Medicine, State and Society

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The demand for cure and for the care of a growing range of health conditions which elude any particular system of medicine has made pluralism in therapeutic options a way of life. The spread and continuity of indigenous systems of medicines, namely, ayurveda, siddha and unani, have thrown up a lot of concerns as well: how to incorporate these systems into a centralised health infrastructure; their expansion through the pharmaceutical industry for herbal products, massage centres and spas; the relations and negotiations between the practitioners of different coexisting systems of medicine; the position of psychosocial and spiritual dimensions of cure and care in contemporary forms of indigenous systems of medicine and the debate on notions of efficacy in multiple, coherent systems of medicine. All these are worth serious study as they raise fundamental questions not just about ISMS, but about organising healthcare in India.

A framework for the analysis of ISMS requires not only recognising the presence of diverse medical systems, but engaging with them as live and efficacious traditions. The collection of papers in this special issue attempts to address some of these matters.

Healthcare in India presents a complex scenario that is shaped by colonial and post-colonial history and politics, enhanced by a vibrant and thriving medical pluralism. Multiple medical systems such as biomedicine, ayurveda, unani, siddha, homeopathy, naturopathy, yoga and the practitioners of a variety of folk traditions, all contribute to providing healthcare in present time. Of these, unani medicine came from west Asia 800 years ago, while homeopathy, naturopathy and biomedicine entered about 200 years ago from Europe to become part of the medical traditions in this region. The emergence and arrival of different medical systems, their acculturation into various communities as well as the syncreticism and contestations with the indigenous are quite unique to Indian medical and cultural history.

Though this region has been home to several systems of medicine, state-sponsored healthcare in India since 20th century has been based on biomedicine. The model is one in which “other” systems of medicine, namely, ayurveda, yoga, unani, siddha and homeopathy (AYUSH) systems, that have popular support in terms of usage, cultural consonance and larger number of practitioners have been cast against biomedicine which is the official system of state medicine. This is not only true of India, but has been a trend in general, including Europe and North America, where biomedicine is the official system of medicine in the state health services and public demand for “complementary and alternative medicine” (CAM) has been at odds with state efforts to provide a standardised system of healthcare.

The term “medical pluralism” was introduced by the social sciences in the mid-1970s to characterise the situation in the third world, in which people resorted to multiple options for healthcare outside the government healthcare system that was based on biomedicine. By the 1990s, however, medical pluralism became the buzzword in the west and came to denote the inclusion of CAM within the state health administration. The demand for cure and care for a growing range of health conditions which elude any particular system of medicine has made pluralism in therapeutic options a way of (post)modern life. State-sponsored medical pluralism is now admitted as a reality of healthcare (Cant and Sharma 1999; Scambler 2002; Turner 2004) in the west and is no longer a feature of societies that are deprived of biomedical care due to poverty and other economic constraints.

But even within the framework of the state-legitimised medical pluralism, the relation between medicine, state and society varies considerably across nation states. In Britain of the 19th century, as in the rest of Europe and America a little later, the state played a key role in the ascendancy of the medical profession by banning all other medical practices. The indigenous systems of North America and Europe, namely, homeopathy,
naturapathy, chiropractic and osteopathy had to go through a century of struggle with the mainstream that is biomedicine, in order to secure the position of CAM in public space. In India, on the other hand, neither the colonial state nor the independent Indian state could either ban or strictly regulate the indigenous systems of medicine (henceforth ISMs), namely, ayurveda, siddha and unani and the other new entrants like homeopathy and naturopathy. The constraints in making western medicine available to the population, the efficacy of ISM practitioners, the social and political power of ISM practitioners at the regional level, the growing market share of ISM medicines and services and the continued power of nationalistic and cultural ideologies, have shaped the character and content of ISMs in independent India.

We have a whole gamut of concerns thrown up by the spread and continuity of ISMs today: (a) the attempts to incorporate these systems that hitherto operated through different kinds of social institutions into a centralised health infrastructure; (b) their expansion through the pharmaceutical industry for herbal products, and currently, through massage centres and spas; (c) the relations and negotiations between the practitioners of different coexisting systems of medicine; (d) the position of psychosocial and spiritual dimensions of cure and care in contemporary forms of indigenous systems of medicine; and (e) the debate on notions of efficacy in a situation of multiple, coherent systems of medicine. All these instances are worthy of serious study as they raise fundamental questions not just about ISMs but about organising healthcare in India. Social sciences in India have perceived and theorised the relationship between medicine, state and society almost exclusively from the perspective of biomedicine. The modernisation theories and the political economy studies, the two most influential and contrasting strands of social science theorising in India, have both accepted definitions of health and medicine from biomedicine.

A framework for the analysis of ISMs requires not only recognising the presence of diverse medical systems but engaging with them as live and efficacious traditions. The attempt here is neither to valorise these systems nor expurgate them. But the presence of these systems over centuries and the fact that they serve a vast population with and without choices calls for serious, critical research. The essays in this collection would address a few though not all the issues raised above.

