SECTION—D

DERMATOLOGY IN MODERN INDIA

(A.D.1700 – TILL DATE)
CHAPTER-I DERMATOLOGY AND AYURVEDA—REVIVAL AND NEW THINKING

Introduction

‘The golden period of Indian medicine was between 800B.C. - 600A.D. During the Moghul period and subsequent years, Ayurveda declined due to lack of State support’." During this stage of decline no new work evolved and the various texts available till then was either destroyed during wars and social turmoil or lost to the natural process of decay and lack of interest and knowledge of preservation.

There were some practitioners of the traditional medicine and some families practicing the subject from time immemorial kept the flow alive, though in a subdued manner. Some research works were done during British period and treatment of many diseases like leprosy with Chaulmoogra oil continued for a long time till the discovery of dapsone. After independence in 1947, the government stressed the research and tried to revive the subject to its past glory.

Authorities of this period

Many vaidas and ayurvedacharya practiced the traditional medicine during this period. Most of them were engaged only in the practice of medicine rather than any research work. In this situation the work of Acharyya Gangadhar lead to the infusion of new energy into life of Ayurveda. He wrote a commentary on Charaka Samhita known as Jalpakaalpataru. This commentary is famous for the rectification of the available corrupt version of the main text. Other famous authorities of recent time are Paresh Kabiraj and
Iswar Kabiraj of Varanasi, Haran Chakravarty of Rajshahi (presently at Bangladesh), Dwarakanath, Rajendranarayan, Gayanath Sen, Govinda Sen, Acharya Shyamadas etc.\textsuperscript{152}

Present scenario

A renewed interest all over the world is seen about Ayurvedic medicine. The use of various time tested medicines and holistic approach for thousands of years has attracted attention of the world of medicine and many treatment modalities have been adopted from it. The use of Psoralen in the treatment of vitiligo is an example in the modern medicine.\textsuperscript{153} In India, Government has also taken steps to upgrade research and promote Ayurveda in the country. A separate body entitled 'Department of Indian System of Medicine and Homoeopathy(ISM&H)' had been established in March, 1995 under Ministry of Health and Family Welfare for this purpose. Some of the goals set by ISM&H are as below:\textsuperscript{154}

(a) To standardize the education and research. For this purpose and promotion of higher education on the subject 'The National Institute of Ayurveda' was established on 7\textsuperscript{th} February, 1976. Different Ayurvedic colleges were visited by the Central Council of Medicine and new courses were started.

(ii) To prevent the mushroom growth of substandard education and thus decline in quality of knowledge;

(ii) To standardize the drugs available for treatment of various diseases;

(iii) ISM&H has notified the 'Good Manufacturing Practice' for the preservation and promotion of quality drugs;

(iv) Non Governmental Organizations have been involved for the promotion of $\equiv M\&H$.
(v) To set up a national Plant Board for cultivation and research of medicinal plants;

(vi) To prepare a database (Traditional Knowledge Digital Library) for the documentation of ancient texts and various researches works. The department (of ISM&H) has its own web site (http://mohfw.nic.in/ismh/) for the dissemination of different knowledge and informations on Ayurveda;

(v) Promotion of the system internationally. For this purpose the department had participated in Expo 2000 in Hanover in June 2000 and the theme was “humankind, Nature and Technology” and arranged a seminar in New York on “Ayurveda- a paradigm shift in health care in the new millennium” in September, 2000 in collaboration with Bharatiya Vidya Bhavan, New York. An international conference on Ayurveda was held in Gujarat Ayurveda University, Jamnagar during 5th to 7th January, 2001. The Department of Ayurveda, Siddha and Homoeopathy (AYUSH) of the Central Government would soon provide safety and efficacy data of all the herbal drugs exported from the country to various drug regulatory agencies throughout the world to meet the need for clarity about any queries regarding the manufacturing, content and standard of the ayurvedic medicines manufactured and exported from this country.¹⁵⁵ Many non-governmental organizations have also taken the task of promotion of the subject. Some of the major web sites for this purpose are http://AyurvedaMed.com, http://ayurvedahc.com, www.niam.com etc.

Efforts have also been underway to promote the concept of Ayurveda and boost the export of auyurvedic medicines to foreign countries by many ayurvedic industrial houses. For example a consortium of ayurvedic industries—‘Care Keralam’ has taken a 33 crore rupees project to set up a Reaserch and Development laboratory at Krotty in Thrissur district of the state of Kerala for the research and promotion of the Kerala brand of ayurvedic medicine and export of the same to other countries.¹⁵⁶

Dermatology has gained interest not only for the treatment of diseases but also as a part of the cosmetology. Various herbal and ayurvedic products are manufactured and used by different reputed pharmaceutical and cosmetic companies for this purpose. Many trials are also done to find the efficacy of different drugs in dermatological diseases.¹⁵⁷,¹⁵⁸ Critical reviews are also done to testify the drugs¹⁵⁹
CHAPTER-II UNANI SYSTEM OF MEDICINE AND DERMATOLOGY

2.1 Introduction

The Unani and Tibb system of medicine originated outside India, but has become an integral part of the health care system of the country. This system whose route of origin is traced to the Greco-Arabic, entered in India during 10th century with Muslim rulers and during 13th century was found to be practiced widely in many parts of India, mainly in Delhi, Aligarh, Lucknow, and Hyderabad etc. The system continued to flourish till the establishment of the British rule in 18th century. The scholars of Unani-Tibb system mainly came in the beginning from middle-east. After they settled here, they felt the need of drugs comparable to those that were used in their country of origin. Hence they substituted many of them with those that were easily available in Indian subcontinent. Thus the whole system was further enriched and in the course of time the whole system had become the part of the very core of Indian health care system.

History shows that for the healthy development of any subject patronage from the state is mandatory lest the system/subject loose its momentum. The same story was true for the system of Unani-Tibb during the British rule. During this period it suffered set back and its development was disturbed due the lack of state support which it enjoyed for the last 700 years of Muslim rule, but the subject continued to be practiced as it had already reached up to the bottom-line of the society. The contribution of two families--Sharifi family of Delhi and Azizi family in Lucknow in the preservation and improvement of the system during this adverse period remains unforgettable. The Nizam of Hyderabad also helped for this cause. The dedication of Hakim Azmal Khan (1868-1927) enthroned the Unani into an important position.
2.2 Unani and dermatology -- present scenario:

2.2.1 Few words about basic principle and treatment:

The basic of good health in Unani medicine is dependent on the correct humoral balance amongst the four humors— *Dam* (blood), *Balgham* (phlegm), *Safra* (yellow bile) and *Sauda* (black bile) - in the body with the help of the power of self preservation or *Quwwat-e-Mudabbira*.

When this state of perfect balance is disturbed, disease appears. For the management of diseases various types of treatment are employed, such as *Ilajbid-Tadbeer* (regimental therapy), *Haj bil-Ghiza* (dietotherapy), *Haj bid-Dawa* (pharmacotherapy) and *Jarhat* (surgery). These therapies also include measures like cupping (*Mahazim*), sweating (*Tariq*), venesection (*Fasd*), diuresis (*Idrar-e-Baul*), massage (*Dalak*), cauterization (*Kai*), Turkish bath (*Hammam*), purging (*Ishal*), vomiting (*Qai*), leeching (*Taleeq*) etc.

In pharmacotherapy of diseases, drugs of natural origin are used. They may be derived from animal, plant or mineral in origin. Materials derived from these sources are processed into Powder (*safij*), pills (*haboob*), tablets (*qurs*), oxides (*khustajat*), syrups (*sharbat*), semi-solids (*itrefal* and *khamirajat*) etc. for the management of various diseases.\(^{161}\)

2.2.2 Some medicines for skin diseases:

There are many drugs for the management of different skin diseases. Some of the proprietary preparations are mentioned here: \(^{162}\)

*Majoon Musaffi-e-Khoon* and *Arq-e-Mundi* are used to treat acne and boils. They are taken internally. *Marham-e-Gulabi* and *Raugan Kamila* are topical preparation for the same disorders.
Scabies and other pruritic diseases are treated with *Majoon Mundi, Marham Kharish, Mahroom Kafoor* etc.

