Pre-modern Ayurveda is a health tradition based on Hindu and Buddhist cosmologies. Its earliest texts, compiled in Sanskrit, are at least 2,000 years old. These texts are concerned not just with curing disease but also with promoting a happy and fulfilled life. Beyond remedial medicine, Ayurveda is also traditionally concerned with caring for the self, and optimising health and well-being understood in the widest sense (Alter 1999; Cerulli 2012). Philosophical, spiritual, ethical, moral, dietary and lifestyle precepts and guidelines are all an inherent part of the Ayurvedic body of knowledge.1

In the traditional Ayurvedic perspective, the human body relates to the cosmos as microcosm to macrocosm. The understanding of human bodily processes is based on a theory of three humours, those of wind (vata), bile (pitta) and phlegm (kapha). Understandings of the body in pre-modern Ayurveda are very different from what we associate with biomedical and anatomical understandings today. Health here is understood in terms of humoral balance and harmony between the human microcosm and the macrocosm (Zimmerman 1979, 1980). Classical Ayurvedic texts recommend a range of procedures for treating illness, including alterations in diet and lifestyle, the ingestion of (mainly herbal) medicines, and procedures of elimination using such methods as purgation, emesis, enema oleation and sudation.

Ayurvedic practitioners have been receptive to insights provided by other health systems such as Unani (Greco-Arabic medicine) first brought to India around the eleventh century. From the late nineteenth century onwards they increasingly encountered the paradigms and practices of Western biomedicine, introduced to India by the British. This engagement resulted in sweeping changes to Ayurveda’s representation, organisation and forms of practice in late colonial and post-colonial times. I use the terms ‘modern/modernised Ayurveda’ here to refer to the Ayurveda that developed as a result of this encounter. The history of modern Ayurveda can in fact be read as the history of this tradition’s gradual biomedicalisation. Critics argue that the scale of this transformation is such that modern Ayurveda has very nearly lost its identity as a distinct health tradition.2

Alongside science and biomedicine, conceptions of spirituality and religion, as well as ideas of Indian nationhood, have all played a significant role in shaping modern forms of Ayurveda’s self-representation and practice. The relative significance of the three strands
has differed in different contexts, as have some of the meanings associated with each one. Spirituality, in particular, has assumed different meanings over time, and become particularly important in the course of Ayurveda’s relatively recent popularisation within Western holistic health networks. In the following sections I will examine Ayurveda’s modernisation in colonial India, its career in independent India, and recent developments resulting from Ayurveda’s passage to the late-capitalist contexts of North America and Western Europe.

Perceptions of Ayurveda in colonial India

By the 1830s British colonisers in India had come to see science, technology and medicine as clear evidence of Britain’s superiority over India. India was seen increasingly as superstitious and backward, and the colonisers saw it as part of their ‘civilising mission’ to transform India. In 1835 they closed down the ‘Native Medical Institution’ in Calcutta (set up 11 years previously) that had provided Indians with biomedical education alongside training in indigenous traditions. In its place a new Medical College was set up, which was to teach Western medicine exclusively, using English as the sole medium of instruction (Arnold 2000: 61–65).

This move was charged with symbolic meaning: Western medicine was clearly now the hallmark of a superior civilisation with a progressive agenda while indigenous practice was seen to be backward and to have outlived its use. The decision to close the Native Medical Institution was taken in the same year as Macaulay’s Minute on Education, which was a decisive turning point in the history of the Raj. The Minute marked the victory of the Anglicists over the Orientalists in determining the pattern of higher education in India for the next hundred years (Arnold 2000: 61–65).

The setting up of the Medical College in 1835 ushered in a new era in Indian engagement with Western medicine. At first the Indian medical profession developed only gradually, partly because of the limited career prospects and financial rewards it offered. By the First World War, however, the number of Indian medical schools and colleges had grown, and enrolment in these was on the rise. A growing number of Indian men and women were now entering the profession in the cities, and finding employment with commercial and state enterprises as well as practising privately (Arnold 2000: 61–65).

Even as the biomedical institutional presence grew in the subcontinent, Ayurvedic practitioners began to feel increasingly marginalised – there was no state support for their tradition, and in comparison with biomedical practitioners, they commanded little authority in official circles and had access to few resources. In the 1890s, they came together to launch a move to revive Ayurveda – this initiative was closely aligned with the nationalist struggle against colonial rule that was now gaining increasing momentum (Leslie 1976). At the forefront of the Ayurvedic revivalist movement were Western educated elites who, on one hand, identified wholeheartedly with the project to modernise India, but who, on the other, sought to renegotiate the authority of science and translate it to fit the needs and idioms of Indian society, enabling India to forge a modernity appropriate to its own cultural legacies (Prakash 1999).

