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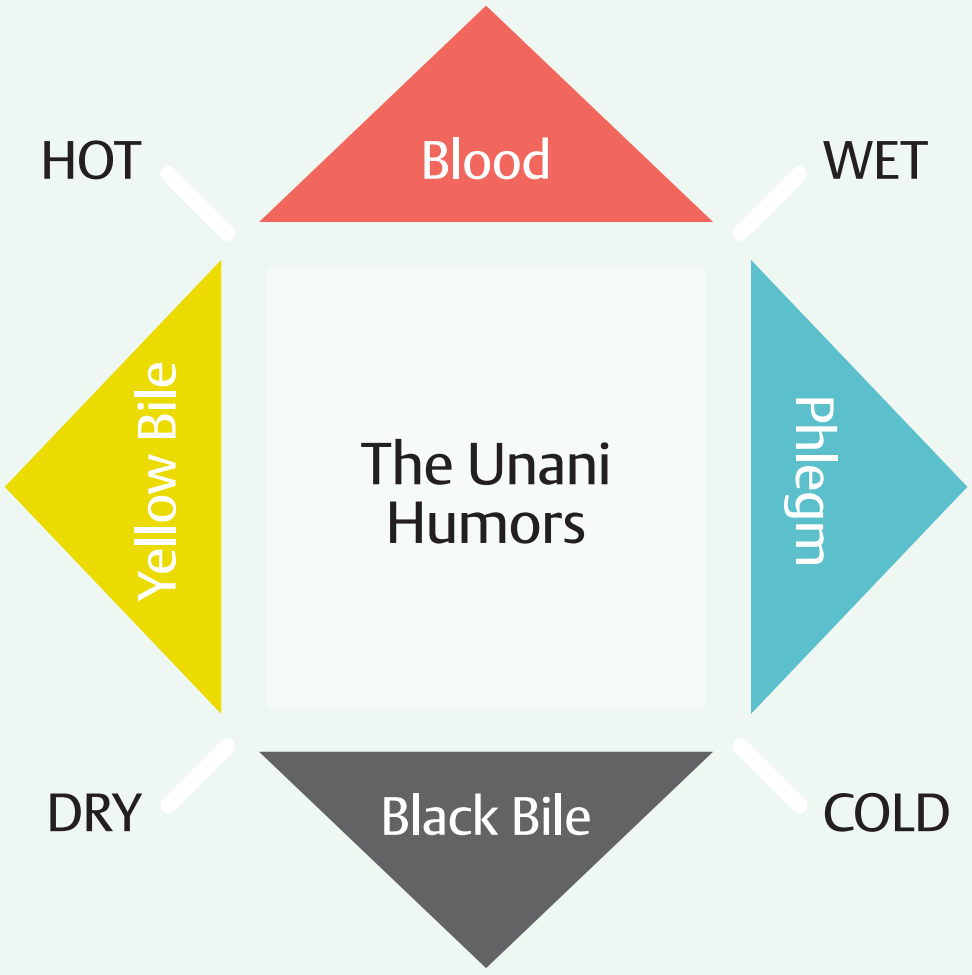
Essentialising the body

Unani refers to the Graeco-Arab system of medicine as it has developed in the Indian subcontinent since the 12th century. Unani responded to the western medical absolutism of the colonial period and the communal machinations of the post-colonial period also by essentialising the body. This is true for Unani's representation of the human body as for its body of knowledge. This was in part 'tactical' in the face of a perceived threat of extermination, domination and denigration by the structures of power; and also to critically foreground the constitutive elements of Unani medicine distinct from other forms of medicine, which acquired specific connotations in the given situation. The body became tension ridden. Unani-Muslim, canonical-local, elite-subaltern, colonialism-nationalism-communalism, Ayurveda-Unani-western medicine, are some of the oppositions that formed the constitutive elements. These categories were manipulated in the process of defining the human body and the body of Unani knowledge.

