

With One Heart: Medicine, Culture, and Tibetan S

STORY AND PHOTOGRAPHS BY SIENNA CRAIG

Lhakpa Dolma sat under the shade of a cottonwood tree, on a brilliant autumn day in Tibet. The tree's leaves blazed gold in the waning light, and the river, beside which we sat, coursed clear and cold over small boulders. A neon blue wool scarf, woven through with silvery thread, covered Lhakpa Dolma's head and shaded her eyes from the high plateau sun. Her chapped cheeks hinted at days spent under the clear intensity of Tibet's skies. It was harvest time and she had worked alongside other villagers all day, cutting barley stalks; soon they would begin the threshing.

Lhakpa Dolma wore another scarf across her back, into which had been tucked an infant. The child appeared to be sleeping. Older village children scampered about, tossing discs of dried yak dung at each other. The brave and curious among them approached me—the yellow-haired foreigner who spoke their language—and gawked. As Lhakpa Dolma and I talked, a bus driver, a few cyclists, and a man in a horse-drawn cart moved past us, each with his eyes cast down against an imminent sunset.

"How many children have you had?" I asked Lhakpa Dolma, beginning our interview.

"Three," she said tentatively. "But I only have two now."

"When did you lose the other child?"

"It came early and didn't live long," she answered. Her eyes did not meet mine.

"Why do you think the baby died?" I asked.

"Maybe because I was working too hard," she said. "Or because I carried heavy things on my back. Many women say this can cause a child to die, or make birth difficult. But if you don't work when you're pregnant, that is not good either. You become weak. When the baby's time arrives, you struggle."

"Who did you tell when you knew you were pregnant? When did you tell them?" I asked.

Lhakpa Dolma's face flushed. Although she had given birth three times, simply speaking about pregnancy made her embarrassed even now. This reaction was characteristic of the Tibetan women I spoke with.



"I told my husband at about three months. Everyone else knew when I started to show," she answered.

"How old is your new baby?" I gestured toward the sleeping bundle on Lhakpa Dolma's back.

"About one month."

"Did you find the birth easy or difficult?" I asked. "Did you give birth at home, in the township clinic, or in the county hospital? Who helped you?"

"The birth was okay. Not too painful," responded Lhakpa Dolma. "I gave birth at home. I've never given birth anywhere else. With this baby, my husband was with me. With my eldest daughter, I had help from my mother-in-law. But the old woman has since died."

"Where did you give birth?" I continued. "Who cut the umbilical cord?"

"After my water came, my husband prepared a place in the corner of our house, away from the hearth."

"Why away from the hearth? Do you worry about pollution?" I asked.

Lhakpa Dolma nodded. "My husband was there with me, but he could not help me cut the cord because he would have to do the cooking while I recovered. So, he handed me a knife and I cut the cord myself. If he had cut the cord, he would have been polluted. He couldn't have cooked for us."

"Did you clean the knife before or after you cut the cord?"

"After" she said. "To get rid of the pollution."

Lhakpa Dolma's response was typical. In Tibetan culture, as in many other cultures, rules about pollution and purity govern

much social behavior. Birth itself is considered a defiling, and therefore dangerous, activity. Yet pollution is not the same as what we might label “dirty” or “unhygienic.” It does not relate to germs or grime but rather to physical elements, such as blood and iron, as well as states of being. Likewise, purity is not restored by a good scrub with soap and boiled water; instead, substances such as juniper incense and butter are used to purify what many Tibetans perceive as a polluted environment.

“Would you consider giving birth at a clinic or a hospital?”

I asked.

“Maybe,” she responded, blushing. “If something went wrong. If I bled too much or if the baby did not come.

But then, I would have to find the money for a ride on a tractor, or in a car. In an emergency, sometimes people charge you more.”

“I know a few women who have gone to the hospital,” she continued. “But sometimes they die there. Or the baby has its soul snatched. With all those strangers around, anything can happen.” Lhakpa Dolma spoke with a sense of authority now, as if she had heard this adage many times. According to Tibetans, a young sentient being, not yet at home in this world, is particularly vulnerable to assaults by spirits or demons.

“Before your baby was born, or after, did you go to the township clinic for check-ups?”

“I went once or twice before giving birth. I know that I should go more often—they tell us to come at least every few months—but the ride to the clinic is expensive.” As if to illustrate, Lhakpa Dolma glanced toward the road, where a rickety, blue tractor was making its way back to the village, loaded with hay.

“I would only take a child to the doctor if it were sick—if it refused milk, for example, or had a fever.”

“Do you know many women who have died during childbirth?” I asked.

