

Abstract

The important diversity of indigenous medical systems around the world suggests that gender issues, well understood for Western science, may differ in significant ways for non-Western science practices, and are an important component in understanding how social dimensions of women's health care are being transformed by global biomedicine. In this article I present ethnographic research with formally-trained women Ayurvedic doctors in Nepal within which features of medical knowledge and practice beneficial to women patients are identified; these features are potentially transformed by modernizing health care development.

Women Ayurvedic Doctors and Modernizing Health Care in Nepal

Introduction: Gender and Medical Transformation

The diversity of indigenous medical systems around the world suggests that gender issues, well-understood for Western science, may differ in significant ways for non-Western science practices, and are an important dimension of how women's health care is transformed by global biomedicine. In the context of plural medicine that is familiar to women and their families in many parts of the world, we might ask if biomedical modernity compresses indigenous medical plurality in a manner that bears on people's gendered experiences of medicine. Indeed, women's health care prospects may significantly depend on how gender relations in health and medicine transform through globalized Western science and medicine projects, particularly at the crossroads of indigenous medicine and biomedicine. This article takes up the question of gender and medical transformation in Nepal through the experiences of women Ayurvedic doctors who increasingly confront biomedicine within the country.¹ Relying on ethnographic research with formally-trained women Ayurvedic doctors that focuses on indigenous medical transformation, I identify gendered features of medical knowledge and practice that can change with biomedical influence. The women's experiences and perceptions about being professional healers in a modernizing health care context lead us to think more broadly about the connections between social (gender) and medical transformation, as these co-evolving realms can create tensions and contradictions for women providers, as well as provide new opportunities for developing health care policy that is guided by concerns for women's health and their professional advancement.

There are four main points I wish to develop here about medical transformation and gender. First, in addition to inherent paradigm differences between Ayurveda and biomedicine, the social

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and cultural features of women's professional practice indicate contradictory paradigms in which medical authority contravenes women's social subservience. Women patients' strong preference for female healers is the most evident example of a gender order that stratifies on the one hand and empowers on the other, as the women doctors enjoy high social status and patient demand for their medical services in an otherwise male dominant society. Second, the field of feminist studies has long called us to look more closely at the connection between the secondary status of women and the kinds of work women perform in society. The official government view of Ayurveda as secondary to biomedicine belies Ayurveda's enormous popularity in rural areas and pockets of urban communities; it has also simultaneously become a first choice for young women seeking a professional career in medicine. The personal satisfaction and the social power that come from caring for the health care needs of women, men, and children emerges from the ethnographic portraits presented here as one explanation for women's choice. Third, the very qualities that render Ayurveda officially inferior to biomedicine are those that bring women healers and women patients together, including non-invasive and low-technology diagnostic techniques, low cost, and clinical interactions that encourage culturally-relevant medical knowledge exchange. Fourth, potential sites of medical and social transformation related to the gendered dimensions of health care, when correlated to increasing biomedical hegemony, suggest areas that should receive attention by those advocating plural medical systems that benefit women's health.

To understand how gendered aspects of Ayurvedic practice change with biomedical influence, I look to insights from feminist theory and medical anthropology that address the relationship between scientific ideology and gender on the one hand, and the ways culture and society impact medicine on the other. Feminist scholars of Western science have greatly

advanced our understanding of gender and modern scientific ideology and their applications in women's health lives, to provide a framing by which we can apprehend gender and medical transformation in non-Western medical contexts. From the philosophically grounded work of Evelyn Fox-Keller and Helen Longino (1996) on the gendered ontology of scientific language to the well-known work of Emily Martin (1987) on the language of gender embedded in medical school textbooks, the abundant findings of feminist scholars of science provide ample evidence of science as a gendered social practice with real consequences for women. In the area of science, culture, and social change, medical anthropologists have shown the variability with which indigenous healing systems are impacted by the power of modern science and globalized biomedicine in non-European contexts (Connor and Samuel 2001). Here I synthesize and extend these two lines of inquiry to identify certain features of women doctors' practice that speak to their agency and their limits as professional scientists, their concerns about medical modernization and biomedical power, and their unique position to effectively treat women patients.

