

In the Presence of Biomedicine: Ayurveda, Medical Integration and Health Seeking in Mysore, South India

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This paper is based on a research on medical integration and health seeking in Mysore, South India. It explores the use of Ayurvedic services, the impact of biomedicine on Ayurvedic practices and the meaning of instruments with respect to the expectations of patients and healers. The research was done during 2002 and 2003. The empirical data are derived from interviews, participant observation and survey material. Participant observation was carried out in two hospitals and nine clinics offering Ayurvedic services; 25 Ayurvedic practitioners and 30 patients were interviewed. A total of 233 respondents were surveyed in the University of Mysore and on trains and buses between Mysore and Bangalore. Results suggest that Ayurvedic medicine serves as a health reserve in urban Mysore. For the majority of informants biomedical treatment was an obvious choice of treatment, a form of therapy that was taken for granted, if compared with the preference for Ayurvedic services, which were usually utilized because of the failure of biomedicine. Regarding the position of Ayurveda, three issues are vital: first, the lack of experience and first-hand knowledge of Ayurveda on the part of health seekers, secondly, the significance of instruments, tools and technology as regards the expectations of proper consultation, and thirdly, the impact of medical integration, which seems to be critical for modern Ayurveda to thrive in the health market. In short, in order to gain popularity in an urban context, Ayurvedic practitioners favour institutional integration and adoption of items and practices particular to biomedicine.

It is almost self-evident to argue that if healers are fascinated by a chosen medium, whether words, sounds, movements or things, patients are obsessed with medicines. Evidently, the realm of Ayurveda in South India does not make an exception.

Although there are people who are familiar with Ayurvedic treatment, knowing that it is a long process based on various dietary instructions and advice for personal conduct, many patients are first and foremost preoccupied with the instructions concerning the daily regimen of medicines produced by the ever-growing Ayurveda-industry and bolstered by the accelerating commercialization.¹ Interestingly, if the association of biomedicine with pharmaceuticals and hospital technology characterizes a Southern Indian medical context, so does the association of Ayurveda with manufactured drugs. The most common answer one receives in Mysore city after asking the benefits of Ayurvedic treatment is that it does not have side effects. Apparently the medical, cosmological and philosophical basis of Ayurveda is obscure and imprecise for most laymen. In short, whether allopathy or Ayurveda, the medicine is frequently reduced to the icons of efficacy, if one offers quick fixes, the other has no side effects.

This connection between Ayurveda and biomedicine, or an English medicine as it is often referred to in an everyday life in South India, leads us to issues that are relevant for the arguments set forth in this paper. Generally speaking, the issues under discussion are related to the popularity of biomedical treatment in relation to Ayurveda and the use of biomedical instruments and technology in the context of Ayurvedic services. It is significant that according to many Ayurvedic practitioners in Mysore city, they have to fall back on the display of instruments designed for biomedical checkups and treatment—although they might not use them—because of their patients' expectations concerning the effectiveness of therapy. Successful treatment is often associated with a practitioner's familiarity with technical devices, as stated by Ayurvedic practitioners themselves. It is worth mentioning that while patients seem to expect to find these instruments from Ayurvedic clinics, most of them are tending to consult Ayurvedic practitioners only as a secondary resort.

What follows is an attempt to explore these troubling issues. It is argued that Ayurvedic medicine in Mysore city is operating in terms of institutional integration and by adopting items and practices prevalent in the biomedical sector and, moreover, that in order to understand the current position of Ayurvedic medicine, it has to be examined in connection to various levels of medical integration, particularities of health-seeking pattern and the significance of instruments. In the following account these aspects are discussed one after another. The material is gathered in 2002 and 2003. The empirical data are derived from interviews with various healers and patients, survey material, and participation in consultations and diagnostic assessments in clinics and hospitals. Altogether 25 Ayurvedic practitioners and 30 patients were interviewed. Participant observation was carried out in two hospitals and nine clinics offering Ayurvedic services. Also two colleges offering Ayurvedic training were visited.² Finally, a questionnaire (see Appendix) was administrated to a total of 233 respondents who were surveyed in the University of Mysore ($n = 101$) and on trains and buses between Mysore and Bangalore ($n = 132$).

In order to continue, one conceptual reservation should be made. On the following pages the concepts of Ayurveda and Ayurvedic treatment refer to those arguments and practices which are based, above all, on classical Ayurvedic literature, written

during post-vedic times and associated primarily with the names of Caraka and Susruta (see Wujastyk 1998; Kutumbiah 1999). These arguments and practices are referred to and applied, in particular, by those Ayurvedic practitioners in Mysore who are trained either in private or Government colleges and whose training, therefore, is based on these texts or their translations and commentaries. Briefly, the conceptual approach to Ayurveda that has been chosen here represents the standpoint of an officially qualified Ayurvedic practitioner, a college-trained doctor who is recognized by the Government of India and registered with Government bodies. These doctors represent the majority of *vaidyas*,³ Ayurvedic practitioners, in Mysore city.⁴ It should be added, however, that Ayurvedic medicine as it is practised today in South India could not be regarded as an expression of orthodox medicine. It has various local manifestations, which are not often consistent with the canonical textual sources (see Leslie 1976, 1992; Zimmermann 1992; Nichter & Nichter 1996, pp. 205–206). Moreover, it is well-known that there are various kinds of Ayurvedic practitioners whose medical knowledge is based on diverse sources, and who are not necessarily trained in colleges, nor skilled in Sanskrit, the language of classic texts, and whose awareness of these texts might be rather rudimentary.⁵ Consequently, the border between Ayurvedic and non-Ayurvedic treatment is often relative.

