist hotels are filled with the 'cultural' sounds and movements of Bhutanese songs and dances drenched in the romanticization of epic love stories, the urbanite's bucolic village origins or religious and political antiquity. All of these things seemed to take up many waking hours for many of the people I worked with in Thimphu. If not in hospitals or clinics seeking or providing healthcare, my informants could often be found partaking in some part of these national rituals, either in real life or by the various media outlets. Within this urban setting I lived in private accommodation and divided my time between learning Dzongkha and conducting participant observation, interviews and discussions in the city hospitals with patients and health staff.

The introductory period to the Thimphu fieldsite and the Dzongkha language was successfully expedited and made easier by three factors, two of which had to do with my pre-fieldwork preparations.

First, I had a working knowledge of written and spoken Tibetan. Dzongkha (rdzong kha), the national language of Bhutan, shares much of its alphabet and grammar structure with Tibetan, and I was easily able to adapt my previous language skills to speak with patients, healers and doctors within the first two months of my stay with the help of one-on-one language lessons.<sup>18</sup> Although twenty-five other languages are commonly used in Bhutan (Ethnologue, ISO 639-3, 2013; Driem et al. 1998; C. T. Dorji 1997; Bodt 2012), there was no official avenue to learn them, and my time restrictions made it impractical to dedicate myself to learning popular languages such as Sharshop. Dzongkha, on the other hand, was spoken and understood by most of the people in my Thimphu and Mongar fieldsites and, given my previous training in Tibetan, was the fastest and most practical to learn. It should also be noted that English was the medium of education in all school curricula; therefore, English proficiency was relatively good, especially among younger populations. I argue that when researching an ethnography of Bhutan, English is a crucial working language, given how widely it is used, especially in hospital settings. Thus I used English as a secondary language of the study, when following an ethnographic trajectory involving the specific use of English or if Dzongkha or translation services were not available.

Second, my previous research for my BA degree involved six months of ethnographic fieldwork in the Lhasa Mentsi Kang (Tb: sman rtsis khang, 'traditional-medicine hospital') in Tibet, where I gained knowledge, insight and experience to both *sowa rigpa* in a clinical setting and to patient-focused ethnographic fieldwork methods. My familiarity with the *sowa rigpa* canon, its practical application in a hospital context, the medical language and theory, the institutional organization and the political tensions with biomedical institutional counterparts helped me to orient myself to this new yet similar ethnographic iteration in Thimphu. Also, I had worked with patients in Tibet, Peru and Nepal for over two years in other projects, and thus I was familiar with the sensitivities and tactics of interviewing and conducting participant observation with sick persons – an experience and exposure that I severely underappreciated the first time I worked with patients who were suffering.

Finally, although gaining access to Bhutan was incredibly difficult and took over a year and a half, once approved, with visa in hand, an endorsement from the minister of health, a collaborative working relationship with the National Traditional Medicine Hospital along with one of its traditional-medicine doctors as a research counterpart,<sup>19</sup> I was afforded ample access to health personnel, institutions and events. More importantly, the doctors, nurses, healers and patients I worked with were very encouraging and accepting of the research project and would often revel in the rare opportunity to meet, talk and work with a foreign researcher. I often described that the front door was like Fort

Knox, difficult to enter, but once inside, I was warmly welcome to visit any rooms I wanted and speak with whomever was present. I bought a car while in Thimphu that, combined with road permits processed by the National Traditional Medicine Hospital, permitted me to travel freely, again an extreme rarity in Bhutan. This relatively free access to people and places meant I could follow the ethnographic narratives on their own terms.

With access to the National Traditional Medicine Hospital and the Jigme Dorji Wangchuck National Referral Hospital, I spent my days observing treatments and diagnoses, talking with and interviewing patients and doctors and observing the use of medical resources and treatment options. If significant rapport was built with a patient – as happened with Pema, whose name is changed like all others in this book and who I discuss in chapter 1 – I would spend time in their social environments and follow their health narrative in greater ethnographic detail. I also interviewed many Ministry of Health officials across all administrative, educational, and clinical platforms. These officials were responsible for managing, providing and developing the public health services. They included the head of nursing in the Jigme Dorji Wangchuck National Referral Hospital, the nurses themselves and a trainer of nurses who was just completing her own PhD from an Australian university. I also held focus groups with select village health workers who routinely acted as bridges between rural populations and their local health clinics. As I was following patients, insights by those that worked in the gaps between homes and hospitals proved crucial to understanding the wider picture of patient migration.