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

Although the doctors' training and the problems they confront varied among the different locations, what remained similar were the reasons behind the strong preference women patients expressed for women doctors. The "ecology" and "economy" of the body and person in Ayurvedic thought fundamentally differ from the mechanistic and compartmentalized biomedical model of the body. As it is widely practiced in South Asia, Ayurveda regards the patient's daily practices, social relationships, and environmental surroundings to be integral to diagnosis and treatment (Langford 2002; Nichter 1981, 2001; Sharma and Dash 1998; Zimmermann 1987). A humoral-based, integrated theory of the human body, non-medicalization of the human life cycle, and non-invasive techniques of diagnosis potentially make Ayurvedic practice less detrimental to female bodies than biomedical science has been shown to be. Within this broader framework of practice, specific characteristics of clinical interactions that make Ayurvedic medicine more acceptable to women include the following: (1) an experience-based and reflective understanding of the complex social and gender factors of health; (2) doctors' willingness to convey medical knowledge that involves appropriate explanation of the cause and cure for a condition; (3) skillful diagnosing of medical conditions utilizing non-invasive techniques that are familiar to women, such as pulse examination, evaluating foods regularly eaten, and identifying recent abrupt changes in living and other "environmental" conditions that may disrupt humoral balance; (4) reading certain cultural practices as biological, natural, or health-related in ways that reinterpret the language of women's impurity; (5) expressing an empathic rather than a detached objectivity toward the patient; (6) encouraging culturally relevant and feasible preventive medicine; (7) being staunch advocates of the Ayurvedic scientist's identity; and (8) critiquing biomedicine as misused in a poor country. The article describes these features in the women's medical practice.

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

In a recent excellent review of women's health ethnographies over the last twenty years, Marcia Inhorn (2006) notes a lack of feminist models to understand gender, culture, and health care. Here I would add to Inhorn's concerns a paucity of research on women professional practitioners of non-Western medico-science, and suggest a way to expand our understanding of women's health globally with the specific case of women professionals of Ayurvedic medicine. Their unique encounters with Western science and social change generate new considerations they must confront when treating patients and when reflecting on the roles of medicine, modernity, and science for women and for society. Their position importantly compares with women allopathic practitioners and indigenous midwives, two groups that have received considerable research attention. Ayurvedic women doctors, too, are highly-educated and skilled in a field that is medically and socially desirable for women, yet little researched they remain poorly understood.

In her review, Inhorn points out the disproportionate amount of research that anthropologists have conducted on women's reproductive roles (constituting between 75 and 90 percent of the ethnographies she reviews), suggesting that while this is a unique and important aspect of women's health care, more research could be done on other health care issues of concern to women. Here I take her observation to partially explain the lack of research on women professional providers, for not only have anthropologists (overly) focused on women's reproductive health, midwives and other informal providers of health care have been at the center of research attention by anthropologists and related others. The "production of health by women" (Inhorn 2006: 358-59) is significant in its quantity and quality, taking place in the home, in the midwives' quarters, and in the sacred spaces of spiritual healers. The record, though, leaves the impression that women are not significant players in professional medicine, those non-Western medico-science traditions that have histories and lineages of knowledge transmission found in formal and non-formal institutions. However, women have been part of indigenous Ayurvedic medicine's evolution and practice for at least the past century in South Asia, and the number of women formally trained in both Ayurveda and biomedicine has steadily increased with the acceptance of women's higher education. The production of health by women clearly also occurs in clinics and hospitals by professional practitioners of indigenous medicine, who provide for women's health and are agents of change and of resistance to modern practices potentially unfavorable to women.

Thus, the near invisibility of women professional healers in medical anthropology has limited our understanding of the gender dimensions of professional non-Western medicine and science, and has confined our models of the relationship between social change, gender, and health to informal female healers in a variety of communities (Huber and Sandstrom 2001; Jeffrey et al.

1989; Jordan 1983; Kaufert and O'Neill 1993; Laderman 1983, 2001; McClain 1995), and to male professional and informal healers in South Asian medical anthropology (Burghart 1984; Desjarlais 1992; Durkin 1988; Kakar 1982; Leslie and Allan 1992; Macdonald 1975; Maskarinec 1995; Nichter 1980, 1981, 2001; Nordstrom 1989; Obeyesekere 1992; Parker 1988; Stone 1976, 1986; Trawick 1992; Zysk 1991). In Nepal, where traditional medical practitioners such as shamans and midwives have been identified as bridges between the people and the state's modern messages of health care (Pigg 1992), we might ask about Ayurveda's parallel role and in particular, its female practitioners. Women providers from such traditions stand in a unique position not only to their patients, but also to the state. Thus, frameworks for understanding the relationship between modernity, gender, and health care must account for all forms of medicine in a plural medical system.

