AYURVEDA (RE-)INVENTED
Engagements with science and religion in colonial India

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Introduction

In an era boasting a highly fertile social media as a platform for popular opinion, the return of the iconic Hindu epic, Ramayana, on India’s National Television channel, once again reverberates with tales of the intertwining of medicine, religion, and health, and perceptions of them in the public mind generally. Amid a fight against the current deadly pandemic of COVID–19, the Information and Broadcasting Ministry in India recently announced that ‘Ramayana would be re-broadcast on DD National from March 28, Saturday, on public demand’ (Pune Mirror 2020). As the first television series to gain immense success and popularity in the 1980s, The Return of Ramayana (Dubey 2020) has reified the significance of religion and its impact on culture in our daily lives. It has also brought to the fore the relationship between religion, health, and society.

In the current pandemic, the importance of Ramayana lies in its metaphorical notion of not crossing the ‘home boundary’ (see Ohm, this volume, for further details) as a preventive measure against COVID–19. In the mythological epic, this boundary, called Lakshman Rekha, occupied a special place. Lord Rama’s younger brother, Lakshman, had marked the boundary outside the house of Lord Rama’s wife, Sita, before going to the forest in search of Lord Rama. When Sita stepped out, crossing the boundary, to give alms to Ravana, Ravana captured her. In his second address to the nation, the Indian Prime Minister Narendra Modi highlighted the significance of Lakshman Rekha in fighting this battle against the virus, reiterating that ‘one step out of your door, beyond the Lakshman Rekha, can bring in this deadly disease to your home’ (Business Standard 2020). The underlying tones of this major lockdown advocating ‘social distancing’ also reflects the social context of setting up one’s moral, spiritual, and social boundaries to ward off afflictions.

This chapter will evaluate the unique encounters of Ayurveda with biomedicine and their mutual involvements through the lens of various social, cultural, religious and nationalist perspectives forging new identities and transformations. The first section will look at Ayurveda and its religious connections. The religious associations of medicine and the religious connections of medicine and medical practice, associations that can be found throughout Hindu history and are found already in the Vedas. In the second section, we will look at the encounter between the colonial government and Ayurveda. We will then explore this topic in relation to
rising nationalism, Partition, the Mahasammelan and various other political aspects. Then our attention will turn to conflicts between Hindu medical practice and the colonial government on healthcare, and the place of Homoeopathy in the religious and nationalist framework. The final two sections preceding our concluding remarks will explore renegotiating the relation between Hindu science and Ayurveda, and the influence of the print culture.

**Ayurveda and religious connections**

The links between medicine and religion are deeply embedded in almost all societies; in India, the origins of Indian medicine, Ayurveda, and its religious associations can be traced to the Vedic texts. The ancient repositories of Hindu culture contain reflections on aspects of divinity, science, medicine, and religion (Langford 2002: 93) as inseparable. These Vedic texts include the **Rgveda**, **Samveda Yajurveda**, and **Atharvaveda**. While all four Vedas contain religious hymns and incantations in praise of Hindu deities, they are also the ‘most iconic books of Hinduism’ (Sigerist 1961: 151). Initial traces of Ayurveda are found in the Atharvaveda, as is also reflected in the medical compilations written between the sixth century BCE and the first century CE (**Caraka Samhita**) and between the third century CE and seventh century CE (**Susruta Samhita**). Because of these traces in ancient religious texts, we can conclude that Ayurveda was initially closely associated with religion.

Nonetheless, it was only with reference to Indian medicine’s first codification in such compilations can we say that Ayurveda had a ‘systematised beginning’ (**Caraka Samhita** 1949). The main tenets of Ayurvedic knowledge are contained in three main texts or compilations (in Sanskrit, Samhita), often referred to as ‘the three elders’ or **Vrddhatrayi** (Chattopadhyaya 1977): the **Caraka Samhita** (a medical text explaining diseases and their nomenclature), **Susruta Samhita** (giving surgical details), and **Astanga Samgraha** (a medical manual that combines the former two compilations). The diagnosis of disease according to Ayurveda is based on the three humours (air, bile, and phlegm), while its therapy is based on ‘balancing’ these. The social environment was called **bhumi-pariksha** (**bhumi** means earth/place and **pariksha** means examination), an examination of the place, which was also important in Ayurvedic practices (Chattopadhyaya 1977: 92; Bala 1991: 26).

In addition to its religious associations, Ayurveda was also influenced by the rise of Indian philosophies, primarily Lokayata philosophy founded by Carvaka in the sixth century BCE. Its main tenet was a belief in direct observation and perception as the only means of acquiring knowledge, thereby rejecting Vedic scriptures and the medical knowledge reflected in the incantations and hymns. The unity of humankind and nature assumed prime importance—a feature that found a place in Ayurveda in later years. The rational processing of empirical data, which included a three-step procedure—observation of the patient, diagnosis of the disease, and prescription of drugs for a complete cure, as well as its application, called **yukti**—marked a major transition from earlier magico-religious practices prescribed in the Vedic texts to empirical methods of healing based on the empirical observation of facts.

