WHITHER OTHER SYSTEMS OF MEDICINE ?

India, like other ancient civilisations of the world, had several highly evolved and sophisticated systems of medicine long before the advent of the so-called modern or allopathic system. Historical forces, such as the Greek and Muslim migration into the subcontinent, brought with them yet other systems which flourished and grew, with a mutually beneficial cross-fertilisation of ideas and techniques. Alongside these 'formal' systems of Ayurveda, Unani and Siddha (formal in that they had written treatises and established universities for teaching and training), was the rich, varied and location-specific lore of folk medicine and folk psychiatry, based on local plants, herbs and belief systems. Tribal medicine, and the home remedies of 'Ajji cha batva' (grandmother's purse) fall into this category. Another vital source of indigenous health care were the traditional midwives or 'dais', who not only performed the important function of birthing, but also abortions, in addition to advice and aids for contraception.

There is considerable controversy regarding the role of these systems and their practitioners in history, and indeed about the impact of the arrival of western medicine on them. Some scholars argue that the latter was primarily responsible for the atrophy and decline of traditional medical systems, even stating that the British sought to systematically destroy them on the grounds that they lacked 'scientific' bases and were filled with superstitious nonsense and positively harmful remedies. Others feel that this is too simplistic a view, and that some of these systems were in decline long before western medicine arrived on the scene.

This indicates the need for critical research into the social history of the pre-allopathic systems of medicine. We need to understand their interaction within the socio-political context of different historical periods. What, for instance, was their ideological framework, and how did this reflect contemporary socio-economic and political structures ? The question of 'scientificity' is also often raised. But it can be established that even pre-allopathic systems were scientific, if the term means posing questions, seeking their answers through methodical study (using the means available at the time) and accepting a thing as true only if the same result is repeatedly derived. But this spirit of enquiry and experimentation seems to have gradually declined. Why this happened, whether it was the lack of concurrent technological development to facilitate it, or due to socio-cultural, economic and political forces, is what must be determined.

In this context, it is worth considering exactly how one measures the role of a given medical system, and how one assesses whether it has declined, remained or grown. One must address this question at two levels : first, at the level of theory. What is the extent and nature of growth of the theoretical base, both in depth and breadth, over a period of time? Second, at the level of practice, are the practitioners of a system growing in number, and hence the number of recipients of that type of care?

Evidence shows that upto Independence, the availability of allopathic treatment was largely limited to the cities and towns, and that too mainly to the higher socio-economic groups. If this was the case, then certainly the practice of other systems was not seriously affected since the majority of people, especially the poor, continued to rely upon them. But at the level of theory, the 'formal' systems at least seem to have suffered from stasis and decline, and perhaps because of the following two reasons : one, state patronage by Indian monarchs, which had provided the chief source of support for theoreticians and researchers, was not forthcoming from the British. Two, the growing intellectual domination of western science and thought, especially among the Indian elite, reduced the legitimacy and credibility of nonallopathic systems.

This situation did not change drastically even after Independence. The commitment of the post-Independence leadership to 'modernising' India, to promote (Western) science and technology in the country, and to provide 'modern' health services to all, ensured that state patronage would continue to be given to allopathy, whose practitioners had by then become a powerful lobby alongwith the pharmaceutical industry. Only the residue of the Swadeshi movement, and those leaders (like Gandhi) who were fervent advocates of indigenisation, ensured the allocation of some limited

resources for the development and strengthening of other systems of medicine.

Notwithstanding this, the status of traditional systems is fraught with confusion and subject to periodic swings. The major trends, however, seem to be the following:

The 'synthesis' school of thought which argues that the best of each system—including allopathy—should be studied and combined to create a 'National System of Medicine' (this manifests the heavy influence of the Chinese model). The 'purists' feel that this is both impossible and fatal to the future of traditional medicine. Fatal because it would result in the irrevocable decay of the non-allopathic systems, since allopathy would dominate both theory and practice; and impossible because the conceptual frameworks of the different systems are inherently incompatible, and thus they cannot be studied or evaluated using an alien methodology. Each system must be left severely alone to go in its own direction. Still others argue that the whole question of 'system' is irrelevant; what is needed is a safe, effective and affordable range of therapeutics for use in mass health care. If traditional medical systems have useful remedies which fit the bill, then they should be utilised without recourse to philosophical arguments. Finally, the 'modernists' within traditional medicine feel that the only way to restore their legitimacy is to apply the techniques of modern science to research and standardise these therapies and remove the cloak of mysticism from about them.

These differing and sometimes warring schools are scrabbling for a slice of an already minute cake. The last four decades have witnessed the growth of a plethora of indigenous medical schools, professional bodies, and research centres.

At the same time, these indigenous institutions, their teachers, students, researchers and administrators, generally suffer from an inferiority complex vis-a-vis their allopathic brethren. A 'keeping up with the Joneses' syndrome thus develops, based on the rationale that by acquiring the characteristics of allopathy, the indigenous systems will regain recognition. One example of this is the widespread use of allopathic drugs by indigenous practitioners, made possible by the relatively easy availability and rapid action of these drugs. Non-allopathic practitioners argue that with the spread of and exposure to allopathy, people have become impatient with the slower-acting indigenous therapies which, if properly prescribed and taken, demand more from the patient (like dietary and life-style changes) than allopathic treatments. This is also an interesting comment on the marketing strategies and ethics of the allopathic pharmaceutical industry. Another sign is the 'me too' phenomenon in the growing indigenous drug industry, which is developing, producing and marketing non-allopathic drugs and pharmaceuticals at a rapid rate—particularly vitamins, tonics and restoratives.

