GOING BEYOND ELITE MEDICAL TRADITIONS: 
THE CASE OF CHANDSHI*

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Abstract

The historian’s overwhelming reliance on textual sources has kept the tradition of ‘Chandshi’ outside the view of the rich corpus of South Asian medical historiography that has developed of late. By supplementing the scant textual evidence by personal interviews and sittings in the clinics of these physicians, I seek to re-construct the history of this little-known, non-textual medical tradition practised by members of a socially dis-privileged caste group. By studying the present modes of self-presentation, I suggest that the search for status and legitimacy may have, in the past, led physicians of this system to speak of themselves as ayurvedic rather than Chandshi-practitioners.

South Asian medical historiography has been greatly enriched by a growing interest in the so-called ‘indigenous medical systems’. Yet there are ways in which this historiography remains trapped within the constraints imposed upon it by the nature of its material. Historians have traditionally been sceptical of oral narratives and have tended, even in those limited cases where oral narratives have been used, to look for final corroboration in textual references. Texts, though, bear the indelible mark of the times in which they are constructed and hence the information they give us remains inextricably structured by the categories according to which such information was collected.

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in the first place. The recent works of anthropologists such as Jean M. Langford and Joseph S. Alter have described the complex constellations of discourses within which ayurvedic texts are constructed and interpreted.¹

Most of the early reporters on South Asian medical traditions in Bengal, such as F. J. Mouat and T. A. Wise, tended to see a ‘medical system’ as one that had a proven textual basis, derived from clearly stated principles and, most importantly, as traditions with long and verifiable historical antecedents.² Hence, traditions that were perhaps of more recent origins and not based on ancient texts and clearly articulated first principles were either ignored altogether under the label of ‘superstition’ or ‘quackery’, or indeed sometimes subsumed under any of the major traditions such as ayurveda and unani. Or they were seen to be inferior versions of these canonical traditions. The historical record thus documents very little of the non-textualised, localised traditions commonly practised by various communities in South Asia. Chandshi is just such a practice. Older people in Calcutta still recall Chandshi practitioners who used to treat various kinds of wounds (khoto chikitsha), but textual references to these practitioners are extremely rare.

The earliest, and one of the only written references to Chandshi, can be found in the District Gazetteer of Bakarganj, published in 1918. The author, J. C. Jack, mentions in passing that there was a group of hereditary healers hailing from the village of Chandshi. He also mentions that these practitioners were of the namasudra caste.³ The namasudras were one of the most socially dis-enfranchised caste groups of the region and were usually derogatorily referred to as ‘chondals’ by the upper castes. This was a name harmless in itself (and, in fact, there is sufficient controversy about the actual etymological derivation) which, through centuries of derogatory usage, had come to reflect the disdain and disgust of the upper castes towards the subaltern orders. In fact, the name was often used in conjunction with another lower caste group, the doms, who traditionally worked at the cremation grounds. The chandals were usually smiths and palanquin bearers, occasionally also taking to agricultural work and petty trade. From the beginning of the twentieth century, they

¹ Langford 2002; Alter 2004.
² Mouat 1847; Wise 1845.
³ Jack 1918, pp. 44–5.
started agitating for a higher caste status and insisted on being called 'Namashudras' or 'sudras worthy of worship'. They argued that they were born from the miscegenation of brahmin mothers by shudra fathers.4

By the early 1920s, however, the well-known Bengali writer, Raj Shekhor Basu, better known as Poroshuram, informs us in an essay that Chandshi, too, was one among the several alternative medical options available to the sick in the colonial metropolis of Calcutta.5 Unfortunately though, Basu then moved on to discuss the more 'important' systems of ayurveda, allopathy etc. and we do not hear about Chandshi again. These stray references, while not sufficiently elaborate to allow us to re-construct the past of this mode of treatment, does signal and corroborate oral accounts of its existence in the early decades of the twentieth century, at which time, as Jack points out, it had already been known for some time.

