

Medicine as Culture: Indigenous Medicine in Cosmopolitan Mumbai

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Using the framework of medicine as culture and focusing on the indigenous medicine of ayurveda, this paper examines the relationship between health, culture and medicine, and its social reproduction in contemporary India. Specifically it deals with the cultural construct of “Kerala ayurveda”, and the modes of its societal reproduction and recreation simultaneously as culture and as medicine in cosmopolitan Mumbai. Through an analysis of the historical and cultural roots of Kerala ayurveda and the role of community organisations in its translocation into a city, the paper shows the analytical fragility of the tradition/modern binary in the understanding of contemporary indigenous systems and questions the belief that state and market provide the foremost sites for institutional and secular practice of indigenous medicines.

While examining the relationship between health, culture and medicine in post-colonial India, the dominant perspective in sociological and anthropological literature conceptualises medicine and culture as autonomous domains and views the relationship between the two in oppositional terms where culture (lay persons’ beliefs and practices) is seen largely as impeding the progress of biomedicine (allopathy, modern medicine). In this conceptual schema, all medical knowledge other than biomedicine is denied any valid medical status, clubbed as culture devoid of any cognitive content, and is seen coterminous with religion and superstition. Other related assumptions are that cultural influences on healthcare are prominent in rural settings and less so among the educated in modernising societies. This perspective largely ignores the ground reality of the spread of indigenous medical systems and practices, their cognitive relevance, the complex reasons for people’s healthcare choices and the contribution of indigenous medicine to people’s health.

However, there are a few studies that show the cultural influence of indigenous systems such as ayurveda in terms of providing people with a broad conceptual framework to not only understand health and illness, but also address epistemological and ontological concerns, regardless of the medical system they use (Kakar 1982; Obeyesekere 1976). The ubiquitous and recurring influence of ayurveda in people’s modern lives has been described as a form of “cultural praxis” (Zarrilli 1998), or ayurveda is seen as providing a “cultural template” or a “root metaphor” in people’s everyday lives (Trawick 1995). Recent sociological studies point to the epistemic basis of indigenous medical knowledge that goes into the making of the health culture of a region (Sujatha 2007). Concepts and practices pertaining to diet, work, daily routine and lifecycle are more coherent than generally viewed and constitute the health culture of a region derived from indigenous medical traditions. This health culture conditions therapeutic choices made by people in a situation of medical pluralism. In this interweaving of culture, health and medicine, culture extends beyond religion or superstition and includes various societal institutions and arrangements that reconstitute medical knowledge and health practices in dynamic ways. A sociological study of the role of societal institutions in the shaping of the culture-medicine relationship from the perspective of ayurveda, an indigenous system, provides us with an opportunity to understand the reproduction of indigenous knowledge, both as culture and as medicine, in postcolonial societies.

Contemporary ayurveda is characterised by multiple sites of changes – modern colleges, research establishments and

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pharmaceutical production centres (Abraham 2005). Such changes are often viewed as a part of modernisation through institutional and professional development – processes thought to be conducive to secularisation. It is believed that modern institutions minimise the influence of ascriptive criteria in knowledge acquisition by reducing the traditional authority of individual preceptors and by subscribing to criteria supposedly based on universal norms operating through impersonal bureaucratic structures. In this regard, as far as indigenous medicine such as ayurveda is concerned, state and market are seen as the two foremost institutionalising and secularising agencies. This is the overt or tacit assumption of studies viewing the revival of ayurveda in the 20th century (Brass 1972; Leslie 1976; Langford 2004). Such formulations, however, assume that modernity is the ultimate destination of negotiations with state and market institutions by social groups located in diverse sites. Further, they deny any agency to the social groups and actors concerned who assimilate selectively challenging categorisation of their actions as either modern or traditional.

This paper examines the relationship between health, culture and medicine, and its societal reproduction in contemporary India, through an analysis of “Kerala ayurveda” and its contemporary practice in Mumbai, city. Through an analysis of the modes of its social reproduction simultaneously as culture and as medicine in cosmopolitan Mumbai, this paper shows the analytical fragility of the tradition/modern binary in the understanding of contemporary indigenous systems and examines the belief that state and market provide the foremost sites for institutional and secular practice of indigenous medicines. The paper argues that community organisations such as *samajams*, which are secular in character, translocate and sustain Kerala ayurveda in Mumbai. By occupying a public space between the state and the market they create niches for ayurvedic practice in a city where healthcare is dominated by the powerful ideology and institutions of biomedicine.

In this paper “Kerala ayurveda” refers to ayurvedic care offered through dispensary-cum-pharmacies run by Kerala/Malayali *samajams*. Kerala *samajams* are organisations of migrants from Kerala (including second generation Malayalis in Mumbai), that provide them a socio-cultural and political identity in the city, while, at the same time, providing them with a collective experience of the social and cultural life that they have left behind. There are several such *samajams* in Mumbai and many of them run dispensaries that offer “Kerala ayurveda treatment”. Similar dispensaries are also run in Mumbai by a few ayurvedic pharmaceutical manufacturers from Kerala. Our discussion here does not include individual private practitioners of ayurveda or those commercial establishments that offer massage and assorted services that are often advertised as “Kerala ayurveda”.¹ This paper is based on fieldwork conducted in Mumbai and in Kerala during 2006-08.