Ayurveda and the Question of Medical Integration

One of the most debated issues among Ayurvedic practitioners concerns the advantages and disadvantages of the incorporation of biomedical instruments, technology and concepts into Ayurvedic routines. This process has often been referred to as ‘medical syncretism’ or ‘integration’ (see Leslie 1976, 1992). Regarding the current situation in India the term ‘integration’ is, however, more appropriate than ‘syncretism’, for the latter is, apparently, too narrow and problematic to elucidate a state of affairs.

As a social and political phenomenon medical integration is occurring in various contexts in the field of health and healing: (1) in public health care, (2) in medical education and training, (3) in the drug industry and (4) in therapeutic practices. To be precise: first, by promoting medical pluralism the Government has been propagating a health policy in which the Indian systems of medicine, such as Ayurveda, Yoga and Siddha, as well as the production of traditional drugs, are regarded as an important component of health care, and thus their integration into ‘national health-care programmes and delivery systems’ are encouraged in order to offer alternative services for growing clientele (Sharma 2001; see also Bodeker 2001, pp. 165–166).⁶ Secondly, there is an intention to promote integration between the Indian systems of medicine and biomedicine by teaching the principles of the former to the graduates of biomedicine and vice versa (see Sharma 2001). The educational integration has been probably the most controversial issue (see Mudur 2001). Notwithstanding the critique, the integrated approach has been followed at least in many Ayurvedic colleges, for instance in the Ayurvedic and Unani College in Mysore, where elementary courses in biomedicine are integrated into the curriculum. Thirdly, medical integration is manifesting itself in the health market.

In order to gain a footing in the modern market, Ayurvedic industry has followed the marketing strategies peculiar to multinational and national pharmaceutical companies (Banerjee 2002). And finally, integration is taking place in terms of incorporation of biomedical solutions, such as instruments, technology and concepts, into non-biomedical routines during the training and practicing of Ayurvedic medicine, for example (see Leslie 1992). Concerning the following arguments, it is the first, third and fourth levels that are most crucial, for the first and third can be explored in relation to the popularity of medical approaches and health-seeking behaviour, and the fourth with respect to the power of instruments in the context of consultations.

This last level of integration is often discussed in terms of syncretism, and some scholars, Leslie for example (1992), use both terms interchangeably. The problem with the latter term is that it refers, historically, to the amalgamation of traditions or a synthesis of old and borrowed cultural elements within the framework of religious systems. The question, then, is whether or not the context of religious phenomena works as a model for medical practices and conventions, whatever the relationship between health, healing and religion. To be exact, if medical syncretism is associated with a medical system, which emerges from the previous forms of healing because of the blending of traditions or the adulteration of an earlier tradition, it is hardly an appropriate term to explain the exploitation of biomedicine in Ayurvedic hospitals and clinics in today's Mysore (cf. Langford 2002, p. 216). That is to say, intentional use of instruments and hospital and diagnostic technology during the last four decades, if only for display, has not resulted in a new Indian system of medicine.

The mixing of elements regarding Ayurvedic practices should not, however, be thought of as a modern phenomenon, mainly due to the impact of Unani and allopathic medicine from the thirteenth and nineteenth centuries onwards, respectively, not to mention the impact of various forms of folk medicine (Leslie 1976, 1992; Arnold 2000, pp. 65–75, 176–185; Patterson 2001; Pugh 2003). Therefore, it might be that the historical transformations that have taken place in the field of Ayurveda during several centuries could be explored with reference to syncretism or in relation to syncretistic phenomena. However, as emphasized, the present situation in the clinical reality of Mysore does not suggest syncretism, in the historical sense of the term, but to a deliberate and symbolic integration of things, concepts and routines into Ayurvedic practices—basically to serve the interests of practitioners and clients. The merger of elements, in other words, is a pragmatic solution to demands and assumed demands to fulfil the expectations of patients, to modify and to elevate the practice of Ayurveda and to reach a wider clientele, though not uncritically accepted by everyone.

The contrast between pure (*suddha*) and impure Ayurveda has been an important element in the discourse of health and healing in India. Several Ayurvedic practitioners who were interviewed referred to the split between the purists and integrationists (see Leslie 1992, pp. 185, 191–195). Although these characterizations are probably ideal types, they have relevance to a discussion about Ayurveda and its

future, and certainly there are practitioners who could be seen to represent one or the other types. The difference between these two positions could be formulated as follows: according to the purist, Ayurveda is a self-sufficient medicine, a science with a divine history, capable of dealing with any affliction; according to the integrationist, in turn, only by accepting the use of modern technology and integrating it into Ayurvedic methods and education, will the existence of Ayurveda and its popularity and utilization in a clinical setting be secured. It could be argued, however, that whatever the benefits or detriments of medical integration, the point is that in the face of the emergence of commercial forms of Ayurveda, the question of integration in relation to purity appears to be of secondary importance. Clearly, the aim of this paper is not to defend medical orthodoxy, to advocate pure Ayurveda or to stress harmful influences of other medical approaches, which could be seen, from a point of view of a purist, to deteriorate the classical foundation of Ayurveda.