**Chandshi today**6

No one is quite certain today of exactly why and where the practice of Chandshi arose. There are still at least four practitioners in the city of Calcutta who describe their mode of treatment as being Chandshi. For the purpose of this article, I am interested specifically in the discursive frames within which these physicians represent and understand their own methods of treatment. The choice of this line of enquiry is both pragmatic as well as methodological. It is pragmatic since, functioning at the fringe of the medical markets, these

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4 For a good discussion of the namasudra politics of the period, see Bandyopadhyay et al., 1994.
5 Basu 1987.
6 This account of Chandshi today was compiled during the course of two field trips to Calcutta. The first trip was undertaken between September 2003 and February 2004 and the second between December 2005 and January 2006. During these trips, I spoke extensively with, and attended the clinics of three practitioners, Raj Krishna Pillai, Probir Kanti Haldar and R.L. Sikder. I interviewed them on the following dates: Pillai 28 November 2004; Haldar 23 November 2004 and Sikder 27 January 2006. Any quotations from these physicians, unless indicated otherwise, should be understood to be quotations from these interviews. All the interviews were semi-structured and conducted principally in the Bengali spoken in urban Calcutta. Each interview lasted between two to three hours, excluding interruptions caused by patients coming in. This gave me an opportunity to observe consultations with patients without any prior preparation on the part of either the patient or the physician.
physicians are loath to divulge details of their practice beyond broad generalities. The cloak of secrecy is their only guarantee against others poaching on their methods which they wear closely. The methodological choice is determined by the fact that developing objective criteria for defining these practices would be necessarily deploying categories external to the practices themselves, since they are a non-textualised mode of treatment with little attempt at standardisation. This, in my view, would constitute a sort of epistemic violence. It is with similar objections in mind, too, that I avoid passing any judgement upon the 'efficacy' of these methods. That some of these practices have survived since the beginning of the last century is, I believe, evidence enough to suggest that a fair number of people continue to use these methods, which in turn is sufficient ground to study them.

All four clinics are situated in densely populated areas. Apart from the tightly packed houses of the middle classes, slums and a market are close by. Outside the clinics hang red sign boards with a white snake painted on them. This is the traditional motif connected with Chandshi practitioners and they themselves claim it to be related to the snake goddess who is their tutelary deity.

The clinics comprise of two rooms. In the front of each clinic is a consulting room, made up of an old wooden table, a couple of wooden benches and one or two glass-fronted old almirahs or cupboards in which are kept the medicine bottles. In the case of R. L. Sikder, these are still the old glass bottles with hand-written labels. In Proibir Haldar's practice, we can find plastic bottles with labels of the big herbal companies such as Dabur and Zandu. The only other features may consist of a picture of Ma Monosha, the snake goddess on the wall or above one of the almirahs. The pictures bear the signs of regular devotion and worship since they are marked with sandalwood and have incense sticks burning in front. This in itself though is not very different from any of the other shops in the market. Most of them would have the picture of a tutelary deity with similar marks of devotion. The difference lies alone in the somewhat unusual choice of the tutelary deity, since Monosha is no longer one of the major goddesses in the urban milieu and least of all in the market place.

Monosha was essentially a folk deity incorporated into the brahmanic pantheon from around the thirteenth century. Being the patron deity of snakes, snake charmers and jhatas or shamans worshipped her, but importantly groups such as the chandals, who were only partially brahminised, continued to worship her as well.
The consultation room usually has a large door that connects it to the market outside. In fact, the distinction between the consulting room and the market does not seem to be marked with any degree of precision. People keep moving between the two spaces with a casual nonchalance that would surprise any patient used to the sanctity of the modern doctor’s chambers. Stall-owners in the market drop in to ask for change from the physician or the errand boy at the tea-shop down the road comes in to ask if the physician wants tea for his patient, right in the middle of a consultation and occasionally even participates in the conversation. Mr Sikder, for instance, casually asks the chaiwala or teaboy if he remembers the difficult case he had from Rajasthan a few years back, as if trying to convince his new patient (and perhaps me) of his nationwide reach.

In direct contrast to this is the back room, which functions as an examination and more rarely a treatment area (in most cases, the actual treatment is done by the physician regularly visiting the patient at home on appointed days). All the physicians I spoke to refused to allow me inside the examination room while they treated the patients. In this refusal, however, they may have been driven more by the fear of their skills and practices being divulged than by ideas of the patient’s privacy. This was due to the fact that they openly discussed with me the details of their cases in the presence of the patients, without asking them for permission to do so.