1 The Making of Kerala Ayurveda

Although the presence of several strands within ayurveda across regions and even within a region has been noted by researchers (Meulenbeld 1992), the historical and cultural roots of Kerala ayurveda show that it embodies certain unique

features developed and sustained over a long period by the regional socio-political culture. Various textual sources and contemporary practices indicate that the Kerala region had well developed medical traditions prior to the arrival of the Sanskrit, textual tradition of ayurveda during the 6th and 7th centuries AD (Varier 2005). The almost exclusive reliance on plant sources for medicines, wide use of *kashayams* (herbal decoctions) prepared from local plants that do not find a mention in the ayurvedic texts of Caraka and Sushruta, extensive use of medicated oils and *gruthams* (ghees), elaborate *aharapathyas* (diet regimens), specific *panchakarma* procedures of *Dhara*, *Pizhichil*, *Nhavarakizhi*, *Sirovasti*, etc, are therapeutic features unique to this region.

Apart from these therapeutic differences, the preferred ayurvedic text is also different in Kerala. The *Samhitas* of Caraka and Sushruta, and the *Ashtangsamgraha* of Vagbhata, together constitute the theoretical and therapeutic corpus of ayurveda. While the former two *Samhitas* are the preferred texts elsewhere in India, an abridged form of the third known as *Ashtangahrudayam*, also attributed to Vagbhata, is the most widely known and used ayurvedic text in Kerala.² Families of traditional *vaidyans* possessed several “copies” or versions of palm leaf manuscripts of *Ashtangahrudayam*. The traditional *vaidyans* and college-trained ayurveda graduates whom we interviewed in Kerala showed strong intellectual allegiance to this particular text. Locally popular medical texts such as *Sahasrayogam Vaidyamanorama*, *Chikitsamanjari* and others also contain medical knowledge unique to Kerala and are used as therapeutic guides in everyday practice.³ However, a privileging of the text *Ashtangahrudayam* is evident. The former texts are not part of the modern ayurveda curriculum, but are used by the graduates of modern colleges, in Kerala. Thus, traditional texts continue to be relevant in contemporary practice.

Ashtangahrudayam was studied not only by those training to be ayurvedic physicians but was a core text in the general curriculum imparted through traditional schools in Kerala (Nagam 1906; Wood 1985). The scholarly training in ayurveda was organised in the gurukula format at the residence of the *vaidyan guru* for a few students or was in the form of filial apprenticeship. There were gurukulams such as the one at Kottunnallur (Kodungalloor) which had as many as 300 students studying various subjects including ayurveda. Gaining proficiency in Sanskrit was integral to the learning. The accounts of a scholar who studied at this centre during 1894-98 show that it was funded by the princes of Kottunnallur, located within the palace premises and that several members of the royal family taught various subjects (Wood 1985). The brahmins mainly followed filial apprenticeship, centres like the Kottunnallur catered largely to upper castes, while lower castes attended *kutipallikootams*, *ezhuthupallis* or *kalaris* where they learnt elements of *vyothisham* and ayurveda (Ganesh 2004). Ayurveda was part of the various traditions of learning in Kerala, both oral and literate. While *Ashtangahrudayam* became the textual authority for the ayurvedic physicians (the specialists), some of its contents were shared by the literate lay public as well.

Medical practice of ayurveda was not restricted to specific castes or to Hindus, although brahman vaidyans (*ashtavaidyans*) enjoyed special social status and political privileges. There were well-known Muslim and Christian families of vaidyans who were learned in the Sanskrit textual tradition, who had even tutored under brahman vaidyans. Similarly, there were members of the Ezhava castes who were accomplished Sanskrit scholars and ayurvedic practitioners.⁴ Yet, biographies of practitioners from different social backgrounds show that caste and community identities and tensions played out in important ways while tutoring under upper caste scholars or while establishing vaidyasalas of their own. However, the participation of various communities and castes in ayurvedic training and practice helped universalise ayurvedic culture in Kerala.

There were, until recently, a variety of traditional specialists in healthcare such as bone setters, *visha* vaidyans, midwives, and practitioners of *marma chikitsa* who belong to different castes and communities and whose knowledge and practices overlapped with the ayurvedic system, expanding the social base of ayurveda in the region. Occupations such as these also indicate that medical practice was not the exclusive domain of vaidyans. These occupations have declined as they have become “unfashionable” and economically unviable. Yet, a small number of such specialists and elements from such traditions continue to survive in Kerala.⁵ Further, performing arts such as Kathakali and martial arts such as Kalaripayattu also share some knowledge with ayurveda: knowledge about the body, procedures to attain flexibility of body without causing harm or injury, and specific treatments for injury accruing from training and performance (Zarrilli 1998). It is important to note that the body of knowledge in these specialisations is not completely in consonance with ayurveda, yet, they share a common epistemic frame and a cosmology that allows exchanges across knowledge borders.⁶