Neshat Quaiser



Inset:
Unani modernizer Hakim Ajmal Khan (1868-1927) who belonged to the Sharifi family.

UNANI MEDICINE IN INDIA has always been a dispersed medical practice with broadly two parallel streams – a canonised and elite form and a more relaxed and heterogeneous subaltern form often challenging the elite medical authority. From the dominant literate perspective, in the public, political and professional sphere Unani's canons and its social identity became important tools in essentialising the body in relation to western medicine during the colonial period. Logic was that a deeply canonised western medicine, promoted by the state, was to be countered by an equally authoritatively canonised non-colonial medicine. According to this same rationale, in the post-colonial period it was Ayurveda that was to be similarly countered, but then with regards to its communal politics. Culture, economy and identity formation became organising principles in this process.

Essentialising Unani's history

The origin and history of Unani and its Indian connections emerged as a critical site to essentialise the body to counter the colonial onslaught. The past was deployed to create a space where the battle could be fought for the present. Hippocrates, Greek philosopher-physician and founder of canonised Unani medicine, established that disease was a natural process and that the chief function of the physician was to aid the natural forces of the body. His chief contribution to the medical realm is the humoral theory. Galen (131-210 AD), after Hippocrates, is considered to have consolidated its foundation on which Arab physicians like Abu Bakr Muhammad bin Zakariyya Ar-Razi (Rhazes) (850-925 AD) and Abu 'Ali Husain bin Abdullah bin Sina, popularly known as Ibn Sina, (Avicenna) (980-1036 AD) built the contemporary structure. It was consistently claimed that Ibn Sina's Qanun (Canon Medicinae) was the most authoritative medical work in European medical institutions for five centuries. Thus, western medicine was projected as an extension of Unani.

Improved and systematized by Arab Scholars, Unani medicine arrived in India in the 12th century. Here Unani was further developed and it flourished throughout the Indian subcontinent, becoming immensely popular among the great masses. Even after the advent of western medicine, Unani's popularity continued. Despite its Muslim connection, Unani was never Islamic but inclusive in its nature. Nevertheless, Unani's supposed Islamic identity was strategically employed as a significant component in essentialising its body in the colonial and post-colonial period. Thus, despite Unani's inclusive approach, theoretical openness, and wish to 'renew' itself in the face of theoretical protectionism of western medicine and Ayurveda's claimed nationalistic and indigenous exclusiveness, the body was essentialised both canonically and syncratically.

Essentialising Unani's ontology

Unani's fundamentals also became a potent site to essentialise the body in its resistance to both western medicine and Ayurveda. The fundamentals of Unani are based on humoral theory which emphasizes the body's internal capacity to remain healthy and fight disease. This differs from the germ theory of western biomedicine, where germs threaten the body as external agents. In its opposition to British colonial monopoly on medical know-ledge Unani essentialised the body and used the externality of germs as a metaphor. Like germs attacking the body from the outside, western medicine invaded India's geographical body and the bodies of individual Indians.

Every person is supposed to have a unique humoral constitution that represents his healthy state. To maintain the correct humoral balance the body has the ability of self-preservation and adjustment called *Quwwat-e-Mudabbira [medicatrix naturae]*. Medicines and diets are employed to maintain or restore humoral balances. Unani has laid down six essential prerequisites for the prevention of diseases known as *Asbab-e-Sitta Zarooriya:* air; food and drink; bodily movement and repose; psychic movement and repose; sleep and wake-fulness; and excretion and retention. These fundamentals were crucial and useful as distinct markers to essentialise the body by Unani, in opposition to the colonial and communal politics of western medicine and Ayurveda respectively.

