

**Digesting Modernity:  
Body, Illness and Medicine in Kolkata (Calcutta)**

STEFAN M. ECKS

London School of Economics and Political Science  
University of London

Ph.D. Thesis  
Social Anthropology  
2003

UMI Number: U615839

All rights reserved

INFORMATION TO ALL USERS

The quality of this reproduction is dependent upon the quality of the copy submitted.

In the unlikely event that the author did not send a complete manuscript and there are missing pages, these will be noted. Also, if material had to be removed, a note will indicate the deletion.



UMI U615839

Published by ProQuest LLC 2014. Copyright in the Dissertation held by the Author.  
Microform Edition © ProQuest LLC.

All rights reserved. This work is protected against  
unauthorized copying under Title 17, United States Code.



ProQuest LLC  
789 East Eisenhower Parkway  
P.O. Box 1346  
Ann Arbor, MI 48106-1346

THESIS

F

8152

1012816

## Abstract

This Ph.D. thesis presents an anthropological perspective on popular and professional concepts of the body in Kolkata (Calcutta), with special reference to ideas about the stomach/belly and the digestive system.

By altering the routines and practices of daily life, changes brought about by modernization, globalization and urbanization are often associated with a decline of mental and physical well-being. In this context, the aim of this study is to juxtapose popular practices of self-care with professional views on illness and medicine. How do people in Kolkata perceive their bodies? How do they speak about health problems linked to digestion? What are the perceptions of health and illness among different medical professionals? How does this discourse reflect anxieties about the consequences of modernity in Kolkata?

The data of this study are drawn from ethnographic fieldwork carried out between July 1999 and December 2000. Interviews and participant observation were conducted with a cross-section of the Bengali Hindu population in a local area in South-West Kolkata, and in selected other areas of the city. Data collection focused on metaphors around stomach/belly (Bengali: *pet*), and on popular practices of self-care in relation to bodily well-being. For research on professional medicine, interviews and participant observation were carried out with healers from three different medical systems: allopathy (biomedicine), homeopathy, and Ayurveda. From each of these systems, fifteen to twenty healers were interviewed on how they perceive their patients, and how these perceptions influence their medical practice.

## **Table of Contents**

**Illustrations** 5

**Acknowledgements** 6

**Introduction** 8

### **I. The belly in social theory** 13

1. "King Tongue" and the lack of self-control 13
2. Friedrich Nietzsche: *Genealogy of Morals* (1887) 17
3. Norbert Elias: *The Civilizing Process* (1939) 35
4. Michel Foucault: The "care of the self" (ca. 1976-1984) 41
5. Ethnographic perspectives 49

### **II. Research methodology** 54

1. The initial research question 54
2. Research setting and sample 59
  - 2.1. Community-based research 59
  - 2.2. Health care settings 64
3. Study design 68
4. Data analysis 70

### **III. Popular perceptions of the belly** 74

1. The belly in popular language and practice 74
  - 1.1. Survey of the word field *pet* (belly) 74
  - 1.2. The belly as container of (limited) goods 81
2. Popular epidemiology of digestive illnesses 85
  - 2.1. Bengali terminology of digestive illnesses 85
  - 2.2. Hot/cold classifications 88
  - 2.3. Risk behaviour 98
  - 2.4. Risk groups 109
    - 2.4.1. Social groups 110
    - 2.4.2. Gender 114
    - 2.4.3. Age groups 117
3. Keeping the belly (and the mind) cool 122

<b>IV. Allopathic gastroenterology</b>	<b>132</b>
1. The gap between professional allopathic and popular perceptions	132
2. Doctors' perceptions of patients' "bowel-obsession"	139
3. Doctors' reflections on patient aetiologies	145
4. Doctors on patients' perceptions of therapy	149
<b>V. Homeopathy</b>	<b>160</b>
1. An Indian system of medicine	160
2. "Sour, sweet, salty, spicy?": Food dis/likes in diagnosis	166
3. The "vital force"	171
4. Immaterial ingestion	174
5. "No toothpaste allowed!": Antidotes to medicine	177
6. Disease in "the modern world of suppression"	179
7. How to deal with the modern (biomedicalized) patient	183
<b>VI. Ayurveda</b>	<b>190</b>
1. "No problem, it's just acidity": A <i>kaviraj's</i> illness narrative	190
2. The relation between Ayurveda and popular ideas	193
3. Ayurvedic views of digestion	195
4. Digestion according to Kolkata <i>kaviraj</i>	198
5. Pollution and corruption	205
6. Diagnosis and therapy	208
7. From hero to zero?	217
<b>VII. Conclusion</b>	<b>223</b>
<b>Glossary with transliterations</b>	<b>236</b>
<b>Bibliography</b>	<b>241</b>

## Illustrations

- Plate 1: A modern view on human digestion (Poster, 60 x 42 cm)
- Plate 2: Environmental education message on Rabindra Setu (Howrah Bridge), Kolkata (Photograph, 1999)
- Plate 3: A wall with Tollywood film posters (Tollygunj, Kolkata) (Photograph, 2000)
- Plate 4: The theme of indigestion (*bad hajam*) in popular health journals (Title page of *Shucikitsa*, 1 November 1999)
- Plate 5: A packet of *TK Das's Digestive Amla* (15 x 10 cm)
- Plate 6: Environmental conflict in South-West Kolkata (Ghosh 2000)
- Plate 7: Advertisement for astrological and herbal therapy in central Kolkata (Photograph, 2000)
- Plate 8: Baidyanath Ayurvedic children's tonic (Newspaper advertisement)
- Plate 9: AUM, Ma Kali, Ramakrishna, Sharada Devi (Poster, 60 x 42 cm)
- Plate 10: Brilliant Tutorials for medical entrance exams (Newspaper advertisement)
- Plate 11: Britannia biscuits with Isabgol (Newspaper advertisement)
- Plate 12: "The clear choice," Fujinon endoscope (Business advertisement)
- Plate 13: An International Standards Organization (ISO)-certified homeopathic clinic (Newspaper advertisement)
- Plate 14: Dr. Sarkar's tonics for liver, head, and hair (Newspaper advertisement)
- Plate 15: Ramakrishna's realization of "different paths, one goal" according to the comic series *Amar Chitra Katha* (1982: 22)
- Plate 16: Ayurvedic capsules for weight gain (Newspaper advertisement)

## Acknowledgements

I would like to say a few words of thanks to all the people who, over the last years, gave me so much support. I am greatly indebted to my Ph.D. supervisors at LSE, Chris Fuller and Jonathan Parry. Without their unwavering support I would have never finished this thesis. William Sax made it possible for me to take up a teaching position in Heidelberg without having fully completed the dissertation, for which I am very grateful.

The people whose knowledge and kindness made my time in Kolkata so enjoyable deserve my heartfelt thanks: Bonani Roy, Jakesh Francis, Jhunu, Suhasini Kejriwal and family, SK Mukherjee, Rajlakshmi Ghosh and family, PK Sarkar, Manju Sarkar and family, Tapati Guha-Thakurta, Debdas Banerjee, AK Biswas, Gautam Chakraborty, Shrimoy Roy Chodhury, Bhaskar Mukhopadhyay, and of course, Anirban and Rumila Das, Anup Dhar, and all the members of *From the Margins*. I would like to thank two colleagues and friends for keeping me connected to the London school of rationality: Henrike Donner and Indranil Chakrabarty. Special thanks go to Annu, Françoise, and Leo Jalais; and to Shanu and Damayanti "Dodo" Lahiri. The greatest thank must of course go to all my informants, whose time and patience made this study possible at all.

I would like to thank those who gave me invaluable comments on parts of this work, from the first version of the proposal to the final draft: Partha Chatterjee, Lawrence Cohen, Georg Elwert, Christoph Emmrich, George M. Foster, Richard Fox, Robert Frank, Heather Hindman, Markus Höfner, Martin Kunz, James Laidlaw, Mattison Mines, Mark Nichter, Stacey Pigg, Chris Pinney, Malabika Sarker, David van Sickle, Dominik Wujastyk, and Francis Zimmermann. Special thanks go to Mukulika Banerjee and Roger Jeffery for giving the thesis a very detailed and thorough reading. The lively debates with members of the LSE Department of Anthropology also left their mark on this work; for all the people that could be mentioned here, I would like to thank Peggy Froerer, Kriti Kapila, Lucia Michelutti, and once more, Annu Jalais. For being my affiliate supervisors at the Delhi School of Economics, I thank André Beteille and Abhijit Dasgupta. My colleagues at the South Asia Institute Heidelberg deserve heartfelt thanks for accepting me in their scholarly community, and for giving me much encouragement during the last phase of the dissertation.



Last but not least, I would like to thank the two organizations that funded my research: The Economic and Social Science Research Council (ESRC), and the Studienstiftung des deutschen Volkes. The Studienstiftung deserves special thanks for supporting me not only during my doctoral studies, but also during the undergraduate years that led me there.

The debt to my parents is too great to be put into words. This work is dedicated to them.

## Introduction

In his famous preface to *The Protestant Ethic*, Max Weber (1988 [1920]: 1) maintains that one can only study "universal history" if one tries to explain the uniqueness of "occidental culture." Only occidental culture developed a stance towards the world that was both culturally unique *and* able to transcend all cultural boundaries. Weber seeks to show how values of rational conduct, hard work, and this-worldly asceticism were, at first, specifically Protestant, but went on to become universal standards of behaving. For Weber, "modernity" is the phase of history when the Protestant ethic has shed its religious implications and has become the required way of relating to the world. The capitalist mode of production, the professionalization of work, the rising power of state bureaucracies, urbanization, the individualization of the person – all these processes first emerged in the West, but went on to become the criteria of "modernity" the world over.

As Chris Fuller (2002: 14) notes, not even recent writings about "multiple," "alternative," or "Other" modernities could fully dispel all ethnocentric misconceptions about "modernity" and its alleged opposites ("tradition," "pre-modernity," and so on). Neither could these writings resolve the paradox of how modernity can be both culture-specific *and* culture-transcendent. Partha Chatterjee (1997) diagnoses that, if the origin of modernity is perceived to be irreducibly "Western," non-Westerners (here: Bengalis) can only choose to be either mere "consumers of universal modernity," or to remain outside of "modernity" altogether. If non-Westerners give up trying to become quasi-Westerners and start to create an alternative modernity, they pit themselves into the paradox that this "Other modernity" is always already in the past: "The bitter truth about our present is our subjection, our inability to be subjects in our own right. And yet, it is because we want to be modern that our desire to be independent and creative is transposed on to our past" (Chatterjee 1997: 209-210). If the Weberian question about the "origins" of non-Western modernity produces more paradoxes than it can solve, would it not be better to suspend it altogether?

The fixation on the origins of modernity distracts from a more urgent question: what are the *consequences* of modernity? In a number of writings, Ulrich Beck, Anthony Giddens, and Scott Lash (Beck 1986; Giddens 1990; Beck, Giddens, and Lash 1994) put forth the hypothesis of "reflexive modernization." According to them, a shift has occurred from "classical industrial society" to "risk society."

Industrial society is characterized by conflicts over the distribution of "goods" such as income, status, and social security. In the risk society, in which a relatively high standard of living has been reached, a new form of conflict arises over the distribution of the unwanted and unplanned ills of industrial production. Popular fears about the unpredictable effects of environmental pollution, global warming, or gene technology make contemporary Western societies turn away from "linear" towards "reflexive" modernization. Unbroken faith in progress and technology is replaced by a more cautious, self-questioning attitude. Belief in science is both undermined *and* strengthened by the multitude of conflicting expert opinions. The "sub-politics" of environmentalist movements acquires more and more importance in political decision-making. Once the unpredictable threats of industrial development are taken serious, they necessitate "self-reflection on the foundations of social cohesion and the examination of prevailing conventions and foundations of 'rationality'" (Beck, Giddens, and Lash 1994: 8). Although Weber's definition of rationality also entailed the notion of self-reflexivity, he did not foresee the extent to which the side-effects of modernization would become a formative force. The unseen and unplanned becomes just as important as what can be seen and planned: "The side effect, not instrumental rationality, is becoming the motor of social history" (Beck, Giddens, and Lash 1994: 181). Weber (1946 [1917]) was pessimistic about science being able to provide any (ethical) value orientation, but he never put science, as objective knowledge about the world, into question. In the risk society, there is not one objective "science," but a multiplicity of "experts" who more often than not come up with diametrically opposed assessments (Beck, Giddens, and Lash 1994: 11). Even if risks are irreducible, and even if the consequences of any action are ultimately unpredictable, society should not fall into a kind of nihilism about the future. Instead, it should take "risk" as an opportunity to reflect on its very foundations and take uncertainty as "a providential gift for the universal self-reformation of a previously fatalistic industrial modernity" (Beck, Giddens, and Lash 1994: 51-52).

The theory of "reflexive modernization" was formulated in view of the affluent post-industrial societies of the West. Nevertheless, it applies directly also to contemporary "non-Western" societies. Other than the "origins" of modernity, the unwanted side-effects of modernization are undoubtedly part of *everyone's* life. Indeed, poor countries bear disproportionately *more* of the globally produced "bads"

than the "goods." What "reflexive modernization" might look like in a country such as India could be theorized about. But to understand how the consequences of modernity are popularly perceived in India, the problem must be confronted ethnographically. Chris Fuller holds that much remains to be done in this regard: "In anthropological writing on India, there is a vast amount of information about modernity and traditionalism among ordinary people, although most of it is not explicitly focused on these issues" (Fuller 2002: 19). The present work tries to make a contribution towards such an ethnographic study of Indian modernity.

The data for this study are drawn from eighteen months of ethnographic fieldwork in Kolkata (Calcutta),<sup>1</sup> carried out between July 1999 and December 2000. The subject of my research were the popular and professional understandings of body, illness, and medicine in the context of the urban metropolis. Interviews and participant observation were conducted with a cross-section of the Bengali Hindu population in a local area in South-West Kolkata, and in selected other areas of the city. The focus of my research lay on ideas about the belly and digestion. When I started my first interviews on health-related issues, I had no special interest in digestion; nevertheless, all the responses I received seem to revolve around digestive health. It is no exaggeration to say that it was not me who chose the belly, but that the *belly* chose *me*.

Apart from interviews with the lay population, I also conducted research on how different medical systems deal with their patients' digestive complaints. From among the plurality of medical professionals, I focused on healers from three systems: allopathy, homeopathy, and Ayurveda. As is implied in the title *Digesting Modernity*, this study looks at the double themes of "digestion" and "modernity" simultaneously. The "side-effects" of modernity are both real and metaphorical. By altering the routines and practices of daily life, the ills of modernity evidently lead to a plethora of digestive diseases. At the same time, the "moral" coding of the belly's suffering provides a reflexive commentary on modernity's unwanted consequences. The choice of a seemingly "Subaltern" body part such as the belly enabled a discussion of modernity from a new angle. First, it made it possible to reconsider common issues in the medical anthropology of India (e.g., hot/cold classifications, the evil eye, Ayurveda) from an *oblique* position. Second, it motivated ethnographic research on several subjects that have, so far, received little or no attention in the

---

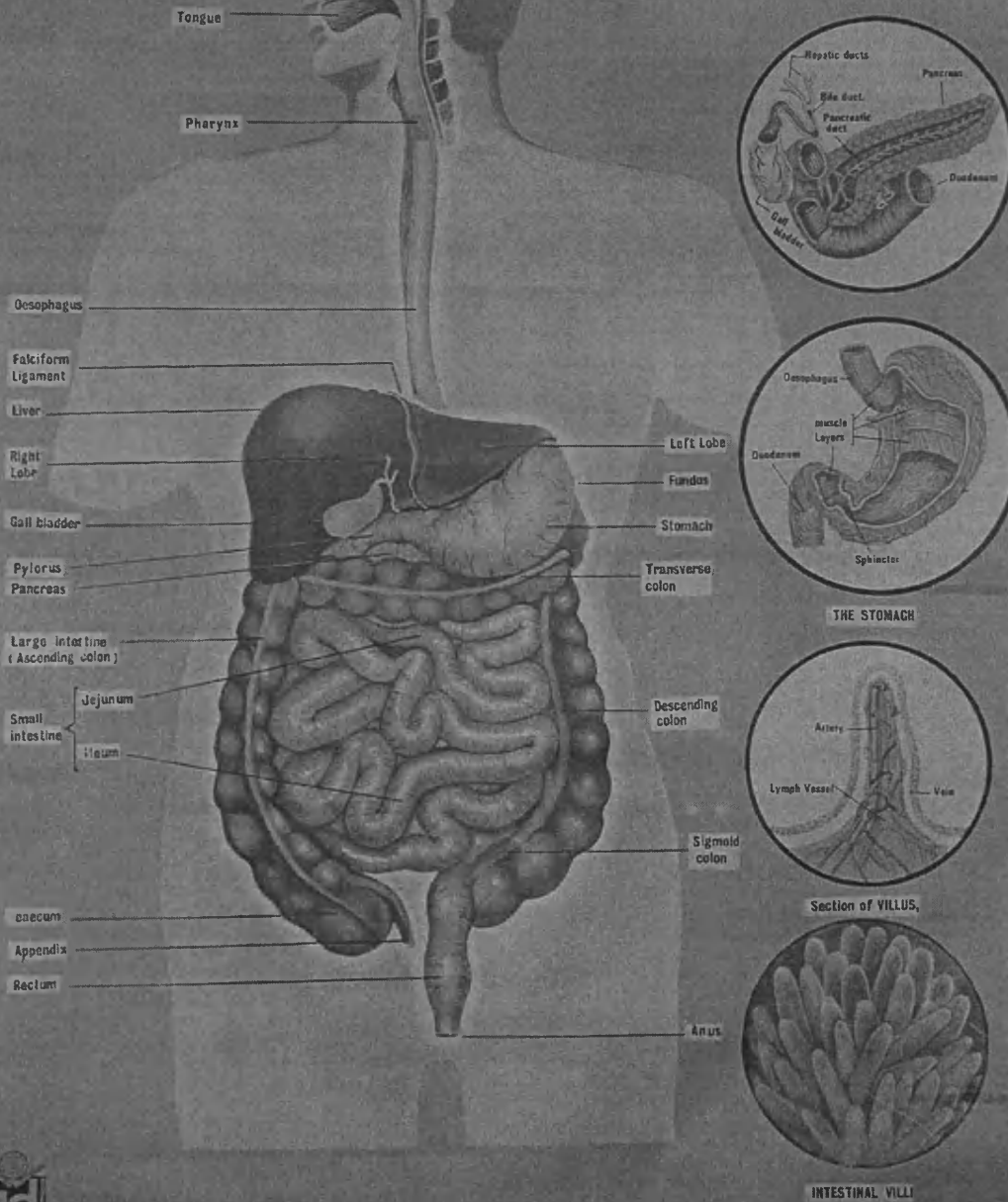
<sup>1</sup> "Calcutta" was renamed "Kolkata" in 2000. The argument behind this change of name was that "Calcutta" is too closely associated with the British colonial era.

anthropology of India, such as allopathic gastroenterology, homeopathy, or the "popular epidemiology" of risk groups and risk behaviours. Taking the belly as a vantage point also made me re-read some key texts of social theory in a slightly slanted way. The theory chapter tries to deconstruct rational modernity through Nietzsche, Elias, and Foucault's writings on power, sovereignty, and self-care in relation to digestion.

The structuring principle of the present thesis is the multiplicity of different perspectives on modernity and digestion. In the first chapter (I), I reconstruct the contributions of both "Western" and "non-Western" theoretical writings on this theme. The second chapter (II) explains in more detail the methodology used in this study. The third chapter (III) tries to capture Bengali popular perceptions of the belly. The following three chapters (IV-VI) look at how medical professionals perceive their patients and their own position within modernity. First, I look at the currently hegemonic system of medicine, allopathy (IV). Second, I describe homeopathy, Kolkata's second most popular system after allopathy (V). Third, I give a depiction of Ayurveda, which formerly was synonymous with "Indian medicine," but which has been deeply transformed by modernity (VI). In the concluding chapter (VII), I return to the theory of "reflexive modernity" in light of the ethnography of contemporary Kolkata.

# THE HUMAN BODY

# DIGESTIVE SYSTEM



PUBLISHED BY: INDIAN BOOK DEPOT, MAP HOUSE 2937, Sahasra Ganga Road, Near Deputy Ganga, Delhi 110006

PRICE: Laminated 1980 Plastic Cover: Rs. 25  
Laminated 400g. Tin: Paper: Rs. 25  
Paper: Rs. 150 with Tin Plate: Rs. 150

Plate 1: A modern view on human digestion (Poster, 60 x 42 cm)

## **I. The belly in social theory**

If one were to write a concise dictionary of key concepts in social theory, which terms should be included? *Modernity, power, individual* – such words are likely to appear. But an entry on *belly*? Or an entry on *digestion*? Neither the belly nor digestion seems to play any role in social theory whatsoever. And yet, this chapter sets out to show why the belly and digestion exert a kind of subterranean agency in social theory. For scholars specialized in the social anthropology of India, the theme of belly and digestion may not come as a complete surprise. How metaphors and practices of eating/digesting are important in Indian culture has often been described. But how these same metaphors and practices might also be significant in *social theory* is less well described; and how these theories might be useful for an understanding of Indian culture, even less so. In this chapter, I want to re-read a number of texts – both Indian and Western – to show how digestion can be interpreted as a key concept in social theory. In the first part of this chapter, I retrace (post-)colonial writings related to the digestive theme. In the following, I look at some classic contributions by Friedrich Nietzsche, Norbert Elias, and Michel Foucault. In the final part, I describe how all of this might shed new light on the ethnography of contemporary India.

### **1. "King Tongue" and the lack of self-control**

In November 2000, I spent a week in Kolkata's National Library to complement the ethnographic data with readings from popular health books. The Library's holdings of such writings proved to be staggering. Titles on how to deal with common sickness or on the advantages of various medical systems (allopathy, Ayurveda, homeopathy, Yunani, Yoga, and so on) resulted in a list of more than a hundred publications, and a thorough search would have produced many times more. Titles in Bengali and English were both common. The dates of publication reached back to the middle of the nineteenth century. During the late nineteenth century and early twentieth century, health-related publications seemed to outnumber publications on any other topic. A number of these books have been reprinted in several editions.

Books that spend fewer pages on formulaic prescriptions in favour of general reflections on what it means to be "healthy" were particularly exciting to read. Let

me quote from Sundaram's (1945) treatise on *Diet and Digestion*.<sup>2</sup> The author, a Yoga practitioner, develops an intriguing political philosophy around the theme of eating and digesting. For Sundaram, the cause of sickness in Indian bodies, Indian society, and Indian politics is people's lack of care for the stomach. To eat polished rice is equal to eating death. Modern rice machines are "rice-killers," therefore equal to "man-killers" (1945: 10-44). Coffee and tea have replaced milk in people's daily diet, leading to a weakening of mind and body (1945: 54). Oily food and spicy food beguile the senses but destroy the nerves and digestion. The most evil ingredient of daily cooking is chili, an ingredient as oppressive as the colonial regime: "This evil-spirit of Chilli, this enslaver of the Deccan, this bane unparalleled in the world for its clever penetration and unequalled inflictor of suffering" (1945: 122). As bad as the food itself are modern-day people's irregular eating habits. They eat in the morning, before having properly cleansed themselves. They eat at any time during the day. They eat late, just before going to bed. They overstuff their bellies. All of this does only results in severe indigestion; it also results in a loss of health, of "manhood," and of the ability to regain political sovereignty:

"How can this befit the great present day Indian who has lost his country to the foreigner and his senses to the boastful western civilisation? The first ruler of the Indian is 'King Tongue!'" (Sundaram 1945: 48)

Instead of changing these bad habits, modern man adds insult to injury by gulping "a perennial stream of medicines to keep good company with the wrangling mass in the stomach" (1945: 2). To break free from all these ills, a new sense of responsibility for one's own health must come first. Caring for oneself is the best way of caring for the country:

"The country we lost to the foreigner. But why sacrifice life at the dreadful altar of the palate? We are slaves politically but why pawn our senses – and manhood too? [...] Reform your diet. Health will be within your reach. Death in youth will fade out. Poverty will follow suit. Not only these results, much better fate will be yours. The senses will get under control. Passion will subside. Bad Temper will vanish and life will become fruitful. These are not empty boasts. Our ancients reaped these rewards. Even now some are reaping these harvests in glory. One shudders to think of the treatment meted out to the stomach. Some stuff in unwanted stuffs [*sic*]. Many bloat this into bursting sacks. Millions are there who without mercy, day in and day out, munch, munch and munch agony. [...] Deficiency diseases flay us in

---

<sup>2</sup> A fuller survey of popular health literature in India still remains to be done. I quote from Sundaram's book because he develops the relationship between diet and self-control with particular clarity. Even if other authors keep it shorter, I would argue that Sundaram's arguments are typical for this genre of writing.



and out. Hunger is absent. There are frequent eructations. The stomach aches – pays back the inconsiderate owner in the same coin. The liver becomes lethargic. The loaded colon gets into a comfortable cinderella-sleep! The brain gets confused and dulled [*sic*]. The blood becomes impure. [...] In some, the flesh rots and makes the owner a beast of burden. One cannot detail all that comes of wrong food and indiscriminate eating." (Sundaram 1945: 2-3)

Sundaram's views of diet and digestion may be particularly graphic, but they are without doubt typical for popular health books in general (e.g. Sarasvati 1948; Sarma 1978; Vora 1997). The trope of "greedy eating" is also prominent in M.K. Gandhi's writings. Similarly to Sundaram, Gandhi perceives an immediate connection between the care of the stomach and the care of the nation. In his manifesto *Hind Swaraj* ("Indian Self-Rule") of 1909, Gandhi sharply criticizes modern Indian people for indulging themselves in gluttony. According to him, people are not only taking too much food, but they are also taking too many medicines to counter the ill effects of overeating. People's futile attempt to cure illness, which is nothing other than "nature's punishment" for greediness in eating, puts them into a triple dependency. They are slaves to their senses, slaves to medicines, and slaves to foreign rule:

"The fact remains that the doctors induce us to indulge, and the result is that we have become deprived of self-control and have become effeminate. In these circumstances, we are unfit to serve the country. To study European medicine is to deepen our slavery" (Gandhi 1984 [1909]: 59).

One of the immediate strategies against this situation is, therefore, to start taking control of one's diet. Once "King Tongue" and the stomach are brought under control, dependency from medicines will vanish. Once sovereignty over the body is re-established, sovereignty over the country is only a matter of time.

The intimate relation between regimes of power ("colonial," "postcolonial," "modern," or other) and body discipline has been of central importance in recent writings on the impact of colonialism in South Asia, especially by scholars of the Subaltern Studies group. David Arnold's (1993) *Colonizing the Body* was one of the most influential works in this direction. Partha Chatterjee (1997), in his interpretation of Bengali writings on the body from the colonial period as having a weak digestion but still craving for more and more food and commodities, concludes that the Bengali educated classes tried to develop a notion of another, alternative modernity, which would enable them to break free from their role as mere "consumers of universal modernity" and to become "creators of our own modernity" instead

(Chatterjee 1997: 204). In *Another Reason*, Gyan Prakash (1999) analyzes popular health books in which Indian authors criticize their countrymen for being effete, being deprived of self-control, and for being corrupted both politically and bodily. Prakash sees this discourse as an internalization of the "colonial representation of Indians as effete weaklings" and, in response to this, the attempt to train this enfeebled body for a strong, nationalist, independent future: "It was to transform this weak, disease-prone body that Gandhi had secretly experimented with eating meat during his youth" (Prakash 1999: 151-152). Focusing on Gandhi's obsession with dietetics, fasting, and other technologies of overcoming the colonized body, Joseph Alter (2000) discusses "how nationalism can be viscerally embodied, and how the practice of embodiment produces visions – fragmentary and transnational – of alternative world orders in the microscopic physiology of self-rule" (Alter 2000: 154). Alter interprets Gandhi's visions of a "nonviolent, minimalist, Rusian gastropia" (2000: 34) as a "patient praxis of decolonizing bodies" (2000: 27). For Gandhi, to control the colonized body's cravings, such as greed for food, sex, or commodities, is the first step towards political independence.<sup>3</sup>

The close connection between food and power may seem, at first sight, to be an Indian (and especially Hindu) idiosyncrasy. That Hindus see strong connections between the kind of food they eat and the kind of religious, moral, social, and political beings they are is a well-known and extensively documented fact (e.g., Appadurai 1981; Khare 1976a, 1976b, 1992). The logic of the traditional Hindu caste system, for example, can be analyzed through the question of who can accept food from whom, or who can eat together with whom (e.g., Marriott 1968). Even after the partial decline of caste hierarchies during the modern era, food remains at the centre of social interaction. Hindus worship their gods through food offerings. Everyday discourse about health focuses on what kind of food to eat under which conditions,

---

<sup>3</sup> It should be underlined that the trope of "greedy eating" defies all-too-easy dichotomies such as West/India, or colonizer/colonized. The sins of overeating also play a major role in European popular health books. To quote only one random example, George Cheyne, one of London's leading physicians during the eighteenth century, published numerous books on the debilitating effects of changed eating habits of his contemporaries. With the rise of British colonial power, wicked new diseases had become rampant, especially among those who indulged themselves in the delicacies of exotic food and drink. Against the degenerative effects of this new gluttony, only a return to simple diet could be effective: "Abstinence and proper Evacuation, due Labour and Exercise, will always recover a decayed Appetite" (George Cheyne, *An Essay on Health and Long Life*, London 1724; quoted in Turner 1992: 188). Broadly speaking, greedy eating as (potential) loss of sovereignty belongs to the paradigm of humoralism; hence it is neither "Indian" nor "Western," neither clearly "traditional" nor clearly "contemporary." The crucial differences between, say, Cheyne and Sundaram, rely on how they relate "greediness" to a specific socio-political context (Richard Fox, personal communication).

and popular diagnostics always begin with an inquiry about the functioning of the digestive tract. Axel Michaels gives a succinct summary of the Indian concern with ingestion and digestion: "Orality and morality belong together" (Michaels 1998: 200; my translation).

While being a central metaphor in India, digestion does not, at first, seem to be equally important in the West. What I want to argue in the following is that the digestive theme is perhaps more significant in the West than it may seem on first sight. Specifically, I want to examine how ingestion/digestion is not only a concern in past and present European "folk" cultures (cf. Bakhtin 1984), but also among some of the most influential thinkers of modernity. I will try to substantiate this claim by a re-reading of a number of classic works of social and political theory, most notably works by Friedrich Nietzsche, Norbert Elias, and Michel Foucault.

## **2. Friedrich Nietzsche: *Genealogy of Morals* (1887)**

Nietzsche has been called the "absent giant of contemporary social thought" (Stauth and Turner 1988: 3). Although few writers acknowledge their debt to Nietzsche openly, his influence on twentieth-century thought has been enormous. Max Weber's (e.g., 1976, 1988) theory of asceticism and rationalization cannot be understood without Nietzsche. Many of Freud's (e.g., 1934) propositions seem like a reformulation of Nietzsche in psychoanalytic terms. Nietzsche's deconstruction of modernity, rationality, and civilization has left deep traces not only in the social sciences, but also in philosophy, theology, psychology, as well as in the arts. As I hope to show, some of the key arguments of Nietzsche's *Genealogy* can be understood as an extended metaphor of ingestion/digestion, a metaphor with potentially wide-ranging implications for the modern social science in general, and an ethnographic understanding of contemporary Kolkata in particular.

Nietzsche's philosophy is usually described as fragmented, incoherent, and contradictory. One might even suggest that quoting from Nietzsche should be prohibited altogether, since anything and everything could be claimed as Nietzsche's "authentic opinion" through quotations taken out of context. Given the historical precedence of various (mis)appropriations of Nietzsche's philosophy, most notoriously that by the Nazis (Aschheim 1992; Strong 1996) and by various strands of anti-feminism (Patton 1993; , there is certainly good reason to be cautious.

Nietzsche himself warned against oversystematization of ideas: "The will to systematicity reflects a lack of honesty" (GD: 57).<sup>4</sup> I believe, however, that there is a good deal of systematicity in Nietzsche's argument, certainly more than is often granted to him. The systematicity of Nietzsche's thought relies partly on the persistent use of a handful of key metaphors. As I will argue in the following, metaphors of ingesting and digesting are among these. The frequent reference to digestion in Nietzsche's works has been noted by a number of scholars (Blondel 1991: 220; Grosz 1993; Hillman 1997: 89-92; Stauth and Turner 1988: 194). However, to my knowledge no commentator on Nietzsche's *Genealogy* has as yet realized the importance of eating and digestion in his argument.

As Derrida (1967: 409) points out, structures of signification need a *centre* that is not itself part of their structure. In order to begin making sense, a point has to be established that is not itself in question, a point *prior* to the beginning, a point of reference which makes it possible to say: from here onwards, something new, something different is happening. To understand a statement that claims to be meaningful, it is necessary to know, at least implicitly, the stable point to which the statement refers. In Western thought, one of the most enduring (and perhaps doubtful) centres of this kind is "nature." At one point, an entity called "culture" splits away from it, and from then onwards, nature and culture are diametrically opposed to each other. Forever split yet mutually dependent on each other, culture is what nature is not, and vice versa (cf. Latour 1993).

In philosophical anthropology, the dichotomy of nature/culture is interpreted in various ways. Jean-Jacques Rousseau, for example, in the *Discourse on the Origin of Inequality* (1755), develops the image of the "noble savage," arguing that humans were happy, healthy, and free in the state of nature, but became corrupted through culture. Taking the opposite viewpoint, Thomas Hobbes holds in *Leviathan* (1651) that, in the state of nature, "man is man's wolf" (*homo homini lupus*). For Hobbes, human beings are essentially self-interested individuals, driven only by their desire for power, unfettered by moral or legal obligations. Before "culture" began, humans were engaged in an unremitting "war of all against all" (*bellum omnium contra omnes*). Without any considerations for the common good, human life was "solitary,

---

<sup>4</sup> It is no coincidence that Rapport and Overing (2000: 294-303) start their discussion of the keyword "postmodernism" with this quote from Nietzsche. Nevertheless, they also show Nietzsche's traces in anthropological keywords such as "classification," "individualism," "interpretation," "irony," "reading," and several others. As Rapport and Overing make clear, to see in Nietzsche *only* a postmodernist *avant la lettre* would be shortsighted.

poor, nasty, brutish and short." This state of nature can only be overcome by establishing a social contract, which puts all power into the hands of an absolute sovereign.

The split between nature and culture, with nature being the stable point of reference for the meaning of culture, also structures the argument of Friedrich Nietzsche's *Genealogy of Morals* (1887). In the opening sentence of the *Genealogy*, Nietzsche asserts, "We remain unknown to ourselves." "Knowing," in the sense in which Nietzsche uses it here, alludes to the moral knowing described in the Bible's Book of Genesis: to know is to know the difference between good and evil. Instead of trying to define the difference between "good" (*gut*) and "bad" (*schlecht, böse*), as a more conventional work on ethics would do, Nietzsche aims at overcoming this distinction altogether. Going back towards the "origin" of morality and retracing its genealogy, Nietzsche asks: How did the distinction between good and bad come about in the first place? Who made this distinction, and for what purpose?

Similarly to Hobbes's dog-eat-dog (or rather, wolf-eat-wolf) anthropology, Nietzsche assumes that it is the natural state of humans to be engaged in perpetual warfare against each other. Giving the problem a different spin, Nietzsche replaces the wolf-eat-wolf schema by that of "wolf-eat-sheep." Hobbes's natural individuals are basically equal to each other, and it is this lack of an acknowledged hierarchy that produces incessant civil strife. For Nietzsche, on the other hand, men are naturally *unequal*. Before civilization created a homogenized idea of "man," there were only "masters" and "slaves" ordered in a hierarchy of power. According to Nietzsche, what is called "moral values" is basically an inversion of the master/slave hierarchy, in which the attributes of mastery are turned into vices, while the attributes of slavery become virtues. The pride of mastery becomes a sin, and being meek and humble becomes strength. The introduction of morality brings about a "slave revolution," in which the hierarchical authority of the powerful is reversed and the values of the slaves are put into their place. What was good becomes bad, what was bad becomes good.

Alimentary metaphors, such as wolf-eat-wolf, are of some importance also in Hobbes's political theory, but in Nietzsche's *Genealogy*, they become central. Nietzsche's anthropology could be outlined as follows: in the state of nature, the strong *eat up* the weak and digest them happily. Culture and civilization spoil this natural hierarchy; the weak bring the strong to believe that it is morally bad to devour

them. This causes the strong to gradually lose their appetite, until they do not enjoy living in this world anymore at all. An attitude of nihilism towards the world is the final result of this process. The remedy prescribed by Nietzsche against this nihilistic indigestion is to destroy moral judgments and become a "superhuman" (*Übermensch*), which he calls in the *Genealogy* a "sovereign individual." Let us look at each of these aspects in detail.

Nietzsche explores the idea of the master/slave relationship in a variety of ways. To this effect, he translates "master" and "slave" into various analogous terms. The clearest translation of the master/slave relationship into an alimentary metaphor is that of the birds of prey (i.e., masters) and the lambs (i.e., slaves) (GM: 29-30). Nietzsche argues that in the state of nature, before morality, birds of prey would devour the lambs without any pangs of conscience: "indeed, we love them: there is nothing tastier than a tender lamb" (GM: 29). Even if the lambs tell themselves that the birds of prey are "bad," it makes no difference to the birds. The problem only starts when the birds of prey take over the lambs' point of view and begin to think that what they are doing is indeed "bad," and stop eating the lambs. For Nietzsche, there is nothing wrong with the meek being meek. But that the meek could bring the strong to believe that powerlessness is superior to power presents a corruption of values. The brute fact that weakness is weakness and strength is strength is overturned by the deception that weakness is strength. But his "dry matter of factness" of original power relations

"...has, thanks to the forgery and self-deception of impotence, clothed itself in the magnificence of self-abnegating, calm, and patient virtue, exactly as if the weakness of the weak man itself – that is, his *essence*, his action, his whole single, unavoidable, irredeemable reality – were a free achievement, something willed, chosen, a *deed*, a *merit*." (GM: 30)

The precondition for this distortion of values was, for Nietzsche, a changed perception of subjectivity and agency. Originally, there was no difference between the doer and the deed, because there was no recognition of an agent's intentionality. Birds of prey eat lambs because that is what birds of prey do. To act as birds of prey is the direct expression of their being. At some point, however, a split occurred between doer and deed, and the idea came about that agency is free and intentional. Once the deed was distinguished from the doer, it became possible to hold the doer *accountable* for his deeds. The recognition that agency is free and intentional was the necessary precondition for the doer's moral responsibility for his deeds. Only with an

idea of intentional agency was it possible to say that the birds of prey are choosing to be birds of prey, are choosing to eat lambs, but that they might also choose to be meek and not to behave in this way. Such moral responsibility was also the necessary precondition for the "civilized" modes of punishment, which do not primarily look at the deed, but at the doer's intention. That the culprit deserves punishment *because* he could have acted differently is a very recent form of legal reasoning.

Nietzsche expresses his ideas on subjectivity, intentionality, and responsibility with another variation on the ingesting/digesting theme. At the beginning of the second part of the *Genealogy*, Nietzsche draws a similarity between memory and indigestion. The work of the brain is likened to the work of the digestive tract. In a state of natural health, an organism can take in any amount of outside stuff, metabolize it, keep what is beneficial, and excrete what is harmful. In the digestive process, the elimination of waste matters does not proceed passively, but requires an active, healthy working of the guts. Similarly, Nietzsche holds that *forgetting* is not due to the mind's weak retentive powers, but rather to its active effort to get rid of corrupting matters. Such elimination is of vital importance, because "there could be no happiness, no serenity, no hope, no pride, no *present* without forgetfulness" (GM: 38). Those who lack digestive power literally suffer from a bloating of the mind. To drive home his point most graphically, Nietzsche compares the effect of remembrance to symptoms of dyspepsia: "The man in whom this inhibiting apparatus is damaged and out of order may be compared to a dyspeptic (and not only compared) – he is never 'through' with anything" (GM: 39). The kind of "memory" that Nietzsche talks about is, again, a memory in relation to morality. To be a moral actor requires the ability to give promises and to keep them, as well as to take promises from others and to hold them accountable for them. For Nietzsche, being a moral actor amounts to suffering from a kind of indigestion.

Since Nietzsche considers forgetfulness and the concomitant absence of responsibility as the original and healthy state, he asks how moral memory could become ingrained into the mind of the human "animal" at all. In terms of *who* authored this training process, Nietzsche's statements vary. Sometimes he speaks of "nature" performing the training herself ("The breeding of an animal which is *entitled to make promises* – is this not the paradoxical task which nature has set itself with respect to man?" GM: 39). At other times, he holds humans themselves responsible ("the special work of man on himself throughout the longest era of the

human race," GM: 40). As members of society, humans are both active subjects and passive objects of this process, which Nietzsche describes as one of coercion and normalization. Society, for Nietzsche, is a moralistic "straight-jacket" that humans have forced upon themselves to make themselves calculable (*berechenbar*): "it was by means of the morality of custom and the social straight-jacket that man was really *made* calculable," GM: 40).

The civilizing process, as Nietzsche conceives it, consists in the inculcation of memory. There are, broadly speaking, two types of "technique[s] for remembering things" (GM: 42) that come to be used: the infliction of pain, and the creation of (bad) conscience. Of these two techniques, pain is the more archaic one. In Nietzsche's view, the history of humanity is a history of blood, torture, and mutilation: "Ah, reason, seriousness, mastery over the emotions, the whole murky affair which goes by the name of thought, all these privileges and showpieces of man: what a high price has been paid for them! how much blood and horror is at the bottom of all 'good things!'" (GM: 44). To inscribe the difference between good and bad as deeply as possible, people traditionally employed a wide array of punitive methods, such as stoning, trampling by horses, boiling in hot oil, and so on (GM: 43). By means of such punishments, humans slowly formed an idea of what is "good" and what is "bad," solely based on the amount of pain with which a "bad" deed would be sanctioned. Techniques of corporeal asceticism, such as fasting and other types of self-mortification, also belong to this category: "In a certain sense, the whole of asceticism belongs here: a few ideas to be made inextinguishable, omnipresent, unforgettable, 'fixed'" (GM: 43).

Corporeal punishment is the archaic sibling of the more sophisticated type of mnemonic technique, the "conscience." Every animal can be trained by inflicting bodily pain, but the conscience is exclusively human. Indeed, the very specificity of humans, in contrast to animals, came about with the creation of conscience. The analysis of this process is one of the most complex in the whole of the *Genealogy*, as it draws on many other central notions of Nietzsche's philosophy, such as the "will to power." What is important about it in terms of the ingesting/digesting theme is a general idea of "internalization" and the consequences of this, namely a loss of appetite for life.

What Nietzsche says about the creation of conscience could be described as follows: instead of the masters devouring the slaves, civilized humans now gnaw on



*themselves*: "The man who is forced into an oppressively narrow and regular morality, who for want of external enemies and resistance impatiently tears, persecutes, gnaws, disturbs, mistreats himself," GM: 65). The "will to power," which is the ultimate driving force in the Nietzschean cosmos, has two possible directions, towards the outside and towards the inside. In the original state, the will to power was directed towards the world, towards what is outside of each being. The bird of prey, for example, exercises its will to power over what is outside of it (e.g., the lamb). With the creation of conscience, however, the will to power is directed towards the inside (e.g., the soul). Trapped in the confines of society and morality, the human animal cannot exercise its will over others anymore, and begins to direct its energies against itself, its own interior. To renounce violent behaviour towards the outside world does not mean, for Nietzsche, that violent behaviour stops altogether. Instead, it becomes sublimated and internalized. Where there was no "interior" to humans before, a kind of bloating occurs, and in this newly created space "the soul" takes shape:

"Every instinct which does not vent itself externally *turns inwards* — this is what I call the *internalization* of man: it is at this point that what is later called the 'soul' first develops in man. The whole inner world, originally stretched thinly as between two membranes, has been extended and expanded, has acquired depth, breadth, and height in proportion as the external venting of human instincts has been *inhibited*."  
(GM: 65)

Man's interior becomes his self-created "place for torture" (GM: 65), in which he begins an endless series of sadomasochistic experiments on himself. Nietzsche sees this work of man upon the self as an act of self-rape. This violence against oneself and one's animal instincts is, however, not only destructive, but also creative. Where the beast inside is being tortured and killed, a new, "beautiful" soul comes into being. The process of self-creation in itself is likened to the work of an artist, who destroys in order to create ("artists' violence," GM: 67).

Nietzsche suggests that "beauty" itself was created in this violent process of obliterating the "ugly." But since the civilizing project is incomplete, humans tend to see more that which is ugly, repulsive, and disgusting than that which is beautiful. The result of the drive to bring daily life under the purview of aesthetics is that humans lose their appetite from seeing too much ugliness. On the way to becoming morally good and proper, humans became aware of their own filthy lives: "On his way to becoming an 'angel' [...], man has bred for himself that dyspepsia and furred

tongue, as a result of which not only the joy and innocence of the animal have become repugnant to him, but even life itself has lost its savour" (GM: 48).

The *Genealogy* is full with expressions of this sort. Most of them occur in connection with a discussion of religious ascetic practices. For Nietzsche, the civilizing process is the main culprit for humanity's bad stomach. In this process, religion plays a strongly supportive role. With its supernaturally sanctioned regulation of food intake, prohibition of sexual behaviour, and other forms of bodily conduct, religion hastens the domestication of the human brute, and thereby furthers the corruption of the natural, healthy state. However, religious asceticism is not only a driving force of civilization. Instead, Nietzsche sees religion primarily as a kind of misguided reaction *against* civilization, a reaction that only entrenches more deeply that which it is trying to overcome. Nietzsche's argument is, once more, embedded in metaphors of ingesting and digesting.

Civilization causes indigestion of the world. The suffering that comes with it is real; it is bodily, physiological suffering. In its search for a cure, the human "half-animal" turns towards religion. The priests, or more generally, religious specialists, exploit this desire for a return to health and trick half-civilized man into believing that religion provides the only real cure from the sufferings of civilization.

Physiological illness is misinterpreted as "sin." By replacing the true cause of suffering with bogus religious reasons, the torment is made worse. The religious techniques of self-mortification masquerade as therapies, but in fact they only exacerbate the agony. What Nietzsche tries to achieve through his genealogical analysis of morality, religion, and asceticism is to recover the truth about suffering.

Emotional, psychological, and moral agony is, for Nietzsche, nothing but a misrecognized state of physiological imbalance: "man's 'sinfulness' is not an established set of facts, but rather only the interpretation of a set of facts, that is, of physiological distemper" (GM: 107). If seen clearly, what appears to be the "agony of the soul" is only "a fat word" (GM: 107), which signifies nothing substantive.

Those who are healthy simply digest whatever the world presents to them; yet those who are sickened and weakened by civilization cannot do so: "If someone cannot deal with 'spiritual suffering', then, to put it crudely, this is not the fault of his 'spirit'; but more probably that of his stomach. [...] A stronger man with a better constitution digests his experiences" (GM: 108).

Religion pretends to solve the problem of bodily suffering by turning it into an abstract, theological crisis. Theodicy and the problem of evil, for example, present the priest's attempt to explain why there is misery in the world, and to furnish the idea that happiness and freedom from suffering can only be found beyond it. To denigrate this world in favour of the heavenly Kingdom or other outworldly abodes of bliss is, however, only a pseudo-solution, designed to strengthen the power of the priest as someone with special knowledge about how to reach there. In order to rebut the notion of evil altogether, Nietzsche's physiology of morals brings into play an eclectic mixture of humoral medicinal notions (e.g., "excessive secretion from the gall-bladder")<sup>5</sup> and nineteenth-century allopathy (e.g., "degeneration of the ovaries"). The sufferer who asks feverishly about *why* he is suffering and *who* is responsible for this, does so only because of the deceptions created by the priests, instead of sound medical truths:

"Someone must be to blame for the fact that I do not feel well' – this kind of reasoning is characteristic of all sickly people, and all the more so the more the true cause of their not feeling well, the physiological one, remains hidden (– it may lie in a sickening of the *nervus sympathicus* or in excessive secretion from the gall-bladder, in a deficiency of sulphuric or phosphoric potash in the blood, or in poor circulation in the lower body, or in the degeneration of the ovaries or the like). The suffering are gifted with a horrific readiness and inventiveness in finding pretexts for painful feelings; they even enjoy being suspicious, grumbling over misdeeds and apparent insults, they rummage through the entrails of their past and present in search of dark, questionable stories" (GM: 106)

This physiological deconstruction of morality not only draws on medicine, but also on a number of other nineteenth-century materialist discourses, such as racial theories. Nietzsche's views on race (GM: 108-110) include notions of miscegenation between different ethnic groups, unhealthy intermixture of social classes, the incompatibility of particular races to their environment, and the ageing and degeneration of races. Alongside these theories, Nietzsche mentions bad dietary habits (e.g., alcoholism, vegetarianism) and epidemic diseases (e.g., syphilis, malaria) as causes for degeneration. Nietzsche often refers to concrete names and places to illustrate these problems. For example, he hypothesizes that the people of India went into racial degeneration because they were unable to adapt to the extreme climate of the Subcontinent, or that the hideous character of the Germans,

---

<sup>5</sup> The reference to an "excessive secretion" of bile is reminiscent of hot/cold models of anger and discontent (see chapter on popular perceptions).

symptomatically expressed in their "servility" and "faint-heartedness," are the result of an epidemic of syphilis during the seventeenth century (GM: 109).

It would be easy to equate, as has often been done, Nietzsche's brand of racial theory with Nazi ideology, but this would be an anachronistic reading. Nietzsche passes insulting comments against everything and everyone, including, in particular, "the Germans." It often seems that Nietzsche's aim was to shock his readers by any means necessary, including countless nonsensical, slanderous remarks against particular categories of person (e.g., women, Brahmins, Germans, Christians, Jews, priests, scientists, and so on), and for these remarks he is justly infamous (see below). The political (mis)appropriations of Nietzsche aside, what is important in this context is that his physiology of morals employs the whole gamut of nineteenth-century materialism in order to argue against the work of religion. This is why, immediately after talking about race and disease, Nietzsche comes back to the question about the true meaning of asceticism (GM: 109, *passim*).

Asceticism is, according to Nietzsche, as universal as the reach of civilization itself, and the depression of appetite that comes with it. As such, it numbers "among the universal facts of ethnology" (GM: 110) that people all over the world try to overcome their bodily desires and affects with a wide array of ascetic techniques. Nietzsche points out the close connection between religion and body-mortification, and claims that religion is, in its very essence, a set of techniques that minimizes body metabolism. The ultimate aim of asceticism is to reduce the body's desires, and to make it go into a state of hibernation. Meditation, restraint of affective behaviours, and dietary regulations (e.g., abstention from salt, which has an arousing effect), all these techniques are utilized to diminish attachment to the world:

"Where possible, will and desire are eliminated entirely; everything which produces 'feeling', which produces 'blood' is avoided (a salt-free diet: the hygiene of the fakir); no love; no hatred; equanimity; no revenge; no self-enrichment; no work; begging; where possible, no women, or as few as possible; [...] The result, expressed in terms of psychology and morality is the 'loss of the self', 'sanctification'; in physiological terms, hypnosis – the attempt to achieve for man something approximating *hibernation* for some kinds of animal, *estivation* for many plants in a hot climate – the minimum metabolic rate which maintains life below the level of real consciousness." (GM: 109-110)

Exemplary expressions of ascetic religion are not only Christianity, but also Indian religions, comprising Hindu, Buddhist, Jain, and other strands. Where asceticism is developed to the highest level, the misled reaction against the

weakening effects of the civilizing process is also strongest. Quoting from Paul Deussen's translations of the Indian philosopher Shankara (*ca.* 700-750 CE), Nietzsche holds that much of Indian thought expresses the same ideas as some of the major Greek philosophers, such as Epicurus (341-270 BC), according to whom freedom from suffering in both mind and body is the ultimate goal in life.<sup>6</sup> What these doctrines extol as liberation from the world is, to Nietzsche, only the "deep sleep" (GM: 111) of those who are tired of life, a sleep that is being mistaken as union with *brahma*.

Nietzsche's materialist understanding of morality leads him to believe that religious ascetic practices are part of the reason why there was such a widespread feeling of nihilism and disgust with the modern world during the nineteenth century. Ascetic practices were invented by the priests in order to make the suffering inflicted by the world go away. Failing to do so, they only substituted the real, physiological suffering with spiritual suffering. In one of his most emphatically materialist moments, Nietzsche sees chronic gastrointestinal disease as both the motivation for the development of asceticism, as well as its result. Speaking about Brahmins and their ascetic techniques (abstention from meat, fasting, sexual chastity), Nietzsche reasons that their sufferings from bowel disorders and "the whole anti-sensual and enervating metaphysics" (GM: 18) they expound are intricately linked to each other. Instead of curing the problem, asceticism only makes it worse:

"There is from the outset something *unhealthy* in such priestly aristocracies and in the customs which prevail among them, customs which are turned away from action and combine brooding with emotional volatility. The consequence of these customs is the almost unavoidable intestinal sickness and neurasthenia that afflicts priests of all times. [...] Mankind itself continues to suffer from the after-effects of these naïve priestly cures!" (GM: 18)

With secularization and the "death of God," religion may have lost its hold over society, but not the ascetic ideal as such. Instead, this ideal is very much alive. To illustrate this point, Nietzsche mentions several categories of persons, among them workers and scientists. The modern work place, with its highly standardized techniques, is described as a vulgar form of asceticism, designed to suppress the state of depression caused by civilization. That his nineteenth-century contemporaries call repetitive, mechanical work a "blessing" is, for Nietzsche, no coincidence. Workers, whom he considers as "working slaves or prisoners" (GM: 112), perceive their

---

<sup>6</sup> Paul Deussen (1845-1919), one of the first German Sanskrit scholars, was a close friend of Nietzsche. They knew each other since boarding school, and kept in touch throughout their lives.

employment as a blessing not because of the income they earn, but because the stupidity of the task permits them to forget themselves. The mechanization of work allows them to enter into a quasi-meditative state of mind where the pain of the world is momentarily relieved. That people are so keen to use their time off work for activities that are at least as mindless as their daily toil ("prescription of a *modest pleasure*," GM: 113) goes hand in hand with the struggle against depression.

The modern scientist, in turn, is a direct successor to the priest. In Nietzsche's understanding, religion, and modern science are not opposed to each other, but two branches of the same degenerating tree of civilization. Deconstructing the commonly held opposition between "science" and "religion," Nietzsche sees them as continuous to each other: "No! this 'modern science' – only open your eyes to it! – is at present the *best* ally of the ascetic ideal" (GM: 129). Modern science defines itself as an objective, value-free approach to the world that does not, by itself, provide any value orientation, it "never creates values itself" (GM: 128). However, this does not present a radical break with religion: both are, in essence, ascetic practices. Where the priest abstains from bodily pleasures, the scientist abstains from subjective opinions.<sup>7</sup> The refusal to pass value judgments in favour of a pursuit of "truth" is, for Nietzsche, only the ultimate triumph of the ascetic ideal. It is not surprising, then, that the other prototype of the gastric patient is the scientist, both his and the priest's earnestness being a reliable symptom of a diseased metabolism:

"Even when examined from the point of view of physiology, science rests on the same foundation as the ascetic ideal: both presuppose a certain *impoverishment of life* – a cooling of the feelings, a slowing of the tempo, dialectic in place of instinct, the impression of *seriousness* upon face and gesture (seriousness, the most unmistakable sign of a straining metabolism, of an increasingly arduous struggle for life)." (GM: 129)

In the *Genealogy*, Nietzsche speaks about the civilizing process mostly in terms of its corrupting effects. On how to overcome this situation, Nietzsche is more explicit in other works. His *Thus Spoke Zarathustra*, in particular, speaks more about what is meant by, for example, the concept of the "superhuman" (*Übermensch*), that is, a kind of post-moral state that humans should aim to achieve. There are, however,

---

<sup>7</sup> A celebrated application of Nietzsche's theme of science as ascetic practice is Max Weber's lecture on "Science as a Vocation" (Weber 1946 [1917]). In his discussion of modern science, Stanley Tambiah also arrives at a Weber/Nietzschean conclusion: "In sum what I am saying is that the 'technical sciences' that we have allowed to proliferate may not be able to deliver the best moral values we wish to live by" (Tambiah 1990: 151). For a new reading of science and ethics in light of the genome project, see Rabinow (2002).

several important remarks in the *Genealogy* that elaborate on Nietzsche's vision of a post-moral mode of being. In one crucial passage (GM: 40-42), Nietzsche suggests that the civilizing process is cruel and stifling for most of the history of humanity, but that it may at last reach a splendid end in the "sovereign individual": "the *sovereign individual*, the individual who resembles no one but himself, who has once again broken away from the morality of custom, the autonomous supramoral individual [...] – in short, the man with his own independent, enduring will, the man who is *entitled to make promises*." (GM: 41).

The work of civilization culminates in the sovereign individual. This is, for Nietzsche, a being that is entirely in control over its own existence. This individual is fully responsible, but in the non-moral sense of being only answerable to the values he has set for himself. The rule of society and morality, earlier imposed from without onto it, is overcome by this ethically autonomous being. Definitions of what is "good" or what is "bad" are no longer oriented along social consensus (located outside of the individual), but created only in accordance with the individual's free and independent will, inside of the individual. A self-governing person can truly give a promise to others and remember it for all that it is worth because a promise is only given if it is consistent with its will. Therefore, the end of humanity's long and hard labour upon itself is a being that is *self-ruling*. Those who can govern over themselves will then be legitimate masters over others, over those who are still slaves to external moral codes and to their own insufficiently controlled conduct:

"This liberated man, who is really *entitled to make promises*, this master of *free will*, this sovereign – how should he not be aware of his superiority over everything which cannot promise and vouch for itself? [...] and how much mastery over circumstances, over nature, and over all less reliable creatures which less enduring wills is necessarily given into his hands along with his self-mastery?" (GM: 41)

Nietzsche's utopian anthropology thus reveals a kind of spiral-form development: in the original state, human animals are ordered along a clear hierarchy of masters and slaves, eaters and those who are eaten. Through a long and painful civilizing process, all values become inverted, health becomes corrupted, and the appetite for life becomes gradually lost. When the development reaches a point of utter exhaustion and total nihilism, the promise of the superhuman appears. A hierarchy is once more put into place, but this time, the masters are masters not because they can overpower those who are weaker. What marks them out as masters is their power of mastery over their own self and appetites.

So far, I have tried to give a rough summary of Nietzsche's *Genealogy of Morals* along the metaphors of ingestion/digestion and violence. As has been pointed out already, Nietzsche's philosophy is not without its contradictions and internal tensions. A more detailed analysis of the arguments mentioned so far, and their implications for social science, would require much more space than is available here. From amongst the possible issues that could be explored, I only want to highlight one question: How serious is Nietzsche in his claim that the basis of a true understanding of society and morality is the physiology of the body? The question about Nietzsche's brand of materialism is crucial for an understanding of how his philosophy was taken up by other writers. What is striking about the reception of Nietzsche in the social sciences, in particular, is that his insistence on human physiology has been entirely ignored. Max Weber, for example, was strongly influenced by Nietzsche's remarks on religion, nihilism, and asceticism, but he never took their medico-material underpinnings into account. If, as my reconstruction of the *Genealogy* suggests, bodily processes play an important role in Nietzsche's theory, would this theory fall apart if a physiological basis of social processes were rejected?

Uneasiness about Nietzsche's materialism can be felt in most of the commentaries on his works. In an attempt to rescue Nietzsche from claims that his philosophy is a kind of biological reductionism, Stauth and Turner (1988: 8) argue that, for Nietzsche, "not even the body of human beings is a stable point of reference." However, attempting to show how Nietzsche could be seen as the founder of theories of "embodiment," Stauth and Turner hold that Nietzsche's view of bodily processes were not just metaphorical: "Nietzsche saw the body as a metaphor for political, social and artistic debates, but it was also the case that Nietzsche conceptualized the body in physiological terms as a real entity" (Stauth and Turner 1988: 194). A similar ambiguity of subjectivism and materialism, or "naturalism" and "anti-naturalism" is observed by Callinicos (1999: 115):

"Nietzsche develops a critique of modernity that is peculiar in the way in which it combines naturalism and anti-naturalism. The human subject is naturalized, reduced to an incoherent cluster of biological drives, while nature is subjectivized, since all aspects of the physical as well as the social world are expressions of the will to power."

Nietzsche's insistence on physiology is difficult to reconcile with the currently dominant reading of his work, which is by and large following a social constructivist



paradigm. With its focus on "nature" as a construction, social theorists find it hard to recognize how Nietzsche could base his arguments on material bodily processes. As we have seen, Nietzsche himself delivers a sharp critique of modern sciences, claiming that it is nothing other than the latest avatar of the ascetic ideal. The scientist's asceticism expresses itself in his renunciation of "interpretation," that is, of a subjective point of view:

"[T]he complete renunciation of interpretation (of violating, adapting, abridging, omitting, padding out, spinning out, re-falsifying, and whatever else belongs to the *essence* of all interpretation). [...] But what *compels* these men to this absolute will to truth, albeit as its unconscious imperative, is the *belief in the ascetic ideal itself* [...] it is the belief in a *metaphysical* value, the value of *truth in itself*." (GM: 127)

Nietzsche's claim is, therefore, that "objectivity" is in itself not objective, but a mode of rationalized action that has been chosen in favour of other possibilities. There is not objectivity without a metaphysical *belief* prior to it, a belief that holds that objectivity is a stance towards the world that is not only *possible* but also *desirable*. Against the pretence of absolute scientific truth, Nietzsche proposes a notion of perspectivism. Relating the idea of will to power to the pursuit of truth, Nietzsche rejects objective truth independent of a subject that formulates this truth according to its own desires and power strategies. Perspectivism is thus a move against the "petit fatalisme" (GM: 127) of the objective sciences, which claim that the scientists' particular subject position can be fully eliminated.

Nietzsche's perspectivism should, however, not be misunderstood as a kind of relativism, that is, as a claim that there are no standards of truth at all. The difference between perspectivism and relativism is that a perspectivist can say: "This and only this is the truth" if he chooses to do so. A relativist could not say the same; he would have to admit that the other's viewpoint is just as valid as his own. Another distinction between these two positions is that Nietzsche's critique aims much more at the "moral" dimension of science than at its epistemological possibilities. For Nietzsche, it is only of secondary interest if what science proclaims is objectively true or not, or if science can truly know the truth or not. His analysis targets, instead, the moral basis of science, and asks: if the aggressive imposition of one's own will to power is the original condition, under what circumstances does the human animal come to decide to renounce all subjectivity and become "objective"? Relativism addresses an epistemological problem, while Nietzsche's perspectivism addresses the moral problem of scientific objectivity. His genealogical approach leads towards a

sociological and historical examination of the circumstances under which it became *desirable* to develop an objective and value-free attitude towards the world. If we now return to the question whether Nietzsche's perspectivist critique of modern science contradicts the medico-materialist groundwork of the *Genealogy*, the answer is clear: there is no contradiction. If Nietzsche chooses to use body physiology to prove that morality is nothing but a misdiagnosed case of indigestion, he may do so without saying the opposite to what he says elsewhere. If he chooses to juxtapose the medical truth of the guts to the high-minded, disembodied falseness of morality, he can do so without running counter his own critique of objective science.

Nietzsche's perspectivism is also vital for an understanding of the role of women in his works. As many of his critics have pointed out, Nietzsche's views on women are at least as troubling as his views on politics (cf. Patton 1993; Oliver 1995; Oliver and Pearsall 1998). Many of his elitist and aggressive pronouncements seem symptomatic for both his anti-egalitarian politics and his belittling of women. When Nietzsche talks about the "body" or the "individual," it seems clear that he is primarily talking about the male body and about masculine forms of becoming: "Nietzsche's language is the language of the conqueror, a masculine image of the hero" (Oliver 1988: 26). Nietzsche applies a male/female divide not only to body physiology, but also, metaphorically, to the philosopher's task. For example, the motto that introduces the third section of the *Genealogy* reads like this: "Carefree, mocking, violent – this is how wisdom wants us. She is like a woman, she only loves a warrior" (GM: 109). In her review of philosophical works that look at the relation between Nietzsche and women, Nutt (1995: 205) rightly asserts that Nietzsche's misogyny is upsetting, but that a tacit acceptance and lack of criticism of these views among contemporary philosophers was perhaps even more troubling. Even those passages in Nietzsche's works where he speaks highly of women can be interpreted as a male idealization of women (Oliver 1995). Despite all this, Nietzsche can still be seen as one of the philosophers who provided a stepping stone for radical feminist thinking. As Conway (1998) shows in his appraisal of the *Genealogy*, a carefree and mocking attitude towards male wisdom is characteristic of much contemporary feminist writing. In particular, Nietzsche's perspectivism has been highly influential on postmodern feminist epistemologies. Conway argues that Nietzsche's perspectivism "adumbrates the postmodern strategies of feminists like Donna Haraway" (1998: 253). Judith Butler (1993) could be quoted as another example of a

feminist using a Nietzschean brand of perspectivism *against* a foundational reliance on male body physiology, enabling a critique of male-dominated philosophy without falling into the trap of re-essentializing "woman" and the female body.

The "language of the conqueror" to which Oliver's (1988) critique refers is the set of sexual and reproductive metaphors that Nietzsche uses to attack conventional modes of morality: "The metaphors of castration, impotence, and emasculation are masculinist metaphors which Nietzsche uses to critique the tradition" (Oliver 1988: 26). By contrast, all the metaphors that I have highlighted above refer to digestion. If one is generally suspicious of Nietzsche, one might hold that his understanding of digestion as "overcoming" and "self-constituting" is also "masculine." However, I would hold that at least Nietzsche's digestive metaphors are not gender-specific. Even images such as that of the birds of prey eating up the lambs (GM: 29-30; see above), which draw a parallel between digestion and aggression, cannot be reduced to an exclusively masculinist interpretation. To identify "eating up" with males and "being eaten" with females would only reinstate traditional gender stereotypes. Nevertheless, it is important to be aware of Nietzsche's masculinist bias even in respect to digestive metaphors.

By way of drawing a first conclusion about how Nietzsche's *Genealogy* can be applied to the study of Indian culture (and Indian bellies), I want to look at B.K. Smith's (1990) analysis of eaters and social hierarchy in ancient India. It is well known among scholars of India's past and present, textual and ethnographic, that the Hindu tradition abounds in countless religious, mythological, and philosophical ideas and practices that establish an immediate relationship between food and power. The "law of the fishes" (cf. Parry 1994: 112-115), which holds that the big fish would inevitably eat up all the small fish if the king does not keep them in check, is the most famous formulation of this theme. Smith's point of departure is Francis Zimmermann's (1987) theory about food and violence in the (Ayur-)Vedic tradition. Zimmermann notes that the Vedic image of war is that of the strong eating up the weak: "The hero swoops down on his enemies, thereby adopting the path of salvation: if he is victor, it is the *dharma* of the warrior to dominate, just as do beasts of prey. [...] In a direct sense, warriors devour each other" (1987: 208). Building on Zimmermann, B.K. Smith delineates two principal Indic models of food/power: the Vedic "dog-eat-dog world" on the one hand, and non-violent (*ahimsa*) vegetarianism of the post-Vedic period on the other. The first model puts every being in the world

into a hierarchical food chain: "Nature in the Veda was regarded as a hierarchically ordered set of ... Indian stomachs" (Smith 1990: 177). The stronger, the higher up the hierarchy. To eat means to subdue and to kill: "consuming food was regarded as an exercise of power in its most naked form" (1990: 179). Those who are strong, eat. Those who are weak – are eaten. Relations between humans are no exception of this all-encompassing rule of the cosmos: "The social order is to replicate the natural order so as to lend to the former the prestige and authority of the latter" (1990: 190). However, from the sixth century BC onwards, a "revolution of values" occurred which gradually replaced the dog-eat-dog model with one that extols abstention from violence towards other beings. Given that vegetarian food necessitates only a minimum of violence, it becomes mandatory to abstain from eating meat. To be free from impurity becomes the new criterion for one's standing in the social hierarchy. Smith's hypothesis for why this inversion of values happened is that the priestly castes realized their own physical weakness vis-à-vis the warrior castes and tried to reformulate the principles behind the caste ranking in a way that suited best their own interests. For Smith, this revolution of values exemplifies what Nietzsche, in the *Genealogy of Morals*, considers to be the origin of morality:

"The shift in the ancient Indian context is comparable to what Nietzsche claimed the early Christians did by systematically turning inside out the 'pagan' values of the Romans. An even more comparable situation could be constructed if one adds to vegetarianism and *ahimsa* the ideology of *bhakti* with its emphasis on 'service', 'grace', 'humility', and 'love' – all which may be regarded as inversions of Vedic ideals." (Smith 1990: 197, Fn.35)<sup>8</sup>

Based on Smith's argument, we can draw a first tentative conclusion about the role of food and power in respect to popular health discourse. As important as the two models may be for an understanding of how power relations in India are expressed through alimentary metaphors, neither one of them fully captures the post-/colonial anxieties about "lack of self-control" or "greedy eating." For example, Sundaram's (1945) recommendations for a healthy regimen is not concerned about whether violence is inflicted upon *other* beings, but more with the violence one

---

<sup>8</sup> In her introduction to *The Laws of Manu*, Wendy Doniger also subscribes to the Nietzsche/Smith analysis of the non-violent "revolution of values." Elsewhere in the same text, she dismisses Nietzsche's readings of the Hindu texts, and takes issue with Nietzsche's mistaken glorification of Hindu body concepts and esteem for women. However, the question of eating, killing, and hierarchy remains untouched by this. Doniger closely follows Nietzsche/Smith when she points out that notions of eating and killing are inseparable: "Eating and killing were regarded as two sides of the same coin. But eating was also frankly envisioned as the perpetual re-enactment of the defeat and subjugation of one's rival" (*The Laws of Manu*, Preface: xxv).

inflicts upon *oneself* by overstuffing the stomach. For him, the proper care of the self does not raise one's status in the social hierarchy, but it enables one to become a sovereign individual, able to control one's appetite, one's body, one's life. Moreover, Smith's discussion does not address the question of what happens if there is a gap between ideal and actual behaviour. It is one thing to ask what kind of food one should eat, and quite another if one cannot stick to this ideal. Whether one chooses non-violence or violence as one's principle in life is one question. Whether one can turn one's ideal into reality is an entirely different question. At stake is not just what is ideal, but also if one can exercise enough sovereignty over one's own body and thoughts to realize one's ideal in daily practice. For Sundaram and Gandhi, the issue is *why* people do things that they consciously reject. "Sovereignty" (or the lack thereof) over one's body and one's appetites is the key question. Smith's reference to Nietzsche in regard to the "revolution of values" is highly appropriate, but does not reach far enough. For fuller discussions of bodily sovereignty and self-care, we must now turn to two of Nietzsche's most influential followers, Norbert Elias and Michel Foucault.

