SOCIAL RESEARCH AND HEALTH CARE PLANNING IN SOUTH ASIA- PART 1

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ABSTRACT: This paper discusses the social research and health care planning systems of South Asia. Also, the Author attempts to indicate the scope and nature of this work done in this territory to identity elements relevant to health care planning

Social Research on South Asian Medical Systems

The comparative study of medical systems was a new subject in 1965, when I surveyed the literature to recommend this kind of work in South Asia (Leslie 1967). Medical anthropology has rapidly developed since that time. New associations have been founded in England, Germany, and the United States. The Society for Medical Anthropology affiliated with the American Anthropological Association grew to over 2000 members. The Royal Anthropological Institute began to award the Welcome Medal to the authors of works on medical subjects. Fifteen universities in the United States initiated special graduate programs in medical anthropology. Five journals started publications: Ethno medicine and psychiatry (Holland); and Social Science and Medicine (England), which publishes four issues a year devoted to medical anthropology.

Fifteen years ago the literature did not contain a single book of social research on South Asian medicines, and the most frequently cited articles drew their data from field research that had been concerned with other matters. Two of these articles were in Benjamin Paul’s Health, Culture and Community, Published in 1955. In one of them Moris Carstairs, a physician, contrasted his expectations about how doctor-patient relationships should proceed to the quite different expectations of villagers. The point was that the norms of Western medicine were not intelligible or satisfying to villagers, and caused health professionals to act in ethnocentric and ineffective ways. The second article, by McKim Marriott, made essentially the same point. The practitioner of indigenous medicine belonged to the villager’s moral universe, so that his manners were appropriate to their relationship, and his therapies fitted the villager’s understanding of things. In contrast, the health worker trained in Western Medicine was an outsider whose remedies and actions appeared arbitrary or even threatening. The message of these articles was the utility of a relativistic cross-cultural understanding in planning public health projects, and in promoting the use of modern medicinal resources. Carstairs and Marriott did not praise indigenous medicine. On the contrary, they assumed the superior efficacy of Western medicine and the need to make it more available and more understandable to villagers.

The anthology in which the Carstairs and Marriott articles appeared was designed as a
textbook for schools of public health, and was widely used in courses on applied anthropology. In 1965 three other articles had been published that became standard references on South Asia in the burgeoning field of medical anthropology, and they were all published in Human Organization, the journal of the Society for Applied Anthropology. Of these, the most frequently cited article is by Harold Gould. It became popular because it describes a common response to the situation in which humble people try to cope with obtuse and arrogant health professionals. Villagers in Latin America and other parts of the world distinguish their own remedies from “doctor medicine” in a manner that resemble the villagers in Uttar Pradesh described by Harold Gould. Their medicine is best for chronic illnesses, or those had do not incapacitate the sufferer, but they seek “doctor medicine” for acute incapacitating maladies. Since most illnesses are the first kind, they rely for the most part on home remedies and local curers. The distinction between “doctor medicine” and “village medicine”, with corresponding notions about the situations to which they are appropriate, has the advantage for villagers of minimizing their contacts with health professionals, who may rip them off, if they are in fee-for-service practice, or keep them waiting for hours and then treat them in an abrupt and insulting manner, if they are in government service. The essays by Carstairs, Marriott and Gould emphasized the relationships between practitioners and clients, and described local concepts of health and illness only as they were needed to explicate these relationships. Two other articles, by R. S. Khare and Morris Opler, did not describe these structural relationships, but concentrated on the concepts of villagers. And the various ways that they simultaneously interpreted illnesses. The humoral theories of villagers have been explored in greater depth by subsequent research, but the articles by Khare and Opler serve with those by Carstairs, Marriott And Gould to establish a base line for the present summary of research on medical ethnology, and to introduce generalizations that will be useful for our analysis of health planning.