**Indigenous Systems of Medicine**

Before we proceed, some engagement with the term “indigenous” as it is used in this collection is necessary. It has been the subject of several debates for its positive and negative connotations. We have used the term indigenous to denote the civilisational origin of systems of medicine, and in this broadest sense, biomedicine, homeopathy and naturopathy are indigenous systems of European civilisation. There seems to be no need to view indigeneity as a special cultural trait of the medical knowledge of the third world.

This introduction and the collection of essays to follow specifically focus on the Indian situation; hence, we refer to systems of medicine like ayurveda, siddha and unani, ISMs in order to distinguish them in terms of civilisational origin and temporal continuity in this region. In the light of the history of assimilation, change and transformation, the term “hybrid” is often used in the post-colonial situation to depict cultural configurations. But the term hybrid has little heuristic value in delineating the components and conditions of a cultural combination and it is oblivious to social structural correlates of culture.

We could talk of ayurveda, siddha and unani as ISMs in India in relation to biomedicine that was introduced by the colonial state two centuries ago. Interestingly, homeopathy and naturopathy, that were also entrants during the colonial rule, have found considerable voluntary support among people and have been formally grouped together with the ISMs in the current acronym of the government department (AYUSH). Homoeopathy in India today has the second largest number of practitioners after ayurveda, and naturopathy, which was consonant with Gandhi’s philosophy of life, is aligned with yoga to offer a coherent model for healthy lifestyle in contemporary India.

Yet, we have to distinguish ayurveda, siddha and unani, whose epistemology has been transmuted into a cosmology through long-standing historical processes generated and sustained through the lived experience of the people, from systems of cure like biomedicine and homeopathy which are widespread but largely as therapeutic options, at least for now. We do not intend to convey any sense of an unchanging indigeneity rather a dynamic one in which concepts and practices change and also shift from one social stratum to another, over the years. The classical medical texts themselves observe that the basic principles (tattvas) of ayurveda are not supposed to change, and that this is true only to a limited extent of its theory (sasthras) and not true of the praxis (vyavahara) that may vary considerably (Ram Manohar 2005).

Notwithstanding the trend of focusing on differences, breaks and ruptures, we refer to ayurveda or siddha as indigenous systems here. In the context of differentiating between ayurveda, siddha and unani from each other we call them systems, while we acknowledge that they could be dissolved when we make observations at a different level or about another unit of analysis. So the language of difference and of continuity alternates in our accounts of ISMs in this collection.

There are several difficulties in talking about the contemporary significance of ancient systems of medicine and the field is wrought with several typifications like tradition-modernity and science-culture whose temporal and spatial ramifications are unclear. One aim of this introduction is to highlight the perspectives underlying research on ISMs in India as subject of interest to historians and anthropologists. The second aim is to highlight the seminal concerns with regard to the situation of ISMs today in order to indicate concerns for future research.

**History of ISMs in Colonial India**

The history of ISMs, from the medieval times onwards, indicates that medical services were supported by the state as well as the wider society. The crucial point, however, is that unlike the colonial state, the medieval state did not produce a discourse about its subjects/citizens (Cohn 1990). We have autobiographies, portraits and inscriptions, but no reports that classify and categorise subjects and their culture that could become the basis for history writing as in the colonial period.
Colonialism, apart from other changes that it produced, seems to have altered the relation between isms and the state in two ways. It created a situation in which the state subscribed to one system of medicine and that was the official system. Secondly, parallel to policymaking and intervention, there was a discourse being advanced by the colonial state about its subjects who also were objects of investigation. As we know, it is this body of discourse enshrined in archives that has been the substance for the historiography of medicine in colonial India. There is a large body of erudite literature on several aspects of colonial state and biomedicine and we are not going to engage with it here. Our point is that the historiography of medicine in India does bear the influence of it being created out of the state discourse on isms rather than sources within isms.

For instance, there are several accounts of the experiment of National Medical Institution established in 1822 in Calcutta, where isms were integrated with western medicine and taught in Sanskrit and Urdu (Sarbadhikari 1962; Jaggi 1977; Arnold 1988; Gorman 1988; Khaleeli 2001). They report that when this institution was replaced by a modern medical college and when Madhusudhan Gupta, an ayurveda vaidya dissected the first cadaver, there was an official cannon salute of 50 rounds at Fort Williams to symbolise the triumph of modern science in India. While this act was ridden with symbolism both for the colonial state and for a certain variety of medical history writing, what is of interest to us is the response of the ayurvedic practitioners towards introduction of modern medicine, and specifically, to such symbolic acts. These historical accounts concur with the colonial portrayal of indigenous medicine as “closed” systems opposed to scientific methods and the tendency to ignore the fact that anatomy and dissection as epistemic tools were not new to ayurveda; that during this period several vakds and hakims learnt modern anatomy and surgery from Indian or British surgeons and that some of them chose to incorporate it into the curriculum in the new ayurveda and unani colleges that they established.

