

Medicines, Travellers and the Introduction and Spread of ‘Modern’ Medicine in the Mt Everest Region of Nepal

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Abstract: The significant contribution of medicines in the introduction and spread of ‘modern’ medicine has, with the exception of vaccination, been neglected in historical studies, yet medicines have been a significant factor in people’s experiences of sickness and in their use and non-use of health services. Although medicines are implicitly acknowledged in the literature as important in the provision of health-care, this article uses a case study of the Mt Everest region of Nepal during the second half of the twentieth century to argue that medicines have had an explicit and central role in the introduction and spread of modern medicine in this region. It also highlights the importance of travellers in the process. While this article focuses on biomedical products, modern medicine, as elsewhere in the wider Himalayan region, continued to be practised within a changing but plural medical environment. The first part of the article discusses medicines and travellers who, in the absence of biomedical services, were the main source of medicines prior to the mid-1960s, while the second part considers medicines and Khunde Hospital, which was built in 1966 by the area’s most famous overseas traveller and became not only the area’s main provider of modern health services but also the main source of medicines.

Keywords: Medicines; ‘Modern’ Medicine; Medical Pluralism; Travellers; Nepal; Sherpas; Sir Edmund Hillary; Khunde Hospital

Introduction

‘This assistant could be taught the uses of the appropriate pills for the treatment of the major fevers, dysentery and high altitude headaches. Besides assisting the party home, it would slowly diminish the deep-rooted superstitions that exist in the home villages,’ wrote New Zealand mountaineer Norman Hardie in his account of the several months

in 1955 that he spent living among the Sherpas of the Mt Everest region of Nepal.¹ European travellers, and the routes taken, have had a considerable influence on the introduction and spread of 'modern' medicine in many parts of the Himalayan region, and Hardie was under no illusion about the importance of the 'appropriate pills' for treating sickness and also for promoting this new system of medicine to the inhabitants of the area.²

While it can be argued that such a comment about the importance of medicines was not surprising in the 1950s, when the discovery and introduction of many new medicines (and particularly antibiotics) were revolutionising medical treatment, especially for infectious diseases, twenty years earlier, Lieutenant-Colonel F.M. Bailey, in his report from the British Legation in the Nepalese capital of Kathmandu to the Foreign Office in London, wrote that 'A large number of pensioners come in from the surrounding areas. . . They make use of the opportunity of obtaining medicines from the Legation hospital.'³ Earlier still, the Indian explorer Hari Ram travelled through the Everest area for the Survey of India in 1885. He was disguised as a 'baid' [physician] and carried with him 'a stock of European and native medicines'.⁴ Even if Hari Ram had more 'native' medicines than European ones, the carrying of medicines was normal practice and they were intended for giving out to the local population.⁵

Medicines are a key tool in the prevention and treatment of sickness, but, although interest in medicines is increasing in the literature, their central role in the introduction and spread of modern medicine in the late nineteenth and twentieth centuries, apart from vaccination, has been given inadequate attention in histories of medicine. Yet, as Michael Worboys notes, medicines 'more readily transferred across cultures than other features of Western medicine'.⁶ While medicines are viewed as part of the material culture of empire,⁷ historical studies about the introduction and spread of modern medicine more commonly examine knowledge, power, disease, institutions and people. Alex McKay, in his study of the development of modern medicine in the Himalayan region, focuses on the political environment in British India and the conversion strategy of Christian missionaries.⁸ References to medicines are scattered throughout the text and

¹ Norman Hardie, *In Highest Nepal: Our Life Among the Sherpas* (London: George Allen & Unwin, 1957), 121.

² In this article I have mostly used 'modern medicine' to refer to what is variously referred to in the literature as Western medicine, modern medicine, biomedicine, scientific medicine, cosmopolitan medicine or allopathic medicine. Multiple terms reflect multiple views. In Nepal, 'modern medicine' and 'modern medicines' are commonly used, as is 'allopathic'.

³ Annual Report, 1935 and 1936, Nepal. File: Nepal, General, Annual Reports 1937–1945 EA 1 Box 132 240/1/2 part 1A [Archives New Zealand/Te Rua Mahara o te Kawanatanga, Head Office, Wellington, hereafter ANZ].

⁴ Report on Routes by Explorer Hari Ram, *Records of the Survey of India: 8(2) Exploration in Tibet and Neighbouring Regions, 1879–1892* (Dehra Dun: Survey of India, 1915), 383.

⁵ 'I have always made my explorers take a supply of medicines with them, mostly of native kinds, with only a few ordinary European sorts to present to people on their journeys.' Memorandum on the Trans-Himalayan Explorations for 1871 by R.E. Montgomerie, Deputy Superintendent G.T. Survey, in charge of the Trans-Himalayan Exploring Parties in *Records of the Survey of India: 8(1) Exploration in Tibet and Neighbouring Regions, 1865–1879* (Dehra Dun: Survey of India, 1915), 116.

⁶ Michael Worboys, 'The Spread of Western Medicine', in Irvine Loudon (ed.), *Western Medicine* (Oxford: Oxford University Press, 1997), 249–63; 255.

⁷ Jude Hill, 'Globe-trotting Medicine Chests: Tracing Geographies of Collecting and Pharmaceuticals', *Social & Cultural Geography*, 7, 3 (2006), 365–84; Ryan Johnson, 'Commodity Culture: Tropical Health and Hygiene in the British Empire', *Endeavour* 32, 2 (2008), 70–4.

⁸ Alex McKay, *Their Footprints Remain: Biomedical Beginnings across the Indo- Tibetan*

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allude to their important role in the introduction and spread of modern medicine in the region. McKay quotes from the diary of Captain R.S. Kennedy of the Indian Medical Service, who was travelling in Bhutan in 1910, which records that 'One gained the impression that they had great faith in our English medicines.'⁹ Nevertheless, an appreciation of their significant role is implicit in the text rather than explicit. Similarly, in my recent study about Khunde Hospital and the Mt Everest area, the presence of adequate medicines to provide health services is assumed and medicines are otherwise viewed as a supply issue by hospital staff.¹⁰

A much richer source of literature about medicines is the many anthropological studies that have been undertaken, particularly since the growth of the specialised field of medical anthropology since the 1970s.¹¹ Leading medical anthropologist Mark Nichter has written recently that 'Indeed, I do not think it an overstatement to say that explanatory models of pharmaceuticals have proven just as important as explanatory models of illness. Of even more importance is the interactivity of explanatory models of illness and medicines.'¹² Within the Everest area, however, despite the considerable activity of anthropologists since the 1950s, there are no specific studies about medicines and the Sherpa.¹³ In her doctoral thesis, Sherry Ortner discussed different types of medicines in Sherpa culture and linked them to some of the meanings of food symbolism, seeing medicines as 'super-food' because they had the ability to create health from illness.¹⁴ John Draper has examined the complexities of choice and health-seeking behaviour among Sherpas, but in this study, as in other research, references to medicines and medicines of different medical systems are scattered throughout the text.¹⁵

McKay notes two other forces as relevant to the discussion about the introduction and spread of modern medicine in the wider Himalayan region. These are trade and the influence of European travellers, and both could spread the influence of modern medicine beyond official efforts.¹⁶ Although the Everest area is on a long-distance route and Sherpas travelled, trade was not an important aspect of the introduction and spread of modern medicine in the region; however, the influence of European travellers, as the initial quote

Frontier (Amsterdam: University of Amsterdam Press, 2007).

⁹ *Ibid.*, 176.