Essentialising Unani as anti-colonial

With the onset of colonialism, medicine became a hotly contested zone and emerged as a crucial colonial tool of domination. We find a twin process of *domination* of western medical knowledge and *resistance* to it. However, despite indigenous systems being declared 'static' and 'irrational' by the colonial authorities, it was India's indigenous systems of medicine that treated most medical issues of colonial India. Despite this fact, medicine did not figure crucially on the nationalist agenda, with Indian nationalists displaying a very lukewarm response to the renewal of Unani.

Unani's opposition to western medicine during the colonial period was grounded in a deep sense of injustice – committed by western medical absolutism. The upholders of Unani emphasised characteristics of Unani, such as its belief that knowledge is a shared heritage, its inherent opposition to the logic of the capitalist market, and its anti-colonial signature. In the colonially structured situation of domination and denigration Unani thought it necessary to essentialise its body of knowledge and its conceptual-isation of the human body by delineating its ontological borders, its history and its contribution to the making of western medicine.

Locating medical domination and resistance

The social historian Projit Bihari Mukharji, in his influential work *Nationalizing the Body* (2009/2012), through an excellent exploration of the social world of Indian practitioners of western medicine –the *daktars* –has argued that western medicine was absorbed and vernacularised within society in British Colonial Bengal, and as it was not solely guided by the colonial state it did not remain 'western'. Western medicine was practised by postgraduates of the Calcutta Medical College, as well as by all sorts of people such as dressers, compounders, and quacks, and all were accepted as *daktar.* But this did not suggest any ontological distinction between *daktari* and biomedicine –what they practised was still western medicine. Vernacular forms of the word 'doctor', such as *daktar, dagdar,* and *daktari, dagdari, angrezi dawa* [English medicine], etc., did not make it local or native. The middleclass Bengali *daktar* constructed his identity in the image of a western doctor, with all the visible signs of authority, and also through the ways in which people, including uneducated ones, imagined doctors and biomedicine, which was certainly not like any other local medicine, but decidedly English medicine. And if *daktar* had a fluid identity as Projit argues, so too did the *hakims* [Unani practitioners]. Along with trained *hakims* there were large numbers of Unani practitioners without any formal training and without a license, such as *a'ttars* [apothecary] and *pansari* [grocer].

When in need, people consider all sorts of medicine and healing practices that are accessible and affordable. Biomedicine was used because it was popularised and made accessible. After all, like the Permanent Settlement, Fort William College, English Education, *babus, sahibs, mems,* new judiciary, or Indians in the army and the police, western medicine became a reality to them. Yet there was almost no scope for reciprocal sharing. Local, traditional medical knowledge and healing practices were declared irrational, unscientific, and inauthentic. Heterogeneity of healing practices was to be replaced by western medicine's absolutism. The process of the absorption of western medicine in Indian society was linked to the colonial ideological state apparatuses where knowledge was intrinsically linked with power.

But to argue that there existed a neatly drawn bipolarity between western medicine and Indian forms of medicine, would not be true. For instance, in the case of Unani we find a 'simultaneity' of resistance-learning-renewal, and contextually propelled issues such as what counts as quackery, and the controversy over medical registration and medical reform. This constituted a complex whole fuelled by the spread of and challenge from western medicine.

Essentialising Unani post-colonially

Unani in the post-colonial situation is intrinsically linked with its colonial contexts. With the defining event of India's first struggle for independence in 1857, colonial India's various social spheres were increasingly communalised, and medicine too did not remain untouched, resulting in Ayurveda and Unani being projected, respectively, as the markers of Hindu and Muslim interests and identities. 1857 also radically altered the social lives of the Muslim high caste elite who later emerged as the visible propagators of Unani. Efforts to bring Unani and Ayurveda together on an anti-colonial platform collapsed soon after the partition of India in 1947.

