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Decline of Ayurveda in British India

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Ayurveda is a holistic lifestyle system that teaches the practical details of the arrangement of food, body work, rest periods, and work, which aims to achieve balance of body, mind, and soul. The main classical Ayurveda texts begin with accounts of the transmission of medical knowledge from the Gods to sages, and then to human physicians. In Sushruta Samhita (Sushruta's Compendium), Sushruta wrote that Dhanvantari, Hindu god of Ayurveda, incarnated himself as a king of Varanasi and taught medicine to a group of physicians, including Sushruta. Ayurveda therapies have varied and evolved over more than two millennia. Therapies are typically based on complex herbal compounds, minerals and metal substances (perhaps under the influence of early Indian alchemy or rasa shastra). Ancient Ayurveda texts also taught surgical techniques, including rhinoplasty, kidney stone extractions, sutures, and the extraction of foreign objects. Ayurveda flourished in Ancient India, lived in harmony with Unani medicine in Medieval India but declined during British rule. The present Research Paper wishes to explore the reasons for decline and finds that Colonial mindset of British Empire was responsible.

Medicine represents for direct intervention in, and interaction with, the social, cultural and material lives of the Indian people. This dual engagement – with the environment and with culture- helped fashion not only the distinctive character and preoccupations of the India's colonial medicine, but also the manner of its Indian reception and assimilation.

Early British attitudes to what was known of Ayurvedic, Unani and even folk medicine were often tolerant and even appreciative. The British appreciated that there was much that they might usefully learn from indigenous medicine, particularly from its rich materia medica, accumulated over centuries of empirical trial and observation.

Continuing availability and perceived efficacy of indigenous medicine, the British were obliged to recognise the existence of older and culturally entrenched therapeutic beliefs and practices, and much historical debate has focused in recent years on the nature and consequences of the resulting interaction between Western and indigenous medicine and the extent to which the two constituted rival or complementary systems.

In 1814, the Court of Directors identified itself with this quest, noting (on the basis of reports received from India) that there existed in Sanskrit `many tracts of merit... on the virtues of plants and drugs, and on the application of them in medicine, the knowledge of which might prove desirable to the European practitioner.

In Calcutta in 1824 and in Bombay two years later, training institutions were set up for this purpose, primarily designed to supply the army with sub-assistant surgeons, dressers and apothecaries. Calcutta's Native Medical Institution was to provide the Company with a regular supply of `native doctors', taught through the vernaculars and through translations of English textbooks with parallel instruction in the indigenous medical systems. Classes in Ayurveda were also given at the Sanskrit College, using the works of Caraka and Susruta, while for Muslim students classes in Unani medicine were held in Urdu at the Calcutta Madrassa. A similar pattern of translation and vernacular instruction was followed at Bombay.

When the Calcutta Institution closed in 1835 it brought to an end an era of `peaceful' cooperation and `friendly' coexistence between the Western and Indian systems and signified the replacement of a benign Orientalist policy of patronising and learning from indigenous medicine for an intolerant Anglicist one, with disastrous consequence for the subsequent history of indigenous medicine. Main difference between the two was that `Orientalists advocated syncretic schemes for self-help to one's own value system, whereas Anglicists were less sympathetic to traditional values and more convinced that no real change was possible without radical assimilation to the British style of life.

The function of the Calcutta Native Medical Institution was never to promote indigenous medicine (which anyway formed a secondary part of the curriculum) as an equal or alternative to the Western system, but to `train up a class of native practitioners who would employ suitable native medicines with skill'. Offering instruction in Ayurveda and Unani medicine was also a ploy to attract recruits from the Vaidyas and other communities with a tradition of medical practice. Once recruited, it was assumed that they would come to recognise the superiority of Western medicine, even if they used cheap `native remedies' instead of costly imported drugs in their professional work.

In Bengal in 1833 the Governor-General, Lord Bentinck, appointed a committee for the purpose of `improving the constitution and extending the benefits' of the Native Medical Institution and creating a system of management and education better suited to official needs. The committee advised the abolition of the Institution and in 1835 the Native Medical Institution was replaced by the New Medical College.

Western medicine after 1935 was taken as the hallmark of a superior civilisation, a sign of the progressive intentions and moral legitimacy of colonial rule in India and the corresponding backwardness and barbarity of indigenous practice. James Ranald Martin compared the creation of the Medical College to Bentinck's other acclaimed act, the abolition of *sati* in 1829.