Much of this work involved a ‘bottom-up’ approach to the collection of ethnographic material, locating answers to my research questions in the analysis of patient-based narratives. This is similar to the work of Lewis (2000) in his ethnographic narration of the illness and death of a Papua New Guinean man and to the work of Desjarlais (2003) in his biographic accounts of shamanic healers in Nepal. However, I attempt also to examine practices to move beyond narration and to infuse a critical analysis of sickness and healing into a body of regional literature that is heavily influenced by national politics. Throughout this work, I set new ethnographic material founded in patient experiences against historical accounts or government agendas. I do this not to criticize these narratives but to shed new light on the lives and activities of patients, so that institutions might more appropriately engage with the people they aim to help.

I did not limit my ethnography to patients who have particular diseases, such as many similar projects have done (see Mol 2003 on atherosclerosis and 2008 on diabetes, or Cohen 1998 on Alzheimer’s). The study included all disease diagnoses used by patients, biomedical doctors, traditional physicians and alternative healers. This was a deliberate methodological approach because I was following patients who move between diseases, diagnoses and practices, sometimes for the same symptoms, such as a stomachache, or for multiple symptoms, such as an arthritic knee, a lost soul and a karmic imbalance. Following patients



with a single classified disease is a good way of focusing a study and illuminating theoretical arguments: Mol's (2003) use of atherosclerosis to argue for her ontological notion of the 'body multiple' is a good case in point and will be discussed in chapter 1. This book is not concerned with making such philosophical claims, thus requiring a singular disease focus, but is rather interested in describing the life-worlds of patients in Bhutan and how subjects go about seeking care from multiple practices. It focuses on the movement between disease types and their corresponding networks of care, and how the plurality of cure, practice and body was affecting patients. Patients and their healthcare-seeking experiences were dynamic across a range of enactments, pain experiences, rationalizations and bodies, hence my choice to follow a multiplicity of diseases was reflected in the patient experience, rendering what I will go on to argue enacts the praxis of a 'patient multiple'.

The goal of this first stage of fieldwork in Thimphu was to gain a broad outline of national health services as they were used and propagated in the capital of Bhutan. The Ministry of Health and Thimphu hospitals were major policy and practice hubs in Bhutan. I intended to gather ethnographic data on these important sources of state healthcare narratives in order to understand how extensions of these powers were influencing patients in my second fieldsite in the Mongar Hospital as well as other national healthcare clinics.

For the second phase, consisting of six months, I was situated in and around the Eastern Regional Referral Hospital in Mongar town (population approximately 7,500, Office of the Census Commissioner, OCC 2005: 22) in the Mongar *dzongkhag*, which has a population of approximately thirty thousand, 80 percent of whom live in rural areas (OCC 2005: 22). The majority of these rural dwellers are subsistence agriculturalists living in the more remote areas of the district, some of which can now be accessed by farm or paved roads; however, transport services are limited, and walking to road heads is still common. Twenty-three BHUs and forty-six smaller outreach clinics provide basic biomedical services. Two of these smaller health centres have a *menpa* (*sman pa*, traditional clinical assistant) that offers traditional-medicine check-ups, referrals and medication.

Mongar town is considered one of the largest and most influential urban centres in the east of Bhutan, although it is still dwarfed by Thimphu's prominence on the social and geographic landscapes. It is situated on the crest of a mountaintop, below which several valleys and their rivers conjoin in an epic display of rugged topography. It's known as a gateway urban centre between the eastern and central regions – all roads to Thimphu from the east went through Mongar, making it a major economic and agricultural centre. With this access, in the past decade, similar to Thimphu, Mongar has undergone a construction boom, extending its concrete Bhutanese multi-storey housing blocks down steep mountainsides. But unlike the capital, it retains more of its small-town feel, with agriculture still very much framing the surrounding landscapes and market trade.



