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The Evolution of Indian Government Policy on Ayurveda in the Twentieth Century

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Health regulation in the nineteenth and early twentieth centuries

The attempts by the British and Indian governments to regulate medical practice in India generated an outpouring of numerous, long and scattered documents. In order to be able to grasp the outlines of these processes of attempted control, I offer here a framework for understanding this landslide of documentation. I shall also offer some perspectives concerning the relative importance of some of these documents, as well as a sense of their content and influence.

Broadly speaking, the documentation can be divided into two classes:

- **Reports** into specific topics commissioned by governments, and
- Government legislation in the form of **Acts**.

Documents in both these categories have been generated both by

- **individual** Indian states, and by
- the **central government** in Delhi (and Colombo).

Some regional reports (presidency or state) seem to have had as much authority as central government ones. For example, the Usman *Report* of 1923 was a regional Madras report but had national importance. Regional reports predominated in the period up to Independence, after which central government reports become the norm.

As one might expect, in many cases the *Report*s led to legislation in the form of Bills and then Acts. However, sometimes the findings of committees were politically or socially unacceptable in whole or part, and it took several committees to produce a consensus which would satisfy the legislators at a given period.

For example, the Chopra *Report* of 1948 can be seen as a direct reaction to the Bhore *Report* of 1946. However, the present essay does not primarily address the evolution of government Acts, but the discussions that preceded them, in which policy was formed prior to legislation.

I begin with a brief overview of the main documents that were relevant to health policy formation.

Government Reports

State Government committees in the pre-independence period that dealt specifically with indigenous medicine in South Asia include the following:[1]

1923 Madras: The Committee on Indigenous Systems of Medicine ("The Usman Report") [§§ 44–58].

1925 Bengal: The Ayurvedic and Tibbi Committees [§§ 59–69].

1926 United Provinces: Ayurvedic and Unani Committee [§§ 70–73].

1927 Ceylon: a Government Committee [§§ 104–106].

1928 Burma: Committee to Enquire into the Indigenous Systems of Medicine [§§ 74–75].

1939 Central Provinces and Berar: The Committee to Examine the Indigenous Systems of Medicine [§§ 76–83].

1942 Mysore: Committee "to go into the Question of Encouraging the Indigenous Systems of Medicine" [§§ 100–103].

1941 Punjab: The Indigenous Medicine Committee [§§ 84–92].

1947 Bombay: The Indian Systems of Medicine Enquiry Committee [§§ 93–95].

1947 Assam: The Scheme Committee to Report on Steps to be Taken for the Development of Ayurveda [§§ 96–97].

1947 Orissa: The Utkal Ayurvedic Committee [§§ 98–99].

1947 Ceylon: Commission on Indigenous Medicine, Ceylon [§§ 107–108].

In the period after Independence, the following reports on ayurveda were published under the auspices of the Ministry of Health of the Government of India (Brass 1972: 454):

[1] The paragraph numbers (§) refer to discussions of these *Report*s by Chopra 1948: 25–67.

1948 The Report of the Committee on Indigenous Systems of Medicine ("The Chopra Report").

1951 Report of the Committee Appointed by the Government of India to Advise Them on the Steps to be Taken to Establish a Research Centre in the Indigenous Systems of Medicine and Other Cognate Matters ("The Pandit Committee Report").

1956 Interim Report of the Committee Appointed by the Government of India to Study and Report on the Question of Establishing Uniform Standards in Respect of Education & Practice of Vaidyas, Hakims and Homoeopaths ("The Dave Report").

1959 Report of the Committee to Assess and Evaluate the Present Status of Ayurvedic System of Medicine ("The Udupa Committee Report").

1963 Report of the Shuddha Ayurvedic Education Committee ("The Vyas Committee Report").

1981 Health for All: an Alternative Strategy ("The Ramalingaswami Report").

The last item was not in fact a government report, but an independent document published by the Indian Institute of Education and distributed by the Voluntary Health Association of India. However, Ramalingaswami was a senior figure who contributed to many aspects of government health policy on other occasions, and the report was treated as an authoritative statement.

By far the most important health policy report was that produced by the Bhore Committee in 1946. This pre-independence report did not primarily address indigenous medicine, although it expressed a disparaging view of it at various points. The Bhore *Report* can be said to be the main blueprint for the Indian Government's post-independence health system, which to this day adheres almost exclusively to the biomedical model.

Other government reports on health matters in general sometimes also refer to indigenous medicine in greater or lesser degree. Thus, the strengthening of primary health centres was recommended by the Mudaliar Committee of 1961, while the Kartar Singh Committee of 1973 and the Srivastava Committee of 1975 both made recommendations for multipurpose health workers, for medical education and for support of manpower, with emphasis on community health workers.

Government Acts

Legal provisions regarding health matters preceding Indian independence are to be found scattered over at least 40 enactments dealing with diverse subjects. Some examples include:[2]

1825 The Quarantine Act

1859 The Indian Merchants' Shipping Act

1860 The Indian Penal Code

1880 The Vaccination Act

1886 The Medical Act

1890 The Indian Railways Act

1896 The Births, Deaths and Marriages Registration Act

1897 The Epidemic Diseases Act

1898 The Code of Criminal Procedure

1899 The Glanders and Farcy Act

1911 The Indian Factories Act

1917 The Indian Steam Vessels Act

1922 The Indian Red Cross Act

1923 The Indian Mines Act

1924 The Cantonments Act

1933 The Indian Medicine Council Act

1938 The Bombay Medical Practitioners Act

Efforts to regulate teaching, practice, and research specifically in indigenous medicine continued after Independence with many more government acts, such as:[3]

1956 The Madras Registration of Practitioners of Integrated Medicine Act

1961 The Mysore Homoeopathic Practitioners Act, and

1962 The Mysore Ayurvedic and Unani Practitioners Registration Act

1970 The Indian Medicine Central Council Act[4]

[2] The Acts up to 1924 are cited from Bhore 1946: Survey, 29.

[3] The acts up to 1962 are cited from Stepan 1983: 302.

[4] Government of India 1970.

1984 The Central Council was reconstituted

1995 The Central Council was reconstituted again

2002 The Central Council Amendment[5]

The most important of these Acts, from the point of view of present-day ayurvedic practice, were those of 1938 and 1970. The former established the first professional register for ayurvedic (an unani) practitioners, effectively creating a pan-national profession for the first time. The 1970 Act, with its later Amendments, established the Central Council Council of Indian Medicine, whose objects were as follow:

1. to prescribe minimum standards of education in Indian Systems of Medicine, i.e., Ayurveda, Siddha and Unani Tibb,

2. to advise Central Government in matters relating to recognition and withdrawal of recognition of medical qualifications in Indian Medicine,

3. to maintain the Central Register of Indian Medicine and revise the Register from time to time, and

4. to Prescribe standards of professional conduct, etiquette and code of ethics to be observed by the practitioners.

The Act included the following important "schedules" which are frequently referred to in later legislation and documentation, and which are regularly updated (at least 60 times between 1970 and 2002):[6]

> **The Second Schedule:** "Recognised medical qualifications in Indian medicine [Ayurveda, Siddha, Unani] granted by Universities, Boards or other medical institutions in India".[7]
>
> **The Third Schedule:** "Qualifications granted by certain medical institutions before 15th August, 1947 in areas which comprised within India as defined in the Government of India Act, 1935".[8]
>
> **The Fourth Schedule:** "Qualifications granted by Medical Institutions in Countries with which there is a scheme of reciprocity [Only Sri Lanka]".[9]

[5] Government of India 2002.

[6] The First Schedule deals with bureaucratic matters concerning regional representation on the Council.

[7] See `http://www.ccimindia.org/1_10.htm`.

[8] See `http://www.ccimindia.org/1_11.htm`.

[9] See `http://www.ccimindia.org/1_12.htm`.

In short, following the 1970 Act, the CCIM became the main national and central regulatory body for overseeing indigenous medical education and maintaining a register of recognised practitioners.