The revivallists emphasised the need to establish Ayurveda as India’s national medicine, arguing that it was uniquely appropriate to Indian bodies and Indian environments. The revivallist discourse was characterised by a number of crucial features (Arnold 2000; Ganesan 2010). First, it borrowed heavily from Orientalist perspectives, arguing that following a period of early achievement, Indian civilisation, and traditions like Ayurveda, had fallen into decline, and now needed revival. Second, the early period of achievement was described
in terms of a prevailing scientific spirit; thus if science was to serve as the yardstick for measuring medical knowledge and practice, then Ayurveda was the first and most ancient science. Third, this scientism of the early period was not seen as antithetical to the religious or spiritual realm. Instead, commentators on Ayurveda saw the early scientific and progressive spirit as supported by the divine insights and intuitions of spiritually enlightened sages who commanded extraordinary visionary powers of a kind as yet unknown to modern science. Ayurvedic knowledge was understood to be divinely revealed, scientific and true for all time.

The revivalist movement found institutional expression in the All India Ayurveda Mahasammelan or Ayurvedic Congress, established in 1907. This was the first professional interest group of indigenous practitioners to be set up in India. The Indian National Congress lent political support to the Ayurveda Mahasammelan and threw its weight behind the demand for government patronage for Ayurveda. In keeping with the Orientalist tradition, a number of intellectuals set out to document the scientific accomplishments of Ayurveda, and to re-establish its continuity with the modern world. They mined early Ayurvedic texts in order to try and showcase the scientific achievements of ancient India (Arnold 2000: 169–176).

The renowned Bengali Ayurvedic physician, M. M. Gananath Sen, for instance, argued in his Hindu Medicine (1916) that the spirit of Ayurveda was the spirit of progress. ‘[…] when the greater part of the world was submerged in the abyss of ignorance’, he wrote, ‘it is the Indian sages who first understood the necessity of dissection of the human body in the education of Physicians and Surgeons’ (Ganesan 2010: 115). Nagendra Nath Sen Gupta, also a physician from Bengal, wrote: ‘It would be no exaggeration to say that of all nations of the earth, the Hindus first turned their attention to the study of disease and the means of its alleviation’ (Ganesan 2010: 112). It was a short step from arguing that the ancient Indians got there first, to arguing that other medical traditions were derived from Ayurveda. Shiv Sharma, who served as president of the All Indian Ayurvedic Congress for successive terms, could thus argue that Ayurveda’s ‘glowing embers had lighted the torch of Arabian medicine, and through it the fire of European medicine’. Extolling the ‘high antiquity and originality’ of Hindu medicine, he asserted that in the domain of medicine, the Greeks and Arabs were forever indebted to Hindus (Ganesan 2010: 113). The revivalists sought to forge a distinctively Indian kind of modernity, and a distinctively Indian kind of science, which would be continuous with, and borrow deeply from, both Indian (Hindu) traditions and Western science. Ayurveda in this view was at once part of an ancient Indian heritage and a symbol of Indian modernity; as such, it was also a source of Indian, and particularly Hindu, nationalistic pride.

Cooperation between indigenous systems of medicine and Western biomedicine was advocated both for ideological and pragmatic reasons. Western biomedicine appealed to most of these Indian elites as a modern, rational, research-oriented system, which had already demonstrated its usefulness in multiple areas of health and disease. They also recognised that Western biomedicine was here to stay, given the extent to which it was patronised by the colonial government. Despite the often acrimonious exchanges between advocates of Ayurveda and practitioners of Western biomedicine, the former tended by and large to seek some form of integration with the latter, in the spirit of what Gananath Sen described as ‘open-hearted and liberal cooperation’, which, in Sen’s view, would serve well not just patients but also the larger medical profession in India as a whole (Ganesan 2010: 121).

Integration between Western biomedicine and Ayurveda was already being attempted in different Indian regional contexts. Dominik Wujastyk (2009: 211–217) has shown how from the late nineteenth century, illustrations of the Ayurvedic body were beginning to appear
Maya Warrier

in print in ways that borrowed from Western anatomical drawings. The royal physician at
the court of Farrukhabad, Muralidhar Sharma, produced in 1898 an edition of the ancient
Ayurvedic text, the *Sushruta Samhita*, carrying a number of innovative medical images
based on what Wujastyk (2009: 212) describes as a ‘syncretic view of the human anatomy’
combining Ayurvedic and Western elements. The Bengali physician Gananath Sen similarly
used Western anatomical illustrations in his published work, providing Sanskrit explanations
and terminology. P. S. Varier, a leading figure in the Ayurvedic movement in Kerala, authored
publications on Ayurveda in Sanskrit using illustrations and explanations of human anatomy
based on biomedical understandings. These authors seemed to make no real distinction
between the Ayurvedic understanding of the body’s constitution and the modern anatomical
one; in their view both were valid, and could unproblematically be synthesised (2009:
213). These were hybrid texts, and they showed some epistemological dissonance between
two completely different traditions. Wujastyk argues that perhaps precisely because of this
dissonance, they made great strides in the illustration of Indian medical texts. These works,
in Wujastyk’s words, were ‘earnest, ideologically informed, and the product of real learning’
both in Sanskrit Ayurveda and in anatomy (2009: 217).

