

**Authority, Knowledge and Practice in Unani *Tibb* in India,  
c. 1890 – 1930**

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## Abstract

This thesis breaks away from the prevailing notion of unani *tibb* as a 'system' of medicine by drawing attention to some key arenas in which unani practice was reinvented in the early twentieth century. Specialist and non-specialist media have projected unani *tibb* as a seamless continuation of Galenic and later West Asian 'Islamic' elaborations. In this thesis unani *tibb* in early twentieth-century India is understood as a loosely conjoined set of healing practices which all drew, to various extents, on the understanding of the body as a site for the interplay of elemental forces, processes and fluids (humours). The thesis shows that in early twentieth-century unani *tibb* the boundaries between humoral, moral, religious and biomedical ideas were porous, fracturing the realities of unani practice beyond interpretations of suffering derived from a solely humoral perspective. The principal objective of the thesis is to draw attention to the tensions manifest in different spheres of unani practice as certain practitioners reconfigured their knowledge and practices through the prisms of nationalist and communitarian politics, changing social and moral norms, the expanding use of print and colonial inspired models of legitimacy. These phenomena presented challenges to the authoritative practice of *tibb* as a local, family affair. Unani practitioners were forced to take stock of what they thought to be good, authentic and legitimate in order to represent this knowledge to the public on a vastly new scale; both to gain and maintain their trust and their custom, and in order to represent the credibility of their practices in new, less personalised administrative, judicial and political domains. The thesis emphasises the importance of the market in the reform of *tibb* during this time, an area which is especially important in the context of the collapse of courtly patronage for elite unani practice in most parts of India during the nineteenth century. The principal themes framed in this study are: plague and unani reform; legitimacy in relation to institutional and family practice; the emergence of *tibb* as a 'national' enterprise; new engagements with women and change in the treatment of certain women's diseases; conceptualisations of male sexuality; and the role of the unani journal in the establishment of innovative practices and relationships with the public.

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## **Note on Romanisation**

For the transliteration of most Urdu and all Arabic words I have adopted the romanisation guidelines of the Library of Congress for these languages. I have romanised all passages quoted from Urdu and Arabic sources; these appear as footnotes to English translations to these passages given in the body of the text. The few Urdu/Hindi words which I have not included in this romanisation scheme are the names of persons, 'Hakim' when it appears in titles, and the terms 'unani' and 'ayurveda' (except where these are quoted or appear in the titles of works). In these cases I have followed the conventions of South Asian English, while Arabic and Persian names have been romanised.



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## Chapter 1

### Introduction

Unani *ṭibb*<sup>1</sup> can lay claim to a legacy of tremendous scope both geographically and temporally, having been embraced and shaped by peoples over the last thousand years in cultures stretching from the Eastern Mediterranean and West Asia to North Africa, Hispano-Arabia and Western Europe in the West, to Central, South and South-East Asia to the East. In South Asia the vitality of unani *ṭibb* continues to exist, in text, practice, commerce and institutional structures. Unani *ṭibb* has also been practised in an ad hoc manner in pockets of the South Asian diaspora, such as in East Africa, the UK and the USA, although in recent years unani institutions have emerged in the diaspora as well, such as the Mohsin Institute, founded in Leicester in 1978. These trajectories of translocation raise the fundamental questions of what the relationship between the unani medical tradition and applied knowledge and practice at specific times and places is, what the processes that have either motivated or inhibited the elaboration of certain forms of knowledge are and how they are to be identified. In this thesis I shall argue that a productive, but to date little explored, means of approaching these themes lies with recognising the operation of different forms of authority.

The late nineteenth century and early twentieth century present us with a time of critical importance for the development of unani *ṭibb* in South Asia, for exploring its

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<sup>1</sup> 'Unani medicine', is the term common in South Asian English for '*yūnānī ṭibb*', (and is pronounced as *yūnānī*), derived from Arabic as a translation of the term 'Greek medicine'. In West Asia and Europe it has gone under several names: Greco-Islamic medicine, Arabian medicine, Galenic medicine, Islamic medicine, Perso-Arab medicine. According to current convention, I shall refer to this tradition as Greco-Islamic medicine in the context of West and Central Asia and unani *ṭibb* for the Indian subcontinent. *Ṭibb* ('medicine') derives from the Arabic root /ṭbb/ , from which stem the cognates *ṭabīb*, *ṭabība*, and *ṭibbā* ('medical practitioner', masculine and feminine singular, and plural nouns), *ṭibbī* and *ṭibbiya* ('medical', masculine and feminine adjectives). *Ṭabīb* and *ḥakīm*, ('one who arbitrates'), both denote practitioners of *ṭibb*, except that *ḥakīm* can be used in other contexts, as a title for poets, and for saintly or wise men, while *ṭabīb* always denotes a medical practitioner. Both terms are used interchangeably in this thesis, although it should be noted that in the twentieth century there is a tendency for some elite practitioners to favour *ṭabīb* over *ḥakīm*, except in titles, in order to distinguish their medical practice from the other associations of *ḥakīm*.

heterogeneity and the tensions of its transformations. It was a period of conjuncture. Political and religious upheaval and mobilisation combined with crises of epidemic disease, social and economic change in the negotiation of modernity and the increasing use of lithographic print technology. The authority of elite, principally the learned hereditary, practitioners was being challenged by the proliferating use of lithographic print by '*hakīms*' new to the profession in new forms of commercial enterprise. Printing in Urdu became essential for the dissemination of *tibb* to attract wider constituencies as a new technology which mediated authority. The privileged place accorded to hereditary practice was also being eroded by the emergence of new forms of professional structures and accreditation in the drive to modernisation that large numbers of practitioners advocated. Medical practices, technologies and knowledge imported from Europe and North America or developed within the Indian colonial context were also being reworked and adopted or contested in various unani circles during this period. There were then a number of competing pressures that revolutionised the ways that unani knowledge was transmitted, constituted and translated into practice.

Recent scholarship, as we discuss in greater detail below, has begun to grapple with aspects of these tensions, but has not sufficiently engaged with important dimensions of the reform of *tibb*. Notions persist in specialist and non-specialist media of unani *tibb* as a 'system' of medicine which, without a nuanced theoretical definition, reveal little about its dynamism and heterogeneity, let alone the processes by which change takes place. *Tibb* continues to be unproblematically characterised with reference to a set of key figures, texts, theories and practices elaborated in the unani textual tradition. Its status as a Muslim profession in this period has gone unquestioned. And of great importance, the reform of unani *tibb* in the twentieth century has been viewed as primarily an engagement with western forms of knowledge, power and practice. Where debates with colonial / western medicine have been investigated they have in some cases resulted in the unfortunate polarising of 'reformists' and 'purists', which understates the complexity of the reform process. In my analysis colonial medical knowledge and practices in India feature as only one important realm of authority among others that gave shape to the evolution of professionalised unani *tibb*. Although unani practitioners seeking to recast

their profession were in many cases inspired by colonial models, their adoption of these models was not a straightforward process.

In this thesis I examine domains in which the unani profession was in dialogue with itself, with a variety of other medical practices – folk, private and state allopathic (western/colonial medicine), ayurvedic, and Islamic healing practices and traditions –, and most importantly with the public, those who sought its services, as practitioners of *tibb* sought to define authentic and legitimate unani knowledge and practice. The thesis is concerned with exploring domains that were of acute public concern, such as epidemic outbreaks, where it focuses on plague in particular, but also matters of every-day life and intimacy, where it discusses unani *tibb* and the treatment of women's and men's disorders and their societal contexts. It explores unani culture in Hyderabad and north India, in relation to emerging institutions, new forms of professional organisation and print culture. This thesis is thus divided up into a number of arenas in which the connections between authority and unani knowledge and practice are examined. The composite strands of the thesis are not intended to provide a comprehensive analysis of the state of unani *tibb* in early twentieth-century India, but rather to provide fresh insights into the nature of the unani profession of the time. By focusing on a number of specific themes, by looking beyond one regional context of *tibb* and by elucidating the interplay of realms of authority I reveal a complexity in the process of unani reform that has so far not been recognised.

My concern with studying unani *tibb* in South Asia around the turn of the twentieth century stands in relation to a wealth of scholarship on *tibb* in West Asia written over the last 150 years. This scholarship has focused on West Asia within the Abbasid period (750-1254). These spatial and temporal boundaries are related to the nineteenth-century construction of this period, especially the ninth to the eleventh centuries, as the 'golden age' of learning and literature in Islam. The fallaciousness of this construction is easily exposed, especially as one takes into account the vibrant strands of practice and learning outside this time-frame, in the Ottoman Empire, Iran and South Asia. But the fixation with the 'golden age' has also had more insidious legacies, which relate to the understanding of unani *tibb* as a 'system' of medicine and to the perceived centrality of

the unani textual tradition. Therefore, before we engage with the principal thematic concerns of this thesis in section III, we turn briefly to examine ‘golden-ageism’ and *tibb*, and discuss ideas of *tibb* as a medical system.

## I. Beyond the Golden Age

In 1996 the respected historian of Arab-Islamic culture, A. I. Sabra, called for the need to localise the study of Arabic sciences.<sup>2</sup> He was reacting against philological and text-based approaches that in his view frequently did not pay adequate attention to the social, political and economic contexts in which the texts that scholars edited, translated and elucidated were produced. His charge could be applied as well to Greco-Islamic medicine as to other branches of inquiry into sciences in Arabic, even though by the 1990s there was a growing body of work that attended to the situation of the text, those of Lawrence Conrad, Michael Dols, Nancy Gallagher, Irmeli Perho and Emilie Savage-Smith, to name a few.<sup>3</sup> The primacy of the text and the philological method dates back, in relation to the study of Islamic sciences, to mid nineteenth-century Europe, and needs to be seen in the context of broader scholarly representation of Islam and the ‘Orient’.<sup>4</sup> As Said has demonstrated, the pioneering French philologist Ernest Renan’s representation of science in Islam was clearly related to his notions of Western cultural and political superiority.<sup>5</sup> The famous German orientalist Ignaz Goldziher’s influential account of an ‘orthodox’ Islamic reaction in the fourteenth century against sciences derived from Greek sources has been shown to have more relevance to the politics of his day than to his purported

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<sup>2</sup> A.I. Sabra, ‘Situating Arabic Science: Locality versus Essence’, *Isis*, 87, 1996, pp. 654-670.

<sup>3</sup> Lawrence Conrad, ‘Scholarship and Social Context: A Medical Case from the Eleventh Century Near East’, in Don Bates (ed.), *Knowledge and the Scholarly Medical Traditions*, Cambridge, 1995, pp. 85-100; Michael Dols, ‘The Origins of the Islamic Hospital: Myth and Reality’, *Bulletin of the History of Medicine*, 61, 1987, pp. 367-390; M. Dols, *Majnūn – The Madman in Islamic Medieval Society*, Oxford, 1992; Nancy Gallagher, *Medicine and Power in Tunisia, 1780-1900*, Cambridge, 1983; Irmeli Perho, ‘The Prophet’s Medicine – A Creation of the Muslim Traditionalist Scholars’, Helsinki, 1995.

<sup>4</sup> E. Said, *Orientalism*, London, 1978.

<sup>5</sup> *Ibid.*, p. 123 f.



topic of study.<sup>6</sup> Influential scholars of the history of Islamic science, philosophy and especially medicine were Ferdinand Wüstenfeld, Mauritz Steinschneider, Lucien Leclerc, Carl Brockelmann, Edward G. Browne and Paul de Koning. Their prodigious enterprise focused on texts produced in the Abbasid period (750-1254), especially those composed from the eighth to the eleventh centuries. Their work encouraged the idea of this period being seen as the 'golden age' of Islamic civilisation, a view which has persisted.

As a result, scholarly interest in Islamic medicine and sciences has been channelled to this period and to this region, that is, roughly from Baghdad westwards. Thus historical study of the Greco-Islamic medical tradition not only in South Asia, but also in Iran and the Ottoman Empire have until recently been overlooked.<sup>7</sup> The construction in European scholarship of the golden age was partly governed by the urge to establish a sense of European scientific heritage, which went back to ancient Greece, and which valued the Arabic versions of Greek philosophical and scientific works in this period for their functioning merely as repositories of classical knowledge.<sup>8</sup> This passage from E.T. Withington's *Medical History from the Earliest Times* typifies the sentiment:

It was this people [i.e. Arabs/Muslims] who now took from the hands of unworthy successors of Galen and Hippocrates the flickering torch of Greek medicine. They failed to restore its ancient splendour, but they at least prevented its extinction, and they handed it back after five centuries burning more brightly than before.<sup>9</sup>

The Arabist and historian E.G. Browne, who quoted this passage, did not agree with the overstated chronology, but he did concur with the sentiment that the importance of 'Arabian' medicine lay in its role as a repository of Greek knowledge. Embedded in this

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<sup>6</sup> Dimitri Gutas on Goldziher, in *Greek Thought, Arabic Culture*, London, 1998, p. 173 f.

<sup>7</sup> For the Ottoman Empire, see Terzioğlu Arslan, *Beiträge zur Geschichte der Türkisch-Islamischen Medizin, Wissenschaft und Technik*, Istanbul, 1996. For Iran, Hormuz Ebrahimnejad, 'L'Introduction de la Médecine Européenne en Iran', *Sciences Sociales et Santé*, 1999, pp. 69-96; For nineteenth-century Egypt, see Khaled Fahmy, 'Medicine and Power: Towards a Social History of Medicine in Nineteenth-Century Egypt', *Cairo Papers in Social Science*, 23, 2000, pp. 1-46.

<sup>8</sup> I have given a more thorough examination of the golden age and scholarship on Greco-Islamic medicine in G. Attewell, 'Islamic Medicines: Perspectives on the Greek Legacy in the History of Islamic Medical Traditions in West Asia', in Helaine Selin (ed.), *Medicine Across Cultures*, Boston, 2003, pp. 325-350.

<sup>9</sup> Edward G. Browne, *Islamic Medicine*, reprint, New Delhi, 2001.

argument is the question of originality; the basis of this viewpoint is the contention that the Arabs did not creatively develop the Greek medical learning which they inherited.

A 'golden age' entails 'decline', and this was explained by Renan, Goldziher and others in terms of the rise of Islamic 'orthodoxy'. This kind of explanation has been quite persistent, but has been recently challenged in the writings of Dimitri Gutas.<sup>10</sup> In relation to *tibb*, J.C. Bürgel, contributing to Charles Leslie's *Asian Medical Systems* as recently as 1976, remains locked in this paradigm. He framed the regressive shift in this way: 'After a golden age from about the tenth to the twelfth century, Arabic medicine came to a standstill, which gradually changed into a slow decline leading to the most deplorable decay imaginable'.<sup>11</sup> Instead of exploring unani medical knowledge on its own terms, Bürgel ignored its very evident lack of decline in terms of the increasing knowledge of herbal, mineral and animal remedies that were incorporated into unani pharmacopeia as unani medical practice became, for example, more intimately connected to the wealth of India's medicinal flora from the fourteenth century onwards. Instead he measured progress and decline by reference to trajectories of thought in Europe and to the challenging of the authorities of ancient knowledge. The 'decline' of *tibb* was then partly a function of the lack of an 'evolutionary conception of science' in *tibb*. This perceived 'fault' coupled with lack of technological innovation meant that practitioners could not '[pierce] the veils of nature and thereby [break] the fetters of the Galenic system'.<sup>12</sup> The 'progress' of European science is the standard by which Bürgel calibrated the history of *tibb*. Surgery was progress, but it could not advance further since 'dissection of human bodies ... was strictly prohibited by Islam'.<sup>13</sup> As Emilie Savage-Smith has recently shown, Islam cannot be blamed for this absence, since there is no evidence of such prohibition in any Islamic codes of law.<sup>14</sup>

The most important reason why Greco-Islamic medicine was seen to decline was, however, laid at the door of Islam. In lines of reasoning very much in tune with the historiography of the nineteenth century, Bürgel argued that there was an 'orthodox'

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<sup>10</sup> Gutas, *Greek*.

<sup>11</sup> Jan Christoph Bürgel, 'Secular and Religious Features of Medieval Arabic Medicine', in Charles Leslie (ed.), *Asian Medical Systems*, Delhi, 1998, (first published Berkeley, 1976), p. 53.

<sup>12</sup> *Ibid.*, p.53.

<sup>13</sup> *Ibid.*, pp. 53-54.

<sup>14</sup> E. Savage-Smith, 'Attitudes Towards Dissection in Medieval Islam', *Journal of the History of Medicine and Allied Sciences*, 50, 1995, pp. 67-110.

Muslim reaction to Greek sciences and that it manifested itself in the medical sphere with the emergence of a rival medical tradition that derived its authority from the Prophet. This was *ṭibb al-nabī*, (Medicine of the Prophet), which was based on the sayings and actions of the Prophet and his companions concerning medicine and health as compiled in *ḥadīth* literature (narratives of the sayings and conduct of the Prophet and his companions). In Bürigel's positivist history writing *ṭibb al-nabī* represented one of the 'hothouses of irrationalism', which, along with alchemy, astrology and magic brought about the demise of Galen's natural philosophy, 'long before his supercession by the progress of European science'.<sup>15</sup> A more sophisticated, situational study of *ṭibb al-nabī*, by Irmeli Perho, has recently underlined the absorption, not the displacement, of Galenic medical theory in *ṭibb al-nabī*. The 'Islamic dethronement of Galen' that Bürigel wrote of is not only difficult to countenance in West Asian contexts, but is a wholly inappropriate way of thinking of *ṭibb* in South Asia.<sup>16</sup> For Bürigel, unani *ṭibb* was extrinsic to 'Islamic culture', in contrast to ayurveda's relationship with 'Indian culture'. With this statement he wished to emphasise an essential alienness of *ṭibb*, as a Greek 'system', in the Muslim world, hence its 'decline'. Instead he could have chosen to see the vitality of *ṭibb*, the ways in which Galenic medicine became absorbed within a variety of cultural contexts, whether in Islamic West Asia, Iran, South Asia or elsewhere. And no-one can seriously question that *ṭibb* has been inextricably part of Indian Islamic culture. It was Bürigel's determination to pitch science against religion that led him to these tendentious positions. What is of interest, arising tangentially from Bürigel's discussion, is the question of local adaptations and manifestations of *ṭibb*, and what their relationship would be with the medical tradition in a supra-regional sense. We expand on this theme throughout this thesis. A similar approach can be found in some of Byron Good and Mary-Jo DelVecchio Good's anthropological studies of popular medicine in contemporary Iran.<sup>17</sup>

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<sup>15</sup> Bürigel, 'Secular', p. 59.

<sup>16</sup> *Ibid.*, p. 60.

<sup>17</sup> Byron Good, 'The Heart of What's the Matter: The Structure of Medical Discourse in a Provincial Iranian Town', Ph.D. thesis, University of Chicago, 1977; Byron Good and Mary-Jo DelVecchio Good, 'The Comparative Study of Greco-Islamic Medicine: The Integration of Medical Knowledge into Local Symbolic Contexts', in Charles Leslie and Allan Young (eds), *Paths to Asian Medical Knowledge*, Berkeley, 1992, pp. 257-271; Mary-Jo Good, 'Of Blood and Babies: The Relationship of Popular Islamic Physiology to Fertility', *Social Science and Medicine*, 14B, 1980, pp. 147-156.

Richard Eaton's remarks that scholarly work on Islamic history in the greater part of Asia or Africa has lagged far behind that done on West Asia applies equally to the context of unani *ṭibb* as it does to other branches of history that may come under the rubric 'Islamic'.<sup>18</sup> Only in the last three decades have new perspectives on *ṭibb* in South Asia been offered, which we discuss in detail in section III in this chapter. The only qualification to Richard Eaton's observations would be that scholars of the subcontinent, often themselves practitioners of medicine, have at various points over the last century contributed in Urdu and, especially in the last thirty years, in English, to the historiography of *ṭibb*. Writings on the bio-bibliographies of practitioners, such as Zillurrahman's *Dilhi aur Ṭibb-i Yūnānī* and Rahbar Faruqi's *Islāmī Ṭibb*, are the elaboration of an indigenous literary genre, the *tazkirah*. For an English readership journals such as *Hamdard Islamicus* and *Hamdard Medicus* (Karachi), *Studies in History of Medicine* (Delhi), *Bulletin of the Indian Institute of History of Medicine* (Hyderabad) have done a tremendous service in making studies of unani *ṭibb* accessible to non-Urdu readers. The concerns of these historical writings, can be broadly characterised as an interest in bio-bibliographies of *ṭabīb*s of a particular area or period, in locating and describing unani manuscripts, and in discussing the contributions to medical history of particular physicians.<sup>19</sup> These studies show the emphasis laid on lineage, important personas, and the textual tradition within Indian Islamic scholarship on *ṭibb*. Largely descriptive in nature, they are also extremely valuable for developing a prosopography of *ṭibb* and for the light they shed on the location and content of rich manuscript sources. By pointing to a variety of sources beyond the commentary or abridgement of a 'classical' text, they raise the questions of how to conceive of authoritative knowledge in *ṭibb* and of what the relationship between the classical text, the commentary, other forms of unani writing is. Ultimately there is the issue of whether and how this knowledge is translated into practice.

To illustrate this problem, we can refer to an instance presented in writings of the sixteenth century Portuguese physician, Garcia da Orta. Garcia da Orta, who settled in

<sup>18</sup> R. Eaton, 'Islamic History as World History', in *Essays on Islam and Indian History*, New Delhi, 2000, p. 33.

<sup>19</sup> A few notable monographs include Rahbar Faruqi, *Islāmī Ṭibb*, Hyderabad, 1937; Ali Kausar Chandpuri, *Atibbā'-yi 'ahd-i Mughaliyya*, Karachi, 1960; Hakim Sayyid Zillurrahman, *Tazkirah-yi Khāndān-i 'Azīzī*, Aligarh, 1978; *idem.*, *Dilhī aur Ṭibb-i Yūnānī*, Delhi, 1995.

Goa and interacted with practitioners at the courts of Nizam Shahi and Adil Shahi rulers, to whom he attended. Da Orta remarked on the treatment of one of Burhan Nizam Shah's sons, that although the court *ḥakīms* were familiar with the famous *al-Qānūn fī al-ṭibb* of Ibn Sīnā, in place of the latter's diagnosis and prescription they had adopted local practices.<sup>20</sup> Garcia da Orta cannot be seen as a dispassionate observer; his only work, the *Coloquios dos Simples e Drogas e Cousas Mediçinais da India* was written at the end of his career with the intention of showing his knowledge of two worlds: first-hand experience of India's medicinal wealth and his own knowledge of medicine based on Arabic sources. Nevertheless, his remarks should caution us that although some of the core writings of the unani tradition have been in more or less continuous circulation among elite practitioners in South Asia, and have been the source for many later elaborations of *ṭibb*, the authority of the text was not the sole basis determining how the *ḥakīm* actually practised.

## II. The Question of System

The long-standing appreciation and study of *ṭibb* in the context of an authoritative textual tradition revolving around a set of well-known texts goes hand in hand with the conception of *ṭibb* as a coherent body of knowledge and practice. Special attention is usually drawn to Ibn Sīnā's *al-Qānūn fī al-ṭibb* and its Arabic-Persian-Urdu derivatives.<sup>21</sup> The enduring nature of this textual tradition encourages a view of the continuity of unani *ṭibb*. In late nineteenth-century India the 'classical' unani medical tradition derived from Hippocrates and Galen, and elaborated in the ninth to thirteenth centuries in West and

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<sup>20</sup> Guy Attewell, 'India and the Arabic Learning of the Renaissance: The Case of Garcia da Orta', unpublished MA thesis, Warburg Institute, University of London, 1997, p. 28.

<sup>21</sup> The impressive textual legacy of Ibn Sīnā in India has been traced in Hakim Abdul Hameed and Hakim Abdul Bari, 'Impact of Ibn Sina's Medical Work in India', *Studies in History of Medicine*, 8, 1984, pp. 1-12; C. Liebeskind, 'Unani Medicine of the Subcontinent', in Jan Van Alphen and Anthony Aris (eds), *Oriental Medicine*, Boston, 1997, pp. 51-52.

Central Asia by such well-known figures as Ibn Sīnā and al-Rāzī, was only one strand in the authoritative strands of knowledge in *ṭibb*. These also included healing traditions associated with the Greek god of healing Asclepius and the folk-Islamic figure of Luqman. These latter figures and the resulting frameworks of authority tended to be eclipsed in elite unani discourse of the early twentieth century, as learned practitioners intent on revitalising their tradition elevated the ‘classical’ writings of *ṭibb*, which became the principal objects of the translation endeavours into Urdu of this time and formed the basis for curricula in the new institutions of unani *ṭibb*, established from the turn of the twentieth century onwards. It is, however, the formative period of Greco-Islamic literary production that has drawn most scholarly attention.

Conventionally unani *ṭibb* has been characterised in academic and non-specialist writings as a ‘system’ of medicine.<sup>22</sup> In the South Asian context the application of the term ‘system’ to unani *ṭibb* found currency in late nineteenth-century discourse on indigenous medicine in India, and has been widely adopted ever since. The understanding of *ṭibb* as a system of medicine is encouraged by numerous factors that are characteristic of *ṭibb*: the existence of an authoritative textual tradition; a pervasive humoral pathology; a set of diagnostic techniques based on the pulse; urine and stool examination; treatment aimed at the restoration of bodily balance based on the principle of opposites (*contraria contrariis*, or *‘ilāj bi-al-ḍidd*) and involving a number of regimental practices, such as cupping, leeching, venesection; as well as a common stock of types of preparations derived from herbal, mineral and animal sources, such as syrups, powders, pills, electuaries and decoctions. As an example of the representation of unani *ṭibb* as a system according to some of these characteristics, we may refer to a recently published article written for a non-specialist readership by Helen Sheehan, an American social scientist, and S.J. Hussain, a respected authority on *ṭibb* in India and director of the Central Research Institute in Unani Medicine, in Hyderabad.<sup>23</sup> The usefulness of this article lies

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<sup>22</sup> Many works refer to unani *ṭibb* as a system without problematising the term, some instances include Bürgel, ‘Secular’; A.H. Israili, ‘Education of Unani Medicine during Mughal Period’, *Studies in History of Medicine*, 4 (2), 1980, pp. 119-135; Professor Jamil Ahmed and Hakim Ashhar Qadeer, *Unani, the Science of Graeco-Arabic Medicine*, New Delhi (n.d.); Neshat Quaiser, ‘Unani’s Debate with Doctory’, in Biswamoy Pati and Mark Harrison (eds), *Health, Medicine and Empire*, New Delhi, 2001, pp. 329-330.

<sup>23</sup> H.E. Sheehan and S.J. Hussain, ‘Unani Tibb: History, Theory and Contemporary Practice in South Asia’, *Annals, AAPSS*, 583, September 2002, pp. 122-135. All references to Hyderabad in this thesis are to Hyderabad-Deccan (India).

in their outline of current institutional structures for *tibb* in India. I refer to it here to show a conventional presentation of unani's systemic qualities. Drawing on the works of Mazhar Shah and Bürgel,<sup>24</sup> it delivers a standard account of some of the fundamental concepts of health and disease in *tibb*:

Unani tibb, a humoral medical system, presents causes, explanations, and treatments of disease based on the balance or imbalance of the four humours (*akhlaat*) in the body: blood (*khun*), mucus (*bulghum*), yellow bile (*saфра*), and black bile (*sauda*). These combine with four basic qualities (*quwaat*); heat (*garmi*), cold (*sardi*), moisture (*rutubaat*), and dryness (*yabis*) ... . Dominance of one of the humors in the body gives each person his or her individual temperament (*misaj*) – sanguine (*dumwi*), phlegmatic (*balghumi*), choleric (*safravi*), and melancholic (*saudawi*) ... .<sup>25</sup>

Sheehan and Hussain discuss the elaboration of these concepts in the unani medical tradition, the principle arena for this being ninth to eleventh century West Asia:

As the system developed in West Asia / the Middle East, the contributions of the Persians, Ibn Sina (Avicenna, 980-1037 A.D.), and Rhazes (ar-Razi, Muhammad ibn Zakariya, 865-923 A.D.) were central to the system's development.<sup>26</sup>

The authors cite Manfred Ullmann, an authority on the classical texts of Perso-Arabic-Islamic sciences, to highlight the centrality of the textual tradition, especially Ibn Sīnā's *al-Qānūn fī al-tibb*:

'in India right down to the present day Unani medicine, that is Greek medicine transmitted through Arabic and Persian sources, is practised alongside ayurvedic and modern European medicine. Here the tradition...was never broken off. The main text-book of this Unani medicine is as always the Canon of Avicenna [sic], together with other commentaries and elaborations.'<sup>27</sup>

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<sup>24</sup> Bürgel, 'Secular'; Shah, *The General Principles of Avicenna's Canon of Medicine*, Karachi, 1966.

<sup>25</sup> *Ibid.*, p. 125.

<sup>26</sup> *Ibid.*

<sup>27</sup> *Ibid.*, quoting M. Ullman, *Islamic Medicine*, Edinburgh, 1978, p. 52.

For the authors unani *tibb* is 'the active representative of a great historical tradition'.<sup>28</sup> In this presentation of *tibb* we are invited to think of *tibb* of the present day as the seamless continuation of a tradition that began over a thousand years earlier. This way of characterising *tibb* bears little relation to the historical realities of *tibbī* knowledge and practice.

The use of the word 'system' in the contexts above consolidates the impression of continuity, connoting internal coherence, discreteness, completeness and homogeneity. 'System' in its application to South Asian medical knowledge and practice has, however, been analysed from theoretical perspectives. Helen Sheehan used the concept in her study of the roles of ayurvedic and unani practitioners in institutional settings in Hyderabad.<sup>29</sup> For her the 'explanations, institutions, healers and therapies' which each society has 'constituted a system enabling its members to cope with health and illness'.<sup>30</sup> She used 'system' to enable her to discuss the professional activities of *vaid*s and *tabīb*s. She recognised the theoretical validity of adaptiveness in *tibb* and that in the course of time *tibb* has interacted with ayurveda in the Indian environment. But the problem suggested by the use of 'system' in these contexts lies with its inability at the same time both to distinguish and also to identify common ground between different 'medical systems' operating in similar social milieux.

Frederick Dunn, contributing to *Asian Medical Systems*, the ground-breaking volume on indigenous medicine in Asia edited by Charles Leslie, proposed an understanding of a medical system that similarly did not exclude adaptiveness. He defined a medical system as 'the pattern of social institutions and cultural traditions that evolves from deliberate behaviour to enhance health, whether or not the outcome of particular items of behaviour is ill health'.<sup>31</sup> Although this definition allows for change in the system, and it is necessary to appreciate individual agency in the determination of the nature of the system, it is unrealistic to predicate the formation of the system solely on

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<sup>28</sup> *Ibid.*

<sup>29</sup> H. Sheehan, 'Using Sociological Concepts in the Study of Indian Medical Systems: Medical System, Role and Profession', *Bulletin of Indian Institute of History of Medicine* (henceforth *BIJHM*), 26, 1996, pp. 103-118.

<sup>30</sup> *Ibid.*, p. 104.

<sup>31</sup> Frederick L. Dunn, 'Traditional Asian Medicine and Cosmopolitan Medicine as Adaptive Systems', in C. Leslie (ed.), *Asian Medical Systems*, New Delhi, 1998, p. 135.



behaviour aimed at improving health. Agency that gives shape to a medical 'system', whether unani or any other, has to be seen as operating within structures of authority: social, political and economic. Thus, the shift that we see in unani *tibb* and ayurveda in late nineteenth-and early twentieth-century India to what we might call 'remote commercialisation', through print, advertising and mail order services, could be seen as an awareness of the new conditions for practice afforded by widespread use of print, and the opportunities they offered the practitioner in a competitive market.

The unani *tibb* that Dunn described is mainly limited to Abbasid West Asia, which in many ways bears little relation to the *tibb* that we will discuss in this thesis, which has been of course the product of totally different conditions. In *tibb* at the turn of the twentieth century there was a strong emphasis on rational internal medicine based on humoral pathology, perhaps even a renewed emphasis on natural causes, but magical and religious approaches were also apparent, which Dunn, in common with conventional presentations, stated had little place in the unani 'system'. In line with conventional treatments of *tibb*, Dunn identified innovation in *tibb* as being principally limited to pharmacology, medical education and hospital building. By contrast the nineteenth and twentieth centuries present wholly different forms of innovation in professional structures, practice and also theory. Unani was, according to Dunn, principally an urban practice, and he speculated that the clients were mainly elite and male, even though there is ample evidence, to which he did allude, that prominent practitioners in Baghdad in the tenth century, like Muḥammad Ibn Zakariyyā al-Rāzī, also treated people from various backgrounds and occupations.<sup>32</sup> Patronage was certainly a key institution of Greco-Islamic medicine/unani *tibb*, but in India by the late nineteenth and early twentieth centuries the courtly structures of unani patronage had been almost entirely dismantled. There is evidence that men and women of various social standing consulted *hakims*, and *tibb* was also practised in rural areas.<sup>33</sup> We are then, in the context of early twentieth-century India, considering a vastly different 'system' of medicine than the one described in Dunn's study.

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<sup>32</sup> Cristina Alvarez-Millán, 'Graeco-Roman Case Histories and their Influence on Medieval Islamic Clinical Accounts', *Social History of Medicine*, 12, 1999, pp. 19-43.

<sup>33</sup> For accounts of *tibb* in rural areas of India, see E. Wilkinson, *Report on Plague in the Punjab, October 1<sup>st</sup>, 1901, to September 30<sup>th</sup>, 1902*, Lahore, 1904; Colonel Thomas Holbein Hendley, *General Medical History of Rajputana*, Calcutta, 1900.

Dunn further subdivided medical systems according to their spheres of influence. Thus *tibb*, along with ayurveda, are 'regional' systems, while folk medicine is 'local' and 'western' is cosmopolitan and global. Such a classification is problematic. One problem is the notion of 'region', since the reach of ayurveda and unani *tibb* have historically been quite different, with the diffusion of unani *tibb* throughout West Asia and beyond. In addition, the relationship between region and locality in unani *tibb* cannot be addressed with Dunn's classification. On the one hand it is necessary to recognise that the unani profession transcends a particular locale, but conversely the locality was also of great importance for the practising *tabīb*. He could derive legitimacy, apart from the 'regional' aspects of his practice – his place in the tradition, the acquisition of potent drugs from outside the locality (often imported from other parts of the subcontinent or Central Asia) – also by his place in a particular community and his connections and knowledge of local plants and minerals. Thus in Hyderabad, certain unani practitioners of the early twentieth century were especially praised for their knowledge of local plants and their competence in Telugu, which enabled them to gain greater familiarity with local medicinal resources.<sup>34</sup> The complexion of unani practice could, then, be significantly influenced by local conditions. Furthermore, one could argue that unani *tibb* has a much wider reach than 'regional' suggests on the basis of its diffusion in the South Asian diaspora. A parallel, but still more wide-reaching, globalisation exists with ayurveda, which has entered mainstream European and North American culture (while unani has not) in the decades since Dunn's article.

A more useful way of understanding the multifaceted nature of unani knowledge and practice in South Asia is provided in the work of the medical anthropologist, Charles Leslie, who is widely recognised as having mapped out in the 1970s a research agenda that has informed a new generation of anthropologists and social scientists working on medicine in Asia. Leslie has outlined a pluralistic model of indigenous medicine in India, in which he identified various types of medical knowledge and practice.<sup>35</sup> His categorisation included the *tibb* of the classical Arabic texts, and 'traditional-culture medicine', which embraces the syncretic tendencies of *tibb* and ayurveda. The latter,

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<sup>34</sup> See Chapter 3.

<sup>35</sup> This is especially so in C. Leslie, 'Ambiguities of Revivalism in Modern India', in C. Leslie (ed.), *Asian*, pp. 356-378.

Leslie argued, became largely transformed into syncretic 'professionalised' forms of indigenous medical practice which evolved through the accommodation, in varying degrees, of 'cosmopolitan' medicine in the nineteenth and twentieth centuries. In addition there are 'folk' and 'magico-religious' medicines as well as the 'popular culture medicine' which emerged with the institutions of mass society, advertising and so forth, which is highly eclectic and may combine humoral theories with vitamin regimens and germ theory. Leslie wrote that in practice a great many professionalised ayurvedic and unani practitioners would employ some form of 'popular culture medicine'.<sup>36</sup> This model is of importance for its concern to reflect practice, the world of unani *tibb* in relation to patients, clients, and consumers. It dispelled the notion of any homogeneous unani practice, as Leslie pointed to the malleability of categories.

Charles Leslie's work on pluralism in South Asia has delineated a range of possible forms of medical knowledge. His task was not to provide a rigorous analysis of these categories and he, like Dunn, was not concerned with process from social, political and economic perspectives, although he did draw attention to the revivalist ideologies of indigenous medicine in the early twentieth century. Leslie proposed different spheres of practice, but he was not concerned with investigating the interactions between the 'traditional-culture', the professionalised and the popular. Jean Langford, in *Fluent Bodies*, her fascinating interdisciplinary study of ayurveda in the twentieth century, confronts the 'seduction' (her term) and ultimately the emptiness of 'system' to capture the varied perspectives on ayurveda, and the disjunctures in its practice, among practitioners, social scientists and the consuming public.<sup>37</sup> She questions the logic by which ayurveda as classical medicine is thought to operate. Although this thesis charts different ground, it does share some of her concerns, such as the reinvention of indigenous medicine in the twentieth century and the modes by which practitioners constructed the authenticity of their traditions. In the context of *tibb*, the eminent historian of nineteenth- and twentieth-century Indian Islam, Barbara Metcalf, has also rightly drawn attention to syncretism in unani *tibb*, where she remarked on its being

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<sup>36</sup> *Ibid.*, pp. 358-360.

<sup>37</sup> Jean M. Langford, *Fluent Bodies: Ayurvedic Remedies for Postcolonial Imbalance*, Durham, 2002, see especially p. 14f.

inherently 'open'.<sup>38</sup> The question remains, however, of identifying what the parameters of this openness are, what is accommodated and how, and what is not and why.

In fact, the term 'accommodation' perhaps misleadingly suggests that new forms of knowledge and practice unproblematically found a place within unani frameworks. It would be better to recognise that we are in many cases dealing with the reworking of knowledge. Thus, as we see in the context of plague, in many cases practitioners of *tibb* reformulated germ theory and western-derived sanitary principles in their efforts to derive authentic and authoritative unani perspectives. Furthermore, the kinds of relationships obtaining between learned and popular spheres of knowledge need to be addressed. A theme recurring throughout this thesis is the dialectical relationship between elite, learned unani *tibb* and the multifaceted popular domain. This domain would embrace the practices of those initiates to the profession who perhaps learnt their *tibb* through the flourishing of Urdu print culture, who used print to disseminate their competence, or the practices of those at the fringes of the reinvented, secular paradigm of neo-classical *tibb*: the astrologers, religious healers, the 'folk' healers and other would-be *hakīms*. In this relationship, we can discern the markings of unani revivalist ideologies, but also, in other contexts, the blurring of boundaries and the interdependence of various herbal traditions, cosmologies and supernatural models of well-being and disease. Much of the story that is told in this thesis does not hinge then on the putative dichotomies of 'reformist' and 'purist', 'western' and 'indigenous', 'modern' and 'traditional' but rather on a politically and culturally charged dialogue and interaction between groups of practitioners, their epistemologies, practices and ways of seeing the world. And as shall be made clear, such dichotomies as do exist, do so only as an ideological imagination, a rhetorical wish.

The concept of unani *tibb* as a 'system' is in fact historically implicated in the process of the evolution of the unani profession in the twentieth century. 'System' finds its place in the discourse of indigenous medicine in the context of professional representation, through associations, conferences, the lobbying of provincial governments, from the first decade of that century, gaining currency through the 1910s

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<sup>38</sup> Barbara D. Metcalf, 'Nationalist Muslims in British India: The Case of Hakim Ajmal Khan', *Modern Asian Studies*, 19, 1985, p. 5.

and 20s. Its existence in fact reveals the tensions within a professional elite, whose sphere of authority until this time was rooted in localised, familial and personal contexts, but which gradually through the late nineteenth century and into the twentieth woke up to the need to compete on a more global scale – through print, the mass production of medicines, professional organisation. The arenas in which these tensions are manifest form the backbone to this thesis, as we trace the desire among *ṭabībs* to reach out, organise and reconfigure knowledge, practices and their relationships with the public.

### III. Arenas of Authority in Contexts of Unani Reform

In this thesis I shall be moving away from the idea of unani *ṭibb* as a ‘system’, and it is not my intention to develop a theoretical perspective that would make ‘system’ a useful and meaningful term to deploy. The purpose of this thesis is rather to historicise our understanding of *ṭibb* by examining the forces at play that gave shape to the unani profession in early twentieth-century India, that conferred a sense of authority on the practitioner, his (it was predominantly a male practice at that time) knowledge and his practice. The thesis examines the diversity of approaches to healing in learned unani discourse and highlights the fluidity of the boundaries of the profession. Drawing extensively on what were understood to be learned unani journals of the early twentieth century, especially in Chapters 2 and 6, I show that lively discussions on the moral and religious dimensions of health and disease, magical practices and astral causation found their place within ‘learned’ unani discourse, as well as approaches derived from colonial and European medical disciplines. These discussions reveal tensions about the process of reform in *ṭibb*, and the ways that practitioners were casting their professional identity. To understand the processes by which unani knowledge and practice were constituted in different ways this thesis argues that we need to examine unani discourse from the perspective of authority. Authority is partly constituted in the social realm, it is informed by social, economic and also political factors, such as the relationship with ruling

bodies/patrons. In addition it connotes the relationship between the practitioner and the patient and how this is constructed. How does the practitioner convey competence in relation to others, what are the sources of his endeavours to legitimise his practice, and where does the patient understand the *ḥakīm*'s competence to lie?

In this work unani *ṭibb* is situated firmly in its cultural contexts, with the aim of revealing the contingent nature and heterogeneity of *ḥakīms*' knowledge and practice in their engagements with the public. I do not argue that practices within unani *ṭibb* are reducible to social constructs, that there is not also a question of the effectiveness of certain medicines prescribed for certain disorders. Francis Zimmermann has recently levelled a charge along these lines at Lawrence Cohen's discussion of ayurvedic tonics in Cohen's rich and thought-provoking study of discourse of the 'old body' in India.<sup>39</sup> Evidently part of a *ḥakīm*'s authority rests on his or her ability to treat people who seek his or her aid according to their expectations and satisfaction; there are domains of expertise in unani practice which exist for reasons that have to do with their knowledge of the particular effects of simple and compound drugs.

Nevertheless, this thesis conceives of the unani profession as being engaged in a dialogue with itself, with other forms of medical practice – colonial medicine, private allopathic practice, ayurveda, folk medicine, Islamic healing traditions – and with the public at various levels. Viewing the profession in this way shifts the historiography of *ṭibb* in new directions. It is an entirely different understanding of the profession from that proposed in Poonam Bala's study of indigenous medicine in Bengal.<sup>40</sup> For her the unani and ayurvedic professions are defined and examined in terms of their relation to state structures and policy. The challenge to indigenous medicine in Bala's argument lay with the western practitioners who were State employees.<sup>41</sup> The existence of various forms of government in British India and in the Princely States, their multifaceted bureaucratic structures and their policy agendas did most certainly influence the formation of unani *ṭibb* in fundamental ways. Chapters 2, 3 and 4 discuss some contexts in which colonial/state policies had a profound impact on the profession. Nevertheless, Poonam

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<sup>39</sup> Lawrence Cohen discusses the issue and responds in *No Aging in India: Alzheimer's, the Bad Family and Other Modern Things*, Berkeley, 1999, pp. 317-18, note 61.

<sup>40</sup> Poonam Bala, *Imperialism and Medicine in Bengal*, New Delhi, 1991.

<sup>41</sup> *Ibid.*, p. 67.

Bala's approach to see the reason for indigenous medical revival as, on the one hand, based on the desire for government recognition and the perception of threat from western medicine, and on the other, as a product of 'rising national consciousness', following an argument made by Ralph Croizier, gives little room for the movements of reform in indigenous medicine to emerge from tensions within the profession.<sup>42</sup>

This thesis argues that the movements to reform *tibb* have to be seen not only in the context of unani practitioners' relationship with colonial medicine, but also in terms of the relationship of the hereditary elite practitioners with the manifold practices at the margins of, and intersecting with, learned *tibb*. The impulses to reform were quests to cast professional identity, to reconfigure unani knowledge, to define the *hakīm*'s role in society among others professing to treat people's ills. The roles of the clients of *tibb* in the formation of the profession need to be recognised. Hence the emphasis in this thesis is on unani *tibb* and its relationships with the public, in addition to specific colonial policies which impacted on the unani profession, dealt with primarily in Chapters 2, 3 and 4.

The collapse of courtly patronage for unani *tibb* in the nineteenth century, maintained into the early twentieth century in mostly limited ways in some Princely States, such as Rampur, Gwalior, Indore, Bhopal and Hyderabad, coupled with social, economic and technological change, encouraged new professional formations in *tibb* in which the market-place and public perception were of profound importance for unani practitioners. Indeed, much of what this thesis describes is ultimately about practitioners reaching out to new constituencies and how practitioners sought to establish their competence in the eyes of the public. The need to see reform in indigenous medicine in relation to the changing market-place was in fact pointed out by Roger Jeffery in 1979, where he criticised Charles Leslie and Paul Brass for viewing reform in indigenous medicine principally as an emulation of colonial western medicine,<sup>43</sup> but this theme has not been rigorously explored from a unani perspective.

Indeed, one might argue that practitioners' concern with state policy, whether in terms of lobbying for governmental support for schools and so forth, or lobbying against

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<sup>42</sup> *Ibid.*, pp. 16, 40f.; R. Croizier, 'Medicine and Modernisation in China', *Comparative Studies in Social History*, 12, 1970, pp. 275-291.

<sup>43</sup> R. Jeffery, 'Indian Medicine and the State', *Bulletin of the British Association of Orientalists*, 11, 1979-80, p. 63.

legislation that was perceived as a defamation of the profession, like the Medical Registration Acts of the 1910s, ultimately reflects the practitioners' concern with the public's perception of them. Chapter 4 of this thesis treats the mobilisation among indigenous practitioners that surrounded the passing of the Medical Registration Acts in India's provinces. I argue that the prime fear of practitioners was that their standing in the eyes of the public would suffer because, unlike for western medicine, there was no legal provision at that time for them to be recognised. Where some historians and commentators have emphasised the actual negative impact of these Acts on indigenous medicine,<sup>44</sup> it seems that the passing of the Acts, which were designed to regulate homeopathic and western medical practice and not to delegitimise *vaid*s and *hakim*s, may in fact have only had a limited impact on the daily practice of *hakim*s. There were, however, some cases in Madras and Bombay of doctors who supported indigenous medicine being struck off the registers, as Jeffery and Bala have pointed out. This thesis sees the attempts of unani practitioners to gain recognition with the government and to seek parity with the colonial medical profession as part of a larger trend to present the credibility of their profession to the public. In practitioners' endeavours to this end, the thesis shows that many factors contributed to perceptions of a *hakim*'s authority, and hence to the trajectories of reform.

Recent insightful studies on the history of *tibb* at the turn of the twentieth century may be interpreted as explorations of unani discourse and the question of authority. Claudia Liebeskind has shown how three prominent *hakim*s variously contested allegations, current among some western-trained doctors and medical administrators in the provincial governments, that *tibb* was not a scientific discipline, and in the process questioned scientific claims to universal truth.<sup>45</sup> Hakim Kabiruddin's defence of *tibb*, which she discusses, was especially important in the context of the report of the Committee set up to investigate the qualities of indigenous medicine with a view to government support, published in Madras in 1925. The unani practitioners' debates of

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<sup>44</sup> Most forcefully in O.P. Jaggi, 'Indigenous Systems of Medicine during British Supremacy in India', *Studies in History of Medicine*, 1, 1977, pp. 320-347, and Zafar Ahmed Nizami, *Hakim Ajmal Khan*, New Delhi, 1988, p. 22; and more circumspectly in Bala, *Imperialism*, p. 85, and R. Jeffery, *The Politics of Health in India*, New Delhi, 1988, p. 53.

<sup>45</sup> Claudia Liebeskind, 'Arguing Science: Unani *Tibb*, Hakims and Biomedicine in India, 1900-50', in Waltraud Ernst (ed.), *Plural Medicine, Tradition and Modernity, 1800-2000*, London, 2002, pp. 58-75.



this subject were certainly concerned with the question of authority. Assertions of the irrationality of *tibb* by some doctors and some in the colonial medical administration struck at the heart of learned unani professional integrity. Also connected with this theme is Neshat Quaiser's study of debates among *hakims* on surgery.<sup>46</sup> He has usefully demonstrated how some unani practitioners legitimised their adoption of western medical disciplines, in this case surgery, by emphasising a common past between unani *tibb* and western medicine. Unfortunately he has also created polarised categories of 'reformist' and 'purist' with reference to practitioners associated with Delhi's Sharifi family and the Azizis of Lucknow respectively, without acknowledging that the Lucknow physicians were also very much engaged in the process of reform. This is evident through the very establishment of their famous school in Lucknow, the Takmīl at-Ṭibb, in 1902, and their creation in 1911 of a professional association, the Anjuman-i Aṭṭibbā, also in Lucknow, both of which were replications of western-derived forms of professional organisation.

While surgery and scientific method were two of the most powerful tools by which the practices of colonial and indigenous medical disciplines could be differentiated and were thus subjects of discussion of great importance for *ṭabibs* in certain contexts, the debates they describe took place only within elite, circumscribed, even if influential, circles. My work complements elements of Quaiser's and Liebeskind's studies, but takes the question of authority into new domains. I analyse authority in its manifestations in institutional realms and, especially, in realms that engaged with the public, which all gave shape to the evolution of professionalised unani *tibb*.

#### **IV. Institutions and Family Practices**

The period under study in this thesis spans the emergence of distinct teaching institutions for *tibb* in India from the late 1880s and the consolidation of movements for the reform of

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<sup>46</sup> Neshat Quaiser, 'Politics, Culture and Colonialism: Unani's Debate with Doctory', in Biswamoy Pati and Mark Harrison (eds), *Health, Medicine and Empire: Perspectives on Colonial India*, New Delhi, 2001, pp. 317-355.

*ṭibb* over the subsequent four decades. Institutions are key markers of the reform process, and teaching institutions have attracted some attention in the literature to date. This thesis examines principally two kinds of institution: the unani teaching institution in Chapter 3 and a 'national' professional organisation in Chapter 4.

Just as the power of colonial medical discourse has been emphasised in the studies on surgery and science, so has the professional organisation of western medicine been seen to impact on the formation of unani institutions. Thus Charles Leslie has pointed to the fact that professionalised unani and ayurveda have modelled themselves on 'cosmopolitan' (the term he and Dunn used to denote 'western' medicine) medical knowledge and institutions, in terms of colleges, associations, journals and conferences.<sup>47</sup> As Barbara Metcalf has noted, the new institutional arrangements manifest in the emergence of the Madrasa Ṭibbiya, a unani school, in Delhi in 1889 introduced 'paid staff and fixed requirements to replace the informal settings of family homes and apprenticeship'.<sup>48</sup> Such modes of organisation have been interpreted as dispensing with the traditional *dars* (the circle of students reading texts with a recognised practitioner) and introducing new forms of regular attendance of courses following specific curricula, professional accreditation based on examination and the awarding of degrees, as a development that paralleled bureaucratised colonial medicine.

In relation to teaching institutions, the arguments proposed in this thesis are firstly, that the process of institutionalisation of *ṭibb* in India was not uniform, neither in terms of the motivation to institutionalise, nor in the nature of the teaching institutions themselves. Secondly, the new institutions did not necessarily conform to the bureaucratic model of an institution outlined above. Thirdly, their emergence did not mean the immediate breaking down of pre-existing paradigms of authority which informed both the patient's trust in unani *ṭibb* and the *ṭabīb*'s confidence in his own practice. Because of this disjuncture between the kind of training that a unani institution could deliver and the kind of knowledge and authority that was required for successful practice, the new unani teaching institution derived from colonial models occupied an ambiguous and incongruous place in unani *ṭibb* during the early twentieth century.

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<sup>47</sup> Leslie, 'Ambiguities', p. 358.

<sup>48</sup> B.D. Metcalf, 'Nationalist Muslims in British India: The Case of Hakim Ajmal Khan', *Modern Asian Studies*, 19, 1985, p. 4.

In Chapter 3 we investigate unani institutions in Hyderabad in the context of the rise of institutions elsewhere in India. The Hyderabad experience reveals that the process of institutionalisation need not be predicated on unani revivalist ideologies, so evident in Delhi and Lucknow. Religious nationalism, while most certainly significantly impacting on the direction of reform in indigenous medicine, cannot be seen as a universal feature of the institutionalisation process. The institutionalisation of *ṭibb* in India was moreover a multifaceted and socially and politically contingent enterprise.

In Delhi, for example, it seems that the motivation for the establishment of the Madrasa Ṭibbiya and the subsequent agenda to reform *ṭibb* arose rather from professional concerns among elite *ṭabībs* as part of an endeavour to distinguish elite practices, accomplishments and reputations from popular forms of practice. The boundaries of what constituted *ṭibb* were fluid in the early twentieth century and a variety of practices may have gone under the name ‘unani’, or the titles ‘*ḥakīm*’ or ‘*ṭabīb*’. I speculate here that the activities of the ‘*ishtihārī aṭibbā*’ (‘advertising *ṭabībs*’), who had taken advantage of the expanding use of print to market their services, may have provided an important impetus for certain elite *ḥakīms* to give further definition to their profession. Efforts to distinguish elite practice from folk and other types of practice were by no means restricted to the Delhi region. They were indeed a feature of the late nineteenth-century *ṭibb* in Hyderabad and throughout north India and attention is drawn to them throughout the thesis, specifically in relation to advertising *ḥakīms* in the context of plague (Chapter 2), in discussions of theories of astral influence in the same chapter, concerning the place of Islam (Chapter 4) and concerning hysteria (Chapter 5), to give some instances. These all relate to the ways in which the boundaries of what constituted valid *ṭibbi* knowledge were being set. Seema Alavi has recently engaged with this theme. She analyses the efforts of Hakim Abd ul-Aziz in Lucknow to distinguish elite practices from those of the ‘illiterate’ *ḥakīms* and *dais*.<sup>49</sup> In an illuminating seminar paper that she recently gave, she argued that the reform of *ṭibb* in India was based on elite *ṭabībs* distinguishing their practice from the various forms of print-culture *ṭibb* of the nineteenth century, specifically that drawing on hybridised European – unani literature.<sup>50</sup>

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<sup>49</sup> Alavi, ‘Nationalist’.

<sup>50</sup> Alavi, South Asia History Seminar, School of Oriental and African Studies, 27 May, 2003.

The case of Hyderabad, however, in which the first government-funded unani school opened in 1891, two years after the Delhi school and ten years before the Lucknow Takmīl at-Ṭibb, does not conform to her argumentation. Here the process went through two distinct phases. It was not a family-based, elite practitioner enterprise to revive *ṭibb*, although the theme of revival did come into play in the second phase of institution building with the seventh Nizam and increasing practitioner mobilisation. In the first phase there was a conflation of interests, of the government to provide an apparatus for the regulation of the profession, of the public who seem to have wanted free unani medication, and potentially of the practitioners of *ṭibb* as well, marginalised from traditionally courtly roles in the context of an increasingly visible colonial-based medical infrastructure. The second phase of institutionalisation was more clearly influenced by a revivalist ideology. By introducing a comparative perspective into the history of institutionalisation the thesis is able to show that there was thus not one undifferentiated cause for the reform process in *ṭibb* throughout India.

The institutional arrangements of *ṭibb* of the early twentieth century represented a new realm of authority in unani culture. Qualifications from institutions in Delhi, Lucknow, Hyderabad, Lahore and Bhopal were valued. In Hyderabad a certificate from the unani school, or from their examiners, was in most cases essential for government employment in state-sponsored unani dispensaries. But while it might be presumed that institutions readily transformed unani culture, I show that they did not replace existing forms of authority, such as transmission of knowledge through hereditary practice. Hereditary practice is still a vital feature of the landscape of unani *ṭibb* in South Asia today. Sheehan and Hussain note that in 1995 of the 35,350 registered practitioners of *ṭibb* in India, 13,116 were institutional graduates.<sup>51</sup> Nearly two-thirds then did not have a background in a unani institution, and although one cannot be certain from this statistical evidence, it is highly probable that a large proportion of these practitioners without an institutional background may have had family connections to the profession. Hereditary practice locates the practitioner in a chain of knowledge that can be understood as both reliable, through the cumulative experience with medicinal preparations gained and transmitted over generations, and as powerful through the secrecy that surrounds the

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<sup>51</sup> Sheehan and Hussain, 'Unani', p. 130.

guarding of family knowledge. Contextualising these parallel forms of legitimisation in Hyderabad balances the discussion of unani institutionalisation in the third chapter of this thesis.

## V. Print, the Dynamic Profession and the Public

Probably the most important development which underpinned the process of reform in *ṭibb* and the new modes of relationship with the public was the use of print, although its importance has not been fully recognised in publications on *ṭibb* to date. The ambiguities of the impact of print technology in nineteenth- and twentieth-century Indian Islam have been brought out by Francis Robinson, and my work on the implications of print specifically for *ṭibb* is intended to complement his insights on Islamic scholarship.<sup>52</sup> In spite of the limitations of low literacy, Robinson has shown how print fundamentally changed the landscape of South Asian Islam. There are many parallels between the changes in the transmission of Islamic knowledge and unani knowledge that the use of print brought about, which we contextualise in chapters 2, 4, 5 and 6. The accessibility of the printed work challenged the primacy of the teacher/practitioner in the transmission of *ṭibb* just as it ultimately stripped the *‘ālim* (Islamic scholar) of his sole authority to interpret Islamic traditions. It rendered obsolete a common traditional form of accreditation – the *ijāzah* (certificate), which was written on the inside cover of a manuscript (medical as well as religious) as proof that the student had mastered a given text to the teacher’s satisfaction. Print dramatically increased the possibilities of becoming a *ḥakīm* without affiliations to the elite or hereditary practice, and print made western medical knowledge more accessible and more easily accommodated into unani domains, a point which Seema Alavi’s recent work highlights. While undermining the elite dominance of the profession, print also served the interests of institutional revival.

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<sup>52</sup> F. Robinson, ‘Islam and the Impact of Print in South Asia’, in Nigel Crook (ed.), *The Transmission of Knowledge in South Asia: Essays on Education, Religion, History, and Politics*, New Delhi, 2001, pp. 62-97.

The revival of *tibb* was in part made possible through the production of journals and the printing of the classical texts in Urdu translation in the late nineteenth and early twentieth centuries.

Print also had tremendous implications for changes in medical practices and health-seeking behaviour on a general level, although it raised acute issues for *tibb* in particular. The marketing of unani drugs through advertisements and mail order lessened the contact between the practitioner and the client/patient. This contact, the practitioner's physical diagnosis and observation of the patient, is in theory and traditional practice a particularly important part of humoral-based unani practice since disease is seen as a result of the body's imbalance and cannot be treated in isolation from its individual embodiment. Treatment is, therefore, usually considered to have to take into account the individual's constitutional condition. In these new contexts advertised medicine marginalises the art of diagnosis, the proof and the symbol of the practitioner's mastery of his discipline in which reading the pulse can border on an act of divination. It dispenses with individually composed prescriptions. It shifts the onus on to the patient/consumer to know or to find out about their condition before they use the product. Concomitantly, the practitioner is removed from the treatment process, and ceases to have direct connection with or influence over the lifestyle pattern of the patient, or knowledge of the prognosis of the disease. We witness here a major set of transformations in medical practice in the relationships of the patient with his or her body and complaint, and with the practitioner. As we discuss in relation to the plague in Hyderabad, elite *hakims* recognised the influence of advertising on the public and decried these practices as debased. But such were the pressures of a changing market that respected practitioners of hereditary backgrounds began mass-producing drugs and advertising them from the late nineteenth century.

Until the 1920s and 30s, this was perhaps more a feature of north Indian unani culture. Many newspapers in the 1890s in Hyderabad, for example, carried advertisements of unani products available via mail order from Lahore, but not of locally manufactured products. This suggests that unani culture in the late nineteenth and early twentieth century differed significantly in localities that were nonetheless considered as centres of unani learning.

Chapter 6 of the thesis explores the transformative role of journals in unani *tibb*, an area which has not been explored in studies on *tibb* to date. Discussion in this chapter focuses on two prominent and respected Lahore-based unani journals, which apart from being voices of learned unani practice, were also part of a conglomerate for the production and marketing of unani drugs. Through journals, debate, mobilisation and the exchange of ideas among *hakims* could be conducted on scales hitherto inconceivable. They also gave rise to new forms of engagement with patients and the public. Usefully for the researcher interested in patient-oriented perspectives on medical practice, the concerns of patients and how they described their disorders are recorded in question and answer columns in many unani journals on a scale which is not available in other source material. No study to date on unani *tibb* has used patient narratives as a way of understanding the practices of *tibb*. The significance of patient narratives are discussed in greater detail in section (VIII) below. Chapter 6 analyses the variety of unani discourse which these journals propagated and their advertising priorities and strategies. Markus Daechsel's recent PhD thesis on consumer culture in Lahore is the only study to my knowledge which begins to explore medical advertising in the Urdu press as a rich source of data for social history.<sup>53</sup> Chapter 6 examines advertisements in unani journals to see how they reflect on commercialised learned unani culture.

Print, then, mediated the authority of the practitioner in new ways, and by facilitating the emergence of new dynamics of knowledge and practice in *tibb*, became itself a realm of authority with which practitioners intent on the reform of their art had to engage. The act of using print to transmit knowledge beyond elite circles was inextricably connected to the language in which this knowledge was to be transmitted. The switch from Arabic, the language par excellence of the learned *tabīb*, to Urdu, the language of the new constituencies of unani *tibb*, represents a crucial moment in the reform process. The adoption of Urdu for a treatise on plague by Hakim Ajmal Khan, Delhi's most celebrated practitioner of *tibb* and a political activist of the early twentieth century, and his description of his choice of language as *bid'a* (innovation), a term which resonated in the age of Islamic scriptural reform as a pernicious act, drew the attention of the historian

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<sup>53</sup> M.B. Daechsel, "Faith, Unity, Discipline" – the Making of a Socio-Political Formation in Urban India, Lahore 1935-53', unpublished Ph.D. thesis, University of London, 2001.

Barbara Metcalf.<sup>54</sup> In our discussion of this treatise we can see that this endeavour was part of Ajmal Khan's project to break down the elitism of learned unani *ṭibb* as a necessity for its survival. Reform, therefore, from the perspective of one of its greatest advocates, was as much about language and print in the effort to reach new constituencies as it was about institutionalisation and the adoption of western medical practices, such as surgery.

## VI. Crisis and Reform

The perception of crisis was a powerful force in the reform of *ṭibb*. Chapter 2 of this thesis treats the impact on the unani profession and responses of *ḥakīms* to the crises in north India and Hyderabad that plague brought about, from 1896 and over the next two decades. Chapter 4 examines the development in the 1910s and 20s of the Āl India Vaidik and Yūnānī Ṭibbī Kānfarans,<sup>55</sup> a national forum for the mobilisation of *ḥakīms* and *vaid*s. There are parallels between the emergence of the AIVUTC and the outbreak of plague: both were connected to the perception of crisis in the profession, both entailed renegotiations of authority in *ṭibb*.

Plague and epidemics in general have attracted much scholarly attention, as phenomena that cast light on the relationship between medicine, the colonial state, and political and social formations in the nineteenth and twentieth centuries. Analysis has focused on colonial medical structures and discourse.<sup>56</sup> Some studies, such as those by

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<sup>54</sup> Metcalf, 'Nationalist', p. 5.

<sup>55</sup> References to this organisation will be as the 'All India Vedic and Unani Tibbi Conference', 'AIVUTC', or 'the Conference'.

<sup>56</sup> D. Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India*, Berkeley, 1993; I. Klein, 'Plague, Policy and Popular Unrest in British India', *Modern Asian Studies*, 22, 1988, pp. 723-755; I.J. Catanach, 'Plague and the Tensions of Empire, 1896-1918', in D. Arnold (ed.), *Imperial Medicine and Indigenous Societies*, Manchester, 1988, pp. 149-171; I.J. Catanach, ' "Who are your Leaders?": Plague, the Raj and the "Communities" in Bombay, 1896-1901', in P.G. Robb (ed.), *Society and Ideology*, Delhi, 1993, pp. 196-221; R. Chandavarkar, 'Plague Panic and Epidemic Politics in India, 1896-1914', in D. Bates (ed.), *Knowledge and the Scholarly Medical Traditions*, Cambridge, c.1995, pp. 203-240; M. Harrison, *Public Health in British India: Anglo-Indian Preventive Medicine, 1859-1914*,



I.J. Catanach have examined indigenous responses.<sup>57</sup> The study of plague in Chapter 2 adds a new dimension to the discussion of plague by examining the impact of the outbreak on the dynamics of the unani profession. Plague struck at a pivotal time in the reform process of *tibb*, and practitioners' responses to it reveal the ambiguities and tensions of the profession. This account is partly about the definition of 'good' practices in unani discourse, showing the configurations of the relationships of *tibb* with European, colonial and popular modes of thought and action. The authoritative place of the unani textual tradition, the miasmatic world of plague in the writings of Ibn Sīnā and other unani authors, are thus juxtaposed with new, contingent forms of authority. We see that learned practitioners sought to set off their practices from the popular realm, and the activities of those '*hakīms*' capitalising on people's desperation to find cures. At the same time learned unani discourse was conversant with and articulated popular dimensions of thought and action, such as widely held views on astral traditions that placed human lives at the mercy of celestial bodies, and Islamic, and indeed also ayurvedic, traditions on plague framed within the context of the collapse of just, moral society. Equally authority was seen to reside in colonial sanitary theory and practice, and later in germ theory. Sanitation for some was a manifestation of modernity and a tool to further the reform of the profession. Moreover, the early years of colonial interventionism in the plague allowed practitioners of indigenous medicine to draw on ideas of cultural authority – their knowledge and respect for the traditions of the country, their access to women in *pardah* – to validate their actions.

The colonial experience and the prevailing political conditions encouraged other notions of authority to emerge that emphasised the difference between the indigenous and the foreign. Some *hakīms* and their supporters countered colonial medical initiatives, such as inoculation and the use of allopathic drugs, by drawing loosely on ecological conceptions in *tibb* of the symbiotic associations between climate, the land, its produce and the people that live there, to assert that only Indian medicines were appropriate for Indian bodies. This formulation subsequently becomes a standard argument in the

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Cambridge, 1994; Manjiri Kamat, "'The Palkhi as Plague Carrier': The Pandharpur Fair and the Sanitary Fixation of the British State; British India, 1908-1916", in B. Pati and M. Harrison (eds), *Health, Medicine and Empire: Perspectives on Colonial India*, New Delhi, 2001, pp. 299-316.

<sup>57</sup> I.J. Catanach, 'South Asian Muslims and the Plague, 1896-c.1914', *South Asia*, 22, 1999, pp. 87-107.

defence of *ṭibb*. We have here an incipient nationalism, a hint of nativism, akin to *swadeshi* ideology, which, in the context of *ṭibb*, nevertheless did not materialise into sustained, organised political agitation against British Rule.

While it is problematic to see the origins of unani revival as an offshoot of the rise of nationalism, nationalist and communitarian ideologies current in the political climate of the late nineteenth and early twentieth centuries impacted on the course that reform took. The most useful studies on nationalism in the context of *ṭibb* are Barbara Metcalf's studies of Hakim Ajmal Khan, who at the beginning of his career was involved with the Muslim League, which pressed for a separate Muslim electorate and privileges for Muslim communities, but later in his life saw that Muslim interests could be safeguarded within the framework of the Indian National Congress.<sup>58</sup> Metcalf speculates that his interest in the Congress Party, as an organisation bringing together Hindus and Muslims, could have been motivated by his experiences as a *ṭabīb* in Delhi.

In Chapter 4 of this thesis we explore the forum for the reform of *ṭibb* which Ajmal Khan set up, the All India Vedic and Unani Tibbi Conference (AIVUTC), at the time that his interests were switching to Congress ideals. This was an influential forum that had national ambitions, convening in major cities throughout northern India as well as Bombay and Hyderabad in the 1910s and 1920s. The ideological orientation of the conference, which was founded to serve the interests of *vaid*s and *ṭabīb*s, provided an important counterpoint to separatist movements of the time. The historian Mushirul Hasan has recently made a case for the importance, in the current political climate charged with communitarian ideologies, of studies that shed light on movements that have tried to unite Hindus and Muslims.<sup>59</sup>

We find in the proceedings of the Conference sessions, and in the journals which followed their progress, that *vaid*s and *ḥakīm*s deplored the manner in which ayurveda and unani had been pitched against each other, condemned the way that people had claimed knowledge to belong to one tradition and not the other, and lamented that interest groups were being formed along sectarian divides across northern India. They attempted to counteract these developments. At the Conference *ṭabīb*s and *vaid*s also challenged the

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<sup>58</sup> Metcalf, 'Nationalist'; 'Hakim'.

<sup>59</sup> Mushirul Hasan, 'Introduction', in David Lelyveld's *Aligarh's First Generation*, Delhi, 1996, p. xxxv.

mapping of religious identity onto medical practices, the automatic association which was being made then, and continues to be made in popular thought and specialist writing about medicine in India, that ayurveda is Hindu and unani is Muslim. What is of special interest for us in this thesis is to see how these debates impacted on the reform process, and here we return to the question of authority. The chapter argues that the ideological orientation of the conference promoted a vision of *tibb* which, rather than looking solely to the classical traditions of West Asia as its well-spring, incorporated unani's bonds with Hindustan as a source for its rightful place as a national medicine. In their programme for the reform of the profession, they called for new, more systematic, cooperative attention to the *desh*, the country, and her plant wealth. Informed by a nationalist ideology, and almost certainly seeking to appropriate British interest in India's medicinal plant riches within a discourse of indigenous medicine, practitioners emphasised the need to re-establish their links with the land as a matter of national interest. I trace the resonance of these ideas in unani journal literature of the 1930s, where there is a more explicit expression of the need to liberate the Indian body from the yoke of 'foreign' medicines by encouraging *hakims* to actively engage with India's plants and to share their experiences with other practitioners and the public. Without wishing to gloss over the contradictions that this vision entailed, such as wishing to banish western drugs, but at the same time introducing western methods of analysis and establishing laboratories to analyse India's drugs, it was in spirit an endeavour to 'decolonise the body'.

## VII. Intimate Spheres of Authority: Women, Men and the Home

The place of women in *tibb*, either as practitioners or patients, important though it is, is a subject which is almost entirely absent in the historiography on *tibb* to date. Before the twentieth century there are occasional references to women as practitioners, as

Zillurrahman, R.L. Verma and N.H. Keswani have pointed out.<sup>60</sup> What is clear is that we should not equate the relative absence of women practitioners in the historiography of *ṭibb* to date with reality. There is no reason to suppose that there were not female practitioners of *ṭibb* who served the *zenānas* of the nobility, or who practised among the general population specialising in the treatment of women's conditions, alongside *dais* practising as birth attendants. In the early twentieth century, however, new forms of engagement with women in *ṭibb* emerge, and women themselves gain a more prominent role in professionalised *ṭibb*, as the profession expanded into new domains of practice, part of the globalising trajectory that *ṭibb* assumed in this period. Chapter 5 of the thesis examines these trends in relation to the treatment of women.

Hakim Ajmal Khan's Madrasa Zenāna Ṭibbiya, inaugurated in Delhi in 1909 for the training of women *ṭabībīs* and *dais*, was evidently inspired by models of western midwifery. But this chapter shows that colonial-derived ideas coalesced with other trends in late nineteenth-century India to reform women. Similarly, *ḥakīms* partially adopted the discourse on sanitation and public health of the colonial medical administration, blending it on occasions with prescriptions on hygiene in Islam, as they sought to reform the home environment. The study of the incorporation of colonial sanitary theory and practice within indigenous medicine complements studies on the evolution of public health in British India and imperial prerogatives.<sup>61</sup> The dissemination of sanitary ideas fused with unani precepts was also articulated outside the realm of unani literature. Thus Shah Jahan Begum of Bhopal, whose influence in the women's movements of the early twentieth century has recently been demonstrated in the thesis of Siobhán Lambert-Hurley,<sup>62</sup> wrote numerous treatises which spoke to the literate female elite on principles of home management and health. The examples of the reworking of the concept of sanitation in these contexts show firstly certain practitioners and reformists innovatively drew on ideas from a number of domains, 'scientific', *ṭibbī*, spiritual and cultural in their attempt to fashion a new culture.

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<sup>60</sup> Zillurrahman, *Dilhī*, pp. 43-44; R. L. Verma and N.H. Keswani, 'Women in the Arab Medicine', *Studies of History of Medicine*, 1, 1977, p. 280.

<sup>61</sup> Mark Harrison, *Public*; Arnold, *Colonizing*.

<sup>62</sup> Siobhán Lambert-Hurley, 'Contesting Seclusion: The Political Emergence of Muslim Women in Bhopal, 1901-1930', unpublished Ph.D. thesis, University of London, S.O.A.S., 1998.

Within unani spheres the impact of the movements for women's education in the early twentieth century and the journals which supported them meant that female practitioners could also advertise their services to a female clientele. This represents a new and important development in the transformation of unani *tibb* which has not been recognised in the historiography. It precedes the developments that took place later in the twentieth century which saw a tremendous increase in women students in unani institutions, as is currently reflected in the large number of female students in the Nizamia Tibbi College in Hyderabad and the Hamdard's College of Eastern Medicine in Karachi.

In the new forms of engagement with women in *tibb* there were other spheres of authority in operation than the emulation and accommodation of western discourses on midwifery, sanitation, home management and nursing. Drawing on the recent excellent work on women, reform and South Asian Islamic culture by Gail Minault,<sup>63</sup> Barbara Metcalf,<sup>64</sup> Francis Robinson<sup>65</sup> and Faisal Devji<sup>66</sup> among others, this chapter argues that one of the reasons why women become of concern in the reform of *tibb* is because of the current among Islamic reformers of the late nineteenth century that saw women, their education, their piety and good conduct as essential for the survival of Islamic culture. An exposition of unani *tibb* forms part of one of the most popular guides for the conduct of Muslim women of the twentieth century, the *Bihishtī Zewar* of Maulana Ashraf Ali Thanavi. Like no other written work of the time it took learned unani knowledge, as well as healing traditions based on prayer, to women in an effort to rid them of 'superstitious' custom.

The need to control and reform women is replicated in the interest among *hakīms* in hysteria, in their interpretations and reinterpretations of this resonant 'female malady'. Concern with hysteria has a long tradition in West Asian and European medicine that can be traced back to the Hippocratic corpus. Exemplary studies of hysteria spanning ancient

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<sup>63</sup> Gail Minault, *Secluded Scholars: Women's Education and Muslim Social Reform in Colonial India*, New Delhi, 1999.

<sup>64</sup> B.D. Metcalf, 'Maulana Ashraf Ali Thanavi and Urdu literature', in C. Shackle (ed.), *Urdu and Muslim South Asia: Studies in honour of Ralph Russell*, London, 1989, pp. 93-100; B.D. Metcalf, (trans.), *Perfecting Women: Maulana Ashraf Ali Thanawi's Bihishti Zewar*, Berkeley, 1990.

<sup>65</sup> F. Robinson, *Islam and Muslim History in South Asia*, New Delhi, 2000.