More importantly, Kerala’s engagement with modernity, especially the spread of modern science and technology, did not lead to confrontations with ayurvedic theories or generate conditions for its displacement. On the contrary, modern literacy and print culture helped further democratise and universalise ayurveda in Kerala. Several vaidyans established printing presses and converted personal manuscripts into printed books. Print technology also encouraged vaidyans and scholars to write commentaries and document their therapeutic experiences and innovations (Varier 2005; Wood 1985).⁷ Vaidyans from lower castes were actively involved in the translation of Sanskrit ayurvedic texts and publishing commentaries and therapeutic compendiums in Malayalam. For instance, by the middle of the 19th century a number of books on various subjects were published in Malayalam and the number of books on ayurveda constituted the largest number (369) in any subject category.⁸ These developments reflect the growing claims made on behalf of both ayurveda and lower castes on the new public spaces opened up by the modernising forces of late 19th and early 20th century Kerala. As we shall see later, in this process, certain features and forms of ayurveda came into prominence while yoking tradition with processes of modernisation and institutionalisation

that in general reorganised the social and political life of Kerala (Panikkar 1995).

The continued influence of ayurveda in contemporary Kerala can be seen from its wide presence in the state, in terms of the number of ayurvedic practitioners, dispensaries and pharmacies, both modern and traditional. The ayurvedic presence may be most visible in its institutionalised medical and tourist settings but it continues to be experienced as a pervasive culture that guides everyday events of cooking, bathing, personal grooming to specific events of childbirth, and the household management of a host of ailments that cut across class, caste, gender, religious and educational backgrounds.⁹ The explicit awareness of ayurveda in the broader ecological and cosmological sense may have declined for individuals but it has an implicit, embodied presence in their everyday lives.

Political Support

It is also important to note that freedom from direct colonial intervention in health especially in the princely states of Travancore and Cochin, the sustained political support for ayurveda from the princely states through the colonial period and the continued support of successive governments after independence is again perhaps unique to this region. However, it is the various socio-historical factors and the agency of societal groups that prepared the ground for a more universal, democratic and secular ayurvedic culture in Kerala. Although many individual practitioners may exhibit religious symbols and incorporate rituals into their everyday practices, ayurveda in Kerala reflects a secularism and cosmopolitanism evolved through wider social participation in the re-articulation of tradition and modernity. It is perhaps these features that enabled the persistence of a traditional, indigenous knowledge amidst widespread modern education, science popularisation movements and widespread hi-tech allopathic institutions in Kerala.¹⁰

Social analyses of ayurveda anticipated that the modern institutional developments, especially the college-based training, would reduce ayurveda to a paraprofessional status as the rich integrated learned tradition of pharmacopoeia and therapeutics disintegrate into a few esoteric recipes or die out in confrontation with modernisation (Zimmermann 1979). Such analyses, acknowledge the coherence and integrity of traditional practice and the agency of the traditional vaidyans, which ensured continuity for centuries until modern training and pharmaceutical production were introduced. At the same time they deny agency to actors to transform traditions and redefine authenticity in structures and sources other than Sanskrit texts and the gurukula system, for example, followed by the ashtavaidyas of Kerala. Professionalisation and institutionalisation of ayurveda did not result in a complete erasure or rupture of the traditions. Rather, as pointed out earlier, traditions are continuously being recalled and reinstated into the modern and contemporary practices. This is also evident in the continuous intellectual and political contestations between different groups of ayurvedists (traditional vaidyans and ayurveda doctors, commercial producers and home-based producers) and between social groups in contemporary Kerala. A century after the modern institutionalisation of

ayurveda began in Kerala, nearly half of its ayurvedic practitioners are still non-institutionally qualified (Government of India 2005).

The socio-cultural rootedness and the relative political support of ayurveda were perceived as inadequate against the coercive and hegemonic pressures of colonialism and modern medicine. Ayurvedists such as P S Varier saw these forces as a threat to the very survival of ayurveda in Kerala. Re-institutionalisation was one of the ways in which proponents of ayurveda across the country responded to these circumstances. One of the objectives was to unify ayurveda across the country by “standardising” teaching and practice and by modernising production of medicines through new institutional forms. In contrast, the institutionalisation of ayurveda in Kerala, especially under the leadership of Varier, strategically incorporated both the medical and the socio-cultural distinctiveness of the region and contributed to the shaping of a distinct regional ayurvedic identity – the Kerala ayurveda.

2 Institutional Development of Kerala Ayurveda

The processes of modernisation of ayurveda in Kerala are largely attributed to the efforts of P S Varier, the founder of the Arya Vaidya Sala (AVS) at Kottakkal.¹¹ He established an ayurveda college, hospitals and more importantly modernised the production of ayurvedic medicines, under the brand name of “Arya Vaidya Sala, Kottakkal”. The influence of these institutions made the name “Kottakkal” synonymous with ayurveda in the collective consciousness of modern Kerala. P S Varier believed that the future of ayurveda relied critically on the availability of quality medicines and trained practitioners which he hoped to provide through the institutional networks of dispensary-cum-pharmacies that he established. For him changes had to be brought about both at the level of scholarship and at the level of everyday clinical practice. He established journals such as *Danwantari*, serving as its editor for a long period, published scholarly articles on ayurvedic theory and practice and carried political discussions on the future of ayurveda as well. He effectively used the new public spaces created by modern literacy, print technology, national conferences and public meetings to argue in favour of selective modernisation of ayurveda.

