THE END OF THE LINE? THE FRACTURING OF AUTHORITATIVE TIBBI KNOWLEDGE IN TWENTIETH-CENTURY INDIA

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Abstract

This article examines the fissures that emerged between different forms of unani knowledge during the twentieth century in India and, specifically, the disjuncture between unani knowledge derived through institutional training and that gained by apprenticeship to established family practitioners. The first section sketches historically the modes of acquiring knowledge in tibb—through apprenticeship, institutional training, and self-tuition. Discussing the formation of unani institutions in the early twentieth century provides a foundation to explore the locus of authoritative knowledge and practice in tibb and a key to appreciating the kind of knowledge patients and unani practitioners alike consider reliable and genuine. The second section is intended as a counterpoint to this historical discussion. It reports on various forms of contemporary unani practice, mostly within family-based settings. This part highlights the fragility of forms of knowledge that are not a significant part of the curriculum within the network of government-funded and private unani teaching institutions in India. Three distinctive modes of practice in tibb serve as examples: urine diagnosis, pulse diagnosis, and the preparation of medicines.

The term ‘unani tibb’ is at once suggestive of a history of great translocation in time and space.2 ‘Unani’ means ‘Greek’ in Arabic (pronounced as yunānī), and refers to foundational theories in Perso-Arab

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1 The research on which this article has been based was conducted for a Ph.D. at the School of Oriental and African Studies, University of London, funded by the Wellcome Trust, and during a recent trip to south India for a research fellowship at the Wellcome Centre for the History of Medicine at UCL. I am grateful to all the practitioners and patients, some of whose views are found in these pages, who helped me in the course of this research: in particular Hakim Arif, Hakim Jawad, Hakim Imran, Hakim Khairuddin, Hakim Muhammad Ismail, Syed, Hakim Khaleefathullah, Hakima Amina Ather, Hakim Ihtisham Ali, among many others. I am also grateful to two anonymous reviewers of this article.

2 This paper uses tibb, unani tibb and tibbi (adjectively) alternately. Tibb is reserved for references to pre-colonial times.
Hippocratic and Galenic medical traditions. ‘Tibb’ is Arabic for medicine. In India this fusion of medical traditions has come to be known as ‘unani tibb’, though it was known as just tibb or hikmat in medieval Arabic sources. As Speziale has recently suggested, the term ‘unani’, as a means of describing this fusion of traditions, gained popularity as late as the nineteenth century. Practitioners (hakim, pl. hukama) sought to link those texts and practices in India that frequently invoke ancient Greek authorities and their Arab and Persian successors as a body of medical knowledge.³ Unani tibb is often portrayed by both lay people and specialists as a unified body of knowledge and practice—a misrepresentation captured in the indiscriminate twentieth-century use of the designation ‘the Unani System of Medicine’ and challenged by recent historical studies.⁴ Recognising that tibbi knowledge is not a homogeneous body does not diminish its contemporary status or its claims to having effective treatments (according to individually and culturally defined expectations) for a range of conditions within its numerous methods and practices. The intention here is to place tibb in historical contexts—in the case of this article, in contemporary and twentieth-century society in India—and to highlight various constraints and impulses motivating the evolution of certain kinds of unani knowledge and practice, and the displacement of others.

Part 1: The late nineteenth and early twentieth centuries

Revolutions in the learning of unani tibb

Prior to and continuing into the nineteenth century a basic knowledge of tibb could be acquired through private study (if one were wealthy or fortunate enough to have access to the principally Arabic or Persian manuscripts of tibb) or through seminary (madrasa) education.

³ My thanks to Fabrizio Speziale for this perspective. His ideas will be detailed in his article ‘Linguistic Strategies of De-Islamization and Colonial Science: Indo-Muslim Physicians and the unani Denomination’, expected in the forthcoming issue of the Newsletter of the International Institute for Asian Studies (Leiden). See also Speziale 2003, p. 149, fn. 1.

There continued to exist in the mid nineteenth century a number of Arabic and Persian-medium seminaries, where students could familiarise themselves with the key works of the tibbi tradition, even if no formal qualification resulted. In a survey of educational institutions in northwest India, R. Thornton remarked that in Shahjahanpur (Avadh province) in the mid nineteenth century, for example, there were five ‘Arabic schools’ (madrasas) that followed a curriculum based on the following subjects: grammar, medicine, logic and religious studies.\(^5\) Interest in learning unani tibb was by no means restricted to practising hakîms. The nobility and religious scholars, ‘ulamâ and maulvis, and sufis acquired knowledge of medicine as a complement to their other realms of learning and activity.\(^6\)

G.W. Leitner, in his survey of indigenous education in late nineteenth-century Punjab, noted that medicine could be learnt either as part of a general education at one of these ‘Arabic’ seminaries, or privately from a maulvi.\(^7\) But for those who actually wanted to practise unani tibb, and who had the requisite social connections, a more viable option (not mentioned by Leitner), was apprenticeship to an established practitioner. The practitioner (hakîm, who may also have been a sufi or religious scholar) would instruct the student in whatever books might be available (darsi), and might also be able to guide the student in practice (matab). In the absence of any formal qualifications, a student might receive an ijâzah (certificate) from the teacher, a method of validation already common in early periods of the tibbi medical tradition in medieval West Asia.\(^8\) Ijâzahs remained a common feature of madrasa education in India.\(^9\) Prominent physicians of tibb in India also issued permits, sometimes in the form of sanads, or certificates. The following is an excerpt from the ijâzah granted by a distinguished physician of tibb in mid nineteenth-century Rampur, Hakim Azam Khan (1813–1902), to his nephew and student, Najmulghanian Khan. It gives a flavour of the kind of tuition that one might expect among the elite, learned physicians of tibb at this time:

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\(^5\) Thornton 1850, p. 51.
\(^6\) See the excellent article by Fabrizio Speziale on sufism and tibb, which clearly shows how the development of tibb in India was closely tied to the activity of sufis, Speziale 2003.
\(^7\) Leitner 1991, p. 74.
\(^8\) Vajda 1956; Schacht and Meyerhof 1937, p. 52.
I taught him many books, lesson by lesson. These included Qānūncha, al-Mujāz, al-Aqsārā, al-Naṣīṣ, al-Sadītī, Sharḥ al-Asbāb wa'l-ʿAlamāt and al-Qānūn of Shaikh al-Raʾīs Abu Ali Sīna.¹⁰ Thereafter he worked on diagnosis of diseases and examination of urine and pulse, under my supervision. I found him intelligent and skilful. He possesses wisdom as is demanded of a physician. On these grounds I have given him permission, as my experienced and wise master and teacher, Maulvi Hakim Nur al-ʿIslam, gave to me, to demonstrate his proficiency in the field of medicine.¹¹

Notice the combination of theoretical and practical knowledge that this student of tibb was exposed to. In this passage, we need to draw attention to the importance of diagnostics in tibb. It is explicitly mentioned here that urine and pulse diagnosis formed the basis of the practical guidance personally offered by the master to the student. Pulse and urine examination are a very important part of the constellation of authoritative knowledge in tibb—examples of famous hakims renowned for their mastery of one or the other of these arts abound in the legendary accounts of their lives and deeds. And yet, these skills become marginalized through the twentieth century, as the focus in the institutional tuition of tibb shifted to biomedical diagnostics, and apprenticeship appears to have become less common.