<sup>66</sup> F. Devji, 'Gender and the Politics of Space: The Movement for Women's Reform 1857-1900', in Zoya Hasan (ed.), *Forging Identities*, New Delhi, 1994, pp. 22-37.

Greek medicine, the Middle Ages, Renaissance and up to the twentieth century have been produced by Monica Green,<sup>67</sup> Helen King,<sup>68</sup> Elaine Showalter<sup>69</sup> and Thomas Laqueur,<sup>70</sup> but no study on hysteria has until now been done in the context of Greco-Islamic medicine/unani *tibb*. My research on women's diseases in *tibb* in the early twentieth century makes it clear that Barbara Metcalf's claim that women's bodies were not considered inferior to men's in Galenic medicine in India, does not stand up to scrutiny.<sup>71</sup> In some twentieth-century unani writings on hysteria, the educated, urban woman was seen to be especially susceptible to uncontrollable carnal desires which might corrupt her body. It is evident that one of the means by which women's reproductive roles could be controlled in early twentieth-century Indian society lay in the *hakims*' authority to treat hysteria and other women's conditions.

Anxiety concerning sexuality in the late nineteenth and early twentieth centuries was, however, not gender specific. It was not only women's bodies and sexuality that had to be controlled. The question of the overlapping of morality, medicine and the society surfaces again in the context of male sexual practices. The patient-oriented interactions in the question and answer columns of the journals in Chapter 6 reveal an overriding popular concern with the impact of male sexual practices on bodily and mental health, and the authority in which *hakims* were held to deal with these 'disorders'. The manifold effects of 'perverse' male sexual practices – masturbation, homosexual acts, excessive sexual activity – on the male body and mind can be captured in the umbrella term *kamzorī*, a non-gender specific general weakness of the body-mind, which was nevertheless often conceived in relation to male sexuality. Markus Daechsel has recently pointed to men's obsession with weakness in mid twentieth-century Lahore society and speculated whether the concern with male weakness was something particular to

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<sup>67</sup> Monica Green, 'The Transmission of Ancient Theories of Female Physiology and Disease through the early Middle Ages', unpublished PhD thesis, Princeton University, 1985.

<sup>68</sup> Helen King, 'Once upon a Text: Hysteria from Hippocrates', in S.L. Gilman et al., *Hysteria beyond Freud*, London, 1993, pp. 3-90.

<sup>69</sup> Elaine Showalter, *The Female Malady: Women, Madness and English Culture, 1830-1980*, New York, 1985.

<sup>70</sup> Thomas Laqueur, *Making Sex: Body and Gender from the Greeks to Freud*, Cambridge, 1990.

<sup>71</sup> Metcalf, *Perfecting*, p. 11.

Lahore's society or a more widespread phenomenon at this time.<sup>72</sup> He located this discourse in the economic and social hardships in Lahore's changing patterns of lifestyle.

The study in Chapter 6 of unani journal literature speaks of a broader concern among men in India at the time with weakness. Practitioners made the reform of male sexual practices a concern of theirs. Such was the prominence of this concern that it is reflected also in the debates of the national forum for unani *tibb*, the AIVUTC. In the construction of this discourse of weakness of the male body and mind, and its presumed origins in male sexual conduct, there were ramifications at a societal level and the health of subsequent generations. From the research for this study it becomes clear that the *hakim*'s authority to deal with male sexual 'disorders' was mutually constituted through the actions of both the practitioners and the public, and the chapter discusses the formation or continuation of a specialism in unani *tibb* dealing with issues of male sexuality and perceptions of ill-health. The study reveals the prominence of an ethical discourse within discussions of the body in early twentieth-century *tibb*. It shows how many *tabibs* saw it as their role to reach out to the public with their insights into morality and the body and the intertwined fate of the individual and the collectivity. By developing this theme of forms of control of male and female sexuality in indigenous medicine this study is contributing to an emerging body of literature on sexuality in colonial India, as outlined by Patricia Uberoi in a recent edited volume.<sup>73</sup>

## VIII. Sources

The range of issues explored in this thesis is reflected in the variety of sources that have been used. The greater part of my sources has been printed works in Urdu. Some of my most prominent sources are unani journals published between 1911 and 1935. *Rafiq al-*

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<sup>72</sup> M.B. Daechsel, 'Faith', p. 100.

<sup>73</sup> Patricia Uberoi, 'Introduction: Problematizing Social Reform, Engaging Sexuality, Interrogating the State', in Patricia Uberoi (ed.), *Social Reform, Sexuality and the State*, New Delhi, 1996, pp. ix-xxvi.

*Aṭibbā* and *al-Hakīm*, both published in Lahore, became established voices of learned unani discourse. The editorials reported widely on political dimensions of *ṭibb*, and in each issue there are articles on theory and practice, letters from practitioners and the public, and question and answer sections, providing valuable insights into interactions of practitioners with the public. The analysis of these journals is complemented by reference to *al-Masīh* from Delhi, and *al-Mu'ālij* and *Hakīm-i Dekkan* from Hyderabad. Although tremendously rich, unani journals have not been extensively used in studies on *ṭibb* to date. Other Urdu journals that I have consulted are the women's journals, *Mu'allim-i Nisvān*, *Khātūn* and *'Ismat*, which Gail Minault so perceptively examined as part of her study *Secluded Scholars*. Material from these journals fed into the chapter on treating women, Chapter 5. As illustrated by the discussion of the advert placed by a female *ṭabībah* in *'Ismat*, using these journals provides important new insights into the role of women in *ṭibb*.

The sources for the thesis also span a wide range of pamphlets and treatises of unani *ṭibb* in Arabic and Urdu, as well as other literature relating to understandings of health and disease, most of which was published from the late nineteenth century onwards. These include some of the core texts of classical *ṭibb*, such as Ibn Sīnā's *al-Qānūn fī-al-ṭibb* in Arabic, and the Urdu translation of one of its most commonly referred to abridgements, *al-Mūjiz* (the fourteenth century abridgement of the Ibn Sīnā's *al-Qānūn*, by Ibn al-Nafīs); the Urdu translation of Muḥammad Akbar Arzānī's Persian *Mizān al-ṭibb* (c. 1700) and the *Sharḥ al-asbāb* of Nafīs ibn 'Iwaḍ (fifteenth century). I have made extensive use of a number of other medical writings – tracts on plague, hysteria, a published collection of case notes, works on preventive health, sanitation and women's diseases. The printed proceedings of the All India Vedic and Unani Tibbi Conference represent another interesting source that has scarcely featured in any studies to date, and forms the basis for Chapter 4. Where original newspapers have been absent I have used the Selections from the Vernacular Press, in the records section of the Oriental and India Office Collection at the British Library. These have been especially useful for the chapters 2 and 4, on plague and *desī ṭibb*.

Archival material in Urdu and English from the Andhra Pradesh State Archives is drawn upon for Chapter 3 on *ṭibb* in Hyderabad. In this particular study another major



source is the *tazkirah* literature of the early twentieth century, which is a fascinating but again little utilised source for exploring how *hakīms* presented themselves; the qualities of *hakīms* which were valued, their lives and their teachers.

Most of the research for this thesis was conducted in Hyderabad and Delhi, drawing on material available in archives, public libraries, private collections, in many cases made accessible through the generosity of interested individuals, and from second-hand book stalls. The greater part of the Urdu and Arabic material presented here is translated into English for the first time, and I take full responsibility for the accuracy of the translated sections.

## Chapter 2

### Contesting Knowledges: Plague and the Dynamics of the Unani Profession

Over the last two decades epidemic disease has become an established area of research in the emerging field of medical history of South Asia.<sup>74</sup> Epidemics have been viewed as paradigmatic of crisis in society, as phenomena that inform about the relationship between medicine, the colonial state and political and social formations in the nineteenth and twentieth centuries. The plague that broke out in Bombay in 1896 and subsequently spread predominantly through northern and western India, has had a particular contribution to make to this field, with the unparalleled panic that it caused in official circles and the public at large. The disease has been extensively studied, in common with smallpox and cholera, from the perspective of colonial medicine.<sup>75</sup> These studies have elaborated on plague as a major public event, one which caused deep-seated panic among British officials, unprecedented levels of colonial medical intervention, and widespread public agitation. They have developed an understanding of how the disease was variously constructed among the British colonial authorities, of its implications for medical policy and imperial prerogatives in India and to some extent of responses to the crisis among local populations.

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<sup>74</sup> D. Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century India*, Berkeley, 1993; D. Kumar, *Disease and Medicine in India: A Historical Overview*, New Delhi, 2001; R.W. Nicholas, 'The Goddess Sitala and Epidemic Smallpox in Bengal', *Journal of Asian Studies*, 41, 1998, pp. 21-44; I. Klein, 'Imperialism, Ecology and Disease: Cholera in India 1850-1950', *Indian Economic and Social History Review*, 31, 1999, pp. 649-680; S. Bhattacharya, M. Harrison and M. Worboys, 'A Very Peculiar Triumph: The Control and Eradication of Smallpox in India', *Wellcome Trust Review*, 1998, pp. 48-51.

<sup>75</sup> Arnold, 'Colonizing'; I. Klein, 'Plague, Policy and Popular Unrest in British India', *Modern Asian Studies*, 22, 1988, pp. 723-755; I.J. Catanach, 'Plague and the Tensions of Empire, 1896-1918', in D. Arnold (ed.), *Imperial Medicine and Indigenous Societies*, Manchester, 1988, pp. 149-171; I.J. Catanach, 'Who are your leaders?': Plague, the Raj and the "Communities" in Bombay, 1896-1901', in P.G. Robb (ed.), *Society and Ideology*, Delhi, 1993, pp. 196-221; I.J. Catanach, 'South Asian Muslims and the Plague, 1896-c.1914', *South Asia*, 22, 1999, pp. 87-107; R. Chandavarkar, 'Plague Panic and Epidemic Politics in India, 1896—1914', in D. Bates (ed.), *Knowledge and the Scholarly Medical Traditions*, Cambridge, c.1995, pp. 203-40; M. Harrison, *Public Health in British India: Anglo-Indian Preventive Medicine, 1859-1914*, Cambridge, 1994; Manjiri Kamat, 'The Palkhi as Plague Carrier': The Pandharpur Fair and the Sanitary Fixation of the British State; British India, 1908-1916', in B. Pati and M. Harrison (eds), *Health, Medicine and Empire*, Hyderabad, 2001, pp. 299-316.



Plague was one of a number of epidemics, including malaria, cholera and influenza, which decimated the population of India in the fifty years between 1880 and 1920, in addition to the heavy toll caused by famines, diarrhoea and respiratory diseases during this period.<sup>76</sup> Plague deaths peaked India-wide between 1902 and 1907, claiming over a million lives in each of the years 1904, 1905 and 1907.<sup>77</sup> Although plague did not cause the huge mortality of malaria and cholera, it brought about what David Arnold has characterised as a 'new interventionism' on the part of the colonial authorities. Plague also raised particular tensions surrounding the public-health management of pilgrimage: the haj to Mecca and also to religious fairs within India.<sup>78</sup>

The purpose of this work is not to critique the range of insights that the studies on plague and colonial policies have provided. Rather, it is to shift the focus away from the perspective of colonial medical structures and discourse to examine the internal dynamics, dilemmas and tensions that arose around the plague outbreaks among communities of unani practitioners.<sup>79</sup> Although plague swept through rural districts, especially in the Punjab, it raised particular concerns for urban environments, which in many cases also happened to be heartlands of unani learning and Islamic culture. This is reflected in the geographical focus of this study, which draws particularly on the activities, debates and writings of unani practitioners in some of these centres: Delhi, Lahore and Hyderabad.

Although a devastating disease, the epidemic plague moment played to the strengths of learned unani *ṭabībs*. They could claim historical, moral and medical legitimacy to deal with the disease, heightened in the face of widespread public suspicion of western interventions, like segregation and inoculation. In the context of this initial interventionism plague acquired a particular resonance in the way that the body, the home and women were to be treated. The critical lines of approach to plague and *ṭibb* in this chapter is to analyse the diverse ways that *ḥakīms* sought to bring their ethical/medical agendas concerning the plague to the literate public.

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<sup>76</sup> Arnold, *Colonizing*, p. 200 f.

<sup>77</sup> *Ibid.*, p. 201.

<sup>78</sup> Harrison, *Public*, p. 133 f.; Kamat, 'Plague'.

<sup>79</sup> Regarding plague and indigenous medicine in India, only Kavita Sivaramakrishnan has touched on how plague impacted upon the development of ayurvedic organisation in early twentieth-century Punjab, 'The Use of the Past in a Public Campaign: Ayurvedic Prachar in the Writings of Bhai Mohan Singh Vaid', in Daud Ali (ed.), *Invoking the Past: The Uses of History in South Asia*, New Delhi, 1999, pp. 178-191.

For *ḥakīms* keen to reform unani practices, such as Ajmal Khan, the crisis of plague encouraged transformation within the profession – to seek new modes of engagement with people’s lives – and the advancement of a modernising agenda. In the articulations of others, such as Altaf Hussain, a prominent practitioner of Hyderabad, it was an opportunity to distinguish learned unani practices from those of the market-place; to warn the public of the hazards of being lured by advertisements and new forms of commercial enterprise. In yet other cases the plague highlights the interface between learned *ḥibb* and popular understandings of health and disease. Plague brought about tensions within the unani profession that provide a rich insight into the nature of this profession and its interface with popular culture and other streams of learning: theology, astrology and emerging bacteriology. These tensions surface in *ḥakīms*’ tracts on plague, in the large-scale coverage of the disease in the vernacular and English language press, and also in the unani journals that were in wide circulation, all of which form the principal sources for this study. The plague episode, in the various contexts explored in this chapter, raises questions of the role of *ḥibb* in society and the central issues that we are concerned with in this thesis: the different approaches to, and changing nature of, authentic and authoritative unani knowledge and practice.

Learned *ḥakīms* at the turn of the twentieth century in India had at their disposal a variety of authoritative sources within their own traditions of learning for developing knowledge of plague. The most influential compendium of *ḥibb* in the subcontinent, Ibn Sīnā’s *al-Qānūn fī al-ḥibb*, and the commentaries it spawned, contain passages on the nature of the disease and means of treating it, and his account of plague was equally held to have been the most authoritative throughout medieval times in West Asia.<sup>80</sup> Less well known but nonetheless often cited by *ḥakīms* in the outbreak in India as an authoritative source on plague was the Tunisian Dā’ūd al-Antākī’s (d.1599) *Tadhkirah al-Ṭā’ūn*.<sup>81</sup> There were a number of other treatises composed in Arabic and Persian which some *ḥakīms* referred to but they were not widely diffused among learned unani circles. In Islamic learning there was also a body of authentic *ḥadīth* (traditions) that relate to plague specifically, and to God’s power to bring retribution upon society at large, as well as an

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<sup>80</sup> M. Dols, *The Black Death in the Middle East*, Princeton, 1977, p. 87.

<sup>81</sup> For a discussion of the reception of his theories in Tunisia, see N. Gallagher, *Medicine and Power in Tunisia, 1780–1900*, Cambridge, 1983.

authoritative tradition which was founded on *ḥadīth* but then developed into its own genre relating *ṭibb* to Islamic learning, *ṭibb al-nabī* (medicine of the Prophet).

These traditions of learning informed in various ways the kinds of discourse about plague that *ḥakīms* produced, but, as we shall see throughout this chapter, how *ḥakīms* negotiated the plague can only be understood in the context of broader popular action and reaction, and to folk healing practices. As Rajnarayan Chandavarkar has cautioned in the case of Bombay and as Ian Catanach has amply shown principally among Muslim communities in north-western India, responses to the plague and the plague measures were highly varied.<sup>82</sup> For example, the violation of *pardah* in the colonial segregation policy of the early years of the plague administration provoked widespread hostility among many Muslim groups and some higher caste Hindus in many parts of northern India.<sup>83</sup> Nevertheless, in Bombay many in the Khoja and Bohra communities collaborated with the British, as did many among the elites in Punjab and North-West Provinces (henceforth NWP).<sup>84</sup> Catanach suggests that in the Punjab British officials co-opted well-respected '*ulamā*' to produce *fatāwa* (decrees) sanctioning disinfection, evacuation and inoculation, while other local mullahs pronounced it impious to evade the plague and God's will.<sup>85</sup> One of Lahore's pro-British medical figures, Ghulam Nabi, a municipal commissioner and a practising *ḥakīm*, seems to have had a leading role in organising the pronouncements of '*ulamā*' in favour of the government's unpopular measures.<sup>86</sup> The contestation between '*ulamā*' on these contentious issues was public and took on more than a local complexion, as illustrated in the published exchanges between the '*ālim*' and head teacher of Dār al-'Ulūm Nu'māniyah, Lahore and Maulvi Abdulahad Khanpuri.<sup>87</sup> As Catanach points out, there was no abiding religio-legal authority, no 'chain of command' in Indian Islam by which the British could have leverage over popular thought and action regarding the plague.<sup>88</sup>

Apart from the outcries against the British carried in the press and the sporadic rioting, people sought various means to try to spare themselves or their loved ones from

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<sup>82</sup> Chandavarkar, 'Plague', p. 205.

<sup>83</sup> Catanach, 'Muslims', p. 90.

<sup>84</sup> *Ibid.*, p. 91; The North-West Provinces became the United Provinces in 1906.

<sup>85</sup> *Ibid.*, pp. 94.

<sup>86</sup> Ghulam Nabi, *Plague Inoculation from the Muhammeden Point of View*, Lahore, 1903.

<sup>87</sup> Ghulam Murtaza, *al-Bayān wa al-Ḥamāsa ba-jawāb al-Bayān wa al-Aghāsa*, Lahore, 1908.

<sup>88</sup> Catanach, 'Muslims', p. 95.

the plague's grasp. Viewed by many as a divine visitation, people prayed, sometimes collectively.<sup>89</sup> The *Bihishtī Zavar* of Ashraf Ali Thanavi, a popular work of reformist Sunni Islam, included an incantation based on a verse from the *Qur'ān* to ward off plague to be recited before eating or drinking at the time of an epidemic.<sup>90</sup> Edgar Thurston, who wrote on social customs in southern India, remarked that a *faqīr* (a Muslim ascetic) undertook to drive away plague in Bellary; a goat was sacrificed at a crossroads, over which the *faqīr* performed incantations. The poor were fed from the money collected, but the plague apparently did not abate.<sup>91</sup> Amulets and talismans were worn to protect oneself from the strikes of the *jinn* (spirits). Jinn were beings that might assume human form, who were notoriously mischievous, but they could bring prosperity as well as misfortune. They have a long association with plague in Islamic literary and folk traditions, while also being embedded in folk understandings of the vagaries of fortune across northern India.<sup>92</sup>

Newspaper reports from the time reveal the great range of popular understandings of the plague. One Sayyid Ramzan Ali of Rohtak proclaimed that plague was the result of the rotting of the lochia left in the uterus after widows or unmarried women attempted an abortion, and for that reason Hindus kept their women away from such people.<sup>93</sup> 'Corrupting' women were also blamed for plague in other contexts, as we shall see. The appearance of comets and meteor showers were also popularly ascribed the power to precipitate an outbreak of plague, as indeed they had been nearly four centuries previously, when plague broke out in the Punjab in 1618 during the reign of Jahangir.<sup>94</sup>

<sup>89</sup> Catanach describes the sympathy for others that plague aroused and the role that prayer played in coming to terms with the grief of loss, in 'Muslims'.

<sup>90</sup> Thanavi, *Bihishtī Zavar*, Delhi, 1334 hijri, p. 310.

<sup>91</sup> E. Thurston, *Omens and Superstitions of Southern India*, London, 1912, pp. 266-267.

<sup>92</sup> L.I. Conrad, 'Epidemic Disease in Formal and Popular Thought in Early Islamic Society', in T. Ranger and P. Slack (eds), *Epidemics and Ideas: Essays on the Historical Perception of Pestilence*, Cambridge, 1992, especially pp. 84-87. Dā'ūd al-Antākī appraises the role of jinn in plague in his *Tadhkirah al-Ṭā'ūn*, N. Gallagher, 'Medicine', p. 42. Catanach refers to jinn in folk medicine in India, 'Muslims', p. 99, citing H.A. Rose, *A Glossary of the Castes of the Punjab and North-West Frontier Province*, I, Government of Punjab, 1970 (reprint), p. 561. The widespread idea of jinn as agents of fortune but also distress is especially evident in the frequent references to them in W. Crooke (ed.) *Punjab Notes and Queries*, 1883-1888, and *North Indian Notes and Queries*, 1891-1896.

<sup>93</sup> *Akḥbār-i 'Ām* (Lahore), 19 January 1898, *Punjab Native Newspaper Reports* (hereafter *NNR*). Cited also in Catanach, 'Muslims', p. 101.

<sup>94</sup> H.M. Elliot and J. Dowson, *The History of India as Told by its own Historians*, 6, 1872, p. 406; W. Crooke, *Religion and Folklore of Northern India*, Oxford, 1926, pp. 45-46. See below for a discussion of astral influences.

To relieve suffering people also resorted to the herbal and mineral preparations of *vaids* and *hakims*, whose practices varied widely, spanning folk and learned traditions. Through the agency of *hakims*, the plague patient was scarified, bled or cupped to draw out the poisonous blood. Cupping, as it is described in the reports on plague in rural Punjab appears to have been quite a perilous procedure, as it involved pricking the patient's skin and creating a vacuum over this part with a conical receptacle; the practitioner then sucked up the blood through a hole at the tip of the cone, without ingesting it.<sup>95</sup> Leeches were also applied to the plague bubo, principally by a class specialised in this practice for general application, so-called leech-men and –women.

This brief summary of popular ideas on plague causation and the means of salvation provides a backdrop against which we can gauge the articulation of discourse on plague among learned *hakims*, and the areas of tension and contestation that they reveal. We may take Barbara Metcalf's point, reiterated by Ian Catanach, that *unani tibb* was inherently 'open',<sup>96</sup> but what we can see emerging throughout this plague episode is that *hakims*, motivated by a range of socio-economic factors, were contesting this openness, approaching in various ways a number of questions: what kind of medicine is *unani tibb*, or what should it be? Should it accommodate the contemporary principles of western medical intervention in plague: disinfection, segregation, inoculation and subsequently germ theory? Should *tibb* be subsumed within Islamic notions of punishment and redemption? Should it be a communitarian or a commercial enterprise? Ultimately how was *tibb* to address its own traditions and maintain or foster relationships with the public, and which kind of public? Our explorations of these themes shall begin with a treatise on plague by Hakim Ajmal Khan written not long after the outbreak of plague in Bombay. In this work the most celebrated figure in the revival of *tibb* in twentieth-century India seized the opportunity afforded by plague to capture the attention of his professional peers and the literate public in order to articulate his vision of where *tibb* should be going; for this *hakim* the plague moment was a moment of reform.

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<sup>95</sup> C.H. James, *Report on the Outbreak of Plague in the Jullundur and Hoshiarpur Districts, 1897-1898*, p. 141.

<sup>96</sup> B.D. Metcalf, 'Nationalist Muslims in British India: The Case of Hakim Ajmal Khan', *Modern Asian Studies*, 19, 1985, p. 5; Catanach, 'Muslims', p. 95f.

## I. Hakim Ajmal Khan's Treatise *al-Ṭā'ūn*, a Vehicle for a Modernising Agenda

Hakim Ajmal Khan, the scion of a prestigious family of *ḥakīms* in Delhi, who became equally well known as a political figure in India's emerging nationalist movements and the early years of the Congress, published a treatise on plague in 1898, at the height of British interventionism in the plague and the public agitation that it entailed. Ajmal Khan grappled with the reorganisation and reorientation of *ṭibb*, and the plague crisis urged him towards these ends: the reform of learned unani culture. Studies have already established the position that Ajmal Khan occupied in construing unani *ṭibb* as a symbol of a glorious Muslim heritage, while urging *ṭibb* to adopt western knowledge where he considered *ṭibb* deficient, which included surgery, anatomy and midwifery.<sup>97</sup> In this respect his views were widely shared by other elite physicians in Lucknow and Lahore keen to recover and maintain the prestige of their knowledge and practices. But Hakim Ajmal Khan's approach to reform was more complex than has been suggested in studies to date.

*Al-Ṭā'ūn* was Ajmal Khan's first published work, and unlike others that he wrote during his employment in Rampur, and subsequently published, it was the only one written in Urdu, not Arabic. This is a highly significant aspect that reveals, as we will see, much about Ajmal Khan's approach to the transformation of unani culture at this time, and also indicates that plague had a motivating role in this transformation. Ajmal Khan wrote the treatise at 35 years of age when he was employed as private physician to the Nawab of Rampur, well on his way to establishing himself as a worthy successor to his family's high pedigree unani practice in Delhi. The Sharifi family was one of the most influential in Delhi's elite society, steeped in Perso-Islamic scholarship and with connections as unani practitioners to the courts of north India over several generations. His eldest brother, Hakim Abdulmajid Khan had been involved in the early phase of the institutionalisation of *ṭibb* in India, establishing the Madrasa Ṭibbiya in 1889. Ajmal Khan took over the running of the school in 1902 after the demise of his brother Hakim

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<sup>97</sup> Metcalf, 'Nationalist'; Metcalf, 'Hakim Ajmal Khan: Rais of Delhi and Muslim leader', in R. E. Frykenberg (ed.), *Delhi through the Ages: Essays in Urban History, Culture and Society*, Delhi, 1986, pp. 299-315.



Wasil Khan, and began publishing the school's journal *Majallah Tibbiyah* (a unani magazine) in 1903. He later went on to establish a school for the training of midwives in 1906 and the All India Vedic and Unani Tibbi Conference in 1910.

Ajmal Khan's first statement in *al-Tā'ūn* on the causes of plague was that there was no difference between what the European doctors and unani *ṭabībs* considered to be true, and at this time, as we have mentioned above, many in the Indian Medical Service did indeed consider plague to be essentially miasmatic.<sup>98</sup> But his goal in writing this treatise was not simply to advocate the unity of allopathy and *ṭibb* as some legitimacy strategy, which at this time might not have been so successful in any case given the levels of public antipathy to the British over the plague. Rather he aimed to bring what he considered to be sound knowledge about plague, its causes, means of prevention and treatments to a new constituency, and to do so he had to challenge forms of representation of unani knowledge: he had to modernise the text. Ian Catanach has remarked on *al-Tā'ūn* that it 'in many ways...followed the format of older medical treatises', in offering a historical account of the disease and numerous prescriptions. Catanach's observation is correct up to a point, but he does not pick up on the fact that the author was pitching it as a revolutionary text in terms of style and content. Ajmal Khan's project was encapsulated in a brief but revealing foreword to the treatise, entitled: 'A necessary submission in the service of the readers'.<sup>99</sup>

In this submission to his readers, Ajmal Khan presented his treatment of the subject as ground-breaking in many fundamental ways. He described his writing in Urdu and not Arabic as *bid'a* (innovation),<sup>100</sup> a term derived from Islamic law that carried particular poignancy in late nineteenth century India when movements of Islamic reform emerged that sought to rid Islam of the accretion of non-scripturally sanctioned practices. The Arabic language, Hakim Ajmal Khan wrote, 'has safeguarded unani *ṭibb* for centuries, as it continues to support it today'.<sup>101</sup> For Ajmal Khan knowing Arabic and being able to access the works of the literary unani tradition had been one of the keys to guaranteeing valid unani knowledge. He thus anticipated that those interested in *ṭibb* 'will

<sup>98</sup> Ajmal Khan, *al-Tā'ūn*, 1315 Hijri [1898], p. 29.

<sup>99</sup> *Ibid.*, pp. 2-4: 'Nāzirīn kī *khidmat* meṅ *zarūrī* *guzārish*'.

<sup>100</sup> *Ibid.*, p. 2.

<sup>101</sup> *Ibid.*: 'Is meṅ *kuch* *shakk* *nahīn* *kih* *yūnānī* *ṭibb* *kī* *sadiyon* *se* 'arabī *zabān* *ṭibb* *kafālat* *kartī* *ā'ī* *hai*, *aur* *Hindūstān* *meṅ* *ab* *tak* *yehi* *zabān* *ṭibb* *kī* *parvarish* *kar* *rahī* *hai*'.

turn up the nose and frown' that Urdu was the chosen medium.<sup>102</sup> Ajmal Khan was highly proficient in Arabic, as contemporaries like the famous scholar Shibli Numani testified,<sup>103</sup> and he composed several short pieces in Arabic. These writings were primarily intended for fellow learned *ṭabīb*s and addressed quite technical issues within *ṭibb*. Ajmal Khan also expected this treatise on plague, quite naturally, to be read by fellow professional readers, but, I would argue, these were not his target readership/audience.

Writing in Urdu made the work accessible to the literate lay person, broadening the constituency of unani *ṭibb* beyond those who had Arabic or Persian madrasa education. This was especially important in the context of plague. The tremendous public concern over plague had definitely made the question of treatment a matter of great public interest, as is borne out in the numerous articles advocating *ṭibb*, ayurveda and western medicine that appeared in newspapers. Indeed, there is an evident concern in the treatise to challenge the narrow circles of unani literary production and reception. Tapping the public concern with plague, Ajmal Khan recognised that a treatise on plague in Urdu was an ideal vehicle through which he could present himself as one committed to reforming how learned knowledge of *ṭibb* should be represented and for whom it should be written. Beyond an exposition on plague by a prominent *ḥakīm* from an influential Delhi family, the treatise may be read as an assault on the prevailing elite literary unani culture, and how it had to adapt to changing times. It is worth examining this foreword in some detail.

Language was just one of a number of devices that Ajmal Khan consciously used to expound his 'radically new method' (*bilkul nā'ī dhang*) and to place this work outside the framework of conventional learned unani discourse. The author enumerated those aspects of his work that he expected the *ahl-i fann* (people of the art, i.e. learned *ṭabīb*s) would object to. Ajmal Khan proclaimed that he had done away with the usual structure of the unani book or treatise: the division of the work into introduction (*muqaddimah*), chapters (*abwāb*), sections (*fuṣūl*) and conclusion (*khātimah*).<sup>104</sup> Instead, all that he wrote was 'entirely plain' (*mu'arraḥ*). He expected that the learned *ṭabīb*s would find his omission

<sup>102</sup> *Ibid.*: 'nāk bhaun carhā'egā'.

<sup>103</sup> M. Razi ul-Islam Nadvi, *Rasā'il Masīḥ al-Mulk*, Aligarh, 1991, Introduction by Hakim Sayyid Zillurrahman, p. 12.

<sup>104</sup> Ajmal Khan, *al-Ṭā'ūn*, p. 4.

of the *khujbah* 'distasteful'. The *khujbah*, which he described as 'the first model of the *ṭabīb* author's competence', is the address in Arabic with which unani works conventionally began.<sup>105</sup> The learned *ṭabībs* would object to the way the preface was written, 'in the style of some piece in a newspaper'.<sup>106</sup> They would see that none of the conventional Persian and Arabic dictionaries had been consulted in tracing the origins of the word for plague *ṭā'ūn*. They would note that the literal meaning and conventional usage of the English word 'plague' transliterated in Urdu had been used throughout the text alongside *ṭā'ūn*, something 'totally against the custom of unani writers'.<sup>107</sup>

In terms of content, the reader would see with consternation, Ajmal Khan predicted, that a large section of the treatise was devoted to the history of plague. An independent study of this aspect of the disease, Ajmal Khan wrote, 'has not been written by any *ṭabīb* until today', and *ṭabībs* would wonder what the occurrence of plague in France, Turkey, Austria, Asia, Germany had to do with the outbreak of plague in India, what benefit would this knowledge bring?<sup>108</sup> Ajmal Khan argued that this history was in fact highly relevant to the current situation, that what had happened in other countries bore testimony to the contagiousness of plague. Chronologies are in fact common aspects of the plague treatise genre,<sup>109</sup> but it is in this sense that Ajmal Khan's treatment of the history of plague differs from other accounts of the subject in Arabic and Persian literature: his use of history was guiding the reader through the arguments for and against contagion, which were to lead to a conclusion in favour of the concept, using evidence derived from European sources, from experiences in non-Islamic lands. Furthermore, he remarked that he did not even refer to the authority of any *ṭabīb* to back up his statements on this issue.<sup>110</sup> He was in this way providing a source of authoritative knowledge on plague which was not derived from the learned unani tradition, which he presented as a radical move.

<sup>105</sup> *Ibid.*, p. 2: 'jo ek mu'allif ṭabīb kī liyāqat kā pehlā namūnah hai'.

<sup>106</sup> *Ibid.*: 'jo akhbār kā ek maẓmūn sā ma'lum hotā hai'.

<sup>107</sup> *Ibid.*, p. 3: 'yūnānī mu'allifon ke dāb ke bīkul khalāf hai'.

<sup>108</sup> *Ibid.*, p. 3: 'Agar Landan meṅ plaig paidā hū'ī to hamēn us se kyā ta'alluq? Firāns, Turkī, Āstriyā, Aishiyā, Jarman meṅ ṭā'ūn huwā to hamārā us ne kyā bagārā hai?'

<sup>109</sup> L.I. Conrad, 'Arabic Plague Chronologies and Treatises: Social and Historical Factors in the Formation of a Literary Genre', *Studia Islamica*, 54, 1981, pp. 51-93.

<sup>110</sup> A. Khan, *al-ṭā'ūn*, p.3.

In a similarly combative tone Ajmal Khan wrote that he would discuss some of the 'absurd' (*mohmal*) notions of the causes and signs of plague. For example, he dismissed the notion of astral influence as a cause of plague as 'a common idea' that was inconsistent with the recent experience in Bombay and with the historical record, although, interestingly, he did not challenge the premise that there could be such influence.<sup>111</sup> He anticipated 'astonishment' that he should include poverty and weakness in the section on causes. It certainly is the case that such social conditions are not mentioned in classical unani texts, like Ibn Sīnā's, which deals with the question of putrefaction as an abstraction. Finally, in his discussion of the prevention and treatment of plague he listed several unani simples and outlined unani methods. But as he commented in the preface, where he mentioned compound medicines he did not follow the organisational schema of the classical unani tradition, in terms of temperament, parts, elements, description, prescription. Again he was consciously setting himself apart.

By outlining these approaches Ajmal Khan was casting himself as the exponent of a fundamental shift in the way unani knowledge was to be approached. The presentation of knowledge was a key element in this vision. Gone were the conventional markers of a classic unani text like *al-Qānūn* and its derivatives, and in their stead was plainly written Urdu and a transparent arrangement of material with a comprehensive contents section for easy reference. In highlighting his historical method, he was attempting to establish the meaning of the disease beyond the limits of conventional unani discourse by discussing plague as a historical phenomenon, tracking its course progressively and systematically through the centuries. In so doing he was most probably drawing inspiration from British commentators on the plague, who frequently began with summaries of the history of the disease. Indeed, he refers to 'English historians' as authoritative sources for plague in India.

The polemical strain in this foreword is quite evident. Ajmal Khan was not as iconoclastic as perhaps his foreword would suggest. He may have done away with the organisational schema of the classical unani plague text, but he did in fact organise his work according to a format that was common among contemporary unani writers, based on the themes of causes, signs and treatment. Moreover, we should not be misled that

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<sup>111</sup> *Ibid.*, pp. 33-34.

Ajmal Khan did not refer to the established authorities of *ṭibb* in this treatise on plague. It was only in the context of contagion that he did not refer to any. Thus it is clear in the body of the text that he situated his understanding of the cause of plague within the miasmatic framework elaborated by Ibn Sīnā, one of foul and poisonous vapours rising from the earth and corrupting the air.<sup>112</sup> Ajmal Khan was after all just one of a number of unani *ṭabīb*s who began writing in Urdu in the late nineteenth century. In evaluating his purportedly radical stance, however, perhaps we should take into account the fact that he belonged to a highly respected and influential family of unani practitioners with a long-standing tradition of service at the courts of Mughal rulers. In this treatise Ajmal Khan was turning his back on the expectations and insignia of a learned *ṭabīb* from this kind of background.

Hakim Ajmal Khan was evidently firmly committed to *ṭibb*, but was intent on pushing it in new directions. Apart from the evident self-publicising in the text, Ajmal Khan had another more compelling motive to write it, and that was to reach out to the literate middle classes, to guide them and inform them about plague. He wanted to reach into people's homes, lives, minds and change their attitudes and behaviour. In the preface to the work he laments the mothers whom the plague has made widows, the children orphaned, the fathers made childless, and addressing his readers directly with the familiar 'you' form (*tum*), asks 'Is this such a thing that you can look upon in your usual way? And pretend not to be concerned?'<sup>113</sup> People, Ajmal Khan was suggesting, had to take responsibility for themselves and for others, and in this work he took it upon himself to show them that the causes of the disease were known, and that there were specific ways in which they could protect themselves from it. The usefulness and necessity of this work was in no doubt in Ajmal Khan's mind:

You need to read about the fearsome consequences [of doing nothing about plague] in this treatise and protect yourself from this fatal harm. Arrange all your activities according to what has been written in this treatise. You may certainly be able to

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<sup>112</sup> *Ibid.*, pp. 30-31.

<sup>113</sup> *Ibid.*, p. 6: 'Voh kyā aisī cīz hai kih tum us ma'mūlī naẓar se dekho? Aur us se be parvā'ī zāhir karo?'

organise yourself and your house but you will not be able to expel plague from this country.<sup>114</sup>

This is the reason why he had to make this work accessible, clear and relevant to the issues confronting people at the time. In Ajmal Khan's view sanitation and public health were the keys to ridding the country of plague, just as European countries had done.<sup>115</sup> To make this point required him to give a detailed history of the plague; one which differed from all other accounts contemporary and past in *ṭibb* for its systematic chronological (by century) arrangement of the subject matter and more importantly, which leads the reader to the conclusions that history showed that plague was contagious, that sanitation and public health (quarantine, evacuation) measures were beneficial.

This was in fact quite a brave position to take as a *ṭabīb*. He was writing at the height of public agitation against the plague measures in Bombay Presidency, and was deeply disturbed by the public hostility towards the British authorities. 'You should thank your benevolent Government, which thinks more about your health than you do', he wrote, 'and without them there would be no such public measures which would prevent the plague from spreading to parts free from it'.<sup>116</sup> He wrote *al-Ṭā'ūn* within a year of the assassination of a plague official in Puna, W.C. Rand, and he lamented that a party of educated people in Puna (led by Bal Gangadhar Tilak, perhaps) had opposed the measures in 'the most deplorable fashion'.<sup>117</sup> As David Arnold has pointed out there was often a strong class element in discourse that emerged on plague, as the attitudes of the middle-classes reflected in the press scorned the 'superstitious beliefs' and 'ignorance' of the masses, while advocating western sanitary practices.<sup>118</sup> A classist and paternalistic element is also present in Ajmal Khan's writing here: popular opposition was 'ignorant aversion'; the country was 'far from the light', and educated people like himself had a responsibility to lead others from darkness to the light of sound practice and knowledge,

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<sup>114</sup> *Ibid.*: 'Tumheñ cāhīe kih us ke kḥaufnāk natā'ij ko is risāle meñ parh kar apne ṣiḥat ko us ke muhlik ḡarar se mahfūz rakho. Tum apnī tamām cizon kā intizām karo. Tum apne aur apne ghar ke muta'alliq ḡarūr intizām kar sakte ho lekin mulk se vabā ko dur nahīñ kar sakte'.

<sup>115</sup> *Ibid.*, p. 8.

<sup>116</sup> *Ibid.*, p. 7: 'Aur is bāt ke liye tumheñ apnī meherbān ḡaurnamāñ ka shukr ḡuzār honā cāhīye, jo tum se ziyādah tumhārī ṣiḥat kā kḥayāl kar rahī hai, aur jis ke ba-ḡhair ko'ī aisi 'ām tadbīr hargiz nahīñ ho saktī, jo vabā ko Hindūstān ke in ḥiṣṣon meñ nah phelne deñ jo ab tak us ke aṣr se mahfūz haiñ'.

<sup>117</sup> *Ibid.*

<sup>118</sup> Arnold, *Colonizing*, p. 225.

constituted by European sanitary measures cohabiting with unani precepts and guidelines for treatment.<sup>119</sup>

Nevertheless by emphasising sound knowledge and deprecating ‘ignorance’, Ajmal Khan was tacitly engaging in a dialogue with popular conceptions of the disease and associated practices. The physical realm of cause and effect was the only realm in which he was going to operate, pointing to the care of the body and the physical environment as a life or death issue. This is the transformation that he was preaching: the writings of *tibb* should be concerned with engaging with the public in their day to day activities, in their intimate spaces, in making them better people. In the place of common, intrusive procedures like bloodletting, Ajmal Khan favoured gentle prevention and treatment – personal hygiene and sanitation, cooling, heart-fortifying medicines, cooling, bitter food and cooling drink and the medicinal use of scents. These were practices which were not necessarily mediated by the *hakīm* and which people could take up in their own lives and environments. This kind of engagement coincided with other reform movements opening up fields of Islamic learning to new target readerships in Urdu, like Ashraf Ali Thanavi’s *Bihishtī Zavar*, a product of scripturalist Islamic reform intended for a female readership/audience. It was a message delivered in the crisis of plague, but it was born from broader societal concerns and was clearly meant to have wider implications for the role of unani literary enterprise in *tibb* and society.

## II. Social Pressures and the Contingency of Medical Knowledge: Contagion, Segregation, and Inoculation

In this and the subsequent section we explore how *hakīms*’ relationships with western medical intervention and the public played out in practice. The day to day coverage in the press of the early years of the plague, as well as the insights into indigenous practices in government reports on plague in rural Punjab reveal areas of great tension in the

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<sup>119</sup> Ajmal, *Tā’ūn*, p. 7.

profession. They throw light on how *ḥakīms* negotiated their own traditions and the exigencies of the time. Plague presented constraints for indigenous practitioners but also opportunities, for recognition, employment and as the guardians of the cultural authority of medical practice. It also presented the dilemmas of collaboration with the British in relation to public approval, as well as the tangible perils of treating the sick.

Prior to the state inoculation campaigns which began in earnest in the Punjab in 1902, of all the plague regulations segregation was the most contentious. This was especially so where it was effected with compulsion. The motive for segregating the sick from the healthy derived from ideas of contagion then current among the British medical authorities. Although bacteriological models of disease were becoming influential throughout the 1890s, and Kitasato and Yersin had identified the plague bacillus in Hong Kong before the plague broke out in India, the mode of transmission of the disease was not understood in this way when the Epidemic Diseases Act was promulgated in India in 1897. Prevailing ideas revolved around the production of 'germs' in miasmatic conditions, which could be transmitted from person to person. Thus, in these early years, some possibility on a conceptual level for common ground between *ḥakīms* and European doctors did exist. However, if *ḥakīms* accepted contagion then they would also have to condone segregation, which in the early years would prove highly unpopular with the public at large. Nevertheless, the stark reality of the spread of the disease among persons of the same household, or the same locality must have been powerful evidence for the perception of its potential to be transmitted. We can thus expect to find contesting ideas on this subject.

The issue of contagion was addressed by several *ḥakīms* in the press. The opinion of one Hakim Muhammad Asmatullah Sufi of Amritsar was evidently shaped by his observation of plague control measures. 'Bubonic plague' he wrote, 'is not a contagious disease and the fact that the plague officials seem to enjoy perfect immunity from it is a proof of this'.<sup>120</sup> He added that therefore, 'quarantine and segregation cannot ... prove of any help in stamping out the plague'. This *ḥakīm* did not go so far here as endorsing the widely held view that Europeans somehow spread the disease, but he was seeking to

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<sup>120</sup> *Public Gazette*, 24 April 1900, Punjab, *Native Newspaper Reports* (henceforth *NNR*).



explain the apparent immunity of Europeans to the plague.<sup>121</sup> The *hakīm* went on to claim that segregation from one's near relatives in different stages of the disease actually increased its virulence, and to label it as 'inhumane'. There is no communal identification here, simply an appeal in universalist terms to appropriate humane conduct; he was making a point which would have had popular appeal.

Similar issues were addressed in a series of communications by Hakim Mian Muhammad of Rampur published in the popular Lahore-based Urdu newspaper *Paisa Akhbār* in 1898. While concurring with the understanding of the disease by the government's medical advisers, he nevertheless took issue with the government over segregation: 'since it has been admitted that the plague is generated by impure air, no amount of segregation can stamp out the disease'.<sup>122</sup> The *hakīm* thus maintained the miasmatic nature of the disease but denied it any contagious power. This amounted to an endorsement of disinfective measures alone, which, he recommended, should consist of fumigating houses with sulphur and cleaning wells. He also advised that there should be 'no migration from infected areas'. This line resonates with advice on the plague given in Islamic *ḥadīth*, the sayings and actions ascribed to the Prophet Muhammad and his companions. The following tradition on plague is found in the *Jāmi' al-Ṣaḥīḥ* of Bukhārī (d.970): The Prophet said that if you hear of plague in a land do not enter it; but if it breaks out in a land and you are already there do not leave in flight from it (*ḥadīths* 32, 33, 34). In this tradition there is an implicit recognition of the contagiousness of plague that perhaps sits awkwardly with the *hakīm*'s earlier pronouncement based on miasmas, but Hakim Mian Muhammad did not resolve this. The statement reveals the existence of sources of authoritative knowledge of the plague in which the boundaries between Islamic interpretations of plague and those derived from Galenic medicine were blurred. We shall deal at greater length with some of the implications of this below.

The issue of contagion was taken up more explicitly in the report of the *Shahna-i Hind* (Meerut): 'according to European, Hindu and Muhammadan systems of medicine bubonic plague is a contagious disease and the segregation of the plague patient and the

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<sup>121</sup> Arnold, *Colonizing*, p. 224.

<sup>122</sup> 3 March 1898, Punjab, *NNR*.

improvement of the sanitary arrangements are necessary to check its spread'.<sup>123</sup> Contagion *could* be justified in unani *ṭibb* through recourse to the miasma, although it is an entirely different concept than the bacteriological understanding based on the rat flea as vector of the plague bacillus, first theorised by the French bacteriologist P.L. Simond in 1898, and verified by Glen Liston in 1906. In early Islamic societies the concept of '*adwā*, (most frequently found in nineteenth- and twentieth-century unani discourse in its adjectival form *muta* '*adī*), connoting a sense of contagion/infection was prevalent,<sup>124</sup> although it did not become an established concept in unani literature on plague. Even without referring to the ancient term '*adwā*, Hakim Ajmal Khan, as we have seen, supported the notion of contagion in a miasmatic framework: the spread of putrefaction through the pores of the skin and inhalation, similar in fact to the views held at the time by many of the British medical administrators mentioned above.

Nonetheless, contagion was a fractious issue, one in which much was at stake in a practitioner's relationship with the public. As the same paper declared just two months later: 'The circumstances attending the spread of the plague show that it is a contagious disease, though hakims or native physicians still persist in calling it non-contagious from selfish motives lest they should lose their credit in the eyes of the natives'.<sup>125</sup> The position that *ḥakīms* were adopting with regard to contagion was certainly shaped by the widespread aversion to segregation. While there was evidently no sense of consensus among *ḥakīms* about contagion, the exigencies of plague did bring *ḥakīms*, and also *vaid*s, together on a local level where they did try and find a common voice. On the tenth of April 1898, it is reported that the *ḥakīms* of Lahore met at the house of Munshi Muharram Ali Chishti. They came to a joint conclusion that 'segregation serves no good purpose, beyond putting the patients and their relatives to unnecessary hardship and trouble'. And furthermore, 'they [i.e. the *ḥakīms*] are better able to combat the plague than the European doctors'.<sup>126</sup> *Ḥakīms* played on the much contested question of the segregation of women to validate their methods of care: 'all classes of people complain that the *pardah* of females is not respected by Doctors & co'. They therefore suggested

<sup>123</sup> 1 March 1898, NWP, *NNR*.

<sup>124</sup> Conrad, 'Epidemic', p. 83.

<sup>125</sup> *Shahna-i Hind*, 16 May 1898, N.W.P., *NNR*.

<sup>126</sup> *Paisa Akhbār*, 13 April 1898, Punjab, *NNR*.

that the segregation of the sick should be in 'compounds' or in 'specified rooms' of their own houses, where *ḥakīms* would be able to attend them without violating family honour.<sup>127</sup>

As contentious as the question of segregation was inoculation. In 1902 Charles Rivaz, the Lieutenant Governor of the Punjab, introduced the Punjab Plague Inoculation Scheme, using a medium which had been developed in the laboratory of Dr. Haffkine in Bombay. Reports in the press reflect the mixed reception that the scheme received. The *Paisa Akhbār*, the *Victoria Paper* of Sialkot and the *Ghankhvār-i 'Ālam* of Lahore all published articles in favour of inoculation as 'the best preventive measure', although it was decried that 'the ignorant among the people seem loth [sic] to get themselves inoculated'.<sup>128</sup> Rumours were rife that inoculation lead to death, the loss of eyesight and virility. Nevertheless, large numbers of people began to be inoculated, amidst accusations that the authorities had compelled them.

As with the issue of contagion, the responses of *ḥakīms* to the inoculation programme varied. A report on plague in rural Punjab remarked that one of the first to get inoculated in the village of Garhshankar was an elderly *ḥakīm*.<sup>129</sup> At a meeting in Lahore, 'largely attended by Hindus and Muslims' Hakim Ghulam Nabi made a speech on the advantages of inoculation.<sup>130</sup> Hakim Ghulam Nabi, who had obtained the highest qualification in *ṭibb*, '*Zubdat al-ḥukamā*' ('the best of the physicians') from Oriental College, Lahore, also underwent training in Lahore in western medicine. He was also employed there as a municipal commissioner. He wrote numerous works *on ṭibb*, three in Urdu specifically about plague in which he described causes, treatment and prevention, and one in Persian where he had selected sections on plague from western doctors and various Persian unani sources.<sup>131</sup> In one of his Urdu works, *Tā'ūn aur uskā 'Ilāj*, he made his own position clear combining nascent bacteriological conceptions with miasmatic unani theories in order to explain contagion. He argued that unani *ṭabīb*s who did not accept the existence of germs (*ajrām*) could not account for the numerous examples of

<sup>127</sup> *Umballa Gazette*, 3 May 1898, Punjab, *NNR*.

<sup>128</sup> *The Sialkot Paper*, 8 October 1902, Punjab, *NNR*.

<sup>129</sup> James, *Report*, p. 141.

<sup>130</sup> *Raftiq-i Hind*, 4 October 1900, Punjab, *NNR*. Ghulam Nabi, *Inoculation*.

<sup>131</sup> Hakim Ghulam Nabi, *Hirz-i Tā'ūn*, Lahore, n.d.

places where extremely unsanitary conditions prevailed but plague did not occur.<sup>132</sup> Ghulam Nabi thrived during the plague outbreak producing medicines and disseminating his written works on plague. According to the *Chaudhvīn Sadī* (Rawalpindi), he had ‘discovered a specific which has been extensively used and has cured about half of the patients to whom it has been administered’.<sup>133</sup> The phial of the specific was being sold for one rupee, but the *ḥakīm* had ‘distributed thousands of these and large numbers of the copies of the aforesaid pamphlets gratis’.<sup>134</sup> Apart from his individual enterprise he worked in Lahore’s administration and favoured the government’s plague operations. He considered segregation (*qārānīnah*) a necessity, and hoped for the success of Haffkine’s serum in inoculation programmes.<sup>135</sup> Hakim Ghulam Nabi succeeded in occupying a middle ground, where he could lend his medical authority to support the government, and market unani drugs for plague. Holding public office, his authority was, however, based neither exclusively on the regard on his qualities as a unani practitioner, nor the regard in which he was held by other *ḥakīms* and the public.

Other prominent *ḥakīms* opposed the inoculation programme. *The Public Gazette* of Amritsar reports on twenty-ninth October 1902, of an open meeting that followed a conference organised by the Deputy Commissioner of Amritsar in which the benefits of inoculation were explained to the invitees – gentry, journalists and physicians. This event was indicative of a shift in plague policy in British India following the initial rioting that sought to use indigenous elites to assist the government in the public acceptance of plague measures. In this particular instance it was a prominent local *ḥakīm* who scuppered the show. After speeches were held in praise of inoculation, the extract continues: ‘Hakim Abu Turab got up and opposed the measure, thereby rendering the meeting a failure. The Hakim based his opinion on a certain medical work and asserted that inoculation had in nowise proved efficacious’.<sup>136</sup> Later meetings at other wards offered ‘no better result’. Hakim Abu Turab had set up a school in Amritsar where he taught *ṭibb* and religious subjects.<sup>137</sup> One can conjecture that his opposition was at least

<sup>132</sup> Hakim Ghulam Nabi, *Ṭā’ūn aur uskā Insidād*, Lahore, 1898.

<sup>133</sup> 15 April 1902, Punjab, *NNR*.

<sup>134</sup> *Ibid.*

<sup>135</sup> Nabi, *Ṭā’ūn*, pp. 51 f., 67 f..

<sup>136</sup> *Public Gazette* (Amritsar), 29 October 1902, Punjab, *NNR*.

<sup>137</sup> Hakim Ferozuddin, *Rumūz al-Aṭṭibbā*, 1911, p. 399.

influenced by public aversion and his position as a leading figure in Amritsar's unani circles. He would not have wanted his reputation to be sullied in the same way that Hakim Abdulmajid Khan had suffered a few years previously. Hakim Abdulmajid Khan, the founder of the Madrasa Tibbiya in Delhi, had been approached by the Commissioner of Delhi to intercede on the administration's behalf to allay public fears over plague operations and to try to prevent a mass exodus. Abdulmajid Khan was considered 'the most influential man in the city'.<sup>138</sup> But perhaps as a result of his alignment with the British he suffered abuse for 'supporting the Government...following the Christians', as had been written on a placard on the Delhi Clock Tower.<sup>139</sup>

Although it is highly doubtful that this particular episode had any lasting impact on Abdulmajid Khan's status, the prospect for a practising *vaid* or *hakīm* collaborating with the plague officers was nevertheless fraught. In the case of one *vaid*, Pundit Shiva Ram Pande, the setbacks that his practice suffered after he reported plague cases to the authorities, were perhaps mitigated by his subsequent employment by the Municipal Board.<sup>140</sup> Hakim Abu Turab's success in challenging inoculation at the public gathering in Amritsar was soon overshadowed by an event that made a far longer lasting impression on public attitudes to inoculation. Less than one month later the inoculation disaster of Malakwal, in the Punjab, occurred: 19 of those inoculated died of tetanus. A report on plague in the Punjab for 1910 revealed that people some eight years later still had little confidence in the measure: 'inoculation, though a splendid means of individual protection, cannot be used to check an epidemic owing to popular prejudice'.<sup>141</sup>

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<sup>138</sup> Quoted in Arnold, *Colonizing*, p. 235, *Akhbār-i Ām* (Lahore), 1 March 1898, Punjab, *NNR*.

<sup>139</sup> Quoted in Catanach, 'Muslims', p. 97.

<sup>140</sup> *Natya Patra* (Allahabad), 1 May 1902, NWP, *NNR*.

<sup>141</sup> *Report of the Punjab Plague Committee*, 1910, p. 1.

### III. Plague and the Legitimacy of Unani Practice

If the interventionist policies of the state presented challenges to the authority of *hakīms*, they also afforded great opportunities. The fear and suspicion which the government's policies often provoked led to a clamour in the press for state recognition and support for indigenous medicine in general, and the consultation of *hakīms* and *vaid*s in the framing of plague regulations in particular. Arguments along this line were pitched on various levels. Some drew especially on the failure of the government's policies to stem the plague. The *Jāmi' al-'Ulūm* of Moradabad, whose editor was soon to be arrested for the paper's coverage of the plague under the newly passed sedition laws, published the following: The editor demanded why

should not [the government] allow [the people] to have recourse to native hakims. If the doctors knew of an efficacious remedy, the people might put up with the loss of caste, honour and wealth out of a desire to save their lives. But when they are helpless why should they be forced to give up the ghost with the assistance of these ignorant men?<sup>142</sup>

Other modes of reasoning in favour of *hakīms* employed notions of compatibility. This could be either on medical grounds or in terms of custom. So we find the frequent assertion that 'native hakims' understand 'native constitutions', and are therefore more successful in treatment than European doctors, which was a very common refrain.<sup>143</sup> Ecological arguments were also adduced to validate the practice of indigenous medicine, based on the special relationship between the land, the plants, the climate and the people, as in the following: 'English medicines are based on experiments in a cold country, they are not suited to inhabitants of hot India'.<sup>144</sup> These arguments were not exclusive to plague, but found a particular resonance to explain why people do not, or should not, take English medicines to combat plague. They were based ultimately on the concept common

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<sup>142</sup> 21 March 1897, N.W.P., *NNR*.

<sup>143</sup> For example, *Lahore Punch*, 31 March 1897, Punjab, *NNR*.

<sup>144</sup> *Prayag Samachar* (Allahabad), 9 November 1899. N.W.P., *NNR*.

to unani and ayurveda of mutual habituation, of people, the produce of the land and the environment, and were used in a great range of legitimacy contexts. It was frequently asserted that English medicines were too hot, too powerful and too fast acting for people accustomed to the heat of India.

The accessibility of patients was another ground of preference. *Hakīms* and *vaid*s 'are the usual medical advisers of the country' and 'they have free access into the houses of the people, the rich as well as the poor'.<sup>145</sup> *Hakīms* potentially stood to gain from the widespread opposition to English doctors and plague officials (labelled on one occasion as 'emissaries of death' on another as 'executioners'), against whom suspicion was heightened through their apparent 'immunity' to the plague. In the wake of the riot in Garhshankar in 1898, in which nineteen people died, the government is reported to have relented on the question as to whom patients were at liberty to consult, permitting its residents 'to place themselves under the treatment of whomsoever they like'.<sup>146</sup> The editor of the *Sialkot Paper* confirms the poignancy of this issue, adding that most of the plague riots that had taken place were because of 'people having been compelled to place themselves under the treatment of Doctors against their will'.<sup>147</sup>

Government reports on plague in the Punjab consistently remark on the popularity of indigenous practices over western medicine at this time. Dr. Fateh Chand, for instance, one of the plague officers in Ludhiana commented that 'throughout the epidemic [in 1901-1902] the European method of treatment was not given', while the main treatment offered by *hakīms* consisted of applying leeches to the buboes, cupping and scarification.<sup>148</sup> In Lahore district for the same period no European medical treatment was accepted by plague patients.<sup>149</sup> Nevertheless, we should caution here that resort to English medicines was not eclipsed by any means. There are numerous reports in the press of *hakīms* prescribing English medicines. The *Rohilkhand Gazette* remarked, for instance, that 'it is a very common practice among native physicians, and even druggists,

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<sup>145</sup> *Sialkot Paper*, 24 May 1901, Punjab, *NNR*.

<sup>146</sup> *Akhbār-i 'Ām*, 27 May 1898, Punjab, *NNR*.

<sup>147</sup> 24 May 1901, Punjab, *NNR*.

<sup>148</sup> E. Wilkinson, *Report on Plague in the Punjab*, Oct. 1901 – Sept. 1902, pp. 56, 61.

<sup>149</sup> *Ibid.*, p. 73.

to freely prescribe strong English medicines like antifebrine, which are prescribed even by experienced doctors with extreme caution'.<sup>150</sup>

Sources also suggest that *hakīms* and *vaid*s were actually being employed at a local level by the state in the implementation of the plague programmes. Concessions to indigenous practitioners in the Punjab seem to have been made at various points during the first decade of the outbreak. The *Siālkoṭ Paper* in its comments on Rule 18 in the revised plague rules issued by the government in 1901, according to which the opinions of *vaid*s and *hakīms* were to be granted in the examination of persons suffering from plague, lamented that the Health Officer's opinion was final.<sup>151</sup> The following report in the same paper in November of that year, when plague was beginning to worsen in the Punjab, seems to reflect a popular perception that becoming a *hakīm* could lead to employment: '[The *Siālkoṭ Paper*] alleges that several persons who have never practised medicine and have passed no medical examination have applied to the local Municipality for employment as *hakīms* in connection with the plague administration'.<sup>152</sup>

The training of *hakīms* was in transition during this period. The Oriental College in Lahore had been offering tuition in *ḥibb* leading to qualifications equivalent to licentiate and masters degrees from 1872, classes which were later taken over by Lahore's Islamiya College (see Chapter 3). Those 'few' *hakīms* 'who possessed diplomas of the Punjab University testifying to their having passed the required examination', were requested to present themselves for employment on plague duty by the Punjab administration in June 1902.<sup>153</sup> At this time institutional qualifications had yet to be accepted as equally legitimate as hereditary practice, and only very few would have passed through the course. Therefore it is of no surprise that the invitation by Lahore's Deputy Commissioner to local *hakīms* was met with apparent misunderstanding and a large number of people turned up.

Demand for indigenous practitioners must have risen dramatically in the plague outbreak as people sought out available treatments. As demand rose so did the prospects of custom for those without any medical experience. Although before the plague outbreak

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<sup>150</sup> 24 August 1901, NWP, *NNR*.

<sup>151</sup> 1 May 1901, Punjab, *NNR*.

<sup>152</sup> 16 November 1901, Punjab, *NNR*.

<sup>153</sup> *Rafiq-i Hind* (Lahore), 1902, Punjab, *NNR*.



there had been intermittent calls in the press for government action over incompetent *vaid*s, *hakīm*s and homeopaths,<sup>154</sup> as plague took hold the number of complaints rose dramatically. While the press called for the encouragement of indigenous medicine, and the consultation of *vaid*s and *hakīm*s in the framing of plague regulations, these exhortations were frequently tempered by the perceived need to distinguish the competent *hakīm* from the opportunist. The *Mashīr-i Şulţanat* (Budaun) for example pressed the government to ‘improve and encourage the unani system, granting *sanads* or diplomas to able hakims...and forbidding incompetent physicians, who are responsible for the deaths of a large number of people, to practise’.<sup>155</sup> The *Hindūstān* (Kalakankar) called for ‘a prescribed exam for unqualified hakims and vaid’s, and observed how during plague ‘native physicians were extorting their fellow countrymen’, but assured its readers that the well-known *hakīm*s and *vaid*s were ‘not inferior to doctors in their knowledge of medicine’.<sup>156</sup>

The press also voiced concern over *hakīm*s ‘innocent of all knowledge of medicine’ who used the print medium to market their products. The number of ‘advertising hakims’ the *Akhbār-i Ām* lamented in 1898 was ‘daily on the increase’. Reports in the press suggest that the problem was further exacerbated in the Punjab when the administration relaxed their attitude to the consultation of indigenous practitioners: ‘Since the change in government policy, leaving people to place plague patients under the treatment of whomsoever they like, quite a host of quacks have sprung up in different parts of the Punjab’.<sup>157</sup>

It should be noted however, that ‘quacks’, and for that matter any *hakīm* or *vaid* who personally attended to plague patients, were willing to take considerable risks (that for plague officials were mitigated by inoculation and rigorous protective measures), which understandably prevented many indigenous practitioners from coming into contact at all with plague cases. But in spite of these risks many did treat plague patients. One woman from the chamar caste (one of the ‘untouchable’ castes) acted as a *hakīm* in plague cases in a village Rasulpur in Jullundur District (Punjab), scarifying people where

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<sup>154</sup> *Bhārat Jīvan*, 27 November 1893, N.W.P., *NNR*.

<sup>155</sup> 11 January 1898, N.W.P., *NNR*.

<sup>156</sup> *Hindūstān*, 21 April, 31 August 1899, N.W.P., *NNR*.

<sup>157</sup> *Public Gazette* (Amritsar), 24 November 1902, Punjab, *NNR*.

bubonic swellings would appear.<sup>158</sup> She soon succumbed to the disease, as did the leech-woman of the village of Bilron, Mussamat Bakhtwari, and as did a *vaid* Nathu. Fellow villagers held in a segregation camp with Nathu castigated him for having brought the plague to their village after unlawfully crossing a government imposed cordon to treat patients in another village.<sup>159</sup> We see in these cases, as in many others, that the motivation, whether among formal or informal practitioners to treat plague was not just about making money, as alleged in the press, but also about a sense of performing a duty to help others in need.

The particular policy changes in the Punjab may have given the issue of ‘quackery’ particular prominence and a local complexion, but learned *hakīms* throughout India were keen to distance themselves in their public discourse from the activities of ‘*jāhil*’ (ignorant) *hakīms*. For *hakīms* in British India attempting to secure support for unani schools the activities of the unregulated sector of indigenous practitioners threatened to compromise their professional reputation. Efforts to define the boundaries of *ṭibbī* practice along the lines of institutionalised colonial medicine were already under way by the last decade of the nineteenth century. Thus, one of the four aims for establishing the Madrasa *Ṭibbiya* in Delhi had been to ‘[do] away with the unqualified Tabibs who infect the various parts of India to the greatest detriment of the health of the inhabitants’.<sup>160</sup> Likewise some years later the Punjab *Ṭibbī* Conference, a local branch of the All India Vedic and Unani Tibbi Conference, called for regulatory measures to be imposed on practising *hakīms*. But even where state support was substantial and guaranteed, as in the case of Hyderabad, learned *hakīms* felt the need to counter the rise especially of ‘advertising *hakīms*’, who represented a challenge to the conventional modes of legitimation and practice among learned practitioners, and undermined the reputation of the profession in the eyes of the public. The origins of this form of ‘unani’ practice lie with the harnessing of print technology and the changing political economy of medicine in India during the late nineteenth century. The plague, however, made this phenomenon more acute.

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<sup>158</sup> James, *Report*, pp. 78.

<sup>159</sup> *Ibid.*, pp. 85, 92.

<sup>160</sup> Ajmal Khan, *The Scheme of the Ayur-Vedik and Unani Tibbi College*, 1911.

#### IV. Representing Knowledge: Hakim Altaf Hussain of Hyderabad on the Plague

One means of challenging the culture of the 'illegitimate' *hakīm* during the plague outbreak was to write a treatise on plague in which the learning and experience of the *hakīm* in the classical tradition could be expressed, the shortcomings of advertising practitioners, and setting itself apart from less authoritative pamphlets which flourished during the 1910s and 20s. This I believe was one of the prime purposes of Hakim Altaf Hussain's contribution to unani literature on plague, written in 1918, ten years into his employment as the chief medical officer (*Afsar al-ʿAṭibbā*) in the unani administration of the Hyderabad government.

Born in 1852, Hakim Altaf Hussain acquired his knowledge of *ṭibb* from his father, Hakim Mir 'Inayat Ali Khan, one time private physician to the Maharaja of Nagpur, and experience in his father's clinic in Hyderabad.<sup>161</sup> He was known for his sound knowledge of Arabic and Farsi but also Telugu.<sup>162</sup> Such was his reputation that he was reportedly called upon to treat the two sons of the sixth Nizam Mahbub Ali Khan, Salabhat Jah and Basalat Jah in their youth.

The tone of Altaf Hussain's work, *Mufīd Khalā'iq* ('for the benefit of the people') very much reflects the responsibilities he had as the official representative of *ṭabīb*s in Hyderabad. He is deferential to the Nizam, the British authorities and the police in Hyderabad for their handling of plague outbreaks in the city. There had been public agitation and suspicion over the implementation of plague measures in many districts where plague broke out repeatedly from 1897, and also in Hyderabad city where plague made its first major appearance in 1911. In the 1911 outbreak, the Resident Colonel Pinhey reported on 'an assault by a large mob of men of various castes and professions' on two local policemen on plague duty accused of sprinkling poison on the roads, commenting that this was 'only one of many instances ... of a spirit of lawlessness in the City, which if not speedily suppressed with a strong hand will certainly spread, as it is

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<sup>161</sup> Hakim Shifa Hyderabadī, *Tazkirah-yi Aṭibbā-yi 'Ahd-i 'Uṣmānī*, Hyderabad, 1952 p. 13.

<sup>162</sup> *Ibid.*; Ghulam Samdani Khan, *Tuzk-i Mahbūbiya*, Hyderabad, 1903, pp. 12-13.

undermining the authority of the police'.<sup>163</sup> But in Hakim Altaf Hussain's work there is no reference to the controversial aspects of the authorities' handling of plague. Here we have the voice of a professional, learned practitioner in an exposition that only develops themes at the core of a unani interpretation of the disease, in terms of causes, signs and treatments. Nevertheless, Hakim Altaf Hussain set his account of the disease apart from others by emphasising its foundation on his own experience of plague and patients during outbreaks in the city in which he claimed to have successfully treated 1822 people afflicted by plague.

His own experience was in fact interpreted very much in the light of conventional conceptions of the disease in *tibb*, its causation and its pattern of proliferation, even if a certain elasticity in his diagnoses (the boundary between high fever and plague seeming on occasion to be blurred) may partly account for this rather impressive statistic. Hakim Altaf Hussain's 'own researches' had determined that poisonous vapours emitted from the earth, were the root cause of the disease, not emanations from the heavens, as some ancients had written.<sup>164</sup> In this explanatory model putrefied and corrupted air rises from the earth, enters the body through the nose and mouth, proceeds to the heart and is then passed on to the liver and the brain, which together with the heart comprise the tripartite principal organs (*a'zā ra'isīyah*) of the body in the unani view. The passage of the disease to organs that govern life is swift, so the affected body has to be treated early if it is to be cured. The *hakīm* emphasised early treatment to fortify the heart but especially prophylaxis. The rationale for this was intimately connected to the conception of the disease outlined above and was also related to a fundamental principle in unani *tibb*, the role of resistance of the strong body, the *quwwah mudabbirah*, or the *vis medicatrix naturae* (the regulating power of nature).

The framework for Hakim Altaf Hussain's discussion of the disease is purely natural causation. The behaviour of animals is one of the signs of the presence of plague-causing air. Mongooses, rabbits and rats start to die because they, as burrowing creatures, are the first to be overcome by the toxic wastes of the earth. Their death in this reasoned explanation is proof of the production of localised earthly poisons, and 'this for man is a

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<sup>163</sup> Letter Pinhey to Kishen Parshad, 5 November 1911. Andhra Pradesh State Archives (henceforth APSA), Instalment 22, List 8, Serial 10.

<sup>164</sup> Hussain, *Mufīd Khalā'iq*, Hyderabad, 1336 Hijri (1918), p. 6.

means of communication from nature that anyone who is able to keep away from this place will in my opinion be spared [the disease] in most cases; to keep away from danger is a general principle of unani *tibb*'.<sup>165</sup> Nature could almost be transcribed with a capital 'N', since it is endowed with an agency that others might easily ascribe to God; in this tract the *hakīm* adheres closely to the Hippocratic-Galenic tradition of seeking answers to human suffering in the physical environment.

On the question of the communicability of plague Hakim Altaf Hussain had 'seen with his own eyes' that if someone dies in a room others will die from coming into contact with the patient and the room.<sup>166</sup> This grasp of the transmission of plague is explained as the emission of the toxic wastes from the patient's body and breath that mix with the surrounding air and produce the same sickness when inhaled by another, 'just as if there is an aloe candle to give light and then its fragrance fills the room'.<sup>167</sup> The *hakīm* grappled with this notion of transmission and accommodated it within a conventional unani aetiology. He had to explain why plague did not affect all people breathing the same air equally, why in the same locality some contracted the disease while others did not. As he says '[I have seen people], for example, who have taken plague patients in their laps and were not separated from them from the first day to the last day of their illness, and they did not get the disease'.<sup>168</sup> He explained it by viewing the health of the body as the ultimate arbiter of the patient's fate. If the blood was free from impurity and the heart strong then the body could deal with the toxicity of the disease. He attributes susceptibility to plague to an impurity of the blood of the patient, a *qābilyat-i jazb* (an attracting quality) which draws the toxicity towards it rather than repelling it. Similar concepts of predisposition to plague had been elaborated by physicians in the Greco-Islamic tradition in West Asia and Andalusia contemporary with the Black Death, notably by two Andalusian physicians Ibn al-Khāṭib and Ibn Khatīma.<sup>169</sup>

<sup>165</sup> *Ibid.*, pp. 10-11: 'yeh insān ke li'e ek qudratī ṭīlā' kā zarī'ah hai pas jin ashkhāṣ ne us maqām se 'alāhidagī ikhtiyār kī mere khayāl meṅ ek ḥadd tak voh mahfūz rahe, maqām maḥdūsh se 'alāhidagī ikhtiyār karnā uṣūl-i ṭibb-i yūnānī kā 'ām qā'idah aur ihtiyāṭī kā muqtaṣā hai'.

<sup>166</sup> *Ibid.*, p. 24.

<sup>167</sup> *Ibid.*: 'Miṣāl us kī aisī hai kih agar ek makān meṅ 'ūd batī roshan kar dī jā'e to uskī khūshbū se tamām makān kī havā mu'aṭṭar ho jāī hai'.

<sup>168</sup> *Ibid.*: 'dusre aise ashkhāṣ bhī dekhe ga'e hain jinke god meṅ ibtidā'i maraṣ se ākhir dam tak marīz 'alāhidah nah rahā unheṅ kuch bhī nah huwā'.

<sup>169</sup> Dols, *Black Death*, p. 74 f.

Activities that stimulated the blood and overexcited the temperament, such as sex, were to be abstained from, while fumigation with camphor, aloe and other sweet-smelling substances (that strengthen the heart and the brain), ingesting blood purifiers and spreading neem leaves on the floor to repel animals were the main preventive measures. Hakim Altaf Hussain equated unani treatments for strengthening the body to the goal of inoculation, which ‘tries to make the body resist the disease’. In this articulation we see that the *hakīm* was bringing western medicine and *ṭibb* into the same sphere of action. In tune with his non-confrontational stance to the government’s measures, he did not disapprove of inoculation but neither did he especially condone it. Inoculation had been proceeding in the districts since 1898, with plague officials noting that the 78,278 people inoculated in Hyderabad city in 1911 was reported to be highest number of inoculations attained in an Indian city during a single outbreak.<sup>170</sup>

The issue for Hakim Altaf Hussain was to convey that unani treatments were successful in repelling the disease, and that through his vast experience, not only of plague but in treating people on a day to day basis, he was qualified to administer them correctly. The *hakīm* was evidently secure in his exposition of cause, prevention and treatment; it was not the proponents of germ theory, which he does not refer to, that threatened to undermine the foundations of his knowledge and therefore his power, but rather the activities of *ishtihārī aṭibbā*, or advertising physicians, who were exploiting the crisis of plague and radically changing the medical market-place. He remarked on the way people at the time of plague ‘run hither and thither wherever there is a sign “*ṭabīb*”’. His whole learned treatise is to be contrasted with the method of representation and the kind of knowledge of the *ishtihārī aṭibbā*:

During the period of the plague outbreak a great number of ephemeral healers have appeared who are incapable of distinguishing the dry from the moist, and for their own profit they prepare any kind of prescription; the powders of any *ṭabīb*, his pills, antidotes, essences, fumigants, or massage remedies. [They do this] in order that the

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<sup>170</sup> *Report on the Administration of the Nizam's Dominions, 1320-1321 Fasli [1910-1912]*, p. 65.

commendation of their medicines may be printed in the newspapers so they can sell them and profit from them.<sup>171</sup>

The newspaper was not Altaf Hussain's vehicle, rather it was the learned tract in which he could reason through the complexities of this disease and present soundly argued knowledge and guidelines for people's benefit in the rich but not overly obfuscating Arabicised language of natural philosophy. The cultured *hakīm* has the refinement of knowledge that goes beyond the crude and popular dichotomy of hot and cold and discerns the effects of moisture and dryness. But in the context of emerging consumerism the authority of the learned *hakīm* was in danger of being usurped by those who exploited new forms of commercial enterprise. Hakim Altaf Hussain presented this as a physical danger to be borne by the clients/patients resorting to these unsound practices:

Some of these drugs, like cinnamon, violet flowers, *khūb-kalān*<sup>172</sup> and hemp seeds are totally mismatched and are not appropriate for the disease; and these prescriptions contain poisonous elements, like the root of aconite, cinnabar [mercury sulphide] and others which have the inevitable effect of making the patient vomit blood. It is remarkable that [the advertising *tabībs*] boast so brazenly of the effect of their remedy and yet they have no knowledge of the current condition of the patient, what stage the disease has reached and which kind of medicine would be appropriate to administer at this particular time.<sup>173</sup>

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<sup>171</sup> Hussain, *Mufīd*, p. 30: 'Us maraḥ ke shuyū' ke zamānah meṅ hangāmī mu'ālij kih jinko raḥab o yābis kā imtiyāz tak nahīn kaṣīr at-ti'dād paidā ho jāte haiṅ aur apne jalab-i manfa'at kī gharāḥ se ko'ī ek nuskhah tayār kar lete haiṅ kissī ṭabīb kā sufūf kissī ke ḥubūb kissī kī tiryāq aur kissī kā 'araq aur kissī kī dhūnī kissī kī mālīsh kī davā algharāḥ apne adviyāt kī ta'rīf akhbāron meṅ bhī ṭab' kirā lete haiṅ kih farukhat hūn aur naḥ' kar liyā jā'e'.