After these exercises, the Central Government of India formulated and adopted its new National Health Policy in 1983.[10] This new Health Policy was influenced by the Alma Ata Declaration (WHO 1978). In 2002, the Department of Indian Systems of Medicine & Homoeopathy, part of the Indian Government's Ministry of Health & Family Welfare, published the National Policy on Indian Systems of Medicine & Homoeopathy—2002.[11]

Control of Drugs

Parallel to the reports and Acts discussed in this paper, a mass of documentation and legislation exists concerning the control of drugs and poisons. This literature surrounds and intersects with that relating to medical registration and the practice of indigenous medical traditions. One of the Bhore Committee's members, Dr R. A. Amesur, for example, made the following recommendation for legislation concerning the allowable use of the title "Doctor" based on the danger to the public of the illicit distribution of registered drugs (Bhore 1946: II, 459):

> (i) no medical practitioner shall be entitled to affix the designation " Doctor" before his name unless he is a registered medical practitioner in modern scientific medicine.
>
> (ii) no person shall be entitled to prescribe drugs which are in the British Pharmacopoeia, especially injections and poisonous preparations, unless he is a registered medical practitioner and
>
> (iii) those who practise the Unani or Ayurvedic system of medicine may style themselves as "Hakims" or "Vaidyas" as the case may be.

Three quite distinct issues are amalgamated in these recommendations: the use of professional titles, the right to prescribe certain medicines, and the exclusion of those styled "Vaidyas" and "Hakims" from such a right.[12] The possibility that

[10] The full text is available at `http://mohfw.nic.in/kk/95/ii/95ii0101.htm`.

[11] Government of India, Dept. ISMH 2002.

[12] The discussion of these recommendations makes reference to Rule 65(9) of the Drugs Rules, 1945, under the Drugs Act, 1940, which provides that a number of poisons shall not be sold in retail except on and in accordance with a prescription of a registered medical practitioner. Major Government reports had already addressed issues of drug use and control in the nineteenth century, for example the *Indian Hemp Drugs Commission 1893–94* (Mackworth Young 1894–95).

"doctors" might style themselves "vaidya" or "hakim" is not addressed, which marks the social gradient implicit in Bhore's treatment.

Whether or not it is logically satisfying in particular instances to discuss such issues together, policies concerning drugs and poisons do intersect with the issues of how medical personnel are defined and regulated. Although interesting and important, however, the history of drug and poison control will not be further addressed in the present paper.

Individual Reports

I shall now turn to an examination of selected reports, chosen for their intrinsic interest and later importance and influence.

The Usman Report, 1923

Sir Mahomed Usman, K.C.S.I., (1884–1960) was born of a noble Muslim family from Madras.[13] His father was Mahomed Yakub Sahib Bahadur, and Usman himself married Shahzady Begam, daughter of Shifaulmulk Zynulabudeen Sahib Bahadur also of Madras. He was educated in the Madras Christian College, and between 1916 and his retirement in the late 1940s he held a number of senior posts in the legal, civic and educational establishments of Madras. Having served on the Executive Council of the Government of Madras for nine years, he became Acting Governor of Madras in 1934. He was Vice-Chancellor of Madras University between 1940 and 1942, , and he participated in the Governor-General's Executive Council for India from 1942 to 1946. It was in 1921, at a relatively early point in his career, that he was invited to prepare a report on the Indigenous systems of medicine practised in India.

The Usman *Report* (Usman 1923) was the first major health report to be published in India. It appeared before 1947, and it was only a regional report, not a central Government one. But already looked towards a time when India would be independent.

The Government object of the enquiry was (Usman 1923: i.154),

> ...to afford the exponents of the Ayurvedic and Unani systems an opportunity to state their case fully in writing for scientific criticism and to justify State encouragement of these systems

[13] In his report, he gives his name as Khan Bahadur Muhammad Usman Sahib Bahadur. Details from Anon. 1964, 1967: 1110.

The *Report* noted that experiments in State encouragement of these systems was already being tried in several Indian States, including Hyderabad, Mysore, Baroda, Indore, Jaipur, Travancore, Cochin, Gondal, Rewa, Gwalior, and others. The *Report* also showed an awareness of a tension between practitioners of indigenous and Western systems of medicine. It noted that practitioners who had mastered both systems of medicine, such as Sir Bhalachandra Krishna and Dr Deshmukh of Bombay, or Mahamahopadhyaya Kaviraj Gananatha Sen and Kaviraj Yamini Bhushan Roy of Calcutta, could reasonably supply the "scientific criticsism" called for in the Governments objective (Usman 1923: i.154).

As Reports go, it is long, containing four major parts. The Report itself is 50 pages long, but the appendices and evidence take it into two long volumes, of almost 500 pages. It is organised as follows:

Part I: The Report with Appendices

1: Introductory

2: Medical Registration

3: Medical Relief and Medical Education

[4:] Appendices, including

- pp. 1–96 comprise "Appendix I: *A Memorandum on The Science and the Art of Indian Medicine*" by G. Srinivasa Murti, Secretary to the Committee on the Indigenous Systems of Medicine, Madras.
- pp. 135–53 comprise "A List of Indian Medical Works Extant (both Printed and Manuscript)"

Part II: Written and Oral Evidence.

1. Evidence from outside the Presidency of Madras,
   a) Written in English: 26 vaidyas
   b) Written in Skt.: 5 Vaidyas
   c) Urdu: 5 hakims
2. Evidence from Pres. of Madras:
   a) Written in English: 16 vaidyas
   b) Written in Skt.: 5 Vaidyas
   c) Tamil: 10 hakims
   d) Telugu: 1
   e) Malayalam: 1

f) Kanarese: 1

g) Oriya: 1

3. Oral evidence: pp. 429–468

The Usman Report contains several interesting and important features. First, the Appendix I, *A Memorandum on The Science and the Art of Indian Medicine*, by G. Srinivasa Murti, is a book-length study of traditional Indian medicine, old-fashioned in style, but clearly written and still of value today. The tone of the work is defensive, vis-à-vis Western medicine, with passages, for example, seeking to show that Ayurveda was aware of concepts parallel to the germ theory of infection. Second, the appendix giving *A List of Indian Medical Works Extant, Both Printed and Manuscript* is a valuable survey of the medical literatures in Sanskrit, Urdu and Tamil that were generally known in the 1920s.

But it is the evidence gathered in Part II of the Report that is of most unique interest. This comprises the testimonies of many vaidyas and hakims provided in their various original languages. They describe in their own words the Ayurvedic and Unani medical traditions, their importance and value for their patients, and their basic tenets. The material is quite extensive, the oral evidence alone covering forty pages. A fuller study of these testimonials would be very interesting.

The committee prepared a detailed questionnaire (reproduced at Usman 1923: i.97–8) which was translated into Sanskrit, Urdu, and several vernaculars of the Madras Presidency, and widely distributed. 183 written replies were received, from all over India, written in English, Sanskrit, Urdu, Tamil, Telugu, Malayalam, Kanarese and Oriya. Forty representative witnesses were orally examined, and a three-member subcommittee toured all over India, visiting important centres and meeting with leading exponents and promoters of indigenous medicine. The *Report*, therefore, represented an all-India survey, although it was commissioned and published specifically in Madras.

The Bhore Report, 1946

The next Government committee of major importance, the Health Survey and Development Committee, was convened over twenty years later under the chairmanship of Sir Joseph Bhore (Bhore 1946).

Sir Joseph William Bhore, K.C.S.I, (1878–1960) was born in Nasik, the son of Rao Saheb R. G. Bhore.[14] In 1911 he married Margaret W. Stott, who herself received a number of honours including the O.B.E. He was educated at Bishop's High School and Deccan College in Pune, and University College London. He

[14] Details from Anon. 1964, 1967: 100.

entered the Indian Civil Service in 1902, and held a number of senior government offices in Madras and Cochin. He was the Acting High Commissioner for India in the UK, 1922–1923 and was an acting Member of the Governor General's Executive Council, 1926–1927, and full Member 1930–1932. His public service was predominantly in the Departments of Agriculture and Lands, Industries and Labour, and Commerce and Railways. In 1935 he represented India at the Silver Jubilee Celebrations in London.

Bhore was a slightly older, but considerably more politically senior figure than Usman. Both men were Knights of the same two orders. They received their first knighthoods (K.C.I.E) only three years apart (Bhore 1930, Usman 1933), but their second (K.C.S.I) over ten years apart (1933, 1945). Both served on the Governor General's Executive Council, but Bhore served nearly twenty years before Usman. These facts highlight the more rapid promotion and more senior record of public service achieved by Bhore. Bhore's career was was spent more in central Government agencies, whereas Usman's was more specifically focussed on Madras, the city and especially the university. It is true that Bhore had gained relevant experience in 1928 as Secretary to an Indian Statutory Commission. Nevertheless, the fact that Bhore, rather than Usman, was invited in 1943 to provide a report on medical policy for the Government suggests that the topic itself had, since the Usman report, become more important, and therefore worthy of more senior representation from a central rather than regional Government figure. It also suggests that central Government sought committee leadership with a more political than academic colour. Most important, it suggests a decisive swing in Government opinion away from any recognition that indigenous medicine could make a contribution to the nation's health. It is impossible that Bhore did not know Usman personally, or that he was unaware of the Usman report. Both men had worked at a senior level in the administration of Madras institutions at the same time, and both received knighthoods in 1933. However, Usman's name and his report receive no mention in Bhore's work.