¹⁰ Susan Heydon, *Modern Medicine and International Aid: Khunde Hospital, Nepal 1966–1998* (New Delhi: Orient BlackSwan, 2009). Between 1996 and 1998 my husband (a medical doctor) and I were volunteers for the Himalayan Trust at Khunde Hospital. This experience, together with ongoing involvement and subsequent visits, has underpinned my research. It has given me access to the archives of the hospital and, as I wrote in the introduction to the book (27–8), an entry into the local community and people's lives that was more difficult for an outside researcher. As such, I did not wish to abuse this privilege or people's hospitality by asking questions that people would not want to answer. I also knew that there were people with whom it would have been useful to talk, especially those more ambivalent towards the hospital and modern medicine, but because I was associated with

the hospital they would have been reluctant to criticise it. I have used ethnographic accounts to help fill some of these gaps.

¹¹ Susan Reynolds Whyte, Sjaak van der Geest and Anita Hardon, *Social Lives of Medicines* (Cambridge: Cambridge University Press, 2002), 10.

¹² Mark Nichter, *Global Health: Why Cultural Perceptions, Social Representations, and Biopolitics Matter* (Tucson: University of Arizona Press, 2008), 85.

¹³ My use of the expression 'the Sherpa' refers to the ethnic group and is in no way intended to homogenise the considerable variation that exists within and between different groups of Sherpas.

¹⁴ Sherry Ortner Paul, 'Food for Thought: A Key Symbol in Sherpa Culture' (unpublished PhD thesis: University of Chicago, 1970), 166–75.

¹⁵ John Draper, 'Beyond Medicine: Sickness, Healing, and Order in Sherpa Society' (unpublished PhD thesis: University of Sydney, [1995]).

¹⁶ McKay, *op. cit.* (note 8), 27–8.

suggests, was. The Everest area provides a case study to examine the neglected role of medicines in this process and also serves to highlight the significant contribution of travellers. While I make some reference to individual medicines, the emphasis in this article is on considering medicines more generally, issues and context. The first part examines medicines and travellers. Visitors carried medicines to treat themselves, employees and the people of the areas through which they travelled. In the great majority of instances, the care provided by travellers was short-term, and McKay uses this point to distinguish the role of travellers from those of government and missionaries.¹⁷ In the Everest area, however, the region's most famous Western traveller, New Zealand mountaineer Sir Edmund Hillary, turned his initial short-term involvement into a long-term one. The second part of the article discusses medicines and Khunde Hospital, which was built by Hillary in 1966 and became the main source of medicines for people living in or travelling through the area. While this article focuses on biomedical products, modern medicine, as elsewhere in the wider Himalayan region, continued to be practised within a changing but plural medical environment.

Medicines and Travellers

In 1955, Norman Hardie was part of a British mountaineering expedition that made the successful first ascent of Mt Kangchenjunga, the world's third highest mountain. Wanting to learn about the Sherpa, who by this period had become an integral and celebrated part of Himalayan climbing expeditions, he journeyed on foot through the mountains to their home villages in the Everest area. While European visitors were part of a long tradition of travel in the Himalayan region, Hardie was one of the early Western travellers to approach Everest from the southern, Nepalese side of the mountain, as the Nepalese government had only allowed the first Western visitors into Khumbu (the Sherpa name for the area) in 1950. Although Nepal may have been a generally friendly neighbour to British rule in India, it had largely retained its independence and kept out its more powerful neighbour and other Westerners, despite the presence of a British Residency in Kathmandu.¹⁸ Early attempts to climb Mt Everest were made from the northern side via Tibet, but as China intensified its presence in Tibet from 1950, and with the withdrawal of the British from India after independence in 1947, the Nepalese government responded to the changed political climate in the region and began to pursue a less isolationist policy towards Western countries.¹⁹

Although few Western personnel had been allowed to visit Nepal, such exclusion did not preclude the entry of Western goods or ideas about modernisation. From the late nineteenth century, European medicine slowly expanded within Nepal and was promoted by the government along with – rather than instead of – Ayurvedic medicine. Services and personnel were limited for either system, but medicines had a wider reach. Hemang Dixit, in the third edition of his useful and ongoing history of health services in Nepal,

¹⁷ *Ibid.*, 28.

¹⁸ Michael H. Fisher, *Indirect Rule in India: Residents and the Residency System 1764–1858* (Delhi: Oxford University Press, 1991), 414–22; Asad Husain, *British India's Relations with the Kingdom of*

Nepal 1857–1947: A Diplomatic History of Nepal (London: George Allen and Unwin, 1970).

¹⁹ Eugene Bramer Mihaly, *Foreign Aid and Politics in Nepal: A Case Study*, 2nd edn (Lalitpur, Nepal: Himal Books, 2002 [1965]).

writes that 'to make medicines more freely available' the Chandra Sale Dispensary was set up at Bir Hospital in Kathmandu in 1917.²⁰ Many of the personnel at the hospital were recruited from India, and specimen signatures of the medical practitioners were kept at the Dispensary to prevent the misuse of drugs. Dixit also refers to the speech of Colonel Kishore Narsingh Rana at the opening of the Military Hospital in 1926. He spoke of how Maharaja Chandra Shumsher, the ruler of Nepal, had established 'several allopathic dispensaries' in populous areas of the hills and Terai, but in remote areas he 'has arranged to start many Ayurvedic pharmacies... where up to now the nostrum from village quacks was all the medical help available to the people'.²¹ Chandra Shumsher also opened Ayurvedic schools 'to provide trained men for those pharmacies'.

By the time the number of Western visitors to Nepal increased in the 1950s, people throughout the country had heard about allopathic medicine even if they had little access to its treatments. As in Bhutan, Christian missionaries were not allowed into Nepal, but in 1952, the Nepal Evangelistic Band, which was based at Nautanwa close to India's border with Nepal, received permission from the Nepalese government to set up a hospital in the Pokhara valley.²² Dr Lily O'Hanlon described their journey as the small group walked through the hills with porter-loads of medicines and equipment. A father approached them asking for some medicine for his baby. He declined the surgical help that the group thought the baby needed. 'Just a little medicine and it will be all right. I have heard much about your medicine and how good it is.'²³

Prior to the 1950s, Sherpas living in their home area of Khumbu had little access to modern healthcare or its medicines, and none on a regular or long-term basis. The Sherpa are ethnically Tibetan and first came over the mountain passes and settled in the high valleys in the early sixteenth century. Approximately three thousand of them lived in a series of villages.²⁴ Like other remote areas, government services in the Mt Everest region were very limited. Nepal, along with other countries in South Asia, was developing a state-funded health service, but no government health services were as yet established in the Everest region. Located near Nepal's northern border, the area was also far from the Christian missions that were to be found to the south in India and that some Nepalese accessed.²⁵ In the 1950s, a military check-post was situated at Namche Bazar, the administrative centre of the Everest area, but the Nepalese military had no significant involvement in providing healthcare to local people. A long-distance trade route between northern India and Tibet passed through the region, with the Sherpa holding a monopoly along the Everest section. Nevertheless, while Sherpas travelled extensively for trade and religious purposes, they appear to have carried and purchased while away 'traditional' medicines.²⁶

²⁰ Hemang Dixit, *Nepal's Quest for Health*, 3rd edn (Kathmandu: Educational Books, 2005), 13.

²¹ *Ibid.*

²² Lily M. O'Hanlon, *At the Foot of the Fish-Tail Mountain* (Varanasi: Pilgrims, 2005).

²³ *Ibid.*, 30.

²⁴ S.D.R. Lang and Ann Lang, 'The Kunde Hospital and a Demographic Survey of the Upper Khumbu, Nepal', *New Zealand Medical Journal* 74,

470 (1971), 1–8. A common alternative to the spelling of Khunde is Kunde.

²⁵ Jan Minderhoud, 'The Christian Presence in Nepal before 1951', *Indian Church History Review* (December 1990), 144–64.