<sup>172</sup> 'Name of a seed of a cooling quality', J. Platts, *A Dictionary of Urdū, Classical Hindī and English*, reprinted New Delhi, 1997, p. 495.

<sup>173</sup> *Ibid.*, p. 31: 'bāqī adviyah miṣl dār cīnī va gul banafsha va khūb-kalān va tukhm kā sanai bilkul be jūr jisko marāḥ se munāsibat nahīn aur muskhajāt meṅ sammī ajzā miṣl bacnāk va shungarāḥ va ghairah sharīk kī'e ga'e the jiske isti'mal se marīḥ ko khūn kī qai lāzīmī rahtī qābil ghūr yeh bāt hai kih apne ta'sīr davā par isqadr lāf kih adhar faru'e ḥalq huwī kih marīḥ tandurust aur marāḥ zāyil hogayā magar unko yeh nahīn ma'lum kih maujūdah ḥālat-i marīḥ kī kyā hai aur marāḥ isvaqt kis paimānah par pahuncā hai aur kis qism kī davā dene kā isvaqt mauqī' hai'.

He concluded this passage by writing that ‘Only someone can [know such things (and therefore proclaim the worth of his treatments)] who has had hundreds of patients under his care’, which would naturally have included himself and excluded the advertising physicians.<sup>174</sup> The theoretical formulations of his treatise were grounded in a common body of works of *ṭibb* dealing with plague circulating in India at this time, such as Ibn Sīnā’s *al-Qānūn* and Dā’ūd al-Antākī’s *Tadhkirat al-Ṭā’ūn*. He also referred to Ajmal Khan’s work. Nevertheless, the *ḥakīm* viewed the existing unani literature on the plague as deficient for its lack of foundation on personal experience of the disease, something that this treatise replete with tested prescriptions sought to address. The kind of tract that he wrote was itself a statement legitimising the form of knowledge that the *ḥakīm* advocated, i.e. that of the scholarly *ḥakīm*. Senior to Ajmal Khan, Altaf Hussain was not driven to reinvent the elite profession, and the formal codes of literary production. His concern was rather with maintaining distinctions between learned, discerning unani practice and generic, ‘popular’ unani treatments. His condemnation of advertising *ḥakīms* should not, however, be read at face value. Not all *ḥakīms* who advertised were necessarily ‘uneducated’, even if they did not conform to the educational and cultural paradigm of the hereditary practitioner. The enterprising Hakim Ghulam Nabi ‘*Zubdat al-ḥukamā*’ of Lahore, (whom we mentioned above) for instance, advertised a variety of products in Hyderabad’s newspapers in the 1890s, for gonorrhoea, syphilis, constipation, weak eyesight, diabetes among others.<sup>175</sup> Nevertheless, Hakim Altaf Hussain urges caution about the public acceptance of the new forms of unani’s market economy, which were to gain increasing prominence in the years to come. He does not only criticise the lack of the advertising *ḥakīms*’ learning, but points out that this practice is at odds with a fundamental aspect of unani practice: the determination of which medicine to use for the individual’s temperament, a process that demanded the *ḥakīm*’s direct knowledge of the patient, and the *ḥakīm*’s prognosis of the disease.

<sup>174</sup> *Ibid.*: ‘*Hālāt-i maraḥ aur ṭarīqah-yi ‘ilāj ko vahī khūb jān saktā hai jiske zer ‘ilāj hazār hā murazā’ rahe hūn*’.

<sup>175</sup> Hakim Ghulam Nabi operated a mail order service, placing his advertisements in the Urdu newspapers the *Dekkan Punch*, e.g. 17 September 1889, *Haiderābād Dekkan Gazette*, e.g. 26 March 1895.



## V. Plague, Society and the Heavens: The Interface of Classical *Tibb* with Popular Realms

### 1. Plague as Punishment

Learned unani discourse, represented for instance in the works of Hakim Altaf Hussain and Hakim Ajmal Khan, was firmly embedded in the philosophy of natural causation. These *hakims* wanted to speak for the learned profession but theirs were only some of the most prominent voices amid a chorus of others that are less accessible but nonetheless contribute to the rich variety of unani conception and practice. Plague sharply brings into focus some of these other realms of discourse at the margins of and overlapping with the Galenic stream; namely Islam and astrology.

The idea that plague was a form of divine retribution was one that seems to have been popularly entertained, and was certainly commonly ascribed to popular culture. The press frequently referred to 'the people' viewing plague as a visitation from God.<sup>176</sup> As we shall see below, in Islamic learning there was a tradition which accommodated plague within this 'popular' vision of human suffering. The sources for our discussion are articles which appeared in a reputable unani journal of Lahore, the *Rafiq al-Aṭibbā*.

There was evidently demand among the readership of this journal for religious interpretations of the plague. The journal published a letter by one Hakim Ghulam Muhiuddin Faruqi in January 1912 in which the *hakim* argued that the disease was sent by God on account of sin and forbidden practices. By this time plague had become well established in India; as the *hakim* remarked, it had 'taken up residence'.<sup>177</sup> It was in his view not a contagious disease (*maraz muta 'adī muntaqilah*), but rather, he suggested, 'a general disease' (*maraz 'ām*), that is, one that God has visited on all in India. He connected it with other disasters that had befallen Hindustan, like the 1908 floods of the River Musi in Hyderabad, a fire in Madras, acts over which individuals had no control,

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<sup>176</sup> For example, *Oudh Punch*, 25 February 1897, N.W.P., *NNR*; *Anis-i Hind*, 24 March 1897, N.W.P., *NNR*.

<sup>177</sup> Hakim Ghulam Muhiuddin Faruqi, 'Istifsār dabārah Ṭā'ūn o Vabā', ['an enquiry about plague and epidemics'], *Rafiq al-Aṭibbā*, 1 January 1912, p. 27.

and collectivities were punished.<sup>178</sup> Medical explanations were not sufficient for him, they were deflecting people from recognising the real cause of plague. He hoped that those who read his letter in order to understand plague

would not be content only with *ḥibbī* principles, but also on the sound evidence from the holy *Qur'ān* and *ḥadīth* ... May God make clear to them that the roots of plague and epidemics are God's wrath caused by adultery and forbidden acts; it is not a deadly, communicable and contagious disease.<sup>179</sup>

Islam presented in this interpretation a way of denying the power of medicine to explain suffering on such a large scale. This perspective also provided the context in which the commercial exploitation of affliction in general and plague in particular could be criticised. There had been a proliferation of medicines for the treatment of plague, but the *ḥakīm* was not convinced of their success. He remarked that 'various kinds of medicines have been and continue to be invented, but there is no prosperity before the wrath of God'.<sup>180</sup> In support of this he cited an intriguing line of poetry: 'the disease spread as long as medicine was given'.<sup>181</sup> This suggests the idea that peoples' efforts to treat the disease in fact perpetuate the disease, for it is futile, the *ḥakīm* implies, to conceive of disease always in medical terms. This is reminiscent of the concept of *tawakkul* (reliance on God alone), and the refutation of medicine (*tark al-tadāwī*) propagated in ascetic Islam.<sup>182</sup> Clearly this was an extreme position, but for this *ḥakīm* plague was an extraordinary disease.

The tensions that this position entailed for unani treatments of plague were not resolved in the journal. In the same edition there was an elaborate discussion of prescriptions for the buboes that appeared in the glands of the groin, armpit and neck,

<sup>178</sup> *Ibid.*, p. 28.

<sup>179</sup> *Ibid.*, p. 29: 'Umīd hai kih *ghūr farmāne ke ba'd yeh liḥāz rakhā jā'e*. *Ṣirf ḥibbī usūlon par hī qinā'at nah farmāven balkih Qur'ān majīd va ḥadīṣ ke sāth pukka subūt mil jā'e...* [*khudā*] *un ke dilon ko sābit ho jā'e kih tā'ūn ka usūl yeh hai az qism balā hain bā'is qahr-i parvaridgār maujib zinā va ḥarām hain. Marāz muhlik va muntaqila va muta'adī nahīn*'.

<sup>180</sup> *Ibid.*, p. 28: 'Aqsām kī adviyah ijād hū'īn aur ho rahī hain, magar *ghaḥab ilāhī aur qahr-i khudā ke rūbarū kissī kī galī nahīn*'.

<sup>181</sup> *Ibid.*: 'marāz bhartā gayā jūn jūn davā' kī'.

<sup>182</sup> See I. Perho for an excellent discussion of the intellectual context of the origins of this tradition, *The Prophet's Medicine – a Creation of the Muslim Traditionalist Scholars*, Helsinki, 1995, p. 67 f.

which in the *ṭibbī* understanding indicated toxicity in the three major organs respectively: the liver, heart and brain.<sup>183</sup>

The editor of *Rafīq al-Aṭibbā*, Hakim Ferozuddin, a highly regarded *ḥakīm* who participated in national forums for the promotion of *ṭibb*, was nevertheless open to metamedical approaches to plague. In the following and successive issues a series of articles were published in which the explicitly moral/theological approach to plague were extensively dealt with, especially in Hakim Saror Shah's 'Plague and its Prevention'. His account is of further interest because he does not entirely dispense with conventional miasmatic theories, while also subsuming the notion of germs as pathogens within unani frameworks of disease causation. Nevertheless, the view that the *ḥakīm* propagates is of a corrupt society. For Hakim Saror Shah plague was a vehicle by which to challenge the conduct of society that deviated from divine injunction, and tolerated 'adultery, masturbation, sodomy, drinking, and forms of debauchery and sinfulness'.<sup>184</sup> He characterised this view as transcending religious persuasion; it was 'a matter agreed upon not only by each creed and community, but also by philosophy and proper upbringing (*tahzīb*)'.<sup>185</sup>

The *ḥakīm* was ostensibly concerned with the root cause of plague: why had plague appeared in India at this particular time? Exploring the answer to this question led him to subjugate miasmas and germs as derivative causes in a rationale firmly located in the ethical world of a pious gentleman, countering mistaken popular ideas about how to preserve oneself from plague. He developed the argument proposed in an article by a Pundit Mahendra Nath in a previous issue of the journal that some people had mistakenly pursued 'sport and pleasure' as a means of preserving themselves against the plague. These activities allegedly 'strengthened the heart' – the strength of the heart as we have seen is a crucial element in the notion of resistance to plague in unani *ṭibb*. Proponents of this view had claimed that 'market whores' were not susceptible to plague because of their sexual activity. In the *ḥakīm*'s counter to this position, prostitution became the

<sup>183</sup> Hakim Abdurrauf, 'Dastūr al-'Ilāj Ṭā'ūn', ['The procedure for treating plague'], *Rafīq al-Aṭibbā*, 1 January 1912, pp. 17-21.

<sup>184</sup> Hakim S. Shah, 'Ṭā'ūn aur uskā Insidād', *Rafīq al-Aṭibbā*, 16 February 1912, p. 7: 'Va ammā asbāb aṣṭī pas voh aqsām be-farmānīhā'e *khāliq hain*, *miṣl kusrat zinā o jalaq o livāṭat o sharāb khvārī va anvā' fasaq o fajūr va ghairah*'.

<sup>185</sup> *Ibid.*: 'aur yeh bāt har ek mazhab o millat balkih 'ilm-i falsafa o tahzib me bhī musallam o ma'lūm hai'.

symbol of the lapse of society. But at the heart of his reasoning was that plague was part of the colonial predicament of a people who were not able to mete out their own justice. He enumerated the punishments that would be meted out according to *shari'ah* for adultery, but complained that the laws introduced by the British were too lenient. The *hakīm* claimed that an adulterous woman for example would get no more than 6 months imprisonment at most, if at all.<sup>186</sup> The British authorities were blamed for giving brothels licenses. Women were also at fault. He implied that prostitution was a matter of choice for women, 'a way of making a living', and threaded the notion that literate women were at risk, and that this risk was born by the society as a whole:

Readily available obscene writings give precedents of these crimes...hence sins of this kind enter the mind, and because they are not forbidden they have become at this time a cause of caprice among Hindustani women. So why don't they face retribution for these coquettish deeds, and reap the reward for what they have done.<sup>187</sup>

In associating plague with sin Hakim Saror Shah's position was in line with a number of plague treatises of West Asia written by scholars of religio-legal traditions. Ibn Abī Ḥalājah in fourteenth-century Damascus, for example, construed plague as a punishment for sins such as adultery, usury and drinking alcohol.<sup>188</sup> Saror Shah concluded that the women of Hindustan were not to be blamed for the existence of these crimes and obscenities, but the reason for plague did at this time lie with them.<sup>189</sup> Even this association of women, prostitution and plague reflected other religio-legal writings. The fifteenth-century Egyptian religious scholar Ibn Ḥajar al-'Asqalānī narrated how in 1438 Sultan Baybars passed laws to control the movement of women in Cairo after consulting with scholars and jurists on how to stop the plague.<sup>190</sup>

<sup>186</sup> *Ibid.*, 1 June 1912, p. 20.

<sup>187</sup> *Ibid.*: '*Gharẓekih zamānah dūn bad qalamoñ kī 'ām āzādī ne har ek ko jarāsīm peshgī ka sabaq diyā ... pas jo jo aqsām gūnahgārī ke 'aql meñ ā sakte haiñ, bavajh nah hone māni' ke voh sab ke sab is zamānah meñ bī Hindūstān kā māyah-yi nāz ho cuke haiñpas kyon nah yeh nāznīn apne kartaboñ kā khamyāzah uthā'e aur ki'e hū'e kī phal pā'e*'.

<sup>188</sup> Ibn Abī Ḥalājah, *Kitāb al-Ṭibb*, fols. 143b-144b, quoted in Dols, *Black Death*, p. 114.

<sup>189</sup> Hakim S. Shah, 'Ṭā'ūn', p. 21.

<sup>190</sup> Dols, *Black Death*, p. 115.

What marks out Hakim Saror Shah's account, however, is firstly that it is embedded within a critique of justice under the British, and secondly that it related the print medium and the increase in women's literacy as causes for the moral impoverishment of society. Fears for a society in which women were out of control were central to this argument, a position which was common especially among scripturalist Islamic reformers of the time, as we discuss in greater detail in chapter five on the treatment of women in *ṭibb*. Although the interpretation here was Islamic we should emphasise that the idea of the moral decay of society being at the root of the plague was certainly not restricted to Muslim groups. It was, after all a Pundit, Mahendra Nath, who had formulated the argument along similar lines in *Rafīq al-Atibbā*. Moreover, those *vaid*s who sought to find mention of plague in the ancient texts would have been familiar with Caraka's writings that the fundamental cause of epidemics is 'unrighteousness'.<sup>191</sup> As with Caraka, the miasmatic conceptions of plague were thus relegated in Hakim Saror Shah's account to the status of derivative causes. The first step in treatment was therefore repentance, then sanitation, which is itself given overtones of pious ablution, 'the cleansing of the air and the spirit'.

Despite being in tune with elements of popular thought that understood plague as punishment, Saror Shah drew strong criticism from other practitioners for explicitly adducing religious arguments. Seeking to illustrate how God might punish humankind for their misdeeds, Saror Shah cited *ḥadīth* from al-Khāṭib's *Mishkat al-Maṣābiḥ*, although in the tradition which he cited plague itself was not named specifically as the scourge; rather it was famine, earthquakes and a destructive red wind. This particular interpretation of plague drew a critical response from a fellow practitioner in a subsequent issue of the journal. Hakim Sayyid Aḥmed Shah of Bhekampur began his letter by writing that '[s]urely it need not be stated that *Rafīq [al-Atibbā]* is specifically concerned with the art of medicine';<sup>192</sup> he went on to denounce Saror Shah for quoting the *ḥadīth* when the passage clearly had no bearing on medical issues. He wrote, '[do you think] that people will accept this; that those people nowadays in whose brains is the

<sup>191</sup> Caraka on epidemics from the *Caraka-saṃhitā* 3.3, in D. Wujastyk, *The Roots of Ayurveda*, New Delhi, 1998, p. 41.

<sup>192</sup> Hakim Sayyid Ahmed Shah, *Rafīq al-Atibbā*, 1 July, 1912, p. 30: 'Yeh amr to muḥtāj bayān nahīn hai kih Rafīq mukhtaṣṣ ba-fann-i-ṭibb'.

splendour of new light, and who deliberate rationally on every issue, will believe this *ḥadīth*. Never'.<sup>193</sup> By adducing religious arguments Saror Shah was accused of bringing the unani profession in general and the journal *Rafiq al-Atibbā* in particular into disrepute. This episode reveals contestation within *ḥibb* about the commensurability of religious and medical interpretations of disease at this time, the issue of the representation of the profession in a learned 'unani' journal and how authentic *ḥibb* should be conceived.<sup>194</sup>

## 2. Astral Emanations

Not only was there a strong theological component in Hakim Saror Shah's articles, but his treatment of derivative causes showed us how alive ideas of astral influence were at the margins of learned *ḥibbī* discourse. He explained to the 'obstinate detractors' that gases and fumes (*dukhānāt*) are emitted, like light, from the heavenly bodies which then collide with earthly miasmas, corrupt the air and thus bring about the plague. The effects were especially potent as a result of unusual meteor showers, or the passing of comets, or the conjuncture of several fixed stars with the planets. He linked the outbreaks of plague in 1910 and 1911 in Lahore to the large number of meteor showers that coincided. The writer was explicit about how out of favour these ideas were among his peers:

Moreover most recent *ḥabīb*s, some philosophers and unknowledgeable bigots, especially those possessing the new light of the present times, whose truths are mostly conjecture, think that these causes are nothing but fantasy and false prattle, and are always ready to severely repudiate them. Generally most doctors and *ḥabīb*s of the present time are among the group who are of this belief.<sup>195</sup>

<sup>193</sup> *Ibid.*: 'aur mulk ke sab bhā'ī is ko qubūl o manzūr farmāyenge, aur āj jin bā-fahm ḥazrāt ke dimāghon meṅ na'ī roshinī kī jhalak hai aur voh har bāt ko mīzān-i 'aql tūlte haiṅ voh is ḥadīṣ par imān le āyenge. Hargiz nahīṅ'.

<sup>194</sup> See Chapter 6 for further discussion of the journal *Rafiq al-Atibbā*.

<sup>195</sup> Saror Shah, 'Ṭā'ūn', *Rafiq al-Atibbā*, February 1, 1912, p. 11: 'Illā akṣar aṭibbā muta'akhirīn aur ba'z falāsifa yā kam 'ilm mullāyān kḥuṣūṣan zamānah-yi ḥāl ke akṣar nā'ī roshinī vāle (jo akṣar ḥaqā'iq nare andhere ke misdāq haiṅ) un asbāb ko maḥaḥz mauhūmī bāt aur choṭā ḍhakosātā khayāl karte aur sakht

But theories of celestial causation were quite commonly discussed, even in such established unani journals as *Rafiq al-Aṭibbā*. Another contributor to *Rafiq al-Aṭibbā* who wrote on plague and astral influence, Hakim Hussain Allahabadi nevertheless expressed his apprehension at writing about astral causation in this journal. He was conscious of latching on to popular ideas and bringing them into established learned unani discourse, which had its conventions. The editor had asked him to write a long piece about astral influences, but he decided to keep it short, since he anticipated that readers would object

that this is a faulty study because it is going beyond the sphere of the fundamentals particular to the unani art, since the name *Rafiq al-Aṭibbā* means that *ṭibbī* fundamentals should be presented, which should include *asbāb* [causes], *alamāt* [signs] and *mu'ālijāt* [treatments]. I did not even intend to write about this [astral] cause, but I do so obediently and briefly.<sup>196</sup>

But plague was exceptional and it demanded extraordinary events in order to be explained. The *hakīm* had been encouraged to write about this by the editor of the journal, Hakim Ferozuddin, who through his publications was stimulating debate about the place of astral causation in *ṭibb*. In the 1911 first edition of his *Rumūz al-Aṭibbā*, a compendious and fascinating biography of practising *hakīms*, he included a piece by Hakim Ajmal Khan, in which the latter, writing in Arabic, criticised the theory of a connection between celestial particles and the critical periods of an illness. This polemic was part of Ajmal Khan's larger project to contest unani knowledge and power in north India, stimulating criticisms and counter-criticisms as part of the regional rivalry between the Lucknow and the Delhi schools.<sup>197</sup> Hakim Hussain Allahabadi's misgivings about

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*tardīd o inkār par kamarbastah rahte hain. Aur 'umūman akṣar dāktar ṣāhibān o atibbā'e zamān ussī 'aqīdah ke groh se hain'.*

<sup>196</sup> Hakim Maulvi Muhammad Hussain Allahabadi, 'al-Ṭā'ūn Vabā', *Rafiq al-Aṭibbā*, 16 May 1912, p. 18: 'Agar ṭūl dūngā to nazīrīn-i Rafiq ḡhalq mabḥas meṇ paṛ kar dā'irah-yi uṣūl khāṣ fann-i ṭibb se 'alāhidah ho jā'enge. Kyonkih Rafiq al-Aṭibbā kā nām hī is amr ko butlāta hai kih uṣūl ṭibbiya is meṇ daraj honā cāhi'e jin kā shumūl asbāb, 'alamat, mu'ālijāt ko ho. Merā bhī qaṣd nah thā kih is sabab ko likhūn lekin ikhtisāran ittibā'an likhtā hūn'.

<sup>197</sup> This text of Ajmal Khan's is one of the 'Khamsah masā'il' ('Five matters'), printed in Ferozuddin, *Rumūz*, (in Arabic original and Urdu translation), pp. 92-101; Reprinted in Razi ul-Islam Nadvi, 'Rasā'il',

connecting the heavens, the earth and the body reveal the conscious process by which the boundaries of what constituted valid learned unani practice were being cast.

The emphasis which these articles place on supernatural and heavenly causation represents fascinating glimpses into the interface of popular ideas and mainstream learned unani discourse. They show that learned unani *tibb* was informed by much more than the classical fundamentals of Galenic medicine, even if some of its practitioners conceived it as such. *Tibb* could easily be subsumed within broader theological and ethical frameworks, and likewise be inflected by realms of popular discourse, like the effects of comets and meteor showers, that perhaps were so pervasive at a popular level that they had to be accounted for and situated within learned discourse.

## VI. Adopting Germs

The final section of this study affords a perspective on another quite different form of discourse on plague, whose focus is not geared towards the public as such, but rather the colonial medical and scientific establishment. It reveals unani *tibb* in dialogue with western science, and a mentality which would on the one hand critique it and on another dissolve the boundaries between science and *tibb*.

In the late nineteenth and early twentieth centuries two approaches to understanding and treating the sick body impacted on discourses on health and disease in unani *tibb* that were fundamentally new to the conception of the humoral body: the construction of the body according to western pathology, physiology, and concomitant surgical procedures, and germ theory. We have seen in our discussions above that in the early years of plague there was much room for a common understanding of the causes of plague between unani *ṭabībs* and western trained doctors, which both focused on earthly poisons and putrefaction. Germ theory, however, pioneered by Robert Koch in the 1880s, came in

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pp. 81-86. See Hakim Sayyid Zillur Rahman's introduction to '*Rasā'il*' for more details on the Delhi-Lucknow contestation over this and other publications of Ajmal Khan, pp. 14-15.



time to be as powerful a force as surgery with which elite *hakims* contended, or which they perhaps more subtly imbibed. Plague became one of the major vectors through which germ theory was introduced to unani *tabibs* of the early twentieth century, and plague therefore becomes an important site within which to see how *hakims* negotiated an entirely different epistemology with implications for an evolving understanding of the humoral body in twentieth-century unani *tibb*. But unlike surgery, where the power of excision was so unequivocal, *tabibs* acquainted with ancient texts where the prognosis of plague is elaborated, or with collections of the *hadith* of the Prophet providing guidance, could be more confident in their knowledge of plague; moreover they had developed strategies by which they could conceive of treatment in terms of fortifying the body and expelling or balancing out the poison, which did not directly conflict with germ theory.

One of the contexts in which germ theory was directly addressed by unani practitioners was in the wake of committees of enquiry set up to investigate whether indigenous medicine should receive state support. These arose from the Montagu-Chelmsford reforms of 1919, which gave the authority for decisions on the disbursement of the medical budget to legislative councils in British India in which for the first time Indians could be elected in the majority. This development had a significant impact upon the the development of unani institutions in India.<sup>198</sup> The first committee to report, from Madras Presidency, had invited *hakims* and *vaid*s throughout India to contribute to the report by indicating the merits of their practices and traditions. Hakim Kabiruddin, a prominent *hakim* who had studied in Delhi under Ajmal Khan, wrote a lengthy contribution in which he argued for the recognition of unani *tibb* as a scientific enterprise.<sup>199</sup>

Scientific method underpinned germ theory, and some prominent *hakims*, Hakim Kabiruddin included, as Claudia Liebeskind has amply demonstrated, challenged the notion propagated by many in the colonial medical establishment that unani medicine (and for that matter ayurveda, too) were devoid of any scientific rationale, and questioned

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<sup>198</sup> Zillurrahman lists the unani schools and colleges which were opened during the 1920s and 30s in many urban centres in India, 'Unani Medicine in India 1901-1947', *Studies in History of Medicine and Science*, 8, 1994, pp. 97-112.

<sup>199</sup> *The Report of the Committee on the Indigenous Systems of Medicine*, Madras, 1925, parts I and II. Hakim Kabiruddin's contribution was the only one by a *hakim* to be translated from Urdu, reflecting no doubt the importance which it was given.

the cultural neutrality of western science.<sup>200</sup> Hakim Kabiruddin's overarching aim was to legitimise *tibb* by emphasising the points of confluence between *tibb* and biomedicine. *Tibb* was the 'holy progenitor of allopathy', the divergence between the two 'systems' he argued was 'more apparent than real'.<sup>201</sup> He pointed to germ theory, however, as the element around which the contention of divergence is made, 'the dividing line between the Western and Eastern systems'.<sup>202</sup> But, he stated, there was no difference in substance:

[germ theory] does not differ in essentials from the theory of the humours inculcated by the unani system. The followers of the latter system hold that diseases are caused by the putrefaction of humours and the resultant deleterious matter, while the allopaths contend that diseases are indirectly produced by bacteria and directly by the poisonous matter (toxin) engendered by them.<sup>203</sup>

This distinction had no practical consequences, Kabiruddin argued, since in the case of plague or cholera practitioners of both groups seek to eliminate or 'neutralise' either the germs or the poisonous matter.<sup>204</sup> The same course applied for influenza, which had a particular currency having caused perhaps as many as 12 million deaths in India in the 1918-1919 pandemic, two years previous to the compilation of the report. According to the *hakim* it was the technological advances made by the Europeans that were at the heart of claims of difference. From Kabiruddin's perspective the invention of the microscope had allowed western doctors to see deeper, to discover the minute organisms 'in what was previously called matter', but not to discover a fundamentally different reality. Kabiruddin was arguing that the distinction between the understandings of toxicity and disease between biomedicine and *tibb* was at the level of method and language, not at the level of reality. Germ theory was a powerful discourse, but through these strategies of argumentation, it could be reconciled with *tibb*. This was a rhetorical point in an argument contesting truth-claims, but as Kabiruddin pointed out, the existence of germ theory was probably of little consequence for unani physicians in practice.

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<sup>200</sup> C. Liebeskind, 'Arguing Science: Unani *Tibb*, Hakims and Biomedicine in India, 1900-1950', in W. Ernst (ed.), *Plural Medicine, Tradition and Modernity, 1800-2000*, London, 2002, pp. 58-75.

<sup>201</sup> Hakim Kabiruddin, *The Report*, part I, p. 90.

<sup>202</sup> *Ibid.*, p. 93.

<sup>203</sup> *Ibid.*, p. 91.

<sup>204</sup> *Ibid.*

This observation is indeed supported by the insights afforded by journals into the day to day activities of *ḥakīms* in the 1920s. Learned unani journals like *al-Ḥakīm*, successor to the *Rafīq al-Aṭibbā*, reported on bacteriological researches into plague and cholera. Following a severe recurrence of plague in Bihar, U.P. and Punjab in April and May 1923, the editor of *al-Ḥakīm*, Hakim Muhammad Sharif, wrote articles on bacteriology and plague.<sup>205</sup> They are dispassionate in tone, noting the identification of the plague bacillus by Alexandre Yersin and Kitasato in 1894, and the established connection between rats, fleas and man. But this information was only partially translated into advocacy of a different mode of action among *ḥakīms*. Guidelines compiled, published and disseminated by the learned (*fāzil*) *ḥakīms* of Lahore's Anjuman-i Aṭibbā, (*tibbī* association), for instance, gave advice on sanitation, hygiene, clothing, massage oils, fumigation and prescriptions, all quite established areas of unani knowledge, but also included many details about how to deal with rats.<sup>206</sup>

It is clear that the *ḥakīms* connected with this journal and the Anjuman were very active in the publicising of prescriptions for prevention and the treatment of plague along established unani lines. They acknowledged inoculation as a preventive measure but drew on continuing public concerns about it, and provided a unani alternative. They produced plague '*goliyān*' (pills) 'for those people averse to inoculation'; pills which, they claimed, would protect a person from any epidemic disease for the duration of one year, while inoculation, they claimed, would only offer protection for six months.<sup>207</sup> They distributed the pills free of charge and placed advertisements for the ingredients of these prescriptions in several of the major Hindi and Urdu newspapers. Thus it seems as though plague business in the unani realm continued in this period largely unaffected by the theoretical power of germ theory. Over twenty years *ḥakīms* had established a market for their products, partly aided by the trauma and public disaffection with western medicine in the early years, and partly motivated by the creative use of ever more sophisticated means of reaching their constituents, and, who knows, maybe also on account of the effectiveness of their medicines?

<sup>205</sup> Hakim Muhammad Sharif, 'Ilm al-Jarāṣīm', *al-Ḥakīm*, June 1923, pp. 11-12; 'Ṭā'ūn ke Muta'alliq Ma'lūmāt', *ibid.*, pp. 23-24.

<sup>206</sup> 'Ṭā'ūn kā Ḥifz mā Taqaddum, Fāzil Aṭibbā Lahaur kī ṭaraf se Zārūrī Hidayāt', *ibid.*, p. 4.

<sup>207</sup> *Ibid.*, Editorial, p. 5.

## Conclusion

There is a compelling temptation when analysing plague in the context of unani *tibb*, to interpret the actions of *tabībs* in relation to the colonial medical establishment as the site where power and authority were contested, given the dramatic forms of intervention and the clamour in the press that has been captured in the existing historiography. We cannot deny that there were certainly contexts where it was important for *tabībs*, in demarcating their own areas of legitimacy, to either align themselves with western practices or position themselves against them. However, plague comes to highlight the issue of authority in a much broader and multifaceted manner than the above would suggest. When analysing several spheres of discourse about plague and the actions of *tabībs*, one key area has emerged which unites them: Each articulation was in its own way addressing the concern with authority, in relation to unani traditions, commercialisation, Islam, modernity, folk medicine, the state and the public. Plague opened up tremendous tensions and dilemmas among *tabībs* about the nature of unani *tibb*, as a communitarian profession, but also an increasingly commercialised one; as a profession conversant with popular themes and yet at the same time distancing itself from them; and as a learned enterprise that was championed by an elite 'for the benefit of the people', recasting *tibb* for the new world of the lithographic press and a much wider constituency. Plague highlighted the relationship of *tibb* with the state, since the Epidemic Diseases Act of 1897 was the first government legislation in British India which, even if patchily enforced over a short period of time, sought to curtail the treatment of plague cases by indigenous practitioners. Plague also reveals the tensions within *tibb* between the global and the local. Ajmal Khan appealed to the importance of public health measures and the need to break down the circumscribed elite circles of authoritative unani knowledge. Other practitioners sought to emphasise the local nature of plague, either in terms of bodily putrefaction or personal impiety, for which the individual and the collectivity may be punished. Altaf Hussain's writing captures a learned practitioner's view of a unani *tibb* catering for new markets and changing practices in the process.

One dimension is perhaps remarkable for its absence, and that is the lack of a political or ideological agenda in which the plague and the concerns of unani practitioners were entwined. One might perhaps want to view Ajmal Khan's position on British plague measures as a political manoeuvre, but the project which he elaborated in his treatise conveys a much more complex picture than that. One might also want to read the exhortation of certain *vaid*s that people should rely on indigenous medicines alone as the expression of an emerging national consciousness. However the political ramifications of the plague were interpreted by British administrators, or such prominent figures as Bal Gangadhar Tilak, who drew concerns over plague into Hindu Nationalism, or Sayyid Ahmed Khan, who expressed fears of a second 'Mutiny', it seems that for *hakims* their concerns regarding plague lay in questions of leadership and cultural authority, the unani 'constituency', the economy and the dilemmas of practice, rather than the advancement of political strategies. These are the dynamics of a profession grappling with self-definition and the concern with authoritative knowledge triggered by the experience of *hakims* with the plague, the state and the public.

### Chapter 3

## **Models of Authority: Assessing the Place of Institutions in the Unani Profession in Early Twentieth Century India, with Special Reference to Hyderabad**

Between the 1880s and the turn of the twentieth century new institutions for the instruction of unani *tibb* were established in many of the centres of Islamic learning on the subcontinent, in Lahore, Delhi, Lucknow, Bhopal and Hyderabad. These new institutional arenas, especially those of Delhi and Lucknow, have occupied the foreground in historical studies of the revival and reform of unani *tibb* in the nineteenth and twentieth centuries,<sup>208</sup> and yet a number of important issues concerning the nature and place of unani institutions in India remain unaddressed. The institutionalisation of indigenous medicine in India has been interpreted principally as resulting from the rise of religious nationalisms in the late nineteenth century, and as a move to challenge the power of and seek equivalence with western medicine through the emulation of its professional models.<sup>209</sup> What has been mostly absent in these discussions, however, is attention to the fact that the will to reform was in some cases a product of tensions within the unani profession. Barbara Metcalf pointed to this fact in one of her illuminating articles on Ajmal Khan,<sup>210</sup> but this line of thinking has not generally been pursued. It is

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<sup>208</sup> B.D. Metcalf, 'Nationalist Muslims in British India: The Case of Hakim Ajmal Khan', *Modern Asian Studies*, 19, 1985, pp. 1-28; Zillurrahman, 'Unani Medicine in India 1901-1947', *Studies in History of Medicine and Science*, 8, pp. 97-112, 1994; A. Vanzan, 'Physicians and 'Ulama: Unani Medicine and Islamic Revival in British India', *Hamdard Medicus*, 38 (3), 1995, pp. 5-14; N. Quaiser, 'Politics, Culture and Colonialism: Unani's Debate with Doctory', in Biswamoy Pati and Mark Harrison (eds), *Health, Medicine and Empire: Perspectives on Colonial India*, New Delhi, 2001, pp. 317-355; S. Alavi, 'A National Medicine in Colonial India? The Muslim Physicians and the Takmil ut-*Tibb* College at Lucknow', 10 October, 2002. [online]. <http://www.fas.harvard.edu/~asiactr/archive/newperspectives/Text/Seema.htm>.

<sup>209</sup> P. Bala, *Imperialism and Medicine in Bengal: A Socio-Historical Perspective*, New Delhi, 1991, pp. 16, 40ff.; R. Croizier, 'Medicine and Modernization in China', *Comparative Studies in Social History*, 12, 1970, pp. 275-291; C. Leslie, 'Ambiguities of Revivalism in Modern India', in C. Leslie (ed.), *Asian Medical Systems*, New Delhi, 1998, pp. 356-378; Metcalf, 'Nationalist', pp. 4-5.

<sup>210</sup> Metcalf, 'Nationalist', p. 5.

only recently, in a seminar paper presented by Seema Alavi, that this subject has been broached.<sup>211</sup> Significant regional variations in the causes that led to institutionalisation, and resultant differences in the nature of these institutions have not been adequately reflected in contemporary studies. Moreover, to my knowledge no study on *ṭibb* to date has questioned the place of these institutions within the broader frameworks of legitimation in unani culture that existed at the time.

The study in this chapter of the process and nature of institutionalisation in Hyderabad, which is of special interest for the state-run institutions that operated there, will be preceded by an overview of emerging contemporaneous institutions in Punjab, Delhi and Lucknow. The focus in north India is on teaching institutions, but in Hyderabad the discussion of the unani school will be placed within the broader context of a state infrastructure for unani *ṭibb*. The discussion then moves on to examine the significance which the first of Hyderabad's unani schools assumed in relation to other markers of authority in unani culture: aspects of lineage, the *ḥakīm*'s character, education, but also individual commercial enterprise. This second section of the chapter will be based on an analysis of a specific literary genre, the bibliographical directory (*tazkirah*), which gives us insights into the representations of authority in *ṭibb* at the time. The very survival of this genre in the twentieth century points to the continuing importance of a culture that sustained pre-institutional modes of authority and transmission. This chapter problematises the notion that the emergence of institutions marked a radical and immediate disjuncture in the orientation of unani *ṭibb*, which would imply the supplanting of pre-existing forms of instruction and legitimation: the importance of person to person transmission of knowledge, the power of family-based remedies, the qualities of the 'good *ḥakīm*' and prestige-enhancing social networks among practitioners. Hyderabad presents us with a useful way to examine broader trends of reform in *ṭibb* and to explore how *ṭabīb*s reconfigured notions of authenticity in their modes of knowledge transmission, practice and self-representation.

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<sup>211</sup> S. Alavi, South Asia History Seminar, School of Oriental and African Studies, 27 May, 2003.

## I. Unani Instruction in Nineteenth-Century India

Before 1870, there was no institution offering formal education for a *ṭabīb* in India. The Government of Bengal had experimented with instruction in indigenous medicine at the Native Medical Institution in Calcutta, through which ayurveda and unani *ṭibb* were taught from 1826 as adjuncts to a western medical education at the Calcutta Sanskrit College and the Calcutta Madrasa respectively.<sup>212</sup> But the project was disbanded less than nine years later following the famous minute of Thomas Babington Macaulay of February 2, 1835, which proposed the ‘promotion of European literature and science among the natives of India’.<sup>213</sup> Governor-General Bentinck’s following resolution signalled a dramatic shift in British official attitudes to end the patronage of indigenous education; it is commonly termed the triumph of the ‘Anglicists’ over the ‘Orientalists’.<sup>214</sup> But, as Martin Moir and Lynn Zastoupil have cautioned, the ‘victory’ of the Anglicists was not complete, since after protests in Calcutta, Bentinck amended his first resolution to remove Macaulay’s phrasing that the Calcutta Sanskrit College and the Calcutta Madrasa should be abolished altogether.<sup>215</sup> Regarding British policy towards indigenous medicine, Roger Jeffery has also written that Macaulay’s minute should not be seen as a watershed, since it did not signal the end of British support for indigenous medical instruction,<sup>216</sup> a point which shall be amplified below. Jeffery characterised British public policy towards indigenous medicine until the late nineteenth century as one of ‘non-decision making’, in terms of the framing of legislation which would impact on indigenous medical practices.<sup>217</sup>

Seminaries throughout northern India continued to exist in the mid nineteenth-century at which one could be familiarised with some of the key Arabic and Persian works of *ṭibb* circulating in the subcontinent, even if they did not lead to any form of institutional qualification. R. Thornton remarked that in Shahjahanpur (Avadh) in the mid nineteenth century, for example, there were five ‘Arabic schools’ (*madrasas*) and the

<sup>212</sup> Bala, *Imperialism*, pp. 41-48.

<sup>213</sup> Macaulay cited in M. Moir and L. Zastoupil, *The Great Indian Education Debate*, London, 1999, p. 28.

<sup>214</sup> Bala, *Imperialism*.

<sup>215</sup> *Ibid.*, p. 32.

<sup>216</sup> R. Jeffery, ‘Indian Medicine and the State’, *Bulletin of the British Association of Orientalists*, 11, 1979-80, p. 62.

<sup>217</sup> *Ibid.*, p. 61.



studies included grammar, medicine, logic and religious studies.<sup>218</sup> 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.<sup>219</sup> Leitner did not mention perhaps the most authoritative channel for transmission – through family (*khāndānī*) practice.

Interest in learning unani *ṭibb* was by no means restricted to practising *ḥakāms*. The nobility and religious scholars, *ulamā* and *maulvīs*, acquired knowledge of medicine as a complement to their other realms of learning and activity, and it can be assumed that women also had varying degrees of knowledge of local forms of unani medical practice, even without formal training. Sufis also practised varieties of unani *ṭibb* at shrines throughout North India and the Deccan.<sup>220</sup> According to Leitner, medicine was 'the most accessible scientific subject in a considerable number of schools as it is considered both in the light of a general accomplishment, as also in that of a professional study'.<sup>221</sup>

The observation on the professional opportunities afforded by learning *ṭibb* was significant at a time when the *sharīf* class, who had served in the pre-1857 administration of the late Mughal Empire, would be seeking new means of livelihood which could conform, as *ṭibb* did, to ideals of culture and learning. *Ṭibb* also offered employment prospects for those who perhaps otherwise would have made their careers teaching in religious schools, the opportunities for which were attenuating as patronage systems for indigenous educational establishments were being eroded. Evidence of the importance of providing vocational training in a predominantly religious education is demonstrated in the case of the seminary at Deoband, founded by Rashid Ahmed Gangohi and Sheikh Naunatavi in 1867. Barbara Metcalf notes that from the end of the nineteenth century Deoband began to offer the instruction of *ṭibb* at the school, as well as calligraphy, for the employment opportunities they provided. This move was however opposed by Rashid

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<sup>218</sup> R. Thornton, *Memoir on the Statistics of Indigenous Education within the North-West Provinces of the Bengal Presidency*, Calcutta, 1850, p. 51.

<sup>219</sup> G.W. Leitner, *History of Indigenous Education in the Panjab since Annexation and in 1882*, Lahore, 1991, p. 74.

<sup>220</sup> F. Speziale, 'Tradition and Modernization of Islamic Psychiatric Care in the Subcontinent', *The International Institute for Asian Studies Newsletter*, March 2003, p. 30.

<sup>221</sup> Leitner, *History*, p.74.

Ahmed Gangohi, who considered them a 'distraction' from more important matters.<sup>222</sup>  
On the curriculum were some of the key texts of unani *ṭibb*:

*Qānūnchah*, an abridgement of Ibn Sīnā's *al-Qānūn fī al-ṭibb*, by Sharīf al-Din

Muḥammad bin 'Umar al-Chāghminī (fourteenth century);

*Mūjaz al-Qānūn*, an abridgement of the *Qānūn* by Ibn al-Nafīs, thirteenth century;

*Mizān al-ṭibb*, by Muḥammad Akbar Arzānī (with diseases and treatments listed according to body parts, from head to toe), late seventeenth century;

*Kifāyah Mansūrī*, by Mansūr ibn Muḥammad ibn Aḥmed, thirteenth century.<sup>223</sup>

Graduates from Deoband, who completed their studies there probably before *ṭibb* was introduced into the curriculum, played important roles in the institutionalisation of *ṭibb* in Hyderabad. The analysis presented below, in the second section of this chapter, of the biographical literature on the lives of *ḥakīms* in the nineteenth and twentieth centuries points to the continuing significance of hereditary practice. It is nonetheless remarkable that many of the new recruits to Hyderabad's state unani service (which we shall discuss in detail below) did not have family connections to unani *ṭibb*. This is in fact emblematic of the shifts at play in the late nineteenth-century unani profession which we can see in the complexion of unani practice in Hyderabad. The unani profession was not only drawing in people attracted by the prospect of harnessing the opportunities of new print technology, but also learned scholars for whom the unani profession was seen as a means of making a livelihood and maintaining a life of gentlemanly and learned integrity. Hakims like Mansur Ali Khan and Abdulwahab Ansari (the eponymous Ḥakīm 'Nabina', 'the blind', who lost his eyesight after an attack of smallpox in his youth), had gained their knowledge and their authority through affiliation and experience with respected scholars and *ṭabībs*, rather than through family lines. They both read Arabic. Hakim Mansur Ali Khan, the son of a military officer in Moradabad, was the first full-time teacher of the Madrasa Ṭībābat in Hyderabad, teaching there for twenty years from 1901. He gained his practical experience of *ṭibb* at the clinics of well-known physicians in

<sup>222</sup> B.D. Metcalf, *Islamic Revival in British India, Deoband 1860-1900*, Princeton, 1982, p. 103.

<sup>223</sup> This is the title of the lithographed version (printed in Lucknow in 1869) of the thirteenth-century text *Kifāyah Mujāhidīyah*.

Lucknow, and when he arrived in Hyderabad he stayed with the head physician of Hyderabad's state unani service, Hakim Said Ahmed Amrohi, another *ghair mulkī* ('outsider', one from beyond Hyderabad territory), *ṭabīb*, from Amroha in Avadh. Hakim Mansur Ali Khan initially found employment in Hyderabad teaching religious sciences ('*ulūm naqliyyah aur 'aqaliyyah*, or the revealed and the secular sciences) in the Madrasa Dīniyyah, before being employed as a unani tutor.<sup>224</sup>

Hakim Nabina was appointed as head physician in 1938 in the Hyderabad state unani service at a very senior age. His life-story, as recounted by his son, illustrates a number of significant points about the networks of unani knowledge, and the opportunities afforded by the unani profession in the second half of the nineteenth century.<sup>225</sup> He came from a district town in UP from a *sharīf* family that had no connections with *ṭibb*. Born two years after the *ghadar* (rebellion, or 'Mutiny'), in 1859, Nabina was among the first batch of graduates from Deoband, studying under its first principal Muhammad Ya'qub Naunatavi and its co-founder Rashid Ahmed Gangohi.<sup>226</sup> Renowned among his peers and his teachers for his powers of memory -- he was a *ḥāfiẓ* (one who has committed the *Qur'ān* to memory), and had reputedly learnt by heart three authoritative works of *ḥadīths* (Islamic traditions) -- Nabina completed his religious studies, and pursued *ṭibb* in the dispensaries of respected practitioners. He spent time in the circle of students of Hakim Wasil Khan, one of Hakim Ajmal Khan's elder brothers, studying key texts of unani instruction like *Sharḥ Asbāb* and the work of Ibn al-Nafis.<sup>227</sup> He acquired fame as a *nabāẓ* (one who specialises in reading the pulse, *nabẓ*), and towards the end of his life Nabina's eminence brought him to the attention of the Unani Department in Hyderabad, where he was employed as its chief unani physician in 1938.<sup>228</sup> A highly respected figure in Hyderabad's unani culture, Nabina's inability to see perhaps even enhanced his charisma, since the visual powers that he lost he gained in his sense of touch, his sensitivity to the movements of the pulse. Apart from this singularity, the unani profession offered Nabina a means of maintaining connections with Islamic

<sup>224</sup> Hakim M. Zafaruddin Nasir, *Tār bah Hadaf*, Hyderabad, 1944, p. 11.

<sup>225</sup> Hakim Abdulghani Ansari, *Mujmal-i Hālāt-i Zindagī-yi Ḥakīm Nābīna*, Hyderabad, date not known.

<sup>226</sup> *Ibid.*, p. 4 f.

<sup>227</sup> *Ibid.*, p. 16.

<sup>228</sup> Letter from Finance Department, 15 Ābān 1347 Fasli [20 September 1938], Andhra Pradesh State Archives (henceforth APSA), Instalment 85, List 3, Serial 534, document 6.

learning, an authoritative standing in the community where he lived, in Delhi and later in Hyderabad, and ultimately a lucrative livelihood.<sup>229</sup>

Medical practice in mid nineteenth-century Hyderabad, as in other parts of India, was highly diversified, with a range of healers offering their services.<sup>230</sup> The respected historian of medicine in Hyderabad, Subba Reddy, refers to a report by Dr. George Smith, Residency Surgeon in Hyderabad and director of the Hyderabad Medical School from 1854-1861, who describes the range of practitioners practising in the city in the early nineteenth century:

[There were] educated Hakeems, following hereditary profession, uneducated quacks, the Hujams or barber caste who form the surgeons of India, herbalists of the shepherd caste, druggists, oculists, lithotomists, fakeers, midwives and leech women. There were neither hospitals nor dispensaries. European medical men did not practice in the city.<sup>231</sup>

Here we see a division of labour that separates surgical practices from those of the educated, hereditary practitioner. Surgery, which would become a subject of great debate among unani practitioners by the late nineteenth century, at this time is likely to have included cauterisation, the lancing of boils and abscesses, and bloodletting. Bloodletting was a common practice to rid pathological plethora in the body, both in the classical literature of Ibn Sīnā and al-Rāzī and in unani practice in India, until the early twentieth century when its use began to wane. One account of a case of bloodletting on a nobleman in Rampur in the late nineteenth century suggests that the *ḥakīm* would prescribe bloodletting, but for the actual operation a *jarrāḥ*<sup>232</sup> would be called in. But just as there were *ḥakīms* and ‘*ḥakīms*’, there were also high class and low class *jarrāḥ*. For instance, there remains in Hyderabad a strong tradition of bone-setting. The bone-setters refer to themselves as either ‘*azzām* or *jarrāḥ*. Their ‘surgery’ is non-operative, but uses massage

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<sup>229</sup> Nabina’s salary was Rs. 700 per month during his employment in Hyderabad. His son Hakim Abdulghani was employed on Rs. 200 a month in order to help with administrative tasks.

<sup>230</sup> A similarly diverse account to the one that follows concerning Hyderabad is given for north-west India in *The General Medical History of Rajputana*, by Col. Thomas Holbein Hendley, Inspector General of Civil Hospitals Bengal, Calcutta, 1900.

<sup>231</sup> S. Reddy, on Smith’s, *The Hyderabad Medical School: Its Past History and its Present Condition*, Madras, 1859. Reddy, ‘Advent of Modern Medicine in Hyderabad’, *Proceedings of the Academy of Medical Sciences*, Hyderabad, 3, October, 1961, p. 56.

<sup>232</sup> The nearest English equivalent would be barber-surgeon, or bone-setter.

and splints and some herbal remedies. They are not what one might conventionally call unani physicians, but they use the denominator '*hakīm*', follow a hereditary profession and some, like present day practitioner Hakim Ghulam Rasul, trace consistent royal patronage for their family's services to the Nizam throughout the Asaf Jah dynasty.<sup>233</sup> The skills of such practitioners on the fringes of 'unani' practice were not incorporated into the new institutional environments of unani *tibb* of the early twentieth century.

In general it is fair to say that the involvement with touching the body and blood in India until the early twentieth century were not considered as fine an art as the *hakīm*'s practice of internal medicine. It is also noteworthy in George Smith's account that midwifery is placed in a separate domain from that of the *hakīm*, although this picture is complicated in the process of institutionalisation, which I shall come to below. A further significant point arising from this account is that although European doctors were present in the cantonment areas at this time, there was before 1846 no effort to diffuse western medical practice among the general population of Hyderabad. The shift to institutional modes of unani instruction in Hyderabad happened in the last decade of the nineteenth century. By this time the first institutions for *tibb* had already been established in north India, and as we shall see in the following sections, they varied in nature.

## II. Emerging Institutions of Unani *Tibb* in North India

### 1. Unani Instruction and Colonial Objectives in the Punjab

It was with the support of the Government of Punjab that the first institution in India to offer degrees in unani *tibb* was the Oriental College in Lahore. Courses of four years' training for the licentiate equivalent with the title *hakīm-i hāziq* ('the thoroughly proficient physician'), and the subsequent M.B. equivalent '*umdat al-ḥukamā*' ('the greatest of the physicians') were initiated in 1872 by the Oriental College under the auspices of the University of Punjab. The instruction was devised as a dual system of western medicine and either unani or ayurveda in mid nineteenth-century Punjab as

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<sup>233</sup> Personal communication at his family practice in Shah Ali Banda, Hyderabad, January, 2002.

described by J.C. Hume.<sup>234</sup> Instruction in western medicine, surgery and anatomy was given at the Lahore Medical School, and therefore was not integrated into the curriculum for unani, as happens in later institutions, but existed in parallel. The motivation behind this state involvement in this form of indigenous medical education was the Mercer programme, or the 'hakim system', instituted in 1867 for the district-wide employment of *hakims* and *vaid*s. The scheme was developed in order to extend state medical provision, especially in rural districts, in what was deemed the most expedient, locally acceptable (Indian doctors had begun to be employed by the Punjab government, but most graduates at this time were Bengalis, who were apparently unpopular with the Punjabi population), and cost-effective manner. Apart from treating diseases, *hakims* and *vaid*s were to distribute simple medicines, such as quinine, act as sanitary inspectors, register vital statistics, and participate in vaccination schemes.<sup>235</sup>

In the Punjab the functions of 'the hakim system' were clearly defined by western medical priorities, and therefore differ greatly from subsequent institutional developments. Anil Kumar may be right to some extent to point to underlying imperial motives aimed at rather insidiously promoting western drugs and practices at the expense of local medical practices.<sup>236</sup> G.W. Leitner, the author of a history of indigenous education in the Punjab, made this intention explicit, even while recognising that some *hakims* and *vaid*s had a knowledge of indigenous medicinal plants that commanded some degree of respect among European practitioners:

The Hakims and Baid

s of the Oriental College, who to a thorough study of their own systems of medicine and of the use of native drugs, a subject in which the most eminent European physicians admit they have much to learn, add a course of instruction in European Medical Science, are more likely to be welcome advocates of our system among the masses of the people as well as original enquirers, than persons trained only in our Medical Schools.<sup>237</sup>

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<sup>234</sup> J.C. Hume, 'Rival Traditions: Western Medicine and Yunan-i Tibb in the Punjab, 1849-1889', *Bulletin of the History of Medicine*, 51, 1977, pp. 214-31.

<sup>235</sup> *Ibid.*, p. 221.

<sup>236</sup> A. Kumar, 'The Indian Drug Industry under the Raj, 1860-1920', in B. Pati and M. Harrison (eds), *Health, Medicine and Empire: Perspectives on Colonial India*, New Delhi, 2001, p. 365.

<sup>237</sup> Leitner, *History*, p. 78.

However, what mitigated this ambition was that the *ḥakīms* employed on this scheme were also trained in unani or ayurveda. Since there was little supervision of their activities it is difficult to see them in practice necessarily functioning as agents of western medicine.

At its inception the Mercer programme employed *ṭabīb*s who were already in practice, and they used local forms for identifying competence. The candidate had to present a certificate stating competence from a recognised authority.<sup>238</sup> The granting of a 'permit' [*ijāzah*, or commonly (in India) *sanad*, 'certificate'] by a prominent practitioner to an able student has a long tradition not only in *ṭibb* – there are extant records of *ijāzah* from ninth century West Asia – but also has been maintained in madrasa education in India.<sup>239</sup> The teacher would write a list of the books which the student had studied, or inscribe his recommendation in the first pages of the book itself. Since *ṭibb* was often included in Arabic and Persian language nineteenth-century madrasa education in the Punjab, it is likely that this system could have constituted an important form of qualification of *ṭabīb*s.<sup>240</sup> But from 1872 on, as we have mentioned above, formal training was undertaken for the attainment of a standardised and recognisable qualification.

In spite of the apparent popularity of the scheme, the experiment in training unani practitioners for government service proved short-lived, being wound up in 1889. Following the passing of the 1858 Medical Registration Act in Britain, and a proposal for the implementation of a similar act in British India, western medical practitioners in the Punjab feared their professional status would be eroded if *ḥakīm* graduates from this scheme were accorded equal status as western medical practitioners. Hence the Punjab government stopped employing *ḥakīms* and *vaid*s. Nevertheless, it seems that the initial impetus in the second-half of the nineteenth century for the formalisation of unani and ayurvedic teaching in Punjab came through these initiatives in the colonial administration.

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<sup>238</sup> Hume, 'Rival', p. 222.

<sup>239</sup> Robinson, *Islam and Muslim History in South Asia*, New Delhi, 2000, p. 71; Metcalf, *Islamic*, p. 94; See below for a fuller discussion.

<sup>240</sup> Leitner, *History*, p. 73.

## 2. The Consolidation of *Tibb* as Culture: Islamiya College, Lahore

The unani and ayurveda classes once given at the Oriental College were taken over by private colleges in Lahore.<sup>241</sup> The Dayanand Anglo-Vedic College and the Islamiya College were both products of religious reform movements, and they began to offer tuition in ayurveda and unani *tibb* respectively from the end of the nineteenth century.<sup>242</sup> The two colleges were affiliated to the Punjab University, and the classes in *tibb* and ayurveda were subsidised without a formal recognition of the qualification the students would gain in these courses. In these institutions indigenous medical traditions were markers of culture and community, to be upheld and defended. The Dayanand Anglo-Vedic College was opened in 1887, after the death of the founder of the Arya Samaj, Swami Dayananda, with the aim of promoting the Samaj agenda. It encouraged the study of the Vedas in conjunction with English literature and sciences.<sup>243</sup> The Anjuman-i Himāyat-i Islām ('Association for the Defence of Islam'), founded in 1885, promoted vernacular and Anglo-vernacular educational programmes with the aim of bettering the social lot of Muslim communities, and established the Islamiya College to this end. Both institutions received support from the Punjab government into the 1920s.<sup>244</sup> Given this investment, the Punjab government did not want to subsidise a new college, although they came under pressure to do so from unani associations, which lobbied the new legislative council following the Montagu-Chelmsford reforms of 1919. Under these reforms policy decisions on the budgets for medical provisions were made by local Indian majority councils in British India.

The unani classes offered in Islamiya College differed greatly from the organisation and curriculum of the Delhi and Lucknow schools. Unlike in Delhi, or even Lucknow by the 1910s, it seems that there was no attempt to integrate western medicine and surgery in the unani classes at the Islamiya College.<sup>245</sup> Indeed, the texts used there for the qualification of *ḥakīm ḥāziq* ('the proficient physician') and *zubdat al-ḥukamā* ('the best

<sup>241</sup> Hakim Ferozuddin, *Rafīq al-Atibbā*, 16 May 1912, p. 5.

<sup>242</sup> R. Jeffery suggests this happened in the late 1880s, *The Politics of Health in India*, p. 51; K. Sivaramakrishnan notes that in 1901 the DA-V College took over the classes in ayurveda that had been taught previously at the Oriental College, 'Use of the Past', p. 182.

<sup>243</sup> J.N. Farquhar, *Modern Religious Movements in India*, New York, 1918, p. 125.

<sup>244</sup> In 1927 this amounted to Rs. 10, 000 per annum for both institutions, a substantial increase from previous years. *Punjab Legislative Council Debates*, 15<sup>th</sup> July, 1927, pp. 999-1004.

<sup>245</sup> *al-Hakim*, 7, July 1922, p. 15.



of the physicians’) in 1922, were almost identical with the texts that formed the basis of the unani curriculum at the Oriental College in Lahore in the 1870s and 80s – an expansion of the unani works taught at Deoband.<sup>246</sup> While instruction in *ṭibb* at Deoband in the late nineteenth century was in Arabic and there was no independent qualification offered in *ṭibb*, Islamiya College offered a course for the lesser qualification (*ḥakīm ḥāziq*) in Urdu, clearly reflecting the widespread shift of the times towards making instruction in unani *ṭibb* accessible to a larger constituency. The course at the Islamiya College did not find universal approval among unani practitioners. Some leading personalities of the unani community in Lahore, like Ḥakīm Ferozuddin, editor of two unani journals in the city, were critical. In 1912, Ferozuddin wrote that he had received a large number of letters of complaint over several years about the organisational procedures of the unani classes, and he considered the standard of tuition (*tarz-i ta’līm*) to be of very poor quality (*behad nāqis*). He advised Mufti Salim Ali Khan, the vice-principal and the secretary of the Anjuman Himāyat-i Islām, and also the principal of the College to improve the standards or the ‘Anjuman especially will get a bad reputation on account of the management of the unani classes’.<sup>247</sup> Islamiya College was not a site for the reform of the unani corpus, and the reason for this is that the inclusion of *ṭibb* in the teaching of the college was not driven by practitioners of *ṭibb* themselves. Rather *ṭibb* was seen as one element of a ‘Muslim’ social and educational enterprise that required formal support.

### 3. Redefining Authenticity: The Madrasa Ṭibbiya, Delhi, and the Takmīl aṭ-Ṭibb, Lucknow

Religious nationalism undoubtedly impacted on the Madrasa Ṭibbiya in Delhi and the Takmīl aṭ-Ṭibb in Lucknow – the two most prestigious schools of *ṭibb* in the early twentieth century – and shaped their agenda of reform. But the specific agenda they both pursued, in different ways, was to reclaim and demarcate the boundaries of authentic unani practice.

<sup>246</sup> Leitner, *History*, pp. 73-78.

<sup>247</sup> *Rafīq al-Aṭibbā*, 16 May 1912, p.6.

Their understanding of this authenticity differed. The Delhi school favoured tuition in ayurvedic practices also, besides *tibb*, such as the preparation of *kushtajāt* (remedies based on calcined metals). Hakim Muhammad Sharif Khan of Delhi, court physician to the Mughal emperor Muhammad Shah in the late 18<sup>th</sup> century, gained fame as one who popularised these remedies in *tibb*,<sup>248</sup> although their use seems so diffuse that it seems unlikely that one practitioner could have had this role. The linkage with ayurveda at the Delhi Madrasa was looked upon critically by the Hakim Abd ul-Aziz and his supporters at the Takmīl aṭ-Ṭibb school in Lucknow.<sup>249</sup> The Delhi Madrasa placed a greater emphasis on surgery, anatomy, physiology and chemistry than Takmīl aṭ-Ṭibb. Although Alavi states that surgery was incorporated into the teaching of the Lucknow school, an account of one of its former students which appeared in a unani journal in 1913, some eleven years after the foundation of the school, emphasised how instruction in 'modern' anatomy was considered 'absolutely forbidden'.<sup>250</sup>

Despite differences in their conception of what sound unani knowledge and practice might be, both schools were borne out of the changing educational and professional patterns of the late nineteenth century. Both were the products of family enterprise. The founder of the Madrasa Ṭibbiya in Delhi, Hakim Abdulmajid Khan, is said to have associated himself with Sir Sayyid Ahmed's movement for educational reform.<sup>251</sup> Recent work by Neshat Quaiser sheds further light on the connections between the ideological orientation of the Madrasa and Sir Sayyid. Quaiser points out that Sir Sayyid Ahmed Khan gave an address at the inauguration of the Madrasa in 1889, which indicates the reformist tenor of its programme.<sup>252</sup> In his speech he is reported to have 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

<sup>248</sup> Hakim Fazlurrahman, 'Ṭibb-i Yūnānī aur Kushtajāt', *Hakīm-i Dekkan*, 7, 1944, p. 17.

<sup>249</sup> Alavi, 'National', p. 10.

<sup>250</sup> Muhammad Shafi (Hakim Gilani), 1<sup>st</sup> degree graduate from Madrasa Takmīl aṭ-Ṭibb Lucknow, 'Madrasa Takmīl aṭ-Ṭibb Lucknow par tanqīdī nazr us ke ek sanadyāftah kī qalam se', *Rafīq al-Aṭibbā*, 16 November 1913, pp. 30-7: 'Aur nah hamen tashrīh jadīd ke ta'līm se hī paṛhā'ī gayī balke usse ḥarām mutlaq samjhā'.

<sup>251</sup> Abdur Razzack, *Hakim Ajmal Khan: The Versatile Genius*, New Delhi, 1987, p. 11.

<sup>252</sup> Quaiser, 'Unani', p. 335.

for the betterment of the Muslim community in India is well known.<sup>253</sup> This appears to have been his only public endorsement of unani *ṭibb*.<sup>254</sup> The Madrasa probably attracted him for its inclusion of instruction in western anatomy and surgery in a formalised institutional setting. Regarding the Lucknow Madrasa, the studies of Claudia Liebeskind and Seema Alavi indicate that Hakim Abd ul-Aziz wished to systematise unani instruction around the texts of Ibn Sīnā, supplemented by practical instruction in surgery and anatomy.<sup>255</sup>

While Charles Leslie and Barbara Metcalf have stressed that the desire to imitate colonial institutional and professional models encouraged unani institutionalisation, it is important to recognise that the pressure for reform came from within the expanding and fractured unani profession, not directly as a result of the will for equivalence to colonial institutional norms. As we have mentioned when discussing the plague, Hakim Ajmal Khan wrote that the scheme for the Delhi Madrasa Ṭibbiya had been devised in order to distinguish learned *ṭibb* from popular, corrupted and 'ignorant' unani practices.<sup>256</sup> On the issue of professional demand for reform, Seema Alavi has recently advanced a fresh and exciting perspective. She has made the case that the availability of European medical literature in mid nineteenth-century Avadh fostered a new class of unani practitioners, who had no family connections to unani practice, and who embraced print technology to propagate their versions of unani *ṭibb*. In a similar argument to the one we proposed above, she sees this in the light of changing employment possibilities for educated classes post-1857. Alavi further suggests that the proliferation of printed works drawn from this pool of medical literature that combined unani and western medical precepts, which she terms 'bridgehead' literature, spurred the revival of learned *ṭibb* among hereditary practitioners through institutional structures, as they sought to reassert their control of the profession. While my sources cannot support or refute her position, what is clear is that for Ajmal Khan, much as for Hakim Abd ul-Aziz,<sup>257</sup> the revival process was evidently

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<sup>253</sup> D. Lelyveld, *Aligarh's First Generation*, Princeton, 1978; F. Robinson, *Separatism among Indian Muslims: The Politics of the United Provinces Muslims 1860-1923*, Delhi, 1997.

<sup>254</sup> A. Kumar, 'Drug', p.377, cites Lelyveld that Sir Sayyid did not support or give any speeches on unani *ṭibb*, and that he was keen to visit hospitals on his trip to Britain.

<sup>255</sup> Alavi, 'National', p. 12; Liebeskind, 'Unani Medicine of the Subcontinent', in Jan van Alphen and Anthony Aris (eds), *Oriental Medicine*, Boston, 1997, p. 58.

<sup>256</sup> See Chapter 2 on plague.

<sup>257</sup> Alavi, 'National', p. 5.

much concerned with distinguishing authentic *ṭibb* from the practices of ‘ignorant’ (*jāhil*) *ḥakīms*, *dais* (midwives) and *jarrāḥs* (surgeons), even though their visions of this authenticity differed.

### III. The *Ṭabīb* in Government Service: Hyderabad

Institutional developments in unani *ṭibb* in Hyderabad, though broadly contemporaneous, differed greatly from those in other regions of India and were the product of dissimilar political and social conditions. While institution-building in Delhi and Lucknow was initiated and led by prominent and influential families, reflecting the abiding power of kinship in unani culture, in Hyderabad, like Bhopal, the institutionalisation of *ṭibb* was primarily a state initiative.

There were two distinct phases in the institutionalisation process in Hyderabad. The first, begun between 1889 and 1891, involved the setting up of three government run unani dispensaries in the city, a unani school, a warehouse for storing medicines, and a branch of the medical department (*Serrishtah Ṭibābat*) for the running of unani operations and a management council (*Majlis Intizāmī*) to oversee unani affairs. The second involved the implementation of the *iskīm jadīd* (‘new scheme’), in which the seventh Nizam of Hyderabad, Osman Ali Khan, took a personal interest and invested substantial sums of money. This stage culminated in the opening in 1939 of the Nizamia Ṭibbi College and Hospital.

Hyderabad with its tradition of unani and ayurvedic patronage had long attracted physicians and druggists seeking employment. The hospital *Dār ash-Shifā* (the standard term for a hospital in Arabic, ‘Place of Healing’), was a powerful symbol of this patronage – built on the order of the founder of Hyderabad city, Muhammad Quli Qutb Shah, in 1595 on the banks of the River Musi, not far from the city’s hub, Char Minar. Primarily constructed to cater for the city’s sick-poor, the hospital could accommodate 400 in-patients around a central courtyard, who were attended by unani *ṭabībs* and

voids.<sup>258</sup> When Aurangzeb took control of Hyderabad in 1687 and the Qutb Shahi dynasty crumbled, the hospital fell into dereliction. Nevertheless patronage of *ṭibb* continued in the form of land rights (*jāgīrs* or *mansabs*) granted by the nobility to *ḥakīms* who had excelled in their service. The revenue from this land would fund the *ḥakīms*' dispensaries. Sufi shrines (*dargāhs*) have been another prominent site for the practice of unani *ṭibb* up to the present, as in other parts of India as well.<sup>259</sup>

*Ṭibb* continued to be a mobile profession in the nineteenth and early twentieth centuries, with *ṭabīb*s moving from one town to another to study with prominent practitioners or in search of employment. *Ṭabīb*s from north India were recruited into service in Hyderabad, and interestingly, students of *ṭibb* with the means to do so also went to study in the Delhi Madrasa to complete their education, a point to which we will return below. Many of the leading practitioners in both phases of the new institutional development of *ṭibb* in Hyderabad, like Nabina and Mansur Ali Khan whom we have mentioned, came from North India. The first head of the state unani service (*Afsar al-aṭibbā*) ('the chief of the physicians') Hakim Ahmed Said was from Amroha (Rohilkhand). Biographical literature and the petitions of *ḥakīms* for employment reveal that Hyderabad continued to act as a hub for unani practice into the late nineteenth and early twentieth century, attracting *ḥakīms* for government employment or subsidy from Avadh and Punjab in the north but also from Mysore, Arcot and Madras to the south.

The transition from the pre-institutional to the institutional stage was described by Hakim Maqṣud Ali Khan in a speech at the All India Vedic and Unani Tibbi Conference in Delhi in 1922. Ḥakīm Maqṣud Ali Khan, a prominent *ṭabīb* of Hyderabad's state unani service, looked back over the 30-year period of the 'revival' of *ṭibb* in India. Paying tribute to the hosts of the conference, he acknowledged the role of the Sharifi family of Delhi in this movement, but then described Hyderabad's own process of 'revival'. He remarked on unani education and the structure of the *ṭabīb*'s profession in Hyderabad in 1889:

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<sup>258</sup> The figure '4000' cited by Jaggi, *Medicine in Medieval India*, is clearly wrong. V.K. Bhatnagar, S.A. Hussain, Momin Ali, 'A Brief History of Ayurveda in Hyderabad', *Bulletin of Indian Institute of History of Medicine* (henceforth *BIHM*), 24, 1994, pp. 63-74.

<sup>259</sup> F. Speziale, 'Tradition', p.30.

Thirty-two years ago the great unani physicians of Hyderabad, apart from working in their dispensaries, also gave students lessons at home, but there was neither a formal school, nor a formal department as a means by which this noble art could operate through the government of his most exalted Excellency [the Nizam], save in a private capacity. Unani physicians had access to the Nizam's vestibule, and they also had influence in the villas of the nobility. Through private means they used to perform public services, but there was no system by which they could serve the public with government resources.<sup>260</sup>

The *hakīm* clearly wished to place this early phase in the institutionalisation of *tibb* in Hyderabad in the context of its revival in North India. What became one of the most elaborate state supported unani services in India started out on a very humble scale, and shared very little with developments in Delhi, Lucknow and even Lahore.

In accounts of this process by Maqṣud Ali Khan and others, we find the interests of the government and the public at large represented, while those of prominent *hakīms* are absent.<sup>261</sup> This underscores a profound difference in the experience of Hyderabad and North India. In Maqṣud Ali Khan's account of this process, the sixth Nizam of Hyderabad Mir Mahbub Ali Khan, Nawab Asman Jah, and Nawab Viqar ul-Mulk (revenue minister) were the leading personages involved in these reforms. Asman Jah was Diwan<sup>262</sup> of Hyderabad from 1887 to 1893, and came from one branch of the most prominent Hyderabad noble family after the Nizam's, the Paigah. Hakim Maqṣud Ali Khan credits Asman Jah with patronizing movements (*tahrīkāt*) in the arts and sciences. It seems that the nature of the unani 'movement' to formalise unani education and practice in Hyderabad was, in ideal terms as expressed by Asman Jah, one that imitated western models. In his role as Diwan, Asman Jah is known to have promoted western

<sup>260</sup> *Āl Indīa Vaidik aind Yūnānī Ṭibbī Kānfarans* [henceforth AIVUTC] ke Gyārhaven Sālānah Ijlās kī Rū'idād, Delhi, 1922, p. 130: 'Go kih āj se batīs sāl qabl Ḥaidērābād meṅ nāmī grāmī aṭibbā maujūd the jo maṭab karne ke 'ilāvah ṭulabā ko ghar par bhī diyā karte the magar nah ko'ī bā zābīṭah madrasah thā nah bā zābīṭah sarparastah jis se is sharīf fann ka sivā'e khānagī sūraton ke a'lāḥazrat kī gaurnamant sarkārī ṭarīqah par ho. Aṭibbā-i yūnānī peshgāh-i khūsrovī meṅ bhī bāryāb the umarā kī deorhiyon meṅ bhī un kī rusūkh thā khānagī ṭaur par pablik bhī khidmāt bhī karte the magar sarkārī ḥaiṣiyat se pablik kī khidmāt karne kā ko'ī intizām nahīn thā'.

<sup>261</sup> Rehber Faruqi, *Islāmī Ṭibb*, Hyderabad, 1999; Waliuddin Ahmed Qarshi, *Muslim Hind ke Ilmī, Fikrī, Siyāsī aur Ṣaqāfī Irtiqā'* meṅ Ḥaidērābād Dekkan ka Kardār, Karachi, 1978.

<sup>262</sup> The Diwan was the Nizam's leading official, often in an intermediary diplomatic capacity between the Nizam and the British Resident.

education under the patchily modernised administration in Hyderabad that was developed by Sir Salar Jung I.<sup>263</sup> He is reported to have instructed the Council for unani affairs to: ‘Prevent an ignorant *hakīm* from endangering life; arrange for the collection of sound medicinal drugs and arrange for the repose of those patients who need help and care in the unani dispensaries, like in the English hospitals’.<sup>264</sup> For Asman Jah a degree of government control of the unani profession was desirable. It is not clear how the Medical Department of the time, headed by Residency Surgeon Major Edward Lawrie, viewed government support for *tibb*. It is manifestly clear in the reports of the Medical Department in the 1890s that Edward Lawrie generally held unani practitioners in contempt, and would rather have steered the public towards the state-run European medical services.<sup>265</sup> His reticence not to have addressed this issue directly may have been prompted by the small-scale ambitions of the Unani Department, and Lawrie had died long before the plans were proposed in 1926 for the establishment of the Nizamia College.