In the second section of this paper, we will look more closely at aspects of urine and pulse diagnosis in contemporary settings, and also at some of the factors that account for their marginalisation. Returning to the issue of authority in tibb, brought out in the ījāzah of Najmulghani Khan, it is also noteworthy that his teacher, Hakim Azam Khan, in turn links himself to his own teacher, extending the chain of authority to the recipient of the ījāzah. The ījāzah also mentions, though not quoted here, the importance of the sound moral conduct of the student. There is clearly more to the persona of the good practitioner than his strictly medical skills. The tradition of granting ījāzahs continued into the twentieth century.¹²

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¹⁰ These are all well-known and authoritative works at the heart of the Perso-Arab literary tradition of tibb, and were especially favoured for teaching purposes. Most or all of these texts were on the curricula of courses in tibb from Islamiya College in Punjab in the 1890s to the Government School of Indian Medicine in Madras, in India’s south, in the 1920s.

¹¹ This ījāzah appears in Siddiqui 1980, p. 234.

¹² For example, in Hyderabad, as evidenced in Nasir 1944, p. 58, concerning one Hakim Muhammad Ali Khan Naqshbandi (born c. 1892). Interestingly, in this case the ījāzah was given by one prominent āyurvedic physician in Hyderabad, Hari
Some celebrated unani physicians of the late nineteenth and early twentieth centuries learnt their tibb through apprenticeship with prominent physicians who were not family members. This is illustrated by the career of the well-known Hakim Mansur Ali Khan. He was the son of a military officer from north India, and he became associated with the Princely State of Hyderabad.\textsuperscript{13} As the first full-time teacher at the Madrasa Tibbiya (Unani School) in Hyderabad, he was employed in the school from 1901 for the next twenty years. His own son also rose among the ranks of unani physicians to occupy important posts in the unani administration.

In spite of high profile examples of successful apprenticeship, it was perhaps more common for viable practice to emerge from apprenticeship with a family member who had his\textsuperscript{14} own davākhāna (dispensary, \textit{lit.} place of medicine) and who inherited knowledge from practitioner forefathers. Such hereditary practitioners are known among Urdu-speaking groups as khāndānī (family) hakīms. Those in the elite strata of society were frequently physicians to the nobility and received land-rights and privileges. They had access to the cumulative experience of the effects of simple drugs and their admixture gained by their forefathers, commonly compiled in the prescription notebook, bayāz. Apart from enjoying a confidence derived from easy access to tried and tested remedies (mujarrabāt), hereditary practitioners might well also have benefited from trust accumulating across generations to a family of healers within a certain locality. Moreover, apprenticeship with reputable practitioners, whether connected by blood or not, ensured that reliable unani practice essentially took place within localised circles or among circumscribed elite classes knowledgeable in Persian and Arabic (the pre-eminent, but by no means the only, textual languages of tibb in pre-nineteenth-century

Govind Kaviraj. Indeed, the student-disciple relationship is a notable feature of learned āyurvedic knowledge transmission. For examples in Bengal, see Gupta 1998, pp. 368–78.

\textsuperscript{13} Nasir 1944, p. 11.

\textsuperscript{14} Before the twentieth century most public unani practice was run by men, although this statement must be qualified since the appearance of women physicians in historical records is an under-researched area. Apart from the ever-increasing numbers of professionally qualified women unani practitioners since about 1940, it is common nowadays that women family members are involved in many aspects of the running of the family davākhāna, such as the procurement of medicines and their preparation.
India). Two developments in the nineteenth century, both directly linked to the changing technological, social and economic climate under British colonial rule, changed this pattern irrevocably.

Firstly, as Alavi has shown, the utilisation of new print technology in vernacular languages (in the case of tibb, especially in Urdu) during the nineteenth century allowed ideas derived from western medicine and science to circulate among a growing literate middle class, such as clerks and administrators who had no former links to unani knowledge and practice.\footnote{Alavi 2004.} Print also encouraged the dissemination of many contrasting views on health, disease and therapy, including homeopathy, ayurveda, Islamic health traditions (such as those derived from codes of conduct based on the sayings and actions of the Prophet—hadith—tibb al-nabi), astrology and magic, and fringe western medical practices such as mesmerism and hydropathy. There were profound consequences for the ways that practitioners articulated knowledge of medicine, bodily and spiritual health. The established patterns of transmission of unani knowledge were disrupted. The content and dissemination of tibbi knowledge were no longer exclusively in the hands of elite practitioners who had previously composed the materia medica, the abridgements, epitomes and commentaries that formed the bulk of the Persian and Arabic manuscript literature in the unani medical tradition of earlier centuries. The public face of tibb was no longer that of a high-status group with reputable practices, who issued ijazahs and whose forefathers may have supplemented their daily clinical practice with attendance on members of the nobility and the courts of the rulers. Although the practical knowledge of lower status practitioners whose technical and operative medical skills were still used widely in rural and urban areas through the nineteenth century—the blood-letters, oculists, bonesetters, leechers,—their knowledge did not find a place in the new printed world of medicine through which the institutional reform of tibb was made possible.\footnote{For a description of the kinds of medical practice on the streets of Hyderabad in the early nineteenth century, see Smith 1859. It should be noted that not all of these groups could be considered low class. Famous families of bonesetters, such as that of Ghulam Rasul in Shah Ali Banda in Hyderabad, claim past royal patronage and today enjoy a public reputation for their services.}
The second major transformation of unani tibb from the late nineteenth century was the emergence of new forms of commercialisation, largely sustained by advertisements placed in the flourishing vernacular language newspapers and journals, and through pamphlets and product brochures. Inspired by the marketing of allopathic medicines, āyurvedic practitioners in Calcutta were the first to set up companies for the mass production of indigenous medicines. Other urban centres, such as Bombay, Lahore and Delhi also became sites for large-scale production of products including those sold as unani medicines.

The use of print and new forms of the commercialisation of medicine emerged against the background of a rising literate middle class in the second half of the nineteenth century. They were the readers of the flourishing newspapers and journals, and it is reasonable to assume that they were also the new patrons of both the commercialised practitioners of tibb,—the so-called ishtihārī atībbā (‘advertising unani doctors’)—and the other producers of patent medicines flooding the market. Printing and commercialisation undermined the elite nature of tibb, facilitating the dissemination of ideas and practices. Elite practitioner families sought to recapture their authority. Institutionalisation was one of their strategies to achieve this end. We can identify parallel struggles over authority brought about by the use of print in other, traditionally elite, Islamic disciplines, such as jurisprudence (fiqh). This is the discipline by which Islamic scholars (ālim (sing), ulamā (pl.)) have decided what is right and what is prohibited according to the sunnah (authentic tradition) of the Prophet. Robinson’s research shows that in nineteenth and twentieth-century India, ulamā struggled unsuccessfully to contain new and varied interpretations of Islamic law in the Indian context. In the last five to ten years the internet has offered similar possibilities for individual expression, unbounded by any legal chain of authority. Part of the mushrooming health-industry sector on the internet, ‘unani’ or ‘Islamic’ medical sites often claim their products effect total cures for a range

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17 Gupta 1998.
18 Aspects of consumerism, medicine and advertising in the Punjab are covered in Daechsel 2001, p. 100; Attewell 2004.
of diseases—regardless of the fact that legitimating authentic unani practice is beyond the purview of any body, or whether the advertised preparations have been shown to have any clinical benefit or injury.

The rise of unani tibb’s famous teaching institutions in north India is best viewed against this background of a changing professional culture with roots in the nineteenth century.