For Varier, this meant adopting modern techniques to improve manufacture of ayurvedic medicines and to expose practitioners to modern science including biomedical subjects, which he believed would preserve the integrity of ayurvedic knowledge and would help practitioners excel as physicians. According to him, the marginalisation of ayurveda was not just the result of state neglect alone or the colonial branding of it as “unscientific”, but the sense of inferiority that these produced among ayurvedic practitioners. The former could be fought by political mobilisation but the latter required a fostering of “openness” and cosmopolitan orientation which could be achieved only through an internal reorganisation of ayurveda. While these views were in tune with the intellectual climate of Kerala (Panikkar 1995) they were opposed by prominent Indian ayurvedists who feared that the power of biomedicine and its better economic prospects would lure ayurvedists away (Brass 1972). Having studied allopathy, Varier persisted that exposure to biomedical

knowledge would only strengthen the convictions and acumen of ayurveda practitioners. He not only introduced modern anatomy in the ayurvedic curriculum in his college but taught the subject himself.

Regional Identity

In the pharmaceutical transformation, Varier stressed “purity” and “authenticity” as markers of his medicines. The surprising profits in the early years itself encouraged him to expand the distribution of his medicines through dispensaries-cum-pharmacies, which has become the model for the institutionalised clinical practice of modern ayurveda in Kerala. While his contributions to the pharmaceutical development are highlighted the role of dispensaries-cum-pharmacies as micro institutions in spreading ayurvedic culture in modern times has been ignored.

Varier became a role model for vaidyans, not only due to his vision for ayurveda, but also because of his social stature, cosmopolitan and liberal views, philanthropic ways and commitment to art and literature. This helped project ayurveda as a progressive knowledge system, rooted in tradition and local culture yet of significant contemporary relevance (Krishnankutty 2001; Panikkar 1995). Over the years, AVS grew into a large establishment with branches all over India and countries abroad. Several vaidyans became franchisees of Kottakkal medicines and relied on these medicines for their practice and many others followed the path of commercial production. Some of the ethical norms that Varier institutionalised helped reclaim the “authenticity” of ayurveda. The norms that he established were far ahead of his times. For instance, while AVS was widely advertised, medicines produced by AVS were not to be advertised and they could be dispensed only after consulting a practitioner. The strategies adopted for the distribution of Kottakkal medicines and the model of micro institutions reflect these norms.

Varier’s efforts were significant in two ways, in establishing the regional identity of Kerala ayurveda and locating its “authenticity” in the “quality” (“purity”) of medicines and the quality of practitioners, in a general context of unregulated pluralism.¹² In many ways, Varier’s work and leadership also eased the emerging anxiety about traditional practices in a modernising intellectual context in Kerala through a reworking of the tension between tradition and modernity by carefully manoeuvring modern institutions to preserve some of the unique features of traditional ayurveda, both as medicine and as culture. The contemporary cultural construct of Kerala ayurveda thus embodies the regional tradition of medicine as well as the particular engagement with modernity of Kerala society. As we shall see, Kerala ayurveda in Mumbai brings out the continuous reworking of the tensions between tradition and modernity, nation state and community, and between regional and national identities in the contemporary practice of ayurveda.

3 ‘Kerala Ayurveda’ in Mumbai

The social and institutional arrangement for the practice of Kerala ayurveda in Mumbai city shows how a culturally embedded medicine travels beyond its locale and retains its distinctive identity. In this section, I analyse the practice of Kerala ayurveda in Mumbai organised by Kerala/Malayali samajams. My analysis

is based on data gathered from four dispensaries run by two different samajams.¹³

Mumbai, a favourite destination of people from all social classes and communities in Kerala since the 1920s and 1930s, has a good network of samajams and Malayali associations, the oldest being the Keraleeya Samajam established in 1931 much before the state of Kerala was constituted. Like any migrant community organisation, the samajams organise cultural programmes, regional music, dance and language classes, celebrate festivals and hold literary readings and stage plays. However, a distinct feature of Kerala samajams is the ayurvedic dispensary-cum-pharmacies that they run. For instance, the Keraleeya Samajam has been running such dispensaries for more than 50 years and it alone runs five dispensaries in different parts of the city. Through the dispensaries, samajams ensure that ayurvedic medicines and practitioners from Kerala are available to the migrant community. Care offered in these dispensaries is perceived by users as well as practitioners, as having certain unique features that differentiate it from the “national” or “north Indian” ayurveda (here north India includes Maharashtra too). As a cultural baggage, ayurveda often accompanies the large migrant population of Kerala to different parts of the country and to the middle eastern and western countries.