Religious associations with medicine also become apparent as we look at the role played by Buddhist monastic communities in shaping Indian classical medicine, as evident from the various Buddhists texts (Zysk 2000: 22–23). Buddhist monks possessed adequate knowledge of medicinal drugs, which they used in their practice. Several physicians followed Buddhist texts in their healing practices. Various texts in **Vinaya Pitaka**, for instance, make appreciative mention of Jivaka, a personal physician to Buddha; apart from being a collection of rules for the Buddhist order (Bala 1991: 31), these texts emphasize various aspects of meditation and specifications regarding food and medicine for the Buddhist monks (Stuart 2014).
Colonial rule in India provided new spaces within which colonial imperatives were to be exercised in their interactions with indigenous healing practices already existent in India. The gradual emergence of the middle classes as a result of new educational policies and influential patrons of Indian traditions, science, and medicine were some of the most significant outcomes of these developments.

Let us now turn to the dynamics of colonial engagement with the socio-political changes taking place in India. This colonial engagement reinforced religious links as the movement to free India from colonial rule intensified. Under colonial rule, the middle classes represented a small section of the Indian population and were at the helm of ‘reorganizing science and medicine,’ dealing with the intimate relationship and complexities between Indian medicine and colonial dictates. This takes us beyond conflicts between science, medicine, and colonial rule to understand the significance of Indian engagements in renegotiating the authority of Ayurvedic learning as well as enabling the emergence of a ‘modern’ nation. These contradictions determined the fate of Indian medicine in its struggle under colonial authority and the unequal power relations of medical pluralism. Vulnerability, and hence some anxiety, was an important factor in colonial strategies, policies, and various representations.

**Medical encounters: background**

The end of the East India Company’s rule in 1857 and the consolidation of British rule began a new chapter in the history of India as well as in its medical profession. Manifested through colonial imaginings of encouraging an independent medical profession—a ‘profession of Indian doctors’ to be employed as hospital apprentices in the mofussil (rural) areas where European civil officers were stationed—there were also implicit colonial ideas to ensure ‘an efficient economic exploitation of the empire’s natural resources’ (Jones 2004: 5).

In a unique and long process of Indian–Western encounter, new visions of Ayurvedic learning were entertained, aided by the nationalist movement and popular consciousness of a ‘glorious’ heritage, with expressions of post-colonial integration into the modern healthcare system. In this dynamism, the significance of religious beliefs could not be discounted. Ayurveda itself was identified as a ‘nationalist’ symbol—a symbol that would pave the way for ideas of modernity in India.

Religious beliefs and values (re-)surfaced under British rule when Ayurveda became increasingly linked with the ancient Vedic ‘Hindu’ culture as part of nationalism and the anti-imperialist movement. Advocates of nationalism also advocated new understandings of Ayurveda through various reforms—social, religious, educational, and medical. In these encounters between medicine and colonial imperatives, Western-educated Indian intellectuals, Indian practitioners, and nationalists successfully laid claim to the professional authority of Ayurveda within a broader paradigm of a ‘Hindu’ cultural identity.

The British authorities were motivated by practical concerns with respect to the empire and in so doing ignored the practical realities of governing the vastly different cultures of India. The unique, often tumultuous, encounters between Indian medicine and biomedicine in colonial India have become increasingly significant, unravelling new definitions of medicine as a result. Changes in the Ayurvedic paradigm were accentuated and apparent with the introduction of biomedicine, and these changes were often intercepted by collisions, conflicts, contradictions, and the much-vaunted appropriation of medical knowledge. On a more positive note, expressions of popular resistance to ‘colonial apathy’ toward India’s existing traditions and culture included new understandings of the ecological surroundings, innovation, and increased
literary activities promoting new ideas, aided by the emerging print culture and the new, urban, Western-educated middle class— the purveyors of knowledge.

When one assesses the anxieties and fears that often resulted from the repeated occurrence of epidemics and global pandemics, one may see the impact of medical encounters. In colonial sites, fear, anxieties, and other negative emotions were often associated with pandemics; indigenous responses have, thus, contributed to and shaped the history of colonial empires (Fischer-Tiné 2016: 1). State policies and institutional strategies to deal with various epidemics were largely determined by a multitude of responses, causing a perception of instability. Exchanging new ideas and practices and discussions on how to deal with disease situations contributed to the ‘making of a new science.’ Plague, for instance, catalyzed the development of medical institutions for the infirm and sick (Benedict 2011).