Ring worms of the skin are treated with *Marham Quba, Arq-e- Afsanteen, Arq-e-Afternoon* etc.

_Sufoor Bars_ is used to treat depigmenting skin diseases like leucoderma and vitiligo.

_Raughan-e-Amla, Raughan-e-Baiza-e-Murgh* and *Murabba-e-Amla* are used in the management of different kinds of hair problems.

_Itrifal shahtara* is used for the treatment of impetigo, eczema, and furunculoses.

_Dawai-e-kharish jadid* is very helpful for pruritic skin diseases.

### 2.2.3 Modern research works in Unani and Tibb:

There were many new works on dermatology done by the physicians of this system. Some famous works on the subject are as follows:

Hakim Abd-al-Aziz (1855-1910) had framed some famous regimen on alopecia. Hakim Abd al Hafiz and Hakim Abd al Wahid did some work on itching due to dryness. Hakim Abd al-Latif Falsafi also composed management of skin disease like small pox. Hakim Mahbub Rada's work was published in 1954 from Aligarh _Tashkhis-i-Rada_ which deals with the observation of hair, skin face, nose chest ears etc. on the diagnosis of diseases. Some authorities of modern medicine of recent days have also shown interest in the various therapies of Unani medicine in dermatology and pursued trials on the subject.
There are various methods of management of skin diseases in Unani medicine. The Central Council Research in Unani Medicine (CCRUM) has also started trials of Unani medicine in some difficult-to-treat skin diseases like Bars (Vitiligo), Daussadaq (Psoriasis), Nar-e-Farsi (Eczema) and some conditions related to the skin diseases like Sukkari (Diabetes mellitus), Deedan-e-Ama (Worm infestation), Sailanur rahem (white discharge per vaginum) etc. The CCRUM at Hyderabad has attained international fame in the management of vitiligo.167,168

After independence in 1947 the Government of India put an effort for the up gradation of the Indian system of medicine. As a part of the plan Central Council for Research in Indian Medicine and Homeopathy was established and in 1978 separate councils were formed for each system. The Central Council Research in Unani Medicine (CCRUM) is now responsible for the research, education and propagation of knowledge in Unani system of medicine in India.169 There are two web sites of the council where one can have updates regarding the researches and other informations about Unani medicine: http://www.Unanimedicine.com and http://www.unanimedicine.org.

Significant contribution also came in the research on medicine in general and dermatology in particular from several non-governmental institutions like Hindustan dawakhana, Hamdard dawakhana etc.
Introduction:

Though the discussion of the history of modern India usually starts from A.D. 1700, the groundwork of the British reign started much earlier. To study the history of medicine one ought to know the brief historical background of this period. The history of this period is usually subdivided into three segments depending on the important landmarks:

- From the entry of the British and others up to A.D. 1857
- From A.D. 1857 to the independence of India from the British rule in A.D. 1947
- From A.D. 1947 till the present days.

3.1 From the entry of the British and others up to A.D. 1857

3.1.1 A brief lookback:

This period of the medical history of India is the history of entry and establishment of the Western medicine. Although the indigenous system maintained its flow, but not as before due to many factors like lack of state support and interest of the common people towards the Western system of medicine. Before we enter into any discussion about the history of dermatology during this period, we should have a brief review of history of that period so that the total picture becomes clearer to us. Though this country witnessed a new rule by the British for a period of about 150 years since this
time, other races from foreign lands were also in the fray for catching hold of the business as well as power in Indian Territory.

This history begins with the discovery of a new route to India by Vasco da Gama who reached India on 17th May, A.D. 1498 at the famous port of Calicut. On 9th March, A.D. 1500 Pedro Alvarez Cabral sailed out from Lisbon to India, but it was Alfons de Albuquerque who established the firm ground for the Portuguese in India in A.D. 1503.

About a century after these, on 31st December in A.D. 1600 the English East India Company received a royal charter from Queen Elizabeth granting them the monopoly of business in India. The Danes came in India in A.D. 1616 and a Swedish East India Company was formed in A.D. 1731, but it was Sir Thomas Roe's visit to the court of the then Mogul emperor Jahangir at the end of A.D. 1615 that paved the path for the British mainly towards the making of the history for the next two centuries in the soil of this country.

In the year 1639, Francis Day obtained the lease of Madras from the ruler of the Vijayanagar kingdom. After many historical ups and downs Job Charnock established a factory in Calcutta in August, 1690. Though the British started their voyage to India with the purpose of business, it ultimately got involved in the power game of this country which resulted into their involvement in the decline of the Nawab Shiraz-ud-Dowlah in the war of Plassey on 23rd June of 1757. The result of this war was so significant that it has been aptly said: "the battle of Plassey was hardly more than a mere skirmish, but its result was more important than that of many of the greatest battle of the world. It paved the way for the British conquest of Bengal and eventually the whole of India." East India Company obtained Diwani of Bengal, Bihar and Orissa on 12th August, A.D. 1765 from the Mogul Emperor Shah Alam II, which led to the further spread of the British power in this region. British force also got hold in many other places like Madras, Bombay etc. in India. Up to this period of history they ruled in those regions from behind the curtain.
After a long period punctuated by many wars like Carnatic wars, Anglo-Maratha wars, Anglo-Mysore wars, Pindari wars etc. British had to experience the trouble of the Revolt of 1857. After this period of turmoil British Empire developed a very stable foundation in the soil of this country that flourished for about a century.

3.1.2 Establishment of the new school of Medicine in India — a brief history:

The East India Company secured the diwani from the Mogul Emperor in 1765, but the condition of the common people remained the same or may even become worse in the next few years. Recard Becher a Company person wrote to the Board of Directors on 24th May, 1769: "It must give pain to an Englishman to have reason to think that since the accession of the Company to the Dewani the condition of the people of this country has been worse than it was before........ This fine country, which flourished under the most despotic and arbitrary government is verging towards ruin."[171]

From the above statement it is very clear that British rulers were not very much interested in the welfare of the native inhabitants in the beginning of their rule. Though the hospitals were established, the main object was the treatment of the Europeans living in this country. In the course of time it laid the foundation stone of the modern medical system which we see today.

3.1.3 First few hospitals and medical schools up to the establishment of medical colleges in India[172]

After the British triumph in the significant war of Plassey, they established a hospital for their own requirement in the year A.D.1707 in Calcutta near St. John's Church. Second hospital was established in A.D.1760 and in the year 1768 the famous Presidency General hospital was established. In the year 1794 a native hospital was founded in Chitpur area of Calcutta where native people interested in the western
medicine used to get knowledge from the European doctors. Ultimately on 21st June, 1822 the “School for Native Doctors” was established for imparting education on the medical system. In the beginning the education was mainly imparted in the native language and the syllabus was mainly restricted to the basic anatomy and common diseases like cholera, eye diseases, rheumatism, different types of fevers and toxicology etc. In the year 1835 Medical colleges were established in Calcutta and Madras. This led to the beginning of the full fledged education of Western medical system in this country.

3.1.4 Dermatology during this period:

Dermatological disorders some time led to the development of epidemic and thereby affected the socioeconomic scenario. From the Siyar mutakasarin of Gholum Hossein we come to know about the epidemic of smallpox which affected the country in 1770 for about three months. Again in the year 1850 another similar epidemic of smallpox in Calcutta lead to the death of 3,329 persons amongst the total 3,87,398 population of that place. An endeavor to vaccinate people against pox was started in 1805.