### **3. Norbert Elias: *The Civilizing Process* (1939)**

Norbert Elias's theory of the "civilizing process" combines Nietzsche with ideas from Weber (especially theories of rational conduct or *Lebensführung*) and Freud (especially the parallelism between ontogenesis and psychogenesis). His interest in a history of manners and cleanliness was provoked by his work on the French court society of the seventeenth and eighteenth centuries. The question emerged why "courtly" manners, appearance, clothing, and ways of speaking were of such crucial importance in court society. After completing the first version of *The Court Society* (*Die höfische Gesellschaft*, Elias 1969) in the early 1930s, Elias embarked on an enormously wide-ranging project: to elicit the gradual and systematic changes of manners of the secular elites of Western Europe, from the middle ages to the early twentieth century, in relation to the socio-political transformations that occurred during the same period. *The Civilizing Process*, written from 1935 to 1939 during his London exile, tries to reconstruct both the *psychogenetic* and *sociogenetic*

transformations of European societies. Ideas from Nietzsche are central to this theory (cf. Mennell 1989; Rundell and Mennell 1998: 25).

Elias (1990: 71) later declared that one of the main targets of his concept of *psychogenesis* was the image of human beings as having an unchanging psychological make-up. Just as political organizations can only be understood through their historical development, human behaviour can only be understood when its historical development is traced. That habits and manners cannot be analyzed in terms of timeless psychobiological universals was the formative insight that spurred his project.

The history of "civilization" is reconstructed through changing practices of bodily conduct. Searching for sources that could provide evidence for the gradual changes of manners, Elias discovered etiquette books. With their focus on the minor and "shameful" aspects of human life, such as blowing one's nose, dining, and defecating, etiquette books have not been deemed worthy of serious consideration by a historiography more concerned with great men and great ideas. To write about Western Civilization and to quote, for example, the great Humanist scholar Erasmus of Rotterdam on subjects such as farting and spitting, instead of free will and Christian philosophy, is one of Elias's most Nietzschean moves.

A tradition that looms large in Elias's work but which he hardly ever mentions is cultural history. By searching for *Kulturgeschichte* in spittoons and chamber pots, Elias implicitly attacks a disembodied history of ideas for "unduly confusing innovations in the content of thoughts with changes in the psychological dispositions of individuals" (Chartier 1988: 91). More important for the civilizing process than conscious ideas are unconscious transformations of bodily habitus.

However wide the historical and geographical scope of his project, Elias arrives at a fairly simple formula about the logic of the civilizing process. In the psychogenetic process, the "threshold of shame and embarrassment" (*Peinlichkeitsschwelle*) becomes more and more restraining. Behaviours that might not have aroused any repulsion in earlier times, e.g. defecating anywhere, at any time, and in view of others, becomes more and more unacceptable and shameful. Gradually, even to talk about of certain practices is too embarrassing to be tolerated, even in etiquette books.

Crucial to this process is that the restraints on behaviour are more and more internalized self-constraints. Because of external pressures, people cannot defecate

whenever they want anymore. On the contrary, over the centuries people have gradually internalized the social pressures that govern "proper" behaviour to such an extent that it would never occur to a "civilized" person of today not to behave in any other way.

Court society's regulation of proper behaviour compares those who relieve themselves without shame or constraint with rustics (or children and madmen), who have not been to court and have never seen how respectable people behave. On evidence like this, Elias makes another important assumption about the logic of the civilizing process: "proper" behaviour is first defined in the aristocratic courts. It is from the circles of the elite that right manners gradually reach the lower social groups. However, courtly manners do not simply diffuse from top to bottom. In Elias's model, the lower groups, e.g. the lesser nobility or the bourgeoisie, *emulate* the behaviour of the court society. They thereby put the manners of the higher groups constantly under pressure of devaluation. In turn, the courtiers have to refine and civilize their behaviour more and more to escape the inflation of their ways of behaviour and to maintain their social distinction. It is this mechanism that Elias conceives as the main driving force in the civilizing process (Elias 1992: I, 134-135).

Elias wrote *The Civilizing Process* in two parts, the first dealing with changes in manners, the second with socio-political changes. Since psychogenesis and sociogenesis are moving more or less simultaneously in the same direction, the increasing self-restraint of behaviour goes hand in hand with an increasing centralization of political power. Broadly speaking, the development from a relatively loosely knit feudal society to a centralized court society, and from there on to modern capitalism is a development towards increasingly long and densely woven bonds of interdependence (*Interdependenzketten*). This process would not be possible without a growing standardization and normalization of individual behaviour. Yet his standardization through social pressure has its limits and will ideally not lead to a situation in which all natural urges and desires are suppressed. For Elias, the process of civilization is successfully completed when a type of social organization is found that matches a balance between the conflicting needs of the individual on the one side and society on the other (Elias 1992: II, 454). However, it remains unclear at which point this balance lies.

Social distinction and the demands of increasing interdependence are the factors that account for the changes in manners and bodily habits. Consequently,

Elias discounts the assumption that these changes were motivated by rational beliefs about hygiene and health (Mennell 1989: 45-47). When people are advised in an etiquette book from thirteenth-century Germany not to scratch themselves with the same hand with which they touch the food on the shared plate, health considerations are not mentioned – what counts is "courteous" (*höflich*) behaviour (Elias 1992: I, 113; 153). Elias holds that only *after* the threshold of shame is lowered might rational explanations in terms of health and hygiene be constructed for it. And even if a rational reason for certain behaviours is found, its role is, at best, to *reinforce* the threshold of shame (Elias 1992: I, 155).

The civilizing process follows its own logic, independent of medical science and ideas about health. Analyzing the gradual disappearance of spitting, he quotes from an English etiquette book of 1859: "Spitting is at all times a disgusting habit, I need say nothing more than – never indulge in it. Besides being coarse and atrocious, it is very bad for the health" (in Elias 1992: I, 212). Not even the Pasteurian revolution was of any bearing in this process. On the contrary, all evidence suggests that scientific views of contagious diseases did not give rise to sentiments of shame; hence they could not be the motor of actual behavioural changes (Elias 1992: I, 215). Thus, Elias makes two strong assumptions: First, he denies that medical knowledge, independent of it being true or not, has any significant bearing on the history of manners. Second, he obscures the crucial difference between *distinction* and *discipline*.

In the 1930s, when Norbert Elias wrote *The Process of Civilization*, the Institut Pasteur had revolutionized ideas about disease contagion and hygiene in western Europe. For his contemporaries, bacteriology had driven a deep gap in the history of medicine between a "pre-Pasteurian" and a "Pasteurian" age. It was general opinion that modern medicine was about to achieve a total victory in the "war against microbes." Recent science studies throw a new light on the Pasteurian revolution. As Bruno Latour's (1988) analysis shows, Pasteur was part of a wide movement of "hygienists" devoted to the clean-up of cities and peoples. The enthusiastic reception of his discoveries was only possible because all the hygienists' highest hopes were fulfilled.

Since the eighteenth century, the social reformers have been looking for exact cause-effect relationships to enable precise and efficient interventions (Laqueur 1989:178). Pasteur's microbe gave them the most specific target to date (Goubert



1986; Hannaway 1993: 301; Latour 1988: 45; Vigarello 1988: 203). In this context, it is remarkable that Elias constructed his history of the civilizing process as having such a *longue durée* that Pasteur played no particular role at all. For him, the discovery of "Pasteur's little monsters" caused no revolution whatsoever.

"Bacillophobie" was, at best, the last step in a steady development in which manners and increasingly lower thresholds of shame have been the driving force. Elias quotes from Cabanès's etiquette book that accounts for the disappearance of both spitting and the spittoon by 1910 as follows:

"Avez-vous observé que nous reléguons aujourd'hui dans quelque coin discret ce que nos pères n'hésitaient pas à étaler au grand jour? [...] Il en était de même d'un autre meuble, qui ne fait plus partie du mobilier moderne et dont, par ce temps de 'bacillophobie', d'aucuns regretteront peut-être la disparition: nous voulons parler du crachoir." (quoted in Elias 1992: I, 212)

Elias is right to assume that no absolute "break" in health practices occurred during the late nineteenth century. As is evinced both by the prohibition of steam-baths in times of the plague and by the removal of corpses and other putrid matters from the proximity of the living, the control of public health is undoubtedly a long-standing concern (cf. Cipolla 1992; Porter 1993; Stolberg 1994). But the insistence on a continuity of the historical process obscures differences between *distinction* through manners and *discipline* through medical science.

Much scholarship has been devoted to the shift from largely Hippocratic ideas to scientific, positivist concepts of hygiene. Historians may differ in their interpretations of this development. Some may analyze public health policies as a formation of state power, others as a necessary alleviation of the outcomes of rapid industrialization and urbanization (cf. Coleman 1982). Either way, the enormous importance of public health campaigns during the nineteenth century is hardly a matter of dispute. Why, then, does Elias not consider this problem at all? The closest he came to the issue of public health was in his book on death (Elias 1987), but even there, no mention is made of it.

As we have seen, Elias conceives social distinction as the driving force in the civilizing process. Although the aristocracy had lost most of its political power by the nineteenth century, Elias assumes that the shadow of the court society still defined "proper" behaviour. Nothing of any significance changed during the nineteenth century. The civilizing process continued unerringly, even culminated during that era. Self-constraints had reached such a high level and had become so

deeply ingrained that the once reached standard of civilized behaviour was "secured" and not threatened by future regressions (Elias 1992: I, 190).

What Elias fails to see is that, broadly speaking, the motor of the civilizing process was not so much the emulation of distinguished manners, but rather the often even forceful imposition of discipline. To be sure, this does not mean that discourse of the elite translated immediately into everyday practices. Against Foucault's neglect of popular agency, Alain Corbin documents how members of all classes resisted strategies of deodorization (Corbin 1986: 231ff). What is important for the problem at hand is, however, that the changes in attitudes towards cleanliness during the nineteenth century cannot be understood through Elias's theory of distinction. The health reformers, who were all members of the new bourgeois elite, explicitly aimed at the standardization of behaviours throughout all classes.

Elias cannot allow any development of manners to be merely accidental. Social distinction does not just produce a virtually endless series of arbitrary fashions, but leads systematically to *one* final goal. If the civilized courtier in eighteenth century France breaks his bread with the hands and is horrified by those barbarians who cut it with a knife, this is not simply "an aristocratic way of affecting simplicity" (Flandrin 1989: 303), but a further step in the process of civilization (Elias 1992: I, 132). The same applies to all other trends: anything that happens must, in the long run, be part of the Great Plan. The manners of modern Western civilization *must* be the most civilized since they are the manners of modern Western civilization.

By turning bourgeois patterns of behaviour into the acme of a unilineal process of civilization, Elias obscures what is most crucial for adequate understanding of the hygienist movement: they rose to power by the combined forces of *distinction* and *discipline*. They not only defined bourgeois standards as "civilized," "modern," and "rational," but also turned their supposed superiority into a legitimization of discipline. The hygienists, particularly the Pasteurians since the 1890s, were not only distinguished from the "stinking crowds" by proper manners – they assumed the right and the duty to give them a thorough washing in the mainstream of civilization.

These criticisms aside, Elias's attention to the changes of everyday bodily practices has pioneered a way of writing about history in which the control of digestive processes is at the basis of the process of civilization itself. Elias puts

increasing self-constraints at the heart of his theory. What he still lacks is a more sophisticated understanding of bodily practice as a *self-reflexive* care of the self. This theme is more fruitfully developed in the late writings of Michel Foucault.

#### 4. Michel Foucault: The "care of the self" (ca. 1976-1984)

Michel Foucault is best known for his works on total institutions, such as prisons, hospitals, and mental asylums. In each of these studies, Foucault is concerned with the question of how "power" takes possession of humans, exercises "discipline" over them, and shapes them according to the needs of the modern state. What Foucault is primarily interested in is that aspect of the civilizing process that Nietzsche describes as the oppressively moralistic "training" that turns human animals into responsible subjects, answerable to the demands of power. For Foucault, the quandary of modern society is that it creates the free, sovereign subject through a long and violent process of moralistic inscriptions: "The central paradox of the world depicted by Foucault's analysis is that the modern growth of individual rights necessarily requires greater surveillance of persons in the interests of an abstract notion of equality" (Stauth and Turner 1988: 190). To a large extent, Foucault's works can be read as a historical analysis of this process. For Alexander Nehamas, Foucault's notion of "care of the self" elaborates central ideas from Nietzsche's *Genealogy* (Nehamas 1998; Ansell-Pearson 1995). In Jürgen Habermas's (1985) comprehensive discussion of "modernity" and its critics, Foucault is interpreted as one of Nietzsche's direct followers (cf. Habermas 1985: 120, 279-343).<sup>9</sup>

Foucault is not commonly known as a theorist of digestive processes. However, as I will argue in the following, Foucault's writings, especially those of his latest work period, are important for an understanding of self, body and science in

---

<sup>9</sup> A fuller discussion of Habermas's (1985) reading of Nietzsche and Foucault in view of the contested concept of "modernity" cannot be attempted here. A closer look at his work seems particularly interesting since many of the quotations he chooses from Nietzsche's writings also contain digestive metaphors. For example, Habermas (1985: 106) quotes a passage from Nietzsche's *Vom Nutzen und Nachteil der Historie* where modern people bloat their bellies with undigested historical knowledge. From *Geburt der Tragödie*, Habermas (1985: 108) cites Nietzsche's view of the human sciences (especially those who deal with a historical or cultural "Other") as driven by an insatiable hunger for the myths of other people (after one's own myths were destroyed by modernity).

relation to diet and digestion.<sup>10</sup> My re-reading of Foucault begins with a passage from an interview that he gave shortly before his death in 1984. It contains, in a nutshell, the new understanding of "power" that he derived from an examination of Greco-Roman ethics:

"I believe that among the Greeks and Romans – especially the Greeks – concern with the self and care of the self were required for right conduct and the proper practice of freedom, in order to know oneself [...] as well as to form oneself, surpass oneself, to master the appetites that threaten to overwhelm one. Individual freedom was very important for the Greeks – contrary to the commonplace derived more or less from Hegel that sees it as being of no importance when placed against the imposing totality of the city. Not to be a slave (of another city, of the people around you, of those governing you, of your own passions) was an absolutely fundamental theme. The concern with freedom was an essential and permanent problem for eight full centuries of ancient culture. What we have here is an entire ethics revolving around the care of the self; this is what gives ancient ethics its particular form."  
(Foucault 1997: 285)

The similarity between Nietzsche and Foucault is perhaps most obvious in respect to the notion of the "sovereign individual." Drawing on the work of the Sorbonne classicist Pierre Hadot (1981), Foucault sees the Greco-Roman practices of self-control as a form of aesthetic, non-moralistic self-creation. To achieve "individual freedom" in ancient culture, one had to become first of all master of oneself. In the modern understanding of ethics, "freedom" is an ascribed quality, not one that is achieved and maintained on an individual basis. In modern, post-Enlightenment law, each subject is free because the state guarantees freedom irrespective of individual qualities. Each human is free because, and only because, the law *gives* each and every human equal freedom towards the law. In Foucault's construction of ancient law, on the other hand, freedom is the result of individual *practice*. Freedom is not given, but individually achieved.

Typical of the Greco-Roman ethics is the close relationship between control of one's bodily desires and control over society. Not to be a slave of one's own passions and not to be subordinate to other people is, in view of ancient society, basically the same. To be entitled to speak, to make legal decisions, and to be present in the political arena is dependent upon one's personal habitus. Emblematic of this concept are words by Socrates, Plato, and Xenophon directed to young men: "You

---

<sup>10</sup> In Lock's (1993) influential survey of anthropological approaches to the body, Foucault's work on self-care is not even mentioned in passing. In medical anthropology, the reception of Foucault's late writings is only beginning now.

want to become a politician, to govern a city, to care for others, and you haven't even taken care of yourself. If you do not care for yourself, you will make a poor ruler" (Foucault 1997: 293). In this view, legitimate authority and individual bodily habitus are intimately linked to each other.

Given that Foucault's historical focus had always been on the early modern and modern eras, his turn to the Greeks and Romans continues to baffle many of his critics. Why did Foucault think it important to examine this particular period in history? Even if he looked at this time in history, why did he not, as in many of his other works, look at the dividing practices of "power," e.g., the separation of madness from sanity, or of normalized behaviour from deviance? If Foucault's late work is read through Nietzsche, his concerns become more clear: (1) Given that Nietzsche sees Christianity as one of the main forces in the "slave revolution" of morality, Foucault became interested in the pre-Christian era, and the changes that occurred when Christianity emerged. If modern subjectivity is rooted in Christian morality, what kind of subjectivity existed among the "pagans"? (2) Foucault's earlier works on power (especially *Discipline and Punish*) stressed the body's docility, its near infinite malleability to outside intervention. Akin to Nietzsche's image of a human half-animal trapped in the prison of civilization, Foucault focused on how power takes possession of human beings and moulds them into "subjects." The later works are an elaboration of the more utopian elements of Nietzsche's *Genealogy*: What strategies are there to counter the enslaving effects of morality? What possibilities are there to become a "sovereign individual"? (3) A significant difference between Foucault and Nietzsche exists, however, with respect to *knowledge* of the self. Foucault juxtaposes the "care of the self" to knowledge of the self. As we have seen, Nietzsche is rather unconcerned about what one can *know* of the body. His "physiology of morals" draws heavily on medico-materialist understandings that were common during his time without questioning their validity. In contrast to Nietzsche, Foucault is more careful about what can be known about humans, society, or history. Let me explain these points in more detail.

Foucault proceeds from the assumption that there is no naturally given, or substantive, subject, but only historically contingent practices of subjectivization:

"What I wanted to try to show was how the subject constituted itself [...]. I had to reject a priori theories of the subject in order to analyze the relationships that may exist between the constitution of the subject or different forms of the subject and games of truth, practices of power, and so on" (Foucault 1997: 290).

Opposing the commonly held opinion that his work was centred on "power," Foucault points out that his concern is an understanding of how *subjectivity* is being formed: "it is not power, but the subject, which is the general theme of my research" (1982a: 209). Whereas his earlier works focus more on subjectivity as a passive object of power, his work on Greco-Roman ethics is primarily about active self-creation: "I am now interested in how the subject constitutes itself in an active fashion through practices of the self" (1997: 291; cf. Foucault 1982a: 212). Stressing individual practice, it is characteristic of Foucault's last works that theoretical considerations figure much less prominently than earlier, in favour of a concrete examination of the technologies of the self employed by the Greeks and Romans.

Along with the rejection of a substantive, unchanging subject, Foucault also rejects an idea of "the body" as unchanging, stable basis of thought (cf. Dreyfus and Rabinow 1982: 109-110). The body, its organs, its processes, is an effect of discourse, and is subject to historical changes. As if it was a plate of wax, the body bears the traces of changing subjectivizations and power relations (what Foucault here calls "descent") in its very physiology: "[Descent] inscribes itself in the nervous system, in temperament, in the digestive apparatus" (1984: 82). It is the task of "genealogical" history "to expose a body totally imprinted by history and the process of history's destruction of the body" (1984: 83). Such scathing remarks on body and power are more characteristic of his earlier works rather than the later ones, as he shifted the emphasis of how power moulds the subject to how the subject moulds itself in a creative way. Yet the basic idea of the body's malleability remains the same throughout.

One important way in which the self was created in antiquity was through a controlled intake of food and a close attention to one's digestive tract. Mastering one's appetites, so that they may not overwhelm oneself, is not just a metaphor for the need to restrain one's desires, but a concrete concern about one's ethical being. The "small things" of life, everyday routines of increasing self-perfection, become an important source of one's self-definition. To illustrate this point, Foucault quotes from a letter written by Marcus Aurelius (121-180 CE) to his teacher Fronto. The letter dates from around 144-145 CE, when Marcus was 24 years old (two years later he acquired the powers of Roman emperorship):

*"Hail, my sweetest of masters. We are well. I slept somewhat late owing to my slight cold, which seems now to have subsided. So from five a.m. till nine I spent the time partly in reading some of Cato's Agriculture and partly in writing not quite such*

wretched stuff, by heavens, as yesterday. Then, after paying my respects to my father, I relieved my throat, I will not say by gargling – though the word *gargarisso* is, I believe, found in Novius and elsewhere – but by swallowing honey water as far as the gullet and ejecting it again. After easing my throat I went off to my father and attended him at a sacrifice. Then we went to luncheon. What do you think I ate? A wee bit of bread, though I saw others devouring beans, onions, and herrings full of roe. [...] After coming back, before I turn over and snore, I get my task done and give my dearest of masters an account of the day's doings, and if I could miss him more, I would not grudge wasting away a little bit more." (Marcus Aurelius, quoted in Foucault 1997: 233)

What Foucault finds striking about this passage is the meticulous concern with ostensibly "unimportant things," which nevertheless become, through constant practice and careful reflection, the basis of one's self-creation. The qualities that mark out an emperor become inscribed in the most simple, most quotidian activities of daily life. These activities are not understood as mindless routines, but as embodied ways to self-perfection.

Although one's own self is the primary object of action, the care of the self is not a solitary pursuit. It leads to an "intensification of social relations" (CS: 53), since the self engages with others who either act as teachers and models, or as superiors and subordinates. The technologies of self are not invented by the individual, but are "proposed, suggested, imposed upon him by his culture, his society, and his social group" (1997: 291). Nevertheless, the care of the self is prior to the care for others. That care of the self could later be criticized as a kind of immoral egoism is one of the deep-seated changes that came through Christian morality. According to Foucault, the Christian idea that salvation cannot be found in this world, but has to be sought through a renunciation of self also brings about a decline of the ethics of the care of the self (1997: 285). This change from self-creation to self-renunciation is, for him, symptomatic of Christianity's notion of truth as always already inscribed in the individual soul. For example, Foucault considers it a typically Christian idea that the soul harbours evil thoughts and desires which have to be decoded by the individual person in order to realize the "truth" about itself. Moreover, a change occurred from self as process towards self defined by sexual drives, a self threatened by corruption of chastity:

"Physical integrity rather than self-regulation became important. [...] This new Christian self had to be constantly examined because in this self were lodged concupiscence and desires of the flesh. From that moment on, the self was no longer something to be made but something to be renounced and deciphered." (1982b: 366)

Foucault's critique of sexuality as a given fact that determines the truth of the subject is what integrates the volumes of the *History of Sexuality*. This explains why the first volume examines the discourse on sexuality since the eighteenth century, whereas the second and third volumes deal, in a seemingly abrupt manner, with antiquity. To go back before the Christian era is Foucault's attempt to find alternative possibilities of being, possibilities which liberate from the "sexual imperative" of twentieth-century society. Foucault, taking the word directly from Nietzsche, defines the method of retracing the development of certain ideas in order to deconstruct them as "genealogy." The Foucauldian definition of writing history as genealogy acknowledges that there is no interpretation without invested power interests, and that the aim of writing history should be to disrupt received ideas about the world in order to "cure" them (1984: 90), and thus to achieve greater freedom.

"[Genealogical critique] will not deduce from the form of what we are what it is for us to do and to know; but it will separate out, from the contingency that has made us what we are, the possibility of no longer being, doing, or thinking what we are, do, or think. It is not seeking to make impossible a metaphysics that has finally become a science; it is seeking to give new impetus, as far and wide as possible, to the undefined work of freedom." (Foucault 1984b: 46)

Therefore, in the late works on the ethics of antiquity, the object of study ("technologies of self") and the goal of study ("genealogy") become one. Foucault acknowledges that his interest in the care of the self is part of a local strategy to break away from oppressive structures of the present: "I mean that this work done at the limits of ourselves must [...] put itself to the test of reality, of contemporary reality" (Foucault 1984b: 46). His genealogical approach to history puts Nietzsche's perspectivism into practice, recognizing the risk of deliberate deformation of "truth" in favour of potential transformation. History, in this sense, is a *desirable* science, because it opens up possibilities for greater freedom.

Foucault's ideas about how care of the self and knowledge of the self are related to each other are complex. This is due to the fact that "knowledge," "thought," "science," or "truth" have constantly shifting meanings. In the late works on ethics, he proposes a basic distinction between, on the one hand, power/knowledge, and "care of self" on the other. "Technologies of power" submit individuals to rules of conduct and objectivize them. Alternatively, "technologies of self" allow the individual to effect "a certain number of operations on their own bodies and souls, thoughts, conduct, and way of being, so as to transform themselves



in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality" (Foucault 1997: 225). Applying this distinction to the analysis of the Greco-Roman world, he suggests that in this era the maxim "Take care of yourself" is more important than to "Know yourself" (Foucault 1997: 228). In Christianity, on the other hand, a one-sided emphasis on knowledge of the self prevails, that is, an obsessive concern about a "true" self that has to be explored, discussed, and deciphered. The practice of confession is the prototypical technology associated with this concept of self. In the pre-Christian period, however, more weight was given to practices of self-care. Instead of knowing one's true self, the maxim was to "become who you are," to create oneself: "In Greco-Roman culture, knowledge of oneself appeared as the consequence of the care of the self. In the modern world, knowledge of oneself constitutes the fundamental principle" (Foucault 1997: 228). In this view, "knowledge" appears as something fixed, stable, and somewhat oppressive, whereas "care" is flexible, creative, and potentially liberating. This distinction mirrors the Nietzschean opposition between "slave morality" and "sovereign individuality": "Knowledge of the self" stifles individual freedom, whereas "care of self" allows it to come into its own.

That individual practice produces knowledge, instead of the other way round, leads him to distinguish his understanding of asceticism from Max Weber's. According to Foucault (1997: 224), Weber's question is: what do I have to *do* according to what I know about myself? For example, knowledge about the soul in relation to God comes first, this-worldly asceticism and other practices associated with the "Protestant Ethic" follow from it. By contrast, Foucault's (and the Greek's) question is: what do I *know* about myself according to my daily routines? Foucault's general project being "the different ways in our culture that humans develop knowledge about themselves" (1997: 224), his genealogy of ethics in antiquity tries to recover a mode of self-knowledge which is not given from the outside, but created through individual practice. The stakes in the "games of truth" are thus reversed: what outside knowledge, or "science" in general, proclaims as true becomes relativized: "The main point is not to accept this knowledge at face value but to analyze these so-called sciences as very specific 'truth games' related to specific techniques that human beings use to understand themselves" (Foucault 1997: 224). Foucault follows much of Nietzsche's *Genealogy*, but does not take on board the claims of science as easily as Nietzsche.

The opposition between "knowledge" and "care" informs Foucault's view of ancient regimes of the body, as opposed to those of the Christian, and later modern, eras. One of Foucault's significant observations regarding this concerns different notions of sexuality in the Greco-Roman world. His hypothesis is that in the ancient world, sexuality is not a problem of moral normalization of "good" and "bad" acts, but a non-moral practice of bodily self-care, especially in terms of daily routines and physiology. In antiquity, the appropriateness of a sexual act for an individual actor is considered along various criteria, especially physiology and social relations. In the Christian era, on the other hand, sexuality becomes defined in absolute terms. An outstanding example of this change in attitude is homosexuality, which is principally abominable in Christianity, while in Greco-Roman culture it may be either allowed or prohibited, according to specific circumstances. For Christians, sexuality becomes constituted as "a permanent and complete grid of classifications among permitted and prohibited acts" (CS: 35). The emphasis is entirely on the sexual act as such, not on the individual actor and "his way of being, his particular situation, his relations to others, and the position he occupies with respect to them" (CS: 35). Physiology plays a key role in this, as it provides a measure to how sexual acts should be performed.

Foucault underlines that in Greco-Roman writings, sexuality is framed in the context of regimen (diet, exercise, sleep, and so on). A study of the connections between sex and dietary regimens evinces how strongly the sexual act is dependent on the physiological circumstances that might make it harmful or beneficial, and what impact a sexual act has on all parts of the body. Sexuality is a balancing act between desire and one's physiological energy levels. Given that humoral medicine perceives a vital connection "between the sexual act and the substantial, violent, paroxysmal, and dangerous expenditure of the vital principle that it involves" (1997: 91), to take care of sex is closely linked to care of the self.<sup>11</sup> How to have sexual intercourse is another form of the question of how to eat, how to exercise, and how to regulate one's daily routines in a way that suits one's physiological dispositions. Sexuality, daily regimen, and medicine are variations of the theme of well-being, and thus border on, or even merge with, philosophy, to form, as Plutarch (46-119 CE) puts it, "'a single field' (*mia chora*)" (CS: 54). In the Greco-Roman understanding,

---

11 The Greco-Roman physiology of semen and orgasm are, some details aside, the same as those of Ayurveda. The arithmetic of how many drops of blood go into one drop of semen, and of how many orgasmic paroxysms a man can endure without ruining his health, are a mainstay of ethnographies on Indian ideas of physiology (e.g., Alter 1997; Parry 1989).

medicine is one aspect of the question of how to care for the self in a rational, systematic manner.

As is spelled out in *The Birth of the Clinic* (Foucault 1989), modern medicine is a technology of power, which objectivizes the body in order to control it. The picture that Foucault draws of ancient medicine is, however, decisively different: Greco-Roman medicine does not aim to exercise power over the individual, but enables it to exercise greater freedom. The ethics of ancient medicine is, Foucault argues, to give individuals a set of rules that enables them to care for their health themselves. It aims to foster individual self-reliance, and maximum independence from the need for direct medical intervention:

"Thus, medicine was not conceived simply as a technique of intervention, relying, in cases of illness, on remedies and operations. It was also supposed to define, in the form of a corpus of knowledge and rules, a way of living, a reflective mode of relation to oneself, to one's body, to food, to wakefulness and sleep, to the various activities, and to the environment. Medicine was expected to propose, in the form of regimen, a voluntary and rational structure of conduct." (CS: 99-100)

Recently, Nietzsche and Foucault have become influential on a number of anthropologists who work in India. How have Nietzsche's genealogy of morals and Foucault's self-care been applied to an ethnographic study of Indian modernity?

## 5. Ethnographic perspectives

As we have already seen in relation to B.K. Smith's insights on eaters and food in ancient India, Nietzsche can be fruitfully applied to the study of Indian culture. In this section, I want to discuss briefly the work of three ethnographers of India (Laidlaw, Alter, Nichter) who have, in recent years, studied sovereignty and self-care in India, each of them dealing with diet and digestion. In each case, a Nietzschean/Foucauldian notion of "self-care" is implicit in the argument.

In his 2001 Malinowski Memorial Lecture, James Laidlaw (2002) applies Nietzsche and Foucault to the study of Jain asceticism, especially its strict adherence to non-violence (*ahimsa*) in diet and in social conduct. Laidlaw's point of departure is that anthropology has neither developed a sophisticated theory of "freedom," nor a way of approaching ethics comparatively and ethnographically. He suggests that the most fruitful way to conceive of an anthropology of ethics and freedom is to turn to

Nietzsche and Foucault, despite these two being "perhaps initially surprising authors" (2002: 316) to draw on for an anthropologist. In regard to Nietzsche, Laidlaw underlines the necessity to critically assess "the *value* of the values we think of as morality" (ibid.), especially the values of asceticism and self-denial. Laidlaw points out that Nietzsche's genealogical deconstruction of asceticism is not limited to the Judeo-Christian tradition, but applies to all "self-denying systems of values" (2002: 318), including those of Brahmanism, Buddhism, and Jainism. The scope and depth of Nietzsche's questions make his ideas an appropriate starting-point for anthropology. If Nietzsche asks the right question, Foucault's later writings on self-care show, according to Laidlaw, what a possible answer could look like. From Foucault's work, Laidlaw takes two aspects. First, ethics cannot be properly understood if only social rules of morality are looked at. Instead, the study of ethics must include modes of self-fashioning. Second, these modes of self-fashioning, or techniques of the self, have a specific cultural and historical context, which calls for an ethnographic approach. Foucault's writings on Greek and Roman technologies of the self turn Nietzsche's genealogy of morals into a fruitful approach for the social sciences:

"Foucault's great achievement in my view was to see, and to show, how we can have a history of this: that by describing the different techniques of the self, one can tell the story of different ways in which people purposefully made themselves into certain kinds of persons, and therefore of the historically specific and definite (and of course always limited) forms which ethical freedom has taken." (Laidlaw 2002: 324)

Laidlaw's reading of Nietzsche and Foucault is original and convincing, yet its application to *ethnography* remains imprecise. In this article, Laidlaw's approach to Jainism stays on the level of abstract philosophical speculations about *karma*, *ahimsa*, and self-purification, and does not take into account a Jain person's own reflections. By not asking how Jains themselves think about what they are doing, especially about the gaps between ideal and reality, he misses out on Nietzsche and Foucault's most fruitful contribution to an anthropology of ethics.<sup>12</sup> However, Laidlaw must be credited with the most sophisticated discussion of Nietzsche/Foucault from an anthropological angle to date.

In a series of writings, Joseph Alter also draws on Foucault (and in occasional footnotes, on Nietzsche) to approach practices of self-care ethnographically. In a

---

<sup>12</sup> In fact, Laidlaw's detailed ethnographic work on the Jains addresses these issues, especially *Riches and Renunciation* (Laidlaw 1995).

study on male celibacy (*brahmacarya*) and semen loss (*virya-nirodha*) in Benares, Alter (1997) compares Foucault's notion of "self" with those among his North Indian informants. Their anxieties about semen loss take on special pertinence when they do not simply reiterate traditional Yogic ideas of physiology, but reflect on the crisis of body boundedness under the conditions of modernity. The argument that Indian men are highly concerned about the quantity and quality of their semen is well documented (e.g., Bottéro 1991; Carstairs 1957; O'Flaherty 1973, 1980; Zimmermann 1991). Alter's Foucauldian perspective enables him to take a new angle to the problem. Unfortunately, Alter only draws on Foucault's early writings on Christian sexuality, and misses out entirely on Foucault's later writings on ethics.

By way of analyzing Ayurveda's Sanskrit sources, especially those that deal with daily regimen and the physiology of digestion, Alter (1999) argues that Ayurveda is not primarily concerned about curing illness, but about achieving "super-health." His characterization of Ayurveda is strongly indebted to Nietzsche and Foucault:

"As I will show, Ayurveda, seen as an applied philosophy of physiology – what might be called metaphysical fitness – is a radical, often forceful, always struggling mode of metabolic, humoral body-building and cosmic self-improvement – a quest for equipoised perfection in an inherently and naturally imperfect world." (Alter 1999: 45)

Similarly to Laidlaw (2002), Alter also includes no ethnographic data on how persons who use Ayurvedic practices of self-care reflect on what they are doing. To consider only Ayurvedic *texts*, and only those portions of the texts that are located on an "ontological" level – instead of studying ethnographically contemporary Ayurvedic practice – leaves his argument without any specific ethnographic context. His assertion that Ayurveda is not about curing illness but about "super-health" seems slightly exaggerated. In my opinion, no present-day Ayurvedic healer would make a claim like this. Nevertheless, Alter's point is well-taken that "medical anthropology" must not only look at illness and medicine, but also at notions of good health.

Alter's most sustained attempt to apply Foucault to an Indian context is in his studies on Mahatma Gandhi's micropolitics of the body (Alter 1996, 2000). For Alter, Gandhi's obsessive concerns about the control of diet and semen expenditure are an attempt to achieve political sovereignty through bodily sovereignty. Although he acknowledges Foucault's influence, Alter claims that Foucault does not provide "a

guide for understanding how people work with their bodies and thereby both tangle and untangle configurations of power" (Alter 2000: xviii). Arguably, Alter overemphasizes once more Foucault's early writings on power and discipline at the expense of his later writings on ethics. In my view, Alter's approach to "the fundamental mechanics of self-discipline, self-overcoming, and self-rule" (2000: 35) is already fully developed in Nietzsche and Foucault. Nevertheless, the close connection he establishes between these two thinkers and Gandhi's political programme is suggestive and appropriate.

In his ethnography of indigestion as "sign and symptom of defective modernization," Mark Nichter (2001) juxtaposes Gandhi's body-politics against modernization with popular and Ayurvedic complaints about gastric troubles.<sup>13</sup> He asks if Gandhian notions of health are "deemed relevant by Indians today as a means of understanding their experience of modernity" (2001: 86). His study consists of four case studies on Ayurvedic practice in a semi-rural area of Karnataka. In each case, Nichter looks at how patients present their complaints to Ayurvedic healers (*vaidya*), and how the healer diagnoses and treats them. Throughout his ethnographic study, digestive "dis-ease" is the focus. Indigestion is, in Nichter's interpretation, "both a central trope for defective modernization, as well as a bodily response to environmental (physical as well as social) degradation and change" (2001: 102). For example, in the first case study (Nichter 2001: 89-92), a Brahmin patient who had been allopathically diagnosed as a chronic "BP" ("blood pressure") patient comes to the Ayurvedic practitioner to get medicine against the side-effects of the tablets he is taking. These side-effects are indigestion, *gas*, lack of appetite, mental weakness, and sleeplessness. The patient's diagnosis is that the side-effects of the medicine have made it impossible for him to digest it properly, and he asks the Ayurvedic healer to give him medicine to boost his digestive power. Since the patient also complains about various psychosocial tensions, such as his difficulties marrying off his daughter, Nichter suggests that the patient could also have been treated as a psychosomatic patient. Instead of giving medicine, should not the social and economic affairs of the patient and his family be changed? In response to Nichter's question, the *vaidya* responds that Ayurveda sees the patient's stomach trouble as the "root cause" of all the patient's other troubles. In Nichter's interview transcript, the healer asserts: "To break the cycle of undigested food and undigested, uncontrolled

---

13 Unlike Laidlaw and Alter, Nichter never quotes Nietzsche or Foucault. However, his argument about "defective modernization" puts him into the same school of thought.

thoughts, I must first treat the stomach. This is the root cause of the problems" (2001: 90). The social context of the patient's digestive complaints is not rejected, but in a hierarchy of priorities, the stomach comes first:

"[The *vaidya*] advocated working from the stomach outward. Medicines were provided to clean out [the patient's] system, improve his digestion, balance his humors, and restore a sense of rhythm to his life. Achieving good digestion would lead to better thinking capacity, self-control, a more balanced emotional state, and self-confidence: all of which would result in improved social relations in his household. [The patient] was encouraged to focus on his own health concerns before trying to solve larger life problems." (Nichter 2001: 92)

For Nichter, the Ayurvedic healer duly takes into consideration socio-political problems in the diagnostic process. However, by focusing the therapeutic recommendations on the patient's individual self-care reveals, to Nichter, that contemporary Ayurveda pursues a strategy of accommodation vis-à-vis the ills of modernity. Instead of going to the socio-political "root causes" of sickness, Ayurveda limits itself to more or less superficial cures of symptoms. Ayurveda acknowledges the ills of modernization, such as the overuse of chemical fertilizers to treat worn-out fields, and the overuse of allopathic drugs to treat worn-out bodies.<sup>14</sup> But its critique does not become political. Instead, Ayurveda has "co-opted" (2001: 104) these ills to sell its own medicines. In the final analysis, contemporary Ayurveda reduces the Gandhian ideal of sovereignty over both body and politics to relieving the bodily symptoms of defective modernization.

Nichter's study presents an excellent example of how digestive complaints, medicine, and modernization can be approached ethnographically. We must now turn to the ethnography of Kolkata: How is modernity digested there?

---

<sup>14</sup> For further ethnographic descriptions of ill-being and environmental degradation in contemporary India, see Alley (1998) and Gold (1998).

## II. Research methodology

From July 1999 to December 2000, I carried out ethnographic fieldwork on popular and professional notions of body, illness, and medicine in Kolkata. To cope with the complexity of the data, I did not study "the body" as a whole, but only ideas and practices related to a particular region of the body: the belly and the digestive system. Research on popular perceptions comprised interviews and participant observation among a cross-section of the population in an area of South-West Kolkata. For research on professional medicine, I talked to practitioners of three systems: allopathy (i.e., biomedicine), homeopathy, and Ayurveda.<sup>15</sup> The Indian government nowadays acknowledges and supports seven medical systems: allopathy, Ayurveda, Yunani, Siddha, Yoga, homeopathy, and naturopathy. Among these seven, I found allopathy, homeopathy and, to a much lesser extent, Ayurveda, to be the most established in Kolkata, so I chose these three for an in-depth study. Research with the professional healers aimed at elucidating an "outside" perspective on popular perceptions. My questions focused on what complaints the healers hear most often, how patients react to their diagnoses, and how patients act in response to the therapies prescribed.

In this chapter, I will describe the methodology used in this project. I will first describe the initial research question, then go on to describe the research setting and sample, the design of the study, and important aspects of the subsequent data analysis.

### 1. The initial research question

My choice of "the belly" as object of ethnographic study needs some explanation. At the beginning of my fieldwork in Kolkata, I set out to study popular perceptions of environmental pollution and its effect on health. Chris Pinney's (1987, 1999) research on conditions of life in Nagda, a badly polluted industrial area of Madhya

---

<sup>15</sup> Like Kolkatan doctors, I use the term "medical *system*" only in a generic way. From a sociological point of view, a succinct definition of "system" would be necessary. Arnold and Sarkar (2000: 49) remark that the discourse on "medical systems" implies that different practices are "on a seemingly equal footing without expecting one to be subsumed in the other" – which is not exactly the case. If I still speak of "medical systems," it is only for want of a better term.



Pradesh, was one of the starting points of my project. Pinney describes how popular perceptions of industrial pollution are mediated through traditional concepts of body and illness. For example, air pollution caused by carbon disulphite is perceived to be "hot." In turn, therapies against the ill-effects of the gas include "cooling" foods such as milk and ghee (Pinney 1987: 474). In traditional Indian notions of health and illness, the body is perceived to be always in flux, always threatened by disequilibrium. The aim of indigenous medical practice, as well as of the householder's daily care of the self, is to keep this disequilibrating flow under control, and possibly even to reverse the flow and to achieve a kind of super-health (cf. Alter 1999; Parry 1994: 167). In this context, Pinney argues that people in Nagda see their power to attain sovereignty over their bodily fluxes as severely compromised by the conditions of life to which they are subjected. Pinney's high-caste informants also see a connection between pollution-related illnesses and Hindu notions of cosmic time. The current age is that of the *kaliyuga*, the last and most decrepit of the four world ages.<sup>16</sup> In the *kaliyuga*, it is virtually impossible to control the body's disequilibrating fluidity, and life tends to be miserable and short. The traditional Hindu notion of the *kaliyuga* is turned into a meta-narrative of industrialization's sickening consequences.

When I set out to do a similar study, the choice of Kolkata for such a study on pollution-related illnesses seemed straightforward. Metropolitan Kolkata is home to about 14 million people, not counting the directly adjacent areas. Population density is extremely high.<sup>17</sup> Once the unrivalled economic hub of colonial India, but in gradual decline since at least the 1960s (cf. Bose *et al.* 1999), Kolkata continues to be Eastern India's metropolitan centre of industry, finance, and trade. Pollution statistics consistently diagnose Kolkatan air and water as being among the most polluted in India.<sup>18</sup> Its sister city across the Ganges river, Howrah, has even been classified by the Central Pollution Control Board of India as one of the 24 most

---

16 For a concise formulation of the *kaliyuga* and the four cosmic Ages, see *The Laws of Manu* (I.84-6). For further discussions, see Lingat (1962, 1973), Brockington (1981: 195), Pinney (1987: 438-81). For an anthropological approach to time in general, see Gell (1992). For the role of the four Age model in modern Indian historiography, see Chatterjee (1996).

17 According to a recent survey (<http://www.citypopulation.de>), Kolkata is ranked 12<sup>th</sup> among the world's megacities in terms of population size. In regard to population density, the city is one of the most densely populated. Metropolitan Kolkata only comprises 897 square kilometers. By comparison, Los Angeles, with nearly 17 million people, covers an area of 12,561 square kilometers. Buenos Aires, with nearly 14 million people, covers 3,094 square kilometers (Bronger 1997: 39).

18 The evidence for high pollution levels is well documented, both in scholarly articles (e.g., Chakraborti 1997; Chakraborti *et al.* 1998) and in the Indian media (e.g., Halarnkar and Menon 1996, Ghosh 2000, Sengupta 2000).

critically polluted areas in the whole country.<sup>19</sup> Given that large-scale epidemics, such as those caused by smallpox, cholera and enteric fever, have been brought more or less under control, the epidemiological profile of the city is moving towards chronic, crippling afflictions.<sup>20</sup> Many of these, such as asthma or gastrointestinal disorders, can be directly attributed to environmental pollution.

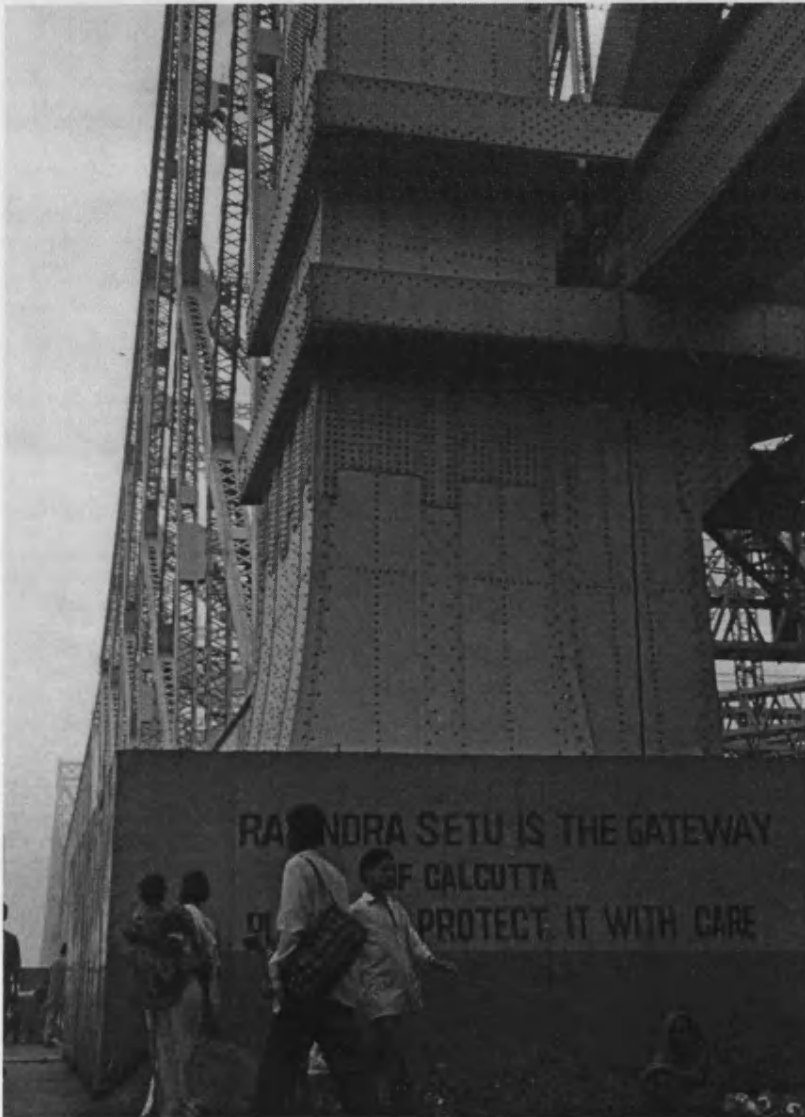


Plate 2: Environmental education message on Rabindra Setu (Howrah Bridge), Kolkata (Photograph, 1999)

---

19 India, Ministry of Information and Broadcasting, *India 1998* (1998: 158); India, Ministry of Finance, *Economic Survey 1998-99*. For a detailed study on urban ill-health in Durgapur, where most of West Bengal's steel plants are located, see Crook (1996).

20 To be sure, epidemic outbreaks of infectious diseases still occur. For example, during the monsoon months in 2000, hundreds of patients were admitted to hospital with enteric diseases due to flooding and water-logging.

For a number of reasons, I expected Kolkatans to be highly aware of pollution-related illnesses, and their "meta-narratives of modernity" to be rich in allusions to traditional concepts such as the *kaliyuga*. Historians of Bengali culture have pointed out how Bengali writings are replete with scathing accounts of modern city life. For example, Dipesh Chakrabarty (1996) describes how early twentieth-century literature compares the polluted life in Kolkata to the beauty and health of the pristine home village. Sumit Sarkar analyzes how these writings commonly link modernity with the *kaliyuga*. A popular pun on the city's Bengali name, *Kolkata*, was used to portray it as the heart of *kaliyuga*, an era "in which aliens rule and hierarchies of caste, gender, and age are inverted" (Sarkar 1998: 177).

Western visitors to the city also perceive mostly the city's dark sides. Western accounts of Kolkata are obsessed with dirt, poverty, and disease. Dipesh Chakrabarty (1991) and John Hutnyk (1996) show how Western writings perpetuate an image of Kolkata as the irredeemable dystopia of the Third World city. All recent Nobel Prize winners whose work has a connection to Kolkata reaffirm this picture in some way or another. First, Mother Theresa's work for the dying poor. Second, Günter Grass's writings and paintings of Kolkatan rag pickers tucked away in endless mountains of rubbish (e.g., Grass 2000). Third, Amartya Sen's economics of famine and social inequality (e.g., Sen 1981).

Contemporary social scientists also tend to be rather bleak about the city's present and future prospects. Books on Kolkata's urban development typically bear titles like *Calcutta: An Urban Disaster* (Mitra 1990). In his best-selling portrayal of Kolkata, the geographer Geoffrey Moorhouse (1994:15) relishes in the description of "the traveller's confusion and the sick feeling he begins to detect in the pit of his sensitive stomach," especially "if he happens to be British." Among the anthropologists, Claude Lévi-Strauss's depiction of Kolkata in *Tristes Tropiques* marks a low point in the history of Western perceptions of the city: "Filth, chaos, promiscuity, congestion; ruins, huts, mud, dirt; dung, urine, pus, humours, secretions and running sores" (Lévi-Strauss 1992: 134). The stereotype that Kolkata is not a place to live in but a "sanitary problem" that has to be remedied emerged during the nineteenth century, when the British colonial regime formulated the need to "civilize" the country and its natives (cf. Arnold 1993; Harrison 1996).

In view of such writings, I was curious to find out what kind of image an *ethnographic* study of popular perceptions on the ill effects of living in a polluted

city would yield. As I soon realized, however, few of my questions about "pollution" (Bengalis mostly use the English term) or its specific forms (e.g., *dushita jal*, "faulty/bad water") triggered answers that seemed "interesting" from an anthropological point of view. Not that people were unaware of pollution or its detrimental effects on health, yet the answers I received were short and entailed few details. Some of the standard replies were, for example, that pollution was, of course, very bad for the health, one of Kolkata's major problems, but an unavoidable hazard if one wanted to live in a modern Indian metropolis. Probing questions about the sources, trajectories, and effects of pollution seemed to take me nowhere. Moreover, the people I interviewed did not see any connection between pollution and the *kaliyuga*. When I asked directly whether such a connection existed, most people just smiled (as if the question was rather *cute*, especially when asked by a European), and many did not even know what the "*kaliyuga*" is. Slowly I came to realize that conditions of health and illness in Kolkata are not expressed through complaints about pollution, the *kaliyuga*, or other abstract concepts. Instead, they are expressed through something much more immediate, something much more simple: through digestive complaints. Let me illustrate this with a statement of a 30-year-old lower middle class Bengali man, who described the reasons for his chronic stomach pains as follows:

"During the day, whatever comes in front of me, I eat it. After eating I realize what I did. Whatever comes in front of me, I cannot control myself. So now I have to suffer. [Question: *Is this related to water pollution?*] No, no complaints about water. I don't use anything for water treatment, no *filter*. I was planning to buy a *filter*, but then we said, why buy a *filter*? Chilli, spicy food, if I avoid, then I am OK. Now by the grace of God I am not feeling so bad. You have to control your food. But I don't control. Greediness (*lobh*) is such a bad thing. But what to do, I cannot control."<sup>21</sup>

The causes of illness mentioned here do not exclude "pollution" altogether, but the emphasis is clearly on other concerns: irregular food timings, excessive amounts of food, and the wrong type of food ("spicy food"). The popular concept of "greediness" (*lobh*) points to the ultimate source of stomach problems: a self-ascribed lack of control over one's appetites. Far from being only a popular belief, many of the medical professionals whom I interviewed shared this view, especially

---

21 The Bengali verb "to eat" (*khaoya*) has a much broader meaning than the equivalent verb in English. In Bengali, anything that is being ingested is "eaten." For example, to smoke a cigarette is called "eating" it.

practitioners of Ayurveda (see below). Once I realized how many Kolkatans talked openly and in great detail about the state of their bowels, and that this kind of discourse entailed a detailed reflection on the conditions of modernity, I started to shift the focus of my research from "pollution" towards popular perceptions of the belly.

## **2. Research setting and sample**

Fieldwork combined community-based research with research in health care settings, in order to gain a comprehensive understanding of both lay and professional ideas. According to Pelto and Pelto (1996: 318), research in medical anthropology today tends to concentrate on one particular disease entity to be able to follow it around several different sites. In my case, the focus on stomach and digestion made it possible to interlock findings from community and professional settings. In the following, I will first describe the neighbourhood in which I was based, and then describe research in the health care settings.

### **2.1. Community-based research: Tollygunj**

Research on popular ideas and practices was mostly conducted in a mixed residential and commercial area in South-West Kolkata. The best-known landmark of this part of the city is the Kalighat Temple, which is probably the most important place of pilgrimage in all of West Bengal (cf. Basu Roy 1993; Samanta 1994). The area where I lived, Tollygunj, is located two kilometres south of Kalighat. Tollygunj's main claim to fame is its film industry. Since many large studios are based in this part of Kolkata, the nickname of the Bengali film industry is "Tollywood," in allusion to its more famed siblings, Bollywood and Hollywood. However, the studios have little influence on the character of the area. Most people who live in Tollygunj are lower-middle and middle-class people who work partly in the local shops and businesses, partly in central Kolkata. There are a number of *bustees* ("slums")

throughout the area, most of them Hindu, some of them Muslim.<sup>22</sup> The male residents of the *bustees* engage in various types of informal wage labour. Many of the *bustee* women work as domestic servants in the local middle-class households.



Plate 3: A wall with Tollywood film posters (Tollygunj, Kolkata) (Photograph, 2000)

Although there have been scattered settlements in the area since at least the eighteenth century, Tollygunj belongs to those parts of the city which have come under full development only during the twentieth century (Kundu and Nag 1996). A period during which Tollygunj's population grew fastest were the 1950s, when the city authorities settled thousands of refugees from East Bengal here.<sup>23</sup> In the middle-class housing cooperative where I had rented a flat, Hindu Bengali families from East Bengal still made up most of the residents. The area's brick-built houses were built mostly between 1960 and 1980, and today predominate in the area. Water is

---

22 It is customary among Bengali Hindus in Kolkata that the core meaning of the term "Bengali" (*bangali*) is "Hindu Bengali," whereas Bengali Muslims are called "Muslim" (*musulman*). Although this local use of language is politically problematic, I will follow it myself; not least since my sample consists mostly of Bengali Hindus. Hence in this thesis, if I speak of "Bengalis," I usually mean "Hindu Bengalis."

23 According to Ramachandra (1999: 70), the influx of refugees from East Pakistan was a driving force of urbanization in West Bengal. The refugees settled in Kolkata and rural West Bengal, in Assam, and in Tripura. Since more of the East Pakistani refugees settled in rural than in urban areas, the impact of the refugees on urbanization was not as pronounced in West Bengal as in the northwestern states of India.

partly supplied by the Calcutta Municipal Corporation (CMC), partly by local deep tube wells. In Tollygunj, I have not heard of evidence of arsenic contamination.<sup>24</sup>

Access to people in Tollygunj was relatively easy. Most people were curious about what I was doing, and were open to talk. My questions about "health" and "medicine" never caused any suspicion. Everyone I talked to seemed to accept that issues around people's health are a worthy field of study. Given the widespread presence of Western-funded medical charities in Kolkata, "health" was perceived to be a subject that Westerners are likely to be engaged in. Moreover, Bengalis have a very high esteem for formal education. To do research for a Ph.D. degree at a famous school like LSE was a well-regarded endeavour.<sup>25</sup> I also had few problems in getting people to spend time answering my questions, even people who were working in the shops or who had other things to do. Kolkatans are proud to say that Kolkata is not as "mechanical" and anonymous as other large cities in India, and that people still have time to sit and chat whenever they feel like it. Indeed, the non-Bengali residents of Kolkata like to make fun of the Bengali chattiness. One of my neighbours, who had moved here from Delhi, remarked on the Bengali's love for talking: "Uh, they talk endlessly. They write poems. *Akash, patash* ('sky, leaf'). So it goes on." The "chatty Bengali" seems to be a popular stereotype across South Asia. Nevertheless, my fieldwork site was in an urban environment, and not in an isolated village. Although I did not too strongly encounter the problems of access that are associated with urban anthropology (cf. Low 1996; Sanjek 1990), I could not do what is possible for anthropologists in a small-scale setting, namely to be "present with [the informants] in as many situations as possible, learning to know them in as many settings and moods as he can" (Berreman 1968: 340). I tried to cope with the problem of relative

---

24 One of today's most threatening health problems is the arsenic pollution of the groundwater (Chakraborti 2000). Arsenic trioxide is used in insecticides and a few other products, but today's problem comes from the huge amount of arsenic that occurs naturally in the ground; hence it is not primarily a problem of industrial pollution. Nevertheless, arsenic poisoning is mostly "man-made" in the sense that the growing population needs drinking water. Deep tube wells provide this water, but the ground strata they tap into are often affected by excessive levels of arsenic. Drilling deeper down does not help, since sooner or later, arsenic is washed into these strata as well. Today, Bengal's arsenic poisoning is perhaps the greatest mass-poisoning in world history, affecting millions of people in Bangladesh and many parts of rural West Bengal. The problem does not (yet) seem to be as severe in Kolkata as elsewhere in West Bengal, although some areas of the city are already affected, among them Alipore, Kolkata's upper-class neighbourhood. Arsenic leads to slow poisoning, with an ultimately fatal outcome. Many of the symptoms of arsenic poisoning look like digestive problems: nausea, vomiting, abdominal pains, burning of the mouth and throat, diarrhoea or constipation, and a feeling of weakness. That neither doctors nor lay Kolkatans seemed to be much concerned about arsenic poisoning (it was hardly ever mentioned to me) marks a striking absence, for which I do not have explanation.

25 The former Chief Minister of West Bengal, Jyoti Basu, whose communist party (CPI-M) is ruling West Bengal since 25 years, is an LSE alumnus.

anonymity as best as I could. Most importantly, I was blessed to find a few true friends in and around the area, without whom fieldwork would have been much more difficult.

In preparation for fieldwork, I started to learn Bengali in London, and spent the first six weeks in Kolkata studying the language. For most of my fieldwork, I employed Mr. Jakesh Francis as a research assistant, who accompanied me for interviews and helped out in translating the taped material. I also employed a Bengali teacher, Mrs. Bonanie Roy, with whom I continued to study Bengali and whose knowledge of Bengali language and culture was of much help.<sup>26</sup> As in other cities in India, English was as important a language to converse in as Bengali. Indeed, knowledge of English is so widespread in Kolkata that it is difficult to immerse oneself fully in Bengali language. Especially educated middle-class Bengalis always preferred to speak in English with a foreigner like me, even after I had become reasonably conversant in Bengali.

For research among people in and around Tollygunj, I used the standard techniques of ethnography: participant observation and interviews. Participant observation was mostly unstructured. Day-to-day observations were recorded in a fieldwork diary. Besides everyday encounters, I conducted unstructured and semi-structured interviews. The results of these interviews were noted in the diary along with the data from observation.

In the beginning of my fieldwork, I had planned to conduct a house-to-house survey on socio-economic status, common illnesses, and health seeking behaviour. Eventually I decided not to spend time on such a task, since survey data seemed to be not deep enough for the research question at hand. Overall, the sampling method used in this research followed the rules of nonprobability sampling. According to Bernard (2002: 141-142; 180-202), cultural data about *how* things are done (in contrast to how *often* they are done) do not require a controlled sample, but a number of people "who know a lot about the rules of a culture, are highly articulate, and are, for whatever reasons of their own, ready and willing to walk you through their culture" (Bernard 2002: 187). Exactly this is the case with most data on popular notions of stomach and digestion. I am aware, however, that the lack of statistical data tilts my results towards unquantifiable "ideas" and "perceptions." If it is allowed

---

26 Mr. Francis and Mrs. Roy agreed to be acknowledged by name.



to quote Shri Ramakrishna,<sup>27</sup> somewhat out of context, as a spokesman for nonprobability sampling: "If one has come to eat mangoes...then what is the gain by counting the trees, branches, and leaves?" (quoted in Biswas 2000: 192).

For the study of metaphors around stomach and digestion, I interviewed one key informant for at least fifteen hours, then conducted 20 semi-structured, open-ended interviews with a set of other informants (see below, Chpt. II.4). To have a basis of quotable interview data about popular perceptions, I recorded and transcribed 95 interviews with people from different social groups. From among these interviews, 79 were with Bengali informants, 16 with non-Bengali informants. 78 interviews were with Hindus, 14 with Muslims, and three with Christians. For reasons of good rapport, I did not, as a rule, ask all of my informants about what kind of "caste" they belong to (see below, Chpt. III.2.3), hence it is impossible for me to make an accurate statement about caste membership.

In terms of socio-economic class, 31 of the interviews were conducted with low-class informants, 48 with lower-middle/middle-class informants, and 16 with upper-middle/upper-class. When I use the term "class," I do so only in a generic sense, as the implications of class in Kolkata cannot be dealt with sufficiently in this thesis. When Bengalis themselves speak about "class," they draw a broad distinction between the rich (*bara lok*, "big people") and the poor (*garib lok*, "poor people"). Depending on the speaker, the line between these two groups can vary strongly. For example, a lower-ranking white collar government employees appears as a *bara lok* to a slum dweller, but as a *garib lok* to a member of the upper classes. The distinctions that are drawn in this thesis between low, lower-middle, upper-middle, and upper-class are nonspecific. Roughly speaking, "low" means that people can hardly scrape a living, are staying in rickety houses, and have enjoyed no or only rudimentary education. "Middle-class" people live in decent brick-built houses, have at least a few years of formal schooling, and have a reasonable amount of disposable income. Members of this class represent that category of educated middle-class people that is called *bhadralok* ("respectable people") since the nineteenth century. The difference between lower-middle and upper-middle is only one of degrees. In

---

27 Shri Ramakrishna (1836-1886) is one of West Bengal's most influential saints. His teachings were popularized by a number prominent disciples, among them Svami Vivekananda. Ramakrishna's sayings are widely known thanks to the educational and charitable work of the Ramakrishna Mission (founded in 1897), and especially its pioneering use of print technology: "Today, an average middle- or lower-middle-class Hindu household in Bengal can be expected to have a portrait of Ramakrishna somewhere, along with, quite possibly, a well-thumbed copy of the *Kathamrita* [biographical account of Ramakrishna's discourses, translated as *The Gospel of Sri Ramakrishna*]" (Sarkar 1998: 283).

terms of economic standing, for example, lower-class people have no or only a few luxury goods such as washing machines or cars, whereas upper-middle class people have several of these items. Lastly, "upper-class" people have been through many years of English-language education and enjoy the same living standard (or even higher) than average citizens of Western Europe or North America. In any case, as I will argue in the chapter on risk groups (see below, Chpt. III.2.4), distinctions between different kinds of bellies do not give a neat mirror image of socio-economic class distinctions.

From among the 95 tape-recorded interviews, 56 were conducted with men, 29 with men and women together (e.g., husband and wife), and 10 with women only. Given that men were much easier to access, the interview sample undoubtedly has a bias towards male perspectives. To a large extent, I could balance out this bias by having five women among my key informants (one low-class, one lower-middle, three upper-middle class). Even though I talked to a greater number of men than women, I always felt that the quality of information given by women was better. Women were generally more interested in the questions I asked them, more engaging, and more dialogic. There were a few points on which women had different perspectives than men (see below, Chpt. III.2.4), but I never perceived any truly categorical differences. In my view, stomach and digestion belong to the least gender-specific aspects of the body.

## **2.2. Health care settings**

My first approach to health care settings was to compile a list of medical facilities in the area, including doctors of different systems, diagnostic centres, and medicine shops. The list included mostly allopaths, allopathic medicine shops, and allopathic diagnostic centres, ranging from "Extasy X-Ray Clinic" to "Well-Fit Shri Ramakrishna Pharmacy," but also a large number of homeopathic and Ayurvedic doctors and shops. A full quantification of the available facilities would have taken more time than I could spare. In the first phase of interviewing, I concentrated on allopaths in general practice, and then shifted to gastroenterologists. In the second phase, I studied homeopaths, in the third phase, Ayurvedic doctors. To study the medical systems in this order was motivated by their relative popularity: I started with the most often frequented and ended with the least frequented. Since I had

expected to find much more Ayurvedic practice than I actually did, I even considered not studying Ayurveda at all (fortunately, I later changed my mind on this). Since virtually no anthropological work had ever been devoted to homeopathy, it took me a while to realize its importance in the Kolkata setting.

Gaining access to doctors and health care settings was relatively difficult. The kind of participant observation that is possible in small-scale settings, and with less formalized practice, was more or less impossible in Kolkata. In each of the three medical settings, I had the opportunity to carry out a few days of observation, but nothing more than this. Doctors of all systems were reluctant to let themselves be followed around for any longer amount of time.

My attempts to get a permit to access government hospitals were in vain. Although officials in the West Bengal Ministry of Health initially promised me that such a permit was "no problem," all my visits were insufficient to satisfy their requests for "further clarifications." After about five weeks of trying, I gave up this futile endeavour.<sup>28</sup> It should be stressed, however, that this permit only concerned official access to state hospitals as such, not access to the doctors who worked there. As long as I approached the doctors on a "private" basis, outside of the hospital setting, bureaucratic prohibitions against research could be circumvented. Without going through the official channels, I conducted several interviews on hospital premises (allopathic, homeopathic, and Ayurvedic), when the doctors were not on duty, hence in a "non-official" role. However, all my observation data of medical practice had to be drawn from private settings.

From among all the different healers, homeopaths were easiest to approach. That I am from Germany, like Samuel Hahnemann, the founder of homeopathy, facilitated my research greatly.<sup>29</sup> It was not unusual for the homeopaths to point to a portrait of Hahnemann in their chamber and exclaim something like: "Hahnemann,

---

28 It comes as no surprise that government officials are touchy about granting such research permits. Most of Kolkata's government hospitals are in a deplorable state. For example, at MR Bangur District Hospital, a large 600-bed government hospital in Tollygunj, there is no intensive therapy unit, no power generator, no water testing, and no medical officer for emergencies. Although these facts were splashed across the newspapers (e.g., Ukil 2000), the government has little interest in supporting further inquiries.

29 Already during the nineteenth century, a close link existed between criticisms of British colonial hegemony and criticisms of allopathic hegemony. In the Indian perspective, "Germany" and "homeopathy" bypassed both of them: "The appeal of homoeopathy in nineteenth-century Bengal was thus in part that it by-passed the colonial medical establishment, dominated by the (then almost entirely British) Indian Medical Service (IMS), and the political, racial and cultural authority it represented. Perhaps it helped that Hahnemann was German and not British" (Arnold and Sarkar 2000: 43; cf. Uberoi 1984).

our God (*bhagavan*)!" My study of homeopathy has also benefited greatly from cooperation with Robert Frank, a Ph.D. student of medical sociology from the University of Bielefeld. Because of the confluence of our research interests, we conducted about half of the interviews together. To be interviewed by one German was already extraordinary to the homeopaths, to be interviewed by *two* such types even more so. Allopaths were slightly less receptive, but on the whole also cooperative. The greatest problem with allopaths, especially the most successful and busy among them, was that they were short of time, and were hardly ever willing to talk for more than an hour. Ayurvedic doctors were the most difficult to deal with. I sometimes felt like stumbling into an ongoing turf war between rival groups of doctors. Many of the *kavirajs* were unwilling to introduce me to other *kavirajs*, under the pretext that that they did "not know anyone else." On one occasion, a *kaviraj* refused to talk to me after I had naively mentioned that I had already interviewed a particular other doctor, whom he disliked intensely. Hence for research on Ayurveda, I had to travel the farthest around.

Besides a limited amount of participant observation, the principal method that I used with healers was the semi-structured, open-ended interview on a one-to-one basis. A personal introduction through people who knew the doctor made access easier, but was not essential. The key to a successful introduction with a professional healer in Kolkata is the seemingly trivial, but highly effective visiting card. "Professional" demeanour was also imperative. Doctors were most willing to talk if I played the role of a hard-nosed, result-driven researcher, instead of signalling that I wanted to get to know them "in as many settings and moods" as I could. Sticking to pre-appointed times and a clearly formulated research agenda was part of this. At the beginning of my research, I did not use a questionnaire. As I soon realized, however, doctors did not take me seriously as long as I did not pull out a nicely printed questionnaire from my black leather case. During the interviews, I always used a tape recorder. Doctors did not oppose the use of them, except for two occasions. Many of the interviews were fully transcribed, some only in extracts. Beyond the circumscribed interview situation, there were always one or two doctors in each group whom I got to know in their private lives as well.