The history of Indian medicine was likely to be `of more interest than utility'. It was not to be expected that the imperfect science of the *Baids* and *Hakeems* of India would offer `any instructive lessors to their better educated brethren of Europe' must be objects of interest.

Not until a generation after Jones, between about 1810 and 1830, did scholar-surgeons like Benjamin Heyne and Whitelaw Ainslie in Madras and H.H. Wilson in Bengal begin in earnest to study Ayurvedic texts. Their work was followed in 1838 by J. Forbes Royle's *Antiquity of Hindoo Medicine*, with its seminal claim for the anteriority of Hindu over Greek and Arabic medicine. What they saw (in Orientalist fashion) as the debased, present-day remnants of a system of medicine that, having flourished in ancient times, had long since fallen into deep decline. Ainslie, although had two grounds for reproaching Hindu medicine. The first was the way in which medicine had become mixed up with religion, so that Ayurveda was revered as a gift of the gods, `a circumstance which has been an insurmountable obstacle to improvement' and a reason it was `still sunk in such a state of empirical darkness'. Secondly, he regretted that the practice of dissection, referred to in ancient texts, had been abandoned and forgotten, thus leaving the Ayurvedic physician profoundly ignorant of the body's internal functions and disorders. Wise acknowledged Ayurveda as a scientific `system' in its own right. But he contrasted ancient achievements with the complacency of modern physicians, who were `satisfied with the knowledge and power... acquired at a very early period' and attached such `blind reverence' to their ancient texts as to `perniciously' retard any further advance.

Western medicine already operated on a more securely scientific basis and that Indians acted only from `practical knowledge' of the effects of the treatments they used, without much attendant understanding or reasoning. Western medicine felt increasingly secure in its superior knowledge and the isolation of active chemical ingredients.

In the 1820s James Annesley of Madras argued that medicine in India could be put on a `rational footing' only if due attention were paid to climate, season and the geographical distribution of disease.

Britain, it averred, had a moral obligation to help its Indian subjects by giving them the benefits of Western civilisation and since in India `government is everything' that required greater and more determined action on the part of the colonial state. In theory, this marked a vital stage in the emergence of state responsibility for public health in India.

The state was not the sole patron of Western medicine in India. ***Christian missions, too, saw great potential value in medical work***, and their involvement in medicine, specifically in women's medicine, is a reminder of the way in which medicine could also serve and inform wider agendas of religion and gender.

From the 1830s, the London Missionary Society in south India began to take up ***medical work as part of its evangelising activity, believing that medicine could `open to wide and effectual door into the hearts and minds of the natives'***. Main initiative remained with the missionary societies. The task of their women doctors was to effect a ***`double cure' – the healing of spiritual as well as physical `disease'.***

"A second area of medical intervention centered on moves to reform Indian midwives (*dais*) or, alternatively, replace them with Western-trained midwives. In the second half of the nineteenth century, ***dais came to be portrayed as `wizen hags'***, whose `barbaric' and `primitive' practices brought suffering and death to women in childbirth and drove infant mortality to horrnedous levels. The issue of midwifery seemed, like to pit ***a progressive, humane West against a cruel and backward East***; the *dai* thus became `a symbol of [Indian] superstitution and dogged resistance to change'."

The colonial regime gradually withdrew most of its patronage to the indigenous systems of medicine. The practitioners of these systems, the vaidyas and the hakims, suffered significant loss of prestige against Western medicine's claims of being a more rational "superior" system of medicine.

In the 1830s, the anglicists managed to overturn several cultural educational policies started by the vernacularists and orientalists. Charles Trevelyan, an ardent Westernizer, chastised the British policy of educating Europeans in the languages and cultures of the East and recommended that "the Asiatics ought to be educated in the sciences of the West." In 1833, Lord William Bentinck appointed a committee to look into the state of medical education in Bengal and the teaching of indigenous systems of medicine. In 1834, the report, submitted by the Committee led by Dr. John Grant, criticized the medical training and assessment conducted by the Native Medical Institution. Absence of instruction in practical anatomy was also censured. The report recommended that the state should found a medical college for the "education of natives." The various branches of medical science should be taught to students, as in Europe. The trainees should be able to read and write in English, Bengali, and Hindustani, and must be proficient in arithmetic.