The Western medical educationists and the British government had to face a problem of ‘Anglicist-Orientalist controversy.’ So they tried to impart education according to the Western system of medicine, but at the same time they also could not avoid the indigenous system of medicines. They started research about the diseases prevalent in this country and its treatment in both system of medicine. The Asiatic society of Bengal formed a solid platform for discussion and exchange of thoughts amongst the scholars. For these purpose medical persons of the East India Company assembled in a meeting on Saturday, the 1st March, 1823. In the subsequent proceedings of the society dialogue on various problems of dermatological disorders was undertaken along with the other medical problems. Few such examples are as below:
• 3rd January, 1824— the discussion on Leprosy and the effect of different herbs on it (e.g. akanda) was the most important amongst the other agenda.
• 1st July, 1826— Dr. Adam discussed on gangrene.
• December, 1826— a discussion on the article by Dr. Lessly took place on the subject of necrotic ulcer.
• October, 1828— Dr. Adam described about a skin disease of a native patient in this meeting. There was also discussion on two articles on skin diseases written by Dr. Adam.
• October, 1830— in this meeting Dr. R. Titler read about a tumour and septicemia.
• December, 1830— a paper on scurvy was read in this meeting.
• 1831— In this year different issues on skin diseases like boil on the head, vaccination against pox, fungal infection on the eye lid of a person etc. were discussed in several occasions.

There were some individual efforts to promote the dermatological and other medical disorders during this period. Some diseases were reported from India in the world literatures which were not very much known till then in the Western world. The report of the Mycetoma of feet, entitled 'Tubercular disease of the foot' in the Lancet of 10th June, 1843 by Godfrey from Madras is one such famous example.179

The impact of dermatological problems of the society was far reaching and it influenced the law makers of country. The social attitude of towards the lepers and their poor fate culminating into the act of committing suicide and in some cases of homicide of the lepers by the others (particularly relatives) was noted by many eminent personalities. These reports provide us the picture of the effect of a skin disease on the contemporary social life, the law of the country and the government. The dismayed condition of the leprosy afflicted patients provoked them to commit suicide. These incidences were mentioned in the writings of many famous personalities of that period.180,181,182 Though the law of the land did not justify the assistance of the others to a person desiring to commit suicide even in the early days
of the history of this period (Regulation 3 of the Company Government enacted in 1799), the Nizamat Adalat (The Criminal Court of appeal) Calcutta in 1817, clarified that such an act is not applicable in the case of commission of suicide by a leper as it had the sanction from the religious point of view.\textsuperscript{183}

During this period, dermatology was mentioned only occasionally and that too as a part of the other medical discussions; it did not enjoy a separate status. This is also evident in the medical curriculum of that period. When Dr. Breton, the patron of the Native Medical and general hospital, Calcutta recommended some books for the education of the medical students there were no specified books on dermatology and allied subject.\textsuperscript{184} The same thing was repeated in Dr. Titler’s booklist. We see mention of books on scurvy, dropsy and one Ayer’s Researches into the nature and treatment of dropsy in the brain, chest, abdomen, ovaries and skin etc. in one booklist published as an advertisement from Mr. J.J. Fleury’s library.\textsuperscript{185}

It may be concluded from above discussion that there were no major impact of the Western medicine in common Indians till this period. There were some key landmarks in the history of Western medicine in India:

- Beginning of Native medical schools to impart medical education, gradual introduction of the Western medicine with the patronage of the British Authorities and establishment of the Medical colleges in Madras and Calcutta in 1835.

- As far as the dermatology is concerned no separate importance to the subject was evident in this period. In the health system (which was not at all organized at that point of time) some importance was seen about the vaccination against poxes as the disease used to take its toll every year.

- Academicians were also more interested in the general medical disorders and surgeries, though some times passing remarks were made about some skin ailments in different meetings and conferences.

- Indian system of medicines and quackery admixed with superstition remained the main mode of treatment for the common people.
3.2 From A.D.1857 to the independence of India from British rule in A.D.1947

3.2.1 A Historical look back:

The ‘First Indian Revolt’ of 1857-1859 was the outcome of the various factors like political, economic, social and military. This revolt marked the turning point in the history of India. The control of governance was finally assumed by the Crown and in 1858 an act for the better Governance was passed on 2nd August.186 The country witnessed changes in various aspects of life. This also had a bearing upon the medical system of the country.

3.2.2 Dermatology during this period

3.2.2.1 Introduction:

The most epoch making fact of this period is the emergence of ‘Dermatology’ as a separate specialty. Till this period dermatology was treated as a part of the internal medicine and barring a few physicians, most of the medical personnel were little concerned with the skin.187 During the last decade of 19th century some outstanding medical personalities of the Western world, like Heberden, Cullen, Hebra etc. laid the foundation of the subject upon which the edifice of present day dermatology was built.

The dermatological disorders and their management were known in our country from the Vedic period. But a systematic approach as to the study of the subject as well as the prevalence and impact of the diseases of the skin on the medical system had never undertaken till British authority became aware about the necessity of the knowledge of prevalence of skin diseases in India.188 The British government appointed Dr. Henry Vandyke Carter
(1831-1897), Surgeon Major, HMS Indian Medical Services to take the stock of the situation. This was the first ever scientific endeavor to study the prevalence of skin diseases in this sub continent. In the year 1872, Fox and Farquar determined the prevalence and pattern of skin diseases in India. With the effort of Major C. Fernandez the first chair of dermatology was established at Grant Medical College, JJ Hospital, Bombay in 1895. The second department of dermatology was established at School of Tropical Medicine, Calcutta in 1923 under the able effort of Dr. Ganapati Panja and Colonel H.W. Acton. Dr. Acton received ‘Chasterfield medal’ for his contribution to the dermatology—a less known specialty at that time. One important development during this period is the beginning of publication of various books and journals on dermatology. In the year 1935, Dr. U.B. Narayan Rao first started publication of the ‘India Journal of Venereology’ which was later renamed as ‘India Journal of Venereal Diseases and Dermatology’ in 1940.

This is the period when leprosy witnessed many developments in treatment as well as research. For a long time leprosy was seen as stigma associated with many superstitions. As there was no effective cure so the patient was seen as threat to the society and they were segregated to the asylum. The first such asylum was known to exist in Calcutta during 19th century and the second was established in Varanasi. Leprosy was surveyed for the first time as a part of the First ever census of India (British Imperial census) in 1871-72. The prevalence rate of lepros during this period was 0.55 oer 1000 population. The major turning point in the history of leprosy is the introduction of dapsone in the treatment. Another major factor in the change of attitude of the society and management is the beginning of works by the Christian Missionaries. The ‘Mission to Lepers’ was started in 1875 in Chamba in Himachal Pradesh.
First well organized action against leprosy was actually started with the establishment of the India Council of the British Empire Leprosy Association in 1925. This association also started the publication of researches, news and other academic contents in its quarterly journal ‘Leprosy in India.' A leprosy training course was also started by this association in the School of Tropical Medicine in Calcutta in 1925.

3.2.2.2 Development of the subject and its branches:

For a long time dermatology had been treated as branch of the internal medicine. This notion had continued till the beginning of this period. The most notable development during this period is the emergence of dermatology as a separate specialty. This lead to the renewed interest about the subject and the subject blossomed into a much larger form. Venereology, especially Syphilology, and Leprology surfaced as subspecialty. Innumerable researches added many new features to the subject. Many distinguished authorities like Culen, Heberden, Hebra, Hansen, Hunter; Virchow added and altered the subject to a more matured form. This is the period that witnessed development in the entire arena of medical science: Louis Pasteur (1822-1895) argued his germ theory; Robert Koch (1843-1910) proposed his famous postulates in 1882 and so on.