**Illustration 0.5** An Eastern View of Mongar Hospital, *Mongar*. The five-story white wings of Mongar Hospital fan outwards from the central column. Each wing and floor houses a different ward or medical department.

The Eastern Regional Referral Hospital was completed in 2009, bringing newfound importance to Mongar. It serves as the primary state healthcare centre for the eastern regions, drawing in the remotest of inhabitants who sought the highest possible treatment levels on a national hierarchy of care, next to Thimphu. It offers biomedical services previously unavailable to eastern populations unless they travelled to the capital, such as surgeries, laboratory and pathology testing, endoscopy, obstetrics and gynaecology, radiography, specialized internal medicine, dialysis, and accident and emergency care. These services are supported by a growing number of biomedical doctors, nurses, administrative officers, ambulance drivers and hospital workers, most of whom live in nearby staff housing. I was provided with private hospital accommodation usually reserved for visiting international physicians.<sup>20</sup> The hospital also has the largest traditional-medicine unit, with two *drungtsho* (*drung 'tsho*, traditional physician) and two *menpa* on staff, as well as steam and bloodletting therapies. These two *drungtsho* and the traditional unit were my official hosts when in Mongar, as arranged by the National Traditional Medicine Hospital.

Along with these institutionalized healthcare options, the *dzongkhag* also hosts the second largest assortment of alternative healers in Bhutan, according to the Bhutanese newspaper *Kuensel* (Pelden 2012b) that reported over one hundred active practitioners. Although it's tempting to strike up a correlation between the number of alternative healers and the percentage of population

living in rural areas, this would be falsely presumptuous, as alternative healers operate in both rural and urban populations. Thimphu is a good example of this where alternative healers thrive in the urban setting. Urban centres such as Mongar may offer a better location for such healers given their proximity to road networks, religious institutions and larger populations, all of which help to increase their caseload; for many alternative healers their practices are an important additional source of income and social capital. Clearly people in the Mongar *dzongkhag*, both rural and urban, have access to a large variety of alternative healers.

My initial meetings were centred on the Mongar Hospital. I first contacted the biomedical and traditional doctors and other administrative and medical staff to identify myself as a social researcher and not a medical practitioner (a firm and clear line I kept throughout fieldwork for ethical reasons – for example, I never wore a white coat, which would have given the impression I was a practising international doctor). When these relationships were well established, and agreed as appropriate, I started looking for patients to talk to.

Over the course of the fieldwork I engaged these informants in interviews, discussions and focus groups, and I observed diagnoses and treatments, including surgeries, consultations, bloodlettings, steam treatments, injections and general ward care. The aim was to collect patients' healing narratives, including the input and perspectives of doctors, nurses, healers and family members, thus creating a network of supporting narratives revolving around those of the patients. The institution of the hospital as well as the powers of the state health-care system were important in the structure and ethnographic content of these patient narratives; I treat these state influences as narratives in and of themselves, therefore collecting biographies of the state and its health practices.

Through these relationships formed around the hospital, I also extended my informant base away from the hospital and into surrounding areas. This included accepting invitations to villages in rural areas, accompanying the *dzongkhag* ambulance, visiting BHUs or other hospitals and clinics, attending religious ceremonies, eating in the homes of patients and staff, participating in social events, travelling with hospital staff on outreach clinics to remote areas or restricted monasteries and meditation centres, visiting with alternative healers and spending time in garages fixing my car (dubbed 'The Tuna Can'). In total I visited ten different hospitals and ten BHUs, as well as a number of remote outreach clinics and healers' homes. Again, the focus of these social excursions was to add greater ethnographic detail to patient and state narratives, as they extended away from institutionalized services and into the socialities of everyday life in Mongar.