“A few,” said Lhakpa Dolma. “Sometimes there is too much blood. Other times they are weak. They have fevers, their milk dries up, then they die.”

“How did you feel when you gave birth? Were you scared?”

“Scared, yes. Happy and scared.”

Unlike many cultures in the world, Tibetans have no history of formalized traditional birth attendants, or midwives. A sister or mother-in-law often assists during childbirth, but women just as often give birth alone. Sometimes they will deliver in an animal pen, so as not to offend household protector deities or pollute the hearth. Women rarely prepare for a birth, as it is considered inauspicious. Even in the postmodern milieu of urban Lhasa, with its high rises and wide boulevards, many women still give birth at home; hospitals and skilled birth attendants are used as a last resort by many women. From a biomedical and public health perspective, many of these behaviors are viewed as unsafe. They put women at risk of dying from manageable complications such as pre-eclampsia, sepsis, or postpartum hemorrhage. Practices such as giving birth amidst yak dung or household dirt, cutting the umbilical cord with

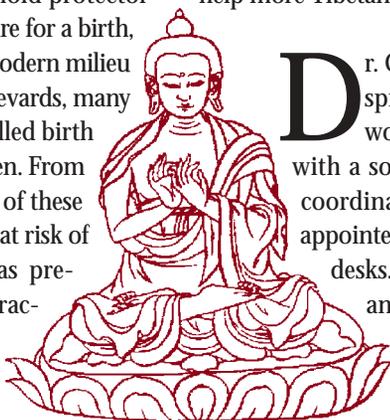
an unsterilized instrument, or feeding a child anything other than breastmilk for the first six months of life, places Tibetan women and their children in harm’s way. These behaviors contribute to the high maternal and infant mortality and morbidity rates among Tibetan communities.

And yet, during pregnancy, Tibetan women will seek blessings from Buddhist teachers, to ask that the fetus is protected, or sometimes from traditional Tibetan doctors, who analyze the health of mother and child by pulse diagnosis. Sometimes expectant mothers will eat special foods, including the sustenance of ritual, or *chinlab*, divine blessing. Women and other family members will go on pilgrimage and make offerings, in preparation for a safe delivery. Likewise, Tibetan women will avoid water mills because the churning movements of the water can cause the umbilical cord to wrap around a fetus’s neck. After birth, mothers will often ask a respected lama to name the child. If an infant gets sick frequently, parents will give the child a new name—that of a blacksmith, for instance, or others whom Tibetans consider to be of low birth—as a way of tricking malevolent forces into leaving the child alone. When a child is a few days old, the new member of the community is honored with elaborate life-welcoming ceremonies and a first feeding of *gyu mar*, a substance most often made of butter and roasted barley flour—staples of life on the Tibetan Plateau. This act not only grounds the infant in this world, but also ties the child to its home and lineage, endowing this new life with the strength of generations.

Medical anthropology teaches us that illness and healing can never be reduced to biology. Culture matters. But the specters of biomedicine—the possibilities of its miracles and its more mundane public health benefits—are ever present, driving health policy and defining what we mean by “disease” or “risk.” Here in Tibet, birth is part of the larger cycle of death and rebirth that Buddhists call *samsara*, cyclic existence. It is also commonplace: something that happens between harvest and threshing, or as people move from high summer pastures to winter dwellings. Yet birth also precipitates much pain, suffering, and fear among many Tibetan women. For a rural Tibetan woman to survive a complicated delivery, or for a child to live past age five, is to beat the odds.

And so, we are faced with a challenge: how to work with Tibetan culture, to respect and honor it, and at the same time help more Tibetan women and children survive?

Dr. Gephel balanced two paper cups, filled with sprinkles of loose jasmine tea, in each of his work worn hands. He opened his office door with a soft kick. Namgyal, our Lhasa-based project coordinator, and I followed him. The office was appointed with rusting file cabinets and two wooden desks. The walls were graced with anatomy charts and TB prevention campaign posters and a portrait of Mao, Deng, and Zhao on a pastel background, framed in fake gold leaf.



We envision a world where tradition and modernity work together



As the co-director of this county's Epidemiological Prevention Services (EPS) program, Gephel shared this room with another county doctor. The Maternal and Child Health (MCH) unit, for which Gephel was also responsible, occupied the adjacent office. Namgyal and I had come to talk with Gephel about infant and maternal mortality, and the obstacles to safe births in his country. We were a motley crew that included traditional Tibetan doctors, Tibetans trained in Western medicine, American doctors, nurses, midwives, and medical anthropologists, and a translator or two. Despite our differences, we had a common goal: to reduce the mortality rates for pregnant women and their newborn babies in the Tibet Autonomous Region (TAR), which are among the highest in the world. This experiment in integrated healthcare, a hybrid of research and direct intervention, is the first of its kind in Tibet.