Throughout this period Ayurvedic texts were translated into English and a range of Indian
languages, thus giving the revivalist movement the textual basis and authority it required,
and making classical Ayurveda accessible to a wider audience. The printing press played
a significant role in churning out articles, tracts, commentaries and medical journals on
Ayurveda and supplying the literate public with information about Ayurveda and Ayurvedic
remedies. Ayurvedic dispensaries came to be set up providing the public with treatments
packaged in new forms more akin to biomedical treatment.

The revivalist movement made some headway when, on the basis of the Montagu-
Chelmsford Report, the government in 1919 recommended reforms to increase Indian
participation in the provincial governments (Arnold 2000: 183). The Indian National
Congress passed resolutions asserting the usefulness of Ayurveda and Unani, and demanded
the setting up of schools, colleges and hospitals based on the indigenous systems (Arnold
2000: 183). Members of the legislatures took up the cause and in a conciliatory move,
the governments of Bengal and Madras set up committees of inquiry into the indigenous
medical systems.

In Madras, the Minister of Health appointed a committee with Sir Muhammad Usman
as chairman. The secretary and author of the committee report was Captain Srinivasa Murti.
He was a doctor trained in biomedicine who had been an officer in the Indian Medical
Service from 1917 to 1921. His report, the Usman Committee Report, published in 1923,
was the first major government-backed study of indigenous medicine. It recommended
that the state create bureaucratic structures for indigenous medicine parallel to those
of modern medicine. It proposed that a Department of Indian Medicine be set up in the
Ministry of Health. This would then be guided by a General Council of Indian Medicine
composed of physicians and doctors sympathetic to the indigenous systems. All practitioners
of indigenous medicine would be registered. After a period of time, once schools started
producing ‘qualified practitioners’, those lacking the approved institutional training would
no longer be admitted to the register. The report further proposed setting up a system of
state hospitals and dispensaries linked to the schools of indigenous medicine (Arnold 2000:

Srinivasa Murti was an integrationist par excellence. In his view, given that all systems
of medicine sought to preserve health and prevent or cure illness, there could in reality
only be one system of medicine. The many existing systems, in his view, were but parts of
this ‘one system’ – each a special ‘school’ rather than an independent system of medicine (Ganesan 2010: 119). He proposed setting up schools providing students with training in Indian systems of medicine while also inculcating a working knowledge of the Western system. Members of the Indian Medical Service expressed anger and dismay at the proposals of Murti’s report; both professionally and politically, they found the syncretism it advocated unacceptable. However, ‘for political reasons of its own’ (Arnold 2000: 185), the Madras government chose not to heed the outcry and instead accepted the proposals. It sanctioned the setting up of a School of Indian Medicine in Madras along the lines recommended by Murti.

The School was opened in November 1924 by the Governor of Madras. Srinivasa Murti was appointed its Director. In a manner reminiscent of the Native Medical Institution of Calcutta in the 1820s, but with a different emphasis, once again indigenous medical knowledge was imparted alongside modern anatomy, physiology and surgery. Staff compiled textbooks and papers identifying ‘correspondences’ between the indigenous and Western systems. In 1932 the School was also entrusted with maintaining a register of all indigenous practitioners in the province (Arnold 2000: 185).

Over time, provincial governments began to grant assistance to institutions imparting instruction in Ayurveda. A few state governments set up boards to regulate indigenous practitioners. Most provinces had branches of the Ayurvedic Congress or independent professional organisations representing the interests of indigenous practitioners at regional level. On the eve of India’s independence, there were more than sixty Ayurvedic colleges in the country. The Ayurvedic movement was on a fairly strong footing both at regional and national level.

**Ayurveda in independent India**

Most revivalists believed that Ayurveda would come into its own once India gained independence and Indians took over the governance of the country. Their expectations were belied however. The Indian government, sharing in the Nehruvian vision of the developmental state, sought to cast India in the mould of Western modernity. In the first two decades after independence, though central and state governments were sympathetic to the cause of Ayurveda, they supported modern biomedicine as the basis for the development of national health services, supporting training and research in Ayurveda only because they hoped that Ayurveda graduates would extend some form of medical relief to the countryside where biomedicine had not sufficiently made inroads (Leslie 1973; Brass 1972).

Spokespersons for Ayurveda who continued to lobby the Indian government for recognition and professionalisation of this tradition, did so on the strength of its Indianness. These interest groups argued that foreign rule (first Muslim, then British) had led to the suppression of indigenous medical knowledge and practice, and that the patronage and support of the newly formed government of independent India was indispensable for Ayurveda’s revival. They argued that the political emancipation of the country was not enough – this needed to be backed by the emancipation of Ayurveda (Brass 1972: 350). They demanded that the government should declare Ayurveda as the national system of health care. Supporters of biomedicine who opposed this demand, they argued, should ‘quit India’ following the British example. Opposition to Ayurveda was seen as an insult to India’s traditions, culture and people (Brass 1972: 350). Lobbyists couched their demands not on the strength of Ayurveda’s intrinsic value as a health system, nor on the basis of a realistic assessment of its prospects and potential contribution to public health, but mainly on the
basis of Ayurveda’s value as an indigenous tradition, and therefore a symbol of nationalist aspirations.

