Recognised but Not Equal: Indigenous Medicine and the Remaking of Medical Authority in the Madras Presidency, 1914–1947

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Abstract

This article looks at how the colonial state in the Madras Presidency handled the practitioners of Ayurveda, Siddha and Unani between 1914 and 1947, and how those practitioners answered. It begins with the Madras Medical Registration Act of 1914. The Act did not ban indigenous practice. What it did was give legal privileges to Western-trained doctors alone, and this left the vaidya and the hakim free to practise but without standing in law. The article then follows the Koman inquiry, the Usman Committee of 1921–1923, the government's decision of 1924 to support Indian medicine, the Government School of Indian Medicine, and the register of indigenous practitioners opened in 1933. The sources are government reports, the text of the Act and its amendments, the reports of the Usman and Chopra committees, the All India Ayurvedic Directory, and recent historical work on Madras. First, the state recognised indigenous medicine because it was useful for rural medical relief, not because it accepted its claims to science. Second, recognition came through executive orders, a school diploma and a register divided into classes, and this created new ranks within indigenous medicine itself. Third, wherever Indian medicine came close to equality with Western medicine, the line was held. By 1947 indigenous medicine in Madras had become a recognised public service, but not an equal profession.

Keywords: Indigenous medicine, Ayurveda, Siddha, Unani, Madras Presidency, medical registration, professionalisation, Usman Committee, colonial state, medical authority

Introduction

In 1923 a committee appointed by the Government of Madras wrote a sharp sentence about the way the law treated the presidency's indigenous doctors. The government, it said, gave titles like "Vaidya Ratna" and "Shifa-ul-Mulk" to eminent practitioners, yet allowed these same men "to be treated as medical untouchables with whom no registered allopathic practitioner can professionally come into touch without losing his caste" (Committee on the Indigenous Systems of Medicine [CISM], 1923, p. 25). The image of caste was chosen with care. It was written in a province where the non-Brahmin movement had made caste a matter of hot public debate, and it named a problem that the practitioners of Ayurveda, Siddha and Unani had been living with for close to a decade. Between 1914 and 1947, who had the right to be called a doctor in the Madras Presidency, and who made that decision? The question leads into larger ones. How did a colonial government try to govern healing? How did indigenous practitioners respond? And what did it mean, in practice, for old systems of medical knowledge to be "recognised" by a modern state?

Historians have written a good deal on Western medicine in colonial India and on the state's handling of epidemics and public health (Arnold, 1993; Harrison, 1994). The revival of Ayurveda has also drawn steady attention, though much of it centres on Bengal and North India (Berger, 2013; Leslie, 1976; Mukharji, 2016). For Madras, scholars have studied rural medical care (Muraleedharan, 1987), the use of indigenous doctors in early colonial service (Brimnes, 2013), and the rise of Siddha as a Tamil system (Hausman, 1996; Weiss, 2009; Kanagarathinam & Lourdusamy, 2023). Work on the Koman inquiry and on indigenous medical education in the presidency has added useful detail (Chitra & Rao, 2018; Kanagarathinam, 2019). The article deals with the 1914 Act and the kind of exclusion it created, looks at the Koman inquiry and the Usman Committee, and at how practitioners argued their case, examines the government's change of course in 1924 and the founding of the Government School of Indian Medicine and the register, the class system and the limits of recognition up to 1947.

Registration and Exclusion: The Madras Medical Registration Act of 1914

The Madras Medical Registration Act of 1914 is often described as the moment when indigenous medicine was shut out by law. The Act did not forbid anyone from practising medicine. It set up a Medical Council and a register of practitioners who held Western qualifications, and it gave those on the register a set of privileges. Only a registered practitioner could sign a medical certificate required by law (Madras Medical Registration Act, 1914, s. 4(1)). Registration was the gateway to certain public posts. And the Act allowed the Council to remove from the register any practitioner found guilty of "infamous conduct in any professional respect" (Madras Medical Registration Act, 1914, s. 16(2)). In practice, professional association with unregistered men could be treated as such conduct.