Opler began by citing a major government document, the Report of the Committee on Indigenous Systems of Medicine, published by the Ministry of Health in New Delhi in 1948. That report advocated a program to utilize indigenous medicine to extend and improve health care, particularly in rural areas. The goal was to create an integrated system of allopathic and indigenous medicine suited to the distinctive character and problems of Indian society. Opler did not discuss the program recommended by the report, but quoted descriptions of Ayurvedic theory from it and asserted that village concepts of illness in Uttar Pradesh closely followed those of the national leaders of Ayurvedic medicine. He then described the ways that villages reasoned about illnesses. Khare asserted that the “Ideas of Ayurvedic and Unani systems of medicine stand nearer the elements of folk-medicine than Western medicine and therefore are more communicable within the society” (1965:40) He did not describe these ideas, but he was referring to the mahapanchabhuta, the dosas, dhatus, gunas rasas, and so on, used recurrently throughout South Asia in handling food, in ritual, and in medicine. The interesting thing about Khare’s article is that he immediately followed this generalization with the observation that “In Golpalpur, homeopathy, as a system of treatment, is more acceptable to the villagers than the Ayurvedic or Unani system” (emphasis added) Thus, indigenous medicine as a system of ideas was more comprehensible to villagers than other
systems, but in practice they often preferred one of another of these systems, Khare’s observations were interesting because he assumed that the relationships between ideas, desires and practices were problematic. After all, a person does not have to understand physics to want a wristwatch, or to comprehend clinical theory to want an injection. What people want, understand, and do are related to each other in various and often ambiguous ways. White Khare assumed this mix and variety, Opler’s perspective was less complex. He also asserted the continuity of village concepts with Ayurveda, and he emphasized the role of health concepts in moral discourse. He wrote that he most common explanation of illness was faulty diet, and that humeral imbalance were also caused by other forms of immoderate or inappropriate behavior. These ideas could be used to produce different interpretations of particular cases, and Opler gives the example of a prominent man whose illness was variously attributed to sexual excesses, harshness in business dealings, and involvement in events that caused the death of a Brahman.

The pluralistic character of healthcare resources in Indian villages was a central concern of the early anthropological essays, yet researchers with medical training ignored indigenous medical institutions, or treated them as a source of difficulty for programs to improve healthcare (Leslie 1967). The anthropologists described the manners and concepts of modern health professionals as barriers to greater use of their services, at the same time that they observed the openness of villagers to the symbols and drugs of modern medicine. Marriott wrote that “the stethoscope, the opthalmoscope, and especially the hypodermic needle” were highly prized by villagers, so that many indigenous physicians had added them to their kits. A practitioner in the village Gould studied administered “indigenous compounds with a hypodermic syringe and his business have boomed since he began doing this”. And Khare described an itinerant folk specialist who removed wax from ears nut also treated other ailments:

His knowledge of various disease is an interesting mixture of several types of information which he has gathered during his itinerancy… He is an agency who periodically receives, transforms and transmits his new knowledge to his clients in various villages. For example, there is the interesting case of his introducing patent medicines such as Anacin and Vedana-Nigraha-ras (an Ayurvedic medicine) into the lower strata of society. (1963: 39)

A great deal of social research has been published and new work undertaken in the years following the articles I have just discussed. As background for Parts 2 of this essay, I will review some of this work, concentrating on themes that we have already identified: (1) pluralism, or the co-existence of diverse traditions of health care, (2) the cultural continuity between indigenous medical practitioners and laymen, which we will see is grounded in the fact that concepts in health care are also used in other domains of activity, and (3) the conflation of concepts and practices from different medical traditions.

This discussion must be selective, even with reference to studies that report observation relevant to our themes. The library of new social research on healthcare in South Asia includes specialization in many fields of scholarship. For present purpose we are setting aside large categories of work,
including studies of social roles in hospital and medical schools (e.g. Madan, 1980; Oommen, 1978; Srivastava, 1979; Venkataratnam, 1979), studies of fertility and family planning (e.g. Mandelbaum, 1974; Maru, 1976), health program evaluation (e.g. Mutatkar 1979), and research in social epidemiology (e.g. Carstairs and Kapur, 1976; Koachar,1979).