The crux of the problem is that as a result of omnipresent health markets the differentiation of care has impacted also on Ayurvedic treatment. And, as far as the Ayurvedic industry is concerned, it has even been remarked that the 'encounter with the modern market is successful only to the extent that Ayurvedic pharmaceuticals accept the ground rule; the industry responds and caters only to those who could afford its products' (Banerjee 2002, p. 464). Hence, despite the importance of the question of purity, a more crucial issue seems to be the relationship between the integration and increasing inequality in a non-biomedical sector. Apparently the disparity in treatment in the field of Ayurveda is a result of several interrelated reasons, such as: (1) the establishment of luxurious private Ayurvedic centres, actively advertised for foreigners and wealthy consumers, (2) the fact that Governmental subsidies for public Ayurvedic institutions lag behind the ones given to biomedical care, which strengthens the differentiation of Ayurvedic services, (3) the increase in the price of Ayurvedic products and services due to the commercialization and standardization of Ayurvedic therapy in the context of a booming industry and marketing and (4) the conversion of Ayurvedic practitioners from 'small-scale producers to consumers of large-scale manufactures' (Banerjee 2002, p. 446), an aspect that effectively associates Ayurvedic practitioners with an Ayurvedic industry.

So, if it is that in order to be successful in domestic and global markets, 'Ayurvedic medicine had to be cast in the mould of modern medicine and disconnected from its relationship to the knowledge system' (Banerjee 2002, p. 438), it follows that the growing inequality in the field of Ayurveda goes hand in hand with the market-oriented Indian medicine, which, in turn, fosters the integration between Ayurveda and biomedicine. Whether opposed or not, medical integration between therapeutic approaches in India will, obviously, become more intense, irrespective of repercussions. And since it is a multidimensional phenomenon, it has implications that are ramified throughout the entire health-care system. However, in order to understand these implications, as far as the Mysorean health culture is concerned, we must turn first to health-seeking behaviour, and secondly, to healing objects.

Health Seeking in Mysore

Like most cities in India, Mysore is packed with clinics, pharmacies and hospitals. In terms of quantity, people have easy access to health services, mainly allopathic, Ayurvedic and homeopathic. This does not mean that every Mysorean can afford these services or choose between different alternatives, for it might be that there are no alternatives for them—they have to consult the practitioner they can afford to or who is available for them. However, there is an abundance of therapists to be consulted and pharmacies to be visited, and for the majority of urbanized Mysoreans there are at least some services to be utilized. Clearly, from the vantage point of Mysorean plural medical culture,⁷ the question of medical integration appears to be an even more multifaceted issue than indicated above. To put it simply, while consulting different therapeutic authorities for specific symptoms and ailments, patients are contributing to the integration of therapies they are undergoing.

Yet, despite these options the choice of therapies follows a specific path, as will be shown. It is also interesting that clients' ignorance of the details of specific medical approach(es) does not necessarily contribute to the decline of medical pluralism or a lessening of integration, at least in Mysore. The ignorance of one approach, however, does contribute to the popularity of other approach(es). Consider the following cases from Mysore city.

Case 1

April 2002, a middle-aged woman, 41, an in-patient in a private Ayurvedic hospital (based on an account given by the patient and her husband in a general ward):

The woman has suffered from haemorrhoids for the last 6 months. She first consulted an allopathic doctor who was, however, unable to help her, though she was administered various drugs. She visited another allopathic doctor who referred her to a cancer hospital. She underwent radiotherapy, but the treatment was unsuccessful. Afterwards the haemorrhoids ruptured and resulted in a serious problem. Because her husband had consulted an Ayurvedic doctor for tonsils ten years earlier, and the result of treatment was good, they decided to visit an Ayurvedic hospital next to their home. The husband stated that he was also supposed to be operated in an allopathic hospital for his tonsils, but due to the advice of his friend they visited (the husband and his friend), before the intended operation, an Ayurvedic doctor who was familiar with his friend. The doctor prescribed him one lotion and a specific powder and soon his problem was gone without any operation. The husband said that he would not have expected and believed that Ayurvedic drugs would cure him. Later he had advised his family members to consult Ayurvedic practitioners. Regarding the haemorrhoids, his wife, however, first wanted to consult an allopathic doctor because of her expectations of proper treatment and because of her unfamiliarity with Ayurveda. The wife's medication has, in fact, just started and doctors have ordered her food restrictions (*pathya*).

Case 2

April 2002, a middle-aged man, 44, an in-patient in a private integrated hospital (based on an account given by the patient in a single room in a ward):

The man had psoriasis. He used to take allopathic medicines and had consulted allopathic doctors for his ailments until October 2001, when he visited for the first time an Ayurvedic hospital. His problems had started one year previously. He had visited a temple and offered a lock of his hair to the God (the patient did not, however, discuss the relationship between his offering and illness, he only alluded to it). Two months later he started to suffer from skin problems. He consulted a dermatologist who diagnosed his ailment as psoriasis. The doctor prescribed him a very expensive cream and some pills. The result was, however, negative. And, moreover, psoriasis had spread from his head to his legs. Finally, his friend told him to approach an Ayurvedic doctor who could be consulted in a specific nursing home. He had his doubts about Ayurveda, but because his condition was becoming worse, he had been willing to consult the doctor. He visited the nursing home for the first time in October 2001 and was admitted for a week; the second visit was in December 2001, again for a week. His third and last visit started in April 2002, and he was waiting to be discharged at the time of the interview. He was administered oils, tonic, tablets and powder with some food restrictions and was advised to drink hot water. His sufferings were over. According to him, he was totally cured. He was extremely happy about his condition and was full of confidence in Ayurvedic treatment.