These had direct consequence on the medical system in India. The British government also put an effort about the up gradation and modification of the medical system of this country that naturally followed the European way. As already stated, Dr. Vandyke Carter took the task of studying the prevalence of dermatoses in India. As about the academic aspect is concerned, Seth GS Medical College had the post of honorary
dermatologist and venereologist and an honorary lecturer since 1926. In the year 1942 a committee was formed to frame the rules and regulations regarding the postgraduate examination in dermatology. First ever examination for the ‘Diploma in Dermatology and Venereology’ was held in 1945 by the Bombay university.¹⁹⁷

Venereology also developed in the same line though much slowly. During the post First World War period there were no organized system of treating the venereal diseases in the country and only in 1918 a special clinic was opened by the Empire wide League for Combating Venereal diseases to serve the red light area of the city.¹⁹⁸,¹⁹⁹ As far as the academic aspect is concerned, Dr. U B Narayan Rao first published the Indian Journal of Venereology in 1935 and it was later merged with the Indian Journal of Venereology and Dermatology in 1940.²⁰⁰

Leprosy was quite well known in this country for thousands of years and any major text in indigenous medicine used to deal in detail about the disease. The paradox is that the country forgot the medical approach towards this disease for an extended period as there were very little or rather no research for a long time and instead the disease bore the stigma and all sorts of wrong ideas. During this period with the discovery of the lepra bacilli and introduction of sulfones in the treatment of leprosy changed the whole scenario.

The first leprosy asylum was established in Calcutta. A leprosy survey was carried by the Bombay Plague Commission in 1896. A legislation was about the leprosy was proposed in 1896 and was promulgated in 1898. Till about 1940 Chaul moogra oil was the mainstay of treatment. There were individual efforts and ways of treatment also: Dr. Bhau Daji treated in his own way (details are not known yet). Pundit Kriparam claimed of curing the disease in about 1915.²⁰¹
Thus this period is most important in the history of dermatology in India as far as the development of dermatology and allied specialties. It emerged as a separate specialty. On this edifice the subject of dermatology took the present shape.

3.2.2.3 A brief look at the subject during this period

As it has already discussed that dermatology had emerged as a separate branch of medicine during this period, but in most hospitals of the country and medical colleges it was dealt as a part of the internal medicine.

One important phenomenon of this period is the direct effect of the Western Medicine on the medical system in India; this was due to the following factors:

(i) Establishment of the academic institutions to impart medical education according to the Western system;

(ii) patronage of the state to the promotion of the Western system of medicine—this had a direct bearing upon the traditional medicine of the country;

(iii) the quick, visible and profound effect of the modern medicine (e.g., use of penicillins for the management of any infection) over the traditional one lured people towards the Western system;

(iv) stagnation in research and development in the traditional system and entry of many non-qualified person in the system leading practically to collapse of the system;

(v) most of the texts of the traditional system for a long period were written in languages like Sanskrit and Arabian which were not in use in the common population;
(vi) scanty available study materials with variation in the reading as well as interpretation leading to confusion, controversy and standstill in the propagation of knowledge;

(vii) the education and knowledge of the traditional system were confined to families of Voids and Tabibs and there was always an effort to confine the subject in a secretive way within the families;

(viii) the educated and well established people of the society opted for the Western medical system as a sign of status. This fact attracted commoner towards the system;

(ix) many students from India got their training in England and hence influenced the medical system of this country with their knowledge.

So it can be seen how the newer modalities of treatment entered the country. In the West, medical science was undergoing a rapid change with the regular discovery of newer diagnostic methods leading to the precision in detection of the diseases as well as speedy discovery of medicines like antibiotics etc., that worked as life saving drugs for the then known incurable and killer diseases. Microscope had revolutionized the aetiological aspect of many diseases; histopathology, biochemical study gradually became the cornerstone in the diagnosis and classification of many groups of diseases.

3.2.2.4 Some new developments:

In India dermatological training was mainly based on the British texts. Diagnosis was mainly clinical but there were many laboratory methods then became available for better diagnosis. Physicians started following a systematic approach towards the skin diseases that was mainly based on the
methods of Willan and Bateman. Many new text books on skin diseases became obtainable though skin had remained largely a part of the internal medicine even up to a major part of this period.

The new feature of the books on skin diseases were the addition of many illustrations and photographs at a later period that provided a much clearer conception about any disease.

As about the leprosy, Dharmendra developed his Lepromin in 1942; sulphone was available for treatment of leprosy in mid 1940.202

There were many new materials available for the treatment of skin diseases. Walker in his book listed the following medicines: arsenic, antimony, mercury, sulphur, ichthyol, salicylic acid, quinine, iodide of potassium, ergot, iron, pilocarpine, alkalies, purgatives, thyroid extracts, suprarenal extracts etc for internal uses; tar, carbolic acid, cocaine, nicotine, hydrocyanic acid, salts of lead, zinc, bismuth, caustic potash, pyrogallol, paraffine oil, balsam of Peru, styrrax, iodoform, resorcin and many more was used as external therapy. Concepts of using bath, ointments, poultice, lotions, soaps, varnishes entered into the armamentarium. Phototherapy and use of x-rays for the treatment of skin diseases became available.203 Many of these remedies are still in vogue.

So it is seen that the Allopathic system in India followed the British footsteps. This system gradually became the main scheme of medical practice all over the country with the patronage of the government. Students from this country went to receive training in England and returned armed with the European degrees which were held in great esteem. Thus a new beginning of the subject of dermatology was witnessed in this period and surpassed the all other means that were practiced in the past in this country.
3.3 From A.D.1947 till the present days

3.3.1 Introduction:

The British Empire ruled India for nearly 150 years and on 15\textsuperscript{th} of August, 1947 India became an independent and sovereign country. The country since then concentrated on the overall development. Many changes in the health system had been undertaken to improve the medical system. Allopathic system remained the mainstay of the medical system. Other systems of medicine were also given prominence that was overdue for a long time. Many new developments in the research led to the contribution of knowledge towards the science and technology including medical science. An overall change towards betterment had been witnessed in all spheres in the last few decades.

3.3.2 Newer developments:

During the last few decade medical science including dermatology experienced many major changes in the diagnosis, treatment and other aspect of diseases. India followed the same line as the other countries in the world. With advent of the molecular biology, immunology, genetics, immunohistochemistry, biotechnology, genetic engineering and many more new branches of science dermatology witnessed a sea change in the diagnosis and management of different diseases.
Most of the hospitals and clinics in the country have got the basic facilities of common and base line investigations. Drugs for many common disorders like leprosy are supplied from these hospitals at free of cost. Medical colleges and higher centers perform many modern tests like immunofluorescence, advanced radiological investigations, serological investigations etc. to provide most advanced diagnoses of the diseases. As about the management is concerned, many higher centers provide the latest facilities like phototherapy, LASER, cosmetic surgical procedures etc.

So far as the subject of dermatology is concerned, the methodology, classification, diagnostic criteria for diseases etc. are followed in the country in line with those of the international system. In some cases India has its own system like the classification of leprosy. Some modifications in the system have been done according to the need of the country. Immunization against major health problems are in force and it has controlled many epidemics of the past. India has eradicated small pox and many such programs to eradicate or eliminate various diseases from the face of the country are underway.

3.3.3 Present scenario of Indian dermatology:

India is a large country with an enormous population. There is diversity in climate, language, custom, religion, economy, life style, food habits and many more things. Consequently the type of diseases and their epidemiology also varies. For example ‘kangri cancer’ is seen only in Kashmir whereas ‘mudichud’ in Kerala only, again dermal leishmaniasis is more common in Bengal, Bihar and Assam. With the change in socioeconomic condition and behavioral attitude the scenario of dermatological diseases is also changing. Even few years back leprosy was seen as a stigma, but with the effort of the
government, medical societies and social welfare organizations the incidence of the disease and attitude towards it has changed a lot. Only few years back dermatologists in India were busy with the management of skin diseases mainly whereas now many of them are practising some more advanced specialties like cosmetology and LASER surgery. Dermatology has now many new branches like dermatologic surgery, cosmetology, paediatric dermatology, geriatric dermatology, dermatopathology, contact dermatitis and so on, but if the situation is considered from the epidemiological point of view then it may be seen that scabies, pyoderma, mycotic infections, eczema and leprosy form the largest group of dermatological problems. About 25-35% of the out door patients of primary health centers have dermatological problems. It has been estimated that about 1 in every 20 person of the country has a skin problem.

