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Systems of medicine and nationalist discourse in India: Towards "new horizons" in medical anthropology and history

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Abstract

While accepting medical "pluralism" as a historical reality, as an intrinsic value inherent in any medical system, and as an ideal or desired goal that any multicultural society ought to achieve, this paper argues the need to go beyond the liberal pluralist tendencies that have dominated the debate so far. It holds that while documenting or dealing with the "co-existence" of varied medical traditions and practices, we must not ignore or underplay issues of power, domination and hegemony and must locate our work in a larger historical, social and political context. With this perspective, and based essentially on Assembly proceedings, private papers, official documents and archival materials from the first half of the 20th-century, this paper identifies three major streams in the nationalist discourse in India: conformity, defiance and the quest for an alternative. It shows that while the elements of conformity to biomedicine and its dominance remained more pronounced and emphatic, those of defiance were conversely weak and at times even apologetic. The quest for alternatives, on the other hand, although powerful and able to build trenchant civilizational and institutional critique of modern science and medicine, could never find adequate space in the national agenda for social change. The paper further holds that although the "cultural authority" and hegemony of biomedicine over indigenous science and knowledge were initiated by the colonial state, they were extended by the mainstream national leaderships and national governments with far more extensive and profound implications and less resistance. In light of the growing global networking of "traditional", "complementary" and "alternative" health systems on the one hand and the hegemonic and homogenizing role and presence of multilateral organizations (such as the World Bank and IMF) in shaping national health policies on the other, such insights from history become extraordinarily important.
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Introduction

Since the late 1960s, the idea of medical "pluralism" has been debated both within and outside the forum provided by *Social Science & Medicine*, and, indeed, never has the concept been so popular as in the last one and a half decades. While accepting medical pluralism as a historical reality, as an intrinsic value inherent in any medical system, and as an ideal or desired goal that any multicultural society ought to achieve, this paper argues the need to go beyond the liberal pluralist tendencies that have dominated the debate so far. It holds that while documenting or dealing with the "co-existence" of varied medical traditions and practices, we must not ignore or underplay issues of power, domination and hegemony and must

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locate our work in a larger historical, social and political context (Ernst, 2002). In this sense, this paper responds to the call by Waltraud Ernst for a "critical and informed pluralist perspective" and intends to make some contribution to "new horizons" in medical anthropology and history (Ernst, 2002; Nichter & Lock, 2002).

In particular, I focus here on systems of medicine and mainstream national politics in India in the first half of the 20th century. The purpose is to explore varied shades and trajectories of the nationalist discourse and their struggles for hegemony; and to examine how different (or not) were the nationalist perceptions, policies and programs towards different systems of medicine in India from those of the British colonial state. Such an exercise not only helps us understand different patterns of contemporary politics in this field but also throws light on important and longstanding issues of the decline of "indigenous" systems of medicine (particularly Unani and Ayurveda), the nature of their interactions with biomedicine in the first half of the 20th century, and, most importantly, with hindsight, their subsequent status in the post-colonial period in India.[1] Moreover, a study of this nature may also provide a far more concrete ground for testing Indian nationalist positions than the domains of politics, art and literature. While not an uncharted territory, medicine as a part of social history and medical anthropology is relatively new ground for assessing Indian nationalism and anti-imperialist struggle in India.[2] In the context of "globalization" and the hegemonic role and presence of multilateral organizations such as the World Bank and IMF in shaping national health policies, such insights from history become all the more relevant.

This paper—based essentially on Assembly proceedings, private papers, official documents and archival materials—identifies three major streams in the nationalist discourse. The first falls in the category of conformity to biomedicine (or what is usually identified as the Western system of knowledge) and its dominance, as well as to its wide application to Indian systems of medicine as a sign of modernization. The second consists of elements of defiance against the dominance and alleged superiority of the Western system of knowledge and its wide application. The third involves a quest for an alternative based on India's own experiences. The paper argues that the zeal for conformity to biomedicine and the Western system of knowledge remained more pronounced and emphatic, while the elements of defiance were weak and, at times, even apologetic. The quest for an alternative, on the other hand, although powerful and able to transcend Western hegemony, could never find adequate space in the national policy for social change. The dominance of the voice of conformity to Western "science" and "progress" did not simply mean an inherent acceptance of western superiority and a fractured, dislocated version of "colonial governmentality" (Prakash, 1999), but also a continuation of the colonial legacy of subordination and subservience of Indian systems of knowledge, a situation fundamentally not different from the colonial past.