Efforts to validate the colonial scientific and medical authority led to curiosity on the part of the colonizers to learn from India’s arts, sciences, language, and cultural representations. Colonial encounters also created various political, cultural, and socio-economic relations, and public spaces for critical interactions endorsing Indians as both empowered and disempowered (Rashkow et al. 2017). But how do we explain the impact of these encounters? The discussion here is premised on understanding the trajectory of medicine and its creation as a nationalist symbol within the ‘Hindu’ nationalistic paradigm, which served a dual purpose: first, it reified and enforced a ‘return’ to the Vedic and Hindu origins of Indian medicine and, second, it became a site for powerful expressions of Indian conceptions of the empire in the form of literary activities, and social and religious reforms, undertaken to (re-)define Indian medicine and at the same time free India from colonial interventions.

Ayurveda and emerging nationalism

In the wake of various colonial policies and the interplay between Indian medicine and biomedicine, expressions of power and authority and their contestation acquired prominence. What were the main policies governing these interactions? For purposes of our discussion here, I identify three major events that motivated the implementation of colonial policies or were a reaction to them. As we will see, these policies and their expressions influenced the nature of medicine and its practice in the early decades of the twentieth century within the nationalist framing of a political agenda, progressive science, and religious affiliation. The three events were, first, the Partition of Bengal in 1905, second, the foundation of the Ayurvedic Mahasammelan in 1907, and, third, the implementation of various legislative measures to regulate medical practice between 1912 and 1919. Nationalism was an outcome of these policies which posed a threat to the extant medical knowledge and, at the same time, its practitioners were a constant challenge to colonial power and authority. Amid these developments, Indian medicine provided a platform to create a shared national identity that echoed a unified vision of practitioners of plural healings—Ayurveda, Unani, and Homoeopathy.

Partition in 1905

By the late nineteenth century, the benefits of general and medical education seemed to have percolated, yet they were confined to the urban, rich elite of Indian society. By the turn of the twentieth century, however, new educational policies altered the social and political scene in India. Curzon’s educational policy of 1901, which not only brought education under state control, but also posed limitations on students of state-recognized English schools entering government service, met with vehement criticism and opposition from the elite and practitioners
Curzon’s new policy of 1905 was a turning point in the political history of India. The Partition of Bengal in 1905 was a divisive policy that created a communal schism in the country; it divided the intellectually and politically advanced population of Bengal into a predominantly Muslim East Bengal and a predominantly Hindu West Bengal. With ‘communal awareness,’ the Indian national movement was weakened to the extent that the Muslim community even viewed the Indian Congress—the political voice of the Indian population—with suspicion when it adopted religious ideals and support for ancient wisdom as a means to attain freedom from colonial rule. The formation of the All India Muslim League in 1906 by the Muslim elites was an expression of safeguarding their interests alongside its function as a political voice of the Muslim community.

The Ayurvedic Mahasammelan

The formation of the Ayurvedic Mahasammelan (hereafter, Mahasammelan) as the top organization of Ayurvedic practitioners in 1907 was ‘a new landmark in the history of medical engagements in colonial India’ (Bala 2014: 18). Its genesis as a reflection of indigenous reactions to threats of professional exclusion and marginalization by the colonial authorities cannot be discounted. As the first organized effort by the vaidas and nationalists, the Mahasammelan saw a new vision of India—cultural representations of a ‘new’ India were premised on local knowledge and the country’s medical past. It also provided new opportunities for Ayurvedic practitioners to position themselves within the nationalist framework of scientific authority and progress and became an indispensable part of the rising national consciousness. The national movement was a compelling force for change—a change that could covertly enable a (re-)surfacing of Hindu religious ideas reinforcing indigenous projections of Indian science and medicine as a powerful, and autonomous profession.

While the Mahasammelan existed as a forum for all activities related to Ayurveda and gave a national voice to public and indigenous practitioners, its influence decreased when the General Medical Council (GMC) framed new regulatory practices for medical education in India. Practical training in midwifery was considered a benchmark for gauging the quality of education in medical colleges and, in 1924, a ‘dissatisfactory’ report by R.A. Needham, the then Inspector-General of medical education, compelled the authorities to de-recognize medical degrees of the Calcutta Medical College and by 1930, the decision to de-recognize all medical degrees in India spurred national and public critique. It was not until 1933 that the formation of the All India Medical Council to regulate standards in medical practice led to a renewed recognition of all medical degrees in India in 1936.