The idea of Ayurveda’s Indian provenance tapped into the idea, in circulation since the closing decades of the nineteenth century, of India as a land of spirituality. These ideas have retained their grip on the Indian imagination right up to the present. As Langford (2002: 17) notes, promoters and practitioners in late twentieth-century India have continued to ‘employ potent neo-orientalisms, promoting Ayurveda as spiritually attuned, anti-materialist, and non-violent, in contrast to biomedicine’. These popular accounts of Ayurveda are in essence accounts of ‘Indianness’; they are trenchantly nationalistic and often anti-Western in tone. They depict India as a land of ‘traditional’ wisdom, mystical and esoteric insight, and ‘spiritual’ prowess. India’s so-called ‘spirituality’ in these popular discourses is contrasted with what is stereotypically portrayed as the ‘shallowness’ and ‘fragility’ of the ‘materialistic’ West (Langford 2002: 17).

In the face of the demands of the revivalists, the government’s strategy over the years was to set up committee after committee to examine the key issues, sometimes making small concessions to the revivalists (Brass 1972; Langford 2002; Wujastyk 2008). Compared to biomedicine, Ayurveda remained drastically under-funded. In the states, the progress of Ayurveda varied considerably, with some states devoting significant proportions of the medical budget to Ayurveda, and others choosing to withhold financial support. Ayurveda students and graduates felt undervalued, since they could secure employment only in inferior positions in the health services earning salaries far below those granted to graduates of modern medical colleges. Throughout India, there were multiple strikes, demonstrations and agitations launched by students in Ayurvedic colleges demanding equality in status and pay with modern medical graduates (Brass 1972).

Even as late as the 1970s, there were no uniform educational standards binding on all Ayurvedic training institutions and no agreed professional standards for practitioners. Though all Ayurveda proponents agreed that national educational and professional standards would be desirable, they could not agree on the content of the curriculum and the qualifications necessary for professional status. Ayurveda interest groups seemed divided into two camps, that of the integrationists and that of the purists, but in fact the ideological differences between the two groups are far from clear (Brass 1972; Langford 2002: 108–116). Superficially, the integrationists favoured a modern curriculum that would incorporate both Western biomedical and Ayurvedic theory and practice. There were significant differences between these individuals, however, on the question of how much Ayurveda and how much biomedicine the curriculum should ideally incorporate. The dominant form of Ayurvedic education right up to the early 1970s was the integrated or concurrent version and most individuals recognised that this system was not working; it was producing practitioners qualified in neither system of medicine. The purists sought a return to the ancient Ayurvedic texts, and demanded that pure Ayurvedic theory should constitute the core of the curriculum. They too, however, were not averse to introducing aspects of Western anatomy and surgery into the curriculum – all such elements, however, were to be assimilated within an Ayurvedic framework.

The political antagonism between the two camps marked the history of Ayurveda throughout the 1950s and 1960s. Each group sought and secured the backing of powerful sections of the political system at central and state levels. The different government-appointed committees looking into the matter of standardisation and professionalisation took sides with one or the other camp, with the result that the issue remained unresolved for nearly three decades.
Finally, in 1970, the Ministry of Health established the Central Council for Indian Medicine (CCIM) and tasked it with drafting a standard Ayurveda curriculum, regulating practice, and designing research programmes for indigenous traditions.

In 1977, the curriculum prepared by the CCIM was finally adopted by Ayurvedic educational institutions (Langford 2002: 115–116). Following this curriculum meant that students would complete five years of study, divided into three parts of approximately a year and a half each. Successful candidates would be awarded the degree of ‘Bachelor of Ayurvedic Medical Science’ (BAMS). Whereas the new curriculum was seen as something of a victory for the purists, in fact it remained eclectic in its borrowing of both Ayurvedic and biomedical elements. Anatomy, for instance, was (and is currently) taught along biomedical lines while physiology followed (follows) Ayurvedic principles (Langford 2002: 115–116). The incompatibility between the two frameworks is seldom questioned or addressed, and students in effect get partial inputs from both, and a comprehensive understanding of neither. Most graduates go on to run private clinics or work for privately owned treatment centres. Some serve in less lucrative posts at government-run Ayurvedic colleges and hospitals.