The state of knowledge

Before we deal with these three major strands in detail, it is important to note that in the last few decades, there has been a surge of interest in the medical history of India under colonial rule. In particular, works of Arnold (1985, 1993, 2000), Harrison (1994), Pati and Harrison (2001), Jeffery (1988), Ramasubban (1982), Chandavarkar (1992), Kumar (1997a, 1997b), Bala (1982, 1991), and Anil Kumar (1998), among others, are of great relevance. However, most of these works remain primarily confined to the 19th century and focus on colonial medical interventions and their socio-political implications. There have been some substantial efforts to understand popular perceptions and response to "colonial medicine" and the way such responses informed and shaped imperial science projects (Arnold 1993, 2000; Kumar, 1997a). There have

[1] In Indian nationalist discourse biomedicine was very often referred to as "allopathy", "modern medicine" or "Western system of medicine" as against categories such as "Indian medicine" or "indigenous systems of medicine" that broadly included Ayurveda, Unani, Siddha and folk medicines. Sometimes, even Homeopathy was added to the list of "Indian medicine". These categories are not without problems; however, I am using them here interchangeably as they appeared in the context of the discourse. For some details about the problems around the use of such categories and the risk of cultural polarities, please see Arnold and Sarkar (2002). Also, see Leslie's "Introduction" to *Asian Medical Systems* (1976), although his preference for the term "cosmopolitan" is also problematic.

[2] I am deeply indebted here to the ideas and rich insights of David Arnold, Gyan Prakash, Ashis Nandy (e.g., Nandy, 1983), Partha Chatterjee and Dipesh Chakrabarty (e.g., Chakrabarty, 1992), among others, who have made significant historical and theoretical/critical contributions in the field directly and/or indirectly.

also been questions raised about class contradictions and hegemonic projects led and sponsored by national elites at the cost of popular medical practices (Arnold, 1993; Metcalf, 1985; Panikkar, 1992). Such questions and concerns, in the face of the gravitating force of colonialism, however, remain more or less marginalized. Overall, except for Jeffery's *The Politics of Health in India*, there has been no substantive effort to examine the mainstream nationalist agenda on medicine and health in India. And, when it comes to policy making as reflected through assembly proceedings and debates, in particular, there seems to be a near absence of any literature in the field.

There have been some specific studies focusing on individual and group efforts and their struggles around the revitalization of Ayurveda, Unani and Homeopathy in India. Here, works of Leslie (1976a, 1976b, 1992), Metcalf (1985), Brass (1972), Panikkar (1992), Arnold and Sarkar (2002), and Quaiser (2001) are particularly useful and can help us in assessing the nationalist discourse. Similarly, Prakash (1999) has recently used Foucault's concept of "governmentality" to assess the history of science and imagination of modern India and powerfully reflects on the dilemmas and ambiguities of colonial state, Indian nationalism and modernity.

Here we need to address the concept of medical pluralism in a little more detail. A major credit in this regard goes to Charles Leslie who through his life-long project has pursued medical pluralism as a value and as a core theoretical framework for engaging in historical and comparative studies of varied medical traditions and practices. It is this value and framework as popularized by Leslie that makes many of us see Asian medical systems, unlike the conventional understanding in the West, as intellectually coherent, intrinsically dynamic, evolving, and culturally and historically mediated syncretic traditions (Leslie, 1976a, 1976b; Leslie and Young, 1992). Leslie insists on seeing all medical systems as "pluralistic structures" differentiated by a "division of labor" that exists between practitioners who represent different traditions (Leslie, 1980). Thus, "Even in the United States, the medical system is composed of physicians, dentists, druggists, clinical psychologists, chiropractors, social workers, health food experts, masseurs, yoga teachers, spirit curers, Chinese herbalists, and so on" (Leslie, 1976b, p. 9). He seems to have a mosaic view of medical system where different traditions through historical processes negotiate and interact with each other and perform different roles in complementary and competitive spirit and in an open and infinitely malleable environment. However, while sensitive to historical processes, Leslie does not really pay as much attention to the larger questions, such as those of capitalism and colonialism (and now globalization) and their close inter-linkages with biomedicine and its dominance in the world. For example, while dealing with Ayurveda (and Unani) and the ambiguities of medical revivalism in modern India, he barely recognizes the discriminatory nature of the British state in favor of biomedicine or that there was any deterioration or decline of the indigenous system. His preoccupation with documenting elements of syncretism does not allow him to entertain the theory of decline or pay enough attention to issues of domination and control (Leslie, 1976a, 1976b, 1992).