In post-colonial India, colonial and post-colonial time zones collapsed into one. In both periods the nature and manner of complaints are strikingly similar. However, with a change in contending parties –from Unani vs. western medicine in the colonial period to Unani vs. Ayurveda in the post-colonial state. The past is constantly referred to in a critique of Unani's present situation. In the post-colonial period Ayurveda was projected as indigenous and as the only Indian medicine representing the spirit of India, whilst Unani became an outsider, inextricably linked with Muslims who partitioned the sacred body of mother India (see Hardiman on indigeneity and global market). However, in addition to communal politics, several other dimensions such as economy, market and new identity came into play in the post-colonial situation.

For the post-colonial health and medicine related state policies the Chopra committee, formed towards the end of colonial rule to address the problems of Indigenous Systems of Medicine, became an important benchmark. State policy in the initial years after 1947 was influenced by the recommendations made by this committee's report (1948), particularly by what it had to say on integration or synthesis of the three systems of medicine –Unani, Ayurveda and western. The Chopra Committee was followed by the C. G. Pandit and D.T. Dave Committees. However, most of their recommendations were concerned with Ayurveda, not so much with Unani. These recommendations were opposed by Unani practitioners as they were seen as a way to ultimately destroy Unani. They were also seen as a testimony of discrimination against Unani in the communally hostile post-colonial atmosphere where the Indian state appeared to be favouring Ayurveda. Once more Unani's independent identity was negated and essentialising Unani became necessary.

In 1969, systematic research in indigenous systems of medicine began with the establishment of the Central Council for Research in Indian Medicine and Homeopathy (CCRIMH) by the Government of India, but in 1979 the Central Council for Research in Unani Medicine (CCRUM) came into existence because votaries of Unani felt subsumed within the CCRIMH structure. In 2009 the CCRUM consisted of twenty-three research centres across thirteen Indian states. Now there are forty-one recognised Unani colleges, spread over twelve states, including the National Institute of Unani Medicine in Bangalore. Unfortunately, compared to India's Ayurvedic infrastructure, the number of Unani institutions is still miniscule.

Essentialising Unani in response to the market

In the given atmosphere of statist and non-statist medical communalism Unani manufacturers complained that the manufacturing and marketing of Unani products became adversely affected causing serious impediments to the growth of Unani as a distinct form of medical knowledge. The Indian state was accused of discriminating against Unani as the following quotes illustrate: "After 1947 unani, its medicine and manufacturing has declined and weakened due to the policies and attitude of the people who hold power", and "ayurveda is making steady progress under the patronage of government" (Quaiser, 2012b).

Notwithstanding, Unani has in recent years made vigorous endeavours, beyond the mode of complaining, and has entered the arena of the competitive market for standardised products and is succeeding in popularizing Unani. This has added market driven demands, particularly since the World Health Organization listed Unani as one of the medical systems to be employed to achieve its goal 'Health for All by 2000'. In its attempts to enter the competitive medicines market, Unani has been reinventing its traditions in post-colonial India. To compete and cope with the adverse situation, Unani traditions of recent origin have been given continuity through the historical past with the objective to establish legitimacy and authenticity in the light of debates on alternative medicine and medical pluralism.

Various strategies such as free Unani camps, the establishment or restructuring of Unani manufactories, new marketing strategies such as newspaper and billboard advertising, television commercials, promotional short films, solicited governmental support, the creation of foreign markets, the establishment of wholesale agencies in different cities –all have been adopted to compete particularly with Ayurveda. Competition among different Unani manufacturing companies has also become a reality. This has clearly caught the public imagination and has attracted users of Unani medicine beyond its traditional constituency.

Survival, protection, prejudice, market and profit, all got mixed up and produced a complex whole. In the present context, market competition and profits occupy a significant space in Unani's imagination and representation. The mass-scale production and marketing demanded a government license, which became a marker of authenticity. However, the government rules regarding the manufacturing of Unani medicines are simultaneously opposed because rules for the production and sale of biomedical pharmaceuticals cannot be applicable to Unani products. This issue continues to be a source of both opposition and solidarity among Unani manufacturers and other stakeholders. This resentment, combined with comparative market strategies, has further advanced the process of essentialising the distinct body of Unani in India.