According to a few accounts, the colonial administration had to rely on the services of indigenous practitioners, even to establish the western medicine, for instance, hakims and vaidyas in the Punjab during the 1860-70s (Hume 1977) and traditional midwives (daüs) in eastern India from 1902 onwards (Forbes 2005). Hume notes that practising hakims and vaidyas were given training in the aspects of western medicine through vernacular instruction and were employed periodically to implement medical measures in the rural areas. Little is known however about what the hakims and vaidyas made of the western medicine imparted to them, what kind of medicine did they actually practise, or, how they negotiated their dual roles and identities within their communities. Recent research on daüs and the colonial discourse shows contradictory descriptions of daüs in the 19th century records from being competent, courageous and experienced women to the quintessential unhygienic and dangerous women, the prime cause of maternal and infant deaths in India (ibid). The daüs refused the paltry monetary incentives offered for their retraining by a system that viewed them as dangerous and treated them with disdain and the midwifery classes gradually picked up with enrolment of Christian women. According to Forbes, the new midwives “went to homes, delivered babies like doctors and left. Cleaning up the afterbirth and nursing the mother during the days of confinement were not part of their duties” (ibid: 99). The variety of functions performed by daüs from the start of labour through the delivery and the post partum care are now reduced “strictly” to the polluting job of cleaning up, especially in the upper class homes and confined the professional domain of the daüs to the deliveries of lower caste and poor households.

Conspicuously absent in the large body of literature on the colonial history of medical institutions and medical services (Jeffery 1988; Patti and Harrison 2001; Ramanna 2006) is any analysis of the role played by the large number of ism institutions and practitioners. Little is known about the ground realities of the working of western medical institutions and its Indian practitioners. In some of these accounts, it is mentioned in passing that Indian medicines were used in the dispensaries and hospitals in Bombay, especially when they ran out of medicines that had to come from Britain; that the surgical instruments used in the hospitals towards the end of 19th century were similar to that described by Sushruta; that the availability of chloroform and morphine enabled hundreds of rhinoplasty (traditional procedure for reconstruction of the nose) to be performed; that reports from the mofussil areas stated the doctor’s inability to function without the help of indigenous practitioners, that daüs were regularly called into assist hospital nurses, and so on. Instances such as these and others where the everyday working of western medicine not only included, but relied crucially on isms, finds no place understandably in the colonial discourse, but surprisingly, even in the historiography of medicine during the colonial period.

By the turn of the 20th century, there were oppositions from various, often contrary, quarters to the colonial discourse against indigenous systems. There was opposition to the denial of medical registration to the large number of ism practitioners, withdrawal of land grants and other allocations made to vaidyas, and deregistration of allopathic practitioners who associated with isms. For example, Mahendra Lal Sircar, a well-accomplished doctor of western medicine in Calcutta left his medical practice in protest and embraced homeopathy (Bhardwaj 1981). Iyothee Thass (1845-1914) “a Tamil savant, siddha medical practitioner and socio-political activist” (Aloysius 1998: 17) defended the lifestyle recommended by the siddha system of healthcare against that of allopathy, though he considered the British system of administration superior to that under brahmans, while Srinivasamurthy, an MBBS doctor, explained how the relation between science and religion in the Indian context was different from the manner in which it was understood in the west. P V Sharma, P S Varier, the Azizis, Ajmal Khan and others established new institutions for training and commercial production of isms (Liebeskind 1995; Krishnakurty 2001; Varier 2002; Alavi 2007). The vernacular press and print technology were used extensively by the supporters of isms (Warrier 1997; Wood 1985; Sivaramakrishnan 2006). The development of isms training institutions continued with support extended by wealthy patrons and

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the princely states of Travancore, Cochin, Gwalior, Mysore and Hyderabad with the result that at the time of India’s independence there were more than 40 colleges of ISM (Abraham 2005). Unlike in the case of western medical education, the institutional developments in ISM did not bring an end to the traditional forms of training conducted through patasalas and through apprenticeship. In fact, the non-institutionally qualified practitioners constituted the bulk of the ISM practitioners even till 1990.

On these developments we have very little by way of analysis. What is said is that in the encounter between indigenous systems and western medicine during the 18th and 19th century, the indigenous practitioners were not passive receptors of the developments that occurred. But the responses of ISM protagonists were labelled as nationalist without due analysis of the regional and local initiatives that did not always mirror nationalist trends. For instance, arguments coming from varying structural positions were placed under the title “image of the archaic” reduced to nationalist response to colonial science (Prakash 2000). In this account, there is no analysis or data on medical institutions created by vaidyas and hakims, their resource base, activities and innovations in curriculum and clinical practice; rather we have a deconstruction of some narratives of few protagonists.

Analysis of how vaidyas and hakims understood their situation in relation to the colonial state and the manner in which this was different from their relation to the pre-colonial state and society is central to any historical understanding of the responses of vaidyas and hakims. A few studies that draw upon regional language sources, biographies of practitioners, family records, records of indigenous institutions and oral histories provide insights into the internal working of the ISMs in colonial India (Panikkar 1995; Sivaramakrishnan 2006; Alavi 2007), indicating different possibilities for the history of ISMs in colonial India.