Perhaps partly noticing this weakness in Leslie, Nichter and Lock (2002), while dedicating their recently edited volume to him and his great contribution to medical anthropology, emphasize the need and importance of exploring "new horizons," such as the need to go beyond recording medical pluralism to critically examining global public health agendas and their "homogenizing" and "rationalizing" influences on national health policies. Similarly, Ernst (2002) while defending medical pluralism as capable of providing sophisticated analyses, highlights the importance of paying attention to issues of power, domination and hegemony. She cautions us against the risk of exclusive focus on medical pluralism that colludes with "the image of the medical market place….where biomedicine could not only be simply one of a number of different modes of healing but also abstains from undue claims of epistemological superiority and greater efficacy and efficiency" (p. 4). It is with this critical framework on medical pluralism that I intend to examine the nationalist discourse in India.

On methods, background and sources

As indicated above, I focus here on systems of medicine and mainstream national politics in India in the first half of the 20th century, particularly the 1930s and 1940s. There is more or less a general consensus among scholars that by the late 1920s and 1930s, the idea of India getting political freedom had become quite widespread, so much so that the

Indian National Congress (INC), the main organizing nationalist body, had instituted a National Planning Committee to prepare blueprints on various issues for what it felt would be a "planned" change after 1947. The INC had won a majority in almost all major municipalities and district boards by 1924 and had achieved an absolute majority in provincial legislatures by 1937.[3] Being in power at local and provincial levels before 1947, they were, despite some political and financial constraints, virtually the policy makers, and health and medicine from 1919 onwards were very much under their control. On the other hand, as late as 1914, Western medicine in India, despite being a state-sponsored system, was still confined to "colonial enclaves"—the army, prisons, hospitals, civil stations, etc.—and hardly reached beyond metropolitan elites, the rest of the country relying solely on the indigenous systems (Arnold, 1993; Harrison, 1994; Marriott, 1955; Ramasubban, 1982). In other words, much depended on the policies and programs pursued by Indian national leaderships, and their critical assessment could potentially help Indians plan future policies and programs in the field better.

This study is mainly based on The Proceedings of the United Provinces Legislative Assembly and makes use of private papers, official documents and archival materials. This by no means claims to represent the complexity of nationalist discourse on medicine and health at all India level. However, it does provide us with a trend, and given that the United Provinces, now called Uttar Pradesh, has historically been the most populous state in India with significant impact on democratic and national politics, including India's struggle for political independence, the legitimacy and significance of the voices and trends emerging from the policies and debates at this provincial level can hardly be overemphasized. This study becomes much more significant when combined with the views and thoughts of key national leaders such as Mahatma Gandhi and Jawaharlal Nehru.

[3]In 1937, having achieved absolute majority in five provinces—namely, U.P., Bihar, Central Provinces, Madras and Orissa—and the largest single party status in four provinces, the INC was able to form its first mass elected representative governments in seven out of 11 provinces. Later, in September 1938, the province of Assam, too, had a Congress ministry, and in Bengal, after December 1941, there was a new Cabinet, and the INC participated in it. For details, see, Gupta (1970, pp. 174–177). Sarkar (1983) is also a great resource on varied facets of Indian national movement and constitutional reforms.

This study is, thus, in the mould of a discourse and policy analysis, and in the process, asserts the role of history and narratives in social studies of medicine.

The voice of conformity

The voice of conformity is best represented by "The United Provinces Indian Medicine Bill, 1938," passed by the United Provinces (U.P.) Legislative Assembly in 1939. The Congress ministry that had formed the first mass elected representative government in the province introduced the Bill. Briefly, it proposed reconstituting the Board of Indian Medicine as a statutory and representative body consisting of experts and public men and women with adequate funds and power to coordinate the system of medical education and training, the system of examination, and the granting of degrees, aid and funds. It sought to establish teaching and research institutions and laboratories and to develop the art of surgery based on the allopathic system. It also proposed to regulate the system of appointment of Vaids and Hakims[4] in the government services and in private practice so as to discourage "quackery,"[5] which was considered a "menace" to the progress of Indian systems of medicine.

From the provisions of the Bill and the spirit of the debate in the Assembly that followed, it is quite clear that the goal was to "modernize" the Indian systems of medicine with allopathy taken as the idealized model. It is noteworthy that, up until this time, reforms in Indian systems of medicine had been largely private individual and group efforts. Consequently, there could not evolve "uniform educational and professional standards" (Brass, 1972, p. 349). That by bringing about this Bill the effort was to follow in the footsteps of allopathy is greatly reflected in the statements made by the Minister of Local Self-government and Health, Vijaya Lakshmi Pandit. Explaining the reasons behind the Bill, she said that the government sought to "raise the Indian Systems of medicine and bring it (sic) up in line with the scientific knowledge of the Western system of medicine"(*The Proceedings*, 1939, Vol. 16, p. 49). She went on to emphasize, "this system, as a whole, must go forward along

[4]Vaids were the Ayurvedic doctors while Hakims were those who practiced Unani medicine.