After the first consultation, for which a nominal fee is charged, a time frame and the costing for the cure are worked out. The physician proposes to cure the patient within a specific period of time in exchange for a certain fixed sum. This sum is then paid in a pre-determined number of instalments. In the case of poorer patients, however, the regularity of these instalments varies according to their circumstances and occasionally remains outstanding even after the cure, with the patient continuing to pay what he can, and the physician making repeated visits to the patient’s house to collect the dues. To the outsider, the exchanges between the physician and the patient seem akin to a debt-collector collecting a bad debt, with all the attendant use of rough language and the moral stigma invoked against leaving the dues unpaid. Interestingly though, these charges are not fixed a priori but negotiated through complex physician-patient encounters. Negotiations take place at the first meeting, and later the patient might cite straightened circumstances or the cure having taken longer in order to re-open the negotiations about payment.
This reflects the fact that these physicians attract a predominantly poor clientele, whose unstable earnings need a more flexible payment pattern. It could also be seen as indicative of a more egalitarian power relation informing the practitioner-patient encounter.

It is difficult to date the emergence of these practices, but the physicians I spoke to told me that their grandfathers had started the practice. All of them agreed that the method dated back about a century and a half, i.e. to the second half of the nineteenth century. They claim it was revealed in a dream to a common ancestor called either Podmo Daktar or Podmo Lochon, in which the goddess Monosha appeared to the ancestor and taught him the secrets of the Chandshi method, forbidding him to share it outside the family.\(^8\) Probir Haldar felt it was because of this that no one had ever written it down.

**Status, identities and modes of legitimation**

The flawed classification of Chandshi practitioners as ayurvedic doctors may not necessarily have been the result of prejudice and ignorance on the part of British Gazette officials. In 1910, one Kobiraj Shoshi Kumar Baruibiswas published a pamphlet called *Nomoshudrer Dwijotitwo* (Arguments for Considering the Namasudras being Twice-Born).\(^9\) Not only did Shoshi Kumar call himself a kobiraj, but indeed his ten students who are said to have subscribed to the publication, and of whom at least nine were namasudras or similar ranking castes, used the epithet ‘kobiraj’ too.\(^10\) It is quite possible that these kobirajes were actually Chandshi practitioners. The practice of ayurvedic medicine had, by the second half of the nineteenth century, come

\(^8\) The use of the word Daktar or Doctor here, in preference to Kobiraj, is interesting and quite likely to be related to contemporary visions of medical competence, rather than being the title actually used for such a practitioner in the nineteenth century. Podmo Lochon is a common Bengali name, meaning the ‘Lotus Eyed One’.

\(^9\) Baruibiswas 1910.

\(^10\) The term ‘Kobiraj’ is used in Bengal to designate any practitioner of ‘indigenous’ medicine. In most contemporary historiographic references it has tended to be used to refer to practitioners of ayurveda and therefore interchangeable with terms such as ‘vaid’. I suggest that it is a wider and more open-ended category. H. H. Risley, for instance, mentions that even ‘a plucked student’ of any of the several Calcutta-based colleges teaching ‘western’ medicine could pass as a kobiraj. Risley 1891, p. 362.
to be related to higher caste status and the decision of these low-caste practitioners to use the epithet kobiraj may well have been due to their ambition to get the namasudras accepted at a higher caste rank. Just as they had perceived the insult couched in the name ‘Chondal’ and insisted on ‘namasudra’, they may well have sought to bolster that claim, aligning themselves with Ayurveda. The Gazette officials may simply have taken their politicised self-representation at face-value.

The relation with ayurveda remains a vexed one and marks the inequities of power that continue to shape the complex and heterogeneous field of ‘indigenous’ medicine. Probir Haldar, for example, on being asked if what he practised was ayurveda, replied somewhat perplexedly, ‘Of course, we too use herbal medicines.’ Further enquiry clearly showed he neither made any use nor knew much of the ayurveda’s tridosha pathological system.\(^{11}\) He asserted an almost commonsensical increased incidence of all disease and referred to the eruption of new diseases like ‘cancer’ and ‘AIDS’. He felt the increase was related to the government’s bad policies, which led to factories closing down, especially since the 1990s, leaving people jobless. This meant they no longer had wholesome food, he said. To make a living people had to now also depend upon soul-killing clerical jobs. On top of all this, the increasing number of cars and the consequent smoke and pollution, not to mention the growing adulteration of foods, all combined to make people sick.

A practitioner of the closely related system of Madrasi Chandshi (Madras Chandshi), Raj Krishna Pillai, agreed in principle that his mode of practice was ayurvedic as both used herbal medicines. In fact, Pillai even referred to ayurvedic colleges in Madras, which taught the Chandshi technique. He even claimed to have passed an examination at one of these colleges. On being pressed further, he confessed that he had never been to Madras and had heard about these schools from others. His degree, he clarified, was obtained by correspondence. However, on being asked to produce the degree document, he avoided the issue altogether.