Bhore's committee was the last but one to be convened before Independence. It was appointed in 1943 by the Government of India to provide the following (Bhore 1946: 2):

- a broad survey of the present position in regard to health conditions and health organisation in British India, and
- recommendations for future developments

The terms of the committee were sweeping, allowing it to examine all aspects of the nation's health and medical establishment.

Reading Bhore today, it should be remembered that at the time of the committee's work, modern medical facilities were restricted mostly to India's metropolitan and capital cities. Hospitals existed at the district and sometimes at the taluk levels, but these were generally ill-equipped and did not provide any specialized services. Among its many final recommendations were two in particular which addressed issues at either end of the spectrum of the health and medical education system: the establishment of Primary Health Centres and the creation of a major central institute for postgraduate medical education and research (Bhore 1946: II, ch. 20). After Independence, the new National Government established the first Primary Health Centres in 1952 and the All-India Institute of Medical Sciences (AIIMS) in 1956.

The Bhore Committee was a large group, consisting of twenty-four participants. The group was predominantly composed of figures from the world of British state medicine. The committee was a panel of the great and the good in establishment medicine, almost all of whom had trained in medicine in Britain. Several of the committee members had collaborated on previous government commissions. For example, Cotter, Paton, and Banerjea had worked together on the Jolly Committee of the Central Advisory Board of Education which produced the 1941 *Report on The Medical Inspection of School Children and the Teachings of Hygiene in Schools*.[15]

The *Report* produced by this committee is an even longer and more detailed document than the Usman *Report*. It has four volumes:

vol. 1: Survey (228 pp.)

vol. 2: Recommendations (532 pp.)

vol. 3: Appendices (351 pp.)

vol. 4: Summary (90 pp.)

In the initial part of the *Report*, the committee takes pains to locate itself within a particular history of medical work (Bhore 1946: I, 29), by listing a series of earlier legislative Acts relating to medical administration (listed above, p. 4). The Bhore *Report*'s list is presented as a representative series of examples taken from 40 earlier medical-related Acts. The list itself is interesting for at least 3 reasons: First, it is informative at the factual level. Second, it amply exemplifies the scattered and disjointed nature of past efforts to regulate health. These efforts can be categorized as being:

- in the States (i.e., at the periphery);
- buried as health-adjuncts in legislation primarily aimed at other issues;

[15] See `http://shikshanic.nic.in/cd50years/g/52/4W/Toc.htm`.

- temporally scattered over almost a century;

Third, and most important of all, it reveals the tradition of work and the medical belief-system within which Bhore and his committee locate themselves. The *Report*'s list suggests that the committee itself is a successor to this series of earlier legislative Acts. But the *Report*'s list is heavily edited. The Acts it lists, which go up to 1924, are those which do not deal with indigenous medicine; subsequent Acts that regulate indigenous medicine are omitted. No reference at all is made to acts or government efforts related to non-allopathic medicine. There is no reference to professionalisation efforts such as the formation of the All-India Ayurvedic Congress or the state-level work towards professionalisation by P. S. Varier and others. There is no reference to the 1933 Indian Medicine Council Act or the even more important 1938 Bombay Medical Practitioners Act, which for the first time established a separate medical register for vaidyas and hakims, simultaneously legitimising and controlling their practice.

The Bhore *Report* is robustly scientist in its views and unreflective about the hegemonic nature of what it calls "scientific medicine." But being unreflective about its own preconceptions does not mean that it is not assertive about its views concerning indigenous medicine. It says (Bhore 1946: IV, 74):

> ... no system of medical treatment which is static in conception and practice and does not keep pace with the discoveries and researches of scientific workers the world over can hope to give the best available ministration to those who seeks its aid.

The committee's view that indigenous medicine was static was based on a common misconception of the nineteenth century that Indian culture was ancient and unchanging. The history of the emergence and uses of this view are complex and will not be discussed here.[16] But it has been decisively demonstrated for Ayurveda that from its very earliest roots, the tradition of medical thought and practice was in constant flux and tension, with different schools vying for their own theories, different physicians using different therapies, and in more recent times traditionalists exchanging medical therapies and ideas with foreigners.[17]

The Bhore *Report* opens its principal statement on indigenous medicine in the following way (Bhore 1946: II, 455):

> In considering the question of the place which the indigenous systems of medical treatment should occupy in any planned organisation of medical relief and public health in the country, we are faced with

[16] Pollock 1989 is a valuable point of entry into the large literature on this topic.

[17] Meulenbeld (1999–2002) documents these changes extensively. See also Wujastyk in press .

> certain difficulties. We realise the hold that these systems exercise not merely over the illiterate masses but over considerable sections of the intelligentia [*sic*]. We have also to recognise that treatment by practitioners of these systems is said to be cheap, and it is claimed that the empirical knowledge, that has been accumulated over centuries, has resulted in a fund of experience of the properties and medicinal use of minerals, herbs and plants which is of some value. Further, the undoubted part that these systems have played in the long distant past in influencing the development of medicine and surgery in other countries of the world has naturally engendered a feeling of patriotic pride in the place they will always occupy in any world history of the rise and development of medicine. This feeling has not been without its effect on the value which is attached by some to the practice of these systems.

In this opening statement, we already see some of the attitudes which are played out more fully later in the *Report*. The indigenous medical systems are associated with "illiterate masses", over which they have a "hold". The pejorative use of language here already discloses the *Report*'s presuppositions: other grammatical subjects that would more usually be said to "have a hold" over their predicates would typically include "superstitions" or "drugs" or any other force by which something or someone is affected or dominated through non-rational means. A note of supercilious incredulity may be detected in the statement that some of the intelligentsia are equally under the power of such medical systems. The knowledge of materia medica accumulated in the indigenous medical traditions, so highly valued in today's world of bio-piracy and patent protection, is reduced to a mere claim by unspecified persons that this knowledge may be only of "some" value. Indigenous medicine is projected into the historical past of global medicine, where no doubt the authors of the *Report* felt it rightly belonged. Indigenous medicine is also associated with patriotic pride, and this, rather than any intrinsic medical merit, is given to account for the value which some, perhaps otherwise intelligent people, find in these systems. Although identifying themselves with a scientific and progressive world view, the authors of the Bhore *Report* offer no quantitative evidence for their criticism of indigenous medicine, offering instead only personal opinions and critical rhetoric.

The language and style of the Bhore *Report*'s remarks on indigenous medicine reveal an impatience with the whole subject and a desire to despatch it as soon as possible to some other realm where it need not trouble the makers of India's future health. The subtle use of metaphor and phraseology serve to undermine indigenous medicine without actually going to the trouble of presenting thought-out

refutations or serious, factual or research-based arguments for or against counterhegemonic medicine.[18]

The committee was clearly not prepared to engage in any serious consideration of the merits of indigenous medicine, and roundly dismissed it on the grounds that it did not share the quality of progress, by which scientific medicine was characterised. The Bhore committee believed that (*ibid.*),

> It has, however, to be recognised that great improvements have taken place in the field of public health as the result of the many discoveries of science which are and can be implemented only through the scientific system of medicine and through personnel trained in such a system. It is also to be recognised frankly that the indigenous systems of medical treatment do not at present deal with such vital aspects of medicine as obstetrics, gynaecology, advanced surgery and some of the specialities. Above all it is necessary that we should keep prominently before our eyes the intimate relation between science and the advancement of medicine. No system of medical treatment, which is static in conception and practice and does not keep pace with the discoveries and researches of scientific workers the world over, can hope to give the best available ministration to those who seek its aid.

In this passage and most others, the *Report* writer is careful to distinguish implicitly between indigenous medicine as practised in the 1940s and as represented in the ancient literature of medicine. The ancient Sanskrit treatises do, of course, contain much material on obstetrics, gynaecology, moderately advanced surgery and other specialities.[19] That many of these practices had fallen out of use amongst indigenous physicians by the 1940s means that a distinction between ancient art and modern practice will implicitly devalue the tradition and pre-empt an argument for the value of indigenous medicine based on the rich tradition of the ancient texts.

