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Special Issue on ‘Indian medicine between state and village’ for Asian Medicine: Tradition and Modernity

Indian Therapeutic Hierarchies and the Politics of Recognition

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Abstract: Social science research on medicine in India has moved from village-based ethnographies to studies of the major medical traditions, and from a focus on indigenous folk practices to the influence of global biomedicine. This article shows how these academic trends have influenced the contemporary understanding of medical pluralism in India. The article then describes the socio-political structuring of medical plurality, by relating historical shifts in government policy on indigenous medicine to ethnographic material on ‘bone doctors’ and other subaltern traditions in north India. It highlights the role of the state as constitutive of contemporary medical pluralism and suggests how current analytical frameworks for understanding the phenomenon of medical plurality might be reconceived to better characterise shifting relations of power among professional and vernacular therapeutic forms. It concludes that concerns over the decline of subaltern medical traditions, seen in government policies and vernacular explanations alike, can be understood as intracultural narratives that are replicated in academic scholarship.

Keywords: India; traditional medicine; folk medicine; health systems; AYUSH; medical pluralism

Introduction

This article argues that what we understand to be “Indian medicine between state and village” is inflected by academic trends that have shifted both locus of inquiry and scale of analysis over the past century. The article explores historical shifts in some official and unofficial status hierarchies between different treatment modalities in India’s plural medical milieu that

affect access to these modalities by different sections of the public.¹ It highlights the role of the state in shaping what constitutes medical pluralism in India and suggests how current analytical frameworks for understanding the phenomenon of medical plurality might be reconceived to better depict shifting configurations of power among professional and vernacular therapeutic modalities. Finally, it suggests that statist claims about the incipient demise of subaltern medical traditions are replicated in vernacular explanatory narratives and echoed in academic scholarship.

In what follows I summarize trends in anthropological work on Indian medicine since the early twentieth century to show how theoretical shifts have influenced contemporary understandings of medical pluralism in India and to highlight the way that scholarly accounts have replicated certain state-sanctioned tropes. I review shifts in policy to suggest that over the past century, scholarly representations and policy accounts alike have treated the medical domain as consisting exclusively of putatively discrete knowledge systems, while excluding certain other types of therapeutic practice that are deemed inferior or illegitimate. I then report on recent research into two vernacular medical traditions in Rajasthan to illuminate the variable role of state authorization in shaping the pasts and futures of vernacular therapeutic forms, before discussing recent attempts to reconceive the study of medical pluralism itself.

Background and Settings

My analysis is informed by long-term research work since 1984 conducted primarily in the erstwhile Jeypoor State, in both the city of Jaipur and a rural area which is now part of Tonk District, Rajasthan. My doctoral research sought to document *all* forms of therapeutic practice used by ordinary people (which I hence termed “popular”) in that part of Rajasthan.² During this early ethnographic work the role of “the state” in health care was visible only as an inadequate and flawed provider of allopathic (biomedical) and Ayurvedic treatment that seemed to impinge little upon the lives or consciousness of the people with whom I lived.

The therapeutic formations and treatment-seeking practices I documented in Jaipur and in and around a multicasite, predominantly Hindu village with a few Muslim and tribal families, were highly diverse. I noted the provision of injectable antibiotics and glucose drips by the assistant at the local government Ayurvedic dispensary, who, like the physician

¹ Cf. Attewell et al. 2012.

² Lambert 1988.

(*vaidya*) posted there, saw more patients privately than during clinic hours, when purely Ayurvedic diagnosis and treatment were available. The dispensary was so infrequently attended that I abandoned early plans to conduct observational work there followed by home-based interviews. More common was the use of *mantra* with and without ritual sweeping (*jhara*) and/or herbal medicines from lay specialists and religious officiants for a wide range of health problems.³ These included skin problems, evil eye (*nazar*), and, prominently, typhoid fever (in a 10-kilometer radius of the village where I conducted fieldwork, there were twenty practitioners locally known to be able to treat “typhoid” by ritual sweeping using an empowered branch of margosa leaves). From time to time I witnessed various problems, including snakebite (the specialist domain of the deity Tejaji) and miscarriage (attributed to the spirit of a dead fetus or to witchcraft), being taken to local shrines where deities regularly became embodied in their shrine priests. The village shrine to Bhomiaji—frequented mostly by nonresidents—was particularly reputed for the extraction of ensorcelled black lentils (*urad daal*). I also documented a common manipulative procedure to treat abdominal discomfort.⁴ I learned that cauterization was occasionally administered on the breastbone of babies with pneumonia and heard about the even more occasional use of blood cupping. Rather intermittently, I witnessed the efforts of the local ANM (auxiliary nurse-midwife), who hailed from Kerala, to enroll women into prenatal care or family planning. People sometimes consulted an unqualified private “doctor” in the nearest town (although no one seemed to visit the government Primary Health Centre there), and occasionally emergency cases were taken to the hospital in the district capital twenty kilometers away.