The clinical and epidemiological pattern of various diseases of skin follows the classical pattern, but there are some conditions which are peculiar to this country. Dermatophytosis of the genitals is common in India. Actinic lichen planus and lichen planus pigmentosus is more prevalent here. Childhood pemphigus is another skin disease more widespread in India. Leprosy is still a serious health burden. Other diseases like cutaneous tuberculosis, pigmentary disorders, and deep fungal infections are familiar in this country. The recent upwards trend of HIV infection has become a matter of concern.

The present scenario of health management is much improved in comparison to the past though of course not adequate. There were only a few dermatologists in the country only about fifty years back. In 1991 the Ministry of Health and Family Welfare put the number to around 2000 for a population of 843 million. Now Indian Association of dermatologists, Venereologists and Leprologists is the largest organization with a strength of
early 5000 members and 23 state branches. Health care system is more reachable today even at the remotest corner of the country.

Dermatology of present time in India is not confined to the clinical problems only. Newer branches and subspecialties like dermatosurgery, dermatopathology, paediatric dermatology etc. and some more specified areas like pulse therapy, pigment cell research and photobiology are emerging as new development.

So it may be concluded that the course of the journey that started with the management of only a few skin diseases with a handful of dermatologists now is a prominent subject with advanced treatment with most modern research.

3.3.4 Contribution of Indians in the field of dermatology:

India not only developed and upgraded the medical system including dermatology of the country, but it has added much knowledge to the subject that is acknowledged internationally.

In this regard the contribution of Dr. J.S. Pasricha in the field of contact dermatitis and pulse therapy is well known.

Dr. L.K. Bhutani made significant contribution towards the cosmetic, especially vitiligo surgery.

The contribution of Prof. Sardarilal, Dr. Rajam, and Dr. Rangiah in the field of venereology is well known. Many pioneering work on leprosy had been
done by famous personalities like Muir, Lowe, Rogers, and Dharmendra in India with regard to research. Dr. Paul Brand was accredited for the pioneering work on reconstructive surgery in leprosy.\textsuperscript{217}

The contribution of Khanolkar and Talwar in development of vaccine in leprosy is also a major landmark in the history of leprosy research. Some diseases like madura foot, kala-azar are described from this country first in the world literature. Diseases like mudichud\textsuperscript{218}, kangri cancer\textsuperscript{219} is frequent in some states of the country and some condition like involvement of genitals in dermatophytoses is widespread in the tropical climate of the country.\textsuperscript{220} These have added and modified the age old view. There is a lot of contribution in the world literature on dermatology from Indian authors in these days. Indian authors have contributed in various well known texts referred all over the world.

3.3.5 National programme for the control of various dermatological diseases\textsuperscript{221}

Since independence the National Government has formulated various programmes to curb the march of the various diseases affecting the health of the people. Many of the international agencies like WHO, UNICEF, UNFPA, SIDA, USAID, World Bank etc are in assistance. Many of these national programmes are directly related to the dermatological disorders and some other has got an indirect but significant impact on it. A brief account of various relevant national programmes is as below:

(i) National leprosy eradication programme: started as National leprosy control program in the year 1955 for early detection of cases and supply of dapsone monotherapy. It gained momentum in the fourth five year plan and
subsequently the programme was changed to ‘eradication’ programme.

(ii) National AIDS control program: with the march of the killer menace of AIDS all over the world, the Government of India constituted a task force to take the stock of the situation in 1985. In the year 1987 National AIDS control program was launched and in 1992 National AIDS Control Organization (NACO) was formed. Two major plannings under this program are national blood safety program and national STD control program.

It is mandatory to test every unit of blood for transfusion for HIVs, syphilis, hepatitis B, malaria. This had helped in the detection of many new cases of these disorders.

As most of the STDs are coupled with the risk of transmission of HIV infections, STD control program has got much attention. This will help not only the control of AIDS but also of other STDs.

The phase-II of the National AIDS control program was launched on 15th December, 1999 with an objective to keep the situation more under control. The goal was to put restraint on the spread of infection under 5% in state like Maharasthra, 3% in Andhra Pradesh, Tamil Nadu, Manipur and Karnataka, and under 1% in rest of the country.

(iii) Universal Immunization Program: From the example of eradication of small pox it is obvious that an intense and well plane immunization program can wipe out a vaccine preventable disease from the surface of the earth. Hence in 1974 an ‘Expanded Program on Immunization’ was launched against six diseases, viz., diphtheria, pertussis, tetanus, polio, tuberculosis and measles.
Other eradication/control program that have direct or indirect effect on dermatological disorders:

(a) Reproductive and child health program (launched in 1987) — prevention of AIDS and STDs.

(b) Kala-Azar control program: for early diagnosis and control of cases.

(c) Dengue fever control program - to control dengue/dengue haemorrhagic fever.

(d) National diabetes control program.

(e) National guinea worm eradication program.

(f) National cancer control program, etc.

3.3.6 Medical education, research and publications in dermatology:

Medical education:

The commencement of academics in dermatology was marked about more than a century back when the first chair of dermatology was established in Grant Medical College in 1895. Major C Fernandez, better known as "founder of Indian Dermatology," is credited for this endeavor. Subsequently dermatology department was established in school of Tropical Medicine, Calcutta (1923), SGS Medical College and KEM Hospital, Bombay (1926).

As far as the post graduate teaching is concerned, Seth GS Medical College had a post of honorary dermatologist since 1926; a resident registrar and a house physician in the department of dermatology was appointed in the year 1930 and 1931 respectively. The honorary dermatologist was engaged in the
teaching of dermatology to the undergraduates of the college. In the year 1942 Bombay University appointed a committee to frame the rules regarding the conduction of diploma in dermatology and venereology and DVD was awarded to the successful candidate. It was a one year course and first ever examination was held in 1945. Another development in this regard is the permission of the College of physicians and Surgeons (Bombay) to the candidates to appear in the fellowship examination of the college in 1947. During the period of 1956-1974 various state governments set dermatology departments in the medical colleges of the states. In the year 1956, All India Institute of Medical Sciences (AIIMS) was established in New Delhi. Prof.K.C.Kandhari was appointed as the first head of the department of dermatology in 1960.\textsuperscript{225} This institute was entrusted with the training of teachers in the subject with an aim to establish departments in various colleges with the help of them. In the year 1961, the ‘Indian Academy of Medical Sciences’, later known as ‘National Academy of Medical Sciences’ was established by the distinguished authorities from different branches of medical science. Well known dermatologists like Drs.S.Rajam, Rangiah and Kandhari were among the founder members. There were 80 chairs of dermatology in different medical colleges all over the country and 272 post graduates admitted every year in various universities till 1993. There are 172 medical colleges in the country which have a dermatology department.\textsuperscript{226,227}

Following degrees and diplomas are awarded by the universities:\textsuperscript{228}

**Degrees:**

Doctor of Medicine (MD) in Dermatology, Venereology, and Leprology

Doctor of Medicine (MD) in Dermatology

Doctor of Medicine (MD) in Venereology

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Diplomas:

Diploma in Dermatology and Venereology (DVD)
Diploma in Dermatology (DD)
Diploma in Venereology (DV)
Diploma in Leprology (D Lep)

For the uniformity in the standardization amongst various post graduate degrees awarded by the universities, 'National Academy of Medical Sciences' started independently an examination held twice every year and it awards Diplomat of the National Board of Examinations (Dip.NB/ DNB) to the successful candidates. Any post graduate in the subject and graduates with a specified period of post graduate training in some accredited institutions may appear for the examination. Till recently the board conducted two separate examinations for 'Dermatology' and 'Dermatology and Venereology'. At present only examination for 'Dermatology and Venereology' is held.