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\(^{11}\) The tridosh pathology is usually understood as a proto-humoural system in which ill-health results from the imbalance or, at times, vitiation of \(vata\) (wind), \(pitta\) (bile) and \(kaph\) (phlegm). On the variety of meanings historically attributed to this conceptual frame, as well as the objections to translating them as the Greek humours, see Scharfe 1999.
In a similar gesture, Sikder mentioned in passing that one of his patients told him that the allopath he had consulted previously had suggested Chandshi treatment to him and even shown him an allopathic textbook with pictures of the Chandshi method. The allopath is, moreover, alleged to have said that medical students too were taught the method at college, but very few were skilled enough to practise it. Although Sikder seemed to mention this episode disinterestedly, adding that he did not know if the patient’s story was true or not, clearly the very mention of the story shows his inclination to establish that his methods were legitimate by virtue of their inclusion in an official medical curriculum.

Clearly, the practitioners seek to relate their method to easily recognisable and socially legitimate modes of healing, such as ayurveda or biomedicine in order to further their own needs of legitimacy and status. Moreover, this alleged connection is no longer with an amorphous tradition, such as a broadly defined ‘ayurveda’ or kobiraji, but rather with systems institutionalised through colleges, text-books and degrees.

Another strategy to gain professional legitimacy is of course to claim wide renown. The practitioners referred to claimed to have cured either foreigners, or at least people who had been abroad for a long time and therefore possibly tried the best that ‘modern’ medicine had to offer. Sikder, for instance, mentioned a Dr Nripen Das, who had studied medicine in England and whose own younger brother had been cured by Sikder after Das had failed. Similarly, Haldar mentioned a barrister called Arun Roy, whose son is a practising doctor in London. Such stories are structurally very similar: the patient has been to the west and is thereby presumably financially quite well-off and has seen what modern medicine could achieve. Furthermore, there is also a modern doctor present in these episodes who is closely related to the patient and thereby stands guarantee against any possible malpractice or negligence in the treatment. The patients turn to Chandshi as a last resort and are cured, re-asserting Chandshi’s legitimacy and indeed supremacy to other modes of treatment. Haldar even lamented to me that the famous West

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12 Interestingly, the very need for this ‘guarantor’ in these narratives might betray a lasting fear of negligence or at least lack of sympathy on the part of biomedical doctors, which the Chandshi practitioners seek to exploit for their own ends.
Indian cricketer, Sir Vivian Richards, whom he thought to be English (on my pointing out he was West Indian, Haldar answered that 'whichever province he belonged to, he was still English, just as, whether Bengalis or Biharis, everyone was still Indian!'), had apparently retired from cricket because the English doctors could not cure his piles. Haldar felt he could easily have cured them.

**Locality and identity**

There is a group of three practitioners in and around Calcutta, who claim to be 'Madrasi Daktars' (Madras Doctors). Their system is often referred to as 'Chandshi' by patients and laymen, while other Chandshi practitioners refer to them as ‘Madrasi Chandshi’. They work in almost identical ways to the other practitioners, but do not use the tell-tale snake on their signboards, preferring instead a red cross, like allopaths. They insist that their ancestor had migrated from Madras (now Chennai) sometime in the nineteenth century. They claim that the current generation is the seventh living in Bengal, and apparently none of them have ever gone to Madras. Their claim to have descended from a single ancestor seems valid since the three practitioners have definite kinship ties and keep in touch. Pillai, whose clinic is the oldest and situated in a small by-lane that skirts along the walls of the Calcutta Medical College, showed me a book of testimonials that had been maintained since the early days of his grandfather's practice, soon after he opened the clinic at the present address. Pillai claimed his grandfather, V. Gopal Krishna, had started the practice in 1901. Yet the earliest testimonial, and thereby written evidence, in his book of testimonials from satisfied patients, dated from 1924 (a date that is consistent with Poroshuram’s reference). Among these testimonials, the ones he seemed most proud of were those written by a sitting judge of the Calcutta High Court and a relative of Netaji Subhas Bose, from a slightly later date.

On being asked about his connections with the other Chandshi practitioners, Pillai says ‘their treatment is long and painful, our’s is painless and quick’. He also clarifies that they still use Madrasi herbs and not the local Bengali ones. On being asked how he procures them since he has never been to Madras, he says he has relatives and caste-fellows who send the herbs, but avoids giving any further details. His shelves are well stocked with herbal medicines bearing
the labels of well-known firms such as Dabur and Zandu, and a few painkillers and disinfectants.