Medical pluralism is not peculiar to South Asia, but a structural characteristic of medical systems everywhere. This fact must be asserted because the term “medical system” is often used as a ready-made concept loaded with historical assumptions. I have written elsewhere:

The concept is an artifact of the division of labour in nation states with Department and Ministries of Health, and of legislators, physicians and other specialists who claim responsibility for supervising the health status of populations. The generic conception of a medical system is thus based on a single, historically recent system. Here we conceive of a bureaucratically ordered set of schools, hospitals, clinics, professional associations, companies and regulatory agencies that train practitioners and maintain facilities to conduct biomedical research, to prevent or cure illness, and to care for or rehabilitate the chronically ill. From this perspective other forms of healthcare are outside the medical system, and they are usually ignored. When they are not ignored they are derogated as curiosities, or as fringe medicine, quackery and superstition. (Leslie, 1980)

Indigenous medicine is thus stigmatized in South Asia, as well as being politically and legally subordinated to modern medicine. Indigenous medical traditions are associated with people or customs that are lowly, backward, rural and impoverished, while they are also prized and essential to life among all classes of people. I will describe this conflicted aspect of medical pluralism in Part 2 of the present essay, in relation to the World Health Organization policy that urges developing countries to integrate traditional and modern medicine in healthcare planning.

To gain objectivity it is useful to conceive of medical system as origination in acts of consultation between laymen and specialists. Of course, other criteria come into play when we refer to the Yunani system, or the Ayurvedic or Homeopathic systems. The notion of systems within systems need not be confusing, but alternative terms (tradition, practice, institution) may be used to that the term system will have greater weight in referring to the pluralistic structure of the whole society.

The problem is to get a fix on the variety. Besides distinctions between vaidya, hakim, doctor and so on, practitioners are distinguished from each other according to whether or not they are registered or unregistered with government agencies, qualified by college training, in full-time or part-time practice, and engaged in governmental service or private fee-for-service practice. Carl Taylor initiated a series of studies to discover the scale of variation (Taylor 1970, 1976) He estimated that about 20 percent of all medical care in India was provided by qualified practitioners divided half and half between the state health services and private practice. Another 20 percent of all medical care was provided by “Indigenous Medical Practitioners”. And the remaining 60 percent was met by folk practitioners and home remedies. One of the studies that was used in making these estimates was of a development block in the Punjab were there were 59 “Indigenous Medical Practitioners” in a population of
80,000 people. Their use of modern medicines caused Taylor to declare that the study had uncovered.

a widely pervasive and previously unrecognized separate system of medical education. The professors are the drug-detail men from pharmaceutical companies, often the largest and most reputable companies in the world. The junior faculty are the pharmacists in the cities. Each pharmacist has a continuing class of practitioners scattered throughout the neighboring villages. (Taylor 1976; 288)

In the Punjab 87 percent of the patients observed consulting the so-called practitioners of indigenous medicines received allopathic drugs, alone or in combination with traditional remedies, but a matching study of practitioners in Kerala found that only 22 percent of their patients were given allopathic medicines, and 76 percent were treated exclusively with traditional medications. (Neumann, Bhatic, Andrews and Murthy, 1971). This comparison is subject to sampling errors, but however local practices vary, it is generally agreed that modern drugs are used by many practitioners who are not qualified in allopathic medicine.

The problems of malpractice in the use of modern drugs should be considered in an even-handed manner. This will be particularly difficult for health professionals since the quackery of other people will always appear worse than one’s own. Physician qualified in modern medicine are also students in the profitable system of commercial drug distribution that Carl Taylor described. Mark Nichter, an anthropologist, tells about a physician with an MBBS degree who returned to practice in the rural area of South Kanara where he grew up. He treated many patients by proxy, and administered injections on demand, sometimes substituting water for drugs. He characterized his own practice and that of there rural physicians from the perspective of his college training as “90 percent quackery and 10 percent medicine” (Nichter, 1977: 401). The authors of another study describe the often severe exigencies of private and government practice in both urban and rural Indian communities, and discount “the myth of scientific medicine” under these circumstances (Takulia, Parker, Srinivas Murthy, 1977).

In the region of South Kanara that he studied, Mark Nichter described 18 varieties of practitioners and a complex set of traditions that they used to interpret, prevent and cure illness. Among the registered practitioners using allopathic medicines he described two physicians who served villagers in an area with limited access to college trained doctors. One of these physicians was self-instructed, and the other one had taken a course in homeopathy.