Post graduate teaching in dermatology is well advanced in this country in comparison to other developing nations but much has to be done to form a uniform standard all over the country among different universities and also improvement is indispensable in the post graduate teaching and training. Another lacuna is the undergraduate training. In MBBS courses dermatology is dealt as small part of 'Medicine' and only few modules are allotted in entire tenure. The 'Medical Council of India' has recently set a guideline for the uniformity in teaching on dermatology in undergraduate course.
Research:

Since the commencement of modern dermatology research work has remained an important part of the system. Various multicentered drug trials, epidemiological studies and detection of various undefined diseases, diseases that are unknown/rare in other countries but common in India (e.g. mudichud, dermatophytoses of the genitalia etc.) have enriched the world literature on dermatology. The research works like discovery of urea stibamine for kala-azar by Sir U.N. Brahmachari or research of Dharmendra on Lepromin are few examples in this regard. The various trials using BCG and other mycobacteria for the development of leprosy vaccine is worth mentioning in this connection.

Publications in Dermatology:

The publication of research materials in dermatology dates back to the beginning of the Asiatic Society where reports on various diseases were read, discussed and subsequently recorded as the proceedings of the society. This has already been described in previous section of this study. The first organized publication was started with the “Scheme for obtaining a better knowledge of the endemic skin diseases in India” by Fox and Farquer in 1872. They also published the first epidemiological study conducted by Dr. Vandyke Carter as “Notes by Vandyke Carter” in 1876. This trend continued since then. Hundreds of papers on scientific research on dermatology and allied subject have been published in various national as well as international journals and many international text books have cited the work of Indian origin.
The 'Indian Journal of Dermatology, Venereology and Leprology (IJDVL)' is the official organ of the 'Indian Association of Dermatologists, Venereologists and Leprologists (IADVL)'. There is a long history behind the origin and development of the present journal. In the year 1935 Dr U.B. Narayan Rao first published the 'Indian Journal of Venereology' as a private publication. It was later renamed as 'Indian Journal of Venereal diseases and Dermatology' in 1940 and was published quarterly. On 31st March, 1955 the journal became the official publication of the 'Indian Association of Dermatologists and Venereologists' and there were three editors: Dr.G.Panja, Dr.R.V.Rajam and Dr.U.B.Narayan Rao. They were entrusted with the responsibility of 'dermatology', 'venereology' and 'managing editorship' respectively. In the year 1973 the name of the association was altered to 'Indian Association of Dermatologists, Venereologists and Leprologists' and the journal was also renamed as 'Indian Journal of Dermatology, Venereology and Leprology'. The maiden issue under this new name was published in 1976. The present journal is a bimonthly publication of the IADVL and it is indexed with PUBMED, EMBASE, Bioline International, CAB Abstract, GlobalHealth, DOAJ, Health and Wellness Research Centre, SCOPUS, Health Reference Centre Academic, InfoTrac One file, Expanded Academic, ASAP, NIWI, INIST, JADE, Uncover, IndMed, Indian Science Abstract and Publist. The web site of the IJDVL (URL: http://www.ijdvl.com) is available in 8 international languages in association to English. Apart from this publication of the IADVL there are several other journals published by the subspecialties of dermatology like Indian Journal of Leprosy, Indian Journal of Sexually Transmitted Diseases, Indian Journal of Pediatric Dermatology, The CSI journal of Cosmetic Dermatology etc.

Standard text materials used in teaching and reading in this country are mainly of British and American origin, but Indian dermatologists felt the need of some books that should be specially oriented to the requirement of the country. Hence many eminent dermatologists like Pasricha (e.g., Contact dermatitis, Clinical methods in dermatology, Treatment of Skin diseases, Colour Atlas of Sexually transmitted Diseases, Illustrated textbook of Dermatology etc), Sehgal (e.g., Clinical Leprosy, Venereal Diseases,
Textbook of Clinical Dermatology, Dermatological Drug Directory, Donovanosis, Histoid Leprosy etc.), Behl (Practice of Dermatology etc.)\textsuperscript{235}, Bhu	an i (Color Atlas of dermatology)\textsuperscript{236}, Khanna (illustrated Synopsis of Dermatology and STD)\textsuperscript{237}, Savant (Textbook and Atlas of Dermatosurgery and Cosmetology)\textsuperscript{238}, Khopkar (An illustrated hand book of skin diseases and sexually transmitted infections with an update on HIV infection)\textsuperscript{239}, Ganapati (Leprosy an overview)\textsuperscript{240} etc., undertook the job and published some of the very well written books as mentioned on various aspects of dermatology. A landmark in the history of publication of text book is set when at the 18\textsuperscript{th} IADVL National Conference at Jaipur in 1990 took the proposal floated by Drs Siddappa, Marquis and Valia for the publication of a text book by the IADVL. Accordingly the first edition of ‘IADVL Text book and Atlas of Dermatology’ was published in 1994. This is an extended text on the subject and oriented in the line of India dermatology.\textsuperscript{241}

**Formation of Associations and bodies:**

As the Dermatology was appearing as a speciality, dermatologists of this country felt the need of formation of a platform of their own that would facilitate the expansion of the subject further. There are many associations of Dermatologists, Venereologists and Leprologists like Indian Association of Dermatologists, Venereologists and Leprologists (IADVL), Indian Association of Leprologists, Indian Association for The Study of Sexually transmitted Diseases and AIDS, CODFI, Indian Association of Pediatric Dermatology, Associations on Histopathology, Cometology, Pulse Therapy, LASER etc., and regional or state dermatological bodies, some with independent existence like Bangalore Dermatological Societies\textsuperscript{242} Of them the IADVL is the largest and parental body with strength of nearly 5000 members and 23 state branches.\textsuperscript{243} A brief history of evolution of IADVL is discussed here:
In the year 1940, Bombay Association of Dermatologist took birth and had two chapters: Madras and Calcutta. The first all India conference of the association was held on December 27 and 28, 1947 at JJ Hospital, Bombay and was presided by Dr. R. V. Rajan. The rules for the all-India body were approved in June 26, 1948. In the second conference that was held in Calcutta in 1951 merger of three different chapters in to a single one was done. The association was named as “The Indian Association of Dermatologists and Venereologists”. The founder president was Dr. A. C. Rebello. There were only 24 members that constituted the association. The association was split in 1960 when a separate society took shape in the name of Dermatological Society of India (DSI) under the president ship of Dr. S. Rajagopalan. After a period more than a decade IADV and DSI decided to meet in Calcutta in order to formulate the amalgamation of the two into a single body. The meeting was held on 20th August, 1972. A final and unanimous decision was taken on 28th January, 1973 in Udaipur regarding unification and thus the ‘Indian Association of Dermatologists, Venereologistst and Leprologists’ came into existence. The first President was Dr. B.N.Banerjee and the first Honorary General Secretary was Dr. L.K.Bhutani of this newly formed association. The association was registered on 8th May, 1975 at Lucknow under the Societies Registration Act (21 of 1860). The association is a member of the South Asian Regional Association of Dermatologists, Venereologists and Leprologists (SARAD).

Other subs-specialities and their associations:

With the further development in the research and knowledge the volume of the subject has increased enormously. This has led many dermatologists to concentrate upon a particular subject and hence different subspecialties are coming into existence. The emergence of subspecialties has prompted the refining and redefining the various aspect of the dermatology. The like minded research workers and physicians have joined to form different associations to promote this task. Many new associations like Indian Association of Leprologists, Indian Association of Sexually Transmitted Diseases and AIDS, Indian Association of Pediatric Dermatology, Cosmetic Surgeons of India (CSI),
Pemphigus and Pulse Therapy Foundation, Contact Dermatitis Forum of India (CODFI) etc. are working in this direction. These bodies are holding regular conferences and publishing research works in their respective journals. Along with these IADVL has decided to set up special interest groups to tackle the problems and develop new knowledge on various subjects. There are many groups like contact dermatitis/occupational dermatitis group, pigmentary disorders group, pemphigus group, atopic dermatitis group, genodermatoses group, photodermatology group, dermatopathology group, pediatric dermatology group, dermatosurgery/cosmetic dermatology group, geriatric dermatology group, HIV/AIDS and STI group, dermatology clinical and epidemiological trials network, cutaneous adverse drug reaction study group, dermatology nursing group, teledermatology group etc. would be formed to work towards this goal.