Therefore, while the indigenous medicine infrastructure is larger and stronger than it was at independence, it suffers from the same diseases which afflict modern medicine in India—commercialisation, mystification, professionalisation, rising costs and curative bias. The only difference, perhaps, is that its controlling elite is more fragmented and less cohesive in its functioning and goals.

What, then, is the role of the various indigenous system in a people's health system? Should they all be clubbed together or does each one have a distinct and separate role ? And what of Homeopathy, another imported system which has taken firm root in India and provides an important alternative especially in urban areas? Obviously, all these questions must be researched and cannot be fully answered at this point, but we can review existing information to throw some light on them.

For instance, it is useful to look at the ways in which people actually utilise these different systems (where they are available) at grassroots level, to see if these use-patterns provide some clues. A few studies of this type were undertaken in the 'fifties and the 'sixties in Punjab, UP and Karnataka. Interestingly, most of them found one common thread : people's use of alternative health care sources was highly rational. By and large, allopathy was used for acute conditions and for those diseases where it offered known cures—such as TB, malaria, and infectious diseases. Ayurvedic, Unani and herbal treatments were sought for chronic ailments like skin diseases where these systems offer far more effective therapies than allopathy. And home remedies or folk cures were resorted to for simple self-limiting complaints like colds, coughs, diarrhoeas and fevers. Of course several factors like cost, distance, attitude and behaviour of the providers influenced (perhaps more strongly than cure-effect alone) the choices people made. But essentially, the strengths, weaknesses and relative benefits of each system seem to be perceived quite clearly by people.

Unfortunately, there is a growing feeling (though little documented evidence) that this situation has undergone considerable change in the past decade or two. One of the main reasons is the greater penetration of allopathy into rural areas as a result of the overproduction of MBBS doctors who find private practice unlucrative in the saturated city market and opt for rural areas as comparatively profitable. This phenomenon has resulted not only in increased availability of allopathy in the rural private sector, but also an exposure to its rapid-fire remedies. Thus more and more people have been 'hooked' onto treatments which are either wrongful applications or overuse of valuable, even life-saving interventions. The prime examples are the preference for injections over oral medication and the demand for overnight cures which bring their own costs through widespread drug-resistance and toxic side effects.

What then are the tasks ahead of us if we wish to rid indigenous and other systems of medicine of their present ills and make them part of a radical people-based health care system?

First and foremost, it is clear that no changes within these systems nor in their role in health care can occur without corresponding changes in the role and nature of allopathy. The battle on both these fronts must be based on similar strategies: major structural changes in the socio-economic-political system which controls and shapes (or distorts) all of medicine and health care.

Within the health care sector, the following steps would then perhaps bring us closer to the goal: first, demystification and popularization of all medical knowledge, regardless of system. This may in fact be easier with traditional medicine, whose basic concepts are closer to people's beliefs and health culture than those of modern medicine. Second, the trend of professionalisation must be reversed. Since a significant part of indigenous therapeutics is based on herbs and dietetics, they lend themselves to decentralised cultivation, production and distribution. Axiomatically, the commercialisation of traditional drugs and pharmaceuticals, particularly for producting useless vitamins and tonics, must be stopped. This should only be permitted where the economy of scale and geo-climatic limitations favour centralised production, and that too for really useful remedies which are needed for mass health care. This will keep indigenous medicines within people's reach, and discourage the growing consumerism which is being cultivated by vested interests in order to market phony, expensively-packaged medicaments. Finally, a massive re-education of the people is necessary to wean them from dependence on the rapid-fire cures which unscrupulous practitioners (especially of allopathy) have used to win their faith.

Finally, there is one more important issue which must be examined with reference to indigenous systems of medicine: the question of gender bias. Sexism in indigenous systems is a completely uncharted area which demands exploration. Much has been written about the gender-biases in the theory and practice of modern medicine, but how do other systems view women? This question must be studied at three levels: 1) Is there a gender bias in the conceptualisation of women's health and disease in other systems? 2) Is there a sex-distinction in their therapeutics and in the delivery of care to women? and 3) Is there discrimination against or decimation of women practitioners of indigenous systems, including folk and tribal medicine? And if so, are pressures arising from within the system, or from the spread and influence of allopathy?

There is an urgent need to study these questions and, if necessary, sensitise non-allopathic systems to the special health problems and needs of women. This is all the more crucial since traditionally, popular medical knowledge and wisdom was largely the preserve of women, but this rich resource is being eroded and lost. Organised medicine systematically discredits it, without offering an adequate substitute. Thus women are losing their traditional source of self-care (especially poor women), but with nothing to replace it but a growing dependence on a health system which throws them its crumbs.

In this issue, we present articles which focus on the debates and controversies about traditional medicine, its role and relevance. Dhruv Mankad attempts a dialectical analysis, using the Chinese experience as an illustration. Sujit Das and Smarajit Jana's analysis presents a contrasting view. Ravi Pathak describes the grass-roots practitioners' perspectives. We have also reproduced two articles from *Social Science and Medicine*, Roger Jeffrey's which gives an historical account of the policies towards indigenous healers, and Catherine Mac Donalds' which examines the political economy of traditional systems. In addition, we present Anant Phadke's article which looks at the role of doctor's

organisations in the context of their recent struggles (this article was held over from the previous issue). We hope these articles will stimulate further discussion and research.

— Srilatha Batliwala
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