For each of the three systems, between 15 and 20 doctors were interviewed. This number of informants seemed to be the most pragmatic strategy. A smaller number of informants would have yielded perhaps more "ethnographic" data, but that

would have been too problematic in terms of generalizability. In my experience, the data collection started to be "saturated" at this sample size. Any less would have given only a rough idea of the different opinions. However, adding more interviews did not promise to contribute greatly to the quality of the data in relation to the extra time spent. In some cases, it would have been hard to get more than 20 doctors for an interview. For example, specialist gastroenterologists are so rare (perhaps no more than 50 in all of Kolkata, according to what doctors told me) that I was lucky to get to talk to ten of them at all. Ayurvedic healers also seem to be relatively rare, and only a few of them are listed in phone directories. These logistic difficulties prompted me to leave Tollygunj and to travel to other parts of the city, for more than half of all interviews. This may seem like an unjustified break with the study of a "local" setting. However, in my experience, "neighbourhood" is not a crucial factor in either patients' or professional healers' practice anyway. Patients often travel all over the city to see the doctor in whom they trust most, and doctors normally practice in up to three different chambers in various parts of the city. One of my longest conversations with a gastroenterologist took place over several hours, when we were both sitting in his car and were hopping from one clinic to the next. No doubt, convenient access to a healer is a factor in people's health seeking behaviour. But in a metropolis like Kolkata, mass transportation tends to dissociate "convenient access" and "neighbourhood." That place of residency and place of medical treatment are disjointed was also evident when I asked my neighbours to which doctors they go to, and if they might be able to introduce me to one of them. Many of the referrals I received were to doctors beyond Tollygunj. Even if people's tendency to name only the most prestigious doctors is taken into account, the fact remains that most of them *knew* doctors outside of Tollygunj. During participant observation in the different health care settings, I usually saw patients from different areas of Kolkata, sometimes even patients from other parts of Bengal. Allopaths often point out that many of their patients even come from abroad, especially from Bangladesh. The "bigger" the doctor, the further the distance a patient is willing to travel. In Tollygunj, only the least popular practitioners drew clients merely from the immediate vicinity.

### 3. Study design

If the object of study is a specific part of the body (here, the belly), and if ethical reflections, such as on the "lack of self-control," take on unusual importance, the tools of medical anthropology have to be redefined. If no disease entity is looked at, and if "non-medical" concerns are as important as "medical" ones, what kind of methodological approach should be taken?

Since the 1980s, the "explanatory model" (EM) has been one of medical anthropology's standard tools of research. Introduced by Arthur Kleinman (1980: 104-9), an explanatory model describes an agent's ideas and practices concerning a particular disease event. In order to describe an EM, Kleinman suggests that the following questions are to be answered in the course of research: (1) What is the presumed cause of sickness? (2) How are time and mode of onset of symptoms described? (3) What is the pathophysiology of the sickness? (4) Which course will it take? (5) Which treatment is being recommended? The analysis of explanatory models focuses on the differences between patients' and healers' views of sickness, and how these differences are negotiated in clinical settings. Kleinman devised EMs as an elucidation of possible sources of misunderstanding between healers and patients. By laying open conflicts between lay and professional EMs, anthropologists should facilitate interactions between them.<sup>30</sup>

In medical anthropology, the well-known distinction between "emic" and "etic" approaches on culture motivated the distinction between "disease" and "illness" (cf. Weiss 2001: 12-14). "Disease" is commonly used for the professional/scientific perspective, "illness" for lay/subjective perceptions of the problem. For example, what an allopath might diagnose as "amoebic dysentery due to *entamoeba histolytica*" is likely to be labelled *amasha* in popular Bengali language. The distinction between disease/illness does not necessarily entail a privileging of the "objective" disease definition over "subjective" understandings. The advantage of EMs is that they enable a description of both "lay" and "scientific" EMs as if both were *equally valid cultural representations*. By giving weight to emic understandings of sickness, the EM belongs to the meaning-centred approaches of

---

30 Kleinman (1980: 106) distinguishes "explanatory models" from "general beliefs" about illness and healing. There is undoubtedly a difference between general beliefs and beliefs within a specific situation, but for most purposes, it is not useful to separate them too strictly.

medical anthropology (cf. Good 1994), as opposed to the more etic methods of the "ecological" and "critically applied" approaches (cf. Hahn 1995: 57-75).

The explanatory model is a heuristic tool. As such, it has to be redefined according to the needs of each research project. For example, a decision can be made if the description of an EM should focus more on the patient's or the healer's point of view. Because of categories such as "pathophysiology," Kleinman's terminology was criticized for giving too much weight to the (allopathic) healer's perspective. To redress such shortcomings, Helman (1990: 96) developed a set of alternative questions to describe EMs: (1) What has happened? (2) Why has it happened? (3) Why has it happened to me? (4) Why now? (5) What would happen if nothing were done about it? (6) What are the effects on others if nothing was done about it? (7) What shall I do?

What is clinically defined as a "disease" might be recognized as a "healthy" state in lay EMs. The locus of "therapy" may lie entirely within the household and not venture outside of it, as in the case of self-therapy through a dietary regime. Thus Kleinman's original formulation of EMs undervalued the "healthy" body in everyday life, in favour of the sick body in the clinical setting. This bias was later corrected by Kleinman himself: "Perhaps more important than any other principle for guiding research is the observation that the therapeutic process does not begin and end with the discrete therapeutic event" (Csordas and Kleinman 1996: 19).

Explanatory models are not the coherent and stable systems of thought which the anthropologist's account might make them appear. They are designed to structure the researcher's thoughts, not the informant's. Ambiguity is likely to occur on two levels: internal incoherence of an EM, and frequent switching between different EMs. I agree with Kleinman that "[v]agueness, multiplicity of meanings, frequent changes, and lack of sharp boundaries between ideas and experiences are characteristic of *lay* EMs" (1980: 107; my italics), but contest his opinion that professional healers only have *one* unambiguous and invariant model. It can happen that professionals may switch between different EMs as smoothly as non-professionals.

Taking these points into consideration, I decided to focus on the following questions: (1) What are Bengali notions of the (healthy) body? (2) What are notions of the ill body? (3) Which therapies are being preferred? (4) Which therapies are actually chosen? Each question was asked with reference to digestion and the belly,

for example, "what is 'health' in relation to the belly?" By juxtaposing the allopathic EM with that of homeopathy and Ayurveda, I tried to avoid privileging the allopathic EM as the only "objective" model.

For research on allopathy, I did not devote much time to how the doctors describe their EM of digestion (as this only triggered "textbookish" answers), but focused on how they perceive conflicts between their own model and those of their patients. For homeopathy and Ayurveda, more attention was given to the peculiarities of their respective professional EMs. But the emphasis lay again on how they perceive their patients and their ways of thinking about the belly, digestion, and diet. The core of my research is the popular Bengali EM of stomach and digestion. The chapters on professional EMs aim at a kind of "triangulation" of the popular EM from the viewpoint of three different medical systems. I first try to reconstruct the popular EM, and then show how it is similar or different from the three professional EMs.

#### **4. Data analysis**

Analyzing interviews and observations of the healers was not excessively complicated, owing to the relative precision of professional EMs. However, to get a grip on "popular perceptions" was an enormous challenge. Summarizing decades of ethnographic research on folk medicine in Mexico, George Foster (1994) underlines the massive methodological difficulties that come with it: "to attempt to formulate the principles underlying health beliefs and practices is somewhat akin to fitting together the pieces of a gigantic jigsaw puzzle" (1994: 21). Other aspects of culture, such as religious rituals or daily work chores, tend to be relatively public, routinely, and observable from beginning to end. Yet illness episodes can only be observed in a fraction of the population, hardly ever from beginning to end, and their episodic character tends not to be moulded into routines. To shift one's attention to the (comparatively) public and routinely behaviours in doctor/patient encounters does not, of course, solve the problem of studying *popular* understandings. Hence ethnographic research on popular perceptions must rely heavily on what people *say*. What people say does not take the form of coherent narratives, but must be gathered from brief statements and passing remarks. Moreover, anything that relates to health



and "the body" is often only tacit know-*how*, instead of explicit know-*that* (cf. Bloch 1998; Dreyfus 1991; Taylor 1995).

To analyze data which are largely linguistic, largely fragmentary, and largely about tacit know-how, I relied on methods developed by cognitive linguists, most famously by George Lakoff and Mark Johnson (Johnson 1987; Lakoff 1987; Lakoff and Johnson 1980).<sup>31</sup> Lakoff and Johnson were the first to argue systematically that metaphor is not some sort of rhetorical embellishment, but "is pervasive in everyday life, not just in language but in everyday thought and action" (1980: 3; cf. Danesi and Perron 1999: 161-184). No doubt, this approach is not unknown to anthropologists (e.g., Desjarlais 1992; Kirmayer 1993; Parry 1985, 1991). More than a decade ago, Mark Nichter had already claimed that these linguistic tools will "give rise to a new generation of illness classification" (Nichter 1989: 118). Since they have not become standard methods in medical anthropology as yet, I will describe them briefly in the following.

According to cognitive linguistics, metaphors work because of a human tendency to think of all things in the world in terms of other things, for example, to think of human behaviours in terms of stereotypical animal behaviours ("He eats like a pig"). When a number of such phrases are collected, a metaphorical formula such as HUMANS ARE ANIMALS emerges. These formulas are called "conceptual metaphors." Much of the ethnographic data presented in the following chapter are, for example, related to the conceptual metaphor HUMANS ARE BODYPARTS. People's roles in society are characterized through metaphors like "He is his right *hand*" or "The pope is the *head* of the Catholic Church," or Bengali: "He is a '*belly* everything' (*pet sarbasva*)." Conceptual metaphors systematically relate a source domain (BODYPARTS) to a target domain (HUMANS), mapping one upon the other.<sup>32</sup>

Cognitive linguists assume that metaphors are an expression of "the body in the mind" (Johnson 1987), i.e. an expression of elementary bodily experiences of location, orientation, shape, and so on. Sensory experiences of the body motivate systematic "image schemata," or *Gestalt* structures, with which the world is described. There are three basic types of image schemata. (1) "Orientational"

---

31 Friedrich Nietzsche was one of the first Western thinkers to realize the metaphorical nature of everyday practice (Eisler 1904: 1806), but he left it at sporadic remarks.

32 Expressions based on the conceptual metaphor HUMANS ARE BODYPARTS are not always metaphors, but can also be metonymies, i.e. parts signifying a whole. For example, in statements like "We need new *faces* in the team" or "Lend me your *ears*," one part of the body stands for the whole body (or the whole person). However, expressions like "He's the director's *right hand*" are truly metaphorical, because *right hand* does not signify "director" as a whole person.

schemata are based on experiences of up/down, left/right, etc. For example, HAPPINESS IS UP, SADNESS IS DOWN. (2) "Ontological" schemata associate emotions, activities, and abstract events with concrete substances. For example, the image schema of a CONTAINER informs conceptual metaphors such as THE MIND IS A CONTAINER. In turn, this conceptual metaphor motivates phrases such as "I'm full of memories." (3) Any combination or elaboration of orientational and ontological schemata is called a "structural" image schema.

For an anthropological perspective on culture and society, the most challenging assumption of cognitive linguistics is that *all* cultural models are built on conceptual metaphors. Both popular and scientific thought can be analyzed as a compound cluster of metaphors (cf. Blumenberg 1999; Bachelard 1978). Metaphors are "good to think with" because they are readily understandable, turn abstract ideas into concrete terms, and are able to create something like "common sense" through sheer sensual simplicity. Given that metaphors change more slowly than actual practice (e.g., we still speak of someone who is over-committed as having "too many fires burning"), a close study of metaphors also enables to detect the traces of half-forgotten traditions:

"Metaphorical codes are powerful shapers of worldview because they are so understandable. They make thinking easy. They are automatic, effortless, and established by community consensus. More often than not, they are guides to a culture's past." (Danesi and Perron 1999: 183)

One aim of my discussion of Nietzsche in the previous chapter was to show that eating and digesting motivate conceptual metaphors with a relatively high degree of cultural universality, i.e. they are not bound to a particular cultural context. EATING IS KILLING is a conceptual metaphor that is common to Vedic ideas of sacrifice and late-nineteenth-century Nietzschean philosophy. Other metaphors are more specific to a particular cultural context. For example, IDEAS ARE COMMODITIES, which motivates phrases like "Foucault's ideas sell well" is historically and culturally more specific than IDEAS ARE FOOD, for complex reasons such as notions of individual authorship, "copyright," the commodification of intellectual property, and so on. The argument I will develop in the following chapter is that conceptual metaphors around the "belly" are a powerful shaper of Bengali worldview. The belly

acts as a kind of cultural "super-metaphor" which connects domains of body, health, and morality in a specific way.<sup>33</sup>

Among scholars of Indian society, Jonathan Parry developed the most sophisticated discussion of metaphors of eating and digestion. Here I want to focus on his 1985 paper on "death and digestion," in which he takes up Lakoff and Johnson's work and applies it to North Indian mortuary rites. Parry argues that bodily processes of eating and digestion structure Hindu thought about the cosmic and social orders: "ingestion and digestion of food in Hindu culture belong to that class of natural kinds of experience based on the body, and on direct physical experience of the world, which are repeatedly used to define and get a handle on other kinds of cultural reality" (Parry 1985: 612). Parry shows how metaphors of digestion connect the domains of cooking, eating, purity/impurity, kinship, caste, illness, and the cycles of cosmic time. Just as bodily digestion distills the nourishing part of food and expels the waste part, so do funeral priests "digest" the corpses of the deceased, separating their pure ancestral essence from their impure sins. Just as butter is produced from the churning of milk, so are thoughts and behaviours produced from the churning of everyday food. Just as bad food disturbs digestion and starts to rot in the stomach, so does dishonestly acquired money (e.g., bribes) get stuck in the belly and starts to corrupt the person from within.

Taking a lead from Parry's work, I systematically collected Bengali expressions around eating and digestion. From among the parts of the body that are related to digestion, I focused on mouth, tongue, throat, belly, stomach, liver, guts, anus, as well as on terms for digestive processes. With this list of metaphorical expressions, I conducted interviews with Bengali informants. For example, I asked informants what an idiom like *pete pete* ("in the belly belly," i.e. "secretly") means, and if they can think of situations from their own life where this expression could have been used. These interviews prompted informants to name other idioms, and so slowly the data collection increased in volume and depth. In the following chapter, I focus on the word field "belly" (*pet*), show how terms around it are used in everyday practice, and finally how the belly's greedy tendencies can only be kept under control by the "mind" (*mon*).

---

33 Only a few anecdotal attempts will be made to compare Bengali metaphors of the stomach with those in other languages. Bengalis often claim that their language contains more phrases around the belly than any other Indian language, including Hindi. In turn, Hindi-speakers may claim that *they* have the most elaborate expressions of this kind. The question can only be raised here, but not be dealt with.

### III. Popular perceptions of the belly

The aim of this chapter is to describe popular perceptions of the belly that I have recorded during fieldwork in Kolkata. How do Kolkatans speak about the belly? What are the physiological, medical, social, and moral connotations of eating and digesting? Have different social groups different kinds of bellies? How can the individual person protect his belly (and, be protected *against* his belly)? In the first part of this chapter, I describe the popular usage of the Bengali word *pet* ("belly") as comprehensively as possible. From this analysis, two key characteristics of the belly will emerge: the belly as a "container" of limited goods ("greediness"), and the belly as the body's vital "fire-place" where food is "cooked" and digested. Building on this socio-linguistic analysis, I will look at different ways of treating the belly, and how these imply different risks for digestive health. How risk behaviours are associated with specific social categories of persons (cultural groups, gender groups, age groups) will be the subject of the following section. If the person is at risk from the belly's excess of heat and greed, how can the belly be kept under control? In the final part of this chapter, it will be asked if the belly's dangerous tendencies can be balanced with the cooling and restraining powers of the "mind" (*mon*).

#### 1. The belly in popular language and practice

##### 1.1. Survey of the wordfield *pet* (belly)

In Bengali language, the basic term for belly is *pet*, which signifies "stomach," "belly," and in women also "womb" (more specifically called *garbha*). Bengali has terms for the various organs that are contained in the belly, e.g. *yakrit* (liver), *pliha* (pancreas/spleen), or *antra* (intestines). From among these terms, *pet* is by far the most prominent, thus the following discussion will focus on it. My emphasis on the "stomach" aspect of *pet* introduces a limitation to eating and digesting. Apart from a few short remarks, I will not be dealing with those uses of *pet* that refer to pregnancy, childbirth, or gynaecological disorders, as this would have gone way beyond the purpose of this thesis. Similarly, those parts of the digestive system that

are not located in the belly, e.g. the mouth (*mukh*), the tongue (*jibh*), and the throat (*gala*), will only be mentioned in passing.

*Pet* being a very broad term, it is sometimes qualified through adjectives that specify sub-areas, e.g. *tal pet* denotes the abdomen. An alternative term for *pet* is *udar*, which can be traced back to the Indo-European root *\*udero*, which also informs Greek *uderos* and Latin *uterus*, both meaning "abdomen/belly" (Mallory and Adams 1997: 2). In a statement attributed to the nineteenth-century Bengali saint Shri Ramakrishna, *udar* appears along with anus (*guhaya*) and sexual organs (*linga/yonis*) as the third constituent part of a *tribhumi*, "land of the three" or "three-partite land." For Ramakrishna, most people's thoughts never get beyond the borders of these "lands," whose sole sovereign powers are food, sex, and excretion. Otherwise, however, *udar* is an elegant Sanskrit expression and rarely used in everyday speech.

Another Sanskrit word for belly, especially for the stomach part, is *pakasthali*, the "place of cooking." *Paka* also means "digesting" and "ripening." In popular belief, the stomach is the body's central kitchen, where food is being cooked with the addition of heat and various juices. This notion is widely held and puts popular physiology in close relation to Ayurvedic theories of the body and digestion. The word *pakasthali* itself is, however, rarely used. A further Sanskrit expression for the belly (especially the womb) as a cooking-site is *jatharagni*, the "digestive fire." According to Parry, "the digestive process is itself represented as a matter of cooking – or re-cooking – food in the digestive fire of the stomach (*jatharagni*)" (1985b: 614). A metaphorical expression for the belly is *surya-grantha* ("sun belt"), underlining that the heat generated within it first and foremost defines this part of the body. Ayurvedic theories of physiology have elaborated the theme of digestion as cooking in greatest detail (as will be discussed in a later chapter).

In contemporary Bengali slang, the belly is often called, in English, a *machine*, a *factory*, or an *engine*. "Everything goes inside the *engine*," or "If your *machine* works properly, there is no gastric" were common statements. Machine metaphors are, in my opinion, closely related to the idea of the belly as a kitchen. In both places, raw materials enter, are processed, and "delivered." Both images imply a notion of heat and transformative energy. The machine metaphors are usually perceived as comic, that is, people usually speak of the belly as a machine with a hint

of humour.<sup>34</sup> Nevertheless, these terms are widely used, especially among the younger generation. The idea of the belly as an engine, factory, or machine is evoked to illuminate two issues. First, some people can eat whatever they like and still stay healthy, whereas others fall ill even with the healthiest food. That is because the *engines* of different people do not all run equally well. Second, leaving the belly empty for too long produces symptoms of nausea, excessive *gas*, and all sorts of aches. In contrast to the "traditional" metaphors of the belly as container and the belly as fireplace, the BELLY IS A MACHINE image schema does not seem to motivate any further metaphors. That is, there is no further reasoning about what is going on inside the belly that is based on this image schema.

A notion of BELLY IS A GOD is entailed in the turn of phrase *pet puja* ("belly worship"). This is, at most times, an ironic phrase for the pleasures of eating. It may also signify that someone puts personal satisfaction before the satisfaction of the gods. To criticize greedy eating as a sacrilegious act against the gods can perhaps be retraced to notions of sacrifice that existed already in Vedic times. As Charles Malamoud (1989) points out regarding Vedic orthodoxy, *all* food that has been transformed by cooking properly belongs to the gods: "Manger de la nourriture cuite est donc prendre quelque chose au repas destiné aux dieux" (Malamoud 1989: 48). Popular Hinduism retains the belief that all food comes from the gods and should only be taken in reverence of the gods.

*Bhudi* is used specifically for fat or swollen bellies. It appears commonly together with *mudi* (a colloquial form of *mudo*, "head") in the expression *mudi-bhudi*. To keep the whole person healthy and whole, mind and belly have to be aligned and closely connected. Keeping the mind healthy will keep the belly healthy, and vice versa. A Kolkata woman explained:

"*Bhudi thanda thakle, mudi thanda thake!* ("If belly stays cool, head will stay cool"). That's what my grandmother always said. If food properly is digested, all health will be good. Also: If someone is hungry, he gets irritated. He gets annoyed quickly. His mood changes. When appetite is satisfied, the mood cools down."

Looking inside the belly, several synonyms for *pet* stress its perennial emptiness. *Gahavor* is a relatively elegant term for a hole or cavity and is used particularly in relation to insatiable hunger. *Khadol* is a very colloquial expression, which portrays the belly as a deep hole. Several synonyms of *pet* refer to the outer

---

<sup>34</sup> However, the metaphor of BELLY IS A MACHINE is often employed, without humoristic intentions, in popular health literature, (e.g., Vora 1997).

appearance in a joking way: a fat belly can be compared to the musical instrument, and be called a *tabla*. Or it may be compared to the traditional large round cooking pot, and be called a *gamla*.

On its most basic level, the belly acts as a container. Two salient features of a container are its *shape* and the *pathway* of substances through the container. For example, the type of container represented by a "bottle" can be analyzed according to these aspects. The shape of the bottle can be described as something that is round on its sides and flat on its base, with one opening located at the top. The typical pathway of the substances is to enter through the hole on top, and also to leave through this hole.

In outward appearance of its shape, the belly is typically of round form. In its appearance from within, it is an emptiness waiting to be filled. For daily purposes, most of my informants found this description fully sufficient. (Indeed, despite my insistent asking about further details of the belly's internal structure, I would hardly receive any replies: "Why ask me? Ask a doctor!").

Besides its shape, metaphors of the belly focus on the trajectories of substances through it. On a general level, metaphors of the belly describe it as being full or empty, as being filled or emptied, and as either able to hold or able to let go. The belly allows substances to enter and to leave it through three principal orifices: mouth, anus, and the organs for both sex and excretion (for men, the penis; for women, the vagina). Whatever substance enters or leaves the belly, it must enter through a particular orifice and leave through a particular orifice, otherwise disorder ensues. Each substance that enters has a particular trajectory; any deviation or reversal of it would be harmful. For example, if food leaves the body again through the mouth, as vomit, it would obviously present a problem. Moreover, each substance is expected to complete its trajectory within a particular duration of time. Deviation from the expected time would also indicate illness. The most obvious example for this would be the difference between diarrhoea and constipation.

In popular physiology, two substances have special importance: food and semen. The typical trajectory of food is to enter through the mouth and to leave through anus/urinary organs. The trajectory of semen is to enter through the vagina and, once gestation is complete, to leave through the vagina as a baby. Given that digestion is a relatively swift bodily process, the full trajectory of food seems easy to retrace, whereas the trajectory of semen, and its effects, are much less obvious. In the

following, I will concentrate on food-related metaphors. Some relating to sexuality and pregnancy will only be mentioned in passing.

In the anthropological literature on South Asian body concepts, it is noted that these bodies are permeable and open. Food is said to leave the body almost as quickly as it enters it. Ironically exaggerating the difference between Western "bounded bodies" and Chicago ethnosociological views of Indian "fluid bodies," Lawrence Cohen holds that Westerners typically suffer from constipation, whereas Indians suffer from diarrhoea: "Indians, more constitutionally soft and placid, suffer from the contrary disposition: they let everything out. They survive the heat, but at the cost of any attention to boundaries or to physical hygiene. Indians are filthy and fluid" (Cohen 1998: 23).<sup>35</sup> This view is supported by popular Bengali metaphors for the belly, albeit with a different accentuation: the belly that "lets go" too quickly is the *ill* belly. Too much of flux is certainly not a normal condition. Only the belly that "holds" (*pet dhara*) is the healthy belly. To be cured of digestive illness is called "the belly has held" (*pet dhareche*). Only when the belly starts to become "closed" or "glued" (*pet anta*), as in times of constipation, does health become endangered. Indigestion is common for people who cannot "tolerate in the belly" (*pet saoya*). The English expression "to stomach," that is, to endure hard times, abuse from others, or any difficulty, has an equivalent in this expression.

The belly-container is located at the centre of an individual person's body. Whatever is ingested into the belly disappears from sight and is practically out of reach. At the centre of an individual's body and hidden from view, the belly's contents are not shared with anyone else. The good and bad effects of what is done to the belly affect only one single person. Whatever goes inside of it only belongs to the person alone. This is of fundamental importance for the "moral" coding of the belly: filling one's own belly is a core metaphor of individual egoism and selfishness. On the other hand, filling someone else's belly with food is an expression of caring altruism and selflessness.<sup>36</sup>

In popular Bengali language, to eat one's belly full (*bhara pet*) is one of the most cherished and most satisfying feelings. Accordingly, an expression of caring for

---

35 The most extensive ethnography of the Indian "fluid body" is E.V. Daniel's (1984). According to Daniel (1984: 152), Tamil villagers insist that one must defecate at least once per day. They also believe that Westerners (and everyone who is "modernized") only does so once a week.

36 For a recent ethnography of gender and food in Kolkata, see Donner (1999). In regard to "filling other people's bellies," Donner describes how meals cooked by the mother with her own hands stands as "the ultimate signifier of maternal love and wifely devotion" (1999: 296). Donner's data from a neighbourhood in central Kolkata tally fully with those presented here.



others is to give them all the food they need to feel satisfied. One says that one "feeds someone the belly full" (*pet bhariye khaoyano*). This aspect of Bengali hospitality oscillates between generosity and a gentle form of torture.<sup>37</sup> After finishing a meal, the ritually asked question is "Have you eaten your belly full?" (*pet bhare kheyecho?*). The proper reply to this is: "Yes, I have eaten my belly full" (*hyae, pet bhare kheyechi*). A related set of metaphors is also based on the perceived connection between maternal care and the belly as womb. To raise a child with much affection is to raise it "in the belly, on the back" (*pete pithe*). A boy-child who is particularly dear to the mother is her "belly's boy" (*peter chele*); this expression is mostly used by a mother for her male children, not by other people. When a child turns out to be a nuisance to the mother, it literally becomes the "belly's enemy" (*peter shatru*). This is a rather cruel expression, and it would not be used directly towards the child, unless to hurt it deeply.

Having considered some of the states in which the belly is full, or can be filled, we will now look at the reverse case: the belly as a container that is empty or being emptied. "Empty belly" (*khali pet*) is a common expression for hunger. A "light" or "thin" belly (*pet patla*) is one that cannot hold anything. Similarly to a bag made out of weak material, it threatens to tear and lose whatever is inside of it. The metaphor implies either a weakness of the body or a weakness of character. It may mean that the person suffers from sensitive bowels and frequent diarrhoea. It may also mean that someone is unable to keep a secret (see below). Persistent diarrhoea thins a person's body, up to a point where the belly "does not hold the clothes" (*pete kapar thakena*). This denotes severe illness with emaciation as an outward symptom. On the other hand, if the belly is overloaded and cannot release what is inside it properly, it is necessary to "loosen" it (*pet naram kara*), through massages or the use of laxatives.

The belly that "becomes" (*pet haoya*) is the pregnant belly. Just like food has to be "held" before leaving the belly, so do semen and blood first have to be "held" so that a baby can be formed. "Coming into the belly" (*pete asa*) means to become pregnant, and to "hold in the belly" (*pete dhara*) is an expression for conception. Conversely, to "give away the belly" (*pet khasano*) or "not staying in the belly" (*pete thakena*) means to have a miscarriage. The baby that is alive and healthy is "the belly's wealth" (*peter dhan*).

---

<sup>37</sup> To be "fed the belly full" in a compulsive way is not limited to guests in West Bengal: "Coercive feeding is an experience with which many ethnographers are familiar" (Parry 1985: 626).

The association between digestion and pregnancy (as well as between eating and having sex) is evident in a number of proverbs. One of them, brings together sex, food, and jealousy in an inimitably crass yet graceful way:

*Kha kha kha, lo tui, pete na thute,*

*Sha sha sha, lo tui, shatin na javalate.*

Eat! Eat! Eat! Hey, you! [As long as] the belly doesn't hold,

Shag! Shag! Shag! Hey, you! [As long as] the co-wife doesn't trouble you.

In this proverb, food and sex, digestion and pregnancy, become impossible to differentiate. Two closely related image schemata inform this proverb: HAVING SEX IS EATING, and GESTATING IS DIGESTING. The "you" of the proverb is a young wife. She is told to "eat" as long as the belly does not "hold." Clearly, "eating" means having sex with her husband. She should enjoy it as much as possible as long as she is not pregnant. Once the belly "holds," the husband will lose interest in her and will abandon her in favour of another wife (*shatin*). Given that *shatin* signifies the second wife in polygynous marriages, the abandonment of the woman is not one of divorce and separation, but primarily of sexual attention.<sup>38</sup> The idea that the belly is a container brings the domains of sex and food together. The comic effect of the proverb comes from putting as identical the two openings of the belly-container: the mouth and the vagina.<sup>39</sup>

---

38 A detailed discussion of how belly and kinship are related is beyond the scope of this thesis. For further references on Bengali kinship, see Donner (1999), Fruzzetti (1990), Östör, Fruzzetti and Barnett (1982). For Akos Östör *et al.*, the key symbol in Bengali notions of kinship is blood. My research focuses on body *parts*. The next step would be to look more closely at body *fluids*.

39 In regard to Chinese concepts of the body, Mark Elvin (1993: 230) also notes a close association between sex and eating: "It is necessary to be cautious in making generalized remarks about the somatic predispositions of an entire culture, but a number of scholars have remarked that the Chinese seem to have a relatively strong consciousness of their oral and digestive systems, and a relatively weak consciousness of their genital systems. Sex is frequently metaphorically assimilated to eating: examples being the comparison of intercourse with a woman to eating a plucked chicken, and the Shahnghaai term for the virile member, 'the eating finger' (*shir-zhii*)." For carnivalesque inversions of mouth and vagina in European folklore, see Michail Bakhtin's *Rabelais and His World* (1984: 279, *passim*). Bakhtin's brilliant study of belly metaphors in Rabelais' work would have merited a much more detailed discussion than can be attempted here.

## 1.2. The belly as container of (limited) goods

Sex and pregnancy are one aspect of sustaining life through the belly. Earning one's daily livelihood is another. Just as there are metaphors that connect the belly to sex/pregnancy, so there are many which link the belly to work and living. The process of filling the belly is usually rendered as "making the belly go" (*pet cala*). Food, being the most essential item of one's daily livelihood, comes to stand metonymically for economic subsistence in general. Food is the fruit of labour. Hence it is common to ask about someone's job: "What are you doing to keep your stomach going?" (*tomar pet cale ki kare?*). Work with only a minimum of pay, just enough to feed oneself, can be called "belly food" (*pet bhat*). In this expression, as elsewhere in popular Bengali language, rice (*bhat*) means "food" in principle. As a kind of cultural superfood (cf. Greenough 1982), it can stand metonymically for all other kinds of food. To earn one's living, one must be prepared to take any amount of trouble and pain. Hence, to "eat one's belly [full], the back tolerates [anything]" (*pete khele pithe soy*), that is, even the hardest work is worthwhile if it pays off in the end. To criticize somebody for leading a slothful life at the expense of others, one could ask: "Are you not doing any belly thinking?" (*tumi peter cinta karana?*). Those who "swallow without worrying" (*gelar cinta nei*) are people who are using up other people's fruits of labour without contributing something themselves. As filling the belly takes priority, other aspects of life may suffer. When I once asked an older Muslim man why so many of the Muslims do not have a good education, he replied not with an answer, but with a proverbial question (in Hindi): "Will you first study or fill your belly?" (*pahela parega yah pet bharega?*).

Securing one's daily livelihood and "filling the belly" go hand in hand. If only a limited amount of food is available, filling one's own belly implies that someone else's belly goes empty. Anthropological accounts of pre-capitalist ideologies often point out how the notion of the "limited good" is central to moral reasoning (e.g., Dundes 1992; Foster 1965). In popular Hinduism, not only food, but also life itself is often a limited good that can only be had if other beings (humans, animals, plants, souls) are deprived of it (Parry 1982: 74). In Foster's (1965) classic discussion of this topic, the ideology of the limited good exists typically in non-capitalist economies, where resources seem to be fixed and productivity does not grow. By contrast, the ideology of capitalism is one of limitless growth. If resources are ever-increasing, filling one's own belly does not have to hit someone else's belly.

Bengali metaphors of the belly make little mention of the "limitless" good. Instead, the notion of the *limited* good underlies common expressions about how filling one's belly attracts other people's envy. If one cannot avoid filling one's own belly, one should at least be careful not to do so in a "greedy" way, and take more than what is needed. If the belly's inherent and insatiable desire for food cannot be suppressed, it should at least be controlled by modesty. When the belly is seen as an agent in its own right, it is the embodiment of self-centeredness. It comes as no surprise, then, that in everyday Bengali language, eating and the belly are core metaphors of the lowest, most egoistic, most anti-social tendencies of human beings. Eating, ingesting, and the belly are metaphors to express destructive and sinful behaviour.

The close link between eating/digesting and destructive selfishness is not unique to Bengali culture, but has been documented in classic ethnographies of other cultures as well. In *Coral Gardens*, Bronislaw Malinowski (1935) describes Trobriand rituals around the yams houses that aim to "close" people's bellies. Without these rituals, people's craving for food would be limitless. Based on unpublished data from Franz Boas's fieldwork among the Kwakiutl, Walens (1981) characterizes their symbolism of the mouth as primarily destructive:

"[T]he mouth and the things it does are representations of the bestial, antisocial, destructive aspects of human nature, which must be constantly guarded against, constantly obviated. People must either turn these primal forces to their advantage, or they must suppress them through the proper performance of social interaction."  
(Walens 1981: 14)

Bengalis perceive uncontrolled ingestion as dangerous to the community.<sup>40</sup> Gluttony is the first deadly sin associated with the belly. A person who is called a "belly everything" (*pet sarbasva*) is someone who likes to devour limitless amounts of food. The belly is often described as a bottomless pit, as a big black hole that can only be filled up temporarily, if it can be filled at all.

Taking away someone else's work is an act of severe aggression. To have this happen to oneself is equal to having one's belly "killed" (*pete mara*), or to have one's "food killed" (*bhate mara*). To counter such aggression, one could tell someone:

---

40 The icon of Ma Kali devouring the demons must be mentioned here. The goddess does not eat up the demons for selfish greed, but for her unselfish desire to rid the world of evil. Nevertheless, Ma Kali's "divine digestion" (cf. Samanta 1994) is an expression of the conceptual metaphor EATING IS DESTROYING. Those who eat the "limited good" do damage to others; those who eat the world's "limited evil" do others a favour (cf. Parry 1985). For an intriguing discussion of the "hungry god" in Tamil devotional writings, see Shulman (1993).

"Don't kick my stomach!" (*amar pete lathi merana!*). This means as much as: "Leave me alone, don't take away my livelihood." Feeding oneself and one's family is usually portrayed, by Bengalis of all social classes, as a daily struggle for survival. In this struggle, earnings must be made by any means necessary, if need be even illegal ones. Therefore, "for your belly, what are you capable of doing?" (*pete janye ki karte paro?*) is a question that can be directed at someone who is being suspected to be involved in illegal activities. Competitors in the work place who deprive one of one's job by foul means are "eating it up" (*cakri khaoya*). The boss who fires one from the job can also be said to have "eaten" the job. It can also happen that one's anger and resentment makes one turn aggressive against oneself. Auto-destructive behaviour of this kind is to "keep sitting, beating one's belly" (*pete khil mere bashe thaka*).

A great number of popular expressions revolving around disturbance and destruction are also based on the idea of eating as an act of irreparable damage. "That's eaten up!" (*ei kheyechhe!*) means that something is completely destroyed, that a great opportunity has been missed, and so on. If a woman's husband dies a premature death, she is being blamed for "having eaten" him (*svami khaoya*). Bad boys who seduce a good boy to alcohol and drug abuse may be accused of "eating" his good character (*caritra khaoya*). To "eat head" (*matha khaoya*) is a very common expression, which has many different shades of meaning. Friends who exert a bad influence on a girl or boy are said to "eat" her/his "head." The mother who pampers her child excessively is also said to "eat the child's head." An expression that the ethnographer was confronted with while asking too many stupid questions was: "Don't eat my head!"

As greed for money is often considered to be the typical symptom of modernity's corrupting influence on moral standards, several expressions combining money and eating are part of everyday discourse among Bengalis. A common complaint concerns rampant corruption among government officials, who are being accused of "eating bribes" (*ghush khaoya*). If somebody borrows money and later denies that he has done so, he is accused of having "digested" it (*taka hajam kare phela*). Money that has gone into the digestive system is money that somebody has unrightfully taken and spent, so that it cannot be recovered anymore.

Other types of antisocial behaviour commonly associated with the belly are treachery, duplicity, or any other kind of secretive conduct. All these metaphors also

belong to the image schema of BELLY IS A CONTAINER. What all of them emphasize is that the belly's contents are invisible to others, and that whatever is inside it is hard to bring back into the shared open space. For example, many expressions represent the belly as the place where secrets and bad intentions are hidden. Not to know what is "inside [someone else's] belly" (*peter bhetare*) means that one does not know what he is thinking. If one conceals one's true desires, one has "hunger in the belly, coyness in the face" (*pete khide mukhe laj*). The "belly's word" (*peter katha*) is knowledge which is not being shared with anyone else. If somebody thinks "in the belly belly" (*pete pete*), that is, deep inside the belly, he is thinking in a deceitful, cunning manner. The English expression that somebody is "two-faced" has an equivalent in the Bengali expression "in the belly one [thing], in the mouth/face another [thing]" (*pete ek, mukhe ek/mukhe ar*), that is, his mouth/face tell one thing, but deep inside, the true intentions are different. If someone's belly is said to be "swelling" (*pet phala*), this may mean that he keeps a secret that he can hardly contain, a secret that threatens to burst out into the open.

Some popular expressions for extreme stupidity represent a kind of comic inversion of the idea that the belly is a container of the "good" of knowledge. To say "there is absolutely nothing in his belly" (*or pete kichu nei*) is to say that someone has no knowledge or intelligence whatsoever. To underline such an allegation even more forcefully, the belly is compared to an empty sack of rice. If one were to stick a bomb into such a belly, nothing would come out (*pete bom marleo, kichu berabena*). A similar expression for extreme stupidity is to say *pete bom marleo, "ka" berabena*: if you made someone's belly explode, not even "Ka," the first letter of the Bengali/Sanskrit alphabet, would emerge. In this way, an empty belly stands for illiteracy and ignorance. In other expressions, the belly is portrayed as the first place of learning. Whatever has not been learned in the mother's belly, one will not learn later in life (*pet theke pareita keu shikhena*). In Hindi, "to learn in the belly" (*pet me sikna*) stands for a knowledgeable and skilful person, someone who has started to learn as an embryo in his mother's womb.

## 2. Popular epidemiology of digestive illnesses

### 2.1. Bengali terminology of digestive illnesses

Popular language around *pet* entails a complex taxonomy of digestive disorders. The centrality of the belly for any kind of feeling is expressed in sayings like "all pain comes from the belly" (*peter bhetar theke byatha ase*). Here, pain does not only stand for physical pain, but also for deep psychological anguish. The mouth and the belly are where disease enters the body. From there, disease comes all over the body.

The simplest expressions are that of having a "bad belly" (*pet kharap*) or "ill belly" (*pet roga*). The "belly's chaos/confusion" (*peter galmal*) also denotes any kind of digestive problem. Being built with the Sanskrit word *udar*, a more formal, yet rarely used term for digestive troubles is *udaramay*. A generic term for indigestion is *bad hajam*, "indigestion," associated with symptoms like a sour taste in the mouth and belching. Various kinds of loose motions are called "thin stool" (*patla paykhana*), or simply "stool happens" (*paykhana hay*).

When the belly falls ill, it is hard to tell what is going on. Once more, the belly appears, in popular physiology, as a dark container, whose contents and states are invisible to the eye. Barred from looking directly into it, people thus look out for other symptoms. The first among these is the outer shape of the belly. As a flexible container, the belly's expansions and contractions give indexical signs of what is going on with it. To be excessively thin is an obvious sign of malnutrition; to have a fat belly (*pet mota*), the opposite. If the belly is "swollen" or "bloated" (*pet phala*), it may indicate "indigestion," but also "pregnancy."

Besides having a visible shape, the belly also makes various noises. It is in connection to these noises that the belly is ascribed a kind of animal-like agency. A rumbling, disturbed belly is a "calling belly" (*pet dakche*). A "pinching belly" (*pet cincin kara*) can denote stomachaches, or pains due to menstruation or pregnancy. Another kind of "pinching" (*pet kui-kui kara*) inflicted by the belly is related to sensations of hunger. A "biting belly" (*pet kamracche*) means to feel pain in the stomach, often in relation to loose motions, or dysentery. This expression appears in TV advertisements for *Woodward's™ Gripe Water* (a over-the-counter digestive drug for babies) in which the product's long history of trust among generations of

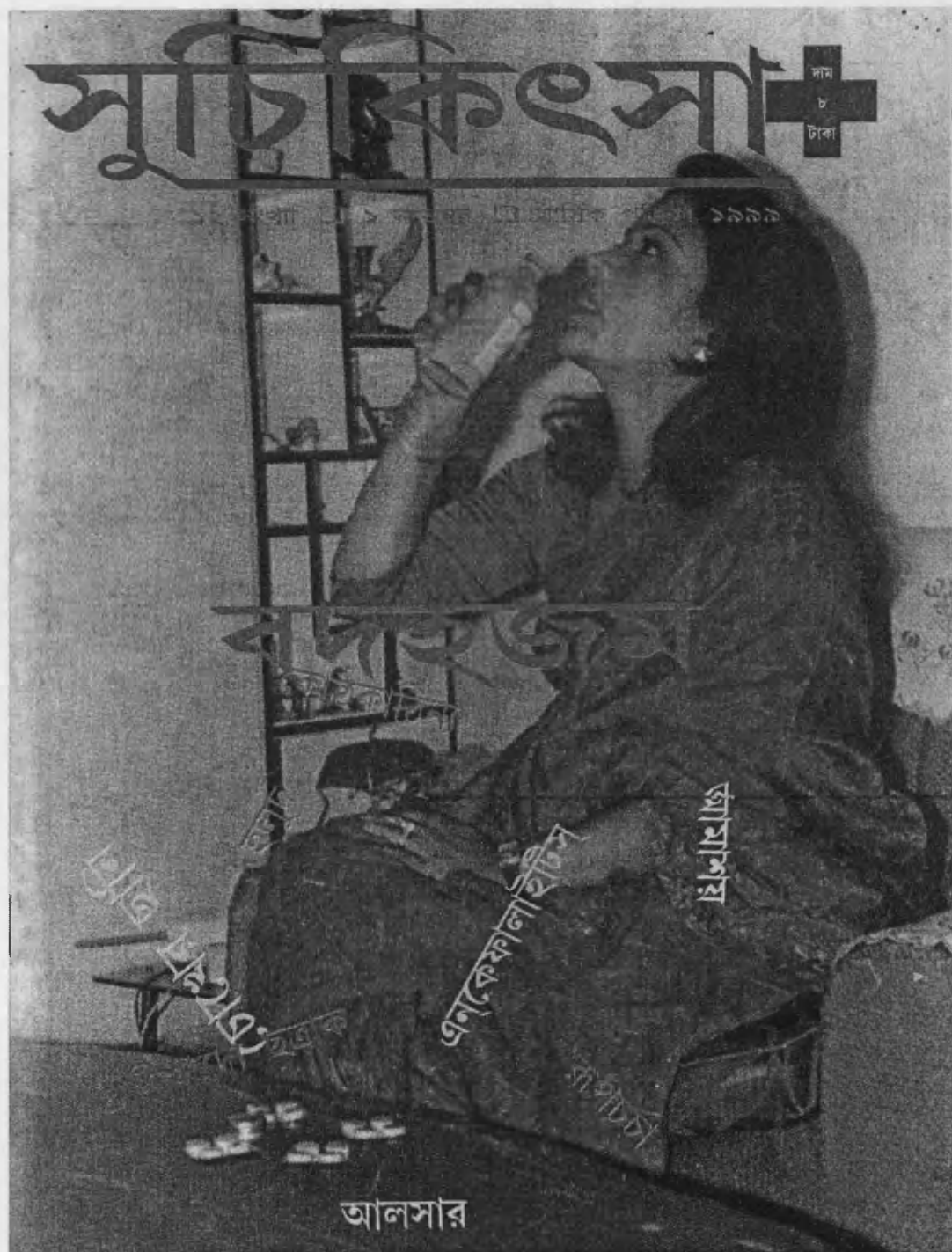


Plate 4: The theme of indigestion (*bad hajam*) in popular health journals (Title page of *Shucikitsha*, 1 November 1999)

Bengali women is emphasized.<sup>41</sup> The TV ad shows a scene of domestic self-medication. Present are the baby whose belly "bites," its mother and its grandmother. The baby is crying, and the mother does not know what to do about it. The

<sup>41</sup> *Woodward's™ Gripe Water* is a British-made medicine, first marketed in 1851. Its active ingredients are dill oil and sodium bicarbonate. Its original recipe (not in use any longer) contained a generous dose of alcohol.



grandmother assures her: "Her belly is biting, so give her *Gripe Water*! My mother has given it to me, too!" (or *pet kamracche, oke Gripe Water dao! Amar ma, amake-o diten*). The next scene shows how the same situation occurs one generation later, and how the mother, now grandmother, tells her daughter the same as her mother had told her: *Gripe Water dao!*

An animal-like agency of the belly is also expressed in the "twisting/wrenching" belly (*pet mocrano*), which is used to speak of diarrhoea. Sensations of a "wringing/twirling" belly (*pet pakano*) are more associated with feelings of nausea. The opposite of an active belly is the "dead belly" (*pet mara*), denoting a prolonged and serious loss of appetite. A similar term exists in which the navel comes to stand metonymically for the belly: to be "navel-dead" (*narimara*) means to have lost one's appetite or one's digestive power.

Besides these phrases, there are many more that use *pet* and a second qualifying term to define digestive illnesses. There is also a range of concepts that describe stools of a various consistencies, hiccups of various rhythms, or guts in various states of bloating. Since an analysis of these terms would neither add much to the reader's delight, nor to the argument presented here, I will not further detail them. For the sake of completeness, two popular illness concepts have to be added here: *amasha* and *antrik*.

In their ethnographic account of cholera outbreaks in Kolkata during the 1990s, Ghosh and Coutinho (2000) observe that Kolkata slum-dwellers have never heard of the term itself, even when directly affected by cholera: "[T]he bio-medical term cholera was absent in all the illness narratives" (2000: 688). Instead of this disease category, the authors discover a folk taxonomy of diarrhoeal diseases. *Amasha* denotes an alteration of sometimes solid, sometimes loose motions. If blood (*rakta*) is present, it is called *rakta amasha*. The biomedical term *diarrhoea* is popularly used to describe continuous watery motions coupled with nausea and vomiting. Lastly, *antrik* sometimes stands for any kind of "enteritis," sometimes for a disease entity that triggers symptoms of *diarrhoea*.

My own data tally with Ghosh and Coutinho's. *Amasha* was translated to me as dysentery, an abdominal disorder characterized by diarrhoea with stools often containing blood or mucus. The concomitant symptoms are feelings of weakness, depression, irritability, and skin diseases. The reason for *amasha* is incomplete digestion, leading to an accumulation of stool in lower intestines. This brings with it

an accumulation of toxins. The term is also used in a comic way, e.g. when someone is being made fun of for looking always sad and grim. The Indian national cricketer Rahul Dravid, for example, is jokingly said to suffer from *amasha*, because he always wears a grim expression on his face. The most significant characteristic of *antrik* is not its symptoms (diarrhoea, vomiting), but its highly contagious nature. Ghosh and Coutinho's interview data include the statement that "when *antrik* spreads, diarrhoea occurs." This supports the view that *antrik* is distinguished from diarrhoea not by the symptoms but by its contagiousness.

## 2.2. Hot/cold classifications

We have already mentioned the connection between digestion and gestation. In popular physiology, both these processes are seen as acts of *cooking*. Bengali notions of the belly also portray it as the body's "kitchen," a place where substances that have entered it are being heated up and cooked. Terms that describe the belly as *pakasthali*, the transforming heat of the belly as *jatharagni*, and the abdominal region as *surya-grantha* evince a close association between belly and heat.

What I found in everyday Bengali discussions about the belly is that this notion of BELLY IS A FIREPLACE does *not* translate into phrases that describe "heat" in the belly as a "normal" or healthy condition. To digest food, the belly's fire must be hot, but not *excessively* hot. It seems that humoral ideas of balance and moderation override ideas about "hot" being healthy. On the contrary, a "burning" stomach is clearly a symptom of disease. "Belly burning" (*pet jvala*) denotes intense feelings of hunger, or the sense of acidity that comes from not having eaten properly. If asked why one accepted work that gives much humiliation and few earnings, one could answer that it was "for one's belly's burning" (*pet jvalay*), expressing the hunger that comes from an inability to secure one's livelihood.

In popular belief, the navel is the only part of the body that is not being destroyed in the funerary fire. The idea seems to be that the navel is that part of the body that defines bodily identity. It is this part of the belly from which the child starts to grow, and from where it is cut off from his mother at birth. When the navel is seen as indestructible, it stands as a kind of bodily counterpart to *atman*, the

indestructible soul. If someone says that "hunger makes my navel burn" (*khide nari jvalche*), he expresses a sensation of extreme, destructive hunger.

Besides hunger, aggressive emotions towards other people belong to the concept of the "burning" belly. There are many examples to illustrate the image schema of ANGER IS HOT. The sight of someone who evokes anger, hatred, or jealousy "makes the belly burn" (*pet jvala kare*). Alternatively, one could say that "bile" (*pitti*, the popular expression for the Ayurvedic concept of *pitta*) begins to burn (*pitti jvala*). Feeling one's bile going "hot" (*pitti garam hay*) means "to go mad." The type of madness expressed here is always one that is connected with loud anger and aggression.

While aggression towards others is a symptom of a "burning" belly, to experience aggression against oneself leads to the opposite feeling, namely a "chilling" of the body. The image schema can be defined as FEAR IS COLD. Again, there are plenty of expressions in English that also connect the feeling of chill to feelings of fear and shock. The "chilling" effect of fear is also reflected in Bengali language, often in ways that find no equivalent in English. For example, to say "the belly's cooked rice has become raw rice" (*pet bhat cal haye geche*) denotes a person's extreme shock and bewilderment.<sup>42</sup> Connecting the idea of "cold" fear directly with the idea of the belly as a fireplace for food, this metaphor holds that strong fear can be so "chilling" that even rice (or generally, food) that has already been "cooked" in the belly becomes "uncooked" again. A comical use of this image is the saying "out of fear, the wife excretes raw rice" (*bhoye bou cal hage*), meaning that, out of great chilling fear, the rice inside the woman's belly has turned raw again. A similar saying holds that fear may lead to a disturbance of one's liver (*pile camke yaoya*). For example, a boy who had to "eat" the scolding of his father can be said to have his liver perturbed (*babar dhamak khey cheletir pile camke geche*).

The popular physiology of hot and cold states deserves a more detailed look. Much research in medical anthropology is devoted to hot/cold classifications and their relation to popular healing practices (cf. Rubel 1996: 188-120), not only in studies of Latin American (e.g., Foster 1994) and Asian cultures (e.g., Laderman 1991; Unschuld 1992), but also in contemporary Western cultures (e.g., Helman 1978). Most ethnographies which look at South Asian medical ideas mention the hot/cold system at least in passing, and many put it at the centre of ethnomedical

---

<sup>42</sup> Bengali language distinguishes between raw uncooked rice (*cal*) and cooked rice (*bhat*).

research (e.g., Beck 1969; Carstairs 1957; Lindenbaum 1977; Mull and Mull 1988; Nichter 1989; Pool 1987; Rizvi 1986). Foster's (1994) research on the topic is unsurpassed in breath and precision, so I will relate much of my discussion to his analysis. Only those aspects of the hot/cold system will be mentioned which relate to digestion and the care of the self.

If people speak metaphorically of certain entities as "hot" or "cold," not their actual temperature in degrees is meant, but the subjectively perceived effects of these entities on the human body. In principle, any entity or act can be classified as metaphorically hot or cold, but where these classifications are most elaborate are food classifications. A controlled intake of food is a central technology of the self that lay people use to keep healthy, to which elaborate recommendations about the right kind of food for the right kind of person, eaten at the right time and at the right place, testify.

Actual temperature and perceived effects can relate to each other in four different ways. First, thermal and metaphorical values can be in congruence with each other. For example, sunlight is both hot in temperature and metaphorically hot in its perceived effect on the body. Second, thermal and metaphorical values can contradict each other. In South Asia as in other parts of the world, cold coffee is thermally cold but metaphorically hot. Daniel (1985: 185) recorded an extreme example of this: Tamil villagers classify Western-style ice cream as hot. Third, an entity can be "neutral" in terms of temperature, but be metaphorically hot or cold. For example, biomedical tablets do not have a "temperature" as such, but are often considered to be very hot. Fourth, an entity may be metaphorically neither clearly hot nor cold, while being hot or cold in terms of temperature. Examples of this are, however, difficult to find. In South Asia, ambient air might be quoted as one example of this possibility.

The hot/cold classification is probably not only the most pervasive idea in the global history of medicine, but perhaps even "the longest-lived of all scientific paradigms" (Foster 1994: 204). The pervasiveness of hot/cold classifications belongs to the set of traditional medical theories that hold that the body needs to be in a state of "balance" to be healthy. Any kind of excess, be it "too much" or "too little" of a substance, an emotion, or an action, is potentially harmful. Even if a hot or cold insult does not instantly lead to illness, it puts the body into what Foster (1994) calls an "at risk" state: the more insults, the higher the likeliness of falling ill.

An excessively hot state of the body must be "cooled," yet this cooling process should be done with care and moderation, otherwise a state of "shock" would be the result, which can be even more harmful than the excessive state it tried to counteract. Foster (1994: 34) calls this mechanism the "temperature differential." Harm ensues not only when an excessive deviation from the healthy median occurs, but also when a sudden change happens, irrespective of which direction this change takes.

The humoral classification knows no absolute values. Instead, entities are classified along a continuum from "very cold" to "very hot." Such a continuum includes the possibility of a "neutral value," which people use when they perceive an item to be neither hot nor cold. Foster (1994: 113-128) notes that South Asianists, in contrast to Latin Americanists, mostly fail to mention this category. He raises the question if this is due to a lack of attention on the side of the researchers or due to a real cultural difference between the two regions. The neutral value is certainly more difficult to deal with than either hot or cold, because the frame of reference is harder to discern. An informant may either believe that something is neutral, or he may simply not have a definite opinion at all.

The fact that hot/cold systems are so pervasive in human cultures does not imply that their perceptions would also be the same everywhere. As can be grasped from the ethnomedical studies available, hot/cold classifications can vary substantially among different regions, social groups, individuals, or even in individuals in different contexts. As entities are seen as hot/cold in relation to other entities, results from interviews depend much on the way in which they are conducted. Foster suggests that one should, at least at first, avoid asking informants directly whether they consider something as "hot" or "cold." Instead, it is best to ask general questions about how people use food items and treat illnesses within the household, and to see to what extent hot/cold is being mentioned. This technique is the best safeguard against oversystematizing informants' views.

Hot/cold classifications are a typical expression of what Lévi-Strauss (1966) calls the *pensée sauvage*, that is, a mode of thinking in which everything in the world is related to everything else in terms of similarity and difference. Based on relations of similarity and difference, causal relations are being drawn. For example, if chillies are hot, and if states of emotional agitation are also hot, then the conclusion is drawn that eating chillies will lead to emotional agitation. Drawing on Leach's (1970)

analysis of Lévi-Strauss's work, Foster considers hot/cold as a distinction that is originally "natural," but which culture has "removed from nature and transformed into a cultural artefact that [...] maintains the same structure as the natural form" (Foster 1994: 3).<sup>43</sup>

A classification of the cosmos in terms of hot/cold is irreducible to other categories. As such, hot/cold are *primary* characteristics of all entities. However, hot/cold classifications are frequently coupled with other elementary perceptions of body and cosmos, such as "wet/dry," "light/heavy," "lustrous/dark," and so on. Hippocratic medicine, for example, describes the four basic elements through a combination of hot/cold with wet/dry: air is hot/wet, fire is warm/dry, water is cold/wet, and earth is cold/dry. The four humours of ancient Greek medicine are characterized in the same fashion: blood is hot/wet, black bile is cold/dry, yellow bile is hot/dry, and phlegm is cold/wet. The four basic personality types also fit into this scheme: sanguine (predominance of blood), melancholic (predominance of black bile), choleric (predominance of yellow bile), and phlegmatic (predominance of phlegm). Even if this theory lost its claim to be a "science" sometime during the eighteenth century, it shows surprising buoyancy in the West even today (cf. Helman 1978).

Among the many works available on this subject that deal with South Asia, I only want to highlight E.V. Daniel's (1984) study of a Tamil village, as it raises some intriguing questions about the connection between hot/cold and digestive diseases. Daniel observes that the hot/cold classification is applied to the *tridosha*, the three dynamic principles or "humours": *vata* ("wind"), *pitta* ("bile"), and *kapha* ("phlegm").<sup>44</sup> Due to the three-fold structure of the *tridosha*, they do not lend themselves to a classification in terms of hot/cold as easily as the four-fold structure of Hippocratic humoralism. Nevertheless, Daniel's (1984: 187) informants categorize

---

43 The synthetic way of thinking is flexible enough to bring even such "modern" phenomena as air pollution under its fold. For example, Chris Pinney documents how air pollution and its cure are also classified along hot/cold classifications. The management of GRASIM, a large textile plant in Madhya Pradesh, gives "cold" foods to their employees to counter the effects of "hot" air pollution of carbon disulfide: "This gas is nearly always blamed for all symptoms of *durblata* (weakness) and *sattvik* (cooling) foods are recommended to counteract the ill effects. These are primarily ghee, curds and milk which is issued by the factory as part of a special 'milk allowance'. The Vice President of GRASIM was reluctant to acknowledge that milk was given to ameliorate the effects of CS<sub>2</sub>, claiming instead that 'milk is good for gastro-intestinal problems', although other managers with whom I had contact informally advance it as a cheaper alternative to expensive waste treatment" (Pinney 1987: 474).

44 Since the *tridosha* concept cuts across popular medical ideas and professional Ayurveda, I will discuss it in more detail below.

the Ayurvedic *tridosha* as follows: *pitta* (or "pittam") as hot, *kapha* ("kapham") as cold, and *vata* somewhere in the middle (but as rather hot than cold). This popular perception tallies with scholarly Ayurveda, which classifies *pitta* as hot (as it derives from *agni*, fire), *kapha* as cold (earth and water), and *vata* as neutral. Originating from the combination of *akasha* ("ether") and *vayu* ("air/wind"), *vata* is neither hot nor cold (yet as the principle of movement, it is rather hot than cold). Two central parts of the digestive system, the stomach and the liver, are associated with *pitta*, therefore they are also classified as hot.<sup>45</sup>

Daniel describes that, in Tamil villagers' perception, most illnesses are hot, i.e. caused by an excess of heat. From among a list of the 26 most common illnesses, Daniel's lay informants identified 25 as heat-related, and only one as cold-related. Therefore, "heat is far more likely to be implicated in causing bodily disorders than cold" (1984: 187). Furthermore, digestive disorders are virtually always seen as hot: "Most intestinal disorders are considered to be heat caused" (Daniel 1984: 213). Even if such correlations are discovered, the causal relations between heat, *pitta*, the digestive system, and various diseases remain difficult to understand. Several hypotheses can be constructed from the data. First, illnesses that occur in a hot part of the body also tend to be classified as hot. Conversely, most illnesses occurring in cold parts of the body (e.g., the lungs) are classified as cold. This hypothesis states that hot/cold classifications of *body parts* are primary, whereas classifications of illnesses are secondary. A second hypothesis is that heat is *principally* more dangerous than cold. Given that the digestive tract is seen as hot, it would be chronically more "at risk" than other parts of the body. If a comparison is possible at all, this would contradict the bulk of the Latin American data, which indicate that there, cold is considered to be more dangerous than heat (Foster 1994: 69). A third hypothesis, which is closely related to the second, would be that the belly is seen as the "root" of most illnesses, digestive or not, because it is the region from which threatening heat originates. Owing to the *pensée sauvage* character of these hypotheses, many more could be constructed, all of them perhaps being plausible in one way or another. What unites all of them is that digestion and heat are central in popular theories of illness causation.

---

45 Dwarakanath (1967: 20) traces the meaning of *pitta* to the Sanskrit root *\*tap* (burning, heating). Concepts of fire and heat also inform Hindu notions of purification and alchemical enhancement (see chapter on Ayurveda).

The Bengali term for hot is *garam*, the term for cold is *thanda*. In Kolkata, prototypically hot foods are meat, egg, garlic, onion, mango, and ginger; prototypically cold foods are boiled rice, yoghurt, cucumber, papaya, and bananas. These items are commonly cited in the literature on Bengal (e.g., Jelliffe 1957), and on Hindu South Asia at large (e.g., Michaels 1998: 201-202).

According to popular Bengali concepts, a disturbance of bodily balance is more likely to be caused by an excess of heat than an excess of cold. This rule applies particularly to digestive complaints. Similarly to the Tamil villagers studied by Daniel, my Kolkata informants diagnose most digestive problems as arising from an excess of *pitta* (hot) or an excess of *vata* (middling, but tending towards hot). It would be wrong to say, however, that digestive complaints are never due to an excess of cold. Too much cold food and fluid will lead to a cold stomach and put one's health at risk. An excess of cold is diagnosed when the stool contains a large amount of mucus, signifying too much of cold *kapha*.<sup>46</sup>

Even if hot insults are more commonly mentioned than cold ones, the lines between thermal and humoral classifications are often blurred. In general opinion, hot digestive troubles and the hot weather are closely linked. One informant pointed out:

"The trouble comes from the climate. Everybody has it [gastric problem]. If the weather is hot, then the secretion of *pitti* becomes more, and then the body becomes even hotter. That's why one must never stay on an empty stomach in hot weather, because that will further increase *pitti*."

The relation between "hot/cold" and "wet/dry" in Bengali popular health culture is different from the Hippocratic concept. Hot/dry and cold/wet stand in a more direct causal relationship to each other. Thus, hot conditions have a "drying" effect, cold conditions a "moisturizing" effect. The reverse effects, namely that dryness is "heating" and moisture "cooling," is also true. Consider, for example, the health recommendations in a best-selling Bengali almanac (*panjika*) for the month of *vaishak* (April-May; Skt. *vaishakha*), one of the hottest and most strenuous of the year:

"In this month the sun will be very hot. For this reason, the land and the ponds will be very dry, the people will suffer from lack of water and from the reduction of fat. Because of the reduction of fat, the animals will get tired and weak. For this reason, in this time, ghee, milk, and lots of *carbohydrates* are to be taken. Especially barley

---

46 Helen Lambert (1997: 257) describes how Rajasthani villagers perceive cold-related illnesses to originate from the head.



mixed with sugar, with water added, made into syrup; it will be good when you take this syrup in the month of *vaishakh*. Papaya, green coconut, watermelon, seeds of the palmyra palm, lemon, butter, buttermilk, and very green mango syrup, etc., are used to get rid of tiredness. Too much exercise, too many stimulating matters, too much sunlight, too much salt, and bitter-tasting drinks are prohibited. After having lunch, it is necessary to take rest, in an area with plenty of air, and at night, sleeping in an area with plenty of cool air, is good for getting rid of tiredness and weakness." (*Panjika* 2000: *Dinapanjika*, 5)

These recommendations for one's daily "care of the self" are based on the observation that the heat of the sun dries out both the land and the bodies of humans and animals. The main symptoms of this process of desiccation are described as "weakness" and "tiredness." To counter these ill effects, it is recommended to take food that is watery, fatty, and rich in "carbohydrates." Papaya, green coconut, watermelon, and lemon all contain (moisturizing) water and have a "cooling" effect on the body. Ghee and butter build up fat. Milk and buttermilk replenish both fat and water. Barley, sugar, mango syrup, and palmyra seeds refuel lost energy. On the other hand, it is advised to avoid food that would exacerbate the heat of the sun. Salt is considered to be harmful in this sense, since it drains the body of water. "Bitter-tasting drinks" is a euphemism for alcoholic drinks, which are extremely heating. In terms of bodily exercise, it is counselled to take it easy (sweating is desiccation), and to ensure good ventilation (fresh air is moisturizing).

The passage from the *panjika* contains essential elements of the humoral worldview. (1) Body and cosmos are governed by the same principles. There is no principal difference between the "inanimate" and the "animate." Changes in the environment have an immediate effect on the body, e.g. the sun heats both the land and the body. (2) Every health recommendation has two sides, one for "positive" action, and one for avoidance. For example, to counter the desiccating effects of heat, one should take food that replenishes water, and avoid food that drains water. In humoral medicine, the causal link between these two sides is always evident, whereas in biomedicine (allopathy) it is not. It is, for example, fairly obvious that watery and salty food should not be taken at once, if the goal is to replenish water. The same cannot be said for even the most simple biomedical medicines. It may be clear that the intake of aspirin is a "positive" action against headaches. However, no "avoidance" is immediately obvious, because the workings of aspirin cannot be easily explained in humoral terms. If it were recommended to take lots of water along with aspirin, this would reflect a humoral model, not a biomedical model. (3)

The key to good health lies in the proper care of the self, especially in regard to diet and exercise, which makes it possible to rebalance body and cosmos. In Bengali, the special medicinal properties of food can be named more precisely than in English. The term *pathya* signifies food that is taken expressly for healing purposes, as against *khobar*, which is food for everyday nutrition.

Hot/cold classifications are not only an essential aspect of popular diagnostics, but also of therapeutics. A home remedy (*totka*) against infant diarrhoea is, for example, a blend of boiled green bananas and yoghurt, which are both classified as cold. However, there are also many *totka* that are not seen as cold as such, but only as being able to "control" the stomach's humoral imbalances. For example, two popular remedies against *ambol* ("sourness," a very common complaint) are caraway seeds (*joyan*), *amla*, or a mixture of dried *amla* and *haritaki* fruits. None of these remedies is seen as cold in themselves, but as potent means to bring excessive sourness "under control."

Complaints about *ambol* point towards classifications which complement – and sometimes override – hot/cold classifications. For example, Bengalis stress that not only hot/cold have to be balanced, but also the six basic "tastes" (*svada*).

Reminiscent of the *rasa* found in Ayurvedic texts, the six tastes are, in Bengali, *teto* (bitter), *kosh* (astringent), *jhal* (pungent, spicy), *tak* (sour), *nunta* (salty) and *misti* (sweet). In order to control excessive heat in the stomach, bitter and astringent foods are effective. The bitter leaves of the *neem* tree, for example, are commonly recommended during the hot season to keep excess heat under control. Yet opinions about how to classify the six tastes in terms of hot/cold vary widely. For example, *neem* leaves are more often seen as cooling than as heating, but there was no common view on this. Contradictions are often solved with reference to dosage: if taken in moderation, bitter things are cooling. If taken in excess, they are heating.<sup>47</sup>

---

47 Bitter *neem* is a traditional remedy against smallpox (Bang 1973; Nicholas 1981; Wadley 1980). According to popular belief, the goddess of smallpox, Ma Shitala, takes possession of a human body and "burns" it from inside. Ma Shitala, the "Cool One," is a goddess who likes to be cool, yet starts to burn when she gets upset: "First and foremost, she is always [...] a goddess who abhors heat and who seeks coolness. While rewarding those who make her cool, she 'burns' those who cause her to burn" (Wadley 1980: 35). Beyond hot/cold classifications, it is also said that gastrointestinal worms are driven away by the bitter *taste* of neem. Worms love the taste of sweetness, and abhor the taste of bitterness.

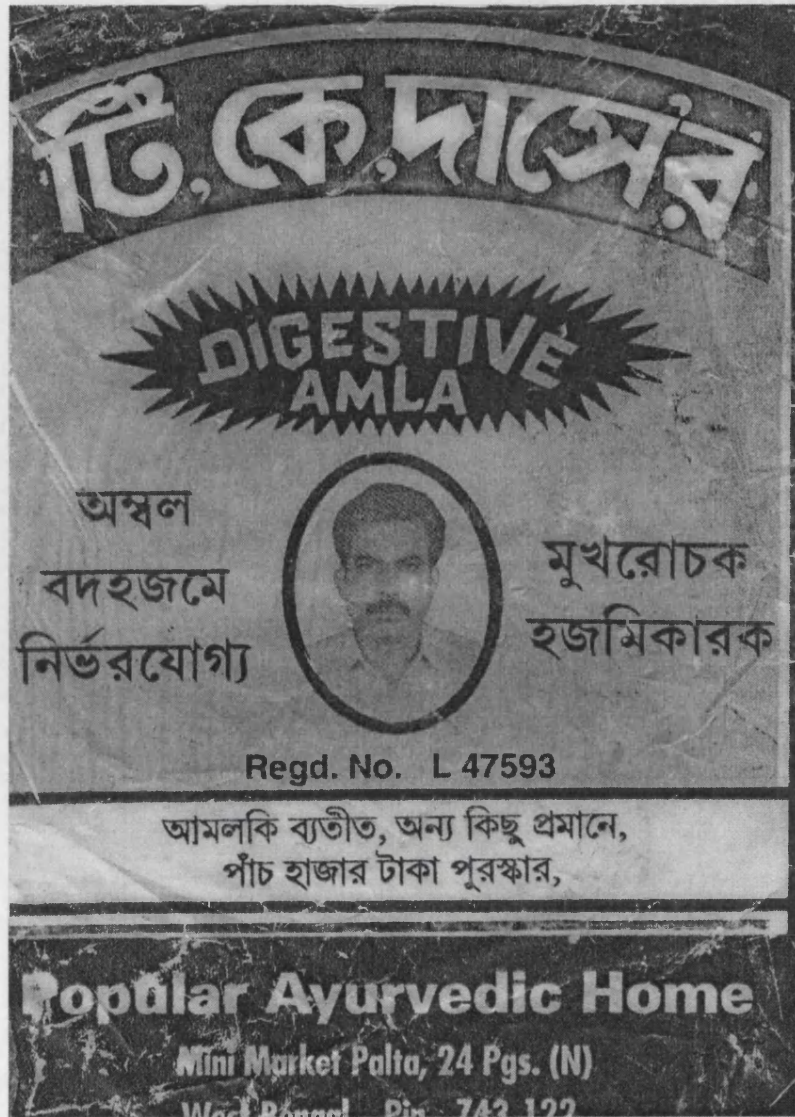


Plate 5: A packet of TK Das's Digestive Amla (15 x 10 cm)

Incongruities between hot/cold and other classificatory principles are often brushed aside as an expression of informants' lack of knowledge, or context-dependent variation of opinion. For Foster (1994), however, these incongruities are the key to understanding how hot/cold classifications are actually used.