Some individual institutions have also trying to improve the subject of dermatology according to their own effort and capacity. The arrangement of post-doctoral fellowship program started by the department of Dermatology, STD and Leprology of the Bangalore Medical College, Bangalore under the auspices of the Rajiv Gandhi University of Health Sciences is a notable incidence in this connection.248

**Awards and scholarships for the promotion of the subject:**

There are many awards, orations and scholarships for the up gradation and promotion of researches on the subject. Few of them are mentioned here:

**Orations:**

i. Dr. B.M. Ambady Oration
ii. IADVL GSK Oration
iii. IADVL Fulford Oration
Awards, medals and prizes:

i. Prof. K.C. Kandhari Foundation award
ii. Prof. J.C. Shroff Memorial award
iii. Dr. Leslie Marquis Memento award
iv. Dr. L.N. Sinha award
v. Prof. B.N. Banerjee gold medal
vi. Dr. B.B. Gokhale medal
vii. Prof. F. Handa prize
viii. Dr. Bishnupriya Debi award
ix. Indubala Debi award
x. M.G.M. Medical College prize
xi. Prof. H.C. Mohanti award
xii. Prof. K. Siddappa medal
xiii. Prof. D.K. Gupta medal
xiv. Dr. Manu Patel memorial award
xv. Best Branch (of IADVL) award
xvi. Dr. C.S. Bhabanikumar memorial award

The Indian Association of Dermatologists, Venereologists and Leprologists have also arranged training fellowships for the young dermatologists for the improvement of learning in many institutes of repute. The different subjects on which training fellowships available are: clinical and laboratory teaching in leprosy, contact dermatitis, dermatohistopathology, HIV/AIDS clinical, HIV/AIDS counseling, dermatosurgery and phototherapy training etc.
CHAPTER IV EFFECT OF WESTERN MEDICINE IN INDIA

HOMOEOPATHY AND DERMATOLOGY

Introduction

Homoeopathy is a system of medicine first advocated by Dr. Samuel Hahnemann (1755-1843) lived in Saxony of East Germany. While experimenting with cinchona in 1790 he observed that the high dose of cinchona that contains quinine produced malaria like symptoms whereas a very low dose of the same can cure malaria. He reached a conclusion that a substance that produced a disease in very high doses could be cured by the very low dose of the same substance: *similia similibus curentor* or like cures like.\(^{251}\)

In this system of medicine the patient is treated in totality i.e., if a patient comes with multiple problems, his/her all problem are deduced to the selection of a common source of defect and a medicine is chosen that has an effect on that particular defect may cure the disease. So homoeopathy does not have any superspeciality or sub-branches like allopathic system of medicine. Homoeopathy which had its origin in Germany, later spreaded to United States of America, France, England and other countries of Europe. In India homoeopathy entered during the British rule.

A brief review of history of homoeopathy in India:

Homoeopathy in India has a very old history. The practice of this system of medicine started during the life time of Dr. Hahnemann. The exact date on which homoeopathy started in India is not known but it is said that one German geologist started practicing in 1810 in Calcutta.\(^{252}\) Dr. John Martin Honigberger reached Lahore in 1829 and started the practice. The first endeavour to practice and broaden the subject happened in 1846 when a homeopathic hospital was established at Pudukota of Tanjavur district of Andhra Pradesh by a retired surgeon Samuel Brooking with the help of the local kings and highly
reputable persons of the society. The second such hospital was established by Dr. C.F. Tommeire in 1851 in Calcutta and the third in Bananas in 1861. Afterwards many hospitals were established in the country though with the personal effort as the system did not receive state patronage from the British Ruler.

Many celebrated personalities including many allopathic physicians adopted the new method. The system was firmly established in Bengal first and later made its entry to other parts of the country. Many physicians from abroad like Dinette Bering (stayed in India during 1864-1870), Leopold Salazar (1827-1907), also came to India and contributed in the development of the subject. Homoeopathy was thus practiced far and wide in British India.

In independent India many steps were taken by the government to uphold the system. A number of medical colleges and hospitals were established and a ‘Central Council of Homoeopathy’ was established according to the Central Council of Homoeopathy act of 1973. It maintains a register of qualified homoeopathic doctors and performs other activity to ensure a good standard of homoeopathic practice and training in the country. Research activity is conducted by Central Council for Research in Homoeopathy (CCRH). The web site of the council, http://www.ccrhindia.org has been framed to disseminate knowledge regarding the subject to the common people as well as research scholars of the medical science.

Homoeopathy and dermatology:

As per the philosophy of the homoeopathy is concerned it does not have any superspecialities like that of the allopathic system. It treats all the skin diseases as part of the manifestation of one or other disturbance of one or more of the miasmatic components. Now a day many topical preparations are used to treat various skin diseases. Many homoeopathic practioners claim a remarkable success in the management of viral warts, psoriasis, eczema etc.
5.1 Other Alternative System of Medicine

5.1.1 Introduction

The history of mankind shows that man has been in search of cure of his diseases through various modalities of management. His dependence for this purpose ranged from 'faith healers' to the 'super specialists' of modern medicine. In the course of time different methods took shape and practiced. Many of these systems are intertwined with the practice and belief of a particular group of people and particular geographical boundary. In the present days of medical care, the treatment methodology is mainly dependent on the allopathic system of medicine. Other ways of treatment apart from that of modern medical sciences are broadly termed as 'alternative system of medicine'.

It has been perceived that any particular system is not enough to tackle problem related to health and hence the need of critical analysis of all the available avenues of treatment in the light of scientific knowledge has been stressed. The modern allopathic system is becoming more and more dependent on highly advanced and technologically dependent diagnostic and therapeutic system. Though these advancement has lead to the development of the science, but at the same time the health care system going out of the reach of the masses due to high cost and little availability of the newer modalities. Therefore question has been raised about the logic of following such methods and also there is growing concern about the efficacy of the modern allopathic system from various points of view. All these factors have generated curiosity in the other systems of medicine.
5.1.2 Reasons for the emergence of alternative system of medicine

An article entitled ‘alternative medicine and dermatology’ have tried to put the issue in following manner: ‘...why do some of our patients look towards alternative forms of treatment in preference to those offered by conventional medicine in general and dermatology in particular. The answer, however painful, must be that we are failing in some way to come up to our patients' expectations and there are many possible reasons for this failure.\textsuperscript{255} Along with high cost, low coverage, there are other factors that have become an impediment for the highly advanced system of medical science. There are many reasons why alternative systems of medicine are becoming popular among the masses:

(a) The limitation of the allopathic system in curing many diseases effectively have fascinated people towards the other avenues;

(b) The cost of alternative system of therapy is much less;

(c) Medical personnel of the allopathic system of medicine are overburdened and hence spend much less time with the patients. On the contrary, the therapists of alternative system lend a patient hearing to the complaints of the patients which is a corner stone of a better doctor-patient relation as well as outcome of the management;

(d) Side effects of many modalities of modern allopathic system sometimes become a concern of the patients which are reportedly lesser in alternative systems. The role of media in this regard can not be denied. They have sometimes become overzealous in the criticism of the allopathic system;\textsuperscript{256}

(e) Alternative system of medicine most of the time uses drugs of indigenous origin which are easily available and low cost. Therapists of these systems are not dependent on the developed countries for procuring medicines etc. Some of the system, like yoga, chiropractic etc. even do not use any medicine at all;
(f) The upsurge of nationalism in many countries has lead to the introspection and development of the indigenous system in the health care system denouncing the foreign methods of treatment;

(g) The holistic approach in the health care delivery system has also supported the emergence of alternative systems of medicine.

5.1.3 Different alternative system of medicine and their relation to skin diseases

All the available modalities of alternative systems of medicine may be broadly classified into four groups:

(a) Completely self dependent systems: Other than allopathic system systems that are complete in diagnosis as well as management are Ayurvedic, Unani, Homoeopathy and acupuncture.