**Diverging paths in institutionalising tibb: Delhi, Lucknow, Hyderabad**

New forms of teaching institutions giving instruction in unani tibb began to emerge in the late 1880s in parts of north and central India—Lahore, Delhi, then Hyderabad, Lucknow and Bhopal. Teaching institutions are key markers of the process of reform then underway in tibb and ayurveda, and have attracted some attention in the literature to date. Just as the power of colonial medical discourse has been emphasised in studies of surgery and science, so too the professional organisation of western medicine has been seen to impact on the formation of unani institutions. Leslie demonstrates how professionalised unani and ayurveda were modelled on ‘cosmopolitan’ or ‘western’ medicine medical knowledge and institutions, its colleges, associations, journals and conferences. Madrasa Tibbiya, a unani school in Delhi, according to Metcalf, introduced new institutional arrangements in 1889 with ‘paid staff and fixed requirements to replace the informal settings of family homes and apprenticeship’. Apparently dispensing with the traditional circle of students reading texts with a recognised practitioner, the new institutions introduced regular attendance at courses that followed specific curricula, professional accreditation based on examination and the awarding of degrees, in a development that paralleled bureaucratised colonial medicine.

The following three points are significant in our understanding of the nature and role of institutions in unani tibb. Firstly, there was no uniform process of institutionalisation of tibb throughout India, neither in terms of motivation, nor in regard to the nature of the

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23 Metcalf 1985, p. 4.
teaching institutions. Secondly, the new institutions did not necessarily conform to the bureaucratic model outlined above. Thirdly, the new institutions did not mean the immediate collapse of pre-existing paradigms of authority, which continued to inform both the patient’s trust in tibb and the tabib’s confidence in his own practice. Because of this disjuncture between the kind of training that unani institutions could deliver and the kind of knowledge and authority that was required for successful clinical practice, the position of those unani teaching institutions derived from the colonial models in the early twentieth century was both ambiguous and incongruous.

In discussing ‘institutional’ modes of knowledge in tibb, let us not overlook the disparities between the various unani institutions that were established during the nineteenth and twentieth centuries. It was not until the Central Council of Indian Medicine was established in 1971, that a single curriculum for unani tuition was introduced as part of a programme of measures to improve standards of education. Previously unani institutions had not presented a unified vision of knowledge and practice. We will take the case of three important schools that were set up in the early twentieth century in Delhi, Lucknow and Hyderabad.

Two of the first and most prestigious unani schools to operate in the early twentieth century were the Madrasa Tibbiya, opened in Delhi in 1889, and the Takmil ut-Tibb, founded in Lucknow in 1902. Their shared agenda was to reclaim and demarcate the boundaries of authentic tibbi practice, but their understanding of authenticity differed.

The Madrasa Tibbiya was set up by Hakim Abdulmajid Khan. He came from an influential family of reputable hereditary unani practitioners based in Delhi. In a climate of increasing religious and nationalist mobilisation, the political environment shaped the concerns of those hakims intent on reforming the knowledge and practice of unani medicine. Nonetheless, religious nationalism has, in my view, been overemphasised, for example in the work of Poonam Bala, as one of the primary causes for the ‘revival’ of indigenous medicine in India at the expense of the changing demands of the unani profession.24

The Delhi school favoured tuition in āyurvedic practices as well as tibb. For instance, the school incorporated instruction into the preparation of kushtajāt (remedies based on calcined metals). Known as bhasma in Sanskrit, these remedies have had a prominent place in āyurvedic therapeutics since at least the fourteenth century. According to Fazlurrahman, Hakim Muhammad Sharif Khan of Delhi, court physician to the Mughal emperor Muhammad Shah in the late eighteenth century, gained fame as one who popularised these remedies in tibb. Their use in tibb seems so diffuse, however, that it is unlikely that one practitioner could have single-handedly had this role. The tibb connection with ayurveda at the Delhi Madrasa was looked upon critically by the Hakim Abd ul-Aziz and his supporters at the Takmil ut-Tibb school in Lucknow. There was a greater emphasis on surgery, anatomy, physiology and chemistry at the Delhi Madrasa than at Takmil ut-Tibb. Although Alavi states that surgery was incorporated into the teaching of the Lucknow school, some eleven years after the foundation of the school a former student writing in a 1913 unani journal emphasised how instruction in ‘modern’ anatomy was considered ‘absolutely forbidden’.

Despite differences in their conception of what sound unani knowledge and practice might be, both schools were born of the changing educational and professional patterns of the late nineteenth century. Both were also the products of family enterprise. The founder of the Madrasa Tibbiya in Delhi, Hakim Abdulmajid Khan, is said to have associated himself with the well-known Muslim social and educational reformer, Sir Sayyid Ahmed Khan, the founder of the Aligarh Muslim University. In an inaugural speech at the Delhi Madrasa Sayyid Ahmed reportedly expressed the hope that the Madrasa would encourage western medicine as well as unani tibb so that their differences would be overcome. Sir Sayyid Ahmed’s advocacy of western education for the betterment of the Muslim community in India is well known. This appears to have been his only public

25 Fazlurrahman 1944.
26 Alavi 2002.
27 Shafi 1913: ‘Aur nah hame tashrīṭ jadid ke ta’lim se hi parhā’ī gayī balke usse harām mudlaq samjha’.
28 Razzaq 1987, p. 11.
endorsement of unani *tibb*. The Madrasa probably attracted him for its inclusion of instruction in western anatomy and surgery in a formalised institutional setting. Hakim Abd ul-Aziz wished to systematise unani instruction at the Lucknow Madrasa around the texts of Ibn Sīnā, supplemented by practical instruction in surgery and anatomy.

It is important to recognise that the pressure for reform in unani *tibb* came from within an expanding and fractured unani profession. It did not result solely from a desire to imitate colonial institutional and professional models. Thus, one of the four aims for establishing the Madrasa Tibbiya in Delhi was to ‘[do] away with the unqualified Tabibs who infect the various parts of India to the greatest detriment of the health of the inhabitants’. For Ajmal Khan, much as for Hakim Abd ul-Aziz, the revival process was concerned with distinguishing authentic *tibb* from the practices of ‘ignorant’ (*jāhil*) *hakīms*, *dais* (midwives) and *jarrāhs* (surgeons), and both pursued this objective through the medium of institutions. The Delhi and Lucknow schools were both driven by practitioner families. The case of Hyderabad presents an altogether different scenario, which we will briefly discuss.

*Tibb* has had a long-standing association with the city of Hyderabad. From the establishment, by Quli Qutub Shah, of a large, now derelict, hospital at the time of the founding of the city in 1593 to the construction of the Nizamia Government Unani College and Hospital in 1939, Hyderabad has been a centre for *tibbi* institutions. Beyond the domain of institutions, from the sixteenth century to 1948, hakims in Hyderabad were often influential figures in the courts of the ruling dynasties, the Qutub Shahi and then the Asif Jahi, and were patronised by the nobility. Thereafter the Hyderabad State was annexed to the Union Government of India and the last Asif Jahi ruler, Nizam Osman Ali Khan, was deposed. Grand tombs of several court hakims of Quli Qutub Shah are to be found in the same precinct as those of the ruler and his family in the grounds adjacent

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31 Kumar 2002, p. 377, cites Lelyveld that Sir Sayyid did not support or give any speeches on unani *tibb*, and that he was keen to visit hospitals on his trip to Britain.
33 Khan 1911.
to the fort of Golconda. Sufis also seem to have played an important part in the practice of *tibb* in the Deccan region, of which Hyderabad is a centre.\(^{34}\)

There were two phases of professional mobilisation among hakims in Hyderabad between 1890 and 1948. In the context of the increasing presence of local medical personnel trained by British medical-military officers at the Medical School, which opened in 1846, and a growing western medical infrastructure from the time of the celebrated administrative reformer Salar Jung I in the 1870s, pressure mounted for a parallel state-funded unani medical service. The process began in 1891 with the establishment of the Unani Medical Department (Serrishta-i Tibabat Yūnānī). Soon after followed the opening of a school, and the funding of unani dispensaries, first within Hyderabad city and later at the district level. The process was stimulated by a nexus of interests of practitioners, the public, and figures within the government, such as Asman Jah, the then Dīvān, who sought to bring *tibb* within the ambit of government regulation, albeit a loose regulation.