Debates in Social Anthropology

Public health in India has been based on biomedicine and crucial issues surrounding healthcare delivery have been the primary focus of social science research. Barring a few occasional studies (Bhardwaj 1975; Izhar 1990), even the large number of studies on healthcare utilisation, have not looked at the role of ISM practitioners in any serious manner considering their spread and scope. However, there has been a sustained interest for five decades now, among North American anthropologists in the study of Asian systems of medicine. Some issues for debate in the anthropology of medicine that is more or less common to the discipline in the countries of the south are as follows:

Cultural Resistance to Biomedicine: During the 1950s, the government of independent India was seized with the problem of reducing infant and maternal mortality rates and improving life expectancy. The US government, apprehensive of another socialist revolution in the third world (Singh 1986), promoted the idea of development that included improvement of health status of third world population. Organisations like Ford Foundation and Rockefeller Foundation sponsored collaborative studies by physicians-cum-social scientists from the US and their Asian/Indian counterparts. The origin of anthropology of medicine of the third world will have to be viewed against this background.

The initial impetus was set by a number of biomedical physicians turned anthropologists who started their clinics in Indian villages such as Marriott (1955), Benjamin Paul (1955), Morris Carstairs (1955), Opler (1963), Harold Gould (1965) and Henry (1981). They found that the villagers were not keen on visiting their clinics and wanted to know why people did not resort to allopathy though it was more effective. They recommended that western medicine should be presented in the cultural idiom of the people in order to be accepted and this became the basis for the field of health education and communication in the third world. Suggestions such as conducting training programmes for health workers in renowned temples to ensure popular acceptance, and adoption of social marketing strategy like that of the coco cola company were made (Nichter and Nichter 1996). Later studies on health education certainly went beyond behaviouristic approach and looked at folk cognition and anthropologised the issue, but were nevertheless part of the mandate of health education under the World Health Organisation regime which saw Asian and African systems as “ethno” medicine. 6

Scholars on public health in India such as Banerji (1986) did not accept that cultural resistance to western medicine was the problem. They pointed out how health education studies reduced the health problems of the third world population to cultural hang-ups without any reference to social structural factors. Banerji, a physician who was part of the National Tuberculosis Programme, has noted that when doctors and medicines were made available in the health centre, people approached them on their own without any investment on health education.

Sociologists have critiqued the cultural resistance theory on the grounds that continuity of traditional medical practices did not mean the non-acceptance of modern medicine (Ahuwalia 1967). Khare (1996) has explained that the notions that inform the villager’s therapeutic system, namely, dava (medicine) and dua (blessing) were based on the cultural markers, body and being, respectively. He concludes that the villager accommodated the improved results of doctor’s medicine within his broad theory of life based on the concepts of dharma, karma and daiva.

Gupta’s framework (1988) does not envisage a separate mandate for sociology and anthropology of illness; it laid out four basic components common to both disciplines. Gupta points out that resort to multiple systems of relief to gain relief from suffering was basic to humans in general, and cannot be explained as cultural obduracy or ignorance of the third world population. Neither was it due to the absence of proper allopathic facilities, for multi-systemic approach is found even when the best of facilities are available. He also argues that the coexistence of traditional and modern medicine has, therefore, to be seen not as dichotomies, but as “overlapping instrumentalities” (Gupta 1988: 407).

Thus the anthropological interest in the indigenous systems was only matched by the disinterest among sociologists who called for a less essentialist view of culture. It is important to note that, this debate was not specific to the Indian situation. For instance, reviews of disciplinary trajectories (Duarte-Gomez et al 2007) have reported a similar debate by Mexican scholars against the theory of cultural resistance to biomedicine among Mexicans, who advocated “intercultural medicine” that included the curative services of biomedicine (2007: 74).
Civilisational Approach to Medical Knowledge: By the 1960s, trends in the history of science did broaden the scope of enquiry into isms and pitched them at the level of civilisational character- istics. Especially, Marxist scholarship on science sought to apply the principles of historical materialism to establish the relation between science and (capitalist) society. Debiprasad Chattopadh- hyaya's analysis (1977) of ayurveda inspired by Joseph Needham's approach to medieval Chinese science has been the most detailed philosophical treatment of the medical classics for an English- speaking, social science audience. As a Marxist philosopher of sci- ence, Chattopadhhyaya, explains the materialistic orientation of the Nyayasavishekika, the school of Indian philosophy on which ayurveda theory was based. Chattopadhhyaya wants to know why the scientific content of ayurveda was stifled despite sound medical theory and epistemology. He concludes that the intrusion of a counter ide- ology, namely, a religious one, by later authors of Hindu orthodoxy led to the decline of the empiricist impulses of Indian science and prevented it from evolving into a modern, positivist science.

Bajaj (1981) argues that any system of medical knowledge is built on the edifice of foundational premises which define its scope and development, and that the question why it did not evolve in the same manner as the other is biased and based on the unilinear theory of scientific development. Employing the idea of Homo ludens, (culture as a playful exploration) Alvares (1991) explained that science and technologies emerged in the creative and often playful engagement that societies had with their environmental and human resources. So a teleological model that presumes that civilisations tend toward a particular purpose would not help understand how the sciences and technol- ogy of China, India and Africa achieved sophistication in terms of their environmental and human base.