Coherent cultural logics underlying many of these approaches to the management of health problems could be discerned, but the totality of this wide array of diverse therapeutic forms appeared to lack the characteristics of a local “health care system,” in the sense of predictable or coherent paths of referral and linkage between the elements.⁵ Trying to understand the contemporary configuration of therapies that appeared as a patchwork of therapeutic options drew me to investigate their historical antecedents, and to a clearer recognition of the influence of the state—in its princely, colonial, and postcolonial

³ Summarized in Lambert 1996.

⁴ Described in Lambert 2012b.

⁵ Kleinman 1980 depicts a “local health care system.” On cultural logics, see Lambert 1992, 1997a. On lack of system characteristics, see Lambert 2012a.

manifestations—on the contemporary configuration. Subsequent investigation demonstrated the importance of governance structures and state provision, even in relation to the entirely unregulated and unorganized medical formations that have been the primary focus of my research. In previous work I have therefore contested dominant representations of “folk medicine” as religious, timeless, and impervious to secular trends—for example, by demonstrating that the establishment of European dispensaries and hospitals in Rajputana (Rajasthan) preceded the decline of folk specialists in surgery (couchers [*sathiyas*]; barber-surgeons [*jarrahas*]; lithotomists) and by tracing continuities between elements of “folk medicine” as documented ethnographically and elements of “classical” Indian medicine.⁶ The following analysis builds on these accounts and on perusal of documentary and archival records, as well as on a more recent period of field research in Jaipur with practitioners known as “bone doctors,”⁷ whom I chose to study precisely because nonaccredited specialists who cannot be classified as religious have been neglected in most accounts of “indigenous medicine.”⁸ In so doing I seek to highlight the value of reading *across* specific medical traditions to uncover common processes that affect access to and provision of all forms of health care.

Anthropological Accounts of the Medical Sphere in India

Little early anthropological work in India concentrated on health-related practices, focused as it was on documenting social groups for purposes of governance.⁹ Early medical anthropological studies took their lead from more general post–Second World War trends, when anthropologists started to take an interest in modernization and development. An initial assumption (here as elsewhere) was that the primary explanation for the continuing use of other, non-biomedical forms was to be found in “cultural barriers” to the use of biomedicine—the domain of anthropology. Early ethnographic studies, drawing on village-based fieldwork,¹⁰ offered explanations of observed preferences in terms of “cultural

⁶ See, e.g., Lambert 1995, 1997b, 2012a.

⁷ Fieldwork was conducted in 2009–10.

⁸ See Lambert 2012b.

⁹ See Fuller 2017 for a recent account of such work.

¹⁰ E.g., Gould 1965; Marriott 1955; Opler 1963.

resistance,”¹¹ although some authors offered more nuanced accounts of hierarchies of resort,¹² the nexus of medical treatment and religious faith,¹³ or political economies of health.¹⁴ This research into noncodified medical traditions focused on laypeople’s perceptions and actions in the treatment of illness and on forms of ritual healing rooted in local cosmologies. Thus, studies of the medical domain in this phase were concerned in one way or another with the “folk,” mainly in rural populations. These anthropological accounts also contributed to a substantial literature on the healing of affliction—particularly spirit possession—by ritual means and, importantly, were viewed as contributing to an understanding of the locally variable “little traditions” associated with village society, in contrast to the unitary “great tradition” associated with Sanskritic Hindu beliefs and practices.¹⁵ The authors of these accounts tended to interpret their material in relation to local religious practice;¹⁶ the study of Indian medicine per se was understood as the province of Indologists studying the “classical” texts.