Coincidentally, Foster's main example from Mexico for his discussion of this problem is also about digestion:

"The most striking incongruency is presented by *bilis*, interpreted as due to an overflow of hot bile from the liver into the stomach. *Bilis* is often described as *un calurón*, a terrific heat logically calling for the coldest of remedies. Yet the ingredients most often mentioned by informants as indispensable in the multiple-ingredient *bilis* remedy are predominantly hot [...]. 'Sympathetic' qualities of some of the ingredients appear to override humoral consistency: *manrubio* is said to be efficacious, among other reasons because, like bile, it is bitter [...]. The sympathetic

quality of a remedy, of course, is not a part of humoral theory." (Foster 1994: 136; italics in orig.)

Besides other classificatory schemes, such as "sympathetic" relations between symptom and remedy that override hot/cold classifications, many remedies do not make sense by any general classificatory system. The solution to this problem lies, according to Foster, in thinking of hot/cold as a classificatory scheme which does not *prescribe* certain remedies for their humoral qualities, but which *validates* remedies which have empirically proven themselves efficacious: "Most therapy consists of the administration of empirical remedies – learned remedies and procedures – applied to specific symptoms, with little or no thought given to humoral consistency" (1994: 75). Drawing on definitions of "culture" proposed by A. Kroeber, C. Kluckhohn, and other exponents of American cultural anthropology, Foster (1994: 143-144) interprets hot/cold as a "belief system" that can be used flexibly to validate behaviour, but which does not prescribe behaviour in a mechanical way.

Foster's conclusion that hot/cold classifications are ultimately subject to concrete experiences of efficacy is important and, in my opinion, correct. However, to think of this complex phenomenon in terms of the "care of the self" might be even more productive. A careful, often individual reflection on how food, climate, emotions, health, and illness are connected is at the heart of hot/cold thinking. This careful reflection can lead one to validate culturally shared perceptions, but they can also make one suspend the rules of hot/cold in specific cases. If hot/cold is interpreted as a technology of self-care instead of a model based on cultural-consensus, deviations and alterations become easier to understand.

### 2.3. Risk behaviour

Hot/cold classifications are an essential aspect of popular perceptions of disease causation. Popular aetiology takes into consideration a wide variety of aspects to explain the occurrence of disease. Everything that enters the belly is being accounted for in terms of 1) what it is, 2) how much is being ingested, 3) where it happens, 4) when ingestion takes place, 5) the manner in which this happens, 6) who has prepared the food, 7) who ingests it, and 8) in whose company it is ingested. Any transgression against what is good food, what is a good timing, and so on, will put one at risk, and can lead to illness. Respectively, the more of these criteria one

violates, the higher the likeliness that illness will strike. Based on this classification, some foods emerge as quintessentially healthy, others as unhealthy. The prototype of healthy food is a plate of rice with boiled vegetables, eaten in the family home, at a fixed time during the day, eaten in moderation and without hurry. A typical example of an unhealthy eating habit would be to gulp down quickly, outside one's regular eating times (*avelay*, "untimely, irregular"), a number of *singara* (the Bengali *samosa*) which have been cooked two days earlier, with too many spices and too much oil, by the roadside, in a poor neighbourhood. Rice and simple boiled vegetables thus incorporate everything that is wholesome and cooling, *singara* everything that is harmful and hot. Indeed, the most common answer to the question about what lies behind Kolkata's epidemic of *gastric* is "spicy food, oily food," reoccurring with mantra-like certainty in all interviews I have conducted. Besides *singara*, other typically harmful fast foods are tea, egg rolls, and Chinese-style *chow mein* bought from street vendors.

However, the fact that all of these items are not healthy does not impair their popularity. Being aware of harmful effects is one thing, being ready to renounce the pleasures of eating this food another. Those who only eat bland food are laughed at for being overly health-conscious, for missing out on the pleasures of hot, spicy food soaked in oil. Often, this food is eaten among a circle of friends and colleagues enjoying some free time together, and anyone who would refuse it would appear as a spoilsport. Mothers who insist on serving their family bland and healthy food are often mocked by their children: "Ma, why this food? Do we have a *gastric*?"

That outside food, bought from vendors or small restaurants, is the cause of some anxiety is not only due to the lack of hygiene, but also to the fact that those who cook the food are often Muslims. For orthodox Hindus, such food is not only questionable from a public health point of view, but also because of its association with the potentially dangerous "impurity" that flows from the hands of Muslim cooks. Given the enormous importance of caste structures in India,<sup>48</sup> I initially expected purity/impurity concerns to be much stronger. However, none of my Hindu informants ever said explicitly that food from Muslim restaurants was "impure" in the sense of compromising their status in the caste hierarchy, or their access to the deity in worship. Indeed, it is part of Bengali "political correctness" to deny that caste has any importance in everyday life, and questions about caste are turned down as

---

48 For a recent discussion of caste in modern India, see Fuller (1996).

inappropriate, or even as outright offending. Very few Kolkatans even agree that there is any impurity attached to Muslims as cooks; only the food they cook is dangerous for its "heating" effects. The only area in which caste concerns are still highly important and very explicit is kinship. Most families still prefer to marry their children into "appropriate" castes. It could be asked whether the irrelevance of caste concerning food is perhaps only an official ideology, whereas practices are different. According to my observations, Kolkatans are *not* concerned about impurity even in daily practice. When employed as domestic servants, Muslims not only prepare everyday food in Bengali middle- and upper-class houses, they are also employed to cook the offerings to the deities during ritual festivities. Even *pujas* that are celebrated in the private home often employ Muslim cooks. No doubt, Hindu Kolkatans are *aware* that, going by orthodoxy, they should not take food cooked by Muslims. Yet everyone I talked to underlined that these rules were outdated and were no longer followed. In short, I would argue that anxieties about "outside food" exist because this food is from the outside, and only to a very limited extent because Muslims might cook it.

Even if contemporary Kolkatans are, by and large, unconcerned about impurity in relation to caste and religion, they are still strongly concerned about the improper mixing of bodily substances. The Bengali term for impure food is *eto* (cf. Fuller 1992: 77). To classify certain food items as *eto* includes considerations of substance (e.g., orthodox Hindus classify all alcohol as inherently *eto*), but also, and much more importantly, if the food is spoiled by someone else's bodily effluvia. For example, if several people eat together and one of them touches accidentally someone else's plate with the hand he has been eating with (and which has come into contact with the person's saliva), that plate of food instantly becomes *eto*. Today, only the most orthodox Hindu families still follow the rules around the avoidance of food that is *eto* "in substance." However, rules against the improper mixing of body substances are followed conscientiously. For example, if people eat together, they must avoid touching someone else's plate. Since rules regarding *eto* are followed consistently, their deliberate *suspension* enables a powerful expression of social intimacy. For example, close friends, or lovers, can express and reaffirm their closeness by eating together from the same plate.

A type of food classification related to *eto* is that of "stale" (*basi*) food. Any cooked food that is not eaten freshly is *basi*, and should be avoided. But opinions

about the health risks from stale food vary widely. Some people claim never to eat stale food, others say they sometimes eat it, others say they eat it often and do not think that there is a problem with it. One middle-class man, for example, claimed that he had "never in his life" eaten warmed-up food, even if nowadays refrigerators make the hygienic conservation of cooked food very easy:

"[Question: *Have you ever eaten stale food?*] No, never in my life. Nowadays people have fridges. But in olden days there was no fridge. They used to keep their food, sometimes even in the open. Air got into it, flies, and *germs*, all gets into it. The *bacteria* form and become a *poison*. Anyone who eats it will get sick, and suffer from food poisoning. I cannot remember to have eaten stale food in my whole life."

Poorer Kolkatans cannot afford to be so strict about stale food. For the poorest people, considerations whether food is freshly cooked or not is an unaffordable luxury. If food is expensive and limited, one has to eat anything that comes along. As one beggar woman told me:

"[Question: *Does stale food make you sick?*] No, it doesn't affect us. We eat it since childhood. If it's bad, we vomit. If the food smells bad, we don't eat. If you have a bad stomach, pain from hunger, then you have to eat even spoiled food. There are so many poor people in Kolkata, they don't get food to fill their stomach. [...] Whatever we get from the houses, we take. Whatever my husband brings, we eat. We don't have a choice in food and how to fill the stomach."

The only stale food that even those would eat who are particularly strict about their diet is *panta bhat*, that is, rice that has been cooked the day before and had been left soaking in cold water over night. Far from being a health hazard, such rice gives strength and "keeps the stomach cool":

"If you take *panta bhat*, it always keeps your *pet* and *mon* cool, and you won't fall sick. People who do hard work, labourers, they take stale rice before they go to work. There's no question of falling sick, you'll be healthy."

Besides *eto* and *basi* food, Kolkatans also see contemporary city life as a major hazard to digestive health. The Bengali category of all types of health risks associated with modernization and urbanization is, not surprisingly, a "modern," English term itself: *pollution*. This concept appears in relation to a variety of aspects of the metropolis. As has already been pointed out, certain spaces are considered as threatening: the *bustee*, for example, is an inherently unhealthy environment, and any food taken there is hazardous for anyone who is not accustomed to it, not just because of the food, but because of the whole "atmosphere" (*jal haoya*, "water [and] air"). The division between food bought at outside restaurants and food cooked in

one's own home exists also in the space of the village, but is particularly significant in the urban environment, where those who sell spoiled food are hard to make accountable for their fare.

Just as the pollution of places makes one sick, so do the pollution of air and water. The quality of water is widely held to be questionable. Even if people are not able or willing to use a water filter, most are aware that one has to be cautious about the water one drinks. A direct link is also established between gastric troubles and air pollution. Several reasons are being given for why air pollution is bad for one's digestive system. For example, air is a substance that one *ingests* like food. Therefore, it brings the risk of "blackening" one's stomach. One middle-class patient with chronic digestive disturbances told me that her condition is partly due to all the smoke in the air "covering the glands" in her stomach, "blocking" the regular secretion of digestive juices. In this way, air pollution disturbs the power of the stomach to transform and to cook the food that enters it. Another middle-class man related the prevalence of the *gastric* in Kolkata to the lack of "*oxygen*" in the polluted air. He held that the stomach works like a combustion motor: in order to "burn" the food-fuel properly, a great amount of oxygen is required. Yet oxygen is rare in a polluted city like Kolkata. He believed that village air is full of *oxygen*, whereas Kolkata air only contains "*17 percent oxygen*." With such a serious lack of fresh air, there could be little wonder that most of the food that enters the stomach is not fully digested, but remains lying there, rotting, slowly becoming rancid, emitting foul gases. The microcosm of the body mirrors the macrocosm of the decaying city:

"It's like garbage on the streets. If you leave things in the stomach, it ferments, and then hurts. It pollutes the blood. The *oxygen* that we take through the lungs is not sufficient to fight the bad effect of the *gas*."

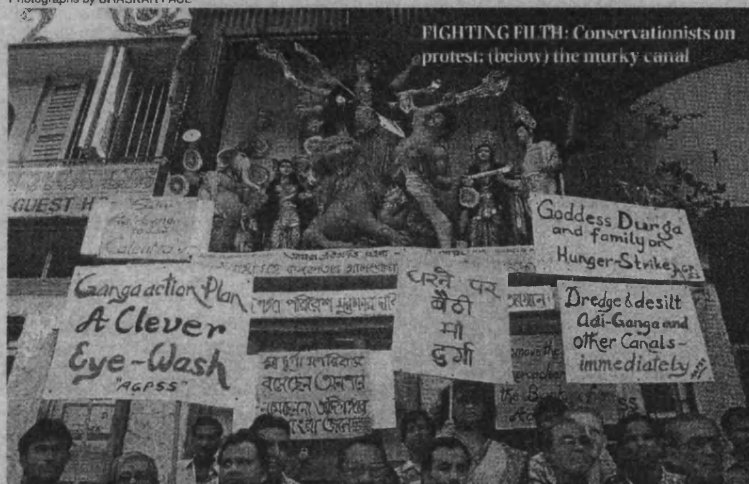
The modern city not only delineates a particular space to live in, but also particular time constraints. The first principle of good digestion is regular meal times, sufficient time for meals, and enough time to rest after meals. Just as



# MUCK BATTLE

The Adi Ganga is so dirty Calcuttans refuse to immerse idols in it. Now the people demand a clean-up.

Photographs by BHASKAR PAUL



FIGHTING FILTH: Conservationists on protest; (below) the murky canal

**I**N 1775, MAJOR WILLIAM TOLLY had a problem. The ship carrying his wife Anna Maria would dock in Calcutta that summer, but how could he save her the long, hot inland ride to their estates in east Bengal? Simple—just take the ship all the way. Tolly got the distributary leading from the main Hooghly river right up to east Bengal extended. In six months, an excellent cross-country waterway was created and Anna Maria practically sailed to her front door. "That's probably the last time anyone spruced up the Adi Ganga," says aeronautical engineer Barin De, on the canal that was renamed Tolly Nullah after the enterprising Englishman.

But it's a curiously prophetic moniker: for the Adi Ganga has now become what activist R. Bhattacharjee calls "a 15-km toilet dispenser". The canal that extends from the city's port area of Hastings right up to suburban Baruipur—touching most of south Calcutta—is today an unbroken river of sludge, stink and toxins.

Recently, De and his wife Mamata, along with 50 other Calcuttans and a clutch of conservationists, began a unique protest to demand the canal's clean-up. They enlisted an unlikely supporter—Goddess Durga. This year, following Durga Puja, people in the Des' neighbourhood refused to im-



**"As a boy I swam here but now it's just a toilet dispenser."**

R. BHATTACHARJEE, activist

merse their idols in the Adi Ganga. Instead, the largest one has been put on display at the Des' guesthouse. No pandal, no daily offerings, it's a deliberate desecration. "Our Durga is on a hunger-strike to save the Adi Ganga," says Mamata De.

The idea struck Barin De last year while watching an immersion in the Tolly Nullah. A 12-ft clay idol that was being given a ceremonial send-off bobbed up instantly. After a long struggle, the worshippers—much to De's horror—made a boy stand on the idol. "They got him to stamp on its face," says an outraged De. "Is this any way to treat the goddess we call our mother?"

For the south Calcutta families

who immerse their idols in the Adi Ganga—because of tradition or proximity—this last stage of the festivities is now an annual headache. The canal, which is only 10 ft deep, has a 5-ft bed of alluvium. It's been a decade since it was dredged (work on the first 1.5 km was begun in 1998, but stopped for want of an appropriate dredger) and with immersions every year the silt bed only rises. "Bengalis have six pujas crammed into five months," says air pollution activist S.M. Ghosh, who propelled the Des into the Adi Ganga Protection Committee. "That's almost 650 idols in the Tolly Nullah every year."

On September 29, when a freak high tide hit Calcutta, the silt-clogged Adi Ganga overflowed. The dirty water spread and inundated Union minister Mamata Banerjee's home. That kick-started the Des' protest: if the Government doesn't clean up—and quickly—next year they plan to move court to ban all immersions in the Adi Ganga.

A lawsuit on similar grounds—this time involving the main Hooghly river—was filed last week by a Howrah green group. But as usual, officials have no answer. They're busy playing political tag. Says Trinamool Congress leader and Mayor-in-Council, Sewerage, Rajib Deb: "We just took over the cmc four months ago. How can I tell you why the previous (Left Front) officials neglected the project?" Mayor Subrata Mukherjee, offering some promises, adds, "We haven't done much yet, but soon there'll be too much activity for Calcuttans to handle."

In 1985, the Tolly Nullah was included in the ambitious Ganga Action Plan Phase II, which also covers the smaller canals that criss-cross Calcutta and its outskirts. But apart from some cosmetic uplifts, very little has been done. "The corporation did carry out some preliminary work like dredging parts of the canal and evicting about 800 encroachers in 1999," says Raghavendra Das, chief engineer in charge of the project. But removing and rehabilitating over 40,000 encroachers will take at least four years, he adds. Till then, they will have to rely on divine intervention. —Labonita Ghosh

Plate 6: Environmental conflict in South-West Kolkata (Ghosh 2000)

important as the time to eat is the time for proper defecation. For perfect digestion, daily defecation, at the same time, during the morning, is essential. In popular

perception, however, the pressures of daily life neither allow for regular meal times nor for regular defecation. According to a male middle-class informant:

"In my job, it's difficult to keep time for lunch. Always late. Then I get pain in the stomach. Then it travels from the stomach to the back, then I cannot even sit, or sleep. Then I cannot explain where the pain is, it's all over my body. Unless I have an acidity tablet, it doesn't go away. Then I have to take proper food, rest, and tablets. A strong burning sensation in the stomach is always there."

Beyond the perceived disruption of daily rhythms due to modern urban life, the digestive process is also put at risk through natural time cycles. As evinced by the Bengali almanac's food recommendations quoted above, the six seasons of the year pose various risks to the digestive process. The best time for digestion is during the relatively dry and cool time from October to February. The worst times are the hot and the monsoon seasons. During the hot season, hot *pitti* is in excess, while at the same time the body is "stricken by weakness" (*durbal lage*), hence unable to digest properly. The monsoon time is also seen as dangerous for digestion, as it is an extreme time, and any extreme time puts at risk. It is also a time when the body contains too much fluid. The staple food during this time is *kicchuri* (a kind of gruel made of rice and yellow lentils), because it "drains" the body of excess fluids. Vegetables and fruits that cannot be cleaned easily (such as leafy greens) are to be avoided. The rainy season is also perceived to be dangerous because the water is at risk of being polluted through water-logging, overflowing sewers, and so on. This is also the season when diarrhoeal diseases increase. The monsoon season is dangerous not just because of faulty sanitation, but also because the heating (thus purifying) power of sunlight is less, thus pollutants, insects, and bacteria are more.

More esoteric influences on health come from the moon and the planets. According to which phase the moon enters, digestive problems may occur. The power to digest is believed to diminish during both the full moon and the new moon. Indeed, one's health is generally believed to be at risk during these times. People who are particularly sensitive to lunar phases are recommended to take only light and dry foods, and anything that is not too hard to digest. Fish, meat, and eggs are to be avoided. An informant said: "We fast on full and new moons to avoid feeling of heaviness. Best is only to take drinks and fruits. [...] But nothing made of rice, [that food is] too heavy."

The principle that seems to be at work is that the body is perceived as a container of various fluids (especially of water and blood). The Bengali expression

for this is *sharirer ras hay*, "the body's juices flow." The "link" (*yog*) between moon phases and the body is one of gravitational forces. During full moon, the attraction of the moon is strong, hence fluids go "up," and feelings of dizziness, mental excitement, or sleeplessness may result. During new moon, the gravitational force of the moon is supposed to be weakest; hence body fluids sink "down" into the lower parts of the body, causing trouble in all of its lower parts. Such changes of gravitational force can exacerbate existing illnesses. For example, a popular proverb holds that *punimar yoge, jvar bare* ("during full moon, fever rises").

Another cosmological influence on health comes from the impersonal agency of the stars (cf. Fuller 1992: 241-245). In the Bengali system of astrology, the human body is schematically divided into a rectangle of nine fields, with each of the four cornerfields being divided by a diagonal line, thus creating a total of thirteen fields. Twelve of these fields are inscribed with various body parts; the thirteenth field in the middle of the chart remains empty. As a Kolkata astrologer pointed out to me, the basic structure of the chart is meant to resemble a human body with arms and legs spread wide apart:

2. neck 3. hand	1. head	12. feet 11. calf-muscle
4. chest		10. knee
5. belly ( <i>pet</i> ) 6. stomach ( <i>pakasthali</i> )	7. urinal	9. thigh 8. rectum

Based on a person's time and place of birth, astrologists can calculate how each of the twelve body zones is associated with the planets (Jupiter, Saturn, Venus, and so on). Each of the planets has a specific influence on the body part with which it is coupled. Inauspicious planetary constellations can put a body zone at risk of becoming affected by disease. For example, to have *Rahu* or *Ketu* govern one's belly does not bode well for one's digestive health. Moreover, certain planets are considered to "rule" over certain parts of the body. In one astrological consultation I witnessed in Kolkata, an 11-year old boy was diagnosed to have a weak stomach because of an unfortunate constellation of planets in this area. The astrologer gave this diagnosis although the mother of the boy, who escorted him, did not make any inquiries about current or future health problems. She was more interested to know if her boy passes his exams, be more popular with other children, and get into a computer career later. In his diagnosis, the astrologer did not only use astrological calculations, but also resorted to hand-reading. The main remedy prescribed against the boy's weak stomach was a combination of gemstones that would help to neutralize negative influences from the planets. Such gemstones are carried by Bengalis of all classes, usually set in rings, and worn on a specific finger of one of the hands.<sup>49</sup> When the question is raised whose company poses a risk to digestive health, a range of aspects opens up. There are important differences between eating in the family, in the company of friends, with superiors, strangers, and so on. An adequate discussion of this topic is beyond the scope of this chapter. I only want to highlight one issue which resonates most clearly with the BELLY IS A CONTAINER metaphor and anxieties about "greedy eating," namely popular beliefs about the "evil eye" (*kharap cokh*).<sup>50</sup> Ideas and practices around the evil eye are an extremely well-documented

---

49 One of my neighbours explained to me the effect of these gem stones by analogy with a remote control: "Suppose you are here, you switch on a remote, and you see that 50km away from you the bomb explodes. In the same way the stone works. You cannot see what is going on between the stone and the planets. This is a logical thing." Beyond gemstones, astrologers may also prescribe certain diets to counter possible misfortunes. Parry (1985: 629, Fn.14) notes the following about a Benares astrologer: "Even a renowned astrologer I knew regularly prescribes dietary precautions against the misfortunes he can foresee in his clients' horoscopes. The horoscope enables him to predict the kinds of illness to which a person is predisposed, and in almost all his consultations he lays particular stress on the foods which must be avoided if his client is to remain healthy." For more details on the relation between astrology and well-being in North India, see Fuller (1992: 241-245) and Pugh (1983). For a treatment from an astrologist's point of view, see Bhasin (1986). For a discussion of health and auspiciousness in rural Rajasthan, see Lambert (1997).

50 Another term for the evil eye is *najar* (or *nazar*). This term is of Urdu origin and more associated with Muslim culture than with Bengali Hindu culture. Some also hold that *kharap cokh* and *najar* are synonyms, but that *kharap cokh* is more harmful than *najar*.

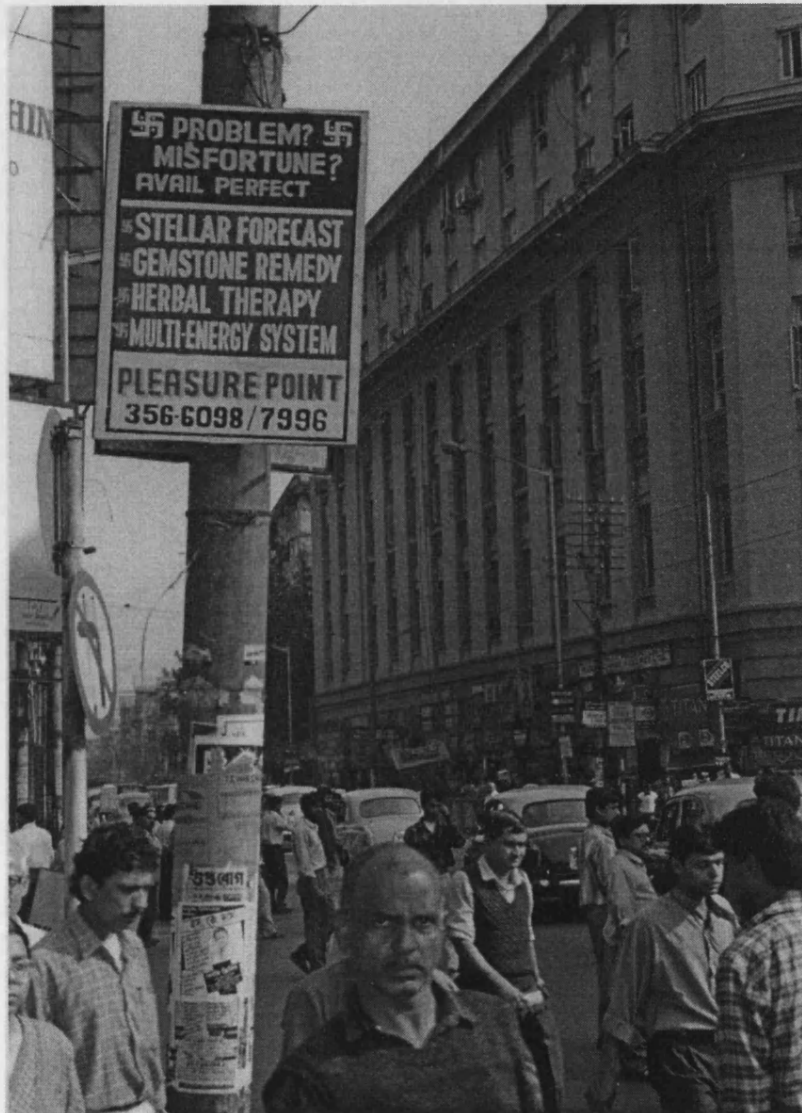


Plate 7: Advertisement for astrological and herbal therapy in central Kolkata (Photograph, 2000)

theme, both in Indian and other settings (e.g., Carstairs 1957: 197; Dundes 1992; Fuller 1992: 238-240; Gonda 1969; Pocock 1992; Pollen 2001; Rubel 1996). The concept of life as a "limited good" is the key to an understanding of the evil eye. Due to greedy tendencies, one person envies another person for his health, beauty, possessions, or social prestige. Even the unspoken or unfelt impulse of greed can have a harmful effect on the person who is envied. According to Dundes (1992), the evil eye does not simply harm its victim in the way that an arrow or bullet would harm its victim. Instead, the evil eye tries to *take away* the "good" from one person, and to transmit this "good" back to the person with the evil eye. Since the evil eye is not just about visual glancing, but about an actual transfer of substances, Géza Róheim interprets the evil eye as a form of "evil mouth." The evil eye does not just

look at an object of desire, but "swallows" it up like a hungry mouth: "The oral quality of the evil eye is evident. In French we have the saying 'Devorer des yeux', in Hungarian 'His eyes are bigger than his mouth', i.e., he desires more than he can manage" (Róheim 1992: 217). Regarding popular beliefs about the evil eye in rural Tamil Nadu, Clarence Maloney (1976) observes that stomach-aches are frequently attributed to the evil eye. Any consumption of food outside of the house puts a person at risk of the evil eye, especially from those who are lacking in limited goods:

"Anyone in the process of eating is susceptible, as is the food in front of him. A hungry look at someone's food may make the eater sick or give him diarrhoea. Therefore, a poor or hungry person should not see one eating, nor should one eat in the presence of others without giving them some of the food" (Maloney 1976: 106)

In Bengal, evil eye beliefs are strong among all ethnic and social groups. In his early ethnography of Bengal, Biren Bonnerjea (1927: 130-144) considers the evil eye important enough to devote the largest part of his chapter on "popular medicine" to the evil eye. In contemporary Kolkata, I found evil eye beliefs to be very common, not only in relation to health, but also in relation to success in education, business, and many other aspects of life. A direct link exists between the evil eye and digestive illness. A popular saying exists which accuses the glance of "greedy" people of causing gastric trouble: *O khub lobhi, pet kharap habe* ("He is so greedy, bad stomach will happen"). The "eye's hunger" (*cokher khide*) is an expression which also stresses a link between the eye and the hunger for other people's goods. Many of my informants agreed that a link between digestive health and the evil eye exists, but stressed that not all people are equally susceptible to its influence. If someone is weak in mental power, the evil eye can strike; if one is strong in mental power, it can have no effect. Such references to the strength of a person's *mon* ("mind"; discussed in more detail below) often makes it impossible to distinguish between gastric troubles which are actually caused by the evil eye, and those which only happen because someone *thinks* he is struck by the evil eye:

"[*Question: Is there a link between the evil eye and gastric troubles?*] That depends on your *mon*. If you think this while you eat in front of someone and you have stomach pain, then you'll have a pain. If you do not think in this way, you will not have [stomach pain]. If you eat on the road, if the food is bad, then you have stomach pain. If you keep your mind free, nothing will happen. If you keep your mind free, and eat poison, it won't affect. If you think you'll die, you'll die. But if your mind is free, nothing will happen."

In my view, most Kolkatans believe that the evil eye exists, yet give primary importance to mental self-control (cf. Fuller 1992: 239). The stress on self-control has two versions. First, only those people who are of a weak mind can be affected by the evil eye. Second, only those people who are weak in mind even *believe* in the existence of the evil eye in the first place. That is, a mere belief in the evil eye is a symptom of mental weakness. However, as Chris Fuller (ibid.) points out *vis-à-vis* the evil eye, such "complete skepticism is rare." In any case, it is every individual's responsibility to keep the *mon* strong. Hence it is every (mature) individual's responsibility to either ward off the evil eye by being mentally strong, or by not even believing in it.

#### 2.4. Risk groups

The discussion has so far focused on the belly at large. The emphasis on language and metaphor introduced a certain bias towards those aspects of the belly that seem to apply to all bellies at all times. In this section, I will illustrate ideas about the most important *differences* between the bellies of different categories of persons in Kolkata. As strange as this question may sound at first, it is a deadly serious one. Any in-depth epidemiological study of digestive disorders in Kolkata would easily find significant variations between the disease profiles of different social groups. For example, a 20-year-old *rickshaw-wallah* probably has very different problems than a 50-year-old government official.

Since digestive diseases are among the leading causes of death in contemporary India, social differences may decide about life and death. According to recent health statistics,<sup>51</sup> diarrhoea remains the primary cause of death in early childhood in India; every minute, one child dies of dehydration caused by diarrhoea. In the mid-1990s, around 1 million Indians were estimated to die each year of diseases associated with diarrhoea. Roughly 50 percent of *all* illnesses are linked to poor sanitation. Only about 30 percent of the urban populations in India has adequate sewage disposal.

How are epidemiological statistics related to popular perceptions? What can an ethnographic study, which gives most prominence to the "native's point of view,"

---

51 Data according to Library of Congress Country Studies (<http://lcweb2.loc.gov/frd/csquery.html>).

contribute to an understanding of India's health profile? As I will show, major social differences in terms of class, gender, age, education, religion and rural/urban divides are indeed perceived to be relevant by the lay population. Yet even if popular perceptions of different bellies mirror, to some extent, existing social differences, the image that emerges will seem inadequate and strangely amorphous. Although I tried to gain a more precise picture of disease distribution through a "popular epidemiology" of illness beliefs, the answers I received remained on the level of social stereotypes. Indeed, it seems that it is an intrinsic characteristic of any "geography of blame" (Farmer 1992) around specific illnesses that groups are typecast without giving much attention to detail: "AIDS only strikes gay men" is one of the most infamous examples of this. In a recently published study of popular stereotyping around an epidemic of dengue haemorrhagic fever in Delhi, Renu Addlakha highlights the usual suspects: "Class, ethnicity and gender are well-known criteria of stereotyping within society" (Addlakha 2001; cf. Rapport and Overing 2000: 343-349). In the following, I will focus on different social groups, on gender divisions, and on differences between generational/age groups.

#### **2.4.1. Social groups**

Opinions about how class and digestive troubles are linked differ with the type of illness that is given most prominence. When illnesses connected with unhygienic living conditions are concerned, the "poor" are seen by Bengalis (of all classes) as most susceptible to digestive problems. The link between social inequality and an unequal access to clean water, hygienically prepared food, proper sanitation, and so on, is more or less obvious to everyone. Thus, the argument that "poor people suffer most" can be often heard.

However, as far as gastric troubles such as acidity, indigestion, and general unease are concerned, opinions vary strongly. Sometimes rich people are said to suffer most, sometimes poor people. Rich people are at risk because of an affluent life style. In terms of diet, rich people are held to take food both high in quantity and in quality. They also take more synthetic stuff such as fizzy drinks and more factory-produced food. In terms of timing, they are freer to eat whenever and wherever they like to, leading to overeating and obesity. They do not do any hard physical work, so



their digestive fire is weaker than that of labourers. The bellies of the rich are also held to be more delicate and sensitive than those of poor people. According to a slum dweller I interviewed, poor people do not fall ill as much as the rich do because of God's "blessing" (*ashirbad*), and because of being accustomed to it:

"[Question: Do you eat stale food?] Yes I ate. It's bad for the health. But we are used to it, so it doesn't affect us. That's God's blessing, that it doesn't affect the poor people (*garib lok*), but only the rich people (*bara lok*). If rich people eat stale food, then they have to go to the doctor. But if poor people eat it, it won't affect. That's the difference between poor and rich."

A different reply to this question came from a number of middle-class informants, who also thought that the "poor" are eating whatever comes in front of them, but that they do so at their own peril. A middle-class Bengali woman thinks that even if the poor are not as sensitive to bad food, sooner or later they will also feel the negative results of their diet, just like rich people:

"[Poor people] can't stand boiled food, they want spicy food, heavy food. *We* [educated, middle-class] want light food, but they want heavy food. They are not aware [of the risks]. Poor people are not habituated to light food, it makes them vomit! [...] But ultimately, it makes them sick. They say: 'We'll die one day, so why not take spices?'"

By reference to a lack of "awareness" among poor people, this middle-class informant saw higher socio-economic status and "education" as synonymous. Given that, in Kolkata as elsewhere in India, levels of income and levels of education are evidently correlated, this is not surprising. In popular discourse, "education" and socio-economic class are commonly seen as the same: *garib lok* are taken to be illiterate, *bara lok* to be literate. Literacy determines access to media information on public health issues and the latest news about what diet and daily routine is considered to be healthy by "scientists." The level of an informant's education has a discernible influence on how people talk about health. More educated informants evoke "bacteria" and other basic knowledge about public health that they have learned in school or through the media. Less educated people speak of "dust" (*dhulo*) or "dirt" (*moyla*). In the following statement, a slum resident explains:

"We have to eat carefully whatever we eat. In the *bustee* we don't have a dining table or a separate room to eat. Six to seven people in one room, living together. So we all sit together to eat. So there will be some dirt (*moyla*) which has a bad effect. I believe that there is too much of dust (*dhulo*) and disease (*asukh*). It's such a small space, someone has to go outside with the plate and have it there. So the dust comes in, and the disease. It can affect your health if you eat that. The dirt goes in, and then

you fall sick. It can affect your health, your stomach. [...] This happens so often, it's uncountable."

The difference between "dust" and "bacteria" is important. One refers to something essentially visible, the other to something invisible.<sup>52</sup> In many of my conversations with slum dwellers, it was pointed out to me that there is no stomach problem as long as one keeps the home "clean" from the "dust" that enters from the outside. If the boundary between the polluted environment and the space of the home is clearly drawn, then digestive disorders stand little chance of entering. Once contamination is defined in terms of visible pollution ("dust"), issues of public health become an issue of care for oneself, members of the family, and the space of the home.

With better education comes a basic knowledge of risk as a property of populations that can only be explained in terms of probability. This throws up the question of "statistical reasoning" among the population. In contemporary Kolkata, reference to statistics is very popular among those who are educated, not least as a marker of distinction. The answer of a 45-year old middle-class man to my question about a possible link between income and gastric health is typical: "Poor people suffer most. If you ask them, 80 percent will say that they suffer." People who lack a basic knowledge about "risk" in terms of probability are, on the other hand, more likely to claim that "everyone suffers." This view is based on "anecdotal" evidence of the occurrence of gastric disorders even in the most well-to-do families. The fact that rich people are principally also affected overrides statistical patterns that show that socio-economic class and risk of disease are markedly correlated.<sup>53</sup>

Religion is another socio-cultural factor that is seen to influence digestive health. Among my Hindu informants, I could not discern any particular relation between Hindu faith and gastric health. There is, however, a strong perception

---

52 Latour (1988) shows how the "Pasteurian revolution" (and the demise of the humoral paradigm) of the late nineteenth century was only possible because Pasteur was able to give *visual proof* that bacteria truly existed. Hygienists had long tried to pinpoint relations between a definitive disease and a definitive cause: "As a result, the period showed keen interest in identifying the corrupting forces, the double agents, the miasmas and contagions, and accorded immediate trust to those who might, in identifying them, be able to take measures against them. It was at this precise point that the microbe and the revealer of microbes appeared" (Latour 1988: 33).

53 Ian Hacking (1990) argues that the idea of "probability" has only risen to prominence during the nineteenth century, when idealist classifications were pushed back in favour of empirical possibilities. In relation to self-care, popular understandings and uses of statistical information about health would merit a more detailed description. Statistics bring into play a notion of risk that strikes "blindly" within a population, thus breaking up any immediate causal relation between individual health behaviour and its consequences. Moreover, a detailed ethnography of popular uses of statistics could show how they bring about changes in daily living habits, e.g. how statistics about cancer rates might convince people to stop smoking.

among Kolkata's Bengali Hindus that the local Muslims are manifestly at risk from being afflicted by digestive diseases. For Hindu Bengalis, Muslims combine all risk factors: they are seen to be predominantly low-class, therefore they are at risk from polluted water and a generally unhygienic living environment. Hindu Bengalis also stress that poor Muslim *bustees* are even more dirty and unhealthy than Hindu *bustees*. It is said that Muslims neither care for the cleanliness of their streets, nor for the cleanliness of their houses.

As far as personal hygiene is concerned, Hindus think that Muslims keep their bodies clean with water and soap just as much as they themselves, perhaps even more scrupulously, because they have to wash five times per day before prayer. But what they put into their stomach is, however, mostly unhealthy, and partly unhygienic. First, the kind of spicy and oily food that Kolkatans see as one of the major reasons for gastric troubles is clearly associated with Muslim cuisine. Items like *biryani*, *singara*, or *paratha*, as well as *tandoori* dishes, are all clearly marked as food of Muslim origin. Hindus tend to view this kind of food as risky but pleasurable, and as food that one may occasionally indulge in without harm, but which is certainly not to be taken every day. Muslims are said to eat nothing other than spicy/oily stuff. According to a Bengali Hindu woman:

"Muslims have spicy, meaty food everyday, and then they are surprised that they have gastric problems! [...] Muslims take the wrong food, but they say that it is their custom, so they don't know [the harmful effects]. [...] Muslims don't like anything which is not spicy, or without oil, garlic, or onions. Even papaya they take with spices!"

The excess of spices and oil in Muslims' daily diet is related to their excessive consumption of red meat. Bengali Hindus, including Brahmin castes, have a long tradition of eating fish, a fact that has brought them much ridicule from Brahmins in other parts of India. Other animal product, such as mutton, also seems to have been part of Bengali Hindus' diets for a long time. Today, Bengali Hindus are very fond of meat, especially mutton and chicken. If a family can afford to pay for it, it is not uncommon that meat would be eaten at least once a day. As liberal as they may be, most Bengali Hindus still abhor pork and beef. While Muslims share the Hindu disgust for pork, they are fond of beef dishes. Hindus see beef not only as impure for religious reasons. The common view is that beef is a health hazard because cows are only slaughtered when they are old and sick, when their meat is infested with worms

and bacteria. Moreover, beef is also one of the "hottest" kinds of meat; hence it makes the body dangerously hot.

According to Bengali Hindus, Muslims behave in a hazardous way partly because they lack the self-control necessary to eat only bland and healthy food, but also partly because they are seen as uneducated and ignorant about the effects of their diet. Instead of knowing the "scientific" facts about proper diet, they are steeped in "superstition." One Hindu middle-class man told me that Muslims think rather of "bad spirits" as the cause of digestive disease than of diet and living habits:

"Everything they attribute to it [evil spirits, evil eye, magic]! I knew one family, totally illiterate; they threw their baby into boiling oil, so illiterate. The difference is: we Bengalis are more educated, especially the middle class, that's why we think about digestion when it comes to illness. That's the scientific view. But Muslims are less educated, and although they suffer from digestive problems, they are not aware [of the true causes], but bring everything down to superstition."

Unfortunately, I did not have enough time to collect sufficient data on Muslim's views of Hindus. The Hindus' critique of Muslims as superstitious, badly educated, and lacking self-control would have certainly been challenged by them.

#### 2.4.2. Gender

When asked about possible relations between gender and digestive troubles, informants' first reply tends to be that there are *no* gender differences. Since both men and women suffer from bad stomachs, it all depends on an individual's constitution, irrespective of gender. Given that one of the main reasons for digestive disease is "oily" and "spicy" food, and that there are no popularly perceived preferences of males or females for either spicy or bland food, it is not a surprising finding that gender differences do not feature prominently. There are, however, significant imbalances between the eating habits of men and women. The most important factor is that men are hierarchically superior to women, which determines *how much* is eaten, *when* it is eaten, and *where*.

First, males tend to get more expensive food (e.g., fish) than females. If little food is available, the male members of the family will receive more of it than the female members, or even all of it. In the poorer families, if there is only one piece of fish to go around, the male head of the family eats it. Men also tend to get more of all

other items, including rice. The common rationale for this hierarchical distribution of food is that the man must be strong enough to work, and so to fill his family's bellies. The preference for males also includes the children. Next in line in the distribution of food come the male children. Boys tend to be more spoiled with food. In order to get them to eat as much as they can, they are told "Treasure, eat!" (*sona khao!*). On the other hand, girls are told not to make a fuss and to "swallow!" (*gelo!*). As I have witnessed several times when eating in neighbours' houses, the boys in the family were hand-fed by the mother, so as to make them eat as much as possible. Of course, girls are also hand-fed in their early years of life, usually until they are three or four years old. Yet boys tend to be hand-fed for much longer, sometimes well into their teenage years. In one of my neighbours' houses, I have seen boys in their early twenties being hand-fed by their mothers, without any embarrassment of an outsider like me looking on. Food that is given by one's mother's hand is supposed to be more tasty, more nourishing, thus better for the stomach.

Gender-specific hierarchies in the distribution of food not only affect the amount of food that females may eat, but also *when* they may eat it. In many families today, all members of the family take food at the same time. In more traditional families, however, female members of the house eat *after* the males have finished their meal, and mothers only eat after everyone else has eaten their stomachs full. Besides getting less food, females also suffer from digestive troubles that result from waiting for their meals longer than other family members. As has been discussed earlier, it is a health hazard to go on an empty stomach for too long, because *pitta* rises, *gas* forms, and so on. When the meal is prepared and the woman is hungry, she must wait until the male members of the household have eaten. Even if the husband comes several hours late for the meal, the woman is not allowed to take food before him. The kind of stomach upsets that come from this situation are a salient example of gender-specific risks to digestion. The suffering caused by an empty stomach is, however, seen as bestowing merit on the woman. She is able to control her appetite for the benefit of the family. A woman who does not follow the custom of letting the male household members eat first is seen as greedy, selfish, and lacking self-control.

The obligation that a woman controls her urge to eat is particularly important during *puja* celebrations. No one in the family observes rules of religious fasting (*upavas kara*) before ceremonies more conscientiously than the women of the house. The woman is responsible for the well-being of the family in all spheres of life

except earning a living. If a religious ceremony requires a period of fasting, male members in the household *may* adhere to it, but the leading female members *must* adhere to it. That fasting can put digestive health at risk is widely acknowledged. All the same, the necessity that women take this suffering upon themselves for the well-being of the family goes unquestioned. Of course, fasting is also perceived to be *beneficial* for the digestive system. Religious fasting is, after all, not only about self-inflicted suffering, but also about "cleansing" oneself both mentally and physically. It has never been mentioned to me, however, that women fast more than men because they were more health-conscious. Even if there are perceived health benefits from religious fasting, these are not seen as gender-specific.

To alleviate the risks of outside food, many men (and schoolchildren, too) take home-cooked food with them. The *tiffin-boxes* in which these meals are being carried are an essential accessory of middle-class office employees, sometimes the only item they can be seen carrying on their way to work. They usually contain a full meal of curries and *chapatti* bread, freshly cooked in the home in the morning. But not even the home-cooked *tiffin* can prevent a *gastric*, as this male government clerk underlines:

"Cold [stale] food is more harmful. Hot food, it's in the *tiffin*, but it becomes cold and watery. We Bengalis say: *ambol hoyeche* ("sourness has happened"). [...] In the morning you prepare your lunch, put it in the box, then have it at 2 or 3 o'clock in the afternoon. Making it hot would be better."

Given that women stay more in the home than the men makes them less vulnerable to the bad effects of street food and water of unknown origin. But domesticity may also increase the risk of digestive troubles. Staying at home can give rise to "greedy" eating at irregular times of the day. Especially middle-class women often complain about being bored with housework, so that one of their greatest pleasures is treating themselves to little snacks throughout the day, which can lead to overweight and a weakening of the digestive fire.

Gender differences do not only appear in regard to *what* is being said about the bellies of men and women, but also in regard to *who* emphasizes certain points in contrast to others. Women tend to speak more elaborately than men about all those aspects that relate to filling other people's bellies. Similarly to this, women tend to be more concerned with the hot/cold properties of food. They seem to use a more detailed vocabulary for the various illnesses that afflict the belly. Furthermore, almost all of my interview data on pregnancy are derived from conversations with

women. None of this should come as a surprise: the daily burdens of cooking, of caring for their children's and husband's well-being, and of pregnancy, are aspects of life that demand a heightened concern for the belly from the women. In contrast to this, men have a tendency to stress those aspects of the belly that relate to "greed," aggression towards others, and the evil eye. Complaints about eating outside the home, including stale *tiffin* food, are also voiced more frequently by men than by women. Given that a man's role is that of the bread-winner who goes out of the house to struggle for the family's economic sustenance, men's emphasis on these facets of the belly could also be expected.

It must be underlined, however, that these are only weak tendencies. Most women are equally concerned about, for example, the evil eye, and most men are equally aware of the hot/cold qualities of food. Perhaps the only clear gender bias emerges in statements about how much food is eaten, and when. That men get more and better food was mostly mentioned by women, especially by *middle*-class women in respect to *low*-class men. Likewise, that many women are only allowed to eat after the men is a point that men usually do not mention. Another gender bias can be perceived in statements about stale (*basi*) food: *male* complaints about stale food can imply a critique of their own "modern" wives, who may cook food in advance, store it in the fridge, and thereby liberate themselves, if only temporarily, from being bound continuously to the kitchen.

### 2.4.3. Age groups



Digestive power varies with life stage. It follows the same path as one's overall bodily constitution: weak and unbalanced during infancy and childhood, strongest among healthy young people, slightly diminishing in later adult life, until being weak again in old age. One neighbour, who read many popular health books, related age and digestive power to the Ayurvedic *tridosha*: children and old people suffer from a predominance of *vata* and *kapha*; adults from a predominance of *vata* and *pitta*. However, such Sanskrit models are very rare, more common are simple extrapolations from experience. Children's digestion is said to be volatile. Their appetite comes and goes. If they feel hunger, they cannot control themselves. If they

have food, they are often unable to hold it in the belly, and suffer from frequent diarrhoea. Or they hold it for too long and suffer from constipation.

**Sachin Tendulkar**      **Arundhati Roy**      **Amartya Sen...**

... of the future.

Now there is a Chyawanprash, formulated specially for your child.

 <p><b>Young Genius</b> Brahmi and Shankpushpi to enhance memory &amp; academic performance</p>	 <p><b>Baidyanath Junior CHYAWANPRASH</b></p>
 <p><b>Sports Champion</b> Banslochan - builds stronger bones to help excel in sports</p>	
 <p><b>The All-rounder</b> 52 essential herbs build natural resistance against diseases, ensure active participation in every field of life</p>	

Business offer: Imported tax free with every pack

Plate 8: Baidyanath Ayurvedic children's tonic (Newspaper advertisement)

Children suffer not only because of their vulnerable constitution, but also because of how they behave. That children play around on the ground and stick their fingers in the mouth is known to cause worm diseases in children. However, traditional beliefs, such as that worms are caused by the excessive consumption of sweets, and that children suffer most from worms because they eat more sweets than adults, are also very common, not just among uneducated Kolkatans.<sup>54</sup>

<sup>54</sup> In this chapter, I can only hint at a few common popular beliefs about digestion in childhood. Given that children are at a much higher risk of dying from digestive disease than adults, the topic would merit a much more detailed analysis. Much research has already published on the problem (e.g., Lindenbaum 1977 on Bangladesh), especially from the angle of public health/development.



The best age for regular, powerful digestion is one's adult years. To one of my questions about age and the risk of digestive disorders, a 26-year-old man of strong build replied:

"We are young, we don't have a *gastric*. Whatever we eat, we eat. Our stomach is like a *godown* [i.e., warehouse, factory].<sup>55</sup> We pour food into it. *Gastric* only happens to old people, not the young people. To old men, fat men. If you give me an iron rod, even that I can digest."

Among adults, those who do regular physical labour are believed to have the best digestion. Strong digestive power also characterizes newly-wed couples. Not just because of the "physical labour" they do, but also because their mind is joyous and eager to incorporate the world. The Bengali proverb *tustite pusti* means "in joy, there is nourishment." During my stay in Kolkata, friends and neighbours used to look at me and worry about me being "too thin." This expression of the care of others was not primarily connected to questions about a possible *gastric* disease, but to my personal well-being, especially my lack of a wife to look after me.

The more physical strength vanishes, the more digestive power vanishes, too. The digestion of older people is weak and ineffective. However, there is a strong popular perception that older people keep on eating a lot, more than they can cope with. The reason given for this is that the strength of appetite and the strength of digestion are "out of sync" in old people. The idea that old people tend to eat "too much" can be assumed to be a hidden critique from the side of the younger people of the elders "devouring" *their* fruits of labour while already being unproductive themselves. A culturally sanctioned example of this belief is the dietary regimen that widows have to follow. The fact that widows in Hindu India are often severely limited in what they can eat is well-known. Most attention is paid to those types of food that are seen as both sexually stimulating (heating), e.g. onions, garlic, and all protein-rich foods (e.g., fish and meat, but also lentils). The amount of food to be eaten is also at stake. I have often been told that in traditional Bengali society, old people in general, and widows especially, were given much less food than the rest of the family. This "superstition" was now overcome. However, it is seen until today as meritorious for old people to fast often and to eat only the simplest food, in order not to take away food from the family as a whole. The idea that old people crave for more food than they can take might perhaps be a trace of this custom. The

---

<sup>55</sup> The word *godown* ("warehouse") is a folk etymology of the Malay word *gudang*. The belly as *godown* belongs to the conceptual metaphor of BELLY IS A CONTAINER.

prohibition against spicy and protein-rich food for widows might aim not only at reducing sexual cravings, but also at limiting their metabolic rate as much as possible.

Even if the younger people try to talk the elderly out of eating "too much," piety demands that they are given anything they like to eat during the last days of their lives. The rule is that, shortly before death, any craving must be met: *ya khete cay diye dao!* ("[Whatever] s/he likes to eat, give!"). Once death is near, considerations of a "good death" override concerns for either digestive health or even ritual restrictions. One lower-middle-class woman mentioned that her mother, who was already very ill with heart disease, dreamed about all kinds of food that she was not allowed to eat for many years, and asked her daughter: "Please, can I have it?" Such requests have to be met; otherwise someone might die with a grudge against the children and relatives, who dared to deny the last wish before death. To attract a dying parent's curse is too great a risk to take.

Old age implies a weak digestive fire, but the fact that someone *is* old signifies, in turn, that digestion must have worked well for most of his life. In Kolkata (as elsewhere), one of the first questions asked about someone who reaches old age and is still physically and mentally active is about his or her diet. When Jyoti Basu was still Chief Minister of West Bengal at the age of 87 (he retired in 2000), his daily diet was a topic of popular discussion (*ki khay?*, "what does he eat?").

Ideas about old people's digestion overlap with ideas about inter-generational changes. In his discussion of "Our Modernity" in Bengal, Partha Chatterjee (1997) argues that perceptions of the decline of Bengalis' digestive power are part of popular perceptions of modernity. The widespread notion that people's health was much better in earlier days, especially in the pre-colonial period, can be traced back to at least the nineteenth century. Chatterjee quotes from the writings of Rajnarayan Basu (1873) and Motilal Ghosh (1912), who claim that changes in daily diet have spoiled Bengali appetite. These vernacular writings argue that Bengalis lost their digestive power due to the influence of modern English dietary habits. For example, people replaced cooling milk for heating meat, including even beef. The alleged increase in the consumption of beef did not only bring an excessive amount of heat into the Bengali diet, but also an increase in the price of milk, which could have brought back some balance. Chatterjee notes that similar arguments are still popular today: that people eat too much hot and harmful food, and have thereby lost their natural power

to digest. For Chatterjee, the presumed digestive power of earlier generations, and the loss of it among the present generation, articulates deep anxieties about modernization in an idiom of physiology:

"[W]e ourselves talk all the time about how people of an earlier generation were so much stronger and healthier than ourselves. The question is: why have we held on to this factually baseless idea for the last hundred years? [...] The bitter truth about our present is our subjection, our inability to be subjects in our own right. And yet, it is because we want to be modern that our desire to be independent and creative is transposed on to our past." (Chatterjee 1997: 196; 209-210)

My data strongly support Chatterjee's interpretation. Some of my informants doubted that *general* health was better in earlier times, since the health infrastructure was much better today than before. But that people's stomachs were much healthier before is taken as a self-evident truth. The image of *Sonar Bangla* ("Golden Bengal"), the ever-abundant Bengali Motherland of earlier times (cf. Chakravarty 1959; Greenough 1982; 1983; Weiß and Kunz 2002) goes hand in hand with the image of ever-strong digestive powers. In the old days, not only was the land exceptionally fertile, but also people's bodies were able to enjoy all its fruits. Just as *Sonar Bangla* was destroyed by modernity, colonization, and the Partitions of 1905 and 1947, so healthy digestive power declined.

While such "postcolonial" critiques are still strong in popular discourse, today the emphasis is less on British colonialism than on the effects of modernization as a global phenomenon. Thus the excessive consumption of hot food is not blamed on the British as such, but on dietary habits that are perceived to have penetrated the whole world. Synthetic food, environmental pollution, and other destructive influences are not seen to affect only Bengalis. In regard to quintessentially hot foods such as *biryani*, Bengalis blame Muslims (also erstwhile colonizers) for having introduced them. Yet the enjoyment that derives from this food often outweighs its disadvantages.

Anxieties about earlier generations' better digestion are not only discussed in terms of "environmental" factors such as diet, air, or water, but also in terms of changes in family structure. The current generation of children is believed to suffer from a weak digestive system because of the small number of children in the family. The rapid rise of single-child families among the middle and upper classes has produced a discourse about the "spoiled" child. The single-child family may seem to have the same conditions of "indulgence" that were ascribed to the lost *Sonar*

*Bangla*. Yet the modern version of indulgence appears to be an ugly parody of earlier times. A mother of two complained about the lack of discipline among the other mothers of her generation:

"Kids today are pampered, they often refuse food. Before they even ask for food, they get it, hence they lose the desire for traditional meals [i.e., cool, wholesome food]. They are too pampered, and just to attract attention they will refuse to eat. [...] More and more greedy. If they don't get [what they demand], they refuse to eat."

Since parents now concentrate their resources onto rearing a single child, instead of spreading them over a larger number of children, the middle- and upper-class child lives in (relative) abundance. However, the single child does not know how to appreciate this wealth. Instead of being modest and thankful, it rebels against the parents. The single child demands hot food, and the parents give in to its demands, even though this will spoil both its character and its digestive power.

### 3. Keeping the belly (and the mind) cool

If the belly is so unruly and undisciplined, how could it possibly be brought under control? As we have discussed, the belly is an anti-social agent, almost like an "animal within." Earning one's livelihood is feeding one's belly. Whatever disappears in the belly is irreversibly lost to others. Greediness is located in the belly. Dark thoughts and deceitful intentions are harboured within it. The belly's role is to transform whatever enters it by means of heat. Food that comes into the belly is "cooked," and through this transforming process the body is able to assimilate what is good, and to expel what is bad. The belly as a place of cooking is necessarily a (relatively) hot place. The belly's nature quickly leads to an excess of greediness, and to an imbalance of the strength of the belly's transforming furnace. The uncivilized and hot nature of the belly needs an agency that is able to keep greediness and temperature in check. In popular Bengali notions of the body, this agency is the "mind" (*mon*).

The characteristics of *mon* are diametrically opposed to those of the belly. Where the belly exerts an animal-like agency, *mon* brings the person closer to the gods. The belly desires to be filled and to be fed, whereas the mind aims to take in as little as possible. Where the belly is moving and heating, the ideal *mon* is cool and

still. In short, the belly constantly threatens a person's self-control, whereas the *mon* is the part of the body that can bring self-control. Is *pet* to *mon* like nature to culture? Let us look into the meaning of *mon* in more detail.

*Mon* is the Bengali term for mind (or "heart-mind"), mood, affection, and concentration. It is etymologically related to Sanskrit *manas*, Greek *menos*, Latin *mens*, and English *mind*. Bengali *mon* does not have a specific location within the body. When people use the term, they either point to the solar plexus area of the chest, or they point to the forehead. *Mon*'s location between head and heart motivates the English translation "heart-mind," which is slightly more precise than just "mind" (Desjarlais 1992: 27). Although the concept of *mon* (or its equivalents) is not exclusive to Bengali language and culture, it seems more widely used here than elsewhere in India. At least, this is what educated Kolkatans often told me.<sup>56</sup>

References to *mon* occurred extremely often in all my discussions with Kolkatans. The answer "that depends on your *mon*" (*eta tomar moner bepar*) was a kind of catch-all phrase to answer my questions about various beliefs and practices. In relation to medicine, it depends on your *mon* if you stay healthy or if you fall ill. It depends on your *mon* if medicines work for you or not. It depends on your *mon* if you are susceptible to the bad influences of the evil eye or not. In religious practice, it depends on your *mon* if you believe that the gods accept your sacrifices or not. It depends on your *mon* if you follow Shiva, Kali, or Krishna. In all aspects of life, it depends on your *mon* if you succeed or not.

Bengalis also quote *mon* when they speak of different eating habits and the impact of different types of food. The Chicago school of ethnosociology emphasizes that popular Hindu notions of the body are monist, and not dualistic like in the West (e.g., Daniels 1984; Marriott 1976, 1989). That is, no sharp difference exists between mind and body. Food has an immediate effect on one's thought and actions, and thoughts have a material effect on reality. This may basically be correct, but to most of my Kolkata informants, the monist view of body and cosmos is often suspended in favour of the view that *mon* is the ultimate basis of sovereign agency. For example, in interviews on how food of different inherent qualities (*sattvik*, *rajasik*, *tamasik*)

---

<sup>56</sup> To my knowledge, no extensive anthropological work exists to date on the Bengali notion of *mon*, and its similarities and difference to other notions of "mind" in India. In his "philosophy of the Indian mind," Bagchi (1975: 75-92) claims that the notion of *hridaya* ("heart") is the "physiological definition of mind" in India. Agarwala and Moebus (1996: 121) mention that *\*hrd* and *jathara* both mean "inside of the belly," and are used interchangeably in the Rig Veda. No doubt, the term *hridaya* is used by Kolkatans today similar to *mon*. However, *hridaya* is elegant Bengali and is much less commonly mentioned than *mon*.

determines the thoughts and actions of a person, the most common explanation ran approximately like this: (1) mind and body (*sharir*) are separate entities. (2) Mind and body interact with each other. (3) This interaction is hierarchically structured: it is a good interaction if the mind is in control over the body; it is a bad interaction if the body is in control over the mind. (4) In order to control the body, the mind must be disciplined, steady, and calm. If it is disciplined, it can control the body. If it is undisciplined, it loses control over the body. (5) If the body is controlled by the mind, the mind is not influenced by the body. (6) If the mind is in control, any type of food can be eaten. It will not have an impact on the mind. Only if the mind is weak, food of different qualities can have an influence. (7) Therefore, a person with a strong and pure mind can eat whatever he or she likes. Indeed, in daily practice, Bengalis do not have any qualms about eating *tamasik* foods such as meat. The *raison d'être* was: "If meat is good or bad for you, that depends on your *mon*."

If everything depends on one's *mon*, this part of the body would constitute the original source of agency, a source that does not further fall apart into sub-agents. A number of linguistic expressions around *mon* support this view, but there are many instances that throw this sentence into paradox. In one of my interviews on the causes of illness, a Bengali pundit answered this:

"If you concentrate, do *sadhana*, [you achieve] "one/single mind" (*ek mone*). You get *mental satisfaction*. But now it's a *computer world*, so many things to be kept in mind, thousands of problems. [...] So for that you need mental peace (*mone shanti*)."

The notion of a "single mind" (*ek mone*) fits the concept of *mon* as non-individual source of agency. But if we look more closely, something paradoxical happens: every time *mon* appears as full-fledged *agent* of its own, this spells doom for the agency of the person to whom it belongs. If we distinguish grammatical agency from semantic agency, one almost always works against the other. That is, if *mon* becomes a grammatical agent of its own, the person *loses* agency. Conversely, if *mon* is still and steady, the person develops most power to change and transform the world, if he or she desires to do so.

The insertion of the term "person" here and in the following is only a prosthesis. People do not use it directly, but it is *implied* in the construction of the sentences. As such, one could almost compare it to a phantom body part: it is not really there, but it is needed to construct a meaningful sentence. For example, an expression such as "keep your *mon* cool" (*mon thanda rakho!*) implies that *mon* is

different from the person to whom this sentence is addressed.

The first set of metaphors is centred on the "cool" *mon*. The very best situation is when the mind is "peaceful" (*moner shanti*), remains "cool" (*thanda mon*), or simply "stays put" (*mon thaka*). A peaceful, cool, unmoving *mon* is the best precondition for the person achieving whatever she or he sets out to do, be it staying healthy, passing an exam, or becoming one with God. We have already mentioned the close connection between a "cool" belly and "cool" thinking with reference to the expression *mudi-bhudi*: "If the belly stays cool, your head will stay cool" (*bhudi thanda thakle, mudi thanda thake*).<sup>57</sup> The reverse sentence also applies to *mon* and the belly: If your *mon* is cool, your belly will neither be excessively greedy, nor will it be excessively hot.

The second cluster of metaphors presents the opposite of coolness: excessive heat and movement. Once the *mon* gets going and moving, trouble starts for the person. As the unmoving mind is the precondition for concentration, so concentration is lost when the mind starts to wander. At once, the person becomes "unmindful" (*anmona hay yaoya*). In turn, if the *mon* is concentrated and "stays," it enables the person to move across time and space, as this Bengali man explains:

"It all depends on the *mon*. Your mind's power (*moner jor*) is stronger than anything (*sab theke bara*). The *mon* is very important, it's the greatest thing (*anek bara jinis*). Suppose I sit here and think that I'll go to New York, I'm sitting here, but my *mon* is gone there! If your *mon* is good, everything is good."

Even if the mind "stays," it remains vulnerable to any kind of disturbance. It may start to "shake" under great pressure. It may "become small" (*mon choto haoya*) when it feels inferior towards others. Pressures and depressing feelings may cause "mind's pain" (*moner byatha*), make it "become bad" (*mon kharap haoya*), or make it "break" (*mon bhang*). In all expressions that depict *mon* as actually doing something, *mon* is grammatically the subject, but in semantic terms, it is the object, the patient, even the victim, of outside influences.

The third set of metaphors speaks of *mon*, in terms of grammar, as the *patient* of action. But in terms of semantics, they speak of personal agency. Once again it holds true that, where *mon* is the agent, the person loses agency, and where it is *patient*, the person wins agency. When one "makes mind" (*mon kara*), one makes a resolve and becomes clear about one's goals of action. When one makes an

---

<sup>57</sup> Mothers prohibit their children from eating heating foods such as eggs during exams, because only a "cool" head can bring home good grades (Annu Jalais, personal communication).

impression on other people, one succeeds in "winning" their minds (*mon paoya*). A lasting impression on others is achieved when one "draws a line in the mind" of others (*mone dag kata*), especially in romantic encounters. Less incisive but perhaps equally successful is to "soften" or "melt" (*mon gola*) the mind of others with sweet words. To give tender affection to someone may either mean to give him or her one's mind (*mon daoya*), or to give the other person a place in one's mind (*mone sthan daoya*).

A fourth set of metaphors portrays the mind neither as subject or object of action, but as a container, or locus, of other entities' agency. I want to mention two entities that exert their agency by being placed in the mind: "fire" and "words."

When the "mind's fire" (*moner agun*) burns, the person feels grief, worries, and all sorts of other negative emotions. The problem with this fire is that it is not easily extinguished, and burns only very slowly (*moner agun dhiki-dhiki jvale*), burning invisibly and slowly as dried shells of coconut. In a more upbeat way, *moner agun* can also express positive passions about someone else. This fire of the mind is also hard to extinguish, in contrast to the "body's fire." As a Bengali saying has it: the body's fire can be extinguished (i.e., satisfied), but the mind's fire cannot be extinguished (*sharirer agun nibhana yay, kintu moner agun yayna*). A further example is "words" in the mind. Similarly to *peter katha* ("belly's word"), the mind's word (*moner katha*) denotes secrets hidden away from others in the dark chamber of the mind. In contrast to *peter katha*, however, the *moner katha* is not nasty gossip, but rather the tender truth about one's feelings. On the other hand, *moner kali*, the "mind's blackness," stands for dark, destructive urges within someone. A person who appears to harbour such thoughts can be asked to "open" this dark container and let words and feelings come forward (*mon kholo!*). Hence one can ask someone to speak directly "from the mind" (*mon theke bala!*). Once the mind (as CONTAINER) opens up, it can become "clean" again (*mon parishkar*).

The paradoxical meaning of *mon*, as being both the ultimate source of agency and a passive, unmoving entity surfaces in many of my informants' statements about the relationship between *mon* and health. Here is an excerpt from an interview with a middle-class Bengali woman, in which the slippage between the mind's agency and "patiency" become particularly clear (the interview was conducted in English):

"I was so weak from thyroid [i.e., disorder of endocrine glands]. I was in mental stress, and that caused the glands to become sick. My heartbeat was very fast. The medicine didn't help. I wanted to stop it. The doctor wanted me to take rest. But I



said I must work, care for the children. In two months, I got cured, through mental power. That is God. [Afterwards] I went to one allopathic specialist for endocrine glands. They did tests, something like sonography. Everything checked. Mental power got the cure."

On the one hand, this is clearly a narrative about personal agency. Without taking any more medicines, the woman managed to become healthy again. On the other hand, the ultimate source of agency remains hard to pin down. *Mental stress* caused the illness, but it was *mental power* that got the cure. The agency expressed in "I wanted to stop" clashes with the patency of "I got cured" or "mental power got the cure." When it seems that *mental power* is an expression of the woman's personal agency, she claims that such mental power is somewhere else, someone else: *That is God*. It may be that my informant, if I had urged her to "clarify" her statement, might have answered: "It all depends on the *mon*." Accordingly, *mon* also acts as a kind of meta-narrative about certain types of personal agency. What is fluid and complex is hypostasized as a quasi-physical part of the body. *Mon* then appears to be almost like an anatomical organ.

What I want to stress in this chapter is the relation between *mon* and health in general, and between *mon* and digestion in particular. A peaceful and controlled *mon* is generally seen as the best precondition for a healthy life. The basic principle is: When you are not worried about anything, when you keep your mind concentrated on one point, you will always be healthy. The symptoms of a cool mind are a shiny, radiant face; success in any sphere of life in which one chooses to excel; and the ability to transcend the realm of petty worldliness altogether. Conversely, there are dire consequences for health if *mon* is disturbed. Listing a few of the illnesses that informants mentioned in relation to *mon* give a rather frightening picture. Disturbance of *mon* can result in fever, headaches, high blood pressure, diabetes, obesity, deranged hormones, heart stroke, drug addiction, and various digestive disorders.

Usually, my informants did not have any theories about how exactly a disturbance of *mon* produces illness. That too strong outside influences on the mind, too many worries and tensions make you sick is taken as an obvious fact that needs no further justification. The most elaborate explanation I heard presents a peculiar combination of religious ideas and industrial production. It was explained to me that eating is like doing worship. If there is no concentration on the act, there cannot be satisfying results. If the mind is not peaceful, no saliva will be produced. No gastric

secretions will flow; the liver will not give its juices. Only if you concentrate your mind on the food you are eating, then *rasa* will be manufactured in the lower intestines. Urine and stool will be separated from the subtle matter, which goes into the blood. If the mind is very disturbed, one cannot digest anything. Only with the concentrated mind can the "*inside machine*" do its work.

So far, one could think that the connection that Bengalis see between *mon* and illness is similar to the connection that allopathy sees between mental problems and "psychosomatic" diseases. As far as the illness symptoms are concerned, the similarity is striking. In fact, it is increasingly popular among educated Bengalis to translate *mon*-related illnesses into "psychosomatic" illnesses. The spread of an allopathic vocabulary for psychosomatic illnesses among them is due to an increasing influence of popular health journals and health columns in newspapers. For example, I have sometimes heard about the worrying spread of "*anxiety neurosis*" among Bengalis in modern times. The increasing number of "*BP [blood pressure] patients*" and "*sugar patients*" was said to be one of the effects of an increasingly tense *mon*. If the source of illness is a disturbance of the *mon*, a true cure cannot come from taking medicines, but only from mental relaxation.

The symptoms of a concentrated or disturbed *mon* include most of those attributed to psychosomatic "stress" or "tension," but go far beyond it. *Mon* exceeds purely physiological processes, and touches upon spheres of religion and ethics, of supernatural powers and of *dharma*. To begin with, *mon* is closely related to the notion of *visvas*, "faith." It is a recurring statement in all my interviews that for healing to be effective, the patient must "believe" in its effectiveness, and whether you believe or not is dependent upon your individual *mon*. This is similar to the idea that perfect digestion is only possible if it goes along with perfect concentration on food.

A cool, controlled *mon* is first of all beneficial to one's own health. Among the "technologies of the self" used by Bengalis to cool the *mon*, meditation and exercises in concentration are primary. The exact technique that is used to meditate is not important. What is essential is that the mind comes to rest. Although probably only a minority of the population actually practices Yogic or other types of meditation, everyone has heard of these techniques and is convinced of their efficacy. Meditation gives a "cool mind" (*thanda mon*) and thereby gives health. If performed with a concentrated *mon*, everyday *puja* can also be a powerful way to

calm the mind. The explicit purpose of *puja* is to give satisfaction to the deity. But just as important is to give comfort to one's own *mon* (*moner shantana*). Indeed, the lines between cause and effect are, in regard to *puja*, often blurred. Praying and performing *puja* gives mental satisfaction, but it is not clear whether this mental satisfaction comes from concentration itself, or whether peace of mind is a gift granted by the deity, as this male devotee of Ma Kali explains:

"If you really think while you pray and you concentrate in your prayer that today I'll talk to Ma Kali, if you really have faith and you really concentrate (*dhyān*), you will get the fruit (*phal*). If you ask God to give, you also have to give something. If you want to get work done, without work you can't expect to get a result. [First] you give *proper labour* to Ma Kali, only then you will get result."