In such contexts, practitioners like Balakrishna and Krishna Bhat have played a crucial role in initially introducing villagers to modern ideas, medicines, techniques, and the framework of modern therapy. Moreover, they have won villager’s confidence by functioning within the culture, paying credence to the moral and social aspects of disease and the symbolic aspect of medicine. It is not unusual to see Balakrishna placing his stethoscope on a patient’s paining leg. This is not because he does not know the proper use of the instrument, nor is it as ludicrous as it may first appear. Patients are impressed by the instrument and Balakrishna uses it symbolically. The action affirms the patient’s worth, emphasizes the importance of the condition and assures the patient that the specialist is
using all of his available resources to promote a cure. (Nicher, 1977: 390)

A study of 10 villages near Varanasi with a population of 9,832 people located 406 cures, of which 396 were part-time and 10 were full-time practitioners (Shukla, Marwah and Goel, 1978) A review of research of this king estimated that 86 percent of all of the man-power in healthcare is engaged in the indigenous systems, and that on an all India basis there are at least 40 full-time and 600 part-time practitioners for every 100,000 population (Kochar, Marwah and Udopa, 1977). I have represented the variety of full-time and part-time practitioners in a diagram where one axis defines a continuum between the poles of traditional, orally transmitted by the mass media, and a second, vertical axis defines a continuum between the poles of learned secular and sacred practices. (Laslie, 1976)

The conflation of traditions occurs in various parts of the system represented by the diagram. When the [kan khodana] that Khare descried began to purchase aspirin tablets and commercial Ayurvedic preparations to supplement his practice of removing car wax, he moved on the continuum between folk tradition and popular culture practice. When professional health workers combine humeral conceptions of diet with concepts of proteins, vitamins and calories, they move in the continuum between popular culture and learned secular practice (e.g. Leslie, 1973; Obeysekere, 1976)

Professional cosmopolitan medicine

[Diagram]

learned mexico-religious medicine

Figure 1. Model of pluralistic South Asian medical system showing regions of typical practice, and hypothetical distributions of full-time and part-time practitioners.

Regions of typical practice:

(A) Physicians of cosmopolitan medicine with M.D. degrees (most practitioners have M.B.B.S. degrees, or diplomas)
(B) Professionalized Ayurvedic and Yunani physicians.
(C) Homeopathic physician
(D) Learned traditional culture Ayurvedic and Yunani physicians
Pandits and other religious specialists with reputations for unusual learning and healing powers.

Folk practitioners.

Classic Ayurvedic and Yunani text descriptions of medical education and practice.

Yet another way of describing medical pluralism was devised by Fred Dunn, a physician-anthropologist who distinguished three systems in the on-going structures of Asian societies. They were:

Local medical systems, a category which can accommodate most systems of “primitive” of “folk” medicines; regional medical systems, such as Ayurvedic, Unani, and Chinese medicine; and the cosmopolitan medical system.... (which) is a transplant in most parts of the world, in the sense that it arose in the “west” and retains “traditional” elements which betray its regional origins. (Dunn 1976: 135-136)

Dunn compared the concern for preventive and curative medicine in the different systems, access to care, the characteristics of practitioners, and so on. His purpose was to suggest how we might evaluate the contribution of local and regional systems to the health status of populations.¹

Neither Dunn’s essay, my work, or the other studies that I have mentioned so far were designed to describe systems of health care belief. In recent years, however, a good start has been made on research to describe the theoretical nature of South Asian medical thought. Our discussion of this work will concentrate on humoral traditions, setting aside studies of ritual curing, including such varied yet interrelated topics as shamanism (e.g. Allen, 1976; Hitchcock and Jones, 1976; Spencer, 1970), tantric medicine (e.g. Henry, 1977; Stablein, 1973), Muslim shrines (Pfleiderer, 1979), and Singhalese exorcist theater (Kapferer, 1978, 1979; Obeyesekere, 1969, 1970).