These approaches to studying the medical domain began to shift in the latter part of the twentieth century. Contrary to the assumptions of global health and development experts, it became apparent that far from being resisted, allopathic medicine (as biomedicine is referred to in India) was widely accepted (perusal of archival records suggests that “English medicine,” as it is commonly described, for the treatment of certain complaints had been popular since the late nineteenth century).¹⁷ Social scientists began to study biomedicine and modern health services as part of India’s medical plurality,¹⁸ and some commentators concluded that the continuing use of non-biomedical therapies resulted from the inaccessibility and poor quality of biomedical care in many places.¹⁹

¹¹ Sujatha and Abraham 2012a, 14.

¹² Beals 1976.

¹³ Carstairs 1955.

¹⁴ Djurfeldt and Lindberg 1975.

¹⁵ Marriott 1955.

¹⁶ Mandelbaum 1970; Carstairs 1955.

¹⁷ See Lambert 1995, 1997b.

¹⁸ E.g., Minocha 1980; Madan 1969, 1972; Jeffery 1988.

¹⁹ Most famously Banerji 1973; see also Bode and Hariramamurthi 2014.

Among anthropologists, there was a gradual move away from conducting ethnographic studies of “folk” therapies and their users in rural settings. Heavily influenced by Louis Dumont’s use of Indological materials, his seminal work on caste, and his call to establish a comparative sociology of India that would give due weight to the civilizational character of Indian culture,²⁰ social anthropologists began to focus increasingly on the cultural manifestations of mainstream Indian civilization. The central focus on the “bounded universe” of the village as the appropriate unit of ethnographic investigation under the synchronic approach advocated by postwar structural-functionalism, began to give way to more processual and historically informed analyses, as scholars began to combine field observations with the use of documentary materials. It was increasingly seen as essential to prioritize textual authority as manifested in the textually based “classical” or “codified” traditions. In studies of the medical domain this approach was given significant impetus by the work of Leslie,²¹ which ushered in a focus on specialist medical traditions in India that has continued to foreground the textually sanctioned medical traditions of Ayurveda and, to a lesser extent, Unani and Siddha ever since.²²

The convergence of social science scholarship on these textually based traditions with the work of historians of Indian medicine has fruitfully documented processes of legitimation since the second half of the nineteenth century in which certain traditions of indigenous medicine have been reformulated as unified and professionalized systems of medical knowledge and practice.²³ While Leslie argued that “access to medical knowledge and to consultation with specialists is another critical variable for comparing medical systems,”²⁴ research on the formation and character of single “systems” permits little exploration of relations *between* different traditions in contexts of use. This has also tended to obscure the fact that most of the professionalized medical traditions have, at least until recently, mainly served an elite minority of the population.

²⁰ Dumont and Pocock 1957.

²¹ Leslie 1976.

²² See, e.g., Langford 2002; Leslie 1976; Leslie and Young 1992; Sujatha and Abraham 2012b; Zimmerman 1982.

²³ See, e.g., Attewell 2005, 2007; Banerjee 2009; Hardiman 2009; Langford 2002; Leslie 1976.

²⁴ Leslie 1976, 6.

Indian anthropologists, privileging a positivist scholarly tradition that draws mainly on physical and biological anthropology, have continued to document ethnomedical and ethnobotanical practices, mostly among “tribal” peoples, but the study of local therapeutics and of vernacular (noncodified) traditions has generally become somewhat anachronistic. Over the past two decades, medical anthropologists of India have increasingly turned away from the study of “Indian medicine” to focus on more global concerns: for example, the pervasive and expanding influence of the pharmaceutical industry and global markets for bioscience, the trade in donor organs, maternal health, and the ethics of reproductive surrogacy in India.