[5]Quackery here implied medical practices by healers who were not certified and recognized by the Board of Indian Medicine.

scientific lines progressively and reach the same height that other scientific systems of medicine occupy today" (*The Proceedings*, 1939, Vol. 18, p. 444). To Vijaya Lakshmi Pandit, while Indian systems of medicine were "systems," they were less than a "science" and far from modern, Western science that they must pursue in order to be modern. Her views resonated with many other members in the house. For example, Kunwar Sir Maharaj Singh noted: "I look forward to a time…when these systems of medicine will be modernized to substantially the same extent as the allopathic branch of medicine…"(*The Proceedings*, 1939, Vol. 16, p. 49). Thus, allopathy and the West, despite not being part of the Bill, were nevertheless acting as *referent* and setting the agenda of reform.

This zeal for reform along allopathic line was, however, not inspired by any intention to replace or supercede the system of allopathy. On the contrary and as logically expected, the system of allopathy came to hold a central position in the nationalist choice, while the indigenous systems, namely Unani and Ayurveda, were given only a subservient and subordinate role. This is confirmed not only by the attitude of the Congress ministry and its efforts to evolve a so-called "uniform policy" based on "modern scientific methods", but also by the patronage given to the two different systems of medicine—both indigenous and Western—and the public appointments made. For example, while introducing the U.P. Indian Medicine Bill, Vijaya Lakshmi Pandit explained the government's position, stating, "this Bill is being introduced not with any preconceived prejudice in favor of any particular system" (p. 56). Furthermore, as late as 1950, when Jawaharlal Nehru heard that some of the ministers of the Central Government and those of the state governments were making statements in regard to the public use of indigenous medicine, he wrote a "Note to Chief Ministers" on 22nd July, 1950, stating that he felt unhappy "when what is called modern medicine was condemned and other systems were praised" (*Selected Works of Jawaharlal Nehru*, April–July, 1950, Vol. 14, Part 2, p. 288). He directed all the Chief Ministers that it was the business of the Health Ministry to propose a "uniform policy" and get the approval of the cabinet to it. He further clarified:

> The science of medicine would not be divided up into compartments but would be built upon solid foundations of past and present experience tested by modern scientific methods…The proper approach, therefore, should be that any system of medicine to be followed or encouraged must be modern and up-to-date and should take advantage of all the accumulated knowledge we possess (pp. 288–289).

Not only was there no question of replacing or superceding the Western system of medicine, but even to get government encouragement, indigenous systems had to be "modern" and "up-to-date" and, of course, the scale of measurement would be provided by the system of allopathy. In the light of more critical studies of science, medicine, knowledge and development discourse available (Cunningham & Andrews, 1997; Escobar, 1995; Harding, 1998; Howard, 1994; Latour, 1987, 1999; Marglin & Marglin, 1996, 1990; Nandy, 1988; Rahnema & Bawtree, 1997; Sachs, 1992; Shiva,1993), one feels that the whole logic of the "uniform policy" based on "modern scientific methods" was quite discriminatory to the indigenous systems, and it inevitably meant giving a dominant position to the system of allopathy in policy formulation. Moreover, at a deeper level, it sounded not much different from the approach adopted by the British state. Jeffery (1977, p. 570) points out that whenever there were pressures on the British to recognize Ayurveda and Unani, they insisted on scientific evidence of safety and efficacy and "privately, they believed that to place these systems on a scientific basis would be to destroy them utterly." Jeffery also adds later that Nehru, too, was never convinced of the value of indigenous systems of medicine (Jeffery, 1979).

Further, a major chunk of government grants went to allopathy (The *Proceedings*, 1947, Vol. 31, pp. 481–482). In terms of employment, Ayurvedic and Unani graduates were rarely appointed to the posts of Medical Officer in the Provincial Medical Service and never to the higher posts, such as that of Inspector General of Civil Hospitals. In response to concerns raised by Mr. Dhulekar, a member of Legislative Assembly, Mrs. Pandit stated that Vaids and Hakims did not have the "background" and sufficient "fundamental education" and that unless they fulfilled these conditions, only allopathic doctors would be appointed to the higher posts (pp. 487–488). However, she did not clarify what she meant by "background" and "fundamental education." Besides Mrs. Pandit, such discriminatory policies were also reinforced by the individual

biases of several key figures within the Assembly who felt that allopathy was superior to the indigenous systems of medicine and, therefore, deserved priority treatment by the government.