The data collected from these sites and ethnographic methods were recorded in a secure database designed and built from the ground up by myself, using Filemaker Pro. Creating a bespoke database solution for this project allowed me to record fieldnotes specific to the patient, practice and material narratives designed in the fieldwork methodology. I kept specific notes on events (including

daily journaling), persons and materials, all of which were interconnected and cross-referenced through a confidential coding system. I also used audio recording and photography, with permission, to accurately capture interviews, discussions and observations. All photographs presented in the book are my own. Some photographs were taken at the time or place of events described; some were not and are illustrative of the ethnography.

## Chapter Overviews

The book has five chapters and a conclusion.

Chapter 1 argues for the concept of a 'patient multiple', a subject category that I use throughout the work to better place patients in relationship to the many types of practices, healths and bodies they engage with during one or many illnesses. This theoretical claim is drawn from the following of a patient narrative, that of Pema, with whom I worked closely during my fieldwork and continued to do so through the writing period. I trace her interaction with biomedical, traditional and alternative healing practices as she attempted to cure two different health problems. In doing so I also introduce more thoroughly these healing practices, setting them up for further analysis in the following chapters.

The second chapter explores the traditional-medicine services and their effects on patients' experiences of suffering and healing. The first section looks at the use of the term 'traditional' and how it was used by informants. This terminology is important because it was used by patients and health staff to clearly delineate between practices, themes of segregation and inclusion that had meaningful effect on patient healthcare-seeking narratives. The next section looks at the organizational structure of these services, both in Thimphu and across a national network of clinical centres. By doing so I introduce the forms of institutionalization, nationalization and professionalization that are going on to affect what 'traditional medicine' is in Bhutan, as well as how it was enacting its patients. The chapter then explores how traditional-medicine patients are created within this institutional healthcare service. It takes a close look at medical records and consultations to show, in ethnographic detail, the interaction between practice and patient. The final section explores how the conjunction of the traditional institution and traditional patient creates new forms of ethics, bodies, and conceptions of health, as defined by the knowledge and practice of *sowa rigpa*. I argue that because traditional medicine is incorporated into a state healthcare project moving towards a rapid nationalization of services, what is beginning to happen is the formation of a new type of citizenship, one defined by a *sowa rigpa* body, health and practice. Patients' experiences of suffering and healing are then ultimately shaped and enacted by these new forms of *sowa rigpa* national identity, or what I call 'bio-traditional citizenship'.

The third chapter looks at the effects of practice plurality on the processes of patient decision-making. It looks at two specific ethnographic cases where healthcare decision-makers had to choose between practices, charting the influences and logics that persuaded certain healthcare-seeking behaviour. The first patient narrative is that of a newborn child who was failing to feed and as a result became dangerously dehydrated and jaundiced. The parents, Tshomo and Sonam, oscillated between visiting Mongar Hospital and conducting religious rituals. The second vignette is that of Dechen, a young girl with chronic arm pain, who was treated with religious rituals for three months before being taken to Mongar Hospital. These narratives reveal critical healthcare decision-making junctures, where the patients were at risk of death, and decisions between practices had to be made. Through the logic of care presented by the decision-makers as well as the staff of the Mongar Hospital and public health programming, we learn about an emerging ethics of 'appropriate healthcare-seeking behaviour' and how patients are implementing and navigating such ethical discourses.

The fourth chapter considers how alternative practices affect patient experiences of illness. It starts by looking at the contemporary world of alternative healers in Mongar and Bhutan at large, placing their practices and patient interactions in the context of specific political, social and economic networks that were in some ways defining their healing role. It then gets more specific, exploring a disease category, known as *ja né*, that was said to be treated by alternative healers. From my ethnographic data I identify three particular types of *ja né* and how each operates through a biomedical, traditional or alternative practice. The final section zooms in further to the *ja né* disease treated by alternative healers, whereby they practice sucking genital discharge from both male and female patients. I conclude by placing such practices back into the wider political and social contexts of healthcare in Bhutan, looking at some of the challenges facing such controversial healing methods. Ultimately, *ja né* and genital discharge sucking doesn't fit into a logic of care outlined by biomedical or traditional practices, yet it still holds meaningful agency for patients and healers, thus identifying a divergence in the way diseases are thought of and acted upon, again emphasizing the place of the 'patient multiple' in a modern-day Bhutan healthcare context.