Indian Medicine in Contemporary Health Policy

Characterizations of health care in contemporary India mostly describe “Indian medicine” as essentially comprising the institutionalized text-based medical traditions, both indigenous (Ayurveda, Unani, and Siddha) and introduced (“allopathy,” or biomedicine, and homeopathy), although most of these “systems” actually encompass both college-trained, qualified practitioners and “traditional” providers who have acquired expertise through informal apprenticeship.²⁵ Having described recent shifts in Indian government policy regarding non-biomedical forms of health care in detail elsewhere,²⁶ I comment here only on the recent official bifurcation of Indian medicine into “AYUSH” and “local health traditions” (a term that first appears in policy documents in 2002).²⁷ Since the Ministry of Health and Family Welfare renamed their former Department of Indian Systems of Medicine and Homeopathy the Department of Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy, or AYUSH, in 2003,²⁸ the acronym has been adopted by policy-makers, practitioners, and sections of the educated urban public to describe all non-allopathic medical practices. This usage obscures the great diversity among the AYUSH traditions, which share only the features of not being biomedical and of being regulated through state-accredited training institutions that provide recognized qualifications. The institutionalization of this

²⁵ Bode and Hariramamurthi 2014. See Sébastia 2012 for the case of Siddha and Jansen 2016 for naturopathy.

²⁶ Lambert 2012b.

²⁷ Payyappallimana and Hariramamurthi 2012:285; National Policy on Indian Systems of Medicine & Homoeopathy 2002.

²⁸ See the website of the Ministry of AYUSH, <http://indianmedicine.nic.in/>; Government of India 2010; Chandra 2011.

newly created category of medicine within the government health care system occurred with the launch of the National Rural Health Mission (NRHM) to improve rural health care provision, with its stipulation that a qualified AYUSH practitioner as well as a qualified MBBS (biomedical) doctor be stationed at all primary health care centers under the NRHM.

In one sense, the formation of AYUSH has expanded the domain formerly recognized as “Indian medicine” by the Government of India to a degree unprecedented in national health policy. Other forms of indigenous treatment that are not syndicated or included among the categories of professional AYUSH have also been acknowledged in government policy for the first time; the intention to support the “revitalization of local health traditions” was included in planning strategy for AYUSH in India’s eleventh Five-Year Plan,²⁹ and funding for this was allocated in the twelfth Five-Year Plan.³⁰ The implicit assumption behind the policy of “revitalization” is that the uncodified medical traditions are residua of the past that are in danger of extinction. This view is evident in some of the literature discussed above and was common in the mid- to late nineteenth-century writings of British officials of the Indian Medical Service, suggesting that for as long as these informal experience-based traditions have been officially documented, they have always been seen to be in the process of disappearing.

Contemporary policy documents provide little clarity on what the “local health traditions” (or LHTs) referenced in recent policy documents actually refer to. A national survey by the NRHM on the “status and role of AYUSH and local health traditions” treated AYUSH as a single category in its survey of facilities and usage and recognized LHTs as going beyond home remedies and awareness of medicinal plants.³¹ “Informal providers” of LHTs were subdivided into four categories: “Traditional Health Practitioners,” “Folk Healers,” “Faith Healers,” and “Dais” (traditional birth attendants).³² However, the only concrete implementation activities specified for LHTs in NRHM policy documents are the collection, testing, and promotion of medicinal plants.³³ “Validation,” testing, and utilization of these bioresources by local communities and primary health workers are advocated,

²⁹ Government of India 2008, 114.

³⁰ See Payyappallimana and Hariramamurthi 2012 for a comprehensive history of policies relating to local health practitioners.

³¹ Priya and Shweta 2010.

³² *Ibid.*, 140.

³³ Government of India n.d.

implying that only certain LHTs (those involving the use of medicinal substances) are envisaged to have potential for integration with state-sanctioned care.³⁴ A wide variety of vernacular therapies—from those that employ *mantra* or other ritual approaches to those that deploy manual manipulation or diet-based treatment—are excluded by omission from the state’s specification of LHTs. One possible reading of this emphasis is that commercialization of herbal knowledge is a potential aim:

The Department of AYUSH gladly supports LHT projects only if they are likely to uncover some practices not known in the AYUSH texts, which could be validated and added to the existing texts and AUS [Ayurvedic, Unani, and Siddha] pharmaceuticals. However, the promotion of local uses, or people’s empowerment through the legitimisation of their knowledge, is generally not considered a meaningful objective.³⁵

In response to departmental policy, a range of schemes have been initiated to promote local medicinal plant use and to certify indigenous practitioners.³⁶ In these accreditation schemes, individual certification and/or membership in healers’ organizations are made available exclusively to practitioners who use only herbal medicines. The generalized stigma associated with therapeutic forms that are regarded as subaltern and that lack potential for pharmacological validation and subsequent commercialization for commercial gain indicates that recognition and revitalization are permissible only within certain limits. Social scientists have begun to study the indigenous medicine industry and processes of pharmaceutical extraction from bioresources,³⁷ but the consequences of the official prioritization of herbal medicines for the configuration of therapeutic practices, the social distribution of therapy, and patterns of access to treatment have so far not been assessed.