Case 3

March 2002, a young woman, 25, and her mother, 56, out-patients in a private Ayurvedic clinic (based on an account given by the daughter in an Ayurvedic clinic):

The daughter felt that her eyes were dry and she was worried because of the yellowness in her eyes. She had consulted an allopathic doctor, as her first option, but the medicines, which she got, did not improve her condition. According to her, the doctor did not pay attention to her complaints. She was very disappointed with the care and was getting desperate after unsuccessful treatment. Eventually her brother recommended her to visit a specific Ayurvedic doctor. He himself had consulted him. The brother suffered from asthma. He was well at the time of the interview. The sister followed her brother's advice, and she was satisfied with the way the doctor dealt with her problem. He had prescribed her an oil treatment. She thought that her condition had already improved. This was her second visit. She took her mother with her because of the mother's obesity and dry skin. The mother did not have previous experiences of consultation with Ayurvedic doctors. The daughter said that she was hoping that the doctor could help her mother.

It could be argued that there is a general pattern behind the health-seeking behaviour in Mysore city. Regarding the patients who were interviewed, the first choice of treatment, for the majority, was biomedical treatment—a finding that is supported by a small survey, conducted in trains and buses and at the university of Mysore (see below; cf. Pillai *et al.* 2003, pp. 785–786). Certainly many people, before consulting a doctor, rely on self-medication, consisting of various methods, medicines and articles, such as allopathic and Ayurvedic drugs, herbs, liquids and

food items, which form the base of medical knowledge in a local popular sector. The form of self-medication that is based on the knowledge of herbs, spices and other food items is often called in Mysore *haggi/hithala oushadi*,⁸ the grandmother's medicine, indicating the inherited and family based quality of treatment. One may add that the therapeutic use of foodstuffs brings the grandmother's medicine near to the realm of classical Ayurveda. This alludes, apparently, to the ambiguities in the cultural conceptualizations, which are related to Ayurvedic medicine. Needless to say, however, everyone does not have specific knowledge of herbs and spices. Regarding the Mysoreans, there are no omniscient informants, and regarding the grandmother's medicine, every Mysorean is not an equally knowledgeable informant.

This finding does not come as a complete surprise to anyone. The incompleteness of laymen's medical knowledge, whether in the biomedical context, Ayurveda or grandmother's medicine, is the rule rather than the exception. As clear as this is that familiarity with healing techniques directs the choices of health seekers by giving preference usually to those who are known over those who are not.⁹ However, in plural medical culture the knowledge or lack of knowledge of therapeutic options and techniques has specific outcomes when it comes to choosing among therapies. Clearly, the disinterest in or lack of first hand knowledge of other approaches does not necessarily threaten the existence of plural culture, but patterns it.

To put it simply, ignorance of Ayurvedic practices is shaping the health seeking in Mysore. Biomedical treatment was an obvious choice, a form of therapy that was taken for granted, if compared with the preference for Ayurvedic practitioners who were consulted usually because of the failure of biomedical interventions. Consistent with these findings is that biomedicine, in terms of hospitals, clinics and pharmacies, dominates the medical scene in the city. The difference in quantity between allopathic and Ayurvedic services is considerable. Everyone who was interviewed was familiar with biomedical fixes, and had used either pharmaceuticals or injections. Everyone had consulted a practitioner who identified himself/herself with biomedicine. And whatever the outcome of biomedical treatment, the experiences of consultations followed in most cases the expectations of consultations. This is not to say that when searching for treatment, patients, because of the setbacks and disappointments, would not have visited several allopathic doctors, but to emphasize the commonplaceness of consultations in a biomedical context. Furthermore, even though some of the informants were familiar with their doctors, prior to the initial visit, one could not assume that the reason to consult a practitioner who was trained or assumed to be trained in biomedicine would follow, mechanically, from one's prior acquaintance with him/her.

The consultation of an Ayurvedic practitioner, on the other hand, was based, in most cases, on recommendations and suggestions that were obtained from friends and relatives after unsuccessful biomedical treatment. The impact of social relations is evident whenever people choose among the therapies. However, with regard to the information about Ayurvedic treatment, it appears to be extremely important, for most of the informants had no previous experiences of Ayurvedic treatment—as the three cases perfectly demonstrate. In short, people tend to consult allopathic practitioners, and only if the treatment and medicines are not able to improve their

condition, do they turn to Ayurvedic practitioners, usually after they have consulted several practitioners practicing English medicine. Clearly, Ayurveda was an obvious choice for only a small proportion of interviewed Mysoreans and, moreover, most of them had only rudimentary knowledge of Ayurveda, if not even that.

This is an extremely interesting finding. One would have expected that because of the energetic marketing of mass-produced Ayurvedic medicines and by advertising them through pharmacies and the media, information about Ayurveda would have been more widespread (cf. Banerjee 2002). But possibly because of the advertising, informants were usually able to name one or two Ayurvedic products manufactured by the leading companies, such as Himalaya or Dabur, mentioning that Ayurvedic drugs are not supposed to have side effects. This was, however, often all they knew about Ayurveda.