Given the growth in the number of advertising *hakīms* in Hyderabad, it is also likely that the interests of the government and learned *ṭabībs* would have converged on the issue of regulating unani practices in the city. Popular demand for government-supervised unani dispensaries was cited as the major factor in their obtaining government support. Hakim Maqsd Ali Khan refers to a petition, published in the government gazetteer (*Jarīdah I’lāmiyah*), which was submitted to Asman Jah in 1300 Fasli (1891) in which people requested the Hyderabad government to run unani dispensaries.<sup>266</sup> He remarks that ‘on this petition there were a great many signatures of individuals bearing the intention of

<sup>263</sup> K. Isaksen Leonard, *Social History of an Indian Caste: The Kayasths of Hyderabad*, Hyderabad, 1994, pp. 193-4.

<sup>264</sup> *Nim hakīm khātrah-yi jān aṭibbā ka insidād kare, ‘umdaḥ advīyah kī farāhimka intizām kare aur miṣl angrezī hospītālōn ke yūnānī davākḥānōn meṅ jin marīzōn kī sukūnat ka intizām publik kī imdād wa i’ānat se kare’*. Document addressed to Nizam Osman Ali Khan by Hakim Maqsd Ali Khan concerning the inauguration of the Nizamia Tibbi College, APSA, Instalment 85, List 3, Serial 534, 10 Meher, 1347 Fasli [16 August 1938], document 29.

<sup>265</sup> *Report on the Civil Medical Department for 1300 Fasli* [1892], APSA, Instalment 17, List 8, Serial 10, File j2/b1, p. 22.

<sup>266</sup> *AIVUTC ke Gyārhaven*, p. 130. I could not locate the *Jarīdah I’lāmiyah* for this year in the libraries and archives of Hyderabad. There were of course a large number of private unani dispensaries in Hyderabad city.

all classes of people, with no regard to faith or community'.<sup>267</sup> Asman Jah agreed to the request, with the backing of the sixth Nizam Mahbub Ali Khan, who maintained links with unani *hakīms* as personal physicians.<sup>268</sup> It is perhaps surprising that such a petition was submitted, since unani *ṭibb* was undoubtedly widely resorted to in any case. In the absence of the original document, it is problematic to draw any firm conclusions. We do not know who drafted the petition, or how many people signed it. We can speculate that the public wanted free unani treatment, as the poor would have received at the Afzal Ganj Hospital, for example. Or perhaps the public shared the government's concern about the lack of credibility of many practitioners: a government-supported unani service might conceivably ensure a standard of quality, although this possibility is more remote. It may also be the case that unani practitioners organised the petition in order to support their case for government support as it is also conceivable that by the end of the nineteenth century *ṭabībs* in Hyderabad might have felt marginalised in the face of an increasingly sophisticated state organisation along the lines of colonial medical services.

In Hyderabad, as in other centres of Muslim culture in the subcontinent, families of *hakīms* had often enjoyed long standing associations with the court of the ruler and the nobility. While these connections were maintained to some extent in Hyderabad, from the mid nineteenth century a state apparatus for medical care evolved that began to eclipse the personalised functioning of the unani profession. This emerging state-run medical care was organised strictly on western lines.

In 1846, on the initiative of the then Resident General Fraser, and with the support of the fourth Nizam of Hyderabad, Nasir ud-Daula, a medical school was set up for training young Hyderabadi men (and later women) in western surgery and medicine.<sup>269</sup> The aim of the school, according to Dr. George Smith, Residency Surgeon and director of the school in the 1850s, '[was] not, as some imagine, to prepare for the public service a class of Medical Subordinates, but, to train medical men, qualified to take up private

<sup>267</sup> *Ibid.*: 'Is mazḥar par tamām ṭabaqāt-i ru'āyā ke sarbarāvar voh afrūd ke kaṣīr-i ti 'dād men dastkhaṭ bilā liḥāz-i mazhab o millat the'.

<sup>268</sup> *Ibid.*

<sup>269</sup> Reddy, 'Advent'; W. C. Maclean, *Memories of a Long Life*, Edinburgh, 1895.



practice in the city and fitted to act as talookha surgeons under the Native Government'.<sup>270</sup>

The first batch of 17 graduates of the school was mostly in the employ of the nobility of Hyderabad: Sir Salar Jung, and one of the school's advocates Nawab Shams al-Umra. Only two started private practice.<sup>271</sup> Despite its modest beginnings, the school formed the basis for an increasing investment in western medical sciences. It was the only medical school in India at the time in which a vernacular language was the medium of instruction, though English eventually replaced Urdu in 1884. The prestige that it acquired was such that it attracted students from hereditary unani backgrounds to study western medicine.<sup>272</sup> By 1898 there were a total of 86 dispensaries and hospitals throughout the state, the majority of which were supported by the government, catering to over half a million patients.<sup>273</sup> There was also provision for female patients in the Zenana Hospital, and lady doctors were being trained in the Medical School. By 1909 total expenditure on the Medical Department was Rs. 674,002.<sup>274</sup>

In the light of this state involvement in western medicine, it is possible that professional interests might have motivated the institutionalisation of *tibb* in order to re-establish links between the ruling apparatus and unani medical practice. From this perspective the establishment of government-aided unani dispensaries could have been an important opportunity for unani *ṭabīb*s to reclaim a sense of authority and parity. The city dispensaries treated minor surgical cases, although only one of them had in-patient facilities. Bearing in mind the caveats of interpreting rather sparse statistical data, it seems that the government unani dispensaries were quite popular, though few in number (by 1898 there were six government-supported dispensaries in Hyderabad city). Nevertheless, one does not know from these statistics at what stage of illness the patients sought help, and for what kind of problems; whether the patients sought multiple forms of treatment, or presented themselves on more than one occasion to the same clinic. Moreover, one does not know whether the statistics were accurately compiled. As far as

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<sup>270</sup> Smith (1859) quoted in Reddy, 'Advent', p. 56.

<sup>271</sup> *Ibid.*, p. 58.

<sup>272</sup> S. A. Hussain, 'Medicine under the Royal Patronage of the Asifeyya Kings', *BHIIM*, 20, 1990, 141-50.

<sup>273</sup> *Report of the General Administration of H.H. the Nizam's Dominions* (henceforth *RGA*), for the years 1304-1307 Fasli [1894-1898], Hyderabad, pp. 215-19.

<sup>274</sup> *RGA*, for the years 1320-1321 Fasli [1910-1912], p. 61.

inferring popularity is concerned one should also take into account the ease or difficulty with which patients could have reached the clinic, and the cost of treatment as factors in help-seeking behaviour. Notwithstanding these areas of uncertainty, the data do point to a situation where there was no discernible progressive decline in the popularity of indigenous medicine in the late nineteenth century. Anil Kumar shows that there was a demonstrable rise in people's resort to allopathic drugs and attendance at western medical dispensaries during the late nineteenth century,<sup>275</sup> but this does not imply that the use of indigenous medicines declined. One cannot presume that patients did not resort to multiple forms of treatment. We should note that we are only dealing here with government-backed dispensaries in Hyderabad. It is not possible, from material available, to gauge either the popularity of western or unani medicines in private practice.

The process of institution-building in Hyderabad differed from that in Delhi and Lucknow in that unani practitioners in Hyderabad made no effort to reform the practice of traditional birth attendants (*dais* or *qābilahs*, a term derived from Arabic, meaning 'competent woman') in this early phase. In Delhi and Lucknow, meanwhile, the question of reforming dais' practices was on the agendas of Hakim Ajmal Khan and Hakim Abdulaziz, who had both been exposed to the activities of the Dufferin Fund and the prioritisation of women's health.<sup>276</sup> The Dufferin Fund, by which the National Association for Supplying Female Medical Aid to the Women of India was commonly known, was established in 1885 with the objective of training women in order to treat female patients.<sup>277</sup> In 1909 Lady Hardinge inaugurated the Zenāna Madrasa at the Madrasa Ṭibbiya in Delhi for the purpose of training *dais*.<sup>278</sup>

In Hyderabad, early attempts to introduce English birthing practices were not very successful. The celebrated administrative reformer of the mid nineteenth century, Salar Jung I, opened a *zenāna* dispensary with the aid of an American lady doctor, but it was forced to close in 1880 due to the opposition of local women.<sup>279</sup> In accord with contemporaneous colonial discourse on indigenous midwifery, the Hyderabad medical

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<sup>275</sup> A. Kumar, 'Drug', pp. 364-5.

<sup>276</sup> Alavi, 'National', p. 5.

<sup>277</sup> D. Arnold, *Colonizing*, pp. 262-267.

<sup>278</sup> Abdur Razzack, *Ajmal*, p. 25.

<sup>279</sup> A. Asghar Ali, *The Emergence of Feminism among Indian Muslim Women, 1920-1947*, Karachi, 2000, p. 96.

establishment viewed the *dais* with contempt. Residency Surgeon Edward Lawrie in his report of the medical department for 1891 spares no detail in depicting the horror of *dais*' practices. He recounts, for instance, that if post-partum haemorrhage occurs, 'the patient is made to stand up against a wall and an old woman butts at her abdomen with her head like a goat'.<sup>280</sup> Variations on this practice are still evident among *dais* to this day. Sameera Jain's recent documentary film on traditional birth attendants in India, 'Born at Home', shows that this technique, a gentle massage with the head (not necessarily a 'head butt') of the post partum woman's abdomen, is used to help expel an accumulation of blood from her body. Lawrie lamented that it was not only the practice of midwifery that was 'almost entirely in the hands of uneducated dhais [sic]', but also the treatment of women's and children's diseases in general.<sup>281</sup> Along with the *dais* he castigated 'the uneducated Hakims who flood the city' for their ignorance and the harm they cause. His solution was to try to limit the recourse to indigenous practitioners by opening more western dispensaries, each with a lady doctor attached.<sup>282</sup> It is not surprising then that he mentioned nothing of incorporating midwifery into unani dispensaries, although this did happen. Although there was no formal training mechanism connecting traditional birth attendants and unani *tibb* in Hyderabad, as a result of the institutionalisation of *tibb* from 1891, *qābilahs* became attached to unani dispensaries. It is in midwifery that the popularity of unani dispensaries, compared to western medical provision, is most apparent. Over a four-year period, from 1895 to 1898, *qābilahs* attached to unani dispensaries dealt with 15,012 deliveries, while the British administered Zenana Hospital in Hyderabad totalled only 401.<sup>283</sup> A *dai* training scheme was in place at the British administered Victoria Zenana Hospital at least by 1914, although few passed the course, (five passed in 1914).<sup>284</sup> It is highly unlikely that any trained *dais* would have sought employment through the unani department. Those women who did go to the Zenana Hospital to give birth were from the elite strata of society more exposed to the influence of western culture and medical practices. As an administration report notes for the years 1910-1912: 'The demand for English treatment at the time of confinement...is chiefly

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<sup>280</sup> *Report on the Civil Medical Department*, APSA, 1892, p. 22.

<sup>281</sup> *Ibid.*

<sup>282</sup> *Ibid.*

<sup>283</sup> *RGA* for 1910-1912, pp. 219, 221.

<sup>284</sup> *Annual Report of His Highness the Nizam's Civil Medical Department for the year 1323 Fasli* [1914].

amongst the upper classes, and the poorer women of Hyderabad are still much maltreated by the dais, in whom they trust implicitly'.<sup>285</sup>

The data mentioned above raise a number of questions, and problems. The data are very minimal for midwifery practised through unani dispensaries; there are, for example, no data on complications in delivery, or maternal or infant mortality. The midwifery practised through the unani dispensaries was without any doubt for home deliveries, but we do not know if complicated births were referred to the British administered hospitals. We know next to nothing about who these *qābilahs* were and how they came to be employed by the government. In the discussions over the reform of the unani services, which were first proposed in 1914, there was no discussion of training schemes for the *qābilahs* who were employed in the unani dispensaries, only new suggestions for pay.<sup>286</sup>

What one can draw from this rather fragmentary evidence is that with the establishment of government supported unani dispensaries traditional birth practices were brought into an institutionalised context on a larger scale than before although *ḥakīms* were not actively engaged in reforming provisions for women's health.

#### IV. The Nizam and Professional Mobilisation

The year 1914 marks the second phase in the institutionalisation of *ṭibb* in Hyderabad. The Medical Council set up in 1911 to oversee unani affairs made a number of suggestions for the reform of the unani administration, which constituted the 'new scheme' (*iskīm jadīd*).<sup>287</sup> These included instruction in surgery and anatomy as compulsory subjects in the curriculum of the Madrasa Ṭibbiya, with the option of studying ayurveda.<sup>288</sup> Nizam Osman Ali Khan, who had assumed the throne in 1911,

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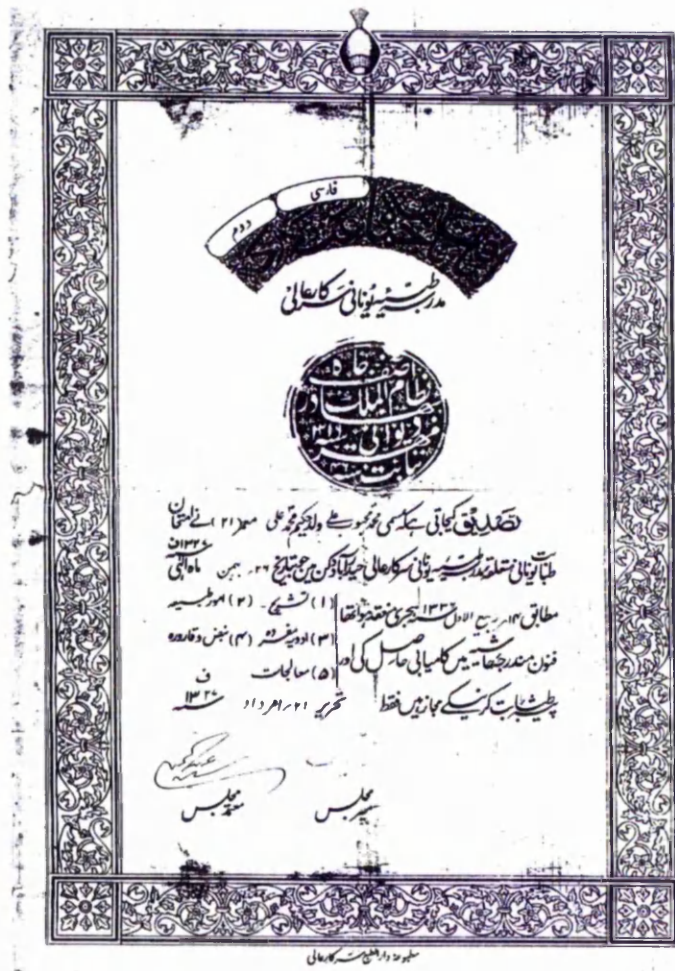
<sup>285</sup> *RGA* for 1910-1912, p. 219.

<sup>286</sup> 'Iskīm jadīd izlā' va taraqqī-i yūnānī shifākhānājāt', 30 Rabī' al-awal 1332 Hijri [26 February 1914], APSA, Instalment 79, List 2, Serial 126.

<sup>287</sup> *Ibid.*

<sup>288</sup> *AIVUTC ke Gyārhaven*, p. 133.

sanctioned these reforms 'for the sake of [putting] the madrasa on a good standard'.<sup>289</sup> The certificate (see below) awarded by the school in 1918 to one of its graduates, Hakim Muhammad Mahbub Ali, who ran a dispensary and was a physician of the Nizam Osman Ali Khan, shows that he had received instruction in anatomy, but there is no suggestion that he had also been trained in surgical practices, although surgery was taught at the school by the time that Hakim Maqsud Ali Khan addressed the Vedic and Unani Conference in 1922.



The certificate of Muhammad Mahbub Ali granted by the Madrasa Tibbiya Unani (Hyderabad) on 26 June 1918. 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*.<sup>290</sup>

<sup>289</sup> *Ibid.*

<sup>290</sup> My thanks to Hakim Muhammad Khairuddin for supplying me with this document.

In this second stage of the reform process, many prominent *hakīms* in Hyderabad were active in petitioning and trying to win support for their activities. Hakim Maqsud Ali Khan, who would become the first principal of the Nizamia Tibbi College, was the first secretary of the Anjuman-i Aṭibbā-i Haiderābād, an association of unani physicians in Hyderabad which lobbied for reforms in the unani profession.

The Anjuman-i Aṭibbā was formed in 1920 following the establishment of the Haiderābād Nizām Āyūrvaidik and Unani Ṭibbī Conference in 1919, by the *vaid* Hakim Hari Govind Kaviraj, and had links with the Delhi-based All India Vedic and Unani Tibbi Conference (AIVUTC). The foremost of its aims was to create ‘accord and unity’ (*ittifāq wa ittiḥād*) among unani *ṭabībs* – a useful indicator that no such unity existed at that time. The 79 members of the Anjuman in 1921 comprised the elite of Hyderabad’s unani *ṭabībs*, and it had the support of various influential figures in the Hyderabad administration, including Ali Akbar Hydari, the then finance minister who was one of the most prominent figures in Hyderabad politics in the 1920s and 30s, and Nawab Vilayat Jung, the justice minister, but the opposition came from within the ranks of *ṭabībs* themselves. As Maqsud Ali Khan commented at the AIVUTC of 1921.

I, or we, have contacted unani physicians, and it is difficult to create the authority (*quvvat*) to do [our] work, although the Anjuman, in its short life, has really put some effort towards this goal. However, there are currently some individuals who are unfamiliar with the blessing of working in unison, and frequently, in fact, they are prepared to oppose it.<sup>291</sup>

The Anjuman had the objective to revitalise and reform unani *ṭibb* in Hyderabad, as expressed by Hakim Maqsud Ali Khan: ‘Through [the Anjuman] the inertia of unani *ṭabībs* will, in the right spirit, be changed, and then they will regain the old status and prestige which has been lost’.<sup>292</sup> Its aims included the following:

<sup>291</sup> AIVUTC ke Gyārhaven, p. 137: ‘Aṭibbā-i yūnānī main yā ham milkar kām karne kī quvvat paidā karnā mushkil hai aur go kih anjuman ne apnī choṭī sī ‘umr meṅ us maqsad par bahut koshish kī hai lekin abhī aise afrād maujūd haiṅ jo ittiḥād-i ‘amal kī barkat se nā āshnā balkih basā auqāt ‘amalan is ke mukhālifāt karne par tayār ho jāte haiṅ’.

<sup>292</sup> Ibid.: ‘Aur uske zarī‘ah se qṭibbā-i yūnānī kī jumūd va sace iḥsās se badal jā‘egā aur apnī khū‘i hū‘i qadīm qadr o qīmat ko phir do bārah ḥāṣil karenge’.

- to organise means by which *tibb* might progress;
- to lobby the Hyderabad government for the progress of *tibb*;
- to make known medicines and preparations to be used against plague, influenza and malaria;
- to conduct research on medicinal plants of the region [mulkī] and to encourage unani tabibs to use them;
- to publish and support the publication of works on *tibb*;
- to fulfil its goals through unani journals
- to try to encourage prejudices between medical practices [tibābatīn] to be abandoned
- to revive the rare, hoarded<sup>293</sup> unani books and to publish complex old works in Urdu<sup>294</sup>

The agenda of the Anjuman was certainly inspired by the model of the AIVUTC (see chapter 4). The Anjuman emphasised breaking down the barriers of traditional unani knowledge by publicising prescriptions and making accessible rare works on *tibb*, by conducting research on medicinal plants and encouraging cooperation among practitioners. The Hyderabadī *tabibs* of the Anjuman saw the usefulness of journals to fulfilling their goals. But unani journal literature of the time in Hyderabad bore little resemblance to the unani journals that were brought out in North India, such as *Rafiq al-Aṭibbā*, *al-Ḥakīm* and *Ḥikmat* from Lahore. While *Rafiq al-Aṭibba* was first published in 1906, the first unani journal published in Hyderabad was *al-Mu‘ālij* (‘the healer’), edited by Hakim Bashir Ahmed, came out some ten years later in 1916. A thin publication, a sample copy from 1918 reveals that it discusses a variety of treatments, the medicinal virtues of mangoes, for example, but it has none of the political engagement and exchange of ideas which characterised many unani journals in north India. This fact points again to the comparatively late engagement by Hyderabadī *hakīms* with the revival of *tibb*. It was only in 1935, with the publication of *Ḥakīm-i Dekkan* by the board of the

<sup>293</sup> ‘*zakhīrah*’, hoarded like treasure.

<sup>294</sup> *AIVUTC ke Gyārhavēn*, p. 138.

Hyderabad Anjuman, that a journal was produced in Hyderabad which resembled much more closely its counterparts in north India in style and content.

One rallying call for unani and ayurvedic practitioners in British India had been the passing of the Medical Registration Act through provincial legislatures in the 1910s, (see chapter 4). Hyderabad's *hakīms* and *vaid*s did not have to battle against such an act, which in British India was widely perceived among unani and ayurvedic physicians to be defamatory to their profession. In 1898 Hyderabad *hakīms* and *vaid*s were given a degree of legal parity with doctors. A court ruling in their favour, backed by the Revenue Department against a case made by the Chief Medical Officer in Bidar, stipulated that sick certificates granted by unani *hakīms* were admissible, and, with the exception of post-mortem cases, their certificates would be on equal status with those of the western trained doctor.<sup>295</sup> But the ruling also made it conditional that the unani *hakīm* from whom a certificate was sought would have a dispensary, and would be able to provide evidence of a qualification. If he were not able to do so, the certificate would be open to question.<sup>296</sup> This instance attests to the importance for a *ṭabīb* of a fixed practice and a recognised qualification, two central features of the process of the bureaucratisation of indigenous medicine gathering pace at this time.

There were attempts to register practitioners in Hyderabad. In 1911, the *Qānūn Ṭibābat* ('Medical Act') was promulgated in Hyderabad, contemporaneous with the passing of the Medical Registration Act through the Bombay legislature, and a *Majlis Ṭibābat* ('Medical Council') was formed, whose design was based on the 'principles of England'.<sup>297</sup> The great difference between the legislation in Hyderabad and Bombay was that 'contrary to the case in England and British India, which gives only doctors the right to register, the names of unani and *miṣrī*<sup>298</sup> practitioners were to enter the register'.<sup>299</sup>

<sup>295</sup> Judicial, Police and General Departments, Proceedings, 7/2 Medical, 26<sup>th</sup> December 1897, p. 1; 'Resolution regarding the granting of certificates by unani and other hakims', Instalment 17, list 8, serial number 27, file j2/b19, 1898, p. 1.

<sup>296</sup> *Ibid.*, pp. 2-3.

<sup>297</sup> *AIVUTC ke Gyārhaven*, p. 132.

<sup>298</sup> The term is used to refer to Hindu practitioners in the Deccan by Persian-Urdu speakers, and is said to be derived from the Arabic *miṣr*, 'town', for the practitioners were townfolk. It is mostly used synonymously with ayurveda.

<sup>299</sup> *AIVUTC ke Gyārhaven*, pp. 132-133: '*Is daurān men qānūn-i ṭibābat nāfīz wa majlis-i ṭibābat qā'im hu'e jis ka munshā' Inglīstān kī uṣūl par magar Inglīstān aur Brīṭish Inḍiyā ke bar khilāf kih ṣirf dāktarī hī haqq-i rajīstrī rakhte hain qāṭibbā-i yūnānī miṣrī aur āyurvaidik ke nām bhī daraj-i rijīstar karnā*'.



This legislation seems, however, to have had little value in practice, and no registration of practitioners of any kind took place in Hyderabad during the period of this study.

Accounts of the history of *ṭibb* in Hyderabad have often tended to emphasise the role of the Nizam in bringing about change in the medical profession. Rahbar Faruqi's *Islāmī Ṭibb*, for example, ties the fate of *ṭibb* with the personal involvement and attitude of the ruler, resulting in a kind of dynastic history of *ṭibb*.<sup>300</sup> Thus the fourth Nizam is associated with the rise of allopathy in Hyderabad, the sixth Nizam with the beginnings of *ṭibbi* revival, and the seventh Nizam, Mir Osman Ali Khan, is credited with its very renaissance. In the case of Mir Osman Ali Khan, with his personal investment in unani *ṭibb* and his acquiescence to petitions made by *ṭabībs*, there is most certainly some justification in this attribution. We need to see his role here in the context of the political situation of the time in Hyderabad. Margrit Pernau's meticulously researched study of Hyderabad's changing political culture in the first half of the twentieth century brings to light the tensions in Mir Osman Ali Khan's striving for legitimation.<sup>301</sup> Within the first decade of his reign, the Nizam was caught between maintaining alliances with the British and his ambition to assume the role of the leader of Muslims with the demise of the Ottoman Khilafat.<sup>302</sup> Although by 1920 he had fallen out with the Khilafat movement as its methods of mass mobilisation threatened to destabilise his own authority, and despite the constitutional reforms that the British forced upon him, the Nizam into the 1930s continued to entertain notions of becoming the leader of India's Muslims. The marriages that he arranged for his sons to the daughter and niece of the last Turkish Sultan support this contention.

During the rule of Nizam Osman Ali Khan the government expenditure on unani *ṭibb* and the number of unani dispensaries rose quite markedly.<sup>303</sup> But the most radical development was the construction of a huge building in Indo-Saracenic style that accommodated the Nizāmia Ṭibbī College, subsuming the Madrasa Ṭibbiya, and a unani

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<sup>300</sup> Sections of this work have been translated by S.A. Hussain, see bibliography for details.

<sup>301</sup> M. Pernau, *The Passing of Patrimonialism: Politics and Political Culture in Hyderabad 1911-1948*, New Delhi, 2000.

<sup>302</sup> *Ibid.*, especially pp. 96-114.

<sup>303</sup> In 1937 there were 27 unani dispensaries in Hyderabad city, 10 government and 17 private aided, which treated 1,553,203 patients, compared to three government and two aided dispensaries in 1912, treating 726,923 patients. *RGA for 1346 Fasli* [1937], p. xxv; *RGA for 1320-1321 Fasli* [1910-1912].

hospital with 150 beds, the Sadr Shifākhānah Nizamia. For the date of the construction of the unani college and hospital the Nizam composed a chronogrammatic verse inscribed over the entrance, *'hiya bait al-ḥikmat wa al-shifā'* ('this is the house of wisdom / *ṭibb* and cure'). This is a clear allusion to the Bait al-Ḥikmah ('House of Wisdom') of Abbasid Caliphate fame, the library and place of scholarship that became a legend in the construction of the golden age of Greco-Islamic learning.<sup>304</sup> Perhaps we are to see Osman Ali Khan's role as the patron of unani *ṭibb* as the reflection of the caliphs al-Mansur and al-Ma'mun's devotion to patronising scholarship. It is interesting that he chose *bait al-ḥikmah* as the motif and did not refer to another great symbol of royal patronage of *ṭibb* closer to home, one much more a part of Hyderabad's own history: the Dār ash-Shifā ('house of cure'), which we referred to above. This suggests that Osman Ali Khan was looking beyond Hyderabad and saw himself as the patron of a much broader constituency, one resonating with the Khilafat ambitions in which *ṭibb* had become a potent symbol of a glorious Muslim heritage. The Nizam inaugurated the college in 1939, the culmination of a process that began with his issuing a *firmān* (directive) in 1926, requesting that a scheme for investigating the duties of *ṭabībs*, improving the means of supplying medicines and improving the instruction at the Madrasa Ṭibbiya be drawn up.<sup>305</sup> The Nizam certainly supported the moves of the Anjuman that *ṭibb* should emulate western medical institutions and incorporate some of its apparatus. The college included anatomical charts, model skeletons, a dissection hall (*dār at-tashrīḥ*) and a chemistry laboratory.<sup>306</sup>

The large and equally grand western medical hospital, Osmania Hospital, had been constructed at vast government expenditure during his rule. The two lavish structures are manifest symbols of power; the unani hospital was built in the heart of the old city, adjacent to Hyderabad's principal landmark, Char Minar, and opposite Mecca Masjid, Hyderabad's large congregational mosque, and the western hospital is not far away on the banks of Hyderabad's River Musi overlooking the law courts. In sanctioning these huge projects we can perhaps see the Nizam projecting himself through his munificence as the

<sup>304</sup> Dimitri Gutas, *Greek Thought, Arabic Culture*, London, 1998.

<sup>305</sup> *Dastūr al-'Amal Nizamia Ṭibbi College*, Hyderabad, 1937, p. 2; A. W. Zahuri relies on this document for his account of the Nizam's directives and the programme of the college, 'The Nizamia Tibbi College, Hyderabad, Deccan', *Hamdard Medical Digest*, 4-6, 1966, pp. 5-15.

<sup>306</sup> *Dastūr al-'Amal*, pp. 21-2.

heir to a medical tradition that was part of Hyderabad's Muslim cultural heritage, and at the same time, as a ruler in touch with modernity. It should be acknowledged that the Nizam also supported ayurveda. In 1938 the Nizam granted the attachment of an ayurvedic section to the unani department and sanctioned the expenditure of Rs. 35,000 for it.<sup>307</sup> The nature of the political relationship between *tibb* and ayurveda in Hyderabad from the 1930s through to the accession of Hyderabad State to the Union government of India in 1948 and beyond remains a subject for further study. One has to see the communalisation of medicine in Hyderabad as a possibility in the context of rising communal tensions in the 1920s and especially the 1930s. The Hindu proselytizing mission, the Arya Samaj, began to mobilise in Hyderabad in the 1920s. Bahadur Yar Jang founded an organisation to promote conversion to Islam, the Majlis Tablīgh-i Islām in 1927 and set up the Hyderabadī branch of the Khaksar movement in the 30s; in 1928 the Majlis Ittihād al-Muslimīn (Council for the Unity of Muslims) was created with one of its objectives being 'to protect the economic, social and educational interest of the Muslims'.<sup>308</sup>

The opening of the Nizamīa Tibbī College in 1939 heralded a new era in the kind of unani instruction and organisation available in Hyderabad. Such was the importance attached to selection for the post of principal, that various ministries of the Hyderabad government and the British Residency worked together with the Central Intelligence Department (C.I.D.) in British India in order to assemble detailed character profiles on the prospective candidates. Clearly, excellence in *tibb* and administrative skills were not enough. The chosen candidate, who would receive an ample salary of Rs. 1000 a month, had to be respected for his sound and upright character. The information provided by C.I.D. proved critical in the final selection. A highly respected and well-known *hakīm* from Delhi, Muhammad Ilyas Khan, although warmly recommended by Hakim Maqsud Ali Khan, head of the unani department in Hyderabad, was dropped from selection on account of a confidential report which made extraordinary allegations against Ilyas Khan of embezzling AIVUTC funds, and of having committed sexual offences with male and

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<sup>307</sup> RGA 1347 Fasli [1936-37], p. xxii.

<sup>308</sup> L. Benichou, *From Autocracy to Integration: Political Developments in Hyderabad State (1938-1948)*, Hyderabad, 2000, p. 39.

female students in his role as Principal of the Ayurvedic and Unani Ṭibbi College.<sup>309</sup> The post was ultimately taken by another prominent *ḥakīm* of the 1920s and 30s, also a graduate of the Delhi school, Hakim Kabiruddin, although Ilyas Khan's son was also appointed within the administration.

The vast expenditure in the 1930s, this semi-political appointment, coupled with the wide-ranging adjustments in administration and instruction show clearly how much the complexion of unani *ṭibb* had changed over the fifty years between the setting up of the first institutions in Hyderabad and the inauguration of the Nizamia. The question remains of how to assess the function and place of *ṭibb*'s new institutions in the prevailing culture of unani practice. How different were these new arenas from pre-existing teaching practices? What did it mean for a *ṭabīb* embarking on a career to possess a qualification from one of these institutions? Are we to understand the authority of the qualification as immediately recognisable? In the next and subsequent sections of this chapter we will examine these issues in relation firstly to the Madrasa Ṭibbiya in Hyderabad and the Madrasa Takmil at-Ṭibb in Lucknow, secondly through the prism of biographical literature produced in Hyderabad.

## V. 'Revival' and the Incongruity of the Institutional Model?

That we are not dealing with a 'revival' of *ṭibb* in the early phase of institutionalisation in Hyderabad is underscored in the operations of the unani school, the Madrasa Ṭibbiya. Its origins were modest. It consisted of four rooms in a house in the centre of Hyderabad.<sup>310</sup> In its early years the language of instruction at the Madrasa was Arabic and it employed only one teacher.<sup>311</sup> In one of the few administration reports to survive

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<sup>309</sup> Confidential letter dated 22 March 1939 from Mr. M.S.A Hydari, Delhi to Sir Akbar Hydari, Hyderabad, 'Tanzīm' document 10; Shamshad Hussain, letter to the 'Secretary', *ibid.*, document 22; Nizam's order (*firmān*) concerning Ilyas Khan's employment, 29 Rabi' al-awal, *ibid.*, document 23.

<sup>310</sup> G. Kirschke, 'Die Ausbildung der Ärzte in Hyderabad (Indien)', *Arbeiten der Forschungsstelle des Instituts für Geschichte der Medizin der Universität zu Köln*, Band 29, Köln, 1983 p. 85.

<sup>311</sup> *Dastūr al-'Amal*, p. 1.

that provide more than the most rudimentary details about government-aided unani provision at this time, we are informed that by 1898 twenty-one students had completed the course of study, and 36 more were under instruction.<sup>312</sup> There was in fact little difference in the early years of the Madrasa's existence between this 'formal' education and training in traditional personalised settings. Correspondence relating to a report for 1894 between government officials criticises 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...'<sup>313</sup> This style corresponds to the *dars* of traditional unani instruction, in which students read texts under the guidance of a teacher, which is to be supplemented by experience in the *maṭab* (clinic). The government official reviewing the unani report further criticises the unani department for only giving scant information about midwifery cases.<sup>314</sup>

The comments of the official highlight the incongruousness of the institution in the prevailing structures of the unani profession in Hyderabad. There was evidently a gulf separating how the 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 in Hyderabad of the complaints levelled at the management of the unani classes at Islamiya College in Lahore which we referred to above. But unlike in Delhi and Lucknow, there was no attempt in Hyderabad to bring instruction in *ṭibb* into a new domain of professionalism, to reinvent *ṭibb* to varying extents by engaging with western disciplines and modes of organisation. The absence of such aims in the early years of institutionalisation in Hyderabad point to the fact that institutionalisation here was not predicated on the 'revival' of *ṭibb*, but rather on the will for *ṭibb* to be incorporated into the government infrastructure. In the 1880s and 1890s there was no palpable sense of the decline of *ṭibb*. The currents that informed the enterprise of Hakims Abdulmajid Khan and Abd ul-Aziz in Delhi and Lucknow were not manifest in Hyderabad. Nevertheless, there are more general points that need to be made

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<sup>312</sup> *RGA*, 1304-1307 Fasli [1895-1898], p. 220.

<sup>313</sup> 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 ... 1306 Fasli, 1896-97*.

<sup>314</sup> *Ibid.*

about the meaning of *tibb*'s new institutions in India, which apply equally to Hyderabad and its north Indian counterparts. They will serve to contextualise our observations about the process in Hyderabad, and bear specifically on the overall theme of this thesis, the conceptions of authoritative knowledge and practice in *tibb* in the first decades of the twentieth century.

Even in the context of institutionalisation in Delhi and Lucknow we should not assume that the transition to an institutional model of instruction was one that was smoothly achieved, and that it was comfortably accommodated in the existing structures of authority in *tibb*. The new institutions, ultimately derived from colonial models, might have introduced 'paid staff and fixed requirements to replace the personalistic settings of family homes and apprenticeship', in Barbara Metcalf's oft-cited wording,<sup>315</sup> but in practice the conversion was perhaps not as radical as has been supposed.

A critical letter in 1913 from a graduate of the much esteemed unani school in Lucknow, the Madrasa Takmīl at-Ṭibb, gives us a perspective on the running of this institution which 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, who referred to the founder Hakim Abd ul-Aziz, by this time deceased, with great respect and who composed his letter in a measured tone, took issue with a great many aspects of the management, teaching and syllabus of the school. He wrote that neither the *ḥakīm* teachers nor the students kept to the timings; students who were supposed to attend regularly often did not, but because a register was not properly maintained, this was not commented upon; one student was absent for a year, but could still turn up to take the examination.<sup>316</sup> Muhammad Shafi wrote that he was ashamed of his weak knowledge of anatomy, which was based on only partial instruction from the *Qānūn*, and was inferior to the instruction at Delhi.<sup>317</sup> He described the omissions in the instruction of treatment of parts of the body, wished that the curriculum, centred on the *Qānūn*, was more wide-ranging. He remarked that, although an accomplished work, the *Qānūn* was only an introductory book (*kitāb ibtidā'ī*) when compared with western

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<sup>315</sup> Metcalf, 'Nationalist', p. 4.

<sup>316</sup> Muhammad Shafi, 'Madrasa', p. 33.

<sup>317</sup> *Ibid.*, pp. 33-34.

medical works.<sup>318</sup> Importantly, he emphasised his disappointment that the family-inherited knowledge of medicines among the teachers at the college was not shared among the students. When plague struck, he wrote, the students were dispensing special pills at the clinic in Lucknow, although they did not know their ingredients.<sup>319</sup> Their insufficient knowledge or confidence in prescribing medicines, and their reliance on their teachers had, according to this former student, 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 had ordered at a price. They become good special agents.<sup>320</sup>

Graduates, Shafi continued, may end up serving as brokers among different healers, but it was difficult for them to set up independent practice as unani *ṭabībs*. This lack of confidence also meant that the graduates became ‘dazed and dazzled’ (*‘cukā-caund aur khairah’*) by the powerful effects of allopathic drugs, and the cheapness and benefits of homeopathic drugs. Shafi noted that most students come from Bihar, where they return to practice, but because the Lucknow school was not famous there (at this time), and Hakim Abdurrashid, the son and less well-known successor to Abd ul-Aziz as the principal of the college, the graduates did not have a high standing there. From this fascinating and illuminating letter from the perspective of someone graduating from the new institutions of *ṭibb* some of the key issues of authority, knowledge and practice in early twentieth-century *ṭibb* emerge: 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 which inspires trust among the help-seeking public and attracts their custom.

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<sup>318</sup> *Ibid.*, p 34.

<sup>319</sup> *Ibid.*, pp. 36-37.

<sup>320</sup> *Ibid.*, p. 37: ‘*Ab voh sanadyāftah ho kar apne apne makān āne haiṅ. Aur khūsh naṣībī se marīẓon kā un ke yahāṅ marjū’ah hotā hai. Phir dekhī’e ba’z to aise sanadyāftah haiṅ kih vahīṅ apne ustād ke khāṣ murakkabāt aur paītaṅt advīyah qīmatan Lakhnau se mangvā kar marīẓon ko de rahe haiṅ aur acche khāṣ aījaṅt bane hu’e haiṅ’.*

The qualification from even such a respected institution as the Takmīl aṭ-Ṭibb did not, at this time, convey authority on a ḥakīm in the same way as traditional indicators did. This is not to say that there were not examples of practitioners who set up successful and respected unani practice but who were not hereditary practitioners. But this was a rarity, according to Hakim Ferozuddin, one of Lahore's famous ṭabībs of the early twentieth century. In his work *Rumūz al-aṭibbā*, he remarked:

It does not come as a great surprise if those people who are *khāndānī ṭabībs* make their lives successful and obtain a high rank among unani physicians; but 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 *ṭibb*. Nevertheless, you have collected together excellent prescriptions. Singly due to your efforts you have become famous in the city of Amritsar.<sup>321</sup>

The *Rumūz al-aṭibbā* ('the hints of the physicians') first published in 1911, is a work in which the lives of practitioners are presented with a selection of their prescriptions. It is a form of biographical literature (*tazkirah*) whose existence in early twentieth century *ṭibb* sheds light on the perception of authoritative knowledge and practice in *ṭibb*. Unani *tazkirah* works similar to *Rumūz al-aṭibbā* were also written in Hyderabad. This literature, although mainly a reflection of the concerns of elite sections of the unani profession, offers us insights into how ḥakīms understood and represented, for the public and other ḥakīms, aspects of their lives that marked them as legitimate practitioners. In exploring this literature we are moving into a discourse that will allow us to further assess the relevance of colonial-derived models of authority embodied in the

<sup>321</sup> Hakim Ferozuddin, *Rumūz al-aṭibbā*, Lahore, 1913, vol. 1, p. 247: 'Jo log *khāndānī ṭabīb* hote haiñ voh agar apñi zindagī kāmyāb banā leñ aur aṭibbā meñ achā darajah paidā kar leñ to ko'ī qābil-i ta'ajjub mu'āmilah nahīñ hotā, magar jin logon ke *khāndān* meñ *ṭibābat* kā ziyādah circā nah ho, aur *ṭibābat* kī ṭaraf tavajjuh karne kī ibtidā unhī se hū'ī ho, voh agar 'ilāj mu'ājjah meñ achī kāmyābī ḥāsil lar leñ aur 'umdah 'umdah nuskḥajāt bahum pahuncā leñ, voh bi-l-zarūr qābil-i ta'rīf hote haiñ. Minjulah unke ek ḥakīm sāhib mamdūh aṣ-ṣadr haiñ. Āp ke *khāndān* meñ *ṭibb* kā ko'ī ziyādah silsilah nah thā. Tāhum āp ne ache ache nuskḥajāt bahum pahuncā'e haiñ, aur maḥaṣ apñi koshish se aur shahr-i Amritsar meñ āp kī khāṣ shuhrat hai'.



unani school and the qualification in the context of traditional markers of authority and the new signifiers of competence in the medical market-place.

## VI. *Tazkirah* Literature: Frameworks of Legitimation in the Self-Representation of the Ḥakīm

Prior to the late nineteenth century, knowledge of unani *ṭibb*, in common with all other spheres of learning in Islamic culture, passed predominantly from person to person. As the historian Francis Robinson phrased it: ‘The best way of getting at truth was to listen to the author himself.’<sup>322</sup> Muslim scholars travelled throughout the Islamic world to acquire and put into practice their learning. The legitimising apparatus of the unani profession, again in common with other fields of scholarly endeavour, was attuned to this understanding of what constituted authoritative knowledge. The teacher giving instruction in a text awarded an *ijāzah* or permit to the pupil who had gained sufficient competence in that text. The following is an example of an *ijāzah* that was given to an 11<sup>th</sup> century physician of Baghdad, Ibn Butlān by his master, Abū al-Faraj ibn al-Ṭayyib, reported by the biographer Ibn al-Qiftī:

I saw the copy of an autographical note of Abu l-Faraj for him [Ibn Butlan] (in a copy of) the book “Fruits of argument”, a commentary of Abu l-Faraj, in the following terms: “Has read with me this book from beginning to end the excellent Shaikh Abu l-Hasan al-Mukhtar ibn al-Hasan [Ibn Butlan] – may Allah prolong his authority... Written by ‘Abdallah ibn al-Tayyib’.”<sup>323</sup>

<sup>322</sup> F. Robinson, ‘Islam and the Impact of Print in South Asia’, in F. Robinson, *Islam and Muslim History in South Asia*, New Delhi, 2000, p. 72.

<sup>323</sup> Reproduced in J. Schacht and M. Meyerhof, *The Medico-Philosophical Controversy Between Ibn Butlan of Baghdad and Ibn Ridwan of Cairo*, Cairo, 1937, p. 52.

*Ijāzahs* remained a common feature of madrasa education in India.<sup>324</sup> There is evidence that the award of *ijāzahs*, though not necessarily inscribed within a book, rather perhaps a form of certificate, continued into the twentieth century. The *ijāzah* tradition, though itself not unchanging, presents the notion of a chain of authority linking successions of teachers and pupils over generations. That the *ijāzah* still had value some thirty years after a formal unani qualification was introduced in Hyderabad will support our argument, elaborated below, that personal modes of authorisation continued to exist alongside institutional ones.

In this interpersonal realm of transmission, knowing who had written on a learned subject, like *ḥibb*, or who had passed knowledge on was evidently fundamental to the validation of this knowledge. There are various forms of biographical literature that emerged across the Islamic world, and are particular to it, which have attempted to provide this form of validation, to secure the transmission of truth and the transmission of culture, to compensate, as Francis Robinson remarks, 'for the absence of the author in the text'.<sup>325</sup> Pre-eminent among them in Perso-Indian contexts was the biographical directory or collective biography, often termed *tazkirah*. The collective biography was not universal in its scope, but rather was restricted to certain classes or groups in society. The literary or scholarly classes were the typical focus of the genre in medieval Persia, especially Shia divines, Sufis, sayyids (those who trace their line back to the Prophet) and poets.<sup>326</sup> Physicians also were the subjects of biographical works, like the *Tārīkh al-Hukamā* of Bayhaqi, a civil servant at the court of Ghaznavid rulers in the late 10<sup>th</sup> century.<sup>327</sup>

In India, the genre had a similar scope, with '*ulamā*, Sufis, poets and also *ḥakīms* the subjects of compilations. On physicians, there is, for example, the Persian *Tazkirat al-Hukamā* written in India by Ismail bin Ibrahim Tabrizi in the seventeenth century. The term *tazkirah* though does not have a fixed frame of reference from the mid nineteenth century. Apart from collective biography it can also refer, for example, to a biography as

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<sup>324</sup> F. Robinson, 'Islam', p. 71.

<sup>325</sup> *Ibid.*, p. 73.

<sup>326</sup> A. Lambton, 'Persian Biographical Literature', in Bernard Lewis (ed.), *Historians of the Middle East*, London, 1962, pp. 141-51.

<sup>327</sup> *Ibid.*, H. Gibb 'Islamic Biographical Literature', in Bernard Lewis (ed.), *Historians of the Middle East*, London, 1993, pp. 54-8; Mujtaba Minovi, 'The Persian Historian Bayhaqi', in *ibid.*, pp. 138-41.

a form of pedagogical guide, of one person's life and examples from his teachings and practice, like the *Tazkirah-yi Sharīfī*, compiled by the students of Hakim Sharif Khan, Delhi in 1886. Or, with exposure to European narrative forms, it could refer to a biography in the current sense, like Muhammad Amin Zabiri's *Tazkirah-yi Navvāb Vaqār al-Mulk*, published in Aligarh in 1925.

Of interest for our study is that the collective biography still had a place in Islamic fields of learning and culture in the twentieth century. Of those *tazkirah* that specifically dealt with *ṭibb*, one of the most well known is the two-volume *Rumūz al-Aṭibbā* by Hakim Ferozuddin of Lahore, first published in 1911 and issued in several editions since. Ferozuddin collected biographies from *ḥakīms*, mostly contemporaries, throughout India but with a particular emphasis on Punjab. In Hyderabad two collections are well-known, *Tīr bah Hadaf* ('Hitting the mark'), compiled by Hakim Muhammad Zafaruddin Nasir and published in 1941 and again three years later. The second is the more comprehensive *Tazkirah-yi Aṭibbā-yi 'Ahd-i 'Usmānī*, compiled by Hakim Shifa Hyderabadī in the mid 1930s and published posthumously by Hakim Maqṣud Ali Khan, in 1952. One of the most famous collective biographies of eminent Hyderabadīs, which included notices of the lives of several *ḥakīms*, was *Tuzk-i Mahbūbiya* by Ghulam Samad Khan, brought out in 1903. This last work differs in many respects from the other two and will be discussed separately. All three should be distinguished from writings of a more historical nature that may also include biographical material. One such that is concerned with unani *ṭibb* is *Islāmī Ṭibb* by Rahbar Faruqī, written in Hyderabad in the 1930s. This work presents the lives of physicians in the form of a dynastic history, following especially the notable physicians of the Asifiyya dynasty of Hyderabad since its inception. By contrast *Tīr bah Hadaf* and *Tazkirah-yi Aṭibbā-yi 'Ahd-i 'Usmānī* are not intended as works of history. Their subjects are contemporaries, or near contemporaries, (and their ancestry), of the compilers, and they bear very much on contemporaneous unani culture.<sup>328</sup>

The notices of lives in these collective biographies are accompanied by a selection of the physician's tested prescriptions, and it is in this light that we should approach these works. The lives provide a context for interpreting the quality of the prescriptions, a

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<sup>328</sup> This study is based principally on *Tīr bah Hadaf*, although there is a great deal of similarity between the two *tazkirah*.

means of validating the prescriptions. As the compiler Hakim Zafaruddin Nasir commented in the preface to *Tīr bah Hadaf*, '[i]t was considered necessary to give brief details of the events [in the lives of] those who have given their prescriptions because their personality sheds light on the importance of the prescription'.<sup>329</sup> The principal concern in these biographies was validation: to portray the qualities of an individual *ḥakīm* in the context of frameworks that gave his persona authority, that legitimated his practice as a *ḥakīm* and often his position as a figure in the community. They are broadly chronological but are nonetheless thematically organised in terms of birth, education, and practice, often interspersed with anecdotes that illuminate the subject's character or ability as a physician. The compiler of *Tīr bah Hadaf*, Ḥakīm Muhammad Zafaruddin Nasir was the editor of Hyderabad's unani journal of the 1930s and early 1940s, *Ḥakīm-i Dekkan*, and he had requested in the journal that practitioners submit details of their lives as well as some of their tried and tested prescriptions for publication. The variety of profiles suggests that practitioners volunteered the information which they thought would be relevant to understanding their qualities as practitioners. It is not clear whether the editor himself also approached *ḥakīms* in person, although this I think is a very likely option with the better known *ḥakīms* in Hyderabad, with whom he naturally had much interaction. But this open invitation accounts for the variety of practitioners who contributed to this publication, not just from Hyderabad, but from United Provinces and Punjab. Not all contributors were unani *ḥakīms*. *Vaids*, a few doctors and a homeopath also contributed, which gives an impression of the scope of *Ḥakīm-i Dekkan*'s professional readership, and one might add, the importance of the persona of the physician in other contexts of medical practice in India, not just in regard to *tibb*.

In common with the genre as a whole, only those elements of a *ḥakīm*'s life were included in the biography that bore on the question of his authority, which in turn reflect contemporaneous conceptions of that authority. In general, we do not, for example, read of marriages, daughters and the occupations of parents, or circumstantial aspects of a *ḥakīm*'s life unless they were seen to contribute to the appreciation of the *ḥakīm*'s standing. Thus the marriage of Hakim Mansur Ali Khan to the daughter of Nazir

<sup>329</sup> Zafaruddin, *Tīr*, p. 7: 'Mujarrabāt ke sāth sāhibān nuṣkhah ke muḥtaṣar vāqi'āt ka iltizām is li'e rakhā gayā hai kih nuṣkhah kī ahamiyat unkī shakhsiyat se roshan ho sake'.

Muhammad Sa'īd Khan in Aligarh is mentioned in order to establish the connection between him and the learning and status of the woman's father, who was a prominent scholar and close friend of Sir Sayyid Ahmed Khan. Having access to a special knowledge of plants and prescriptions is one of the common themes of the biographies. This may be implicit where the *ḥakīm* comes from a family tradition of *ṭibb*, as we shall discuss below. There are occasional references to *ḥakīms* associating with *sanyāsīs* and *faqīrs*, ascetic groups who were often healers and thought to possess powerful or miraculous remedies. Many were itinerants who passed through rural areas, and so acquired local knowledge of plants. The biographies under discussion, mainly written by and about *ḥakīms* who came from the districts of Hyderabad State, came out of a unani medical culture that greatly valued Telugu based local knowledge of plants and prescriptions. So it is not surprising that being fully conversant with Telugu was considered worth mentioning as the ground for a *ḥakīm*'s sound knowledge of *desī* (indigenous) plants.<sup>330</sup> It is in these asides that one sees *ṭibb* in its local arenas, and its connections as a predominantly urban phenomenon with local medicines and medical knowledge, a crucial aspect which is otherwise seldom credited in the literature.

The predominant, but not unexpected, feature that distinguishes writings in this genre in the early twentieth century from those of previous times is the inclusion of the qualification from a unani school or college as a mark of authority and competence. In the lives of a great many of the *ḥakīms* from Hyderabad in the twentieth century, attendance at the Madrasa *Ṭibbiya* is mentioned in the compilations. In this context reference is made to the principal teachers at the school, like Hakim Mansur Ali Khan, which itself may be an echo of the personalised reference to an esteemed teacher in the pre-institutionalised system of teaching. The self-representation of the *ḥakīm* in this biographical literature also reveals that an institutional grounding was just one element in a broader paradigm of authority that prevailed among unani practitioners at the time.

We have noted above that the family (*khāndān*) was central to the transmission of authoritative unani learning prior to the emergence of institutions. What the biographies clearly reveal is that the importance of the *ḥakīm*'s family, as a legitimating force, was not supplanted by the rise of a new professional culture. The quality of being a *ḥakīm* is

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<sup>330</sup> This is the case for example with Hakim Muhammad Ismail, Zafaruddin, *Tār*, pp. 91-2.

therefore to be partly understood in relation to his place in genealogy and the line or network of scholars who transmitted knowledge of *ṭibb* to him. A narrative of descent introduces, as a rule, each biography. It is immediately made clear whether the *ḥakīm* is from a *khāndānī* background. A long-established family practice meant that the *ḥakīm* would have been privileged from an early age to gain experience in diagnosis and in dispensing inherited prescriptions. This knowledge had the allure of guarded secrets and the prospect of reliability, of prescriptions which had been tried and tested over generations.

But beyond this strictly medical dimension, the genealogy could also function to establish a network of associations between different forms of authority which ultimately had a bearing on the authority of the *ḥakīm* in question. The biographies of Hakim Maulvi Ahmed Khairuddin Siddiqi Naqshbandi are an example of this.<sup>331</sup> In the early phases of his professional career, 35 years old at the time of the compilation of *Tazkirat al-Aṭibbā*, he is vested with the authority of his illustrious predecessors who were not only *ḥakīms* with royal patronage but also prominent religious figures. His lineage is traced to the arrival of his ancestor Hakim Maulana Abd ul-Qadir to the Deccan from Bukhara, and the setting up by his family of a *khānqah* (shrine or monastery), Musa Suhag, in the Qadriyya Sufi line. According to the narrative, the second Asaf Jahi ruler of the Deccan, Mir Nizam Ali Khan, came to know of his family's virtues and fame, awarded his ancestor the title 'Qādir Yār Khān Ḥakīm al-Ḥukamā Muḥī ad-Daulah', granted the family *jāgīrs*<sup>332</sup> and *mansabs*, and appointed him as his primary court physician. The narrative continues with the father, also a famous physician, being nominated as spiritual successor to the famous Sufi saint Hazrat Miskin Shah. We thus have noble and religious authority integral to the presentation of the *ḥakīm* as a competent physician. Moreover, the bond between the *ḥakīm* and his relations is emphasised by the use of the pronoun *āp* (you) to refer equally to the *ḥakīm* and any one of his relations, (instead of having *āp* (you) to refer exclusively to the young *ḥakīm*, the 'subject' of the biography, and *yeh* (he, they) for any of the *ḥakīm*'s elders, as one might

<sup>331</sup> Hakim Shifai Khan, *Tazkirat al-Aṭibbā-yi 'Ahd-i 'Usmānī*, pp. 27-8; Zafaruddin, *Tīr*, pp. 165-7.

<sup>332</sup> Land and villages granted as a reward for services, or as a rent-free grant. This was one of the conventional ways among the Deccan rulers of patronizing *ṭibb*, by giving them land, the rent from which would pay for the hakim's services to the public; Faruqi, *Islāmī*, p. 166, note 1.

expect). This is a syntactic means of conflating individual identity with one's progenitors, which logically devolves the power accrued by one in the lineage upon another. This particular use of *āp* is not found in all biographies in the collection, which perhaps points to its relevance for particular cases.

References to figures of religious authority or noble lineage in a *hakīm's* genealogy are very common in the biographies. For example, in the biography of Hakim Maulvi Muhammad Azam Siddiqi, a government unani inspector in Hyderabad, we learn of his grandfather, Hazrat Shah 'Abdunnabi, and that his shrine is still visited.<sup>333</sup> Similarly, the biography of Hakim Azhar Ali Khan Shahjahanpuri notes that many members of his family have been *hazrats* (distinguished sufis).<sup>334</sup> Being of noble descent elevated the subject in the hierarchically organised pre-modern Hyderabad state, and this formed part of the notion of worth in the public perception. Several *hakīms* in the biographies pointed to their noble heritage as members of families that had been granted *jāgīrs* or *mansabs*, among whom Hakim Muhammad Maulana, Hakim Maulvi Mir Sa'adat Ali and Hakim Mir Samin Ali.<sup>335</sup> A few *hakīms*, like Hakim Ahmed Khairuddin, mentioned above, could lay claim to both religious and noble authority in their heritage.

Connecting oneself to the exemplary character and deeds of one's forefathers was clearly one way of reflecting their eminence upon oneself as a legitimating device, but there continued to exist well into the twentieth century another way that was likewise based on the concept of *ta'alluq* (connection). This was the connection of a *hakīm* with his teacher(s). While those who had a college education and degree would mention this in the biography, it was still considered important to list those known in the scholarly milieu, and in the unani schools, who had passed on their knowledge. We find a variety of combinations of private education, private certification (*ijāzat*), college attendance and college degrees in the biographies. The most common pattern is a family tradition in unani *ṭibb*, some amount of training by a family member, and a college education resulting in a qualification. However, some *hakīms* studied only privately with a family member or tutor, but in order to obtain a government position as a *ṭabīb* took the government unani examination of the Madrasa Ṭibbiya. This is the case with Muhammad

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<sup>333</sup> Zafaruddin, *Tār*, p. 24.

<sup>334</sup> *Ibid.*, pp. 137-8.

<sup>335</sup> *Ibid.*, pp. 54, 93, 99-100.

Amin, who held a position with the unani state dispensaries.<sup>336</sup> Other *hakīms* did not have any institutional connection. Hakim Muhammad Ali Khan Naqshbandī (b. ca. 1892), for example, whose family had links with *ṭibb*, studied under Hakim Hari Govind Kaviraj (one of the leading proponents for institutions for ayurveda in Hyderabad), from whom he was given an *ijāzat* (permission) to open a dispensary and a *sanad* (certificate) of competence.<sup>337</sup>

As in this example, if the teacher is a prominent personality, he is specially mentioned. Rashid Ahmed Gangohi, the grandson of one of the founders of the Dār al-‘Ulūm at Deoband, likewise practiced *ṭibb* without any form of institutional qualification. He had graduated from Deoband but had not attended a unani school. He learnt *ṭibb* from Hakim Muhammad Hasan Deobandi and the famous blind physician ‘*Rā’īs al-shaikh al-thānī*’ (‘the second great master’, that is, after Ibn Sīnā) Hakim Nabina, who was a royal physician in Hyderabad in the 1930s before moving to Delhi near the end of his life.<sup>338</sup> The biography in *Tīr bah Hadaf* of Hakim Ahmed Khairuddin, whom we referred to above, does not mention his graduation from Lahore as a ‘*ṭabīb ḥāziq*’,<sup>339</sup> but rather lists his teachers in religious sciences and *ṭibb*. In this form of self-representation the *hakīm* is located in the network of the transmission of knowledge; this is deemed the significant fact, rather than the *hakīm* as a product of an institution, the bearer of a formal qualification.

In addition to the power of association, the *hakīm*’s worth is to be judged, as reflected in this literature, by his qualities as a person. Humility, good manners and conduct, and generosity are some of the most common character traits found in the biographies that mark the subject as a man of respect and worth, as for instance in the characterisation of Hakim Muhammad Nizamuddin, a relatively young *hakīm* and scion of a celebrated scholarly family. There are frequent references to a *hakīm*’s vocation viewed as a service to God’s creation (*khidmat-i khalq*), or special mention of a *hakīm* treating the poor for free. Piety, going on hajj (pilgrimage to Mecca) or attending to the strictures of fasting and prayer, also convey a legitimacy message to the reader. These

<sup>336</sup> *Ibid.*, pp. 39-40.

<sup>337</sup> *Ibid.*, pp. 58.

<sup>338</sup> Abdulghani, *Mujmal*; Zafaruddin, *Tīr*, pp. 58-9.

<sup>339</sup> A qualification probably obtained from Islamiya College.



character traits, detailed in the biographies to a greater or lesser extent, are conventional in Perso-Islamic traditions of ideals of gentlemanly character and comportment.

All of these characterisations point to the persistence of older modes of legitimation within a context of newly emerging sources of authority. Family connections and teacher-pupil relationships as the basis for determining a *ḥakīm*'s worth continued to provide an alternative model to the one derived from the new unani institutions ultimately derived from colonial models. Given the prominence of the movement for *ṭibbi* revival in the major centres of Muslim learning in the subcontinent, Delhi, Lucknow, Hyderabad, Lahore and Bhopal, and the central role which institutions played in the movement, it is tempting to assume that their impact on unani culture was all-pervasive. Such a viewpoint exaggerates the power of the institution in relation to that of other structures of authority which persisted until at least the mid twentieth century. It also discounts the question of access, both in terms of geography and class. Some of those seeking a profession in unani did certainly travel widely in order to attend unani schools in centres like Hyderabad, if they had the means and the connections. The biographies themselves attest to these movements from qasbahs and towns of the Deccan. But many had neither the means nor the connections and the number of those who actually obtained a qualification from such an institution must have been very small in proportion to the number of practitioners who went by the name of '*ḥakīm*', practising even in quite large district towns like Bidar, Aurangabad and Gulbarga. Moreover, entrance to the Madrasa *Ṭibbiya* in Hyderabad was conditional upon knowledge of Arabic or Persian until the late 1930s, which limited access to learned elites.

Nevertheless alongside what I have described as traditional forms of legitimation qualification from the Madrasa *Ṭibbiya* or passing an examination set by government *ṭabībs* was certainly considered valuable in the eyes of the public. It was important not just because it was required for an appointment to a government position. We can see in the biographies that a *ḥakīm*'s formal achievements were considered valuable in addition to his other qualities. Thus Hakim Maqṣud Ali Khan is singled out for his administrative abilities and his role in unani and government organisations;<sup>340</sup> Hakim Muhammad Wahiduddin's accomplishments and involvement in various educational conferences and

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<sup>340</sup> Zafaruddin, *Tār*, p. 15.

religious institutions and programmes are listed, in addition to his exceptional scholarship, noble character, eminent lineage, and a dream that his father had before his birth foreseeing his abilities in Arabic sciences.<sup>341</sup>

Many biographies elaborate on the *ḥakīm*'s role serving the government in unani dispensaries, but the political economy of *ṭibb* in the twentieth century also opened outlets for large-scale commercial enterprise that obeyed norms of legitimation neither based on family connections and learning, nor on institutions and government connections. The *taẓkirah* literature reflects some of these changes in unani culture. One biography is of Hakim Maulvi Ghufran Ahmed Ansari. The *ḥakīm* gives no detail about his family background, and only cursorily mentions his passing the exam at Madrasa Ṭibbiya, while the bulk of his presentation relates to his success in manufacturing and marketing unani medicines. He opened a *davākhāna* in Hyderabad in 1935-36 and secured patents for five medicines, adverts for which he placed in newspapers and journals. The names of these products – *Masāka*, *Nisāka*, *Boṭānika*, *Āsiyāka*, *Shāvazīrka* – are unusual for unani products and signify the shifts in authority at play in *ṭibb* of this time. They are straightforward and simple names. *Masāka* was for men's diseases (sexual weakness), *Nisāka* (literally 'for women'), for women's fertility, and uterine complaints, and with *Boṭānika*, incorporate English terminology. They are breaking away from Perso-Arabic conventions in product nomenclature, such as *Iksīr al-Amrāz* ('the elixir of diseases') or *Mufarriḥ-i Marvārīd* ('pearl cordial'), applied to products manufactured by the company of an established hereditary practice in Lahore from the 1910s to the 1930s. This breaking away from unani traditions and conventions is also replicated in the products' marketing as generic products. They were sold as products that could be used 'in every season, for every *mizāj* [humoral constitution], for every age', signalling a time to come when consultation with the *ṭabīb* would become redundant.<sup>342</sup>

Hakim Ghufran Ahmed prided himself on having recognised the attractiveness of English pharmaceutical products, and introducing innovative strategies in the production and sale of unani medicines. He claimed to have set up the first limited *ṭibbī* company in India, with a stock value of 20,000 rupees, none of the shareholders of which were

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<sup>341</sup> *Ibid.*, pp. 85-87.

<sup>342</sup> Advert in *Ḥakīm-i Dekkan*, 4 (1-2), 1940, p. 118.

themselves *ṭabīb*s, and began producing medicines on a large-scale with machines. This account plays on the distance that he sets between his own and conventional unani practices. He noted that 'at first most *ṭabīb*s objected to my method of doing business, but now some of them are favouring this way; these days one has to do business the western way, as well as the *maṭab* (dispensary).'<sup>343</sup>

The difference between this account and most of the others in the collective biography is reflected in content and the style of its composition. It is written in the first person, instead of the more common second person plural/polite form. It omits the notion of personal connection, as a legitimating principle, to authoritative figures in Islam, learning, institutions, and ruling bodies. What counts is commercial success and the support of (non-*ṭabīb*) shareholders. The *ṭabīb* also derived his legitimacy from his relationship with the public. But this is no longer one based on ideals of charity in Islam, that is, service to God's creation and provision for the poor; it is transactional, impersonal and relies on marketing devices.

We have seen then in the continuation of a tradition of self-representation in the form of *tazkirah* literature that *ṭabīb*s configured their legitimate place in the medical realm in Hyderabad in numerous, widely diverse and overlapping ways. *Ḥakīm*s adopted models derived from colonial professional culture, embodied in the institution and its qualification, but also retained alternative models involving networks of transmission centred around the family, well-known physicians and charismatic figures. Furthermore, the biographies attest to how *ḥakīm*s responded to particular socio-economic pressures and in the process developed ways to situate the quality of their practice which owed little to earlier, conventional conceptions of the identity of the *ḥakīm* and structures of authority in *ṭibb*.

This co-existence of multiple legitimacy frameworks in unani *ṭibb* was in all probability not particular to Hyderabad. There are nonetheless interesting parallels between this diversification of sources of authority in *ṭibb* and in other fields of social and professional organisation in Hyderabad. Margrit Pernau's study of politics in Hyderabad charts the transition from a patrimonial state to a bureaucracy over roughly the same period in which the institutionalisation of *ṭibb* occurred. The patrimonial state,

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<sup>343</sup> Zafaruddin, *Tār*, pp. 74-5.

as Pernau has defined it, was a system of governance based on a network of personal bonds between the ruler and the office bearer, while the bureaucrat directed his loyalty not to a person but to an abstract instrument, the law.<sup>344</sup>

The exercise of power in the patrimonial state was determined through the relationship between the ruler and hierarchies of nobility, for whom title, ancestry and essentially noble character traits defined their noble status. For our purposes her analysis of changes in the ideals of the educational system is especially relevant. The traditional aim of education of the elite was to cultivate the noble character by imparting refinement and manners (*tahzīb*), but with bureaucratisation in the early twentieth century, the preservation of the role of the nobility in the axis of power entailed new ideals of what an educated person should be or how he should act. While cultivating the (elite) personality remained the goal, the ideal was not to become 'the generous Nawab, who calculated neither time nor money, who strove to mould his life into a work of art'.<sup>345</sup> Rather, the aim was to develop those aspects of oneself that centred on a disciplined, punctual, duty-bound existence, suited to the new, British inspired Hyderabad administration.

Pernau's study shows that the new ideal did not supplant the old; rather the new was given the garb of traditional legitimation. Thus the new ideal of the education of an efficient administrator in the 1930s was subsumed within a discourse of moral aesthetics. But the existence of multiple forms of legitimation that we find among *tabībs* was not merely the new taking on the guise of the old; it was a co-existence, a parallelism of the old and the new. This parallelism is indeed replicated in Hyderabad's political arena. The legitimation of Osman Ali Khan's rule was expressed on the occasion of the Silver Jubilee of his accession in 1936 on different levels: in terms of his family's origin, his qualities, his piety, his understanding of poetry, but also as a competent and dutiful administrator.<sup>346</sup>

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<sup>344</sup> Pernau, *Patrimonialism*, p. 58.

<sup>345</sup> *Ibid.*, pp. 176-77.

<sup>346</sup> *Ibid.*, pp. 179-183.

## Conclusion

The process and nature of unani institutionalisation in Hyderabad was clearly different from that of other parts of India in its early phase. The 'new' modes of professional organisation in Hyderabad that accompanied this process in its early stages were not informed by a 'revival' ideology, or a substantive re-engagement with the unani medical tradition. While this experience distinguishes Hyderabad from Delhi and Lucknow, the emergence of colonial models of institutional practice did not lead to a complete reconfiguration of the authoritative loci of unani *ṭibb* either in Hyderabad or in other parts of India. Family or teacher-pupil relations remained important, as did the connections with inherited knowledge of plant, mineral and animal substances and their interactions as compound medicines. As the observations from the graduate of the Lucknow school, the composition of the *tazkirah Rumūz al-atibbā* by Hakim Ferozuddin in Lahore and the examination in this chapter of the biographical literature of Hyderabad, make clear: in order to credibly practise *ṭibb* it was not enough simply to hold a degree from one of the modern schools, or to know prescriptions, perhaps derived from the copious unani literature. Ideally one had to have access to the family *bayāz*, the invaluable prescription notebooks passed from father to son, or at least one had to know who had used publicly accessible prescriptions, in order to ascertain that they really were *mujarrabāt* (tried and tested) by a reputable (in all the socio-cultural connotations that this word implies) practitioner. This was where the power of *ṭibb* lay, both in the eyes of the public and the practitioners themselves, and the guarding of this knowledge, while not facilitating, as Anil Kumar rightly observes, the emergence of unani pharmaceutical enterprise,<sup>347</sup> could only increase the hold of the *ṭabīb*'s secrets, his authority.

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<sup>347</sup> Kumar, 'Drug', p. 375.

## Chapter 4

### ***Desī Tibb*: Reform and ‘National’ Medicine in Early Twentieth-Century India**

*Hamāre dast-i qudrat meṅ shifā kā jumlah sāmān hai  
shifā bakhsh kā jo da ‘vá karen voh hamko shāyān hai  
Ho yūnānī ke vaidik us kī mulk ashyā mān hai  
musāvī jumlah insānoṅ peḥ in donoṅ kā ihsān hai  
Yeh do behenaiṅ haiṅ donoṅ ne piyā dūdh ek pistān se  
yeh do paude haiṅ jo paidā huwe sirf āk gulistān se...*

We have in our grasp all that we need to cure  
we are worthy of our claim to cure  
Whether unani or ayurveda, they depend on the things of their country  
both do good to all people equally  
They are two sisters who have drunk milk from the same breast  
they are two saplings which have sprouted from the same garden...

Hakim Muhammad Karim Ansari, officer of Anṣāriya Medical, Bombay,  
‘*Tibb-i Yūnānī ka Khair Maqdam*’<sup>348</sup>

The pithy lines of the poem above were read to the hundreds<sup>349</sup> who attended the fourth annual session of the All India Vedic and Unani Tibbi Conference (‘AIVUTC’, or ‘the Conference’) convened in Amritsar in March 1914. Poetry recitals such as the one read by Hakim Ansari were interspersed with the matter at hand, that is, debates over how best to ‘breathe new life’ into unani *tibb* and ayurveda. Indeed, the proceedings of these annual sessions give a clear insight into the changing culture of *tibb*, perceptions of its decline among practitioners and the programmes initiated for its revival. Hakim Ansari’s poetry captures the spirit of the Conference, at least in its early years, one in which the fates of ayurveda and *tibb* were seen and projected as ineluctably intertwined. It underscores the feeling of many *hakīms* that unani’s heritage did not lie solely in the

<sup>348</sup> ‘An ovation to unani tibb’, the poem is a *musaddas*, i.e. comprising verses of six lines. *AIVUTC ke Cauthe Sālānah Ijlās kī Rū’idād*, [1, 2, 3 March 1914, Amritsar], Delhi, 1915, p. 105.

<sup>349</sup> In 1914 there were 236 members of the Conference.

regions of the classical unani tradition: Greece and West Asia, but that it was also firmly rooted in Hindustan, the motherland, which the *hakīm* poignantly evoked in the language of fertility and nourishment. This new vision was encouraged by a number of forces, political, social and economic; the Conference was its product, and became the vehicle for the expression of this vision. It created a space for *vaid*s and *hakīm*s to exchange ideas and present a common front in lobbying for recognition and support in British India.

Ajmal Khan first declared his intention to found an organisation for the revitalisation of indigenous medicine at a meeting of the Madrasa *Tibbiya* in 1906.<sup>350</sup> It first convened in 1910 and remained an influential organisation for unani and, to a lesser extent, ayurvedic practitioners, (who had their own national organisation, the *Āyurved Mahāsamelan*), until the late 1920s, when its influence began to wane. The Conference was funded through membership, which cost five rupees per annum. Attendance was also open to the members' guests, who had to pay a much smaller amount for entrance to the annual sessions; the annual exhibitions of plants and medical paraphernalia held by the Conference were open to the public. It was the only unani association which had supra-regional affiliation. Regional associations began to be established in the 1910s, in Lucknow in 1911 and in Madras in 1913 and Hyderabad in 1919. The AIVUTC was the first organisation to lobby for the combined interests of unani and ayurveda, or *desītibb*. *Des*, or *desh*, connotes 'land', or a 'territory', and in some contexts it also has connotations of rusticity. Its use to describe *tibb* in the contexts discussed in this chapter it relates principally to India's formal indigenous medical traditions of north and central India (the geographical focus of the Conference's activities), a usage which would nonetheless not necessarily exclude folk/tribal medicine, as the discussion on medicinal plants below makes clear.

The importance of the AIVUTC for the articulation of *tibb* as a tradition embedded in the medical heritage of India, and the implications that this had for the relationship of medicine to communal politics in the early twentieth century has to date been neglected in the few historical studies of *tibb* that have brought in social and political dimensions. The political statement which the Conference made, of the unity of ayurveda and unani, was related to an understanding of the priorities of reform and the formation of both

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<sup>350</sup> Tazimuddin Siddiqui, 'Hakim Ajmal Khan', *Studies in History of Medicine*, 6, 1980, p. 154.

unani *tibb* and ayurveda as modern professions. As a product of the Delhi unani sphere, and in particular the efforts of Hakim Ajmal Khan and his family, it also precipitated rivalry for regional power over the representation of *tibb* in north India. The Conference records prove to be a rich source for an analysis of the tensions of reform that will form the core of this chapter.

An examination of reform through the prism of the Conference also links up with themes explored throughout this thesis, namely how elite practitioners negotiated authority in relation to other spheres of medical practice, to the state and also to the public. The aim of this chapter is to develop an understanding of the importance of political and professional contexts for the elaboration of programmes of reform of the unani profession. To this end, the chapter analyses the propagation of a new rationale for unani *tibb*, especially as it is applied to India's medicinal plant resources, which were seen as the potential saviour of respected and trusted unani practice.

The question of the relationship of nationalism to the revival of *tibb* and ayurveda is one that has attracted some recent scholarly attention. Barbara Metcalf has provided some excellent insights into the fusion of nationalist politics and *tibb* in the person of Ajmal Khan, which are clearly important for this study.<sup>351</sup> More recently Seema Alavi has proposed that the *tibb* practised and propagated in Lucknow by the Azizi family can perhaps be termed a 'national' medicine, one whose constituency was not narrowly defined to a Muslim *qaum* (community), but rather to the general public of the *mulk*, the country.<sup>352</sup> The view of practice as non-communitarian cannot be restricted to the Azizi family of Lucknow. *Tabibs* practising in Hyderabad who were involved, for example, in the institutionalisation of *tibb* did not pitch their practice exclusively at Muslims, and there were similar cases in other centres of unani practice, like Delhi and Lahore. Moreover, most practitioners who associated themselves with the Conference actively discouraged the communitarian politicisation of indigenous medicine, as we shall see below. Seema Alavi, did not claim that the Azizis and their following in Lucknow were the only group of Muslim physicians who thought of their practice in this way. She was

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<sup>351</sup> B.D. Metcalf, 'Nationalist Muslims in British India: the Case of Hakim Ajmal Khan', *Modern Asian Studies*, 19, 1985, pp. 1-28.