²⁶ Author interview, Ang Rita Sherpa, Chief Administration Officer, Himalayan Trust, Kathmandu, 29 June 2003.

Khumbu was a centre where medicinal and aromatic plants grew, but their local use was limited. Geographer Stanley Stevens refers to some families collecting medicinal mountain herbs such as *hugling* in Khumbu and adjacent regions, which they took south to the Terai or further on to India to sell.²⁷ They then bought grain for use back home, for buying trade goods to sell in Tibet or to barter for salt or wool. Anthropologist John Draper has suggested that Sherpas were not as entrepreneurial as might first appear. When *hugling* [huling] became highly sought after by Indian traders around the early 1960s, Sherpas rapidly over-harvested the herb, over-supplied the market and sold it at low prices in competition with each other.²⁸

New forms of transport, with the construction of an airstrip at Lukla in 1964, facilitated the distribution of medicinal plants. Louise Hillary, wife of Sir Edmund, wrote at the end of 1966 how they came across a group of Sherpas carefully packing a root into large baskets. 'The root was so precious that the owners were willing to have six baskets of it flown to Katmandu at considerable cost.'²⁹ At first, the group was unwilling to say what it was or its use, but eventually she found that 'the root was to be sold in India for use in making a cough mixture'. The people's appearance of being 'secretive and embarrassed' was perhaps not surprising as she had just come from the opening of a small new hospital at Khunde. Medicinal plants were also transported north. Dr Lhakpa Norbu Sherpa refers to plants being harvested in Khumbu and then sent to Tibet for processing.³⁰ When Tibetan demand declined, Khumbu people stopped collecting the plants. The later rise of tourism in the Everest area provided an alternative source of income, but the collection of plants also became prohibited because of the area's national park status from 1976.

While Sherpas inhabit a world that is full of supernatural beings that are considered to be dangerous if offended or ignored, these can be appeased through appropriate measures.³¹ Sherpas employ a number of strategies to deal with sickness, including prevention, self-help or consulting a *lama* or *lhawa* [spirit medium]. Finding out the cause takes precedence over dealing with the symptoms, although the perceived severity can influence whether or not the patient or family sought assistance. Draper has argued that while individuals do seek to choose appropriate healers, their choices are constrained by the structure of knowledge–power relations to be found in Sherpa society.³² Among Sherpas of the lower Solu region where she carried out her research in the 1960s, Ortner described three types of medicines: Western medicines, folk medicines and religious medicines. Folk medicines referred to 'medicines found and/or made by laymen for their own use, without the assistance of religious or curing specialists.'³³ Particularly popular were medicines to cure poisoning. Religious medicines referred to medicines made by a *lama* from instructions in the religious books. These medicines might be a charm printed on paper and generally not edible, or a medicine to eat compounded from medicinal

²⁷ Stanley Stevens, *Claiming the High Ground: Sherpas, Subsistence and Environmental Change in the Highest Himalaya* (Delhi: Motilal Banarsidass, 1996 [1993]), 343.

²⁸ Draper, *op. cit.* (note 15), 96.

²⁹ Louise Hillary, *A Yak for Christmas* (Garden City, NY: Doubleday, 1969), 161.

³⁰ Author interview, Dr Lhakpa Norbu Sherpa, Dunedin, 16 January 2005. He was the first Sherpa to gain a PhD and a former warden of the Sagarmatha National Park.

³¹ Heydon, *op. cit.* (note 10), 100–12.

³² Draper, *op. cit.* (note 15), 371–89.

³³ Ortner Paul, *op. cit.* (note 14), 168.

plants and herbs and generally made to order for a specific person and their complaint.³⁴ In Khumbu, some medicines were regarded as more preventive and 'not really medicine'.³⁵ Small red or brown/black pills were beneficial for everything and helped a person keep healthy. Sherpas in the Everest area also had another option for obtaining medicines – the use of an *amchi*, a practitioner of Tibetan medicine. Oral sources, indicate that prior to 1950, however, there were no *amchi* there on a permanent basis.³⁶

Apart from an occasional visitor, such as Hari Ram in 1885, who 'endeavoured to ingratiate himself with the inhabitants by treating their sick',³⁷ Sherpas had to travel outside the area if they wanted to obtain allopathic medicines. The *rinpoche* [reincarnate lama] at Tengboche monastery, the leading monastery in the area, recalled that when he was about six years old he was taken to Kathmandu to have a smallpox vaccination.³⁸ Some Sherpas travelled to Darjeeling to look for employment with the climbing expeditions, and these often carried an extensive range of medical supplies.³⁹ Renowned British climber Eric Shipton described the struggles of the 1933 Mount Everest Expedition to keep fit and healthy. 'The valiant efforts of the doctors had little effect. We consumed enormous quantities of anti-septic tablets and were forever gargling and dousing our noses... Nor were the Sherpas exempt.'⁴⁰ In another account, fellow expedition member Frank Smythe recounted how Dr Raymond Greene had to anaesthetise Lobsang with chloroform to set a broken collar bone, that Lobsang's heart stopped soon after he became unconscious, but that he was given an injection of coramine and the heart started to work again.⁴¹

While references to medicines are scattered in the texts, one medicine that is mentioned specifically in a number of travellers' accounts is medicine to combat malaria. Sherpas rightly associated the lowlands with disease. Ralph Izzard, a reporter for the British newspaper the *Daily Mail*, was sent to cover the 1953 Everest Expedition in competition with *The Times*, which had copyright to the expedition's dispatches. Izzard organised his own expedition in search of news. He wrote how 'medical supplies I purchased in abundance not so much for myself (I was only to use Paludrine) but to patch up the coolies when necessary...'⁴² Hardie wrote that the 'Sherpas are well aware of the value of paludrine, and they always ask for their ration if someone has forgotten to issue it.' He continued that 'although they frequently go out to Darjeeling to sell equipment given to them by expeditions, I have never heard of a man selling his precious paludrines.'⁴³

The situation began to change in the 1950s and 1960s with the arrival of different groups of Western visitors into Khumbu. Other scholars have noted, and expedition

³⁴ *Ibid.*, 170.

³⁵ Author interview, Dr Kami Temba Sherpa, Khunde Hospital, 15 February 2010.

³⁶ *Ibid.*

³⁷ Report on Routes by Explorer Hari Ram, *op. cit.* (note 4), 386.

³⁸ Ngawang Tenzin Zangbu, *Stories and Customs of the Sherpas*, Frances Klatzel (ed.), (Kathmandu: Mera Publications, 2000), 58.

³⁹ R.W.G. Hingston, 'Medical Notes', in E.F. Norton, *The Fight for Everest 1924* [1925], repr. (Varanasi: Pilgrims, 2002), 350–3. The list includes a 'Congo' medicine chest. See Hill, *op. cit.* (note 7).

⁴⁰ Eric Shipton, *Upon that Mountain* [1943], repr. (London: Pan Books, 1956), 124.

⁴¹ F.S. Smythe, *Camp Six: An Account of the 1933 Mount Everest Expedition*, 2nd edn (London: Hodder and Stoughton, 1938), 77–8. At this time, expedition 'Sherpas' included Tibetans as well as ethnic Sherpas.

⁴² Ralph Izzard, *An Innocent on Everest* (New York: E.P. Dutton, 1954), 67. Paludrine is an antimalarial drug. The more neutral term 'porter' has replaced 'coolie'.