This finding is in striking contrast with Trawick's view that 'the basic categories of Ayurveda—the names and activities of the humors, the qualities of different times and places and types of weather, the categories of food and their effects upon the body—are common knowledge in Tamil Nadu as elsewhere' (1992, p. 130). Plainly, one could question this assertion as far as the situation in Mysore city is concerned. In fact, Trawick's statement about 'the basic categories of Ayurveda' as 'common knowledge' requires a considerable amount of knowledge of physiology and how it is explained according to Ayurvedic theory. Consider, for example, the activities of the three humors—*vata*, *pitta*, *kapha*—that are essential for Ayurvedic medicine. Trawick's view contrasts sharply also with the following remark: 'The present system of Ayurvedic education, with its emphasis on the therapeutic part rather than on the conceptual basis, also leaves many things to be desired', that is to say, 'we have now, innumerable practitioners throughout India, but have only few Ayurvedists who are proficient in Ayurvedic concepts' (Sivarajan & Balachandran 1994, p. 3). If there is a need to improve the knowledge of the conceptual foundation of Ayurveda among practitioners, surely this holds good in the case of laymen. Evidently, there is nothing like a shared Ayurvedic knowledge in Mysore city. Although there exists an Indian medicine, which is available for most Mysoreans, there are so many people 'who don't know anything about it', as many Ayurvedic practitioners mentioned.

An obvious argument is that in the Mysorean plural medical culture Ayurvedic services work as a secondary health resort, and as such they offer a health exit for dissatisfied patients. They are known to exist, but it is not usually known what is included in them. The biomedical power in India has, of course, a distinct history. During the colonial period the preference, on the part of health authorities, was given to biomedical treatment—curiously enough, inequality in support has continued during the era of independence (see Gupta 1976; Banerji 1981; Jeffery 1982; Arnold 1993, pp. 50–60; Kumar 1998, pp. 19–22, 68–77; Arnold 2000, pp. 65–75; Krishnankutty 2001, pp. 66–73, 90–92). Hence, despite the fact that during the colonial rule and afterwards Ayurveda has had its clientele, above all in rural areas, the colonial impact on health culture cannot be overlooked. This is true especially in cities, and a royal city like Mysore, which was the seat of the Maharaja of Mysore and the base of British Resident, is no exception.

In modern urban Mysore the users of Ayurvedic services are in the minority among health seekers, and Ayurvedic services have an auxiliary role to play. The hierarchical order of therapies cannot be disregarded. This is not to argue, however, that Ayurvedic medicine is of no value. Despite its position as a secondary health resort, it makes up a considerable health resource. Patients who were interviewed were usually satisfied with the treatment they had obtained from Ayurvedic practitioners. In addition, the position of Ayurveda is anything else but static. As underscored, there are several factors to be noted. First, because of the promotion of Indian systems of medicine and their integration into the state health-care system, the status of Ayurvedic medicine, in the proximity of biomedicine, is increasing, at least with reference to health policy, if not in the minds of health seekers. Secondly, because of the booming Ayurvedic industry and medicine marketing, the relationship between Ayurveda and biomedicine is intensifying. Manufacturers and entrepreneurs from both fields, with homogenized strategies to reach the consumer, are equally active players in the health market. The border between Ayurveda and biomedicine is becoming more indefinable as regards the marketing of medicines and services. And finally, when searching for treatment and consulting various practitioners, possibly to a growing extent due to the former reasons, health seekers are creating bonds between various approaches and at the same time blurring their boundaries. All these reasons bolster integrated health care and increase the awareness of Ayurveda. However, there is nothing that indicates that Ayurvedic services in Mysore city will not continue as a secondary health resort also in the years ahead, or that the health-seeking pattern in the city will change radically. This view is supported by the issue we shall discuss now.

The Appeal of Instruments

If the health-seeking pattern in Mysore city has a specific nature, one could assume that it might also have specific implications that are related to the expectations as regards the consultations and treatment. Moreover, if instruments designed for biomedical checkups and treatment are widely used in the context of Ayurveda, one could argue that this is an additional example of medical integration—as has been suggested above. Clearly, the same tools, the same professional etiquette, the same attitude to medicines, and the same figures—gods and gurus, divinities and teachers—are embodied in the routines taking place in various forms of health services. If so, patients' familiarity with medical instruments, pharmaceuticals and technology within the framework of biomedical treatment has possibly something to do with the expectations occurring in other fields of therapy.

In order to examine the appeal of instruments more deeply, in addition to interviews and participant observation, a questionnaire was administered to 101 students in the Library of the University of Mysore and to 132 passengers in trains and buses between Mysore and Bangalore (total 233).¹⁰ According to the results, 83% gave a positive and 17% a negative answer to an assertion 'Whenever I am sick I prefer English medicine' (Figure 1). Out of the same sample 46% gave a positive and 54% a negative answer to an assertion 'I am familiar with