It seems pertinent, here, to examine the views regarding the reasons for the decline of indigenous medicine in India. Although there are some scholars who do not seem to entertain the theory of decline and argue that there was actually a relative deterioration in the "average social position of elite Vaids and Hakims" mainly due to their internal divisions and the decline in the clientele (Jeffery, 1988; Leslie, 1976a), there are others who point out that Indian medicine, especially Ayurveda, declined because of its lack of professionalization and "scientific élan" (Bala, 1982, 1991; Kumar, 1998). Common to all these views, as also suggested by a third group of scholars, is a significant lack of focus on the role of public policy and the state (including colonial and national governments) and political economy in the making or unmaking of a knowledge system (Banerji, 1981; Frankenberg, 1980, 1981; Gupta, 1976; Panikkar, 1992; Ramasubban, 1982). For example, Frankenberg and Banerji have shown close inter-linkages between capitalism, ruling class ideology and biomedicine in Indian context.

An important question remains. What made the Congress government seek to "modernize" the Indian systems of medicine? It seems that it was more a response to the urgency of unmet needs for medical care in rural areas, what may be called "pressure from below" as well as the government's financial constraints.[6] Morbidity and mortality rates were high in rural areas, and the rural population was without adequate provision of health services—allopathic services remaining mainly confined to urban areas. These are facts not only reported frequently in the Assembly but also substantiated by the 1946 *Report of the Health Survey and Development Committee* (also called the Bhore Committee report). The committee, for example, points out that in the United Provinces, one medical institution served an average rural population of 105, 626, which was on average, 224 villages (Government of India, 1946, pp. 35–38). Thus, moved by urgency and compelled by its own financial constraints, the ministry had no option but to fall back on the indigenous systems to fill the gap. The allopathic system was reportedly too expensive and beyond the reach of the general population. Throughout the debate on the Bill, Indian systems of medicine were praised more for being cheap than as systems of knowledge. Their cheapness was emphasized so much that once Nehru felt compelled to comment:

> It is said that some systems of medicine are cheaper and therefore more suitable. That is hardly an argument. We should make prevention and treatment of disease cheap. But we cannot do so regardless of its efficacy or utility (*Selected Works of Jawaharlal Nehru*, April–July, 1950, Vol. 14, Part 2, p. 289).

Elements of defiance

Against the zeal for conformity to the Western model of scientific medicine, the voice of dissent within the nationalist ranks could never evolve into an effective opposition. The debates within the legislative assembly reveal that those who represented the voice of dissent were mostly defeated in the arithmetic of votes. There were very few members within the Assembly who protested against the voice of conformity. Moreover, the voice of dissent, it seems, was caught in the dilemma of the framing of the issue as a choice of tradition versus modernity. It appears that those who raised the voice of dissent were actually not against the spirit of reform or modernization but against the problems associated with it. They feared that under the banner of "professionalization" and control over "quackery," the modernization process might lead to the marginalization of so-called "unqualified" Indian doctors and surgeons and, ultimately, might reinforce the hegemony of allopathic medicine. This is substantiated by an exchange in the Bihar Legislative Assembly, where similar voices were raised against the introduction of a resolution for a Drugs Regulation Bill. A private member, Mr. Branjandan Prasad proposed that a resolution be passed to seek the formulation of a Government of India federal act to control spurious drugs. Several members opposed the resolution on the grounds that there could not be a uniform standard of drugs

[6] We cannot ignore the popularity of indigenous systems of medicine and their being culturally integrated in Indian society as a factor behind the modernization effort of the Congress ministry, but these, at best, acted as facilitating factors. Brass (1972), on the other hand, highlights the role of pressure groups and the modernization of Indian medicine as a political instrument in support of Ayurveda against the "entrenched and hostile" Western medical profession. This, again, in the light of the assessment made above seems only partially true.

for the different systems of medicine and that it might lead to the marginalization of the indigenous systems. For example, Mr. Gur Sahai Lal opposed the Bill saying:

> We must not lose sight of the fact that in a province like ours a large number of people depend upon indigenous medicines, and if for the preparation of the indigenous medicines some sort of license will be required, then I am sure indigenous drugs and medicine will be in a way wiped out. There will be a small number of persons who will get license, because the majority, though (they) prepare very good medicine, have small industry and that would be checked and hampered (National Archives of India, 1938, pp. 22–23).

Legislative member, Syed Muhammad Hafeez also opposed the resolution arguing "this will affect indigenous drugs and indigenous medicine because even now the Hakims and Vaids who prepare medicines at home in village, will labor under considerable difficulties if such measure is passed" (pp. 20–22). Syed Mubarak Ali, another member, further added, "my apprehension is that this enactment…might go to help the western manufacture of medicine at the cost of our old system of medicine"(p. 36). On the whole, the fear of marginalization dominated the voice of dissent, but despite this fear and opposition, the resolution was finally passed as those who were in favor of the resolution were in a majority.