A cool *mon* is crucial for one's own health, but it can also be used to make other people healthy. When I once talked with one of the *pujaris* at Kalighat Temple about the power of mantras, he said that the proper performance of mantras could also be used in the most serious medical emergencies:

"Suppose someone falls sick, if anybody has problems, if anybody is serious and is in hospital, and doctors have given up, and when doctors give 24 hours time [to live or die], then I can keep the patient alive for 48 hours. So much confidence I have, I can turn 24 into 48 hours. What mantra I'll do, there is *power* in that mantra. [...] I cannot stop dying people, no one can stop them from dying, but I can keep a patient alive for six hours. That much faith I have."

An extreme example of how the strength of *mon* is able to heal another person presents itself in apologetics for Ramakrishna's premature death of cancer of the throat. Already during his last years of life, speculations were rife why a holy and perfectly self-controlled man like Ramakrishna could die of such a disease.<sup>58</sup> Among Ramakrishna's followers today, one widely accepted theory holds that he only died of cancer because he consciously took the diseases of others upon himself. Ramakrishna's *mon* was so still and strong that it could take away suffering and disease from others. The same ability to absorb disease due to *moner shanti* is also

---

58 The anonymous author ("M", a.k.a. Mahendranath Gupta) of *The Gospel of Ramakrishna* claims to present a word for word account of the discourses between Ramakrishna and his disciples about the Master's disease. The *Gospel* relates the highly intriguing discussions between Ramakrishna and Dr. Mahendralal Sircar (1833-1904), Kolkata's most prominent proponent of homeopathy and Ramakrishna's physician (cf. Biswas 2000; Arnold and Sarkar 2000: 49-53). The book entails Ramakrishna's own illness narratives about his cancer, as well as about a host of other ailments. Digestive problems play a major role, since Ramakrishna suffered from loose motions throughout his life. Digestive troubles appear often as metaphors for the body's frailty. Ramakrishna also gives food recommendations (e.g., "a man should be given food according to his power of digestion," *Gospel*: 855). Much of his poetic similes for the relationship between The Mother (Kali) and her human devotees use metaphors of feeding, tasting, and eating.

ascribed to Sharada Devi, Ramakrishna's wife (with whom he, as a perfect saint, never had sexual intercourse).

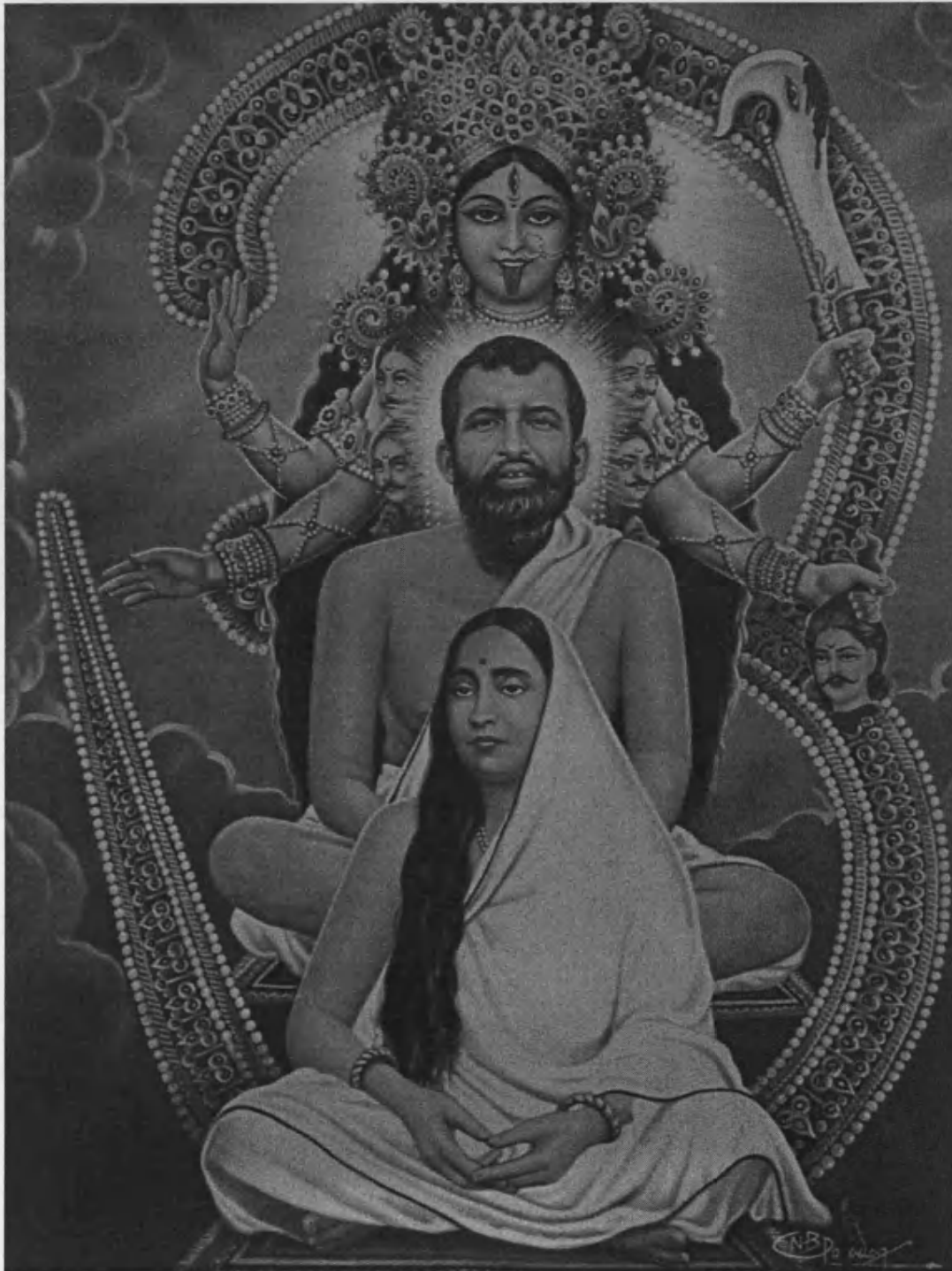


Plate 9: AUM, Ma Kali, Ramakrishna, Sharada Devi (Poster, 60 x 42 cm)

It is important to have an unperturbed *mon* to keep oneself healthy. If one is already sick, it is better to keep the mind as cool about this disquieting situation as possible, so as not to worsen the condition. This results in doctors or relatives not telling seriously ill patients about what is going on. For example, the son of a patient with

cancer explained to me that he would not tell his father about the doctor's diagnosis (which the doctor had only told to the son). He explained that there would be no use in telling his father the truth. First, he would only "get tense" (*cinta pare yabe*) and this would further weaken him. Second, the family would not be able to afford a treatment anyway. The doctor had estimated that the treatment would cost at least Rs. 10,000. The son had already asked his employer for a loan, but was not successful with his request. Neither could he borrow enough money from friends and relatives. Since his father was deeply religious, it was best to let him go to the temple every day and not do anything more about the cancer. After all, "everything is in God's hand" (*sab thakurer hate ache*).

Lastly, *mon* is often said to be the ultimate source for decisions about medical therapies. Choices between allopathy, homeopathy, Ayurveda, or other systems of healing are explained as decisions that one's *mon* makes without the person's conscious reflection. If one "takes to" a particular doctor, or a particular kind of medication, depends on the unconscious workings of the *mon*:

"If I look at the doctor, he is my doctor, I'm having a problem, his medicine works for me. If *you* go, it won't suit you. If I suggest you to go to my doctor, he'll suggest you medicines. But for you, the medicine doesn't work (*kaj karena*). You may be ill, but just to think of your doctor, or to see him, and you become well."

The reasons *why* one's *mon* has certain preferences is often beyond conscious reflection. However, it is important for each patient to bring to consciousness *what* the *mon's* decisions are. Many therapies require the patient to have "faith" in their efficacy; otherwise they would not bear fruit. Some therapies require relatively more faith than others. Allopathic treatments need the least amount of faith, ritual healing the most. Somewhere in the middle are Ayurveda and homeopathy. The need to believe in a particular therapy or doctor is not only a popular belief, but many healers also urge their patients to have faith in them (or else, go away). This will become clearer in the following chapters on medical practice.

As we have seen, the *mon* is often directly opposed to the belly. The belly as a hot, undisciplined, and greedy part of the body can only be brought under control by a cool and restrained *mon*. The belly's greed is not an unwanted side-effect of modernity, but basically a timeless characteristic. But in the context of modernity, the balance between hot belly and cool *mon* is disturbed. In this "computer age," the *mon* is distracted and unable to keep the greedy tendencies of the belly in check.

## IV. Allopathic gastroenterologists

### 1. The gap between professional allopathic and popular perceptions

In this chapter, I will present the results of research on practices of biomedicine in Kolkata. Half the doctors interviewed had a specialization in gastroenterology, the other half were either general physicians (GPs) or doctors of other specializations, such as cardiology.<sup>59</sup> I will focus on how the doctors perceive their patients in everyday practice. My aim is to show how allopaths evaluate and reflect on popular ideas and practices around stomach and digestion. As I hope to show, the doctors see a fundamental gap between themselves and their patients. For them, the patients are more or less ignorant of causes and cures of digestive diseases. They are the ones who "know," whereas their patients only "believe" (cf. Good 1994). The break between their own knowledge and the beliefs of their patients permeates all their statements about their patients. The perceived superiority of their own position extends from the medical domain to the domain of "morality": while they portray their patients as, at best, half-civilized savages, they themselves form the spearhead of modernity. The goal of this chapter is to show, in relation to the theme of *Digesting Modernity*: (1) how the doctors' feelings of superiority are played out against popular perceptions of digestion and (2) how the doctors' perceptions reflect on Kolkata in the context of modernity. The claim to be superior, not only to their patients, but also to practitioners of other medical systems, relies on the allopaths' high degree of professionalization. For the allopaths, to be "modern" and to be "professional" are two sides of the same coin.<sup>60</sup>

One of the primary sites where professionalism becomes a spectacular performance is the conference (cf. Cohen 1995). In November 1999, I had the chance to participate in the "First Indo-US Gastrointestinal Endoscopy Workshop," a transnational medical conference organized by the West Bengal Chapter of the

---

59 The interviews are coded as follows: A-1 to A-10 are specialized gastroenterologists; A-11 to A-18 are GPs or doctors of other specializations. "A" indicates an allopath, "H" a homeopath, and "K" a *kaviraj* (Ayurvedic physician).

60 The distance between allopathic doctors and patients is a key theme in medical sociology. At least since Talcott Parsons' (1951) writings on the (allopathic) doctor-patient relationship, the doctors' tendency to take a paternalistic stance towards their patients has been recurrently documented (e.g., Bissell, Traulsen and Haugbolle 2002; Freidson 1975; Mishler 1984). Many of the data presented in this chapter also support Ashis Nandy's (1995: 145-195) criticisms of contemporary (Indian) allopathy, especially those concerning its iatrogenic effects, high cost of treatment, and the privileging of specialized high-tech medicine over low-tech general practice.

Indian Society of Gastroenterology and co-sponsored by the American Society for Gastrointestinal Endoscopy (ASGE). The main venue of the two-day event was Kolkata's Oberoi Grand Hotel, one of the city's five-star hotels. In the large auditorium, a stage had been built to accommodate a white-clothed table for a number of panellists and four video screens. The screens displayed live images transmitted from the operating theatres of two Kolkatan endoscopy centres. One screen showed doctors and nurses at work on a series of bodies of unidentified patients. The other three screens gave a multiperspectival view of the patients' insides: live images from the endoscope, from an ultrasound machine, and from an X-ray machine.

Through a mediating "master of ceremonies" (MC), the panellists and the audience of doctors were able to ask questions to the doctor at work in the operating theatre (OT) and to discuss the demonstration in progress. The procedures in the OT aimed at demonstrating how various kinds of new equipment enabled the doctor to perform new types of diagnoses and surgical treatments. The language of the event oscillated between high-tech jargon and jokes. The live demonstrations from the remote OT were grouped around themes like "Variceal band and loop ligation" or "Argon plasma coagulation." Most of the questions from the audience concerned the specific uses of the equipment, for example, if this kind of "Dumon-Gilliard prosthesis introducer" produced by company X worked better than that of company Y. Asked about the health of the patient on the table, a doctor replied that "the performer status of the patient is very poor" – as if the patient was "non-compliant" with the ongoing performance. It was clear that the performance of the doctor, and the equipment in use, was far more important than "healing." The performing doctors' comments sometimes even blamed the patient for not having the "right symptoms" for the equipment at hand: "This is not a good patient for this kind of treatment." Besides high-tech terminology, jokes were another common trait of the conference. For example, as one doctor appeared on screen with a red *tika* on his forehead, the MC greeted him: "Hey Vishal, you look pretty blessed this morning!" The doctor replied, with a suave smile and a thick American accent, "Yup, sometimes you need just that!" A joking attitude was especially prevalent in moments when the planned demonstration failed. Having no success with one of his intended demonstrations, a doctor remarked: "I guess I didn't have my cornflakes today." When one of the few participating female doctors appeared on screen with

too little light from the video camera, the MC played on the beauty ideal of fair skin by saying: "You're looking pretty dark!", to the roaring laughter of the audience.

Even if the scale and technical sophistication of this event were particularly high, it brings out some of the features of the self-image of allopaths as members of a *profession* with special clarity. Professionalization can be generally described as a systemic process in which boundaries are erected towards the outside, and rules of conduct are determined towards the inside. Murray Last (1996) defines a "healing profession" as:

"[A]n extended self-conscious grouping of healers with defined criteria for membership (whether through licensing, certification, or registration) and an expertise over which it seeks primary control, it is also an expertise that claims to be more than a craft and has in addition an esoteric, theoretical basis." (Last 1996: 375)

Processes of medical professionalization vary significantly between different countries. Last (1996) and Jeffery (1988) both argue that the situation in post-Independence India is characterized by the state's combination of a liberal stance towards a wide variety of healing practices with a strong ideological and financial support for allopathy. In my view, the example of Kolkatan gastroenterology reveals eight characteristics of professionalized medicine:

(1) *Restricted access to training*: In India, entry to medical studies is severely restricted, as only a small percentage of applicants is admitted to the colleges. Since medicine is one of the most prestigious and most profitable of all professions, private tutorials for the Joint Entrance Examinations in medicine are a booming industry.

(2) *Standardized curricula and degrees*: Medical associations oversee the development of a coherent and structured syllabus for medical studies. According to Unschuld (1975: 309), standardization aims at reducing idiosyncratic practices in favour of shared "textbook" knowledge. Restricted access, long years of study and competitive examinations ensure that degrees such as MBBS (Bachelor of Medicine/Bachelor of Surgery) or MD (Medical Doctor) are only awarded to a select few. A point of discussion at the Workshop was which kind of criteria should be set for the training in gastroendoscopy. A member of the workshop's "International Faculty" proposed minimum standard requirements for the certification of both students and of training centres. A candidate for a degree in gastroenterology should be required to perform at least 200 "oesophago-gastro-duodenoscopies" under supervision and at least 100 independently. Such standardization was necessary



because "a number of ill trained endoscopists have started doing endoscopic procedures which are neither of high standard nor safe for the patients."

(3) *Higher specialization is higher status*: Depending on one's degree of specialization, studies last for a minimum of five years, and can often take ten years or more. In Kolkata, to invest in further specialization seems to be worth the extra investment of time and money. Gastroenterologists were generally better off than average GPs. The "First Indo-US Workshop" took place not in any kind of venue, but in one of Kolkata's luxury hotels. Almost all the gastroenterologists I interviewed not only had the usual MBBS qualification, which takes five and a half years to complete, but had also done postgraduate degrees in gastroenterology from specialized centres. At one private diagnostic centre, all resident gastroenterologists had graduated with a postgraduate degree from Chandigarh, one of the prominent centres of gastroenterology in India.

(4) *Government recognition*: Through restricted access, a standardized curriculum, and the awarding of degrees, the medical profession aims to obtain and/or maintain recognition and strong support from the government. By giving such recognition, the state is legally obliged to prohibit fraudulent uses of degree titles. By and large, the Indian state does indeed make sure that those who carry a degree title have actually earned it. In this regard, the Indian model is similar to that of Britain: "In the British model, instead of outlawing all other forms of healing, regulations merely define who can legally be described by a specific professional label, 'doctor'" (Last 1996: 383). Felicitation letters written by the Governor, the Chief Minister, and the Health Minister of the state of West Bengal prefaces the Workshop's "Souvenir" brochure.<sup>61</sup>

---

<sup>61</sup> Most conferences held in India (scientific, cultural, or otherwise) feature such felicitation letters by representatives of the state, as long as they conform to minimal state-sanctioned rules of conduct. However, it is easier for allopathic conferences to receive a felicitation letter by the political top brass than for their lesser rivals. A more detailed analysis of how the profound influence of the Indian state on practiced medicine is beyond the scope of this thesis. For recent studies this issue, see Fuller (2002) and Kaviraj (1997, 2000).

# More Top Ranking Doctors-to-be from Brilliant!



KAMAL BALI  
LUDHIANA  
RANK : 1  
AIIMS - 2000



BALAJI BHARADWAJ  
JAIPUR  
RANK : 2  
AIIMS - 2000



ASHWANI GUPTA  
SATERGARH SAHIB  
RANK : 1  
CHANDIGARH CET - 2000



VIVEK BINDAL  
CHANDIGARH  
RANK : 2  
CHANDIGARH CET - 2000



RADHIKA DHAMIJA  
CHANDIGARH  
RANK : 3  
CHANDIGARH CET - 2000

## AIIMS & CHANDIGARH CET

4 out of these 5 are students of

# CBSE+

Brilliant's 2 Year Postal Course for Medical Entrance Exams.

*Our congratulations to these Toppers  
and all our other winners in these exams.*

# BRILLIANT<sup>®</sup> TUTORIALS

You can't prepare better

Plate 10: Brilliant Tutorials for medical entrance exams (Newspaper advertisement)

(5) *Globalization*: Indian allopathy is strongly oriented towards international standards laid down by the World Health Organization (WHO) or professional bodies in Europe and North America. Although the nation states retain ultimate

authority over what kind of medical practices are allowed or prohibited within their borders, the professionalization of biomedicine is happening on a global scale. Globalization leaves its mark also on individual doctors' biographies. Most of the gastroenterologists whom I interviewed had several years of professional experience in North America or Europe (especially the UK). The doctor (A-5) who was regarded by many as the "founding father" of Kolkatan gastroenterology practiced for more than ten years in Britain and in the US before returning to Kolkata. The "First Indo-US Gastrointestinal Endoscopy Workshop" attracted a huge audience because it promised to transcend the local context and allow insights into practices with global reach.

(6) *Expansionism*: The ultimate goal of being restrictive about professional standards is the *expansion* of the profession's reach. Professionalization is a means of power in a competitive market, aiming to promote the profession's specialist expertise against the practices of rivals. One of the aims of the Workshop was to foster the future growth of the gastroenterological specialization not only against rival medical systems, but also against other branches of allopathy. First, gastroenterologists aim to become the main authorities for gastrointestinal diseases and to capture a market still dominated by GPs, who neither have specialist knowledge nor specialist technical equipment. Second, gastroenterologists try to prove that their treatments are attractive enough to make investments from both private and public sources profitable. For all the gastroenterologists I talked to, the prospect of rapid expansion and high-growth potentials was the primary reason for them to become specialized in this field.

(7) *Inculcation of a professional habitus*: The professional *habitus* (Bourdieu 1984, 1991) of Indian allopaths comprises a large cluster of attitudes and practices. Gastroenterologists tend to fashion themselves as members of the socio-economic elite, and express this in luxury goods such as cars, watches, and expensive housing. In my interviews with them, they tended to express their elite status towards me. Not a single interviewee spoke Bengali with me, but everyone spoke English. As among all professionals in India, English is a marker of status and education. Moreover, their language was laced with gastroenterological jargon. Last's (1996: 375) observation that the medical profession "claims to be more than a craft and has in addition an esoteric, theoretical basis" was also typical of the interviews. Another aspect of professional habitus is the (real or pretended) lack of time. As for any true

professional, "time is money," gastroenterologists tended to have little time left in their busy schedules for ethnographic interviews.

(8) *Claim to "scientific" practice*: A vital element of allopathy's professionalization is the claim to be the only truly "scientific" medicine (Freidson 1975; Haraway 1997; Latour 1987, 1988, 1993). The claim to scientific superiority permeates all other elements of professionalization. Science is demanding, hence only the brightest are allowed into it. Real knowledge is objective; hence teaching and education can be standardized. Science knows no end; hence higher specialization is higher status. Science is useful and profitable to the state; hence it merits its support. Since science is objective, it transcends local, regional, and national boundaries. If true knowledge is allowed to push back false knowledge, science can continually expand. Science can only be done by people with a scientific habitus. This habitus distinguishes scientists from non-scientists.

Medical professionalization has a profound influence on how doctors interact with people outside their profession. Towards a researcher like me, the doctors had an ambivalent position. On the one hand, as I have no training in medicine, they perceived me as a "lay person," and hence as an outsider not worthy of any special attention. However, it worked to my favour that I could approach them as a researcher from a well-known university, wearing proper clothes and handing over printed business cards to them. I was perceived as member of another profession, and as such, deserving due respect (notwithstanding the low standing of social science research in India). Being white, European, and English-speaking resonated both with their elitist habitus and their claim to be global players.<sup>62</sup>

Towards their patients, all the doctors expressed a strong distance. Based on their self-image as professionals, a conscious distancing from their patients could not come as a surprise. This perceived gap tended to give many of their comments about patients' beliefs and practices a supercilious tone. No matter whether they talked about rich or poor patients, or about well-educated or uneducated patients, a rather patronizing stance could be felt throughout. They portrayed themselves as sovereign individuals who have mastered a difficult field, and hence have mastered *themselves*. In turn, their patients appeared, in their narratives, mostly as half-civilized children.

---

62 An ethnographic study of Indian allopathy realizes aspects of Gupta and Ferguson's (1992: 25) insight on the changed meaning of space and place: "We need to account sociologically for the fact that the 'distance' between the rich in Bombay and those in London may be much shorter than that between different classes in 'the same' city." For a further discussion of anthropology and various global "-scapes," see Appadurai (1996).

They were found lacking not only in knowledge, but also in self-control. That the doctors emphasized their remoteness from their patients was undoubtedly also an effect of me being the interviewer: a kind of "bonding" between themselves and the Western observer further exaggerated the distance from the patients. The basis of such detachment was their status of being highly trained specialists in a field with global application.

## **2. Doctors' perceptions of patients' "bowel-obsession"**

In my interviews on how gastroenterologists in Kolkata perceive their patients, a frequent statement was that "Bengalis are bowel-obsessed." Even if other ethnic groups in Kolkata were also concerned with their digestive health, it was common opinion among the doctors that Bengalis stretched this concern to the extreme – even if all the gastroenterologists I interviewed were Bengalis themselves. What the doctors understand as popular "bowel obsession" is a cluster of ideas and practices that are centred on the notion that if the belly is healthy, the whole body will be healthy, too. First, Bengalis were even more concerned about food than other groups in India – the happiest times of the day were the meal times. Second, Bengalis paid much attention to their digestive processes: how they feel at different times of the day, their appetite before meals, sensations after meals, and so on. Third, even illnesses that are not evidently linked to the digestive system, such as hair loss, headaches or heart disease, were explained as symptoms of the "real" disease, which lay somewhere hidden in the bowels. Fourth, Bengalis loved to talk about their own digestion and that of other people: far from being a dark and shameful area of the body, the bowels were a topic of everyday discussion, wide open to public scrutiny.

When the allopathic doctors talked about popular fixations on the belly, they usually did so in a mocking manner, as if to distance their own worldview as far as possible from that of the lay population. As professional healers of the bowels, they did not deny the importance of digestive health for one's general well-being. However, they derided the lay beliefs as naïve and ill-informed. Popular bowel obsession was based on a fragmentary grasp of human anatomy and pathophysiology:

"They talk about liver, stomach, *gas*, bowel movements. They are not bothered about pancreas, they are not bothered about gall bladder, they are not bothered about

spleen. They are only bothered about stomach and liver. Everything else is just 'down there.'" (A-1)

The gap between their own highly specialized knowledge of the digestive system, and what they perceive to be a very rudimentary grasp of it, was sometimes directly mapped onto the gap between knowing adults (the allopaths) and ignorant children (the patients): "[For the patients] everything is connected to the tummy. The patients are like children. As you know, when children complain about pain, they point to their tummy" (A-5). In this doctor's view, popular "bowel obsession" is not even credited as a form of knowledge of particular parts and processes of the body. Patients talk about their bowels simply because they are located at the centre of the body. The patients' lack of differential knowledge was so complete that they could just distinguish the body's centre from its periphery, but not much else beyond that.

Beyond the idea that popular bowel obsession is due to the patients' lack of knowledge, none of the doctors had a theory of *why* Bengalis are more bowel obsessed than others. Nor did any of the doctors perceive either a rise or decline of bowel consciousness over the course of time: "I cannot think of any social, cultural explanation for this. No, there is no historical change in perceptions of the digestive system. It has always been like that" (A-5).

According to the gastroenterologists, a number of expressions occurred most frequently when patients describe their illnesses to them. The most common terms were *gas* (translated as "flatulence," "wind," or any pain in the upper body), *peter byatha* ("abdominal pain"), *livere byatha* ("pain in the liver"), *ambol* ("sourness"), *acidity* ("heartburn"), *amasha* ("mucus in stool"), and *paykhana hacchena* ("irregular motions"). Patients also habitually used two medical terms: *colitis* and *dyspepsia*.

Doctors prefer their patients to use simple Bengali terms instead of English or medical terms. Given their professional position, they consider any use of these latter terms as a misuse.<sup>63</sup> Patients who use "professional" terminology without knowing what it means are seen as "complicated," and as more difficult to treat than the "simple" patients with simple symptom expression. As one gastroenterologist explains:

"Simple people express themselves in simple ways and are simple to diagnose.

That's the same all over the world. They tell you exactly what's going on, where the

---

<sup>63</sup> In turn, Rabindranath Tagore (1861-1941) criticized allopaths' arrogance towards their patients. Bagchi (2000: 44) quotes from one of Tagore's theatre plays: "The doctor does not call a cold a cold / Since he knows medical science / He calls a simple cough influenza / So he receives thirty-five rupees as his fees." For a description of Tagore's support of homeopathy, see the following chapter.

pain is, how it started, and so on. More educated people say: "Doctor, I have *gas*, do something." They come up with medical terms, like *dyspepsia* or *colitis*. They have read the paper; they know a little bit, that makes them difficult. They just want me to confirm their own diagnosis." (A-4)

According to this doctor, patients' use of terms like *dyspepsia* or *colitis* make diagnosis more difficult, as he has to ask more details about what patients mean when they use them. Foreign terms, when misunderstood, not only obscured the "real" symptoms, but also *created* them. In the case of *gas*, this doctor observed that *linguistic* confusion could result in *diagnostic* confusion. Patients attributed the cause of headaches and other diffuse pains to the state of their bellies because of a linguistic misunderstanding. Patients conflated the Latin term *gastro* ("related to the stomach") with the English term *gas* (as air-like substance, deriving from Greek *chaos*). Since the excess of *gas* that originates in the stomach could start to travel through the body, it could start to pressurize other parts of the body and give a sensation of pain:

"*Gas* is the common term, used by city and village people alike. They don't know that *gas* comes from the Latin word for stomach, *gastro*. So they don't know that it has nothing to do with *gas*. The complaint about *gas* includes bloating, farting, but goes way beyond it, to include every gastrointestinal disturbance. And even symptoms that have nothing to do with gastroenterology. So they say: '*Gas* goes here [points to head], here [points to hand], here [points to leg]. *Gas* going everywhere and causes problems'. Migraine is very common, but people don't believe that it is purely a head problem, they are convinced it is caused by *gas*.'" (A-4)

Besides the distinction between "simple" and "complicated" disease presentations, doctors also distinguished between those patients who like to talk about their bowels, and those who do not. In their view, Bengali patients meet the stereotype of the talkative patient, in contrast to other ethnic groups. In the doctor-patient encounter, the patients' desire to talk and the doctors' shortage of time was highlighted as an area of conflict. For the doctors, the patients' explanations were only of marginal importance in the diagnostic process. For the patients, on the other hand, talking about their symptoms seemed central:

"They talk at length. And expect us to spend a lot of time with them. If you give them time, they talk endlessly. The more you let them talk, the more they like you.

They talk about anything, work, family, etc. Our patients are very expressive." (A-9)

The conflict of time strategies in the doctor-patient relationship was seen as a general conflict between the characteristics of modern/civilized/disciplined

professionals and traditional/half-civilized/undisciplined patients, especially the Bengali patients. However, as much as the doctors may have made fun of the "Bengali" lack of time-discipline, it was always a light-hearted fun, like parents making fun of their children's lack of good table manners. Moreover, the love for chatting was seen as one of the characteristics that made Bengalis more "human," therefore less "mechanical," than other people, especially people from Europe or North America. When I was invited to a doctor's house in the evening for dinner, the different uses of time among professionalized doctors and the lay population was relativized to apply only to the "inhuman" frame of work duties:

"I've been working very hard today. I didn't even take a cup of tea. Plenty of water, sure, but no tea. So I've been using my time properly. But now, I'm sitting here, chatting. Bengalis are like that, they are good people, they love to chat. They don't use their time in a scientific manner. Fourteen hours I've been working, but still I have time to chat." (A-18)

When the gastroenterologists reflected on how patients diagnose themselves and what kind of symptoms they focus on, the most common answer concerned motility patterns. The most salient element of the "Bengali bowel obsession" was the fixed idea that one *must* have exactly one motion per day, not one more or less, and that it must happen right after getting up in the morning:

"Overall, patients attribute too much importance to the stomach. I can assure you, if the patient has a good bowel motion every day, then most of them will not complain about any stomach problem." (A-7)

"To me, if a patient passes stool twice a day, or once in two days, no problem. But they have this mentality: everyday they must pass, once, and in the morning. And once that doesn't happen, they will attribute all illness symptoms to that. [...] It's very difficult to convince them that nothing is wrong." (A-1)

None of the doctors had a definite theory about the origins of this anxiety about regular motions. Most of them thought that it was simply a cultural tradition, without any deeper meaning: "That has been drummed into us from early childhood: First thing when you get up, you go to the toilet" (A-5). Some of the doctors associated this habit with the daily rhythms of peasant life. Other doctors related it with what they saw as Kolkata's incomplete modernity: modern economic life forces people to leave the house everyday, without giving them the chance to come back during working hours. At the same time, the public infrastructure was too weak to support this mode of working, so people had to deal with a lack of toilets (especially



a lack of *clean* toilets).<sup>64</sup> Especially women had to suffer much under these circumstances, as public defecation was not at all an option for them. The direct link between popular bowel obsession and India's incomplete economic modernization was subject to several jokes among the gastroenterologists. One of them was centred on the idea that the best policy the government could take to get the economy going was to distribute laxatives for free:

"If they do not have a regular bowel movement, they get very anxious. If the government of India would distribute *Isabgol* [a laxative] for free and if people would take it up to three times a day, the productivity would go up in bounds in this country." (A-5)

"Their whole day's work is hampered if that [regular motion] doesn't happen. [...] They are worried about going to work, going in the train, and so on. So they take a day off! If the Indian government would distribute *Isabgol* free of charge, the economy would boom." (A-6)

Besides motility patterns, popular diagnostics also focused on the characteristics of the stool: its colours, textures, and smells. Patients' readiness to talk at length about this topic was often remarked on by the doctors, especially by those who had worked in the UK or in the US, where patients often felt too ashamed to talk about it at all. Comparing his experiences in the UK with those in Kolkata, one doctor said:

"There are days, when I've just woken up from sleep, having my morning tea, reading the newspaper, when a patient of mine calls up and tells me that he just had the most awful looking stool in his whole life, with the most awful smell. I just sort of manage to gulp down the tea! [laughs] I keep telling myself: why do they do this to me in the morning? Really, they feel very free." (A-2)

Another aspect of the "Bengali bowel obsession" is, according to the doctors, that patients interpret all the body's illness symptoms as symptoms of disturbed

---

64 Michael Anderson (1992: 24) discusses how the clash between economic development and lack of sanitary infrastructure was played out in colonial Calcutta. Earlier, it was the labouring and dispossessed classes that were most affected by the politics of discipline and punish against those who committed a "public nuisance."

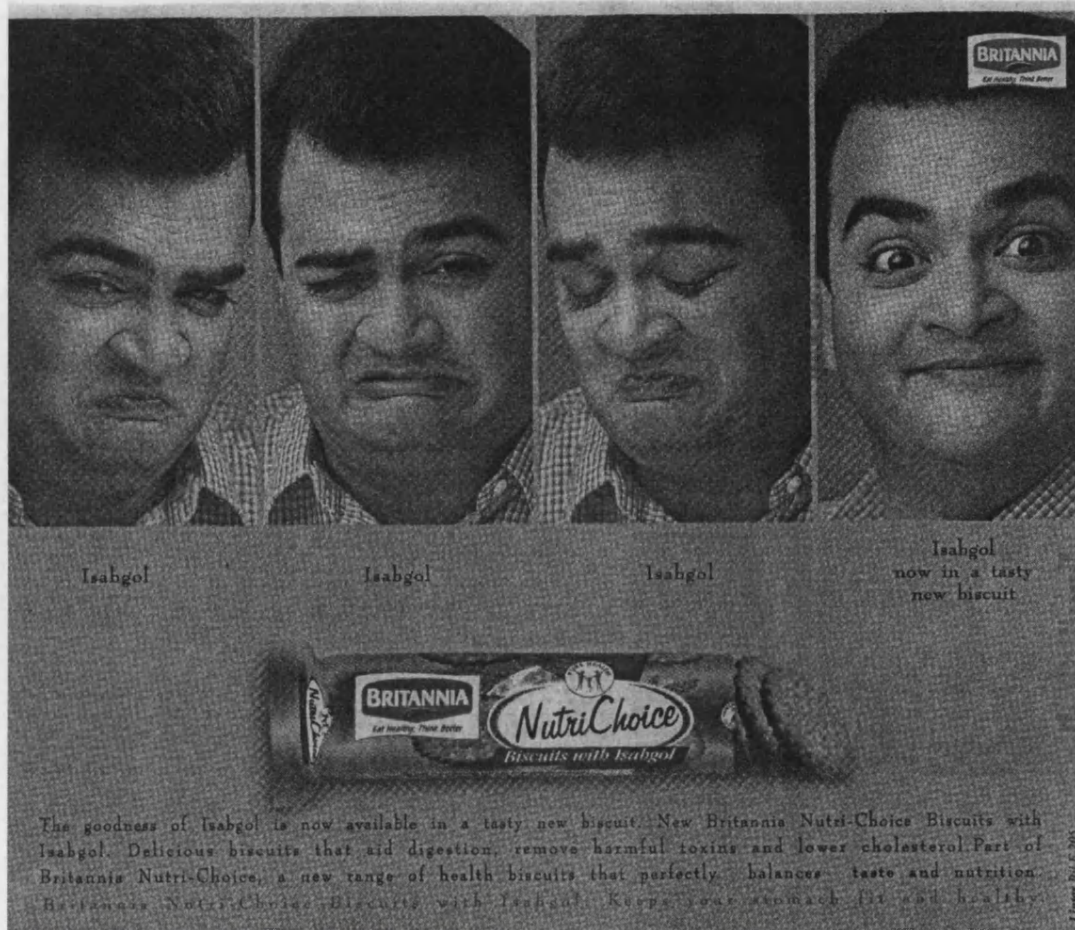


Plate 11: Britannia biscuits with Isabgol (Newspaper advertisement)

digestion. Such a popular "holistic" view of the body and illness was based on the patients' lack of knowledge about how the body truly works. No matter if the symptom was hair loss, impotence, headaches, skin disease, nausea, or any diffuse weakness – at the root of the problem lay an imbalance of the bowels. For the doctors, this over-attribution of symptoms was partly a harmless expression of ignorance (e.g., when patients think that *gas* causes headaches), but it was also partly a reason for severe conflicts with patients, especially in cases of severe diseases linked to the heart. First, patients tend to present heart and circulatory symptoms as gastric symptoms: "They say 'there's a pain' and 'It's probably due to *gas*, acidity'. [...] They don't want anything related to the heart at first, so they say *buk* [Bengali for chest, upper body]" (A-4). Second, patients who are diagnosed with a heart disease often refused to accept this diagnosis. They hoped that, by going for a thorough gastroenterological examination, the true cause of their symptoms would be found in their bowels: "Patients refuse to accept it is a cardio problem. I would tell them again and again, but they only go to a cardiologist *after* their first heart attack"

(A-3). As a cardiologist pointed out, it was usually better to be diagnosed as a "stomach" patient than a "heart" patient, because heart diseases tend to be harder to treat and harder to survive:

"Everyone knows it: Once you are a heart patient, you are a heart patient, and you are bound to decline. [...] Acidity you can take easy, it may be uncomfortable, but the patient knows that he is safe." (A-15)

Patients' readiness to interpret illness symptoms as digestive disorders can be consciously abused by doctors. In a private conversation, one GP suggested that doctors use the catch-all diagnoses of "gastric" or "colitis" to get rid of patients whenever they do not want to deal with their actual problems. Whenever one could not come up with a convincing diagnosis for a patient's symptoms, one could always appease them by diagnosing them as "gastric" patients. This was usually enough to satisfy both the patient and his family. An outright abuse of popular bowel consciousness also occurred in emergency situations of which a doctor does not want to take care:

"I should not say this, but there are some doctors – not me! – who, if they get an emergency call in the middle of the night about chest pain, they just say: 'Come on, it's a gastric, take some *Jerosil* [a brand of antacids] and see me tomorrow in my chamber'. But in fifty percent of cases, it's a heart attack." (A-17)

### 3. Doctors' reflections on patient aetiologies

When I asked the allopaths about how patients describe the aetiology of gastric illness, a diffuse cluster of causes was mentioned. Two sets of causes can be loosely distinguished: those that relate to substances entering the body, and those of a psychosomatic character. Among the substances taken into the body, food is the most prominent. According to the doctors, patients commonly mention "spicy" and "oily" food as reasons for gastric troubles. The doctors by and large agreed with the popular perception of such food being dangerous for the digestive system. Yet the doctors disagreed with their patients on exactly *why* spicy and oily foods are risky. The doctors' explanation was based on a biochemical model entailing enzymes, molecules, and proteins. In contrast, the patients' model is based on "unscientific" notions such as hot/cold classifications, which were rejected and derided by the allopaths. The doctors distanced themselves from the popular notions to such an

extent that they portrayed hot/cold thinking as weird and far removed from their own thinking:

"I've observed one funny thing: eggs are very hot. Might cause boils on the skin. People come and complain about burning in the stomach, and say that they take green coconut water. I think that's very funny! It's just water. And I tell my own mother: eggs are not hot, if you take out the cholesterol, you can give to any kid as much as you like." (A-9)

"There was a woman, completely illiterate, whom I gave capsules. She took them, but hesitated. Later in the day she came back, asking: 'Doctor, I know that this medicine is very hot in my stomach. So what shall I take along with it? Do you think that I should take coconut water to cool the stomach, instead of plain water?'. First I thought I'll explain to her that it doesn't matter, that her idea is wrong, but then I thought, OK, whatever: 'Yes, please, take it with coconut water, that will cool your stomach.'" (A-16)

Since all the doctors have grown up in Kolkata, one can expect that they have at least a basic familiarity with popular ideas such as hot/cold (e.g., "my own mother"). If one of the doctors (A-9) says that he has "observed one funny thing" about his patients, this clear distance can be interpreted as an exaggerated expression of the allopaths' professional status. Such distancing is also a means to delegitimize patients' anxieties about the side-effects of allopathic medicines. When such concerns are expressed in a popular idiom such as hot/cold, it becomes easier for the doctors to shrug them off as unfounded lay perceptions. Obviously, the doctors were more ready to dismiss popular beliefs towards *me* than towards their patients, in order not to unnecessarily alienate them.<sup>65</sup>

In comparison to food, water was rarely mentioned to the doctors as a cause for digestive illness. The doctors mostly said that the population was not much aware of the risks of contaminated water.<sup>66</sup> People would, at most, pay attention to the appearance of the water, whether it is clear or not, and whether it has no strange odour:

"They just look at the colour of the water: If it's clear, it's OK." (A-1)

---

65 George B. Shaw (1911) captured this beautifully as "the doctor's dilemma": "Doctors must believe, on the whole, what their patients believe, just as they must wear the sort of hat their patients wear. The doctor may lay down the law despotically enough to the patient at points where the patient's mind is simply blank; but when the patient has a prejudice the doctor must either keep it in countenance or lose his patient. If people are persuaded that night air is dangerous to health and that fresh air makes them catch cold, it will not be possible for a doctor to make his living in private practice if he prescribes ventilation" (quoted in Shorter 1993: 797).

66 As discussed above, there is actually considerable popular awareness of water pollution. That the allopaths claim that there is none or little reflects more their self-identity as those who "know" against those who do not, than an empirical reality.

"Although water is a major problem, people rarely complain about water. Maybe they are not aware of the problems involved. They drink from any roadside restaurant. They don't know exactly of what quality the water is. Whether the glasses have been properly washed or not. And I don't think that a lot of people are aware of the problem, they just drink whatever they get." (A-7)

Although there was a growing awareness of the health risks posed by water pollution, there was still not enough awareness that would substantially change daily practices. Most of the blame for the patients' lack of consciousness of environmental issues fell on the Indian state. The state's failure to educate people on environmental problems was part and parcel of its failure to give all its citizens equal access to education. The media, especially the newspapers, may have taken up environmental pollution as a topic worthy of attention, but much was left to be done. Even if the doctors tried to educate people themselves, they could not achieve much:

"If I may say that, the government strategy of spreading the message is not remarkable. The media are not very active in spreading medical knowledge. So the layman doesn't understand the causes, what things to avoid. That knowledge is quite poor. And as you know, education standards are low in this country. But now people are more health-conscious. At least ten years back they were not bothered at all. But now the media have started reporting on it, so there is more consciousness. [...] We also sometimes write in magazines, in local languages, to educate the people." (A-8)

Most of the allopaths I interviewed shared the view that pollution is a problem that could only be dealt with by the public health agencies of the state, not by the individual citizens. Yet the government was seen by all the doctors as too weak to take the necessary steps. One senior gastroenterologist (A-5), the head of a prestigious private gastroenterology unit, was particularly outspoken about the inadequacy of the state's commitment to public health. Referring to one of biomedicine's famous critics, Thomas Szasz (although Ivan Illich might have been more fitting), he wondered if India's incomplete modernity might not be heading towards imminent catastrophe instead of a bright future:

"As you know, Thomas Szasz said that there are only two advances in medicine: one is the realization that hand-washing prevents infection, and the second is that water with salt and sugar prevents dehydration, and stops children from dying of diarrhoea. [...] But then, what if you do not have enough water to wash yourself properly? And if you have enough water, how do you make it pure? You must boil it for half an hour, but from where do you get the fuel? From the patients' point of view, they don't ever really think about this. They are so used to bad water, overcrowding, that they don't even think about it, from where the risks are coming. We hear a lot about the nuclear holocaust. But as far as I am concerned, I am more

concerned about the biological holocaust in this country. [...] I don't know where begin and where to end. Worst is, that we have become so callous about it." (A-5)

While responsibility for India's "biological holocaust" lay mostly with the Indian state, this gastroenterologist also blamed the Indian middle and upper classes, including the medical professions, for allowing it to happen. In contrast to many of his colleagues, who tended to blame the prevalence of gastric disease mostly on popular ignorance, this doctor blamed *all* Indians for neither exercising proper self-care over themselves and their country, nor bothering about this deplorable situation. Each and every gastric affliction was for him a symptom of the contemporary Indian's *moral* failure to act responsibly.

According to the doctors, patients' awareness of the risks of alcohol was greater than that relating to polluted water. That alcohol can cause liver disease was widely known. Since the drinking of alcohol makes the body hot, increases sexual desire, and weakens one's self-control, a social stigma is attached to its open consumption. Yet the doctors believed it to be as widespread in Kolkata as in the West, among members of all social classes. While digestive processes were a kind of "public zone" about which one could talk freely, alcoholism was shameful and had to be hidden, especially by those who consider themselves as members of the respectable *bhadralok* class.<sup>67</sup> Patients' hesitation to admit alcohol abuse made the doctors' diagnosis difficult: "One thing people always underplay is alcohol. It's a taboo in our society. Even if they take, they won't admit. When they admit that they drink 'a little', then I understand" (A-1).

Beyond illness aetiologies that focus on ingested substances like food, water, or alcohol, patients also mentioned "stress" and "tension" (*cinta*; see chapter on popular perceptions) as reasons for digestive illness. However, the gastroenterologists perceived their patients to be much less concerned with psychosomatic reasons than they were. The reason for this was that up to half of all patients with gastric illness are diagnosed with "Irritable Bowel Syndrome" (IBS), a disorder of the intestinal motility patterns:

"IBS is most common. Your endoscopic findings will be normal in it. 15 to 20 percent of world population, including me and you, suffer from IBS. Out of 100 patients who come to me, fifty percent will have IBS. Fifty percent! See? It's the commonest gastrointestinal disorder" (A-8).

---

<sup>67</sup> *Bhadralok* might be translated as "respectable people." To belong to the *bhadralok* means to belong to the educated, decent, middle and upper classes.

Medical science has, so far, failed to identify an exact cause (bacteria, genetics, etc.) for why IBS occurs. Many of the Kolkatan doctors whom I interviewed believed that the reasons were of a "psychological" order, even if for lack of a better explanation than for faith in the psychosomatic approach.

In his ethnographic study of patients in a Boston clinic who were diagnosed with "psychosomatic" problems as the cause of their digestive disorders, Cecil Helman (1988) concludes that the doctors, failing to determine an exact cause of the disease, "respond to the uncontrollable aspect by increasingly 'psychologizing' the condition – i.e., by shifting the responsibility for aetiology or flare-ups to patients' emotions, personality, or early psychological experiences" (1988: 117). Helman's study focuses on therapeutic approaches that try to cope with IBS (and similar psychosomatic conditions) in a psychotherapeutic way, by prodding the patients to reflect on their individual life stories and the psychic traumata that have happened to them. In contrast, the Kolkata allopaths did not seem to be much interested in psychotherapeutic approaches to cope with psychosomatic disorders. Instead of psychotherapy, they mentioned the prescription of mild tranquillisers as the best way to get a grip on the patients' mental anxieties. The *gas* comes from the brain, not from the bowels:

"I prescribe a lot of anti-anxiety medication, tranquillisers. Initially I never believed in these, but I found that the stress level is so high, even in people who don't come across that way, many of the gastric symptoms are much reduced, even disappear, when treated with tranquillizers. So now I've come to believe that all the *gas* is not really gas. The motion of the *gas* is coming from the brain. Therefore you have to treat the brain if you want to get the stomach OK. [...] They come with bizarre symptoms. But they don't have anything. And you wonder what the hell is going on. But if you just sit back, it all comes down to that they are stressed." (A-2)

Even if popular discourse stresses the need for a cool *mon*, patients do not commonly mention "tension" or "anxiety" towards an allopathic doctor. Once they decide to consult an allopath or even a specialized gastroenterologist, their expectation is that he will be able to determine a physical reason for their illness. The doctors, on the other hand, tend to avoid lengthy discussions about possible psychosocial reasons for their condition and prefer to prescribe tranquillizing drugs.

#### **4. Doctors on patients' perceptions of therapy**

According to the gastroenterology specialists, patients came to them because their diagnostic and therapeutic powers far exceeded those of other doctors. When the doctors spoke of their own decision to specialize in gastroenterology, they stressed that there was "huge scope" in the field, because of the power of medicine, and because of the sheer number of patients suffering from gastric diseases:

"I just happened to work in the gastroenterology department. After a few months I realized that I was attracted to the subject and there was quite a lot of scope in the subject. There was a lot of interventionist scope in it. That was the reason why I took up gastroenterology after that. It's developing day by day. It's not possible to say that progress is only being made in the interventionist field, progress is being made in all aspects." (A-7)

"I'd say that in ten years, gastroenterology will be the first, or at least second-ranking medical speciality. In the West, it's now the most sought-after medical specialization after cardiology. Such huge scope! So if there's so much scope in the West, imagine how much scope there is in India! [laughs]." (A-2)

From the patients' point of view, the power of gastroenterology was at least as strong a criterion for choice as the negative experiences with other healing choices. Once a patient comes to the doctor, he has lost hope of getting healthy by himself. Changes in the daily habits of eating and living had not been successful. Attempts to "clean out" the bowels, either through laxatives, or even more drastic purges, had also been in vain ("Some people drink one litre of water and then vomit. Some people put the finger in their anus and clean it," A-5). To the doctors, the patients often delayed coming to them for too long, which leads to extremely pronounced symptoms:

"Lack of education is a problem for the people in India, but it's a very great help for us doctors! Why? Because we see classical cases here which you people in the West will never see. A lot of people come from rural areas, it's not uncommon to see massive growths in the stomach, filling three-quarters of the stomach. They have neglected for so long." (A-9).

The lack of education and the lack of money often prevented patients from seeking treatment earlier. Moreover, the spurious promises and "quackery" of other healers delayed the patients' choice of gastroenterology. For some of the specialist doctors, this "quackery" even extended to their unspecialized colleagues in general practice, as well as to their colleagues in the crumbling government hospitals:

"If you consider the population as a whole, and the number of patients who come with gastric problems to the general practice, six to seven patients out of ten will



have these problems, all these days they were treated by these so-called general practitioners, but they never got better. They were gradually losing hope." (A-2)  
"In West Bengal, as you probably know, the government hospitals have almost collapsed. They can't afford the treatment, the medicine, the maintenance of the wards. So people have lost faith in the system." (A-2)

Beyond patients' active choice of gastroenterology, the majority of patients does not make this choice themselves, but is being referred by GPs, private/state hospitals, or healers of other medical systems. Since endoscopes are difficult to handle and expensive, some gastroenterologists developed into pure diagnosticians who only live off referrals, and of whom little or no therapy is demanded:

"Many come and just want to hear my opinion without actually listening to what I prescribe. [...] That's also because I have become a bit of a diagnostic doctor. They just want to know the problem, then go back to their own doctors for treatment.

They want to know: Will I live?" (A-9)

According to the doctors, patients' perceptions of the power of gastroenterology are shaped by endoscopy. The "spectacular" ability to make visible even the darkest corners of the human bowels is the most fascinating aspect of gastroenterology, not only to the patients, but also to the doctors themselves.<sup>68</sup> The powers of visualization give allopathy a competitive edge that none of the other medical systems has. One field in which allopathy exercises a near-complete hegemony is the "scientific" diagnosis.<sup>69</sup> A salient feature of present-day India is the rapid growth of private diagnostic centres. Even if most of these centres offer both diagnosis and treatment, they do most of their business in diagnosis by referral. They typically advertise all the diagnostic techniques on offer on billboards visible from the road, making up long lists of cryptic acronyms ("MRI," "CAT-Scan," etc.). The principle of advertising is to make the list as long and as unintelligible to the layperson as possible. The names of the centres tend to stress the specialization in diagnostics, such as in "Eastern Diagnostics" or "Eko X-Ray." Patients usually come to these centres by referral from a doctor in order to get specific tests done, but sometimes also go directly to a centre of their own choice. In the patients' perspective, "getting a test" goes beyond a regular consultation with a doctor and

---

68 "Visualization" is a key technique of modernity (e.g., Jay 1992). The ability to visualize every nook and cranny in the body was a vital element in turning medicine into an empirical science (e.g., Foucault 1989; Latour 1988). Gastroenterology's power of visualization is a direct continuation of this tradition.

69 I use the word "hegemony," along Raymond Williams's (1983: 144) definition, as "predominant practice and consciousness." Allopathy occupies a hegemonic position in contemporary Indian medicine since its models and procedures are taken as "normal reality," especially in the field of diagnostics.

often serves to signal to family and friends that something "serious" is going on. A test from a "lab" is seen as much more "scientific" than the impromptu diagnosis done by regular GPs. To benefit from the halo of "science," healers of *all* medical specializations nowadays refer their patients to these labs. From the point of view of many non-allopathic practitioners, specialized diagnostic centres are not even doing "allopathy," but reveal the truth of the body independent of therapeutic specializations. Therefore, doctors of homeopathy and Ayurveda see a fierce competition with allopaths in terms of therapy, but not in the field of diagnostics. For a "scientific" view of the belly and its diseases, allopathic diagnostic centres have achieved undisputed supremacy (see chapters on homeopathy and Ayurveda).

Not all of these tests derive their authority from visualization per se. I once ran into one of my neighbours whose wife had a long history of painful stomach ulcers. During a recent flare-up of symptoms, her doctor, a specialized gastroenterologist, had referred her to a nearby diagnostic lab to "get tests." Knowing that I did some sort of "medical" studies, my neighbour pulled out the lab report he had just collected. It showed the results of a stool test, detailing various features of the stool and a rating, e.g. "E-coli +," "Vegetable matter +," "Undigested particles ++." The truth of this diagnosis was not the direct visualization of body parts or substances. The truth of this diagnosis lay in a translation of suffering into scientific categories, in giving them a scaled rating, and in having a computer to print them neatly on an official-looking coloured sheet of paper.

In comparison to results that are merely presented in writing, Kolkatan gastroenterologists highlighted visualization, especially endoscopic visualization, as the most persuasive technique at hand. To begin with, patients were concerned about the costs of diagnostic procedures. The quicker a reliable diagnosis was reached, the less the patients had to pay, even if endoscopy was more expensive than blood or stool tests. The doctors felt pressured to come up with a convincing diagnosis as quickly as possible; otherwise the patients became irritated and angry. If a series of tests is done without conclusive result, the patient or his relatives started to criticize the doctor: "If you haven't found the problem after 15 tests, the patient will switch to another doctor and start calling you names" (A-9). Given that about half of all patients are eventually diagnosed with IBS, a condition which can only be diagnosed with some certainty after an endoscopy has been done, it becomes clear why visualization is so important: *visual* proof that there are no ulcers, tumours, or any

other dangerous growth in the bowels was far more convincing than a series of tests which only yield written results.

Endoscopy was even more convincing when it was not only used for diagnosis, but also for therapeutic intervention. Contemporary technology enables the doctors to perform treatments that before had been the task of surgeons. The endoscopic "theatre of proof" is at its most convincing when diagnosis and therapy are performed together. For example, even if a patient doubted that he actually had a gall stone, the doctor could prove him wrong on the spot: "You can take out a patient's gall stone without general anaesthesia, and hand it over to him right away!" (A-3).

Despite these spectacular powers of visualization, the doctors were ambivalent about letting the patients see the insides of their bowels themselves. In one diagnostic centre where I was allowed to watch a series of endoscopies, I observed that the practicing doctors sometimes concealed the monitor from the patients, sometimes put it right into their view. Depending on the changing angles of patient, monitor, and doctor, patients were sometimes able to see their own insides, sometimes not. When asked whether they show the live endoscopic images to their patients, some doctors argued that they like to show their patients what is going on in order to convince them. However, the majority of doctors said that they preferred the patient *not* to see directly, and only showed if the patient explicitly asked for it. For the doctors, the risk of triggering an uncontrollable reaction in the patient tends to outweigh the gains of convincing them through letting them see inside themselves. In this doctors' statement, the reason for not showing anything to the patient is, once more, the perceived lack of the patients to exercise self-control, in contrast to "Western" people:

"I've tried both, keeping the monitor inside the consultation room and outside. In my experience, it helps *not* to show the patient anything. One great thing about people in the West: They are not scared about the truth. For example, cancer patients want to know where exactly is the cancer located, how long will I live. Here, people start crying first, and it becomes unmanageable. If you take out some tissue from the stomach, and it starts bleeding, nothing serious, but the patient starts panicking, crying, uncontrollable. And I wouldn't want to know how a patient would react seeing a big tumour in his guts!" (A-9)

Alternative strategies can be used to avoid the risks of showing the images directly to the patient. For example, a relative can be brought into the diagnostic

## FUJINON THE CLEAR CHOICE



- ◆ Superior Image
- ◆ Outstanding  
Manoeuverability
- ◆ Ergonomic Comfort
- ◆ Low Running Cost
- ◆ Wide Range



*Comprehensively supported in India by*

WIPRO Biomed  
903, Prakash Deep Building,  
7- Tolstoy Marg, New Delhi - 110 001  
Tel : 332 5677 / 332 9163 Fax : 3738675

**ISO 9002 Certified  
Service Provider**

Regional Offices - Delhi,  
Calcutta, Mumbai,  
Chennai, Hyderabad  
& Bangalore

Plate 12: "The clear choice," Fujinon endoscope (Business advertisement)

room who can look at the monitor in lieu of the patient. Another possibility is to take photographs of the ongoing diagnosis and show them to the patient later, which allows for showing the images in a controllable setting, and for showing only those images which the patient could "stomach":

"What we sometimes do: call a relative inside and show them the video monitor. We also keep the endoscopic photographs for the patient. Whether the patient has an

ulcer, a cancer, bleeding. These photos we give along with the report. [...] Half the patients want photographs, the other half doesn't." (A-8)

Endoscopy not only bears the risk of shocking the patients through gross images, but also the risk of giving uncomfortable or even painful feelings. In contrast to the patients' alleged lack of self-control in regard to the "truth" of endoscopic images, the doctors pointed out that the patients take the endoscopic procedure itself relatively well – at least, once they have made up their mind and go through with the examination, which only about half of the patients who are told to take an endoscopy actually did. The same doctor who described Indian patients as less able than Western people to take the truth also described Indian patients as being more controlled in taking pain. The reason for this higher threshold in withstanding pain was not due to greater "strength of character," but due to the Indian patients' "trauma" of environmental overstimulation:

"One big difference to the West: there, you sedate the patients. But here we don't give any medication, painkillers, sedatives. Even for colonoscopy we don't use, although it is supposed to be very painful. But my patients walk out of the room as if about to join office. It depends on your skills. We call it 'vocal anaesthesia' here: if a patient is moaning we say: 'Shut up, there's nothing wrong!' [laughs]. But my feeling is: an average Indian is more likely to take two minutes of pain than to get an injection or pain killers. Often I tried to give patients tranquillizers, sedatives, but they don't want. Nowadays I hardly ever ask, and they don't ask for it either. My feeling is, in our day-to-day life, we are so much more traumatized. Taking the bus, walking down the street, that's a trauma. You Western people aren't used to that, not used to take pains. Our thresholds are much higher." (A-9)

Compared to patients' sometimes insufficient compliance with invasive diagnostics, the doctors believed that their patients are by and large compliant with the instructions for taking medication (even if they can have only limited knowledge about compliance). They thought that the willingness to follow through with therapies prescribed by the doctor was very high because the patients had spent a great deal of time and money for the diagnosis. Using again the "Western patient" as a foil for comparisons, one gastroenterologist stressed the "trader mentality" that prevails among the Indian patients:<sup>70</sup>

"As far as drug compliance is concerned, it's great. We are traders. So all our patients have a trader mentality. They go to a doctor, they want medicine. They feel

---

70 The modern Indian's addiction to medicines also features prominently in the media: "Pill-popping has become something of a lifestyle choice today, especially with the young. [...] But in this stressful age, when everybody is pushed for time, long-term remedies – like clean living and healthy eating – don't attract too many people. They'd much rather pop a pill and done with it" (Basu 2000).

cheated if they don't get anything. If you write down one or two drugs, they'll say: 'Oh, why not five or six drugs?' So they are great pill-takers. They *love* it! In the UK, there is a lot of non-compliance with drugs. But here we don't have any problems. Patients *love* drugs." (A-5)

This "trader mentality" was also a reason why patients are said to express only rarely anxieties about side-effects during consultations. All the doctors agreed that there were strong popular anxieties about the side-effects of allopathic medicines. However, in the context of a plural medical system, with an ample array of "soft," alternative therapeutic options, patients tended not to worry too much about side-effects once they have chosen an allopathic treatment:

*"[Question: Do patients worry about side-effects?]* Generally not. They don't even ask. I could tell them, if you have these symptoms, please inform me. Otherwise people are neither aware nor much worried. They take whatever it is. During pregnancy, they will surely ask. Otherwise not much. *[Question: Patients often tell me that they are worried]* That's different. If a patient comes to me, he knows that he's going to an allopathic doctor. He knows that I'm prescribing allopathic medicine. So he won't ask me if this or that can cause a problem. They accept it. They just assume that there will be some sort of side-effect." (A-1)

Compliance with prescribed drugs was high for another reason: among all therapies available, taking a couple of allopathic tablets was very simple to do. The doctors concurred that in the majority of gastro-intestinal patients, a change of dietary habits was as important as taking a course of medicines. However, they disagreed on whether there was any point in giving patients detailed instructions about what to eat and what to avoid. Some doctors saw dietary advice as central to a successful therapy: "We have to look after the dietary requirements of each individual patient. That is a very important part of the treatment" (A-7). Others felt that there was little point in telling patients to change their daily habits, because compliance with these recommendations was low. Either patients were constrained by the eating habits of their families ("However much advice I give, the women don't listen. Their mothers-in-law, their grannies decide what is good and what is bad," A-18), or they were simply lacking self-control in food intake ("I don't know how serious they are. They come out from a dietician, and have a bottle of Cola," A-1). Patients' lack of self-control in matters of diet also applied to other possible therapeutic choices beyond medication. For example, patient compliance was low when more exercise was recommended. Anything that needed a true change of lifestyle was seen as too cumbersome by the patients to be actually implemented.

Having come to the conclusion that patients are not very successful in following through with therapies other than easy-to-handle allopathic prescriptions, one gastroenterologist more or less stopped giving dietary advice altogether:

"I don't give much. I just tell them to avoid chillies. I try to tell them to eat a diet with less spices, less oil. I don't want to bind them into a dietary regime. Because, masochist as we are, a lot of us are masochists, you give them a diet chart, but then they take something outside of it, and again something outside of it, they get worried and that makes them even worse." (A-5)

This alleged "masochism" is not the expression of an excess of self-control, but of a lack of self-control coupled with a bad conscience of one's failure. Especially if Irritable Bowels Syndrome was diagnosed, a peaceful mind was important in order not to exacerbate the symptoms by sharpening a patient's sense of "good" and "bad" living habits.

If the discussion has so far focused on the doctors' perception of their patients as lacking in self-control, it should also be pointed out that some of them are also critical of their *own* shortcomings. Given that "professionalism" is the linchpin of allopathic practice (as what sets it apart from the lay population and other medical systems), admitting to one's own breaches of conduct was rare. Nevertheless, one of the doctors I interviewed (A-9) volunteered information about medical malpractice in gastroenterology. According to him, all the problems that beset gastroenterology in India revolved around money. Along with radiology and cardiology, gastroenterology was one of the medical specializations that attracted many students because of the high financial stakes involved. There was "no money" in simple general practice, because it did not use "toys" and big machines like high-tech medicine:

"Every field where you have big machines gives money. There is no money in consultations! Gastroenterology is exciting because you have so many toys. Who doesn't love to play with toys? Every week a sales representative of a medicine company comes here and shows me the latest gadgets. There was a symposium recently, so many new tools, I'd have loved to buy them all! So much fun." (A-9)

Gains from high-tech apparatuses depended primarily on turnover: once a machine had been bought, only maximum utilization ensured profits. The machines used in India were predominantly imported from North America and Europe, and could only be bought at global market prices. For example, a colonoscope that costs US-\$ 4,000 in the US also cost that much in India. If the performance of an endoscopy cost US-\$ 500 in the US, but only about Rs. 600 (*ca.* US-\$ 12) in

Kolkata, the doctors are forced to treat about *forty times more* patients with a machine than in the US until they can make a profit. Even if net prices per diagnosis were hard to compare because of different institutional over-heads, insurance regulations, and so on, the dilemma was still the same. High patient turnover was one way of making the business of gastroenterology profitable. Other ways of cutting cost were to buy "ragged machines, cheap machines" (A-9) and to use them even when quality was compromised. The iatrogenic effects of using substandard equipment in haste were numerous. First, all endoscopies entail the risk of serious injury to the patient if carried out in a negligent way. Second, there are standards for the sterilization of endoscopes, especially in the context of a rising prevalence of Hepatitis B and C, as well as of HIV/AIDS. For proper sterilization, an endoscope has to be left in an antiseptic solution for at least one hour. However, most doctors only owned *one* endoscope, and had to treat lots of patients in a row:

"Colleagues from the West are amazed when they hear that I'm treating up to twenty patients an hour. That's unbelievable to them. I own three gastroscopes, that's more than anyone else has. But even with that, I cannot go by the book." (A-9)

Third, doctors tried to cut additional costs of treatment as much as possible. Indian patients' "high pain threshold" was not only a product of environmental overstimulation, but also of sheer lack of money to pay for full anaesthesia. If more than "vocal anaesthesia" is given, the doctors had to provide for more personnel, oxygen, beds to take rest in, and so on. All such extra costs had to be cut as much as possible.

Medical malpractice was particularly tempting in India, where health insurance was still the exception. Whereas patients could be fooled about whether they get the treatment they are paying for, insurance companies were less gullible. Thus this doctor felt that the development of a better insurance system was the only way out of the current mess, because only insurance companies could make sure that the doctors did not treat too many patients, and that costs for equipment were accounted for: "They want receipts!" (A-9).

Irrespective of such misgivings about malpractice, not even this whistle-blowing doctor ever questioned the supremacy of allopathy. The current defects are not due to a fundamental failure of allopathy, but due to its incomplete development in India. Even if not all current practice was up to global standards, at least there *are* standards. By contrast, the doctors were unanimous in their opinion that other medical systems, including Ayurveda and homeopathy, did not even have proper



standards of professionalism, accountability, efficiency, or ethical conduct. When asked whether they ever referred patients to other healers, all responded with an emphatic "No!" – even if some of them also mentioned that members of their own families often had a strong belief in homeopathy or Ayurveda. An accommodating attitude towards these other systems was that they were only "pre-scientific" and had "not yet" developed the professional rigour that characterized allopathy. More common was that they just scoffed at their competitors:

"A lot of people can be made to believe that [homeopathy, Ayurveda] is cheaper, that it's less toxic. In a semi-literate population, these are ideas which can be very easily implanted. I think the fact that it's easily available is another reason. To practice homeopathy, or Ayurveda, you don't need to be a doctor. Not even a graduate! [laughs]. So I think there's a serious problem." (A-2)

Although the gastroenterologists perceived a "serious problem" in the practice of other systems, they tended not to try to "convert" their patients away from their competitors. On the one hand, patients were impossible to educate. In the end, they only did what *they* thought was right. On the other hand, to criticize doctors who regularly referred patients to them for diagnosis jeopardized their own business: a patient referred from a homeopath is better than no referral at all. Hence an essential part of the allopaths' professionalism is to know when to underline one's own superiority, and when not.

## V. Homeopathy

### 1. An Indian system of medicine

Invented by the dissident physician Samuel Hahnemann (1755-1843), homeopathy has been practiced in India since the mid-nineteenth century. Through an Act of Parliament in 1973, homeopathy was recognized as one of the seven "national systems of medicine." Along with Ayurveda, Yunani, Siddha, Yoga, and naturopathy – but separate from allopathy – homeopathy is supervised by the Department of Indian Systems of Medicine and Homeopathy (ISM&H), a special department within the Ministry of Health and Family Welfare. Today, the "plant" of homeopathy has taken deep roots in the Indian "soil":

"Even being a foreign system of medicine it found very fertile ground for being rooted firmly in the very heart of even the remotest corner of the country. [...] Today it acquired the status of Indian System of Medicines as if it is the traditional way of treating with it." (*HMAI* 1999: 42)

A surprising piece of evidence for the influence that homeopathy had on medical practice in India is that the term "allopathy" has been established on the Subcontinent as the common name for biomedicine. The word "allopathy" was coined by Hahnemann, as a derisive characterization of what he calls "old medicine" (1994 [1833]: 1).<sup>71</sup> Far from being the "rational medicine" that its proponents see in it, allopathy is, according to Hahnemann, thoroughly irrational, crude, and harmful. Throughout the nineteenth century, the scornful connotations of allopathy were still understood, and proponents of conventional medicine resisted being called by this name (Jütte 1996a: 23-27). In contemporary India, as elsewhere, the word allopathy has by and large lost all traces of this mocking undertone. The irony remains, however, that the hegemonic system of medicine received its name from its much less powerful competitor (Arnold and Sarkar 2000: 45).

---

<sup>71</sup> Here and in the following, I quote from a paperback edition of Hahnemann's *Organon of Medicine* that was published in Kolkata and is widely available in the city's bookshops. Thanks to its modest price (Rs. 45), even people of low income can buy it. The edition combines Dudgeon's translation of the Fifth Edition from German into English with W. Boericke's additions and alterations of the Sixth Edition. Similar editions are available in Bengali and Hindi translations. Since there are many significant differences between the texts of the Fifth and the Sixth Editions, Kolkata homeopaths frequently discuss which of the two editions should be preferred. For the purpose of this chapter, I leave this debate to them, and will quote from the combination of the two editions, as printed.

In Kolkata, homeopathy is without doubt the second most popular system of medicine after allopathy. The city became the centre of the Indian homeopathic movement during the mid-nineteenth century (Bhardwaj 1980; Jütte 1996b; Warren 1991), and continues to play a leading role up until the present.<sup>72</sup> Among homeopaths, Kolkata is considered to be the "world capital of homeopathy," with more doctors practicing and more medicines being sold than anywhere else in the world – including its country of origin. According to the latest data (1999) available from the website of the Indian Ministry of Health and Family Welfare,<sup>73</sup> there are 36,107 registered homeopaths in West Bengal, compared to a total of 188,527 across India. That is, every fifth Indian homeopath practices in West Bengal. The regional strength of homeopathy becomes particularly clear if the numbers are compared to those of Ayurveda, its closest competitor in India. Among a total of 366,812 of Ayurveda practitioners in India, only 2,483 (i.e., 0.7 percent) are based in West Bengal. In India at large, there are twice as many Ayurveda doctors than homeopaths. By contrast, there are almost fifteen times more practitioners of homeopathy than of Ayurveda in West Bengal.