Sikder and Haldar, on the other hand, insist that Pillai’s methods are either degenerate forms of Chandshi that they somehow managed to learn from some practitioner, or indeed a complete fraud. A visibly agitated Haldar goes so far as to call them all ‘liars of the first order’. Both further agree that while the crucial feature of Chandshi is that they can cure cases of piles, fistulas and wounds that need surgery, without any surgery, the Madrasis actually ‘use knives’. Pillai, however, denied this charge and volunteered to show us an album of photographs depicting him treating his patient with the traditional Chandshi technique of strings. Both Sikder and Haldar most importantly also stress that Chandshi is a Bengali system and comes out of Barisal. Anybody who claims to be from elsewhere is clearly not a legitimate practitioner.

Both the Madrasis as well as the Bengali Chandshis deploy a complex sense of local geography to substantiate their claims to authenticity. Both agree that the Madrasi practitioners, despite their own claims of having been in Bengal for the last seven generations, remain outsiders, as does their system of treatment. However, while Madrasis use this to their advantage and try to claim a closer nexus with the southern country than perhaps they actually have in order to frame a distinct and somewhat exoticised patina, the Chandshis deploy this to the contrary and seek to disenfranchise their methods.

Identities of these physicians and their methods are inextricably woven into a complex economy of regional identities within the post-colonial states in South Asia. This becomes clear when Haldar, after having asserted the Bengali-ness of his method in the strongest possible words, proceeded to add that today Chandshi was no longer limited to Bengal alone and could be met with in ‘Bangladesh, in Allahabad, in U.P. [Uttar Pradesh], Midnapore, Ghatal, Krishnanagar, and of course Bihar’. He himself, he says, treats ‘all kinds of patients—Hindu, Muslims, Marwaris. Though I get very few Punjabis and fewer Christians’, he adds. Sikder similarly mentions patients from Rajasthan, the Punjab as well as a ‘Madrasi’, and even introduces me to one of his ‘Punjabi’ patients. It is cogent to add that there are quite a few Punjabi settler families in the area where Sikder had his clinic. This gentleman, as well as some of the other patients, may well have been such an immigrant. Indubitably though, the most
curious of Sikder’s artefacts was a testimonial written by a Japanese patient who had been cured by him, written in Japanese!

Nevertheless, one striking difference between the Bengali and the Madrasi approach is that while the latter also teaches their methods to some of the women in the family who then treat women who refuse to be treated by men, this is not the case with the Bengali Chandshis. Pillai’s sister comes in once a week to treat women unwilling to be treated by him. Pillai usually charges higher fees though for such privileges. On being asked why the Chandshis do not have such an option, Haldar retorted ‘why should the sex of the patient be of any concern to the practitioner? To him, man or woman, it is a patient.’

**Modes of healing**

Both the Madrasis as well Chandshis today limit their treatments to mainly ‘piles’, ‘fistulas’, ‘fissures’ and wounds (*ghaa*). Some assert though that they have known Chandshi practitioners in the past to tackle a larger repertoire of complaints.

Sikder clarifies with the help of a diagram that in the human gut lie two big worms. These are crucial to digestion and therefore central to the general well-being of the person. But these worms keep giving birth to smaller worms and these smaller worms are bad for health and must regularly be expelled from the body. This is why the daily movement of the bowels is essential. He explains that this is why one sees faeces left in the open field soon turn to earth, since the small worms eat it up. It is thus, he carries on, that on stirring human faeces found in an open field with a stick, one sees small white worms in them. Moreover, the human anus is, according to Sikder, controlled by three sphincters. The first creates the urge to defecate, the second controls that urge and the last is responsible for the final release. It is when these sphincters malfunction that the problems start. The retained faeces allow the worms in them to bore into the surrounding flesh causing deep sores. This is fistula. Internal piles result, on the other hand, from the expulsion of one of the sphincters through the anus; while external piles are caused by the muscles of the third and last sphincter hardening. Finally, fissures result from the hardened sphincter at the mouth of the anus cracking up.
Thus defined, these four complaints form the basis of the Chandshi repertoire today. The method used to cure piles comprises of tying up the root of the swelling with a thread, so as to deprive it of blood and dry it up, without letting it fester in the process. It is a complex procedure and can take up to six months. Pillai said they used to use horsehair in the olden days, while Sikder mentioned a fibre extracted by boiling some local cacti. Today, however, modern threads are used, though they would not say if they preferred cotton or nylon threads, often claiming they use both.