Locating Women Professionals

Professionals are understood here to be medical practitioners that skillfully apply an organized body of knowledge that is transmitted across generations in formal and informal contexts. They are sought by members of society for their expertise in diagnosing and curing a broad range of illnesses, and some have specialized in Ayurvedic subfields like *panchakarma* ("five actions" or therapies used for a variety of conditions) and obstetrics. In this article, I focus on professionals of indigenous or traditional medicine, and not professionals of Western, cosmopolitan, or allopathic medicine. In Nepal this group includes institutionally- and lineage-trained Ayurvedic doctors, commonly called *baidya* (a word that does not necessarily distinguish educational status, which can vary from 1-year certification to graduate level medical degrees). I limit discussion to women who received formal higher education in Ayurvedic medical colleges

and hold advanced degrees in medicine; I am excluding women baidya who apprenticed with relatives and others in non-formal settings, for they tend to be less integrated into the state's medical apparatus and hence are less impacted directly by the social change forces of concern here. Today in Nepal, approximately 15 percent of the Ayurvedic doctors holding the Bachelor of Ayurvedic Medicine and Medical Surgery degree are women. The number of women doctors-in-training is rising, comprising half the students in recently enrolled classes at Naradevi Ayurvedic Hospital and College, the majority of whom selected Ayurveda over biomedicine as their first choice in higher education, itself a trend reversal.

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

Feminist Insights on Science and Medicine: Non-Western Applications

Feminist theorists' critique of science and biomedicine and their insights on the role of culture and gender in medical praxis have provided me with an approach to identifying how women Ayurvedic doctors mitigate modernizing and cultural forces that erode their effectiveness and authority. Feminist scholars from anthropology, philosophy, and history have systematically identified the elitist, sexist, and objectifying practices of Euro-American science and biomedicine. The feminist epistemology that provides the foundation to my analysis here derives from several science critiques. As Mary Tiles (1987) has outlined it, the lineage of such projects and the very possibility of applying this Western-based critique to a non-Western context begins with the assumption that at least one of the three Platonic premises behind science is false: that every genuine question has exactly one true answer, all others being false; the method which leads to correct solutions is rational in character and identical in all fields; and, solutions are true universally, for all times and for all people (cf. Harding 1993). Ayurvedic tridosa theory (three humors) of the body and illness proposes a distinctly different model of the human in nature, provides several centuries of systematic knowledge accumulation and efficacy based on tridosa theory, and thus challenges at least one aspect of Western scientific epistemology, that there is only one true explanation for phenomena.

Questioning assumptions at the heart of Western scientific research has led to fundamental reformulations in knowledge around human issues. Within biological anthropology, we have witnessed the shift in models of human evolution from man the hunter to female-centered gathering (Tanner and Zilman 1976) and from baboons to chimpanzees (Sperling 1991) as a direct result of challenging the male bias in earlier evolutionary frameworks. Within medicine, feminist scholars focusing on race and ethnicity have revealed the troubling lack of ethics around medical experimentation in which socially inferior others (women and blacks) are used to

advance medical knowledge (Mwaria 2001). The interpretation provided here is greatly informed by Donna Haraway's (1989) proposal for an objectivity that is situated and embodied, producing knowledge that aims for reliable accounts of things not reducible to masculine projects of power, omnipotence, and immortality. Finally, the apparent contradictions in the lives of women Ayurvedic doctors – for example, when they advance naturalizing explanations of female impurity over stigmatizing ones, yet follow most cultural prescriptions for proper female behavior - follow the logic of Skeggs' (1994) "modernist" ethnography that concentrates on the complex formation of identity across a range of sites to produce multiple subjectivities. For her, multiple subjectivities are possible when we consider, as I do here, who or what controls and defines the identity of individuals, social groups, nations, and cultures. Taken as a whole, feminist studies of Western science provide me with rich tools to investigate non-Western science practices, in this case Ayurveda, and to ask whether Ayurveda displays a similar or different gender imbalance.