Like Chattopadhya's effort to bring to bear the concepts of historical materialism on ayurveda, Sudhir Kakar's work (1982) brings psychoanalysis to inquire into Indian healing traditions. While he has looked at eastern mystical traditions in terms of western psychiatry, Kakar has not considered an examination of European religious healing in terms of psychoanalysis. His work, therefore, revolves around the dichotomy of the traditional east and the modern west and the quest for the essential Indian psyche.

Civilisational View in Anthropology: The civilisational view fostered by the history of science had a definite impact on the nature and character of anthropology’s perception of non-western medical systems. In medical anthropology, the civilisational pers- pective was inaugurated by Charles Leslie. Leslie argues against the theory of decline of ayurveda whether it was because of the objection to dissection by Buddhist values of ahimsa, the inter- ventions of Hindu religious orthodoxy or because of neglect by Muslim rulers. His edited volume Asian Medical Systems (1976) stresses the contemporary significance of isms and their concep- tual and therapeutic aspects as borne out by the clinical practice of the vaidyas and hakims.

By this time, French structuralism had made possible the study of a conceptual framework without reference to an existential base. Zimmermann (1987) has adopted the structuralist approach to the study of three classical ayurvedic texts and identified certain binary categories that ran through the textual taxonomy of landscapes, vegetation and animal life. As is true of structural- ism, in general, it is not clear whether the binaries were intrinsic to the texts because he does not refer to any commentary but relies on his own exegesis. He concludes that the ayurvedic texts constitute erudite literature that was closer to poetry than to the science of zoology or botany. Zimmermann’s analysis only re- veals that a method of analysis such as structuralism that defines its object as a discursive entity is likely to be self-fulfilling.

There have been studies focusing on the subject of medical knowledge, namely, the practitioner, as distinct from the study of ayurveda as a conceptual framework. In the 1980s, anthropolo- gists were either taking apprenticeship under vaidyas or wrote on how vaidyas went about theory building through their clinical practice (Trawick 1987). Obeyesekere (1993) explains how clini- cal practice and medicinal preparation constituted in situ experi- ments for the practitioner and he refers to it as samyogic experi- mentation. His case study of a Sinhalese Christian ayurvedic practitioner, who had “a critique and an interpretation of the Sanskrit origin myth of ayurveda” (ibid: 174) has showed how empiricism combined with Buddhist atheism could produce a variant of ayurveda devoid of the Hindu Samkhya metaphysics.

Politics of Medical Pluralism: Parallel to the study of isms as a civi- lisational trait were debates about their contemporary relevance and role in the health policy. By the 1980s medical anthropology saw its role as a progressive one in terms of its “even handedness” towards pluralism as opposed to the “normative” approach of the health administrators and the medical professionals, who were entrenched in notions of standardised medical care and were intolerant to local health traditions operating outside the purview of the state (Leslie 1980). Leslie has addressed the frequently made alleg- ation that folk medical traditions involved quackery and argued that anthropologists never found quackery in the local traditions because the folk practitioners were under the vigilance of the village community. Pointing to the misuse of biomedicine, he has argued that “others quackery appeared to be worse than ones own”.

Minocha; however, had a different take on medical pluralism and argues that people’s health-seeking behaviour was not deter- mined by their cultural perception of a medical system, rather by the availability, accessibility and quality of medical care in any particular system in an area (1980: 219). Despite criticisms of the impersonal nature of relations in the hospital and insensitivity of personnel, there is overutilisation of the hospitals in the country that indicates a certain need for curative services. Minocha cau- tioned that traditional practitioners were handing out potent allopathic medicines to their clients with little knowledge of its consequences and the clients consumed it just as they would take traditional remedies (that were not dangerous like biomedical drugs taken without prescription). She was doubtful, if this could be seen as an “adaptability of traditional medicine” (ibid: 220).

It is interesting that sociology of medicine in India and medical anthropology of Asian systems often see issues pertaining medi- cine, state and society differently. Public health and sociology of medicine in India have been interested in the challenges to health status posed by ongoing transformations and have maintained a
respectful distance from the ISMs. Medical anthropology, on the other hand, has looked at the significance of indigenous systems of medicine as self-contained cultural wholes. A similar disinterest in medical anthropology is noted among Brazilian scholars, who chose to do anthropology of health because they want to ground the significance of systems of medicine in relation to the issues of health and nutrition instead of looking at them as cultural wholes (Leibing 2007). Despite its concern for the contemporary, medical anthropology tends to emphasise the epistemological distinctness of cultural configurations over ontology, namely, the institutional, structural and practical conditions under which culture becomes meaningful to agents in action.