Furthermore, the possibility of medical revival or the stimulation of growth from within the indigenous medical systems is not entertained. To be fair, however, the authors of the *Report* did recommend the establishment of a professorial chair in medical history at the All-India Medical Institute, one of whose functions would be the study of the indigenous medical systems to discover "the extent to which they can contribute to the sum total of medical knowledge" (Bhore 1946:

[18] Ramsey (1999: 286–291) gives a valuable discussion of terminology, and introduces the term "counterhegemonic medicine".

[19] For surveys of these topics, see, for example, Rây & Gupta 1980, Rây et al. 1980 and Wujastyk 2003.

II, 457). Even here, however, what is proposed is not the stimulation of indigenous medical practice through fresh historical research, but the expropriation of elements of traditional value by modern establishment medicine (henceforth 'MEM').

The Bhore *Report*'s final summary recommendations relating to Indigenous medicine are as follow (Bhore 1946: IV, 73 f.),:

> 281. We are unfortunately not in a position to assess the real value of these systems of medical treatment as practised today as we have been unable, with the time and opportunities at our disposal, to conduct such an investigation into this problem as would justify clear-cut recommendations. We do, however, say quite definitely that there are certain aspects of health protection which, in our opinion, can be secured wholly or at any rate largely, only through the scientific system of medicine. Thus public health or preventive medicine, which must play an essential part in the future of medical organisation, is not within the purview of the indigenous systems of medical treatment as they obtain at present. The indigenous systems of medical treatment do not also at present deal with such vital aspects of medicine as obstetrics, gynaecology, advanced surgery and some of the specialities. Further, no system of medical treatment which is static in conception and practice and does not keep pace with the discoveries and researches of scientific workers the world over can hope to give the best available ministration to those who seeks its aid.
>
> 282. We feel that we need no justification in confining our proposals to the country-wide extension of a system of medicine which, in our view, must be regarded neither as Eastern nor Western but as a corpus of scientific knowledge and practice belonging to the whole world and to which every country has made its contribution.
>
> 283. We have been informed that, in China and Japan, a moratorium extending to a definite period of years was declared after which the practice of the indigenous systems in those countries would not be recognised. We were further told by Dr. Ognev, the Soviet Representative, that indigenous systems of medical treatment were nowhere recognised in the Soviet Union.
>
> 284. We consider that it should be left to the Provincial Governments to decide what part, if any, should be played by the indigenous systems in the organisation of Public Health and Medical Relief. It is for them to consider, after such investigation as may be found necessary,

> under what conditions the practice of these systems should be permitted and whether it is necessary, either during some interim period or as a permanent measure, to utilise them in their schemes of medical relief.
>
> What we have said in regarded to the indigenous systems applies generally to Homeopathy also.

There are several interesting points in this statement, and some disingenuousness. At face value the *Report* states that it did not have the time and resources to investigate the matter of indigenous medicine. But it appears to be more truthful to say that the committee had no wish to engage with the community of indigenous practitioners, because it was ideologically committed to a form of medicine which denied the value and efficacy, and more important, the epistemological basis of indigenous medical practice. For example, the *Report* makes no mention of the Usman *Report*, which provided a great deal of relevant material in a readily accessible form, and which was, moreover, a government-sponsored *Report* of only twenty years earlier. Had the committee had even a slight wish to consider indigenous medicine seriously, it could have begun by looking at the copious materials made available by Usman.

A footnote to the last paragraph, § 284, printed in the *Report*, registers the dissent that existed in the committee on the matter of licensing medical practitioners:

> Drs. Butt, Vishwa Nath and Narayanrao do not accept this view. They desire to see that the services of persons trained in the indigenous systems of medicine are freely utilised for developing medical relief and public health work in the country.

The voices of Drs. Butt, Vishwa Nath and U. B. Narayanarao appear as footnotes at various other parts of the *Report* too. They regularly disagree with Bhore and the rest of the committee in matters relating to indigenous systems of medicine. For example, they want vaidyas and hakims to be brought into a legislative framework within which they could be licensed to function as physicians. Bhore, however, wants to exclude them firmly. In the fuller recommendations relating to Indigenous medicine, for example, the Bhore *Report* says (Bhore 1946: II, 457):

> Three of our colleagues (Drs. Butt, Narayan Rao and Vishwa Nath) desire to make a definite recommendation suggesting the free utilisation of the services of persons trained in indigenous systems for promoting public health and medical relief in India. Their note will be found at the end of the next chapter.

The note in question is reported as follows (Bhore 1946: II, 461, §13):

> Three of our colleagues (Drs. Butt, Narayanrao and Vishwa Nath) desire to make more positive recommendation than that indicated in paragraph 11 above regarding the training of practitioners in the indigenous systems of medicine and their utilisation for promoting public health and medical relief activities in the country. They state "We are of the opinion that the teaching of indigenous systems of medicine should be regulated by the State. The Bombay Medical Practitioners Act, 1938, represents in regard to registration, the medical curriculum and examinations preliminary to registration, a step in the right direction. Practitioners trained and registered under the requirements of the above Act, or similar legislation, should be freely utilised for promoting public health and medical relief in India."

Ultimately, it was the position argued for by these three physicians that prevailed in India after independence.

The impression one gains is that the Bhore Committee refused to engage intellectually with indigenous medicine not, as it claims, out of a lack of time or resources, but as a result of ideological preconceptions which prevented it from engaging with the relevant issues in a meaningful way, and which betray an aversion to all that indigenous medicine represented to the committee members. This impression is reinforced when we read what the *Report* has to say elsewhere about the relationship between "scientific medicine" and indigenous medicine. In its *Recommendations*, The *Report* cites with strong approbation an article from the *Indian Medical Gazette* (Bhore 1946: II, 455–6).[20] The article is a startlingly brazen example of the Whig interpretation of history.[21]

> The science of medicine is a very ancient one. It progressed slowly throughout the earlier ages of history—such slow advance, as there was, being arrested from time to time by religious prejudice or by undue reverence for alleged authority. ... It was not until the middle of the 19th century that medical science became firmly established on a secure foundation. The invention of the compound microscope, the rapid development of Organic Chemistry and latterly of Bio-Chemistry and Bio-Physics have led to such an advance that we can say with truth that 95 per cent of the total corpus of knowledge with regard to

[20] The authorship of this article is not stated, and this raises the possibility that it is by a member of the committee itself.

[21] Whiggish history demonstrates "the tendency in many historians ... to emphasize certain principles of progress in the past and to produce a story which is the ratification if not the glorification of the present." (Butterfield 1931: Preface).

> the working of the human body has been obtained within the life time of men who are still with us. ...
>
> Science is one and indivisible. No advance is possible with one sub-division of knowledge without its reflection in all other sub-divisions, and rejoicing over a discovery is not to be confined to the members of the particular scientific band immediately concerned.

The metaphor of progress which is used in this anonymous citation perfectly illustrates Butterfield's classic characterisation of the immature historian who, "...tends in the first place to adopt the whig or Protestant view of the subject, and very quickly busies himself with dividing the world into the friends and enemies of progress" (1931: Introduction). Butterfield notes that this attitude is characteristic of historians who know too little of their subject. The Whig interpretation is almost always corrected when further research takes place, and when the historian gains fuller knowledge of his historical sources. Perhaps this would have happened if the Bhore Committee had indeed had more time, or had included professional historians on its staff. It is ironic that the most famous and widely-cited example of Whiggish historians is Thomas Babbington Macauley (1800–1859), also the author of the famous *Minute on Education* of 1835 which so decisively changed the course of Indian education away from the study of India's own traditions and towards the wholesale adoption of British educational models in language and content. It was Macauley's reforms which ultimately led to the inevitability of a body like the Bhore Committee, so unsympathetic to India's own historic cultural heritage, being given charge, a century later, of the medical services of India.

The most forceful statement in Macauley's *Minute* begins with a declaration of his own complete ignorance in the matter upon which he is expressing an opinion: "I have no knowledge of either Sanscrit or Arabic." This absence of knowledge did not prevent him from asserting famously that, "a single shelf of a good European library was worth the whole native literature of India and Arabia" (Macaulay 1957). The remarks on indigenous medicine found in the Bhore *Report* are stamped with the same mixture of ignorance and rejection, under the guise of a metaphorical interpretation of history as a wagon in motion, whose wheel hits sometimes a stone of religion, or sometimes one of false authority.