Conceptual systems are orientations to the world created in the process of asking and answering questions. They are not mind games, as some scholars would have it, the products of intellectual play that are simply good to think, but historical entities with historical consequences. The conceptually differentiated traditions that compose medical systems can be sorted into three kinds. The first are the traditions which consider illness to be a punishment inflicted by gods or spirits, and by other people through sorcery and witch-craft. People confront an affliction in these traditions by asking: How did I provoke this suffering? Who is my tormentor? Divination and ritual curing are characteristic forms if practice. The second category includes the traditions of humoral medicine, where the questions are: What disruption of normal processes initiated this illness? What accumulated disharmony now disturbs my body? The characteristic therapies are corrective regimen, medication, and massage. Finally, cosmopolitan medicine deals with the question: What has done wrong with the machinery of the body? How does the pattern of symptoms indicate a specific pathology? Treatment uses chemotherapy and surgery to eliminate the infection, or to correct or remove the malfunctioning part. We might compare the different structures of health care belief in New Delhi and London by
describing the ways that punitive, humoral and cosmopolitan medicine are maintained and related to each other in these societies.

Cosmopolitan medicine is politically and legally dominant in South Asian society, but humoral medicine is culturally dominant in that the pervasive concepts in health care are humoral, and these concepts recur in thinking about agriculture, family relations, cooking, worship, music, and so on. This structure of thought is based upon a system of correspondences. The phenomenon is not peculiar to South Asia. Dylan Thomas used a system of correspondences when he wrote, “The force that through the green fuse drives he flower Drives my green age; that lasts the roots of trees is my destroyer.” Alan Beals began an article about the ways that the villagers he studied in Karnataka decided to consult one or another curer by quoting a Sanskrit verse using the South Asian system: “Earth, my own mother; father Air; and Fire, My Friend; and Water, well-beloved cousin; And Ether, brother mine; to all of you. This is my last farewell.” (Beals, 1976; 184) Metaphors shape thought and experience in all societies, but writing provides what Jack Goody called “a technology of intellect” that transforms their use (Goody, 1977). The compilation of written lists creates objects of reference and reflection that can be rationally elaborated to form systems of analogous relationships. These systems, usually called systems of correspondence, establish canonical orders of thought in civilized societies. Since they are communicated through all forms of expression – architecture, music dance, ritual prescription, medical advice and moral instruction – their adumbration at all levels of society may be affected by writing without depending upon widespread literacy. In this way one understands the anthropologist who asserts, “Popular conceptions about the body in modern village India are very similar to theories found in Sanskrit medical texts of thousand years ago, even though villagers are not aware of the existence of these texts” (Egnor, 1978: 2-3), Goody reproduced he following table from a book by M. Hussey to illustrate a system of correspondences.

1. This review cannot cover all approaches to medical pluralism, and omits, for example. Edward Montgomery’s use of systems theory to describe full-time practitioners to Vellore (Montgomery 1976). John Janzen reviewed models of pluralism (Janzen 1978). For comparison to other Asian societies see: Good 1977; Kleinman 1978, 1980; L;eom,am et al. 1976; Lock. 1980.

Francis Zimmerman has described the way that things and qualities in a system of correspondences are conceived in Ayurveda as a cosmic flow of ecological relationships:

Through his food, habitat, and bodily techniques, the living being is influenced, penetrated, immersed in the system of humors, flavors and qualities that make up the atmosphere, the climate, the landscape in which he takes root. *Rasa*, a juice formed in the living body from all the substances assimilated by digestion, is first present in food, drugs and plants (*osadhi*). The sap (*rasa*) of plants comes from the combinations of rain water with he other major elements (*mahabhuta*), earth, fire, air, ether. The Sun “captures” the *rasa* and the Moon, “Master of *osadhi*,” exudes or frees the *rasa*. The combination of water with the other elements produces six “flavors” (*rasa*): sweet (*madhura*), sour (*amla*), Salty
(lavana), acrid (katuka), bitter (tikta), astringent (kasaya), following the traditional order of recitation of this hierarchic series of technical terms. Thus the relations between a living being and its natural life-environment give birth to a vast metabolism of saps and foods. (Zimmermann 1980: 101).

Zimmermann’s description is based on classic Ayurveda texts and on study with Vayaskara N.S. Mooss, an hereditary practitioner of the Astavaidya caste of Brahmin physician in Kerala. Noting that “Everywhere – from Greece to China – we meet with the humoral theory and the theory of an equilibrium in the relation between the patient and his environment,” Zimmermann recommends that the differences between these traditions be studied, “For example: four seasons in Greece, only three in India; the theory of the cyclic equilibrium of the humors seems to be the same, but the actual partition of time is quite different.” (Zimmerman, 1978: 100-101). Also,

Working in the tradition of Gaston Bachelard and Michel Foucault, Zimmermann is concerned with “epistemological breaks” that create discontinuities in medical discourse, or that divide medical discourse from other cultural domains (Zimmermann 1978, 1979).