Many other indicators evince homeopathy's commanding role in the Bengali setting. For example, the Homeopathic Medical Association of India (HMAI), founded in Kolkata, is one of the largest homeopathic professional associations in the world, with the West Bengal branch uniting more members than any other branch. The National Institute of Homeopathy was established in Kolkata in 1975 to rival the flagship National Institutes of other medical systems that had been set up in other parts of the country. Starting off from Kolkata, homeopathy spread to other regions of India and beyond. K.G. Saxena, one of Indian homeopathy's most prominent promoters (cf. Jütte 1996b: 361-362), considers homeopathy's success in India as the harbinger of its success on a global scale:

"I foresee in the years to come India will be the nucleus and citadel of Homoeopathy in the world and the cult of Homoeopathy will spread out like Buddhism in the developing countries of the world. I wish and pray Homoeopathy will serve the suffering millions of India and the world." (Saxena 1992: preface)

Notwithstanding the slightly unfortunate comparison with Buddhism (is homeopathy bound to decline in India, too?), all of the Kolkata homeopaths I

---

<sup>72</sup> Beyond the material presented in the following, I cannot explain *why* homeopathy is so popular in West Bengal. The topic would merit a dozen doctoral theses.

<sup>73</sup> India, Ministry of Health and Family Welfare, Indian Systems of Medicine and Homoeopathy (<http://indianmedicine.nic.in/>)

interviewed agreed with this bold mission, even if some of them used a bit less pathos to describe the popularity of homeopathy: "In this country, if you throw a stone, it will hit a homeopath" (H-1).

Despite its huge popularity in India, homeopathy has hardly attracted any interest from social scientists. In his influential survey of medical pluralism in India, Leslie (1976: 359) mentions homeopathy as one among the nine most prevalent medical practices. He claims that the practice of homeopathy in India "assimilates elements from Ayurveda and Yunani traditions to form a distinctive popular-culture medicine" (ibid.; diacritics omitted). In his classification, "popular-culture medicine" is defined as "an amalgam of concepts and practices" (ibid.), a *masala* mixture of traditional and modern elements. Leslie does not, however, present any evidence for his argument. Jeffery (1988: 43) also mentions homeopathy briefly as one of the most popular systems of medicine after Ayurveda and Yunani, yet again without presenting further details. Apart from Borghardt's (1990) study on Indian homeopaths' professional biographies and Schumann's (1993) insights on homeopathy as being practiced primarily in private chambers, no anthropological research appears to exist on Indian homeopathy. Jütte (1996b) presents a compact history of India as a "late superpower" of homeopathy, but only includes a few data about the current situation. From among the historians, Prakash (1999: 147) and Arnold and Sarkar (2000) remark that during the nineteenth century, members of the educated elite first took up homeopathy, a move partly understood as a critique of "English" allopathic medicine, which was identified with the colonial regime. Hausman (2002) describes how homeopathy did not only become popular in colonial Bengal, but also in colonial Madras. Most writings on the history of homeopathy in colonial India reiterate a handful of standard insights but contribute little that is new. These works evince that homeopathy remains largely uncharted territory to anthropologists and historians alike.

That homeopathy failed to capture the attention of medical anthropologists reveals more about medical anthropologists' prejudices than about what homeopathy actually is. Given that most anthropological questions are based on dichotomies such as traditional/modern or Indian/Western, this may explain why homeopathy has fallen by the wayside. It is neither a "traditional" practice nor a "modern" practice such as allopathy. Originating from Germany, it is not an "indigenous Indian" system. Nor is it a "truly Western" system, if "Western" is identified with the

hegemony of allopathy. In short, homeopathy does not fit neatly into the commonsensical narratives about medicine in India. As I will try to show in the following, however, the popularity of homeopathy relies not on the transcendence of these categories, but in a peculiar way of interpreting them.

If we first consider the most common replies by Kolkatans about how homeopathy works, it will become clearer how traditional/modern and Indian/Western are played out. I found that the following set of answers can be elicited from the vast majority of Kolkatans, irrespective of socio-economic status, and even irrespective of whether someone actually goes to a homeopath or not.

First, homeopathy does not have any *side-effect*. Even lower-class people who otherwise do not speak English use the English term "side-effect." Allopathic medicine is said to be *khub kara*, "too strict." This is a fuzzy idea that allopathic medicine creates a kind of "shock" to the body and lingers on, with harmful effects. Homeopathic medicine is seen as the opposite of that, *kara nay*, "not strict." The absence of side-effects makes homeopathy an ideal medicine for children and everyone whose "strength" or "resistance" is not strong enough to digest allopathic medicine.

Second, homeopathy is a "slow medicine" (*deri osudh*) and takes a long time to do its work. The fact that it works slowly is a necessary corollary of the medicine not just removing superficial symptoms, but the very "root" of the sickness (*ei rogta shekar theke ber kare dey*). In comparison, allopathy is considered to be a "quick fix" medicine that is efficient in "suppressing" symptoms, but which does not give the patient a permanent cure. Even if most Kolkatans agree that a course of homeopathic medicines, conscientiously followed over a long period of time (six months or longer) can give lasting improvement, many feel that this is too long a duration to be a viable alternative for the quick relief offered by allopathy. Related to this is the notion that homeopathy works best with chronic sickness, not with acute problems. In any case, the "absence of side-effects" makes homeopathy safer to take over a longer period of time than allopathy. Hence homeopathy is particularly useful against chronic ailments.

Third, homeopathy is a "cheap" medicine. Both doctor's consultation fees and prices for medicines, ranging from about Rs. 20 to Rs. 500 (for the elite homeopaths only) are much lower than those of allopathy. Moreover, homeopathic chambers and dispensing medicine shops are dotted across the city, making it easily available.

To go beyond these standard replies, and to elicit a more nuanced picture of how homeopathy works, is difficult. In my experience, a more detailed knowledge of homeopathy is very limited. Among the middle and upper classes, I found a number of people who have familiarized themselves both on the level of practical application and on the level of theory, people who know some of the basic homeopathic concepts, such as "life force" or "miasm." Indeed, the "homeopathy chest," containing a set of common homeopathic remedies, is part of many Bengali *bhadralok* families' household items, a practice dating back to the late nineteenth century:

"The wooden box with fragile glass bottles stopped up with cork and filled with white sugary globules has been an abiding memory from childhood. It was the ubiquitous medical ally in the family to fend off narking everyday crises. [...] it is a scenario that is enacted today in just about every other household in the country."  
(Bhimani 2000)

Leslie (1976: 359) also mentions the phenomenon of "self-instructed part-time practitioners" as a common feature of Indian homeopathy. Arnold and Sarkar (2000: 43) underline homeopathy's "do-it-yourself appeal" that led to its quick indigenization. One of the most famous part-time practitioners of this kind was Rabindranath Tagore (1861-1941), one of Kolkata's Nobel Prize winners. According to Bagchi's (2000: 8-15) "medical biography" of the writer, Tagore was among the members of the Bengali elite who taught themselves the principles of homeopathy from books, and who started to promote the medicine as a rational and cheap alternative to allopathy. Since Tagore had earned a doctoral degree, many people came to him for medical treatment. On some days, he treated more than 150 patients free of cost. On his trips to the remote areas of Bengal, Tagore used to carry a homeopathy chest with him to give medical treatments. At Shantiniketan, where he had founded a reformed university, Tagore also taught homeopathy to other professors. Among his patients was Amita Sen, mother of another Nobel Prize winner from Kolkata: Amartya Sen. Tagore's commitment to homeopathy had its limits, however. Like Gandhi, he believed that true health could only be achieved through a healthy, balanced way of life. Even if homeopathy could not always cure disease, at least it did not bring financial ruin. In Tagore's words, "homeopathy kills a life, but allopathy kills both life and financial resources" (quoted in Bagchi 2000: 14).

In Kolkata today, the most prominent benefit of homeopathy is not its cheapness, but its ability to heal without causing side-effects. My questions about *where* the "root" of the sickness lay, or *why* homeopathy medicines took longer than allopathy to work did not meet with detailed responses.

A simple but striking characteristic of popular opinions about homeopathy is that they all refer to allopathy. If homeopathy is perceived as an alternative to allopathy, it indicates that allopathy is seen as the hegemonic system of medicine. To speak of a "doctor" means, first of all, to speak of an *allopathic* doctor. To acknowledge allopathy's hegemony does not mean that this hegemony goes unquestioned. The popularity of homeopathy expresses severe doubts about "medical progress." Allopathic drugs are regarded as "chemical," "synthetic." Alien to the body, they often do more harm than good. That the "side-effect" plays such a prominent role among Kolkatans reflects a widespread perception of the iatrogenic effects of allopathic drugs.

The fact that homeopathy seems to become more and more popular reflects a situation in which a large part of the population looks for a less harmful alternative to allopathy. If allopathy were "modern," homeopathy would be a kind of "post-modern" successor. A 53-year-old female informant put it this way: "Our grandparents took Ayurveda, we take allopathy, the younger generation chooses homeopathy." To call homeopathy "post"-modern is, of course, highly problematic. Already during the nineteenth century, the Bengali supporters of homeopathy saw it as a kind of "*hyper-modern*" medicine – as *even more scientific* than allopathy, yet without any links to the oppressive British colonial regime (Arnold and Sarkar 2000). From this angle, homeopathy is an element of India's "Other Modernity" in Partha Chatterjee's sense. However, it must not be forgotten that a fierce critique of allopathy provided the basis for homeopathy's self-definition since its very beginning in Germany in the late eighteenth-century. Since allopathic medicine tended to do more harm than good, it was actually an "old" and "irrational" system, whereas homeopathy was the truly rational, "modern" practice. For its European supporters, homeopathy was not a symbol of "Other Modernity," but of "True Modernity." In turn, its critics see homeopathy as neither "post"-modern, "other"-modern, nor "hyper"-modern, but as a kind of "pre"-modern or "anti"-modern quackery. Homeopathy's ability to defy all comfortable periodizations is certainly one of its greatest charms.

The "old school" of medicine that Hahnemann attacked was the allopathy of his contemporary era, bearing little similarity to today's practice. For example, Hahnemann's critique of violent bleedings, emetics and purgatives, aimed to reduce an excess of blood and other humours (1994: ix) evinces that the type of medicine he attacked was quite different from today's. On the other hand, Hahnemann's critique of allopaths' tendency to prescribe too many powerful drugs remains a mainstay of both professional homeopathic *and* popular perceptions:

"[Allopathy] assails the body with large doses of powerful medicines, often repeated in rapid succession for a long time, whose long-enduring, not infrequently frightful effects it knows not, and which it, purposely it would almost seem, makes unrecognisable by the commingling of several such unknown substances in one prescription, and by their long-continued employment it develops in the body new and often ineradicable medicinal diseases. Whenever it can, it employs, in order to keep in favour with its patient, remedies that immediately suppress and hide the morbid symptoms by opposition (*contraria contrariis*) for a short time (palliatives), but that leave the disposition to these symptoms (the disease itself) strengthened and aggravated." (Hahnemann 1994: ix)


Hahnemann's remark on *patients' demand* for quick relief ("to keep in favour with its patient") makes clear that the blame for an over-use of allopathic medicine is not to be put on the doctors alone, but also on patients' lack of self-control regarding their ability to withstand the temptations of a superficial alleviation of symptoms. As I will argue in the following, homeopaths are as ready as allopaths to blame their patients for a lack of self-care. Yet most of the blame is attributed to allopathy, not to the patients. This will become clearer when we look at how Kolkatan homeopaths reflect on their experiences with patients, especially in relation to food and digestion.

## **2. "Sour, sweet, salty, spicy?": Food dis/likes in diagnosis**


The settings in which homeopathy is practiced in Kolkata are modelled along the lines of allopathy. Doctors practice either in their own homes, or in their private chambers, or divide their time between several homeopathic centres. Homeopathy is practiced in several government hospitals, as well as in large private clinics (side-by-side with allopathy). The latest advance is "The world's first ISO 9002 certified homeopathic clinic," which opened in one of Kolkata's business areas in October 2000, promising to deliver "treatment @ the speed of thought" (cf. Bhimari 2000).



*Before*



The World's First Chain of ISO 9002 Certified Homeopathic Clinics. Now in Calcutta



*After*

The Positive Health Clinic (PHC) was conceived as a one-stop body-mind-spirit healing center for several acute and chronic illnesses. The PHC Movement is a pioneer in the field of modern homeopathy and has delivered several 'world's first homeopathic' benefits to patients worldwide.

We believe that care for you, the patient, is of utmost importance and that finding a cure is a human endeavour and not merely a mechanical process.

At the PHC, you are assured of world-class professional homeopathic medical services and unmatched privileges at all time. Some of PHC's unique differentiators:

- ISO 9002 certification, certified by American Quality Assessors: assured international quality
- Custom-designed PHC software for specialised diagnosis and treatment
- Treatment backed by modern diagnostics and extensive research over 1,00,000 cases
- Exclusive, imported homeopathic medicines for effective treatment
- Blister-packed medicines for total hygiene and ease-of-use
- Quick, painless relief with no side effects whatsoever


**Gold Card Membership Privileges**  
Our programme to provide digital age conveniences to you!

- Comprehensive health coverage against ailments and diseases treated at PHC for plan period
- Password protected internet access to your medical history
- Gold Card counters for instantaneous registration; high speed dispensing of medicines
- Request free home delivery of medicines over phone / email
- No need to call or reconfirm appointments; we do it for you

**Treatment @ the speed of thought!**  
At [www.positivehealthclinic.com](http://www.positivehealthclinic.com), the world's first Homeopathic Cyberclinic.


- Extremely user-friendly, highly interactive and fast
- Real-world effectiveness; web world cost
- Twenty five of our own doctors provide on-ground, real-time support
- Your medicines couriered home in less than 24 hours in India; less than 72 hours abroad!

**The world's first ISO 9002 certified homeopathic clinic**



**POSITIVE HEALTH CLINIC™**  
Positive Health • Positive Life  
(Wholly owned by Positive Health Clinic Pvt. Ltd.)

BANGALORE • BARODA • CALCUTTA • LUCKNOW • MAURITIUS • MUMBAI • MUSCAT • NEW DELHI



**ISO 9002**

We treat: Hair and Skin Ailments, Gastroenterological Disorders, Arthritis, Asthma, Neurological Disorders and Rare/Chronic diseases.

**Chairman & Managing Director : Dr. Mukesh Batra** L.C.E.H, F.H.M.A. (U.K.), F.S.R.H. (Med) P. (Lon), F.B.I.H. (U.K.), M.D.H. (USA)  
**Resident Doctors :** Dr. Tejal, Dr. Rhatia • 1F / 1 & 2, Gardenia Home, 227 / 1A, A. J. C. Bose Road, Near Minto Park, Calcutta - 700 020

Fischer/CFT/01

Plate 13: An International Standards Organization (ISO)-certified homeopathic clinic (Newspaper advertisement)

It is common to find that local youth clubs or welfare associations provide space for a homeopath, alongside allopaths or Ayurvedic healers. Elite homeopaths, which charge between Rs. 300 and Rs. 500 per consultation, practice in their own private chambers, inclusive of air-conditioning and soothing background music. Many of

them are heirs of a homeopathic family tradition, some of them being able to retrace their genealogies back over four or five generations to the beginnings of homeopathy in Kolkata.<sup>74</sup> They speak English, wear suits, and are, by appearance, indistinguishable from allopathic physicians. On the bottom of the homeopaths' hierarchy are those who can only charge Rs. 20 to Rs. 50 per consultation. They often practice only half-time, in youth club rooms or in their own homes. These homeopaths struggle to keep at least a lower-middle-class standing.

The following observations on doctor-patient relationships in homeopathy were made in the setting of a charitable "slum clinic" in central Kolkata. The doctor – whom I will call "Dr. Mukherjee" (H-1) – set up this clinic in the close vicinity of the Calcutta Medical College, in order to "beat allopathy in its own terrain" (H-1). He considers himself to be one of Kolkata's most successful homeopaths. He published several books, lectured and practiced in Europe and North America, won gold medals from Calcutta University, and is fellow of homeopathic associations in Germany, England, U.S.A., and Australia. Dr. Mukherjee practices mostly in two private chambers, one situated in central Kolkata and one in South Kolkata. He also spends a couple of months each year at a chamber in England. Emulating the type of medical charity work done by many allopathic doctors, he uses the premises of a *bustee* youth club to treat patients free of cost, twice a week, for two hours. Given that Dr. Mukherjee sees up to fifty patients within the time of these two hours, observations from this setting give a glimpse of the peculiarities of Kolkatan homeopathy. There is only a minimum amount of time available to each patient, thus the doctor has to reduce his questions and his recommendations to the very basics. Diagnosis and therapy can be retraced to Hahnemannian textbook homeopathy,<sup>75</sup> but the fixation on the aspects discussed below seems to cater even more to the

---

74 Some elite homeopaths (and those aspiring to this status) have made a habit of writing their own family genealogies, and to hand out photocopies of them to visitors. In one of these genealogies, a doctor retraces how his great-grandfather founded the family tradition in the 1870s: "At that time a German Homoeopath, named Dr. L. Salzer, M.D. was practicing Homoeopathy in the city of Calcutta and have had good reputation. Late Dr. Kalipada Banerjee consulted him for one of his difficult cases. Dr. Salzer was much impressed [...]. Later Dr. Salzer took him as his Clinical Assistant and also as an interpreter; as Dr. Salzer was not acquainted with local Bengali language which hindered him a lot to take case histories" (Banerjee 2000: 1). The practice of writing these genealogies is also practiced among Ayurvedic doctors. Allopaths are also much aware of their family background, yet they would never put them on paper for visitors to read. How different doctors retrace genealogies is an indexical sign of their different professional self-understandings, and of different conceptions of time and knowledge.

75 A few of the terms used in this chapter are not in accordance with textbook homeopathy. For example, Hahnemann does not speak of "diagnosis," but of "case-taking." However, most homeopaths happily use terms like "diagnosis" themselves – and so will I.

preconceptions and expectations of his (predominantly Bengali) clientele.<sup>76</sup> The minimalist diagnostics that will become visible here are in stark contrast to the extensive history-taking that is otherwise the hallmark of homeopathy. Paying clients receive a much more elaborate diagnosis, based on a wide variety of symptoms. A patient would be allotted between fifteen and forty-five minutes, instead of only two minutes. Before meeting Dr. Mukherjee in the clinic, he characterized his slum clientele as "poor but happy": "They have taken everything from them, but not the smile" (H-1).

Food and digestion played a central role in virtually all of Dr. Mukherjee's interactions with his patients. Within the two or three minutes given to each patient, he would start with a quick question about the patient's main complaints, and the duration of the problem. To diagnose the problem, he commonly asked the following questions: What food do you like: sour, sweet, salty, or spicy? What food do you like: fish, meat, or egg? How are your motions? What time do you have your meals? Do you have a good appetite? What affects you most, hot or cold? "Hot" and "cold" referred not just to food, but also to bath water, climate, and so on. To be sure, questions about food preferences are not peculiar to Kolkatan homeopathy, but are part of the orthodox repertoire. What is peculiar is that Dr. Mukherjee focused entirely on these questions, especially in a setting where he can only spend about two minutes per patient. He asked the food/digestion-questions irrespective of the patient's specific problem. Even patients with pain in the legs, eye problems, or skin diseases were asked about food.

For example, one male patient (*ca.* fifty years old) came on a return visit regarding a number of problems, among them a dry gangrene of the leg, from which he had been suffering for fifteen years. The fact that he could not remove the gangrene did not cause Dr. Mukherjee any embarrassment. He commented that allopathy would have been unable to deal with the problem at all. Even if his medicine was not able to cure the gangrene, at least it saved the patient from an amputation:

<i>Doctor:</i>	How are you?
<i>Patient:</i>	My health is not good.
<i>D:</i>	How is your leg? Show me your leg. ( <i>Examines the leg</i> )
<i>P:</i>	Sir, the cold is not going.

---

<sup>76</sup> All conversations between Dr. Mukherjee and his patients were in Bengali.

- D:* Anything else?
- P:* I won't show to another doctor. I will come to you only. It doesn't matter if my life goes.
- D:* Do you feel hungry?
- P:* No, it's not good. But I eat at home. I eat all, fish, rice, meat and all. But I don't feel the taste. This is the main problem. And I have a problem when I go to the toilet. When I walk, my leg pains very much.
- D:* Buy medicine from a good shop!
- P:* OK... I have this taste problem for the last one year.
- D (nods, turns):* Next!

Other common questions asked about whether the patient has seen another doctor about the problem, as is also implied in the conversation quoted. Those who came for a return visit were asked if they had followed his prescriptions properly and if their health had improved (sometimes phrased as "How many percent betterment? 80 percent? 90 percent?"). Verbal questioning of the patients comprised the largest part of the diagnostic process. Dr. Mukherjee remained seated behind his desk, and only occasionally got up from his chair to touch patients. After his quick diagnosis, Dr. Mukherjee wrote out a prescription. While handing over the prescription, he often gave simple dietary advice, such as "take food in time and don't take *masala*, OK? No *masala*!" (H-1). On one occasion, a middle-aged lady, suffering from chronic diarrhoea, also complained about her hair. After she had left, Dr. Mukherjee turned towards me and remarked:

"Saw these people? All they want is magic. She was suffering for one year [from diarrhoea], and now she is better. And now she wants a development of her hair! Take good food, vegetables, don't take rice. They take plenty of rice. The main thing is plenty of fruit and vegetables. Too much of rice! Rice and *dal*, rice and *dal*, rice and *dal*! The food concept is very poor in this country." (H-1)

The analysis of homeopathy presented so far matches closely with popular conceptions of the body (see previous chapter), as well as with many Kolkata doctors' emphasis on simple, nutritious food and regular eating habits – an emphasis made more or less irrespective of the doctors' specialization. The meaning of food and digestion in homeopathy is, however, much more complex than this.

### 3. The "vital force"

Patients' and homeopaths' explanatory models regarding food, digestion, and daily routines match on the commonsense principle "You Are What You Eat." Most of the homeopaths I interviewed pointed out that good nutrition plays a major role in their therapeutic approach. However, the emphasis on food was not matched by an interpretation of good/bad digestion as the *primary symptom* of good/bad health. Similarly to Dr. Mukherjee, other Kolkatan homeopaths also focus on their patients' digestion and food preferences, because the patients are "cued into" these symptoms. However, when I asked directly whether digestion is central to health, only one homeopath answered positively that "mainly, a person should have clear bowels...bowels is the main thing" (H-7). All others stressed that homeopathy and popular conceptions are different:

"What are *they* telling, what are *you* going to do? Tell me! Whether their ideas are true or not is immaterial. Why give importance to stomach? To heart? To lungs? If you go in that way, there is no solution. Taking only the part into consideration will lead you nowhere. Take the man as a whole! [...] I've seen a lot of cases, they died of brain failure after they had survived a heart attack. A lot of patients develop heart troubles after the cure of the gastric trouble. A lot of people suffer liver problem after operation of the piles. A lot of people develop tuberculosis after operation of fistula. A lot of women get cancer after operation of the cervix." (H-8)

The point here is not that popular ideas about the interconnection of symptoms is wrong (e.g., "*gastric* causes hair loss"). Instead, this homeopath's argument is that the source of sickness must *not* be attributed to a particular region of the body. Neither the stomach, nor the heart, nor any other "part" is the "root" of health problems. The Kolkata homeopaths' emphasis on the "vital force" is part of their adherence to the words of Hahnemann, who defined it as "life itself" and compared it primarily to "spiritual" and "immaterial" forces such as magnetism. When in order, the vital force produces only healthy symptoms; when "morbidly affected," it produces illness symptoms. Drawing a line between "old medicine" and homeopathy, Hahnemann insists that the (allopathic) quest for the *causes* of diseases is both unnecessary and ultimately futile:

"*How* the vital force causes the organism to display morbid phenomena, that is, *how* it produces disease, it would be of no practical utility to the physician to know, and therefore it will forever remain concealed from him; only what is necessary for him

to know of the disease and what is fully sufficient for enabling him to cure it, has the Lord of life revealed to his senses." (Hahnemann 1994: §12, Fn.1)<sup>77</sup>

Following Hahnemann's theory of the "vital force" and its implications, Kolkata homeopaths rejected the idea that certain parts or functions of the body were any more significant than other aspects:

"Vital force is the main thing in homeopathy. When collecting the totality of the symptoms, I particularly have the vital force in mind and then I select the medicine. That is how homeopathy works." (H-16)

Homeopathy's dismissal of disease aetiologies formed, during Hahnemann's times, an important part of its dismissal of "old medicine's" violent purges:

"Homoeopathy sheds not a drop of blood, administers no emetics, purgatives, laxatives or diaphoretics, drives off no external affection by external means" (Hahnemann 1994: xi]. In the early nineteenth-century, this critique was directed against a form of allopathy still rooted in the humoral paradigm. In contemporary Kolkata, this critique rather applies to both popular and Ayurvedic notions that illness is caused by an excess of internal "waste" upsetting the body's balance. Therefore, the stress on "clean bowels" reflects, for orthodox homeopathy, a profound misunderstanding of body, illness, and therapy.

Even if they do not advocate purges and other "clear-outs," homeopaths do not doubt that various types of bad food and external pollutants affect people's health. For example, most of the homeopaths agreed that the digestive health of Bengalis is frail, that spicy and oily food, contaminated water, pollution, and an unhealthy climate are the main causes of this:

"Here, gastritis is the main problem. Rich foods, spicy foods. And the water is not very good. To be very frank and free, I should say [that] the water is not very good here. So amebiasis, diarrhoea, are very common, very common." (H-15)

"Calcutta is a very bad metropolis. Climate is very bad, no drainage system is there. Roads are unclean. Dusts are here and there. Buses, automobiles, smoke from the cars and buses coming out. It's a very bad, a very nasty city. I have seen so many cities of India, but Calcutta is the worst city of India, regarding cleanliness. And when cleanliness is not there, it will affect the citizen." (H-5)

The crucial difference between homeopathy and other medical systems with regard to these outside influences is, again, not the attempt to expel bad matter from the body to regain balance, but to improve a patient's *vital force* irrespective of the causes of illness. Stretching this theory to the extreme, some homeopaths pointed out

---

<sup>77</sup> Hahnemann (1994: §208) maintains that mode of living and the environment exacerbate existing diseases, but are not to be considered as the "cause" of disease.

that not even the dirtiest water or the most contaminated food will lead to illness symptoms, if the vital force was fine:

"I do not believe in the infection. Infection is the secondary part. At first, our vitality is lost. Vital force is the basic factor. Secondary is the germs. And this is the homeopathic theory, so always we insist on the increase of the strength of the vital force. Then there will be no germs, no infection." (H-5)

Since disease aetiologies are explicitly not of interest to homeopathy, health problems related to all sorts of pollution of air, water, food, or even sound, *can be immediately treated* with homeopathic medicines. Based on the principle that "like cures like" (in Bengali: "*eki jinis ekibhabe kaj kare*," H-12), homeopathy only looks at the symptoms, and treats with remedies that would produce these kinds of symptoms if administered in a larger dose. For example, asthma related to air pollution can be treated by remedies that would produce asthmatic symptoms if given in gross form. Hence all the homeopaths I interviewed claimed to be able to treat pollution-related illnesses, not by diagnosing and targeting causes, but by raising the vital force and by lowering susceptibility. Even if the treatment was only "50 percent" (H-15) successful, there is a potential for cure:

"One thing I have to say, some people are hypersensitive to pollution. Of course, you can take care of that. You can help that. Even if the person lives in the pollution, you can take care of that. Like, some people do sneeze all the time. You can improve that to a certain extent." (H-1)

One of Kolkata's elite homeopaths (H-20) was particularly fond of pointing out the therapeutic superiority of homeopathy over all other systems in the context of the modern industrial age. From among "46 types of industrial pollution" (H-20), homeopathy was able to treat "43" of those:

"As regards to industrial toxicity, overpopulation, the impact of noise, homeopathy has specific medicines for that. We have medicines for the bad effect of sound, of noise, for industrial poisoning, for toxic effects of metals, all these drugs are described in our books. In this area, homeopathy has the widest scope. [...] For all sorts of allergies, homeopathy has the basic treatment." (H-20)

Neither are environmental factors out of reach for homeopathic medicine, nor are internal, psychological problems. In the *Millennium Issue* for the 1999 conference organized by the HMAI in Kolkata, the same doctor (H-20) who administers homeopathic remedies against pollution also advocates an increased application of homeopathy to any kind of psychosocial deviance:

"Many gross abnormalities of character such as dullness, irritability, pride, suspicion, fear, instability of mind etc. can be corrected and cured. [...] Mental

aberrations, which bring criminal characteristics in a person, has its proper consideration and instrument of eradication in homeopathic Materia Medica. I do not understand why in India we do not have any mental hospital under homeopathy. Many persons would have not become criminals, had homeopathy taken care of their tendencies in their childhood." (*HMAI* 1999: 61)

In another interview with me, the doctor extended his vision of an all-encompassing homeopathic biopolitics even further. Reminiscent of Freudian theories, he equated children with neurotics and defined both as being in urgent need of homeopathic intervention:

"The great advantage is that [homeopathy] can cure susceptibility. Also character traits: tendency to lie, tendency to cry, tendency to forget, inability to concentrate, the child not performing up to the mark, not getting good results. Homeopathy has medicines which bring about a basic change of character. It can make you more concentrated, it can make a dull child an intelligent one, it can cure a timid person, it can cure a person who is too religious, too fanatic. There are medicines for curing these aberrations. That is why most guardians bring their children to homeopathy."  
(H-20)

Through the concept of the "vital force" and through an exclusive attention to symptoms instead of causes, homeopaths are not afraid to claim the power to remove all ills of modernity at once: environmental pollution, competition for good grades and good jobs, and even the violent excesses of religious fanaticism.

#### **4. Immaterial ingestion**

The principle of "vital force" has a number of ramifications for homeopathic practice, both of which relate to the digestive process. To begin with, it is stressed that homeopathic medicines do not have to be ingested and digested in mouth, stomach, and guts. To further distinguish his system of medicine from the "old" humoral paradigm, Hahnemann stressed that homeopathic remedies are so subtle that they do not have to be digested at all. Instead of "assailing the body with large doses of powerful medicine," which inevitably puts a heavy strain on the stomach and all other parts of the body, homeopathic medicine bypasses digestion. Tongue and stomach all but lose their privileged role in the assimilation of medicine:

"Besides the stomach, the tongue and the mouth are the parts most susceptible to the medicinal influences; but the interior of the nose is more especially so, and the



rectum, the genitals, as also all particularly sensitive parts of our body are almost equally capable of receiving the medicinal action" (Hahnemann 1994: §290)

Only because homeopathic medicines are so subtle can they act on the level of the vital force. Only quasi-immaterial medicines can pass straight through the body's "holes" and "gaps" and go at once to where they exercise the most profound change in the organism – the nerves:

"Our body comprises some holes and some gaps. The gaps, which are mouth, ear, eyes. And there are holes. We are having the holes in the eyes, ears, nose, and the rectum. Similarly, we are having minute holes in the skin. So, these orifices are the external boundary of our body, having contact with the rest of the universe." (H-9)

"The action [of the medicine] comes through the nerves. You put it to the mouth or you rub it, by rubbing it, it goes to the nerves. If it is not possible, you give by olfaction, through the nerves also." (H-17)

"It acts through the nerves, sensitizing the nerves. And that's all. [...] Once it sensitizes the nerves, it's over. It guides the entire system, the entire vital force, entire body and mind. [...] The vital force is located everywhere. Even if you rub the medicine on the skin, it will work. If you smell it from a distance, it will work. Once I had a coma patient, I gave medicine to inhale, and the senses came back." (H-8)

Homeopathy's stress on the subtlety of its medicines is, of course, the first target for allopathy's criticisms since Hahnemann's era. Since its inception, homeopathy is said to be "unscientific," because the active ingredients in the medicine are so highly diluted and "dynamized" that they do not, materially, exist anymore. All homeopathic remedies undergo a progressive dilution, in which the degrees of dilution are expressed as "potency." The higher the potency, the higher the dilution process, but even the lowest potencies cannot be "scientifically" measured – if the allopathic rules of "science" would hold. However, Kolkatan homeopaths consider this to be rather a strength than a weakness. The medicine's "invisibility" is considered to be only a weakness of the measuring techniques currently available:

"There are many things in this world which are physically not perceptible, but their existence has been established by science. Slowly, slowly, our power to see and hear is becoming more powerful. The age of electron microscope is hardly fifty years, so now we can see the viruses. So still we cannot see the finer things. It does not worry me how the medicine works. This is a problem which will be solved in thirty, forty years, when instruments will become finer and finer." (H-20)

"This science will not stop! The day will come! Scientists will come! They will show!" (H-6)

Others are of the opinion that the principles of homeopathy are altogether beyond the horizon of conventional positivistic science:

"If we think about the mind, and mind is not material, it is dynamic and body is material. And we think that mind controls the body. So we think that immaterial power is also necessary to the body. Our laboratory is not chemical, our laboratory is the human being – mind and body. In a chemical laboratory, homeopathic power cannot be established. So, in homeopathy, there is some power above the material body. [...] We believe: the mind controls the body. If the mind is upset, you will not have appetite." (H-5)

"Your body has no power, but it is your mind which populates this body. So, this body is under the control of the mind. And mind is the finest substance on earth!" (H-10)

Many Kolkata homeopaths go even further than this and postulate a deep affinity between popular Bengali notions of *mon* (cf. chapter on popular perceptions) and homeopathy. Like Hahnemann, Bengalis put mind over matter. Aiming to transcend the gross materialism of the modern world, they look to homeopathy as their favourite system of healing. Asked why homeopathy is so successful in Bengal, one homeopath replied:

"Because people have belief in God. You see, God is invisible, and so is homeopathy! [laughs] [...] Where everything is more mechanical, where there is more materialistic thinking, there homeopathy has trouble." (H-19)

The reference to God is no coincidence. In Kolkata, as elsewhere in India, it is part of Hindu notions of *puja* that the deity ingests the food offered to it either by eating it, or by simply smelling it. For Benares, Parry notes that for Hindus, "smelling is a kind of consumption equivalent to eating" (1985: 629, Fn.10).<sup>78</sup> This homeopath's explanation for why people in Kolkata find the homeopathic theory of immaterial ingestion plausible does not seem far-fetched.

---

78 According to a Bengali anecdote about ritual impurity in the traditional caste order, the equivalence of smelling and eating can have serious consequences. Once, a member of a Brahmin family went to a Muslim house during the fasting month of Ramadan. On smelling the intense scents wafting from the kitchen, where cooking was going on during the day, he asked his Muslim host how they can call it a "fast" if they inhale such scents of cooking. His Muslim host got upset and replied: "If smelling is like eating, then you have just eaten beef!" (Annu Jalais, personal communication). The anecdote illustrates convincingly Hindu ideas of smelling and eating as being equivalent, but other aspects of it appear less convincing. For example, the Brahmin cannot be too much concerned about the pollution incurred from smelling cooked beef, since he has already transgressed orthodox purity rules by going to a Muslim house.

## 5. "No toothpaste allowed!": Antidotes to medicine

Among Kolkata homeopaths, there is little doubt that the medicine's immaterial subtlety enables it to "go deep" into the patient's system and to redirect the vital force towards health. However, this immateriality raises the question of how vulnerable the medicine is to influences from other ingested substances, or any event that affects the "nerves." To consider food primarily as a potential *antidote to medicine*, instead of a potential source of health, is a characteristic feature of homeopathy. The basic definition of the issue is formulated as follows:

"Considering the minuteness of the doses necessary and proper in homoeopathic treatment, we can easily understand that during the treatment everything must be removed from the *diet and regimen* which can have any medicinal action, in order that the small dose may not be overwhelmed and extinguished or disturbed by any foreign medicinal irritant." (Hahnemann 1994: §259)

What exactly the patient should avoid is not always clear, however. In the *Organon*, Hahnemann devotes several paragraphs to the discussion of the problem (§259-263), with most of the specific recommendations in a long footnote rather than in the main text (§260, Fn. 2). The list of items to avoid reads like a traditional (humoral) almanac for the everyday care of the self. Similarly to the recommendations for daily regimen given by humoral medicine, food, exercise, hygiene, sexuality, and morality are all taken into consideration. In order to allow homeopathic medicine to work, the following "noxious influences" must be avoided:

"Coffee; fine Chinese and other herb teas; beer prepared with medicinal vegetable substances unsuitable for the patient's state; so-called fine liquors made with medicinal spices; all kinds of punch; spiced chocolate; odorous waters and perfumes of many kinds; strong-scented flowers in the apartment; tooth powders and essences and perfumed sachets compounded of drugs; highly spiced dishes and sauces; spiced cakes and ices; crude medicinal vegetables for soups; dishes of herbs, roots and stalks of plants possessing medicinal qualities; [...] heated rooms, woollen clothing next to the skin (which should be exchanged in warm weather first for cotton, then for linen garments), a sedentary life in closed apartments, or the frequent indulgence in mere passive exercise, [...] prolonged suckling, taking a long siesta in a recumbent posture (in bed), sitting up long at night, uncleanliness, unnatural debauchery, enervation by reading obscene books, ['reading while lying down, Onanism or imperfect or suppressed intercourse in order to prevent conception' in the Sixth Edition] subjects of anger, grief, or vexation, a passion for play, over-exertion of mind and body, dwelling in marshy districts, damp rooms, penurious living, &c [...]." (Hahnemann 1994: §260, Fn.2)

The list goes on much further, touching on many other aspect of individual and social life. Yet Hahnemann determines that it is exactly *these*, and no other practices, that have to be avoided: "Some of my disciples seem needlessly to increase the difficulties of the patient's dietary by forbidding the use of many more, tolerably indifferent things, which is not to be commended" (Hahnemann 1994: §260, Fn.2; cf. Clover 1989: 98).

Moreover, he distinguishes between acute and chronic conditions. The strict rules for diet and regimen only apply to patients who suffer from chronic diseases (Hahnemann 1994: §260). In case of acute diseases, the patient's cravings and desires are to be given free reign: "put no obstacles in the way of this voice of nature by refusing anything the patient urgently desires" (1994: §262).

When Kolkatan homeopaths talked about dietary recommendations for patients, the problem of antidoting influences was a contested issue. The doctors' attitudes ranged from the extremely relaxed to the extremely restrictive. For example, Dr. Mukherjee (H-1) told a story about an experience with a female migraine patient who was addicted to *pan* (betel with condiments). The doctor advised her to stop chewing betel so that the medicine may not be antidoted. One year later, the woman returned for a different ailment. Asked about the migraine, she replied: "'Oh, that was good. You gave me that dose and it was fine. But you told me not to chew betel-leaf when I take my first dose. But I couldn't do that. I put my medicine on top of the betel-leaf and *mmmmh*'" (H-1). Based on this key experience, he concluded that homeopathic medicine, however subtle it may be, is not easily antidoted, not even by noxious substances such as betel, spicy Indian food, or exhaust fumes from buses:

"In this country, you get the betel-leaf with strong tobacco, and since then I decided, homeopathy is not that fragile. If it is the right medicine, it will act. [...] In this country, the typical Indian food, so much of spice and aroma, and India is the best country where homeopathy acts superb. You go to a bus and contract smoke – 'everything will be antidoted'? I think that's a rubbish thought! I'm sorry, I get excited about it. I have a passion for this great science and I love it! And I don't want to say that homeopathy is that fragile." (H-1)

On the opposite end of the spectrum, one homeopath (H-8) applied Hahnemann's warnings about antidotes not only to food, but also to the whole range of daily practices, including the brushing of teeth with toothpaste. His strict regimen inevitably led to many conflicts with the patients, who were either unwilling or unable to follow his uncompromising approach:

"If I find that this man will not adjust to my diet, I simply turn him out. I say: 'Go to

another doctor! I won't treat you!' [...] The patient must follow all of my orders. [Question: Doesn't this cause trouble?] Yes. And how to run the daily life, I tell them not to use toothpaste: 'No toothpaste allowed!' Not possible! That's the main problem. But what to do? If you use toothpaste, it antidotes the action of the medicine. There's a lot of interaction. It will not allow the medicine to work." (H-8)

These two doctors held extreme positions. Most homeopaths expressed opinions which lay somewhere in-between. Those who restricted their patients' diet and regimen, as opposed to those who had a relaxed attitude, were clearly more. However, since there are no cast-iron rules about the effects of antidotes, homeopaths can use their recommendations flexibly: be strict to patients who *demand* a strict regimen, be accommodating to patients who do not want to change their daily habits.

## 6. Disease in "the modern world of suppression"

As has been mentioned earlier, there is a widespread popular perception of homeopathy being able to give a thorough and permanent cure from illness. Instead of focusing on a superficial "quick fix," homeopathy is said to take the illness out from its "root." Popular explanatory models commonly see wrong eating habits and a disturbed digestion as this "root" of illness. Since homeopaths ask their patients many questions about food and digestion, since most of them also give dietary advice, and since the medicines they prescribe are small and "subtle" enough not to produce digestive side-effects, no clash between popular and homeopathic explanatory models has to arise. It may *seem* to patients that homeopathy also sees digestion as the "root" of disease.

Yet, again, homeopathy turns out to contradict popular ideas by dismissing digestive disturbance as the actual "root" of disease. According to Hahnemann (1994: §204), there are three reasons for suffering, especially chronic suffering: 1) a "persistent unhealthy mode of living," 2) "irrational, persistent, harassing and pernicious treatment [...] by physicians of the old school," and 3) "three chronic miasms," namely "syphilis," "sycosis," and "psora."

Hahnemann's understanding of "miasm" is different from that of the humoral models of public health and the environment that were common in European medicine from antiquity up to the nineteenth century (cf. Cipolla 1992; Hannaway

1993; Latour 1988; Parker 1996; Vigarello 1988). In humoral medicine, "miasm" (or "miasma") stands for any kind of "putrefaction" of the air, "vapours" from stagnant water, rotting corpses, decaying vegetable matter, and so on (Hannaway 1993: 295). Hahnemann's concept of "miasm" retains the idea of "noxious influence," but locates miasm not in the environment, but *inside* the human organism. Miasm is the reason behind all "true natural *chronic* diseases" (Hahnemann 1994: §78). It is a kind of hereditary condition, being transmitted from one generation to the next, afflicting mankind "for hundreds and thousands of years" (1994: §204). Among all medicines available, only homeopathy has a cure against miasm. If treated superficially, as in allopathy, the symptoms are only "suppressed," and are bound to re-emerge even more lethally than before.

The common conceptual metaphor to describe "this lingering and deep-seated malady" (Gose 1935: 112) compares miasm either to the "root" of a dangerous plant, or to the "soil" in which dangerous plants can take root. Similar metaphors are already suggested in the *Organon*, and have a long tradition in Indian homeopathy, too:

"Allopathy removes only the product and leaves the germs. Only the branches are cut down, and so the roots are left to grow and put forth new shoots. On the contrary, homeopathy has the power of giving a new form to the corrupted blood and of altering the constitution." (Gose 1935: 112)

"Hahnemann explained Psora as a diseased condition or disposition to disease transferring from generation to generation for thousands of years behaving as a fostering soil for almost every possible diseased condition. Seed, being sown in the soil produces plant. But without extermination of the root, in spite of cutting off plant from the soil, the plant tends to grow again and again from the remaining root. Though the plant originated from a seed primarily now the remnant serves the cause of further growth of the plant." (HMAI 1999: 90).

Allopathy only cuts off the visible part of the plant, but leaves the root in the soil. Eventually, the disease will break forth again, with even greater danger to the organism than before. Skin disorders are among the most common manifestations of the miasmatic "soil" and "root." Allopathy's "quick fix" approach to disease in general, and to skin disease in particular, risks aggravating the condition beyond a point of no return: "Some eminent modern dermatologists' perspicacious observation reveals that suppression of some kind of skin diseases result in virulent internal disorder and occasional death ultimately" (HMAI 1999: 92; cf. Hahnemann 1994: §203-206).

Kolkata homeopaths see the concept of miasm as essential for practice. It is said to be the "main concept" (H-1), "very important" (H-11), "very very very important" (H-7) or "fundamental, fundamental!" (H-6). Miasm "should be considered first" (H-15), and "without miasm, you cannot practice" (H-8). Especially for chronic diseases, diagnosis of the patient's miasmatic constitution is the key to treatment. Properly applied, an anti-miasmatic remedy exercises a kind of "centrifugal" action, because it "goes deep into the system and brings suppressed symptoms to the surface" (H-1).

The concept of miasm is closely related to that of "suppression" of symptoms. In the *Organon*, suppression signifies allopathy's vain and perilous attempts to cure disease by removing superficial symptoms. Among contemporary homeopaths in Kolkata, "suppression" and "miasm" are used interchangeably:

"Well, miasm is my main concept, because basically my grandfather studied miasm from John Henry Allen. And in the modern world of suppression, when the symptoms are suppressed and final modalities are lost, final sensations are lost." (H-1)

"Miasm is very important for treating susceptibilities. And one big advantage in homeopathy is, that while you are treating present complaints, you can also rectify mistakes of the past. With suppressions, whether emotional or physical or traumatic suppression or drug suppression." (H-20).

The similarity of miasm and suppression seems to be motivated by the conceptual metaphor DISEASE IS A PLANT: even if its visible manifestations are eliminated, the invisible root lingers on. Although Hahnemann does not blame the occurrence of miasm on allopathy, Kolkata homeopaths often ascribe the origin to it. At times, miasm, suppression, the effects of allopathy, and modernity at large become indistinguishable. In this homeopath's statement, the "foreign bodies" of allopathic vaccination lead to miasmatic changes in the body; these, in turn, lead to "genetic defects":

"Modernization, development of mental conditions, psychosomatic, and also the vaccinations and inoculations: foreign bodies are being introduced, that's why psychosis is getting more and more. [...] They are trying to introduce the foreign bodies into a previously healthy state, and more and more we are seeing sycosis, sycosis, sycosis. [...] Today's genetic defects: The background is miasm." (H-6)

Miasm and modernity are also associated in regard to some homeopaths' theory that the three miasms that Hahnemann mentions have become "intermingled" in the modern patient's constitution (polluted in substance, unruly in behaviour). The confusing mixture of internal and external makes homeopathic cure very difficult:

"Mixed miasms are very complicated!" (H-7).

When Kolkata homeopaths speak about their patients, "suppression" also comes to stand for any kind of "complicated" personality. This analysis of "complicated" patients is commonly mapped onto the socio-economic hierarchy. "Small" people are simple, "big" people are complicated. The higher a patient's socio-economic standing, the higher the likeliness that they have undergone numerous allopathic treatments, which "suppress" their symptoms and their vital force. Moreover, "big" people are better educated, and education tends to dissociate one's mind from one's body, hence leading to a "suppression" of immediate, unadulterated symptom expression. This model disputes two of the most conventional truths in contemporary public health, namely that "wealth is health" (people can afford to get medical treatment), and that better education translates into better health (people know better what is good and what is bad for them). Since higher incomes and higher educational levels are seen as elements of modernization, homeopaths think that modernization is bad for health. Given that homeopaths equate modernization with Western life styles, a further conclusion is inevitable to them, namely that the constitution of the Indian patient is *healthier* than the constitution of the Western patient, but that further modernization will make the Indian patient just as complicated and "suppressed" as the Western patient. Drawing a comparison between the patients of three different settings (the slum clinic, the South Kolkata chamber for well-off Indians, and his chamber in the South-East of England), Dr. Mukherjee concludes that the poor/simple/non-Westernized slum dwellers may be poor, but that the relative lack of suppression makes them healthier than the rich/difficult/Westernized Indian patients:

"When [the poor] come up with any problem, they will give you the words of the *Materia Medica*. The symptoms are so open. No suppression. [...] In the south [Kolkatan] clinic and in my clinic in England, they are almost the same, because in both these two clinics, there is suppression. And I think, in England it is more emotional suppression, perhaps, and in the south clinic, there is more iatrogenic, like if their child sneezes one time, they will take it down to the paediatrician and have something. Because they can afford. And they are so much cautious about themselves. And the symptoms are suppressed, so it is very difficult to get a clear picture. And many times, it takes a longer course, to be very honest. And you got to change remedies. Whereas over there [in the slum], you give the medicine and in two days: fine! And even with much more advanced pathology! And even, believe me, I published an article on that, although they live in a very unhygienic condition,



poor sanitation, but still, their vitality is stronger. I have to say. Compared to the other children." (H-1)

"Upper-class patients consult too many specialists, so they come with very big files from the allopaths, having all the information. The rich class suffers more, because of suppression. Recently, it has become a status-symbol: 'Just to prove how rich I am and how big I am, I have consulted all these doctors!'" (H-20)

The more patients are "modernized," the more they suppress. The more they suppress, the more they suffer: "They are really having some explosion of the mind" (H-2). The more they suppress, the more difficult it becomes to diagnose them. The harder to diagnose, the harder to treat. Poor people, "they enjoy life, they do not bother about their fever – and that is very good for them!" (H-14). Rich people, on the other hand, tend to get stressed and worried even about the smallest ailment, making a cure hard. The doctors' remarks on how it is relatively easy to treat poor patients ("in two days: fine!", H-1), and on how rich patients come with "big files from the allopaths" (H-20) raises the question of how homeopaths perceive their patients in terms of success of treatment and patient compliance.

## **7. How to deal with the modern (biomedicalized) patient**

As has been discussed above, Hahnemann did not blame only the allopathic physicians for prescribing quick-fix medicine, but also the patients' *demand* for quick relief. This demand does not, of course, stop at the door of the homeopathic practice. Indeed, most Kolkata homeopaths feel enormously pressured to deliver good health as quickly as allopaths. It may be true that homeopathy is popularly perceived to be a "slow" medicine, yet the need for economic survival makes homeopaths think hard about how to cut corners.

Problems with patient compliance begin with the diagnostic process. If a patient comes to a homeopath for the first time, the doctor needs to ask a wide range of questions in order to capture the "totality of symptoms." Depending on the doctor's experience, this process of "history-taking" (or "anamnesis") takes, if properly done, between 30 minutes and two hours. Most Kolkata homeopaths claim to spend between 30 and 45 minutes per first anamnesis. On a follow-up visit, much less time is needed. As is obvious from observations of homeopathic practice, the usual time spend with patients is much less. Two factors influence how long a

homeopath takes per patient: number of patients seen during the day, and the level of fees paid. These factors are more or less independent from each other: many of the elite homeopaths see many patients *and* charge high fees, low-ranking homeopaths may charge low fees but still spend lots of time per patient, and so on. The actual time spent per patient is often cut down by the use of standardized questionnaires that patients fill in by themselves or with one of the doctor's assistants before they meet the doctor in person.

Conflicts with patients arise about the duration and the content of history-taking. In terms of duration, homeopaths tend to complain that patients get easily bored or annoyed, especially the "modern" patients, those who lead a "fast life" and are used to the speed of allopathic consultations:

"Some of the people who live a very fast life and who are accustomed to going to a doctor and telling them, 'Oh, I got a fever', and immediately the doctor writes the medicine. Those people find it difficult, because they don't understand why it is important to ask so many questions." (H-20)

In terms of content, patients often do not understand why the doctor asks them about symptoms which seem unrelated to the health problem at hand, such as dreams, sexual behaviour, or relations with other people. Indeed, questions like "Are you addicted to masturbation?" or "Do you lie to other people?" (which appear in this or a similar formulation in many questionnaires) may seem either too ridiculous or too intimate to be answered.<sup>79</sup> But for some patients, even questions relating to food preferences and digestion, which otherwise build on a strong cultural consensus, may sometimes seem too far-fetched and time-consuming:

"If it is a new patient who has come to try homeopathy, they do wonder: 'I have come with pain in my leg. Why are you asking how am I passing my bowels and about my sleep?'" (H-19)

Further problems arise in relation to patients' ability to articulate their symptoms. The *body* language of "illiterate" patients may be much easier to read than that of educated patients (less "suppression"), yet they are sometimes said to be unable to answer *verbal* questions properly:

"Here, many people are illiterate. They cannot explain the symptoms. So if I ask, 'What type of pain?', they say, 'Pain is there!'" (H-4)

"In case of lower-class patients, I take the help from the body language. There we

---

<sup>79</sup> For example, in *A Guide to case-taking and case-recording*, (written by one of Kolkata's elite homeopaths, S.P. Dey), the homeopath is urged to ask the patient about the following: "Ejaculation – early / delayed / lacking; Orgasm: normal / delayed / absent; *Marital maladjustment*; *Masturbation* / Night pollution / Spermatorrhoea / Prostatorrhoea" (Dey 1993: 19).

are going to see the exact thing. The more sophisticated, the more intellectual, the more the body language is controlled by the emotion. And there it is very difficult to take the case in the upper class in this way." (H-14)

"They are illiterate. They cannot say anything. There is a problem here." (H-15)

On the other hand, literate patients are also difficult to diagnose, partly because they do not want to spend time, or because they have learned enough about different types of diagnostics and therapeutic alternatives to challenge the doctor. Patients who come with "big files" from prior consultations of allopaths or other homeopaths tend to be the most pigheaded:

"If the background is there, sometimes we have to explain. 'Why you are giving this medicine?' Maybe the patient has taken this medicine before without success. So he may know the name of the medicine." (H-17)

"Sometimes they give me a look and I am saying: 'You might have had *Nux Vomica*, but you haven't had my *Nux Vomica*. I have to say, they know the ins and outs." (H-1)

Disagreements between doctors and patients during the diagnostic process pale in significance compared to disagreements about therapy. According to Hahnemannian orthodoxy, it is only allowed to prescribe one single remedy at a time, and to wait for several weeks or even months for it to produce results:

"In no case under treatment is it necessary and *therefore not permissible* to administer to a patient more than *one single, simple medicinal* substance at a time. [...] It is absolutely not allowed in homeopathy, the one true, simple and natural art of healing, to give the patient *at one time* two different medicinal substances." (Hahnemann 1994: §273; emphasis in original)

"[The three fundamental principles of homeopathy are] (1) the law of similia, (2) the principle of single remedy, and (3) the principle of minimum dose." (HMAI 1999: 13)

The question of single remedy/single dose was one of the most hotly debated among the Kolkatan homeopaths that I got to know. The debate was not about whether Hahnemann's doctrine was right or wrong. Kolkata homeopaths portray themselves as faithful followers of each and every word of Hahnemann. Solemn pledges of allegiance, such as "Hahnemann, our God!" (H-18) or "I am practicing strictly! I am a devotee! I am a lover of homeopathy!" (H-6) were an obligatory part of the doctors' discourse on professional belonging. Instead, the debate is about how and why *other* doctors stayed from the path of truth and became traitors to the homeopathic faith.

The problem that the doctors face is: how to deal with the patients'

exaggerated expectations for quick relief without betraying homeopathy? A permissible and extremely common answer to this question is to prescribe *placebos*. From an orthodox point of view, it is not possible to cut short the time needed for the medicine to work. Yet during this time, the patient must be given psychological reassurance, and the best way of doing this is to keep him under regular (pseudo-)medication:

"Placebo is very well, because patient wants medicine. If not necessary, even then he wants medicine. They are mentally satisfied with taking medicine. If I give the patient one dose and ask the patient to come after one month, the psychological effect will be there: 'One medicine for a month. What will happen? I will die! Disease will increase! Doctor has not given me medicine!' Psychologically, they will suffer." (H-5)

"[Placebo] is the only way of satisfying the patient, because they are thinking they are taking the medicine. [...] I never tell them: 'Well, you don't need any medicine', because they would see another doctor! Unnecessary! That's why we close the chapter by giving placebo. Sugar and milk." (H-6)

On the prescription handed over to the patient, the code for a placebo is "/0." The zero stands in lieu of a number code for a medicinal potency, e.g. "/50." Given that a placebo is so easy to make out – once this "secret" is known – it is surprising that the practice works so well among a patient population with a reputation of knowing the "ins and outs" (H-1) of homeopathy. Regarding the homeopaths' claim that placebos are *only* prescribed to satisfy patients who lack the necessary self-control to wait, it seems obvious that the doctors also have a vested interest in keeping up patients' expectations of regular medication. Placebos provide easy revenue to them (more consultations than necessary) and to the homeopathic medicine shops (placebos cost the same as the real remedies).

In any case, none of the doctors had any qualms about prescribing placebos, as it is in conformity with Hahnemann's rules. Indeed, the use of placebos was virtually the only way to compromise with patients' demands without compromising Hahnemannian purity. Placebos were employed to avoid what orthodox homeopaths saw as a homeopath's worst fall from grace: the prescription of multiple remedies, in multiple doses ("polypharmacy").

The basic reason to reject polypharmacy is that Hahnemann strongly rejected it. The doctors commonly blame patients' expectations on their habituation with allopathy:

"Here, people have got the idea: 'If I take more drugs, I will get better', because they

are habituated to taking many allopathic medicines. Like when they take antibiotics, they take vitamins also." (H-4)

That polypharmacy might be more "effective" is not only a popular idea, but is also shared by many homeopaths. Some of them mentioned that they had experimented with polypharmacy at an earlier stage in their careers, even if this experience brought them back into the fold of Hahnemannian orthodoxy:

"If you want to cure a person in a true sense, you have to give a single medicine. Two, three, four drugs, mixed together – you cannot cure a person. I also have experimented with giving them mixtures, but I came to the conviction that it is simply not possible." (H-20)

However, for patients whom the doctor does not want to cure "in a true sense," such as terminally ill patients, polypharmacy can be used:

"In most cases, I use single-medicine, but in the cases in the dying stages, I give combinations of drugs. Just to ease the pain and other things." (H-10)

The distinction between "truly curing" patients and alleviating patients' symptoms is not limited to (in)curable patients. Instead, the distinction is covertly extended to all patients. The idea is that homeopathic remedies *act like allopathic remedies* when prescribed in combination with each other, and are given in multiple doses.

"Here, the people are illiterate, they don't give it any time: 'Uh! Oh! I have to work, so give me that medicine! From tomorrow morning I have to be back in my factory!' Not patient enough! That's the problem. So in India, we give six doses, seven doses, ten doses at a time, so they feel relieved, so they feel: 'I'm OK!'" (H-4)

If multiple remedies are prescribed, a "quick fix" effect could be achieved that is comparable to the effect of allopathy. It may not take out the "roots" of the disease and give permanent cure, but at least the patient is given instant relief. Even if it gave only a superficial cure, it was still better to use homeopathy instead of allopathy, because homeopathic medicine costs less, and was still free of "side-effects." According to one doctor, patients only started to have "faith" in homeopathy in recent times. Although he did not mention explicitly that an allopathic way of prescribing homeopathy was the reason for this, he strongly believed that it was the biomedicalization of homeopathy, in teaching and in practice, which enabled this advance:

"Now they [patients] have faith in homeopathy, since the past ten years. The homeopathic system has totally changed. Now joint entrance examination is there. You have to take an admission test. Now homeopathy is like MBBS [allopathic bachelor]. Anatomy, surgery, physiology, gynaecology, these the homeopaths have

to learn. These are the subjects we have to take while learning homeopathy. Basic knowledge, basic study of these fields is needed. *Bioscience*, the same as the allopaths. Under Calcutta University, all the studies are the same. [...] Both chronic and acute cases, medicines, and doctors are working very fast. Before, when the acute patients used to come, the medicine used to take a long time, but now the system is fully changed. Before, it used to take time. Now we are getting it done quickly. For example, sunstroke, fever, influenza, dysentery, diarrhoea, many, many diseases. Acute pain. For these things we have quick relief medicines." (H-18)

Significantly, this doctor belonged to the "lower class" of homeopaths, and did not hail from an old homeopathic family. Not having his own chamber, shuttling back and forth between several homeopathic centres in Kolkata, this doctor could barely make a living from practicing homeopathy. From his unprivileged point of view, the influence of biomedicine on homeopathy was a positive development, an option for a better future for him. First, it promised to decrease the status of older homeopaths, in favour of homeopaths who have only recently graduated from the colleges and who can claim to know the "science" of medicine. Secondly, to be able to prescribe "quick relief medicines" promised to attract more patients and to make homeopathy a more lucrative business.

On the opposite side of the spectrum, many elite homeopaths claimed that they only prescribed according to Hahnemann's rules. Although they also complained about patients being illiterate, impatient and often non-compliant, they felt more confident about the power of their professional charisma: "I think I maintain a professional ethics with that and say: 'I am the doctor and you are the patient. So what I am giving is my decision'" (H-1). The better-off homeopaths could choose whom to treat and whom not to treat:

"[Poor people] have an idea that homeopathic medicine takes time, but they have to be cured within a short time, otherwise they will not be able to join their work. So they don't come at all to the homeopathic doctor. Even if they come with their babies, I do not like to treat them, because they will not follow my advice. [...] So I also don't like that those people come to me. They are illiterate, they are crude. A temperature is there, they want a cure in one hour!" (H-5)

However, most homeopaths that claimed to be pure Hahnemannians commonly added that they were among the last purists. Although braving the corrupting influences of modernity through strict professional ethics, they felt too weak to counter the corruption within the body of homeopathic doctors. The destructive work of modernity first spoils health through environmental degradation, urbanization, and industrialization. Then modernity further spoils health by creating

an image of allopathy as the only "scientific" medicine, despite knowing that the uncontrollable side-effects of allopathy wreak havoc on people's vital force.

Allopathy's promise to give quick relief spoils patients' expectations about what medicine can actually deliver. Now modernity even takes possession of the last bastion of true health, homeopathy, by spoiling it with allopathic elements and diverting the doctors from the only true path of healing, namely single-remedy prescription as willed by Hahnemann. The result is "total degradation" in all spheres of life, including homeopathy:

"Now it's total degradation, total downfall. [...] The days of Hahnemann are gone. Nowadays, in the modern era, it is said that single remedy, single dose does not work. If you want to achieve quick reputation in the society, you have to prescribe multiple remedies. You have to cure fast, life is very fast, so they prescribe multiple remedies. But ultimately, what do they do? They neither cure the patient, nor give relief. They just jumble up the case. They make a hotchpotch inside. [...] Allopathic medicines work on the physical, organic level. They damage the physical-organic level of the organ. But our medicine alters the nature of the vital force, which is more injurious, more injurious. The patient won't come to know, won't understand. They [bad homeopaths] themselves are taking a lot of medicines by reading faulty books. The effect on the vital force, it takes a long time to understand. By that time, it's too late. Sometimes patients come to me after all this, and I tell the patient: I cannot cure you, you are incurable." (H-8)

As soon as greed for fame and money spoils the homeopath's self-discipline, he becomes responsible for producing side-effects which are even worse than those produced by allopaths. In the view of this doctor, modernity has jumbled up the conditions of daily life to such an extent that not even homeopathy can cure them.

Yet few of this doctor's colleagues expressed similarly pessimistic views. Even if they also felt that certain malpractices, such as polypharmacy and an undue orientation along the lines of allopathy, may compromise the integrity of homeopathy, most of them were hopeful that "the day will come" (H-6) when they could match allopathy in social prestige, economic reward, and scientific recognition. To establish homeopathy as the "truly modern" system of medicine while preventing the biomedicalized patient's impatience from spoiling its purity, is the dilemma they try to solve.

## VI. Ayurveda

### 1. "No problem, it's just acidity": A *kaviraj's* illness narrative

Dr. Sengupta (K-11)<sup>80</sup> and I met at his residence on the outskirts of southern Kolkata. When we sat cross-legged on a couch in the front of the house, his wife served tea and traditional *rasagolla* sweets. For most of the interview, he spoke only in Bengali, as this would enable him, he explained, to speak in more precise terms. Dr. Sengupta was 75 years old. He practiced Ayurveda in the third generation, following the tradition of his father and grandfather. Dr. Sengupta said he wanted to become a *kaviraj* not just to follow the family line, but also because he witnessed many times what healing miracles his father could work. Many patients came in a hopeless condition, but "my father made them stand" (K-11). While showing me around his garden, where he cultivated herbs for use in his medicine, he spoke about his son, who also took up training in Ayurveda. At first, everything seemed to me like a perfect Ayurvedic idyll – until Dr. Sengupta started to talk about the cancer in his oesophagus.

From his childhood days, Dr. Sengupta suffered from a mild pain in the stomach. The pain always went away when he ate something. As he and others thought, this was nothing too serious, just a "gastric" like so many other people in Kolkata have. The problem persisted throughout his whole adult life, until at the age of 65, the pain became unusually strong, and he felt that something more severe was happening to him. He first turned to one of his colleagues, also an Ayurveda practitioner, for a second opinion, but did not get a new point of view: "He said, no problem, it's just *acidity*" (K-11). His colleague discussed his dietary regimen with him, yet did not prescribe any medicines. The pain persisted, and Dr. Sengupta turned to another *kaviraj*, who diagnosed an "enlargement of the liver." Still dissatisfied with the diagnosis, he decided to go for investigations at a private centre for gastroenterology. After a series of tests, including ultrasound, x-rays, an endoscopy, a biopsy and "barium-swallowing" (for visualization), the gastroenterologist who treated him found a cancerous growth in the oesophagus. Dr. Sengupta was referred to a private hospital near his residence in southern Kolkata for

---

80 "Dr. Sengupta" is a pseudonym.



"*ray-treatment*." One month later, he had to do more tests with "barium-swallowing," and it was found that the tumour had almost been cleared out. Yet Dr. Sengupta's pains persisted, as did his difficulties with swallowing food. From a friend he heard about an excellent private centre for cancer treatment in Mumbai, and decided to go there for another check-up. The Mumbai doctors confirmed the initial diagnosis of oesophagus cancer, but found that it had not been fully removed yet. Dr. Sengupta then went through a lengthy chemotherapy, and finally it was said that he had been healed completely. However, the pain during swallowing continued to worry him, he went back for tests, and was found to be healthy again. The doctors only agreed that it was a good idea to keep Dr. Sengupta under investigation, so that for ten years he has travelled to Mumbai every six months for check-ups. Throughout the interview, Dr. Sengupta used the English term *cancer*. When I asked if there is an Ayurvedic term for this, he said that it is commonly called *karkar*, but that the learned Sanskrit term for the condition might be different. He also hesitated when I asked him what the Ayurvedic explanation for the outbreak of the cancer might be. Earlier on in the interview, when I inquired about the prevalence of "gastric" complaints among his patients and the reasons for it, he laughed and said that "greed" (*lobh*) and uncontrolled eating were the reason for it:

"90-95 percent have that! They come with complaints like dysentery, no proper *bile*, *wind*. They say: 'There's wind in my stomach and I have *amasha*.' Strong diarrhoea, chronic diarrhoea. [...] The reason for these troubles is greed (*lobh*). Greedy people get that. Without greed, there is no stomach problem." (K-11)

In regard to his own cancer, he did not mention this argument again. He suggested that even if his earlier pain in the belly might have been related to some dietary fault, the cancerous growth in his oesophagus probably had nothing to do with it. In any case, no one knew for sure the reasons for cancer, not even allopaths.

The costs for the treatment were, of course, enormous. He could only manage to pay for the treatment because he could stay at a charitable home for cancer patients in Mumbai, and because he did not, at the time of the illness, work in private practice. Just before the onset of the more severe symptoms, Dr. Sengupta had started to work as a consultant for a (biomedical) pharmaceutical company that had hired him to support the development of a new line of Ayurvedic remedies. At the company, Dr. Sengupta helped to turn classic Ayurveda recipes into tablets for mass manufacturing. Two of the recipes, one for a cough syrup, and one for a medicine against menstrual problems, were recipes from his father and grandfather.

Despite his feelings of not being fully cured, Dr. Sengupta believed that the allopathic cancer cure was largely effective. He believed that his strong will power played a role in his recovery: "Now I'm better. I have a will power (*moner jor*). I am not afraid of cancer. I was not afraid when I was diagnosed with cancer" (K-11). To counter certain side-effects of the treatment, and to avoid a relapse, he started to self-administer Ayurvedic remedies, among them turmeric, *neem*, and a mixture which he called *Ashvagandho*. For him, the cancer was also an opportunity to experiment with traditional and new formulas for anti-cancer treatment on his own body. He thought of using his insights for the treatment of patients, too. However, the risks involved in it were too high to take, at least as long as no controlled experiments were made with a minimum of 100 patients. If no reliable Ayurvedic cure were available, either for cancer or for other diseases, he would never hesitate to send patients to an allopath for treatment: "If I can't do it, I send them to allopathy. You cannot ignore allopathy, it is so important. It's compulsory. Especially for emergency cases. [...] I have never got a single patient referred from allopathy, not one. But I have sent many patients to allopathy" (K-11). According to Dr. Sengupta, the strength of Ayurveda lies in the treatment of chronic conditions, especially those related to stomach, liver, heart, the brain, and the joints.

However individual his suffering, Dr. Sengupta's illness narrative reveals many points which are, I believe, highly typical for the practice of Ayurveda in contemporary Kolkata. Among them are the strong influence of allopathy, a tendency of Ayurvedic healers to specialize in chronic conditions, and also a certain lack of confidence in their own diagnostic (and therapeutic) powers. To begin with, Dr. Sengupta's experience with Ayurvedic diagnoses of what later turned out to be cancer is a working example. There are two interpretations for the initial Ayurvedic diagnoses of a chronic *gastric* that had simply increased in severity. One interpretation is that any allopathic GP would have probably come up with the same diagnosis: there are countless patients who come with some form of complaint about abdominal discomfort, and the likelihood of one of them suffering from a life-threatening disease, such as a cancer of the oesophagus, is very small. Another interpretation is that the explanatory models of professional Ayurvedic practitioners and of the lay population are similar, if not in many ways identical. Dr. Sengupta and his Ayurvedic colleagues diagnosed his symptoms as digestive illness not as a sop to

popular perceptions of body and health, but from the point of view of the Ayurvedic tradition itself.

## 2. The relation between Ayurvedic and popular ideas

Anthropological opinions on the question of how popular and Ayurvedic perceptions relate to each other strongly correlate with a scholar's principal orientation.