The vaidya and the hakim did not appear in the Act at all. Their practice stayed lawful. The Usman Committee later made this point clearly: those who did not want the privileges of registration were "quite free to continue their practice exactly as they were doing before" (CISM, 1923, pp. 21–22). But a freedom of this kind was worth less than it seemed. The same committee quoted Hakim Ajmal Khan, who said that distinguished hakims and vaids had been "reduced to the position of unrecognized, unqualified laymen, whose professional opinion is at a discount in courts of law and in the eyes of the Government" (CISM, 1923, p. 23). The Act excluded not by prohibition but by privilege. It opened a gap between two kinds of authority. Indigenous practitioners kept their social authority. People still went to them in large numbers, and in the villages there was often no one else to go to (Muraleedharan, 1987). What they lost was legal authority, the power to have their word count in a court, an office or a public appointment. A Western-trained doctor who consulted a vaidya on a case ran the risk of losing his own registration. Much of what happened over the next thirty years can be read as an effort to close this gap.

The government's attitude in these years was quiet at best. In 1912 it held that it was "hardly justified in devoting public money" to the indigenous systems (G.O. No. 90, Public, 23 January 1912, as cited in Kanagarathinam & Lourdusamy, 2023). In 1917 it told a municipality that wished to support an Ayurvedic dispensary that the government could not "be expected to support use of quack medicines" (G.O.

No. 1867, Municipal, 1 November 1917, as cited in Kanagarathinam & Lourdusamy, 2023). The word "quack" shows how the medical department saw the matter. For its officers, there was only one medicine, and the rest was ignorance or fraud.

Practitioners did not accept this quietly. Ayurvedic and Unani conferences passed resolutions against the "differential and derogatory treatment" of the registration Acts, and practitioners "submitted memorials to Government on more than one occasion" asking that "competent indigenous practitioners" be put on the provincial registers (CISM, 1923, p. 23). In the Legislative Council, Krishna Rao Pantulu moved resolutions on indigenous medicine in 1914, 1915 and 1917, and tried in 1918 to amend the Registration Act itself (Kanagarathinam & Lourdusamy, 2023; Sébastia, 2012). None of these efforts changed the law. But they kept the question alive, and they gave the practitioners a political voice in the years just before the constitutional reforms of 1919.

Inquiry and Argument: The Koman Report and the Usman Committee

The first official answer to these demands was an inquiry, and it was not the inquiry the practitioners had asked for. Krishna Rao Pantulu's resolution had asked the government to direct "a research and investigation of the Ayurvedic system of medicine" (Kanagarathinam, 2019). In the Council debate of 1915, T. M. Nair moved an amendment that narrowed this to a study of "the pharmacological action of the indigenous Indian drugs" (Kanagarathinam, 2019). The difference mattered a great deal. A study of a system would have examined its theory, its texts and its methods of diagnosis. A study of drugs would look only at materials that Western medicine might use.

The government took the narrower path. In 1918 it appointed M. C. Koman, an honorary physician at the General Hospital, Madras, as what the Chopra Committee later called "a one-man Commission" (Government of India, 1948, p. 5; Kanagarathinam, 2019, p. 445). Koman tested drugs and reported in 1921 (Koman, 1921). His findings were not hostile in every respect, but his approach drew heavy criticism. Writing in the Andhra Patrika, Gopalacharlu said that the inquiry "was not made with the object of improving them but incorporating in the English

Pharmacopoeia the efficacious drugs which are in use therein" (Native Newspaper Reports, 1918, as cited in Kanagarathinam, 2019, p. 447). Critics noted that Koman did not know Sanskrit or Tamil and had to rely on translations, and that he had not consulted learned vaidyas or bodies such as the All-India Ayurveda Mahamandal (Kanagarathinam, 2019, pp. 448–449). Pandit Narayana Iyengar of Madurai asked whether Koman even knew basic terms such as tridosha and pancha nidana before he was sent to judge the system (Iyengar, 1925, as cited in Kanagarathinam, 2019, p. 448). In 1921 a joint board of practitioners meeting at Mylapore called the report "incorrect, incoherent, misguided and prejudiced" (as cited in Kanagarathinam, 2019).