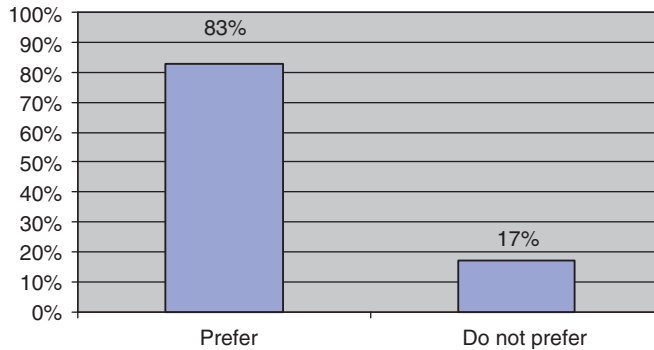


Figure 1 Prefer English Medicine

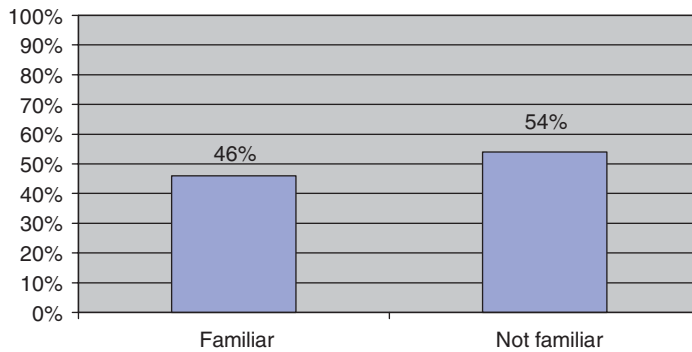


Figure 2 Familiar with Ayurvedic Treatment

Ayurvedic treatment’ (Figure 2). The results of the latter assertion are nearly identical with the results of the next assertion ‘I expect that Ayurvedic doctors use instruments, like stethoscopes’.

That is to say, nearly half of the respondents (46%) stated that they are familiar with Ayurvedic treatment and that they expected to see instruments during the consultation. Yet most of the respondents (83%) preferred English medicine. The preference for English medicine becomes even more interesting when the first two assertions are inter-related (Figure 3). Indeed, from those who were familiar with Ayurvedic treatment, 73% preferred and only 27% did not prefer English medicine—more obvious, of course, is that from those who were not familiar with Ayurvedic treatment, 90% preferred and 10% did not prefer English medicine.

The survey brought to light, however, an additional finding that is vital in this connection. When an extra open-ended question—‘Could you tell us briefly what do you know about Ayurveda?’—was added to the questionnaire administered to passengers in trains and buses, results were informative. Namely, 70% of the passengers did not answer or could not give a sensible response to the question, 13% stated that Ayurvedic treatment does not have side effects, 11% emphasized the time-consuming nature of Ayurvedic treatment and 6% mentioned both that the

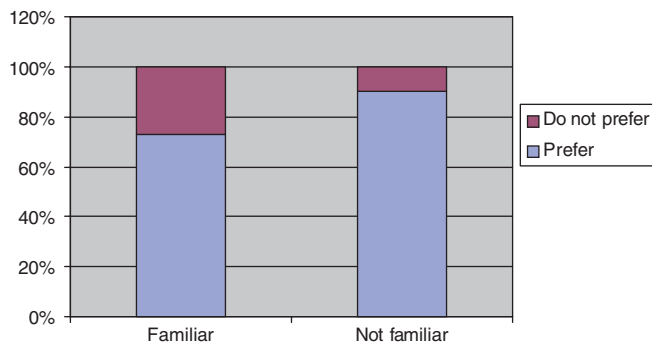


Figure 3 Preference for English Medicine among Respondents who were Familiar/Not Familiar with Ayurvedic Treatment

treatment does not have side effects and that it is a long process. One should remember that these two aspects, the question of side effects and prolonged treatment period, are the two most common cultural idioms that identify Ayurveda in Mysore city. As such these answers could be regarded to serve as examples of Ayurvedic knowledge as a form of cultural knowledge. However, at the same time they reveal the force of conventional expressions. They point to the repetitive nature of culturally accepted information, and as such eventually transform into cultural liturgy. These two aspects were virtually the only aspects the passengers knew about Ayurveda.

There appears to be an interesting paradox. Most of the respondents preferred biomedical treatment, but nearly half of them stated that they are familiar with Ayurvedic treatment. Yet, regarding the passengers, most of them were unable to describe briefly what Ayurveda is, although half of them claimed that they are familiar with Ayurvedic treatment and were expecting that Ayurvedic practitioners use instruments. Any radical Mysore-wide conclusion drawn from the questionnaire would be unreliable. However, regarding the problem of instruments in relation to health-seeking pattern, these results support the information gathered from participant observation and interviews with practitioners and patients. As such, they deserve a more careful consideration. Considering the interviews and participant observation, there are two issues that coincide with these results. The first one is related to the expectations of patients, and the second the exploitation of instruments.

First, according to the interviews many clients were expecting to see instruments in Ayurvedic clinics. A very popular clinic that is run by Doctor R, who is qualified both in allopathy and Ayurveda, offers a good example. Although there is no need to speculate which is the most popular Ayurvedic clinic in Mysore city, the one of Doctor R seemed to attract more patients than many other clinics in town. Some of the patients mentioned that they preferred Doctor R because of his knowledge of both approaches and because he is well equipped for diagnosing patients. Doctor R's clinic was not an exception. Many informants in other clinics with whom the issue was discussed regarded the presence of tools as important. And moreover, all of the

informants who had experiences of consultations with Ayurvedic practitioners had visited one who possessed instruments.