The samajams are different from other civil society organisations such as non-governmental organisations (NGOs), religious organisations or political parties, and occupy a public, secular space and are representative of the wider community than of a particular social group, committed to a political ideology or a social cause. The samajams function in a democratic manner to benefit its members. The practitioners are appointed and paid by the samajam, the services are subsidised for the members but are open to the wider public and the medicines are monitored and procured directly from the manufacturers. The samajam regulates the quality of services provided and ensures the supply and safety of medicines. By occupying an institutional space outside the state and the market, the samajams provide a secular, democratic cultural space for Kerala ayurveda that protects the autonomy of patients and ensures that their interests are not subordinated to the state, the physician or the market.

Some of these dispensaries have recently introduced facilities for Kerala panchakarma procedures for therapeutic purposes and for the currently popular non-medical “rejuvenation” procedures. According to the samajam officials, there is a growing demand for both services in the city. Since several agencies/massage parlours have mushroomed in the city claiming to provide Kerala massages, “corrupting” and “bringing ill repute” to Kerala ayurveda, the samajams have chosen to provide these services in a “safe and affordable manner”. According to them, since the Kottakkal Panchakarma treatments have become unaffordable to ordinary people, they have decided to provide “quality” services at “affordable” prices, especially to their members. The samajam intervenes in a manner to protect its members from an exploitative market while simultaneously reconstituting what is authentic and what is spurious.

Authenticity and Purity

The migration of local culture, transacted through these community networks and micro institutions, allows the migrant

population a continued experience of the “authentic” culture that partially liberates them from “nostalgia” and longing for *naadu* (homeland) simultaneously establishing their identity as a Malayali or Keralite in a cosmopolitan context. Samajams strengthen the cultural identity of migrants in Mumbai and Kerala ayurveda enhances the authenticity of their cultural experience. The Kerala ayurvedic dispensary-cum-pharmacies, spread across the city, are thus important institutional arrangements that provide the structural grid for carrying cultural ideologies and practices that at once unite migrant Malayalis and differentiate them from other migrant communities. Kerala migrants, whether they are active consumers of Kerala ayurveda or not, endorse its authenticity by identifying themselves with the collective experience of an ayurvedic culture back home. The cultural identification with the “naadu” is so pronounced that it would be rare to find a Keralite seeking services of non-Keralite ayurvedic practitioners in Mumbai.

It is through the notions of “purity” and “distinctiveness” of Kerala ayurveda, that the authenticity and distinctiveness of one’s culture is asserted. The authenticity of the *naadu* lies in its “purity” and therefore the medicines and the practitioners must also be from one’s *naadu*. Both practitioners of these dispensaries and the office bearers of the samajams who were interviewed emphasised the fact that “our” ayurvedic tradition represents “pure” ayurveda. One of them elaborated:

Kerala ayurveda is *pure* ayurveda. All other ayurvedic practices all over India are not pure. They are influenced by the Siddha system. ..., they rely on mercury, metals, metallic powder and all that. That is not *real* ayurveda. Definitely, that is ayurveda, but *very different* (emphasis added).

He further provides ecological and political reasons for why “north Indian” ayurveda is different:

Kerala has a variety of abundant herbs, of course the situation is definitely changing now. In north India you don’t have so many varieties... So they have to rely on other things like *bhasmas*.

He also provided historical and political reasons for the differences:

The expansion of one of the Tamil kingdoms to north India led to exchanges between the Siddha system, popular in the Tamil region, and ayurveda, which resulted in the use of metals, a feature of Siddha system.

Purity is thus rooted in the ecology of Kerala and its political stability.

Purity and authenticity, the signifiers of Kerala ayurveda, are materialised through the “purity” of its medicines. For the practitioners and the samajam officials *AVS* Kottakkal symbolised this purity.¹⁴ The dispensaries were well stocked with a large variety of Kottakkal medicines. Medicines are well packaged with ingredients clearly spelt out and the textual source of each medicine revealed on its label, which serves to enhance authenticity. Such “openness”, also followed by other manufacturers from Kerala, was stressed by the Mumbai trained practitioner as it helped her learn the intricacies and distinctiveness of the tradition. According to her, Mumbai-trained practitioners like her, do not learn about medicines and practices that are specific to the Kerala school of ayurveda because such knowledge is not part of the national ayurvedic curriculum. However, she pointed out

that her counterparts from Kerala were well versed with the regional variant despite the common curriculum.

While all practitioners emphasised the difference between Kerala and “north Indian” ayurveda, only the Mumbai-trained practitioner had had any experience of the difference and was also the most articulate about it. She asserted that there are clear therapeutic differences in the two ayurvedic traditions. By comparing the panchakarma practices of the two traditions, she noted, “although they are both panchakarma, the Kerala type practised in the dispensary is different, especially the oils that are used, the variety and even the quantity used. They are specific to the Kerala system.” What we notice here is that the regional cultural variant escapes institutional efforts to universalise a standard curriculum through the ayurveda colleges and is reproduced through other institutional sites. With exposure to both the north Indian and Kerala “traditions”, and now being socialised into the latter, this practitioner becomes a spokesperson who not only endorses but articulates the differences as being significant. Whether the differences are significant or not, from a therapeutic point of view by emphasising these differences the medical basis of cultural distinctiveness is amplified.