Anthropologists whose writings emphasize the continuity of Hindu traditions in contemporary life and medicine's embedding in society tend to focus on the similarities between lay and Ayurvedic ideas. Drawing on Louis Dumont, Francis Zimmermann (1978) gives this stand its clearest formulation. He holds that Ayurveda is the "great tradition" of Indian medicine, and popular practices its "little," vernacular interpretations. Just as the "great" and the "little" traditions of Hindu religion are inseparably linked to each other, so are Ayurveda and popular healing practices. According to Zimmermann, popular and learned healing practices belong to "one and the same cultural framework, within which the *dominant* tradition formulates in a more distinguished or prestigious way the same conceptions that we may discover in popular culture" (Zimmermann 1978: 98; italics in orig.). In his outline of an ethnosociology of India, McKim Marriott's (1989) also postulates a basic continuity between Ayurveda and lay conceptions. What appear to be distinct medical sectors are in fact "mutually implicated levels of reality" (1989: 7). Hindu ideas of society are "based directly upon understandings of nature" (1989: 6), and among the natural sciences that influence these ideas, Ayurveda plays a vital role. Many core elements of Ayurvedic theory, such as the *tridosha*, or three "humours" of *vayu* ("wind"), *pitta* ("bile"), and *kapha* ("phlegm"), are ordered along a tripartite scheme. In turn, Hindu conceptions of society are also structured in a tripartite way. Indeed, Marriott's ethnosociology often reads like an Ayurvedic explanation of social relations.

On the other end of the spectrum are scholars with a more clearly defined focus on contemporary medical practices. For them, popular and professional medicine must be studied first and foremost as a domain in its own right. From their point of view, "similarities" between Ayurvedic and popular understandings must be defined in detail, and be proven through careful ethnographic work. For example,

Mark Nichter (1989) warns against an all-too-hasty levelling of the differences, and recommends that popular and Ayurvedic concepts should be studied separately from each other. Based on long-term fieldwork on both lay and Ayurvedic medical practices in Karnataka, Nichter (1989: 189-190) argues that the wholesale assumption of cultural continuity is mistaken. Nichter first shows how the influence of Ayurveda on popular ideas is, at most, fragmentary. What patients learn by interacting with a healer is not a systematic Ayurvedic view of the body and the cosmos, but only the use of a specific medication. Second, Ayurveda is not the inexpensive, readily available medicine that it is made out to be in most writings: "This myth is propagated by surveys which classify all herbal practitioners as practitioners of Ayurvedic medicine" (1989: 190). Third, authoritative opinion about Ayurveda is limited to a small number of pundits; the majority of Ayurvedic practitioners do not consult the Sanskrit classics, but only "vernacular texts" such as the sales catalogues of drug companies.

Other scholars emphasize less the similarities but the lack of clear boundaries. For example, Charles Leslie (1976, 1992) takes a middle position by dividing "popular-culture medicine" from professional Ayurveda. While seeing a significant conceptual interchange between popular-culture medicine and Ayurveda, he does not reduce one to the other. According to him, popular-culture medicine is best characterized as a *masala* mixture of ideas, which not only includes Ayurvedic concepts such as the *tridosha*, but also includes vitamins, astrology, hormones, germs, homeopathic vital forces, and aspirin tablets. In turn, Ayurveda itself has had, since the nineteenth century, to reckon with allopathy's increasing hegemony. The encounter with allopathy split Ayurvedic healers into "purists" who advocate a strict adherence to the classic Sanskrit teachings, and "syncretists" who support an integration of Ayurveda and allopathy, both on the levels of diagnosis and of therapy. The clash between purist and syncretist positions is still being fought out today.<sup>81</sup>

In my opinion, all the arguments quoted above are equally valid. The contradictions only exist on a superficial level. Depending on what aspect one chooses to look at, and on what level of concreteness one judges "similarity" or "difference," fieldwork data can be interpreted along either one of the three positions.

---

<sup>81</sup> Governmental policy towards Ayurveda has, over the past decades, been partly "purist," partly "syncretist." For example, it draws a clear boundary between the allopathic and Ayurvedic streams, including the professional degrees of BAMS (Bachelor of Ayurvedic Medicine and Surgery) and the allopathic MBBS (Bachelor of Medicine/Bachelor of Surgery). On the other hand, the government made a basic allopathic training mandatory for all students of Ayurveda.

For example, Nichter's point that popular knowledge of Ayurvedic theories of digestion and its Sanskrit terminology is extremely small and fragmentary fully applies to popular notions of digestion in Kolkata. However, if seen in a wider perspective, Zimmermann's argument that both belong to "one and the same cultural framework" (1978: 98) also holds true, as both attach central importance to digestive health, a balanced diet and a balanced way of life. In turn, Leslie's stress on hybridity is also pertinent. For example, both popular and Ayurvedic terminology for digestive processes are under the sway of allopathy, turning *vayu* into *gas*, or *karkar* into "cancer."

### 3. Ayurvedic views of digestion

Regarding the theme of "digesting modernity," two aspects of Ayurvedic theory are particularly relevant: how digestion works, and how a proper "care of the self" is necessary for good health. The physiology of digestion in Ayurveda has been discussed extensively, both by Indian scholars (e.g., Dwarakanath 1967; Majumdar 1971; Ray 1937) and Western scholars (e.g., Alter 1999: 52-55; Zimmermann 1987: 159-179, *passim*). Digestion plays such a vital role in Ayurvedic ideas of health and illness that it is an integral part of any treatise on the subject, and indeed, any book on Ayurveda will inevitably contain a more or less elaborate description of it. From among the vast literature available, the commentary of the Ayurvedic Sanskrit canon by Dhirendra Nath Ray (1937), a Kolkata *kaviraj*, is one of the most lucid.

According to Ray, digestion is a process in which ingested food is "cooked" and successively turned into finer and finer substances. The principle of cooking is heat, and so digestion depends on the proper working of the internal fires. There are altogether thirteen digestive fires within the body (Ray 1937: 90): seven *dhatvagni*, five *bhutagni*, and one *jatharagni*. First among these thirteen fires is the *jatharagni*, as it first receives the food and has the most work to do. The other internal fires come into play after the *jatharagni* has separated the seven different *dhatu* ("tissues") and five different *bhut* ("elements"), each fire coming into play at particular stage of the whole process. The body's digestive fires are basically the same as the three other types of fire in the cosmos: the "terrestrial" fires (e.g., burning wood), the "celestial" fires (e.g., lightning), and the "mineral" fires (e.g., the lustre of gold). The "principle"

of bodily fire is *pitta* ("bile"), one of the three *dosha* that govern all bodily processes. *Pitta* is mostly located in the belly, but it is present everywhere in the body, hence digestion is going on all over the body. Moreover, the other two *dosha* also play a role in digestion: *vayu* ("wind") makes it possible that food and the various digestive products are moved from one place in the body to the next, and *kapha* ("phlegm") softens solid food by moisturizing it (1937: 92). Nevertheless, the heat of *pitta* remains the defining aspect of digestion. The goal of digestion is to turn the "nourishing" parts of food in proper proportion into the seven bodily "tissues," the *dhatu*. From food, a finer substance called *rasa* is produced. From *rasa* comes blood, from blood comes flesh. Flesh is turned into fat, fat into bones, bones into marrow. The last and finest *dhatu* is semen (Sanskrit *sukra*; its *female* equivalent, if any, remains somewhat ill-defined). In all stages of digestion, three parts are being produced: the tissue itself, the "food" that is "digested" by the next higher tissue, and a waste part. That one *dhatu* "nourishes" the next higher up the hierarchy of refinement is, according to Ray, not just a metaphor: one serves literally as food for the next, and each *dhatu* is digested in its own peculiar way: "Thus the *Rasa Dhatu*, derived from the digested food, serves as a food for blood, blood is food for flesh and so on; and in this way the normal condition of the body is continually kept up" (1937: 125). The only exception is semen, which is so refined that it does not have a waste part anymore: "Just as no dross part comes out of the gold which has been burnt a thousand times" (Ray 1937: 127), so semen is pure vital essence.

As can be glimpsed from this short description, the Ayurvedic view of digestion emphasizes the "aesthetic" side of the process: even if various waste matters result from it, Ayurvedic digestion is first of all a kind of alchemical *enhancement* of the food ingested. Only digestive *disturbances*, such as the improper cooking of food or the internal accumulation of dross, lead to aesthetically displeasing results. In essence, the perfect belly turns food not into dirt, but into gold, or at least its metaphysical equivalent, semen.

If the belly is the place from where the nourishment of all tissues of the body flows, it becomes immediately clear why proper digestion is so important for overall health. Bad digestion is the root cause of all health problems: if *rasa* does not nourish the blood, all parts of the body are immediately affected. If blood does not nourish the flesh, one will suffer from weakness, and so on. One *dhatu* feeding the next one higher up is like a chain of dominos: if one link is missing, the whole chain breaks

down. In this context, it cannot be stressed enough that, since semen is an essential part of digestion, *sexual problems are primarily digestive problems*. The wanton squandering of semen, digestion's finest product, causes a plethora of other diseases, as it deprives the body of the most nourishing *dhatu* of all.

The importance of food and its proper digestion puts responsibility for good health into the hands of the individual. Illness not only results from the inherent qualities of food, but also depends strongly on how the food is being ingested. Proper timing is vital. Just as too much wood thrown into the fire weakens or even extinguishes it, so does untimely and excessively "greedy" eating weaken or extinguish the digestive fire in the belly. Care for one's digestion is a vital "technology of the self," and to disregard the belly's internal cooking procedures imperils one's life. A regular style of living, with proper time for eating and digestion, is the best recipe for health. According to the compendium of Caraka (*ca.* 200 CE), the "three pillars of health" are "food, sleep and a chaste life" (Wujastyk 1998: 67). What Michel Foucault observed for the humoral medicine of Greco-Roman antiquity, namely that medicine proposed "a way of living, a reflective mode of relation to oneself, to one's body, to food, to wakefulness and sleep, to the various activities, and to the environment" (CS: 99) also holds true for Ayurveda. In Vagbhata's compilation (*ca.* 600 CE), the section on daily regimen ends with a poignant counsel for health care as a practice of self-care: "My days and nights are passing by: what kind of person have I become? A person who is always mindful of this will never taste suffering" (Wujastyk 1998: 262).<sup>82</sup>

This neat image notwithstanding, perfect health is an unachievable utopia. The current age is characterized by weak digestive powers. The Ayurvedic disbelief in people's self-discipline and in the strength of their digestive fires is as old as Ayurveda itself. Already Vagbhata pointed out, in the sixth century CE, that digestion of contemporary people is almost inevitably faulty: "People in this degenerate modern age have poor digestion, they are short, and they lack strength" (Wujastyk 1998: 312). Caraka contains an intriguing re-reading of the cosmological myth of the four world ages, which interprets the gradual decline of the cosmos from the Golden Age downwards to the current, most decrepit age of the *kaliyuga* from the point of view of Ayurveda (translated in Wujastyk 1998: 84-85). In the Golden Age, Caraka tells us, "there was no limit on men's lives. They were as full of energy as the

---

82 Echoing Foucault, Zimmermann (1989: 182) draws a parallel between Ayurvedic concerns for body, speech, and thought with the Stoa's attention to physics, logic, and ethics.

gods, extremely pure and of broad powers. They could see the gods with their own eyes, as well as the divine sages, virtue, and the precept and practice of the sacrifice." The fall from grace and the subsequent decay of the cosmos came, according to this Ayurvedic text, through *greed* and *overeating*:

"But as the Golden Age waned, some well-supplied people received too much, and because of that their bodies became heavy. Because of this corpulence, they became tired. From tiredness came apathy, from apathy accumulation, from accumulation, ownership. And ownership led to the appearance of greed in that Golden Age. Then, in the Silver Age, greed led to perfidy, from perfidy came lying, and from lying proceeded lust, anger, pride, hatred, cruelty, violence, fear, suffering, grief, worry, impetuosity, and so on. Then, in the Silver Age, [...] the amount of rain that fell in that age diminished by one quarter. [...] That destruction caused the crops to lose one quarter of their qualities of oiliness, purity, savour, potency, ripening, and potential. As a result of that, people's bodies began not to be as well-maintained as they used to be by their diet and lifestyle, both of which were losing one quarter of their goodness. Their bodies, besieged by fire and wind, were soon under attack by disease, fever, and so forth. Then, living creatures gradually lost their vitality."  
(Wujastyk 1998: 84-85)

For Caraka, human bodies have, from birth onwards, bodies with less goodness than would be necessary for perfect health. The food they are eating is also deficient, and they are prone to even worse habits of greedy eating than their ancestors. Poor digestion, short bodies and short life spans amalgamate into an all-pervading decline of individuals and society at large. Ayurveda's tendency to define an (unhealthy) present with reference to a (healthy) past seems to give it an inherently pessimistic outlook. Its fixation on decline distinguishes it clearly from the metaphysics of biomedicine, which rather likes to believe in the transition from a sick past to a hale and hearty future.

#### **4. Digestion according to Kolkata *kavirajs***

In my interviews with Ayurvedic doctors in Kolkata, I asked: "what is most important for health?" and further queried about how they would describe the Ayurvedic view on digestion. In answering these questions, some doctors went into great detail about the nature of *agni*, how digestion relates to the *tridosha*, or why keeping a routine is necessary for good health. Some variation occurred in respect to the anatomical location of digestion. *Agni* was always located in the belly, but some



emphasized the "stomach," some the "liver," and some the "gall bladder." As Zimmermann (1987: 162-167) points out, the Sanskrit texts pay almost no attention to the anatomical basis of digestion. The texts are only interested in the fluid transformations of the internal cooking process, and not with the role of specific organs. The parts of the body only appear as temporary receptacles of the various juices and fluids. Only through the influence of allopathy's obsession with anatomical geographies have Ayurvedic writers started to be more precise about the distribution of labour between different organs, but these retrospective rationalizations remain vague and artificial. What counts is not organic function, but "the opposite, namely, a medicine of properties and virtues, a medicine of metamorphoses" (Zimmermann 1987: 167).

Anatomical vagueness notwithstanding, all the doctors agreed that good digestion is of central importance for good health: "Everything depends on the stomach, your ears, eyes, hair. If you upset your stomach, your *whole system* will be upset" (K-2). Views like this appeared in various formulations in all of the doctors' statements. The doctors also all spoke of digestion as a kind of heat or transformative fire in the belly. The images of "fire" and of "centrality" motivate the key metaphors for digestion. In keeping with the image of fire, a common metaphor for the belly was that of a "kitchen," in which the food is first cooked and then distributed to all parts of the body:

"For a proper stomach, you need good digestive power (*hajam kara shakti*). In Ayurveda language, we say *agni*. How we cook our rice, with the fire, in the stomach we also have that type of fire." (K-11)

"The stomach is connected to the liver. And the liver is the vital kitchen. You must keep the kitchen clean. If the kitchen is clean, there is no problem. [...] Always preserve your *agni*. It is known that even a patient in a critical condition can be saved if his fire is alright. But if the fire is gone, the patient must die." (K-6)

On the other hand, metaphors that stressed the centrality of proper digestion for overall health were based on metaphors of political and bureaucratic centrality.<sup>83</sup> For example, one *kaviraj* compared the stomach to Kolkata's Writers Building, the

---

83 In European literature, no one employed the belly as a metaphor of political centrality more stunningly than William Shakespeare in his play *Coriolanus*. Menenius Agrippa quells a popular revolt against the Senate of Rome by telling the mutinous mob the "fable of the belly," in which the senators are compared to the belly, the people to the other parts of the body. Far from lying idle in the middle, feeding off the work of others, the belly digests and distributes all nourishment to the body's parts, but keeps nothing but the dross for himself: "The senators of Rome are this good belly, / And you the mutinous members: for examine / Their counsels and their cares, digest things rightly / Touching the weal o'th'common, you shall find / No public benefit which you receive / But it proceeds or comes from them to you / And no way from yourselves" (*Coriolanus*, Act I, Sc. I, vv. 147-153)

administrative centre of West Bengal: "The stomach is like Writers Building: it affects everything" (K-9). Just as petitions and official documents enter Writers Building, disappear for a good amount of time from view, and re-emerge stamped and transformed, so does the belly take in food and redistribute it. If Writers Building works too slowly, accumulates "undigested" files, and makes mistakes in their redistribution, then the whole state of West Bengal will be negatively affected. If Writers Building is corrupt, lazy, and incompetent, then everyone will suffer (by implication, this is actually the case: in Kolkata today, Writers Building is a synonym for Kafkaesque ineptitude). Another doctor compared the liver to the body's "head office" (using the English term), on which the proper functioning of the "branch offices" depends:

"First thing we have to see: How is your *head office*? If your head office is *fit*, your *branch offices* will also be *fit*. Your *head office* is the *liver*. If you are a young man, you can eat what you like, as long as it does not affect your liver." (K-13)

While "heat" was unambiguously a property of digestion, the "centrality" of proper digestion for health was sometimes relativized. One doctor underlined the interdependence of all bodily fluids and processes; hence he claimed that no single part could be more important than any other within the system as a whole. Nevertheless, he also pointed out that eating and digestive hygiene were that aspect of people's daily lives over which they had most control, and with which they could achieve most for their own well-being. Even if a balance of all functions was needed for health, digestion was one of the best starting-points for an active improvement of health: "We should also practice to *gain*. One *can* gain. Everyone must maintain a routine" (K-1). The stress on routine also appeared in all other doctors' statements, over and over again. Dr. Sengupta (K-11) put it beautifully clear: "*You* are the medicine" (*tumi er osudh acho*).

Since Ayurvedic doctors put so much stress on the importance of digestive routines, it is not surprising that they never thought that their patients were "belly-obsessed." On the contrary, people were ill because they did not care enough for their bellies. The *kavirajs'* explanatory model is clearly distinct from that of the allopaths and the homeopaths, in whose explanatory models digestion plays a much less prominent role. When I asked the Ayurvedic doctors if their patients paid too much or too little attention to the belly, most agreed that their patients did not care enough for their digestion, and that this lack of care was the reason for countless other afflictions, such as hair loss, eczema of the skin, or even psychological problems.

These replies were diametrically opposed to what the allopaths said about digestion. While the allopaths usually scoffed at the popular notion that one *must* have one motion per day and that it must happen right after getting up in the morning, the Ayurvedic practitioners reaffirmed it emphatically. According to their perceptions, some patients were not even aware of this basic rule of everyday health, and had to be told explicitly about it:

"Often the stomach doesn't give the trouble directly, but they have lots of other troubles: dizziness, perspiration, fatigue, but it's all because of stomach and nothing else. [*Question: Do patients know about this?*] Sometimes they are able to say that it's due to the stomach, sometimes they cannot say. So we have to ask about stool, and so on. So many people are happy although they don't have regular bowel movements. Some go to the toilet two or three times a day and think nothing of it, but it's not a healthy sign. But they don't realize that it's not natural." (K-8)

Food, digestion, and "clean bowels" were also a prominent aspect in all the interactions between Ayurvedic doctors and patients that I observed. Questions about digestion were a routine part of the diagnostic process, and recommendations about diet and the maintenance of daily routines were part of the therapy. When asked about the most common complaints that the patients come with, most of the doctors mentioned gastric complaints. In the doctors' self-understanding, Ayurveda developed the most elaborate knowledge about healthy diet. Hence it comes as no surprise to them that many of their patients come with digestive problems, and dietary advice is expected of them, regardless of the specific complaint.

In the list of most often presented complaints, "sex problems" also featured prominently. As we have already discussed, Ayurveda sees an immediate relationship between sexual fluids and digestion. Semen is not just any other bodily substance produced from food, but it is the quintessence of the whole process. In Ray's (1937: 127) commentary, semen is as refined as the purest gold. Putting this notion into the context of modern capitalism, one of my informants described semen as "money in the bank":

"If you waste all your money in the bank, in the future you will face problems. Semen is like that. If you waste your semen, you will have problems. [...] If you waste it at an early stage, you'll have problems. If you really waste it, you will fall sick, your physical fitness will be less. That will affect health and brain. [...] Through proper food we can regain it. But after regaining, you have to hold on to it." (K-13)

Given the Ayurvedic expertise in all matters related to digestion, both doctors and patients derive from it also an expertise in sexual problems. Advertisements for



Dr. G.P. Sarkar

# AYURVEDIC GhritKumari PlusOil

## An Extra Cool Herbal Oil For Insomnia & Headache

It keeps the head & body cool, relieves headache, removes tiredness, induces sound sleep, nourishes hair roots, aids in the growth of hair and on regular use results to healthy hair.



**Dr. Sarkar's Ayurvedic Formulation & Perk Production**



## Liver Protects Health & Beauty

# LIVOSIN

## Protects Liver & Works Wonder

**LIVOSIN - an Ayurvedic Liver Tonic** cleans the dirty Liver & Stomach, controls acidity, corrects constipation, removes flatulence & improves appetite, relieves fatigue caused by overwork, worries & tension, **restores Health & Vitality.**

**Dr. Sarkar's Herbal Invention & Jupiter Production Since 1970**

# HAIR PROBLEMS?

Excessive Hair Loss, Premature Graying or Dandruff

**You need the right medicines**

**TRIOFER** Tablet with **ArnikaPlus** Vitalizer

Oral Medicine with local application  
to treat the Root Causes of Hair Problems  
internally as well as externally



Plate 14: Dr. Sarkar's tonics for liver, head, and hair (Newspaper advertisement)

tonics and tablets that promise to "remove tiredness" and to stimulate sexual powers thanks to "ancient Ayurvedic formula" appear widely in daily newspapers. In the

doctors' daily practice, anxieties relating to sex and semen are also common: "Fifty percent of patients are *sex-wallah*" (K-2). Along with semen problems, menstrual problems are also a common complaint in Ayurvedic consultations. All the doctors' statements agreed with the basic Ayurvedic theory of semen being the most refined product of digestion, and that Ayurveda's expertise in this field gave it better remedies against sexual problems than those available in allopathy. Therapy consists either of dietary advice or of medicines, or of a combination of the two:

"*Gastric* is the main cause of sex problems. My treatment for sex problems: If patients ask me directly for a specific medicine, I give. If asked for advice, I first give stomach medicines, and see what happens. Only if they don't work, I give special sex medicine. Or I ask about complaints other than sex complaints. If there are absolutely no stomach or liver problems, then I might give sex medicine right away." (K-9)

A disturbance of the digestive process is not the only link between food, digestion, and semen. The model of the progressive metamorphosis of food into semen is about the transformation of one "juice" into another. Part of this model is the notion of *vayu* ("wind") as the principle of internal movement. The body is a container in which substances are carried from one place to another. For movement, there must be different degrees of "pressure" inside of the body-container. The pressure exerted by *vayu* is healthy and necessary as long as they occur in moderation, but *vayu* is easily disturbed. If the ebb and flow of substances in the body is out of balance, then too much pressure builds up. The most "gross" results of this are burping, farting, vomiting, and so on. A disturbance of internal pressures can also have less resounding consequences, one of them being semen loss. Anyone who suffers from *gas* is at risk of losing precious semen, since too much pressure will force it out of the body. This rule also applies to all other states of excessive pressure. For example, constipation leads patients to "strain" themselves, and this overexertion can immediately cause semen loss:

"We try to make the stool normal, and with that the digestion power will grow (*hajam karar shakti bere yabe*). If your stool becomes hard, and you force yourself, give pressure, that will affect your body. There is a *semence* in your body, if that comes out, that is very bad for health. *Automatically* that semen will come out with the pressure. So you'll have a sexual problem. Lots of problems. [...] If it becomes liquid, then all the power (*shakti*) comes out of your body." (K-2)

Semen is precious capital, and must be used wisely. If it is lost or squandered, one's health will suffer. As we have discussed above, Foucault hypothesizes that in

Greco-Roman understandings of the body, sexuality is not a problem of "moral" distinctions between "good" and "bad" acts, but a non-moral practice of bodily self-care (cf. Alter 1997). Ayurveda shares this view: the keeping or losing of semen is not a question of morality, but a question of physiology. For example, Kolkata Ayurvedic doctors commonly mentioned the dangers of masturbation in relation to the dangers of semen loss. Their main concern was health, not morality:

"[*Question: Is masturbation a bad thing (kharap jinis)?*] I wouldn't say 'good' or 'bad'. But you have to eat *sattvik* [cool, wholesome] food. You need to control yourself. Then twice in a month is not a factor. If a person does it many times, more than once a day, he will break and fall." (K-13)

For "modern" people, this kind of self-control was said to be difficult or impossible to achieve. According to one *kaviraj*, bodily degradation due to semen loss was a typical feature of modern times. Modern people get married much later in life than the earlier generations. If boys marry only at the age of 25 or 30, they will "obviously" fall sick from excessive masturbation. Closely related to this is that Bollywood movies, with all their hip-swinging action, blur the young people's minds, and make it even harder for them to keep their heads cool. He explained that an increasing number of his patients consist of young boys who cannot control themselves: "This is all because of these *TV-wallah* and *picture-wallah*, they make them mad" (K-10).

Keeping one's mind cool was mentioned by many of the *kavirajs* as vital for good health. The proper routines of life could only be maintained if the mind was cool and free of unsolved tensions and unfulfilled cravings. Dr. Sengupta's (K-11) belief that his *moner jor* had allowed him to bounce back from his cancer is typical. Hence many of the Ayurvedic doctors pointed out the health benefits of doing Yogic exercises, both bodily postures (*yogashan*) and mental concentration (*moner yog*). One of the doctors (K-1) took an additional diploma course in Yoga cure, another doctor (K-15) kept a large image of his Yoga guru in his consultation room, another (K-2) demonstrated several Yogic postures to me during the interview. Thanks to Yoga, the sages of the mythical past were in complete control over their own body:

"They could see themselves, they could see what is going on inside. We have read so many stories of the sages: they take the stomach out of the body, wash it with the fresh water of the hill, and put it back inside. So many sages could do that. Really! They lived at least 500 years." (K-1)

The mythical ancestors never suffered from digestive problems, both because their intense penances kept their digestive fires burning brightly, and because they could cleanse themselves in a way that seems unattainable to modern people.<sup>84</sup>

## 5. Pollution and corruption

As we have discussed in the previous chapters, images of doom and gloom regarding Kolkata's incomplete modernity feature prominently in the statements of allopaths and homeopaths. Yet neither of these groups was as pessimistic as the Ayurvedic physicians. Almost all the doctors I talked to considered the modern era as an era of degradation and decline. Besides the mental confusion caused by modernity, the most commonly named side-effects of people's "fast life" were an unhealthy and irregular diet and environmental pollution. One of the *kaviraj* (K-6), a 70-year-old physician from an old Ayurveda family (a university chair of Ayurvedic medicine in the Banaras Hindu University is named after his grandfather), elaborated most extensively on the theme of "pollution." According to Dr. Bhattacharya,<sup>85</sup> already the authors of the classic Ayurvedic texts warned against the detrimental effects of pollution. The definition of "pollution" they developed was complex enough to be applied to the modern-day situation, since not only factors of the "physical" environment were taken into account, but also socio-political factors, which he called "human pollution" (the interview was conducted in English):

"In the classic texts of Ayurveda, since thousands and thousands of years ago, our *rishis* [mythical sages] warned the people about pollution of water, air, sound, smell, and last but not least human pollution, what modern science is thinking about now. If water is polluted, what are the possible diseases that may come? Two: If air is polluted, what are the possible diseases? Third, stinking smells being injurious to the nerves. Fourth, they have told: Tremendous sounds affect nerves. Fifth: Human pollution. Whenever the king, the top person, the top of the administration, becomes corrupted, the lower workers also become polluted day by day. From the top to the

---

84 The "inner heat" produced from ascetic practice is a key theme in the Hindu tradition. In the *Laws of Manu*, one of the principal means to expiate transgressions of the cosmic order is called *tapas*, which Sylvain Lévi describes as "l'éclat brûlant qui rayonne d'un corps mortifié par l'ascétisme" (Lévi 1966 [1898]: 23). The term *tapas* signifies both the *act* of "performing austerities" and the *effect* of this act, which is the generation of "inner heat." If a transgression has defiled an evildoer, *tapas* has the power to purify him by "burning away" the "stains" of his deeds: "Whatever guilt people incur in mind-and-heart, speech, or action, they quickly burn all that away with inner heat alone, for inner heat is their wealth" (Manu XI.242; cf. Kaelber 1989; Knipe 1975).

85 "Dr. Bhattacharya" is a pseudonym.

lowest, all the people become corrupt. Society itself becomes polluted. That leads to complete destruction. Caraka has told so." (K-6)

Based on an idiosyncratic combination of Caraka and Einstein, Dr.

Bhattacharya developed his own "formula" to understand the world: "I tell you my formula:  $e = mc^2$ " (K-6). In this formula, "e" stood for "environment" (instead of energy), "m" for "man" (instead of mass), and "c" for "cultural concepts" (instead of speed of light). For him, environmental degradation was caused by human overpopulation of the world, and by a culture of exploitation. The root of all types of pollution was "greed," which Dr. Bhattacharya defined as abuse of "Nature" in its widest sense. Humans could live happily if they based their daily routines on the principles of Nature: "She is the best philosopher, the best friend, the best guide" (K-6). When people started to exploit Her "by means of force, by means of machines" (K-6), they were beginning to dig their own grave: "Fifteen civilizations have already been wiped out from this world, all for greed" (K-6).

The current era was seen as the most exploitative so far. Nuclear bombs and genetically modified food ("everything hybrid!", K-6) were two of the most salient symptoms of humanity's greed for domination. Human pollution also showed itself in social unrest: "Everywhere is murder, nepotism, corruption, despotism" (K-6). The current age was that of the *goondaraj* (the "rule of bandits"). Violent clashes between Hindu and Muslim mobs were also part of the picture. The distance between the rich and the poor was increasing day by day, while generosity and affection was rapidly decreasing. Dr. Bhattacharya also accused modern medicine of having a significant share in this. First, the fees charged by allopathic doctors were too high for poor people. Second, the doctors were distorting people's beliefs about health and healing. Earlier, people knew that warm water with *tulsi* leaves was a good remedy against a cold. But now the doctors were telling the patients that ideas like this were wrong, and making them pay for expensive synthetic drugs instead. With global advertising campaigns, multinational drug companies deepened the public's confusion: "Paper, television, computers, all the channels, all force you to take capsules" (K-6). Greedy politicians, in India and elsewhere in the world, were also part of this wicked scheme.

Dr. Bhattacharya went on to explain how pollution and digestion are related. Along with coughs and colds, breathing troubles and allergies, most of his patients complained about bad digestion. On the physical level, water pollution was one of the immediate causes for this. The water was not only polluted by bacteria and



toxins, but it was also "too hard" (K-6) for the stomach, especially water from deep tube wells. Social class influenced how much a patient is affected by this. The rich could afford water filters and bottled drinks, whereas the poor people drank the water untreated, and must suffer most. Yet the rich also suffer, due to their artificial life style and due to an excess of "hot" food: "Some people nowadays take four eggs a day! But this energy is not spent through movement, work. There's too much within, and soon the explosion will come" (K-6). In terms of age, all generations were equally affected by digestive troubles. Yet the younger generation was perhaps suffering most, because of the increasing pressures of modern life, especially the pressure in the schools. Gender also had an effect. Although both men and women suffer, women were more at risk of malnourishment than men. Patients' religious affiliation also had an effect on their digestive health. Dr. Bhattacharya thought that Muslims are particularly vulnerable to digestive disease, because they were eating too much *tamasik* (hot, impure) foods such as beef: "Their whole nature becomes *tamasik*, their tolerance is less, irritable, patience is less, high alert!" (K-6). Earlier generations of Hindu Bengalis followed a cool, wholesome diet; but nowadays, they were eating as much meat and fried foods as Muslims: "Bengalis have also become *tamasik*. Their bodies have become toxic" (K-6).<sup>86</sup>

Dr. Bhattacharya was also pessimistic about the role of Ayurveda. Not even Ayurvedic advice and medicines could heal the digestive troubles of modern people. This was due to the overwhelming influence of the environment, which no one could resist. There was no clean water, no clean air, no silence, no protection against noxious smells or deafening noises, and no resistance against overpopulation and political incompetence. Nor were Ayurvedic doctors confident enough of their own therapies to convince the patients to comply fully with them: "Whatever we say, we don't believe. Whatever we believe, we don't do" (K-6).

Other Kolkata *kaviraj* had less structured opinions about "pollution" than Dr. Bhattacharya, but none of them believed that the modern era was a healthy time to live in. Neither did they believe that the modern era was a good time to practice Ayurveda. They commonly agreed that the heyday of Ayurveda lay in the past. The problem started with the difficulty of diagnosing patients in the traditional way. Due

---

<sup>86</sup> In her ethnography of an Ayurvedic "quack" in Delhi, Jean Langford (1999: 39) mentions a similar argument. According to the Ayurvedic doctor she interviewed, most modern-day people have an excess of hot *pitta*, whereas people with excessive *kapha* have become rare: "He explained that the reason there are so few *kapha* people is because of the pollution and chemicals in the environment. Chemicals are hot whereas *kapha* is cold" (Langford 1999: 39).

to changed diets and daily routines, the *prakriti* (natural constitution, disposition) of people's bodies had changed. Earlier, Ayurvedic physicians could determine a patient's *prakriti*, and see which one of the *tridosha* was too dominant or too weak. Nowadays, however, it was difficult or impossible to diagnose the *prakriti* properly: "We cannot diagnose in this way [anymore]. Because nowadays, the *prakriti* of patients is complicated. Single *prakriti* are not available nowadays. People are maximum complicated" (K-1). Ayurveda postulates an immediate relationship between the outer world and the "inner world" of the *prakriti*. If the outer world is spoiled and polluted, the inner world will be spoiled as well. If the outside is complicated, then the patient's constitution will also be complicated.

## 6. Diagnosis and therapy

Ayurveda entails intricate prescriptions for how to diagnose patients. Direct perception of the patient with all the body's senses, logical inference, analogy, and recourse to authorities are among the diagnostic procedures. The Kolkata physicians usually underlined three types of examination: seeing (*darshana*), questioning (*prashna*), and touching (*sparshana*): "There are three types of things: looking at patient, questioning, and then touching. Then we get the picture" (K-10). Among these three, seeing and questioning were the most straightforward techniques. Seeing the patient's face and body language is the initial step of any diagnosis. The most skilled physicians, especially those of the older generation, had such sensitivity for their patients that seeing them was sufficient for a proper diagnosis: "For the masters, seeing is diagnosis enough" (K-1).

Questioning the patient was also portrayed as simple. Commonly used questions addressed the onset and perceptions of the illness, the patient's daily routines, whether they have a good appetite, good sleep, and so on. None of the doctors mentioned having any problems with asking patients, and listening to their explanations. As we have discussed earlier, both allopaths and homeopaths perceived a deep gap between the patients' illness expression and their own disease diagnosis. In contrast to them, the *kaviraj* never complained about patients being ignorant about their own bodies. They underlined that the patients do not know Ayurvedic theory, but they never mentioned that the patients were unable to perceive and to describe

the symptoms of their own ill-being. The absence of such conflicts corresponds to the *complete absence of the perception that Kolkata patients were "belly-obsessed."* The Ayurvedic physicians give importance to diet and digestion in their diagnostic questioning, and the patients respond with detailed descriptions of the state of their bowels. Thus neither the physicians nor the patients perceive any dissonance.

The diagnostic technique that causes most concern among Kolkata *kavirajs* is the pulse examination (*nadi-pariksha*). There is a certain irony in the fact that the pulse examination is nowadays considered to be the quintessentially "Ayurvedic" means of diagnosis (not least in popular Western perceptions of Ayurveda), since it is not mentioned in any of the three great classics of Ayurveda (Sushruta, Caraka, Vagbhata). It remains open to scholarly debate when the examination of the pulse was first introduced into Ayurvedic practice, and from where. It is speculated that it might have been introduced from China (Gutschow 1997: 3). Wujastyk (1998: 304) dates its emergence in Indian medical practice to around 1300 CE. By way of examining the pulse, the physician tries to determine both the patient's current problem and his general constitution. Skilful physicians are even said to be able to discern exactly when and how a patient will die: "My grandfather could tell: 'You will die within three months'" (K-6).<sup>87</sup> Therefore the scope of the pulse diagnosis is much broader than a simple exam of pulse rate or blood pressure. The knowledge of the pulse examination is mostly based on an orally transmitted *know-how* and on many years of practical experience. The written sources on how to read the pulse tend to be cryptic, and are rather an *aide-memoire* for the already initiated than a comprehensible instruction for the outsider. Consider, for example, the following lesson from Sharngadhara's compendium (*ca.* 1300 CE):

"When the wind is inflamed, the pulse produces the gait of a leech or snake. When cholera is inflamed, the gait is that of a sparrow-hawk, crow, or frog. When phlegm is inflamed, the gait is that of a swan, or pigeon. When all the humours are inflamed, the gait is that of a bush quail, partridge, or bustard-quail." (Wujastyk 1998: 315)

All the Kolkata physicians I interviewed were convinced of the remarkable powers of the pulse examination, but most of them added that its proper application was limited nowadays. They all used it, yet mentioned that they could not rely fully on it. The reasons for the decline of the pulse examination were numerous. First, the pulse examination was only of secondary importance in the modern college

---

<sup>87</sup> The almost clairvoyant powers of the traditional *kaviraj*, who knows the hour of the patient's death, drives the plot of a popular Bengali novel by Tarashankar Bandyopadhyay (1996).

education, which relies more on textbook learning than on hands-on experience under the supervision of a veteran *kaviraj*: "The main process is pulse-taking. [...] But to be very frank, we were not really taught that way in college" (K-8). Second, the pulse examination needs as much concentration and tranquillity in both the doctor and the patient as possible. The contemporary doctors were too busy to give sufficient time to it. This point was also underlined, unsurprisingly, by Dr. Bhattacharya, who blamed the decline of the pulse examination on the doctor's "greed" for maximum money from maximum patients: "If you don't have the concentration, conception, silence, tolerance, you can't do Ayurveda" (K-6). Third, the patients' constitution was too complicated to diagnose them properly through feeling the pulse. The "fast life" of modern-day people makes the pulse unreadable. Not only is the patients' constitution complicated, but also many patients were also unwilling to comply with the doctor's instructions, for example, not to eat anything before the pulse is taken.

Lastly, patients have become accustomed to allopathic diagnostics: "Patients are not satisfied with pulse-taking only, not even in the villages. They demand pathological tests" (K-15). No doubt, patients also expect the *kaviraj* to perform a pulse examination, since it is this technique that sets Ayurveda apart from other medical practices. In Jean Langford's (1999: 39) view, the pulse examination is one of Ayurveda's primary methods of creating "faith" in the patient.

However, most of the patients have as much faith in "scientific" (allopathic) laboratory tests. One of the doctors also mentioned a growing consumer consciousness among his patients. In case of misdiagnosis (and wrong treatment resulting from it), the patients might bring legal charges against the doctor. With the Ayurvedic way of diagnosing patients, no "scientific" documentation existed. With laboratory results, however, the doctor had written proof for the correctness of his treatments: "There's a consumer act. A patient may complain if he's treated in the wrong way. So doctors nowadays take the lab test. They say: this is the information, so I treat that way" (K-1).

Notwithstanding many patients' demand for "scientific" tests, I expected to find die-hard proponents of traditional Ayurveda who perceive such tests as either insufficient or misleading in relation to their understandings of body and illness. However, not one of the doctors interviewed raised any objections against the tests on the grounds of different scientific paradigms. I suspected that there might be at

least some kind of "Ayurvedic" way of reading them, e.g., an interpretation of blood measurements in terms of the *tridosha*. This hypothesis turned out to be unfounded. As the doctors pointed out, contemporary Ayurveda had fully incorporated the use of pathological tests:

"We ask patients to get *ultrasonography, pathological checks*. There is no difference in diagnosing the patients between us and them. Only the medicine is different. This *urine check, stool check*, everything is done in the *lab*. When we see that a patient is not in a good condition, we ask them to get more tests from the *lab*. [Question: No difference between allopathy and Ayurveda?] The *lab* is all one (*sab eki*). We use it, allopathy uses it, others use it." (K-13)

"I feel that this diagnostic procedure has nothing to do with whether it's Ayurveda, or allopathy, or homeopathy. It's scientific research. It's a technique, a technical body knowledge. It's more precise. We are not so keen to find out everything from the pulse. Maybe earlier Ayurvedics were more learned, could do it without gadgets, but we can't do it." (K-8)

"Ayurveda does not give any objections to that. Questions are questions." (K-6)

The doctors pointed out that the use of laboratory reports had become an important part of their college education. Hence the difficulties of diagnosing patients by traditional means only could be partly offset by the advances of "scientific" diagnostic testing. The expression that "the *lab* is all one (*sab eki*)" (K-13) also resonates with Bengali notions of religious tolerance. When asked about differences between different religious creeds, Bengalis often refer to Ramakrishna, who said that "God is all one." Hindus may call God "*bhagavan*," Muslims "Allah," and Christians "the Lord" but they all refer to the same Supreme Being. Some of the doctors made this connection explicit:

"Everybody is under God's blessing. That's why I think that allopathy, homeopathy, Ayurveda, and all medicines are the same. [...] Hindus talk about their gods, Christians about Jesus, Muslims about Allah, but human is one, and God is one. If you bring in artificial separations, you cannot develop anything." (K-14)

"Ramakrishna Dev said: one goal, different paths. That means: so many opinions, but God is one. Jesus is one. Allah is one. But the ultimate goal is welfare of human beings. [...] For each taste a different medical system." (K-6)

There was more common ground between the different medical systems in the field of diagnostics than in any other field. Of course, the Ayurvedic doctors' appreciation for laboratory tests was also a matter of pragmatism. Since most chronically ill patients usually resort to allopathy first, then to homeopathy, and only thereafter to Ayurveda (if at all), doctors often do not have to send their patients away for laboratory testing: the patients have done the tests already when they enter

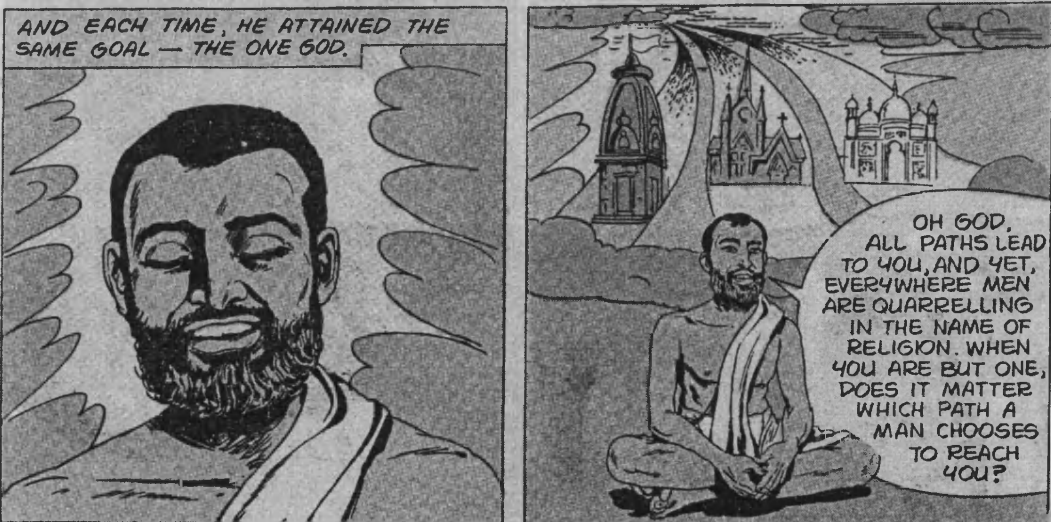


Plate 15: Ramakrishna's realization of "different paths, one goal" according to the comic series *Amar Chitra Katha* (1982: 22)

the Ayurvedic practice. If the laboratories exist, if patients are willing to pay for them or have already passed through a series of tests: "Why not make use of it?" (K-12). Even if the doctors believed that tests were useful, they also pointed out that they only send patients to the labs when they deem it necessary. The main objection

against the use of lab tests was that the costs involved could be too high for many patients. Hence poor patients were often not sent to labs at all, but only examined by the *kaviraj* himself:

"Why should I ask poor people for costly tests? With them, I only do pulse." (K-6)

"As much as I can, I do the diagnosis, I avoid the lab, because it is very expensive.

They would run away from me! So I diagnose myself, and keep my patients." (K-15)

The main argument for the diagnostic tests remains, however, that they are "scientific," and transcend the boundaries of the different medical systems. The doctors did not see much of a problem in the fact that the *lingua franca* of medical diagnostics was that of biomedicine. Differences between Ayurveda's Sanskrit terminology and the biomedical terminology could be overcome through careful translation. During the twentieth-century, a great number of Ayurvedic doctors tried to build terminological bridges between Ayurveda and allopathy. An outstanding example of this project is C. Dwarakanath's *Digestion and Metabolism in Ayurved*, published in Kolkata in 1963 (cf. Leslie 1992: 190-192; Zimmermann 1987: 162). Dwarakanath presents an intricate analysis of Ayurvedic theories of digestion, and translates Sanskrit terms into allopathic terms. For example, the various forms of *pitta* are translated as forms of "digestive enzymes," *pran vayu* becomes a form of "oxygen," and so on. Almost all of the doctors I interviewed supported Dwarakanath's "integrationism" against Sanskritic "purism" (cf. Leslie 1992). The argument they used was the same as that in favour of diagnostic tests: even if there were different paths, there is only "one goal." Scientists might use different languages to express their findings, but science itself was universal. One of the doctors elaborated on this point as follows:

"It's a global village. Think of a Bengali poet: his mother tongue may be Bengali, but he must be translated to be read by the whole world. Scientific language is *one* language. *Every* action in our body is a chemical exchange, *only* a chemical exchange." (K-14)

According to the Kolkata *kavirajs*, Sanskrit texts are in very limited use today. Although some of my informants seemed to be well-versed in Sanskrit (they quoted original *shlokas* along with their explanations), some of my informants admitted that they only have a minimal knowledge of Sanskrit. In the wake of the introduction of a standardized, state-supervised curriculum over the last decades, first-hand knowledge of the Sanskrit texts has been increasingly marginalized. In Kolkata, the clash between those who wanted to keep Ayurveda clean from modern

influences, and those who aimed at a fruitful combination of Ayurveda with allopathy can hardly be felt today. Most of today's practitioners rely either on Bengali or English translations of canonical Sanskrit texts, or on general textbooks written by twentieth-century authors.<sup>88</sup> These textbooks may not be as authentic as the Sanskrit classics, but they seem to be sufficient for daily practice. Even if they learned Sanskrit for a while in college, there is "no profit" in it today.<sup>89</sup> Patients are not interested in an accurate Sanskrit diagnosis, but only in good treatment:

"I did my studies in Bengali. What to do with Sanskrit, I can't use it for talking to patients anyway. They would not understand. There would be no profit for me." (K-13)

"If there is an interested person I can explain [in Sanskrit]. But most are not interested. And they don't have enough time to listen to such theories [laughs]." (K-1)

Since Ayurvedic diagnostics are strongly influenced by allopathy, the *kavirajs* defined their difference from allopathy mostly in terms of therapeutics. Ayurvedic remedies and specific Ayurvedic cures (such as the *pancakarma* purification of the body) were seen as what truly distinguishes Ayurveda from allopathy. Yet even in the field of therapy, the hegemonic power of allopathy to define what is "medicine" and what is not makes itself felt. Today, the production and marketing of Ayurveda has all the trappings of allopathic pharmaceuticals (cf. Nichter 1989, 2001). About a third of my Kolkata informants said that they did not make their own remedies anymore, but only prescribed mass-manufactured products. Those who produced their own hand-made medicines (ingredients are easily available from the central Kolkatan markets) usually pointed out that their patients prefer it to factory medicine. However, none of the doctors had strong opinions either for or against factory medicine. Depending on the patients' demands and the doctors' time and resources, either hand-made or factory-made medicine could be applied. The doctors welcomed the fact large Ayurvedic (or "herbal") drug-companies such as Dabur have taken a sizeable share of the pharmaceuticals market. Unlike Francis Zimmermann (1992: 212), no one saw in this a "corruption" of traditional Ayurveda.

---

88 It should be added that the modern Ayurvedic texts, both in English and in vernacular languages, are often of very high quality. For example, the works of Shivakali Bhattacharya (1908-1992), written in Bengali on all aspects of Ayurveda, are held in high esteem, both by practitioners and even by the educated Bengali population.

89 That there is "no profit" in learning Sanskrit does not apply to fields beyond Ayurveda. For example, Chris Fuller (1999, 2002) shows how Temple priests in Tamil Nadu have profited greatly from returning to a comprehensive learning of ritual texts.



Some of the doctors mentioned that contemporary drug marketing helped greatly to popularize Ayurveda in India, both among villagers and among the upper classes:

"[Question: How do the big drug companies influence Ayurveda?] They have an influence on people. Advertising. They go to the innermost corner of our country through TV. It's going to the upper echelons of society: they become interested after watching TV. There's not just Dabur, Himalayan Drugs, so many companies. In Gujarat, Bombay. Herbal system is a craze today." (K-12)

The doctors' opinions about the efficacy of Ayurvedic treatments were divided. Some among them were stalwart believers in all applications of Ayurveda. However, most of the doctors pointed out certain limitations of their treatments, especially in regard to acute problems and to surgery. Irksome doubts also existed about the use of Ayurveda in the case of life-threatening diseases such as cancer. Many doctors thought that Ayurveda was best if allopathic treatment had already been tried, or was also being used along with Ayurvedic medication. Dr. Sengupta's own experiences with cancer are a case in point: Ayurveda takes on an auxiliary, "cooling" role, after allopathy was used. This kind of accommodation of Ayurveda with allopathy is a widely documented reality of contemporary medical practice (especially Nichter 1989).

An intriguing set of ideas exists about the difficulties of using Ayurvedic medicines for the treatment of the "modern" body. As we have already discussed, the *kavirajs* often find it hard to apply traditional ways of diagnosing because the *prakriti* of modern people had become "complicated." This argument recurs in relation to therapeutics. The weakness and imbalance of the present body was an obvious fact to most of the *kavirajs*. The modern body being so weakened, many of the traditional methods of healing are considered *inapplicable* today. In his famous critique of the "gentle purge," Zimmermann (1992) claims that contemporary Ayurveda has lost its means to use "managed violence" to effect a radical cure through purges, enemas, blood-letting, and so on. Managed violence was erased due to the mistaken belief that Ayurveda could only counter the harshness of allopathic treatments with soft and lenient alternatives. Yet Ayurveda's attempt to achieve "a radical break-up with the evils of modern medicine" (1992: 221) only resulted in stunting former glories. Zimmermann puts the blame for this development partly on

**FROM ZERO**

**TO HERO**

**Increases Appetite for Weight Gain...**

**Banishes weakness and fatigue**

Available at all Medical Stores.

(Note: Results may vary from person to person.)

Marketed by:  
**RACHANA HEALTHCARE PRODUCTS**  
 15/11B, Old Anand Nagar, Next to Yakola Police Station,

WITH SAFE, AYURVEDIC

**BODY**<sup>®</sup>

*plus*

**CAPSULES**

Now! Also in **ECONOMY PACK** of 30 Capsules

**Distributor enquiries**

Plate 16: Ayurvedic capsules for weight gain (Newspaper advertisement)

the reshuffling of Indian medicine after the arrival of allopathy, partly on a Western fascination with "flower power" medicines since the 1970s. The doctors I interviewed expressed similar opinions, but put most of the blame for the decline of violent forms of treatment on a decline of their patients' *demand* for such cures. Ayurveda had become "softer" than in earlier days not because of New Age trivializations, but because of the very weakness of the modern physiology. Patients did not demand violent therapeutics because their body frames had become too tender. Rough treatments of the body, as in the traditional *pancakarma* purifications that Zimmermann describes, can hardly be found in contemporary Kolkata, or the whole state of West Bengal. Patients could not stand these treatments anymore, simply because modern life styles had weakened them too much. When purges were prescribed at all, they could only be applied with the lowest possible force:

"In the *shastras*, it is indicated that *pancakarma* is only for those people who are healthy and strong. But nowadays we can only prescribe the lower dose, the minimum dose. There are three doses mentioned in the *shastras*: Maximum, middle, and minimum. These days only minimum is prescribed. [The modern patients] do not do physical work. They cannot worship. They cannot concentrate. They cannot treat their body to gain extra power." (K-1)

Although patients were weakened through the corrupting influence of modernity, their bodies were more in need of a thorough "clear-out" than ever before. The lingering side-effects of allopathy were particularly difficult to deal with without a proper purge. Ayurvedic medicines *would* work well in a pure, "simple" body. But in the modern, complicated body, Ayurvedic treatment cannot work as well as it should. Yet this very weakness also prevented a proper purification prior to the Ayurvedic cure: "Purifying the body is essential. Make him simple, *then* treat him. Then the medicine will work very elaborately, very swiftly. If the system is cleared, the medicine will be absorbed" (K-6). In this modern age, such purification was practically unattainable.

## 7. From hero to zero?

The corrupting influence of modernity also left its mark on Ayurveda as a medical profession. The Sanskrit texts leave no doubt that Ayurveda understood itself first and foremost as the medicine of the kings (Zimmermann 1987). It was the "Great Tradition" of Indian medicine, "the Sanskritic, literate system that received royal patronage" (Wujastyk 1995: 30). The Bengali name of the Ayurvedic doctor inscribes the claim to sovereign status more explicitly than any other name for him: The *kaviraj* is the "king of the verse," the "king of poets." In Arthur Basham's (1976) colourful portrayal, the Ayurvedic physician made a stately appearance, radiant and superior:

"Attended by an assistant, who no doubt carried his bag of surgical instruments for him and followed by a servant bearing a parasol; clad in white raiment, shod in sandals, a staff in his hand, 'with a calm mind, speaking pleasantly, [...] the friend of all beings', he went from house to house on his rounds." (Basham 1976: 29)

Even if such classical (self-)depictions are taken with a grain of salt, there can be little doubt that Ayurveda has long been relegated to an inferior place by other

medical systems, especially by allopathy. If there is one medicine in independent India that receives the equivalent of "royal patronage," it is allopathy, not Ayurveda.

According to the *Academy of Ayurvedic Doctors in India* (2000: 5), "the Ayurvedic Medical science is now fighting for its existence instead of establishing itself in the global hemisphere" since the Indian government was "incapable of hearing the music of the day."<sup>90</sup> Perceptions of Ayurveda's professional decline are also prominent among Kolkata physicians. In my interviews, a number of reasons for the downfall of Ayurveda were mentioned. To begin with, the Indian state did not give enough financial and ideological support to Ayurveda. The medical infrastructure that the state maintained was predominantly geared towards biomedicine, all public health interventions were based on the biomedical paradigm, and all the powerful positions in the administration were filled with allopaths, or supporters of allopathy. Despite the official rhetoric about fostering "Indian systems of medicine," not much was happening:

"They [the government] say they are helping, but financial support is very poor. They are all in support of modern medicine [sic]. For that they spend a lot. For us, not even one percent of the budget. [...] The last fifty years, after Independence, they didn't pay any attention." (K-6)

"What I have, all I have done on my own. There is no support from the government. You have to do all yourself." (K-13)

"The Indian government is encouraging us. But now we are only fifty years independent. The habit is against Ayurveda. Dependency in all aspects of life, in politics just as much as in medicine." (K-14)

References to Indian Independence were frequent in these statements. For the doctors, it did not come as a surprise that the British colonial regime promoted "English medicine" (i.e., allopathy) and disadvantaged Indian medicine. Yet the continuation of allopathic hegemony after Independence was a disgrace.

The lack of state patronage had ramifications on all other levels of Ayurvedic practice. The quality of Ayurvedic college education only ranged from average to insufficient. First, the teachers were not as competent as they used to be in earlier days, there were very few outstanding *kavirajs* to whom the younger generation could look up to: "There is a dearth of eminent people" (K-1). Second, the quality of the students was not as high as that of the students of allopathy. The students with the highest grades aspired to become allopaths, and only those who fail to secure a seat

---

<sup>90</sup> For a similar assessment of the state's lackluster support of Ayurveda and other indigenous systems of medicine, see Banerjee (2000).

in an allopathic medical college turn to Ayurveda as a second or third choice. Third, the equipment of the college was usually lacking in many ways, even in the better-funded colleges. In turn, the lack of proper education jeopardized competent practice after college:

"Today's graduates don't even know more than ten herbs! Today there is no scope for that. The college is just a structure of brick and iron. You go there from nine to five, then go home. Nothing more than that. They don't have the *natural* knowledge. Not even a herbarium!" (K-6)

Compared to the brilliant job prospects of allopaths (high income, high prestige, high employability), the job prospects of Ayurveda graduates were not very exciting. After passing from college, more than half were unemployed. The government's policy to employ Ayurveda graduates also in some of the state hospitals had helped to brighten up the situation, yet it was still insufficient. The situation was especially dire in Kolkata. According to one *kaviraj*, there were vacancies for government jobs in the rural districts of West Bengal, but no takers. Even students from the rural parts of the country preferred to stay in Kolkata: "The boys from the villages, they spend five years in Kolkata for studies, but afterwards they find no job. They don't have money for a cup of tea" (K-5).

The *kavirajs* sometimes also complained that the state is not active enough against quacks. There were practitioners who have no qualification in Ayurveda, yet no one intervened. They were running their practice on the pretence of knowing about Ayurveda. To conceal the fact that they were unable to prepare medicines themselves, they concocted their own spurious substances. Alternatively, they bought medicines from Ayurvedic pharmaceutical companies and sold them as their own "family recipe": "They remove the labels from the patent medicine and use it as their own" (K-10). The gravest risk to the good reputation of Ayurveda came from practitioners (with or without qualifications) who were mixing Ayurvedic and allopathic medicines in an irresponsible way. Without telling the patients, they were administering medicines fabricated from high-potency allopathic drugs (especially steroids) and a few herbs. At first, the patient may feel better, but in the long run, more damage than good was done. According to the doctors, this type of quackery was more common earlier than now, however. Today, it existed mostly in the rural areas, and in the busy market areas of central Kolkata, where police control was less comprehensive.

Although the doctors criticized the state's lack of interest in promoting and maintaining good Ayurvedic practice, they also blamed themselves for not developing powerful professional organizations that could lobby for the cause of Ayurveda. None of the doctors I interviewed spoke with any enthusiasm about the gamut of organizations that exists. Even those doctors who were active members in Ayurvedic associations seemed not too animated about their influence. The biggest problem of these organizations was their fragmentation. Among my informants, there were hardly more than two doctors who belonged to the same association. The names of organizations that were mentioned to me were, for example, the "National Integrated Medicine Association," the "All India Ayurvedic Congress," or the "Academy of Ayurvedic Doctors in India." Instead of fighting for a common cause, they were fighting against each other. The aim of these lobby groups should be to raise the social status of Ayurveda, and also to make it a more profitable stream of medicine. Yet like in a vicious circle, the economic difficulties that many of the *kavirajs* face were also the reason why their degree of professional coherence was so much lower, especially when compared to allopathy:

"Economics is the root of all. You cannot travel around Kolkata too much, that is a waste of money and time. So these organizations don't live long" (K-5)

"I'm not a member of anything. Too much talking, only spending money for drinks." (K-6)

Despite all the rhetoric of decline, some of the doctors were confident that brighter days were lying ahead. Even if the traditional ways of practicing Ayurveda were lost, and even if its contact with allopathy had transformed it to its very roots, the demand for Ayurveda was now, finally, growing again. In India and around the world, people's increasing awareness of allopathy's damaging side-effects was stimulating a new interest in Ayurveda as a soft, natural, "herbal" alternative. Allopathy's hegemony had, at first, only negative effects on Ayurveda. Now, the benefits of this transformation were slowly emerging. "Herbal" medicines, mass-produced and professionally marketed, were gaining more and more ground. A few doctors felt that these mass products were actually of great benefit for their own practice: the companies were extending the reach of "Ayurveda" further than ever before:

"[*Question: How has Ayurveda changed over the last years?*] In these past five years, I have noticed that Ayurveda has spread all over the world. That really affected me. So I have all the interest in practicing well and giving medicine that works. Patients are all over the world: Germany, America, England. These are the

places where this medicine goes." (K-13)

To some of the doctors, it seemed as if Ayurveda was beating allopathy with its own weapons. The "scientific" approach to medicine was no longer a privileged domain of allopathy. With the aid of modern pharmacology, Ayurveda was able to put the efficacy of its drugs on a firm footing. The best preparations could now be scientifically tested and standardized for global mass consumption. Taking an extreme position, one of the doctors (K-8) even thought that Ayurveda's painful experiences with modernity were now about to be healed in the growing together of all separate "systems" into one single medicine. Antibiotics, free of side-effects, were being produced from Ayurvedic recipes. Harmful substances could be removed from herbs commonly used in Ayurveda by means of allopathic methods. Homeopaths were developing new drugs by taking medicinal substances from the other systems and making them free of side-effects through dilution and dynamization: "Nowadays, we feel that in a few years, there won't be any separation between allopathy, homeopathy, Ayurveda, or whatever. Because they will all amalgamate with each other" (K-8).

In light of these findings, we can now return to the question of how popular ideas and Ayurveda are related to each other. As we have discussed above, there are three ideal-typical (and seemingly contradictory) arguments about this relationship. First, Ayurveda is the "Great Tradition" of Indian medicine, popular ideas only its vernacular derivations. Second, the difference between popular knowledge and the knowledge of Ayurveda pundits is too big to throw the two together into a single category of "Indian medicine." Third, Ayurvedic practitioners use a stable explanatory model, while popular ideas are a hotchpotch of heterogeneous fragments. The view from Kolkata reaffirms all three positions, but with a twist. Ayurvedic and popular perceptions of the belly, digestion, and "greed," are all based on a shared humoral and ethical worldview. In this respect, popular notions are much closer to Ayurveda than to allopathy or homeopathy. Yet it would certainly be wrong to say that Ayurveda is nowadays the Great Tradition of medicine, influencing popular notions most. The truly Great Tradition in contemporary Kolkata is allopathy. Its hegemonic influence reaches and transforms *both* Ayurvedic *and* popular practice. As a result, not only the laypersons' views have turned into a *masala* mixture of different traditions, but also the views of professional Ayurvedic

healers. However hard it was (and is) to digest modernity, some parts of it have been blended into a fluid, digestible mass.



## VII. Conclusion

In his novel *English, August*, Upamanyu Chatterjee (1988) narrates the experiences of a young Bengali civil servant during a year of training in the small district town of Madna. Chatterjee's novel explores how the modernization of India (here especially the bureaucratic modernization of rural India) produces an unending series of comically confused situations. Depicting modernization as hybridization, Chatterjee's characters speak in several tongues at once. Creating a mixture of English, Hindi, Urdu and Bengali, the language constantly shifts between bureaucratic officialese, crass slang, and local idioms. Much of the humorous effect of the novel derives not only from a direct narration of the raucous confrontations between urban and rural, foreign and Indian, modern and traditional, but from their *reflection* in the main character's consciousness.

Chatterjee calls the young civil servant "Agastya Sen" to encapsulate his position betwixt and between tradition and modernity. While "Agastya" is derived from the name of the mythic Hindu ascetic who digested the ocean, his friends nickname him "English" and "August" for his once-expressed wish to speak with an Anglo-Indian accent. Playing on the title of the Roman Emperors, "August" also alludes to Agastya's fascination with the *Meditations* of Marcus Aurelius, his favourite reading during his hellish year in Madna:

"The *Meditations* turned out to be (very incongruously, he thought) his only reading. ... In those months he grew to like immensely this wise sad Roman. Marcus immediately made him feel better, because Marcus seemed to have more problems than anyone else – not the soul-squashing problems of being poor, but the exhilarating abstract problems of one immersed wholly in his self." (Chatterjee 1988: 68-69)

To some extent, Agastya's reflections on the absurdities of modernization are adumbrated in Marcus's stoic self-reflections on the absurdities of worldly life at large. While Marcus Aurelius certainly did not live in the modern era, his self-reflexive stance towards a world devoid of self-evident meaning nonetheless foreshadows modern forms of selfhood. In the last paragraph of the novel, Chatterjee puts an ironic question-mark behind Marcus Aurelius's tendency to counter adversity with self-immersion. Sitting in the train that will take him back to Kolkata (back then

still "Calcutta"), Agastya picks up once more his copy of the *Meditations*, this time ostensibly to avoid listening to his fellow traveller complain about digestive troubles:

"Opposite Agastya sat a bald man eager to talk about his stomach. To avoid him he opened Marcus Aurelius. 'Today I have got myself out of all my perplexities; or rather, I have got the perplexities out of myself – for they were not without, but within; they lay in my own outlook.' He smiled at the page, and thought, He lied, but he lied so well, this sad Roman who had also looked for happiness in living more than one life, and had failed, but with such grace." (Chatterjee 1988: 288)

While getting out of the perplexities of his life in the provincial town that he could never resolve through his own meditations, Agastya cannot help but smile at Marcus Aurelius's "lie" that the perplexities of life are only "within" oneself, and that overcoming them only needs a change of attitude, a new way of self-reflection. Yet at the same time, Agastya admires Marcus for not falling into despair, for not surrendering to passivity, for not giving up his own feeling of agency. Even if Marcus was consciously wrong about the truth of existence, even if he failed, he failed "with such grace." In the last instance, Marcus's reflexive care of the self is not to be judged by standards of objectivity, but by the standards of aesthetics.

The present thesis also touches upon some of the perplexities of modernity in India. Similarly to Chatterjee, who derives most of the plot from Agastya's self-reflections, this thesis deals largely with the self-reflections of people in Kolkata on the conditions of modern life. Instead of writing about the impact of modernization directly, this ethnography retells some of their meta-narratives of modernity. It also tries to capture the different levels of language that are used by people of different social standings, the constant shifts between the high and the low, the popular and the professional, the modern and the traditional. For complex reasons, the *Meditations* of Marcus Aurelius also feature among the inspirations for it. To quote this "wise sad Roman" in relation to Kolkatan modernity is, one might think, incongruous, but only if one believes in the incommensurability of Western and Indian experiences.

These are, of course, only a few fortuitous similarities between the novel and the thesis. One point where the two depart from each other is, not the least, in the attention to how people talk about digestion in daily life. If I had been sitting opposite the man in the train, I would have stopped reading Marcus Aurelius, and

started listening to him talk about his stomach. A meticulous concern for apparently "unimportant things" such as digestion is one important lesson to be learned from the *Meditations*. The strategy adopted by the Stoic philosopher for getting out of perplexity did not only consist in an abstract change of outlook, but also in a concrete, bodily practice of self-reflection. Caring for one's stomach can be as philosophical as talking about the self and the cosmos.

In the beginning, I set out to explore different perceptions of modernity among contemporary Kolkatans, especially the perplexing, unwanted side-effects of modernity. The problem of "side-effects" presented itself as an inversion of Max Weber's question about the *origins* of modernity, namely: what are the *consequences* of modernity? My hypothesis was that the search for the unique origin of modernity inevitably produces hierarchical differences between the (modern) West and its (not-so-modern) Other. Although recent writings on "multiple" or "Other" modernities in South Asia have challenged the vision of universal modernity, they have not been entirely able to resolve the paradox of "modernity" being both culture-specific (to the West) and culture-transcendent at the same time. Instead of asking about the origins and authenticity of modernity, I proposed that it might be more fruitful to study the consequences of modernity instead of its origins. Specifically, I raised the question of the unwanted consequences of modernity, such as environmental pollution, rapid urbanization, increasing work pressures, "stress," changing dietary habits, and so on. A process of "reflexive modernization" (Beck, Giddens and Lash 1994) sets in when these unplanned ills become the topic of a discourse that is carried by both the lay population and a diverse number of "experts" in the field of science, politics, and others. Since there are many players in this debate, there is inevitably a multiplicity of viewpoints. As could be expected, most of this self-reflexive discourse on modernity's side-effects focuses on negative aspects. Yet at the same time, the discourse of reflexive modernization always contains utopian visions for a better future as well.

The dissertation presents an ethnographic contribution to the study of reflexive modernization in Kolkata. The aim of the study was to explore popular and professional medical concepts of the body in the context of this Indian metropolis. Popular concepts were derived from ethnographic research in a neighbourhood in

Southwest Kolkata. Professional concepts were drawn from expert interviews with healers of three different medical systems: allopathy (biomedicine), homeopathy, and Ayurveda. Among the many aspects of the body, I decided to focus on the stomach and digestion. The choice of the stomach as an object of anthropological research might have seemed, at first, rather unusual. However, the ethnographic material presented aims to show that the discourse on digestive troubles can be read as a discourse on the ills of modernization.

In the first chapter (I), I try to contextualize my data in a wider historical, philosophical, and anthropological framework. Initially, the chapter focuses on how Indian writings of the colonial era constructed a close relation between people's lack of care for their stomachs and between a lack of control over the country (I.1). For Gandhi and others, modernity and colonial governmentality are practically the same. In their view, the people of India could only gain political sovereignty if they first regained bodily sovereignty. The chapter goes on to discuss at some length key texts on the relation between bodily sovereignty and socio-political sovereignty by Friedrich Nietzsche (I.2), Norbert Elias (I.3), and Michel Foucault (I.4). An analysis of how digestion and power are linked in Nietzsche's *Genealogy of Morals* takes on central importance. Nietzsche, the "absent giant of contemporary social thought" (Stauth and Turner 1988: 3), has had an enormous, yet little acknowledged, influence on the thought of Weber, Elias, and Foucault. If an attempt is made to avoid the Weberian focus on the origins of modernity, a recourse to Nietzsche's embodied philosophy and its subsequent influence on Elias and Foucault promises to open up a path less travelled by. From the discussion of Nietzsche emerges the concept of the "sovereign individual," which is then followed up in the works of Elias and Foucault. What Nietzsche describes as the "straight-jacket" of civilization becomes "internalized self-constraints" in Elias's work, and is finally interpreted as "technologies of power" by Foucault. In turn, Nietzsche's philosophy of the "sovereign individual" influences Foucault's concept of "self-care" as a practice of freedom, which he develops along Greco-Roman writings of, among others, Marcus Aurelius. What runs through the works of Nietzsche, Weber, Elias, and the late Foucault is a keen interest in the *meta*-narratives of modernity: in what ways do people reflect consciously on social change, and what is the significance of these

self-reflections in a field of power? These questions are taken up in the final part of the chapter (I.5), where I discuss recent ethnographies of India that also take a kind of "Nietzschean" approach to the meta-narratives of modernity. From among the many issues touched upon in the discussion of Nietzsche, Elias, and Foucault, I can only follow up a few of them with my own data from Kolkata. In this view, Chapter I is not a "theory chapter" in the conventional sense of the term, as I do not try to map all the theoretical ideas expressed onto the empirical data from Kolkata in a one-to-one fashion. Since each thinker is to be treated in his own terms, it is inevitable that a surplus of ideas remains, a surplus that could only find implicit echoes in the subsequent ethnography. And even if some of the philosophical concerns remain "incongruous" with Kolkatan modernity, I hope to have argued convincingly that the belly does play a surprisingly vital role in social theory, and that attention to the belly is not at all an idiosyncrasy of Indian culture.