The voices of dissent, like the voice of conformity, were also not directed at replacing the Western system of medicine, nor did they challenge its alleged superiority. The fight mainly remained confined to the demands for better treatment of Indian medicine, or at best, for equal treatment by the "national government" so that Indian systems, too, could grow and flourish. In the course of the arguments for equal treatment, the voice of dissent often remained very weak and apologetic, but sometimes became emphatic, even coming close to questioning the superiority of Western medicine. For example, Raghunath Vinayak Dhulekar, while attacking the discriminatory policy of the government, seriously questioned the view that Ayurvedic and Unani doctors were less efficient or less capable than the allopathic doctors. He argued that even when the students of Ayurvedic and Unani medicine did not do well, it was because of the discriminatory treatment given by the government, because while the government spent lakhs[7] on the allopathic Agra and Lucknow Medical colleges, it spent only a few thousand rupees on Unani and Ayurvedic colleges (*The Proceedings*, 1947, Vol. 31, p. 482). In contrast, Raja Jagannath Baksh Singh, another member of the House, said, "however much effort may be made for its progress, the Indian systems of medicine cannot be a match to the Western system" (pp. 489–491). Yet he wanted Unani and Ayurveda to be granted government assistance so that, being cheap, they could provide medical relief to a much larger number of people and, thus, could reduce the widespread high rates of mortality in rural areas. His argument was that in the absence of any system of treatment, even people with minor diseases developed complications; the chances of this could be reduced if Unani and Ayurveda were available as an "alternative." Despite Mr. Singh's call for funding for indigenous systems, this was a classic case of believing in and succumbing to the hegemony of biomedical discourse.

The voice of dissent was also reflected in protests raised against the resolution regarding the introduction of compulsory vaccination in rural areas. However, while only two or three members in the Assembly were completely against the vaccination, the majority agreed to it so long as it was not made compulsory in the rural areas and remained a voluntary exercise based on people's choice. The resolution was introduced by a private member, Qazi Muhammad Adil Abbasi, who informed the House that smallpox, a preventable disease, affected about half a million Indians every year and caused immense losses. He proposed compulsory vaccination. Against his proposal, Indra Deo Tripathy, another member, stated that going in for vaccination was not only "anti-Swaraj" but also an act of deception to Indian people, because "to them we have always promised that we want to establish Ram Raj" (*The Proceedings*, 1938, Vol. 7, pp. 415–416). Here Tripathy was echoing Gandhi and his campaign against vaccination where Gandhi projected vaccination as "anti-swaraj", i.e., against greater social and political autonomy and home rule. Gandhi also used "Ram Raj" as a metaphor and euphemism to mean "Swaraj", i.e., complete autonomy and ideal home rule. Perhaps, Tripathy was also trying to convey that they must find indigenous solution to the problem of smallpox and

[7] A "Lakh" in Indian currency is equivalent to 100 000.

hinted at the role and importance of Vaids. On the other hand, Keshav Gupta argued that vaccination was not the proper solution to smallpox, as it created many other medical problems. He suggested that the government should rather concentrate on eliminating poverty and improving the standard of living and sanitation (pp. 403–405). Lal Bahadur Shastry, another member (who later became India's Prime Minister following the death of Nehru in 1964), cited examples where despite vaccination, smallpox cases had occurred, and the patients had died (pp. 350–351). He, too, commented that good health provided greater immunity than vaccination. And Ram Swarup Gupta argued that many of the diseases were occurring because of the modern system of treatment as it weakened the natural vitality of the body (pp. 363–364). Such views, nevertheless, were few and far between and could hardly transcend the Western hegemony over the nationalist discourse. The resolution in favor of compulsory vaccination in rural areas was passed, although with an amendment that the government would go for compulsory vaccination as far as practicable in rural areas and would adopt necessary effective methods for the purpose. However weak, ambiguous, and marginalized the voices of dissent in the face of modernization as dominant paradigm, it is important to recognize them as different. They should not be ignored or merged with the voice of conformity.

Quest for an alternative

Mohandas Karamchand Gandhi (1869–1948), popularly known as Mahatma Gandhi, was the central figure who in the midst of this discourse adopted a third path, one that could be termed as the quest for an alternative. His quest in medicine and health evolved from his general critique of modern civilization. Since the West is proclaimed as the birthplace of modern civilization—the system of allopathy or biomedicine being a part of it—Gandhi's critique was also a defiance against the West, and unquestionably at a deeper level than the ones represented by the elements of defiance within the Assembly. Nandy and Visvanathan, too, highlight this point by seeing Gandhi as the one who "linked his theory of the body to the theory of politics on the one hand, and the politics of culture, on the other" (1990, p. 175). Let us, therefore, start with Gandhi's critique of modern doctors and hospitals, as this forms a background to his search for an alternative.[8]

In the modern world, doctors and hospitals are usually seen as a sign of progress, but to Gandhi they were the sign of civilizational decay. The reasons he gave were many. One, he believed that doctors and hospitals undermine self-control by increasing dependency on the system of cure or treatment. He stated:

> I overeat, I have indigestion, I go to a doctor, he gives me medicine, I am cured. I overeat again, I take his pills again. Had I not taken the pills in the first instance, I would have suffered the punishment deserved by me and I would not have overeaten again. The doctor intervened and helped me to indulge myself. My body thereby certainly felt more at ease; but my mind became weakened....The fact remains that the doctors induce us to indulge and the result is that we have become deprived of self-control...(Gandhi, 1938, pp. 53–54).