Professional Exclusiveness

Several institutional practices and professional networks maintain and reinforce the cultural ideology and the perceived distinctiveness of Kerala ayurveda in Mumbai city. The records of patients in these dispensaries are especially useful to practitioners who are not trained in the Kerala school of ayurveda.¹⁵ Although information on diagnosis is limited, prescriptions are detailed and the effects and progress of the therapy can be observed from these records. The Mumbai-trained practitioner used these records as a sort of training manual. As she moved through various branches of samajam dispensaries she had access to records of several years. Her socialisation into the regional form also required that she gains requisite expertise by observing senior colleagues in their clinics. This may be seen as a modern apprenticeship into the regional form of ayurveda. In Kerala, I had interviewed a few graduates of modern ayurveda colleges who, after completion of their studies, had undertaken apprenticeship of six months to two years with one or more traditional vaidyas before starting their own independent practice. The linear narratives of modern ayurvedic development, either as institutional progress or as decline of traditional scholarship, do not take note of these back and forth moves between the traditional and the modern forms.

The professional networks of practitioners in Mumbai dispensaries were also circumscribed by culture. They consisted of a few Malayali practitioners within Mumbai and several classmates, teachers and others “back home in Kerala”. They were neither familiar with many other ayurvedic institutions and practitioners in Mumbai nor felt the need to establish professional links with them. Here cultural identity superseded professional identity. Such professional exclusiveness reinforced not only the perceived distinctiveness but implied a perceived superiority of this difference. For these practitioners, professional exchanges and networks, a key aspect of the modern organisation and dissemination of knowledge, seemed meaningful, necessary or even possible

only within a specific cultural context. The Mumbai trained practitioner too had little professional exchange with her colleagues from college, as according to her many had dropped ayurveda to pursue more lucrative employment. Her professional interactions were now only with the Kerala ayurveda practitioners in Mumbai.

The social networks and institutional arrangements are thus crucial for the smooth functioning of Kerala ayurveda in a city, where elaborate institutional and professional support systems exist that promote biomedicine. Besides creating the cultural ambience for ayurvedic practice, institutional practices of record keeping, unhindered supply of reliable, quality medicines, and a steady flow of clients ensure that the practitioners can “focus on their jobs”. Without such support systems, setting up independent and effective ayurvedic practice is difficult in a city like Mumbai.¹⁶

4 Ayurveda as Medicine

Do the institutional arrangements that protect the identity of Kerala ayurveda in Mumbai also make it insular in a largely biomedical and cosmopolitan context of the city? How does ayurveda respond to the pressures that emanate from such an environment?

In the overall scenario of increasing consumption of medicines, ayurveda is now being seen as a medical system treating specific diseases rather than as providing a broad cultural framework for healthy living. Consumerism in medicine is not a recent phenomenon although avenues opened by the recent global demand for ayurveda has resulted in an increased consumption of specific drugs. The recent trend is marked by an increase in proprietary drugs packaged for a global market under the rhetoric of “holistic”, “alternative” care (Banerjee 2004). As mentioned earlier, the path of modernisation through mass production of ayurvedic medicines and modern training, chosen by ayurvedists to address political marginalisation, in many ways reconstituted ayurveda laying emphasis on its medicines. Expansion of urban lifestyles, requirements of migrant populations, pervasive medicalisation of everyday life and the commodification of ayurveda in a neoliberal market, all in varying degrees, have also contributed to the reformulation of ayurveda as medicine.

This has been a complex denouement in which material reproduction of ayurveda has subordinated the reproduction of ayurvedic epistemology and philosophy, undermining possibilities inherent in ayurveda for providing an alternative ecological ethic and a framework for healthy living, integrating the physical, psycho-social and phenomenological aspects of living in the world. This reconfiguration as medicine finds ayurveda as increasingly treating ailments within a reductionist framework. Medicine which was only a part of ayurveda is increasingly becoming the “whole” of ayurveda, legitimising it as a source of “complimentary” and “alternative drugs”.

Despite their claim to authenticity and purity, ayurvedic practitioners of the dispensaries use modern diagnostic tools to bring efficiency into their practice and to blend it with the city’s overwhelming biomedical culture. This is important because according to them they treat patients who seek cure for specific ailments who, in most instances, have turned to ayurveda after having consulted allopathic practitioners, often more than one.

Practitioners asked their patients to show and were also willingly shown the reports of modern diagnostic tests and prescriptions of allopathic doctors. Occasionally, they also asked patients to undergo tests and made decisions based on them. However, they pointed out that their *anumana* (diagnostic or prognostic inferences) are not entirely based on these tests. Diagnostic tests are not an essential therapeutic requirement but are useful heuristic devices. It is useful in many ways; “in providing explanations to educated patients who come with information from internet and ask so many questions”; “in double checking your diagnosis in certain instances such as tumours and fibroids, which have become so common today”; “so that you don’t miss out on anything and it is better to follow them because of consumer courts”; “there are so many heart patients and we do not want to take any risks. They need immediate attention and in such instances ECG helps.” All practitioners concurred on the point that “in modern times you cannot ignore these tests” for their pragmatic and communicative value. Thus conceptual bilingualism (Narindas 2006), characterises everyday negotiations of modern ayurveda practitioners, especially in cities, with educated clients.