For the past five years, the OneHEART (Health Education and Research in Tibet) project has helped to provide medical education and teach preventative health care practices, with the goal of reducing maternal and infant morbidity and mortality among Tibetans. OneHEART partners with the TAR and Lhasa Municipal Health Bureaus, as well as with the Mentsikhang, Tibet's Traditional Medical Hospital. Our aim is not to replace traditional health practices, but to work with urban Tibetan doctors, rural health care providers, and village women to improve health statistics. In that sense, the project is explicit about the need for communication, collaboration, and respect between rural and urban communities, and across medical systems and cultures. As part of this effort, OneHEART's American and Tibetan partners have worked to develop a curriculum for midwife training that draws on the best practices of both Tibetan medicine and Western biomedicine, and which takes into account Tibetan cultural norms and practices surrounding birth. In the past, these three-month training programs, aimed at township-level health workers and country doctors, have relied on the expertise of American doctors, nurses, and midwives. Since the spring of 2003, OneHEART's midwife training course has been taught primarily by Tibetans.

OneHEART was founded by Arlene Samen, a maternal fetal medicine nurse practitioner who has worked around the world since 1984, and who developed a deep commitment to Tibet. As OneHEART has grown, this project has come to include advanced training in obstetrics and pediatrics for Lhasa's municipal doctors, workshops in research and hospital administration, and community outreach programs, as well as research and interventions geared toward reducing infant mortality.

However, the core of this project's efforts remains that intimate interaction between an expectant mother, her child, and the people who help shepherd this new life into the world. In its aspirations, this project is trying to bridge the gaps of culture and experience between birth practices regarded as "safe" by biomedical doctors and public health experts, and what is thought of as "safe" by the majority of rural Tibetan women. The chasm between these two worldviews, our cross-cultural and multidisciplinary team reasoned, not only could be bridged, but must be bridged, if we really want to make an impact on the survival of Tibetan mothers and children.

The OneHEART team had been working with Gephel since 2002. He facilitated visits to town clinics and oversaw interviews with women about their experiences of birth. He also helped to select trainees for our most recent midwife training course and, in the coming months, would monitor their progress. Gephel is one of those rare individuals who could navigate the relationship between rural life and urban policy with grace. He and I had met briefly in Lhasa, where he had seemed shy, his country accent strong, a bit out of place. But now, in his stained though ironed suit, as he sat in this functional, drab office, with its toothpaste-green wainscoting, Gephel seemed in his element. I asked him of his history. The middle-aged man had a smooth face and a wide smile; unlike most officials I had encountered, he was approachable, even kind.

"How long have you worked at this hospital?" I began.

"Since 1985. I came from one of the townships in this county, where I had been a doctor for five years," Gephel answered. "I've been the director of the Maternal and Child/GYN unit of the county hospital since 1989. I'm from this county, and I always knew that I wanted to come back and work here. It helps to know a place. But it took me a while to get back."

Gephel explained that he had been recruited as a barefoot doctor in 1970, when he was in his early 20s. After several years of this work, which took him far afield from his native county, and to which he referred with no hint of nostalgia, Gephel was able to find a Tibetan doctor, or *amchi*, who was willing to teach him the basics of Tibetan medicine.

"I worked with him for three years, living with his family. That *amchi* taught me to read and write in Tibetan. I studied the medical texts with him and began to learn pulse diagnosis. We went into the mountains where he collected medicinal plants. He showed me how to make medicines. I learned how to make eleven kinds—by hand." Gephel spoke with a sense of wonder as he looked back on this part of his training.

“Those were difficult times,” he continued. “China was poor then. We didn’t have the medicines or the knowledge we do now.” The math was simple enough: Gephel had found his Tibetan medical teacher—somewhere, somehow—during the denouement of the Cultural Revolution.

“Why did you want to learn about Tibetan medicine, after you’d already begun studying and practicing Western medicine?” As I asked this question, the details of language struck me. In Tibetan, one can either refer to biomedicine as “medicine from the West” or “foreign medicine,” though the latter can also mean medicine from *gya nag*, China. Each variant of this concept, in Tibetan, illustrates that the logic of health and illness based on theories of pathogens and discrete diseases promotes a foreign sensibility: a profound shift from the logic of Tibetan medicine. By contrast, that system defines ignorance as the root of all illness. Tibetan medicine is based on a diagnosis and treatment system bound up in the three humors (roughly translated as wind, bile, and phlegm) and the five elements (earth, air, water, fire, and space), in conjunction with an individual’s present environment and behavior as well as the karma of past lives.