The second phase began in 1914 with the framing and implementation of the ‘*istikm jādīd*’ (new scheme). It is marked by greater practitioner mobilisation, the incorporation of western medical subjects into the curriculum at the unani school, and a more extravagant role in the funding of *tibb* by the recently enthroned Nizam Osman Ali Khan. This phase culminated in the opening of the Nizamia Tibbi College and Sadrshifakhana (Main Hospital) by the Nizam in 1939. In the second phase the notion of revival became more prominent. Hakims from Lucknow and Delhi were involved personally in the setting up of Hyderabad’s college. A unani journal, *Hakim-e Deccan*, appeared in the mid-thirties, more akin to its north Indian journal counterparts in style and content than its smaller and more parochial predecessor, *al-Mu’ālīj*.

The early phase of institutionalisation in Hyderabad (1890 to 1914), however, was not a ‘revival’ of *tibb*, as in north Indian centres such as Delhi, Lucknow and Lahore. The origins of the unani school, the Madrasa Tibbiya, for example, were modest and did not conform to the bureaucratic requirements of a western-style educational

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\(^{34}\) Speziale 2003.
institution. It consisted of four rooms in a house in the centre of Hyderabad.\textsuperscript{35} In its early years the language of instruction at the Madrasa was Arabic, which restricted entrance to those who had been through Arabic-medium madrasa/private education, and it employed only one teacher.\textsuperscript{36} An administration report (one of the few surviving reports that provides more than the most rudimentary details about government-aided unani provision at this time) informs us that, by 1898, 21 students had completed the course of study, and 36 more were under instruction.\textsuperscript{37} In the early years of the Madrasa’s existence there was little difference between this ‘formal’ education and training in traditional personalised settings. Correspondence between government officials relating to a report for 1894 reveals criticism of the method and ‘standard’ of tuition. There were apparently no ‘definite rules’ laid down governing the mode of instruction, and the official reviewing the report urged that ‘the education of students ought not to be restricted to mere book lore, but should extend to a thorough practical training’.\textsuperscript{38} This style corresponds to the \textit{dars} of traditional unani instruction, in which students read texts under the guidance of a teacher, which would be supplemented by experience in the \textit{maṭab} (clinic). The government official reviewing the unani report further criticises the unani department for only giving scant information about midwifery cases performed by \textit{dais} (birth attendants/midwives) attached to the unani dispensaries.\textsuperscript{39} 

\textit{Incongruous institutions?} 

Evidently there was a gulf separating the way in which the officials in Hyderabad state expected the new unani institutions to operate, in terms of fixed requirements, the curriculum, style of teaching and accountability, and how they functioned in practice. There are echoes here of complaints levelled at the management of the unani classes

\textsuperscript{35} Kirschke 1983.  
\textsuperscript{36} Dastur al-'Amal, p. 1.  
\textsuperscript{38} Letter 242 from the Secretary of the Judicial, Police and General Departments dated 20 Sharewar 1304 Fasli to the Unani Medical Board in Resolutions issued by the Secretary to the Government in the Judicial, Police and General Departments during the year ... 306 Fasli, 1896–97.  
\textsuperscript{39} Ibid.
at the Islamiya College in Lahore, which also provided tuition in *tibb* at this time. Unlike the Delhi and Lucknow institutions, there was no attempt in Hyderabad to professionalise *tibb*, or to reinvent *tibb* according to the criteria of western disciplines and modes of organisation. It seems that institutionalisation of *tibb* in Hyderabad was less a ‘revival’, but rather founded on the will for *tibb* to be incorporated into the government infrastructure. The rhetoric lamenting a decline of *tibb*, so apparent in northern India at the time, was not present in Hyderabad until the mid to late 1910s. Those same influences on the enterprise of Hakims Abdulmajid Khan and Abd ul-Aziz in Delhi and Lucknow respectively did not manifest in Hyderabad. Nevertheless, there are general points that can be made about *tibb*’s new institutions in India, which apply equally to Hyderabad and its north Indian counterparts. They will serve to contextualise and highlight our observations about the individual process in Hyderabad, and bear specifically on the overall theme of this paper—conceptions of authoritative knowledge and practice in twentieth-century *tibb*.

Even in the context of institutionalisation in Delhi and Lucknow, we should not assume that the transition to an institutional model of instruction was smoothly achieved, or that it was comfortably accommodated in the existing structures of authority in *tibb*. The new institutions, ultimately derived from colonial models, might have introduced certain bureaucratic elements of institutional organisation, but there were constraints on the operation of a unani school modelled on western principles that seem quite specific to the ways in which authentic knowledge of *tibb* might be transmitted and applied.

A letter written in 1913 by a graduate of the much esteemed unani school in Lucknow, the Madrasa Takmil ut-Tibb, gives us a perspective on the running of this institution that differs from what has been presented in recent writing about the college. Moreover, it informs us of the meaning of institutional education in the context of the larger paradigms of authority in unani culture in the early twentieth century. The graduate Muhammad Shafi refers with great respect to the School’s distinguished founder Hakim Abd ul-Aziz, by that time deceased, and the letter is composed in a measured tone. However, he takes issue with a great many aspects of school management, teaching and syllabus. He writes that neither the hakim teachers nor the students kept to the timings; students who were supposed to attend regularly often did not; absences were overlooked
by staff because of inadequate registers; one student was absent for a year, but was still allowed to sit the examination.\textsuperscript{40} Muhammad Shafi writes that he is ashamed of his weak knowledge of anatomy, which is based on only partial instruction from the \textit{Qānūn}, which he considers inferior to the instruction at Delhi.\textsuperscript{41} He says that there were gaps in the instruction he received on treating parts of the body, and he wishes that the curriculum, centred on the \textit{Qānūn}, were more wide-ranging. He remarks that, although an accomplished work, the \textit{Qānūn} is only an introductory book (\textit{kitāb iḥtiḍā‘ī}) when compared with western medical works.\textsuperscript{42} Importantly, he expresses disappointment that the teachers do not share inherited knowledge with the students. When plague struck, he writes, the students dispensed special pills at the clinic in Lucknow, without knowledge of the ingredients.\textsuperscript{43} According to him, the students’ inadequate knowledge or confidence in prescribing medicines, and their reliance on their teachers had major practical consequences:

When the students graduate and set up practice in their own place, and are fortunate enough that patients come to their practice, some of them give the patients the special compound medicines of their masters and patent medicines from Lucknow, which they have ordered at a price. They become good special agents.\textsuperscript{44}

Graduates, Shafi continues, may end up serving as brokers among different healers, but it is difficult for them to find the confidence to set up independent practice as unani \textit{tabibs}. They become ‘dazed and dazzled’ (‘cuka-caund aur khairah’) by the powerful effects of allopathic drugs, and the cheapness and benefits of homeopathic drugs. Most students apparently come from Bihar, where they return to practice. However, they do not enjoy a high standing there, because the Lucknow school and its new principal, Hakim Abdurrashid (the son and successor to Abd ul-Aziz), were not famous at that time. Some of the key issues of authority, knowledge and practice in early

\textsuperscript{40} Shafi 1913, p. 33.
\textsuperscript{41} Ibid.
\textsuperscript{42} Ibid., p. 34.
\textsuperscript{43} Ibid., pp. 36–37.
\textsuperscript{44} Ibid., p. 37: ‘Ab voh sanadṣaṭṭah ho kar apne apne makān āne hain. Aur khūṣh nāṣībī se marīzōn kā un ke yahān mārju’āh hotā hain. Phir dekhī‘e bāz to aise sanadṣaṭṭah hain kh vahīn apne ustād ke khāṣh mūṛṛkābāt aur pāstanṭ adīyāh ẓimātān Lakhnāu se manguā kar marīzōn ko de rahe hain aur acche khāṣh aijānt bane hu’e hain’.
twentieth-century *tibb* shine through this letter from a dissatisfied graduate of one of the new *tibb* institutions: the crisis of confidence in instruction limited to the core texts of the unani tradition, especially with regard to the anatomical understanding of the body; the continuing authority of hereditary knowledge of tried and tested compound medicines; and the abiding authority of personalities that inspires trust and attracts custom.