The political setting changed in 1920 and 1921. Under the reforms of 1919, medicine and public health passed into the hands of Indian ministers who answered to an elected Legislative Council. At its Nagpur session in 1920, the Indian National Congress called for "earnest and definite efforts" to promote schools, colleges and hospitals of Ayurvedic and Unani medicine (Government of India, 1948, p. 5). In Madras the Justice Party, which held office, had its own reasons to take an interest, since Siddha in particular was being claimed as a Tamil and non-Brahmin heritage (Kanagarathinam & Lourdusamy, 2023; Weiss, 2009). On 21 February 1921 the reformed Council "passed a resolution, recommending to the Government to take early steps to encourage the indigenous systems of medicine" (CISM, 1923, Appendix II, p. 97). Later that year the government appointed a committee under Muhammad Usman, with G. Srinivasamurti as secretary, and asked them to plan a programme of work (G.O. Mis. No. 964, P.H., 10 August 1921, reprinted in CISM, 1923, Appendix X, pp. 153–154).

The Usman Committee worked very differently from Koman. It sent out a long questionnaire, set up language sub-committees for Tamil, Telugu, Malayalam, Urdu and Sanskrit, and collected a large body of written and oral evidence (CISM, 1923, Appendix IV, p. 102; CISM, 1924). Its report, published in 1923, is still the most detailed official statement on Indian medicine from the colonial period. The Chopra Committee called it "easily the most outstanding of similar reports" (Government of India, 1948, p. 26). Two features of the report stand out. The first is its argument about registration. The committee wanted a law that would have "nothing to do with particular systems" and would offer "equal recognition for all and favour for none" (CISM, 1923, p. 18). Registration, in its view, was a matter of public safety and fair

treatment, not a verdict on which system was true. It called the rule against professional association an “irritating anomaly” (CISM, 1923, p. 25). It proposed an open first register that would admit every practitioner then at work “rather than do an injustice to one real expert” (CISM, 1923, p. 22). This plan was never carried out in the form the committee intended. The second feature is less obvious but just as important. The inquiry shaped the thing it studied. The questionnaire asked witnesses to put aside scriptural authority and to defend their systems “by proofs or testimony acceptable to modern science” (CISM, 1923, Appendix II, p. 97). Practitioners who wanted to be heard had to present their knowledge as a coherent, written, rational system. Many of them did this very well. But the effect was to make indigenous medicine more textual and more “scientific” in its account of itself, and also narrower. Midwives, bone-setters and village herbalists, whose knowledge could not easily be set out in this form, hardly appear. The committee also treated Ayurveda, Siddha and Unani as “one triune whole” (CISM, 1923, p. 1), though its analysis leaned on Sanskrit categories. This would later become a source of friction with Siddha practitioners, who wanted their system to be seen as separate and Tamil (Kanagarathinam & Lourdusamy, 2023; Weiss, 2008).

The contrast between the two inquiries tells about how medical authority was being contested. Koman’s report treated indigenous medicine as a store of raw materials for Western pharmacology. The practitioners rejected that view by arguing that their systems were sciences in their own right. The Usman Committee took up their case, but only by asking them to prove it in terms set by modern science. Either way, the standard of judgement came from outside indigenous medicine.

Necessity over Science: The 1924 Decision and the Government School

The government’s reply to the Usman report came in 1924. It is one of the most revealing documents of the period. P. L. Moore, the officer whose note shaped the decision, did not accept the committee’s view that the indigenous systems were scientific. He set that question aside. Recognition was needed, he argued, “whether the indigenous systems are scientific or not”, because Western medicine could not reach the villages and the people would go on using indigenous practitioners in any

case (G.O. No. 313, P.H., 22 February 1924, as cited in Kanagarathinam & Lourdusamy, 2023).