Secondly, it is paradoxical that even the most eager defenders of pure Ayurveda were forced to rely on the symbolic power of instruments and were dependent on the technological solutions characterizing biomedical services and practices, such as X-rays. Only one Ayurvedic practitioner, out of twenty-five interviewed, did not have a stethoscope or other instruments associated with biomedical checkups and treatment in his consulting room. Furthermore, clients often ask, in order to estimate a doctor's ability, whether he/she has distinct instruments, such as a stethoscope or a sphygmomanometer. Three Ayurvedic practitioners claimed that they never use their 'allopathic' equipment and that their role was purely to offer 'mental' images to their patients. So, however apparent the therapeutic relevance of articles utilized by various healers, as apparent, it seems, is their symbolic and social relevance. These findings are in accordance with previous studies. It has been stated that 'most registered practitioners [of Ayurveda], and particularly those trained in colleges, are convinced that for the good of their patients, and to support themselves in practice, they cannot give up vitamin and antibiotic injections, or symbols of medical expertise such as the stethoscope' (Leslie 1992, p. 185). And furthermore, as early as 1971, in a study of 'traditional healers' in a rural region around Mysore, it was shown that all full-time practitioners, 30 in all, 'who dispensed allopathic drugs possessed a thermometer and a stethoscope, but only two used these instruments' (Alexander & Shivaswamy 1971, p. 599). Interestingly, 22 out of 30 were Ayurvedic practitioners.

These examples inform us about the commodification of health (see Nichter & Nichter 1996, pp. 269–271). In Mysore city a well-known Ayurvedic practitioner mentioned that earlier in his career he used to fill empty capsules with powdered Ayurvedic drugs to attract suspicious patients with a form of medicine they were expecting to be given. Nowadays he is prescribing only the powders to his patients, rather than in capsules, but, as he stressed, in order to do that he had to familiarize his patients with Ayurvedic medication. Or, as a senior Ayurvedic practitioner in a Government hospital expressed the issue: 'In rural areas, especially, Ayurvedic doctors have to be ready to use allopathic methods, like injections, otherwise patients would not attend to your clinic.' Several practitioners with whom the issue was discussed confirmed the observation. But, as indicated, it is not only in rural areas where practitioners have to draw on biomedical tools and pharmaceuticals—the same holds true for practitioners working in Mysore city: 'You have to have these instruments in your office also in the city, and whether or not you use them, patients are expecting to see them.'

It follows that in spite of differences in the treatment process (biomedical substances and methods vs. Ayurvedic substances and methods) and theoretical sources (biomedical theory vs. Ayurvedic theory) there are no significant differences between biomedicine and Ayurveda as regards the significance of the presence of instruments. What is at issue here is that most Ayurvedic colleges in South India follow the policy of integration. Because courses in biomedicine are included in the curriculum, college-trained Ayurvedic practitioners have usually learned the principles of biomedicine and are familiar with biomedical concepts and

instruments. And as a result, the ancient categories of nosology and physiology are often replaced by biomedical ones in a clinical reality where the difference between Ayurvedic and allopathic practitioners disappears. Apparently, in order to gain popularity and succeed in a Southern Indian medical setting, Ayurvedic practitioners are favouring institutional integration and exploitation of items and practices that are peculiar to biomedicine. Furthermore, it has been underscored that the educational policy that is related to Ayurveda 'has been implemented by people who feel that they have to prove the value of Ayurveda by using the language of modern science' (Leslie 1992, pp. 184–185). The discursive change in Ayurveda and the establishment of integrated colleges during the last five decades has had, however, an additional consequence, namely, the professionalization of Ayurveda, which is an ongoing process. Present-day Ayurvedic practitioners form a profession that has its base on a standardized and formal education obtained from medical colleges. Due to the professionalization, conceptual change and familiarity with instruments and technology, most Ayurvedic hospitals have adopted a culture particular to biomedical institutions. Plainly, in an urban context, like in Mysore city, there are no significant differences between biomedicine and Ayurveda as regards the professional and intellectual context of health and healing.

But how should we interpret these findings? It seems that besides the official status of Ayurvedic treatment—acknowledged by the Government of India as a significant sector of health care—and the formal promotion of medical integration, which strengthens the integration of Ayurveda into the state health-care system, the integration has other dimensions, as noted, such as the exploitation of instruments and technology in Ayurvedic clinics and hospitals. This particular aspect seems to advance the relevance of tools and things. Health seekers' expectations of consultations as well as practitioners' expectations concerning the expectations of their patients are both related, at least partly, to the significance of instruments. In this specific sense the impact of biomedicine on Ayurvedic practices is explicit. In general, the role of instruments and technology should be considered in relation to the omnipresent medical integration, dominance of biomedicine, and a specific health-seeking pattern, in which Ayurvedic services operate as a secondary health resort. All of these aspects seem to strengthen the positive meaning of things and tools that have their origin in biomedicine, and by doing so they are fortifying biomedical therapy against other therapies, which in turn is sustaining the existing health-seeking pattern.

Conclusion

It has been shown that, in order to discuss modern Ayurveda, one should pay attention to medical integration, health-seeking pattern and a demand for material objects. These three issues, being interrelated with one another, form the modern base of Ayurvedic services in Mysore city. To put it briefly, it has been argued that the following aspects characterize the Mysorean medical culture: (1) the popularity of biomedicine as the first choice of professional treatment and the role of Ayurvedic

medicine as a health resource (patients, however, were usually satisfied with the Ayurvedic treatment they had received), (2) the lack of experiences and first-hand knowledge of Ayurvedic medicine on the part of health seekers (the ignorance of Ayurveda has not, however, been detrimental to plural medical culture; despite the biomedical power the Indian systems of medicine have their clients), (3) the significance of instruments, tools and technology as regards the expectations of patients and practitioners in the context of consultations, (4) the influence of biomedicine on other therapies, especially with respect to concepts, discourse, diagnostic technology, instruments and pharmaceuticals, (5) the professionalization of Ayurvedic treatment, (6) the commercialization of Ayurveda and (7) the fundamental nature of medical integration, for it seems that integration with biomedicine is essential for Ayurveda to succeed in the health market.