<sup>352</sup> Seema Alavi, 'A National Medicine in Colonial India? The Muslim Physicians and the Takmil ut-Tibb College at Lucknow', [online], 2002, <http://www.fas.harvard.edu/~asiactr/archive/newperspectives/Text/Seema.htm>.



rather concerned to contrast this perspective of Muslim physicians with other voices engaging with ideas of tradition and identity, such as Shibli Numani, a highly respected *'alim* who was forceful in his argument that *ṭibb* was an Islamic enterprise.<sup>353</sup>

There was, however, a movement that did have what can be more properly termed 'national' in ambition and scope, the one advanced by Hakim Ajmal Khan through the foundation of the AIVUTC. The Conference gave shape to a particular and influential mode of cooperation between *vaid*s and *ṭabīb*s which enabled them to represent the interests of *deśī ṭibb*, indigenous medicine, on a platform that was convened annually in centres of, it has to be said, unani practice in north and central India: Delhi, Lahore, Lucknow, Amritsar, Patna, Rampur, Hyderabad and also Bombay and Karachi. This was the only supra-regional body which represented and articulated the concerns of unani *ṭibb*, although there were other prominent organisations that spoke for the interests of ayurveda. The Ayurved Mahasammelan first convened in 1909 but only became influential after 1911,<sup>354</sup> and may well have been the immediate model of the AIVUTC. There were also regionally influential organisations like P.S. Varrier's Ārya Vaidyashāla which aimed at transforming ayurveda in Kerala. The AIVUTC was more weighted in terms of numbers and geography (though not necessarily in terms of issues, which certainly seemed of equal concern) towards unani practice than ayurveda. The fact that the proceedings of the Conference and the publication of these proceedings were in Urdu also indicates the unani orientation of the Conference at a time when the Urdu/Nagri debates were raging in north India. Nevertheless, one should be cautious about strongly making the connection between faith and language – a great many of the *vaid*s speaking at the Conference were clearly very comfortable with Urdu, especially, but not only, in the Punjab, and even those who felt ill-equipped actually used quite passable Urdu diction. This unani orientation is again reflected in the number of paying members of the Conference. Between 1919 and 1921 there were 236 paying members (some were exempt from payment), with a representation of two *ṭabīb*s to one *vaid*.

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<sup>353</sup> Alavi, 'National', pp. 14-15.

<sup>354</sup> K. Sivaramakrishnan, 'The Use of the Past in a Public Campaign: Ayurvedic Prachar in the Writings of Bhai Mohan Singh Vaid', in Daud Ali (ed.), *Invoking the Past: The Uses of History in South Asia*, New Delhi, 1999, pp. 182-187.

In spite of this apparent inclination towards unani, the AIVUTC was the only organisation that drew its inspiration from the understanding that a shared forum of *vaid*s and *ṭibb*s would be a more powerful one than fora dedicated to only one of the traditions. The Conference was a product of numerous factors, professional as well as political and economic. Among practitioners of ayurveda and unani *ṭibb* there were compelling professional concerns that encouraged the formation of such an organisation, as we shall see below. Influential were models of professional organisation and mobilisation through associations and societies that began to permeate elite Indian society in the late nineteenth century.

The particular formation of the Conference also needs to be seen in the context of religious nationalism in the late nineteenth and early twentieth century, and the concomitant communalisation of medicine. We have pointed to the case of Shibli Numani above, while some organisations of *vaid*s in the Punjab were clear that the fate of ayurveda was consonant with the interests of Hindu revival.<sup>355</sup> Against this background the Conference afforded and encouraged cross-community solidarity in *ṭibb* in response to western medicine and government initiatives, paralleling the political model of the Indian National Congress, with which Hakim Ajmal Khan was involved.<sup>356</sup>

## **I. Unani *ṭibb*, Ayurveda and the Agenda for Collaborative Action**

### **1. A United Front**

The Conference had three main objectives in the reform of indigenous medicine, all of which were interconnected: Firstly, to further the institutionalisation of unani and ayurveda, in separate or combined schools; secondly, to challenge the order of knowledge

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<sup>355</sup> Sivaramakrishnan, 'Use', pp. 187-189; K. Jones, *Arya Dharm: Hindu Consciousness in Nineteenth Century Punjab*, Berkeley, 1976.

<sup>356</sup> Metcalf, 'Nationalist'; 'Hakim Ajmal Khan: Rais of Delhi and Muslim Leader', in R.E. Frykenberg (ed.), *Delhi through the Ages: Essays in Urban History, Culture and Society*, Delhi, 1986, pp. 299-315.

of indigenous medicine by breaking down traditional lines of transmission through families and encouraging the 'horizontal' dissemination of expertise among practitioners; and thirdly to provide a forum to lobby the government for the support of indigenous medicine. The will to transform and project unani and ayurveda as modern bodies of knowledge and professions was at the core of these initiatives.

The process of establishing distinct institutions for the instruction of *tibb* and ayurveda had already been underway for at least a decade before the Conference was formed.<sup>357</sup> The Conference wished to further this process as a means to distinguish learned practice from irregular forms, denigrated as quackery, which were deemed to threaten the authority of practitioners, both with the public and with the state. The teaching institution represented one powerful mechanism in the modernisation of the profession, providing new forms of knowledge transmission. Ajmal Khan and the many *vaid*s and *hakims* who took an active role in the proceedings of the Conference, some of whom will be mentioned in the course of this chapter, wished to take reform further: to inculcate among practitioners the need for a new approach to knowledge and practice, which would foster, in particular, a new relationship between practitioners and the drugs and medicinal plants of India. This enterprise was more than a reaction against the so-called quacks. In fact it sought to challenge the division of labour of indigenous medical practice, in which the *vaid* or *hakim* depended on the druggist to supply the drugs or actually dispense them to the patients. In the debates at the 1914 gathering this was presented as the most common form of interaction between the *hakim* or *vaid* and the patient; the limitation of this interaction was perceived as one of the prime causes in the perception of the decline of indigenous medicine.

The particular conceptualisation of this undertaking to bring practitioners of *tibb* and ayurveda more in touch with medicinal plants had very much to do with the ideological orientation of the Conference and we shall deal with this in detail in the second section of this chapter. The idea of presenting a united front of practitioners of indigenous medicine had arisen partly as a reaction against the sectarian formulations and representations of unani and ayurveda of the time. But it was also encouraged by state interventions that forced a distinction between western medicine and *desi* medicine.

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<sup>357</sup> See Chapter 3 for the discussion of unani institutions.

The Conference first convened in 1910 at a time when learned practitioners felt a pervasive sense of professional marginalisation, which perhaps had not been so acute since the passing of the Epidemic Diseases Act (1897) in the early plague years.<sup>358</sup> The drafting and promulgation of the Medical Registration Act (henceforth MRA) in Bombay Legislative Council between 1909-1912, and its subsequent passage through the provincial legislatures of British India between 1912 and 1919, was the subject of great anxiety for these practitioners, as we shall see below. For *vaid*s and *hakims* this Act highlighted again the question of the relationship of indigenous medicine to the state, and the ramifications that this relationship was seen to have on public perceptions of competent medical practice. Indeed, practitioners made an explicit connection between these two very different Acts in the 1914 meeting and voiced their concern. At a time when elite indigenous practitioners were seeking to enhance the prestige of their practice by increasing the number of reputable schools for their medicine, and to attract government support, the MRA was seen as a blow to indigenous medicine that struck the image if not the substance of their profession. It was perceived as a crisis, and it was perceived as equally damaging to ayurveda and to *tibb*. This is where it becomes especially relevant to our exploration of reform and the agenda of the Conference. The passage of the Act became a focus among indigenous practitioners for debate and mobilisation over the next decade, and strengthened the calls for unity among them. It served as a counterpoint against which the Conference rallied, and crystallised the Conference's ideological position of strength in unity. Indeed it was cited as the principal reason for its existence.<sup>359</sup>

The Act was based on legislation passed in Britain in 1882 to introduce a form of licensing for orthodox medical practitioners. Under the MRA in India full legal rights as medical practitioners in British India were only to be given to those who had been entered into a register as MD or LMS at the universities of Bombay, Madras, Calcutta, Allahabad and Lahore.<sup>360</sup> The MRA was proposed in the Bombay legislature in 1909 and

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<sup>358</sup> See Chapter 2 on plague.

<sup>359</sup> Man Singh, 'Gyāravāṇ Sālānah Rīpoṛṭ', *AIVUTC ke Dasveṇ Sālānah Ijlās kī Rū'idād*, [10, 11, 12 February 1921, Delhi], Delhi, 1921, p. 25.

<sup>360</sup> On colonial policies towards indigenous medicine, including the MRA, see especially R. Jeffery, 'Indian Medicine and the State', *Bulletin of the British Association of Orientalists*, 11, 1979-1980, pp. 58-70;

passed in 1912. It became law in all the provincial legislatures of British India between 1912 and 1919. The Act was designed to distinguish practitioners trained in recognized institutions of colonial medicine from the rest. Although it had no direct bearing on *vaid*s and *ṭabībs* and did not impinge upon indigenous medical practices as such, many perceived the Act to be detrimental to ayurveda and *ṭibb*. Those whom it did affect, as Roger Jeffery has pointed out, were doctors who were integrating indigenous medicine into their practice, or who financially supported indigenous medical institutions.<sup>361</sup>

At the AIVUTC sessions both *ṭabībs* and *vaid*s expressed their mistrust of the government's motivations for passing the bill. They were concerned that this bill was the first step towards a mandatory western medical examination for practitioners of indigenous medicine,<sup>362</sup> or even the eventual prohibition of *desī* medical practice.<sup>363</sup>

The condemnation of the Medical Registration Act was universal, but the coordination of responses to it took some time to emerge, and there were divisions within the Conference, and without, about the most effective manner to proceed. *Ḥakīms* and *vaid*s cooperated in the submission of memorials to the Viceroy and to the Governor of Bombay, petitions to members of the Imperial Legislative Council, and in organising a deputation to Sir Pardey Lukis, Inspector-General of hospitals and soon to become the Director-General of the Indian Medical Service.

At three in the afternoon on twentieth of January 1912 the *vaid* and *ṭabīb* members of the Delhi branch of the AIVUTC convened an emergency meeting in coordination with the Central Standing Committee of the Conference in the buildings of the Delhi Madrasa Ṭibbiya. They met to discuss the impact of the MRA and decide on a course of action. They passed a resolution to submit a memorial to the Viceroy and the Governor of Bombay to make an amendment to the bill to allow for the registration of *ṭabībs* and *vaid*s who had graduated from select schools of ayurveda and *ṭibb* in British India: the Madrasa Ṭibbiya and Banvari Lal Ayurvedic Pathshala of Delhi, Takmīl aṭ-Ṭibb Madrasa

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*idem.*, *The Politics of Health in India*, New Delhi, 1988; P. Bala, *Imperialism and Medicine in Bengal: a Socio-Historical Perspective*, New Delhi, 1991.

<sup>361</sup> Jeffery, *Politics*, p. 53.

<sup>362</sup> Hakim Vazir Chand Khushbash, manager of Bhārat Sīvak Aushadhāliya, Gujrat (Punjab), *AIVUTC ke Cauthe*, p. 69.

<sup>363</sup> Ajmal Khan, *ibid.*, p. 74.

Lucknow, and the Peli Bhet and Jaipur Ayurvedic seminaries.<sup>364</sup> The deputation to Sir Pardey Lukis was planned in 1913 and included key figures in ayurvedic and unani revival movements reflecting the pan-India mobilisation of the Conference, including Kaviraj Gananath Sen of Calcutta; Pundit Yaduji Tekramji editor of *Ayurvedic Granth* Bombay; Pundit Jatasjankar Liladhar editor of *Kalpatrad* Ahmedabad; Hakim Ajmal Khan of Delhi; Pundit Thakar Datt Sharma (the founder of Lahore's famous ayurvedic pharmacy Amrit Dhāra) and Hakim Ferozuddin of Lahore; Pundit Dee Kirpal Jarlu of Madras; Hakim Mansur Ali Khan of the Hyderabad unani school; Hakim Muhammad Abd ul-Vali of Lucknow and Hakim Muhammad Ilyas Khan of Aligarh.<sup>365</sup> The main thrust of their concerns was to press for the amendment of the bill to mitigate against the damage that the bill was thought to have on the *desī* medical professions. This damage related on the one hand to the deepening sense of marginalisation of indigenous medicine from state power, and on the other to feelings of loss of status in the eyes of the public; the Act was seen in short as a defamation of India's own learned medical professions.

The Conference's means of opposing the MRA was by no means universally condoned by practitioners of *desī ṭibb*. For example, the Meerut Local Committee of the AIVUTC vehemently contested the Conference's proposal (mentioned above) for the amendment of the bill to include the graduates of certain colleges. In a letter to the Lahore journal *Rafīq al-Aṭibbā* revealing tensions over the balance of power between the new institutions and hereditary practice in the *desī* medical professions, the secretary of the Meerut committee, Hakim Mahmud ul-Haq, argued that the proposed amendment was inadequate since it omitted the right of hereditary (*khāndānī*) practitioners to be entered in the register.<sup>366</sup> It was unjust, the *ḥakīm* argued, to deny the knowledge and the competence of these practitioners: they had gained tremendous knowledge of *ṭibb* through the collective experience of their forefathers and had done a great service to the nation (*vaṭan*); they had spent most of their life learning *ṭibb* and could not be expected to go to a college to obtain certification, and neither should their students be excluded. He

<sup>364</sup> Proceedings from the Office of the AIVUTC, 'Az Daftar AIVUTC Dīlī', *Rafīq al-Aṭibbā*, 1 February 1912, p. 33.

<sup>365</sup> *AIVUTC ke Cauthe*, p. 66.

<sup>366</sup> Letter 'From the office of the Local Committee AIVUTC Meerut', *Rafīq al-Aṭibbā*, 16 March 1912, p. 37.

suggested that a body be set up to examine the competence of hereditary practitioners, permitting them to be registered as well.

In contrast to both of these positions, advanced by the AIVUTC and the Meerut Committee, some prominent *hakīms* advocated that *ṭibb* should in fact maintain its independence from the state apparatus. Hakim Mukhlis ud-Daula, associate of Hakim Abd ul-Aziz of Lucknow and a one-time graduate of the Calcutta Madrasa ‘Aliya in the late nineteenth century, (where *ṭibb*, ayurveda and western medicine were taught), and Hakim Sayyid Ahmed Hussain, director of *ash-Shifā*, argued that in order to preserve the unani traditions, *ṭabīb*s should not even attempt to petition the government.<sup>367</sup> They should remain as independent as possible, since seeking relations with the government entailed compromising standards and ideals. As Sayyid Hussain wrote:

If we are to attain honour and wealth and to keep *ṭibābat* [unani *ṭibb*] alive we have to support ourselves, equip ourselves with new sciences and arts, learn to raise trust, and not to extend the hand to others, whether the government or some saintly looking person.<sup>368</sup>

The question of the cooperation with the government over registration continued into the 1930s. Following the Montagu Chelmsford reforms of 1919, which entailed the transferral of medical administration to local self-governments in British India in which Indians were in a majority, an amendment to the MRA was passed in the United Provinces (UP) permitting *hakīms* and *vaids* possessing a qualification to be registered. Nevertheless, they were not granted a legal status equivalent to that of western trained practitioners, in terms of the right to issue sick certificates and death certificates. Responses to the MRA amendment differed; there were prominent figures such as Hakim Ilyas Khan (Secretary of the AIVUTC) and Hakim Akhtar Hasan Siddiqui (Secretary of the Anjuman *Ṭibbiya Sūbajāt Mutaḥḥidah* [United Provinces], Lucknow), who, in 1935,

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<sup>367</sup> Letters from Hakim Mukhlis ud-Daula, *Rafiq al-Aṭibbā*, 1 November 1912, p. 31; 1 August 1912, pp. 31-34.

<sup>368</sup> Article in *Vakīl*, 24 August 1912, quoted by Hakim Mukhlis ud-Daula, *Rafiq al-Aṭibbā*, 1 November 1912, p. 31: ‘agar ham ‘izzat o daulat ḥāṣil karnā cāhte aur ṭibābat ko zindah rakhnā cāhte hain, to apnī āp madad karen. Jadīd ‘ulūm o funūn se apne āp ko ārāstah karen apne ūpar bharūsah karnā sikhne aur dusrōn ke āge khvāh voh gaurnamant ho yā ko ‘ī khidr-i šurat buzurg hāth nah philā’ en’.

urged unani practitioners to boycott the act, and those who considered it in the interests of *ṭibb* to accept the government's terms and encourage more *ṭabībs* to register. The argument given on one occasion for this latter approach was based on the fear that *vaids* would outnumber unani *ṭabībs* in UP, a region priding itself as a centre for unani *ṭibb*, and would therefore have greater possibilities to influence government.<sup>369</sup>

This mode of reasoning, which saw the interests of *ṭibb* and ayurveda as distinct, was at variance with the vision of the Conference, as it was propounded in the most active period of its existence, in the 1910s and early 20s. In this vision the essential goal of securing government support could only be achieved if *ḥakīms* and *vaids* throughout Hindustan worked together to revitalise and reorganise their traditions. The restoration of India's medical traditions was to be the fruit of the cooperation of Hindus and Muslims, mirroring the aspirations of the Indian National Congress.

## 2. Challenging the Dichotomies: Muslim - Unani / Hindu - Ayurveda

With the emphasis on cooperation, participants in the Conference challenged current perceptions of the division of indigenous medicine along communal lines and, moreover, simplistic notions of the discreteness of ayurvedic and unani practices. The Conference proceedings reveal tensions at large between ayurvedic and unani practitioners in the early twentieth century over the 'ownership' of knowledge, aspects which have not been recognised in the literature on indigenous medicine to date. The AIVUTC sought to play a role in underscoring the common ground of ayurveda and *ṭibb* and attempted to reconcile differences. Indeed, the Conference represented a unique forum for this kind of interaction.

The unifying role of the Conference was one of the most common refrains pronounced in the justification of its existence. Hakim Ajmal Khan referred to *vaids* and *ḥakīms* as together constituting a '*qaum*' (community) or '*groh*' (group) who together could press for better conditions by working collectively, and asking advice from fellows in difficult cases.<sup>370</sup> Looking back on over ten years of operation, the first secretary of the

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<sup>369</sup> *al-Ḥakīm*, March 1935, pp. 6-7; *al-Ḥakīm*, October 1935, p. 16.

<sup>370</sup> *AIVUTC ke Cauthe*, p. 44.



Conference, Man Singh Vaid, presented the achievement of the Conference as one that went beyond professional expediency, to its special role in stimulating accord between Hindu and Muslim medical practitioners, but also communal harmony in more general terms: 'One special capacity of the Ṭibbī Conference is also this, that its platform is a platform for Hindu and Muslim unity, and today, by the grace of God, this unity is demonstrated in every locality, whereas ten years ago we longed to see this unity'.<sup>371</sup>

Underlying the idea of Hindu-Muslim unity in the operations of the Conference is the assumption that ayurveda was a Hindu and unani *ṭibb* a Muslim profession. This was the standard classification of British commentators on medicine in India, was frequently made by practitioners themselves, and is almost invariably interpreted as such in the historiographical discourse on indigenous medicine in India. Man Singh Vaid, stated in his annual report at the 1914 convention that as a common platform for *vaid*s and *ḥakīm*s,

[t]here is no doubt that the 'Hindu'<sup>372</sup> *vaid* and the 'Muslim' *ḥakīm* can do things within their own circle, but in so doing there is no resource [other than the AIVUTC] by which they can meet up once a year and together raise a common voice for their concerns in unity and in accord.<sup>373</sup>

There are similar sentiments expressed elsewhere in the proceedings. Some years later Lala Sultan Singh, Rais-i A'zam of Delhi, nominated president of the reception committee for the 1921 session, spoke of knowledge (*'ilm*) of indigenous medicine in India as one, either inflected with Hindu belief, which then meant ayurveda, or Islam, which designated unani.<sup>374</sup>

<sup>371</sup> AIVUTC ke Dasveṅ, p. 25: 'Ṭibbī kānfarans kī ek khāṣ haiṣiyat yeh bhī hai ke us ka plāṭfarm hindū aur muslim ittihād ka plāṭfarm hai āj khudā ke faṣl se is ittihād ke muzāhire har jagah haiṅ, magar das sāl pehle is ittihād ke dekhne ko ānkhen tarasti thiṅ'.

<sup>372</sup> In the printed text of the proceedings Hindu and Muslim appear in inverted commas, since during the ensuing debate this kind of designation was questioned.

<sup>373</sup> AIVUTC ke Cauthe, p. 27: 'Beshakk 'hindū vaid' aur 'muslim ṭabīb' apne apne ḥalqah meṅ kām kar sakte haiṅ magar uske sāth unhaiṅ cārah nahīṅ hogā kih sāl meṅ ek martabah voh kisse maqām par jama 'bhī hū'eṅ aur bāhumī rabṭ o ittihād ke sāth apne maqāsid ke li'e mushtarak āvāz bhī buland karen'.

<sup>374</sup> AIVUTC ke Dasveṅ, p. 10: 'Āp kā ta'alluq is a'lā aur bargazidah 'ilm ke sāth hī jo hindūoṅ ke i'tiqād meṅ in ke mazhab kā ek juz' vahī, ya 'nī āyūrvedik, aur musalmānoṅ ke nazdik aisī khās cīz hī jis se ke un ka qaumī fakhr wa albatah hī, ya 'nī ṭibb-i yūnānī'..

This kind of attribution was, however, inconsistent with the reality of practice, at least in the case of unani *ṭibb*, as was clearly manifest in the number of practitioners in the audience of the Amritsar Conference of 1914 who were Hindu unani *ṭabīb*s, and as was challenged by participants in the Conference. The question if there have ever been Muslim *vaid*s remains a separate inquiry. Speaking for the Hindu *ṭabīb*s, and making a point with significant political ramifications at the time, Hakim Farid Ahmed Abbasi, then principal of the Zenāna Ṭibbiya Madrasa connected with the Ajmal Khan's Delhi school, singled out Man Singh's wording, quoted above, for comment:

I do not object to what Man Singh Sahib said in his report except that in my opinion the terms Hindu *vaid* and Muslim *ṭabīb* are not appropriate, and to categorise them according to religion is wrong. Since the constraint that one only practise the medicine of one's faith or that one is not allowed to learn the medicine of a faith understood to be against one's own, does not apply to a Hindu, Muslim, or anyone of another faith, then there is no necessary condition to say Muslim *ṭabīb* and Hindu *vaid*. If a Hindu learns unani *ṭibb* then he is a *ṭabīb* of *ṭibb* unani; if a Muslim is knowledgeable in Suśruta or any other of the ayurvedic texts, then why should he not be a *vaid*. For this reason the only distinction there needs to be is in terms of *vaid* and *ṭabīb*.<sup>375</sup>

Hakim Abu Turab, probably the most prominent *ṭabīb* in Amritsar, to whom we referred in the chapter on plague, approached this question from a different angle, but it was still one that challenged the claim of an inherent link of a particular religious community to a particular body of knowledge and practice. Moreover, Abu Turab, and he was not alone in this, looked at those who might claim a particular body of knowledge to include not only religious groups but any community at all. Such widening opened the door to the debate about the ownership of knowledge and practice beyond the religious

<sup>375</sup> AIVUTC ke Cauthe, p. 58: 'Mujhe report ke kissī fīqrah yā kissī lafz par ko 'ī i 'tirāz ka mauqi '-yi nazar nahīn āyā lekin yeh lafz 'musalmān ṭabīb' va 'hindū vaid' jo report men bayān ki 'e ga'e haiṅ mere khayāl se munāsib nahīn haiṅ aur mazhab ke liḥāz se yeh taqsīm ghalat hai, jabkiḥ kissī hindū yā musalmān yā durse mazhabon par yeh qaid 'ā'id nahīn hai kiḥ voh širf apnī hī mazhabī ṭibb ko taḥšil kare aur duse mazhab kī ṭibb ko ḥāšil karnā apne mazhab ke khilāf samjhe to musalmān ṭabīb aur hindū vaid kahne kā sharṭ vājib nahīn ho saktī agar hindū ṭibb-i yūnānī parḥā hai to voh ṭabīb ṭibb-i yūnānī kā hai aur musalmān agar susrut va ghairah vaidik granthon kā ta'līm yāftah hai to voh vaid kyon nahīn hai. Isli'e is taqsīm men širf ṭabīb yā vaid yeh hī alfāz hone cāhi 'en'.

communitarian divide to allow claims of ownership over practices at that time introduced by western medicine. Abu Turab was editor of the journal, *Ahl-i Sunnat*, a journal for Sunni Muslims, and his lectures on *ṭibb* are replete with references to *ḥadīth*. In the Conference he at one point even referred to *ṭibb* as '*ṭibb-i yūnānī Islāmī*' ('Islamic unani *ṭibb*'), but his comments clarify how he viewed the connection between medicine and religion: 'As you know' he said, 'the art of healing is not the legacy of any particular community (*qaum*) and religion; the one who performs its service is the one who is its master (*mālik*)'.<sup>376</sup> For Hakim Abu Turab there was nothing inherent to the medical practice that linked the practitioner to a religious or other community. This openness was typical of the spirit of the Conference in its first two decades, but an attitude at variance with interpretations in much of the contemporaneous communitarian discourse that connected knowledge claims to a particular community, as we shall see shortly below.

Aspects of this wider communitarian debate did find their way into the debates in the Conference; there was after all much at stake in laying claim to a particular form of knowledge of drugs and treatment. At stake were legitimacy and power. A key to claiming a particular practice as one's own was to establish that its origin lay in one's own tradition. This strategy usually happened in the context of an unequal power dynamic, and was widespread among those advocating the qualities of indigenous medicine, unani and ayurvedic, from the late nineteenth century. For example, proponents of unani *ṭibb* at the Conference attempted to subvert the power relationship between allopathy and unani at a rhetorical level by re-casting allopathy as the 'pupil' of unani, basing this on an interpretation of surgical knowledge that reminds us of Neshat Quaiser's study.<sup>377</sup> Hakim Ghulam Mustafa, a lecturer of *ṭibb* in classes affiliated to Punjab University in Lahore, said he had demonstrated in a book he had written the dependence of western medicine on *ṭibb* through the transliteration of names for body parts in Arabic into European languages. He argued for the instruction of surgical techniques according to the ancient unani texts, like the famous, and at this time much referred to, *al-Taṣrīf* of the twelfth century Cordoban physician al-Zahrāwī, since 'there

<sup>376</sup> *Ibid.*, p. 82: '*Āp ko ma 'lūm hai ke fann-i ṭibb kissī khāṣ qaum o mazhab kā vāriṣah nahīn jo us kī khidmat kartā hai vahī us kā mālik hai*'.

<sup>377</sup> N. Quaiser, 'Politics, Culture and Colonialism: Unani's Debate with Doctory', in Biswamoy Pati and Mark Harrison (eds), *Health, Medicine and Empire: Perspectives on Colonial India*, London, 2001, pp. 317-355.

exists no such operation which is not found in the unani books'.<sup>378</sup> However, he conceded that western procedures, where found to be superior, should be adopted. In a similar manner ayurvedic physicians leading the struggle for the recognition and government support of ayurveda, such as Gananath Sen in Calcutta, pointed to the practice of surgery in ancient Indian society as reflected in Suśruta's *Samhitā*, to emphasise that ayurveda was an advanced medical practice, which should be reformed by incorporating western surgery.<sup>379</sup>

It is still open to investigation whether, as Basham and others following him have maintained, there is no evidence to suggest that relations between *ṭabībs* and *vaid*s have been antagonistic in the longer course of Indian history.<sup>380</sup> The conditions particular to the early twentieth century, however, did give rise to antagonism. At the core of this was a convergence of several compelling factors. Religious nationalism emerged in the political landscape of the late nineteenth century, and medical traditions were adopted as symbols of cultural pride associated with particular communities. The prospect of the Medical Registration Act and its passage first through the Bombay legislature from 1909 invigorated the efforts of indigenous practitioners to emphasise the originality and superiority of their medical traditions. Practitioners grappled with the new technologies and disciplines of western medical culture, physiology, surgery, chemistry, nascent bacteriology and instruments of measurement and diagnosis, like the thermometer and stethoscope. All of these factors entailed an examination of medical traditions from fundamentally new and critical perspectives, which created an environment in which claims could be made at the level of 'system', and which could serve as fuel for those with political or communal agendas. Rivalry for prestige and recognition between advocates of *ṭibb* or ayurveda was widespread at the end of the first decade of the twentieth century.

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<sup>378</sup> *AIVUTC ke Cauthe*, pp. 92-93: 'Ko 'ī āpareshan aisā nahīn jo yūnānī kitābon meṅ nahīn pāyā jātā hai'.

<sup>379</sup> *AIVUTC ke Dasveṅ*, referred to by Lala Sukhber Singh at a session of the Vaid Sammelan in Calcutta, p. 55.

<sup>380</sup> A.L. Basham, 'The Practice of Medicine in Ancient and Medieval India', in C. Leslie (ed.), *Asian Medical Systems*, Delhi, 1998, pp. 18-43.

This rivalry was reflected in the scale of hostile coverage that the Conference received in the press. Newspapers like *Ānand* (Lucknow),<sup>381</sup> *Hindūstānī* (Lucknow),<sup>382</sup> *Rahbar* (Moradabad),<sup>383</sup> *Tafrīh* (Lucknow),<sup>384</sup> *Leader* (Allahabad),<sup>385</sup> *Jīvan* (Kanpur)<sup>386</sup> and *Hindūstānī* (Lahore)<sup>387</sup> all published either articles or editorials expressing great distrust of the motives of the Conference. Most of them drew on the long-standing association of Hakim Ajmal Khan with the Muslim League, which pressed for the interests of Muslims, to speculate that the real motive was to obtain the membership and attendance fees from Hindus rather than to promote ayurveda. Several articles proposed instead that Hindus should fund the opening of an ayurvedic college in Benaras as part of the Hindu University scheme. Thus the *Ānand* urged *vaid*s not to participate in the forthcoming meeting of the AIVUTC at Lucknow. The editor of the *Rahbar* deplored that,

despite this attitude towards them, the Hindus have expressed their willingness to join the Muhammadans in promoting the cause of the AIVUTC, under the impression that it will bring about a revival of the ayurvedic system of medicine ... the Tibbi Conference has so far done nothing towards popularizing the ayurvedic system, while it has established two unani schools, one at Delhi and the other at Lucknow [sic].<sup>388</sup>

The propaganda is evident here as it distorts the facts: the AIVUTC did not even exist when the Delhi Madrasa Tibbiya was opened in 1889, or Lucknow's Takmīl at-Tibb in 1902, so it could not have possibly contributed to their establishment. Nonetheless Ajmal Khan was open to suspicion, with his active association with the Muslim League, taking part, for example, in the 1906 Muslim League delegation to Lord Minto. During the early 1910s his position shifted as he came to see that the aspirations of the Muslim

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<sup>381</sup> *Ānand*, 20 July 1911, p. 683; 9 November 1911, p. 1018; 16 November 1911, p. 1040. *Selections from the Native Newspapers* (henceforth *SNNP*) (United Provinces).

<sup>382</sup> *Hindūstānī* (Lucknow), 25 August 1911, p. 799, *ibid.*

<sup>383</sup> *Rahbar*, 7 September 1911, 14 November 1911, p. 1040, *ibid.*

<sup>384</sup> *Tafrīh*, 28 September 1911, p. 903; 7 November 1911, p. 996; 14 November 1911, p. 1018; 21 November 1911, p. 1040, *ibid.*

<sup>385</sup> *Leader*, 1 November 1911, pp. 997-998, *ibid.*

<sup>386</sup> *Jīvan*, September 1911, *ibid.*, p. 958.

<sup>387</sup> *Hindustān* (Lahore), 13 October 1911, p. 1104, *SNNP* (Punjab).

<sup>388</sup> *Rahbar*, 14 November 1911, p. 1040, *SNNP*, (United Provinces).

League could be accommodated within the programmes of the Indian National Congress in opposition to British rule.<sup>389</sup> Barbara Metcalf speculates that it could have been his experience of fellowship with practitioners of ayurveda that may have prompted him to change his path, and this may well have been a factor given the positive response of many *vaid*s to the Conference.

The fears and the antagonism expressed in the press in 1911 turned out to be misplaced. In 1913, Hakim Ajmal Khan presented with an award by the Āyurved Mahāmandal in recognition of his service to ayurveda.<sup>390</sup> While articles in the press like the editorial of *Jīvan* (Kanpur) in 1911 emphasised difference, and claimed that that Muslim *hakīms* were unlikely to cooperate with *vaid*s, considering that they 'so widely differ from them in language, sentiment as well as in their mode of life',<sup>391</sup> the Conference stressed similarity of outlook and unity.

Over a number of years the Conference tried to foster collaboration between practitioners, whether *ṭabīb*s with other *ṭabīb*s, *vaid*s with other *vaid*s, but especially cross-tradition cooperation, in an attempt to create a new medical culture for indigenous medicine modelled to some extent on western medical practices. The notions of collective action and consultation were not viewed as typical markers of indigenous medical professions, and certainly not at this time. In the 1922 session of the AIVUTC in Hyderabad, one of Lahore's most active and well-respected *vaid*s to participate in the Conference, Pundit Thakar Datt Sharma, played down the differences between ayurveda and *ṭibb*, and seconded a resolution for mutual consultation between *vaid*s and *ṭabīb*s. Following the passing of a similar resolution in 1913, it was reported by *hakīms* from Allahabad and Amritsar that the practice of mutual consultation had been adopted by *ṭabīb*s and *vaid*s in Amritsar and other places, but the tabling of another resolution clearly meant that these practices had not become sufficiently widespread.<sup>392</sup> Mutual consultation by *vaid*s and *ṭabīb*s according to the *vaid* Thakar Datt was a feasible project 'since in my opinion there is in fact very little difference between [ayurveda and *ṭibb*]'. He discussed the lack of cooperation between *vaid*s and *ṭabīb*s in the current climate,

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<sup>389</sup> Metcalf, 'Nationalist', p. 18f.

<sup>390</sup> AIVUTC *ke Cauthe*, p. 111.

<sup>391</sup> *Jīvan*, p. 958.

<sup>392</sup> AIVUTC *ke Dasveṇ*, p. 72.

speaking of the lack of unity destroying 'our' medical practices.<sup>393</sup> He castigated those practitioners who through negligence and ignorance formed two adversarial groups. Each of them, in trying to prove the superiority of their tradition over the other, caused contestation between them. The *vaid* criticised this contemporary culture of rivalry and the concern with disputing origins,

I do not understand what harm there is in thinking that unani *ṭibb* was the first medicine, or if ayurveda is given that title, what is the damage. Supposing that one medicine is the mother and the other the daughter, then one cannot be the adversary and the enemy of the other.<sup>394</sup>

Pundit Thakar Datt argued in favour of the resolution on mutual consultation because 'for the progress of *desī ṭibb* it is extremely important that *desī ṭabībs* consult each other, and help each other with sincerity'. Exhortations along these lines had been on the agenda of the Conference for some time, but had little hope of having any impact on the wider sphere. Nevertheless, given the then current acrimony even the articulation of these sentiments should be considered a significant step, and some practitioners participating in the Conference did heed them.

### 3. Striving for the Unity of Unani and Ayurveda, Widening the Rifts within Unani

While the intention of the Conference was to unite practitioners of different traditions in a single body of indigenous practitioners, it may at first sight seem paradoxical that one of the immediate results of the Conference's establishment was the fracturing, or rather, the deepening of existing fault lines within elite unani practice in north India. The

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<sup>393</sup> *AIVUTC ka Gyārahavān Sālānah Ijlās ... Haiderābād-Dekkan men*, 4, 5, 6, March 1922, Delhi, 1923, p. 59: 'Na-ittifāqī ke betāb bhī hamārī ṭibboṅ par kulhā'ī cal rahe hai ...'.

<sup>394</sup> *Ibid.*: 'Merī samjh men nahīn āyā ke agar yūnānī ṭibb pehlī ṭibb mān līyā jā'e ro kyā harj hai yā āyūrvedik ko avvaliyat ka *khitāb* diyā to kyā naqṣān hai farāz kar lo ke in ṭibboṅ men ek mān se dusrī beṭī, ... ek dusrī ke ḥarīf o dashman to nahīn'.

contestation between the Lucknow and Delhi schools of *tibb* has drawn the attention of a number of scholars in recent years.<sup>395</sup> The events surrounding the Conference shed significant light on this contestation. They reveal that part of the tension between these two centres lay precisely in the national ambitions of the Conference and the subsumption of unani within the concept of *desī tibb*. In the conventional portrayal of the two main opposing factions of unani practitioners in north India, the Delhi school is associated with reform and integration and the Lucknow school with efforts to maintain the 'purity' of *tibb*.<sup>396</sup> This is a dichotomy which does not capture the complexity of reform in *tibb*. Hakim Abd ul-Aziz of Lucknow, the founder of the pre-eminent Lucknow school, *Takmīl at-Tibb*, for example, in fact sought to recast *tibb* principally around the corpus of Ibn Sīnā.<sup>397</sup> This was also a reformist move, and although surgery was perhaps lacking in the curriculum of *Takmīl at-Tibb* in its early years,<sup>398</sup> Zillurrahman and Seema Alavi have pointed out that the school's founder favoured western surgical techniques to the extent that he ensured that his sons were instructed in them.<sup>399</sup> In the disputations between Ajmal Khan and the Azizi Lucknow physicians there was clearly more at stake than 'traditional' versus 'integrative' approaches to *tibb*. Drawing on the work of Zillurrahman, Seema Alavi has pointed out that the Lucknow *hakīms* objected to the positive integrationist attitude of the Delhi school towards ayurveda.<sup>400</sup> Barbara Metcalf suspected that the root cause of the contestation was regional rivalry, but this interpretation has not been developed in subsequent writings.<sup>401</sup> Events surrounding the Conference in its first two years of existence make it clear that one of the main issues of contention between the Delhi and Lucknow schools was the question of who had the authority to represent the concerns of unani *tibb*, rather than the question of reform per se.

<sup>395</sup> C. Liebeskind, 'Unani Medicine of the Subcontinent', in Jan Van Alphen and Anthony Aris (eds), *Oriental Medicine*, Boston, 1997, pp. 36-66; Quaiser, 'Unani's'.

<sup>396</sup> Quaiser uses this categorisation as the basis for his analysis of debates over surgery among unani practitioners; Quaiser, 'Unani's'.

<sup>397</sup> See Chapter 3.

<sup>398</sup> See the comments of one of its graduates, Muhammad Shafi referred to in Chapter 3.

<sup>399</sup> Alavi provides the details of this in her article, 'National', p. 7.

<sup>400</sup> *Ibid.*, p. 10.

<sup>401</sup> Metcalf, 'Hakim'.



The Conference made a claim to give voice to the concerns of *ṭabībs* and *vaid*s, and the question of representation arose with some urgency when indigenous practitioners saw the need to challenge the MRA and limit its impact on their status and practice. By aiming to subsume unani *ṭibb* within *desī ṭibb* and moreover by claiming to represent unani *ṭibb* in the national arena, the Conference posed a direct challenge to the cultural authority of Lucknow's most prestigious and influential line of unani physicians. The anxiety among Lucknow's learned unani physicians about Delhi's influence over the fate of the unani profession is reflected in the first amendment to the Conference rules sought by Hakim Abdurrashid, one of the sons of Hakim Abd ul-Aziz of Lucknow, and Abdurrashid's associates. It requested that the rules governing the Conference be amended to include the clause: 'that the members of each province should be equal'.<sup>402</sup> This suggestion was apparently accepted, but there is an evident undercurrent of mistrust that surfaces here. Another commentator emphasised that each decision by the Conference was taken on a majority basis, in an attempt to dispel fears of an autocratic organisation.<sup>403</sup> The journal *Hikmat* of Lahore, which carried the report of apparently civil exchanges between Ajmal Khan and Abdurrashid, had published numerous articles on the opposition to the Conference. But the commentator on Abdurrashid's fear of unequal representation was keen to allay rumours of the tensions between the two prominent factions within unani *ṭibb* in north India, writing that,

[i]n my opinion the *ḥakīms* of Lucknow are not opposed to the Conference, rather they look upon the usefulness of the Conference and consider supporting it...[Hakim Abdurrashid's] sometimes apparent expression of good intentions and [his] constructive and legitimate objection has in our judgement been misplaced as outright opposition and the spread of this matter must surely be the death of impartiality.<sup>404</sup>

<sup>402</sup> Hakim Muhammad Khalilurrahman, 'Ṭibbī Kānfarans Dilhī', *Hikmat*, 1 August 1911, p. 14: 'Kih kānfarans meṅ har sūbah ke member musāvī honā cāhī'e'.

<sup>403</sup> Hakim Sayyid Ahmed Shah Shikarpuri, 'Ṭibbī Kānfarans', *Hikmat*, 1 August 1911, p. 16.

<sup>404</sup> Khalilurrahman, 'Ṭibbī', p. 15: 'Meṅ jahān tak khayāl kartā huṅ ḥakīm sāhibān Lakhnavī ke khayālāt kānfarans kī jānib abhī tak mukhālīfānah nahīn haiṅ balkih kānfarans kī muḥfid hone ke sāth sāth uskī hamdardī kā unko khayāl o lihāz hai ...Nek niyyatī se kabhī shibh kā izhār aur muḥfid o jā'iz ikhtilāf ko khvāh nah khvāh ke bejā mukhālīfat kā ham ma'nā qarār dekar bāt ko barhānā insāf kā khūn karnā hai'.

Nevertheless, the reality of the lack of accord manifested itself in the formation of the Anjuman Tibbiya, a unani organisation for unani practitioners in Lucknow as a rival forum to the Conference, by Hakim Abd ul-Aziz in 1911, in the last year of his life.<sup>405</sup> It was felt that the concerns of *ṭabīb*s could be best represented by *ṭabīb*s alone. This challenged the premise of the unified fate of ayurveda and unani, the understanding of *desī ṭibb*, on which the Conference was founded. There were, however, Lucknowi physicians of the Azizi family who supported the Conference. One of them was Hakim Abd ul-Vali, the nephew of Hakim Abd ul-Aziz,<sup>406</sup> who was delegated to run the annual exhibitions of the Conference, which we shall come to below. Another was Hakim Abd ul-Hamid, the younger brother of Hakim Abdurrashid, who became a friend of Ajmal Khan and attended meetings of the Conference in the 1920s in his capacity of principal of the Takmil at-Tibb.<sup>407</sup> During his time in this position the Lucknow Anjuman did in fact merge with the Conference.

In the early years of the Conference's existence it would be wrong to think that such a step of setting up a segregated organisation of and for unani *ṭabīb*s was unique to Lucknow. One *ṭabīb*, Abd ul-Hakim Sayyif, from Multan, for example, pointed out that segregated organisations were being established there. In order to counter this trend, which Abd ul-Hakim saw as divisive and an unrealistic reflection of the nature of ayurveda and *ṭibb*, he called for a local organisation that would bring *ṭabīb*s and *vaid*s together to be established in Multan.

In his support of unity between the traditions, he alluded to God's creation of man through the different but complementary elements of unani physiological theory: hot and cold, wet and dry. He wrote that 'Although [the elements, *'anāṣir*] oppose each other and are incompatible, all of them are devoted to maintaining the human being. When there is the slightest difference among them then the sound sleep of man is disturbed'.<sup>408</sup> This is an expression of the accommodating power of unani medical theory, suggesting that

<sup>405</sup> Letter by Sayyid Abd al-Hakim Sayyif, *Rafiq al-Aṭibbā*, 1 January 1912, p. 45.

<sup>406</sup> Zillur Rahman and Tazimuddin Siddiqi, 'The 'Azizi family of Physicians', *Studies in History of Medicine*, 8, 1984, p. 49.

<sup>407</sup> *Ibid.*, p. 53.

<sup>408</sup> Hakim Khuda Bakhsh Sindhi, 'Ittifāq kī Zarūrat Multān meṅ', letter to *Rafiq al-Aṭibbā*, 16 January 1912, pp. 27: '*Maḡar ba-vujūd tazād wa tanāqūṣ* [sic., reading *tanāqūz*] *ke sab ke sab insān kī hastī kī ḥifāzāt meṅ mushṭaq hain jab un meṅ zarā bhī ikhtilāf hotā hai to insān kī miṭhī nīnd ḥarām ho jāti*'.

difference not only exists but exists for the greater good when it is brought into mutual relations. It is a message which the *ṭabīb* then transposed on to the political climate of indigenous medicine in India of the time, being used to justify openness and a united front when many evidently thought their interests could be better served by distinct ayurvedic and unani organisations. The *ṭabīb* adds:

It is surprising that some people think, what is the connection between our Hindi [sic] *ṭabībs* and *vaid*s and unani *ṭabībs*, their medicine is separate from ours. My dear gentlemen! If it is your opinion from the outset not to wish to operate through the power of union, then it is a great pity. It is very unfortunate that some people think that there should be no branch of the *ṭibbī* association in Multan, but rather are prepared to form a small party of their own.<sup>409</sup>

The *ṭibbī* association to which the *ḥakīm* referred was the branch of the AIVUTC, which represented the interests of ayurvedic and unani physicians.

Regarding Lucknow, its predominance in the debates was in part due to the great influence and respect that the learned *ṭabībs* and scholars of Lucknow commanded. The scholars of Firangi Mahal were famous throughout the subcontinent and beyond in Central Asia, and one *ḥakīm* called upon them to back the ideals of the Conference: 'It is important that the well-wishers and defenders of *ṭibb* unite in mutual accord for the *tahzīb* [culture] and progress of *ṭibb*, for these are delicate times and the competition comes from a powerful one'.<sup>410</sup> The importance of attaining some measure of support from Lucknow *ḥakīms* may have prompted the second meeting of the Conference in 1911 to be convened in Lucknow itself. This was heralded as a success by the Conference supporters, with speeches praising the cooperation of *ṭabībs* and *vaid*s. Hakim Abd ul-Vali of Lucknow, who supported the Conference, was subsequently asked to be in charge

<sup>409</sup> Ibid., p. 28: '*Ta'ajjub kā maqām hai kih ba'z sāhibān kā yeh khayāl hai kih ham hindī ṭibbā aur vaidon ko yūnānī ṭibbā se kyā vāsita hai. Un kā ṭibb 'alāhidah hamāri 'alāhidah. Mere mu'azziz buzurgo! Agar ap sāhibon kā ibtidā' hī se yeh khayāl hai kih quvvat ijtimā'ī se kān karnā nahīn cāhī'e to ṣad ḥif hai baṛā afsos hai is amr kā hai kih ba'z sāhibon kā khayāl hai kih Multān kā ṭibbī anjuman ko kissī kā shākh nah banāyā jāve balkeh derḥ aintī kī masjid alag tayār ho jāve'.*

<sup>410</sup> Letter from Hakim Mukhlis ud-Daula, (a Lucknowi physician then resident in Jaipur), *Rafiq al-Aṭibbā*, 1 November 1912, p. 31: '*Is vaqt to bhī khvāhān aur ḥāmilān-i-ṭibb ko bāhum ittifaq aur ittihad aur apnī ṭibb kā tahzīb aur taraqī ifkār karnī cāhī'e. Kionkih zamānah nāzik hai, aur muqābilah ek zabardast se hai'.*

of the committee overseeing the annual exhibition that accompanied the meetings of the Conference. Nevertheless, articles appearing in the press and unani journals of the time covering these events are replete with vituperative accusations and counter-accusations of the 'arrogance' of the practitioners associated with the AIVUTC and the 'selfishness' of the Lucknowi physicians who opposed it. These exchanges point to the depth of feeling that the Conference had awakened as practitioners struggled to give shape to their particular visions of a vibrant profession and to make the concerns of *ṭibb* felt in the political arena.

We have seen, then, that the pursuance of the agenda of unity and collaborative action was fraught with tensions in the early years. But the work of the AIVUTC continued unabated, and over the course of the following years local branches of the organisation sprang up in towns and cities throughout the subcontinent, but especially in the Conference's heartlands in UP and the Punjab. The agenda to unite traditions comprised two interconnected elements. Firstly, as we have seen, was the issue of cooperation between practitioners. Secondly, and equally problematic in many ways, was the issue of extending the notion of sharing knowledge beyond the clinic to the production of pharmacopeia as a common resource. It is in the realm of the organisation of the plant and drug knowledge of practitioners in India that the national ambitions of the Conference are most evident. Attention to the plant heritage of India ranked among the highest priorities for *desī* practitioners of the Conference, alongside the promotion of schools for *desī ṭibb* and the organisation of the profession. In fact, these issues were frequently interconnected.

## II. The Medicinal Plants of India and the Revival of *Desī Ṭibb*

*Ma'mūr haiṅ khazā'in in 'ām kardgār  
par kyā karaiṅ kih hāth hī apnā rasā nahīṅ*<sup>411</sup>

Flourishing treasures are the gift of God  
but what shall we do if the hand does not touch them

To date, the relationship between practitioners, patients and plants in unani discourse of the early twentieth century has been overlooked in studies on the revival of *ṭibb*. While this chapter deals with *desī ṭibb*, it focuses on the unani component. A separate study would be required to analyse this theme from the perspective of ayurveda. But the importance of new forms of engagement of indigenous practitioners, whom we shall discuss below, with India's flora can be seen partly in their legacy for unani *ṭibb*. The kinds of projects developed through the agency of the Conference in the 1910s and early 20s were to have a lasting impact through the 1930s in some spheres of unani activity, and in fact heralded in many ways the research agendas of large private institutions, like Hamdard, and also Government initiatives in the 1970s.

*Ṭabībs* and *vaid*s participating in the Conference proposed the first joint unani and ayurvedic herbarium; they were the first indigenous practitioners to organise exhibitions of medicinal plants throughout the country which brought together unani, ayurvedic and local knowledge; and they saw a bright future for indigenous medicine resulting from the breaking down of traditional lines of transmission of drug knowledge. The Conference was the prime locus for the elaboration of ideas on why and how indigenous practitioners should re-examine India's plant wealth from the perspective of their medical traditions and the particular pressures which were bearing upon them at the time. Their efforts represented the first large-scale undertaking to systematically expand and reorganise unani knowledge of medicinal plants. Our aim here is to examine the emergence of this discourse, and to determine the reason why it took the form that it did.

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<sup>411</sup> poetry recited by Man Singh Vaid, *AIVUTC ke Cauthe*, p. 36.

Like many other areas of reform in unani *tibb*, such as institutionalisation and the incorporation of surgery, attempts to recast the relationship of practitioners to India's plant wealth were ultimately a product of the colonial encounter, which entailed critical self-examination and a reappraisal of the tradition. But the issue of medicinal plants was also one that was intimately connected to specific pressures within unani *tibb*, and by all accounts ayurveda as well, concerning the spheres of authoritative knowledge and the perceived need to move *tibb* from the local to the national arena.

### 1. Poor Quality Remedies and the Decline of *Tibb*

The failure of *tabībs* and *vaid*s to secure quality medicines for the treatment of patients was perceived as one of the most compelling reasons for the decline of indigenous medicine; in the unani context of the Conference it was perhaps judged to be more significant than the neglect of surgery or others branches of healing practice. This is because surgical practices did not form a part of authoritative knowledge in unani *tibb* in India to the extent that internal medicine using herbal prescriptions did.

The criticisms made by practitioners at the Conference were two-fold. Firstly, the druggists (*davāfarūsh*) were considered unscrupulous in the procurement and dispensing of drugs. Secondly, practitioners were not knowledgeable enough about potent effective medicines and, most importantly, did not share this knowledge with each other. A discussion of these failings was a thread that ran through several annual meetings of the Conference as we shall see below and gradually made for a dramatically new vision of unani practice: one where *tabībs* would increase and deepen their knowledge of, take greater care with and responsibility for the identification, cultivation, availability and storage of medicinal plants; moreover knowledge of the effects of plants would not be kept within families, which had hitherto been at the core of most elite private practice. Furthermore, with the passage of time, the calls increased for a central research unit to be set up which would undertake biochemical investigations of medicinal plants.

In 1914, Lala Sukhber Singh, magistrate and an advocate of government support for *desī tibb* at the Imperial Legislative Assembly who was presiding over the Conference,

spoke for many when he told the audience why he thought *desī .ṭibb* had declined. One of the root causes was that,

we cannot get hold of the original<sup>412</sup> drugs, neither the *attār* [perfumer] nor the *pinsārī* [druggist] are concerned with them, giving whatever medicines they have. In spite of the fact that we have excellent *ṭabībs* and *vaid*s, what are these poor [physicians] supposed to do when the medicines corresponding to the prescriptions that they have written are not available, and rubbish is wrapped in a bundle and given. What good will that do?<sup>413</sup>

A resolution proposed at the 1921 Conference declared that although the methods of producing and cultivating medicines had improved somewhat, more attention had to be paid as to why there were discrepancies in the effects of drugs even though their dosages remained constant. The mover of this resolution, Pundit Shariman Narayan Sharma Vaid, interpreted this particular issue as a problem of storage. He spoke of the return to former status and splendour of *desī .ṭibb* as tied to ensuring quality produce for the patient. ‘You know well,’ he said, ‘that the greatest cause of the decline of *desī .ṭibb* lies with the druggists’ class (*ṭabqah*).’<sup>414</sup> This implied that the reputation of the *ṭabīb* or the *vaid* suffered when the patient failed to recover after taking the prescription. At the same session, Hakim Ahmed Bakhsh Ovaisi, a proprietor of a well-known dispensary in Multan, similarly noted, ‘how often it happens that a *ḥakīm* diagnoses a patient’s problem and the patient goes to the *davāfarūsh* who gives him some old *adviyah* [drugs] that are so bad that the patient suffers, and in the end the healer is given a bad name’.<sup>415</sup> The way forward he suggested was for *vaid*s and *ḥakīms* to set up local committees to practically address this problem. Hakim Muhammad Ilyas Khan, a prominent graduate of the Delhi

<sup>412</sup> Original (*aṣlī*) drugs in the sense that they are the ones on the *ḥakīm*’s prescription, to be contrasted with substitute (*naqlī*) drugs often given in their stead.

<sup>413</sup> AIVUTC ke *Cauthe*, p. 19: ‘*kih hameñ aslī adviyāt nahīñ miltaiñ nah ‘attār nah pinsārī kuch ziyādah parvā karte haiñ aur kuch kī kuch adviyah dedete haiñ bavujūd us amr kih hamāre hāñ acche acche ṭabīb aur vaid haiñ magar voh becāre kyā karaiñ jabkīh unke likhe hū ‘e nuskhon ke muṭābiq nahīñ miltaiñ aur kūrā karkāṭ bāndhkar dediyā jātā hai, phir voh fā ‘ida kyā karaiñ’.*

<sup>414</sup> AIVUTC ke *Dasven*, p. 63: ‘*Ap yaqīn jānī ‘e kih desī .ṭibb ke tanazzul kā sab se baṛā sabab davāfarūshon kā ṭabqah hai’.*

<sup>415</sup> *Ibid.*, p. 64: ‘*Rāt din kā mushāhidah hai kih ṭabīb ne tashkḥīṣ-i maraḥ ke ba ‘d bīmār ko nuskhah tajvīz kiyā bīmār nuskhah ko davāfarūshon ke hāñ le kar pahuncā is ne nāqīṣ davā ‘īñ ḥavālah kar den marīz ne isti ‘māl ken fā ‘idah nadārū balkih basā auqāt ulṭā naqṣān aur bad nām ho mu ‘ālij kā’.*

school, suggested that the problem with the druggists was not one of greed or indifference, but simply education. If they only knew where such and such a medicinal plant grew and where good quality produce could be obtained, then the problems would be greatly reduced. Although this frequently cited criticism of the quality of the work of druggists may in specific cases have been well-founded, it should be noted that it sprang from an attitude of blame which can often be observed in this period of unani reform. The *jarrah* (barber-surgeons) were blamed for not advancing surgical techniques; advertising *hakims* were blamed for disseminating quackery through print.<sup>416</sup> The imputation of failure to other less organised practitioners, such as druggists, may have resulted from the insecurity felt by the *desī .ṭibb* professionals in a period of far-reaching and rapid change. However, since its inception, the Conference in its annual session also showed a readiness to engage in self-criticisms and to search for remedies.

Already in 1914 the secretary of the AIVUTC, Man Singh Vaid, had proclaimed that *desī .ṭabībs* needed to engage in new ways with India's medicinal plant wealth:

There is so much that needs to be done. In the meadows of Hindustan, in the wooded lands of Hindustan and in the mountains, on the banks of the rivers and ponds of Hindustan grows the beneficence of God that always brings the message of cure, but our lack of attention and negligence is such that we have deprived ourselves of it.<sup>417</sup>

This passage resonates with a nationalistic fervour that sought to impress upon the audience the richness of India's diverse ecology and to spur it into action. It is noteworthy that the emphasis here is on plants, and not on meats and minerals. Unlike in ayurveda, animal products continued to be a part of the materia medica of *.ṭibb* in the twentieth century, while minerals – gold, silver, those contained in pearls as well as arsenic and mercury – have been widely used as the base for a huge variety of prescriptions in both unani *.ṭibb* and ayurveda. The reasons for the special attention at the Conference towards medicinal plants are, I believe, three-fold. Firstly, the idea of

<sup>416</sup> See Chapters 2 on plague, and 6 on unani practice and the journals.

<sup>417</sup> AIVUTC ke *Cauthe*, p. 35: '*Hindūstān ke sabzah zāroṅ meṅ Hindūstān ke jangaloṅ aur pihāroṅ meṅ Hindūstān ke daryāoṅ nahāroṅ aur tālāboṅ ke kināroṅ par khudā kī bakshish hamesha shifā kā paigham ho kar numūdar hote haiṅ lekin hamāre kam tavajūhhī aur ghuflat hai kīh ham us se mahṛūm haiṅ*'.



collating and sharing local knowledge of medicinal plants was a means of creating a new basis for the indigenous medical professions as collective enterprises transcending the guarding of knowledge of efficacious remedies in localised family circles. Secondly, the idea of unifying a territory, its medical traditions, peoples and plants was informed by a nationalist thinking which underpinned the Conference's activities. Thirdly, the emphasis on plants seems to have been inspired by long-standing and continuing colonial interests in indigenous botanicals.

During the course of the nineteenth century British investigations into the medicinal plants of India became increasingly systematic, as government involvement overtook the endeavours of surgeon-scholars, like Whitelaw Ainslie, who published his *Materia Indica* in 1826.<sup>418</sup> Edward John Waring's *Pharmacopeia of India* had been commissioned by the secretary of state in council in 1867. One of the principal causes for the interest of the Government of India in medicinal plants lay with the possibility of being able to procure substitute drugs cultivated in India as cheaper alternatives to importing drugs from Britain.

Government interest in the India's medicinal wealth in the late nineteenth century also led to the collection and display of medicinal plants for exhibitions.<sup>419</sup> The Government of the North-West Provinces was required to provide products of economic value, in large part medicinal, for the Paris Exhibition of 1877. The Imperial Department of Agriculture provided samples of medicinal plants for the Amsterdam Exhibition of 1883. In India, the Government of Bengal requested the Imperial Government to provide collections for the Calcutta Exhibition of 1883-4. The collections for these exhibitions led to the compilation of lists of mineral and botanical products, with identification aids, names in various Indian languages, provenance and use according to a great variety of sources. The editing of these lists was undertaken by the botanist George Watt, who published them between 1889 and 1892 as the multi-volume *Dictionary of the Economic Products of India*.

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<sup>418</sup> Jane Buckingham, *Leprosy in Colonial South India: Medicine and Confinement*, Basingstoke, 2002, p. 73f.

<sup>419</sup> Edward C. Buck, 'Preface' to George Watt (ed.), *A Dictionary of the Economic Products of India*, vol. I, 1889, p. 3.

## 2. Exhibitions and Herbaria

The exhibition of plants was one of the mechanisms by which the Conference sought to encourage practitioners of indigenous medicine to develop greater knowledge of medicinal plants. The organisation of annual exhibitions was evidently inspired by colonial models. This is confirmed in Neshat Quaiser's brief discussion of the activities of the Conference. He mentions that Hakim Jilani, a prominent *hakīm* of Lahore who had had training in western medicine,<sup>420</sup> suggested in the 1910 meeting of the Conference that the example of Dr. Watt's work should be followed and more attention paid to medicinal plants.<sup>421</sup> A programme for action had already been initiated in the second convention of the AIVUTC in Lucknow in 1911, and became a regular feature of the annual sessions. In this year the Conference established its first annual exhibition in Lucknow's Quaiser Bagh, to which *ṭabībs*, *vaid*s and the general public were invited. The exhibition sought to provide an overview of the state of *desī ṭibb*. Practitioners attending the Conference were encouraged to bring rare books and manuscripts, old and new instruments, and, especially, local medicinal plants (*jarī būṭī*).

The Lucknow exhibition was celebrated as a success, although *ṭabībs* and *vaid*s had not responded to the calls of the Conference organisers on the scale they had wished. In his report for the year 1913, Man Singh repeated the resolution passed that year which urged *ṭabībs* and *vaid*s to pot medicinal plants from their own locality, write down their effects and properties and send them in for the exhibition. But only a few practitioners had responded. For instance, Pundit Shiv Chandarji had brought in pots with some of the medicinal plants of his village Galsiyya Gaon.<sup>422</sup> For the 1914 exhibition one associate, Karpashiji, had spent 'night and day' in the forests during the cold season collecting medicinal plants for the exhibition. Hakim Abu Turab expressed the necessity of collecting and understanding plants that were 'new' (to the tradition). He brought some for display at the exhibition, three of which are included in the proceedings. For instance, *toṭī būṭī*, a plant of Punjab that grows on the shores of bodies of water, had been used for

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<sup>420</sup> See Chapter 5.

<sup>421</sup> N. Quaiser, 'Politics, Culture and Colonialism: Unani's Debate with Doctory', in Biswamoy Pati and Mark Harrison (eds), *Health, Medicine and Empire: Perspectives on Colonial India*, New Delhi, 2001, pp. 341.

<sup>422</sup> *AIVUTC ke Cauthe*, p. 35.

diabetes and gonorrhoea among other complaints, of which he had been informed by a *faqīr*.<sup>423</sup> He described the plant's appearance and mentioned that neither this nor any other of the plants he had brought were mentioned in the current or ancient books of *tibb*, like the famous compendium of unani drugs *Makhzan al-Adwiyah*. The majority of participants, however, did not respond to the call to bring in specimens.

These individual contributions were important, but *ṭabībs* and *vaid*s were aware that the exhibition of medicinal plants for the short duration of the Conference session (three days) was inadequate. One of the first initiatives to overcome these shortcomings was to establish a herbarium at the Delhi Ayurvedic and Unani College, where medicinal plants from most parts of India were to be grown, for the purposes of use and education. Accordingly, *ṭabībs* and *vaid*s were asked to send in plants from their own localities to be cultivated in the herbarium. Plans were also proposed to establish a herbarium in each province, since it was pointed out that many plants would not be able to grow in Delhi. This proposal was rejected as impractical in favour of the idea of linking the establishment of new herbaria to the founding of more new unani and ayurvedic colleges throughout the country. The idea of practitioners organising the cultivation of medicinal plants was new to ayurveda and unani, and that it had not been done before was lamented by Conference participants.<sup>424</sup> It was not necessarily intended to supplant or bypass the druggists, but Hakim Ilyas Khan argued for the benefits of the herbarium in 'educating' them about locality and seasonal availability.<sup>425</sup>

### 3. Plant Directories and Collating Compendia of Remedies

A more ambitious project proposed in the 1921 Conference in Delhi was for *ṭabībs* and *vaid*s to send in details of the medicinal plants of their localities and the markets in which they were sold, which were to be compiled in the form of a register at the Conference headquarters. The purpose was to make information accessible to *vaid*s and *ṭabībs* throughout the country on what grew where and when, and where fresh produce was

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<sup>423</sup> *Ibid.*, pp. 86-87.

<sup>424</sup> *AIVUTC ke Dasven*, p 67.

<sup>425</sup> *Ibid.*, pp. 65-66.

available.<sup>426</sup> The *ṭabīb* who proposed this resolution, Hakim Sayyid Mazhar Hasan, lived in a village, Rangar, in Benares state close to forests with a rich diversity of trees and plants. Familiar with their medicinal uses, Hakim Sayyid Mazhar Hasan realised how limited the knowledge of such riches and their proper use according to unani precepts were in conventional unani practice. He described the range of known and unfamiliar plants that grew, especially and in abundance, in a forest near Ahrora market in Mirzapur district, which sold the medicinal products. The rich information gathered on each locality and systematically compiled in a register would, he said, be a great and useful achievement.

The main issue for the *ḥakīm* was that this information could be utilised for the procurement, as far as possible, of fresh drugs. His arguments are of interest for combining a theory of potency in medicinal plants with an understanding of the impact that trade and transport had on the efficacy of plants. He conceived the life-cycle of plants as mirroring the climacteric of human life, which defines critical stages in life and which underlies understandings of aging and health in unani *ṭibb*. Thus, parallel to the human cycle of birth, growth, strength, decay and death, was the plant climacteric of birth, rapid growth, flower and fruit and withering. The *ṭabībs* of the past, Hakim Sayyid Mazhar Hasan lamented, had been fully cognizant of the propitious times to collect plants, when plants were at their most potent; moreover they knew charms which were able to ensure that the properties of the plant would be preserved. But this knowledge had been lost: the methods for preserving medicines were so now bad 'that by the time the medicine reaches our homes all of its power has gone'.<sup>427</sup> This problem was made worse by trade, which meant that the phase of the medicine's maximum power would totally expire with the passage through various bazaars over long distances. To counteract this, he suggested that 'there should be a market for the sale of the drug in the closest possible place to where the medicine grows'. Local availability was therefore a guarantee of and imperative for effective drugs, seen from the perspective of a theory of potency coupled with the contingencies of trade in medicinal drugs.

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<sup>426</sup> *Ibid.*, p. 69.

<sup>427</sup> *Ibid.*: 'aisā burā hai kih hamāre hāron men davā usvaqt pahuncī hai jabkih quvvat uskī jāī rahī ho'.

Ultimately, Hakim Mazhar Hasan's argument meant that the wealth of India's medicinal plants could be properly appreciated and utilised only by *ṭabībs* or *vaid*s adequately cognizant of their specific floral environments. The proposed register would be a major step forward. It was decided that the knowledge collated in this register would be printed and thereby made publicly accessible. Although this resolution found strong support in the Conference session, it is not at present known if the register was, even in part, realised. As we shall see later, however, the question of the recognition of local knowledge for the vitality of *ṭibb* at a national level was one that found support beyond the immediate activities of the Conference.

This initiative to systematically organise knowledge of India's medicinal plant wealth paralleled in many ways the production by the Conference of a pharmacopeia of *desī* medicines along British lines. A resolution to produce a pharmacopeia had been proposed by Hakim Ferozuddin of Lahore at the first convention of the Conference in 1910.<sup>428</sup> This project, although underway throughout the 1910s, with Conference spokespersons repeatedly and consistently calling for feedback from practitioners on the successful use of their medicines, did not seem to be near completion by the time of the meeting in 1921. The debates over the composition of this pharmacopeia reflect once again the theme discussed earlier of the ownership of knowledge, professional authority and changes wrought in these areas in the reform process. They also highlight a fraught issue in the transformation of unani culture, and that concerns the sharing of knowledge.

In the 1921 session, resolution number three of the proceedings called for the compilation and swift completion of a pharmacopeia of ayurvedic and unani prescriptions. The speeches in support of the resolution propounded an ideology of unity as the key to success. Thus Hakim Atam Chand of Sindh described the whole world as working through the harmony of different forces and their unified action. Even the hint of dissent among *vaid*s and *ṭabībs* brought swift retorts. One *vaid*, Pundit Raghu Nind Sharma of Jamalpur, Bihar, suggested that what was needed was separate books showing how medicines were prepared in unani and ayurveda. Hakim Ilyas Khan immediately took issue with this proposal for an amendment for separate publications. He spoke of the unity of knowledge:

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<sup>428</sup> Hakim Ferozuddin, *Rumūz al-qṭibbā*, Lahore, 1913, p. 11.

only with the simple drugs are there some differences between ayurveda and *ṭibb*, but the fundamentals of treatment are the same. Since the fundamentals of treatment are the same this means that every *vaid* can use a unani prescription (*nuskḥah*) and every *ṭabīb* can use a ayurvedic prescription in their practice. Knowledge and science do not belong to any person, nor are they the possession of any community (*qaum*), so why is it necessary to produce separate pharmacopeias for unani and ayurveda. Anyone can make use of a useful thing. Like with *dākṭarī* [western medicine]...there is no constraint that *dākṭarī* tools are only for doctors...no simple drug bears the name unani or ayurvedic. Likewise, by allopathic, homeopathic etc. is meant the method of treatment not the name of the drugs ... On what grounds can it be that an ayurvedic prescription is only for *vaid*s and a prescription of unani *ṭibb* is specifically for *ṭabīb*s ... If a place is found within our hearts and we accept this resolution the path of the progress of drugs will be blocked.<sup>429</sup>

Hakim Ilyas Khan was here describing his vision of *desī ṭibb*, in which ayurvedic and unani knowledge of the effective use of the drugs of India could not be told apart. The point of his argument was to underline the common ground of unani and ayurveda. In this vision imbued with the ideology of national unity, he was striking at the heart of a communalised vision of medical practice in India, in which attribution and claims of superiority were paramount.

Pundit Thakar Datt Sharma resolved the matter bringing both camps together with an apt example which underscored his support for Ilyas Khan's contention:

Attributing a prescription to ayurveda or unani, apart from being incorrect, is also a difficult task. For example, suppose for a short while that I tell you from my own

<sup>429</sup> 'AIVUTC ke Dasveṅ', p. 49: 'Āyūrvedik aur ṭibb meṅ ṣirf adviyah ke muta'alliq kuch ikhtilāf hai magar usūl-i 'ilāj donoṅ kā ek hai, jab usūl-i 'ilāj donoṅ ka ek hai to yūnānī ka nuskḥah har ek vaid aur vaidik kā nuskḥah har ek yūnānī ṭabīb apne maṭab meṅ isti'māl kar saktā hai. 'Ilm aur sā'ins kissī shakḥs yā qaum kī mulkiyat nahīṅ hai, phir kyā zarūrat hai ke vaidik aur yūnānī fārmakopīyā 'alāḥidah 'alāḥidah banā'ī jāye. Ek muḥid ciz ko har shakḥs isti'māl kar saktā hai. Maṣalan dākṭarī ālāt ko ko har ek ādmī isti'māl meṅ lā saktā hai yeh ko'ī qaid nahīṅ hai kih dākṭarī ālāt ko ṣirf dākṭarī bartīṅ ... Yūnānī aur vaidik kissī davā kā nām nahīṅ hai. Issī tarḥ ālopaiṭhik homiopaṭhik va ḡhairah davāoṅ ke nām nahīṅ haiṅ balkih in se usūl-i 'ilāj murād hai ... Kis banā par vaidik kā nuskḥah ṣirf vaidoṅ ke li'e aur yūnānī ṭibb kā nuskḥah ṭabībōṅ ke li'e makḥsūs kiyā jā saktā ha. Agar dil meṅ jagah de ga'ī aur tarmīm ko manzūr kar liyā gayā to us kā natījah yeh hogā kih davā'ī se taraqqī kā rāstah band ho jā'egā'.

experience that to 'boil mango leaves in water, pour in milk and drink, gives energy and purifies the blood'. So now will you tell me that you think this is a unani prescription or do you imagine that it is an ayurvedic prescription? For sure, I will say this, that for those that are prescriptions derived from books information about the source should certainly be given where this is possible, because this is useful information.<sup>430</sup>

With that summation, the resolution for a swift compilation of a joint pharmacopeia was passed. This project had originally been proposed some ten years earlier, but although haltingly pursued, it still seemed far from completion. One participant of the 1921 session, Hakim 'Ata Muhammad, voiced his frustration that the Conference seemed more like a debating-society than one capable of bringing projects to fruition: 'this resolution is not new, indeed it was first passed some years ago and until today it still has not come to any practical consequence'.<sup>431</sup> Moreover, he claimed that in the ten years of the Conference's existence it had performed no special service to the profession, and that by only passing resolutions it would not accomplish its goals.<sup>432</sup> One of the major problems that seemed to be impeding the course of the *desī* plants project in particular, and one might say, the professional advancement of *ṭibb* in the early twentieth century in general, was that *ṭabībs* and *vaid*s were reluctant to part with the tried and tested prescriptions (*mujarrabāt*) needed for the work. Hakim 'Ata Muhammad's speech revealed the depth of feeling among *ḥakīms* who might have wished to help fulfil the ambitions of the Conference, but who could not afford to jeopardise their livelihood. His speech illuminated the divide between the rich and the poor, the *khāndānī* (hereditary) physicians and other classes of practitioners. It is the duty of the rich *ḥakīms*, he argued, and no-one else, to contribute to the pharmacopeia. These are the practitioners who

<sup>430</sup> *Ibid.*, p. 51: 'Vaidik aur yūnānī se muskḥoṅ ko mansūb karnā thīk nah hone ke 'ilāvah mushkil bhī hai. maṣalan thoṛī der ke li'e farz kījī'e kih meṅ apnā tajribah bayān karūṅ kih ām ke pattoṅ kar pānī meṅ josh de kar is pānī ko dūdh meṅ dākhil kar ke pīne se badn meṅ ṭāqat ātī hai aur khūn kī ṣafā'ī hotī hai to ab āp mujhe batā'eṅ kih is muskḥah ko āp yūnānī meṅ lenge yā vaidik muskḥah tasavvur karenge. hāṅ main yeh zarūr kahūngā kih jo kitābī nuskḥah hūṅ un ke akḥz ka ḥavālah ḥatā al-ḥimkān zarūr diyā jā'e kyonkih yeh ek muftīd bāt hai'.

<sup>431</sup> Hakim 'Ata Muhammad, *ibid.*, p. 46: 'voh ko'ī nayā rizolyūshan nahīn hai balkih ka'ī sāl ka 'irṣah hotā hai kih pehle bhī yeh rizolyūshan pās ho cukā hai magar 'amālī jāmah us ne ab tak nahīṅ pahuncā'.

<sup>432</sup> *Ibid.*, p. 46: 'us ne fann kī ko'ī kḥaṣ khidmat nahīn kī, ṣirf rizolyūshan pās kar lene se shāhid maqṣūd tak rasā'ī nahīṅ ho saktī'.

usually have more than a treasure-trove of *mujarrabāt* since they are usually hereditary *hakīms* or *vaids* 'whose prescriptions are more reliable for having passed from generation to generation and have been continually proven and tested'.<sup>433</sup> By contrast, the common (*ām*) classes of *vaids* and *hakīms*,

only have a few special *nuskhahs* [prescriptions] from which they make an income and a livelihood. If they hand over their *nuskhahs* they will die of hunger...Take me as an example. On the one hand I want to help my beloved art of *ṭibb* and my dear ayurveda, but on the other I have to think of my stomach. If I were free not to think of my stomach then I would be happy to offer my prescriptions.<sup>434</sup>

It seems in fact that this was such a major stumbling block that this project of the Conference never came to fruition. The profession of unani *ṭibb* and ayurveda throughout the subcontinent was at this time still dominated by small-scale private practice. The idea of producing a pharmacopeia which only contained tried and tested prescriptions drawn from the inherited knowledge of *ṭabīb*s and could be used by anyone was too much of a challenge to the structures of unani practice to bear realisation. It was part of the agenda of certain elite professionals trying to standardise the practice of the profession in order to raise its profile both among government officials and also among the educated public.