Chapter II describes the research methodology adopted in the study of Kolkatan reflections on modernity. Beginning with a short account of the initial research question (II.1), the chapter proceeds with a description of the research setting and sample (II.2), the study design (II.3), and principles of data analysis (II.4)

The multiplicity of viewpoints, both lay and professional, is the principle that informs the presentation of results from research in Kolkata (III-VI). The chapter on the popular perceptions of the belly (III) presents an ethnography of the physiological, medical, social, and moral connotations of digestion in Kolkata. The first part of the chapter (III.1) sets out to describe the popular usages of the Bengali word *pet* ("belly") and of related terms. From this analysis, two key features of *pet* begin to crystallize: the belly as "container" and the belly as "fire-place." When the belly is described as a "container," *pet* is associated with people's most anti-social tendencies. The metaphors around the belly as "container" can be interpreted as a striking example of a popular description of modernity as an age of greed and deceit. In turn, the notion that the belly is a "fire-place" focuses on its transformative powers, likening digestion to a process of cooking. This metaphor is linked to a series of other issues which are discussed subsequently, such as popular expressions for digestive disorders (III.2.1) and the complex issue of hot/cold classifications (III.2.2). Then I discuss at some length popular reflections on different risk

behaviours (III.2.3) and different risk groups (III.2.4). The focus of this section is how the bellies of different categories of person demand different ways of treatment, with special emphasis on differences between social groups (III.2.4.1), men and women (III.2.4.2), and age groups (III.2.4.3). The metaphor of the belly as "fire-place" and adjacent notions of its hot/cold properties are part of a humoral medical tradition, yet the chapter shows how they are reinterpreted in the context of contemporary Kolkata. The last part of the chapter (III.3) examines notions of how the belly, constantly threatened by too much "heat," can be kept "cool" through the right attitude of the heart-mind (Bengali: *mon*). It is a widespread belief in Kolkata that most perplexities are just "within," and that to get oneself out of them, a change of outlook, a change of *mon* is the best way. The cooling powers of the *mon* hence appear as an antidote to both the heat of the belly and the heat of modernity.

In the subsequent chapters (IV-VI), I present an ethnographic perspective on professional medical concepts of stomach and digestion in Kolkata. The three systems I look at are allopathy (biomedicine) (IV), homeopathy (V), and Ayurveda (VI). The aim of each of these chapters is to describe how stomach, digestion and modernity are reinterpreted in these different medical settings. The chapter on allopathic gastroenterology (IV) begins with a discussion of medical professionalization as a mode of modernization, and proceeds to show why the doctors portray themselves as standing wide apart from their "quasi-primitive" patients. Homeopathy, the second most popular system of medicine after allopathy, is the subject of the following chapter (V). While these doctors talk about homeopathic notions such as the "vital force" or "suppression" of symptoms, they are at the same time expounding a harsh critique of modernity and its closest ally, allopathic medicine. Yet far from denigrating modernity as such, the homeopaths develop a vision of a homeopathic hypermodernity that is even more modern than modern medicine. The last medicine chapter describes the difficult position of Ayurveda in Kolkata today (VI). Once the most scholarly and most respected traditions of healing, Ayurveda finds itself at the losing end of medical modernity.

The various perspectives (popular, allopathic, homeopathic, Ayurvedic) were kept apart to bring out the discrepancies between them as clearly as possible. By way of drawing a conclusion, I will now try to bring the separate voices together. What

are the *common* perceptions of modernity's side-effects in Kolkata? Of course, I can only do so at the risk of gross oversimplification. The ill-being of the belly is a microcosmic reflection of large-scale defects in the environment and in society. The following "digest" of the main points starts on the macrocosmic level of the environment, and proceeds further and further down to the microcosmic level of the belly. Lastly, I will turn to the medical approaches to the belly's modern sufferings.

(1) *Environment*: In Kolkata, modernity's first unwanted consequence is the pollution of the environment. Opinions about Kolkata's environment tend to be gloomy. The distressing impact of pollution on health is a concern for both patients and doctors alike. Smoke from industries, traffic, and domestic fires pollute the air. Organic and inorganic toxins from domestic and industrial effluents pollute the water. The waste disposal system is inadequate. The noxious noises of city life lead to sound pollution. Bad smells also have an injurious effect. The city's infrastructure is too weak to support the number of people living in Kolkata. The sewage system is insufficient to prevent the annual water-logging during monsoon times. There is a lack of (clean) toilets in the city's common spaces. Because of the lack of clean water and insufficient sanitation, one allopathic doctor (A-5) feared that India is more threatened by a "biological holocaust" than by a nuclear war.

(2) *Society*: "Human pollution" (K-6) is another ill of modernity. Narratives about the current state of Bengali society are often as pessimistic as those about the environment. "Modernity" is seen as a project that belongs to the West, not to oneself; it may even stand as a synonym of colonial and post-colonial dependency. The pre-colonial days of *Sonar Bangla*, "Golden Bengal," were the days of bounty. Most of what came thereafter was decline. Industrialization pollutes Nature and body. People must submit themselves to restrictive time rhythms, and become "mechanical." Since English is becoming the language of choice of "modern" people, Bengali is relegated to an inferior position. Rapid urbanization is seen as a further symptom of the risks produced by modernity. The metropolis is synonymous with overpopulation, an overuse of scarce resources, and of a dangerous mixing of different socio-religious groups. The decline of the caste system is a product of modernization, albeit one of the more desirable ones. Yet even if caste injustice is diminished, the new socio-political order is also found lacking. The demise of caste

does not mean the end of social inequality. On the contrary, caste differences are replaced by class differences. Money translates into privileges in all spheres of life: the rich enjoy education; those who are poor remain illiterate. The modern political order is called *goondaraj*, the "rule of the bandits." Politicians of all parties are corrupt; nepotism and despotism rules. Modernity bequeaths a massive bureaucratic apparatus, yet the people who fill it are not the "rational" types that Max Weber predicted. Bureaucrats are failing to carry out their duties. In Writers Building, West Bengal's administrative centre, petitions lie rotting, only to re-emerge too late or never at all. Last but not least, the media are not of much use either. Instead of raising people's awareness of how to behave in a socially and environmentally sustainable manner, they are confusing people's minds with stories of sex and crime.

(3) *Personhood*: Since the modern environment and the modern social order are disturbed, the modern person is traumatized, overstimulated, and ill-tempered. The character of people is becoming excessively "hot," sensual, and greedy. Everybody craves for more than he can get, and for more than he can use. At the same time, the modern person is too distracted to truly pursue a chosen goal. People are painfully aware of the split between their intentions and their actions. Instead of being worriless in their chase for pleasure, they are full of tension. The modern world is a "computer world," too many things have to be kept in mind. People try to submit themselves to the discipline of modern time, yet they feel guilty about their "unscientific" love for chatting and socializing. The bad conscience inflicts punishments for not behaving in a rational way. The straight-jacket of modern discipline has not been internalized.

(4) *Food*: Materialist, ill-tempered people crave for oily and spicy food. Traditional rules about the balance between "hot" and "cold" qualities of food are not followed properly. Fast food eaten from street-side restaurants is washed down with excessive amounts of stimulating drinks (tea, coffee, alcohol). Cooling milk is less consumed than earlier. Protein-heavy meat dishes replace the cooling, wholesome (*sattvik*) food of the past. People devour too much meat. Red meat enters the domestic kitchen. Modernity increases the consumption of stale (*basi*) foods. Traditionally, anyone who could afford to eat only fresh food would not eat the leftovers of previous days. Today, people have fridges, and are not as mindful as



earlier about the risks involved in eating stale food. Poor people do not have a choice anyway. To scrape a living in the city, slum dwellers have to eat contaminated food, e.g. food spoiled by "dust" (*dhulo*). To survive, beggars have to eat anything they can get. Even the rich people have to suffer, because only hybrid food from chemically fertilized fields is available. In contemporary society, people only have a rudimentary understanding of nutrition; many believe that rice and *dal* is all they need. They are not educated enough about how to prepare nutritious food in a hygienic manner.

(5) *Body*: Defects in the environment, in society, in personal conduct, and in food habits cannot fail to have a detrimental effect on the body. In the mythical past, there was no limit on people's lives. Pre-modern people were energetic and pure. But through greed and a lack of self-control, health began to decline. In the *kaliyuga*, the current and most degraded age, human bodies suffer from bad health, short growth, and premature death. The body is chronically weak. The civilizing process forces people to internalize social constraints on "proper" behaviour. The body language of modern people is not as open and expressive as it used to be. In the modern city, it is impossible to heed the body's natural urges. At the same time, modern overexcitement leads to a reckless squandering of sexual fluids.

(6) *Belly and digestion*: How are perceptions of modernity focused on the *belly*? In the modern age, the techniques of caring for the belly that the mythical ancestors used are out of reach. With perfect self-control, it was possible to take out the stomach and wash it in the fresh water of the mountain. Today's stomachs are firmly locked in the dark, invisible middle of the body. Overburdened with impure food taken at untimely intervals, the digestive fire (*jatharagni*) cannot digest what is meted out to it. An alchemical enhancement of body substance through good digestion becomes impossible. The conditions of the modern city exacerbate the problem. There is not enough oxygen in the air to properly ventilate the body's "vital kitchen" and to fully cook ingested food. Water pollution puts the belly's health at risk. The inside "machine" works reasonably well for adults in the prime of life, but all others suffer. Environmental strains and intestinal worms impair babies' and small children's bellies. The appetite of youngsters is spoiled by an excessive consumption of oily egg-rolls and spicy Chinese noodle dishes. Single-child parents suffer from the kid's shifting strategies of either demanding too much fast food, or of refusing to

eat altogether. The appetite of young adults is disturbed because modern habits of life make them marry too late, leading to mental and physical imbalances. "In joy, there is nourishment," as a Bengali proverb has it; yet in the modern depression, there is little joy and little nourishment. The stomachs of casual labourers overheat by going without food for the whole day. Office workers try to be safe by taking along their own *tiffin*, but this food can only be eaten when it is already stale. Middle-class housewives munch boredom and agony. While modernity brought many negative side-effects, it has not yet delivered many of its liberating promises. In the distribution of food, women are still discriminated against. At daily meals, the woman must wait until the male head of the household starts eating. While the male eats the biggest piece of fish, the mother hand-feeds the male child before eating herself. At religious festivals, the women keep a fast for the well-being of the family; the men take it easy. Widows and elderly women still suffer from dietary restrictions imposed on them. Bengalis of earlier generations could eat as much as they liked and digest it nicely; Bengalis of the modern generations suffer from a lack of appetite, indigestion, tension, and constantly worry about the future. In the mythical past, people did not worry about anything. Free from the straight-jacket of moral modernity, the strong swallowed up the weak without second thoughts. Weighted down by the internalization of social restrictions, defectively modernized people lose their healthy appetite. Mind (*mon*) and belly are not in balance anymore. The traditional, concentrated mind of the past was able to control the belly's greedy tendencies. The modern mind is too hot and distracted to keep the belly cool.

(7) *Medicine*: If modernity leads to digestive disease, what role does medicine come to play? In regard to the unwanted side-effects of modernity, the benefits of medicine are perceived to be highly ambiguous. According to the critics of colonial modernity, illness is nothing other than the deserved punishment for greedy eating and a lack of self-care. The only way to achieve a healthy life is to take control of one's bodily cravings, to reform one's diet, and to become sovereign over one's own fate again. Once the idea of self-care is taken seriously, it is clear that medicine (especially allopathy) turns patients into "slaves" of modernity. They are slaves to the belly's cravings, and slaves to the help of doctors. The lack of self-care becomes the root cause of colonial dependency.

In Kolkata today, the critique of colonial dependency is transformed into a critique of dependency in a broader sense. Allopathy ("modern" or "English") medicine appears as an effective yet superficial quick-fix medicine. It removes the symptoms efficiently, but is unable to take out the "root" of the illness. The price for this short-lived relief is the suffering associated with allopathy's lingering side-effects in the body. Allopathy assails the body with a cocktail of chemical substances, thus produces unwanted consequences for long-term health. According to Kolkatan homeopaths, allopathic treatments lead to a "suppression" of actual symptoms, create an internal hotchpotch in the patient, and seriously weaken the patient's "vital force." For Ayurvedic *kavirajs*, the influences of modern life-styles and modern medicine jumble up the patient's natural constitution (*prakriti*). The result is that patients are too confused for Ayurvedic pulse examination to work, and often too weak to endure traditional treatments such as the *pancakarma* purification. Patients' habituation to fast yet shallow cures puts alternative healing strategies into jeopardy. Kolkata homeopaths complain that their patients are "not patient enough" (H-4). Patients shop around, go from one doctor to the next, and are unwilling to follow a reformed dietary regimen. The homeopaths have to accommodate patients' exaggerated expectations for fast relief by giving placebos and multi-remedy treatments. Ayurvedic doctors suffer from similar expectations to medicine, and see their daily practice transformed by patients' demand for "scientific" diagnosis in the allopathic style.

Allopathy represents the quintessentially "modern" system of medicine. Allopathy achieved its current position by means of rigorous professionalization. Medical education is standardized, and access to it is highly selective. Reliance on high-tech apparatuses increases prestige and financial gains. The claim to be the only "scientific" system of medicine is the basis for allopathy's global reach, expansionism, and firm support from side of the state. As one of allopathy's fastest-growing specializations, gastroenterology embodies all these qualities to an even greater extent than allopathic general practice. A decisive aspect of gastroenterology's "spectacular" power is its ability to make visible even the remotest part of the belly, and to perform endoscopic surgeries without having to cut the body open.

The professionalization of medicine is undoubtedly a *desired* effect of modernity. No doubt, the allopathic doctor is one of the winners of modernity. But the allopathic hegemony over what it means to be a "professional" healer creates trouble for its less powerful rivals. Both homeopathy and Ayurveda are pressured to prove that they are more than irrational quackery. The hegemony of allopathic materialism makes homeopathic theories of "miasm" or of "dynamization" appear like illogical mumbo-jumbo. Comparisons with allopathy pit Ayurveda into the role of "pre-modern" medicine: it may have some fine remedies at its disposal, but without rigorous testing and high-quality education, it looks unable to ever claim an equal standing with allopathy. Confronted with allopathy's supremacy in diagnosis and treatment, the community of Ayurvedic healers splits into "purists" and "syncretists."

From the point of view of allopaths, homeopathy and Ayurveda have, at best, only a supplementary role to play. Homeopathy and Ayurveda face up to this challenge in different ways. Both these systems subscribe to the allopathic dominance in the field of diagnostics; hence both send their patients to the "lab" for pathological tests. Both also try to become as professionalized as allopathy, without betraying the principles that make them distinct. Ayurveda's "syncretist" reformers want to base their practice on allopathic principles. Ayurveda aims to become "modern." In contrast, the homeopaths' self-understanding is best described as "*hyper-modern*": they are not just seeking to reach the standards set by allopathy, but claim to have *surpassed* them already. Their medicine is effective without side-effects. It is able to cure even chronic illness. It is also a (relatively) cheap medicine: where allopathy deepens relations of social inequality, every citizen can afford homeopathy.

Through modern print-media and TV reports, scientific concepts filter into popular discourse on illness. When patients present their symptoms to the doctor, they use "modern" terms like *dyspepsia* and *gas*. Absolute reasoning about the distribution of health risks is supplemented by statistical reasoning. Instead of "all" poor people suffering from digestive problems, only "80 percent" are said to suffer. Instead of Kolkatan air being simply "dirty," it is now said to contain "only 17 percent oxygen."

Whatever the patients' claim to "scientific" medical knowledge might be, professional healers tend to underline the distance between themselves and their patients. Among the different practitioners, allopaths are particularly keen to stress their superiority over their patients. In their view, patients are either pseudo-educated or completely illiterate. To them, patients' concerns about the belly sound rather ridiculous. The patients' "bowel-obsession" becomes a symptom of their quasi-primitive way of thinking. Instead of entrusting themselves early enough to scientific care, patients rely for too long on their own crude remedies. Instead of accepting the doctor's diagnosis, they are hard to convince that a disturbance of the bowels is *not* the reason for all ills. Instead of following the doctor's therapy, they wander off to rival healers.

Similarly to the allopaths, the homeopaths also perceive a distance between the patients' and their own explanatory models. In actual practice, however, a strong accommodation of popular concerns about food and digestion is visible – the need to keep in favour with their patients makes them eschew conflicts. Since the popular "bowel obsession" is, in many aspects, reminiscent of classic Ayurvedic theories, the *kavirajs* do not perceive much of a cognitive distance between themselves and their patients in regard to digestion. The *kavirajs* rather complain that the patients are excessively influenced by allopathy.

If all these points are taken together, the image of "modernity" in Kolkata seems to be highly negative. In Kolkata, the discourse on "reflexive modernization" is clearly focused on the unwanted side-effects of modernity. But what remains of Beck, Giddens, and Lash's (1994) idea that the "ills" of modernity do not necessarily lead to an attitude of defeat and nihilism? Do Kolkatans take the risks of modernity as "a providential gift" for self-reformation? I think that the complaints have to be read between the lines. All the criticisms of defective modernization might also be seen as a utopian vision of the future, rather than just a dark grumbling about the present. One day, we will be not just modern, but *hyper*-modern. One day, all artificial divisions between the different medical systems will vanish. One day, we will hold health in our own hands again. One day, we will be sovereign. One day, we will eat more joyously than ever before. One day, modernity will be digested. If this will get us out of all perplexities remains to be seen.

## Glossary with transliterations

Bengali is difficult to transliterate. Most commonly, words are transliterated by treating Bengali letters as if they were Devanagari (Sanskritic) letters, and then using the standard key for transliterating Sanskrit. This method is not very satisfying, because (1) some elements of the Bengali alphabet have no equivalent in Devanagari, and (2) it does not convey proper pronunciation. For example, *kavirāj* (Ayurvedic physician) is approximately pronounced *kobiraj*. A number of terms have taken on common English spellings, e.g. *bustee* ("slum") would be transliterated as *bastī* (and sound like *bosti*). Bengalis themselves have never adopted a standard system.

Generations of Bengali scholars could not agree on a good system. For want of a better way of doing it, I will also treat Bengali letters mostly like Devanagari letters. However, I make a few exceptions when right pronunciation is more important. For example, *mon* (mind) would be transliterated as *man* (and is spelled in Bengali only "mn," with the "a" being an inherent vowel). For the closeness to the English term "man," I gave preference to the spelling that approximates pronunciation. In the main body of the text, English plural "s" is added to Bengali words for easier reading. The following glossary only contains selected key words. Anyone familiar with the complexity of concepts like *darshana* or *dosha* will realize that the English translations are only meant to give a rough orientation. Bengali terms are marked with "(B)," Sanskrit terms with "(S)." All the Sanskrit terms that appear here are also used in (learned) Bengali, sometimes with a different spelling; and most of the words marked "Bengali" have similar or related Sanskrit forms. Therefore the differentiation between Bengali and Sanskrit is not categorical at all.

*agni (agni)* (S) - fire

*agun (āgun)* (B) – fire

*ahimsa (ahiṃsā)* (S) – non-violence

*akasha (ākāśa)* (S, B) – sky, ether

*ambol (ambol)* (B) – "sourness"

*amasha (amaśā)* (B) – stool with mucus

*antra (antra)* (B) – intestines

*antrik (āntrik)* (B) – enteritis

*asukh (asukh)* (B) – disease  
*atman (ātman)* (S) – soul  
*avelay (avelay)* (B) – untimely, irregular  
*baba (bābā)* (B) - father  
*basi (bāsī)* (B) – stale (food)  
*bustee (bastī)* (B) – slum  
*bhadralok (bhadralok)* (B) – "respectable people," educated middle class  
*bhagavan (bhagavān)* (S, B) – God  
*bhat (bhāt)* (B) – cooked rice  
*bhut (bhūt)* (S) – "element"  
*bara (bara)* (B) - big  
*brahmacarya (brahmacārya)* (S) – chastity  
*buk (buk)* (B) - chest  
*byatha (byathā)* (B) - pain  
*cakri (cākri)* (B) – work, employment  
*cal (cāl)* (B) – raw rice  
*cala (calā)* (B) – to go  
*chele (chele)* (B) - boy  
*choto (choṭo)* (B) – small  
*cinta (cintā)* (B) – thought, tension  
*cokh (cokh)* (B) – eye  
*dal (dāl)* (B) – cooked lentils  
*darshana (darśana)* (S) – sight, seeing (also in Ayurvedic diagnosis)  
*dhatu (dhātu)* (S) – bodily "tissue"  
*deri (derī)* (B) – late, slow  
*dharma (dharma)* (S) – cosmic law of right and wrong  
*dhulo (dhūlo)* (B) – dust, air pollution  
*dosha (dośā)* (S) – fault, defect, "humour"  
*durbol (durbol)* (B) - weakness  
*dushita (duṣita)* (B) – faulty, polluted  
*eto (eṭo)* (B) – impure, spoiled by saliva, left-over  
*gala (galā)* (B) - throat  
*garam (garam)* (B) - hot  
*garbha (garbha)* (B) – womb

*garib (garib)* (B) - poor  
*ghush (ghuṣ)* (B) - bribe  
*guhaya (guhaya)* (B) - anus  
*hajam kara (hajam karā)* (B) – to digest  
*haoya (haoyā)* (B) – to become, to happen  
*haoya (hāoyā)* (B) – air, wind  
*hriday (hṛday)* (B) – heart  
*jatharagni* (S) – digestive fire  
*jibh (jibh)* (B) - tongue  
*jhal* (B) – pungent, spicy  
*jal (jal)* (B) - water  
*jor (jor)* (B) – power  
*jvala (jvala)* (B) - burning  
*jvar (jvar)* (B) - fever  
*kaj (kāj)* (B) – work  
*kaliyuga (kaliyuga)* (S) – fourth and last of the cosmic ages (the present age)  
*kapha (kāphā)* (S) – "phlegm"  
*kara (karā)* (B) – to do  
*karkar (karkar)* (B) – cancer (disease)  
*karma (karma)* (S) – action and its consequence in the future (present or next life)  
*katha (kathā)* (B) - word  
*khabar (khābār)* (B) - food  
*khaoya (khāoyā)* (B) – to eat  
*kharap (khārāp)* (B) – bad  
*khide (khide)* (B) - hunger  
*kora (korā)* (B) – strict, hard, having side-effects (medicine)  
*kosh (koṣ)* (B) – astringent  
*lobhi (lobhī)* (B) – greedy  
*lok (lok)* (B) - people  
*ma (mā)* (B) - mother  
*mantra (mantra)* (S) – sacred formula, magic spell  
*masala (māsālā)* (S) - mixture  
*matha (māthā)* (B) - head  
*mishti (mistī)* (B) – sweet



*moyla (moylā)* (B) – dirt, rubbish  
*mon (man)* (B) – mind, heart-mind  
*mota (moṭā)* (B) – fat  
*mukh (mukh)* (B) – mouth  
*mudi-bhudi (mudī-bhudi)* (B) – head-and-belly  
*nadi-pariksha (nāḍī-parikṣa)* (S) – Ayurvedic pulse examination  
*neem (nīm)* (S) – a tree (*Azadirachta indica*); leaf and twigs have medical uses  
*nunta (nunta)* (B) - salty  
*osudh (oṣudh)* (B) – remedy, medicine  
*pakasthali (pākasthali)* (B) – place of cooking, stomach  
*pākā (paka)* (B) – cooked, ripe  
*pancakarma (pañcakarma)* (S) – Ayurvedic purge  
*panjika (panjikā)* (B) – almanac  
*panta bhat (panta bhāt)* (B) – cold rice soaked in water  
*patla (pātlā)* (B) – thin  
*paykhana (pāykhānā)* (B) – stool  
*pet (peṭ)* (B) - belly  
*pith (piṭh)* (B) – back (upper body)  
*pitta (pittā)* (S) – "bile"  
*pliha (plīha)* (B) – spleen  
*parishkar (pariṣkar)* (B) – clean  
*pathya (pathya)* (B) – healthy food (for healing purposes)  
*prakriti (prakṛti)* (S) – Nature; body constitution  
*prana (prāṇa)* (S) – vital air  
*prashna (praṣṇa)* (S) – questioning (in Ayurvedic diagnosis)  
*puja (pūjā)* (S) – Hindu worship  
*rajasik (rājasik)* (S) – energizing, agitating  
*rakta (rakta)* (B) – blood  
*rasa (rasa)* (S) – juice, taste  
*rasagolla (rasagolla)* (B) – juicy sweet of milk and sugar  
*roga (rogā)* (B) - ill  
*sab (sab)* (B) – all  
*sadhana (sādhanā)* (S, B) – meditation, religious exercise  
*sattvik (sattvik)* (S) – cool, pure

*shakti (śakti)* (S, B) – power, especially of the female goddess  
*shanti (śānti)* (S, B) – peace, tranquillity  
*sharir (śarīr)* (B) – body  
*shastra (śāstra)* (S) – classic Sanskrit teaching  
*shatru (śatru)* (B) - enemy  
*shloka (śloka)* (S) – Sanskrit verse  
*singara (singārā)* (B) – *samosa*, fried triangular pastry, filled with meat or vegetables  
*Sonar Bangla (Sonār Bānglā)* (B) – "Golden Bengal," image of the bountiful past  
*sparshana (sparṣana)* (S) – touching (in Ayurvedic diagnosis)  
*sukra (śukra)* (S) – radiant, pure; semen  
*surya-grantha (sūrya-grantha)* (S) – sun belt, belly  
*svada (svāda)* (S) - taste  
*svami (svāmī)* (B) – husband  
*taka (ṭākā)* (B) – money  
*tamasik (tamasik)* (S) – dark, stale  
*tapas (tapas)* (S) – (ritual) penance, heat of asceticism  
*teto (teto)* (B) – bitter  
*thakur (ṭhakur)* (B) – God  
*thanda (ṭhāndā)* (B) - cool  
*tak (tak)* (B) - sour  
*totka (totkā)* (B) – home remedy  
*tribhumi (tribhūmi)* (S) – tripartite land  
*tridosha (tridośā)* (S) – three humours  
*udar (udar)* (B) - abdomen  
*upavas kara (upavās karā)* (B) – (religious) fasting  
*vaidya (vaidya)* (S) – Ayurvedic physician  
*vata (vātā)* (S) – "wind" humour (*tridosha*)  
*vayu (vāyu)* (S) – wind (element)  
*Veda (Veda)* (S) – "knowledge" (revealed, sacred, Sanskritic)  
*vīrya-nīrodha (vīrya-nīrodha)* (S) – semen loss  
*visvas (viśvās)* (B) – faith  
*yakrit (yakṛt)* (B) – liver  
*yog (yog)* (S) – "link"

## Bibliography

### Printed sources

- Academy of Ayurvedic Doctors in India & Association of Ayurvedic Doctors  
2000 "Editorial." *Aadi Katha* IV (January 2000): 5-6.
- Addlakha, Renu  
2001 "State legitimacy and social suffering in a modern epidemic: A case study of dengue haemorrhagic fever in Delhi." *Contributions to Indian Sociology* (n.s.) 35(2): 151-179
- Agarwala, A., und Oliver Moebus  
1996 "Der frühindische Gedanke vom bewohnten Herzen." In *Das Herz im Kulturvergleich*, eds. G. Berkemer und G. Rappe, pp. 121-142. Berlin: Akademie Verlag.
- Alley, Kelly D.  
1998 "Idioms of degeneracy: Assessing Gangā's purity and pollution." In *Purifying the earthly body of God: Religion and ecology in Hindu India*, ed. L.E. Nelson, pp. 297-330. Albany, NY: State University of New York Press.
- Alter, Joseph S.  
1996 "Gandhi's body, Gandhi's truth: Nonviolence and the biomoral imperative of public health." *Journal of Asian Studies* 55(2): 301-322.  
1997 "Seminal truth: A modern science of male celibacy in North India." *Medical Anthropology Quarterly* 11(3): 275-298.  
1999 "Heaps of health, metaphysical fitness: Āyurveda and the ontology of good health in medical anthropology." *Current Anthropology* 40(Supplement): 43-66.  
2000 *Gandhi's body: Sex, diet, and the politics of nationalism*. Philadelphia: University of Pennsylvania Press.
- Amar Chitra Katha*  
1982 *Sri Ramakrishna*. Script: Gayatri Madan Dutt. Artworks: Souren Roy. *Amar Chitra Katha*, Vol. 595. Mumbai: India Book House Ltd.
- Anderson, Michael R.  
1992 "Public nuisance and private purpose: Policed environments in British India, 1860-1947." London: Law Department, School of Oriental and African Studies. (Working Paper No.1)
- Ansell-Pearson, Keith  
1995 "The significance of Michel Foucault's reading of Nietzsche: Power, the subject, and political theory." In *Nietzsche: A Critical Reader*, ed. P.R. Sedgwick, pp. 13-30. Oxford: Blackwell.
- Appadurai, Arjun  
1981 "Gastro-politics in Hindu South Asia." *American Ethnologist* 8(3): 494-511.  
1996 *Modernity at large: Cultural dimensions of globalization*. Minneapolis: University of Minnesota Press.
- Arnold, David  
1993 *Colonizing the body: State medicine and epidemic disease in nineteenth-century India*. Berkeley: University of California Press.

- , and Sumit Sarkar  
2000 "In search of rational remedies: Homoeopathy in nineteenth-century Bengal." In *Plural medicine, tradition, and modernity, 1800-2000*, ed. W. Ernst, pp. 40-57. London: Routledge.
- Aschheim, Steven E.  
1994 *The Nietzsche legacy in Germany 1890-1990*. Berkeley: University of California Press.
- Bachelard, Gaston  
1978 *Die Bildung des wissenschaftlichen Geistes: Beiträge zu einer Psychoanalyse der objektiven Erkenntnis*. Transl. M. Bischoff. Frankfurt am Main: Suhrkamp.
- Bagchi, Amalendu  
1975 *Indian definition of mind*. Calcutta: Sanskrit College.
- Bagchi, Asoke K.  
2000 *Rabindranath Tagore and his medical world*. Delhi: Konark Publishers.
- Bakhtin, Michail  
1984 *Rabelais and his world*. Transl. Helene Iswolsky. Bloomington: Indiana University Press.
- Bandyopadhyay, Tarashankar  
1996 *Arogyaniketan*. Transl. E. Chatterjee. New Delhi: Sahitya Akademi.
- Banerjea, S.K.  
2000 "Century-old heritage, dedication and contribution to Homoeopathy by Banerjea families." Photocopied Manuscript.
- Banerjee, Madhulika  
2000 "Whither indigenous medicine." *Seminar 489*, May 2000: 44-48.
- Bang, B.G.  
1973 "Current concepts of the smallpox goddess Sitala in parts of West Bengal." *Man in India 53*: 79-104.
- Basham, Arthur L.  
1976 "The practice of medicine in ancient and medieval India." In *Asian medical systems: A comparative study*, ed. C. Leslie, pp. 18-43. Berkeley: University of California Press.
- Basu, Sudipta  
2000 "A pill for every ill." *The Telegraph (Kolkata)*, 14 October 2000.
- Basu Roy, Indrani  
1993 *Kalighat: Its impact on socio-cultural life of Hindus*. New Delhi: Gyan Publishing House.
- Beck, Brenda  
1969 "Colour and heat in South Indian ritual." *Man (n.s.) 4*: 553-572.
- Beck, Ulrich  
1992 *Risk society: Towards a new modernity*. London: Sage.
- , Anthony Giddens, and Scott Lash  
1994 *Reflexive modernization: Politics, tradition and aesthetics in the modern social order*. Cambridge: Polity Press.
- Bernard, H. Russell  
2002 *Research methods in anthropology: Qualitative and quantitative methods*. Third edition. Walnut Creek, CA: Altamira Press.

- Berreman, Gerald D.  
1968 "Ethnography: Method and product." In *Introduction to cultural anthropology: Essays in the scope and methods of the science of man*, pp. 337-373. New York: Houghton Mifflin.
- Bhardwaj, S.M.  
1980 "Medical pluralism and homoeopathy: A geographic perspective." *Social Science and Medicine* 14B: 209-16.
- Bhasin, J.N.  
1986 *Medical astrology: A rational approach*. New Delhi: Sagar Publications.
- Bhimani, Rita  
2000 "Homoeo goes hi-tech." *The Telegraph (Kolkata)*, 20 October 2000.
- Bissell, P., J.M. Traulsen, and L.S. Haugbolle  
2002 "An introduction to functionalist sociology: Talcott Parsons' concept of the 'sick role'." *The International Journal of Pharmacy Practice* 2002, 3:60-68.
- Biswas, Arun Kumar  
2000 *Gleanings of the past and the science movement in the diaries of Drs. Mahendralal and Amritalal Sircar*. Calcutta: The Asiatic Society.
- Bloch, Maurice  
1998 *How we think they think: Anthropological approaches to cognition, memory, and literacy*. Boulder, CO: Westview Press.
- Blondel, Eric  
1991 *Nietzsche: The body and culture*. Stanford: Stanford University Press.
- Blumenberg, Hans  
1999 *Paradigmen zu einer Metaphorologie*. Frankfurt am Main: Suhrkamp.
- Bonnerjea, Biren  
1927 *L'éthnologie du Bengale*. Paris: Librairie Orientaliste Paul Geuthner.
- Borghardt,  
1990 *Homöopathie in Indien*. Berg: Barthel und Barthel.
- Bose, Ajit N. et al.  
1999 *Study report on the plight of industrial revival in West Bengal: A non-governmental investigation*. Calcutta: Nagarik Mancha.
- Bottéro, Alain  
1991 "Consumption by semen loss in India and elsewhere." *Culture, Medicine and Psychiatry* 15(3): 303-320.
- Bourdieu, Pierre  
1984 *Distinction: A social critique of the judgement of taste*. Transl. R. Nice. Cambridge, MA: Harvard University Press.  
1990 *The logic of practice*. Transl. R. Nice. Stanford: Stanford University Press.
- Brockington, J.L.  
1981 *The sacred thread: Hinduism in its continuity and diversity*. Edinburgh: Edinburgh University Press.

- Bronger, Dirk  
1997 "Megastädte - Global Cities: Fünf Thesen." In *Mega-Cities: Die Metropolen des Südens zwischen Globalisierung und Fragmentierung*, eds. P. Feldbauer et al., pp. 37-66. Frankfurt am Main: Brandes & Apsel / Südwind.
- Butler, Judith  
1993 *Bodies that matter: On the discursive limits of 'sex'*. New York: Routledge.
- Callinicos, Alex  
1999 *Social theory: A historical introduction*. Cambridge: Polity Press.
- Carstairs, G. Morris  
1957 *The twice-born: A study of a community of high-caste Hindus*. Preface Margaret Mead. London: The Hogarth Press.
- Chakrabarty, Dipesh  
1991 "Open space/public space: Garbage, modernity and India." *South Asia* (n.s.) 14(1): 15-32.  
1996 "Remembered villages: Representation of Hindu Bengali memories in the aftermath of the partition." *Economic and Political Weekly*, August 10, 1996.
- Chakraborti, Dipankar  
1997 "Calcutta city in pollution perspective." *World Transport Policy and Practice* 3(3): 15-23.  
—, et al.  
1998 "Calcutta's industrial pollution: Groundwater arsenic contamination in a residential area and sufferings of people due to industrial effluent discharge – An eight-year study report." *Current Science* 75(4): 346-355.  
2000 "Endangered generations: Groundwater arsenic contamination in West Bengal, India." Unpublished manuscript. School of Environmental Studies, Jadavpur University, Kolkata.
- Chakravorthy, Taponath  
1959 *Food and drink in ancient Bengal*. Calcutta: K.L. Mukhopadhyay.
- Chartier, Roger  
1988 *Cultural history: Between practices and representations*. Cambridge: Polity Press.
- Chatterjee, Partha  
1996 "Claims on the past: The genealogy of modern historiography in Bengal." In *Subaltern Studies VIII: Essays in honour of Ranajit Guha*, eds. D. Arnold and D. Hardiman, pp. 1-49. Delhi: Oxford University Press.  
1997 *The present history of West Bengal: Essays in political criticism*. Delhi: Oxford University Press.
- Cipolla, Carlo M.  
1992 *Miasmas and disease: Public health and the environment in the pre-industrial age*. New Haven: Yale University Press.
- Clover, Anne M.  
1989 *Homoeopathy reconsidered: A new look at Hahnemann's Organon*. London: Victor Gollancz Ltd.
- Cohen, Lawrence  
1995 "The epistemological carnival: Meditations on disciplinary intentionality and Āyurveda." In *Knowledge and the scholarly*

- medical traditions*, ed. Don Bates, pp. 320-344. Cambridge: Cambridge University Press.
- 1998 *No aging in India: Alzheimer's, the bad family, and other modern things*. Berkeley: University of California Press.
- Coleman, William  
1982 *Death is a social disease: Public health and political economy in early industrial France*. Madison: University of Wisconsin Press.
- Conway, Daniel  
1998 "The slave revolt in epistemology." In *Feminist interpretations of Nietzsche*, eds. K. Oliver and M. Pearsall, pp. 252-281. University Park, PA: The Pennsylvania State University Press.
- Corbin, Alain  
1986 *The foul and the fragrant: Odor and the French social imagination*. Cambridge, MA: Harvard University Press.
- Crook, Nigel  
1996 "Urbanization and health in India." In *Health, poverty and development in India*, eds. M. Das Gupta, L.C. Chen, and T.N. Krishnan, pp. 148-171. Delhi: Oxford University Press.
- Csordas, T.J., and A. Kleinman  
1996 "The therapeutic process." In *Medical anthropology: Contemporary theory and method*, eds. C.F. Sargent and T.M. Johnson, pp. 3-20. Westport, CT: Praeger.
- Danesi, M., and Paul Perron  
1999 *Analyzing cultures*. Bloomington: Indiana University Press.
- Daniel, E. Valentine  
1984 *Fluid signs: Being a person the Tamil way*. Berkeley: University of California Press.
- Derrida, Jacques  
1967 *L'écriture et la différence*. Paris: Seuil.
- Desjarlais, Robert R.  
1992 *Body and emotion: The aesthetics of illness and healing in the Nepal Himalayas*. Philadelphia: University of Pennsylvania Press.
- Dey, S.P.  
1993 *A guide to case-taking and case-recording*. Second edition. Howrah: Smt. Aparna Bhattacharya.
- Donner, Fentje Henrike  
1999 *Women and gold: Gender and urbanisation in contemporary Bengal*. Ph.D. thesis, Dept. of Anthropology, London School of Economics and Political Science, University of London.
- Dreyfus, Hubert L.  
1991 *Being-in-the-world: A commentary on Heidegger's Being and Time, Division I*. Cambridge, MA: The MIT Press.
- , and Paul Rabinow  
1982 *Michel Foucault: Beyond structuralism and hermeneutics. With an afterword by Michel Foucault*. Chicago: The University of Chicago Press.
- Dundes, Alan  
1992 "Wet and dry, the evil eye: An essay in Indo-European and Semitic worldview." In *The evil eye: A case book*, ed. A. Dundes, pp. 257-312. Madison: The University of Wisconsin Press.

- Dwarakanath, C.  
1967 *Digestion and metabolism in Āyurved*. Calcutta: Shree Baidyanath Āyurved Bhawan Private Ltd.
- Eisler, Rudolf  
1904 *Wörterbuch der philosophischen Begriffe*. Zweite Auflage. Berlin: Mittler.
- Elias, Norbert  
1969 *Die höfische Gesellschaft*. Frankfurt am Main: Suhrkamp.  
1987 *Über die Einsamkeit der Sterbenden in unseren Tagen*. Frankfurt am Main: Suhrkamp.  
1990 *Norbert Elias über sich selbst*. Frankfurt am Main: Suhrkamp.  
1992 *Über den Prozess der Zivilisation: Soziogenetische und psychogenetische Untersuchungen*. Zwei Bände. 17. Auflage. Frankfurt am Main: Suhrkamp.
- Elvin, Mark  
1993 "Tales of *Shen* and *Xin*: Body-person and heart-mind in China during the last 150 years." In *Self as body in Asian theory and practice*, ed. T. Kasulis, pp. 213-291. Albany, NY: State University of New York Press.
- Farmer, Paul  
1992 *AIDS and accusation: Haiti and the geography of blame*. Berkeley: University of California Press.
- Flandrin, Jean-Louis  
1989 "Distinction through taste." In *A history of private life, vol. III: Passions of the renaissance*, ed. Roger Chartier, pp. 265-308. Cambridge, MA: The Belknap Press of Harvard University Press.
- Foster, George M.  
1965 "Peasant society and the image of the limited good." *American Anthropologist* 67: 293-314  
1994 *Hippocrates' Latin American legacy: Humoral medicine in the New World*. Langhorne, NJ: Gordon and Breach.
- Foucault, Michel  
1979 [1975] *Discipline and punish: The birth of the prison*. New York: Vintage Books.  
1982a "The subject and power." In *Michel Foucault: Beyond structuralism and hermeneutics*, eds. H.L. Dreyfus and P. Rabinow. Chicago: The University of Chicago Press.  
1982b "On the genealogy of ethics: An overview of work in progress." In Hubert L. Dreyfus and Paul Rabinow, *Michel Foucault: Beyond structuralism and hermeneutics*. Chicago: University of Chicago Press.  
1984 "Nietzsche, genealogy, history." In *The Foucault reader*, ed. Paul Rabinow, pp. 76-100. New York: Pantheon Books.  
1986 *The care of the self: The history of sexuality, volume 3 (CS)*. Transl. R. Hurley. London: Allen Lane/The Penguin Press.  
1989 [1963] *The birth of the clinic: An archaeology of medical perception*. London: Routledge.  
1997 *Ethics: Subjectivity and truth*. Ed. Paul Rabinow. Transl. R. Hurley and others. New York: The New Press.



- Freidson, Eliot  
1975 *Doctoring together: A study of professional social control*. New York: Elsevier.
- Freud, Sigmund  
1934 "Das Unbehagen in der Kultur." In S. Freud, *Gesammelte Schriften*, eds. Anna Freud und Robert Wälde, vol. 12, pp. 27-114. Wien: Internationaler Psychoanalytischer Verlag.
- Fruzzetti, Lina M.  
1990 *The gift of a virgin*. Second Indian impression with a new introduction on 'Some contemporary Issues in Context'. Delhi: Oxford University Press.
- Fuller, C.J.  
1992 *The camphor flame: Popular Hinduism and society in India*. Princeton, NJ: Princeton University Press.  
1999 "Priestly education and the Āgamic ritual tradition in contemporary Tamilnadu." In *The resources of history: Tradition, narration and nation in South Asia*, ed. J. Assayag, pp. 51-61. Paris: Ecole française d'Extrême-Orient/Institut français de Pondichéry.  
2002 "Modernity, traditionalism and the state." Unpublished manuscript.  
— (Ed.)  
1996 *Caste today*. Delhi: Oxford University Press.
- Gandhi, M.K.  
1984 [1909] *Hind Swaraj or Indian home rule*. Revised new edition. Ahmedabad: Navajivan.
- Gell, Alfred  
1992 *The anthropology of time*. Oxford: Berg.
- Ghosh, Ishita, and Lester Coutinho  
2000 "Normalcy and crisis in times of cholera: An ethnography of cholera in Calcutta." *Economic and Political Weekly* 35 (February 19-26, 2000): 684-696.
- Ghosh, Labonita  
2000 "Muck battle." *India Today*, October 30, 2000.
- Giddens, Anthony  
1990 *The consequences of modernity*. Cambridge: Polity Press.
- Gold, Ann Grodzins  
1998 "Sin and rain: Moral ecology in rural North India." In *Purifying the earthly body of God: Religion and ecology in Hindu India*, ed. L.E. Nelson, pp. 165-196. Albany, NY: State University of New York Press.
- Good, Byron  
1994 *Medicine, rationality, and experience: An anthropological perspective*. Cambridge: Cambridge University Press.
- Gonda, Jan  
1969 *Eye and gaze in the Veda*. Amsterdam: North Holland Publishing.
- Gose, Sarat Chandra  
1935 *Life of Dr. Mahendra Lal Sirkar, M.D., D.L., C.I.E.* Calcutta: Hahnemann Publishing.
- The Gospel of Sri Ramakrishna* [Ramakrishna-Kathamrita]  
1996 [1897] Translated into English with an introduction by Swami Nikhilananda. Mylapore, Madras: Sri Ramakrishna Math.

- Goubert, Jean-Pierre  
1986 *The conquest of water: The advent of health in the industrial age.* Introduction by Emmanuel Le Roy Ladurie. Cambridge: Polity Press.
- Grass, Günter  
2000 [1988] *Zunge zeigen.* Göttingen: Steidel Verlag.
- Greenough, Paul R.  
1982 *Prosperity and misery in modern Bengal: The famine of 1943-1944.* New York: Oxford University Press.
- Grosz, Elisabeth  
1993 "Nietzsche and the stomach for knowledge." In *Nietzsche, feminism, and political theory*, ed. P. Patton, pp. 49-70. London: Routledge.
- Gupta, Akhil, and James Ferguson  
1992 "Beyond 'culture': Space, identity, and the politics of difference." *Current Anthropology* 7(1): 6-23.
- Gutschow, Kim  
1997 "A study of 'wind disorders' or madness in Zangskar, Northwest India." *Recent Research on Ladakh* 7. Eds. T. Dodin and H. Raether. Ulm: Ulmer Kulturanthropologische Schriften.
- Habermas, Jürgen  
1985 *Der philosophische Diskurs der Moderne: Zwölf Vorlesungen.* Frankfurt am Main: Suhrkamp.
- Hacking, Ian  
1990 *The taming of chance.* Cambridge: Cambridge University Press.
- Hadot, Pierre  
1981 *Exercices spirituels et philosophie antique.* Paris: Etudes Augustiniennes.
- Hahn, Robert  
1995 *Sickness and healing: An anthropological perspective.* New Haven: Yale University Press.
- Hahnemann, Samuel  
1994 [1833] *Organon of medicine.* Translated from the Fifth Edition, with an appendix by R.E. Dudgeon, M.D. With additions and alterations as per Sixth Edition translated by William Boericke, M.D., and Introduction by James Krauss, M.D. Calcutta: Modern Homoeopathic Publication.
- Halarnkar, S., and S. Menon  
1996 "Gasping for life." *India Today*, December 15, 1996.
- Hannaway, Caroline  
1993 "Environment and miasmata." In *Companion encyclopedia of the history of medicine, vol. 1*, eds. W.F. Bynum and Roy Porter, pp. 292-308. London: Routledge.
- Haraway, Donna  
1997 *Modest\_Witness@Second\_Millennium.* With paintings by Lynn M. Randolph. New York: Routledge.
- Harrison, Mark  
1996 "'The tender frame of man': Disease, climate, and racial difference in India and the West Indies, 1760-1860." *Bulletin of the History of Medicine* 70(1): 68-93.

- Hausman, Gary  
2002 "Making medicine indigenous: Homeopathy in South India." *Social History of Medicine* 15(2): 303-322.
- Helman, Cecil G.  
1978 "'Feed a cold, starve a fever': Folk models of infection in an English suburban community, and their relation to medical treatment." *Culture, Medicine and Psychiatry* 2: 107-137.  
1988 "Psyche, soma, and society: The social construction of psychosomatic disorders." In *Biomedicine examined*, eds. M. Lock and D.R. Gordon, pp. 95-122. Dordrecht: Kluwer Academic Publishers.  
1990 *Culture, health and illness: An introduction for health professionals*. Second edition. Oxford: Butterworth-Heinemann.
- Hillman, David  
1997 "Visceral knowledge: Shakespeare, skepticism, and the interior of the early modern body." In *The body in parts: Fantasies of corporeality in early modern Europe*, pp. 80-105. New York: Routledge.
- Hobbes, Thomas  
1998 [1651] *Leviathan*. Ed. J.C.A. Gaskin. Oxford: Oxford University Press.
- Homoeopathic Medical Association of India (HMAI)  
1999 *XI All India Homoeopathic Seminar and Silver Jubilee Celebration 1999, Calcutta*. Under the auspices of Homoeopathic Medical Association of India. Organised by West Bengal Branch, on 24th, 25th, 26th December 1999, at Dr JN Kanjilal Nagar, Calcutta, West Bengal. (Millennium Issue.)
- Hutnyk, John  
1996 *The rumour of Calcutta: Tourism, charity and the poverty of representation*. London: Zed Books.
- India, Ministry of Information and Broadcasting  
1998 *India 1998: A reference manual*. New Delhi: Ministry of Information and Broadcasting.
- Jay, Martin  
1992 "Scopic regimes of modernity." In *Modernity and self-identity*, eds. S. Lash and J. Friedman, pp. 178-195. Oxford: Blackwell.
- Jeffery, Roger  
1988 *The politics of health in India*. Berkeley: University of California Press.
- Jelliffe, D.B.  
1957 "Social culture and nutrition: Cultural blocks and protein malnutrition in early childhood in rural West Bengal." *Pediatrics* 20: 128-138.
- Johnson, Mark  
1987 *The body in the mind: The bodily basis of meaning, imagination, and reason*. Chicago: The University of Chicago Press.
- Jütte, Robert  
1996a *Geschichte der alternativen Medizin: Von der Volksmedizin zu den unkonventionellen Therapien von heute*. München: C.H.Beck.  
1996b "Eine späte homöopathische Großmacht: Indien." In *Weltgeschichte der Homöopathie: Länder, Schulen, Heilkundige*, ed. M. Dinges. München: C.H. Beck.

- Kaviraj, Sudipta  
 2000 "Modernity and politics in India." *Daedalus* 129(1): 137-162.  
 — (Ed.)  
 1997 *Politics in India*. Delhi: Oxford University Press.
- Kaelber, Walter O.  
 1989 *Tapta-Marga: Ascetism and initiation in Vedic India*. Albany, NY: State University of New York Press.
- Khare, R.S.  
 1976a *Culture and reality: Essays on the Hindu system of managing food*. Simla: Indian Institute of Advanced Study.  
 1976b *The Hindu hearth and home*. New Delhi: Vikas Publishing House.  
 — (Ed.)  
 1992 *The eternal food: Gastronomic ideas and experiences of Hindus and Buddhists*. New York: SUNY Press.
- Kirmayer, Laurence J.  
 1993 "Healing and the invention of metaphor: The effectiveness of symbols revisited." *Culture, Medicine, and Psychiatry* 17(2): 161-195.
- Kleinman, Arthur  
 1980 *Patients and healers in the context of culture: An exploration of the borderland between anthropology, medicine, and psychiatry*. Berkeley: University of California Press.
- Knipe, David M.  
 1975 *In the image of fire: Vedic experiences of heat*. Delhi: Motilal Banarasidass.
- Kundu, A. K., and Prithvish Nag  
 1990 *Atlas of the city of Calcutta and its environs*. Calcutta: National Atlas and Thematic Mapping Organisation, Ministry of Science and Technology, Government of India
- Laderman, Carol  
 1991 *Taming the wind of desire: Psychology, medicine, and aesthetics in Malay shamanistic performance*. Berkeley: University of California Press.
- Laidlaw, James  
 1995 *Riches and renunciation: Religion, economy and society among the Jains*. Oxford: Clarendon Press.  
 2002 "For an anthropology of ethics and freedom." *Journal of the Royal Anthropological Institute* (n.s.) 8: 311-332.
- Lakoff, George  
 1987 *Women, fire, and dangerous things: What categories reveal about the mind*. Chicago: The University of Chicago Press.  
 —, and Mark Johnson  
 1980 *Metaphors we live by*. Chicago: The University of Chicago Press.
- Lambert, Helen  
 1997 "Illness, inauspiciousness and modes of healing in Rajasthan." *Contributions to Indian Sociology* (n.s.) 31(2): 253-271.
- Langford, Jean M.  
 1999 "Medical mimesis: Healing signs of a cosmopolitan 'quack'." *American Ethnologist* 26(1): 24-46.

- Laqueur, Thomas W.  
1989 "Bodies, details, and the humanitarian narrative." In *The new cultural history*, ed. Lynn Hunt, pp.176-204. Berkeley: University of California Press.
- Last, Murray  
1996 "The professionalization of indigenous healers." In *Medical anthropology: Contemporary theory and method*, eds. Carolyn F. Sargent and Thomas M. Johnson, pp. 375-395. Westport, CT: Praeger.
- Latour, Bruno  
1987 *Science in action: How to follow scientists and engineers through society*. Cambridge, MA: Harvard University Press.  
1988 *The pasteurization of France*. Transl. A. Sheridan and J. Law. Cambridge, MA: Harvard University Press.  
1993 *We have never been modern*. Transl. Catherine Porter. Cambridge, MA: Harvard University Press.
- The Laws of Manu*  
1991 With an introduction and notes. Transl. W. Doniger, with B.K. Smith. Harmondsworth: Penguin.
- Leach, Edmund  
1970 *Claude Lévi-Strauss*. New York: The Viking Press.
- Leslie, Charles  
1976 "The ambiguities of medical revivalism in modern India." In *Asian medical systems: A comparative study*, ed. C. Leslie, pp. 356-67. Berkeley: University of California Press.  
1992 "Interpretations of illness: Syncretism in modern Āyurveda." In *Paths to Asian medical knowledge*, eds. C. Leslie and A. Young, pp. 177-208. Berkeley: University of California Press.
- Lévi, Sylvain  
1966 [1898] *La doctrine du sacrifice dans les brâhmanas*. Préface L. Renou. Deuxième édition. Paris: Presses Universitaires de France.
- Lévi-Strauss, Claude  
1966 *The savage mind*. Chicago: The University of Chicago Press.  
1992 *Tristes tropiques*. Harmondsworth: Penguin.
- Lindenbaum, Shirley  
1977 "The 'last course': Nutrition and anthropology in Asia." In *Nutrition and anthropology in action*, ed. T.K. Fitzgerald, pp. 141-155. Assen/Amsterdam: van Gorcum.
- Lingat, Robert  
1962 "Time and the dharma (On *Manu* I, 85-86)." *Contributions to Indian Sociology* 6: 7-16.
- Lock, Margaret  
1993 "Cultivating the body: Anthropology and epistemologies of bodily practice and knowledge." *Annual Review of Anthropology* 22: 133-155.
- Low, Setha  
1996 "The anthropology of cities: Imagining and theorizing the city." *Annual Review of Anthropology* 25: 383-409.

- Majumdar, R.C.  
1971 "Medicine." In *A concise history of science in India*, eds. D.M. Bose, S.N. Sen, and B.V. Subbarayappa, pp. 213-273. New Delhi: Indian National Science Academy.
- Malamoud, Charles  
1989 *Cuire le monde: Rite et pensée dans l'Inde ancienne*. Paris: La Découverte.
- Malinowski, Bronislaw  
1935 *Coral gardens and their magic: A study of the methods of tilling soil and of agricultural rites in the Trobriand Islands*. New York: Paul R. Reynolds.
- Mallory, J.P., and D.Q. Adams (Eds.)  
1997 *Encyclopedia of Indo-European culture*. London: Fitzroy Dearborn Publishers.
- Maloney, Clarence  
1976 "Don't say 'pretty baby' lest you zap it with your eye: The evil eye in South Asia." In *The evil eye*, ed. C. Maloney, pp. 102-148. New York: Columbia University Press.
- Marriott, McKim  
1968 "Caste ranking and food transactions: A matrix analysis." In *Structure and change in Indian society*, eds. M. Singer and B.S. Cohn, pp. 133-71. Chicago: Aldine.  
1976 "Hindu transactions: Diversity without duality." In *Transactions and meaning*, ed. Bruce Kapferer, pp. 109-142. Philadelphia: Institute for the Study of Human Issues.  
1989 "Constructing an Indian ethnosociology." *Contributions to Indian Sociology* (n.s.) 23: 1-39.
- Mennell, Stephen  
1989 *Norbert Elias: Civilization and the human self-image*. Oxford: Basil Blackwell.
- Michaels, Axel  
1998 *Der Hinduismus: Geschichte und Gegenwart*. München: C.H. Beck.
- Mishler, Elliot G.  
1984 *The discourse of medicine: Dialectics of medical interviews*. Norwood, NJ: Ablex.
- Mitra, Manimanjari  
1990 *Calcutta in the 20th century: An urban disaster*. Calcutta: Asiatic Book Agency.
- Moorehouse, Geoffrey  
1994 *Calcutta: The city revealed*. Harmondsworth: Penguin.
- Mull, J.D., and D.S. Mull  
1988 "Mothers' concepts of childhood diarrhea in rural Pakistan: What ORT program planners should know." *Social Science and Medicine* 27: 53-67.
- Nandy, Ashis  
1995 *The savage Freud and other essays on possible and retrievable selves*. Princeton, NJ: Princeton University Press.
- Nehamas, Alexander  
1998 *The art of living*. Berkeley: University of California Press

- Nicholas, Ralph W.  
 1981 "The goddess Sitala and epidemic smallpox in Bengal." *Journal of Asian Studies* XLI (1): 21-44.
- Nichter, Mark  
 1989 *Anthropology and international health: South Asian case studies*. Dordrecht: Kluwer Academic Publishers.  
 2001 "The political ecology of health in India: Indigestion as a sign and symptom of defective modernization." In *Healing powers and modernity: Traditional medicine, shamanism, and science in Asian societies*, eds. L. H. Connor and G. Samuel, pp. 85-106. Westport, CT: Bergin & Garvey.
- Nietzsche, Friedrich  
 1968 [1887] *Zur Genealogie der Moral: Eine Streitschrift* (GM). Eds. G. Colli und M. Montinari. Berlin: Walter de Gruyter. (*Nietzsche Werke: Kritische Gesamtausgabe* VI,2). (*On the genealogy of morals*. Transl. Douglas Smith. Revised Edition. Oxford: Oxford University Press, 1999.)  
 1969 [1889] *Götzen-Dämmerung, oder Wie man mit dem Hammer philosophiert* (GD). Eds. G. Colli und M. Montinari. Berlin: Walter de Gruyter. (*Nietzsche Werke: Kritische Gesamtausgabe* VI,3)
- Nutt, Kathleen  
 1995 "Nietzsche, feminism and political theory." *International Journal of Philosophical Studies* 3(1): 203-205.
- O'Flaherty, Wendy Doniger  
 1973 *Ascetism and eroticism in the mythology of Shiva*. London: Oxford University Press.  
 1980 *Women, androgynes, and other mythical beasts*. Chicago: The University of Chicago Press.
- Oliver, Kelly  
 1988 "Nietzsche's woman: The poststructuralist attempt to do away with women." *Radical Philosophy*, Spring 1988: 25-49.
- (Ed.)  
 1995 *Womanizing Nietzsche: Philosophy's relation to 'the feminine'*. London: Routledge.
- and Linda Pearsall (Eds.)  
 1998 *Feminist interpretations of Friedrich Nietzsche*. University Park, PA: The Pennsylvania State University Press.
- Östör, Akos, Lina Fruzzetti, and Steve Barnett  
 1982 "The cultural construction of the person in Bengal and Tamilnadu." In *Concepts of person: Kinship, caste and marriage in India*, eds. A. Östör, L. Fruzzetti, and S. Barnett, pp. 8-30. Cambridge, MA: Harvard University Press.
- Parker, Robert  
 1996 *Miasma: Pollution and purification in early Greek religion*. Oxford: Clarendon Press.
- Parry, Jonathan P.  
 1982 "Sacrificial death and the necrophagous ascetic." In *Death and the regeneration of life*, eds. M. Bloch and J. Parry, pp. 74-110. Cambridge: Cambridge University Press.  
 1985 "Death and digestion: The symbolism of food and eating in north Indian mortuary rites." *Man* (n.s.) 15: 612-30.

- 1989 "The end of the body." In *Fragments for a history of the human body: Part 2*, ed. M. Feher, with R. Naddaff and N. Tazi, pp. 490-517. New York: Zone.
- 1991 "The Hindu lexicographer? A note on auspiciousness and purity." *Contributions to Indian Sociology* (n.s.) 25(2): 267-85.
- 1994 *Death in Banaras*. Cambridge: Cambridge University Press.
- Parsons, Talcott  
1951 *The social system*. Glencoe: Free Press.
- Patton, Paul (Ed.)  
1993 *Nietzsche, feminism and political theory*. London: Routledge.
- Pelto, Pertti J., and Gretel H. Pelto  
1996 "Research designs in medical anthropology." In *Medical anthropology: Contemporary theory and method*, eds. C.F. Sargent and T.M. Johnson, pp. 293-324. Westport, CT: Praeger.
- Pinney, Christopher  
1987 *Time, work, and the gods: Temporal strategies and industrialisation in central India*. Ph.D. thesis, Dept. of Anthropology, London School of Economics, University of London.
- 1999 "On living in the *kal(i)yug*: Notes from Nagda, Madhya Pradesh." *Contributions to Indian Sociology* (n.s.), 33(1&2): 77-106.
- Pocock, David  
1992 "The evil eye." In *Religion in India*, ed. T.N. Madan, pp. 50-62. Delhi: Oxford University Press.
- Pollen, Roseanna  
2001 "Loss of face: Mind/body concepts among Bangladeshi people in Bethnal Green." Paper presented at the London Medical Anthropology Conference, London School of Economics, 3 July 2001.
- Panjika*  
2000 *Guptapress Directory Panjika 1407 (2000-2001)*. Kolkata: Shrianadicaran.
- Pool, Robert  
1987 "Hot and cold as explanatory model: The example of Bharuch district in Gujarat, India." *Social Science and Medicine* 25: 389:399.
- Porter, Dorothy  
1993 "Public health." In *Companion encyclopedia of the history of medicine*, vol. 2, eds. W.F. Bynum and Roy Porter, pp.1231-1261. London: Routledge.
- Prakash, Gyan  
1999 *Another reason: Science and the imagination of modern India*. Princeton, NJ: Princeton University Press.
- Pugh, Judy  
1983 "Astrological counseling in contemporary India." *Culture, Medicine and Psychiatry* 7(3): 279-299.
- Rabinow, Paul  
2002 "Life sciences: Discontents and consolations." *Journal of Molecular Biology*, 319(4): 947-955.



- Radley, A.  
1994 *Making sense of illness: The social psychology of health and disease*. London: SAGE.
- Ramachandran, R.  
1999 *Urbanization and urban systems in India*. Delhi: Oxford University Press.
- Rapport, N., and J. Overing  
2000 *Social and cultural anthropology: The key concepts*. London: Routledge.
- Ray, Dharendra Nath  
1937 *The principle of Tridosha in Āyurveda*. Calcutta: Chikitsa Prakash Printing Works.
- Rizvi, Najma  
1986 "Food categories in Bangladesh, and its relationship to food beliefs and practices of vulnerable groups." In *Food, society, and culture: Aspects in South Asian food systems*, eds. R.S. Khare and M.S.A. Rao, pp. 223-252. Durham, NC: Carolina Academic Press.
- Róheim, Géza  
1992 [1952] "The evil eye." In *The evil eye: A case book*, ed. A. Dundes, pp. 212-222. Madison: The University of Wisconsin Press.
- Rousseau, Jean-Jacques  
1984 [1755] *Discourse on inequality*. Transl. M. Cranston. Harmondsworth: Penguin.
- Rubel, A. J., and M.R. Hass  
1996 "Ethnomedicine." In *Handbook of medical anthropology: Contemporary theory and method*, eds. C. F. Sargent and T. M. Johnson, pp. 113-130. Westport, CT: Praeger.
- Rundell, John, and Stephen Mennell  
1998 "Introduction: Civilization, culture, and the human self-image." In *Classical readings in culture and civilization*, eds. J. Rundell and S. Mennell. London: Routledge.
- Samanta, Suchitra  
1994 "The 'self-animal' and divine digestion: Goat sacrifice to the Goddess Kali in Bengal." *The Journal of Asian Studies* 53(3): 779-803.
- Sanjek, Roger  
1990 "Urban anthropology in the 1980s: A world view." *Annual Review of Anthropology* 19: 151-186.
- Sarasvati, Srimat Svami Sivananda  
1948 *Yogbale rog-arogya*. Kolkata: Sri Gopal Press. [Bengali year of publication: 1355]
- Sarkar, Sumit  
1998 *Writing social history*. Delhi: Oxford University Press.
- Sarma, L. Ramachandra  
1978 *Indigestion, its cause and cure: A practical guide to the home treatment of stomach troubles and other digestive disorders*. New Delhi: The Indian Institute of Natural Therapeutics.
- Saxena, K.G.  
1992 *Struggle for homoeopathy in India*. New Delhi: B. Jain Publishers.

- Schumann, U.  
1993 *Homöopathie in der modernen indischen Gesundheitsversorgung: Ein Medium kultureller Kontinuität.* Münster: Lit-Verlag.
- Sen, Amartya  
1981 *Poverty and famines: An essay on entitlement and deprivation.* New York: Oxford University Press.
- Sengupta, Kunal  
2000 "Poison air scars children's lungs." *The Telegraph (Kolkata)*, 5 January 2000.
- Shakespeare, William  
1976 [1623] *Coriolanus.* Ed. P. Brockbank. London: Routledge. (*The Arden Edition of the Works of William Shakespeare*)
- Shorter, Edward  
1993 "The history of the doctor-patient relationship." In *Companion encyclopedia of the history of medicine, vol. 2*, eds. W.F. Bynum and Roy Porter, pp. 783-800. London: Routledge.
- Shulman, David  
1993 *The hungry God: Hindu tales of filicide and devotion.* Chicago: The University of Chicago Press.
- Smith, Brian K.  
1990 "Eaters, food and social hierarchy in ancient India: A dietary guide to a revolution of values." *Journal of the American Academy of Religion* LVIII(2): 177-205.
- Stauth, Georg and Bryan S. Turner  
1988 *Nietzsche's dance: Resentment, reciprocity and resistance in social life.* Oxford: Blackwell.
- Stolberg, Michael  
1994 *Ein Recht auf saubere Luft?: Umweltkonflikte am Beginn des Industriezeitalters.* Erlangen: Harald Fischer Verlag.
- Strong, Tracy B.  
1996 "Nietzsche's political misappropriation." In *The Cambridge companion to Nietzsche*, eds. Bernd Magnus and Kathleen M. Higgins, pp.119-147. Cambridge: Cambridge University Press.
- Sundaram  
1945 *Diet and digestion.* Bangalore: The Yoga Publishing House.
- Tambiah, Stanley J.  
1990 *Magic, science, religion and the scope of rationality.* Cambridge: Cambridge University Press.
- Taylor, Charles  
1995 *Philosophical Arguments.* Cambridge, MA: Harvard University Press.
- Turner, Bryan S.  
1992 *Regulating bodies.* London: Routledge.
- Uberoi, J.P.S.  
1984 *The other mind of Europe: Goethe as a scientist.* Delhi: Oxford University Press.
- Ukil, Amit  
2000 "Government hospitals lack every health basic." *The Telegraph (Kolkata)*, 5 May 2000.

- Unschuld, Paul  
 1975 "Medico-cultural conflicts in Asian settings." *Social Science and Medicine* 9: 303-312.  
 1992 *Medicine in China*. Berkeley: University of California Press.
- Vigarello, Georges  
 1988 *Concepts of cleanliness: Changing attitudes in France since the Middle Ages*. Transl. J. Birrell. Cambridge: Cambridge University Press.
- Vora, Devendra  
 1997 *Health in your hands: Acupressure and other natural therapies*. Ahmadabad: Navneet Publications.
- Wadley, Susan S.  
 1980 "Sitala: The cool one." *Asian Folklore Studies* 39: 33-62.
- Warren, Donald  
 1991 "The Bengali context." *Bulletin of the Indian Institute of History of Medicine* 21(1): 17-60.
- Walens, Stanley  
 1981 *Feasting with cannibals: An essay on Kwakiutl cosmology*. Princeton, NJ: Princeton University Press.
- Weber, Max  
 1946 [1917] "Science as a vocation." In *From Max Weber: Essays in sociology*. Eds. H.H. Gerth and C. Wright Mills. New York: Free Press  
 1976 [1921] *Wirtschaft und Gesellschaft: Grundriß der verstehenden Soziologie*. Fünfte, revidierte Auflage. Tübingen: J.C.B. Mohr.  
 1988 [1920] *Gesammelte Aufsätze zur Religionssoziologie I*. Tübingen: J.C.B. Mohr.
- Weiss, Mitchell G.  
 2001 "Cultural epidemiology: An introduction and overview." *Anthropology & Medicine* 8(1): 5-30.
- Weiß, C., and M. Kunz (Eds.)  
 2002 *Goldenes Bengalen? Essays zur Geschichte, sozialen Entwicklung und Kultur Bangladeschs und des indischen Bundesstaates Westbengalen*. Bonn: Bonner Siva Series.
- Williams, Raymond  
 1983 *Keywords: A vocabulary of culture and society*. Revised edition. New York: Oxford University Press.
- Wujastyk, Dominik  
 1998 *The roots of Āyurveda: Selections from Sanskrit medical writings*. Selection, translations and introduction by D. Wujastyk. New Delhi: Penguin Books.
- Zimmermann, Francis  
 1978 "From classic texts to learned practice." *Social Science and Medicine* 12(2B): 97-103.  
 1987 *The jungle and the aroma of meats: An ecological theme in Hindu medicine*. Berkeley: University of California Press.  
 1989 *Le discours des remèdes au pays des épices: Enquête sur la médecine hindoue*. Paris: Payot.  
 1991 "The love-lorn consumptive: South Asian ethnography and the psychosomatic paradigm." In *Anthropologies of medicine*, eds. B. Pfleiderer and G. Bibeau, pp. 185-195. (*Curare* Special issue No. 7)  
 1992 "Gentle purge: The flower power of Āyurveda." In *Paths to Asian*

*medical knowledge*, ed. C. Leslie and A. Young, pp. 209-23.  
Berkeley: University of California Press.

Internet sources

Citypopulation

2002 <http://www.citypopulation.de> [downloaded 7 October 2002]

India, Ministry of Finance

1999 *Economic Survey 98-99*.

<http://www.nic.in/indiabudget/es98-99/environ.htm> [downloaded  
10 May 1999]

India, Ministry of Health and Family Welfare

2002 *Indian Systems of Medicine and Homoeopathy*.

<http://indianmedicine.nic.in/> [downloaded 2 October 2002]

Library of Congress

2002 *Country Studies: India*.

<http://lcweb2.loc.gov/frd/csquery.html> [downloaded 7 October  
2002]