Legislative measures and medical acts

The various legislative measures implemented between 1912 and 1919 altered the way in which issues of medical professionalism were ‘understood’ by colonial authorities. The Bombay Medical Act (1912) and the Madras Medical Act (1914) excluded the registration of practitioners of Ayurveda, Unani, as well as Homoeopathy. Western-trained medical personnel were discouraged from being associated with such practices and could lose standing as a ‘registered practitioner’ under the act. The denunciation of two eminent Indian doctors (trained in Western medicine)—Dr. Krishan Swami Iyer of Madras and Dr. P.P. Vaid of Bombay—their removal from the Register of Medical Practitioners, and threats of expulsion for their alliances with indigenous medicine fuelled antagonism against the authorities. The act was publicly condemned by the local newspapers Sanjivani, Hitavadi and Dainik Bharat Mitra. In a similar
vein, the Indian Medical Degrees Act of 1919 excluded Homoeopathy, Unani, and Ayurveda, aggravating nationalist sentiments and indigenous reactions.

What really changed the course of medicine and provided grace to indigenous practitioners, their practice, and professional negotiations, were the Montagu-Chelmsford Reforms of 1919 that transferred issues pertaining to public health, education, and local-self-government to Indian ministers, while it reserved issues of land revenues and irrigation, among other things, for the colonial authorities. The Reforms gave extended political power and autonomy essential for disbursing patronage to matters of health and medicine. Against this background, it is important to understand the processes that reinforced changes in the outlook of medicine and its practice in colonial India—changes that would make religious outpourings important in matters of public health.

As a corollary, the early 1920s witnessed a new movement that would establish close links between language and Hindu culture. The cow protection movement, the Hindi prachar that advocated using Hindi and Sanskrit in medical translations, started to be backed by Ayurvedic practitioners. Cow’s milk began to be incorporated into most Ayurvedic remedies. More significantly, Ayurvedic texts also advocated ‘healthy’ ideas of self-control, such as brahmacharya (celibacy) (Rai 2019: 421) for complete wellbeing and a healthy body.

Collision and resistance: Hindu beliefs and colonial public health issues

Colonial attempts at transferring ‘medical practices of an industrial society into a vastly different developing society’ (Bala 1991: 67) are best seen in the various public health measures implemented during the late nineteenth century. Epidemics in India shifted the initial and prime concern from delivering these health services to the army to serving the civilian population. The collisions of different worldviews on handling public health were also a collision of Indian and European cultures, as became apparent during the cholera epidemic. These collisions also resulted in new religious presentations of health issues by the Indian population.

For people in India, the cholera and smallpox epidemics illustrate a close relationship between disease and religious beliefs, which also dictated the adoption of new treatment methods. Both Hindus and Muslims made religious connections with the onset of the cholera epidemic, especially in the late nineteenth century; Hindus identified it with the goddess Mariyamma and Muslims with Olabibi (the lady of the flux; Bala 1991: 105). Popular beliefs in attributing cholera to the wrath of Hindu deities reigned supreme. Close-knit family connections and values, family participation, and religious ministrations were indigenous ways of dealing with epidemics. Making vaccination compulsory, as opposed to ordaining it as ‘preferential,’ for instance, made it unpopular and viewed with suspicion as interfering with ‘religious and social taboos’ (Arnold 1985: 179; Bala 1991: 104). Indigenous people frowned upon such colonial coercion and a lack of social and cultural sensitivity.

The occurrence of smallpox also revealed Indian ideas on a divine connection to the epidemic. They related it to goddess Sitala who was believed to reside in the inflicted person’s body. Accordingly, measures to alleviate its impact were followed ‘within a context of a religious ritual,’ as an invitation to ‘Sitala to take protective possession of the devotee’ (Greenough 1980: 345–347). Since family and social connections were considered important in mitigating the impact of smallpox, rituals to appease the irate deity were often carried out in elaborate gatherings. These practices, however, caused great concern for the colonial authorities and led to panic and anxiety because these ceremonies and large public gatherings reified the divergent medical practices adopted to control the epidemics. The only way the colonial authorities
could establish ‘truce’ was to accommodate indigenous practices in limiting the impact of the disease. Western physicians thus combined humoral treatment with the use of a mixture of black pepper, ginger, and calomel. In 1820, Dr. Jameson incorporated opium and calomel into his treatment regimen and, by 1850, colonial appropriation of indigenous drugs paved the way for ‘cholera pills’ (Arnold 1985; Bala 1991: 106). The therapeutic practices regarding cholera, however, were religious in nature. Similar activities were seen in other parts in India as in colonial Punjab, where the appropriation of Ayurvedic essentials proceeded alongside indigenous claims to ‘scientific’ medicine and political change (Sivaramakrishnan 2008). Between 1887 and 1898, indigenous practitioners—vaid̄s and hakeems—were deployed through various government employment schemes.

The enforced replacement of inoculation by locally trained tikadars with Western-trained vaccinators did not gain acceptance at the popular level either. Vaccinations carried out by Western physicians were seen as a ‘secular intervention that stripped the disease of its religious significance replacing [local, Indian] tikadars’ (Streefland 2001: 166; see also Khan 2006). The practice of variolation (a method of inoculating for smallpox) was believed to be associated with Lord Dhanvantari (the Indian god of medicine who, as a renowned physician, passed on medical knowledge to sages and later physicians). As a result, there was a strong preference for and belief in religious rituals above Western medical intervention for treating the afflicted people.