All of the women providers interviewed believe that as women they are in a unique position to care for women patients because they can recognize the social factors of health and are able to educate their patients on health maintenance and illness prevention relevant to their social and economic situations. Still, the doctors differ in their perceptions of other aspects of gender, such as the impurity associated with female bodies and the authority of men over women. Some continue to work within a medical establishment that hinders their professional advancement, while others work independent of direct male authority. Such realities engage with broader feminist concerns that the "female subject" be understood as contextualized historically and culturally, rather than possessing a fixed subjectivity (Skeggs 1994). Nepali women living in a

patriarchal society² are only partially empowered by their elite status as educated high-caste professionals, for they continue to confront cultural barriers to professional advancement and powerful discourses of Western biomedicine that challenge the legitimacy of their practice. Nevertheless, women baidya bring to medicine an awareness of the social conditions of women's health that might otherwise be absent in a male-dominated arena.

As practicing scientists, such women could be seen from the perspective of feminist standpoint theory as occupying heterogeneous and potentially more objective subject positions (Harding 1993), thus suggesting that Nepali women practitioners strengthen medical objectivity by enlarging the discourse of science's role in society and by extending notions of medical truth to include subjective and marginalized states. Women medical scientists employ objectivity by focusing on patients' subjective states and family and community values - an engaged and empathic objectivity - while diagnosing physical signs of aggravated *dosas*. Some of the women I have observed in clinical settings spend considerable time with patients, understanding their emotional states and family situations. At other times they act authoritarian: though they do not disregard their patients' feelings, they exhort them, for example, to stop eating foods that disrupt dosic balance. Such flexibility in clinical interactions makes sense when we consider them in the context of Nepali cultural values that regard persons as constituted by family and community influences that are typically hierarchical (cf. Pach et al. 1998), and from medical principles that assert the patient is nonetheless a unique dosic individual whose physical condition must be adjusted through a doctor's authority.

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

Women Ayurvedic practitioners' multiple roles as healers, wives, parents, and daughters constitute their identity away from a singular female identity to a multiple and fluctuating one. Highly-skilled and well-trained, they are also subjects of a state structure that privileges modern biomedicine over traditional medicine. Their lives are contoured by a patriarchal culture that limits women's ability to advance professionally due to household and family obligations. They embrace certain essentialist ideas, such as the belief that a woman's quintessential role is child-bearing, a natural and biological function that empowers women yet is not overly medicalized by *baidya*. The women providers treat most of women's non-birthing health problems, such as infection, indigestion, headaches, and painful menstruation, while regarding birth as a rather ordinary event compared to other health problems. Though a heterogeneous group, they all agree that because they are women they are able to provide medical care to women differently than male physicians. Although it is problematic to present women Ayurvedic doctors as a definitive case study of female empowerment, their claims to being uniquely positioned to understand the social contexts of gendered morbidity are persuasive and widely shared.

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

The women from the villages and remote hills hesitate to tell us about their gynecological problems. They carry heavy loads during pregnancy and immediately after delivery, and as a consequence they develop a prolapsed uterus. But they do not know exactly what it is, and when they finally tell their mothers-in-law, they are told to keep quiet and that

such a condition is typical. But the condition worsens and becomes chronic, yet they are still not taken to the hospital. The in-laws need the daughter-in-law at home to do the chores, and so they claim they do not have money for treatment (interview July 7, 2000).

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

Medical modernization

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

As a result of widely circulating modern health care discourse, Ayurvedic medicine has met a powerful competitor in international donor-driven and state-supported biomedicine, as the government and development organizations frequently construct it as less scientific than biomedicine. The dichotomy shaping health development discourse presents rational Western therapies and hygienic practices as superior to indigenous, irrational, and potentially dangerous healing systems (Pigg 1992, 1996). One example is recent legislation that seeks to regulate Ayurvedic practice. The Nepali government, following biomedical management, passed in 1998 the Ayurvedic Council Act of 1988 which stipulates that individuals practicing Ayurveda must register with the Department of Ayurveda. Those without institutional certification must meet strict conditions in order to continue treating patients and manufacturing Ayurvedic medicines. The legislation's impact on Ayurvedic practice has altered the relationship between formally- and non-formally-trained baidya (Cameron 2009b). Other modern influences on Ayurveda include the proliferation of allopathic drugs, the government's greater support for biomedical education, the loss of medicinal plants through environmental degradation and illegal exportation, and escalating Indian influence over the export of Himalayan medicinal plants (Cameron 2009a).