These projects concerning *desī* plants and medicines that have formed the subject of our discussion so far – the exhibition of plants, the herbarium, the register and the pharmacopeia – reveal more than any other proposed by the Conference the need felt among practitioners of the time to fundamentally change the nature of knowledge in *ṭibb*, by expanding their knowledge base, organising this knowledge and making it available. While no practitioners denied the technological superiority of the west, and most who spoke as representatives of the profession favoured the incorporation of surgery in the curricula of *ṭibb*, the plants of India were seen as the saviour of the profession. The substantial knowledge accumulated over centuries and passed from generation to generation was a tremendous source of confidence for practitioners at a time when the

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<sup>433</sup> *Ibid.*: '[jinke mujarrabāt] ziyādah istinādī ḥaiṣiyat bhī rkahte haiṅ kyōṅkih 'irsah dirāz ke musalsal āzmāish aur tajribah kī mahar taṣḍīq un par hote hai'.

<sup>434</sup> *Ibid.*, p. 47.



profession was commonly seen as going through a crisis that many thought might lead to its extinction. This was a time, as one *ḥakīm* put it, 'when the swords are out'. Many elite *ṭabībs* challenged the culture of secretive, family-based knowledge of *desī* drugs and knowledge transmission as an impediment to the survival of *ṭibb* as a 'system', in which this knowledge would be shared. Many *ḥakīms* had identified the struggle not in terms of how a practitioner could survive day-to-day competing for custom in the market-place, but in terms of how *ṭibb* could be represented as a modern profession.

The recognition of the importance of expanding ayurvedic or unani practitioners' knowledge of India's medicinal plants was of course not the prerogative of the AIVUTC alone. The Ayurvedic Congress also organised exhibitions, and journals ran features on medicinal plants, and individuals like the famous *vaid* of Kerala, P.S. Varrier, compiled a pharmacopeia of 500 medicinal plants. What was particular to the Conference was that this was to happen on a national scale, it was to reflect the composite nature of *desī.ṭibb*. In the first ten years of the Conference's existence, the problems besetting ayurveda and *ṭibb* were identified by *vaid*s and *ṭabībs* as being fundamentally the same: the scale of 'quackery', the malpractice of druggists, the lack of opportunities for institutional instruction and the need for government support. The Conference's emphasis on *desī* plants was partly a function of the Conference ideology of the common front, presenting *desī* plants as the common heritage of unani and ayurveda. It was also a function of the notion of the modern unani/ayurvedic profession that would share this knowledge for collective benefit.

By the mid to late 1920s the momentum of the Conference and its promotion of *desī.ṭibb* appears to have been diminishing. An editorial in the journal *al-Ḥakīm* in 1929 lamented that four thousand invitations had been sent out, but only a few hundred practitioners had attended the last meeting.<sup>435</sup> In particular, it seems that the attendance of *vaid*s declined, but the editor, Hakim Muhammad Shifa Khan, defended the Conference for protecting the rights of *vaid*s. It was not only *vaid*s who absented themselves, however. It appears that the fragmentation of the Conference into local organisations, which the Conference had itself promoted, was now threatening to undermine the

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<sup>435</sup> 'AIVUTC *Guzishtaḥ Ijlās par ek Sarsārī Nazar*', ['A cursory glance at the last session of the AIVUTC'], *al-Ḥakīm*, May 1929, p. 5.

relevance of the central organisation. We may also see its declining influence in the context of the successful lobbying of the members of the Legislative Councils in the new era of local self-government by unani and ayurvedic organisations, and prominent community figures. This had resulted in the increasing state support for indigenous medicine in Madras, Bihar and UP. We also witness at this time the passing of the charismatic leadership of the Conference in the person of Hakim Ajmal Khan, who died in 1928, and along with it the memory of his political vision, as separatism grew in power and stature. A year after Ajmal Khan's death *hakīms* called for a return to the spirit of the Conference of his days. The Conference subsequently did not vanish entirely, and continues to this day as the All India Unani Tibbi Conference. But gone is the conception of the entwined fates of ayurveda and unani.

### III. Plants and the 'Nation' in the Unani Journal *al-Ḥakīm*

The legacy of the Conference's emphasis on increasing the familiarity of practitioners with India's plant wealth as a matter of national concern did, however, live on. In the mid-1930s Hakim Ghulam Muhiuddin made it his project to promote India's medicinal plants through his editorship of the journal *al-Ḥakīm*, which had consistently supported the ideals of the Conference, and its founder, Hakim Ferozuddin, had long recognised the importance of creating a new awareness among practitioners of medicinal plants in their practice. By promoting this knowledge, the editor Ghulam Muhiuddin declared,

we will have gained this reassurance that we have revived and organised such an important branch of knowledge and art, through which *ṭabībs* and non-*ṭabībs*, in short every person in the country will be able to be independent of foreign [*ghair mulkī*]

compounds, and that they will be able to maintain the natural affinity between their body and spirit [*rūh*] in the best possible way.<sup>436</sup>

The fusion of the political with the medical is evident here. India was a land under occupation by a foreign power, and the Indian body was suffering from the disequilibrium wrought by the use of foreign products. The occupation by English medicines was corrupting. From this nationalist perspective, these medicines were not just hot and fast-acting, but they had a constitutional affect that disturbed the balance and weakened the body and the soul. Ghulam Muhiuddin saw his passionate advocacy of the power of India's plants as a duty to the 'nation'. He used imagery of Indians having gone astray on a journey, lacking their own direction and leadership, to describe their dependence on foreign powers. But he emphasised the role that *hakīms* could play in bringing India back on a good path: 'We are the ones who truly possess leadership and guidance, and this independent-minded *hakīm*, on whom has been conferred grace and favour, occupies himself trying to go forward'.<sup>437</sup> The struggle for independence was to be fought through spreading awareness of India's medicinal heritage. In his vision the reform of *ṭibb* had as its aim the reform of, quite literally, the body politic. As the editor stated in another issue of the journal:

... the secret for the advancement of *desī ṭibb* is concealed within this matter, that we can reform our body with the things that are around about us. This is why we have especially pressed for this movement from economic, moral, national and trade perspectives.<sup>438</sup>

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<sup>436</sup> Editorial, 'Hindustānī Jarī Būṭiyon aur hamāra Lā'ihah-yi 'Amal' ['The medicinal plants of Hindustan and our splendid service'], *al-Ḥakīm*, July 1934, p. 5: 'To hameñ yeh ṭīmān-i qalb zarūr ḥāsil hojā' egā kih ham ne apnī zindagī ko 'ilm o fann ke ek aise aham shu 'bah ke iḥyā' o tanzīm par širf kiyā hai jis kī vasāṭat ṭabīb aur ghair ṭabīb al-gharaḥ mulk ka har fard bashar us qābil ho gayā kih ghair mulkī murakkabāt ke be-nayāz ho kar rūḥ aur jism kī qudratī rishtah ko bi-ṭarīq-i aḥsan bar qarār rakh sake'.

<sup>437</sup> *Ibid.*: 'Lekin ham hain kih is mālik ḥaqīqī kī qiyādat wa rahnumā'ī aur is ḥakīm muṭlaq ke faḍl o karam par bharusah karte hū' e āge barhne kī koshish meñ mašrūf hain'.

<sup>438</sup> Ghulam Muhiuddin, 'Māzī kī Taṣvīr-i Ḥāl ke Ā'inah meñ *al-Ḥakīm* kī Guzishtah yak Sālah Zindagī par ek Sarsāri Nazar', [The image of the past in the mirror of the present, a year in review of *al-Ḥakīm*'], *al-Ḥakīm*, October 1935, p. 16: 'cūnkih desī ṭibb kī taraqqī kā rāz širf issī cīz meñ muḥmir hai, kih ham apne mā-ḥaul kī ašhyā' se apne badn kī iṣlāḥ karen. Is li'e ham ne is taḥrik par iqtisādī, akhlāqī, mulkī, aur tijāratī nuḡṭah-yi nazar se khāṣ ṭaur par zūr diyā hai'.

It was Ghulam Muhiuddin's ambition not only to halt the power of the foreign over the *des*, but to bring back to *desī .tibb* the classes who had been won over by the seductive attraction of English medicines, especially the middle classes.

Hakim Ghulam Muhiuddin framed this vision in a lengthy editorial in July 1934, and in many aspects it is markedly reminiscent of the Conference. It reveals the entrenchment of a scientific approach to understanding medicinal plants within unani *.tibb*, which organises and systematises knowledge and renders it amenable to comparative analysis. This approach was believed to be necessary for the political ambitions of the programme. The programme involved the identification of medicinal plants and reproducing their images in colour, compiling an index of the different names given to a plant in different parts of the country and collating information on the different properties of the plants and all their parts, including their temperaments (all plants, like minerals and animals possessing a humoral nature). It meant providing information on how plants may be cultivated and the most suitable geographical and climatic conditions for their growth; determining the properties of fresh and dry produce, describing the process of how to achieve these properties; and setting up a central *tajribagāh* (a laboratory) to assess and prepare drugs and determine their proper medicinal applications. *Al-Ḥakīm* depended for this project on the contributions of its readers, as had the Conference on its members, who were to relay as much information as they could to the journal. If it was not possible to send pictures of the plant, then, *al-Ḥakīm* stated, its staff were ready to make local arrangements to assess the plant or even to make the trip.

During the course of 1934, *al-Ḥakīm* described and discussed 36 plants in detail and provided 10 colour illustrations. *Al-Ḥakīm* was one of the most widely circulated unani journals in India, and the propagandist element of this project is evident in that many letters of support for the journal under Ghulam Muhiuddin's editorship were published in it. The editor spoke of a 'movement' (*tahrīk*), carrying the connotations of a popular mobilisation, and declared that the greatest part of *al-Ḥakīm* had been devoted to the investigation and dissemination of knowledge of *desī* plants, appearing in editorials and

special features. He thanked people for their support and contributions. ‘There is no part of the country’, he wrote, ‘where there has not been support for this movement’.<sup>439</sup>



Figure 1: *brahmī būṭī*, the lotus<sup>440</sup>

<sup>439</sup> ‘A year in review of *al-Ḥakīm*’, *al-Ḥakīm*, October 1935, p. 16: ‘*Mulk kā ko ī ḥiṣah aisā nahīn jahān se is taḥrīk kī ta’yīd nah kī gayī ho*’.

<sup>440</sup> An illustration by M. Niran Bakhsh in *al-Ḥakīm*, October 1935, pp. 18-19.

The same edition of *al-Hakīm*, October 1935, carried an article by one Hakim Ghulam Hasan Shirani Tonsavi entitled 'The treatment of all diseases with medicinal plants'.<sup>441</sup> In an editorial note to the article the editor wrote how highly he valued the kind of information Hakim Ghulam Hasan presented, which was based on personal experience with plants, and required a lot of diligence, patience and perseverance. The editor supplied references to the issue and page numbers of previous issues of the journal which featured the plants described by the *hakīm* to further aid identification. The editor added,

[i]f some of those who love *ṭibb* have their own experiences with the identification of plants in their own localities and their effects and properties please do keep us informed, [this information] will be prepared in the annual edition. A note of thanks will be included for this kind of information. We are convinced that should the utmost attention be paid to researches into the identification and properties of medicinal plants, then with regard to Hindustan within a short time we will be spared the need for western dispensaries.<sup>442</sup>

In a similar vein, the *hakīm* writing the article praises India as a paradise. Variety is embraced as her boon: 'Just as all kinds of land, mountains, rivers, kinds of peoples, language and faith are found, so fittingly all the *jaṛī buṭī* that grow in various lands they are all found, in fact more are, in Hindustan'. While in other forms of medical discourse it is the power of the healer that effects the cure,<sup>443</sup> here the relationship is reversed: the power lies with the plant. Hakim Shirani continues,

[i]ndeed from ancient times they continue to grow now. Hence the miracles of the *sādhūs* and *sanyāsīs* of old are all due to these [plants] and continue to be so, and these

<sup>441</sup> Hakim Ghulam Hasan Shirani Tonsavi, '*Jaṛī Būṭiyon se har Marāḍka 'Ilāj'*', *ibid.*, pp. 34-35.

<sup>442</sup> *Ibid.*, p. 34: '*Agar ba 'z ṣāhib zauq aur shaidāyān-i ṭibb apne apne zātī tajribāt in būṭiyon kī shanakhāt aur apne apne 'ilāqah ke makhṣūs nām aur khavāṣ o af'āl va ghairah hamen muṭalli 'farmāte rahain, to jaṛī būṭiyon ke muta'alliq jo sālanāmah tayār kiyā jā rahā hai. Is qism ke ma'lūmāt shukriyah samiyat is men daraj kī jā'egī. Hamāra yeh yaqīn hai kih agar jaṛī būṭiyon kī shanakhāt aur un kī khavāṣ o af'āl kī tahqīqāt par pūrī pūrī tavajjuh kī jā'e to Hindūstān kī sarz men 'irṣah qalīl men maghribī davākhanon kī muhtājī se najāt ḥāsil karegī'*.

<sup>443</sup> See Chapter 6 on journals and the practice of medicine for examples of magical cures.

are regularly witnessed. In fact it is due to the medicinal plants, through their specific properties and powerful effects that these amazing results are brought about.<sup>444</sup>

This encapsulates the changing vision of medicinal plants in the popular perceptions of cure, reflected, especially at an earlier time, in the writings of unani *tibb* itself. The *hakīm* continued with the main topic of his article – his experiences with certain medicinal plants of his locality. I provide here a description of a medicinal plant in full to give an impression of the detail with which practitioners embraced the programme of *al-Hakīm*:

‘Hot’ head-ache: *nūnkhā būṭī*, growing abundantly in salty areas with very small fine twigs red in colour, its leaves the size of rice; its small flowers are yellow and they bloom at dawn for two and a half hours before wilting. It tastes bitter and salty. The seeds are black like purslain. The rural people cook it and eat it. It is used for headaches that are caused by heat. Extract the juice from the plant, mix it with rose oil [*roghan-i gul*] and make a salve. Just applying it will bring relief.<sup>445</sup>

The style of the writing is concise and to the point. It provides adequate description of the plant to facilitate identification, and reports on the experiences of local people and credits them with the knowledge of the preparation and its effects.

Introducing this kind of information into mainstream unani practice had been at the fore in the activities of the Conference, and here we see it purposefully continued, couched in a discourse that subsumed *desī* plants within aspirations for a reformed Hindustan. We have traced then the emergence of this discourse as a product of professional exigencies of *vaid*s and *ṭabīb*s framed within the overriding ideology of the unity of Hindus and Muslims, of ayurveda and *tibb*, propagated uniquely on such a large

<sup>444</sup> Hakim Shirani, ‘*Jaṛī būṭiyon...*’, p. 34: ‘*Cunāncih zamānah mā sabaq se āj tak ke sādhuōn aur sānyāsiyon ke kamālāt sab unhī sabab se the aur haiñ, jo barābar mushāhidah meñ āte rahte haiñ, dar haqīqat yahī jaṛī būṭiyon jo apne ta’ayyuni khavāṣ aur zūd asrī ke bā’is hairat-angez natā’ij paidah kar detī haiñ*

<sup>445</sup> *Ibid.*, p. 35: ‘*Dard-i sar hār – nūnkhā būṭī jo akṣar namāk jagahon par mafrūsh hotī hai. Shākhain choṭī choṭī bārīk gireh-dār ba-rang surkh. Barg ba-ta’dud cāval. Phūl ba-rang zard choṭā sā jo ṭulū’-yi āftāb ke derh ghanṭah ba’d shuguftah ho kar do pahar ko muḡmaḡill ho jātā hai. Mazah tarsh wa shūr. Tukhm bārīk wa siyāh miṣl tukhm khurfah ke. Dehātī log is ka sāg pakā kar khāte haiñ. Aise dard-i sar ke li’e jo garmī se ho. Is būṭī ko pesh kar roghan-i gul milā ke lep karen. Śirf lagāne se ārām ho jā’egā’.*

scale by the Conference. Although in the pages of *al-Hakīm* references to ayurveda are not found in this context, the ideals of collating and disseminating plant knowledge were extolled and pursued for the love of the nation, where the 'nation' is understood as a composite body.

## Conclusion

We have witnessed in the discussions of this chapter a special phase in the history of *ṭibb*. This concerns the transformations and disjunctures of a profession attempting to cast for itself a new identity. In this process of reformation elite practitioners struggled with the informal health-care sector, with their own traditions and with colonial medicine to find an authoritative and legitimate place in their relationship with the public.

The security of the elite unani profession required their distinctive authoritative role. This meant recognition by the system of governance, a parity of legal status with other elite medical providers and support for an infrastructure, such as colleges, dispensaries and so forth. But it also meant that the profession needed to newly define its role as a cultural authority in the eyes of the public. Hence we have seen the importance placed on trust and reputation in the debates on *desī* drugs and the practising *ṭabīb* in this chapter, and in the previous chapter of this thesis on ideas of institutional and hereditary legitimation. Unani *ṭabībs* placed themselves in a position to mediate and treat bodily and socio-cultural ills, as we explore more fully in the conjuncture of medical and moral domains in the following chapters on women's diseases and men's diseases. In all of these contexts, practitioners were most concerned to present the credibility of their profession, to demonstrate to the public – and here we may emphasise a literate, public – their authority, their capacities and their trustworthiness.



## Chapter 5

### Treating Women: Women's Engagement with Unani *Tibb* and its Engagement with Women in Early Twentieth-Century India

It is not permissible to bare oneself from one's navel to one's knee, even before another woman. It is only permissible to show one's body when it is absolutely necessary, like in the case of a boil on the thigh, but you should only expose the place where the boil is and nothing more. In this regard put on an old pyjama or sheet and cut away where the boil is, so the *jarrāh* [surgeon] may see it, but none other than the *jarrāh* may look, neither man nor woman.<sup>446</sup>

In the late nineteenth century and early twentieth century unani *tibb* began to engage with women in new ways. The passage quoted above appears in a discussion of women's health in the *Bihishtī Zavar*, a classic of Islamic scripturalist reform of the turn of the twentieth century, (and finds an echo in Salman Rushdie's *Midnight's Children*).<sup>447</sup> This work indicates the extent to which women's health practices were on the one hand an area of great importance in social and religious reform movements in this period, and highlights at the same time the pressures that some women were under to conform to societal norms and expectations in their health-seeking behaviour. Maulana Ashraf Ali Thanavi, the author of *Bihishtī Zavar*, and a number of other social and religious reformers, male and female, encouraged women in various ways, some less circumscribed than others, to take control of their health, either through appropriate self-medication using unani drugs or through the consultation of reputable medical

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<sup>446</sup> Maulana Ashraf Ali Thanavi, *Bihishtī Zavar Mukammal wa Mudallal*, Delhi, 1344 Hijri, p. 257: 'Nāf se zānū tak hargiz badn nangā nah karnā chāhi'e [mas'alah 1.] agar ko'ī majbūrī ho to zarūrat ke muvāfiq apnā badn dikhlā denā durust hai maṣalan rān meṅ phūre kī jagah khūlo ziyādah hargiz nah khūlo. Uskī sūrat yeh hai kih purāna pā'ijamah yā chādar pahin lo aur phūre kī jagah kāṭ do usko jarrāh dekh le. Lekin jarrāh ke sivā aur kissī ko dekhnā jā'iz nahīn nah kissī mard ko nah kissī 'aurat'.

<sup>447</sup> 'A frantic note had crept into Doctor Aziz's voice. "Ghani Sahib, tell me how I am to examine her without looking at her?" Ghani smiled on. "You will kindly specify which portion of my daughter it is necessary to inspect. I will then issue her with instructions to place the required segment against that hole which you see there. And so in this fashion, the thing may be achieved.'" Salman Rushdie, *Midnight's Children*, London, 1995, p. 23.

practitioners, including *ṭabībs*. Although the relationship between unani *ṭibb* and women, as patients and as practitioners, contributes both to our understanding of the position of women in early twentieth century Indian society, as well as the socio-cultural location of unani practices, it has only been touched upon in few studies. Azra Asghar Ali has examined some aspects of women's health issues and unani *ṭibb*, but her intention was not to give a rigorous treatment from the perspective of unani *ṭibb*.<sup>448</sup>

In the early twentieth century unani *ṭibb* came to be seen as an important element in the education and upbringing of a Muslim woman. Unani practitioners identified the home, pre-eminently the woman's domain, as a site that required intervention through sanitation. Unani institutions for the training of *ḥakīmahs / ṭabībahs*, female practitioners, were established and women began to get involved in this process, some of them partaking in the development of a form of unani discourse hybridised with European conceptions of hygiene, nursing and domestic economy. Women also began to set up autonomous clinics in the 1920s and 30s, offering their services to women especially, but not exclusively. This chapter traces salient aspects of these transformations. It also explores gendered dimensions of unani medical discourse, with special reference to 'hysteria', and the extent to which they can be seen to reflect notions of the place of women in Indian society of the time. By examining a variety of sources, by reformers and practitioners, this chapter reveals then a number of ways in which the organisation and also the content of unani *ṭibb* were reinvented in the early twentieth century, in the process exploding the myth of the 'system' of unani *ṭibb*, both through time and synchronically. Social reformers and practitioners reworked authentic and authoritative unani *ṭibb* in relation to the treatment of women as they negotiated the social, political and medical currents of these times.

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<sup>448</sup> Azra Asghar Ali, *The Emergence of Feminism among Indian Muslim Women, 1920 – 1947*, Karachi, 2000, Chapter 3, p. 90 f.

## I. Treating Women

Female unani practitioners, *tabībahs*, do not appear often in the pre-twentieth century historical record. Elite unani practice, associated with the courts, nobility, and hereditary lineage recorded in the biographical directories (*tazkirah*) of practitioners and chronicle literature, was dominated by men.<sup>449</sup> Although there were exceptions to this trend. Mention is occasionally made of female practitioners serving the *zenānas* of the nobility. Siti al-Nisa Begum, sister of the poet Talib Amali, was apparently known for her knowledge of medicine and Shahjahan apparently employed her as supervisor of the royal household after the death of Mumtaz Mahal in 1646.<sup>450</sup> Robert Sigaléa mentions a woman surgeon from Delhi who was brought to Ahmedabad at the beginning of the eighteenth century to treat the wife of the Viceroy of Gujarat for a breast lump.<sup>451</sup> A serious investigation of these and other sources would be required to build a more representative picture of women's medical practice in India before the twentieth century, something which has not yet been done.

Making generalisations about male *tabībs* treating women is also prone to distortion. In the *General Medical History of Rajputana* published in 1900, Colonel Thomas Holbein Hendley pointed out that obstetrics and women's diseases in Rajputana were for the most part 'entirely in the hands of dhais [sic]', who were 'too frequently most skilled as abortionists'. Yet, he went on to say that the *jarrāh*, the surgeons, who 'bleed, draw teeth, cauterise, bandage limbs ... have great influence still, especially with women.'<sup>452</sup> He thus distinguished between the event of childbirth and other situations where women may have sought medical help. Although unani texts frequently give various prescriptions for fertility, contraception, giving birth to a boy, for avoiding

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<sup>449</sup> Jaggi has collected a number of citations from Persian chronicles ca. 1530-1700 that refer to prominent *hakīms* at the courts of Mughal rulers. Om Prakash Jaggi, *Medicine in Medieval India*, Delhi, 1977. Zillurrahman has compiled a biobibliography of *hakīms* practicing in Delhi, from the time of the Delhi Sultanate. Hakim Sayyid Zillurrahman, *Dilhī aur Ṭibb-i Yūnānī*, Delhi, 1995.

<sup>450</sup> Zillurrahman, *Dilhī*, pp. 43-44; R. L. Verma and N. H. Keswani, 'Women in the Arab Medicine', *Studies in History of Medicine*, 1, 1997, p. 280.

<sup>451</sup> R. Sigaléa, *La Médecine Traditionnelle de l'Inde: Doctrines Prévedique, Védique, Āyurvédique, Yogique et Tantrique, les Empereurs Moghols, leurs Maladies et leurs Médecins*, Geneva, 1995, p. 453.

<sup>452</sup> Colonel Thomas Holbein Hendley, *General Medical History of Rajputana*, Calcutta, 1900, p. 40.

miscarriage and for inducing abortion,<sup>453</sup> there is no evidence of their involvement in the actual birth process. Drawing on the image of a child appearing out of the mother's slit stomach, some scholars have concluded that *hakims* performed caesarean sections on women. However, as the historian Emily Savage-Smith points out, this depiction is designed rather to emphasise miraculous birth as an aspect of a hero's larger than life character, than to reflect surgical practices of the time, and caesarean sections are not mentioned in the literature.<sup>454</sup> Manfred Ullmann includes an illustration of a fourteenth century Arabic manuscript, where the Arabic indicates that the woman had died and the child was being extracted, but Ullmann does not comment on this and does not contextualise the illustration.<sup>455</sup>

Where assistance was sought for childbirth from outside the household women in India seem to have singularly relied on the *dai*, whose practices are routinely vilified in the European commentary on midwifery in India. One contributor to the *Indian Magazine* in 1887, remarked that:

Our vaides and hakims do not study the character of puerperal disease, nor as a rule undertake to attend them, and the whole duty of puerperal management devolves on our midwives, who, as a body, are utterly incompetent. They belong to the lowest grade of society, and are never trained to their work. When widowed and old, women of the lowest class, such as Domes, Chamars and Podes & co. first seek employment as attendants on women in confinements, and after a time set themselves up as midwives. There is thus no help for Indian women at the most critical period of their lives, except what may be obtained from these so-called dhaies.<sup>456</sup>

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<sup>453</sup> P. Jeffery, R. Jeffery and A. Lyon write that prescriptions for abortifacients are not found in the classics of unani medicine. In fact, they are, as listed by Abdur Razzack and Ummul Fazal. Patricia Jeffery, R. Jeffery and A. Lyon, *Labour Pains and Labour Power*, New Delhi, London, New Jersey, 1989; Mohamed Abdur Razzack and Ummul Fazal, *The Concept of Birth Control in Unani Medicine*, New Delhi, 1993.

<sup>454</sup> E. Savage-Smith, 'The Practice of Surgery in Islamic Lands: Myth and Reality', *Social History of Medicine*, 13 (2), 2000, p. 308.

<sup>455</sup> M. Ullmann, *Islamic Medicine*, Edinburgh, 1978, p. 34.

<sup>456</sup> Quoted in the *Papers on Indian Reform: Sanitary Reform in India*, Madras, 1888, p. 102. Caton makes a similar observation. 'Practical midwifery does not form part of the professional equipment of the *hakim*, but even if he were a skilful accoucheur he would not be admitted to her presence during labour. The orthodox Hindu woman is accordingly dependent for help in her confinement on the services of the indigenous midwife or dai'. A. R. Caton (ed.), *The Key of Progress, A Survey of the Status and Conditions of Women in India*, London, 1930, p. 48.

The idea of maternal ill-health and poor nutrition as major contributing causes of maternal death and stillbirths is not on the horizon in such observations. Rather, the tropes of filth and ignorance in late nineteenth century colonial discourse of India are perpetuated and replicated in commentary on indigenous midwifery, without a serious engagement with their practices.

Unani treatment of venereal diseases for women, while a possibility, nevertheless seems to have been quite a remote possibility. Discussions of venereal diseases, in which 'gonorrhoea' (*sauzāk*) and 'syphilis' (*ātshāk*) are most common, in both pre-twentieth and many twentieth century unani texts takes place in the context of diseases of male sexual organs, which suggests that they are principally understood as male diseases and women are not legitimate subjects for intervention in these cases. This is not to say that such recourse did not however occur. A further distinction about recourse to *ṭabībs* should be made on the basis of class; higher-class women or women in *pardah* may not have sought *ḥakīms* and *vaid*s at all, a feature that persists to this day among *sayyids* (those who claim descent from the Prophet) in parts of South Asia, for whom honour and shame are of paramount importance, some of whom live in total seclusion within the confines of their families. The same contributor to the *Indian Magazine* observed that:

Unwilling from a sense of delicacy, to communicate even to their male relatives the character and symptoms of their complaints, native ladies either directly consult, or through their maidservants, obtain whatever help they can get from village midwives and quacks of their own sex, and the result is generally very serious.<sup>457</sup>

Other non-English sources tend to support this general view of the poor access of women to health-care provisions. At the turn of the twentieth century, Muhibb-i Hussain (d. 1930), the editor of the women's journal *Mu'allim-i Nisvān*, attacked hypocrisy in the practice of *pardah*, which determined whom a woman may see for treatment. He commented that

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<sup>457</sup> *Ibid.*

[W]hen men and women go on pilgrimage to Mecca in the days of the plague they have to spend weeks in quarantine; there no special importance is given to *pardah*, men and women all stay together in one place, and the male doctor [*mard dāktar*] treats both men and women.<sup>458</sup>

From these preliminary remarks we can draw the following general conclusions: most unani practitioners were male; they did not attend women in labour, and may have rarely had access to women in *pardah*. However, this picture will be amplified as we explore how some of these general characteristics began to change in the late nineteenth century.

## II. Islamic Reform and Unani Medicine for Women: The *Bihishtī Zavar* of Maulana Ashraf Ali Thanavi

In the nineteenth century, the nature, social roles and status of women became a central concern both for the colonisers and for the proponents of the political, social and religious reforms that gained strength in the second half of the century. Women embodied at one time society's ills, but women were also the source of hope and strength. Lata Mani has demonstrated how, in colonial discourse, the treatment of women, especially the practice of widow immolation was used to justify colonial rule.<sup>459</sup> In Bengal, Hindu reformers elevated woman, Bhārat Mātā, and made her a symbol of duty and steadfastness in tradition. In western India in the late nineteenth century non-Brahmin political leaders were preoccupied with the need to control women, especially their

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<sup>458</sup> *Mu'allim-i Nisvān*, vol.11 (10), 1315 Hijri [1899], p. 19: '*Cunāncih jab yahī Hind ke mard aur 'aurataiñ ḥajj bait allāh ke li'e jāī [sic] haiñ to ayām vabā meñ haftoñ voh qarāñīnah meñ rakhe jāte haiñ. Vahāñ unke li'e ko'ī khāś pardah ka ihtimām nahīn kiyā jātā, aur mard dāktar 'auratoñ aur mardoñ dono kā mu'ālijah karte haiñ*'.

<sup>459</sup> Lata Mani, 'Contentious Traditions: The Debate on Sati in Colonial India', in K. Sangari and S. Vaid (eds), *Recasting Women: Essays in Colonial History*, New Brunswick, New Jersey, 1990, pp. 88-126.

sexual conduct, that would damage the community's reputation, as Rosalind O'Hanlon has shown.<sup>460</sup>

There was a parallel occupation with the condition of Muslim women among Muslim reformers of the *ashraf*, the class of Muslim gentry who had served government but evolved into a professional middle class after 1857. This transition is marked by a subtle shift in the emphasis of one of the many meanings of '*sharīf*' from 'noble by birthright' to 'noble by culture, education and moderate temperament'.<sup>461</sup> The Muslim reformers led a concerted movement for the education and social betterment of Muslim women. In these initial stages, the impetus for women's education came from men. Didactic fiction comprised one part of this endeavour. In 1869, Deputy Nazir Ahmed composed his classic of Urdu fiction, *Mirā'at al-'urūs* (the Bride's Mirror), which delineates the *sharīf* woman's ideal conduct. This was followed by the poet Khwaja Altaf Hussain Hali's *Majālis an-Nisā*, a novel again concerned with the need to educate women to preserve the dignity and culture of the *sharīf* class. Journals for women were brought out. Muhibb-i Hussain in Hyderabad edited *Mu'allim-i Nisvān* ('the instructor of women') from the 1880s until 1901. Mumtaz Ali and his wife Muhammadi Begum brought out the *Tahzīb an-Nisvān* from Lahore in 1898, the only Urdu women's journal at this time that was jointly edited by a woman. *'Ismat* was first published from Delhi in 1908 under Rashid ul-Khairi, and lived on into the 50s. Schools for girls were founded in the early twentieth century, and women began to participate in debates on education at a national level.<sup>462</sup>

Although the protagonists of Muslim women's social and educational reform differed widely in their agendas and scope – at variance over questions such as whether girls should be educated in schools or at home, what that education should comprise, whether *pardah* should be maintained – they were all united by the idea that the condition of their women was the gauge of the health of their communities, and that at this time it reflected their ill-health. The reformers saw in women the adherence to bad custom and

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<sup>460</sup> Rosalind O'Hanlon, 'Issues of Widowhood: Gender and Resistance in Colonial Western India', in Haynes and Prakash (eds), *Contesting Power: Resistance and Everyday Social Relations in South Asia*, Berkeley, 1992, pp. 70-73.

<sup>461</sup> I have relied quite extensively in this account of reformist activities on the excellent recent study by Gail Minault, *Secluded Scholars: Women's Education and Muslim Social Reform in Colonial India*, New Delhi, 1999, pp. 4-5.

<sup>462</sup> *Ibid.*

superstition, and the ignorance of Islamic principles, both of which were frequently invoked as the source of Muslim moral and cultural decline, and were believed to imperil the future transmission of Islamic culture. Many reformers framed their arguments with reference to the polarity between the concepts of *nafs* and *'aql*, which were originally elaborated in pre- nineteenth century texts in Persian on ethics.<sup>463</sup> *Nafs* is the self, indulgence, pleasure, and inordinate, often sexual, desire. Women were often considered more vulnerable than men to *nafs*, which the reformers also linked with the lavishness and debauchery of nawabi lifestyle, considered another source for the waning political influence and moral authority of Muslim culture. *'Aql* by contrast is reason, prudence and self-control. To lift the status of Muslims politically and economically meant rooting out wastefulness: a detachment from nawabi culture and a better harbouring of resources. It also meant turning towards the *zenāna*, the women's quarters, and attempting to control women's behaviour, or better, to re-shape it.

It is in this context that Ashraf Ali Thanavi (1864-1943) wrote the *Bihishtī Zavar*, the 'Heavenly Ornaments', one of the pre-eminent reformist works that reflected these concerns. Other guides for Muslim women were being written by Thanavi's contemporaries.<sup>464</sup> Two decades before the *Bihishtī Zavar* appeared, Shah Jahan Begum of Bhopal (1838-1901) wrote an encyclopedic guide for women that included advice on pregnancy, hygiene and remedies for minor illnesses, the *Tahzīb an-Nisvān va Tarbiyat al-Insān* ('the cultivation of women and the instruction of humanity'). This work was one of the first of its kind in Urdu and one of the most highly regarded.<sup>465</sup> But Thanavi's stands out for its more comprehensive discussion of *unani ṭibb*.

The *Bihishtī Zavar* is addressed to girls and women, who are advised to read it as soon as they have finished studying the *Qur'ān*. It was first published in 1905, but quickly established itself as a key guide for Muslim women, to the extent that it was often

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<sup>463</sup> Barbara D. Metcalf, 'Reading and Writing about Muslim Women in South Asia', in Zoya Hasan (ed.), *Forging Identities*, New Delhi, 1994, p. 4.

<sup>464</sup> Gail Minault, 'Other Voices, Other Rooms: the View from the Zenana', in N. Kumar (ed.), *Women as Subjects: South Asian Histories*, Charlottesville, 1994, p. 101 f.

<sup>465</sup> S. Lambert-Hurley, 'Contesting Seclusion: the Political Emergence of Muslim Women in Bhopal, 1901-1930', unpublished PhD thesis, University of London, S.O.A.S., 1998, p. 37; G. Minault, '*Secluded*', pp. 101-102.



given as part of the dowry.<sup>466</sup> In the preface to the book, Thanavi described what had motivated him to write the book:

For many years, I watched the ruination of the religion of the women of Hindustan and was heartsick because of it. I struggled to find a cure, worried because that ruin was not limited to religion but had spread to everyday matters as well. It went beyond the women to their children and in many respects even had its effects upon their husbands. To judge from the speed with which it progressed, it seemed that if reform did not come soon, the disease would be nearly incurable. [So I was greatly worried about how to treat it. Through piety, experience, the indications and my own requisite knowledge, it was clear that] the only cause of this ruination is nothing other than women's ignorance of the religious sciences. This lack corrupts their beliefs, their deeds, their dealing with other people, their character and the whole manner of their social life.<sup>467</sup>

Here Thanavi casts himself in the role of the *hakīm* diagnosing the root causes of society's ills, in a passage that resonates with the menace of a contagious disease that only women carry. The term that he uses for corruption is one with distinctly unani overtones: *fasād*. Thanavi's use of the imagery of corrupting contagion can be well appreciated given that plague was still virulent in north India at the time of writing. But the treatment that Thanavi prescribes for the metaphorically ailing society is to instruct women in the science of religion, and his aim of making the book accessible explains his use of Urdu instead of Arabic. Reaching women, even illiterate women, was crucial to Thanavi's goals. Hence, he clearly indicates the way the book should be approached.<sup>468</sup> A woman who can read should read it aloud, or rather teach it, to those women who cannot. Husbands (presumably literate) should spend time reading the book with women and be there to aid their understanding.

The *Bihishtī Zewar* is encyclopedic in its scope. Applying *sharī'ah*, Islamic personal law, as the standard, the book deals in great detail with many aspects of a woman's daily life where the author considers guidance necessary: the alphabet and the calendar,

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<sup>466</sup> B. D. Metcalf (trans.), *Perfecting Women: Maulana Ashraf Ali Thanawi's Bihishti Zewar*, Berkeley, 1990, p. 3.

<sup>467</sup> *Ibid.*, p. 47.

<sup>468</sup> Thanavi, *Bihishtī*, part 1, p. 2.

religious practices, such as prayer and fasting, proper management of the household, recipes, even how to deal with the post office. The ninth chapter of the book is devoted to medicine.

The author was a descendant of a *sharīf* family that had long been established in Muzaffarnagar district.<sup>469</sup> His father, learned in Persian, worked in the administration of an estate in Meerut. Thanavi studied at Deoband for five years from the age of fifteen, under the tutelage of eminent *‘ulamā* Naunatavi, the school’s founder, and Rashid Ahmed Gangohi. Part of his training as an *‘ālim* in Deoband would have included studying unani *ḥibb*, but the chapter on *ḥibb* in the *Bihishtī Zewar* was not actually penned by him, something that some scholars have overlooked.<sup>470</sup> He commissioned Maulvi Hakim Muhammad Mustafa Bijnori, a resident of Karam Ali, Meerut district to do this, albeit under Thanavi’s supervision. Although, as Barbara Metcalf points out, there are a number of translations of this text in English, not one has been done that includes the section on unani medicine, including her own.<sup>471</sup>

The foreword explains that the section on medicine was written for the ordinarily literate woman, and does not presume prior knowledge of unani.<sup>472</sup> The Arabicised vocabulary of unani is explained in marginal notes. Women should know about how to obtain and preserve their health to perform their religious duties well, but it is especially important for them since they are responsible for the welfare of children. Through their negligence children can fall sick. In addition, concerned about financial resources in difficult times, the author writes ‘there is another worry for men when women fall sick, that is the rupees charged for their medication’.<sup>473</sup>

The ninth chapter begins with a discussion of air and water, then follows to a certain extent the format that is conventional in unani teaching texts of the time, listing diseases and remedies according to the organs of the body from head to toe, although in

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<sup>469</sup> These biographical details are derived from G. Minault, *Secluded*, p. 64.

<sup>470</sup> A. Asghar Ali, *Emergence*.

<sup>471</sup> B. D. Metcalf, *Perfecting*. Similarly, M. Masroor Khan Saroha (trans.), *Bahishtī Zewar (Heavenly Ornaments)* by Maulana Ashraf Ali Thanvi, New Delhi, 1997, p. viii. Masroor’s foreword to his translation states: ‘The portions which are peculiar to India and the chapters dealing with treatment of certain diseases with unani medicines, have been omitted’. The translator probably does not consider this section relevant to or of interest for the readership both in South Asia and abroad.

<sup>472</sup> Thanavi, *Bihishtī*, part 2, p. 228.

<sup>473</sup> *Ibid.*, p. 229.

the *Bihishtī Zavar* the enumeration stops with the womb.<sup>474</sup> There follow sections on fevers, poisonous substances, preparations for travel. A few pages are devoted to childbirth, with quite detailed advice on preparations, diet and remedies, including recommendations of what medicines may be prescribed, taking into account the season, the childbearing woman's temperament and the strength or weakness of her body. Prescriptions for children's diseases, like whooping cough, are also given. Plague receives some attention, while the final section is given to descriptions of charms and incantations.

Only the *dai* is permitted to see the woman expose herself, either at birth or for applying medicines, but even then the woman patient should not be completely naked. For Thanavi there is no question that women should, when necessary, consult male *hakīms*. Indeed, the section on medicine is only supposed to be a guide to health, and the author clearly states that if things become difficult the woman patient should not hesitate to go to a learned and experienced *hakīm*.<sup>475</sup> Where *dais* are mentioned, in the sections on the womb and birth, they are always prefaced with *jāhil*, ignorant/illiterate. Thanavi's denunciation of the practices of traditional birth attendants indicates his belief that women's health-seeking behaviour, both in terms of women patients being able to make better choices about their care and that *dais* should be better educated, suggests an overlap with many contemporary European-colonial perspectives on this issue. Thanavi is keen to reduce women's reliance on *dais* in treatment, but accepts their inevitable presence at birth. The only place in the text where he mentions women physicians is in the context of venerable women in Islam's early history. Here examples of learned, influential and pious women are given with a moral attached to give a contemporary angle. Among them are the sister and daughter of Hafid ibn Zahra Tabib, to whom, Thanavi informs us, the Caliph al-Mansur had entrusted the treatment of his queens.

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<sup>474</sup> The *Mūjiz al-Qānūn* by Ibn al-Nafīs (13<sup>th</sup> century), *Mīzān al-Ṭibb* by Muḥammad Akbar Arzānī (early 18<sup>th</sup> century), and *Sharḥ al-Asbāb* by Nafīs ibn 'Iwaḍ (15<sup>th</sup> century) follow a the head-to-toe format, and were among the most used texts for instruction in unani medicine.

<sup>475</sup> Thanavi, *Bihishtī*, p. 237: "Ilāj hamesha aise ṭabīb se kirā'ie jo ḥikmat aur uskā 'ilm rakhtā ho aur tajribah kār bhī ho". Similar statements are repeated throughout the section.

The moral: This knowledge has completely disappeared among women ... Ignorant midwives bring ruin to women. If they had been educated would this have happened? These women whose fathers, brothers or husbands are doctors should resolve to learn from them for it is a very easy matter for them to acquire this knowledge.<sup>476</sup>

This passage clearly reveals that for Thanavi women are the equal of men in ability. In her writings, the historian Barbara Metcalf has drawn attention to this single standard for men and women that Thanavi applies throughout the *Bihishtī Zavar*. While men and women clearly have different roles and the woman is in a subservient position in the family, she has argued that for Thanavi men and women are essentially the same in terms of nature and potential.<sup>477</sup> When Thanavi was asked whether he would write a book comparable to the *Bihishtī Zavar* for men, he replied that the content of the *Bihishtī Zavar* applied equally to men and women.<sup>478</sup> Women's susceptibility to *nafs*, was thus for Thanavi 'culturally' determined, and not grounded in women's inherent nature. Medical theories of the body, Metcalf argues, played their role in shaping the outlook of Thanavi's and contemporary '*ulamā*:

Maulana Thanavi's society knew no counterpart to the pseudo-scientific medical theories of the nineteenth century [in Europe] that posited such radical difference between women and men ... No such change took place among Muslims, where Galen's theories of common bodily and moral characteristics continued to hold sway.<sup>479</sup>

We will see below that innate equality between men and women is in fact not a feature of Galenic medicine.

Thanavi and Hakim Mustafa were clearly aware of who their intended audience was – in the first instance, women – and this informed the style and content of their chapter on medicine. The authors' sensitivity is reflected on many levels. On a linguistic level, they never use terms that might be inappropriate for a female reader. To illustrate this, in discussions on the womb, they use the Arabic medical term *rahm* in the chapter heading

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<sup>476</sup> B. D. Metcalf, *Perfecting*, p. 293.

<sup>477</sup> B. D. Metcalf, 'Reading', p. 7.

<sup>478</sup> B. D. Metcalf, *Perfecting*, p. 9.

<sup>479</sup> B. D. Metcalf, *Perfecting*, p. 11.

'*rahm kī bīmāriyān*' (diseases of the womb), but otherwise the circumlocutory '*nāf ke nīce*' (below the navel) to refer to women's genitalia.<sup>480</sup> In other unani works it is commonplace to find '*sharmgāh*' (place of shame, pudendum). Although sexual activity has a direct bearing on health and disease according to unani *tibb*, (a theme which we explore further below and in Chapter 6), along with eating, drinking, sleep, evacuation and other aspects of every-day life, the authors omitted any discussion of sexual conduct in the *Bihishtī Zavar* as unsuitable for women. In a parallel selection of unani practice, the authors wrote that women should not use abortifacients, although abortifacients are part of the pharmacopeia of the classical unani texts.<sup>481</sup> Furthermore, charms and amulets are not part of the learned unani tradition, which relies on natural causation, with God often in the position of ultimate arbitrator. But the authors of this chapter conceded that women may use charms, as long as they are derived from authentic Islamic sources; a list of permitted charms is provided at the end of the chapter.

The *Bihishtī Zavar* is a new kind of presentation of authentic unani knowledge and practice, selected and arranged specifically for women. We will examine a concrete case of Thanavi's selective approach to unani medicine when we come to discuss hysteria, a disease which is dealt with in the *Bihishtī Zavar*'s section on diseases of the womb. And we will see below that this kind of editing of unani medicine for a female audience was one that other reformers of the time took up as well, such as Sultan Jahan Begum of Bhopal.

### III. The Home and Sanitation: New Sites for Intervention

We have seen in the preceding section that the *Bihishtī Zavar* was one vehicle by which a form of unani medicine could quite effectively be brought, perhaps as never before, into

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<sup>480</sup> Thanavi, *Bihishtī*, pp. 259-262.

<sup>481</sup> Abdur Razzack and U. Fazal, *Concept*.

the Muslim woman's realm. There were, however, attempts to do this by *hakīms* themselves, for altogether different reasons, and in quite different styles.

In the early twentieth century many *hakīms*, and also *vaid*s, espoused the cause of sanitation. Sanitation had been at the centre of Britain's medical policy in India for much of the nineteenth century, but as Mark Harrison's study of public health in India makes clear, there were tremendous differences in opinion between officials at various levels of the administration as to the appropriate means of implementing sanitary reforms.<sup>482</sup> The medical establishment justified the hold of sanitation on its medical policy, which had significant implications for maritime trade, by recourse to miasmatic theories of disease causation, which emphasised the dangers to public health of putrefying matter and vaporous emissions from the physical environment. The threat to European health in India was thought to be exacerbated in India by the tropical climate, which David Arnold has characterised as the 'environmentalist paradigm' of colonial medicine.<sup>483</sup> Miasmatic conceptions of the spread of disease shares very much with the etiology of epidemics (*vabā'ī amrāz*) in unani *ṭibb*, so there was ample common ground that *hakīms* could find between the goals of the colonial sanitary enterprise and ideas on health and disease in the unani tradition. Although the translation of rhetoric into substantial coordinated action remained patchy, as Mark Harrison has shown, colonial public health programmes entailed a wholly new set of priorities concerned with epidemiology, including the statistical study of the patterns of disease in the public at large, the registration of births and deaths, engineering and urban planning.<sup>484</sup>

In Europe, Lister's, Koch's and Pasteur's experiments in nascent bacteriology in the late nineteenth century were beginning to challenge the miasmatic theories that had until then underpinned the dominance of sanitation as a key concept in public health. Not so in India, where the repercussions of their work and, more significantly Haffkine's research on the plague bacillus, were only to be felt later.<sup>485</sup> Large-scale intervention based on sanitary principles only began following the outbreak of plague in Bombay in 1896, as

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<sup>482</sup> M. Harrison, *Public Health in British India: Anglo-Indian Preventive Medicine 1859-1914*, Cambridge, 1994.

<sup>483</sup> D. Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Colonial India*, Berkeley, 1993, on 'the environmentalist paradigm' of colonial medicine, p. 28 f.; M. Harrison, *Public*.

<sup>484</sup> M. Harrison, *Public*.

<sup>485</sup> *Ibid.*, p. 40.

has been well documented.<sup>486</sup> We have seen in the chapter on plague that *hakīms* adopted numerous positions in relation to plague and the measures implemented by the state. Partially adopting colonial rhetoric of the filth and pathogenicity of India, and the unhealthy conditions in which people lived, social reformers keen on improving the lot of Indian subjects and unani practitioners intent on reforming unani practice as a ‘modern’ profession, engaged with sanitation and pursued its propagation among certain spheres of the public.

The attention of unani practitioners to the sanitary codes of colonial medicine may be gauged by the use of the terms ‘*ḥifz-i ṣiḥat*’ or ‘*ḥifzān-i ṣiḥat*’ to specifically refer to ‘sanitation’. A note of caution is required here, however, about the terms *ḥifz-i ṣiḥat* / *ḥifzān-i ṣiḥat*. Derived from Arabic they literally translate as ‘the preservation of health’, but they are nebulous terms, employed to mean quite different things in different contexts. In general usage in early twentieth century unani writings *ḥifzān-i ṣiḥat* more commonly corresponds to sanitation in its western medical connotations. The term *ḥifz-i ṣiḥat* has a legacy in unani theory and it becomes a regular feature in unani medical journals of the twentieth century testifying to this legacy, but not without innovation. It is used to embrace aspects of living that require discipline: eating, drinking, sleeping, exercise, evacuation and retention and exposure to ambient air. These correspond to the six essential causes of health and disease in the theory of the unani medical tradition (*al-asbāb as-sittah ad-darūriyyah*). But we also find, for instance, articles applying *ḥifz-i ṣiḥat* to the appropriate consumption of meat and milk, or to the nature of respiration.<sup>487</sup> In unani journals the term also embraces the regulation of sexual activity, and such socially relevant issues as the right time to marry.<sup>488</sup> In other contexts the term may be a hybrid of these ideas coupled with western notions of hygiene, or Islamic conceptions of purity. Given these wide fluctuations of meaning we are fortunate therefore that its usage to refer to sanitation is spelled out in the sessions of the All India Vedic and Unani Tibbi Conference (AIVUTC), discussed in the previous chapter. Studying the debates of the

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<sup>486</sup> See Chapter 2 on plague.

<sup>487</sup> *Rafiq al-Aṭibbā*, 16 March 1913; 16 April 1913.

<sup>488</sup> *al-Hakīm*, June 1922.

Conference we have moreover the opportunity to try to assess the extent to which these concerns were applied in practice or remained limited to theoretical debate.

Sanitation represented a way of understanding health and disease that focused on the body's place in the physical environment, especially immediate living conditions, and was therefore intimately connected with the home, the domain most associated with women and children. Although informed by a humoral pathology of putrefaction, sanitary principles emphasised cleanliness, in terms of place, water, air, food and clothing in the physical environment over the individual's balance of humours and putrefaction in the body.

That sanitation was a priority for those *hakīms* and *vaid*s who were most involved in the reform of indigenous medicine is evident from the fourth annual session of the AIVUTC convened in Amritsar in 1914. Hakim Ajmal Khan himself proposed the first resolution of the conference, which ran as follows: 'This conference strongly urges that all *vaid*s and *tabībs* should continue to direct the public towards *sainītaishan* [sanitation] (*ḥifzān-i siḥat*), and thereby do their duty to their esteemed government and their country ... You must know that it is a medical issue to keep water and air pure and clean. Life depends on it'.<sup>489</sup> One has the sense that he was trying to convince the practitioners in the audience of what was at stake, but it is in the ensuing debate that one learns most about what practitioners were expected to do regarding sanitation, and how to engage critically with the household environment which was the domain of women. Pundit Thakar Dutt, an influential *vaid* in Lahore, supported the resolution, and his speech reflected how deeply a woman doctor's outrage at the filthy conditions at childbirth had impressed him:

Once I was present with a lady doctor at the treatment of a woman who had just given birth. I was quite ashamed when this lady doctor said that just where hygiene is most important is where Indians keep the least clean. The small baby has to be kept as clean as possible, but on the contrary the place of birth is dirty, every piece of the mother's clothing and the bedding are dirty, and the *dāyah* [birth attendant] is just as dirty, spare

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<sup>489</sup> AIVUTC *ke Cauthe Sālānah Ijlās ki Rū'idād*, [Amritsar 1914], Delhi, 1915, p. 48.



me! Wherever it is that she comes from [in order to attend a birth] she takes no care whatsoever to even wash her hands.<sup>490</sup>

Like many of his contemporaries, the *vaid* laid the blame on women, and their ignorance, for the dirty surroundings and harmful customs; the education of women therefore needed attention, here on the grounds of physical health:

When someone dies he's kept for some time wrapped in a dirty cloth for an indefinite time, is laid out on [moriyon?] and is mourned for a whole day. What an absurd custom continues among us because of our women. Most women don't even know that air fills our rooms, that through breathing and making fires it becomes bad, and that it has to be kept pure.<sup>491</sup>

The speaker concluded that educating women in the principles of sanitation and hygiene was the solution to these evils, and that *hakims* and *vaid*s had to take part in this initiative:

In the current circumstances in which *hakims* and *vaid*s forget that it is their duty that when they call on a patient they should give appropriate advice on cleanliness, there is no doubt that a small pamphlet on the principles of hygiene should be written and publicised. The educated should read it themselves and put it into practice. In the household it should be read to the women and they should tell the servants so there should be agreement, and day by day the idea of sanitation will be diffused throughout the country.<sup>492</sup>

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<sup>490</sup> *Ibid.*, p. 55: 'Ek daf'ah ek zaccāh ke 'ilāj meṅ ek laiḍī dāktar aur ham ukāthe the. Mujhe kis qadr sharm ā'ī. Jabkiḥ us laiḍī dāktar ne kahā kiḥ jahān sab se ziyādah ṣafā'ī kī zarūrat hai vahān Hindūstānī sab se kam ṣafā'ī rakhte haiṅ. Vāqī 'ī khāyāl farmā'e kiḥ the baccā ko kis qadr ṣafā'ī kī zarūrat ho saktī hai is ke bar khilāf zaccāh khānah ḡhaliz. Zaccāh ke bachone har cīz ḡhaliz hotī hai aur dāyah aisī ḡhaliz hotī hai al-āmān, aur phir vahīn kahān kahaṅ se ā'ī hai, uskī kuch parvāh nahīn hotī hai. Ūske hāth tak dhilā'e nahīn jāte haiṅ'.

<sup>491</sup> *Ibid.*: 'Ek shakhs ke marjāne par mudatoṅ az ḥad mailī cādar pahinna, moriyon par baiṭh kar sārā din peṭā. Kaise behūdah rivāj ham meṅ 'auratoṅ kī ba-daulat jāri haiṅ. Akṣar 'auratoṅ to itnā bhī nah jānte haiṅ kiḥ hamāre kamre ke andar havā haiṅ. Aur yeh sānis se aur āg jalāne se kharāb hotī hai aur us ko ṣāf rakhne kī zarūrat hai'.

<sup>492</sup> *Ibid.*: 'Maujūdah ḥālāt ke andar jahān tamām ḥukamā' o vaid sāhibān kā farz hai kiḥ jab voh kis mariz par jāven is ko ṣafā'ī kī munāsib hidāyat karen jis ko hamāre mu'ālīj ājkal bhūl jāte haiṅ, vahān yeh bhī ṣāf yeh kiḥ choṭe choṭe traikṭ likh kar ṣafā'ī ke usūlon kā parcār karen. Ta'lim yāftah un ko khūd parhen

A more expedient way of spreading the sanitary message was proposed by Hakim Farid Ahmed Abbasi. As principal of the Madrasa Zenāna Ṭibbiya in Delhi, which we will look at in greater detail below, he was himself involved in the reform of *dai*'s practices and instruction in the treatment of women's diseases. For him, the unclean state of the home had a direct impact on the health of women and children:

But our houses are very small; in them we keep animals for milking, whose urine and dung ensures that our places are dirty at all times. The floors are very bad because most are not baked. All the dirt is absorbed into the ground. Where there are *nullahs* they are also not solid. When spoil comes out of them the ground takes it in, and the remainder goes on to make the air in the whole place bad. In such places women and children stay...Because of this most women in India suffer and die from consumption [*sill o diq*], and many children too, and coming generations become weak.<sup>493</sup>

The best way to improve this situation, and women's health, he argued, would be to publish a pamphlet containing sanitary advice written from the perspective of religious tenets. His argument was two-pronged. Firstly, he interpreted religion as the exemplar of sanitation, quoting the Quranic passage that Islam is in fact based on cleanliness: '*buniya al-dīn 'alā al-nadhāfa*'.<sup>494</sup> He described sanitation as but an extension of Islamic injunctions on ritual purity, which in his time had been lost: 'There was a time when worship could not be performed without purity. It is an injunction that one should wash the external parts of the body, through which malaria germs can enter the body, five

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*aur 'amal karen gharon mein 'auraton ko sunna den, apne naukaron ko batā den, jisse un parh se milne kā ittifaq ho. Usse hidāyat sunna den aur dīn ba-dīn hamāre mulk ke andar sainītaishan kā khayāl bharhtā jāve'.*

<sup>493</sup> *Ibid.*, p. 57: 'Ham Hindūstān ke rahne vāle akṣar ismeṅ mubtalā haiṅ kih ghar hamāre choṭe choṭe hote haiṅ. Un hī meṅ ham log dūdḥ ke jānvar palte haiṅ jinkā go hī paishāb hī vaqt hamāre makānon ko ghalīz rakhtā hai. Pā'ikhāne nihāyat kharāb rahte haiṅ cūnkih akṣar khām hote haiṅ. Sab mailā'ī zamīn par meṅ jāzb hotā hai aur nāliyān jo hotī haiṅ voh bhī khām hotī haiṅ jab mailān se nikaltā hai to akṣar ḥiṣṣah to zamīn meṅ hai jāzb hotā hai bāqī tamām makān kī havā ko kharāb kartā rahtā hai. Aisī hī makānon meṅ 'aurataiṅ bacce rahte haiṅ. Aisī ṣurat meṅ tāhir hai kih ham logon kī ṣiḥat kis tarḥ a'lá paimānah par rahaktī hai. Ussīvajh se ā'e dīn meṅ akṣar 'aurataiṅ sill o diq meṅ mubtalā ho kar fanā ho jāti haiṅ aisi hī bahut se bacce zā'ī'ho jāte haiṅ aur ā'indah naslain kamzor ho jāti haiṅ'.

<sup>494</sup> A similar passage was invoked by Shah Banu Begum of Bhopal in a lecture on *ḥifẓān-i ṣiḥat* to an audience at the Prince of Wales Ladies Club in Bhopal in 1913: '*Imma allāha yuḥibbu al-tawābīna wa yuḥibbu al-mutatahhirīna*' (God loves those who repent and those who are pure). Shah Banu Begum, *Ḥifẓān-i Ṣiḥat*, Bhopal, 1926.

times a day'.<sup>495</sup> In these utterances we can observe here how thoroughly intertwined were precepts on disease causation gleaned from a variety of sources, Islamic and biomedical.

Secondly, Hakim Abbasi considered religion as the most effective vehicle to convey the message:

I think that a better way to get [people] to understand the medical situation is to give the advice in the form of religious precepts. This is because it is towards religion alone that people are most tenaciously inclined. The injunctions [on sanitation] of both religions (of the Hindus and Muslims) should be written in the form of a pamphlet and the conference should publish it so that Hindus and Muslims, once they have seen the extent to which their faith regards hygiene will surely pay attention to it, and it is hoped that they will keep their dwellings, the areas where they live and their environs clean.<sup>496</sup>

The imperative to educate people, particularly women, about the need for sanitation meant that *hakīms* had to take on a new and additional role with regard to their patients and their patients' environment. But is difficult to assess to what extent, if at all, unani *hakīms* did indeed take the message of cleanliness into the home. The debates also reveal, how *hakīms* attempted, on a theoretical level, to co-opt western discourse on sanitation by bringing it into an Islamic framework, and thereby assert their authority to implement it. By drawing attention to the necessity of sanitation, especially for women's health, and moreover, by linking it to an Islamic perspective, the speakers were participating in a much broader debate than this particular one in Amritsar on the 1 March 1914. Many prominent social reformers of the time were tackling these very issues, again in various ways and with different goals. Ashraf Ali Thanavi's concerns in the *Bihishtī Zavar*, with its copious information on the injunctions in Islamic law on personal cleanliness, the distinction between the various forms of water for drinking and bathing that are *ḥalāl*,

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<sup>495</sup> *AIVUTC ke Cauthe*, p. 56.

<sup>496</sup> *Ibid.*: 'Lihaza merī rā'ī meṅ ṭibbī ḥaiṣiyat se samjāne se yeh ṭarīqah bahtar hai un ko maḡhabī ṣūrat se tanbīh kījā'e kyonkih dunya meṅ maḡhab hī voh cīz hai kih is kī ṭaraf insān kā maīlān nihāyat shadd o madd se hotā hai aur har shakḡ us kā shaidā o garvaidah naḡar ātā hai ... ek risālah kī ṣurat meṅ donoṅ maḡhaboṅ ke aḡkām likḡkar kā kānfarans kī ṭaraf se shā'i' kī'e jā'eṅ tākah hind o musulmān yeh deḡkar kih hamāre maḡhab ṣafā'ī kī isqadr tāk kar rahe haiṅ to ḡarur uskī ṭaraf mutavajjuh honge aur umīd hai kih apne makānoṅ aur rahne kī jagahoṅ ko ṣāf rakhenge'.

permitted, or *ḥarām*, forbidden,<sup>497</sup> can be distinguished from those of other reformers who were more informed by western discourse on sanitation and who were more intimately aware of the conditions of women's lives, like Muhibb-i Hussain (see below). There were indeed women who spoke on issues of health and hygiene for women; these included Sultan Jahan Begum of Bhopal, whose work is described below.

#### IV. Empowering Women, *Zenāna* Unani Schools and an End to Suffering in Silence?

Maulvi Muhibb-i Hussain in Hyderabad brought out the women's journal *Mu'allim-i Nisvān* in 1898 and the daily newspaper *'Ilm o 'Aml* in the early 1900s. The *Mu'allim-i Nisvān* included a column on health in each issue, where there are numerous reports on the activities of lady doctors, new *zenāna* hospitals and the Dufferin Fund. However, the journal was short-lived; Muhibb-i Hussain's provocative articles on the evils of *pardah* proved too much for local sensibilities in Hyderabad and the journal was forced to close down in 1901.<sup>498</sup> *Pardah* was a persistent theme of the journal. Muhibb-i Hussain blamed *pardah* for the riots in north India that accompanied the medical interventions of the plague years: 'If there were no custom of unlawful [*kḥilāf-i shar'*] *pardah* in India... then there would have been none of the murderous revolts of the past against plague operations'.<sup>499</sup>

The editor also argued at length that there were sound medical reasons for ending the strict seclusion of women in the home. The problems of seclusion are dramatised in a short didactic story which appeared in the journal of a sick young woman, Sakina, of a *sharīf* family, and of her parents approach to her treatment. By focusing on a young woman, the story is highlighting the particular difficulties that young women had to face in overcoming pressure from elders to make decisions about their lives. It is also a

<sup>497</sup> Thanavi, *Bihishtī*, pp. 45-75.

<sup>498</sup> Minault, *Secluded*, p. 109.

<sup>499</sup> *Mu'allim-i Nisvān*, vol. 11, no. 10, 1315 Hijri, p. 19: 'Agar Hindūstān meṅ yeh *kḥilāf-i shar'* *pardah muravvij na-hotā ... to kabhī insidād-i ʿāʿun in khūn-rez muḥālifatōn se sābiqah na-hotā*'.

commentary on the good services of ‘lady doctors’ (women trained in western medicine), how their seemingly new approaches to treatment could be reconciled with the learned unani medical tradition, and how women need to take decisions about their own health, and, by extension, their lives.<sup>500</sup> The editor prefaced chapter two of Sakina’s story with the comment that deprived of fresh air, and the ability to stretch her arms and legs on the *maidan*, a girl’s limbs do not grow as they should. ‘In youth [girls] are pallid and weak like a withered flower’.<sup>501</sup> Like Farid Ahmed Abbasi, one of the speakers the AIVUTC above, Muhibb-i Hussain makes the connection between women at home and their susceptibility to consumption [*sill o diq*] and the weakness of their children, though here strict *pardah* is explicitly the cause.

The chapter begins with Sakina lying partially clothed on a charpoy with a lady doctor, Miss Khursheedji, examining her chest with a stethoscope, much to the mother’s bewilderment. For the treatment of the girl’s lung complaint, the lady doctor prescribes a couple of patent medicines for the girl’s lung complaint, but insists that the best cure for the girl is to take walks to the *maidan* three times a day, and if possible to take sea air. The mother reports this to the girl’s father and her uncle, who turn up after the lady doctor has left. She says:

[The lady doctor] didn’t take the pulse or look at the urine, she put this pipe to Sakina’s chest then to her ear...The devilish woman mentioned a medicine that would never be allowed for a modest girl. Truly it is the wrath of God. She said (God forbid) that Sakina should take sea air. *Mian*, if you permit your family’s nose to be cut off, she may have this treatment.<sup>502</sup>

The father retorts: ‘These women doctors want our girls to take off their veils. Really, what would be the point of our women taking air? I heard a *hakīm* saying that the

<sup>500</sup> *Mu‘allim-i Nisvān*, vol. 12, no. 11, 1316 Hijri, pp. 28-37.

<sup>501</sup> *Ibid.*, p. 27: ‘*Aur voh ibtidā’i ‘umr hī meṅ pazhmardah phūlon kī tarḥ thītar ke rah jāti haiṅ*’.

<sup>502</sup> *Ibid.*, p. 30: ‘[*laiḍī ḍāktar ...*] *nah nabz dekhī, nah qārūrah dekhā, bas ek shahnā’i ko Sakīnah kī chātī par rakh rakh ke us par apnā kān dharti rahī ... nagoṛī ne voh davā batā’i hai jisko ko’i ḥayāvār ‘aurat kabhī manzūr nahīn karegī. Bhalā khudā ka ghāzab hai! Kehī hai kih (dūr pār nauj) sakīnah ko samandar kī havā khulā’i miān! jisse apne kumbe kī nāk kīṭāni manzur ho voh yeh ‘ilāj karegī*’.

woman's temperament is cold, that open air is bad for her'.<sup>503</sup> At this point the uncle, embodying the voice of enlightened reason, provides a different perspective to the *hakīm*'s reported assertion. He cannot deny that women are cooler than men in unani medicine, but he can challenge the inference. He distinguishes between the learned unani tradition and the misguided *hakīms*, on whose shoulders he squarely lays the blame for the ill-health of secluded women. He uses his vision of authentic unani practices, embodied in the teachings of Ibn Sīnā to argue for the need for women to exercise and leave the household, to breathe the fresh air that is a cornerstone of the notion of *hiḥz-i sihat* in unani *ṭibb*:

Ignorant people like the one who told you this have been the ruin of our women. Man is not a beast. Shaikh Bu Ali Sina, the greatest of the physicians, said that open air is necessary for both men and women, and that the lack of it causes consumption [*sill o diq*], and this half-wit *hakīm*<sup>504</sup> says that open air is bad for women. It is because of this fatal notion that so many *pardah nashīn* suffer from this consumption.<sup>505</sup>

In the end Sakina herself speaks out, blaming her father for taking care of women's stomachs but not their souls: They need fresh air and exercise. 'Women', she comments 'are the slaves of men'.<sup>506</sup> The parents consent to her going to Madras or Bombay to go with relatives to the seaside, but she replies that she does not need their permission: 'Our law has given women the right to go to a place of worship, the court of the *qāzī*, or a *hakīm*'s place without taking the permission of the husband'.<sup>507</sup> Finally Sakina declares that she is going to leave the parents in order to teach poor girls.

<sup>503</sup> *Ibid.*, p. 31: 'Yeh dākṭarṇiyān hamāri 'auraton ka pardā uṭhānā cahtī haiṅ. Bhalā hamārī 'auraton ko havā usse kya gharāz. Meṅ ne ek ḥakīm ṣāhib ko yeh kehte hū'e sunā hai kih 'aurat ka mizāj bārid hotā usko havā khurī maḥzar hai'.

<sup>504</sup> The expression he uses is 'nīm ḥakīm *khāṭrah-yi jān aur nīm mullah khāṭrah-yi imān*', an expression commonly used to refer to an ignorant *hakīm*. It translates literally as the 'half-*hakīm* endangers life and the half-mullah endangers faith'.

<sup>505</sup> *Ibid.*, p. 31: 'Aise hī nā-vāqif ashkhāṣ ne 'auraton ko satyā-nās kiyā hai, jis ne āp se yeh kahā hai voh ādmī nahīṅ jānvar hai. Shaikh Bū 'Alī Sīnā aḥsar al-qṭībā to 'auraton aur mardon dono li'e havā khūrī ḡarūrī batātā hai aur kahtā hai kih uskī tark se marāz sill o diq paidā hotā hai aur hamāre ḥakīm khāṭrah-yi jān aur nīm mullah khāṭrah-yi imān yeh farmāte haiṅ keh 'auraton ko havā khūrī maḥzar hai. Yeh ussī muḥlik khayāl kā natījah hai kih voh pardah nashīn 'aurataiṅ aḡsar sill o diq meṅ muḡtalā ho jātī haiṅ'.

<sup>506</sup> *Ibid.*, p. 37: '[ 'auraton] to mardon zarkharīd lūṇḍiyān haiṅ nā'.

<sup>507</sup> *Ibid.*, p. 37: '... hamko hamārī shar' ne ijāzat dī hai, 'aurat ba-ghair ijāzat shauhar 'ibādatgāh qāzī ki 'adālat darasgāh aur ḥakīm ke hān jā saktī hai. Meṅ to ab martī huṅ'.

The story is clearly one-dimensional, but the place of unani *tibb* in it is ambiguous. On the one hand, the *hakīm* is indicted for being part of a male-dominated society that has taken away many of the freedoms for women to access a range of institutions, as laid down in Islamic injunctions but of which the physician is unaware. His is an authority that can go right to the heart of the *zenāna*; that a man can use to keep a woman indoors. But on the other hand, the genuine *hakīm*, who adheres to the core teachings of the medicine he practices, represented by Ibn Sina, is shown to have the best interests of women at heart. The evaluation of good and bad practice does not hinge simplistically on 'western' or 'indigenous' in this story. Muhibb-i Hussain suggests that authentic unani practices should have a role serving women. His concern above all is that women should have access to 'good' care, and be able to make their own decisions about their health. Reforming the notion of good treatment for women began to happen in the unani medical sphere, in Delhi and in Bhopal, shortly after Muhibb-i Hussain's journal folded, and *hifz-i sihat* was again invoked.

The early twentieth century witnessed the small and isolated beginnings of institutional structures for the training of women in unani *tibb*. Bhopal has a special place in the history of Muslim reform movements and the improvement of living conditions of women in the late nineteenth century, with its succession of female rulers, as Siobhán Lambert-Hurley has recently presented.<sup>508</sup> During the rule of Shah Jahan Begum (1838-1901) institutions for European medicine were established. But it was her daughter, Sultan Jahan Begum (1858-1930), who turned towards formalising unani medical training and provision, at the same time when this was happening in Delhi, Lucknow and Hyderabad. In 1903, two years after her accession, she established with the aid of her chief physician Hakim Nur ul-Hasan, the Asefiā Tibbia College, to which women were given access. The school followed a curriculum that combined western surgical techniques with unani *tibb*, informed by the model set by the Madrasa Tibbiya of Ajmal Khan's Sharifi family in Delhi. Sultan Jahan Begum attempted to regulate the profession by making a diploma from the school mandatory for employees of the state health department. In a related effort to regulate the practice of *dais*, she introduced in 1909 a

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<sup>508</sup> S. Lambert-Hurley, 'Contesting'. The account given here on the beginnings of formal unani provision in Bhopal State draws in part on material presented in Chapter 2 of this work. See also S. Zillurrahman, 'Unani Medicine in India 1901-1947', *Studies in History of Medicine and Science*, 8 (1), 1994.

scheme to make the instruction and registration compulsory. Unani dispensaries were maintained by the state, including the Asefia Female Dispensary.

Sultan Jahan Begum's numerous writings also reflect her personal interest in women's health issues, where hygiene, domestic economy and unani *tibb* converge.<sup>509</sup> In 1916 she published a work in two parts entitled *Hifz-i Siḥat*, in which she blended western derived knowledge of sanitation with unani concepts and medicines for a female readership. She pointed out in the preface that the work was commented upon from a unani perspective by one of Lahore's most well known *hakīms* of the time, Ghulam Jilani.<sup>510</sup> She dissuades women from taking the treatment of disease into their own hands, urging that before any treatment is attempted a *hakīm* should be consulted, since people's temperaments differ and change, which means that a medicine's effects cannot be predicted.

She describes hygiene, moderation in consumption, daily exercise and keeping regular timings as the 'four walls of health'; a metaphor that immediately locates the object of her work as the house and identifies women's responsibilities in the house and to themselves.<sup>511</sup> She defined hygiene (*saḥā'at*) as the cleanliness of air, water, food, the body, clothing and place, echoing some of the nineteenth-century sanitary ideas of colonial medicine. The word she used for moderation was *i'tidāl*, a unani term denoting the balance of opposites that constitutes health, which she glossed with the less technical more familiar *miānah ravī*, by which she meant not doing things in excess, especially eating and drinking. She wrote that the most important secret of good health was that 'every part of the body should do the work nature assigned to it, and if this is not done then the organ in question will become weak and feeble, and gradually the affect of this will be felt all over the body'.<sup>512</sup> This teleological conception of the functioning of the body is a clear reference to the idea elaborated in Galen's work that Nature created the

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<sup>509</sup> These include *Hifz-i Siḥat*, Agra, 1916; *Baccon kī Parvarish*, Agra, 1921. *Tandurustī*, Agra, (n.d.).

<sup>510</sup> Sultan Jahan Begum, *Hifz*, p. 1. Hakim Ghulam Jilani was a prominent *hakīm* who had also studied western medicine. He was the author of *Tārīkh al-Aṭibbā* on the history of physicians, unani and 'doctori'. He was also a regular contributor to Lahore's best known unani journals *Rafiq al-Aṭibbā* and *al-Hakīm*.

<sup>511</sup> Sultan Jahan Begum, *Hifz*, pp. 1-2.

<sup>512</sup> *Ibid.*, p. 2: '*Tandurustī kī sab se barā rāz yeh hai kih badn ke har 'uzū se pūrā kām liyā jā'e jo qudrat ne us ke li'e muqarrar kiyā hai agar aisā nah kiyā jā'egā to vahī 'uzū kamzor o nātuvān ho jā'egā aur raftah raftah us kā aṣr tamām jism par paṛegā'*'.



parts of the body in order to fulfil specific functions.<sup>513</sup> The contemporaneous discourse on the cause of consumption (*sill o diq*) also informed Shah Jahan Begum's understandings of what women were vulnerable to and why, remarking that more women suffer from this fatal disease than men because they do not leave the house, exercise and take fresh air, as Muhibb-i Hussain had similarly argued. Although Shah Jahan Begum maintained the veil in public, and argued in its defence, she was here pointing to the ill effects of strict *pardah* on medical grounds.<sup>514</sup> Other sections of the work include clothing, the care of hair, teeth, eyes, throat, body weight and nursing.