Fistulas are cured with an ointment made by mixing special herbs (the names of which once again they are loath to divulge), in a paste made from ground and boiled paddy husk. Apparently, Sikder’s father replaced the paddy paste with one made from old ghee (clarified butter) and herbs. This was done to meet both constraints of available resources and to make the paste more suitable to the urban lifestyle.
Haldar, on the other hand, uses mass-produced antiseptics and pain-killers, as does Pillai. Sikder agrees to occasionally resorting to pain-killers such as ‘Crocin’ and ‘Brufen’ to give some relief to his patients; yet he claims that he does not use mass-produced medicines anywhere else in his treatment. He claims to buy his stock of herbs from the herb-sellers of Lohapotti in north Calcutta and make his own medicaments from these.

Yet there are many other ‘modern’ procedures Sikder uses in his practice, such as keeping consultation rooms and running a ‘nursing home’ jointly with two biomedical doctors. On one of the walls in the consulting room hangs a poster depicting the human digestive system, probably a gift from a pharmaceutical company. Pillai’s walls are similarly adorned by such posters hanging next to the photographs of his ancestors. Sikder, in fact, mentions that he had kept a joint practice with two biomedical doctors for a while and they had also started a small nursing home, which had now closed down.

It might be the proximity to biomedicine that has littered Sikder’s speech with a more concretely mechanistic understanding of the human body and its ailments as he sees them to be controlled by the sphincters and worms, whereas the definitely less refined Haldar,
as we have seen, articulates a theory of illness that relates government policy, economic decline and the cars of the rich polluting the environment. Haldar’s treatment retains a more ecological theme by stressing the importance of diet. While undergoing his treatment, he forbids his patients to eat meat, eggs, onion, garlic, sour foods and brinjals. Pillai also uses dietary restrictions. He explains that most of his patients are Muslims and eat a lot of beef. Apparently this is not good for health. Moreover, they consume much alcohol and also keep late nights. These things are bad for health, he explains, and therefore he forbids them to eat beef, drink alcohol or keep late nights while undergoing his treatment.

Thus Pillai and Haldar, while taking recourse to a more ecological than mechanical model for understanding the human body, deploy this theme to articulate positions influenced by their social positions. Pillai, a caste Hindu, gives his approach a decidedly Hindu orthodox flavour, while Sikder, the low caste scion of an East Bengali family displaced by the Partition, tends to couch it in terms of a lower middle-class critique of postcolonial urban modernity.

Conclusion

The case of Chandshi, while highlighting the sheer heterogeneity of the ‘indigenous’ medical sphere, also shows how the self-representation and rhetoric of practitioners tend to be tied into complex webs of social power and authority. It serves perhaps also as a rider against an over-reliance on textual sources alone in the reconstruction of the historical past. While much more work needs to be directed at such little known, localised, subaltern practices, their largely non-textual nature might also require us to re-visit the hard and fast relationship between history and anthropology. In spite of Bernard Cohn’s efforts in South Asian historiography in general, as well as Michael Taussig’s work on Andean healing cultures, there has been woefully little effort to deploy tools from both disciplines in the study of South Asian medical cultures. There continues to be a tendency for historians to study the textualised traditions such as ayurveda and unani, while anthropologists tend to focus on the non-textualised healing

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processes. Despite the undoubtable merit of these works, they continue to reproduce an absolute split between the textualised and the non-textualised traditions, which itself was largely a nineteenth-century creation. As even this preliminary study of Chandshi shows, such distinctions are difficult to maintain. Often the practitioners themselves, due to a variety of reasons, fail to make this distinction, and this self-presentation also marks the historical records that the historians use in reconstructing the past. A greater deployment of anthropological methods might lead us to evolve new strategies of critical evaluation of historical sources and thereby alter our understanding of South Asian medical history significantly.

Moreover, the new niche market that globalisation, along with the powerful oppositional discourses of modernity, such as Herbalism and Holistic Health, and also the postcolonial cultural and national revivalisms, have created yet more pressure on these practices to conform to easily and internationally recognisable labels such as ‘ayurveda’. They therefore urgently need to be studied before they are either extinguished or appropriated totally by the elite traditions.

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