In official policy, then, Indian medical traditions consist in biomedical and AYUSH medical systems plus local herbal traditions, conceived as a community and national resource; and academic research has focused mostly on the codified indigenous traditions

³⁴ Ibid.; cf. Payyappallimana and Hariramamurthi 2012, 285–86.

³⁵ Priya 2013, 25.

³⁶ Some of these are described in Banerjee 2010; Bode and Hariramamurthi 2014; Dabhai 2012; Payyappallimana and Hariramamurthi 2012; Roy 2012; (Venkat 2012)Venkat 2012.

³⁷ E.g., Bode 2006, 2008; Banerjee 2009; Kudlu 2016.

(especially Ayurveda) and on religious and ritual forms of therapy.³⁸ In addition, the numerous semiqualfied and unqualified providers of biomedical care—often described as RMPs (Registered Medical Practitioners) or, simply, quacks—are subject to general opprobrium but recognized as an important source of medical aid.³⁹ The “informal sector” that exists outside state regulation is often regarded as coterminous with these biomedical practitioners,⁴⁰ and indigenous non-biomedical vernacular forms of medical practice have until recently been little documented. The effects of historical shifts in preference for different medical forms by local populations and of changes in governance of these therapeutic forms have consequently remained largely invisible. This does not mean that they are unimportant. Recent fieldwork and archival research in Rajasthan and Delhi suggest that certain non-biomedical, informal therapeutic modalities have maintained their standing in the years since Independence, despite progressive marginalization by the state. I turn now to an account of one such modality.

The Legitimation and Marginalization of Subaltern Therapies

Bonesetters or, more accurately, “bone doctors” (*haad vaidya*) are unqualified but often hereditary urban practitioners who specialize in the treatment of musculoskeletal problems, using both manual manipulation and herbal ointments. Analogous traditions are found widely throughout India, though they have begun to be documented only recently.⁴¹ Following up preliminary work on this therapeutic specialization after a twenty-year gap,⁴² in 2010 I identified around thirty practitioners in the state capital of Jaipur, many in full-time practice. In Rajasthan, they are popularly known as “wrestlers” (*pahalvaan*), and they provide a well-established, low-cost source of therapy for fractures, sprains, and other musculoskeletal problems outside state-sanctioned forms of medical care.⁴³ In the decades following Independence, they were entitled to seek state registration under the Rajasthan State Board of Indigenous Medicines, as were other types of practitioner who had not obtained a formal

³⁸ E.g., Barrett 2008; Davar and Lohokare 2012; Lohokare and Davar 2010; Sax 2009.

³⁹ Das 2015, 159–75; Nahar et al. 2017.

⁴⁰ See Rao et al. 2011.

⁴¹ See Attewell 2016; Sieler 2015; Unnikrishnan, Lokesh Kumar, and Shankar 2010.

⁴² A brief account of earlier findings is given in Lambert 1995.

⁴³ See Lambert 2012b for an account of the origins of this specialization in the sport of wrestling.

degree from a state-recognized college.⁴⁴ Since apprenticeship was still at that time the predominant mode of medical training in all forms of indigenous medicine, “mode B” registration was established to allow “experience-based practitioners” who lacked an accredited college qualification in Ayurveda or Unani to obtain registration by passing an oral examination.⁴⁵ The board classified those who successfully obtained registration as practitioners of Ayurveda, and although most of the practitioners I interviewed were Muslim, many described their treatment as a form of Ayurveda. These practitioners regarded the mostly home-prepared oils and herbal pastes they used in treatment as the basis of their therapeutic success.⁴⁶