The Indian Contagious Diseases Act of 1868 with a mandate for registering prostitutes and their coerced examination and treatment of those afflicted, fuelled anti-colonial anxieties throughout India. Nationalist women saw this as an unwanted interference in women’s private space and, at the same time, dismissed the act as ‘inappropriate and interfering with women’s private lives’ (Brown 1887: 91–94). Similar voices found expression regarding colonial access to zenanas (women’s private quarters), which were a cultural representation of Indian womanhood: their ‘unknowability’ became a site of new knowledge, especially for English women travelling to India.

Other polices and health measures were greeted with public resentment. The outbreak of the Plague in India in 1896 was also a crucial marker of ‘divine invocations’ and indigenous responses to stringent colonial public health measures. The Epidemic Diseases Act of 1897 was one of the most extreme colonial public health policies for suppressing the plague outbreak. The mandatory destruction of all personal possessions and houses suspected to be infected with the disease met with vehement opposition from the public, as an intrusion into personal and private space. The Act also curbed all religious festivals that involved elaborate gatherings, which further intensified popular agitation and resistance against colonial health interventions. These stringent measures were applied to the whole of British India and in Bombay in particular, these activities were carried out in a ‘militarized’ manner under the strict orders of the army (Arnold 2015). With limited knowledge of the aetiology of Plague and the coercive anti-plague measures, Bombay and Calcutta became ‘troublesome sites of colonial control’ aggravated by poverty, a population increase, and unhealthy living conditions. The end of World War I was accompanied by yet another public health disaster when the Spanish influenza struck the world, claiming between 24.7 and 39.3 million lives (Patterson and Pyle 1991) with a staggering figure of nearly twenty-one million lives lost in India (Mills 1986). Colonial threats of instability and its international reputation loomed large as a result of the contagious spread of the pandemic. Any ideas of deploying practitioners of Indian Systems of Medicine were moot, but registered practitioners of both Ayurveda and Unani medicine were accepted and placed under the Indian Systems of Medicine and recognized as ‘legally qualified with certificates granted to them recognised by law’ (Bradfield 1938: 33).
Homoeopathy in the religious and nationalist framework

In understanding the impact of health policies and their reinforcement of a nationalist paradigm on medicine and religion, it is important to examine the trajectory of Homoeopathy, which, along with Ayurveda and Unani, played a crucial role in reinforcing Hindu religious beliefs and practices. Ayurveda and Unani had a long and documented history of amicable co-existence under royal, popular, elite, and medical patronage under Muslim rule. Both had built up large, willing customer groups who were not only consumers of indigenous medicine but also furthered their cause through financial and social patronage. Similar bases of diagnosis and therapeutics facilitated this, with no perceived threats from each other. The introduction of Homoeopathy in India marked a new ‘phase’ in the development of medical pluralism, institutions, and practices.

Homoeopathy was founded by the German physician Samuel Hahnemann and was brought to India by the French physician Martin Honigberger in the early nineteenth century. Although a Western medical project with European origins, it gained popular acceptance through several processes of Hindu indigenization. Within the nationalist sentiments and expressions, it acted as a handmaiden to Ayurveda and Unani, with indigenous efforts to domesticate and transform it within the Indian cultural paradigm. These efforts were seen largely through several Homoeopathic family firms and commercial enterprises and the participation of Indian practitioners of Western medicine. Some of the reputed family enterprises included, for instance, Berigny and Company headed by Rajendralal Datta and the Sircars owned by Mahendralal Sircar. By the turn of the twentieth century, there were about 200 family-owned firms in Calcutta that supplied Homoeopathic drugs (Das 2019: 46–47).

In Bengal, the indigenization and domestication of Homoeopathy through vernacular print especially was well received by the nationalists and the general public. Driven by the growing commercial market interests of biomedicine, the various biographies of eminent Homoeopaths in Bengal resonated with India’s spiritual character. Allusions to words with Hindu reverberations, such as bhakti (meaning faith) or sheeshya (meaning disciple), were central to biographies of Homoeopaths (Das 2019: 101). The German origins of Homoeopathy, its affordability, and its resonance with Hindu ideas all had a strong appeal for the middle classes as well as the wider public. For instance, the ‘law of similars’ (similia similibus curantur), which formed the basis of Hahnemann’s therapeutic regimen, was seen as resonating with the Sanksrit phrase, samah (equal) samang (homogenous) samayati (come together; Das 2019: 135). Similarly, the effect and strength or the potency of Homoeopathic medicine was related to a powerful expression of inner strength, called shakti, which is also the name of the mother goddess of the Hindus (Elshakry 2013: 297).