In the 1990s there was a further crucial development in Ayurveda’s post-colonial career in India. The central government instituted a new Department of Indian Systems of Medicine under its Ministry of Health in 1995. This has since been renamed the Department of AYUSH – Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy. This development coincided with the sharp rise in international interest in indigenous systems of medicine across different cultural and regional contexts. Among the Indian government’s stated aims were to improve primary, secondary and tertiary care utilising indigenous systems of medicine; invest in human resource development in this sector; preserve and promote cultivation of medicinal herbs and plants; encourage good manufacturing practices; and promote research and development.

The creation of the new Department has meant higher allocation of funds, better utilisation of resources and therefore more activity and higher visibility, as well as more autonomy to this sector. Part of the agenda behind this initiative was to tap into the emerging international market in indigenous medicinal plants and products. As Banerjee (2009) argues, these policy changes to a large extent reflect shifting patterns in global trade, and are prompted by the Indian government’s desire to control the fast growing international market in herbs and herbal products since this market holds out the promise of significant commercial gain for the Indian economy.

Ayurveda retains a significant presence in the system of health provision in India today. Statistics compiled by AYUSH indicate that the total number of Ayurvedic hospitals in India in 2008 was just over 2,400, providing over 43,700 hospital beds for inpatients. The number of Ayurvedic dispensaries in the country that year was nearly 14,000, and there were roughly 8,000 manufacturing units producing Ayurvedic preparations. About 460,000 individuals were registered as Ayurveda practitioners in 2008 and there were 241 such Ayurveda training colleges in India jointly admitting over 10,000 students each year. There is considerable variation between different Indian states in terms of the scale of the Ayurvedic services provided in each. There is also considerable variation between urban and rural areas, and more generally between the rich and the poor.

As noted earlier, in the immediate aftermath of Indian independence, Ayurveda was promoted as a resource which could serve India’s poor and rural populations who had no access to, or could not afford, biomedical facilities. Paradoxically, Ayurvedic branded products and services are now consumed mainly by urban middle-class Indians. At the same
time, biomedical products now reach every corner of the Indian subcontinent and are readily available in rural areas. Bode (2008) argues that something of a market inversion has taken place, with poorer sections turning increasingly to biomedical drugs, and the middle classes becoming the main consumers of upmarket Ayurvedic products.

As far as qualified biomedical doctors and qualified Ayurvedic physicians are concerned, Prasad (2007) notes that many of these individuals, themselves from high-caste and upper-class backgrounds, prefer to serve the relatively affluent sections of the Indian population. The medical needs of villagers and the poorest sections of society are largely met by those with no recognised qualifications in any system, who practise different forms of medicine and therapy. Despite the government’s rhetoric about providing primary health-care facilities in India’s villages, in fact, Prasad argues, medical institutions, most of which tend to perpetuate an upper-class or elite culture, have been framed to suit the needs of the health-care personnel, and not the needs of the masses. The result is a binary medical model with institutionalised forms of medicine (biomedicine as well as indigenous systems) catering to the needs of those who can afford them, and non-institutionalised forms serving the needs of those at the margins of society.

Evaluating modernised Ayurveda in contemporary India

On the face of it, it might appear that modern Ayurveda is thriving in the present Indian context. The reality, however, is more complex. For one thing, Ayurveda continues to occupy a status of inferiority in relation to biomedicine. This is reflected in the significantly lower allocation of government money to Ayurvedic projects and institutions relative to biomedicine. It is reflected also in the attitudes of students, most of whom aspire to a career in biomedicine, and end up studying Ayurveda only because they fail to make the necessary grades in the common entrance exam. Whereas the top scorers secure entry into biomedical colleges, others get relegated to one of the ‘lesser’ programmes including Ayurveda.

The students admitted to Ayurveda colleges are products of a Western system of schooling, which provides little background in critical aspects of Indian classical philosophy that underpin classical Ayurveda. Students also lack the necessary grounding in Sanskrit, the language in which the classical Ayurvedic texts were composed. In the few years of their training, they are unable to acquire enough knowledge of the classical modes of thought and of Sanskrit for them to engage with the full context and depth of the principles and methods undergirding Ayurveda. Their understanding of Ayurveda tends to remain relatively superficial. Additionally, barring significant exceptions, Ayurveda colleges tend to focus on Ayurvedic theory, providing little by way of expertise in practical application. Often clinical training is obtained not at Ayurveda hospitals but at biomedical ones – thus theoretical and practical knowledge are sourced from completely different systems, and there is little attempt to provide a coherent account of the extent to which the two may be compatible.

In the move to systematise, modernise and standardise Ayurveda in independent India, this tradition has been depleted in more ways than one. Consultations at Ayurveda clinics are akin to those at biomedical ones – the physician examines the patient, studies any biomedical reports or test results that the patient may have obtained, writes prescriptions, and in some cases also dispenses medicines. Whereas traditionally the physician would prepare remedies according to the particular requirements of each patient, taking into account his/her constitution, manifestation of symptoms, habits, dispositions, and relationship with the environment, now there is a reliance on standardised therapeutic remedies. Generalised medicines are targeted at diseases with little consideration of the particulars of individual
contexts. The medicines, unlike the traditional concoctions made at home from fresh herbs, are mass-produced by pharmaceutical companies and have longer shelf-lives.