The regulatory board that convened to appraise the experiential knowledge of bonesetters and other uncredentialed practitioners included representatives from allopathy (an MBBS-qualified doctor and a registered nurse) as well as practitioners possessing accredited degrees in either Ayurveda or Unani. This clearly denotes an officially sanctioned hierarchy among indigenous therapeutic forms and illustrates how while “Indian medicine” and its practitioners were regarded as inferior to biomedicine, the systematized medical traditions that provide standardized training and qualifications were in turn deemed hierarchically superior to noncodified medical traditions. An indication that such hierarchies are widespread and enduring is provided in an account of a recent attempt by the government of Kerala to allow certain “sections” of nonregistered practitioners to practice, which was vehemently opposed by the Ayurvedic fraternity in the state, leading to the rapid withdrawal of the notification.⁴⁷

After the Central Council for Indian Medicine Act was passed in 1971, which established an apex body for registration and accreditation of Indian medicine degrees nationwide, the “mode B” avenue of state-level legitimation for nonqualified practitioners was withdrawn. It was the presence of board registration certificates from the 1950s and 1960s hanging on the walls of several bonesetters’ clinics that first alerted me to this subaltern history of legitimation and marginalization.

⁴⁴ Ibid.

⁴⁵ Board of Indian Medicine 1953.

⁴⁶ Lambert 2013.

⁴⁷ Payyappallimana and Hariramamurthi 2012, 297.

This brief outline of the history of encounters between a vernacular therapeutic specialization and governance demonstrates that state regulation may have important and unexpected effects on the provision of medical care; in the case of the bone doctors, the removal of opportunities for registration did not occasion their decline or disappearance as a source of treatment.⁴⁸ However, the effects of professionalization and marginalization may vary, as can be demonstrated by a brief comparison between Rajasthani bone doctors with another type of vernacular specialist—the barber-surgeon (*jarraha*)—who was widely documented in colonial medical officers’ accounts of “indigenous medical aid” in the mid- to late nineteenth century. In contemporary Jaipur, remnants of this specialization in minor surgery remain but it has largely disappeared in contemporary India.

In 2009–10 I identified three barber-surgeons (including two generations of a single family) practicing medicine and minor surgery in Jaipur under this title.⁴⁹ Two had college degrees in Unani medicine and the third, from an older generation, in homeopathy. All three displayed their traditional title on their signboards, though one was reluctant to elaborate on this identification. An elderly local resident whose father had been a distinguished Unani physician (*hakim*) and knew some of the barber-surgeon families, observed that barber-surgery as a hereditary occupation had all but disappeared and that most of these families had turned to other occupations. He explained that the traditional role of barber-surgeons had been as circumcisers, but this had become redundant once Muslim charitable organizations began providing this service, performed by biomedically qualified practitioners. Two of the barber-surgeons I interviewed, however, claimed still to perform circumcisions, as well as providing treatment and minor surgery for skin complaints, in line with their hereditary occupation. This brief comparison suggests that some vernacular specialists may professionalize by seeking accredited degrees in other, codified forms of indigenous medicine, perhaps following a decline in demand occasioned by the replacement of some of their services by biomedicine. The passing observation in a study from elsewhere in India that most bonesetters in contemporary Hyderabad come from barber-surgeon families raises the possibility of yet another occupational trajectory for former barber-surgeons in the contrasting setting of a formerly Muslim princely state.⁵⁰

⁴⁸ Reasons for their continuing popularity among clientele are discussed in Lambert 2013.

⁴⁹ An account of a rural barber-surgeon in western Rajasthan appears in Lambert 1995.

⁵⁰ See Attewell 2016.

This comparison of changes in the trajectories of vernacular traditions over time illustrates the need to determine empirically how diverse treatment modalities within a medically pluralist situation are configured, both historically and in relation to one another and to the state. It also demonstrates how power hierarchies among indigenous therapeutic forms, changes in their relative status, and differing pressures to professionalize or transform practice are rendered invisible when these forms are aggregated into unitary categories such as “traditional (codified) medicine” and “folk medicine” or, in the case of current government designations, “AYUSH” and “local health traditions.”