Besides Zimmermann, two other young scholars with skillful preparation in languages, philosophy, history and social science have in recent years studied with renown Ayurvedic physicians. Margaret Egnor studied with Y. Mahadeva Iyer, a master practitioner and founder of a clinic in a village near Cape Comorin, and Daniel Tabor studied with Sir Bapalal G. Gaidya, the retired Principal of an Ayurvedic college in Surat. All of them were impressed by the functional, process oriented view of he body

| Part of Body | Head | Neck | Shoulder | Upper body | Lower body | Thigh | Knee | Foot |
|--------------|------|------|----------|------------|------------|-------|------|------|
| Sign of Zodiac | Aries | Taurus | Gemini | Cancer | Leo | Virgo | Libra | Scorpio | Sagittarius | Capricornus | Aquarius | Pisces |
| Wind | South | East | North | West |
| Season | Spring | Summer | Autumn | Winter |
| Age | Childhood | Youth | Maturity | Old age |
| Quality | Hot-moist | Hot-dry | Cold-dry | Cold-moist |
| Condition | Liquid | Gaseous | Dense | Solid |
| Colour | Red | Yellow | Black | White |
| Element | Air | Fire | Earth | Water |
| Temperament | Sanguine | Choleric | Melancholic | Phlegmatic |
| Humour | Blood | Yellow bile | Black bile | Phlegm |
processes in cosmopolitan medicine. Also, since bodily processes are thought to be continuous with those in the rest of the environment, they were impressed by the conception of health as a balanced ecological flow of substances.

Tabor and Egnor report that their teachers interpreted most illness to be the consequence of faulty diet, digestion and elimination. “Man’s first disease is hunger, says M. (Y. Mahadea Iyer), and the stomach is the source of all disease thereafter.” (Egnor 1978: 32) Food was thought to be cooked in the fields by sun and water, and then again in the kitchen and the body, undergoing not one but many cooking. Episodes in the processes of growth and digestion, all of them involving a progressive refinement and softening of substances. Thus Margaret Egnor’s teacher thought of health as a softness in the body, and of illness as a hardness caused by the build up of uneliminated substances. "Constipation may be the prime example of hardness and excessive substance in the body", but illness could be a hardness of the liver or blood vessels, or some other body part. The whole process of aging was a progressive hardening throughout the body. (Egnor 1978: 49-52) These ideas will be familiar to anyone who has studied European medical history. Jerome Bylebyl, a specialist on the Renaissance, has suggested that the term “dietetic medicine” be substituted for “humeral medicine” as a better descriptive label.

Daniel Tabor writes,

One of the most important concepts in Ayurveda, as practiced by Vaidyas in S. Gujarat, is that of ama, namely ‘unripe’ or ‘immature’ food juice (Rasa) produced by faulty digestion. According to my teacher, Sri Bapalal G. Vaidya….all diseases were due to unripe food-juice (Tabor 1981: 442) The contrasting Sanskrit term is pakva, which means cooked, ripe and mature. The analogous vernacular term, kacca and pakka have innumerable metaphorical uses, so that Tabor can show the continuity of values and meaning expressed in ordinary language and in the language of practicing Vaidyas. Although he maintains that “ripeness, unripeness, perfection and imperfection, have ‘resonances’ within the culture as a whole that are not, for example, shared by the language of allopathy” (ibid), he emphasizes that his teacher and he other Vaidyas he knew were familiar with allopathic anatomy and physiology, and that “allopathic knowledge was interpreted to harmonize with the basic Ayurvedic categories…. the underlying assumptions of Ayurveda persisted , even where the terminology of allopathy was invoked” (ibid).