The flourishing Ayurvedic pharmaceutical industry in India has taken the preparation of Ayurvedic medicines out of the kitchens and workshops of local physicians, and has professionalised their manufacture, marketing and sales (Bode 2008). Some of the more capital-intensive manufacturing units are fully automated. Ayurvedic products are now presented in new forms such as sugar-coated pills and blister-packed capsules and tablets, and appear in well-designed glossy packages with catchy names. They are promoted by means of expensive advertising campaigns via modern mass media. Many are new products that do not follow classical formulae in terms of composition and methods of preparation; new branded products, including such things as Ayurvedic cosmetics, digestives and tonics, and shampoos and soaps, sell better, and at a higher price. They are therefore more profitable (Bode 2008).

This commoditisation of Ayurvedic medicine has been accompanied by efforts on the part of the industry to demonstrate the scientific basis of the formulations. Pharmaceutical companies claim that their research wings use tissue cultures, experimental animal studies and clinical trials to assess the toxicity and efficacy of products. Commercial interest drives much of this research, particularly given that Indian consumers lay considerable store by claims of scientific testing in product manufacture (Bode 2008). Critics argue that classical Ayurveda gets distorted when modern medical and scientific ideas and conceptions are read into them, and classical concepts are reinterpreted in terms of the principles of biochemistry and modern pharmacology. Yet, these problems are largely overlooked or denied.

In fact, according to Bode (2008) this kind of testing often lacks the rigour that is claimed. The research and review policies lack transparency, clinical trials are often inappropriate, uncontrolled and badly designed, and therefore their reliability is in doubt. Moreover, these processes are not standardised. Though the Indian government has taken steps to regulate the production and sale of Ayurvedic remedies, these measures have been half-hearted and somewhat ineffective (Bode 2008: 48–56). These inadequate levels of standardisation and quality control present particular problems for the export of Ayurvedic preparations, especially to Western countries where the food and drug authorities impose much tighter controls on the identity and quality of herbal preparations.

Ayurvedic products in India are sold increasingly as ‘authentic’ indigenous commodities, and their wholesomeness and trustworthiness are emphasised (Bode 2008). They are contrasted with ‘synthetic’ biomedical products, and ‘unnatural’ modern cosmetics and toiletries. Manufacturers use religious symbols and myths to anchor their products in a Hindu and Indian cultural context. These products appear alongside other Hindu ‘health’ products such as yoga and meditation classes as fashionable, Indian, green, natural and safe alternatives to biomedical products and treatments.

Scholars like Leslie (1976), Brass (1972) and Bode (2008) have noted how the attitude of Ayurvedic revivalists and promoters is riddled with ambiguity and paradox. At the level of discourse they claim uniqueness and distinctiveness for Ayurveda, while in practice they borrow unquestioningly from the paradigms and methods of biomedicine. Others like Langford (2002) and Banerjee (2009) argue that the modernisation of Ayurveda is based on Indian mimicry of modern Western (particularly scientific and biomedical) institutions and practices. This mimicry, Langford argues, is only partial – it only partly reproduces the original, thereby making a mockery of it. The value of this hybrid tradition, Langford (2002) argues, lies not so much in its medical efficacy but in its symbolic cultural meaning and power for Indians.
It is important to note that in addition to the institutions funded by government bodies and private industry, there also exists a small and declining number of traditional practitioners who still practise Ayurveda in a recognisably pre-modern form. Most scholars see these forms of practice as representing ‘true’ or ‘authentic’ Ayurveda as compared to the modernised variants. These traditional practitioners are mostly individuals who have learned Sanskrit and Ayurveda from an early age, usually as members of a family of traditional physicians, and who are apprenticed with experienced physicians in the family. Biomedicine and its paradigms and practices tend to be largely irrelevant to their practice. Anthropologists examining these traditional forms in India and Sri Lanka demonstrate that conceptions of person and illness here are very different from those in biomedicine. The body and the person are conceptualised as fluid and permeable, and as engaged in continuous interchange with society and the environment, in contrast with the biomedical model that understands body and person as discrete and bounded. Illness is understood as a disruption in processes and patterns of relationships such that body and mind, notions of selfhood, and relationships with others, are all affected to varying degrees; in attempting to effect a cure, the physician seeks to address these multiple issues. These forms of Ayurveda are fast disappearing; the traditional physicians have by and large given way to graduates from modern Ayurveda colleges, and their traditional ways of preparing remedies have been overtaken by the large-scale production units run by the thriving pharmaceutical industry.