Conclusion

In this article I have suggested that a gradual shift away from studying treatment as practiced in specific grounded settings is discernible in social science research on “medical pluralism” in India. The focus of scholarly attention has broadened first to the study of codified systems at the regional or national level from an earlier “village-based” approach and, more recently, to documenting the influence of global bioscience. Although valuable in highlighting the importance of extralocal influences, this shift away from fine-grained studies of therapeutic traditions as they are practiced skews understanding of what constitutes medical pluralism in contemporary India in two ways. Links between individual therapeutic traditions and the setting-specific cultural practices (such as wrestling or circumcision) with which they are historically associated and in relation to which they retain or lose local salience are obscured, rendering their continuing resilience in certain settings and declining popularity in others less readily explicable.

Second, inattention to noncodified indigenous therapeutics and the local interactions between different medical formations has led to the alignment of much scholarship on indigenous medicine in India with official policies that erase or stigmatize existing informal therapeutic resources, implicitly endorsing a modernist narrative of decline that posits the gradual displacement and elimination of vernacular traditions that lack official legitimation. The terminology of “revitalization” as applied to “local health traditions” exhibits continuity with long-standing statist assumptions that such traditions are always already disappearing. Official recognition of a role for selected noncodified therapeutic modalities—that is, herbal medicines—signals an important shift in statist views from a position of neglect to a

revivalist advocacy that resonates with the nationalist movement's calls to revitalize Ayurveda in the late colonial period.

The phenomenon of medical pluralism, generally interpreted as referring to the coexistence of diverse medical traditions in a single setting, is a long-standing subject of interest in medical anthropology that has recently regained popularity. The concept usefully highlights the continuing importance of non-biomedical therapeutic modalities but obscures power differentials between different traditions by representing them as notionally equivalent.⁵¹ Recent publications have variously proposed that the concepts of “medical landscape”⁵² and “medicoscape”⁵³ better capture the phenomena under study or that if “medical pluralism” implies “a number of medical traditions coexisting relatively insulated from one another within a region,”⁵⁴ then “medical diversity” better captures the admixture and mutual borrowing between ideas and practices that frequently occur in pluralistic situations.⁵⁵ Yet others argue that medical pluralism is best deployed as a “springboard for attending to phenomena” that may be labeled in other ways depending on context and theoretical framing.⁵⁶

The concept of “medicoscape” “draws on social topographies of power in relation to the idea of global landscapes,” thereby “enabl[ing] the inclusion of the spatial expressions of power relations,”⁵⁷ but thus has traction in analyzing the dynamics of globalization in relation to specific medical conditions, rather than the interplay of therapeutic modalities at the local level. The other alternative characterizations are subject to the same criticism as “medical pluralism” in that they imply parity across multiple interacting medical traditions and ignore the role of the state in constituting the specific configurations that occur within specific medically plural contexts. Rather than seeking alternative terms or concepts, I suggest that this problem may be resolved by restoring the term “plurality” to its proper use as “the state of being plural; the fact or condition of denoting, comprising, or consisting of more than

⁵¹ Broom, Doron, and Tovey 2009; Khan 2006.

⁵² Hsu 2008, cited in Penkala-Gawecka and Rajtar 2016.

⁵³ Horbst and Wolf 2014.

⁵⁴ Parkin 2013, 125.

⁵⁵ Krause, Parkin and Alex 2012.

⁵⁶ Penkala-Gawecka, and Rajtar 2016.

⁵⁷ Horbst and Wolf 2014, 184.

one,” and reserving “pluralism”—commonly deployed as a descriptor instead of “(medical) plurality”—to its literal meaning, “the character of being plural.”⁵⁸

So deployed, “medical pluralism” enables empirical exploration of how medical plurality is variably configured—that is, of its character—in different settings. My analysis demonstrates that in India, the role of the state and forms of governance are constitutive of medical pluralism in this strict sense. This understanding of medical pluralism (as referring to the character, rather than simply the existence, of medical plurality) not only serves to highlight the effects of political formations in shaping both the character of and access to elite and subaltern therapies but also enables greater conceptual clarity in portrayals of medical plurality. In contemporary India, narratives of decline and revitalization may thereby be seen not merely as objective, empirical characterizations of changing conditions that warrant documentation but also as an “intracultural” discourse about medical plurality that expresses a contested vision of modernity.⁵⁹

⁵⁸ *Oxford English Dictionary* (1982 ed.), 1026.

⁵⁹ On “intracultural” approaches to Indian society, see Burghart 1996.

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