⁴³ Hardie, *op. cit.* (note 1), 120.

organisers were also well aware, that ‘Europeans travelling through the wilderness’, as Izzard wrote, ‘are expected to administer a pill or a plaster to all who happen to need them whom he may meet by the way’.⁴⁴ Not all the visitors to Khumbu were associated with climbing expeditions. Anthropologist Christoph von Fürer-Haimendorf wrote in 1963 about his wife Elizabeth, who accompanied him on his travels, that ‘to many she endeared herself also by ministering to their medical needs, and their faith in her remedies enabled her to achieve several notable cures’.⁴⁵

Nevertheless, while the number of visitors to the Everest area rose during the 1950s and 1960s and increased local people’s access to such medical practice, the numbers were still small. In 1964, only twenty outsiders visited Khumbu.⁴⁶ While on an expedition, sick Sherpas were treated with Western medicines and procedures, and some Sherpas assisted the Western doctors. They acquired new knowledge that could then be brought back home, but once back in Khumbu they usually did not have the medicines to prove their effectiveness. Sherpas, however, sometimes received medicines from expeditions for use at a later date. Hardie wrote about a group of expedition Sherpas returning from the lower Indian altitudes who carried ‘supplies to cover a number of ills’.⁴⁷ This group experienced only minor problems, but among another group of nine, who had no medicines and had begun walking home in the monsoon when the risk of sickness increased, five died.⁴⁸ In the early 1960s, in an example that shows indigenous people taking an active role in spreading modern medicine, the teachers from a school that Hillary built at Khumjung began going up to Everest Base Camp and approaching expeditions for medicines.⁴⁹ They then returned to the village, and from their living quarters, provided treatment for the local people.

By this time, Hillary’s involvement with the inhabitants of the Everest area was beginning to change its focus. Although initially Hillary had thought that the school he had built at the end of his Himalayan Scientific and Mountaineering Expedition in 1961 would be a ‘one-off’ project, it was instead to become the start of an ongoing aid programme.⁵⁰ Education was the main thrust of Hillary’s early involvement, but he also believed that Western medicine could help the Sherpa.

In the Everest area most people’s first experience of modern medicine was vaccination during the 1963 smallpox epidemic. New Zealand medical student Michael Gill noted in 1961 that while some smallpox vaccination was carried out ‘by a United Nations doctor at approximately 5-yearly intervals’, most of the population was unprotected.⁵¹ Hillary knew that the disease might be a problem during his Himalayan Schoolhouse Expedition

⁴⁴ Izzard, *op. cit.* (note 42), 67.

⁴⁵ Christoph von Fürer-Haimendorf, *The Sherpas of Nepal: Buddhist Highlanders* (London: John Murray, 1964), xv–xvi.

⁴⁶ James F. Fisher, *Sherpas: Reflections on Change in Himalayan Nepal* [1990], repr. (Delhi: Oxford University Press, 1997), 148.

⁴⁷ Hardie, *op. cit.* (note 1), 120.

⁴⁸ *Ibid.*, 119.

⁴⁹ Author conversation with Shyam Pradhan Krishna, Khunde, 6 December 1996. Shyam went to Khumjung as a teacher in 1965. I do not know how

extensive this practice was or for how long it continued as I was unable to follow this up with Shyam who died in 1998. The overseas staff who were working at Khunde Hospital in 1966 were unaware that this was occurring.

⁵⁰ Author interview, Sir Edmund Hillary, Kathmandu, 16 April 1997.

⁵¹ M.B. Gill, ‘The Sherpas: A Survey of an Isolated Mountain Community’ (unpublished fifth-year dissertation: Department of Preventive Medicine, University of Otago, 1961), 16.

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because the American Mount Everest Expedition had reported a case.⁵² Hillary's expedition came across other cases and deaths, and fear of the disease grew amongst the local population who began asking for help. Hillary resolved that a vaccination programme had to become a major part of the expedition. At Namche Bazar he discussed the situation with the check-post captain who had a radio.⁵³ Hillary sent a message to Kathmandu requesting a supply of vaccine which, 'with unprecedented alacrity', arrived two days later on a Swiss Red Cross plane.⁵⁴ The disease was spreading rapidly. Members of the expedition immediately began vaccinating villagers and eventually were to give over seven thousand vaccinations throughout the district. Hillary later wrote that of all the expedition's activities 'the one most widely appreciated was undoubtedly the vaccination, and this hadn't been part of my original plans'.⁵⁵ On this occasion, the Nepalese authorities in Kathmandu also appreciated Hillary's efforts.⁵⁶

Not everyone, however, was enthusiastic. Gill's account in 1963 of an encounter with the epidemic illustrates the power vested in the physical presence of a medicine. Even allowing for the writer's sense of the dramatic making a good story, Gill was struggling with a group of people who spoke a different language. The medicine was something that people could see and could be more powerful than words. 'I opened an ampoule of vaccine and showed on my arm the sore where I had recently been revaccinated.'⁵⁷ The medicine, here in the form of a vaccine, represented the whole system of modern medicine. 'They will take your medicine if the Head Lama gives it his blessing.'⁵⁸ Acceptance of smallpox vaccination was voluntary and appeared to be a matter for individual choice. The Sherpa were Buddhist, but even the religious adopted different strategies. While the *rinpoche* at Tengboche was vaccinated as a child, at the village of Thamo the *lama* and monks who had recently arrived from Tibet declined the offer of a vaccination from Hillary's expedition. They said that it would show lack of faith with their own powers to deal with the disease.⁵⁹ None of the group died. As Hillary was impressed, then it was also likely that other people in the area would have felt the same way. The additional fact that a woman died, who had been vaccinated a few days earlier, added to the weight of evidence against vaccination. That probably she had already contracted the disease when she was vaccinated, and so the vaccine would not have been effective, was not an appropriate Sherpa explanation. They believed the vaccine had killed her.⁶⁰

Expedition medical practice was, in general, a response to the lack of modern medical services in such regions and inherently a short-term measure. Usually, the expedition would see a patient, treat and move on, not knowing whether or not the person recovered. Hillary wanted to go beyond this type of response to medical problems among local populations. He set up a clinic which provided services for six months, but by the end

⁵² Edmund Hillary, *Schoolhouse in the Clouds* (London: Hodder and Stoughton, 1964), 40–9; Heydon, *op. cit.* (note 10), 49–51.

⁵³ Hillary, *op. cit.* (note 52), 48.

⁵⁴ *Ibid.*, 42. Hillary later received a bill for 800 rupees (US\$105).

⁵⁵ *Ibid.*, 49.

⁵⁶ Ian McIntosh to Hillary, 21 September 1963. File: Himalayan Climbing Expeditions &

Schoolhouse Project ABHS 6949 W4628 NDI 64/14/2 Part 2, ANZ.

⁵⁷ Michael Gill, *Mountain Midsummer: Climbing in Four Continents* (London: Hodder and Stoughton, 1969), 176.

⁵⁸ *Ibid.*

⁵⁹ *Ibid.*, 175–7; Hillary, *op. cit.* (note 52), 47.

⁶⁰ Gill, *op. cit.* (note 57), 177.

of 1963 he was talking to authorities in Nepal and New Zealand about the possibility of establishing a small hospital. In 1966, having received approval from the Nepalese government and having raised the funds privately, Hillary built a small hospital in the village of Khunde.⁶¹ This soon became the main provider of health services in the area. Unlike other parts of Nepal, it was also the main source of medicines.

Medicines and Khunde Hospital

The opening of Khunde Hospital was a major development for local people in terms of medicines and health services as both of these now became available on a year-round basis.⁶² The main single-storey building contained a one-room clinic in which most examinations, investigations and treatments were carried out and where patients received their medicines from the hospital medical staff.⁶³ Although the hospital has always had in-patient facilities, most people continue to be seen and treated as out-patients for a wide range of curative and preventive health services. This discussion of medicines and Khunde Hospital will be framed around a series of relationships that hospital staff had with the community, the government and overseas visitors. These have profoundly affected the spread of modern medicine in the region.