Ayurveda as a ‘global’ health tradition

Western audiences became increasingly aware of Ayurveda since the closing decades of the twentieth century. There have been a number of reasons for this. First, sections of the North American and West European public, growing increasingly disenchanted with various aspects of biomedicine, began to actively seek out alternative forms of treatment and therapy. Ayurveda held out the hope of ‘natural’ and ‘safe’ remedies, particularly for a number of chronic ailments. Second, Ayurvedic treatments and massages came to be included in holiday packages for tourists in parts of India (and Sri Lanka), and soon there was a mushrooming of Ayurvedic spas and retreats targeting well-heeled clients from India and abroad. The tourism ministries of some states have actively encouraged this; in Kerala in southern India, for instance, ‘Kerala Ayurveda’ is now promoted as a distinctive Ayurvedic tradition superior to other forms of Ayurveda. Third, Maharishi Mahesh Yogi’s launching of his Maharishi Ayurveda in the 1980s, on the back of his popular Transcendental Meditation techniques, garnered considerable publicity for Ayurveda in the West (Humes 2008; Jeannotat 2008).

In the decades that followed, the number of promoters and practitioners of Ayurveda in Western Europe and North America grew; they included professionals trained in South Asia who migrated to the West to practise there, Europeans and Americans who trained at South Asian institutions and returned home to set up practice, as well as individuals trained at Ayurvedic training institutions in North America and Western Europe. Unlike the situation in contemporary India where students enter into Ayurvedic training programmes only when they fail to make the grades for entry into biomedical training courses, in North America and Western Europe individuals study Ayurveda mainly out of personal interest in alternative health systems. Many of these students describe themselves as spiritual seekers and their exploration of Ayurveda is often part of their spiritual questing (Welch 2008; Warrier 2009). There is the expectation that Ayurveda will provide them with spiritual insights which will enhance their self-knowledge and lead to self-empowerment.
Among the more visible forms of Ayurveda in the West are clinics, retreats and spas offering a range of health and beauty treatments; popular literature on Ayurveda including, very significantly, self-help books; talks, seminars and workshops; Ayurvedic cosmetics, oils and health foods, and of course the ubiquitous Ayurvedic tea. Clinics and retreats are often located in secluded places of scenic beauty, where clients can get away, both physically and emotionally, from the stress of their everyday lives. There is a very vast body of popular literature on Ayurveda in circulation in the Western holistic health sector. Prominent authors include figures like Vasant Lad, David Frawley, Robert Svoboda, Deepak Chopra, Maya Tiwari (now Swamini Mayatitananda). These individuals emphasise the spiritual aspects of Ayurveda and many of them try and establish connections and correspondences between Ayurveda and other Indic traditions like jyotish (Indian astrology), gemology, postural and meditational yoga, vastu shastra (architecture based on ancient Sanskrit texts), and tantra. In some respects Maharishi Mahesh Yogi paved the way for this kind of interlinking. His Maharishi Ayurveda was a grand synthesising project in which he brought together a whole range of practices, each of which, he claimed, had ‘Vedic’ origins – they included such things as ‘Gandharva Veda’ or music therapy, ‘Vedic Yagya’ or sacrificial ritual, mantra chanting and meditation. The Maharishi also attempted a grand synthesis between Ayurveda and science and biomedicine; he presented his Maharishi Ayurveda as a part of ‘Vedic science’, the ‘integral science of life’ bringing together the ‘latest discoveries of modern physics with the timeless wisdom of the Veda’ (Jeannotat 2008: 290).

In keeping with the trend already established in India, most popular writers on Ayurveda in the West too follow an inclusive approach – combining biomedical and humoral frameworks in innovative ways. One of the most interesting figures in this regard is the vastly popular health guru Deepak Chopra, who started out as the Maharishi’s protégé but then split away from the TM movement to set up his own health practice in the US. Chopra, a trained biomedic, brings his knowledge of biomedicine to bear on his discussion of Ayurveda. His Ayurveda is based on a radical mind-body paradigm of health and disease where disease is attributed to blockages in one’s mental and emotional states. His psychologised version of Ayurveda thus treats all disease as the outward manifestation of deeper emotional and spiritual problems (Baer 2003; Aravamudan 2006: 257–261).

To set Anglophone Ayurveda in the West in context, we need to consider briefly the holistic health sector in Europe and America, which provides a home to this and other so-called ‘complementary and alternative’ health traditions. Scholars have noted important interconnections and overlaps between the holistic health network and networks of unchurched spirituality in Western contexts. Participants in these networks comprise in the main people who describe themselves as spiritual seekers, who reject organised religion, dogmatism and the authority of religious intermediaries, and who valorise, above all else, personal experience and personal authority in crafting meaningful spiritual lives for themselves. Shared meanings of health in this milieu carry references to optimising human potential (rather than simply curing disease), empowering the self through enhanced self-knowledge, and positive thinking. Health is understood here not just in somatic terms, but in terms of inter-linkages between mind, body and spirit. A very high value is placed on individual responsibility for health; health practitioners work with their clients more as counsellors and friends than as authority figures assuming responsibility for the client’s health on the basis of their expert knowledge.