The fifth chapter concerns the effects of medical materiality on patients. I first define medical materiality as things that adopt a healing identity and thus are active non-human subjects that exert influence on patients. The chapter then looks specifically at the increase in biomedical pharmaceutical availability over the past decade and the new networks of care these drugs have built up around patients. I look at the effect of these networks by examining what happened when they temporarily disappeared due to a nationwide drug shortage between 2010 and 2013. When Neyzang, a female heart-valve-replacement patient, dies, possibly due to inaccessibility to the drugs she had become dependent on, the ethics, supply and changing dependencies on such medical

materiality are laid bare. I conclude by arguing that new horizons of what is clinically possible, as well as what is expected from the emerging healthcare services, has changed patient expectations of care. Rather than an unwanted pressure, such patient adaptation to and interest in medical materiality might pose novel opportunities for the Ministry of Health and its service providers; I argue that sensitive and wise advertising of medical materials might help to educate Bhutanese patients, result in more appropriate healthcare-seeking behaviour and ultimately reduce suffering.

The book concludes by first reasserting a call for patient multiplicity considering the ethnography presented in the five chapters. Second, it argues that the ways in which patient multiplicity is assembled, organized and managed by patients are what constitute healthcare decision-making processes. The ethnographic evidence shows that patients are very capable of understanding and layering the different modes of practice, health and body that arise from their narratives of healthcare-seeking. This organizing of the patient multiple constitutes a type of 'logic of care', a theory explained by Annemarie Mol (2008) that, if attended to, could offer new avenues of approach and support for patients by both institutional and non-institutional healthcare providers. By focusing service-provision efforts around the assembling processes of the patient multiple, we can better meet patients on their own terms, thus delivering more effective care.

## Notes

1. The topic of hydroelectric power in Bhutan has received much attention due to its major role in the Bhutanese economy. Other sectors also play an important economic role, such as agriculture (Tshering 2009) and tourism (Singha 2013). However, the government has staked much of its future economic growth and stability on hydropower projects. For a recent assessment on hydropower's role in the Bhutanese economy see Ulmasova (2013).
2. As a side note to poverty statistics, there is a large gap in the poverty rates of urban and rural populations. Rural poverty rates went from 30.9 percent to 16.7 percent from 2007 to 2012, whereas the urban rate went from 1.7 percent to 1.8 percent. This detail to the statistics demonstrates two things: first, there is a wide income gap between rural and urban populations. Second, the dramatic drop in the rural poverty rate is informative to the growth in access and services to these rural areas over the last five years.
3. Readers unfamiliar with biomedicine as a cultural practice, once discussed extensively in medical anthropology, are encouraged to read Burri and Dumit (2007) and Lock and Gordon (1988) for an introduction to its epistemic, material and social implications. More recent summaries of anthropological approaches to biomedicine can be found in Lock and Nguyen 2010 and McDonald 2012 and 2015, for example.
4. A literal translation implies the term 'Buddhist.' Within Tibetan Buddhism, *sowa rigpa*, is one of ten 'Buddhist' sciences (Tb: *rig pa'i gnas bcu*).
5. Both academics and practitioners of *sowa rigpa* in Bhutan are aware of the practice's history with Tibet. Texts, lineages, institutions and training colleges for Tibetan medicine played a crucial part in establishing traditional practices in Bhutan. This is a complex relationship and historical narrative that is discussed at the beginning of this chapter.