In the 1960s Nepal had few doctors or other trained health workers and so the Nepalese government gave Hillary permission to bring in foreign medical staff. They were volunteers who went to work and live at Khunde for around two years and trained local staff to help them. The initial assumption of the overseas staff was that once people saw the superiority of their 'modern' medicine they would use it. Ian Harper has suggested that the foreignness of the United Mission to Nepal hospital, which was established at Tansen in 1954 in Palpa district, south-west of Kathmandu, gave it authority over local traditions and that this applied to both doctors and the medicines.⁶⁴ The evidence from Khunde suggests a somewhat different story. Initial curiosity brought crowds of people to the opening of the hospital and in the first three months of 1967, Dr John McKinnon, the hospital's first doctor, treated 722 patients.⁶⁵ He was optimistic for the future of the hospital, but six months later, when he reviewed Khunde Hospital's first nine months of working in the area, he also wrote of the mixed response to 'modern medicine'.⁶⁶ The total of 1,924 people who attended the hospital for treatment during 1967 was smaller than expected.⁶⁷ McKinnon remained optimistic, believing that attitudes towards using the hospital had begun to change. He wrote that 'the passage of several years, with

⁶¹ For a history of Khunde Hospital, see Heydon, *op. cit.* (note 10).

⁶² Despite its small size, it has always been called a hospital.

⁶³ The hospital has no trained pharmacist or pharmacist assistant.

⁶⁴ Ian Harper, 'Mediating Therapeutic Uncertainty: A Mission Hospital in Nepal', in Mark Harrison, Margaret Jones and Helen Sweet (eds), *From Western Medicine to Global Medicine: The Hospital Beyond the West* (New Delhi: Orient BlackSwan, 2009), 303–29.

⁶⁵ 'Outline of Patients seen from 1/1/67 until 31/3/67'. File: Annual Reports 1967–1983, Khunde Hospital archives [hereafter KH].

⁶⁶ J.R. McKinnon, 'Health Problems of Khumbu: A Review of the First Nine Months Work at Kunde Hospital', Report to the Minister of Health, His Majesty's Government of Nepal, 6 October 1967. File: Annual Reports 1967–1983, KH. This report was later published as 'Health Problems of Khumbu in Nepal: The Work at the Kunde Hospital', *New Zealand Medical Journal*, 67, 140 (1968), 140–3.

⁶⁷ Outpatient register, KH.

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exposure to modern medical practice and local publication of therapeutic successes will lead to even greater acceptance'.⁶⁸

Medical practice at Khunde Hospital held many challenges for the volunteers from New Zealand who had mostly only recently qualified. Away from the environment of medical school and teaching hospital in Dunedin the doctors had limited resources and support. In the case of medicines, they found they had to think about some basic issues and had to adapt their prescribing and dispensing. Dr Richard and Lesley Evans succeeded the McKinnons in 1968. In a letter for radio in New Zealand, Lesley wrote:

The more ordinary things of life cannot be taken for granted. Most people haven't got a teaspoon at home; if they have to measure a baby's cough syrup, we give them one of the few plastic ones that come in the drug packets, and ask the mother to bring it back when she has finished. Not many people know the names of the days of the week; very few people use them. Richard has to say 'Come back after four days', or 'Here is medicine for 20 days'. One cannot instruct a patient to take his tablets at 8, 12, 4 and 8 o'clock. Sherpas don't have clocks, and very few radios to tell the time. You must say 'Take one morning, noon, afternoon and night,' and hope that their ideas of noon and afternoon are not too close together.⁶⁹

For patients, too, the situation was initially strange. People decided whether or not to use the hospital, but Nima Yangen, the hospital's first nurse-assistant, described how people answered questions and had examinations just because they 'had to' rather than because they thought such knowledge was important.⁷⁰ As has been found elsewhere in the Himalayan region, understanding a biomedical model was not necessary for acceptance of health interventions.⁷¹ Also different for patients was that in their traditional healing practices Sherpas ingested little, compared with the role of medicines at the hospital, since people were reluctant to use something for which they did not know the ingredients.⁷² Although Khunde Hospital treated an increasing number of patients annually, either as out-patients or in-patients, and people became more familiar with the way the hospital functioned, their use of the hospital was pragmatic and selective based on people's perceptions of efficacy and whether using the hospital was the appropriate course of action.⁷³ People retained a spirit-based system of disease aetiology and continued with other practices when sick. People could come to the hospital and receive medicine while still going to other healers.⁷⁴ Western medicine was seen to treat the symptoms rather than the cause and so the different medical systems were seen to have varying areas of effectiveness. Martin Gaenzle similarly describes how the Mehawang Rai of East Nepal attribute Western medicine to work on a physical level and the shaman on a metaphysical level.⁷⁵ The two were not contradictory.

⁶⁸ McKinnon, *op. cit.* (note 66), 2.

⁶⁹ Letter from the Himalayas No. 2. From Mrs Lesley Evans, Hillary Hospital, c/- British Embassy, Kathmandu, Nepal. File: Articles and letters from ex Khunde doctors (early), KH.

⁷⁰ Author interview, Nima Yangen Sherpa, Kathmandu, 1 July 2003.

⁷¹ Dorothy S. Mull, Jon W. Anderson and J. Dennis Mull, 'Cow Dung, Rock Salt, and Medical Innovation in the Hindu Kush of Pakistan: The Cultural Transformation of Neonatal Tetanus and

Iodine Deficiency', *Social Science and Medicine*, 30, 6 (1990), 675–91.

⁷² Author interview, Dr Lhakpa Norbu, 2005.

⁷³ Heydon, *op. cit.* (note 10).

⁷⁴ Ortner Paul, *op. cit.* (note 14), 166–7.

⁷⁵ Martin Gaenzle, 'The Shaman and the Doctor: Conflicting Systems of Interpretation and Diagnosis in East Nepal', in Dorothea Sich and Waltraud Gottschalk (eds), *Acculturation and Domination in Traditional Asian Medical Systems* (Stuttgart: Franz Steiner Verlag, 1994), 53–60: 56.

To Nima Yangen, people began to use the Khunde Hospital more for two reasons. Firstly they got better. Along with procedures such as extracting teeth, which freed people from pain, medicines were an important part of these therapeutic successes. Many came for eye ointment for reasons associated with the smoky rooms of their houses.⁷⁶ Cooking was done on open fires in the main room of the house, but windows were small, because of the cold and lack of glass, and there were no chimneys to extract the smoke. This contributed to other problems; the out-patient register shows that much of McKinnon's medical practice was dealing with respiratory infections.⁷⁷ Other common medical problems were worms and impetigo. As Lesley Evans wrote in her diary during the walk into Khunde: 'We saw awful impetigo on two children in tonight's surgery. [...] But gosh, how speedily infections get better. They're so sensitive to antibiotics. ...'⁷⁸ The underlying importance of medicines in treatment and people's use of the hospital is further signified by their lack of enthusiasm for surgery. Although McKinnon had carried out a number of procedures, such as skin grafting for burns cases, and had seen acute surgical cases, 'all patients have refused hospitalisation when seriously ill because of their great fear of dying away from home'.⁷⁹

The second reason that people began to use the hospital more was that when people travelled to Kathmandu they found that medicines were expensive to buy. To make healthcare affordable and accessible, services and medicines were provided free at Khunde Hospital. Sherpas interpreted this differently. If a medicine was free, then it must be no good.⁸⁰ During her fieldwork, Ortner visited the McKinnons at Khunde Hospital and obtained some medicines, but when she returned to Solu and gave these out, many people insisted on paying for them as otherwise they would not be effective.⁸¹ More recently, a focus-group study on health post-usage in Taplejung in north-east Nepal also concluded that the idea of a regular supply of medicines at a supposedly affordable fee would in itself increase attendance 'has been shown to be erroneous'.⁸² Other factors, such as community attitudes, also needed to be taken into consideration.