Qualification by respected institutions such as the Takmil ut-Tibb did not, at this time, convey authority on a hakim in the same way as indicators of a traditional education. Examples of practitioners who were not hereditary practitioners but set up successful and respected unani practice were still rare in the early twentieth century, according to Hakim Ferozuddin, one of Lahore's famous tabibs. In his work *Rumūz al-atibbā*, he remarks:

> It does not come as a great surprise if those people who are *khāndānī* tabibs make their lives successful and obtain a high rank among unani physicians; but as for those whose family does not practise and who begin to turn their attention towards unani practice, if they are very successful in treatment and prescription, and manage to collect good quality prescriptions, they are certainly worthy of recognition. Among them you [Hakim Rahim Bakhsh] are one such. In your family there was no longer a chain of transmission [silsilah] in *tibb*. Nevertheless, you have collected together excellent prescriptions. Singly due to your efforts you have become famous in the city of Amritsar.45

Hakim Ferozuddin reveals that there were indeed exceptions to the notion, still prevailing in the 1910s, that a successful, genuine hakim was one whose knowledge was grounded in his family’s traditions.

In the new professional structures of *tibb* emerging in the early twentieth century, however, qualifications gained at schools or through state-appointed examiners were important, and not only from the perspective of the practitioner’s clientele, who might see the certificate framed on a wall of the *davākhāna* (dispensary), for example. More

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importantly, government funding and employment was becoming increasingly dependent on these qualifications, though before the 1920s this was mostly limited to Princely States, such as Bhopal, Hyderabad, Mysore and Indore.46

The provincial government of Madras Presidency began to fund tuition in learned branches of indigenous medicine (ayurveda, unani and siddha) as adjuncts to western medicine in the Government School of Indian Medicine. This was set up in 1924 at the government’s expense, with a view to providing a lower paid class of medical practitioners than their western-trained counterparts for rural medical relief. Only those who had passed the required examinations could subsequently enter service. Mysore presents a similar case with the opening of the first government-funded hospital of indigenous medicine in Mysore city in 1892. In Hyderabad, practitioners hoping for government service or grants were required to pass an examination set by established practitioners. In fact it was common for even those students who were from khāndānī backgrounds also to obtain certification, whether by following the prescribed course at the school or by presenting themselves for examination.47

State employment and the question of the registration of indigenous practitioners took place in a patchwork manner throughout pre-Independence India. This brought to a head the issue of how to assess practitioner quality. At least formal qualifications satisfied bureaucratic criteria; they certified that a student had been through a sanctioned curriculum in a recognised institution with accountable teachers. In practice, however, the quality of those graduates as capable and reliable medical practitioners was frequently doubted. In the Madras Presidency the first batch of graduates who passed out from the Government School of Indian Medicine in 1929 were not even allowed to enter the State’s register of practitioners.48

In Mysore, the government voiced concerns about the quality of tuition at the Āyurvedic and Unani College there. These were echoed by practitioners themselves. The Central Unani Medical Practitioners Association, based in Mysore, urged reforms to the style of teaching,

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46 There were exceptions, for example in the Punjab. See Hume 1977.
47 The biographical entries of practitioners in the Tir bah Hdadaf reveal that this was the most common pattern for those practitioners covered in this directory of practitioners in the State.
48 Hausman 1996, p. 266.
so concerned were they about the poor quality of graduates from the school, remarking that 'without the least doubt, ... these students are not in a position to start independent practice for want of precise knowledge of the science'. They observed that '[t]hough the syllabus prescribed is of a high standard, it does not seem to have been followed in actual practice'. The lack of coordination between the theoretical and the practical elements was at the core of these concerns: 'what is taught on the theoretical side is not actually practised and demonstrated on the practical side.'

It should be pointed out that problems in the running of institutions were not confined to unani tibb. In Mysore, a city in which there were many reputed āyurvedic and unani practitioners, the āyurvedic school, which opened in 1909, was subject to intermittent government inspection. A senior medical officer, who was not unsympathetic to indigenous medical practices, reported in 1914 that the school, still in its developmental stages, should perhaps abandon altogether the idea of incorporating western medical subjects into the curriculum and return to a system more akin to apprenticeship, which the institution had intended to replace. On examining the students he remarked:

I regret I cannot say that the result was satisfactory. These students have not the advantage of the hereditary instinct, long training and experience of native pandits and hakims of established reputation. The instruction that is imparted to them in anatomy, midwifery and allied subjects is neither full nor practised and accurate with them. With smattering knowledge [sic] they are let loose on society and are of danger.

Clearly, perceptions of some of the problems of tuition and authenticity discussed here in relation to unani tibb may also apply in certain respects to the case of āyurveda.

So far we have charted some of the major contours of the question of medical authority and modernity in tibb. In the following section we examine specific areas of practice in tibb that have become marginalized in contemporary India. These trends are illustrated with

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49 Representation of the Central Unani Medical Practitioners Association [CUMPA], Karnataka State Archives, Muzrai, 284 of 1932, pp. 1–4.
50 Ibid.
51 Usman 1914.
52 J. Langford explores related issues systematically in Langford 2002.
examples drawn from contemporary clinical practice. Further research will be necessary to avoid oversimplification and to fully understand the dynamics involved in the displacement of practices, especially for the period following Indian Independence in 1947. Notwithstanding current limitations, the following section spans the social, political, economic and educational environments of medical practice in India and concludes with some tentative suggestions about the nature of change in unani tibb.

**Part 2: Fragile family practices: some contemporary perspectives from South India**

In this section, attention is drawn to three areas of practice that have been the special preserve of hereditary practitioners: diagnosis through urine, diagnosis through pulse, and the preparation of medicines. This section highlights some areas of practice that were once considered iconic of the profession but can perhaps no longer be seen to represent modern tibb.

*Diagnosis: urine*

Hakim Arif lives and works in a bustling quarter of Mysore City, in a predominantly Muslim neighbourhood. At 76 years of age he maintains a lively unani clinic every morning in a building donated to his grandfather by Krishnaraja Wodeyar IV (r. 1894–1940), an erstwhile Maharaja of Mysore State in pre-Independence India, as a reward for his grandfather’s services as a healer. A small plaque beside the entrance inscribed with the words ‘Hakīm Manzil’ (Hakim’s Residence) and Shifākhāna (Place of Cure) etched in stone above the threshold identify this place as a clinic; there are no other hoardings or signboards in the vicinity. Inside the building, the walls of Hakim Arif’s clinic are dotted with photographs of his practitioner forefathers, his grandfather, Hakīm Daula Miyan, his maternal uncle, Hakim Dula and his father, Hakim Yaqub, as well as framed lines of Islam-inspired poetry. Although Hakim Arif completed a course on unani tibb in the local Government unani college, the knowledge of healing that carries his reputation—evident in the constant flow of patients (male and female, young and old, Hindu, Muslim, Kannada and Hindi/Urdu speaking), through the doors of his clinic—is no
doubt ultimately derived from the time of apprenticeship that he spent from his childhood under his father and his uncle and what he learnt as a khāndānī hakīm, a hereditary practitioner of tībb.