6. Issues of terminology regarding alternative practices are explored more in chapter 1 and chapter 4.
7. The orthographic spelling and the phonetic transliteration of these terms are the same in Dzongkha and Tibetan.
8. The Chagpori Medical College was built in the seventeenth century by Desi Sangye Gyatso, the regent ruler of Tibet after the death of the Fifth Dalai Lama (Clifford 1994: 60). It is famed as the first medical school in Tibet, and it drew doctors from all over the Himalayan region to study Tibetan Buddhist Medicine. See Clifford 1994: 59–62 for more details of this Tibetan medical college.
9. Discussed through private e-mails with Karma Phuntsho, March 2013.
10. The introduction of Buddhism into this region occurred over centuries, drawing into it many important persons, events and texts, all of which are recognized but omitted here.
11. See Meyer 1981 for a comprehensive history of *sowa rigpa*'s development alongside Tibetan Buddhism.
12. Additional discussions on the subject of *la* have been written by T. Dorji (2004), Karmay (1998) and Gerke (2007)
13. Such monumental changes in political organization and social relations must be set against the political reconfiguration of Tibet in the 1950s, when the People's Republic of China asserted new Chinese presence and claim over Tibet (see e.g. Ura 2002). Bhutan recognized a potential invasion threat from the north and acted decisively to delegitimize any Chinese claims to Bhutan land. This included closer political relations with India and the British government, active engagement in the development of an autonomous nation-state and the change from practices such as feudalism that might legitimize an invasion by the Chinese who argued such practices as antiquated and requiring reform.
14. There are four notable publications that engage this 'modernization' trajectory. Rennie and Mason (2008) have compiled a host of contributions primarily from Bhutanese authors reflecting on these changes across a series of topics, including education (Yangka 2008), folklore (D. S. Wangchuk 2008), landscape (Gurung 2008) and culture (Choden 2008). Crins's book *Meeting the 'Other': Living in the Present* explores modern interpretations of gender and sustainability. The latter two works are by the prominent Bhutanese author Kunzang Choden (2013 and 2009), who is writing some of the most forward-thinking feminist fiction in Bhutan. These two books focus on the changing lives of woman in this contemporary development context of Bhutan.
15. At the end of my fieldwork (May 2012), I was invited to present a paper to the Ministry of Health, the National Traditional Medicine Hospital and the Faculty of Traditional Medicine on the topic of medical integration between biomedical and traditional services. This paper was presented in conjunction with a health consultant, Dr. Bjorn Melgaard, working on major healthcare reform in Bhutan. The paper and its integration policies are being worked into these health reform efforts that aim to achieve better communication and interaction between biomedical and traditional national healthcare services.
16. There are valuable and productive efforts to change this. A good example is the United National Solution Exchange Bhutan programme that offers a 'knowledge network to help development practitioners increase the effectiveness of their individual efforts, tapping into the collective knowledge and experience of practitioners across Bhutan' (United Nations 2013).
17. There are many ways to enter Bhutan to conduct research. One of the most popular ways for researchers that I met was to work for a government or Royal University of Bhutan (RUB) institution. Once present in the country, 'sideline' research projects were authorized, although work or teaching duties could take up much of the researcher's time. I had no work or teaching responsibilities and could therefore focus 100 percent of my time on the research project, again a rarity for someone given access to Bhutan for one year.

18. I would like to give thanks to my dedicated and trusted language teacher, Tenzin Jamtsho, of the Institute of Language and Culture Studies, RUB, who spent many hours helping me learn Dzongkha over the entire year of my fieldwork and beyond. His extensive knowledge of the language, as well as the social-cultural context of Bhutan, and his willingness to share it with me hastened and deepened my language-learning process. I would also like to thank the British Association for South Asian Studies for kindly providing a language-learning grant, without which I would not have been able to afford my valuable lessons with Tenzin.
19. Most foreign researchers working in Bhutan are required to team up with a Bhutanese research counterpart, usually from the hosting institution. I worked alongside a traditional physician from the National Traditional Medicine Hospital in Thimphu who was very helpful in all research planning and execution. Given he was a full-time doctor, seeing patients daily, he was limited in his availability to accompany me to many interviews and observations, other than those held in his office. Even with these limitations, he offered a great amount of knowledge and experience of traditional medicine and patient behaviours. I thank him for helping to introduce me so thoroughly to Bhutan, the National Traditional Medicine Hospital and the personal worlds of patients.
20. I'd like to thank the Mongar Hospital for providing me with this fantastic accommodation. They were extremely kind and accommodating to allow me to use it as my research base.