The indigenization of Homoeopathy as a result of its amalgamation with various religious traditions also contributed to its popularity with a large clientele-base. While in India, it became a versatile handmaiden for Ayurveda and its practising philosophies, in Brazil too, it merged with the local religious traditions. In both, contestation of metaphysical ideas with Western biomedicine was conspicuous (see Folk, this volume).

The principle of a life-giving force, the ‘vital force’ on which the Homoeopathic paradigm was based, occupied a central place in almost all scientific discussions of the eighteenth century. By the mid-nineteenth century, however, the professionalization of biomedicine through new developments in science, technology, and medical ideas along with the concomitant rise of the drug industry hampered the development of the Homoeopathic paradigm, which otherwise would have challenged the growing influence of biomedicine in the growing medical market. Homoeopathic practitioners deployed the doctrine of a ‘vital force’ in almost all
Ayurveda (re-)invented

their vernacular writings, often using it against the conclusive establishment of the ‘germ theory of disease’ in biomedicine, more so in the second half of the nineteenth century. Besides this, understanding constitutional types, or a person’s three innate gunas or qualities—sattva (pure/positive), rajas (controlling/selfish), and tamas (impure/negative)—dominated the Homoeopathic paradigm. The combination of the three gunas and their interaction produces three dosas—humours called kapha (phlegm), pitta (bile), and vata (blood)—which identify certain body types. These formed the basic principles of life energy in Ayurveda. The ‘vital force’ in Homoeopathy, likewise, dictated variations in the personality type. With a focus on mind, body, and spirit, an essential feature of Indian philosophical thought, both Ayurveda and Homoeopathy became compelling forces of a unified, ‘Hinduised’ medicine in India; both played a decisive role in the ‘emotional purification’ of the body and soul (Parker 2017: 385).

While Homoeopathic practitioners were defying colonial power and authority through vernacular literature, others with a strong passion for Homoeopathy promoted it, often at great cost to their medical careers. Mahendra Lal Sircar (1833–1904), a great visionary of science and an ardent advocate of Homoeopathy, deserves mention here. As a physician trained in biomedicine, his association with Homoeopathy was looked upon with disdain; nevertheless, his passion and support continued unabated. By the late nineteenth century, Sircar earned much praise for his pioneering efforts in science and its new foundations, establishing the successful Calcutta Journal of Medicine in 1868, and thus reinforcing an awareness of the need to bring scientific and medical education under native management and control (Sircar 1869). Sircar also initiated the ‘historic science movement’ in 1869 by holding science classes in his home (Pai-Dhungat 2019: 86). This historic movement led to the establishment of the nation-wide Indian Association for the Cultivation of Science (IACS) in 1876, due partly to calls from Indian nationalists and practitioners, urging nationalistic visions of Indian science and medicine. Local magnates joined in to provide support to scientific activities. The foundation of the Indian Institute of Science in 1897 under the patronage of Sir J.N. Tata was a crucial step in this direction.

(Re)negotiating ‘Hindu science’ and Ayurveda

The rise of the nationalist movement in colonial India, the ill effects of the various epidemic situations, and the engagements of Ayurveda reinforced new understandings of cultural and religious identities. Various discourses on Ayurvedic science highlighted the dynamics within what the advocates of Ayurveda and nationalists termed ‘Hindu science.’ The interactions between these two sciences, Ayurvedic and ‘Hindu,’ produced a powerful dynamic that enabled the (re-)construction of an indigenous tradition within a new paradigm of religion.

Nationalism also laid down opportunities for its proponents to rationalize their ideas and social actions within a medical and religious framework. It is accepted that nationalism and various socio-religious reform movements under colonial rule were compelling forces for new visions of Ayurveda, or its ‘re-invented’ form (Langford 2002). A new outlook on the authority of the Vedas, India’s oldest repositories of ancient Hindu culture, was in place when the educated, urban, middle class—the Bhadralok (literally, the gentlemen, the elites)—laid claim to the lost ‘glory’ of the pristine heritage of India. These claims found expression in the last decades of the nineteenth century when ‘the Hindu educated elite projected science as the true heritage of its religion and culture’ (Prakash 1997: 538). While some of these elites actively pursued Indian medicine as part of the religious reform ideas of the mid-nineteenth century, Swami Dayananda Saraswati’s (1824–1883) visions of ‘Hindu science’ as part of the Veda offers useful insights in this context. His vision of a science that was also spiritual and his
conviction that ‘the science of the West was but the realization of the scientific programme anticipated by the seers of the East thousands of years ago’ (Pandey 1969: 32) culminated in the 1875 formation of a powerful and influential Hindu reform organization, the Arya Samaj (Society of the Aryans). The society also reverberated his calls to go ‘back to the Vedas,’ which led to several social, cultural, and religious changes in later years. At the same time, Dayanand Saraswati’s non-acceptance of the ‘superiority’ of Western ideals drew support from some with similar ideas about the unity of Vedic science and religion and a recognition of Vedic science as the precursor of all Western scientific knowledge.