**Change and Transformation of ISMs:** The struggles and negotiations of college educated ISM professionals in relation to the government demanding the inclusion of courses on modern biology in their curriculum and eligibility for government posts have been noted (Brass 1972). Whether or not conservative social background is inimical to modernisation seems to have been a major concern with regard to change. Leslie (1993) has advocated syncreticism and argued that conservatizes do not necessarily block modernisation (1976: 358). Instead of dealing with the question through the political choices or substantive ideas of the protagonists, Leslie has foregrounded two personalities of ayurveda of the 1960s: one who publicly advocated shuddha ayurveda but was westernised in personal habits and another who supported integrated medical education but was a conservative middle class brahmin. Against the picture of these persons, the author has given his impressions through the statements like: “He would recruit people who would be loyal to him” (1993: 183) and “his views that he did not mix ayurveda and allopathy amounted to self deception” (1993: 194). The discussion in Leslie’s paper has amounted to elevated gossip infringing on personal integrity of persons who were not alive to respond. Of course, sociology of science has critiqued scientists, but their arguments were pitched at the level of philosophy of science, and largely, by scientists-turned philosophers and were not loose impressions on personal narratives.

This is also true of certain other writings in postmodern cultural anthropology (Langford 2002 and Alter 2004). Langford, for instance, wants to find out whether ayurveda was immune to the modern medical paradigm by examining the difference between vaidyas trained in the *gurukula* system and college-educated ayurvedic doctors. Her analysis uncovers a shift in focus from a loss of physical health to loss of cultural health, namely, the concerns for authenticity of ayurveda, apprehensions of quackery and concerns about copying western medicine. In the process she tells the story of redefinition of ayurveda as a remedy for the imbalances of post-colonialism.

While the work addresses serious issues before contemporary ayurveda, there seems to be no accountability in the deconstructionist zeal that dwells on corruption in India and the ayurvedic curriculum in the same breath. There is a fundamental contradiction between Langford’s postmodern view of ayurveda as an open-ended body of knowledge with several voices and her own mission to provide a singular discourse of modern ayurveda as a remedy for post-colonial imbalances. Despite claims of reflexivity, this work, like others in this genre, suffers from a disciplinary dogma of assuming the absolute nature of (postmodern) social science tropes like difference, open-endedness and no truth/essence. Justifiable concerns of ayurveda vaidyas of the 20th century about the spread of quackery or cultural degeneration due to change in lifestyle appear to be constructions to be decoded by the anthropologist. Even within discourse analysis, it has been possible to address the issue not as a dichotomy between the tradition of the east and the modernity of the west, but between the non-modern and the modern in both the sites (Nandy and Visvanathan 1990). Plural in this discussion implies a plurality produced by a search for oneself in the other.

The foregoing section shows that the process of change and transformation in the ISMs has been described as revivalism, syncreticism and hybridisation of tradition and modernity. While these concepts provide the starting point to the study of change, they are inadequate in several respects. Since most of these concepts are derived from the anthropologisation of the east, there is little conceptual explanation why attempts to rebuild ISMs may be characterised as revival of tradition in the third world, while the search for indigenous alternatives like homeopathy, osteopathy and chiropractic in the west be seen as a move toward post-modernity/late modernity (Giddens 1992; Scambler 2002).

Our argument in this review is twofold: Essentialised conceptions of the ISMs as cultural entities obliterate the fact that indigenity of medicine is not specific to the third world; it is a general phenomenon though it may be referred to differently by sociology and anthropology. Secondly, there is a dire need to restore the consistent contemporaneity of ISMs and avoid accounts that undermine their significance as a counter current within modernity.

**Issues and Concerns for Research**

ISMs today are represented by a number of stakeholders in different sites: the traditional vaidya, the college-educated ayurveda doctor, the ethnobotanist, the pharmaceutical companies, the research laboratories, star hotels, and so on. It is therefore imperative to identify domains of change, such as, institutional norms, class composition of physicians and patients, locale of clinical practice, medical concepts and epistemologies. What this dispersal of subject and object of ayurvedic pursuits in various spaces would mean for the system of medicine is a matter of crucial concern for research. This section highlights some critical research questions with regard to ISMs in the current scenario.

**ISMs and the State in Independent India:** While the state in independent India inherited the functions set up by the colonial forces, its approach to ISMs has been ambivalent: extending legitimacy without economic support or defining any specific role to the vast ISM resources that it recognises. The establishment of various councils, national institutes and drug testing laboratories were direct outcomes of the recommendations made by various committees set up by the government. The key, almost singular concern of the state-induced institutional development, however, has been the validation of ISM drugs in the laboratory along scientific lines, subjecting the ISMS to the political economy of the
laboratory. However, a number of institutions and arrangements have proliferated in the non-state sector through private trusts of vaidyas, their professional associations, community institutions and non-governmental organisations (NGOs) that mitigate the hegemony of the scientific model.

Presently, the AYUSH sector of the Indian government is large enough to warrant a disaggregated analysis of regional trends even though the budgetary allocation for isms has not been significant. First, the data suggests that the isms facilities in the government institutions are uneven across the country (Abraham 2005). For instance, there is a strong presence in the states such as Maharashtra, Uttar Pradesh, Karnataka and Kerala and are virtually absent in Jharkhand, Chhattisgarh, Arunachal Pradesh and Assam. Second, the data indicates that the popularity of ayurveda, siddha and unani varies in different parts of the country and has also waxed and waned over the years. West Bengal which was historically a major centre of ayurveda with famous Kavirajas and Gobaidyas (Gupta 1976; Bala 1991) shows fewer modern institutions in isms. However, Bengal has emerged as a popular centre of homeopathy (Bhardwaj 1981). Third, the data also contradicts the general argument that attributes the popularity of isms to the absence of allopathic facilities; those states with better distribution of allopathic facilities like Kerala, Maharashtra and Karnataka are also the ones with better ism facilities.