Ultimately, we should read the Bhore *Report*'s view on indigenous medicine stripped of its historical pretensions, as a simple assertion by one hegemonic group over another, couched in social and epistemological terms. The Bhore committee consisted almost entirely of British-trained physicians who had reached high positions in the government medical establishment of British India. They were interested in diagnosing India's medical ills according to the criteria they were familiar with from their own tradition of medicine, and in designing treatments for

those ills using solutions they had been taught by their teachers and colleagues in professional British medicine. Their assertions are power claims.

Centre and Periphery

After a number of inconclusive, yet strongly-worded comments on the regulation of vaidyas and hakims, the authors of the *Report* decided to transfer the consideration of all such matters to the Provincial Governments, from the centre to the periphery.[22] This might sound plausible at first hearing, but it was in fact an oblique way of halting any movement towards the registration of indigenous practitioners. For elsewhere in the *Report* it is argued forcefully that the Provincial Governments should have no power over registration or licensing of physicians, and that all such powers should be centralized as soon as possible (Bhore 1946: II, 458–9):

> 3. In India the the Indian Medical Council was established by the Medical Council Act of 1933, but its functions differ materially from those of the General Medical Council in the United Kingdom. It has not been authorised by law to maintain an All-India Medical Register. Moreover, the basic qualifications for medical registration are those of medical licentiates, a body of practitioners who are the concern of the Provincial Medical Councils. The maintenance of Medical Registers and the supervision of the basic qualifications required for entry into them are, at present, responsibilities entrusted to Provincial Medical Councils and Faculties. The supervision of the Indian Medical Council is, as yet, restricted to certain medical qualifications which are granted by Indian Universities and which are incorporated in the First Schedule of the Indian Medical Council Act.
>
> 4. We consider this position unsatisfactory. We are recommending that, for the future, there should only be one basic medical qualification for entry into the profession throughout India and that the portal of entry should be a University degree. . . . the Medical Council of India should be empowered to maintain an All-India Register when the training of licentiates ceases throughout the country. One of us (Dr. Vishwanath) considers that, in such a register, all the existing graduates and licentiates should be eligible for inclusion. With the creation

[22] The theorization of the distinction is owed to Shils (1982) who described how actors close to the centre of society carry or express its main ("core") values, ideas and beliefs. On the other hand, those who belong to the periphery do not accept or promote such values, ideas and beliefs to the same extent. He also outlined various processes of dissemination or diffusion from the centre, and various forms of tensions between the centre and periphery.

> of the All-India Medical Register the functions of the Medical Council of India would approximate closely to those of the General Council of Medical Education and Registration of the United Kingdom. . . .

A footnote to this passage once again raises the familiar voices of dissent (Bhore 1946: II, 459):

> Two of our colleagues (Dr. Vishwa Nath and Dr. A. H. Butt) are not in agreement with the recommendations set out above. They state "In our opinion the functions as at present exercised by the Provincial Medical Councils and the All-India Medical Council are properly discharged and there is no need for any change".

Since it was clearly the Bhore Committee's aim to centralize control of medical education and licensing, its suggestion of devolving decision-making regarding indigenous physicians to the Provinces can only be read as a disingenuous attempt to disenfranchise these physicians by stealth.

Medical Licentiates and the Society of Apothecaries

When reading the Bhore *Report* it is important to remember that the committee was writing at a time before any central national medical authority existed. Thus, large parts of the *Report* show Bhore and his committee wresting with the issues of the relationship between centre and periphery. As shown in the citation above, the Bhore Committee wants to bring control of finance and policy into the centre, to replace a plural and decentralized system of medical licensing with a unified and centralized one that recognizes only university-trained physicians. The model presented for this is the United Kingdom. In particular, the General Council of Medical Education and Registration of the United Kingdom (GMC) is held up as an example to be followed.

However, in contrasting a plural and disorganised Indian situation with a centralized and controlled British one, the Bhore Committee misrepresents the situation in the United Kingdom. In fact, a system of medical licensing quite separate from that administered by the GMC existed in Britain at the time that the Bhore *Report* was written. Indeed, it still exists today.

The Worshipful Society of Apothecaries was incorporated as a City Livery Company by royal charter from James I in London in 1617 in recognition of apothecaries' specialist skills in compounding and dispensing medicines. The Apothecaries' Act of 1815 empowered the Society to institute a Court of Examiners to examine and to grant licences to successful candidates to practise as an Apothecary in England and Wales. It also gave the Society the duty of regulating such practice. The title of the original medical qualificatoin was "Licentiate of the Society of Apothecaries" (LSA).

Following the establishment of the General Medical Council by statute in 1858 the LSA became a registrable qualification. In 1907 the title was altered by parliamentary act to LMSSA to indicate the inclusion of surgery in the examination, a subject required by law following the Medical Act of 1886.

Today, the Society continues to award its Licence as a member of the United Examining Board, which is the only non-university medical licensing body in the UK.[23]

It is impossible that all the members of the Bhore Committee were unaware of the Society of Apothecaries and its Licentiate. But it is not mentioned, and it would seem likely that information about the Worshipful Society was suppressed because it would have greatly strengthened the argument of those who wished to maintain a separate professional licensing system for vaidyas and hakims.

The Bhore *Report* was in many ways a successful and influential document, especially in forming the policy foundation of the allopathic establishment in India. But it created an immediate reaction amongst those who wished the indigenous systems of Indian medicine to have a place in India's national health care scheme. As a result of this, Sir Ram Nath Chopra was commissioned to chair a committee in 1946, and to produce a *Report* to redress this balance (Chopra 1948).

The Chopra Report, 1948

Sir Ram Nath Chopra (1882–1973) was a distinguished Indian pharmacologist.[24] Born in the Panjab in 1882, he was educated at the universities of the Punjab and Cambridge, and at St. Bartholomew's Hospital in London. After service in the war, he spent the majority of his professional career at the Calcutta School of Tropical medicine, retiring as its director in 1941. He held a number of other senior posts and chairmanships, and published extensively. In particular, his famous *Indigenous Drugs of India* (1933, reprinted often) testified to a life-long professional engagement with ayurveda and the other indigenous health systems of India. In his 1941 presidential address at the Annual Meeting of the National Institute of Sciences of India, held at Benares Hindu University, Chopra gave his own overview of the history and prospects for public health organisation and medical service in India Chopra 1941. This wide-ranging and well-informed survey provided a preliminary blueprint for an Indian national health service. Given Chopra's professional eminence in the early 1940s, and his prominent and substantial public statements on health reform, it is surprising that he was not invited

[23] The Worshipful Society of Apothecaries of London 2003.

[24] See the *British Medical Journal* obituary (P.N.C. & G.R.McR. 1973).

to join the Bhore committee. It is tempting to conjecture that Chopra's interest in indigenous medicine disqualified him in Bhore's eyes.

Drs. A. H. Butt, Vishwa Nath and U. B. Narayanarao, the dissident members of the Bhore committee, joined the Chopra committee, which supported their views.

One of the other members on the Chopra Committee, Mazhar H. Shah, later gave the following description of the committee's purposes and activity, which is worth citing as a fair account of matters (Shah 1966: vii):

> In 1946 the Government of India appointed the Indigenous Systems Inquiry Committee, under Sir Ramnath Chopra as Chairman, and three Hakims, three Vaids, Dr. B. N. Ghosh Professor of Pharmacology and myself [Mazhar H. Shah] as members. The committee was required to make recommendations on:
>
> (a) the provision for research in Ayurveda and Unani Tibb,
>
> (b) Improvement of facilities for training,
>
> (c) desirability of state control,
>
> (d) increasing usefulness of these systems, and
>
> (e) holding enquiry as to whether the three systems – Ayurveda, Unani and Modern – could be combined into one comprehensive system.
>
> In their report the committee expressed the view that, "if the aim of all (systems) was the maintenance of health and prevention and cure of disease, they should all be properly investigated and integrated in the form of a single system which should be capable of suitable alteration and adaptation in accordance with the time and other conditions." . . . the sudden partitioning of India brought the inquiry prematurely to a close.

The Chopra *Report* consisted of the following chapters:[25]

1: Introductory. The history and development of Ayurveda and Unani or Arabian systems of medicine—Their past achievements—The cause of decline and their present position—Attempts at their revival.

2: The appointment and personnel of the committee and the procedure adopted by it.

[25] The Chopra *Report*'s title page says that it is Vol.1: *Report* and Recommendations. This is all that is available in the British Library's copy.

3: Progress of work of the committee.