The emergence of the Bhadralok put in place new patronage systems for indigenous medicine. They engaged in medical and cultural deliberations under colonial rule and benefitted from English education, often aspiring to achieve what was denied to them by the economy (Chatterjee 1997: 11). Their successful alliances with the British, the rich, and the educated exalted the social status and prestige of the Bhadralok, which they continued by adopting Western style educational ideals and the ‘literate professions and office jobs’ as their main livelihood (Kopf 1976: 213).

Advocates of Ayurveda deployed various means to express their reverence for India’s cultural and medical past. At a time when nationalist politics and the popular awareness of resistance against colonial rule had reached their zenith, disseminating knowledge through public lectures seemed the most viable and convenient option. Kaviraj Mahamahopadhyaya Gananath Sen Saraswati, a reputed vaid, delivered lectures on Ayurveda, popularizing it as ‘Hindu medicine,’ while others (re-)defined its ‘pristine heritage’ and ‘glory’ (Jaiswal 2014).

While attempts were made to portray Ayurveda and Indian traditions as ‘scientific’ and rational-critical, their ‘revival’ gained further strength as new social and political agendas took precedence. In other parts of India, such as in Punjab, ideas of Hindu cultural and political mobilization were often intercepted by new social, cultural, and political alignments (Sivaraniakrishnan 2008). Medicine, then, became a powerful site of power and a medium for various expressions of encounters between plural healings and colonial imperatives. Medicine also enabled the colonizing process which

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As a site of contestation, intercepted by resistance and adaptation, medicine provided a ground for exploring the relationship with colonial power in the imperial project. Medicine also enabled the consolidation of the British Empire by prioritizing health provisions to the army, troops, and the civilian population. The onset of diseases and epidemics also attracted medical attention and necessitated the implementation of public health policies. Understanding disease aetiologies and their significance for public health also meant re-structuring medical practices to fit Indian culture; sensitivity to Indian customs, culture, and religion was the most obvious expectation. Our discussion on responses to smallpox and cholera epidemics prove this point. As a result, new public health measures marked new scientific thinking about the disease—science—medicine relationship, which influenced medical and cultural change in India. Thus, instead of being a ‘tool’ of the empire (Headrick 1981), medicine became a ‘trusted’ agent through which new ideas could be inculcated. From this perspective, understanding diseases within the rhetorical construction of health and healing in particular social situations cannot be
overlooked (Harley 1999: 432); this understanding also formed ‘the centre of medical history’ (Waddington 2011), locating disease in a social context.

While most of these negotiations were premised on ‘proven’ scientific authenticity as well as the authority of biomedicine, they were not fully accepted by practising vaidas and hakims who took no note of claims to a universalization of Western history, which goaded the ‘Hindu intelligentsia to negotiate the relationship of classical knowledge with Western science and to represent their traditions as scientific’ (Prakash 1999: 118). The intelligentsia firmly believed that ‘it was the Indian scientists’ breakthrough to the world of science that proved more powerful for the cause of science in India and its nationalist perspective than any colonial impediments or “troublesome political questions”’ (Gupta 2011: liii).

At about the same time, advocates of Unani medicine also became aware of a ‘decline’ of Muslim culture following colonial interventions. Both Hindu and Muslim nationalists deployed fresh interpretations of Indian society, culture, and traditions to oppose these interventions. In 1906, the Unani practitioner Hakim Abdul Majid (1883–1922) founded an Unani clinic and a pharmacy in the Hauz Khazi area of the walled city of Delhi. It was called Hamdard, which literally means ‘sharing the suffering of others.’ With such humble beginnings and a symbolic connection to the people’s health and wellbeing, the small pharmacy became one of the largest producers of indigenous drugs (Dharmananda 2003) and by late 1920s, it had built up a huge clientele and strong consumer support.

**The print culture and modernity: reaching the Indian public**

The rise of the print culture had a visible impact on India’s cultural modernity. This was the major force behind India’s ‘cultural efflorescence’ (Guha 2015: 18), especially among the middle classes in Bengal. Indigenous medical practitioners, the educated middle class, and nationalists remained active purveyors of useful medical knowledge through printed newspapers and periodicals. They could, thus, reach the Indian population in smaller towns and villages and build up their clientele. While English newspapers that were owned by the Indian middle classes—*Amrita Bazaar Patrika* and *The Hindu Patriot*—reached an urban clientele, publication of *panjikas* (almanacs) marked a rising Hindu consciousness in opposition to the cultural invasion of the British rulers. Besides listing important dates for various Hindu festivals, *panjikas* became the most popular vernacular and religious publication in India. Because of its popularity in several *mofussils* (smaller towns), especially in the late nineteenth century, *panjikas* acquired the dual role of disseminating a combined knowledge of Hindu religion and indigenous medicine. They opened up opportunities for indigenous practitioners to publish medical notices and to give information about indigenous drugs and details on Hindu rituals and their auspicious timings for celebrations. Medical practitioners, thus, used the cultural space afforded by the print culture to circulate disease-specific remedies with additional undertones of religious celebrations and Hindu astronomical dates.