Interestingly, despite statist and non-statist communal prejudices there is a certain amount of collaboration between Unani and Ayurveda at the popular level of patients and practitioners as both *hakims* [Unani practitioners] and *vaids* [Ayurvedic practitioners] prescribe each others' products –and patients, irrespective of religious affiliations, visit both. The logic behind this is that patients seek a cure and medical practitioners want to make a living.

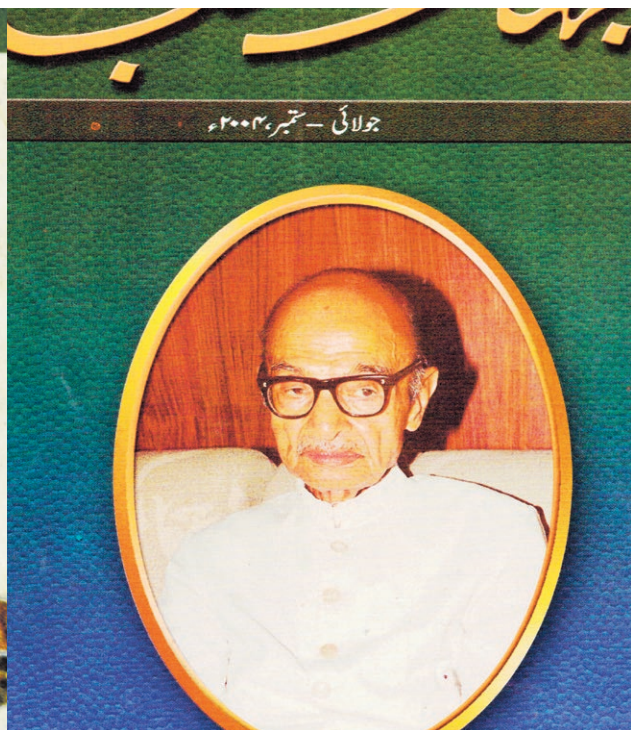
Essentialising Unani's identity

Medical communalism in post-colonial India resulted in a crucial need to essentialise the body of Unani's self in terms of a new Muslim-Unani identity vis-à-vis the 'other', represented by Ayurveda and the Indian state. Essentialising the body of Unani became a battlefield, but it also produced an enclosure when the adversary could not be combated. In the face of communal prejudices, seemingly strange arguments were marshalled in the process of essentialising the body of Unani. Take for example the 'establishment' of links between religious affiliations and the incidence of certain diseases. At one moment it was argued, with reference to a news item in the press, that if Hindus practised Unani medicine and concurring ways of life they would not be afflicted with stomach and gastric cancer. In the same vein are arguments such as "Profession of *tibb* [practicing Unani] (...) is not just a method of treatment but can become divine worship", and "Christian missionaries all over the world propagate Christianity through schools and hospitals" (Quaiser, 2012b). Now that Unani has become linked with Islam and Muslims, Unani practitioners and the public at large are also forced to accept this reality at least tactically. The obvious rationale is that if Unani is accepted as a Muslim knowledge system then it could be saved and developed in the age of 'competitive electoral politics' and 'assured safeguards for minorities'. There is evidence to corroborate this survival strategy and the ways in which it is linked to economy. Local and global senses of victimhood have also become involved. Thus, references to Christian missionaries take on a meaning in the context of local-global (real or perceived) prejudices against Muslims. Myths, metaphors and symbols are produced out of everyday experiences as palpable mechanisms to essentialise the post-colonial Unani body.

Neshat Quaiser, Associate Professor at the Department of Sociology, Jamia Millia Islamia, Central University, New Delhi (neshatquaiser@yahoo.com)

Below left: Advert and package for Unani brain tonic.

Below right: Hakim Abdul Hameed, the founder of Hamdard, the largest manufacturer of Unani products.



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