Services and medicines at Khunde Hospital remained free for local people until 1982. At a meeting of the Kunde Hospital Board in April, which was attended by Hillary and the senior government official in Namche Bazar, it was agreed to introduce a one-rupee charge for each course of medicine and that the funds obtained through this fee were to be used to buy more.⁸³ Consultations remained free. Although imposing a fee was permitted under the terms of the Agreement between the Trust and the Nepalese government, and Hillary's other hospital at Phaphlu had such a charge, the decision was not popular in the Everest area.⁸⁴ A further meeting took place on 10 September, but the

⁷⁶ Author interview, Nima Yangen, 2003.

⁷⁷ In the 'Outline of patients', *op. cit.* (note 65), 10% of patients were diagnosed as having respiratory complaints.

⁷⁸ Lesley Evans, 17 August 1968. Letters from Nepal from Dr Richard and Lesley Evans to their family, 1968–69 (hereafter Evans papers). I am grateful for their permission to consult this wonderful collection.

⁷⁹ McKinnon, *op. cit.* (note 66), 6.

⁸⁰ Author interview, Nima Yangen, 2003.

⁸¹ Ortner Paul, *op. cit.* (note 14), 103–4.

⁸² John C. Chalker, Madhu Kapali and Bhagwati Khadka, 'Health Post Usage in a Mountain District, in Eastern Nepal: A Focus Group study', 16 May 1990, KH.

⁸³ 19 April 1982, Hospital Advisory Committee Book (hereafter HACB), KH.

⁸⁴ Letter from the branch officer, Salleri, to the doctors, Khunde Hospital, 24 August 1982, HACB.

charge was retained.⁸⁵ While the number of patient attendances at Khunde Hospital dropped during the following year, the increase in numbers resumed in 1984 and has continued to do so, despite increases to the patient fee.⁸⁶

From the start, McKinnon visited other villages, and this also gave him the opportunity to reach people who perhaps would not go to the hospital.⁸⁷ He also began to develop services closer to where people lived to encourage patients with tuberculosis to continue medication on a long-term basis. After three months of daily treatment at the hospital, tuberculosis patients returned home to their villages, but still required twice-weekly streptomycin injections and isoniazid tablets for eighteen months to two years. Some villages in Khumbu were up to five-hours walk from the hospital, and the journey could take much longer when a person was sick.⁸⁸ The requirement to come to the hospital for treatment so frequently was a major disruption in people's lives and people could not afford to spend long periods of time away from their homes or work. McKinnon began to train a young man from each of the main villages to give treatment in a patient's home.⁸⁹ By May 1968 there were forty-three patients receiving their treatment in this way.⁹⁰ Nevertheless, in 1970, Doctors Selwyn and Ann Lang reported that, of eighty-five cases diagnosed with tuberculosis since 1967, twenty-three 'have discontinued therapy against advice'.⁹¹ Although the tuberculosis treatment regimen later became shorter, non-completion continued to be an issue for hospital staff.

From 1970, the doctors began to use teachers from the local schools as hospital assistants. As well as being taught to administer the necessary drugs prescribed to people receiving tuberculosis treatment, they had a simple medical kit to treat patients who came to them with minor complaints.⁹² A supply of basic medicines has remained central to Khunde Hospital's village health worker services and contrasted with the government's community health volunteer scheme that was introduced in the mid-1970s and was always short of supplies.⁹³ Villagers in Khumbu did not expect too much from these village health workers and often went directly to the hospital for more serious problems.

Whether medicines were obtained from the village health workers or from hospital staff, positive and negative responses to the medicines played a key role in people's use and non-use of health services. A number of studies from other societies have documented and offered interpretations for the popularity of injections, but in Khumbu, the response to medicines administered by injection was mixed.⁹⁴ Iodised oil injections for

⁸⁵ 10 September 1982, HACB.

⁸⁶ Outpatients at Khunde Hospital, Appendix 3, Heydon, *op. cit.* (note 10), 319.

⁸⁷ McKinnon, *op. cit.* (note 66), 2.

⁸⁸ Temporary settlements, such as those in the higher summer pasture areas, were even further away.

⁸⁹ Boys were more likely to have had some education.

⁹⁰ McKinnon to Dr Das, Director, Department of Health, Kunde Hospital: Six Monthly Report Dec.'67/ May '68, KH. The hospital reports, initially six-monthly and annually from 1970, have different titles, spelling and dates. While it might have been useful to standardise in this article for the sake of clarity, the titles are retained as written on the document for

reasons of authenticity. The variability is characteristic of Khunde Hospital's history.

⁹¹ Lang and Lang, *op. cit.* (note 24), 6.

⁹² Kunde Hospital Report for the Year Ending 31st October, 1971 – Including an Analysis of Cases since 1st January, 1967–1971.

⁹³ Judith Justice, *Policies, Plans & People: Foreign Aid and Health Development* (Kathmandu, Nepal: Mandala in association with University of California Press, 1986), 81.

⁹⁴ H.V. Wyatt, 'The Popularity of Medicines in the Third World: Origins and Consequences for Poliomyelitis', *Social Science & Medicine*, 19, 9 (1984), 911–5; Whyte, van der Geest and Hardon, *op. cit.* (note 11), 104–16. Due to the different sources for

goitre were 'one of the most popular treatments amongst the Sherpas' wrote Evans in his report to Dr Das, the Director of the Department of Health, in 1969.⁹⁵ People who missed out saw the dramatic effects and 'a steady stream present at the hospital for injections'. In this instance, injections were not regarded as a problem, but the hospital's annual report in 1984 referred to 'the perennial problem of injections being blamed for people's death'.⁹⁶ The doctors continued, 'Unfortunately sick people frequently need drips and injections and sick people have a high chance of dying. It is difficult to get around the problem.' Unfortunately, this also had a negative effect on the hospital's vaccination programme. As the doctor was about to vaccinate a child in one village, the mother of another child interjected, 'injections kill babies'.⁹⁷ This was a reference to an incident four years earlier when a baby died of anaphylaxis following a penicillin injection. Not until 1997 could hospital staff report 'a great success' in this village.⁹⁸

Having an adequate and reliable supply of medicines has been a cornerstone for Khunde Hospital. Both staff and patients expected the hospital to have medicines, unlike the government health post at Namche Bazar. Hillary's dealings with Khunde Hospital show that from the beginning, and throughout, he treated Khunde Hospital as an integral part of his broader programme of assistance to the Sherpa.⁹⁹ This meant that despite its remote location, the hospital was able to operate within a supported environment, with a key part of this being the provision of medicines.¹⁰⁰ Although the World Health Organization has promoted the concept of 'essential medicines' since the late 1970s and Nepal has various Essential Drug Lists, Khunde Hospital staff have not had a medicines budget and have mostly operated on the basis of exercising 'reasonableness' when ordering appropriate and sufficient medicines for the range of conditions it treats. Additionally, in a mountainous area without roads, transport costs have always been a significant item of expenditure for the hospital, as it was also for other organisations and businesses that were gradually established in the area. Both airfreight and carriage by porters were expensive. Although from the beginning some drugs were bought in Kathmandu, most medical supplies in the early period were brought from New Zealand with Trust members gathering donations from drug companies and the free samples given out to general practitioners.¹⁰¹ Despite the medicines being donated for an aid project, the Nepalese government levied a tax of ten per cent on these imported drugs and medical equipment.¹⁰²

Gradually hospital staff worked out what medicines were most needed and the quantities. Stocktaking was one of the many duties of the volunteers. Lesley Evans described

obtaining medicines, variable record keeping over time by the overseas volunteers and a probable lack of interest in the issue, it is not possible to quantify the percentage of injections compared with orally administered medicines with any degree of certainty. Future research will focus on different types of medicines and patients' perspectives.