One of the manifest signs of this hereditary knowledge is visible even from outside the clinic, for standing on the thin metal bars that comprise the protective grill of the clinic’s windows are the bottles of urine brought for the hakim’s inspection by his patients. New patients are asked to return the following morning with the first urine of the day in a clear bottle. During my visits to the clinic, this did cause some consternation among some of the patients, who had come to the hakim on recommendation, but were unaware that this was the sole means that the hakim employed to diagnose their ailments. Their apprehension was usually allayed by others sitting and standing in the clinic, who explained to them that this is what is done here. The principal problems for which people come to Hakim Arif are jaundice, fevers, stomach pains, headaches, skin conditions like vitiligo, respiratory complaints, the removal of kidney stones, and impotence.

Many unani clinics partition the space into separate consultation areas for men and women. But in Hakim Arif’s case the consultations take place in a single large room in which women, children and men assemble to wait their turn, often accompanied by other family members or friends, while some former patients spend time in the clinic voluntarily assisting him out of their gratitude for successful past treatment. This open space encourages interactions among the patients. There is little privacy: everyone can overhear what other people’s problems are. This no doubt causes some anxiety among those who would rather wish others not to know this information.

Hakim Arif’s inspection of the urine consists of him glancing up from where he sits at the back of the room at the bottles arranged in the window space, asking the patient to identify their bottle. He looks for colour. The signs of liver malfunction, for example, captured in the umbrella term jāndis, jaundice, are recognisable, partly, by the dark amber colour of the urine. But, more importantly, Hakim Arif adds, he looks at the particles suspended in the liquid; and to discriminate among these requires an expertise born of many years of guidance and practical experience. He was not willing to go into further detail about his methods with me. Many of the patients and former patients hold this practitioner’s method in awe, saying that it is God’s gift, only learnable by the select.
Urine diagnosis (tashkhsīs bi-al-qārūrah/birāz (Arabic) or qārūrah/peshāb kī tashkhsīs (Urdu)) used to be one of the more common forms of diagnosis in tibb. In tenth-century Damascus, for example, when the foundational theories of tibb were for the first time being expounded in Arabic, the flask of urine was the icon of the tabib’s expertise. The place of urine diagnosis in learned tibb in mid-nineteenth-century India is attested in the ẓāzah of Hakim Azam Khan mentioned earlier. In the twentieth century, knowledge of urine diagnosis on a theoretical level could be obtained from many of the core Arabic and Persian unani texts of the literary tradition of tibb, that were made available in Urdu translation from the late nineteenth century. A key literary figure in unani tibb of the early twentieth century, Hakim Kabiruddin, who was responsible for overseeing the translation and also compilation of texts in Urdu that might be useful for teaching, compiled a work Risālah-yi Qārūrah on urine diagnosis.\(^{53}\) However, it reflects changing views on the nature and place of urine examination at this time. Instead of elaborating on the traditional modes of urine examination, Hakim Kabiruddin gives an extensive account of new approaches to urine diagnosis through chemical analyses. This text would have been widely available for students.

In spite of the long association of tibb and urine analysis and the theoretical availability of this knowledge to those who could not read the texts of classical tibb in their original languages, there were constraints on the continued transmission of this knowledge in practice during the twentieth century. One, certainly, was the view that the inherited forms of urine diagnosis were outdated and needed to be thoroughly revised according to advances in understanding the body’s chemistry. This view is reflected in Kabiruddin’s text mentioned above. Another factor was the incongruity of the institutional environment for the teaching of this kind of skill. Such tuition would require a lengthy period of intensive practical guidance in clinical settings. Most schools of tibb that have opened since the turn of the twentieth century have delivered courses of four to five and a half years, covering in their curricula, to various extents, a spectrum of subjects including disciplines of western medicine, such as anatomy, physiology, pathology, chemistry and midwifery, as well as teachings

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\(^{53}\) Kabiruddin 1924.
in the fundamentals of tibb, and methods in preparing medicines of the tibbi tradition. But urine diagnosis eventually lost its distinctive place in those schools where it was taught, such as Hyderabad’s Madrasa Tibbiya. In the current unani sphere, the unusualness of the practice of urine diagnosis was brought home to me by a postgraduate student of tibb at its new and prestigious centre in Bangalore, the National Institute of Unani Medicine. This institution, which started courses in December 2004, drew in postgraduate candidates countrywide. The student was as excited as I was when we talked about practitioners who diagnose through urine. In the case of Hakim Arif, he is the end of the line; he and his wife have no children to continue the line of practice and his knowledge will die with him. I know of only one person who studied under him (learning the diagnosis of liver malfunction through urine diagnosis). In other times, this need not have been the case, since it is likely that more prospective students of tibb would have taken apprenticeship under a hakim of Arif’s repute.

**Diagnosis: pulse**

A similar trajectory to that of the fate of urine analysis can be seen with another means of diagnosis, a perhaps still more iconic symbol of the hakim’s mastery of his art, at least until the mid-twentieth century—reading the pulse (nabz). Accounts of this conjure an almost divinatory aura, and unani lore abounds in stories of hakims being able to discern the pulse of various concealed animals through lengths of string tied to the legs of animals. Hakim Ajmal Khan, the most celebrated physician of unani tibb of the early twentieth century, was famed for his ability to discern the root cause of a person’s ailment by pulse alone. The epithet nabhāz (pulse reader) was also given to those whose skills in pulse diagnosis were widely esteemed. Hakim Nabina (1858–1946), a charismatic blind physician, acquired great fame in Hyderabad and Delhi as a nabhāz. Pulse-reading as a basis for diagnosis likewise requires the kind of lengthy training that is difficult to pursue in an institutional setting, which does not mirror the clinical experience afforded by extended apprenticeship in the davākhāna (dispensary). In the early years of certain institutions, like the school in Hyderabad, pulse-reading and urine diagnosis, were, however, on the syllabus, as we have mentioned. This is evident in the certificate of Hakim Mahbub Ali. Mahbub Ali was the son of a
well-known practitioner in Hyderabad, and was reportedly called upon to treat the Nizam of Hyderabad from time to time. He graduated from the tibbi school in Hyderabad in 1918. His graduation certificate is presented above. The certificate states that Mahbub Ali passed the prescribed courses in anatomy, unani principles, simple medicines, pulse and urine diagnosis and medical treatments, and that he is permitted to practise tibb.

During the latter half of the twentieth century, however, both pulse-reading and urine analysis became displaced as the archetypal

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Fig. 1. The certificate of Muhammad Mahbub Ali, granted by the Madrasa Tibbiya Unani (Hyderabad) on 26 June 1918.\(^{34}\)

\(^{34}\) My thanks to Hakim Muhammad Khairuddin for supplying me with this document.
diagnostic modalities of tibb, although pulse is still more common than urine diagnosis. It would be wrong to say that urine and pulse diagnosis did not appear in the curricula of tibbi colleges during this period. One text, Kulliyāt-i nābz o baul o bīrāz, has been commonly used in tibbi colleges for tuition in urine, pulse and stool diagnosis. It was written by Hakim Sayyid Habibullah Rahman and first published in the early twentieth century, and then republished by the Taraqqi-i Urdu Bureau (Office for the Advancement of Urdu) in 1987. The problem seems to lie in how this knowledge has been practically applied in the course of tuition and in subsequent clinical practice. Further research on the meaning and place of pulse in tibb in Independent India will be necessary to elucidate the dynamics of this process of change.