While Daniel Tabor and Margaret Egnor emphasize the continuity of humoral tradition, Francis Zimmermann emphasizes the discontinuity. Here we encounter different methodological commitments that lead to different interpretations of Ayurveda in modern India. Zimmermann has described his view by referring to Bachelard’s concern for “epistemological breaks” in cultural history, and by quoting Foucault’s assertion than “beneath the gross continuities of thought, beneath the persistence of any genre, form, discipline, theoretical activity, from now on what we shall try to detect is the incidence of interruptions” (Zimmermann 1978: 98). Margaret Egnor seems to take the reverse view, and to look beneath the incidence of interruptions to discover the gross continuities of thought. South Asian ethnologists differ between those that are disposed to study the continuities in the civilization, and those that study its discontinuities. The first tend to emphasize the uniqueness of South Asian civilization,
and the second to draw comparisons between similar developments in it and other societies.

The views of Tabor and Zimmermann may also differ because they have partially adopted the perspectives of their different teachers. Tabor’s teacher advocated modern knowledge and, as Principal of the college in Surat, he championed a curriculum that combined training in Ayurveda with instruction in allopathy. Tabor writes, “These ‘combined’ courses were widely taught in Ayurveda Colleges until the mid-sixties, when they were stopped, so I was told, for political reasons and not because of the conceptual difficulties of combining the two systems.” (ibid, 19). From Zimmermann we get quite a different view of this change in curriculum during the mid-sixties, and of the continuity of Ayurveda in relation to allpathy. Zimmermann’s teacher opposed colleges like the one in Surat, and he advocated pure (shuddha) Ayurveda separate from all modern knowledge. However, another Kerala physician of some renown, P.S. Varier, founded a pharmacy in 1902 that has become quite a large enterprise today, including a college and a sanitarium. In 1925 Varier published a Sanskrit text that combined Ayurveda with modern anatomy, and Zimmermann writes that this work.

Prefigures the so-called “Integrated system of Indian medicine” worked out by the academic authorities in the 1950s and tested in Ayurveda colleges: it was a complete failure and the “Integrated system” has been dismantled since then. The attempt was….to integrate the Western image of the body into a completely different system of thoughts. The meaning of Sanskrit words is fixed by reference to a particular organ or function of the body. Then what happens? Suppose the “channels” mentioned in the classic texts – channels for ingestion of nutrient fluids and excretion of impurities – may be identified with arteries and veins, suppose the seven “fires” that transform the body-elements into one another may be identified with enzymes, suppose vata-rakta, the vitiation of blood (rakta) by wind (vata) is nothing else than rheumatoid arthritis, at it is learnt in Ayurveda colleges today – all of us can see that the traditional notions are thus displaced and distorted…..Actually, the whole system of thoughts is obliterated by the triumph of Western anatomy”. (Zimmermann 1978a, 2-3)

Tabor, like Zimmermann, is concerned with “how the traditional corpus of knowledge, with all its inter-relations, is altered by the impact of Western anatomy and physiology.” But the changes that he describes do not involve a radical epistemological break. The system of thought in Ayurveda is adapted to new circumstances and knowledge, but despite Zimmermann’s assertion, it is not obliterated. For example, one section of his essay describes the combination of Ayurveda and allopathy in the discourse of Vaidyas as they interpret and treat a heart condition. They describe the symptoms known to allopathy, but attribute them to a body wind, apana vayu, which has taken the wrong direction, and flows up rather than down. This wind is flows up rather than down. This wind is normally responsible for bowel evacuation, urination, the secretion of semen, and the flow of menses. It should be treated with a particular bitter medicines that will aid digestion and, according to Tabor’s teacher, turn blood alkaline. The medical discourse combines references to classic texts and concepts, personal clinical experiences, to one’s instruction from a guru, and to various sources of allopathic knowledge. Tabor writes.
“These different ‘levels’ of knowledge become relevant when we examine the general category of ‘heart disorder’s as used by practicing Vaidyas. In the Caraka Samhita the class of ‘heart disorders’ (hrdroga) is described twice (31). Further more the provocation of apan vayu is described in the text as causing a wide range of serious disorders (32). This is similar to the cause of ‘heart disease’ given to me in Surat. However, the structure and function of the heart (Sansk. Hrdaya) in Ayurveda (33) is different from that found in allopathic medicine. It is, for example, regarded as he seat of he ‘vital essence’ (ojas) and consciousness (caitanya) (34), though these technical terms are not easy to define. It is also described as the support of life (dhari) (35), but its function is not clearly identified with that of the circulation of the blood, and the account of its structure cannot be recognized in allopathy. Among the practitioners in Surat, though, the allopathic description of the structure and function of the heart was accepted as correct, though in other contexts some of the Ayurvedic functions would be retained (e.g. the heart as he repository of ‘vital essence’). The category of ‘heart disease’, as used by these Vaidyas, was therefore somewhat ambiguous; but this very ambiguity allowed the assimilation of modern anatomy and physiology to the more general categories of Ayurveda. The problems involved in making equivalences or identifications between the two realms of discourse (Ayurveda, Allopathy) are considerable; but in the clinical situation these identifications were made or assumed as necessity dictated. The diagnosis of a ‘heart condition’. If originating from an allopathic doctor, could therefore be accepted and treated on lines largely kictated by the conceptual physiology of Ayurveda.” (Tabor (1981: 449)