The state recognised necessity, not science. The presidency had far too few Western-trained doctors for its rural population, and the government was under pressure from an elected Council, from organised practitioners and from nationalist and non-Brahmin politics. Supporting Indian medicine was a cheap and popular way of extending medical relief. It did not require the medical department to change its opinion of indigenous knowledge, and it did not. The Surgeon-General and his officers stayed hostile throughout. The push came from ministers and legislators. The state was not of one mind, and the shape that recognition took reflected that division.

The main result of the 1924 decision was the Government School of Indian Medicine at Madras. It was sanctioned by an order of 3 November 1924 and opened on 6 January 1925, under the temporary charge of Srinivasamurti (Chitra & Rao, 2018; Sébastia, 2012, p. 3). The school was much smaller than the Central College the Usman Committee had planned, and no separate Department of Indian Medicine was created in the 1920s (Government of India, 1948, p. 31). Still, it was a real break. For the first time, the government of the presidency was itself training practitioners of Ayurveda, Siddha and Unani. The school taught the indigenous systems alongside anatomy, physiology, surgery and midwifery on Western lines. This followed the Usman Committee's own advice that students of Indian medicine should learn "whatever is useful in Western Medicine" (Sébastia, 2012, p. 3). Its diploma, the Licentiate in Indian Medicine (L.I.M.), created a new kind of practitioner, the "qualified" vaidya: a man, or sometimes a woman, whose standing came from an institution and a certificate rather than from family lineage or years of learning in a teacher's house. The course was later lengthened, and from 1933 it ran for five years (Dharani, 2020, p. 396).

Students did not come only from Madras city. The All India Ayurvedic Directory, which printed short biographies of practitioners, shows practitioners trained in the new institutions at work in many districts of the presidency, a number of them in dispensaries run by local boards (Mooss, 1937, 1938). The Directory is an uneven source. It records mainly those who were literate, organised and willing to send in

their details. But it does give a sense of how quickly a new class of diploma holders spread into the districts in the decade after 1925.

The new practitioner was a real gain for many students, including some from families with no medical tradition. But his position was uneasy from the start. Because he had been trained partly in Western medicine, he could be judged by Western standards, and he was. This becomes clear in the 1940s.

The school was not the only institution of its kind. Practitioners had been building their own colleges for some time. The Arya Vaidya Patasala, linked to P. S. Varier's Arya Vaidya Sala, moved to Kottakkal in 1924, and the Sree Ramamohan Ayurveda Kalasala opened at Bezwada in the same year (Mooss, 1937, 1938). There were colleges and schools at Guntur, Tirupati and Madras as well. Pharmacies such as the Arya Vaidya Sala, founded in 1902, paid for much of this activity through the trade in medicines (Mooss, 1937, p. 25). Associations and journals gave practitioners a collective voice, and much of this life was centred in the Telugu districts as much as in Tamil country (Mooss, 1949, pp. 208–209). Recognition, in other words, was not simply handed down. Practitioners built a great deal for themselves, and the state's institutions grew up alongside theirs.

Local bodies played a large part too. From 1925, district boards and municipalities were allowed to fund institutions of Indian medicine (G.O. No. 1114, 1 June 1925, as cited in Kanagarathinam & Lourdusamy, 2023). This reversed the position of 1917, when a municipality had been refused support for "quack medicines". Over the next two decades the local-fund dispensary became the most common place where a qualified practitioner of Indian medicine could find public employment. By 1947–48, the presidency ran 636 Ayurvedic and 51 Unani dispensaries, and more than four million patients were recorded as treated in a year (Government of India, 1948, p. 73). This was recognition on a large scale. But it was recognition as a substitute for Western medicine in places where Western medicine was absent, not recognition as an equal. The Chopra Committee itself described many of these dispensaries as "ill-equipped, ill-housed and poorly staffed" (Government of India, 1948, p. 70).