Sultan Jahan Begum's *Ḥifz-i Ṣiḥat* was a comprehensive programme for women's preventive health that underscored the importance of disciplining the body. Although she drew on unani concepts, we should not be surprised that she, like Thanavi, did not mention sex as an element of bodily activity that required discipline. This is a feature that sets her work definitively apart from the unani corpus and other writings that incorporate unani concepts of *ḥifz-i ṣiḥat* that were written by men and for men. We may illustrate this by referring to a wall chart on preventive health entitled 'chart on the principles of preserving health' (*Takhtah Qavā'id-i Ḥifzān-i Ṣiḥat*) that was compiled by Asadullah Hussaini, an official at the High Court in Hyderabad, based on the sayings of *ḥakīms*.<sup>515</sup> Asadullah Hussaini, like the Begum of Bhopal was not a professional *ḥakīm* writing for a professional audience, and therefore his chart allows comparison with the Begum's interpretation of *ḥifz-i ṣiḥat*. The chart is divided into seven columns according to men's organs: heart, brain, liver, stomach, kidneys, testicles and penis, each of which is then further divided into two columns according to activities, foods and drinks that are either injurious or beneficial to these organs. Excessive sex is the only element, and at the top of the list, that is injurious to each organ. To underscore a certain misogyny we should also point out that for Hussaini, in the section on the penis, 'having sex with a beautiful mistress / sweetheart preserves health and creates an abundance of semen'.<sup>516</sup>

We shall discuss sex below in the context of unani writings on women's diseases. The issue at hand here is that Sultan Jahan was selective in how she sought to make her

<sup>513</sup> *Ibid.* This is the underlying theme of Galen's *De Usu Partium, On the Usefulness of the Parts of the Body*, New York, 1968.

<sup>514</sup> Sultan Jahan Begum, *Ḥifz*, p. 14.

<sup>515</sup> Asadullah Hussaini, Sighadar of the Government High Court Hyderabad, 1326 Fasli, [1918].

<sup>516</sup> *Ibid.*, 'mahbūbah-yi jamīlah ke sāth jamā' karnā ḥāfiz aṣ-ṣiḥat wa mujīb ziyādatī manī hogā'

readers understand bodily discipline, by choosing those elements of unani which were suitable to her readers and including elements of western sanitary principles, and omitting in the process any discussion of one of the cornerstones of contemporaneous unani therapeutics, i.e. sexual moderation. The reason for this almost certainly lies in the reservations that a woman of her stature and background, a *pardah-nashīn*, would have had in engaging with this, for a woman, taboo and morally questionable subject. An additional reason for this omission may be that the effects of sex on health in unani medicine had always interpreted by men with regard to male and female bodies, and that she had no precedent to refer to. It also suggests that sexual discipline was not something that women were in a position to regulate or control.

Sultan Jahan Begum took great interest in Hakim Ajmal Khan's activities in Delhi with regard to women's health.<sup>517</sup> In 1909, the same year as *dais* were being registered in Bhopal, Lady Dane, wife of the Lieutenant Governor of Punjab, inaugurated Hakim Ajmal Khan's Madrasa Zenāna Ṭibbiya and Zenāna Ṭibbī Shifākhānah in Delhi.<sup>518</sup> The Madrasa began as a school for the training of midwives in a private house in Chori Valan locality. Like Thanavi, Hakim Ajmal Khan was against women resorting to *dais*, especially for childbirth. According to one of the biographies of Ajmal Khan, he recognised the difficulty that *hakīms* had treating women's diseases and the reluctance of the families of *pardah-nashīn* to make use of western *zenāna* hospitals and lady doctors.<sup>519</sup> Later both institutions were attached to the Ayurvedic and Unani Ṭibbiya College, and the curriculum expanded to include instruction in unani, ayurvedic and western medical approaches to women's health.

These undertakings in Bhopal and Delhi were the first efforts to institutionalise education in unani *ṭibb* for women and to provide treatment specifically for women's complaints. But the scale was still so small as to be almost insignificant from a country-wide perspective. In an article entitled 'The need for women's education in *ṭibb*' which was published in the popular Lahore-based unani journal, *al-Ḥakīm* in 1922, Hakim Muhammad Ahsan Qadri Bijnori, a graduate from Bhopal, lamented the lack of female

<sup>517</sup> M. Abdul Ghaffar, *Ḥayāt-i Ajmal*, Aligarh, 1950, pp. 71-74.

<sup>518</sup> Zillurrahman, *Dilhī*, p. 246; R. L. Verma and N. H. Keswani, 'Women', p. 284; B. D. Metcalf, 'Hakim Ajmal Khan: Rais of Delhi and Muslim Leader', in R.E. Frykenberg (ed.), *Delhi through the Ages: Essays in Urban History, Culture and Society*, Delhi, 1986, p. 303.

<sup>519</sup> Ghaffar, *Ḥayāt*, p. 72.

unani practitioners around the country, especially in rural areas.<sup>520</sup> The *ḥakīm* suggested that more effort should be made to encourage women to take up the profession; lessons were to be learnt from lady doctors. He found it surprising that people had not at this time thought that same-sex *ṭabīb*s would be necessary for their ‘beloved sisters’. He stated that male *ṭabīb*s rarely ‘hit the mark’, when they treat women. There should be no barrier between the patient and the *ṭabīb*, like *pardah*, which interfered in the healing process, because he wrote:

... some women’s diseases are so private that women are ashamed of even telling their loved ones and relatives, or sometimes they can’t even know of their own diseases, like [*panghī?*]. For this reason, it is not enough for a doctor or a *ḥakīm* to know only a few traditional conditions and to look at the pulse and the urine. Furthermore, for the diagnosis of the disease it really helps once you have tapped and felt the limbs, to have the sick woman sit or lie down and to look at the eyelids, or the pellicle of the tongue, then to place the stethoscope on her chest, to watch the motion of her pulse, the flow of breath and the colour of her body. For instance, in diseases of the womb, once you are familiar with the internal conditions, all the parts of the woman lying before you are presented for view. In this way the *ṭabīb* and doctor can give the complete prescription for the treatment of a woman’s womb without their using analogy or the ignorant *dais* oral knowledge of the condition.<sup>521</sup>

Hakim Ahsan’s article sheds light on a number of issues. It reveals a sense of mystification regarding women and women’s diseases from a contemporaneous (male) unani perspective, and a lack of confidence in the standard use of analogy [*qiyās*] in unani diagnosis, in the light of western diagnostic procedures. Women are different – a man cannot fathom their bodies without physically examining them, and the doctor’s

<sup>520</sup> Hakim M. Ahsan Qadri Bijnori, ‘Mastūrāt ko Ṭibbī Ta’līm kī Zarūrat’, *al-Ḥakīm*, February 1922, p. 5.

<sup>521</sup> *Ibid.*: ‘mastūrāt ke ba’z amrāz aise mukhfi hote haiṅ jinhaiṅ voh apne ‘azīz o aqrībā se bayān karne men bhī sharmātī haiṅ yā ba’z auqāt apne marāzōn ko voh khūd bhī kamā panghī [?] ma ‘lum nahūn kar saktī haiṅ is li’ e *ṭabīb* wa dākṭar keli’ e shirf cand zabānī hālāt aur nabz o qārūrah ka mulāhizah hī kāftī nahūn hai balkeh ba’z a’zā thūnk ṭaṭūl kar marīzah ko laṭā baṭhā kar ānkh ke pardah wa zabān kī jhillī ko dekh kar sainah par mas mā ‘aṣ-ṣadr (īstetas kop) lagāne raftār nabz o tanaffus ke mailān rang-i badn ke dekhne se tashkīṣ-i marāz men bahut madad milī hai cunānceh raḥmī ‘avāriṣ men andarūnī hālāt kar ke paye kī kul kā’ināt apne pesh-i nazar rakhnī partī hai. Ussī vāṣiṭe *ṭabīb* o dākṭar kissī ‘aurat ke raḥmī ‘ilāj men ba-juz’ uske kih qiyās o qiyāfah se yā jāhil dāyah daryāft-i hāl se nuskhah mukammal kar den’.

diagnostic techniques unveil the conditions which women are unable to know or to express, and which the reading of the pulse is unable to decipher. For the diagnoses of male patients the physical examination does not appear necessary. In this *ḥakīm*'s view there is no contradiction between the anatomical and the humoral bodies, only that the doctors' diagnostic techniques, including the stethoscope and the physical examination, allow one to reach a 'deeper' understanding of bodily distress. But for this wider approach to diagnosis to become a reality there would need to be sufficient numbers of women unani doctors to perform such delicate tasks.

Informal 'unani' practice by women for women was probably widespread – the first treatment in a family context is likely to have been household remedies administered by women – but it is difficult to find written evidence on this subject. What is clear however, is that in the early twentieth century, though the need for unani female practitioners began to be acknowledged and addressed, men continued to dominate the profession. Hyderabad, for example, had only one female unani practitioner in government service until the late 1930s.<sup>522</sup> Nevertheless, as unani schools for women began to open in more cities around the country, in Allahabad and Mysore, for example, the picture began to change. Graduates from the *zenāna* schools set up practice. Women unani practitioners used women's journals to advertise their practice. One such advertisement for the services of a female practitioner was placed by Ravi Banu, a 'unani lady doctor' and Principal of the Zenāna Ṭibbiya School in Allahabad. It is revealing for the way in which the practitioner sets out to empathise with the difficulties women had in getting treatment and communicating their problems. This particular advert appeared in a 1928 issue of *Tahzīb an-Nisvān*, a prominent women's journal which we will discuss more below. This was a purely text-based advert, there were no images, symbols or icons; it targeted thus the literate educated reader. The advert underscores modesty and discretion as the main reason why women had not been able to obtain adequate treatment. It emphasises how women put up with their ills in silence, while their condition deteriorates. The advert reads:

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<sup>522</sup> *Riporṭ Maḥkamah-yi Ṭibābat Yūnānī, bābat 1349 Fasli, (1940).*

Dear ladies! You are ill but they don't treat you. Your complaint gives you trouble day by day, but it causes putrefaction in your body. This is the result: your health becomes bad. Housekeeping ... [illegible phrase, page torn]... . This is all because you cannot tell your problems to someone of the opposite sex. You suffer weakness. But you are patient. You are ill but you endure it, but now you don't need to do this. I am the same sex as you. In my family there are doctors and there are *hakīms* as well. I myself have developed special skills in treating women's diseases. Let me know of your problems, I'll tell you preparations to remedy them. Calm your sorrows, I open the mail myself, your servant.<sup>523</sup>

The advert speaks of the kind of knowledge deemed appropriate for the proper treatment of women's disorders. The practitioner locates her expertise in both unani and allopathy, indicating that for the authoritative treatment of women of this class at this time, unani knowledge alone was not sufficient. Significantly, however, she emphasises that hers is a hereditary profession, which together with her position as the school Principal covers two important signifiers of authoritative 'traditional' and 'modern' knowledge. This kind of intervention in women's health is a radical departure from previous times, by a woman in a public domain, urging women to come forward and take control of their health problems. Despite this remarkable advance in women's health care, the majority of unani interventions in women's health were, until the 1940s, conducted by men. We will see in the next section the mysteries surrounding women's wombs in the eyes of the (male) *ṭabīb*.

<sup>523</sup> *Tahzīb an-Nisvān*, 21, 26 May 1928, inside cover: 'piyārī bahino! Tum bīmār rahī ho lekin 'ilāj nahīn kartī. Ek nah ek shikāyat roz marah tumheñ taklīf detī haiñ. Lekin unheñ saṛā ba-jism kartī ho. Natījah yeh hotā hai kih tumhārī tandurustī kharāb ho jātī hai. Khānahdārī ke ... [illegible words]... . Yeh sab širf is li'e hotā hai kih tum apnī shikāyatōñ ko ghair jins se nahīn kah saktīñ. [Zā] 'if uṭhātī ho. Magar šabr kartī ho. Bīmār rahī ho. Magar bardāshht kartī ho. Lekin ab tumheñ aisā karnā kī zarūrat nahīn. Meñ tumhārī jins kā hūñ. Mere khāndān meñ ḍāḳṭar bhī haiñ, ḥakīm bhī. Meñ ne khūd nisvānī amrāz ke 'ilāj meñ khāšī mahārat paidā kar lī hai. Mujhe apnī shikāyatōñ se muṭalli' karo. Meñ us ke daḳ'iyah ke li'e tadbireñ batā'ūngī. Zāzdārī ka ṭmīnān rakhi'e. Meñ ḍāḳ khūd khūltī hūñ'.

## V. Unani *Ṭibb* and *Amrāz-i Nisvān* (Women's Diseases)

In this section we shall be concerned with how female bodies were distinguished qualitatively from male bodies in the writings of unani medicine in the early twentieth century. In this idea I follow the idea current among social historians of medicine, that medical thinking and practices can add a useful dimension to the understanding of society.<sup>524</sup> Unani medicine, as it is formulated in the authoritative texts of the literary tradition, posits a hierarchical system of elements, qualities and fluids that constitute and pervade every being and object in the sublunar world. Sets of oppositions and correspondences of hot/cold and dry/moist are the organising principles that distinguish seasons, plant, mineral and animal life, people's physiques and temperaments, age and also gender.<sup>525</sup>

Galenic theories of the body have been interpreted to posit the equality of men and women, as mentioned above.<sup>526</sup> To give an example of such equality, men and women are seen to both contribute to the conception of children. In Galen's work man and woman both have semen.<sup>527</sup> But there is nonetheless a hierarchy involved here. The woman's semen is assumed to be inferior to the man's. There is also a hierarchy of sexual organs in Galen, replicated by Ibn Sīnā's *al-Qānūn*; in the translation by Meyerhof and Joannidas: the organs of the woman are analogous to the man's 'Mais l'un de ces organes est complet et tourné en dehors, tandis que l'autre est incomplet et retenu dans l'intérieur du corps'.<sup>528</sup> Thus the women's organs are a degenerate version of the man's.

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<sup>524</sup> It is, for example, this idea that unites, and is amply demonstrated by, the contributors to the volume by Gilman (et al.), in their excellent studies of the intricacies and polyvalence of hysteria. Also the illuminating are the study by Laqueur, and Cohen's approaches to the category of 'old age' in India. Sander L. Gilman et al., *Hysteria beyond Freud*, London, 1993, p. xi.; Thomas Laqueur, *Making Sex: Body and Gender from the Greeks to Freud*, London, 1990; Lawrence Cohen, *No Aging in India: Alzheimers, the Bad Family, and other Modern Things*, London, 1999.

<sup>525</sup> Ibn Sīnā, *al-Qānūn fi al-ṭibb*, Part 1, lessons I-V, New Delhi, 1993, pp. 1-30; Good and Good, for incorporation of these concepts in contemporary Iranian contexts, Byron Good and Mary-Jo Delvecchio Good, 'The Comparative Study of Greco-Islamic Medicine: The Integration of Medical Knowledge into Local Symbolic Contexts', in C. Leslie and A. Young (eds), *Paths to Asian Medical Knowledge*, Delhi, 1993.

<sup>526</sup> Metcalf, *Perfecting*, p. 11.

<sup>527</sup> Galen *De Usu Partium*, See Good, 'Blood'.

<sup>528</sup> Max Meyerhof and D. Joannidas, *La Gynécologie et l'Obstétrique chez Avicenne*, Le Caire, 1938, pp. 12-13.

Another qualitative distinction between male and female bodies is based on temperature. Women are cooler than men, just as youth is hot while the old are cold.<sup>529</sup> Cool correlates with weak, which is why in Ibn Sīnā's account women are shorter than men. According to Ibn Sīnā, women have excess excreta because they are moister and on account of their coldness. In the twentieth century, contributions to unani journals concerning the 'weak sex'<sup>530</sup> continue to describe women as 'cool', and this characterisation is commonplace in other unani writings of the time and in the tradition. Women's diseases are seen as coterminous with the dysfunction of the womb, its inability to produce children (though in *ṭibb* the man may also be considered responsible for infertility), discharges and irregularities in menstruation. One disease which stands out for its connection to women's sexual habits and a host of other issues that relate to women's comportment under the gaze of predominantly male *ḥakīms*, is hysteria.

## VI. *Ikhtināq ar-Rahm* or the Asphyxiating Womb

'Hysteria' has a long history in unani *ṭibb*. The study of the complex symptomology which characterises the understanding of this condition in the classical texts of *ṭibb* and in early twentieth century writings allows us to examine the question of change and continuity in the unani tradition and in practice in relation to a specifically female condition. It is a condition which reflects on the reproductive roles of women in early twentieth-century society in India, and how sexuality could be controlled through the agency of *ḥakīms*. As Roy Porter has written in relation to hysteria in nineteenth-century Europe, though with a relevance to our discussion in this chapter regarding agency: 'Like invisible ink when heat is applied, hysteria was a condition strictly rendered visible by the medical presence'.<sup>531</sup>

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<sup>529</sup> Ibn Sīnā, *al-Qānūn*, Part 1, p.18.

<sup>530</sup> *al-Ḥakīm*, February 1922: 3, editor's wording *ṣinf-i ẓa'īf*.

<sup>531</sup> R. Porter, 'The Body and the Mind, the Doctor and the Patient', in Gilman et al., *Hysteria*, p. 242.

This section of the chapter shows that practitioners in the early twentieth century constructed the 'disease' in different ways, while retaining elements of diagnostic and therapeutic notions formulated in the authoritative texts of *ṭibb*. In an attempt to capture varied approaches, the study draws on the writings on 'hysteria' in unani journal literature, the *Bihishtī Zevār*, as an example of Islamic reformist literature for women, and the writings and case notes of Hakim Ajmal Khan. For some practitioners in the early twentieth century, like Ajmal Khan, 'hysteria' becomes associated with a specific social class – the rich, urban and literate woman, which represents an entirely new way of understanding susceptibility to 'hysteria' in unani *ṭibb*.

In the June 1922 issue of the Lahore-based unani journal *al-Ḥakīm*, a letter appears by one concerned *ḥakīm*, Hafiz Rahim Bakhsh, entitled 'An appeal on behalf of women'.<sup>532</sup> The *ḥakīm* complains that the journal frequently publishes special issues on male health issues, but only rarely on women's diseases. He suggests that each year a special issue be brought out, which contains detailed descriptions of the diagnosis and treatment of women's diseases, and especially cheap prescriptions, since, he remarks, even ordinary medicines have become expensive and it is the lot of Muslims everywhere that they are suffering in poverty. The disease that he singles out for special attention is *ikhṭināq ar-raḥm*, hysteria. He urges that where there might be generosity in publishing prescriptions for this disease, there should also be caution, for, he claims, he has seen in his 31 years of practice that no matter what medicines have been prescribed for this disease, whether English or unani, none have been effective.

Hysteria, if indeed it can be called a disease at all, has a long, but complicated history, about which so much has been written in the European context and so little on its manifestation in Islamic cultures.<sup>533</sup> Recent scholarship makes it clear that hysteria has not existed as a fixed disease category unchanged through time.<sup>534</sup> Helen King has shown how Hippocratic writers and Galen conceptualised the disease differently, and how elements in their interpretations were woven together in the medical compendia of Ibn

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<sup>532</sup> Hakim Rahim Bakhsh, 'Apīl az Jānīb Ṭabaqah-yi Unās', *al-Ḥakīm*, June 1922, p. 22.

<sup>533</sup> King points out this lacuna, but succeeds in giving an overview of the accounts of hysteria in Greco-Islamic medicine from translations and the few studies on women's diseases that have been done. Helen King, 'Once upon a Text: Hysteria from Hippocrates', in Gilman, *Hysteria*, London, 1993, pp. 3-90.

<sup>534</sup> *Ibid.*



Sīnā, al-Rāzī, al-Mājūsī and others in the Greco-Islamic medical tradition.<sup>535</sup> Ibn Sīnā discussed it at length.<sup>536</sup> Epitomes and abridgements of his *al-Qānūn* have been made since the thirteenth century, and in India since the sixteenth. The epitome *Mūjiz al-Qānūn* written by Ibn al-Nafīs in the thirteenth century was one such that was circulated widely in the subcontinent;<sup>537</sup> it was one of the standard texts used for teaching unani medicine in the Oriental College in Lahore in the 1880s, and in Ajmal Khan's Delhi Madrasa.<sup>538</sup>

Like many of the other important compendia in circulation in India at the time, the *Mūjiz* is structured according to the organs of the body from head to toe, along with their various diseases and suggested treatments.<sup>539</sup> These include the womb and its diseases, the site and also the perceived cause of much distress for women. Among them appears *ikhtināq ar-rahm*, literally 'suffocation of the womb', which is the Arabic equivalent and direct translation of Galen's *hysterike pnix*, known as hysteria in Renaissance Europe.<sup>540</sup> The accounts given in *Mūjiz* ('abridgement') and also *Sharḥ al-Asbāb* ('explanation of causes'), both key texts of classical *ṭibb* in India, are quite conventional. The cause of the disease is the retention of the woman's own semen, one of the two principal modes of explanation common in Greco-Islamic thought, the other being the cessation of menstruation, about which we shall say more below. Ibn al-Nafīs, the author of *Mūjiz*, explained how the accumulation of female semen within the womb impacted upon women's health:

On account of the seminal fluid in the vessels [of the womb] the innate heat decreases, and the fluid becomes transmuted into a poisonous quality, which is why there are

<sup>535</sup> *Ibid.*

<sup>536</sup> Meyerhof and Joannidas, 'Gynécologie'; Ibn Sīnā, *al-Qānūn*, book III, chapters 16-18.

<sup>537</sup> *Mūjiz al-Qānūn* was translated from Arabic into Urdu as *Mūzih-i Qānūn* by Mirza Muhammad Mahdi and published in Lucknow in 1907; this is the text I am referring to.

<sup>538</sup> G. W. Leitner, *History of Indigenous Education in the Punjab since Annexation and in 1882*, Lahore, 1991, p. 73; Ajmal Khan's petition to the Nizam of Hyderabad, Andhra Pradesh State Archives (APSA), 1911: 'Course of studies, appendix c (b)'.

<sup>539</sup> Muḥammad Akbar Arzānī wrote the *Mizān al-Ṭibb* in 1112 A.H. / 1700 (Zillurrahman, *Dilhī*, p. 58), and Nafīs ibn 'Iwāq's (fifteenth century) *Sharḥ al-Asbab*, both follow this schema. I have been using the available Urdu versions of these texts, both published in Lucknow in 1907 and 1916 respectively.

<sup>540</sup> Asghar Ali points out the occurrence of this condition in Thanavi's *Bihishṭī Zavar*, but defines it as a kind of swooning, and therefore the fact of it belonging the hysteria tradition eludes her. Asghar Ali, *Emergence*, p. 115.

contraction and cramps. The semen accumulates further in the womb, it rots and because it progresses towards the heart and the brain this disease occurs.<sup>541</sup>

A similar account is given in *Sharḥ al-Asbāb*.<sup>542</sup> This text emphasised the poisonous qualities which the unexpelled semen assumed in the woman's body, as well as the 'very powerful association of the womb with the heart and the brain'.<sup>543</sup> Through this physiological connection between the womb and two of the major organs of the unani body, the seats of mental and emotional life, *ḥakīms* were able to rationalise the physical and emotional stresses which women endured and expressed, brought about through their primarily reproductive roles both in Perso-Arab and Indian cultures.

Sex, as Helen King has observed, belongs to the pharmacopeia of Hippocratic medicine. This applies to later recensions of the tradition as well. While too much sex can weaken the body, too little sex means accumulation and putrefaction of unsecreted seminal fluid in the body. This principle applies equally to men and to women. In the account in *Mūjiz*, the rising of the poisonous matter causes a fit during which the patient's face becomes pale and moist. And, on some occasions 'the woman will feel something like a womb rising from her abdomen up to her heart and she becomes confused. It then reaches her mind [*'aql*] and she faints and becomes deranged'.<sup>544</sup> This description is interesting for a number of reasons. Firstly, there is the notion of the 'wandering womb' reminiscent of the Hippocratic writings. Although discredited by Galen, it re-appears here in the Islamic traditions. The notion of the wandering womb conveys perhaps more explicitly than any other condition affecting women the idea of the womb as potentially pathogenic, and certainly the site of great mystery. The womb's mysterious nature and movements are clear in the strange wording 'something like a womb' [*ek shai kokh*]. Secondly, the womb affects the heart, the seat of *nafs*, the vital faculty; the heart is the organ that is most vulnerable to the passions. Rising from the heart, the sensation from

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<sup>541</sup> Ibn al-Nafīs, *Mūjiz*, p. 180: 'Au 'iyyah manī meṇ pur ḥarārat gharīzī ghaṭ jāṭī hai aur mustahīl ho jāṭī hai ṭaraf kaifiyat sammī ke pās taqalluṣ aur tashannuj hotā hai raḥm meṇ manī se aur buland hote haiṅ injare manī ke kharāb aur pahuncṭe haiṅ ṭaraf qalb aur dimāgh ke pās yeh maraḥ ḥādīṣ hotā hai'.

<sup>542</sup> Nafīs ibn 'Iwaḍ, *Sharḥ*, pp. 208-209.

<sup>543</sup> *Ibid.*, p. 209: 'raḥm ko qalb aur dimāgh ke sāth nihāyat qavvī mushārikat hai'.

<sup>544</sup> Ibn al-Nafīs, *Mūjiz*, p. 181: 'Kabḥī maḥsūs karegī 'aurat ek shai kokh voh cīḥṭī hai peṛū se ūpar ko yahāntak kih qarīb dil pahuncṭī hai ba'd uske mukhtall ho jāṭī hai 'aql aur ḥāṣil hotī hai ghashī aur bāṭil hotī hai'.

the womb then overwhelms *'aql*, reason. The polarity of *nafs* and *'aql* characterises other discourses in Islamic literature, as we have discussed above in the context of the *Bihishtī Zavar*. In the thirteenth-century *Mūjiz*, and in twentieth-century unani writings on hysteria, the womb-heart-brain axis serves to cast women as particularly prone to irrational behaviour.

The appeal of Hakim Hafiz Rahim Bakhsh in 1922 did not go unheard. The new editor of the journal, Hakim Muhammad Sharif, published a special issue on women's diseases in December later that year, in which *ikhtināq ar-rahm*, its causes, symptoms and treatment, was one of the three women's conditions singled out for special attention. The author of the article, one Hakim Sayyid Shabir Hussain from Berar, shows that he is familiar with European discussions of the disease, when in his opening remarks he says 'in English this is *'hiṣṭirīyyā'*'.<sup>545</sup> European medicine of the nineteenth century explained hysteria in terms of the dysfunction of the womb, but it is not clear if Hakim Shabir Hussain was fully conversant with European theory.<sup>546</sup> Before focusing on *ikhtināq ar-rahm*, the author in more general terms traces diseases to the connectedness of the womb, heart and brain.<sup>547</sup> The malfunctioning of the womb is thus causally connected with asthma, palpitations, epilepsy and fainting fits – diseases to which women are seen to be particularly susceptible.

Turning to *ikhtināq ar-rahm* itself, Hakim Shabir Hussain, who is consciously drawing on knowledge in the unani tradition, cites semen retention as one of its causes, but then turns to the other causal factor recognised in Greco-Islamic thought, namely amenorrhea, (*iḥtibās al-tumṣ/ḥaiḏ*, the stoppage of menstrual flow). *Ḥaiḏ* is both the process of menstruation and also the menstrual blood, which is one of the wastes of the body, like urine, stool and sweat. In *ḥibb*, menstruation was considered the prime means for women to rid their bodies of excessive excreta. Failing menstruation was considered extremely perilous to the woman's health since the waste would not be expelled and would putrefy, resulting in a range of diseases, including *ikhtināq ar-rahm*. Men were spared this potential pathogen, but they, too, may have suffered from a superabundance of unshed blood, although it was less likely to be perilous for them since they would be

<sup>545</sup> Hakim Sayyid Shabir Hussain, '*Ikhtināq ar-Rahm*', *al-Hakīm*, December 1922, p. 12.

<sup>546</sup> Roy Porter, 'Body', in Gilman, *Hysteria*, p. 255.

<sup>547</sup> Shabir, '*Ikhtināq*', p. 12.

able to work it off through exercise, something women were unlikely to be able to do. To rid men of this plethora, either as a therapeutic or a preventative measure, it was still common practice in the nineteenth century for *hakīms* to recommend blood-letting (*faṣad*), but this practice was fading significantly in learned practice in early-mid twentieth century.

*Ikhtināq ar-raḥm* is one result of a defective womb, where the putrefied menstrual blood, like the semen, corrupts neighbouring organs – the stomach and the heart – through sympathy, and thence the brain. At the beginning of the hysterical fit, Hakim Shabir Hussain continues, the signs are ‘... a slight headache, darkness comes over the eyes, numbness, tears flow, the calves become weak, impatience, there are heart palpitations, difficulty in breathing, contortions, a yellowing of the skin, yawning, the body becomes heavy and sluggish’.<sup>548</sup> The fit is described as ascending, like the wandering womb, though this notion is not directly mentioned:

In the intestine and the colon there are gases like in flatus [*golā*]... through their ascent, and the distress of the orifice of the stomach and the heart, there are heart palpitations. The patient runs hither and thither in confusion, she prattles foolish things, with increasing intensity the shrieks begin, and becoming unconscious, she falls. Her ability to speak has been lost by now but the ability to listen remains. Breathing is short, her face is red, the throat distended, the body is stiff, there is rapid movement of the eyelids, but the eyeballs don’t move.<sup>549</sup>

The treatment for the condition shares much with its predecessors but also includes, when the cause of the disease is identified as amenorrhea, considerations of whether the patient is pregnant or not. If the patient is pregnant or of hot temperament then the medicine, neither too hot nor too fast acting (which might cause a miscarriage through sudden movements), the *hakīm* advises, should be administered either in the nose or in

<sup>548</sup> Shabir, ‘*Ikhtināq*’, p. 12: ‘... *sar meṅ qadrī dard, ānkhon meṅ andherā, havāṣ meṅ khalal, ānsūon ka jāri honā, paṅḍaliyon meṅ kamzorī, be-cainī, ikhtilāj-i qalb hotā hai, sānis ka ba-mushkil ānā, chahrah par zardī cā’iyān, angrā’iyān badn bhārī aur sust wa ghairah*’.

<sup>549</sup> *Ibid.*: ‘... *mi ‘ā’ qūlon meṅ riyāḥ ka golā kī tarḥ daurah aur riyāḥ kī ṣu ‘ūd se famm-i mi ‘dah aur qalb ko azyyat pahuncne se ikhtilāj-i qalb hotā hai marīḥah ghabrā kar idhar udhar bhāgtī hai, be-hūdah bakvās kartī hai, zūr zūr se caiḥnā shurū’ kar detī aur be-hosh ho kar gir partī hai. Yahantak kih ṭāqat bolne kī bhī nahīn rahtī hai, sānis meṅ tangī, chahrah ka rang surkh, girdan ka khacnā, badn ka ainṭnā, ḥarkat ikhtilājī ka papūton meṅ pāyā jānā, ānkh ke dḥele ka ghair mutaharrik honā*’.

the vulva. The medicine applied here is sweet-smelling: jasmine oil, rose oil, and almond oil mixed with a little musk. This is a treatment common in the Greco-Islamic medical tradition which had its origins in the idea of the wandering womb of the Hippocratics, a notion dismissed by Galen but resurrected in the Perso-Arab medical writings, where the sweet smells would tempt the womb back into its rightful place.<sup>550</sup> Other measures, including intrusive ones, involved the sprinkling of cold water over the patient's face with force, binding the woman's arms and thighs and taking the patient's name, shouting it loudly into her ear.<sup>551</sup>

If the cause of *ikhtināq ar-rahm* was determined to be the retention of semen and abstinence from sex, other forms of intervention were required. The following are prescribed: again applying sweet-smelling medicines to the vulva;<sup>552</sup> bad-smelling substances to the nose (like onion, ammonia gas), originally intended in the Hippocratic writings to repel the 'womb' from its residence in the upper parts of the body; and cupping the woman on her inner thighs and lower abdomen.<sup>553</sup> Apart from these measures, the *hakīm* mentions elliptically, since he leaves three dots where *muqāribat* or sex would be, that sex is beneficial and a good means to bring the fit to an end.

The absence of sexual activity is of course associated with virgins, and *ikhtināq ar-rahm* has accordingly been associated with them in the medical tradition since the writings of the Hippocratic corpus, although this again was absent in Galen's work.<sup>554</sup> The best way to cure virgins, and also widows, writes the *hakīm*, is to marry them off. This remedy for girls, and widows is again a long-standing feature of the tradition,<sup>555</sup> and there is evidence of it being put into practice. As Hakim Shabir Hussain pointed out in 1922: 'The respected Hakim Alavi Khan did just this for a young girl; he prescribed this for her'.<sup>556</sup>

<sup>550</sup> King, 'Once', p. 42, p. 51.

<sup>551</sup> Shabir, 'Ikhtināq', p. 12.

<sup>552</sup> Touching the vulva (often it is explicit that the *qābilah* (mid-wife) should do this) is with intention of producing orgasm and thereby releasing the semen stuck in the body. See note 102 below.

<sup>553</sup> Shabir, 'Ikhtināq', p. 13.

<sup>554</sup> King, 'Once', p. 42.

<sup>555</sup> Ibn al-Nafīs, *Mūjiz*, p. 181. 'If the patient is without a husband then have her married off, and if this is not possible the *dai* should move a small candle over the vulva, with a sweet-smelling oil until the woman reaches climax' ['*agar ho voh marīza be shauhar ke to shādī kirā'īe aur agar nā mumkin ho to dā'ī famm-i rahm ko daghdagha aur harkat de roghan khushbūdār se pas jisvaqt kih voh 'aurat manzil hogī'*].

<sup>556</sup> *Ibid.*

Returning from these conventional accounts of hysteria in unani *ṭibb* from the thirteenth and twentieth centuries to Ashraf Ali Thanavi's and Hakim Mustafa's view of the disease in the *Bihishtī Zavar*, we can now appreciate what was omitted and what retained; in short, how these authors wished women to understand the set of symptoms and causes peculiar to the disease. There is the standard description of symptoms: the confusion of the heart and the anxiety of the brain, the pallid complexion, and the very bad thoughts (*bure bure khayāl*), and 'it seems that something rises from below the navel to the heart and the brain', and ultimately the descent into unconsciousness.<sup>557</sup> For treatment, Thanavi only partially retains the use of scent therapy. There is no mixing of sweet-smelling substances, which he says is for treating fainting fits (though he does not mention it in the section on fainting).<sup>558</sup> This means there is no application to the woman's vulva, no intrusion. There is cupping with foul-smelling substances, like *hing* (*asafoetida*), but he does not say where. As to the cause, the author ignores the retention of semen, he only mentions amenorrhea. This makes his advice that for 'girls or widows who have this disease because they are not married, then the best thing is for them to get married',<sup>559</sup> sound odd, because he does not address the fundamental problem, according to the unani tradition, of childlessness for the health of the female body, and the beneficial effects for her attributed to the expulsion of her own seminal fluid. As a conclusion, he ends by saying, let the *ḥakīm* treat it. When it comes to the woman's reproductive role and the issue of sexuality, then the self-help approach which Thanavi otherwise encourages is clearly not enough.

Another area of change in the conception of *ikhtināq ar-rahm* in early twentieth-century *ṭibb* is reflected in the writings of Hakim Ajmal Khan, appearing in the form of case notes.<sup>560</sup> Although there are no precise dates for these writings (they were published after his death in 1928) they are likely to be roughly contemporaneous with the article in *al-Ḥakīm* in 1922. What is remarkable about Ajmal Khan's writings on *ikhtināq ar-rahm*

<sup>557</sup> Thanavi, *Bihishtī*, pp. 261-2: '... ma'lum hotā hai kih nāf ke nīce se ko'ī cīz uthī hai aur dil aur dimāgh tak pahunc kar pareshān kartī hai'.

<sup>558</sup> *Ibid.*, pp. 249-50.

<sup>559</sup> *Ibid.*, p. 262: 'Albatah jin larḳiyon ko yā bīvā'on ko shādī nah hone kī vajah se yeh marāz ho to sab se bahtar tadbīr shādī kar denā hai'.

<sup>560</sup> Ajmal Khan's *Hāziq*, Delhi, 1965, in its 25<sup>th</sup> edition: descriptions of disease according to organ from head to toe, and his *Ifādāt Masīḥ al-Mulk*, a collection of case notes, republished under the title *Maṭāb 'Amālī*, Lahore, no date.

is not so much the detail of the physiological etiology, the lively description of the symptoms and the treatment – all these follow fairly standard lines, which convey the intimacy of first-hand experience. Rather it is the framework that he gives for the discussion of the disease which reveal more about the tensions of a society undergoing so many transitions, where women occupy an ambiguous place.

In common with many other *sharīf* Muslim reformers of generations before him Ajmal Khan was concerned to do away with superstitions and wasteful customs. He distinguishes unani's epistemology from belief in spirit possession. He writes that *ikḥtināq ar-raḥm* is popularly known as 'bā'ū golā' ('wind-swelling' or also 'colic'), since it is akin to flatus that rises to the throat and blocks off the blood:

Ignorant people have generally considered this disease to be an evil spirit, and once they have thought that this disease is the influence of a demon or such like, they treat those suffering from it with indignity. Therefore, nowadays there are hundreds of wretched people of good faith who lead their women astray with amulets and *gandhe* [twisted cord used as a charm], waste their hard earned money, and ruin their lives.<sup>561</sup>

What is repulsive to Ajmal Khan are ignorance, the squandering of resources, belief in demonic possession, and indignity, which are failings measured against the four key standards of the *sharīf* world-view from the mid-nineteenth century and into the twentieth – culture, moderation, piety, and moral example. For Ajmal Khan the authenticity of unani *tibb* lies in its explaining disease through natural causes, over which people (or at least males in the case of hysteria), with the right knowledge, may have a degree of control. However, Ajmal Khan's interpretation of the causes of *ikḥtināq ar-raḥm*, moves away from the solely uterine etiologies proposed by his predecessors, as he describes women's propensities to nervous disorders and enters into the social and moral space that women occupy, in order to explain the disease:

<sup>561</sup> Ajmal Khan, *Hāziq*, p. 287: 'Avarizāt ke lihāz se 'umūman juhalā is maraḥ ko āsīb aur jinn bhūt wa ghairah kā sā yeh khayāl kar ke is maraḥ ke muḥtalā marizon kī maḥī palīd karte haiṅ. Cunāncih ājkal 'umūman sainkarōṅ be-cāre khūsh 'aqīdah log apnī piyārī 'auraton ko maḥaḥ gande ta'vizon ke cakr men ḍāl kar apnī gāḥī kamā'ī zā'ī' karte aur un kī zindagī kharāb karte haiṅ'.

It is mostly the city-dwelling rich women between the ages of 12 and 40 with their delicate temperaments who suffer from this disease. The causes of the disease are: problems with menstruation, or its cessation for some reason; spending a life of pleasure and gaiety; not having a job or ordinary exercise; being overcome by sensual and carnal desires through either listening to love tales and stories or reading novels; having perpetual constipation, flatulence or stomach complaints; feeling grief and sorrow, anxiety and distress, passion and fear, or the shock of some severe loss; not having girls married while they are young, or too much arousal etc.<sup>562</sup>

This appears to be the first time in unani discourse that *ikhṭināq ar-rahm* is traced to a set of specific social conditions. According to Ajmal Khan, this is a disease that afflicts the rich, urban woman who indulges herself in pleasure. In the womb-heart-brain axis of the female body, the heart and the brain have an agency to cause bodily disorder through emotionally or sensually arousing reading and lustful thoughts. It is no longer just the ascent of the womb which is important; it is also the woman's mental and emotional state: This woman is weak and vulnerable to the perils of pleasure and sexual license, which she cannot control, to sudden shock and distress. Ajmal Khan's denunciation of the life of pleasure that imperils her physical and mental health recalls the deprecation among Islamic reformers in previous decades of the 'decadent' nawabi lifestyle believed to have entailed the demise of Mughal influence. Ajmal Khan was concerned about the effects that reading arousing or sensual stories might have on women's health. This was a concern that was shared by his contemporary Maulana Thanavi, who compiled a list of prescribed reading deemed suitable for women.

Ajmal Khan's account of hysteria can be read as an expression of cultural malaise, and is eroticised in ways that echo nineteenth century European conceptions of the disease. It is an open critique of life outside the circumscribed social norms of marriage and comportment, where immorality is somatised into the fretful, irrational, constipated,

<sup>562</sup> *Ibid.* p. 288: 'Ziyādah-tar amīr aur nāzik-i mizāj shahrī 'auratain bārah sī cālīs baras kī 'umr tak is maraḡ meḡ muḡtalā hū'ā kartī haiḡ. Ḥaiḡ ka taklīf se ānā. Ya kissī vāj se band ho jānā. 'Aish o 'ishrat kī zindagī basar karnā. Kām kāj aur ma'mulī riyāzat bhī nah karnā. 'Ishqiyah qīṣṣe, kahāniyān sunne aur nāvalon ke paḡhne se nafsānī shahvānī khvāhishāt ka ghāib honā. Dā'imī qabḡ ya nafkḡ-i shikam kī shikāyat ka honā. Ranj o ḡhamm fikr o taraddud, ḡhiṣṣah o khauf yā kissī shadīd naqṣān se ṣadmah pahuncnā. Aur javān larkiyon kī 'irsah tak shādī nah karnā. Ya ziyādah jāgnā wa ḡhairah, is maraḡ ke asbāb hote haiḡ'.



disturbed body-mind of a woman on the brink of going out of control. Dissolute hence hysterical woman resembles woman as *fitnah*, the force of chaotic and rampant sexuality believed to be a threat to the social order in pre-nineteenth century Persian ethical treatises.

Ajmal Khan's account of *ikhtināq ar-raḥm* was not formulated as an abstraction of a vital medical tradition. Of the patients who presented themselves with the condition to Ajmal Khan's clinic in Delhi, only two are recorded, all too cursorily, in *Ifādāt Masīh al-Mulk* (a collection of cases arranged by organ and disease). One of them, a woman from Jaipur, had had a miscarriage and since then her periods had stopped. She had had fits once a week and in the words of the *ḥakīm* had 'taken to improper talk'. According to Ajmal Khan's diagnosis she had become thin and weak due to secretions from her uterus. Unfortunately we do not know how he achieved the diagnosis, what he prescribed for her, or how the poor woman fared.<sup>563</sup>

Through this discussion of hysteria we have seen how *ḥakīms* variously constructed the disease and suggested a variety of therapeutic approaches. They were selective in their use of available knowledge on hysteria in the unani tradition, as their formulations were framed to reach new readerships/audiences. Their explanations of the 'disease' reveal the strong connections that were made both in ancient and in early twentieth century *ṭibb* between women's physiological, emotional and mental states. Learned *ṭabībs* could explain hysteria as a result of natural causes. They distinguished their knowledge, practices and authority from the realm of spirit possession, with which the signs of hysteria have been commonly associated in India, as shown in Ajmal Khan's remarks and more recently in Sudhir Kakar's psycho-analytic study.<sup>564</sup> In some instances medical theory and cultural norms coalesce and the former appears to have been used to justify the latter, as we have seen in the area of adolescent marriage.

I am not in a position to say whether hysteria had become the fashionable disease in early twentieth century India that it was at a roughly comparable time in Europe, but it clearly reflects on the social pressures experienced by women leading to the somatic disorders, anxiety and depression reasoned and amalgamated by the physician into the

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<sup>563</sup> Ajmal Khan, *Maṭab*, p. 299.

<sup>564</sup> Sudhir Kakar, *Shamans, Mystics and Doctors: A Psychological Enquiry into India and its Healing Traditions*, London, 1984.

category *ikhtināq ar-rahm*. The last case which we referred to above points us in this direction: the case of the woman who had experienced a miscarriage and who thereafter experienced the stopping of her menstruation. We must assume that women in most spheres of society in India at this time, as indeed before and since, were under tremendous pressure to procreate, given the importance of lineage and the prominence of the patriline in understandings of self-hood and social status. This pressure continues to exist, as recent sociological studies have shown. According to one such study by Anjali Widge, in spite of marked changes in a small section of society, the majority of women in India continue to have a primarily reproductive role in society; their power and status increase with their ability to produce, especially male, offspring.<sup>565</sup> The inability to bring children into the world has been shown to result in the loss of status and prestige, and ultimately for the woman it may result in being severed from the husband's family, with all the existential and financial insecurities that this entails. Menstruation in such contexts, as Widge points out, is a sign of failure, and may be feared. What we see then in the case of the woman who miscarried is perhaps the outcome of these pressures, interpreted by the *hakīm* as pathological disturbances, associated primarily with the womb, to the balance of female bodies.

## Conclusion

In this study we have seen then that women and their living conditions became an issue of great import for unani *hakīms* in the late nineteenth and early twentieth centuries, and that *hakīms* engaged themselves in various ways in trying to reform, intervene, control or, in some cases, better these conditions. The home and women's health-related behaviour were a new site for intervention for unani practitioners. *Ṭabībs* and social reformers interested in women's health issues took their messages, fusing colonial discourse on

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<sup>565</sup> A. Widge, 'Sociocultural Attitudes towards Infertility and Assisted Reproduction in India', in A. Effy (et al.), *Current Practices and Controversies in Assisted Reproduction*, Geneva, 2002, p. 62.

sanitation and hygiene, Islamic precepts on cleanliness and unani concepts of miasmas and humoral pathology, to women and into their 'private' spheres. Partha Chatterjee has argued that anticolonial nationalism in India attained its own form of sovereignty through the division of a material 'outside' – 'of the economy and of statecraft, of science and technology, a domain where the West had proved its superiority and the East had succumbed' – and a spiritual 'inner' realm 'bearing the "essential" marks of cultural identity'.<sup>566</sup> In the outer world the achievements of the colonial power had to be emulated and replicated, but the more this happened the greater became the need to maintain the distinctness of the inner world. But, as he points out 'it is not as though this so-called spiritual domain is left unchanged. In fact here nationalism launches its most powerful, creative and historically significant project: to fashion a 'modern' national culture that is nevertheless not western'. The enterprise of some unani practitioners and social reformers in relation to women's health was likewise a highly creative project which strove to create a new culture by fashioning western and indigenous modes, fusing the two, but it was also one in which 'private' and 'public', 'material' and 'spiritual' domains of life cannot be so easily prised apart as Chatterjee's discussion would suggest. Unani practitioners may be seen to emulate colonial medical practices, such as sanitation or diagnostic technologies, but they also, as we have seen, reworked them into pre-existing categories.

In this chapter we have seen how unani medicine and women's health converged in quite powerful and innovative ways in the writings and activities of prominent reformers of the time, male and female. In their work unani discourse became, in one sense of the word, sanitised and also, one could say, feminised. Unani medicine, in various forms, was now being presented with women as its intended audience, either in print or through public lectures. All these were innovative approaches to challenges faced by a society undergoing immense and rapid transition, in which women were intimately involved. The unani medical tradition had always been propagated by men and for men in West and South Asia, and this is reflected in its pre – early twentieth century discourse on women's diseases. We are marking, however, only the beginnings of a shift in its orientation.

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<sup>566</sup> Partha Chatterjee, *The Nation and its Fragments: Colonial and Postcolonial Histories*, Princeton, 1993, p. 6.

Currently between 70 - 80% of the students in India's largest unani medical school, the Nizamia Government Hospital and Unani Tibbi College in Hyderabad, are female, while 60% of students enrolled in the Faculty of Eastern Medicine in Hamdard University, Karachi, are women. Women's involvement in the practice of unani medicine only really began to take hold in the 1940s and 50s, for numerous social and cultural reasons that may be related, if only tangentially, with our period. Nevertheless, between 1900 and 1930 we witness the embryonic stages of these developments, and some of the concomitant changes in the evolution of unani *tibb*.

## Chapter 6

### ***Ḥakīm* – Patient Relationships: The Unani Journal and Domains of Authoritative Practice in Early Twentieth-Century India**

Recent studies in the history of unani *tibb* in the twentieth century have illuminated aspects of the revival and reform of unani medicine, especially debates between ‘rival’ schools and the negotiation of understandings of science and surgery among unani practitioners.<sup>567</sup> What these studies have not taken account of, however, is how *ḥakīms* actually dealt with patients, and how they attempted to project the usefulness of unani *tibb* to the public. Shifting our attention away from what *ḥakīms* said about the practice of unani to actual forms of engagement with the patients and the broader public takes us therefore into uncharted territory. This chapter explores the interaction of *ḥakīms* with patients, with fellow practitioners and with the public, in the context of a flourishing journal literature. Underlying these broad concerns are themes that relate to the authority of the *ḥakīm*, the great variations of practice, the ways that *ḥakīms* dealt with the question of the authenticity of their practice and how they attempted to hone the image of unani medicine to various constituencies in early twentieth-century Indian society.

Developments in the unani profession and practical applications of unani medicinal theory were for the first time disseminated regularly and rapidly among practitioners across the subcontinent through the coverage of these issues in unani journals. The full implications of this innovative publicising are difficult to grasp and assess. One cannot gauge how far, for example, the particular visions of health and disease advanced by the

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<sup>567</sup> C. Liebeskind, ‘Arguing Science: Unani *Tibb*, Hakims and Biomedicine in India, 1900-50’, W. Ernst (ed.), *Plural Medicine, Tradition and Modernity, 1800-2000*, London, 2002, pp. 58-75; C. Liebeskind, ‘Unani Medicine of the Subcontinent’, in Jan van Alpen and Anthony Aris (eds), *Oriental Medicine*, Boston, 1997, pp. 39-66; B.D. Metcalf ‘Nationalist Muslims in British India: the Case of Hakim Ajmal Khan’, *Modern Asian Studies*, 19, 1985, pp 1-28; N. Quaiser, ‘Politics, Culture and Colonialism: Unani’s Debate with Doctory’, in Biswamoy Pati and Mark Harrison (eds), *Health, Medicine and Empire: Perspectives on Colonial India*, London, 2001, pp. 317-355.

journals informed an individual *hakīm's* practice. But there were a number of more manifest ways in which the journals brought about innovations in every day practice and contributed to the changing culture of unani medicine in the early twentieth century. Their eclectic composition reflected the diversity of practices and strains of thought in unani *tibb* of the time, some of which we will be exploring in this study.

In addition to bringing practitioners together from across the subcontinent, the journals also presented new possibilities for interaction between the unani practitioner and the patient, and to some extent compensating for the absence of detailed unani dispensary records at this time they present an invaluable source for analysing therapeutic approaches in a popular question and answer section that appeared at the end of most journals. Furthermore, the journals record the patient's enquiry, which enables us to go beyond a strictly practitioner centred discussion of health and disease and gives us vivid insights into how patients perceived their illnesses and the potential avenues for cure. From this perspective the present chapter explores an arena in which *hakīms* exerted, and were seen to exert by the public (and one may say in some respects continue to exert), a special degree of authority: sexual 'weakness'. As a case study in the relationship between unani *tibb* of the classical texts and unani *tibb* in the early twentieth century, the chapter examines in detail the ways in which ideas of (male) bodily weakness were framed, both in relation to a rhetoric of civilisational decline and to newly pervasive notions of sexual deviance. We then take into account how patients themselves understood and articulated their ailments. Their enquiries made by patients in the journals take us into the realm of popular discourse on health and disease and give us valuable patient-oriented perspectives, arenas of enquiry that have been lacking in accounts of unani history in South Asia. My analysis here is based on issues for *Rafīq al-Aṭibbā* for the years 1912-1913, and for *al-Hakīm* 1921-1929. This chapter presents in this section how medical understandings of the body concurred with a form of social control of sexual behaviour, a theme that has been little explored in Indian contexts.<sup>568</sup> The form of power and authority that *hakīms* exerted over their patients' bodies was thus mutually constituted, as patients sought out a variety of treatments for their conditions.

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<sup>568</sup> Patricia Uberoi, 'Problematizing Social Reform, Engaging Sexuality, Interrogating the State,' in Patricia Uberoi (ed.), *Social reform, Sexuality and the State*, New Delhi, 1996, p. xix.

The journals are thus entry points to viewing the variety of practices of unani *ḥakīms*. This diversity questions currently understood notions of unani medicine as a ‘system’ of medicine, and opens up the issue of boundaries between magic, medicine and religious healing. In terms of the *ḥakīm*’s relationship with the public, the journal also reveals the *ḥakīm*’s concern for the image and status of unani *ṭibb*. Naturally, one of the essential components of a successful relationship with the public was to ensure the dispensing of quality prescriptions, but we will also see how the standing and viability of the *ḥakīm*’s practice also came to be seen in terms of the form of medicines and a new kind of involvement with the patient. Advertising was one of the foremost public arenas in which the relationship between the *ḥakīm*, the medicine and the patient was articulated. Our study of this dimension of practice will be limited to an analysis of advertisements as they appeared in certain unani journals, through which we will see how *ḥakīms* employed different strategies to legitimise their products and appeal to different constituencies.

### I. Two Prominent Unani Journals: *Rafīq al-Aṭṭibbā* and *al-Ḥakīm*

The use of print by educated *ḥakīms* in the late nineteenth and early twentieth centuries was evidently a fundamental agency through which the movement to revitalise unani *ṭibb* took shape. Indeed, as Seema Alavi has recently argued, the availability of printed medical literature may have initially spurred the process of the reform of *ṭibb* in the mid-to late nineteenth century, as elite, hereditary practitioners sought to consolidate their position, and their knowledge, against the background of a flourishing and unregulated production of ‘unani’ texts.<sup>569</sup> The centres of Islamic learning and Hindustani culture in the subcontinent housed major publishing concerns where various kinds of ‘unani’ works were printed, in Lucknow, Delhi, Lahore, Patna, Kanpur, Calcutta, Bhopal, Hyderabad and other smaller localities besides. The emergence of unani journals from the end of the

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<sup>569</sup> On the impact of print on religious change see F. Robinson, ‘Islam and the Impact of Print in South Asia’, in Nigel Crook (ed.), *The Transmission of Knowledge in South Asia: Essays on Education, Religion, History, and Politics*, New Delhi, 2001, pp. 62-97.

nineteenth century was one manifestation of the adaptation of this technology to the agendas and priorities of *hakīms*, just as ayurvedic journals proved a significant medium among *vaid*s, and by the late nineteenth century their journals were certainly more well established.<sup>570</sup>

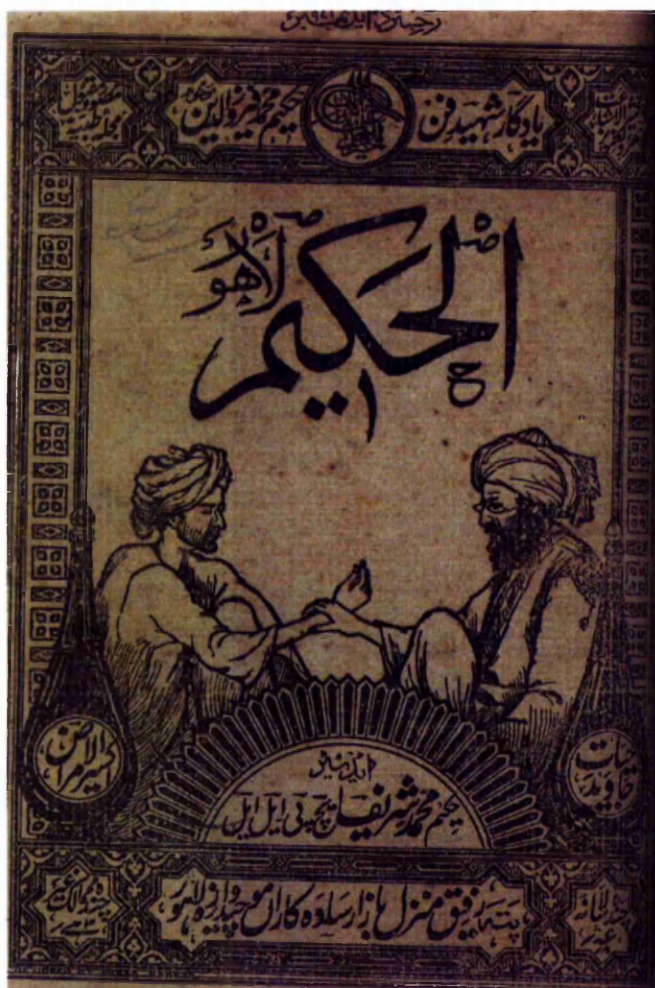
We have seen in previous chapters on plague and on women's diseases that journals were one of the prominent sites for the elaboration of unani discourse of health and disease. Some of these *Risāle* (journals) were in effect brochures of unani and ayurvedic products brought out by *davākhānahs* (dispensaries, 'place of medicine'), like the *Risālah Amriṭ Khūrd* of *Vaid* Thakar Datt Sharma, which carried advertisements for unani and ayurvedic medicines and testimonials of their effectiveness. Others were journals in the more familiar sense, functioning as forums for debate and the exchange of ideas. The *Majallah Tibbiya* was the monthly journal of the first school in India solely dedicated to unani instruction, the Madrasa Tibbiya in Delhi.<sup>571</sup> Another prominent Delhi-based journal was *al-Masīh*. Important journals appeared in Lucknow and also in Hyderabad, first *al-Mu'ālij* (from 1916) and later the more comprehensive *Hakīm-i Dekkan* (from 1935). Several journals were published from Lahore between the 1900s and the 1930s, such as *Hikmat* and *Mushūr al-Aṭibbā*. Of these the most well-known and widely circulated were *Rafīq al-Aṭibbā* and *al-Hakīm*, both founded and edited by Hakim Ferozuddin.

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<sup>570</sup> K.N. Panikkar notes that there were at least fifty ayurvedic journals in circulation by the late nineteenth century. *Culture, Ideology, Hegemony: Intellectuals, and Social Consciousness in Colonial India*, New Delhi, 1998. Parallel to large-scale commercial enterprise in indigenous medical products, it seems as though the journal was first developed, among indigenous practitioners, by *vaid*s and *kavīrājs* in Bengal. See Gupta, 'Indigenous Medicine in Nineteenth and Twentieth Century Bengal,' in Charles Leslie (ed.), *Asian Medical Systems*, New Delhi, 1998, pp. 368-378.

<sup>571</sup> See Zillurrahman for a list of unani journals, 'Unani Medicine in India 1901-1947', *Studies in History of Medicine and Science*, 8, 1994, p 100.





The front cover of the journal *al-Hakim* shows the *hakim* dressed in the apparel of a learned physician, in the iconic pose of reading the pulse.<sup>572</sup>

Hakim Ferozuddin (d. 1920) came from a reputable line of hereditary unani practitioners and was well respected in most unani circles, although his closeness with Hakim Ajmal Khan and his support for the Delhi-based AIVUTC had made him out of favour with some Lucknowi *tabibs* associated with the Takmil at-Tibb school, which he had never been invited to visit.<sup>573</sup> He favoured to some extent the integration of surgery and other biomedical practices into unani *tibb*, but through his journals encouraged a

<sup>572</sup> *al-Hakim*, front cover, January 1929.

<sup>573</sup> Ferozuddin, Editor's note on the Takmil at-Tibb school, *Rafiq al-Aṭibbā*, 16 November 1913, p. 30.

wide range of medical theories to be circulated. Apart from being a successful entrepreneur – setting up a publishing house and a factory for the production of unani medicines – he wrote several works on *ṭibb* himself. One of Ferozuddin's prime areas of concern was to reform practitioners' relationship with medicinal drugs and to make knowledge of effective medicines accessible beyond the confines of hereditary practice.<sup>574</sup> To this end he was both active trying to organise practitioners around this theme in the AIVUTC, as well as in publishing. He compiled the most comprehensive biographical directory of *ḥakīms* in northern India in the early twentieth century, the *Rumūz al-Aṭibbā*, with the intention of providing a context within a which a medicine's effectiveness could be gauged.<sup>575</sup> In 1907 Ferozuddin founded the journal *Hikmat*, but gave the editorial duties to a friend when he was overcome by sudden illness. He continued to edit *Rafīq al-Aṭibbā*, which was first published in 1906, and in 1915 founded *al-Ḥakīm*. These journals form the basis of this study, for their richness of content and the insights they lend into early twentieth-century unani theory and practice.

In December 1913 each issue of the bi-monthly *Rafīq al-Aṭibbā* sold between 1300 and 1400 copies, which made it one of the unani journals with the largest distribution.<sup>576</sup> *Al-Hakim*, first issued in 1915 and ultimately succeeding *Rafīq*, had a similar format and popularity. Both journals published material from a variety of sources. They published articles on new biomedical research into cholera, while also propounding miasmatic theories. They produced anatomical diagrams and yet in other contexts the fluxes of the humoral body remained intact. They reported extensively on political and professional developments, such as the Medical Registration Act, the opening and reform of unani schools, the proceedings of national and local *ṭibbī* conferences. The authorities of ancient *ṭibb*: Aristotle, Galen, Hippocrates, Ibn Sīnā, al-Rāzī were all widely quoted, alongside Socrates (Sūqrāt) and Plato (Aflāṭūn), linked with the divine healer Asclepius. Islamic *ḥadīth* could be quoted to bolster an argument, as we have seen in the chapter on plague, and Luqman, of Quranic provenance but subsequently transformed as a divine healer, was frequently referred to.

<sup>574</sup> See Chapter 4.

<sup>575</sup> See Chapter 3.

<sup>576</sup> *Rafīq al-Aṭibbā*, 1 December 1913, p. 7: 'Ḥālānkeh mazhab-i Islām is se inkār nah karegā, magar zarūrat is amr kī hai kih ṭibbī usūl ke sāth aur sabab-i maraḡ daraj ho'.

The journals came out with articles at the fringes of some contemporary ideas on what constituted unani *ṭibb*. One reader wrote a letter to *Rafīq al-Aṭibbā* saying that he and his friends subscribed to the journal out of interest in *ṭibbī* matters (some of his friends took a professional interest), but they were put off by the ‘sermons’ that they came across. A Muslim himself, he wrote ‘[*Rafīq al-Aṭibbā*] should not refute Islamic precept, it is nonetheless essential that *ṭibbī* principles and the causation of disease are presented’.<sup>577</sup> The journals also included articles on such marginal unani subjects as mesmerism, which was ‘indigenised’ through the name ‘*ilāj rūḥānī*’ (spiritual medicine), complementing ‘*ilāj jismānī*’ (physical medicine), more properly the domain of *ṭibb*.<sup>578</sup> Despite their kaleidoscopic nature, both journals attracted many prominent *ḥakīms* from Lahore, Amritsar, neighbouring localities and further afield such as Delhi and even Bhopal, to contribute to their content. Among these were Hakim Muhammad Hasan Qarshi, founder of a unani school in Lahore, Hakim Dr. Ghulam Jilani and Hakim Farid Ahmed Abbasi, principal of the Zenāna *Ṭibbī* College in Delhi.

The readership of *Rafīq al-Aṭibbā* and *al-Ḥakīm* came from various communities, ethnic and religious. Hindus and Sikhs regularly sought *ḥakīms*’ help through the journals, and indeed a number of the unani *ḥakīms* who worked with the journals were Hindu, one of the most prominent being Hakim Lala Sri Ram. Clearly the common characterisation of unani medicine as ‘Muslim’ is problematic and misleading. The readership was also professional and lay; so much may be inferred from the question and answer section where patients enquire about their illnesses and practitioners about prescriptions, and advice on certain cases and prescriptions. Evidently, when we refer to the relationship between the practitioner and the public fashioned by the journal, it is this literate, and therefore quite circumscribed category of public that we mean. Nevertheless, the journal was a resource for afflicted individuals, and their families, who were desperate, stricken with chronic illness, and often relatively impoverished, emphasising in their enquiries their lack of means to afford expensive medicines or ingredients. Both journals enjoyed wide circulation; this is underscored by the enquiries from readers of these Lahore-based journals as far afield as Bhopal and Hyderabad.

<sup>577</sup> *Ibid.*, 1 February 1912, p. 28.

<sup>578</sup> Hakim Karim Bakhsh, ‘*Ilāj Rūḥānī*’, articles serialised in *Rafīq al-Aṭibbā*, from 1 January 1912.

## II. Male Sexuality and the Medicalisation of a New Moral Order in Early Twentieth-Century *Ṭibb*

In an editorial to the 1912 February edition of *Rafiq al-Aṭibbā*, Hakim Ferozuddin declared that there were three kinds of diseases that were especially afflicting India of his time. Two of them, malaria and plague, attacked lethally but intermittently, and those affected by them usually died. The third was degenerative rather than dramatically lethal and posed in the view of many practitioners a grave threat to society for the insidiousness of its ill effects on the male body and the prospective health of future generations. This disease manifested itself in forms of physical, mental and emotional sickness and weakness (*kamzorī*) resulting from what was perceived as the improper use of male sexual powers. Male sexual dysfunction encompassed a variety of complaints: impotence (*inānat, naqsān bāh*), involuntary emissions (*jiryān*) and night emissions (*ihlām*), 'gonorrhoea' (*sauzāk*) and also syphilis (*ātshāk*). Male sexual dysfunction, the third class of disease after malaria and plague, Hakim Ferozuddin wrote, 'is hollowing out' (*khūkhilā kar rahī hai*) our 'foundation' (*bunyād*) in life, 'it weakens our health and makes it short-lived; it has already reduced our natural life expectancy from 120 to 50 or 60 years, and moreover it continues to do so day by day... Soon a life expectancy of 20 to 25 years will be considered normal'.<sup>579</sup> Indeed, as we shall see below, it was thought at the time that the prevalence of plague, malaria and cholera could be explained as a result of the actions and conditions that gave rise to this all-consuming weakness. Hakim Ferozuddin was evidently convinced that the morbidity and mortality he was witnessing in his experience as a *ṭabīb* were well out of the ordinary. He continued,

It is Hindustan's misfortune that activities have become widespread that are extremely damaging to the powers of men and women. You will perhaps meet only one youth in a hundred who has escaped these activities. If the youth has not begun to practise

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<sup>579</sup> Editorial by Hakim Ferozuddin, *Rafiq al-Aṭibbā*, 1 February 1912, p. 3: 'Hamārī kamzor aur ghair derpā banā rahī hai aur hamārī ṭabīb zindagī kī ḥad ko ṭak se se tak lā cukne ke 'ilāvah dīn ba-dīn aur bhī kam kar rahī hai'... 'voh vaqt jald ānevālā hai jab kih hamārī 'umr-i vafā kī intihā'e 20-25 sāl huwā aur yahī 'umr ṭabīb samjhī jāve'.

masturbation or sodomy by the age of 12 or 13...then when he comes of age he will indulge in excessive sexual activity; apart from ruining male powers these things render their health pitiable.<sup>580</sup>

The perception that these were particularly insalubrious times was widespread among unani practitioners. As Hakim Abd ul-Aziz Ajiz Bhusahi, a regular contributor to *Rafiq al-Aṭibbā*, wrote in a long letter to the journal entitled 'How to remain free from illness':

It is not wrong to say that there have not been all manner of diseases from the beginning of time to the present day, I cannot dispute this. However, it is worth attending to this matter; that just as there are a greater number, an abundance of diseases in the present times, so do ordinary illnesses quickly become fatal. In comparison with previous times, neither were there then so many diseases, nor did general [‘*āmah*’] diseases so rapidly adopt ruinous forms.<sup>581</sup>

These *hakīms* were discussing what was effectively a crisis of, especially, male sexual power in Indian society, a challenge to perceptions of masculinity, which was felt in numerous unani circles, and quite probably among other sections of literate, urban Indian society at large. The observation that Markus Daechsel makes in his illuminating study of consumerism and political culture in mid twentieth-century Lahore that Punjabis

<sup>580</sup> Hakim Ferozuddin, 'Mardānah Quvvatain' [one of a number of articles on 'male powers' serialised throughout 1912], *Rafiq al-Aṭibbā*, 1 February 1912, p. 6. 'Mulk kī bad qismatī se Hindūstān meṅ aise af'āl ba-kuṣrat phīl ga'e haiṅ, jo mardānah zenānah quvvaton ko saḳht naqṣān pahuncāne vāle haiṅ. Aur mulk ke nau javānon meṅ ek fīṣadī shāyid aisā shakhs mil sakegā jo in af'āl se bacā hū'ā ho. Varnah bārah terah sāl kī 'umr se hī jalaq o iḡhlām kī mashq shurū' ho jātī hai aur jo ko'ī is 'umr meṅ is [sic] af'āl se bacā rahtā hai, voh bāni' hone par kuṣrat mubāshirat ka shikār ho jātā hai jis se un kī mardānah quvvaton meṅ bagāṛ paidā hone ke 'ilāvah un kī 'ām ṣīhat bhī qābil-i raḥm ho jātī hai'.

<sup>581</sup> Hakim Sayyid Abd ul-Aziz 'Ajiz (Bhusahi), 'Bīmāriyon se Kionkar Maḥfūz Rakhsakte haiṅ', *Rafiq al-Aṭibbā*, 16 March 1912, p. 29, (continued in the same journal 16 June 1912, pp. 13-16): 'Go yeh kahnā ghalat nahīn kahā jā saktā hai kih roz azal se le kar is vaqt tak har qism ke 'āriḡe aur bīmāriyān hamesha hī paidā hotī rahtī haiṅ aur us ke taslīm meṅ ko'ī cūn o chirā bhī nahīn ho saktā hai magar qābil-i ḡhaur yeh bāt hai kih jis qadr ziyādatī ti 'dād aur kuṣrat anvā' ke sāth zamānah-i maujūdah meṅ bīmāriyān pā'ī jātī hai aur jis qadr jald az jald adne adne bīmāriyān muhlik ho jātī haiṅ muqābilatan us ke zamāne sābiq meṅ nah to is qadr kuṣrat se amrāz ka vuqū' hī huwā kartā thā aur nah 'āmat al-vuqū' amrāz is qadr jald ḡālat-i rivā'at ikhtiyār kar lete the'.

seemed obsessed with weakness rings true for a broader constituency;<sup>582</sup> it was reflected in a variety of journal literature, texts and also the proceedings of national unani conferences. In Punjab, as elsewhere in India, the unani *hakīm* was, and was evidently perceived to be, an authority on male sexual power, and this authority was mediated through various channels.

Enmeshed in the rhetoric of moral, political and cultural decline, 'weakness' was conceived in terms of socio-cultural, temporal and geographical realms. In all discussions of the subject, the prevalence of weakness was considered to be a recent phenomenon. For some commentators it was woven into a nationalist narrative, becoming explicitly a colonial condition, which emerged as a result of the changing lifestyles introduced through contact with European culture. This is captured in a letter from Hakim Ram Lal Ram Narayanji, secretary of the Anjuman-i Aṭibbā-i Bombā'ī (an association of unani practitioners in Bombay), written in the context of the passing of the Medical Registration Act in Bombay, published in *Rafiq al-Aṭibbā*:

I vigorously propose a challenge as to what the reason is why in this age of *tahzīb* [culture] and civilisation our fellow countrymen's lives are decreasing and their powers are daily becoming weaker. Someone may say that it is only the lives of the poor that are less. But observation shows that also the wealthy and the middle classes rarely reach 90 years. To the extent that I know and I heed this, it seems as though the reason is that we have left behind the old ways of living, and we are longing for the ways of other countries.<sup>583</sup>

Weakness here emerges out of a sense of cultural dislocation, being both a product of the seduction of modernity and the dependence of Indians on foreign products, while serving to substantiate the *hakīm*'s nationalist argument for the state restitution of

<sup>582</sup> M.B. Daechsel, "Faith, Unity, Discipline" – The Making of a Socio-Political Formation in Urban India, Lahore 1935-1953', unpublished Ph.D. thesis, University of London, 2001, p. 100.

<sup>583</sup> *Rafiq al-Aṭibbā*, 16 November 1912, pp. 4-5: 'Meñ nihāyat zūr se cailanj detā hūñ kih kyā vajh hai kih is tahzīb aur mutamaddan ke zamānah meñ hamāre mulkā bhā'iyon kī 'umre ghaṭṭī jātī haiñ aur unke qavvāe roz ba-roz kamzor hote jāte haiñ. Ko'ī ṣāhib kahenge kih 'umrīñ ṣirf gharībōñ kī kam hotī jātī haiñ magar mushāhide se ma'lum hotā hai nahīñ daulat mand aur mutavasiṭ-i darajah ke logōñ meñ bhī shōz aur nādir ko'ī ādmī assī nause tak ab pahunctā hai jahāntak meñ jāntā hūñ aur ghaur kartā hūñ mujhe to uskā sabab yahī ma'lum hotā hai kih ham ne apne mulk ke qadīm ṭarīqah-hā'e mu'āshirat chūr dī'e haiñ, aur dusre mulkōñ ke pur zarūr ṭarīqōñ ko shauq se ikhtiyār kar leta hai'.

indigenous medicine in India. Hakim Ram Lal Ram singled out as especially harmful for Indian bodies the use of allopathic medicines, which were hot, and in tincture form, suffused with alcohol, as well as changes in diet. Other *hakīms* sought to understand the weakness of India as the effect of people not embracing ‘progress’ enough. Hakim Abdurrab Khan wrote a lengthy article in *Rafīq al-Atībbā* entitled ‘The cause of the ruination of Hindustan’ in which he argued that weakness was primarily caused by the lack of love between couples at marriage and the marrying of women who were too young.<sup>584</sup> He constructed Europe as India’s ‘other’, where people were healthy because they understood the importance of love between man and woman and the appropriate age for marriage, while in India these fundamental relationships were misunderstood. Drawing on unani physiological theory, he argued that love and desire promoted strong sensations in the body that are passed on into the semen of the man and the woman. Love encouraged *rūḥ* (the vital spirit) to be passed from the parents to their progeny. Where intercourse occurred without love the semen would not contain the power necessary for the offspring to repel illness. Since offspring would inherit their parents’ weakness, as well as their ‘contagious’ (*muta ‘adī*) diseases like ‘syphilis’ (*ātshāk*), he foresaw that India would not be able to escape this ‘chain of weakness’ (*silsilah-yi zu‘af*) – the kind of accumulated debilitation over generations that Hakim Ferozuddin wrote of above – unless they acted in accordance within the ‘natural’ (*qudratī*) limits of their bodies.<sup>585</sup>

The more common rationalisation of weakness in India from the unani perspective, however, connected it with male sexual conduct, in which the wasting of semen (*manī*), *mādat al-ḥayāt*, or ‘the stuff of life’, was paramount. According to unani *ṭibb* men and women produced semen, both of which were considered essential for reproduction, and a regimen of sexual intercourse was considered to be an important part of maintaining bodily health. One of the outcomes of accumulated semen in the woman’s body could be *ikhtināq ar-rahm* (hysteria), as we have discussed in the preceding chapter. Significantly, however, while women threatened to throw society into chaos through their unrequited passions, the discussion of male sexuality in the early twentieth century hinges rather on the problems of venereal excess, and moreover the question of ‘with whom?’. In classical

<sup>584</sup> Hakim Abdurrab Khan, ‘Hindūstān kī Tabāhī ka Bā‘is’, *Rafīq al-Atībbā*, 16 October 1913, pp. 31-37.