This erosion of self-control, according to Gandhi, was the major precursor of immorality in society, which ultimately meant ruination of the whole civilization in his scheme of thought.

Gandhi's second critique of doctors and hospitals is linked with his first argument. He believed that these modern doctors and hospitals only concentrated on the treatment of the body and practically ignored the importance of the soul or spirit within. He held two opinions: first, that while treating the body, doctors should take care that the soul and spirit within was not impaired and, second, that, in fact, treatment of the body could be done or initiated with purification of the soul or what he later called "Ramnama", i.e., taking god's name with pure heart. If one extends the logic of his arguments, Gandhi was actually against the secularization of treatment in terms of its disjunction from spirituality. He called Western medicine "black magic," as it "tempts people to put an undue importance on the body and practically ignores the spirit within" (*The Collected Works of Mahatma Gandhi*, 1920–1921, Vol. 19, p. 357).

Gandhi's third critique was that modern doctors and hospitals concentrated more on cure than prevention. To him, cure was a temporary measure,

[8] It is important to note here that Gandhi also criticizes Ayurveda and Unani systems of medicine, although his critique of biomedicine is much sharper and at a much higher scale.

while the actual solution to health problems lay in prevention, the science of sanitation and hygiene. When he went to inaugurate the opening of Tibbia College (this college had Ayurvedic and Unani departments and an allopathic section) in Delhi in February 1921, he stated:

> I hope…this college will be concerned chiefly with the prevention of diseases rather than with their cure. The science of sanitation is infinitely more ennobling, though more difficult of execution, than the science of healing (*The Collected Works of Mahatma Gandhi,* 1920–1921, Vol. 19, p. 357).

Gandhi was also against the excessive use of drugs. The best physician, according to him, was the one who administered the least number of drugs. He urged all social workers in the field, whether urban or rural, to treat their medical activity as the least important item of service. He said: "It would be better to avoid all mention of such relief. Workers would do well to adopt measures that would prevent disease in their localities. Their stock of medicines should be as small as possible" (p. 105). Similarly, Gandhi was very critical of vivisection of animals for the sake of research to develop treatments for the human body. This was against his principle of non-violence, which "modern" science was violating under its "legitimate" practices (Nandy & Visvanathan, 1990). However, he also appreciated modern western scientists for their "spirit of research" and commended the Tibbia College, Delhi, for having its "Western Wing" (devoted to allopathy), hoping that "a union of the three systems (*Ayurveda, Unani and Allopathy—my additions*) will result in a harmonious blending and in purging each of its special defects…" (*The Collected Works of Mahatma Gandhi*, 1920–1921, Vol. 19, p. 358).

From Gandhi's critiques it becomes clear that his alternative science was one where there would be more emphasis on prevention than cure, where there would be a minimum of drugs used, where the treatment of the body would coincide with the purification of heart and soul, and where vivisection would be forbidden. These components in Gandhi's quest are very well expressed in his own words when, at the time of his speech at Ashtanga Ayurveda Vidyalaya, he said:

> I belong to that noble, growing, but the still small school of thought… which considers that the less interference there is on the part of doctors, on the part of physicians and surgeons, the better it is for humanity and its morals. I belong to that school of thought among medical men who are fast coming to the conclusion that it is not their duty merely to subserve the needs of the body, but it is their bounden religious duty to consider the resident within that body, which is after all imperishable. And I belong to that school of thought among medical men who consider that they will do nothing in connection with that body if whatever they do is going to impair, in the slightest degree, the soul, the spirit within. (*The Collected Works of Mahatma Gandhi*, 1925, Vol. 27, p. 44.)

Based on these perspectives, Gandhi developed his science of Nature Cure. First, it was based on preventive and sanitary measures. Sanitation and hygiene, as shown above, formed the two most important strands of Gandhian preventive medicine. He practiced it extensively in South Africa against the outbreak of diseases and epidemics, such as plague, cholera and smallpox. Secondly, his system of Nature Cure was based on the use of earth, water, light, air and the great void (perhaps, space or sky). These five simple things, Gandhi argued, were easily accessible to poor villagers.