These contrasting interpretations of the relationship between Ayurveda and allopathy refer to professional learning among practitioners Who are concerned with ideological conflicts Among laymen the perspective on coexisting ideologies, insofar as people are aware of their existence, is quite different. The ordinary person does not expect to resolve the ambiguity and multiplicity of things to a single form of clear and certain knowledge. Alan Beals described this attitude very well (Beals 1976, 185-186), and it is confirmed by other ethnologists (e.g. Amarasingham, 1980; Bhat, 1976, Nichar, 1977, Stone, 1977). Beals writes that the ordinary man is not surprised when people hold diverse views, but considers that the contradictions and inconsistencies he perceives are like pieces of a puzzle hat would ultimately fit together had he world enough and time to learn all he pieces. Meanwhile he must act as best he can with imperfect knowledge.

In addition to this pluralistic and humble world view, other traits of mind characterize the layperson’s search for therapy. For brevity I will enumerate several of them;

1. people assume that most events, including illness have multiple cause

2. They believe that various kind of therapeutic action may be combined to deal with the causes of illness Thus, an allopathic injection may alleviate the symptoms of illness while an Ayurvedic regimen will help to restore health

3. The Orientation of laypeople in search for therapy is pragmatic. They draw upon past experience to calculate the seriousness of the illness, its economic and social consequences for the family, and the probable costs and effectiveness of
different courses of action. As in all human affairs, these calculations may involve uncertainly, disagreement, and self deception.

Finally, laymen diagnose illnesses in negotiating decisions between themselves to consult one or another specialist. They may agree that some kinds of illnesses require the ritual interventions of punitive medicine, while others are best suited to allopathic or humoral treatments, but this does not resolve ambiguities about the interpretation of particular illness episodes. For example, Deborah Bhattacharyya described three different afflictions that Bengalis call poglami (madness), bhut bhar (ghost possession) and tuk tak (sorcery). They showed the symptoms of madness but did not have the stigmatic implications of mather golmal (head disturbance), a form of true madness initiated by a shock to the afflicted person’s humoral balance. Susceptibility to mather golmal revealed an inherited flaw in the person and his family, and its symptoms represented “the kind of person one is or has become”. Following the concepts developed by Inden, Marriott and Nicholas to describe South Asian character, Bhattacharyya argued that true madness was a deviant loss of control in the flow of exchanges between he person and his environment (Bhattacharyya, 1977). Although madness was a humoral disorder she found that almost all of the facilities for its treatment in Bengal were allopathic. In so far as he doctors at these facilities had non-humoral conceptions of madness, she showed that laymen were not likely to learn what they were because the role relationships between doctors and clients could proceed very well with both of them acting on different conceptions of the illness (Bhattacharyya, no date, chapter 5). In this respect, her analysis confirms the findings of another study by T. N. Madan of general practitioners in an industrial city near Delhi. Since allopathic doctors are trained in modern science and technology Madan expected them to act as agents of cultural change in their communities, but his study refuted this notion. The doctors he studied practiced a narrow curative medicine. They did not share their concepts and clinical experience with each other, much less their patients, but were oriented to business-like fee-for-service relationships (Madan, 1972).

This completes our review of social research on South Asian medical systems. Our purpose has been to describe methods for analyzing the pluralistic structure of health care. Asserting the cultural dominance of humoral medicine, I have contrasted perspectives that emphasize continuities in the conflation of different traditions of thought and practice with a perspective that emphasizes discontinuity.

(To be concluded)