According to recent data (GoI 2005) there are nearly 7.1 lakh registered qualified AYUSH practitioners in India, of which about 2 lakh are non-institutionally qualified. There has been a doubling of the number of ism practitioners since 1980. Further, the number of institutionally-trained practitioners has been steadily growing, while the number of non-institutionally-trained practitioners shows a marginal increase up to 1995, and thereafter, shows a decline. Thus institutionally-trained ism practitioners are taking the place held by non-institutional practitioners, in both cases far outweighing the practitioners of biomedicine. What are the current institutional arrangements for absorbing ism graduates?

The central government programme for “mainstreaming ayurveda” just utilises AYUSH graduates in primary and district health centres to deliver biomedical services in remote areas, where MBBS graduates are not available. On the other hand, the Tamil Nadu government’s experiment in mainstreaming isms seems to be an engagement with ayurveda and siddha in their own terms. The Tamil Nadu government formed a committee of ayurveda and siddha doctors (as consultants) and developed a kit of 50 medications for regular use. The kit includes pastes (lehyams) for nutritional deficiency prescribed in ayurveda/siddha texts for pregnant women and is distributed through auxiliary nurse midwives (ANMs) and accredited social health activists (ASHA workers) in interior areas. This medication has been well-received and has improved the situation with regard to maternal mortality through improved maternal nutrition.

While the inclusion of professional AYUSH services in healthcare administration raises one set of issues, the elimination of certain other domains of isms by the state is the other side of this process. Those domains of the indigenous systems that lie on the borderland between therapy and ritual and those enmeshed in the living conditions of the socially disprivileged face censure by the state and civic agencies. The ban on popular healing shrines and the position of the dai, are cases to point. Two papers in this collection, one on childbirth care and dai by Mira Sadgopal and the other on dargahs in Maharashtra address the encounter between the state and subaltern practices. Bhargavi Davar and Madhura Lohokare’s paper on dargahs explores in depth the problems in the mental health system and the pertinence of healing shrines.

Research on the manner in which state governments are incorporating AYUSH professionals would throw light on the nature of the relationship that isms have forged with the state in the 21st century.

**Medical Education:** Medical education in isms has seen an enormous growth in the recent years. At present there are 219 medical colleges that offer undergraduate training in ayurveda (Bachelors of Ayurvedic Medicine and Surgery or BAMS), in unani (Bachelors of Unani Medicine and Surgery or BUMS) and in siddha (Bachelors of Siddha Medicine and Surgery or BSMS). The total annual turnover of AYUSH graduates from the 450 medical colleges is around 20,000. A large number of medical colleges in ayurveda and homeopathy have mushroomed in Karnataka and Maharashtra under the expansion of the capitation fee regime but the facilities in many of these colleges and the quality of training are pointed out to be of poor quality.

There have been some experiments in the institutional arrangements for learning ayurveda in the 1990s such as the inclusion of extended periods of apprenticeship with well-known traditional vaidyas within the system of college education. Not only institutional structures, but the epistemological breaks in curricular content are negotiated in the ism colleges. The curriculum for undergraduate degree programme of isms includes biomedical subjects of anatomy and physiology. Leena Abraham’s paper in this collection examines the role of institutions like the Kerala samajams in Mumbai that mediate between the traditional and the modern forms of ayurveda in negotiating the epistemological disturbances produced by college education in ayurveda.

**ISM and the Market:** The ism pharmaceutical industry in India is estimated to be worth Rs 4,200 crore with ayurveda alone accounting for more than 80% of the share. There are nearly 10,000 licensed private manufacturers of ism drugs in India (more than 500 in ayurveda, 300 in unani and 200 in siddha). Banerjee (2002) has examined the encounter between ayurveda and the modern market by looking at production decisions and profiling of ayurvedic products. She concludes that the market for alternative medicines prevented ayurveda from “complete erasure”, but subjected it to its mechanisms of pricing and laboratory testing. In this collection, Harilal’s paper examines the trajectory of commercialisation and industrialisation of ayurvedic drug manufacture in Kerala, with details on who the protagonists of the process are, what kind of output is produced and for whom.

If we turn attention from the value of turnover to the number of firms and their size, we would get an idea of the volume of consumption within the country. A large amount of medicines used within the country continue to be produced by hundreds of small firms and cottage industries of vaidyas as indicated by the fact that there are 6,965...
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Evidence and Efficacy of Medicine under Pluralism: Efficacy of treatment is determined by different actors and classes of people when several systems of medicine co-habit the health arena. Systems of medicine are not just a bundle of therapies, but an episteme with substantive definitions of what constitute a disease and how it is to be cured. Sujatha’s paper in this collection focuses on the siddha parameters of validity of medical knowledge and the manner in which these principles are exemplified in the dyadic relation between the vaidya and the sufferer in contemporary clinical practice in siddha.