In their place, a new medical college was established to train Indian students "in strict accordance with the mode adopted in Europe through the medium of the English language." Calcutta Medical College was established in 1835 and it ushered in a new beginning to medical education in India.

Dr. Charles Morehead wrote that in gifting medical science to the people of India, there was a scope "not merely for the operations of successful imitation but also for the adaptations of original genius." The college was not designed in imitation of the Medical College in Calcutta which intended to produce government servants. The college in Bombay was designed to produce independent medical practitioners from the natives of India.

A medical school was established in Madras in 1835 to "afford better means of instruction in Medicine and Surgery to the Indo-British and native youths".

While nationalism provided a fertile soil for the revival of Ayurveda and other indigenous branches of medicine, therefore, the revivalist efforts during this period placed importance on establishing the scientific and progressive credentials of Ayurveda. A proliferation of books on Ayurveda in English, Sanskrit, and vernacular languages "tried to transform the hitherto relatively inaccessible knowledge into social knowledge.

Ayurvedic practitioners organized themselves and founded the All India Ayurvedic Congress. The themes central to the discourses at these conferences were British orientalism, the synthesis of medical systems, and the institutionalization of Ayurveda. M.M. Gananath Sen, an ayurvedic practitioner from Bengal, founded a college for the study of Ayurveda and a pharmaceutical concern for manufacturing ayurvedic medicine. Several such efforts were made to resurrect Ayurveda in the wave of patriotism.

Claims of the Western superiority and scientific authority isolated Western medicine. Allopathic practitioners saw themselves as modernizers and often treated their indigenous counterparts with contempt for their "inferior knowledge." Local knowledge was labeled unscientific or irrational. While Western medicine was accorded the status of official medicine, the state turned discriminatory and hostile toward the other systems. The rising tides of nationalism also posed to be an obstacle in a healthy exchange of ideas.

The intrusion of Western medicine was resented by the practitioners of indigenous medicine, and they stoutly defended their traditions. These practitioners also tried to avoid humiliation by acquainting themselves with the new techniques of diagnosis. In the 1920s, Benaras Hindu University developed a course which had both Ayurveda and Western medicine.

An article in the June 1928 issue of The Journal of Ayurveda or the Hindu System of Medicine argued, "Medical Education in India should be so devised that it should take into account not only the present-day medical education but also medical knowledge of the past… While Ayurveda cannot move on in an old groove, Allopathy should not be accepted in toto for India. While we should absorb the pathology of the 'seed of disease' from Allopathy, we must give the 'pathology of the soil' in disease to modern medicine. The two angles are at present different but should be harmonized."

Practitioners of Indian systems of medicine are treated as "second-class doctors" in India even today. We have often ignored non-Western concepts of disease, and discarded alternative ways of providing health to people. Even today, Western medicine is more popular.

As Europe moved toward industrial production of pharmaceuticals, Western practitioners increasingly used drugs with a single "active ingredient," distancing themselves from the traditional Indian preference for the whole herb or mineral.

With significant advances in Western medicine, and the emergence of Utilitarianism as the dominant thought guiding British policy in India, the distance between practitioners of different systems widened. By the end of the 19th century, Western medicine had a significant presence in big cities and towns. Hakims and

vaidyas felt threatened and neglected due to the complete loss of state patronage and decline in their social status. Some started questioning their own system, and adopted various different ways to stay relevant. Others stood up for their systems through vigorous defense and promotion of their systems.

Six decades after independence, educationists have still been unable to convincingly shrug off the colonial yoke. Strangely, the curriculum followed by medical trainees has not been fundamentally altered since the days of the Raj. The traditional ways of teaching have continued. There is comfort in continuing with tradition and a reluctance to change.

In the mid-1970s, the Shrivastav Committee advocated reorientation of medical education by national priorities and needs. In 1986, the Bajaj Committee called for the establishment of an educational commission for health sciences.

Simultaneously, some efforts have been taken by the state to support the Indian Systems of Medicine. In 1995, a new government department of Indian Systems of Medicine and Homeopathy was created. This was renamed as the Department of Ayurveda, Yoga and Naturopathy, Unani, Siddha, and Homeopathy in November 2003. This was done to promote indigenous systems, upgrade their standards, ensure quality control and standardization of drugs, and improve educational standards and research in these areas.

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