The emergence of pharmacology and investigations into indigenous drugs contained in Indian medicine opened up a new chapter in therapeutic practices for various ailments. While they encouraged further research into the efficacy of indigenous drugs, they also marked a new phase of rapprochement between Indian medicine and biomedicine when indigenous drugs began to be studied in the light of Hindu religion. Indian nationalists and medical men communicated ideas about indigenous drugs that originated in social, cultural, and religious associations of Indian society. The publication of the first comprehensive list of indigenous medical plants, *The Indigenous Drugs of India*, by Kanny Lall Dey (Professor of Chemistry at Presidency College, Calcutta, later appointed Additional Chemical Examiner to the Government) in
1867, marked an increasing interest in accommodating Indian medicine. This was followed by the *Supplement to the Pharmacopoeia of India* by Moodeen Sheriff in 1869 and *The Materia Medica of the Hindus* by U.C. Dutt in 1877.

The new print culture also became indispensable for arguments supporting claims about the ‘scientificity’ of Unani medicine within a religious framework in the nineteenth century. ‘New’ ideas concerning Unani healing began to circulate in India, most of them with ‘claims’ to religious connections. For instance, the publication of *Maqaalat-i-Ihsan* (Compendium of Ihsan) in 1878 emphasized notions of healing and holiness, of medicine as ‘sacred’ (see Alavi, this volume).

**Concluding remarks**

Concern for the health of the people of India was both an object of colonial policy as well as a means to achieve a colonial objective. It also represented the means through which negotiations and structural and institutional transformations took place. Both medicine and health were crucial to the functioning of colonial stability; tensions, collisions, and conflicts in Indian-colonizer encounters erupted more severely with the colonial control of public spaces within the public health domain.

The strengthening of governance in the post-*Dyarchic* period in 1919 saw multiple voices engaged in the medico-cultural transformations within the political and nationalist paradigm. Embedded in this were claims of a ‘Hindu science,’ which also became a pervasive and enduring feature of nationalist imagination (Prakash 1997). The middle classes, influential patrons and social groups, the existence of plural healing systems—Ayurveda, Unani, and Homoeopathy—and a large indigenous clientele, made it well-nigh impossible for biomedicine to monopolize the medical paradigm of power and authority. Nor could biomedicine be translated into a form that could be imposed on the Indian population as a whole. Issues of health and disease reinforced religious beliefs, which found expression in colonial attempts to mitigate suffering caused during epidemics. Both medicine and religion evoked the (re-)invention of indigenous medicine and its complexities within the nationalist paradigm. Religious societies formed in the early nineteenth century acquired an institutionalized form as they managed medical institutions, modified medical science, and maintained profound connections with Indian culture and traditions. In this context, Ayurveda became a ‘medical catalyst’—an agent of medical and cultural change that was ordained a (re-)invented form that embodied new perceptions of the disease, body, and society constructed within new understandings.

The discourse of Ayurveda under colonial rule was more than that of the dynamics of medicine and colonial imperatives: it was the discourse of engaged dynamics between religion, politics, and medicine. In effect, what we see today in the modern world is not a ‘revived’ science and practice of Ayurveda but its (re-)invented form that portrays a long history of (re-)construction and (re-)formulation. Within the nationalist framework, religious deliberations and their connections with Ayurveda were established so that in the twentieth century Ayurveda became a *swadeshi* (one’s own country’s) science, which resonated through historical networks of self-rule. Nationalism in India presented Ayurveda as a complex and dynamic trope of a cultural movement, juxtaposing ‘spiritual science’ with biomedicine. Thus, within the nationalist framework, various levels of religious deliberations were positioned in defence of Ayurveda, which shaped and (re-)defined the scientific paradigm within which medicine functioned. Can the claims to (re-)invent Ayurveda be reinterpreted as claims of the modernity of a ‘Hindu nation in the making’?
Ayurveda (re-)invented

Dedication

I dedicate this chapter to my mother, Sharda Devi, whose unanticipated demise left a big void with memories of her enduring encouragement and love. I thank Prof. Dorothea Lüddeckens, one of the editors of this volume, for allowing me grace time for its completion.

Note

1 In Bengal, the worship of Basanta Rai (Chakraborti 2018: 64), also a local deity, alongside the goddess Sitala, became popular in both Hindu and Muslim communities.

Bibliography