Ayurveda in this context becomes a means not merely to cure disease but to heal the self in its entirety through enhanced self-understanding and self-nurture. This is the most significant reinterpretation that Ayurveda has undergone in its modern transnational form.
Whereas Ayurveda has developed into a medical system cum heritage product in mainstream post-colonial Indian contexts, in Western networks of health and spirituality, Ayurveda appears as, among other things, a crucial source of selfhood, and a means for enhancing health and well-being through self-knowledge. And this reinterpretation rests, crucially, on a new understanding of the doctrine of the three dosas or humours. Whereas traditionally the humours are understood as indices of states of health or disease, in the new understanding they become part of a typological system for classifying all persons into one of seven types; one may for instance be a pure kapha (phlegm), pitta (bile) or vata (wind) type, or a combination of two dosas, or a type where the three dosas are relatively balanced.

One’s humoral constitution is understood to determine everything from one’s personality, one’s moods, likes and dislikes, to one’s looks, and one’s states of health or disease. Though this kind of categorisation and classification would seem oddly reductionistic in traditional Ayurvedic terms, it does enable adherence to a systematic programme of self-understanding and self-nurture. A number of self-help publications now available in print and online explain the different humoral types, inviting the reader to identify his/her constitution by means of a questionnaire, and offering dietary and lifestyle advice for each category. Ayurvedic food supplements, teas, oils and cosmetics are all often classified in dosa terms – so that there are pitta oils meant for ‘pitta types’ and vata teas intended for persons diagnosed with a vata-predominant constitution.

As Langford (2002: 248) perceptively points out for North American consumers of Ayurveda, prakrti or humoral constitution in these instances takes on connotations of a ‘true inner self’ seeking authentic forms of nurture and expression (see also Warrier 2009, 2011). Moreover as Zimmerman (1992) and others have noted, in its transnational Anglophone manifestation, Ayurveda’s modalities are considerably toned down and softened to suit modern sensibilities. Some of the more violent and invasive practices involved in purgation, emesis and other forms of induced catharsis, still common in the Indian subcontinent, are rejected in favour of soothing, gentle treatments. Treatments cover a wide spectrum, ranging from those couchèd in the language of pampering and self-indulgence at one extreme to those focused on curing specific medical conditions at the other.

Ayurveda in Western contexts too is inevitably shaped and constrained by the institutions and frameworks of biomedicine. Ayurveda’s description as a system of ‘complementary’ and/or ‘alternative’ medicine itself indicates how biomedicine sets the terms for its enframing and how it operates at the fringes of the scientific and biomedical establishment (see Newcombe 2008). In most Western contexts too, practitioners are faced with professionalising dilemmas very similar to the ones faced by their counterparts in India (Reddy 2000, 2002; Warrier 2014). Regulation and standardisation are often deemed necessary by Western governments for domesticating traditions like Ayurveda and making them safe for clients. Ayurvedic medicines are required to meet the quality and safety standards imposed by government bodies. Most practitioners tend to welcome these measures since it gives their practice legitimacy and respectability, as well as greater visibility.

Conclusion

Ayurveda has inevitably undergone unprecedented transformation in the last two centuries. It has been reinterpreted to suit modern contexts; elements deemed least relevant have been discarded, and modern scientific paradigms have been adopted. This transformation has entangled it in larger debates about its place in the modern world. While transformation per se is inevitable, critics question the nature of this transformation – how far, they ask,
can Ayurveda in post-colonial India claim identity as a distinct tradition if it borrows indiscriminately from biomedicine? How far are the different elements that make up this hybrid even compatible with each other?

The increasing interest in Ayurveda in the West, and the new emphasis on spirituality, has led to further changes in this tradition. Ayurveda’s assimilation within a framework of Western spiritual seeking distances it somewhat from its biomedicalised and nationalistic manifestation in India. There are continuities between the two, yet new layers of meaning have been added as a result of Ayurveda’s reframing as a tradition that enables the understanding, expression and nurture of one’s true self. Could this new emphasis on a cosmopolitan and individualistic form of ‘spirituality’ serve as a corrective to Ayurveda’s excessive preoccupation both with nationalistic chauvinism and with science and biomedicine in post-colonial India? The answer to this question is not yet clear; what is clear, however, is that promoters and practitioners in India, the Ayurvedic pharmaceutical industry, as well as the Indian government, are already responding enthusiastically to the new opportunities opening up as a result of Ayurveda’s growing presence in the international market of herbs and holistic health.

Notes
1 For an overview of traditional Ayurveda as a health system, see Wujastyk (1993, 2003).
2 See, for instance, Leslie (1976); Shankar and Manohar (1995); Langford (2002); Bode (2008); Banerjee (2009).
3 It is noteworthy that indigenous folk traditions of healing, some of them highly efficacious for particular kinds of ailments, were largely excluded from this discourse because they were seen as ‘primitive’ and based on superstition; see Shankar and Unnikrishnan (2004).

References
Maya Warrior


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