But in the past century, efficacy of medicine has come to be defined exclusively in terms of the randomised controlled trial (rct) and widely adopted to evaluate alternative systems under medical pluralism (Adams 2002). Besides, it is increasingly realised that controlled trials within laboratory occludes the problems in the transition of medical objects from laboratory to real life. Laboratory tested recipes may not give relief to the patient and the deaths and damages (iatrogenesis) produced by tested medication and procedures is well-documented. Thus lived experience of relief from symptoms is becoming an increasingly important basis for the choice of therapy. If we call this populist measure of efficacy, we should also state that the populist measure is by no means insignificant. It has been the driving force behind the continuity of ISMS in India and the recent emergence of alternative health movements in the west pressurising the state to accept modes of legitimacy outside the laboratory (Unschuld 1980; Stacey 1988; Cant and Sharma 1999; Scambler 2002).

Lived experiences of health vary with social class and locale of the consumer, and interestingly, the clinical tests also have populism about them among certain sections. Naraindas (2006) has pointed out that the educated, urban patients in the Indian metropolis increasingly seek ayurvedic therapies for diseases established by biomedical tests of diagnosis and categories. The ayurvedic practitioner has hence to “contend with other ways than ayurveda in which diagnosis, prognosis and therapies have been framed” (p 2665, 2006). The curriculum of the degree course in ayurveda fosters such “syncreticism” and the college educated ayurveda practitioners get used to this “conceptual bilingualism” (2667, 2006). This is homologous to the situation of CAM therapies in the United Kingdom and the us which have to cohabit with biomedicine in the elite health market. In-depth research is needed to see how this situation of would transform medical concepts, classification systems and theoretical development in the isms as much as notions of efficacy among different classes of patients.

Caste, Ethnicity and Gender: The relation between social stratification and medicine has several dimensions and warrants greater attention than has been given. Class is often used as a proxy for other social indicators in much of the healthcare utilisation studies. Variation in diet, medicinal substances and rituals across castes in the same region is found to have a stable relation to the ecology and occupational patterns (Sujatha 2003). While there were vaidyas from different caste backgrounds, practitioners of the most disprivileged castes probably never treated other caste members. The assertion of vegetarianism in the globalised version of ayurveda of recent times (Zimmermann 1993) is quite different from the importance of meat as food and medicine in the classical ayurvedic texts and by the folk and tribal traditions (Roy Burman 2003). The processes involved in the reworking of the caste-medicine relations from a subaltern perspective are yet to be examined.

Besides the dai traditions, not much is known about women’s participation in the traditional sector of ISMS. There have been womenfolk practitioners in the lower castes, but very few if any, women professional vaidyas under the gurukula system. Charu Gupta’s (2005) lone study based on the writings of an upper caste, middle class successful woman ayurveda doctor, describes how women ayurveda doctors had to negotiate tradition and modernity on the one hand, and the patriarchy in society and in medicine on the other hand differently. Comparative reflections on the gendered experiences of women practitioners of biomedicine and of ISM would reveal the different constellations of social support for women’s education and professional practice.

It is evident that the study of ISMS opens up possibilities of gaining an insight into the interplay of social, economic, political and cultural domains of life in contemporary Indian society. The papers in this collection cover some, not all the concerns identified in the review. The papers are based on the ongoing research on the subject by authors from various fields such as psychology, sociology, economics and public health.

NOTES
1 Biomedicine is the term used for allopathy in social sciences. In this paper, we use the terms western medicine, modern medicine and cosmopolitan medicine as used by the protagonist whose views are present.
2 A Department of Indian Systems of Medicine and Homeopathy (ISM&H) was created only in March 1995 and renamed as Department of AVUSH in 2003.
3 There are studies on the diffusion of biomedical concepts and practices among lay people, but the question is whether a reductionist medical episteme based on expert knowledge, could permit a significant epistemic role to lay knowledge.
4 While it is mentioned that a vaidya left Calcutta in disgust after the first dissection by an ayurveda vaidya, Gupta (1976: 371), himself a well-known vaidya and from a family tradition of well-established vaidyas, refers to it as “a legend” according to which Gangadharma Ray, a reputed vaidya left Calcutta in protest when he heard of the cannon salute and informs us that Ray left for his native place due to health reasons.
5 In the Indian context, the role of the sociologists and anthropologists are not strictly delineated.
6 The prefix “ethno” as in “ethno medicine” is applied to systems of medicine in the third world because of their moorings in culture as opposed to biomedicine, which is a science. Interestingly, homeopathy or naturopathy, the other systems within the west are not referred to as ethno medicine!
7 The surname of Aneeta Ahluwalia mentioned earlier was changed to Minocha.
8 “Mainstreaming ayurveda” is a strategy suggested by the National Policy on ISM&H 2002 by the Ministry of Health and Family Welfare, Government of India.
9 Unpublished papers presented by Padmanabhan, Joint Director, Department of Health, TN government and P L T Girija, ayurveda vaidya, in the Seminar on “Back to the Future: Indigenous Medicine in Contemporary India” organised by Centre for the Study of Social Systems at Jawaharlal Nehru University, New Delhi, 24-25 February 2006.

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