4: Previous committees on indigenous systems of medicine set up by provincial and other governments. Madras (1923) ... Ceylon (1927 and 1947).

5: Existing conditions of medical relief.

6: Integration of Indian and Western medicine leading to their ultimate synthesis.

7: Education and medical institutions

8: The organisation of rural medical relief

9: State control of medical practice and education

10: Research

11: Drugs and medicinal preparations

12: Administration and finance

13: Summary of the recommendations

14: Conclusions.

The Chopra *Report* is often cited in later works, and has several interesting features. Chapter 4 gives a useful overview of the work of previous committees between 1923 and 1947 (cited on p. 2 above).

The *Report*'s apparent aim is to give indigenous medical systems a proper place in India's health care structure. However, this aim is undermined in an insidious way in Chapter 6. This chapter argues that a careful study of ayurvedic principles, for example, will show that the various humours and other traditional and non-allopathic parts of the body will eventually be found to coincide with modern medical categories as revealed by science. Thus, the *Report*'s aim is not to integrate traditional and modern sciences, but rather for modern medicine to absorb traditional medicine by re-interpreting its principle categories. Ultimately, all traditional practices and explanations will be subsumed by scientific medical ones.

Nevertheless, chapters 10 and 11 of the *Report* do emphasise the importance if investigating India's flora and fauna for medical uses. Again, this shows the *Report*'s orientation towards traditional medicine as a source of potential therapies that can be absorbed and taken over by modern medicine. Following his work on the committee, R. N. Chopra himself engaged energetically in this ethnopharmacological activity, and produced a series of important and influential publications on the Indian materia medica (e.g., Chopra et al. 1956, 1958, 1965).

The Aftermath of Chopra: the 1950s and 1960s

The Chopra *Report*, which ultimately proposed complete equality in training and practice between indigenous and establishment physicians, was in fact rejected by the Government of India (Shankar 1992: 146), but a number of committees were convened in the 1950s with the aim of completing, or advising on the implementation of aspects of Chopra's recommendations. The need for these continuing efforts highlights the difficulty and controversy surrounding these issues.[26] A series of committees were appointed to "cherry pick" acceptable themes from Chopra.

One of the issues which repeatedly occupied these committees was whether ayurveda should be integrated with MEM, or whether it should be kept "pure" (*śuddha*), and be taught and practised solely in accordance with tradition.

The Pandit Report, 1951 The Pandit Committee was established to finalise just those recommendations of the Chopra *Report* regarding "Education and Medical Institutions" and "Research" (Dave 1956: 2). The idea was that a common integrated syllabus for all medical colleges would be rejected, but that research should be undertaken into the validity of indigenous medicine from the point of view of contemporary establishment medical science. One early outcome of the Pandit *Report* was the establishment of the Central Institute of Research in Indigenous Systems of Medicine in and the Postgraduate Training Centre for Ayurveda, both in Jamnagar in 1952 (Jaggi 2000: 312, Shankar 1992: 146).

The Dave Report, 1956 The Dave *Report* presented a model integrated syllabus to be used in colleges that would teach only physicians of indigenous systems of medicine (ISM). At the outset, this *Report* positioned itself as a corrective to the Bhore *Report*. It that,

> The Bhore Committee ... was not in a position to assess the value of the various systems on account of paucity of time and opportunity to conduct such investigation into the problem.... (Dave 1956: 1)

This is a notably tolerant response to the Bhore *Report*'s hostility regarding indigenous medicine. After this nod to Bhore, the Dave Committee articulated its work specifically as carrying forward or "finalising" the proposals of the Chopra *Report* relating to the State control of medical practice and education, and to come to a practical solution to the issue of the Chopra *Report*'s recommendations relating to education and medical institutions (Dave 1956: 2):

[26] Some of the key issues arising out of this period have been insightfully explored in a series of studies by Charles Leslie (Leslie 1972, 1975, 1983, 1992, 1998*a*).

> The present committee has been entrusted with the work of recommending the ways and methods and rules to bring about uniformity as regards legislation, medical education and practice of Vaidyas, Hakims and Homoeopaths.

The *Report* cites Sanskrit sources (in Devanāgarī script), including Suśruta, Śukra (*Śukranīti*), Caraka, Kautilya, etc. The main thrust of these quotations is to show that the Sanskrit tradition was aware of the problem of medical quackery and disapproved of it strongly.

The *Report* made 16 recommendations as to the regulation of practice, postponing issues of education to a second part of the committee's *Report* (Dave 1956: 11), which apparently never appeared.

The Udupa Report, 1959 K. N. Udupa was invited by the Government of India to chair the "Committee to Assess and Evaluate the Present Status of Indian Systems of Medicine" (Udupa et al. 1958). The committee's task, undertaken between 1957–1958, was nothing less than to review the entire situation relating to ayurvedic medicine in India (Jaggi 2000: 312). The chief recommendation of the committee was that the Government should establish a Council of Indian Medicine (to regulate educational standards) and a Council of Ayurvedic Research. The latter Council was soon established and itself sponsored further committees to investigate the question of ayurvedic medicine. It arrived at the conclusion that an integrated training was appropriate (Jaggi 2000: 312–3).

Udupa himself was later to participate as a member of the Ramalingaswami Committee.[27]

The Mudaliar Report, 1962 The *Report* prepared by Dr. Arcot Lakshmanaswami Mudaliar and his committee took the opposite approach, rejecting integrated medical education. Instead, it recommend that systems of indigenous medicine should be taught and practised in a purely classical form, with due attention to language skills and access to original sources (Jaggi 2000: 313–17, Shankar 1992: 146). Once fully trained, indigenous physicians could be separately trained in MEM. The final practical effect would be the withering away of indigenous medical practice in the face of superior MEM, which would absorb its best features, although this was not stated quite so baldly as this. But this view is perhaps less surprising when we remember that Dr. A. L. Mudaliar had formerly been a member of the Bhore Committee.

[27] Dr Udupa subsequently met the medical anthropologist, Prof. Charles Leslie, and their detailed conversations informed some of Prof. Leslie's later writings on medical professionalisation and modernization in India (Leslie 2004).

The Mudaliar Committee's recommendations were accepted by the Government and proved influential, laying the foundations for the administrative and regulatory systems in place today (Mudaliar 1962). The Central Council for Research in Indian Medicine and Homoeopathy was founded in 1969 to promote various research agendas defined by Mudaliar.

The Vyas Report, 1963 The chairman of this report, Mohanlal P. Vyas, was the Minister for Health and Labour, Ahmedabad, Gujarat. One of the most prominent among the committee members was Pandit Shiv Sharma. Pt. Sharma was educated in medicine and Sanskrit by his father, the court physician to the Maharaja of Patiala. When Mahatma Gandhi was dying, and his wife called for an ayurvedic physician, it was Pt. Sharma who was summoned. An articulate and scholarly person with a commanding presence, equally at home amongst Sanskrit pandits or at the golf club joking in English, Pt. Sharma became the renowned champion of "pure" (Sanskrit *śuddha*) ayurveda, that is, the practice of ayurveda without any addition of allopathic concepts or therapies.[28] As the report said in its opening statement, the purpose of the committee was,

> . . . to draw up a curriculum and syllabus of study in pure (unmixed) Ayurveda extending to over four years, which should not include any subject of modern medicine or allied sciences in any form or language;

Indeed, the main part of this report, the 56 pages of chapter VII, that give the curriculum and syllabus, were written entirely in the Sanskrit language (Vyas 1963: 31–86). The report's title, *Report of the Shuddha Ayurvedic Education Committee*, emphasised its dedication to the ideal of Shuddha or fundamentalist ayurvedic doctrine and practice.

The Ramalingaswami Report, 1981

Professor V. Ramalingaswami (1921-2001), FNA, FRS, and former President of the Indian National Science Academy, was considered one of the most illustrious Indian scientists of his day. His major scientific work consisted of studies on nutritional pathology, specially protein-calorie malnutrition, iodine deficiency disorders and nutritional anaemia. He served as Director of the All-India Institute of Medical Sciences, and as Director-General of the Indian Council of Medical Research, and contributed of the work of international bodies such as WHO, UNICEF and IDRC.

[28] The career and medical and political views of Pt. Sharma are discussed by Leslie (1992: 179–85, *et passim*), who also reproduces a photograph of him.

The committee which he chaired included in its final recommendations that the existing model of health care in India should be replaced by one that combined "the best elements in the traditional and culture of the people with modern science and technology" (Ramalingaswami 1981: 14f.). In this it differed subtly from the Chopra *Report*, which recommended not a combination of systems, but an absorbtion of the best elements of tradition by modern medical science.