“I wanted to learn about Tibetan medicine,” Gephel answered, “because it is how most people think. For example, many women know, in their brains, that they should go to the clinic for check-ups, or to give birth. But their heart-mind experiences something different. They feel they should give birth at home; there is a distrust in hospitals. ‘Will the doctors really be able to help me?’ they wonder. ‘Or will I die in the clinic?’

“But women also suffer during birth because our health workers are over-burdened and many don’t have enough knowledge or experience. People working at township clinics are supposed to take care of everything from births to deaths. They are always tired. Sometimes they are very young.”

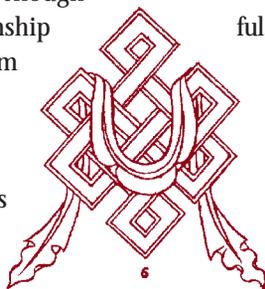
As Gephel spoke, I recalled a conversation with one of OneHEART’s midwife trainees. She was 22 and had received two years of training before she had been posted to a clinic in a nomadic region of northern Tibet. Of the six deliveries she had attended in the last year, one mother and two babies had died. In one case, the woman refused to stay in the clinic after delivery; she went home and succumbed to sepsis. In another, a child had been born “breathless” and the young healthcare worker was at a loss as to how to revive it. As she recounted these stories, she hid her face in her hands and cried.

While listening to Gephel that afternoon, I also recalled something a European doctor who has worked in Tibet for nearly a decade once told me. He had said, “The most difficult thing about doing healthcare work here is that most people are convinced Western medicine was invented in China, in 1950, and that nothing has changed since!” In this context, it was worth asking if “Western medicine” and “biomedicine” necessarily meant the same thing. The disjunction between state-of-the-art obstetrics and rough-and-ready medical practices—such as

the proliferation of IV antibiotics or the manual removal of placentas that one sees in Tibet’s township clinics—was part of the gap our project was trying to directly address. On the one hand, our challenge remains to find a middle ground between a village woman’s understandings of what safe birth entails, and the guidelines and practices endorsed by global institutions such as the White Ribbon Alliance or the World Health Organization. On the other hand, we also need to navigate the divides between Tibetan government health care policy and infrastructure, the demands on local health care providers, and what Tibetan medicine can offer in terms of maternal and child medicine.

Sowa Rigpa, or the Tibetan science and art of healing, includes classical texts and modern commentaries that discuss topics such as embryology, diet, and behavior during pregnancy, even neonatal care, in great detail. Tibetan medical pharmacology includes powerful medicines for afflictions that biomedicine would define as postpartum hemorrhage or anemia. And yet pregnant women are often ashamed by the facts of birth, undernourished, and overworked during pregnancy, and often alone during birth itself. These paradoxes—gaps between elite cultural and medical knowledge and the realities of Tibetan village life—further complicate OneHEART’s project goals. They raise questions about what it means to heal or to save a life, as well as what a safe motherhood campaign and midwife training program should focus on in Tibet. But more than this, we are asking—and attempting to answer—how modernity and tradition might coexist in today’s Tibet, how a culture can at once transform and yet retain its essence, its meaning.

“Tibetan medicine and Western medicine are both useful,” Gephel continued. “Each can be beneficial, even complementary.” His comments, made me think about “integrated” medicine in yet another way. In the first instance, he had no choice about becoming a doctor—and a biomedical practitioner at that. But even in the fragile years of the Cultural Revolution, he had managed to seek out a Tibetan medical teacher, and, in the process, to learn about pulse, humors, and the herbs that grew on the hills of his home. For him, the seemingly complicated interaction between biomedicine and Tibetan medicine—between two ways of seeing health and illness—had become a non-issue. He used both, believed in both. The county MCH office was decorated with framed charts of maternal and infant mortality records: a sweet and yet strange aesthetic in this healer’s domain. In explaining why women and children suffer and die in Tibet, he often found explanations for the causes in Chinese translations of biomedical terms. In other instances, he evoked imbalances in the humors of wind, bile, and phlegm, or workings of the heart-mind. A dual, if not integrated healer’s sensibility rolled off his tongue, fluent. And that is what we have to work with. ■



SIENNA CRAIG, a *Ph.D. candidate in cultural and medical anthropology at Cornell University*, is co-founder of DROKPA, a non-profit that sponsors grassroots development on the Tibetan Plateau. For more information: lhamo47@hotmail.com, or visit: www.uuhsc.utah.edu/oneheart