⁹⁵ Hillary Sherpa Hospital Report 23 August [1968] to 27 February 1969.

⁹⁶ Kunde Hospital Annual Report 1 September 1983 – 31 August 1984.

⁹⁷ *Ibid.*

⁹⁸ Kunde Hospital and Village Clinics Annual Report 1997.

⁹⁹ Heydon, *op. cit.* (note 10), 58–9.

¹⁰⁰ *Ibid.*, 80–1. Since the late 1970s most of the funding for Khunde Hospital has come from the Sir Edmund Hillary Foundation in Canada.

¹⁰¹ Kunde Hospital Annual Report 1 November 1969 to 21 October 1970; personal communication, Diane McKinnon, 24 November 2005.

¹⁰² Report on Kunde Hospital compiled for the WHO/Pan American Health Organisation/ International Biological Programme investigation of high altitude facilities, 18 July 1968, KH.

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that 'when we do the stocktaking on medicines it takes days and days, counting tablets and pessaries and cc's of drugs. We do an afternoon at a time, and we have about four more afternoons to do.'¹⁰³ Although some supplies continued to come from New Zealand, by the mid-1970s the focus had shifted to obtaining the hospital's medicines largely from within Nepal, using a basic range of items from Royal Drugs Limited in Kathmandu, which in 1972 started manufacturing modern drug preparations commercially.¹⁰⁴ Another source was UNICEF.¹⁰⁵ The pharmacy at the United Mission to Nepal (UMN) Shanta Bhawan Hospital was also helpful, but in 1976, their pharmacist had to inform staff at Khunde that they could no longer purchase drugs for the hospital because their own import licence was not large enough for their own needs.¹⁰⁶ Supplies could also be bought at retail outlets in Kathmandu, but these tended to be expensive.¹⁰⁷ The Trust's medical committee in New Zealand would help when the hospital was unable to obtain an item from more local sources. Sometimes the availability of supplies from Royal Drugs was very limited, while in 1987, complicated regulations, imposed by the Nepalese government after the 1986 Chernobyl nuclear explosion in Russia, made it difficult to order from overseas drug companies.¹⁰⁸ Obtaining medicines was a function that, because of their isolated situation, hospital staff could not handle on their own from Khunde, and so the Himalayan Trust's Kathmandu office increasingly liaised, purchased and then despatched to Khunde.

Khunde Hospital provided the people of the Everest area with a wide range of curative and preventive health services, but although initially the doctors sent six-monthly reports to the Director of Health, and later monthly statistics, contact with local and national government health services was limited. Less than fifty per cent of the population of Nepal today has regular access to essential medicines.¹⁰⁹ Periodically, the hospital's annual report mentioned the government health clinic in Namche Bazar, with the most common observation relating to its regular shortage of medicines. This hindered the work that could be done by the clinic's staff, but also highlighted a major difference between the two institutions. 'The main obstacle to his [Biru Gurung] lack of functioning as a very good health worker' declared the hospital's 1987/88 annual report:

[I]s his lack of drugs and equipment (a recent survey of HMG health clinics confirmed that most still only receive supplies for 3 to 6 months of each year). We have given him a few of the basics and he has managed to get hold of some trekker 'left overs', but this is not really satisfactory.¹¹⁰

Hospital staff had more contact with the government regarding preventive health services as its own preventive health programmes became increasingly aligned with those of the government. Most of the medicines for the government's vaccination and family planning programmes, as well as tuberculosis and leprosy treatment, came from international aid sources. This also helped the hospital with its own running costs. Initially,

¹⁰³ Lesley Evans, 27 February 1969, Evans papers.

¹⁰⁴ Hemang Dixit, *The Quest for Health*, 2nd edn (Kathmandu: Educational Enterprise Ltd, 1999), 89.

¹⁰⁵ 21 June 1975. File: Dear Successor, KH.

¹⁰⁶ Letter from Paul Williams, pharmacist, Shanta Bhawan Hospital, Kathmandu to McKinnon, Himalayan Trust. File: Assorted papers, KH.

¹⁰⁷ File: Old drug receipts and orders, KH.

¹⁰⁸ Kunde Hospital Annual Report August 1987 to August 1988.

¹⁰⁹ World Health Organization, *The World Medicines Situation* (Geneva: WHO, 2004), Annex Table 3.

¹¹⁰ Kunde Hospital Annual Report August 1987 to August 1988.

hospital staff obtained some directly from the donor. 'We are greatly indebted to UNICEF for the supply of anti-tuberculous drugs through the TB Control Centre; they have supplied the Hospital with lipidised oil used in the iodination programme, and various other basic drugs.'¹¹¹ Over the next couple of years, staff increasingly found that they were directed to go through the government programme.¹¹² With increasing decentralisation of health services to district level from the 1980s, staff at Khunde also began to deal more with government staff at Salleri and Phaphlu Hospital. For those at Khunde, the relationship centred on ensuring an adequate supply of medicines for the different programmes. The annual report in 1991/92 commented that 'Contraceptive supplies have been a bit of a sore point over the past year. The bureaucracy has intensified and each month there seemed to be another form to fill in before supplies would be given.'¹¹³ Following correspondence and a visit from an official from Salleri 'things were finally sorted out. The situation still remains cumbersome but at least we now know what we are meant to do!' This focus on ensuring an adequate supply has continued, remaining at the centre of the hospital's relationship with the government and essential for enabling staff at Khunde to provide these services.

While visitors were instrumental in the initial establishment of health services in the region, they have continued to have a major influence on medicines and medicines use. This has been accentuated by the great expansion of tourism in the Everest region where the number of visitors has risen from twenty in 1964 to 28,899 in 2008/09.¹¹⁴ Tourists, whether they travel as individuals or in groups, carry medicines since sickness is common; they consume these medicines and other medicines if they seek help from a health facility; and tourists give out medicines to local people who approach them for treatment or they donate to a health facility. All these aspects have been important for Khunde Hospital and contribute to the distinct features of the introduction and spread of modern medicine in the Everest region.

The presence of visitors in the Everest area has contributed to a considerable range and quantity of medicines being widely available in the community. Medicines brought in by tourists could both complicate the work of hospital staff who focused on providing basic medicines and primary health care, and could also assist by increasing hospital supplies with little or no extra cost. In his annual report in 1976 Dr Rob Riley wrote that:

It has been said that the upper Khumbu is now the most 'over medicated' area in Nepal. With the massive influx of tourists and expeditions every year there are large numbers of doctors passing through the area, all carrying extensive medical kits which often contain some of the world's most expensive medicines!

A little later in the report he continued:

No one can blame an itinerant doctor for offering treatment to sick people seen along the path as he feels it is his duty, but for the Sherpa people, to receive pills and potions from so many avenues

¹¹¹ [Kunde] Hospital Annual Report for the Year Ending October 31st, 1974.

¹¹² Letter from K.B. Mathema, Programme Officer, UNICEF, copied to Dr H.D. Pradhan, Senior Public Health Administrator, Department of Health

Services, to Dr Rob Riley, Khunde Hospital, 13 August 1976. File: UNICEF, KH.

¹¹³ Kunde Hospital Annual Report 1 June 1991 to 31 May 1992.

¹¹⁴ Heydon, *op. cit.* (note 10), Appendix 5, 322; Kunde Hospital Annual Report 2008/2009.

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without proper assessment and certainly no follow up, may make them happy in the short term but is far from providing long term, comprehensive and continuing medical care.¹¹⁵

'Trekker medicine',¹¹⁶ as it came to be called, continues to be a factor, but thirty years later, despite much larger visitor numbers, the development of the area and the arrival of other health providers, the hospital's position in Khumbu is well established, staff have become accustomed to change and the level of communication in the area has improved.