The Ramalingaswami *Report* makes bold statements, for example, on the connection between health and social and educational development, and particularly on the connection between political development and health status. It says,

> In most developing countries, oligarchies of the upper and middle classes are in power. Their health status is very good and they derive the largest benefit from the public health services. On the other hand, the poor in these countries who form the large majority and are deprived of effective political power, have a low health status and receive only marginal benefits from the public health services. The situation is very different in countries where the democratic process is taken to the community level and the common people are involved actively in planning and implementing programmes for their welfare. ... It will thus be seen that the political system does exercise considerable influence over the health system.
>
> It is also true that the health system can influence political development. For instance, primacy health care can be organised on a community basis and the people can be actively involved in studying their problems, deciding upon feasible solutions and implementing them. This is an essentially political experience which enables them to organise themselves and fight their battles in other fields as well.
>
> ... The greatest weakness of Indian society today is poverty which compels the majority of its population to live sub-human lives and the great inequality between the small privileged classes at the top and the bulk of the underprivileged people at the bottom. (Ramalingaswami 1981: 19–22)

These hard-hitting remarks on the linkage between health and politics exemplify the sophistication of the Ramalingaswami *Report*, and raise the question of whether it was considered too radical in some political circles. It is noteworthy in this connection that the *Report* was not published by the Government of India, but by an independent educational institute in Pune.

The Ramalingaswami *Report*'s "Alternative Model" of health provision starts by attributing India's present health dilemma squarely to British colonial myopia:

> These [health] services were first organised by the British administrators who totally ignored the indigenous belief systems, life-styles and health care institutions and practices which formed an organic unity. Instead of building on these foundations and evolving a new system more suited to the life and needs of the people with the help of modern science and technology, they decided to make an abrupt and total change by introducing the Western system of medicine *in toto*. This decision created a wide gulf between the culture and traditions of the people on the one hand and the health services on the other. It also deprived the latter of several valuable contributions which the Indian tradition could have made. (Ramalingaswami 1981: 81 f.)

While there is much truth in this claim, there is also some over-simplification. The *Report* underestimates the extent to which the British administrators in some cases continued the medical funding patterns established by the earlier Mughal administration (Brimnes unpublished). Nevertheless, the *Report*'s attribution of the dominance of "urban-biased, top-down, and elite-oriented" medical provision to its origins in the British establishment of such institutions is convincing (Ramalingaswami 1981: 82). It certainly applies to the efforts from Bhore onwards. The main aim of the Ramalingaswami *Report*'s "Alternative Model" (ch. 6) is that health provision should be founded on a strong community base, and that it should integrate promotive, preventive and curative services. Health provision should be focussed on community efforts and interventions, with a radical redefinition of the position of the doctor and drugs. It explicitly distances itself from the recommendations of the Bhore Committee which, it says, "tried to move away from the exclusively curative model [... but still] placed too heavy an emphasis on doctors" (Ramalingaswami 1981: 91). The Ramalingaswami *Report* notes further that the Bhore *Report* was silent on the subject of India's indigenous culture and medical traditions, and in contrast it recommends that the health care system of India should be given a national orientation by the incorporation of the culture and traditions of the people (Ramalingaswami 1981: 95). The *Report* recognises five broad elements of traditional Indian culture which it feels are relevant to its recommendations. 1. the *varṇāśrama* concept of the stages of Hindu life, which inculcates "the right attitudes to pain, to growing old, and to death". 2. A non-consumerist approach to life. 3. A devolved and distributed attitude to health service provision, and a withdrawal of centralized state intervention. 4. The use of Yoga as an instrument for physical and mental health. 5. An emphasis on "simple but effective things" such as naturopathy, the use of simple medicines and home-grown herbs for day-to-day illnesses, games and sports that require little equipment, and similar practices that oppose "a profit-motivated capitalist civilization [that] tries to encourage consumerism" (Ramalingaswami 1981: 96f.).

The central messages of the Ramalingaswami *Report* are about decentralization, devolution and integration of health services, and these messages are normally delivered in a rational and socio-politically sophisticated manner. Unfortunately for this *Report*, the World Health Organisation's slogan "Health for All by the Year 2000" became increasingly jaded and untenable as the end of the second millennium actually approached. Inspired by the justifiable euphoria surrounding the eradication of smallpox in the 1970s, the WHO believed that other major disease groups could also be conquered. But by the 1990s, it was already plain to all that such a goal was beyond reasonable reach. This was not only because of a general loss of faith in medical science and technology, when faced, for example, by the kinds of challenge articulated by Illich (1990, 1986), including the dramatic rise of iatrogenic disease and various other structural failures in scientific medicine.[29] The absurdity of the concept of total world health by 2000 was also shattered permanently by the appearance of human immunodeficiency virus. HIV taught the world what epidemiologists and medical historians had always known, that diseases evolve, and that an ever-changing balance exists between human populations and their viral and bacteriological environments, a balance that shifts in response to random mutations, evolution, and the advances of medical science.[30] The Ramalingaswami *Report*, by necessarily situating itself within the discredited WHO "Health for All" agenda, now shares the fate of that agenda, being ignored for all practical purposes. This is regrettable, since the Ramalingaswami *Report* is the most sociologically astute of any of the Indian *Report*s on health.[31]

Conclusions

In this essay I have surveyed some of the twentieth-century attempts by the governments of India, both before and after Independence, to control and regulate health policy and practice, especially in relation to indigenous types of medicine such as Ayurveda. The initiatives by the British and Indian governments to regulate medical practice in India generated large quantities of documentation. I have investigated some of this material and discussed the contents and purposes of the more important government committee reports which addressed the issue of indigenous medicine. I have also offered a framework for understanding the meaning of these processes of attempted control and a critique of their purposes, which

[29] Further discussion is given in Wujastyk forthcoming.

[30] For a classic evocation of this balance, see McNeill 1976.

[31] Carl E. Taylor, the medical sociologist and anthropologist and colleague of Charles Leslie (see, e.g., Taylor 1998), is specifically thanked in the Foreword of the Ramalingaswami *Report* for his "immense help" in the committee's deliberations and the finalisation of the *Report* (Ramalingaswami 1981: ii).

are often more political and hegemonic than medical. I have also offered some perspectives concerning the relative importance of these documents, as well as a sense of their content and influence.

The unjustly neglected Usman *Report* certainly deserves further study especially for the account it provides of indigenous medicine in India at the beginning of the twentieth century, given in the practitioners' own voices. The Bhore and Mudaliar *Report*s were the chief influences in forming the administrative and organisational establishment of national health care in India today, with their principal support given to MEM, and secondary support (Mudaliar) for indigenous health systems in an integrated form. The Chopra Committee and its sequels attempted to give a more prominent place to indigenous health traditions, but only achieved a limited influence, mainly in establishing institutions to undertake ethnopharmacological study, in designing integrated curricula for colleges of indigenous medicine, and in setting up regulatory bodies for indigenous medical professionals. Finally, the Ramalingaswami *Report* showed the a quantum leap in sophistication in studying the medical situation in India with a modern socio-medical awareness. While perhaps open to criticism in some areas, it is unfortunate that it did not have the influence it undoubtedly deserved.

References

Anon. 1964, 1967. *Who Was Who 1951–60. A Companion to Who's Who, Containing the Biographies of Those who Died During the Decade 1951–60*, *Who Was Who*, volume V. London: Adam & Charles Black.

Bannerman, Robert H., John Burton & Ch'en Wen-Chieh 1983. *Traditional Medicine and Health Care Coverage: a Reader for Health Administrators and Practitioners*. Geneva: WHO.

Bhore, Joseph 1946. Report of the health survey and development committee. Technical report, Government of India, Delhi. "The Bhore Report". 4v.

Brass, Paul 1972. The politics of ayurvedic education. In: Rudolph, L. H. & S. I Rudolph (eds.) *Education and Politics in India*. New Delhi: Oxford University Press, 342–71, 452–59.

Brimnes, Niels unpublished. Coming to terms with the native practitioner: Indigenous doctors in colonial service in South India 1800–1825. Paper delivered at the conference "Imperialism, medicine, and South Asia: a socio-political perspective, 1800–1980" held at Wolfson College, Cambridge, 15–16 June 2001.

Butterfield, Herbert 1931. *The Whig Interpretation of History*. London: G. Bell. Online edition: `http://www.eliohs.unifi.it/testi/900/butterfield/`.