Drawing a distinction between biomedicine and modern technology, practitioners argue that adopting modern diagnostic tools should not be seen as “imitating” allopathy. By assigning autonomy to the domain of technology, diagnostic techniques are made available to ayurveda. For instance, “technology is not biomedicine. They are certain measures, pictures and so on. It is up to the system of medicine to interpret them”, stated one of the practitioners. Thus, while the regional identity of Kerala ayurveda is retained by confining the therapeutic practices and the medicines to those within the Kerala tradition of ayurveda, the practitioners’ “openness” to contextualise and the “skills” to use modern technology developed through modern ayurvedic education enhanced the relevance of their therapeutic services in the urban, cosmopolitan context.

5 Conclusions

The case of Kerala ayurveda illustrates that the efforts to reconstitute ayurveda as a “unified” “national” system through modern processes of institutionalisation and professionalisation, since the early 20th century have not erased certain cultural traditions within ayurveda. As the foregoing analysis shows, “Kerala ayurveda” as a distinct form emerged within the theoretical framework of ayurveda by encapsulating certain medical and cultural elements unique to its specific socio-historical contexts. Historically, there were multiple local traditions of medical practices whose boundaries overlapped with each other and also with the ayurvedic system. The diffusion of the cognitive content of ayurveda into culture, the scholarly practice of ayurveda across social groups, its secular and cosmopolitan orientation together provided the historical and cultural conditions for the creation of Kerala ayurveda and also for its migration outside Kerala. The analysis of Kerala ayurveda in Mumbai shows that ayurveda as medicine and as culture are difficult to delineate and that the historicity of this relationship cannot be ignored. The analysis is not intended to valorise a particular form, but aimed at examining its roots in history as well as in contemporary practice to understand

the societal processes and the agency of actors in shaping medical knowledge and its cultural practice.

Out of “naadu” Kerala ayurveda carries special significance for the migrant population, as a marker of community identity simultaneously providing cultural links with their “homeland”. Notions of purity and authenticity associated with one’s culture are embodied in Kerala ayurveda, where medicines and practitioners come from Kerala. There are institutional mechanisms that reinforce the perceived authenticity of culture and medicine. Both the “open” institutional practices (of record keeping and disclosing ingredients and sources on the labels of medicines) and the “closed” professionalism among the practitioners operate in a manner that preserves the identity of Kerala ayurveda and helps maintain the cultural boundaries of the practitioners. In Mumbai, all these help preserve the “authenticity” of the transplant. The institutional arrangements and the cultural ideology that supports the practice of Kerala ayurveda as well as its ability to contextualise a specific tradition into a cosmopolitan biomedical context create a strong niche for ayurvedic practice in Mumbai.

The development of a regional cultural identity within the epistemological framework of ayurveda and within the “national” (official) system reveals the analytical fragility of the binaries and typologies of modernity/tradition, nation/community, medicine/culture in the understanding of indigenous medical systems in contemporary India. Further, the analysis shows the significant role of societal organisations in mediating indigenous medicine, challenging the notion that state and market are the most effective regulatory agencies in the field of healthcare and that they provide the foremost sites for institutional and secular practice of indigenous medicine.

Kerala ayurveda thus challenges the dominant perception that views ayurveda through the lens of Hinduism and brahmanism. Much of the anthropological literature too assumes such a relationship conflating culture with religion when they proclaim with confidence: “Indian medicine is permeated by multiple religious ideas and practices, such that it is often futile to try to distinguish between ‘religious’ ideas and practices and ‘medical’ ones” (Trawick 1995: 81). Such a perception denies ayurveda its historical diversities, its inherent rational epistemic status (Chattopadhyaya 1977) and the role of social organisations and human agency that reproduces ayurveda through democratic, secular public spaces. This denial prepares the ground for subordinating all of ayurveda to certain trends in contemporary times that appropriate a few elements from it for narrow political and commercial interests.

We may then ask, if indeed there was and is a strong medical and cultural influence of ayurveda in Kerala, which micro studies continue to report (Chacko 2003) then, would it not be necessary to reformulate our research questions about health indicators and healthcare practices in Kerala? There is an overwhelming developmentalist literature that “establishes” the high health indicators of Kerala as outcomes of modern education, political participation and biomedical interventions. While these factors would no doubt have played a role in determining health outcomes, they do not operate in conflict with the ayurvedic health culture, as analysed in this paper. How do we then disaggregate the effect of two sets of practices – medical and cultural

– on health if they are not mutually exclusive? Can we, then, hypothesise a relationship between Kerala's high health indicators such as the low maternal and infant mortality rates, and a health culture that is inclusive of ayurveda? Does the rapidly growing incidence of degenerative diseases, high degree of allopathic

self-medication and overutilisation of allopathic services in Kerala indicate a move away from this culture? If two medical systems are strongly poised in a culture, then it is only prudent to ask questions about health from the perspective of both, as well as from the perspective of people who organise and utilise them.