For the hospital, however, visitors have provided an important avenue for donations of medicines. Despite his reservations about visitors and medicines, Riley, in the same report, mentioned that the hospital received medicines from ten large and many small trekking groups, the British Army and the Japanese Lhotse Expedition. He also noted that the two British doctors at the Pheriche Aid Post passed on a lot of surplus medicines 'that trekkers would be unlikely to need'.¹¹⁷ Over the years, while some visitors brought medicines or equipment that supplemented the basic range stocked at the hospital, others brought items specifically requested by the overseas volunteer doctors. The annual report for 1993/94 commented that more people were contacting the hospital to ask what would be useful.¹¹⁸ Related to the desirability of having donations, was the quality of medicines. The hospital's doctors in the 1987/88 annual report wrote that:

Financial reasons were not the only reason for actively courting these gifts, for with all our drugs coming from the Indian subcontinent and of variable standard it was very reassuring to have high quality European and American products to use for our sickest patients.¹¹⁹

The system of overseas volunteers at Khunde ended in 2002 when Dr Kami Temba Sherpa took charge of the hospital. The number of patients has risen and donations of medicines continue to be important, with antibiotics and analgesics being considered particularly useful.¹²⁰

In recent years, for both residents and visitors, more medicines have also become available in the community as has been the case in other parts of the Himalayan region. A recent study on urban and rural Pakistan comments on the large number of people using medicines.¹²¹ In other parts of Nepal many people obtain their medicines from medicine shops, but these have not been present in the Everest area until very recently. Mohan Joshi and Balkrishna Khakurel suggest that about ninety per cent of medicines sales in Nepal occur in the private sector, and mostly through retailers without training in pharmacy.¹²² Some general shops, especially in Namche Bazar, might have a few medicines for sale, but in 1995, the doctors from Khunde helped set up the newly established dental clinic with a stock of basic medicines that did not require a doctor's prescription.¹²³ Like other parts of the wider region, the 'modern' medicines provided

¹¹⁵ Kunde Hospital Annual Report for the Year Ending 30 June 1976.

¹¹⁶ 9 February 1982, HACB.

¹¹⁷ *Ibid.*

¹¹⁸ Khunde Hospital Annual Report February 1993 – January 1994.

¹¹⁹ Kunde Hospital Annual Report August 1987 to August 1988.

¹²⁰ Author conversation with Dr Kami Temba Sherpa, Khunde Hospital, 15 February 2010.

¹²¹ Shahzad Hussain, Farnaz Malik, Abdul Hameed, Safi A. Ahmad, and Humayun Riaz, 'Exploring Health Seeking Behavior, Medicine Use and Self Medication in Urban and Rural Pakistan', *Southern Med Review*, 3, 2 (2010), 32–4.

¹²² Mohan P. Joshi and Balkrishna Khakurel, 'Drug Rationalization: Now for the Hard Part', *World Health Forum*, 18 (1997), 348–51: 348.

¹²³ Kunde Hospital Annual Report February 1995 – January 1996; Dan Morrow, Nawang Doka Sherpa

through Khunde Hospital continued to circulate within a plural medical environment. Today in Nepal, for political and registration reasons, the ancient Himalayan origins of 'amchi medicine' are emphasised.¹²⁴ With some *amchi* living permanently in the area, their medicines also became more widely available. Recently, the development of the Sacred Land project, founded by and under the chairmanship of the Tengboche *Rinpoche*, aimed both to provide 'traditional healthcare' for the community and also to cater for the large number of visitors to the area with a clinic established in Namche Bazar.¹²⁵ Initially this clinic used medicines brought in from India and had the aim of establishing medicinal herb gardens to make its own medicines. This project, however, has not worked out as intended and a tourist lodge has been built on the nursery site at Deboche.¹²⁶ *Amchi* medicines are also available in Namche Bazar through a medicine shop, the Lord Buddha Pharmacy.¹²⁷

Conclusion

European travellers have had a considerable influence on the introduction and spread of modern medicine since the opening up of the Everest region in 1950. These visitors carried medicines to treat themselves, employees and the people of the areas through which they travelled. In most instances the care they provided was short-term, but while biomedical knowledge and skills were important, medicines often provided the central and visible symbol of an encounter between travellers and local people. People consumed medicines in the expectation of getting better. Some Sherpas came into contact with modern medicines when they travelled out of the area to work on climbing expeditions, but when they returned they no longer had access to these. Sir Edmund Hillary's involvement with local health problems began as the more usual short-term response, but changed to the provision of a small hospital in 1966 that quickly became Khumbu's main provider of biomedical services and its medicines.

Medicines continued to occupy a key role in the spread of modern medicine throughout the area, but to focus only on availability and affordability is too narrow an approach. Khunde Hospital operated in a plural medical environment and people's beliefs and practices were an important factor in people's acceptance of the hospital and the healthcare it offered. From the early days, the volunteer medical staff began to train health workers and develop village-based services so that people could continue their tuberculosis medication and receive basic healthcare, both curative and preventive, and basic medicines closer to where they lived. For hospital staff, a supply of medicines was implicit in their medical practice, while their explicit concern was the need to ensure an adequate supply of medicines for their remote hospital. They also adapted their practice to how people

and W.H. Fallon, 'Dentistry at the Top of the World', *Journal of the Canadian Dental Association*, 64, 8 (1998), 558, 560.

¹²⁴ Amchi Tenzin Bista and Amchi Gyatso Bista, *Himalayan Doctors and Healing Herbs: The Amchi Tradition and Medicinal Plants of Mustang* (Kathmandu: Mera Publications for Lo-Kunphen Mensikhang, 2005).

¹²⁵ <<http://www.sacredland.net/medintro.htm>>, accessed 13 December 2007.

¹²⁶ Personal communication, Rangit Gurung, Supervisor, Himalayan Trust Forestry, 2 February 2010. The Himalayan Trust nursery at Phurte grows some plants.

¹²⁷ Personal communication, Christopher Heydon, 15 December 2009 and Mingma Temba Sherpa, Khunde Hospital manager, 11 February 2010.

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used the hospital. Over the years the hospital aligned itself increasingly with Government preventive health programmes to obtain these medicines, which mostly came from international aid sources, although in terms of medicines for personal healthcare, the hospital maintained its independence and could be more flexible.

Initially, medicines at Khunde Hospital were free, but in 1982, charges were introduced which led to some criticism in the community. The rise of tourism, however, was underpinning the economic development of the region. With increasing numbers of visitors, more medicines circulated in the community as tourists carried medicines for their own use, but also might give these to local people, or at the end of their stay, to the hospital. Economic development also meant that local people as well as visitors could now afford to buy medicines from other outlets in the community, especially in Namche Bazar, or when they travelled to Kathmandu.

This development and expansion of tourism during the second half of the twentieth century can reinforce a belief in the modern origins of globalisation. If, however, the modern visitor in the Everest area is set in a wider context of travel in the region, then the influence of the traveller becomes part of a longer and broader history that moves beyond the rise of the West and its export to the rest of the world. Travellers, whether Sherpa or Western, carried medicines with them, and through these medicines local people encountered the 'modern' system of medicine, while people's experiences with different kinds of medicines influenced their use and non-use of modern healthcare. This study provides an initial discussion for the Everest region, but it also suggests the need to look further into people's attitudes and practices regarding particular types of medicines, whether or not these have changed and if so, how and why. Although interest in medicines is increasing in the historical literature, it is time to acknowledge explicitly their central role in the introduction and spread of modern medicine in the late nineteenth and in the twentieth centuries and give medicines a more prominent place in discussions about the provision of healthcare.

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