<sup>585</sup> *Ibid.*, p. 31.

unani theory, from Galen to Ibn Sīnā, sexual intercourse was viewed primarily as a necessary function for the health of the individual. Corresponding to the pivotal concept of the maintenance of equilibrium (*i'tidāl*) between the hot and the cold, the dry and the wet, sex should neither be indulged in too frequently nor too little. There are no specific prescriptions, since the determination as to how often and how much depended on the individual's age, condition, temperament and habitation. In unani physiology, similar to ayurvedic conceptions, semen is the essence, *jauhar*, of the final 'cooking' (*tabkh*) of food in the body. The classical unani body transforms food into humours through four digestive processes, producing first *balgham* (phlegm), then *saudā* (black bile), *safrā* (yellow bile) and ultimately *damm* or *khūn* (blood). In line with classical unani physiology, Hakim Abd ul-Aziz Ajiz Bhusahi, whom we referred to above, states that semen is the essence of the fourth digestion,

[i]t is created from pure blood and in this pure blood of excellent quality, *rūh* [spirit, one of the fundamental components of the human body] is intermixed; it thus takes a lot of time and a great quantity of pure blood for semen to be produced, and a great quantity of *rūh* is used up.<sup>586</sup>

In classical unani theory *rūh* is described as 'the vapours of the blood; it is the name given to its subtle essence'.<sup>587</sup> In a comment that is revealing of the way that western technology was being woven into the fabric of unani knowledge in the twentieth century, Hakim Ferozuddin pointed out that the subtle vapours that are *rūh* can only be seen with a microscope.<sup>588</sup> Western medicine serves here to unveil the mysteries of humoral physiology; there is no attempt to place unani knowledge beyond and outside the frameworks of western medicine, there is no attempt to square their irreconcilable physiologies. The body remains a unani one, in constant flux and the site for the interplay of elemental forces and fluids. The loss of *rūh* results in the loss of the subtle, vital,

<sup>586</sup> Ajiz Bhusahi, 'Bīmāriyon', March 16 1912, p. 29.

<sup>587</sup> 'Rūh *khūn* ke *bukhārāt* aur uske *laṭīf jauhar ka nām hai*'. Nafīs ibn 'Awz, *Sharḥ al-Asbāb*, 867 Hijri, translated into Urdu by Hakim Muhammad Ayub Israili Aligarhi as *Tarjamah-yi Urdū Sharḥ-i Asbāb*, Lucknow: Naval Kishor, 1918, p. 146.

<sup>588</sup> Ferozuddin, 'Mardānah', 1 March 1912, p. 9: 'Rūh ek qism ke *bukhārāt* haiñ nihāyat laṭīf jo *khūrd binī quvvat ke ba-dūn dikhā'ī nahīn de sakte*'.



balanced body. Hakim Ferozuddin, following conventional unani theory, describes the concatenation of effects on the body that are brought about if semen is emitted too frequently:

If there is daily emission of semen then the *rūh* is dissipated; the organs of the body are prevented from fulfilling their functions, that is to say, the outgoings are great but what comes in is very little. The result is this, the stomach along with the heart, brain, kidneys, liver, tendons, muscles, veins, and blood etc. etc. all become weak.<sup>589</sup>

The relationship between *rūh*, semen and the fluid body reflects the conception of sex in unani *ṭibb* as primarily a matter of ‘corporeal economy’, a term which Thomas Laqueur, in his excellent history of masturbation in European culture, has used to describe very similar conceptions of the function of sex in Hippocratic and Galenic writings.<sup>590</sup> This current of thought prevailed in later elaborations of Galenic medicine, by Ibn Sīnā and so forth. By the early twentieth century, however, unani physicians had departed radically from their ancient authorities in their treatment of sex and health. In ways that paralleled the emerging view of masturbation as an act against nature in eighteenth-century Europe, traced in Laqueur’s recent study, the discussion of seminal emission takes on a moral dimension in early twentieth-century India. It was conventional among the ancient Greek and Perso-Arab authorities to discuss excessive or insufficient sex as two of the key causes of impotence and other sexual disorders among men, but now sodomy (*ighlām*, *ghilmān*, *livāṭat*), masturbation (*jalaq* or less commonly the Arabic *istimnā’ bi-al-yad*) and prostitution are subsumed within this discussion, and it is these aspects of male conduct that were principally thought by many unani practitioners to have been to blame for the crisis of ill-health in India. All of these activities shared the conceptual ground of ‘wasting’ (*zā’i’ karnā*) semen. But the problems that they were thought to bring about go far beyond this ‘economic’ element;

<sup>589</sup> *Ibid.*, 16 March 1912, p. 6: ‘Rozānah manī ka ikhrāj hotā hai rūh taḥlīl hotī hai. A ‘zā’-i badn kān karne se ghaṭe hain ya ‘nī khare bahut ziyādah hai aur āmad bahut kam. Natījah yeh hotā hai kih mi ‘dah ke sāth dil dimāgh girde, jigar, paṭhe, ‘aḳlāt, ragīn, khūn va ghairah va ghairah sab ke sab kamzor ho jate hain’.

<sup>590</sup> T. Laqueur, *Solitary Sex: A Cultural History of Masturbation*, New York, 2003, p. 84 f.

they are discussed in the language of criminality, as the violation of religious injunction (*sharī'ah*), nature (*fitrat*) and culture (*tahzīb*).

The historian Saleem Kidwai has argued that 'men engaging in same-sex sexual behaviour did not face legal prosecution in pre-British India', even though rulers such as Akbar disapproved of homosexuality.<sup>591</sup> As Scott Kugle has pointed out, the criminalisation of sodomy in India began with the legislation framed in part by Macaulay in the early nineteenth century.<sup>592</sup> Kugle has shown how the varying projections of the image of Mahmud of Ghazni in pre-colonial and colonial India, as homoerotic figure and later bellicose hero, reflect the changing attitudes among Persian and Urdu speaking elites to male-male intercourse. He argues that these elites, including such influential figures as the scholar and poet Hali, drew on 'less-than-dominant homophobic elements in the Islamic tradition' to castigate these forms of relationship as immoral and unnatural, as part of Islamic reform in the nineteenth century.<sup>593</sup> This was a post-1857 revisionist movement which aimed at breaking with the projected decadence of the courtly Persian past and returning to the 'pristine' Islam of Arabia, which we have referred to in the context of the treatment of women in the previous chapter.

The disjuncture in the discussion of sex and health that we see in unani medical discourse parallels these trends in Muslim elite culture, as practitioners sought to assert new forms of authority over the body. Ibn Sīnā's discussion of sodomy (*ghilmān*) in *al-Qānūn fī al-tibb* (c. 1000 C.E.) appears in a cursory comment at the end of the section on male sexual disorders. He does condemn it as 'disgusting and considered by everyone to be forbidden in *sharī'ah*', but he also writes that it can be less injurious in certain cases: 'It is less injurious if not much semen is ejaculated, as happens with women, and it leads one into a mode of non-vaginal intercourse'.<sup>594</sup> There is silence here on how homosexual acts/anal intercourse might affect the overall health of the body from a *tibbī* perspective, and this discussion is not incorporated into the main sections on male sexual disorders.

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<sup>591</sup> Quoted in Suparna Bhaskaran, 'The Politics of Penetration, Section 377 of the Indian Penal Code,' in Ruth Vanita (ed.), *Queering India: Same-Sex Love and Eroticism in Indian Culture and Society*, London, 2002, p. 19.

<sup>592</sup> Scott Kugle, 'Sultan Mahmud's Makeover: Colonial Homophobia and the Persian-Urdu Literary Tradition', in Ruth Vanita (ed.), *Queering*, pp. 30-46.

<sup>593</sup> *Ibid.*, pp. 37-38.

<sup>594</sup> Ibn Sīnā, *al-Qānūn fī al-tibb*, Bulaq, 1294, Book 2, p. 535: '*Inna al-manī lā yandīfiqu ma'ahu dafqan kathīran kamā yakūnu fī al-nisā fa-innahu aqallu dāraran wa yalīhi fī hikmat al-mubāshirati dūna al-farj*'.

Similarly, the influential unani text *Mizān al-tibb* of Muḥammad Akbar Arzānī (early eighteenth century), translated from Persian into Urdu at the turn of the twentieth century, only mentions that *ubnah* (passive sodomy) is also known as ‘old man’s sickness’ (*‘illat al-mashā’ikh*).<sup>595</sup> This ‘disease’ brings about ‘the itch’ (*khārish* or *chul*) and makes one want to have more intercourse, he wrote. Treatment for it included cupping (*tanqiyah*). The discussion of *ubna* was not incorporated into the main theme of the causes of impotence, which were lack of nourishment, the humoral imbalance of the semen and lack of sex.

Another authoritative unani work was the *Sharḥ al-asbāb* by Nafīs Ibn ‘Awz, a fifteenth-century commentary on Najīb al-Dīn Samārqandī’s *Asbāb wa ‘alamāt*. Two Urdu translations were done from the Arabic *Sharḥ al-asbāb* in the early twentieth century,<sup>596</sup> and alongside the *Mizān al-tibb* and the *Qānūn*, it was another key text in the curricula of many early twentieth-century unani institutions. In this text, any discussion of sodomy is entirely absent. Similarly masturbation does not feature in the main discussions of sexual health in these pre-nineteenth-century unani texts. Laqueur points out that Galen’s mentioning of masturbation occurs in the context of what to do with excess sperm: masturbation ‘offers one possible relatively safe and unengaging means to achieve an end’.<sup>597</sup> Prostitution is likewise not condemned as a moral vice in classical unani texts. Nafīs ibn ‘Awz wrote that the ascetic is prone to weakness through the accumulation of dryness due to abstinence. ‘[His] *nafs* (soul) does not want or think about sex. The thought that sex is bad affects his body, and ‘[the idea of] opening up his body, being naked and having intercourse with a prostitute appear as shameful to him’.<sup>598</sup> Although seeing that these activities might be shameful to a pious person, Nafīs ibn ‘Awz seems to be suggesting that these would nonetheless help him recover a healthy balance in his body.

<sup>595</sup> Hakim Akbar Arzani, *Mizān al-tibb Urdū*, Lahore, 1917, p. 106.

<sup>596</sup> Hakim Muhammad Kabiruddin, *Tarjamah Kabīr, ya ‘ni-tibb-i yūnānī kī sab se ‘aẓim ash-shān mashhūr wa ma‘rūf kitāb ‘Sharḥ Asbāb’ kā tarjama*, Lahore, 1916; Hakim Muhammad Ayub Israili Aligarhi, *Tarjamah-yi Urdū Sharḥ-i asbāb*, Lucknow, 1918.

<sup>597</sup> Laqueur, *Solitary*, p. 90.

<sup>598</sup> Nafīs ibn ‘Awz, *Tarjamah-yi Urdū Sharḥ al-asbāb*, Lucknow, 1918, p. 149: ‘*Jamā’ kī bahut burā kām samajhnā kih is khayāl se nafs muta’asṣar ho jāta hai aur badn ke khūlne aur barahnah hone aur mubāshirat fāḥishah se usko ḥayyā’ ā jātī hai*’.

In the early twentieth century, however, the proscriptions on sex were very different. The moral lapses that sodomy, masturbation and prostitution are seen to embody provide the paradigm to interpret the sense of crisis in society. As Hakim Abd ul-Aziz Bhusahi notes: 'It cannot be denied that there was sodomy, masturbation and other perversities in past times, but they were less [common]'.<sup>599</sup> And the reason for this was, according to the *hakīm*, that the severity of punishments ensured that this was so. This was wishful thinking, since both Kidwai and Kugle have established the marginality of injunction in Islamic culture against same-sex intercourse. Neither Hakim Abd ul-Aziz 'Ajaz Bhusahi nor Ferozuddin wished in any case to launch into legal debate: the business of *Rafīq al-Aṭibbā* was rather to promote, in Abd ul-Aziz Bhusahi's words the preservation of health (*hiḡzān-i siḡhat*) and curative approaches. Both *hakīms* sought to explain the deleterious consequences that these activities could have on the body, apart from providing the example of Lot (according to Islamic traditions sent as a prophet to the city of Sodom, and from whom one of the words for sodomy in Arabic, Persian and Urdu – *livāṭat* – is derived) to illustrate God's wrath at licentiousness and a particular kind of sexual relationship. And the consequences of this same-sex relationship were many; we will only deal with a selection here to illustrate how their arguments were framed.

We noted above that according to classical unani theory excessive sex led to the diminution of *rūḡ*; sodomy and masturbation are subsumed within this argument, reducing longevity and producing illness: 'Especially through the wrong kind of sex and sex in the wrong place a great quantity of semen is demanded, and by force of its being misplaced a great amount of *rūḡ* is dissipated, and they become tortured with chronic sickness'.<sup>600</sup> The unnaturalness of these activities, captured in the frequently used terms *ghair ṭab 'i/fitrī/fitrat* ('against nature'), is emphasised throughout both accounts, although, as far as I am able to determine, such a concept is absent in pre-nineteenth-century *ṭibb*. Part of the reasoning was derived from the natural philosophy dimension of

<sup>599</sup> Ajiz Bhusahi, 'Bīmāriyon', March 16 1912, p. 29: 'Is se to inkār nahīḡ hai kih avval zamānah meḡ kabhī zinā o livāṭat o jalaq va ghairah favāḡhishāt kā vuqū' huwā hī nahīḡ, vuqū' to zarūr huwā magar qillat ke sāth'.

<sup>600</sup> Ajiz Bhusahi, 'Bīmāriyon', June 16 1912, p. 15: 'ṡuḡbat bi-l-khuṡūṡ khilāf-i vaṡ' o khilāf-i madkhal se manī ke ziyādah kharc hone aur be mauqi' ke jābirānah zūr paṡne se rūḡ ziyādah taḡlīl hoī hai, jis se 'umraiḡ kam ho jāī hai, aur insān be basī ke sāth davāman amrāṡ ke shikanje meḡ kitnā rahtā hai'.

unani *tibb* in which humans are the apogee of the hierarchy of beings, ‘*ashraf al-makhlūqāt*’, (the most noble of created life). Thus Hakim Abd ul-Aziz Bhusahi argued that people who engaged in same-sex sexual acts were no longer worthy of this title; indeed, they were baser than animals and beasts, since even they did not practice such ‘unnatural behaviour’.<sup>601</sup> Those people that do merited the highest contempt. It was ‘against nature for all [beings] with *rūḥ* to indulge in these activities since the ‘anus was designed in order to excrete waste’. Semen in the anus, argued Hakim Abd ul-Aziz Bhusahi, gives rise to worms (*kere*), making that person want to be entered again [*maf’ūl* is used for the passive partner, in distinction to *fā’il*, the active partner] and ‘causes all manner of diseases of the intestines’.<sup>602</sup> The elements water and air become putrefied through contact, causing ‘epidemics like cholera, malaria and plague’.<sup>603</sup> ‘Gonorrhoea’ (*sauzāk*) is thought to be caused through the irritation of the skin of the penis.<sup>604</sup> Madness and derangement could also be the outcome: ‘Unnatural entry also prevents the excitement of desire, which certainly in many cases affects the heart and brings about melancholy, madness (*junūn*) giddiness (*davvār*), cholera and other afflictions’.<sup>605</sup>

Masturbation in early twentieth-century unani *tibb* was associated with weak memory, weak nerves and heart, blackouts, lassitude, constipation and thinness, all aspects of the breakdown of the body’s major organs. It was especially associated with youth, and although it was acknowledged that young women might indulge in this, it was viewed essentially as a male problem. Censure of masturbation was evident in such authoritative works on correct comportment as *al-Huqūq wa al-Farā’iz*, by the distinguished scholar and reformer Nazir Ahmed. In 1906 he wrote that ‘before marriage one shouldn’t engage the genitalia’.<sup>606</sup> Among them masturbation and sodomy (*livāṭat*) totally violate one’s honour’.<sup>607</sup> Such was the concern with masturbation and same-sex intercourse among boys that the All India Vedic and Unani Tibbi Conference, the largest

<sup>601</sup> *Ibid.*, 16 March 1912, p. 30.

<sup>602</sup> *Ibid.* 16 June 1912, p. 15.

<sup>603</sup> *Ibid.*

<sup>604</sup> *Ibid.*; Hakim Ferozuddin, ‘Mardānah’, 16 March 1912, p. 8.

<sup>605</sup> Ajiz Bhusahi, ‘Bīmāriyon’, 16 June 1912, p. 16: ‘*Ghair tab’ī dukhūl se haijān shahvat ruk jātī hai jis se aksar tabāk-i qalb - mālikhūliyyā, junūn, davvār, haizah va ghairah ‘avāriḥ kā paidā ho jānā zarūr hai’.*

<sup>606</sup> Here the word *sharmgāh* (‘place of shame’), a common word for genitalia in Urdu, conveys the shame associated with sexuality. It equates to pudendum, although it can refer, as it does here, to men’s genitalia as well as women’s.

<sup>607</sup> Hafiz Muhammad Nazir Ahmed, *al-Huqūq wa al-Farā’iz*, part 3, Delhi 1324 Hijri (1906), p. 248.

forum for unani practitioners in India, drew attention to it as a ‘national’ problem. The participants, *hakims* and *vaid*s, (revealing that this way of thinking about the ailing body and the ailing society was not restricted to practitioners of unani *tibb*, but was also shared to some extent by practitioners of ayurveda), passed resolutions to spread awareness among the public of the dangers of the ‘abuses done to oneself and in secret’.<sup>608</sup> It was to publish pamphlets ‘in all the languages [of India]’, to be distributed to boarding houses and all community educational establishments spelling out that

One should consider it as an essential duty to spare one’s children from the terrible ruination [caused by self-abuse] (the results of which cause them distress and affliction for the rest of their lives like nothing else can), out of human sympathy and for the love of the nation (*vaṭan*).<sup>609</sup>

These pamphlets had been written but not yet published in 1911 and were to be distributed free of charge.<sup>610</sup> Hakim Ferozuddin had been responsible for the production of the pamphlet and offered financial assistance for its publication and distribution, evidently reflecting on the recognition in unani circles that he was an authority on these matters.<sup>611</sup> He was also willing to distribute, similarly for free, another journal published by his company, *Risālah Hayāt Jāvīd*, which was effectively a product brochure with testimonies as to the effectiveness of his medicines. His dispensary and manufacturing base, Cashmah-yi *Ṣiḥat*, therefore potentially stood to gain from the publicity surrounding the publication of the pamphlet, since the products associated with *Hayāt Jāvīd* were especially for restoring the body’s powers. But it would be cynical and misplaced to assume that Ferozuddin’s concern with male sexual ‘disorders’ was solely based on commercial considerations.

<sup>608</sup> Man Singh Vaid, ‘Dasveṅ Sālānah Rīpoṛṭ’ [10<sup>th</sup> Annual Report], in *Āl Inḍīa Vaidik aind’ Yūnānī Ṭibbī Kānfarans ka Dasveṅ Sālānah Ijlās ki Ruidād* (10, 11, 12 February 1921, Delhi), Delhi, 1921, p. 29: ‘*mukhfi aur khūd kardah kharābiyon*’.

<sup>609</sup> *Ibid.*: ‘*In aghrāz se apne baccon ko khaufnāk tabāhī se (jis ke natā’ij un ke li’e tamām ‘umr kī peshānī aur soguwārī ke sivā kuch nahīn ho sakte) bacāna insānī hamdardī aur vaṭan kī muḥibbat ke liḥāz se apnā ek zārūrī farz khayāl karte haiṅ*’.

<sup>610</sup> Ferozuddin, ‘*Mardana*’, 1 February 1912, p. 6.

<sup>611</sup> *Ibid.*

### III. Weakness and Patient – Practitioner Exchanges

Unani journal literature allows us to see that weakness and male sexuality were not just a concern from the practitioners' perspective. We are not dealing here only with the prerogatives of an elite practitioner discourse. Through the question and answer columns in *Raḥīq al-ʿAṭibbā*, *al-Ḥakīm* and *al-Masīh*, for instance, it becomes evident that concern about the immorality of solitary sex or same-sex sex, and the medical implications of these acts, was widespread in urban literate society, the principal readership of these journals.

Prior to the twentieth century the predominant form of interaction between the practitioner of unani medicine and the patient was face-to-face, either at the *ḥakīm*'s dispensary or in the patient's own home. The emergence of the unani medical journal however meant that the consultation and suggestions for treatment could now happen over distance. Not being able to physically observe the patient, read the pulse, examine urine and stool, which were the mainstays of unani diagnosis, the *ḥakīm*, in the context of the journals, now had to rely on the patient's account of their illness. The patients, or those enquiring on their behalf, for their part, were required to articulate their understanding of bodily disorder. Guidelines for the enquiry were often given in the journal. For example, an editorial note frequently accompanies the question-answer section in the *Raḥīq al-ʿAṭibbā* which states that the patient must include in their enquiry a description of the symptoms, duration of the illness, the designation of the patient's temperament and whether previous medical attention had been sought. Patients were therefore required to think in certain ways about illness and their bodies.

The majority of questions were of a medical nature. Most enquirers were lay people asking for prescriptions to treat a particular illness, afflicting either themselves or someone close to them. The most common term used to describe the person who needed help is *marīz* ('sick person'), the Urdu word for patient, which indicates that this person was submitting to the authority of the practitioner to deal with his or her problem. Fortunately for our analysis, this word is marked for gender, so we can see the proportion of female patients who are enquired about, although whether the enquirer was female,

which would be interesting to know and presumably rather rare at this time, is not indicated. *Rafiq al-Aṭibbā* was a bi-monthly; patients would read or learn of the responses to their query within three weeks, and within five weeks for enquiries to *al-Ḥakīm*, a monthly. This delay meant that people could not enquire about severe illnesses, which led the editor of *al-Ḥakīm* to state that questions about these conditions should not be posed in the journal's columns. A very high number of enquiries, to both journals, were for chronic conditions which had, according to the patients' accounts, usually lasted several years.

Interspersed among questions posed by the subscribers of these journals, encompassing a variety of interests – the identification of certain plants, the right ingredients for certain prescriptions, recommendations of unani and ayurvedic books and so forth – are questions about specific problems and illnesses, commonly: colds, fevers, pains, swellings, injuries, headaches, respiratory problems, eye problems and stomach trouble; in short the common minor or chronic ailments of daily life. Statistically more common than any of these individual complaints, however, are issues of sexual conduct and anxieties over its implications. In samples from *Rafiq al-Aṭibbā* in 1912, spanning the cold and dry, hot and wet seasons in Lahore, questions on weakness and sex accounted for between 17% and 42% of the total number of enquiries about specific ailments.<sup>612</sup> So common were they in fact that in 1912 one practitioner responding to a patient's request, said that readers should pay more attention to the hundreds of prescriptions that had already been published by the journal, and should stop wasting their time. Another respondent, interestingly an ayurvedic practitioner – suggesting that there was more interaction and overlap between *vaid*s and *hakīm*s at this time than has so far been recognised in writings on indigenous medicine in India – Karam Chand Vaid commented that given the number of requests of this nature it would be better to establish a set of prescriptions that could be recommended in each case.<sup>613</sup> This never happened, to my knowledge. A regular contributor to the journal, Hakim Muhammad Shams ul-Haq

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<sup>612</sup> *Istifsārāt* ['Questions'], *Rafiq al-Aṭibbā*, February 1 1912, pp. 40-42: Questions 84-124, total enquiries about specific complaints: 16, enquiries about sex/weakness: 6; *Istifsārāt*, June 1 1912, pp. 42-43: Questions 368-393, total enquiries about specific complaints: 17, enquiries about sex/weakness: 3; *Istifsārāt*, October 1 1912, pp. 40-41: Questions 600-620, total enquiries about specific complaints: 12, enquiries about sex/weakness: 5.

<sup>613</sup> *al-Ḥakīm*, December 1928, enquiry number 65, p. 42.



Amritsari, pointed out: ‘Every day [news of] this villainous (*kambakht*) deed reaches [*al-Ḥakīm*], and *al-Ḥakīm* has already published hundreds of prescriptions given by the noble physicians’.<sup>614</sup> We can see how widespread was a common set of ideas about the physical consequences of masturbation and same-sex intercourse in the way that people framed their complaints in the enquiry section of the journals. We can take the case of one reader requesting *ḥakīms* for a prescription for a ‘friend’ of his, a ‘poor and wretched 18 year old Muslim’ boy who had fallen into the habit of masturbation and sodomy from the age of 12. Six months previously, the narrative continues, he renounced these practices, but his health had been deteriorating. In addition to involuntary emissions and premature ejaculation, ‘his heart keeps sinking, his head aches, his eyesight is failing, his mind and memory have got weaker; sometimes his head spins and he blacks out...his semen is thin, his hair has begun to fall out, all of which is making him extremely anxious’.<sup>615</sup> Another enquirer commented on how he ‘was paying the price [*bhāgat rahā hai*] for his deeds’: he felt ‘withered to the bone’ [*sūkh kar kāntā ho gayā hai*], an expression alluding to the unani theory mentioned above of the body deprived of spirit (*rūḥ*) moisture [*ruṭūbat*] through excessive semen loss.<sup>616</sup> A similar account was given by a 24 year old, who attributes his weakness again to masturbation, anal intercourse, his ‘voluptuous lifestyle’. Apart from the usual weaknesses, he stressed that he could no longer even digest milk (which would have formed an important part of a fortifying diet for sexual problems).<sup>617</sup> Accounts of this nature continued to be prominent over subsequent decades. *Al-Hakim*, the successor journal to *Rafīq al-Aṭibbā*, continued to carry the pleas for treatment for these conditions from a wide section of male readers, after the death of its founding editor, Hakim Ferozuddin in 1921. A nineteen year old wrote in the January 1922 edition that he had been suffering for two years as a result of a ‘bad habit’ and *ighlām*, [anal intercourse]. He emphasised his body’s sexual dysfunctions, *kamzorī* [weakness] and his thinness.<sup>618</sup>

A thirty-eight year old man admitted that in his childhood [*bacpan*] he had ‘suffered from bad habits [*bad ‘ādāt*] and had excessive...[eliptically, ‘intercourse’] after

<sup>614</sup> *al-Ḥakīm*, March 1922, reply to enquiry number 69, p. 29.

<sup>615</sup> *Rafīq al-Aṭibbā*, 1 October 1912: enquiry number 200, p. 40.

<sup>616</sup> *Rafīq al-Aṭibbā*, 1 February 1912: enquiry number 109, pp. 41-42.

<sup>617</sup> *Rafīq al-Aṭibbā*, 16 July 1913: enquiry number 312, p. 42.

<sup>618</sup> *al-Ḥakīm*, January 1922: enquiry number 23, p. 30.

marriage'. He enumerated the damage wrought to his entire body from the catch-all phrase 'bad habits', in particular the weakness of the 'major organs' [*a'zā-yi ra'īsiyah*]: his brain, heart and liver. Noteworthy is his familiarity with this technical unani language to capture systemic effects. Although he commented that he had received treatment for the 'diseases' that emerged after his sexual activities, he still considered this aspect of his history to be pathologically relevant to the conditions from which he had been suffering at the time of writing, many years after the event.<sup>619</sup> Throughout these examples we see how closely the popular view parallels the expert's views of the long-term impact of these transgressions. Although youth may have been targeted as the group most at risk, these ideas had evidently become embedded in a broader section of society.

The question and answer columns of the journals proved immensely popular. By 1928 *al-Ḥakīm* was publishing as many as 170 questions per issue – the December 1922 edition carried 172, and the editor noted that due to this popularity extra space was to be devoted to this column. Masturbation and anal intercourse continued to be widely discussed. Unani *ḥakīms* were evidently popularly perceived to possess authoritative knowledge about these ailments and treatment for them. Moreover, the journal represented a unique and important forum for these issues to be aired and discussed, since anonymity could be maintained. The responses of practitioners to these enquiries in the 1910s and 1920s underline the demand they were in, and at the same time reveal that there was no single approach to dealing with the 'disorders' themselves and their effects. This illustrates the diversity of unani practices. Some *ḥakīms* suggested straightforward herbal remedies without any further discussion, recommending either their own prescriptions or '*Hayāt Jāvīd nambar 4*', a product of the dispensary and manufacturing base connected with the journal, which we will discuss further below. Thus for the treatment of the man who had 'withered away', Hakim Rehmatullah suggested the above product, in addition to *itrifal kashnīzī* (a preparation based on the three fruits of the myrobalan family, with coriander), *ṭilā shangraftī* (an ointment based on cinnabar (mercury sulphide) and a powder (*sufūf*) of his own recipe to be mixed with milk. The powder contained salep (*sal'ab miṣrī*), a botanical that occurs in many prescriptions for male sexual complaints.

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<sup>619</sup> *al-Ḥakīm*, February 1922, p. 32.

Other respondents took a different approach entirely. Hakim Asim Vasim, a regular contributor to *al-Ḥakīm* and the question and answer column, responded to the plea from the nineteen year old boy by first of all expressing his regret and contempt: 'I am very sorry that you are guilty [*murtakab*] of this vile act; I find it surprising that there was not a greater punishment [*sazā*] in store for you'.<sup>620</sup> For this *hakīm* the crime of the act did not square with the bodily disorders it brought about. In his view the jurisdiction to deal with act spanned the physical and the spiritual. The first advice he gave was that the boy go to a saint (*ḥazrat*) and repent from the depths of his heart. It was only after this act of piety that the *hakīm*'s treatment could be effective, although the prescription that follows is suggestive, in its unusual composition and where they should be found, of the disturbing and extraordinary nature of the 'crime':

[Then make the following ointment to be applied to the penis]: seven large leeches should be put on the testicles of a young donkey. When one has drunk the blood, it should be given to the next, and heat [the blood] in a seer of jasmine oil. Then take the residue and mix it with two hundred redheaded ants collected from a graveyard...<sup>621</sup>

Another *hakīm*, again a reputable and regular contributor, Hakim Shamsulhaq Amritsari, responded to a request for a charm (*ta'vīz*) to restore sexual powers with a magic square as well as a herbal treatment.<sup>622</sup> For some *hakīms* then, and also significantly in the minds of some 'patients', acts of sodomy and masturbation were immoral acts somatised and therefore amenable to their intervention. For others they transgressed the threshold of the physical world, the realm of authority of the *hakīm* over the 'knowledge of bodies' (*ilm al-abdān*) and into domain of the spiritual world of the 'knowledge of spiritual matters' (*ilm al-adyān*). Still other *hakīms* bridged these worlds, the natural and the supernatural, and indeed may not have recognised them as being two separate worlds at all, a subject we return to below. By entering the world of practice

<sup>620</sup> *al-Ḥakīm*, February 1922, p. 28: 'Afsos ṣadā afsosis qabīḥ fi'l kā murtakab agar aisī kiyā us se bhī ziyādah sazā nah pāve to yehī ta'ajjub hai'.

<sup>621</sup> *Ibid.*: 'Ek javān gadhe ke kḥaṣiyyah meṅ barī barī sāt jonkain lagā'i jāven jab yeh kḥūn pī kar agar ho jāven tab unko ādh sīr roghan-i canbilī meṅ jalā kar roghan ko chān leṅ phir is meṅ qabristān ke surkh munh vāle '••' adad bare ciyūnte dāl kar ...'.

<sup>622</sup> *al-Ḥakīm*, January 1922: enquiry 51, p. 29; February 1922: response 51, p. 31.

through journal literature we are afforded an insight into the heterogeneity of approaches in *ṭibb*, its blurred boundaries with other healing traditions: the absence of ‘system’ in the practice of unani *ṭibb*.

The journal literature reveals that far from being hushed up, masturbation and homosexuality were openly discussed, despite the contempt with which they were regarded in early twentieth-century literate society. It is certainly the case that ‘patients’ presented themselves in person to clinics, since they occasionally reveal that they had sought help prior to approaching the journal. Nevertheless, the number of enquiries of this nature suggest that the journals provided a particularly useful medium through which these ‘patients’ could communicate with a number of reputable *ḥakīms* without having to compromise their identity. The ‘patient’ could maintain anonymity and did not risk defamation in a society where homosexual acts were evidently stigmatised.

We have established then that in the realm of sexual medicine unani conceptions in the early twentieth century drew on those of the classical texts, and yet dovetailed with them in significant ways as new categories of illness were introduced, entailing various approaches to treatment. We should reiterate that we are dealing with the reinvention of elite unani practice. The reworking of ancient unani theories of sexual health for the twentieth century that we have discussed here had been absorbed into influential mainstream unani thought and practice. While it has not been possible to date when this discourse on sexual deviance and weakness emerged in unani *ṭibb*, as Thomas Laqueur does for masturbation when he points to the tract ‘*Onania: or the Heinous Sin of Self Pollution, and all its Frightful Consequences...*’ published around 1712, it is clear that such ideas were pervasive in early twentieth-century *ṭibb*, and among an urban literate public. It is likely that the ultimate provenance of the vilification of masturbation was British medico-morality. If this is the case, then it is particularly striking how unani *ḥakīms* managed to give it authenticity as unani knowledge. In any case, this chapter shows that the *ḥakīm* was considered an authority for these and related conditions. In India, as we have seen, discourse on deviance and weakness became overlaid onto a rhetoric of decline: moral, physical and juridical, acquiring in the process a particular resonance as a colonial condition. Both masturbation and sodomy could be denounced within the context of personal ethics developed within Islamic reform movements of the

late nineteenth century. As we have seen in the chapter on women, what one did at home and one's individual responsibility became of great concern to reformers, as they sought to change people from the inside out. Perhaps just as effectively *ṭabībs* managed to reach deep into the intimate spheres of people's lives, dissolving a distinction between the private and the public.

#### IV. Magical Medicine in the Journal

The concentration in the historiography of unani *ṭibb* on the contestation of the power of western discourses of science and surgery in the revival of unani *ṭibb* has tended to occlude the interface between so-called learned and popular culture practices. Throughout this thesis we have been concerned with challenging the notion of 'system' as it has been applied to unani medicine. In an essay in *Asian Medical Systems*, Charles Leslie has suggested that unani medicine was going through a process of secularisation spurred by the unani revivalism of the early twentieth-century.<sup>623</sup> This has some validity to some extent in relation to Ajmal Khan and other reformers, unani and ayurvedic,<sup>624</sup> were keen to establish classically based indigenous medicine as a learned discipline to be distinguished from folk medicine, but it facilitates a simplistic dichotomy between 'learned' and 'folk' medicine. The question and answer sections of the journals allow one to see rather the complexity of practice at this time. They take one into the actual interaction of patient and practitioner where boundaries between secular, religious and magical practices were blurred, even among the learned stratum of practitioners.

Charms, amulets and talismans were widely used by many sections of the public to ward off ailments and to try to alter the course of events. Their popularity is present as a common element in the names of products and prescriptions, such as *Ṭilism-i Shifā* ('talisman of the cure'), a prescription well-known in the Punjab, and possibly elsewhere,

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<sup>623</sup> C. Leslie, 'The Ambiguities of Medical Revivalism in Modern India', in C. Leslie (ed.), *Asian Medical Systems*, Delhi, 1998, p. 359.

<sup>624</sup> K.N. Pannikar points out this development in the activities of the famous Keralan vaid P.S. Variar, in *Culture, Ideology, Hegemony: Intellectuals, and Social Consciousness in Colonial India*, New Delhi, 1998.

that was understood to be effective for 150 ailments,<sup>625</sup> or *Zinda Tīlasmāt* ('living talismans'), a product of a *khāndānī* (hereditary) practice Hyderabad Deccan that continues to be produced today. The popularity of magical healing is also attested by Maulana Ashraf Ali Thanavi's *Bihishtī Zavar*, which includes prescriptions for the making of amulets and talismans alongside a discussion of hygiene and unani therapeutics, in spite of the fact that he disapproved of them as an un-Islamic accretion.<sup>626</sup>

In both *Rafīq al-Aṭibbā* and *al-Hakīm* we come across requests for the correct charms to be used for particular purposes. In one example, a man wished to end the illicit relationship his mother was having with another man after her husband had died. He requested the *hakīms* for a recipe for a *ta'vīz*, an object, such as a piece of paper or a stone, on which potent wording would be inscribed that endowed it with magical powers. Again the responses from various *hakīms* are interesting for the light they throw on the realm of competence of the *hakīm*. One suggested that the man go to visit certain Deobandi *'ulamā*, another stressed that widow remarriage was permitted for a young woman in Islamic law and that this would be the obvious solution, by legitimising the relationship. One Hakim Zahid Ali Khan did provide the prescription the enquirer wished for, an incantation to be recited. This example shows us the multiplicity of standpoints that *hakīms* adopted. Some of the respondents saw the solution to this problem in terms of redefining social relations. The recommendation to consult the religious scholars of Deoband remains obscure; we do not know whether they were to provide a prescription or give a judgement in accordance with Islamic law. But one *hakīm* did see this as belonging to the realm that he had competence to deal with.

In another enquiry, to *Rafīq al-Aṭibbā*, one Sayyid Imtiaz Ali asked how to tell the difference between a bodily illness or the effect of various forms of magical force – evil spirit (*āsīb*), magic / sorcery (*sihr*), deity (*dīu*), witch (*churail*), a malevolent fairy (*perī*)<sup>627</sup> and jinn – and if there were any tried and tested (note the same wording as for tested medicines, *mujarrab*) prayer or *ta'vīz*.<sup>628</sup> An interesting and revealing question, which provokes two very different responses from two well-established *hakīms* of the

<sup>625</sup> *al-Hakīm*, January 1922, p. 30, enquiry number 29.

<sup>626</sup> Ashraf Ali Thanavi, *Bihishtī Zavar Mukammal wa Mudallal*, Delhi, 1344 Hijri, pp. 313-320.

<sup>627</sup> Or the ghost of a woman who died in childbirth.

<sup>628</sup> *Rafīq al-Aṭibbā*, 16 February 1913, p. 43, enquiry number 115.

journal. One of the respondents, Hakim Muhammad Chiragh Philori contributed a number of learned articles to the journals, on diseases of the heart and children's diseases, for example.<sup>629</sup> He was born in 1874 of a *sharīf* background descended from the Lodhi dynasty.<sup>630</sup> He learnt English at school in Jalandhar, alongside an Islamic education, and studies in mysticism (*taṣawwuf*) and *ṭibb* with Hakim Maulvi Ghulam Rasul and Hakim Muhammad Bakhsh, in whose dispensary he worked. This biographical account in *Rumūz al-ʿAṭibbā*, points out that Hakim Chiragh had benefited from learning prescriptions from ascetics (*sānyāsīs* and *faqīrs*), who were renowned both for their knowledge of herbal remedies, as well as supernatural healing. Hakim Muhammad Chiragh Philori starts his lengthy reply by describing the effect of *siḥr* (magic):

Day by day the one stricken [*zādah*] by sorcery becomes thinner and restless, he will take aversion to his wife, son and everybody, to food and drink and talking; he will sleep little, and become fearful; some will have headaches and diarrhoea. In order to get to know the condition of the sick person ...<sup>631</sup>

We are still dealing with a 'sick person' [*marīz*], and we can see in this account the *ḥakīm*'s attention to symptomology, as one would find with the description of the '*alāmāt*, the signs, of a person affected by bodily imbalances or a disease. Indeed, the same word is used for the indications of both illness and magic. Hakim Chiragh Philori describes two procedures to determine the natural or supernatural causes. One of them involves taking a length of unbleached cloth and inscribing it with a *naqsh*. *Naqsh* is a common term for a magic square, based on the power of numbers derived from the *abjad* system of ascribing numerical values to letters of the Arabic alphabet.<sup>632</sup> One of the most common forms of magic square is the following arrangement, whose numerical values add up to 15 in each direction:

<sup>629</sup> *al-Ḥakīm*, November 1921, p. 15; December 1922, p. 15.

<sup>630</sup> Ferozuddin. *Rumūz al-ʿAṭibbā*, vol. 1 (1913), p. 459.

<sup>631</sup> *Ibid.*, 16 March 1913, p. 43, reply 115.

<sup>632</sup> *Encyclopedia of Islam, new edition, supplement*, fascicules 3-4, Leiden, 1981, p. 97.

6	1	8
7	5	3
2	9	4

Corresponding to the Arabic:

٦	١	٨
٧	٥	٣
٢	٩	٤

This square has a long history as a talisman in Perso-Arabic magic and mysticism, sometimes known by the term *budūh*, and has been used as a fertility charm.<sup>633</sup> This talisman is mentioned in the *Bihishtī Zavar* for repelling evil spirits.<sup>634</sup> The magic square given in the *hakīm*'s reply in the journal is a more complex arrangement, with 16 three-digit numbers arranged four by four. Having inscribed the cloth with this talisman it was to be lowered over the patient seven times and then placed in a roaring fire. If the letters appeared white then the cause was sorcery, if they were red it was possession by a witch, if no lettering appeared it was possession by a malevolent fairy, while if the lettering was black then the sickness was bodily. Depending on the affliction, the *hakīm* prescribes various *ta'vīz* and charms ('*amaliyāt*'), the recitation of verses and chapters of the *Qur'ān*, such as the *fātiḥa* (the opening verses of the *Qur'ān*), or forty verses with each couplet beginning with the letter *kāf* (*chal kāf*) and the sayings of saint, Hazrat Shah Muhiuddin Abdul Qadir Jilani. One such prescription is good against demons, jinn and epidemic disease (*vabā*), which reveals that, perhaps with epidemic disease, in particular (and madness, as we will see below), the boundaries between natural and demonic causation were fluid. We should remember that we are not dealing with a *hakīm* on the fringes of unani practice. He was an established practitioner of *ṭibb* who was evidently

<sup>633</sup> *Ibid.*, p. 153: '*budūh*'.

<sup>634</sup> Thanavi, *Bihishtī*, p. 316.



knowledgeable in various healing traditions, and the particular contexts of his clinical practice would have determined his approach to treatment.

The other respondent to the enquiry above, again a regular contributor to the journal, had a slightly different take on magic. Hakim Muhammad Ibrahim Amritsari begins with some Arabic: *al-nujūmu siḥrun wa al-sāḥiru kāfirun*, ‘the stars [i.e. astrology] are sorcery and the sorcerer is an infidel’. He then reprimands the Sayyid (one who claims descent from the Prophet), ‘Sayyid Sahib, have you not read in the *Qur’ān* that sorcery is true but the sorcerer is an infidel’. Jinn are mentioned in the *Qur’ān*, but they themselves submit to God’s authority.<sup>635</sup> Go to a *ḥakīm*, he advises, in whose practical formation is the ability to distinguish magic from illness (*bīmārī*). But as for exorcism, for this *ḥakīm* there is no question of amulets or any other kind of charm, only recitation of the *Qur’ān* can achieve exorcism. He considers the prayer against madness (*maraz sauda*, which is linked to melancholy, under the influence of the black bile humour in classical unani theory) to be equally effective against sorcery.

Questions about magic and prescriptions of *ta’vīz*, magic squares and talismans are by no means infrequent in this section of the journals, even though this subject is never taken up in the main sections. It is only in the patient – practitioner exchanges that it comes to light. It is not surprising that the preparation of talismans and kindred items is not singled out for attention in the columns of the journals. *Rafīq al-Aṭibbā* and *al-Ḥakīm* were prestigious organs of unani thought that were focusing on the herbal and mineral medical traditions of unani medicine, supplemented with references to medical and cultural authorities: the ancient Greek and Perso-Arab physicians, as well as the *Qur’ān* and *ḥadīth*. There was clearly an effort to define the main parameters of what constituted unani practice. At the same time, I have shown that in relations with the public in practice, the journal brought into play a number of voices, where even the same individual could on one occasion make a solid argument based on the classical unani principles of natural causation, and then in another context demonstrate his familiarity with occult traditions of healing. Clearly the complexity of unani medicine needs to be recognised, and it cannot be captured by straightforward dichotomies, such as reformist –

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<sup>635</sup> Surah 72, the Jinn, A. Arberry, *The Koran*.

purist, secular – magico-religious. In the domain of practice the journal still accommodated and mediated the commensurability of magic and medicine.

## V. Marketing Medicines

Given that Hakim Ferozuddin, the editor of *Rafiq al-Aṭibbā* and founder of *al-Hakīm*, claimed hereditary specialisation in sexual medicine, it is no surprise that one of his most popular products between the 1910s and 1930s was designed to rid the body of weakness. *Rafiq-i Badn Hayāt Jāvīd nambaṛ 4* ('the body's companion – eternal life number 4') was also one of his best marketed products. In addition to his editorial activities, Ferozuddin was also the proprietor of Davākhānah Cashmah-yi Şihat (the dispensary and factory) and a publishing house Dār al-Kutub Rafiq al-Aṭibbā. This was an effective power base from which to propagate unani knowledge and practice through print and commodity. On the one hand, the distribution of journals and the sale of books and on the other the promotion and sale of products were mutually reinforcing in achieving prominence in the public domain. Analysing the advertisements and product endorsements in this journal reveals much about the relationships that learned unani practitioners were trying to establish with their clients/patients in the early twentieth-century and how this particular leading unani enterprise sought to promote its operations in a competitive market.

In promoting *Rafiq-i Badn* as a medicine to correct male sexual disorders and bodily weakness, the advert carried in *Rafiq al-Aṭibbā* emphasises the aesthetic dimension to the perception of bodily strength: 'Eat and become healthy and fat!' it declares. The text continues 'The special quality of this medicine, and it is a great quality, is that hundreds of thin and feeble men have taken this with seers of milk and a few spoons of butter, and they became fat and revived to a state of blooming health and

strength'.<sup>636</sup> As we have seen above in our discussion of male sexual disorders body-weight was one of the indicators of virility. Thinness could imply impotence, the guilt and shame of degenerate conduct. The aesthetic mirrors both somatic and moral 'health'. The advert uses the technical term for the major organs [*a'zā ra'isiyyah*] of the unani body: the brain liver and heart. It claims to condition the stomach and bladder, eliminate constipation and to halt involuntary seminal emissions. It is in fact geared towards treating the by now very familiar conditions brought on by the illicit acts we have described in detail above.

We have to appreciate the over-determined message that the journal makes to the reading public: we know about your conditions, why they have come about, and we have the expertise to treat you. That this medicine should be taken with milk and butter or ghee, is significant for the properties that milk and ghee were widely thought to have in India. Joseph Alter's study of wrestling culture in north India has shown how conceptions of health in the male body were fused with understandings of a nourishing diet of milk and ghee and the control of seminal fluid.<sup>637</sup> With the unani product *Rafiq-i Badn*, the advert is drawing on these configurations of body size, power, control and diet. Joseph Alter explains the relationship between milk, ghee and sexual strength with reference to the three qualities (*gūnas*) of ayurveda, also found in folk concepts of bodily and mental health: *sattvā* (clarity, calmness, 'wheat' complexion), *rajas* (passion and aggression) and *tamas* (dullness, lethargy, darkness).<sup>638</sup> He comments that 'milk and ghi in particular are thought to digest smoothly into blood and semen'.<sup>639</sup> The 'unani' advert reflects how ayurvedic and unani *ṭibb* could occupy a polysemous and overlapping space in popular views of aesthetics and strength; a fact that questions the accuracy of a picture of discrete medical systems – ayurveda, unani, folk – when from this local perspective of medical practice in Lahore so much is shared by a common culture. As Arthur Kleinmann has

<sup>636</sup> *Rafiq al-Ṭibbā*, 1 October 1912, p. 23: '*Khao aur moṭe aur tandurust bano! Is davā kī yeh khāṣiyat hai aur bahut barī khāṣiyat hai kih siron dūdh aur ka'i chaṭnāk makkān rozāna haṣm kar letī hai, saīnkaron lāghir aur kamzor ādmī isse khā kar moṭe tāze, surkh aur safīd aur qavvī ban cūke haiṅ*'.

<sup>637</sup> Joseph S. Alter. 'The Celibate Wrestler: Sexual Chaos, Embodied Balance and Competitive Politics in North India', in Patricia Uberoi (ed.), *Social Reform, Sexuality and the State*, New Delhi, 1996, pp. 109-131.

<sup>638</sup> *Ibid.* p. 115 f.; Cf. The three *gūnas* of Saṃkhyā philosophy, B. Walker, *The Hindu World*, London, 1968, p. 264.

<sup>639</sup> Alter, 'Celibate', p. 115.

argued, the practice of medicine can be seen to function within socially and culturally defined norms that govern how social groups and individuals react to their bodies in sickness and in health.<sup>640</sup>

By the 1920s the advertisements for *Rafiq-i Badn* are more elaborate, and the message has shifted subtly to include women's sexual problems, such as infertility, and is more explicitly targeted at correcting the bad internal effects on boys' bodies borne by the 'imbalances of youth'. The text reads:

*Rafiq-i Badn* number 4

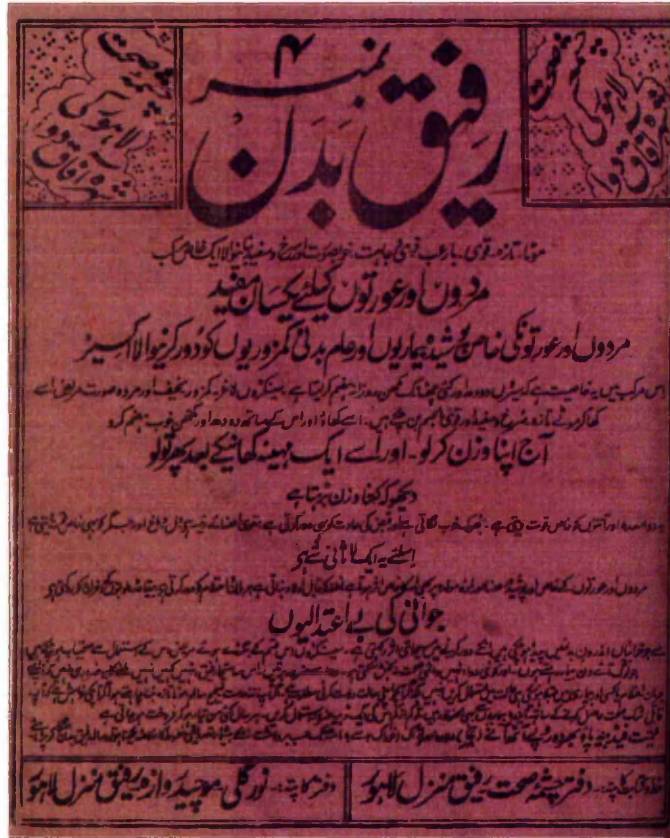
makes you fat, revitalised, strong, awe-inspiring, commanding, beautiful and [gives you]  
blooming health, a special compound  
beneficial for both men and women,  
the elixir that dispels general bodily weaknesses and the complex illnesses special to men and  
women<sup>641</sup>

The journal attempted to project this medicine as a means to achieve respectability and influence in society. In addition to clearing up male weaknesses it will also now make a barren woman fertile. Perhaps the exigencies of competition between products required producers to appeal to new consumer bases, as women and youth are now included within the projected efficacy of this medicine.

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<sup>640</sup> Arthur Kleinmann's elaborates on this concept of the 'health care system' in his *Patients and Healers in the Context of Culture*, Berkeley, 1980, p. 27 f.

<sup>641</sup> 'Rafiq-i Badn nambar char, moṭā, tāza, qavvī, ba ro 'b, zi vajāhat, *khūbshurat*, aur surkh o safid ek *khāṣ* murakkab mardoṅ aur 'auratoṅ ke li' e yaksān muṣīd, mardoṅ aur 'auratoṅkī *khāṣ* poshīdah bīmāriyoṅ aur 'ām kamzoriyoṅ ko dūr karnevālā al-iksīr', *al-Ḥakīm*, December 1922, regularly inside page of the back cover.



Advertisement for the product *Rafiq-i Badn nambar 4* in 1922<sup>642</sup>

Another prominent product of the Cashmah-yi Şihat factory was *Iksīr*, a medicine aimed at curing diseases of poison and putrefaction. The prevalence of epidemic outbreaks in the Punjab over the previous twenty years would perhaps have made it an alluring product, as it claimed to bring those who have been suffering from plague, cholera and malaria ‘back from the edge of the grave to live again’. The target group for this medicine is equally all-encompassing: ‘*Iksīr*, a *ḥukmī* [unani] medicine for children, youth, the aged and all the new and old illnesses of men and women; it will have a

<sup>642</sup> *al-Ḥakīm*, December 1922, inside back cover.

magical sudden effect at home on all complaints'.<sup>643</sup> The advert also suggests how one may increase one's status among the *choṭhe and bare log* (the less privileged and the influential people) of the *maḥallah* (neighbourhood) by keeping a bottle of this medicine always in one's pocket to dispense to others when required. The advert lets us in to the social dimensions of the effects of medical practice: using medicine as a means to social mobility, to gaining authority among one's peers. In this innovative advertising strategy users of this product are now seen as participants of product endorsement, carrying the message of the medicine's effectiveness around their locality, and the message is sold by stressing the benefits that will accrue to them in terms of the prestige they will gain among their neighbours. The advert was also trying to sell the medicine as a product in which the speed of effectiveness was important. Indigenous medicines were seen as slow acting in relation to English medicines, which, as Hakim Doctor Jilani argues in an advert for his book *Davā al-Gḥarb*, was one reason why *ḍāḳṭarī* (western medicine) had become so popular. But this advert stresses the 'sudden' effect of *Iksīr*. At home there might not be time to call a doctor or *ḥakīm*: this was a unani medicine that could be used for pain relief and at short notice. It is quite probable that we are here seeing a subtle means of asserting the capability of unani medicine to deal with problems in the way that English medicines were famous for.

One other significant development in the marketing of this and other products of the time is the place of *tasdīqāt*, or testimonials. In *Rafīq al-Aṭibbā*, testimonials were quoted in special product-based publications (like the journals themselves they were also called *risāle*). There was a *risālah* for the product *Rafīq-i Badn*, for example, where people who had used the medicine testified to its benefits. By the 1920s testimonials were a common feature of advertising in *al-Ḥakīm*. The testimonials were frequently aimed at the general reader. One example bears out the points that we noted above in the advert for *Iksīr*. One resident of Trichinopoly (Tiruchirapalli) in Madras Presidency, indicating the remarkable distribution of Cashmah-yi Şihat's products India-wide, described the miraculous healing powers of this medicine. The testimonial begins with the statement '*tilism thā yā jadū*' (it

<sup>643</sup> '*Iksīr, bacchoṅ, javānoṅ, burhoṅ, aur mardoṅ auratoṅ kī tamām na'ī aur purānī bīmāriyoṅ ke li'e ḥukmī davā. Ghar meṅ acānak honevālī tamām shikayatoṅ ke li'e jādū-i aṣr*', *al-Ḥakīm*, January 1922, regularly inside front cover.

was a talisman or magic). Tales of miraculous and marvellous cures have a long-standing association with unani medicine. They are abundant in Persian literature on the activities of *hakīms* in the royal courts, how they gained favour with the ruler and the nobility.<sup>644</sup> The invocation of magic here plays on this tradition of the extraordinary in unani cures, and encourages what Markus Daechsel has termed the ‘fetishism’ of medical products as objects of worship.<sup>645</sup> The writer of this testimonial related that some friends had gathered at his place when he heard a cry and found that the servant had collapsed unconscious from a snakebite. He administered the medicine to the wound and gave the patient a few drops to drink in water, which led to a miraculous recovery.<sup>646</sup> In this brief narrative we may draw out three important messages: that a unani product from a distinguished unani enterprise was drawing on a magical dimension to enhance its appeal; the speed of the medicine’s effects was emphasised, which made it rival allopathic products; it placed the medicine’s effects within a distinct yet familiar social environment in which this act of healing could take place.

Testimonials by professional practitioners also targeted their peers, who would then dispense these products. One *hakīm*, a regular subscriber to the journal, testified that in his clinic he had found *Iksīr* useful for a range of complaints, similar to those listed in the advert: stomach pain, toothache, earache, gastro-enteritis, cholera and weak digestion.<sup>647</sup> Other testimonials suggest that the *hakīm* using this medicine could also boost his reputation in his locality. One such is the testimonial of one Hakim Muhammad Fathyab Khan, a resident of Sohanpura, who reported that within a few days *Iksīr* had created a stir in his neighbourhood because of its many benefits.<sup>648</sup>

While some adverts were pitched as universally beneficial, others derived their authority from their exclusivity. Here we deal with the last of the three core products of the Cashmah-yi *Ṣiḥat* business that were advertised in *Rafīq al-Aṭibbā* and *al-Ḥakīm: Mufarriḥ Marvārīdī*. The name itself emphasises connections to Persian elite culture.

<sup>644</sup> Jaggi, *Medicine in Medieval India*, Delhi, 1977.

<sup>645</sup> B. M. Daechsel, “‘Faith, Unity, Discipline’ – The Making of a Socio-Political Formation in Urban India, Lahore 1935-1953”, unpublished Ph.D. thesis, London, 2001, p. 108.

<sup>646</sup> *al-Ḥakīm*, January 1922, inside cover.

<sup>647</sup> *al-Ḥakīm*, March 1922, inside cover.

<sup>648</sup> *Ibid.*

*Mufarriḥ* is a classical unani medical term for a cordial, something that brings relief to the heart, and *marvārīd* is the Persian for pearl, in Hindustani ‘*moṭī*’. The advert sells itself partly on the allure of the semi-precious mineral ingredients that make up the medicine, as the heading proclaims: ‘pearl, musk, amber, ruby, emerald and other precious items’ (‘*moṭī, mashk, ‘anbar, yāqūt aur zumrud va ḡhairah qīmatī ajzā*’). What is especially interesting about this advert is that, for the first time in the campaigns of *Raḡīq al-‘Aṭibbā* and *al-Ḥakīm*, a product is branded for select consumers. As the opening lines boldly state, it is ‘a rare gift for lawyers, editors, writers, and high-ranking gentlemen’ and also, lower down the page, students and clerks. The product is pitched to deal with two main problems: impotence and fatigue, and its target is the stressed working man. The medicine claims to relieve any form of exertion, although the emphasis in the branding is on those whose work is mentally demanding.

The advert employs a number of strategies to convince the reader of the worth of the product before the reader. Firstly, there is a strong personal element to the advert. This product was not derived from a hereditary (*khāndānī*) prescription acquiring its name through the accumulated experience of hereditary practice. It had been ‘discovered’ by Hakim Ferozuddin himself. Secondly, we are invited into the process by which the medicine was discovered. The first section of the advert describes the labour, and money, that the *ḥakīm* had expended trying and testing this medicine until it was perfected. Thirdly, there is a brief explanation in technical language, with glosses, of how the medicine affects the body. The *mufarriḥ* affects the brain first, within ‘a few minutes of reaching the stomach’, and within 10 to 15 minutes it brings full movement to all the muscles and nerves in the body. The technical Arabic terms ‘*aḡlāt* (muscles) and *a’sāb* (nerves) are glossed with regular Hindustani terms, indicating that the intended consumer of this product may in fact not be so well read after all. Fatigue is seen as blockage and rigidity in the body. This advert is supposed to impress the reader through knowledge of how the medicine changes the internal workings of the body. There are thus two new approaches to claiming the worth of this product, these emphasise on the one hand research, work and expenditure, and on the other hand explanation of its effects. In this respect they represent a significant shift in the way that learned *ḥakīms* were defining their marketing strategy. We are presented with the toiling *ḥakīm* who brought his



individual expertise, his mental power and creativity, spent his personal wealth on producing a successful product. It is a device that validates the product through the selflessness and dedication of the *hakīm*, and by stressing labour, money, time coupled with applied knowledge, it also places the medicine's maker on the same social and professional level as its prospective consumer – the professional 'white collar' worker, whose work demands mental agility and who suffers from the fatigue and stress of the workplace. It allows those who aspire to these professional achievements to live their fantasy through the commodity. Then there is the explanation of how the body should work in language that allows for understanding but still establishes distance between the specialist and the layperson.

Authentic unani knowledge was thus formulated and projected in various ways, depending on the prospective target and the social conditions of the time. Medical advertising and print culture was, as we have discussed in the context of plague, an unregulated domain. There was no system for regulating and licensing indigenous practitioners in India in the early twentieth century, although by 1927 the local *tibbī* association of Lahore was calling for this to happen in their area,<sup>649</sup> so there was no external mechanism to control the outpouring of printed material and advertisements. The learned unani journals, like *Rafīq al-Aṭibbā* and *al-Ḥakīm*, were thus ideal channels through which to counter professionally threatening elements in this emerging medical culture. The strategy of asserting authentic unani knowledge was most clearly illustrated in an advert placed in *al-Ḥakīm* by one of its regular contributors, Hakim Rafiq Ahmed, of Najibabad, U.P., entitled 'The supreme elixir *ṭilā*'<sup>650</sup> that brings disgrace on [other] advertised *ṭilā*'s'.<sup>651</sup> As the *hakīm* explains in the text of the advert 'I am presenting this unparalleled *ṭilā*' to the public in order to halt the senseless flood of advertised *ṭilā*'s and medicines for the diseases of shame [*sharamnāk amrāz*] that are published mainly by ignorant and unknowing perfumers and druggists ...'.<sup>652</sup> The *hakīm* then presents the

<sup>649</sup> *The Punjab Legislative Council Debates*, 15 July, 1927, p. 1003.

<sup>650</sup> *ṭilā*, or *ṭilā'*, is an ointment used often for male weakness complaints. It is not to be confused with the word similarly spelt *ṭilā*, meaning gold.

<sup>651</sup> *al-Ḥakīm*, March 1922, 31: 'Ishtihārī *ṭilā'* onkī mattī palīd karnevālā iksīr a 'zam *ṭilā'*.

<sup>652</sup> *Ibid.*: 'Akṣar nāvāqif aur jāhil 'aṭṭā'iyon [sic] aur davāfarūshon ke ishtihārāt *ṭilā'* va sharamnāk adviyah ke muta'alliq adviyah shā'ī' karneke ṭūfān be tamayyuzī rukne ke li'e ek nihāyat lā javāb *ṭilā'* publik main pesh kar rahā hūn'.

entire list of ingredients of the medicine, with dosages. This openness to publish shows that he is prepared to have his prescription scrutinised by the journal's readership, and thereby shows confidence in the quality of this medicine and the other products that he sells.

In this survey of medical advertising in two prominent unani journals we have seen how marketing strategies relied on various devices to develop and promote their products, and in terms of branding became more sophisticated over time. They presented authenticity in different ways, and appealed to the ethos of potential consumer bases, who would have bought into the cachet of the product – the rich, powerful, potent and commanding man, or the beautiful, fruitful woman – connected through the name of the product and the location of the advert to the reputation of *hakīms* in the Arab-Perso-Indian unani tradition. The journals *Rafīq al-Atībbā* and *al-Hakīm* buttressed their authoritative weight to the products appearing in their pages.

## VI. Globalising Unani Pharmacy, Reconfiguring the Profession

Through the medium of journals practitioners dedicated to the reconfiguration of unani knowledge and practice were trying to encourage new ways of sharing and making accessible the authoritative knowledge guarded until this time in local, hereditary spheres. *Ṭabībs* like the editor Hakim Ferozuddin of these Lahori journals frequently blamed the decline of *ṭibb* on the miserliness (*bukhl*) of others who did not make known their *ṭibbi* knowledge as the reason why *ṭibb* had declined. One could rectify this problem by publishing, establishing oneself in the eyes of the public as a *khāndānī* (hereditary) *hakīm* with a treasure store of *poshīdah* (secret) prescriptions. *Rafīq al-Atībbā* and *al-Hakīm*, as well as other unani journals coming out of Delhi, Lucknow, Lahore and other centres, published vast numbers of 'tried and tested' (*mujarrab*) prescriptions labelled 'secret' (*sarsārī*), 'concealed' (*mukhfi*), *sadrī* ('from the chest', that is, precious and not widely known) to this end, and also continually encouraged others to do likewise. The oral transmission of knowledge was certainly still alive at this time, and has never been

totally supplanted, but we may mark the early twentieth century as a time of great transition. *Ḥakīms* still invoked the concept of '*isnād*', the chain of authority of Islamic *ḥadīth* and legal traditions, to make the connection to the site where in practice the unquestionable authority of the *ḥakīm* lay at that time (and in many ways continues to be so): the collective experience and the social standing of hereditary practice, embodied in the family *bayāz* (prescription notebook).

The reply of one Hakim Muhammad Abdullah Ansari to an open question in *Rafiq al-Aṭibbā* exemplifies this: 'This is a *nuskḥah* [prescriptions] from the *bayāz* [notebook] of a venerable *ṭabīb*, and it reached me through a reliable *isnād* [chain of transmission]'.<sup>653</sup> In facing the revelation of the importance of hereditary knowledge, a cynical viewpoint might suggest that such proclamations were self-serving. But in the wider context of activity in the unani profession in the late nineteenth and early twentieth century, we can see that these were not primarily self-serving exercises, nor simply a service to the public: there was an ideological dimension. The emphasis on revealing the concealed knowledge of the previous generations of respected *ṭabībs* brings out the concerns among such practitioners as Ferozuddin, and the many others who contributed their knowledge, about the need for reform: The prevailing structures of authoritative knowledge in *ṭibb* should, in their view, give way to the demands of a new climate of medical practice, in which learned *ṭibb* had to reach out to a wider public and should allow new blood to enter the profession. They envisaged a process which could be facilitated through the breaking down of the personalised barriers of hereditary practice that once characterised *ṭibb*, and which had as its objective the survival of a form of the profession that could find credible political representation. The journals were viewed as an essential component of this multifaceted and differentiated professional enterprise.

In this study we have developed a number of different themes that may in themselves seem to have little to do with one another: the medicalisation of sexual behaviour, the use of magic by learned *ḥakīms*, the development of medical advertising in unani journals and the publication of *khāndānī* prescriptions. The themes of this study are unified by the agency of the journal, as a platform that made new forms of

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<sup>653</sup> *Rafiq al-Aṭibbā*, 16 February 1912, p. 41, enquiry number 105.

communication and exchange possible, serving the agendas of practitioners intent on establishing the strength and depth of their knowledge and representing this to other practitioners and a literate public. The medium of the journal reveals the disparate currents circulating in *tibb*, and its relations with a variety of other healing practices and disciplines. It reveals that practitioners conceived of their profession and their roles as practitioners in society in various and sometimes conflicting ways, as sources of knowledge on a body-mind-spirit continuum.

## Conclusion

As ancient paradigms of authoritative knowledge in *ṭibb* became dismantled (but not, as we have argued, altogether extinguished) in the nineteenth and early twentieth centuries – through the collapse of courtly patronage, the commodification of medical products, the use of print, the power of western medical technologies, the emergence of new professional cultures and the exigencies of epidemic emergencies – so *ṭabībs* reconfigured their knowledge and practices through the prisms of nationalist and communitarian politics, changing social and moral norms and colonial inspired models of legitimacy. In this process the authoritative practice of *ṭibb* ceased to be a local, family affair. *Ṭabībs* and *ṭibb* had to confront a wider public in order to compete, survive. The concept of ‘system’ became welded into the evolution of *ṭibb*, and its discourse, in the course of the twentieth century, as practitioners responded to the manifold pressures and crises of the times. They were forced to take stock of what they thought to be good, authentic and legitimate, in order to represent this knowledge to the public on a vastly new scale, both to gain and maintain their trust and their custom, and in order to represent the credibility of their practices in new, less personalised administrative, legislative and political domains.

The leaders of this process, Hakims Ajmal Khan, Abd ul-Aziz, Kabiruddin, Ferozuddin, and the countless other less celebrated but equally committed practitioners, like Hakim Zafaruddin Nasir, the compiler of *Tīr bah Hadaf* and the editor of Hyderabad’s unani journal *Ḥakīm-i Dekkan* in the 1930s and 40s, were well aware of the tensions inherent in this evolving unani profession between on the one hand, the importance of public/political representation, recognition and the demonstration of authority, and on the other the constraints of hereditary, local practices and spheres of influence. Hence the arenas that we have examined in this thesis: the publications in Urdu, and the engagements with the new constituencies of *ṭibb*, including women; the new consumer-friendly products and innovative marketing strategies; the new institutions, national conferences and the *ṭibbī* associations trying to bring *ṭabībs* together, or seeking to defend what they perceived as their interests; hence the

publication of journals with *mujarrabāt* prescriptions and question and answer columns to open new forms of dialogue with the public; hence the reworking of the ethical conceptions of the body in society in order to consolidate the authority of *ṭibb* not just as a science of bodies (*‘ilm al-abdān*), but as a science of the social, moral being. Hence also the condemnation among these circles practitioners of those who they had seen as impeding the progress of *ṭibb*, sullyng its name by association – the druggist, the *jarrāh*, the *dai*, the *jāhil* (illiterate, ignorant) *ḥakīm*.

Along a similar tack we can read the denigration of those who, more alarmingly, threatened to usurp the learned practitioners’ power, and might further have damaged the integrity of the unani profession – the educated upstart to the profession armed with capital, a printing press and a way with slogans, who in the rhetoric of the denigrators is seen as actually a public hazard, not working for the collective good of *ṭibb*, but seeking individual fortune.

Then comes another thrust which surfaces often in unani discourse of the twentieth century and again goes to the heart of the tensions between local unani practices and authority in a globalising era: the condemnation of the miserliness (*bukhl*) of the *ṭabīb* who does not divulge his family’s knowledge and experience, who had stultified *ṭibb* by keeping it parochial. Thus the praise which Zafaruddin Nasir lavished on those *ṭabībs* who responded to the calls for openness and cooperation, by submitting their tried and tested prescriptions for the publication of *Tīr bah Hadaf*,<sup>654</sup> thus the efforts of Hakim Ferozuddin to publicise truly hereditary prescriptions in his journals and his *tazkirah*, *Rumūz al-aṭibbā*. In spite of the more ‘democratic’ trends that we have witnessed throughout our discussions in this thesis, and seen to be embodied, perhaps unhappily, in the new institutional arenas of *ṭibb*, this fundamental problem of authority, knowledge and practice in *ṭibb* has not been properly resolved. In the utterance of their

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<sup>654</sup> Zafaruddin, *Tīr*, p. 7: ‘It was necessary to place the biographical details of the *ḥakīms* with the *mujarrabāt* which they are contributing [to this publication] so that the importance of the prescription can be seen in the light of their personality, and moreover, that by presenting examples of the signs of the selflessness of these blessed beings and the way they break down miserliness, they might serve as a general inducement to others to participate in this act of magnanimity’; ‘*Mujarrabāt ke sāth ṣāhibān muskhah ke mukhtaṣir vāqi ‘āt kā iltizām is li’e rakhā gayā hai kih nuskhah kī ahamiyat un kī shakhsiyat se roshin ho sake nez īsār she ‘ār aur bukhl shikan mubārak hastiyon kī miṣālain pesh-i nazar is khusūs men khulūs-i dil se hiṣṣah lene kī ‘ām targhīb hai*’.

condemnation, the dichotomies of the reformist *ṭabīb* and the purist, the modern and the traditional, are at once blurred, since they were all in the end engaged with the same struggles with authority and representation, but differed only in degree and approach.

One may argue that the guarding of inherited knowledge, the tried and tested prescriptions concealed in the family *bayāz*, has continued to present difficulties for institutional graduates of *ṭibb* who had no access to this kind of knowledge, and little confidence in the medicines they prescribe. But alternative media have come to fill this void. The commercial, manufacturing sector has progressively bloomed since the 1920s with the products of the Hindūstānī Davākhānah (established 1905), later Hamdard, becoming a model unani enterprise. As Maarten Bode has pointed out, the income currently generated from the sale of indigenous medical products far outstrips current Indian government investment in indigenous medicine.<sup>655</sup> More work needs to be done on how various kinds of unani enterprise negotiated the question of authenticity since the 1920s to complement the insights of Bode's contemporary ethnographic work. Since the early twentieth century *ṭabībs* have embarked on another, related, avenue to establish the legitimate place of unani *ṭibb* in the subcontinent: research and development of the unani pharmacopeia is currently being whole-heartedly embraced. The power of a chemical and pharmacological model for demonstrating the efficacy of unani medicines and restoring confidence in their use was felt as early as 1930, when the laboratory for just such a purpose, envisaged by Hakim Ajmal Khan at the Ayurvedic and Unani Tibbi College, was inaugurated there two years after his death. This biomedical approach to *ṭibb* presents a paradoxical situation for *ṭibb*. On the one hand, it is presented as a saviour, since the authority of active ingredients and the clinical trial can occupy the authoritative space once occupied, and in pockets still maintained, by impermeable, localised inherited knowledge. Unani medicines can be demonstrated to be efficacious for a number of especially chronic conditions for which there is, and is seen to be, inadequate allopathic treatments, such as vitiligo, diabetes, rheumatoid arthritis among others, identified through the research conducted through the Central Council for Research in Unani Medicine in India, and at the Hamdard, in Karachi and Delhi.

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<sup>655</sup> M. Bode, 'Indian Indigenous Pharmaceuticals: Tradition, Modernity and Nature', in Waltraud Ernst (ed.), *Plural Medicine, Tradition and Modernity, 1800-2000*, London: Routledge, 2002, pp. 184-203.

The combined use of over-the-counter unani products, as well as the embracing of biomedical approaches to *ṭibb* have had important consequences for what unani came to mean in the course of the twentieth century. As practitioners like Hakim Altaf Hussain, one of the head physicians in Hyderabad's unani service, foresaw in the context of plague in the 1910s, the product is in the process of eclipsing the physician: the uniform drug, the uniform disease are gaining more significance than the correct determination of the individual condition and the *ṭabīb*'s authority. Perhaps in the impersonalisation of health and disease the focus on the drug over the disease has been subtly shifting the conception of disease as a process, mapped in the prognostic arts of the *ḥakīm* by elaborate symptomology and an interpretation of the stages and crises of a diseased, imbalanced body, to disease as a clearly circumscribed entity that can be eliminated by a 'magic bullet'. Although, as Helen Lambert's ethnographic work in Rajasthan reveals, notions of disease as something subtle and transformative that passes through the body, rather than an isolatable condition, remain alive in popular conceptions.<sup>656</sup> The diagnostic art of pulse-reading, still the icon of the skilled *ṭabīb* in the 1920s, as the frontispiece of the journal *al-Hakim* shows, now belongs more to the realm of unani lore, with the exception of a number of senior *ṭabībs* and those fortunate enough to be instructed by them. The process by which the pulse in many cases has merely become one diagnostic aid among others, and the means by which new diagnostic technologies became adopted and accepted need to be further investigated. Changing conceptions of disease, medicines and new methods of diagnosis point to the issue of conflicting notions of humoral and anatomical bodies and the extent to which they have been reconciled. The importance of these reformulations in unani theory can be gauged by the numerous research articles brought out over the years interpreting biomedical categories in the light of the forces, fluids and substances of the humours, such as a recent article on endocrinology and humoral theory.<sup>657</sup>

Ayurveda occupies a similar territory in the dilemmas of its theory and practice and, likewise, in the prospects for using the language and protocols of biomedicine to raise its

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<sup>656</sup> Lambert, Helen, 'The Cultural Logic of Indian Medicine: Prognosis and Etiology in Rajasthani Popular Therapeutics', *Social Science and Medicine* 34, 1992, pp. 1069-1077.

<sup>657</sup> Arif Anees et al., 'Endocrinology in the Light of Unani System of Medicine', *Hamdard Medicus*, 45, 2002, pp. 104-106.



profile as a global medicine, but it appears closer to establishing its claim to validity than *tibb*. Ayurvedic physicians attended earlier to the new commercial opportunities than *tibb*; moreover ayurveda, as Jean Langford has shown, was reinvented during the twentieth century as a cultural asset of India, offering itself as a semi-spiritual healing experience for the imbalanced westerner and modern lifestyles.<sup>658</sup> While retaining an essential role as a health-care provider in India, *tibb* has endeavoured in recent years to present itself to western interest as a 'natural' healing practice, a viable alternative to the 'hot', powerful, fast-acting but potentially harmful and, according to many *ṭabīb*s and their patients, symptomatic, treatments with allopathic drugs.

*Tibb*'s cultural orientation as an 'Islamic' medicine has also provided it with its own global dimension, through its propagation among Islamic communities both in the South Asian diaspora in the U.S., the U.K., Australia and East Africa, as well as in the Gulf States. This cultural location both within South Asia and abroad, reinvigorates the relationship of *tibb* with Islamic precepts, as well as other Islamic medical traditions, such as *tibb al-nabī* (Medicine of the Prophet). These competing demands made on *tibb*, as a scientific and a cultural enterprise, revivify some of the debates of the determination of an authentic unani practice which we have been concerned to discuss in this thesis.

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<sup>658</sup> Jean M. Langford, *Fluent Bodies: Ayurvedic Remedies for Postcolonial Imbalance*, Durham, 2002.

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