Woman-Centered Medicine

Empathy and Authority

At one level, women Ayurvedic doctors clearly practice female-centered therapy by the sheer numbers of women patients they see. This pattern is attributable to female patients preferring women doctors; male doctors, aware of this preference, are hesitant to treat female patients if female doctors are conveniently available. At the hospital that Dr. Shrestha supervises, for

example, women's and men's wards and massage therapy facilities are separate. As she and I talked one late morning in March of 2005, a male colleague interrupted our conversation seeking advice on the "difficult" application of heat to a woman's hip. I offered to end our conversation so Dr. Shrestha could attend to the patient. Another woman doctor, Dr. Katambari Acharya, explained to me that "female patients expect to have female doctors. They feel they can be more open to talk about their problems with female doctors than with male doctors" (interview July 26, 2005).

A new health facility for women on the outskirts of Bhaktapur provides examples of Ayurvedic medical approaches that appeal to women patients. Devima Om Hospital is a new three-story building on a footpath leading from a dirt road that eventually takes one to Bhaktapur. It was inaugurated five years ago by a group of women that invested supplies and money to launch a rural hospital specializing in women's reproductive health care. The staff successfully delivered eight babies during the hospital's first two years. A large photograph of the eight mothers and their infants hangs in the overnight patients' room; the woman doctor, a new graduate of Naradevi Ayurvedic Hospital and College and Dr. Shrestha's protégé, stands tall and proud behind the seated mothers holding their plump babies shining with mustard oil and gajal-lined eyes.

On a normal day, the modest hospital receives between five and six patients. In its first year it received nearly one thousand patients. The staff is paid and the buildings are rented, but Dr. Shrestha does not receive a salary. She uses money earned lecturing in the United States for a few months each year to finance the private hospital, which has an annual budget of between eight and ten thousand dollars. The all-female staff consists of one full-time Ayurvedic doctor, two Ayurveda Community Health Workers (CHWs), two midwives with training in Ayurveda,

and a cook and cleaning person. At least two staff members stay at the facility overnight, the others board in a house next door, and the doctor stays over some nights. The midwives trained for one and one-half years, and the CHWs trained for six months. Dr. Shrestha is on call for emergencies, advising treatment over the phone or summoning an ambulance if the situation requires. There is an Ayurvedic pharmacy on-site.

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

The patients at Devima Ayurvedic Hospital told me they were very pleased when the hospital opened in their community to provide prenatal, delivery, and post natal care within a medical tradition that their experiences told them was efficacious and less "harsh" than allopathic medicine. "We believe in Ayurvedic medicine," one middle-aged woman commented. Twenty-four hour medical assistance was particularly reassuring to them. Flexible fees, short waiting periods, culturally-relevant advice on health and illness, and a respectful staff also contributed to a satisfying clinical experience.

The quality and tone of patient consultations reflect the woman doctor's authority and the patients' acceptance of it. In South Asian clinical settings one often hears an "eldering" tone in

provider–patient dialogue, a culturally acceptable assertion of professional authority. Dr. Shrestha consulted with her patients as an active listener and a wise advisor, gaining the trust of her patients by examining them gently and by inquiring about family and farm. Indeed, patients agree with Dr. Acharya’s explanation that women doctors are “softer in nature and talk to the patient like a sister or a mother” (interview April 6, 2005). But when giving medical instructions that include admonishing unhealthy behavior, Dr. Shrestha and others adopt a strong tone like a parent correcting a child. Having repeatedly observed this approach in Ayurvedic clinics, I found surprising both the doctors’ abrupt code-switching – from active listener to strict lecturer – and the patients’ willingness to accept the stern tone of the doctor. I realized, though, that in a complexly stratified society like Nepal, where a person’s social rank is determined by gender, age, caste, and class, such elderring is acceptable to patients, who rarely directly challenge the doctor’s advice, though they always seek clarification and may sometimes complain about food restrictions. Importantly, cultural scripts like these allow professional women to exert authority regardless of their gender, and to have that authority respected. In turn, patients recognize their own power in health care. For example, they keep their own medical records, they are free to select among a variety of professional healers, and they can even damage a doctor’s reputation through negative gossip.

Expanding Science, Limiting Biomedicine

“There must be a scientific understanding. Without that we cannot understand fully Ayurveda. With science, Ayurveda can understand allopathic medicine, and allopathic medicine can understand Ayurvedic medicine.”