That transition has taken place is clear, however, for its repercussions are noticeable in the present day. Many students and graduates from Delhi, Hyderabad, Bangalore and Chennai have informed me that they did not feel confident to use whatever they had learnt of pulse examination as their main means of diagnosis in their practice. One practitioner in Chennai informed me that greater precision about a patient’s condition could be achieved through using the sophisticated apparatus of western diagnosis, such as scanning technology. Pulse, formerly an icon of the skilled physician, has been relegated to one among many approaches of discerning the causes of illness.

Hakim Muhammad Khairuddin, the son of Mahbub Ali (whose certificate is reproduced above), runs an inconspicuous but busy clinic in Shah Ali Banda in Hyderabad’s old city, to which men, women (mostly veiled), and children accompanied by their mother or father throng in the mornings and evenings seeking treatment. Khairuddin’s two sons are learning how to diagnose and treat patients through their daily experiences in the clinic under the guidance of their father. Khairuddin uses pulse as his principal diagnostic tool, alongside the observation of facial complexion, eyes, nails and tongue. He reads the pulse by placing three fingers on the wrist’s radial vein, and feels primarily for speed, strength and rhythm of the pulse movement. In some versions of pulse diagnosis that are practised, the three fingers are said to cover parts of the vein that correspond to the upper, middle and lower parts of the body. According to one practitioner, Hakim Ihtisham Ali, now retired from private practice, there are twenty-seven variations of the pulse, as a multiple of these sets of three. Like Ihtisham Ali, Khairuddin claims to be able to detect the
onset of pregnancy through the pulse. Such is Khairuddin’s expertise that he is sought out by students of tibb at Hyderabad’s famous Nizamia Tibbi College for guidance in their studies, especially for clinical experience including pulse examination. In this manner, some of the boundaries between institutional and family-based knowledge and practice may be transgressed to some extent.

Medication

The prescription of single drugs or multi-drug formulae is not the only method of treatment in tibb—there is regimental therapy, which includes bathing and advice relating to lifestyle issues, such as sleep, exercise and sexual conduct—but it is the main one followed by practitioners. Within the field of traditional tibbi pharmacy, multi-drug formulae are favoured over single-drug administration.

It is common among hereditary practitioners to prepare their own medicines, but this is not necessarily a reflection of current practice in unani tibb as a whole. Like Hakim Arif, another well-known hereditary practitioner in Mysore and Bangalore, Hakim Sayyid Jawad, goes to great lengths to ensure that the medicines contained in his family’s bayāzāt (prescription books) are faithfully prepared. These are the basis of the medications, which he prescribes, but he may change their composition according to his experience of patient suitability and in case of any minor adverse reactions. Knowledge of their effects has been honed by eight generations of practitioners in Hakim Jawad’s family, over more than two hundred years. No doubt, this plays significantly into the continuing stature of his practice, and also that of his eldest son, Hakim Imran. In the Mysore clinic, Mustafa’i Davakhana, hangs a small, framed certificate and the gold medal awarded to Hakim Jawad for his services to unani tibb. But these are eclipsed by the large portraits of his forefathers displayed along one wall, one of whom apparently practised in Tipu Sultan’s army and another of whom, Hakim Sayyid Mustafa, was a teacher in the first unani school in Mysore, in the 1930s. Hakim Jawad claims to treat ‘all diseases except cancer’. Prominent among them are sex-related complaints, such as impotence and infertility. Unlike many khāndānī practitioners, he does not take the pulse for diagnosis, but relies on patient narrative.

Hakim Jawad employs staff for the purpose of grinding, distilling, boiling and mixing ingredients obtained in markets in Bangalore,
while members of his family, such as his daughter-in-law, are actively engaged in the process of selection and maintaining the correct proportions of ingredients used in multi-drug formulae. I was informed that, if correctly prepared, the medicines would last for many years without losing any potency or going off. On the table behind which Hakim Jawad sees his patients, the various types of medicine are arranged in jars—the electuaries, pastes, sherbets, powders and pills bearing characteristic generic names of the tradition, such as majūn, mufarrīh, javārīsh, khamīrā, sharbat, sufūf and hubūb.

This manner of home production is a key feature of khāndānī practices throughout the subcontinent. But as the commercialisation of indigenous medicines continues apace, hakims (khāndānī or otherwise) are increasingly able to rely on standard products of large pharmaceutical enterprises, allopathic, āyurvedic and unani. In the case of unani, Hamdard is by far the largest of the mass-producers of manufactured unani medicines. Sadar, also based in Delhi, is another large manufacturer and distributor. One hereditary practitioner in Hyderabad, who wished not to be named, was disparaging about the quality of some of Hamdard’s products, saying, for example, that there were key ingredients missing from those listed on their version of the well-known āyurvedic formulation, Chyavanprash. As long as there has been mass production of unani medicines, there has been a degree of contestation among clinic-based hereditary practitioners about the properties and effects of indigenous pharmaceutical products. But hereditary practitioners can by no means be assumed to form a homogeneous group in their knowledge and practices. A hereditary practitioner of Hakim Arif’s repute not only makes use of Hamdard’s product brochure from time to time, but also on occasion dispenses allopathic painkillers in conjunction with his own formulations.

Family participation suits the home production of medicines. Hakim Muhammad Ismail, the son of another locally respected practitioner in a lower-middle class neighbourhood of Hyderabad’s old city, near the famous shrine of Shah Rajju Qattal, runs his own davākhāna now that his father has passed away. It is not more than five kilometres from his elder brother’s larger dispensary, which is closer to the heart of the old city, near Lad Bazaar. Hakim Ismail, like most hereditary tibbi practitioners in India, was obliged to pass the Bachelor in Unani Medicine and Surgery (B.U.M.S.) degree in order to
practise.\textsuperscript{55} This gave him the paper qualification that is required for him to continue with his family practices. His mother and sisters prepare the medicines at home from the raw drugs obtained from the druggist's (\textit{pansārī, dawāsāz}) for use in Ismail's and his brother's dispensaries. He is in the process of filing applications with the Andhra Pradesh Board of Indian Medicine for patents on some of his products, like one for hypertension. These patents will allow him to sell his medicines outside his own dispensary.

Hakim Ismail takes blood pressure, and uses the thermometer and stethoscope in addition to pulse and physical observation to diagnose his patients. Alongside his family-based medicines, he also gives injections and dispenses allopathic drugs, which he says give quick relief but do not successfully cure—a common trope among indigenous practitioners about the merits and defects of 'English' medicines. These, he says, are frequently demanded by his patients, since his courses of treatment have to be taken for over a month or more. But from the many visits I made to his clinic it was clear that the allopathic drugs acted as the complement to his home-made medicines, and not the other way around. Making one's own medicines requires, apart from a high level of confidence in the ingredients and the chosen method of preparation, a great deal of effort, knowledge, time and space. The latter are not generally available to those who have not been brought up in close association with a \textit{dawākhāna}. B.U.M.S. graduates are increasingly acquiring a reputation (whether this is justified or not) as prescribers mostly of allopathic drugs, and this fact does little to help the confidence of those dedicated students who wish to undertake research and clinical trials of \textit{tibbi} medicines, and make this information better known in India and abroad.