It appears that symbols of healing have a demand that exceeds their most obvious context. However, in order to discuss the healer's paraphernalia, one has to identify the interplay between things and social forces that manifest themselves in the field of health and healing. This is obvious in Mysore city, where various levels of medical integration and particularities of health seeking seem to inform us about the meaning of instruments.

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Notes

- [1] For a critique of the modern versions of Ayurveda, see Zimmermann (1992), Nichter and Nichter (1996, pp. 292–299), and Banerjee (2002).
- [2] Interviews with practitioners trained in biomedicine, homeopathy or Siddha medicine, as well as participant observation conducted in biomedical, homeopathic and Siddha clinics, are not referred to in this paper.
- [3] *Vaidya* is an Ayurvedic term for a doctor, the one who cures, see Kutumbiah's excellent introduction (1999, pp. xliv–liv; see also Krishnankutty 2001, pp. 17–28, 111–127). On the work of modern *vaidya*, see Dash (1999, pp. 118–132).
- [4] Regarding the practitioners and clientele, generalizations based on gender seem to be inaccurate. There are many female Ayurvedic practitioners in Mysore city to be consulted. With reference to data, one in three practitioners interviewed was female. Likewise it would be problematic to argue that gender has a crucial role to play in the make-up of clientele. Both male and female patients are regular visitors to Ayurvedic clinics and hospitals. It should be mentioned, however, that it has been argued that in the neighbouring state of 'Kerala, the gender of the child ... did influence whether care was sought in the alternative or the allopathic system' (Pillai *et al.* 2003, p. 789).
- [5] One should state, however, that Ayurvedic medicine could not be considered as a field of activity that could be disconnected from the history of caste hierarchy. The history of the

practice of Ayurveda is bound up with the Brahman caste, despite the fact that the identity of Ayurvedic practitioners had alluded also to other high castes. Due to their knowledge of Sanskrit, Ayurvedic medicine offered a special field for Brahmins, and they dominated it in many parts of India still in the beginning of the twentieth century (see Krishnankutty 2001). The situation has changed, however, considerably during the last 50 years, and although there are still many Brahmins among the contemporary Ayurvedic practitioners in Mysore city, for example, they do not have the majority. And moreover, in spite of caste-related history, caste could not be regarded as a significant factor, which would shape the formation of clientele in today's Mysore. Briefly, it would be impossible to draw any conclusions from the use of Ayurvedic services by relating clients to individual castes. With respect to this argument, caste is not examined below.

- [6] For the rise of revived Ayurveda within the framework of strengthening nationalism, see Leslie (1976; 1992, pp. 179–185), Jeffery (1982, pp. 1835–1837), Kumar (1998, p. 71), Arnold (2000, pp. 176ff), and Langford (2002, pp. 63ff).
- [7] No doubt, pluralism is a state of affairs nearly everywhere. With respect to the arguments presented here the point is, however, that the coexistence of diverse healing and medical practices is most clearly observed in circumstances where biomedicine, historically, is a recent form of therapy and where various indigenous healing and medical practices, in turn, have a long history and cultural acceptance, especially in Asia and Africa.
- [8] *Haggi/hajji* means grandmother in Kannada, the language spoken in Mysore, as in Karnataka in general, whereas *hithala* refers to an uncared for garden or the backyard of house. *Oushadi*, in turn, is a singular form meaning medicine (pl. *oushadigalu*).
- [9] This is not to deny, of course, other reasons, such as economic ones. The poverty-stricken people, especially, do not have time for long treatments, which are distinctive of Ayurvedic therapy, and which would require resting periods. Obviously, it is more convenient for them to consult a pharmacist or biomedical practitioner to get quick fixes. Practitioners working in the Government Ayurvedic hospital in Mysore emphasized this aspect regretfully.
- [10] The questionnaire contained 15 questions, written in English and Kannada, with an option of yes/no. However, only four of them are dealt with in this paper (see Appendix).

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Appendix: Questionnaire

Place:

M/F:

Qualification:

Tick yes or no:

- | | |
|--|--------|
| (1) Whenever I am sick I prefer English medicine. | Yes/No |
| (2) I am familiar with Ayurvedic treatment. | Yes/No |
| (3) I expect that Ayurvedic doctors use instruments, like stethoscopes. | Yes/No |
| (4) Ayurvedic medicines are more expensive than allopathic medicines. | Yes/No |
| (5) Ayurvedic medicines have side effects. | Yes/No |
| (6) I buy medicines without consulting the doctor. | Yes/No |
| (7) I always go alone to the doctor. | Yes/No |
| (8) My father/husband makes the decision concerning the mode of treatment. | Yes/No |

- | | |
|---|--------|
| (9) Allopathic medicines have side effects. | Yes/No |
| (10) I use Hittala Houshadi. | Yes/No |
| (11) I have knowledge of plants and herbs and how to use them for ailments. | Yes/No |
| (12) I use allopathic medicines for self-medication. | Yes/No |
| (13) I use Ayurvedic medicines for self-medication. | Yes/No |
| (14) I visit the doctor immediately I have symptoms. | Yes/No |
| (15) Could you tell us briefly, what do you know about Ayurveda? | |