- Interview with Dr. Devkhola Bhandari, March 29, 2005

In considering the rise of biomedicine in their country, women doctors distinguish between biomedicine and science. They regard science to be an approach to accumulating knowledge that is systematic and replicable, which also includes Ayurveda. Biomedicine, on the other hand, is problematic for them. Ayurvedic doctors are particularly concerned about biomedicine overwhelming Nepal's plural medical system, not because it is more efficacious but because it is more powerful. The doctors reject narrow scientific vocabularies of medical management that are borrowed from global biomedicine and applied to Ayurveda, for example in the form of licensing regulations and other strategies used by the Ministry of Health to manage Ayurveda. In critiquing biomedicine, the doctors point out certain ironies. Dr. Shrestha observes that nearly half the allopathic doctors she knows prescribe Ayurvedic drugs while at the same time criticizing Ayurvedic doctors for prescribing allopathic drugs. Many biomedical doctors do, indeed, use and prescribe Ayurvedic medicine for their families and their patients, including high-level administrators in the Ministry of Health.

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

Still, the doctors differ in the degree to which they integrate Ayurvedic and biomedical practice. Dr. Bista, who we will discuss later, has several relatives who are allopathic doctors and

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

Let us now turn to illustrative periods in the lives of women Ayurvedic doctors to see how they embody and employ practices that make them unique as medical professionals for women.

Dr. Parbati Pradhan and Ayurvedic Medical Training

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

Dr. Pradhan was educated during a period when King Mahendra began radically transforming Nepal's educational system, a process which was continued for several decades after his death by the eldest of his three sons, King Birendra. The traditional Sanskrit-based curriculum of Ayurvedic medical education was converted to an English- and Nepali-based curriculum that integrated biomedicine, and its administration was moved from the Ministry of Health to the Ministry of Education. This move split the regulation of professional Ayurvedic practice from the formal educational system, a division that continues today. The Madhyama and Shastri Degrees of the Sanskrit system were replaced with the Intermediate Degree in Ayurvedic Science and the Bachelor's Degree in Ayurveda; the Acharya Degree (equivalent to an M.A.) was eliminated.³

When she began her medical practice as a young doctor, Dr. Pradhan charged patients very little to nothing for her medical expertise. She explains this arrangement as a suitable compromise between her professional expectations as a physician and Nepali cultural constraints that discourage married women of high caste from earning outside income. The decision she reached is in line with Ayurvedic professional ethics that encourage doctors to be motivated by compassion for the suffering of others rather than by the riches one might receive.

³ Many people believe the reforms weakened Ayurveda by integrating it with biomedicine. Currently, the new educational system requires four and one-half years post-I.A. Degree to obtain the Bachelors in Ayurveda and Modern Surgery degree; five and one-half years earns one a graduate degree. Ayurvedic education in Nepal reached a low point one year after Dr. Pradhan graduated, in 1972, when the new educational system was enacted. Higher degrees in Ayurveda were not offered in Nepal until about a decade ago.

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

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

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

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

Unconventional Marriage

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

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

I finished a two-year course on Ayurvedic medicine at Naradevi and then when I was in my first year of the Shastriya course, I got married. I married at a young age and had to struggle to continue my studies. My husband was a teacher. I wasn't treated well in my husband's home. I had to cook for all the family members but I wasn't given much to eat. Often I had to rush to campus without taking any food. My husband is a simple

gentleman who does not like to say anything on these matters. When he found out that I wasn't eating, we decided to live separately from my in-laws. He even took care of the cooking so that I could study (interview March 22, 2005).

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

Dr. Sita Bista: A Journey to Healing

Dr. Bista was born in the Indian state of Sikkim 37 years ago. She studied in Bangalore in a pure Ayurveda program, one that was not integrated with modern medicine, although she is the only doctor among those with whom I work who occasionally and unapologetically prescribes biomedical drugs. Dr. Bista began studying Ayurvedic medicine when she was 19, after securing a scholarship from the government of Sikkim, and graduated at 24. Her brother, whose opinion she greatly trusts, advised her to study Ayurveda, even though there are family allopathic

doctors, including her own father. In fact, Dr. Bista had not heard about Ayurveda until she went to study it, and was most surprised to learn that much of the course work was in Sanskrit, a language she did not know. She describes the winding journey that took her to Ayurveda.