\textsuperscript{55} There are differences in policy between the states of India. For example, the government of Tamil Nadu continues to register apprentice practitioners of ayurveda, unani and siddha under the category 'enlistment', as 'B' class practitioners to distinguish them from the 'A' class institutionally-qualified indigenous practitioners. 'A' class practitioners can conduct post-mortems and have a role in medical jurisprudence, while 'B' class are prohibited from these roles. There is resentment among some of the enlisted practitioners that the 'B' suggests inferiority. In the state of Karnataka, on the other hand, the enlistment category of registration was dropped in 1984, and since then only institutionally qualified practitioners may be registered. Sources: The Director of the Board of Indian Medicine, Bangalore; the Commissioner of the Directorate of Indian Medicine, Chennai.
Nor is it helpful to those practitioners who are committed to promoting the benefits of *tibb* (whichever mode of *tibb* that may be) that they themselves have experienced.

In concluding our discussion of some hereditary practices in south India, we should not ignore the possibility that the concept of hereditary practice has partly been constructed in order to make various claims to authority. The display of photographs of illustrious forefathers, signs of piety or royal connections or indeed the absence of signboards and the inconspicuousness of clinics, function in multiple ways to set these forms of practice apart and to distinguish them from others. The practices and the practitioners are themselves not a homogeneous group, and they all have different relationships with the traditions they invoke for the modern world, reflecting their own social, educational and religious backgrounds, and the clientele they are aiming to serve.

*Displaced practices: some concluding remarks*

We have seen then that there are certain key areas of diagnostics and therapy that are being displaced in the contemporary practice of *tibb*. In fact, some of the issues with which we have been concerned in this paper regarding medical education in *tibb* were raised in the Tenth Five-Year Plan of the planning commission of the Indian Government. In Clause 2.9.13 it is observed that,

> [w]hile a lot of time is spent on teaching anatomy, physiology and bio-chemistry, not enough attention is paid to train the students to use ISM&H [Indian Systems of Medicine and Homeopathy] diagnostic and therapeutic modalities. As a result these students lack confidence, knowledge and skills in using ISM&H therapeutic modalities and tend to practise the modern system of medicine in which they are not trained. Patients, therefore, do not get the benefit of ISM&H therapy in spite of accessing ISM&H practitioners.\(^{56}\)

It is important to recognise the significance of these issues. Indeed, the passage above echoes the comments of the medical officer who inspected the āyurvedic school in Mysore in the 1910s. It is equally

important to understand the complex contexts within which these issues have become significant. Further research will be required to gain an adequate understanding of the displacements discussed above. However, we may speculate about the importance of the following four factors: the first factor, as we have seen in this paper, involves the tremendous shifts in the professional milieu of tibb during the last 150 years. The elite structures of learned tibb have been broken and the practice of the profession has been taken up by people to whom in earlier times it would have been inaccessible beyond securing a few prescriptions—or for whom it would have been difficult to maintain a successful practice. The commercialisation of ‘unani’ medicines and the power of advertising have played a significant role here. New institutional environments for education did not square easily with the prevailing modes of transmitting what was then considered authoritative tibbi knowledge.

The second factor relates to the policy initiatives towards indigenous medicine in colonial and post-Independence India. Jeffery shows that the issue of educational curricula was deeply contested in the post-1947 era, both at the state level among policy makers and also among practitioners.\(^{57}\) Those who cherished a vision of integrating western and indigenous knowledge and practice were ranged against the so-called ‘purists’ who believed that indigenous medical education should remain free from western medical subjects.\(^{58}\) By the 1970s the ‘purists’ had apparently won a hollow victory. Graduates of both ayurveda and unani institutions perceived their own training to be inferior to that of their MBBS counterparts in western medicine, and were, in any case, largely prescribing allopathic drugs. Many institutions, whether in pre- or post-Independence India, were shaped by the State governments’ expectations that their graduates would provide a cheaper alternative to western medical practitioners and dispensaries, especially in rural health provision. Here we can cite the Āyurvedic and Unani College of Mysore,\(^{59}\) the larger Government School of Indian Medicine in Madras\(^{60}\) [which later became known


\(^{58}\) Jeffery 1982, p. 1840.

\(^{59}\) The college of this name opened in 1928, although the Āyurvedic branch began back in 1909.

\(^{60}\) This school opened in 1924.
as the Government College of Indian Medicine and then in 1956 was renamed as the Government College of Integrated Medicine or the 1950s provincial government policy in Madras, to upgrade the teaching in the college with a greater focus on western medical subjects. Hence, the emphasis was placed not on the complex skills of the archetypal unani (or ayurvedic) physician, but on basic training in a branch of indigenous medicine as an adjunct to key western medical practices.

The third factor relates to how practitioners of tibb have reoriented their traditions towards the technology and concepts at the core of western medicine. One of the key means by which many hakims of the early twentieth century legitimised their practice was to project unani tibb as the precursor of western medicine—in the context of debates on surgery and in the writings of prominent figures of tibb such as Hakim Ferozuddin of Lahore and Hakim Kabiruddin. Yet, the more unani tibb has aligned itself with the development of western medicine and its technological sophistication, the less space there has been for hakims to evolve an independent professional identity—an identity that prevents their relegation to a herbal medical branch of biomedical science couched in diluted theories of humoral activity, and projected in the commonly cited claim of 'side-effect free' medicines. Neither has the idea of the distinctiveness of tibb solidified around the concept of an 'Islamic' medicine, nor has it been moulded around a conception of nation or certain 'essential' values, as has happened with ayurveda in India. The primary agency in the promotion of tibb in Pakistan—where a 'Muslim' 'unani' tibb might have been expected to emerge but did not—was not the state, but well-connected individuals, and in particular the late Hakim Muhammad Said of the Hamdard Foundation in Karachi.

The fourth factor relates to the demands and expectations that the public have had of medical treatment; how these are related to political, economic, cultural and ecological conditions; and in turn how they motivate changes in medical practice. In a country as vast and diverse as India, such expectations are bound to vary enormously across regions and social groups. Valorisation of technology pervades urban areas. The syringe and the pill are vested with enor-

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mous power, as are many other markers of a modern lifestyle in the way unani hakims market themselves and the kinds of knowledge and practices they possess. It is noteworthy, however, that patients who have experienced urine and pulse diagnosis often express a preference for these methods that perhaps evoke an expertise beyond the realm of a technologically superior western medicine. This is indeed reflected in the providential language used by many patients in Hakim Ari’s clinic when referring to the hakim’s diagnostic methods.

In some respects, one may say that unani tibb is alive and well in India—the annual financial turnover of Hamdard (wakf) of 100 crore rupees (25 million dollars) attests to sustained (perhaps increasing?) demand for health and beauty products in the name of unani tibb.\(^\text{62}\)

Unani tibb has significant government support for its nationwide network of teaching and research centres, while some small-scale private initiatives are also thriving, such as Niamath’s Health Academy, founded by Hakim Syed Khalefathullah. Syed Khalefathullah’s father-in-law (Hakim Syed Makhdum Ashraf) was a leading figure of unani tibb in early twentieth-century Madras (now Chennai), and his father, in turn, was a respected doctor trained in western medicine. Syed Khalefathullah graduated from the integrated medical college in Madras and rose to become President of the Central Council of Research in Unani Medicine. His practice, successful from many vantage points, reflects the various influences of his medical education and experience and is presently expanding beyond India to Malaysia.

It is evident, however, that there exist within ‘unani tibb’ a wide variety of approaches to health and illness, and that only some of these approaches are favoured and sponsored in institutional contexts, by policy makers, and under current socio-economic conditions.

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\(^{62}\) Bode 2004, p. 63. The figure given is for 1996.


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