The Register, the Classes and the Limits of Recognition

The Usman Committee's call for an open register of indigenous practitioners was not acted on for a decade. Even the school's own graduates "remained unregistered until 1933" (Sébastia, 2012, p. 4). The change, when it came, had two parts. The first was an amendment to the 1914 Act. The Registration Act was amended six times before independence, in 1929, 1932, 1935, 1938, 1941 and 1943, but only the amendment of 1932 touched indigenous medicine (Madras Medical Registration Act, 1914, as amended). It added a proviso to section 16(2). Under it, no registered practitioner could be struck off "on the ground of his association in any professional respect, with a qualified practitioner of Indian Medicine such as Ayurvedic, Unani and Siddha" (Madras Medical Registration Act, 1914, s. 16(2), proviso, inserted by Madras Act IX of 1932). This was the one registration reform that the Usman Committee had asked for and that Madras carried out almost word for word, nine years late. The mention of Siddha by name was a small but real gain for the Tamil practitioners who had campaigned for it.

Even so, the amendment did not make indigenous practitioners part of the medical profession under the Act. It only allowed Western doctors to work with them. Indian medicine appeared in the law as an outside party with whom the real profession was now permitted to deal. And the word "qualified" left the key question open: who would decide which indigenous practitioners counted? From 1933 the Central Board of Indian Medicine began to register practitioners, including those of ten years' standing (Mooss, 1938, p. 63). The register was made by executive order, not by statute. It was divided into classes. Class A went to the graduates of the government school. Class B went to most others, including graduates of private colleges and older practitioners admitted on the basis of experience. In 1936 the Kottakkal Patasala was recognised for registration of its diploma holders (Mooss, 1937, p. 29), and in 1938 the Ayurveda Siromani was recognised, but only for Class B (Chitra & Rao, 2018, pp. 1441–1442).

The difference between the classes was not only a matter of prestige. Under the rules of 1938, Class A practitioners in local-board service could draw a time-scale of pay, while Class B practitioners received a fixed Rs 40 a month (G.O. No. 2986, 22 August 1938, as cited in Chitra & Rao, 2018, pp. 1441–1442). Graduates of the old

Madras Ayurvedic College, some of whom had taught at the government school itself, found themselves placed in Class B (Chitra & Rao, 2018, p. 1442). In plain terms, the state had made its own diploma the measure of everyone else.

The register thus created a new ranking inside indigenous medicine. At the top stood the L.I.M. Below him came the graduate of a private college, then the older practitioner admitted on experience. Outside the register altogether stood the many who never came in. When the Chopra Committee collected figures in the late 1940s, it recorded 23,340 practitioners in Madras, of whom 13,340 Ayurvedic practitioners were registered (Government of India, 1948, p. 73). If these figures are close, a large share of those at work remained outside the system. This is closure in Witz's (1992) sense, but turned inward. The professional project of indigenous medicine borrowed the logic that had first been used against it. It won recognition for some by drawing lines that left others out.

The three systems did not gain equally from this arrangement. Ayurveda set the terms. Its texts and categories shaped the Usman report, its practitioners were the most numerous, and it had the largest network of colleges and pharmacies. Siddha practitioners organised hard against this. Through local and district associations they asked the government and the Usman Committee to treat Tamil Siddha medicine as a separate system belonging to the Tamils, and to give Tamil physicians a chance to state their own case (G.O. No. 104, P.H., 23 January 1922, as cited in Kanagarathinam & Lourdusamy, 2023). They also produced journals and books that presented Siddha as older than, and distinct from, Ayurveda (Weiss, 2009). Unani had its own section in the government school, but it had a narrower social base in the presidency, and its history in this period is still thinly documented. The figures for dispensaries in 1947–48, 636 Ayurvedic against 51 Unani, show how uneven the outcome was (Government of India, 1948, p. 73).