My father is an allopathic doctor. In fact there are six or seven allopathic doctors in my family. In Sikkim we do not have a university or an Ayurvedic college. So in order to produce doctors, the Ayurvedic colleges in India established scholarship quotas for the people of Sikkim. The year I passed the I. Sc. there were two seats for Ayurveda for the first time in Sikkim. My brother is a lawyer and he tried to get me a medical seat. I even got an M.B.B.S. seat in Bihar. On that same day the health director told me that there was also an Ayurveda seat ... I could try for that. My brother thought that Bihar was not a good place, so I applied for the Ayurveda seat and on the first attempt I got it. It was in Delhi but there was no women's hostel. Again I applied for any college that had a hostel. And the next seat was from Bangalore. That is where I went.

Until then ... I had no idea what Ayurveda was. I knew I wanted to become a doctor. I had scored 89 percent in I. Sc. and I was sure that I would get a medical seat. So this was how I came to Ayurveda. When I went to the college the very first class was in Sanskrit. I thought to myself "what is all this?" My classmates told me ... that everything would be in Sanskrit. After that I started taking tuition classes ... and I committed to finish it (interview July 3, 2000).

Many of the doctors with whom I work, including the informally-trained village healers, chose their practice because of an inspirational family member in Ayurveda. Still other

Ayurvedic doctors have children who go on to practice biomedicine. Dr. Bista's path is unique, coming from a family of biomedical doctors as she does. She recently completed studying Ayurvedic obstetrics in India, funded through the Nepali government and the World Health Organization, and returned to fill the obstetrician's position at Naradevi Teaching Hospital.

Constructing Scientist Identity

Feminist scholars note that the process of symbolically naturalizing cultural and social phenomena depoliticizes gender issues by carrying the belief that such social arrangements are immutable biological facts. For example, Nancy Theriot's (1993) work on the history of locating mental illness in women's reproductive organs illustrates how this notion became embedded in the development of specializations in Western medicine. When naturalizing constructs draw from the discourse of science and medicine, they become powerful tools to obfuscate social inequalities, blocking understanding of the social determinants of health. Women Ayurvedic doctors, too, assert natural reasons behind the ancient medical texts and society's Hindu-based beliefs about women's menstrual and other bodily impurity – and they do so with medical certitude and scientific authority. However, in this case, the natural rationalization potentially empowers women in recognizing their heavy work burdens and the need to not overtax the body's humoral balance that menstrual "seclusion" brings (temporary cessation of household work and most farming and artisan work). Thus, the ambiguous result of naturalizing the social stigma of impurity pits medical science against religion; it is not unusual to find some doctors professionally extolling natural explanations while personally following Hindu precepts that at least partly assert that women have a status lower than men. A good example of this occurred

one late morning in July 2000 when I was interviewing Dr. Bista after her busy morning of seeing several pediatric patients and meeting with three Ayurvedic drug representatives.

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

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

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

Dr. Pradhan, too, presents herself as an objective professional healer in her response to my question about difficulties she experienced while studying. Treating the human body objectively allowed her as an intern to administer care to all patients regardless of gender while being particularly effective in caring for women who were fearful of male physicians causing them shame and dishonor.

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

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

Conclusions

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

The discussion here of Nepali women Ayurvedic doctors finds differing answers to these questions. Indigenous practices beneficial to women are potentially changing under the influence of modern medical regulatory standards; gender sensitive and equitable service are impeded by

state regulation over professional identity, and the government's position that Ayurveda is not a modern medical science impacts women professionals' agency. Countering this are politicians who request more Ayurvedic facilities, and the new communist party leadership supports increased funding for biotechnology research on medicinal plants, among other things (Guo 2008). Finally, cultural factors that influence women practitioners' professional identities and lay women's health status might progressively transform with modern ideas.

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

Women doctors must increasingly negotiate with new medical paradigms and power so as to best provide services to their patients. In Nepal, gender issues in professional indigenous medicine exist in a region that is home to one of the world's oldest medical traditions, and where

some of the world's highest rates of infant, child, and maternal mortality and child morbidity lead to significantly shortened lives. Strengthening Ayurvedic medicine would encourage talented women wanting to practice this living, ancient medical science, particularly at a time when the value of plural medical systems is increasingly recognized. As we consider ways to improve women's health globally, paying attention to women providers of indigenous medicine that advocate for its efficacy, local availability, low cost, and cultural value is critical. The findings presented here suggest that from the perspective of Nepali women doctors, women's health is positively affected when more women are practicing indigenous medicines like Ayurveda.

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