NOTES

- 1 Several establishments in Mumbai advertise massage procedures similar to panchakarma practices as Kerala ayurveda. Ayurveda practitioners dismissed them as having no therapeutic value.
- 2 Several historical, literary, and practical explanations are given by practitioners for this preference: the influence of Buddhist Vagbhata tradition, its compact style that is easy to commit to memory, literary flavour and that it encapsulates the theoretical and practical "essentials" of ayurveda. There are several translations and commentaries in Malayalam and it is the most frequently cited text in the popular discourse on ayurveda in Kerala.
- 3 There are several other texts of this nature. The authors or compilers of many of these texts are unknown but several print versions and editions are available in Kerala.
- 4 The most quoted example is of Itty Achuthan, who worked with Henry Vaan Rheede, the Dutch governor in preparing "Hortus Malabaricus" (on medicinal plants) in the 17th century. He was a vaidyan from the Ezhava community.
- 5 For example, two college trained ayurveda doctors who belonged to families of bone-setters and marma chikitsa traditions stated that they have successfully incorporated knowledge inherited from their family tradition such as specific medications, procedures of massage, types of splinters, etc, into their current practice.
- 6 There is also a view that some of these traditions have evolved independent of or predate ayurveda and that they have an epistemic status different from that of ayurveda. They view the overlap with ayurveda as an appropriation of the folk traditions by the hegemonic, upper caste, Sanskrit tradition of ayurveda (field notes 2007).
- 7 In this regard, names of Uppothu Kannan, P M Govindan Vaidyan, Kumaran Vaidyan, Kaikulangara Rama Warriar, Pachu Muthathu, Raghavan Thirumulpad and others were recalled by the practitioners.
- 8 Namputiri 1991 in Ganesh 2004: 185. Namputiri, N M (1991) Cultural Traditions in Medieval Kerala (mimeo).
- 9 For instance, although about 98% of childbirths take place in biomedical institutions they are followed by post-delivery care based on ayurveda. While the former is widely reported in official studies the latter remains a shared community knowledge.
- 10 There is an apparent paradox here of ayurvedic influence and people's high consumption of allopathic care (Abraham 1989). Commercialisation of healthcare and the consequent availability of sophisticated diagnostic technologies and private hospitals have made modern medical care a high status commodity in Kerala. Like private English medium schools, private hospitals are also ranked according to appearance, comforts (television in the room) and the number of medical facilities (such as whole body scan machines) available. Conversations with users indicate that there is some social status attached to the type of private hospital facility used and that any new hospital that advertises a new feature, like any commodity, seems to attract a large number of consumers. This consumption of allopathy is not at the cost of ayurveda. On the contrary, some practitioners argue that the general trend of commercialisation of healthcare has also increased the general "consumption" of ayurveda (field notes 2007).
- 11 For biography of P S Varier see Krishnankutty 2001, for historical account of the institution see Varier 2002, for an analysis of the influence of the modernising context of Kerala on P S Varier see Panikkar 1995.
- 12 Kottakkal specialised in the traditional Kerala panchakarma practices of *Dhara*, *Pizhichil*, etc, and became well-known for them. Kottakkal has been successfully treating various ailments and has been able to maintain its high reputation. The popularity and authenticity of Kottakkal also comes from its clientele, which include eminent personalities including presidents of the country. However, some of the practitioners interviewed were critical of the elitism and high cost of treatment at Kottakkal and its pharmaceuticalisation of ayurveda through mass production and use of preservatives, questioning its goals of commitment to service and the quality of medicines.
- 13 Ayurveda practitioners (two women and two men) of these dispensaries and the office bearers of two samajams were interviewed. Three practitioners were from Kerala, who were between 40 and 45 years of age grew up and graduated from different ayurveda colleges there; one from a private college and two from different government colleges. The fourth practitioner, a Malayali woman in her early thirties, grew up and graduated in ayurveda from a Mumbai college. She was proficient in English, Hindi, Marathi, Sanskrit and could speak Malayalam. Others learnt to speak English and Hindi after coming to Mumbai. The three practitioners from Kerala had worked in dispensaries in Kerala and two of them had worked in different dispensaries in Mumbai with more than 10 years of experience. All four practitioners were from middle class and middle caste backgrounds. The office bearers were long time residents and some belonged to second generation families. They were actively involved in samajam activities and took pride in the increasing popularity of their dispensaries among non-Malayali communities and the contribution of these dispensaries in the rising popularity of Kerala ayurveda in Mumbai.
- 14 The oldest samajam procured medicines from AVS, Kottakkal since the early 1940s when it was the only established manufacturer of packaged medicines with long shelf life while claiming to retain quality. Today samajams procure medicines also from other manufacturers from Kerala.
- 15 The practice of record keeping may have been institutionalised to ensure public accountability and control over the practitioners or as information useful to the pharmacies that supply these medicines.
- 16 Colleagues of the Mumbai practitioner found setting up ayurvedic practice difficult without any institutional support or supply of quality medicines, forcing them to take up allopathic practice to survive in the city.

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