Chopra, R. N. 1948. Report of the committee on indigenous systems of medicine. Technical report, Ministry of Health, Government of India, New Delhi. "The Chopra Report". Vol.1: Report and Recommendations (further vols. not available).

Chopra, R. N., R. L. Badhwar & S. Ghosh 1965. *Poisonous Plants of India*. New Delhi: Indian Council of Agricultural Research.

Chopra, R. N., I. C. Chopra, K. L. Handa & L. D. Kapur 1958. *Chopra's Indigenous Drugs of India*. Calcutta: Dhur & Sons.

Chopra, R. N., S. L. Nayar & I. C. Chopra 1956. *Glossary of Indian Medicinal Plants*. Council of Scientific and Industrial Research. 3rd reprint, 1992. Volume 2, *Supplement to Glossary of Indian Medicinal Plants*, first published in 1969, reprinted 1986.

Chopra, Ram Nath 1941. Organization of public health and medical service in India. Current Science: supplement, 10(2): 109–116. Available at `http://www.ias.ac.in/j_archive/currsci/10/vol10contents.html`.

Dave, Dayashanker Trikamji 1956. Interim report of the committee appointed by the government of india to study and report on the question of establishing uniform standards in respect of education & practice of vaidyas, hakims and homoeopaths. Report, Government of India, Ministry of Health, New Delhi. "The Dave Report".

Government of India 1970. The Indian medicine central council act, 1970. Technical report. The Hindi text of the Act was published in the *Gazette of India, Extraordinary*, Part II, Section 1A, No.33, Vol.VII, dated the 9th September, 1971 on pages 285 to 318. See `http://www.ccimindia.org/1.htm`.

Government of India 2002. The Indian medicine central council (amendment act), 2002. Technical report. `http://www.ccimindia.org/ccim_1.htm`.

Government of India, Dept. ISMH 2002. National policy on indian systems of medicine & homoeopathy—2002. `http://indianmedicine.nic.in/html/news/draftnat.pdf`. Author of PDF file given as "Opey A.". Date of PDF file "12/12/2002".

Illich, Ivan 1986. Body history. The Lancet: 1325–27.

Illich, Ivan 1990. *Limits to Medicine: Medical Nemesis: The Expropriation of Health*. London: Penguin, 3 edition. First published 1976.

Jaggi, O. P. 2000. Revival of Ayurveda. In: *Medicine in India: Modern Period*, *History of Science, Philosophy and Culture in Indian Civilization*, volume IX,1, chapter 23. New Delhi: Oxford University Press, 311–318.

Kleinman, Arthur, Peter Kunstadter, E. Russell Alexander & James L. Gale (eds.) 1975. *Medicine in Chinese Cultures: Comparative Studies of Health Care in*

Chinese and Other Societies. Papers and Discussions from a Conference held in Seattle, Washington, U.S.A., February 1974. Washington D.C.: John E. Fogarty International Center for Advanced Study in the Health Sciences.

Leslie, Charles 1972. The professionalization of ayurvedic and unani medicine. In: Freidson, Eliot & Judith Lorber (eds.) *Medical Men and their Work*. Chicago and New York: Aldine-Atherton, 39–54. Repr. from *Transactions of the New York Academy of Sciences*, 30(1968): 559–72.

Leslie, Charles 1975. Pluralism and integration in the Indian and Chinese medical systems. In: Kleinman et al. (1975), chapter 24, 401–17. Commented on in Obeyesekere (1975).

Leslie, Charles 1983. Legal aspects: Policy options regulating the practice of traditional medicine. In: Bannerman et al. (1983), 314–317.

Leslie, Charles 1992. Interpretations of illness: Syncretism in modern Āyurveda. In: Leslie, Charles & Allan Young (eds.) *Paths to Asian Medical Knowledge*. Berkeley, Oxford, etc.: University of California Press, 177–208. Repr. Munshiram Manoharlal, Delhi.

Leslie, Charles 1998*a*. The ambiguities of medical revivalism in modern India. In: Leslie (1998*b*), 356–67. First published Berkeley, London: U. California Press, 1976.

Leslie, Charles (ed.) 1998*b*. *Asian Medical Systems: A Comparative Study*, *Indian Medical Tradition*, volume 3. Delhi: Motilal Banarsidass. First published Berkeley, London: U. California Press, 1976.

Leslie, Charles 2004. Personal communication.

Macaulay, Thomas Babington 1957. Minute of 2 february 1835 on indian education. In: Young, G. M. (ed.) *Macaulay, Prose and Poetry*. Cambridge MA: Harvard University Press, 721–24, 729.

Mackworth Young 1894–95. Indian hemp drugs (Mackworth Young) commission 1893–94. Report, Simla, Calcutta.

McNeill, William H. 1976. *Plagues and Peoples*. Harmondsworth: Penguin.

Meulenbeld, Gerrit Jan 1999–2002. *A History of Indian Medical Literature*. Groningen: E. Forsten. 5v.

Mudaliar, Arcot Lakshmanaswami 1962. Report of the health survey and planning committee. Technical report, Government of India, Ministry of Health, Delhi.

Obeyesekere, Gananath 1975. Some comments on the nature of traditional medical systems. In: Kleinman et al. (1975), chapter 25, 419–25.

P.N.C. & G.R.McR. 1973. Brevet-Colonel Sir Ram Nath Chopra. British Medical Journal, 5879(3): 547.

Pollock, Sheldon 1989. Mīmāṃsā and the problem of history in traditional India. Journal of the American Oriental Society, 109(4): 603–610.

Ramalingaswami, Vulimi 1981. *Health for All: an Alternative Strategy*. Pune: Indian Institute of Education (distributed by the Voluntary Health Association of India). "The Ramalingaswami Report".

Ramsey, Matthew 1999. Alternative medicine in modern France. Medical History, 43(3): 286–322.

Rây, Priyadaranjan & Hirendra Nath Gupta 1980. *Caraka Saṃhita (a Scientific Synopsis)*. New Delhi: Indian National Science Academy, 2 edition.

Rây, Priyadaranjan, Hirendra Nath Gupta & Mira Roy 1980. *Suśruta Saṃhita (a Scientific Synopsis)*. New Delhi: Indian National Science Academy.

Shah, Mazhar H. 1966. *The General Principles of Avicenna's Canon of Medicine*. Karachi: Naveed Clinic.

Shankar, Darshan 1992. Indigenous health services: the state of the art. In: Mukhopadhyay, Alok (ed.) *State of India's Health*. New Delhi: Voluntary Health Association of India, 129–61.

Shils, Edward A. 1982. Center and periphery. In: Shils, Edward A. (ed.) *The Constitution of Society*, chapter 4. The Heritage of Sociology, Chicago: University of Chicago Press, 2 edition. First published in 1961.

Stepan, J. 1983. Legal aspects: Patterns of legislation concerning traditional medicine. In: Bannerman et al. (1983), 290–313.

Taylor, Carl E. 1998. The place of indigenous medical practitioners in the modernization of health services. In: Leslie (1998*b*), 285–99. First published Berkeley, London: U. California Press, 1976.

The Worshipful Society of Apothecaries of London 2003. [website]. `http://www.apothecaries.org/`.

Udupa, K. N. et al. 1958. Report of the committee to assess and evaluate the present status of Indian systems of medicine. Technical report, Ministry of Health, Government of India, New Delhi.

Usman, Muhammad 1923. The report of the committee on the indigenous systems of medicine, Madras [1921–1923]. Technical report, Government of Madras, Ministry of Local Self-Government, Committee on the Indigenous Systems of Medicine, Madras. 2v.

Vyas, Mohanlal P. 1963. Report of the shuddha ayurvedic education committee. Technical report, Government of India, Ministry of Health, Delhi. "The Vyas Report".

WHO 1978. Declaration of Alma-Ata. International conference on primary health care, Alma-Ata, USSR, 6–12 September 1978. Technical report,

World Health Organisation. http://www.who.int/hpr/NPH/docs/declaration_almaata.pdf.

Wujastyk, Dominik 2003. *The Roots of Āyurveda: Selections from Sanskrit Medical Writings*. London, New York, etc.: Penguin Group, 3rd updated edition.

Wujastyk, Dominik forthcoming. Policy formation and debate concerning the government regulation of ayurveda in great britain in the 21st century. Asian Medicine: Tradition and Modernity, 1(1).

Wujastyk, Dominik in press . Change and creativity in early modern Indian medical thought. Journal of Indian Philosophy.