The central feature to Nature Cure was, however, the prayer, "Ramnama" or taking god's name. But it had to come from the heart if it was to be a remedy for all one's ailments. Gandhi emphasized its role more than anything else in his science of Nature Cure (*The Collected Works of Mahatma Gandhi*, Vol. 84, p. 203).

It seems that through his Nature Cure and powerful critiques of modern medicine, similar to the institutional critiques that were developed and popularized later by Illich (1976) and Foucault (1975, 1977), Gandhi sought not only to transcend western hegemony but also to free "civil society" from the ever-increasing power and control of the state in general, and the colonial state in particular (Nandy & Visvanathan, 1990).

From the point of view of health and medicine, Gandhi also tried to show the importance of uncooked and un-fried food, the role of physical exercises, as well as the importance of some common Indian products, such as neem and soyabean. In light of the recent controversies around patents on some of these important Indian products, his views become all the more relevant and important.

However, despite these varied experiments and quest for alternatives, Gandhi's views could never receive much support from the policy makers and received only a passing reference in the Report of the Sub-committee on National Health (1948). As already referred to above, Nehru advocated a central role for the Western system of medicine in independent India.

One way to understand such lack of representation of Gandhian thought in national planning and policy making would be to appreciate the "cultural authority" of science and modernity as represented through the long history of colonial experience in India and its deep internalization by the Western-educated elites in general and the national leaderships in particular (Prakash, 1999). Clearly, endowed with the responsibility of building the "nation-state," leaders like Nehru saw science and modernity as the "syntax of reform" and as a "grammar of modern power." But there were weaknesses in Gandhian thought as well. For example, his insistence on the use of "Ramanama" or God's name, with pure heart, as a necessary and most important principle of Nature Cure—however symbolic in expression—limited its appeal in India's diverse society. Moreover, many of the Gandhian ideas, such as those related to the status of women, widow remarriage, sexuality and family planning originated from patriarchical, elite, Brahminical traditions and remained grounded in ancient texts and metaphors. Gandhi also, at times, seems to have overemphasized the role of individuals in understanding causality, prevention and control of disease.

Conclusion

A study of mainstream national politics and nationalist discourse on systems of medicine in colonial India reveals a plurality of ideas ranging from conformity to defiance to the quest for an alternative. While the elements of conformity to the Western system of medicine and its dominance remained more pronounced and emphatic, those of defiance were conversely weak and at times even apologetic. The limits of defiance are apparent in its arguments—their ambiguities and ambivalence over the issue of tradition versus modernity—but also in its weak voice in the Assembly. This was a fact that led to its obvious marginalization in the arithmetic of vote, a *sine qua non* of the so-called democratic culture. The quest for alternatives, on the other hand, although powerful and able to build trenchant civilizational and institutional critique of modern science and medicine, could never find adequate space in the national agenda for social change, perhaps partly because of its own weaknesses and lack of appeal. However, despite the weaknesses and marginality of the voice of dissent and the quest for alternatives, such ideas and practices need to be lauded and recognized while also critically examined.

I feel that although the "cultural authority" and hegemony of Western medicine over indigenous science and knowledge were initiated by the colonial state, they were extended by the mainstream national leaderships and national governments with far more extensive and profound implications and less resistance. In this sense, the national elites of India took upon themselves the universal "civilizing mission" and the fractured project of colonial modernity that often followed the shrewd colonial design of "governmentality"—domination, order, exploitation and control. This task was made relatively easier by the institutional legitimacy attached to "nationalism" and "nation-state". Certainly, they could have created a more level playing field for different systems of medicine. Their favorable approach to biomedicine did not make them less nationalist. In fact, as Chatterjee (1986) would rightly argue, their very justification for supporting biomedicine at the cost of indigenous knowledge and healing practices emanated from "nationalism"—a Eurocentric derivative discourse. Here we need to interrogate both colonialism and nationalism.

In recent years, because of the growing global networking of "traditional", "complementary" and "alternative" health systems, and because of the increasing volume of critical studies in the field of science and medicine, or, perhaps because of the fear or promises attached with the new "gold rush"—i.e., the competition for patents and commoditization of indigenous knowledge—there have been some attempts to pay more attention to traditional and indigenous knowledge systems. In the Indian context, for example, the first-ever *National Policy on Indian Systems of Medicine and Homeopathy* was announced in 2002, and there have been talks of "mainstreaming" and "integrating" these systems into the national health system (Government of India, 2002). How much this would really translate into meaningful dialogue and healthy medical pluralism and how much this would

lead to the actual empowerment of grassroots people and their healthcare deserves critical and fresh scrutiny, particularly given the contrary and simultaneous trend towards homogenization and "monocultures of the mind" as sponsored through global health policy and designs.

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