These lines produced conflict. L.I.M. associations, which spread to the districts in the 1930s, pressed the claims of the government school's graduates against the older practitioners. Siddha practitioners argued for their own representation against the Ayurvedic majority. Andhra and Tamil practitioners did not always share the same aims (Kanagarathinam & Lourdusamy, 2023; Mooss, 1949, pp. 208–209). In 1939 the Central Board was reconstituted, with eight of its fifteen members elected (G.O.

No. 3669, as cited in Chitra & Rao, 2018). This gave practitioners a stronger voice, but the Board could still only advise. The decisions remained with the government.

The limits of recognition show most clearly in the war years. When L.I.M.s offered their services during the Second World War, the government held that their proficiency in modern medicine was below that of the Licentiate in Medicine and Surgery, and it refused them posts in institutions of modern medicine (G.O. No. 2548, 15 August 1942, as cited in Chitra & Rao, 2018, pp. 1443–1444). The next year it refused their request to use the title "Doctor" (G.O. No. 2063, 26 August 1943, as cited in Chitra & Rao, 2018, p. 1443). Here the integrated course worked against its own graduates. The training that set the L.I.M. above the hereditary vaidya also allowed the state to measure him against the Western licentiate and find him wanting. In Johnson's (1972) terms, the state mediated between the two professions, and it mediated, again and again, in favour of the Western one.

The final years before independence brought new energy. After the Congress ministry took office in 1946, Rukmini Lakshmipathi, as Health Minister, took the Madras case to the all-India Health Ministers' Conference, which adopted resolutions calling for research, colleges and schools of Indian medicine (Government of India, 1948, pp. 6–7; Dharani, 2020, pp. 396–397). In 1947 the school became the College of Indian Medicine, and a research institute and a scheme for village vaidyas were sanctioned (Dharani, 2020, p. 397; Government of India, 1948, p. 32). These were real gains. Yet they rested, like everything before them, on executive orders. The bill for a statutory register was still a draft when the Chopra Committee reported (Government of India, 1948, p. 32). And when a separate department of Indian medicine was created in 1949, it was placed under a Western-trained physician (Dharani, 2020, p. 397). Independence did not end the colonial pattern. The structures built between 1924 and 1947 passed into the new state largely as they were.

Conclusion

This account is neither one of simple decline nor one of triumphant revival. In 1914 the law of the Madras Presidency took no notice of the vaidya and the hakim. By 1947 the government ran a college of Indian medicine, a hospital, a research institute and several hundred dispensaries, and it kept a register of more than thirteen thousand

practitioners. That was a large change. It was won through the steady effort of practitioners, legislators, local boards and, at the end, a sympathetic minister.

But the terms of the change were set by the state, and they stayed close to the terms of 1924. Three points sum up the argument. First, indigenous medicine was accepted because it was useful, cheap and popular, not because the state accepted its claims to science. The 1924 decision said this in so many words. Second, recognition came through a school, a diploma and a register divided into classes, all made by executive order. This favoured the institutionally trained practitioner over the hereditary one, and it created new ranks and new quarrels within indigenous medicine. Third, at every point where Indian medicine came close to equality with Western medicine, whether over the title "Doctor", posts in modern institutions or service in war, the government held the line.

The Madras case also suggests something about how professions form under colonial rule. Larson's (1977) idea of the professional project assumes an occupation that bargains with the state from a position of some strength. Indigenous practitioners in Madras had social strength but little legal or institutional power. Their project succeeded only in so far as it fitted the state's needs, and it borrowed the state's own tools of closure, the diploma and the register, to do so. The result was recognition without equality.

Much remains to be done. The Government Orders cited here through secondary studies need to be read in the original files of the Tamil Nadu Archives. The working of the Central Board of Indian Medicine, the careers of L.I.M. graduates, the history of Unani in the presidency and the place of women practitioners all deserve their own studies. So does the experience of patients, whose voices are almost absent from the records used here. The questions that the period left behind, about the place of the hereditary healer, the meaning of a qualification and the relation between Indian and Western medicine, are still being argued over in India today.

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