(b) Alternative diagnostic system: These systems diagnose and search the cause of bodily discomfort by its own way. Some of the examples are kinesiology, iridology, trichology, aura diagnosis, intuitive diagnosis etc.

(c) Complementary medical system: These systems help other system of treatment for the better management of patients. examples are massage therapy, shiatsu, reflexology, chiropractic, zone therapy, osteopathy, manipulation, hydrotherapy, mud therapy, mineral therapy, aroma therapy, art therapy, music therapy, hypnotherapy, magnetotherapy, naturopathy, aversion therapy etc.
(d) **Self dependent treatment system:** in these methods patient can treat himself/herself without the assistance of any other. These are meditation, macrobiotics, visualization therapy etc.

These systems of medicines are sometimes claimed to be of immense help in the management of 'difficult-to-treat' skin diseases. The relation and place of skin diseases with the major alternative systems like Ayurveda, Unani, and Homoeopathy had been already discussed. Some of the examples of roles of alternative systems in the management of skin diseases are discussed here. The claims made by these systems are not always full proved in accordance with the modern medical sciences.

**Kinesiology** may be helpful in the diagnosis of detection of food allergy. The system claims that the kinesthetic behavior of muscle(s) changes as soon as any allergic food is ingested by an individual.

**Trichology** helps in the diagnosis of many diseases by analyzing hairs. Detection of nutritional disorders and diseases secondary to the effect of various metals are very helpful.

**Hydrotherapy** may ameliorate various skin conditions using sauna and steam bath. It may be of help in the management of acne.

**Aroma therapy** uses many fragrant products for the treatment of skin diseases.

**Biofeedback therapy** provides input to the patients about electrical conductivity of the skin, heart rate, brainwave etc and patient is trained to gain control over the monitored function. This method may be helpful in the control of palmar sweat rate and hyperhidrosis, dyshydrotic eczema, Raynaud’s disease.

**Autogenic training** is the method where biofeedback is used directing attention into rather than away from the individual. This is helpful in the management of eczema and psoriasis.
**Behaviour therapy** uses techniques like systemic desensitization, aversion therapy, operant techniques, assertive training etc. These methods are claimed helpful in the management of trichotillomania, erythrophobia, blushing, hyperhidrosis, exfoliative dermatitis etc.

**Hypnosis** has been claimed to be of use in diseases like ichthyoses,\(^{264}\) warts etc.\(^{265}\)

All these systems are practiced more or less allover the country and their role in health care system can not be denied. There are many institutions which provide training and also there are various media broadcast on these subject. These methods, particularly herbalism is becoming very popular now a day with the idea that natural products are human friendly unlike those of the substances used in allopathic system.

### 5.2 Tribal medicine—— A brief overview

#### 5.2.1 Introduction

Tribals are the 'ab-originais' of the country/regions who have a distinct identity of their own. There are many tribal groups living in India from time immemorial. Most of them are indigenous and some of them, like Todas of Nilgiris have been hypothesized to have connection with some distant civilization of the past, like Sumerian civilization.\(^{266}\) The numbers of different tribal groups vary according to different studies, though the most quoted figure is 432.\(^{267}\) There are innumerable variations in different aspect of culture, belief, religious procedures, taboos and many more among different tribes and among different subgroups of a particular tribe. Article 29 of the Indian constitution provides protection to these communities to preserve their languages, dialects and cultures.

Each of these tribal groups has their own way of treatment, many of which are thousands of years old. It is a very difficult task to go into detail of the practice and concepts about the skin diseases in these groups. Most of these groups suffer from
many common diseases of malnutrition and other contagious diseases. They suffer from various skin diseases as well due to polluted water in which they bathe and from the attack of various insects. They tackle the problem with their own way. At times they seek medical help from the modern methods of treatment.

5.2.2 Some tribal medicines and dermatology

There are a number of tribes living in India with cultures that vary from one to another. Their belief, attitude and method of fighting diseases are also varied. Hence the study of dermatology in each of these tribes requires a separate work. A very brief review of two of the major and prominent tribes of the country and their view about skin diseases are outlined here as an example only:

Of the various primitive tribes of central India, koles are very prominent. People of this tribe believe that diseases are the work of unfriendly spirits; for example, cholera and small pox were considered as the work of goddesses. The baiga priests perform procedures to please evil spirits and gods who are supposed to be responsible for the diseases. They perform ceremonies like supa ceremony, totak vidha etc and use mantras for these. Traditionally they use many substances of plant and various other natural origins for the management of different diseases that are prescribed by the baids.

They use charcoal dust for the management of burns. Preparations from different parts of neem tree are used for the treatment of itches. Kanji (Pongamia glabra) oil is also used for the same purpose. Ghee (clarified butter) is applied on various swelling as a part of the management.

Santals are other large tribes forming a sizeable population in India. They look upon the diseases as something unnatural and have their own way of thinking on this belief. They also have some particular concepts regarding some diseases. They held tejo (these may vary from large to as small to be invisible to the naked eyes,
commonly thought as larvae, worms etc.) to be responsible for many diseases. There may be some specific tejo responsible for one particular disease, like one tejo is responsible for leprosy whereas another for cancer of the jaw again some other for the scabies and so on.²⁷⁰ They also please Bongas for the control of diseases and these work are mainly performed by the Ojhas.

Santals have knowledge about many skin diseases. They know about gurmi (venereal diseases), guți (small pox), and mürhuc jom (leprosy). Skin diseases are considered second in prevalence amongst various diseases.²⁷¹ The root of administration of medication may be oral or topical. They some times use ashes mixed with saliva for topical application. Fowl’s feather is sometimes used for applying medication. Medicinal steam baths are also used as remedies for many diseases.²⁷²

Some typical prescriptions as collected by Rev. Bodding about 80 years back are quoted and enlisted below:

1. For darkening the premature gray hairs ([up hende ocoe]): a mixture of Banã ic (bear’s excrement) mixed with Mìthì (Trigonëllä foënum) to be applied for three consecutive Sundays.

2. Telogen effluvium ([ruate pòtorlen khan] - bônga sarjom rehet chal (the bark of the roots of Ventilagö calyculatä) to be grind with gabla darerekko tolok tejo (the insects living on the leaves of Acacia Arabica) in the presence of gotom (melted butter) and bagluça (Martyniä diandra). The mixture has to be boiled and applied on the scalp for regaining the hairs fell as aftermath of fever.

3. There are many medicaments prescribed for ojo (boils) and bìphor (carbunles), ghao (sore), agyo ghao (sores on shin, thigh elsewhere), bohok ghao (sores on the head), bônga khoda (slowly healing ulcer), dora ghjao (an ulcer on the waistline due to wearing of string or dora), kakbirål ghao (axillary lymphadenitis), ghura ghao (?erysipelas), goda ghao (ulcer with oedema of the leg), karghao (? Scabies), khuda jaora ghao (?impetigo), para ghao (ulcer due to mercurial poisoning), uru ghao (tinea capuïtis), kasra (scabies), talsa (measles),
In association with the medications Ojhas used to utter some mantras in expectation of curing the ailing person.

From the above discussions it is very clear that the tribals have their own way of treating different diseases including skin disorders. Though they are more or less dependent on the magico-religious way of treatment they also have recognized different diseases and have a pharmacopeia of their own.

5.3 Quackery and dermatology

India is a vast country with a huge population. The country has its own system of health network. This net work is not sufficient for the whole population due to the inadequate economic support, lack of proper infrastructure and dearth of adequate trained man power. The high cost of modern medical system and dearth of latest diagnostic facilities at the peripheral level has compounded the problem further. The country is producing 12000 Allopathic doctors, 3763 Ayurvedic doctors, 785 Unani graduates, 150 Siddha graduates and 3490 Homoeopathic graduates annually on an average still the supply in respect to the demand is not up to the mark. The suggested norm for doctor-population ratio is 1:3500, but the actual figure is 48 doctors for each 100000 population. Most of the time the present health care delivery system is criticized due to (i) predominantly urban orientation; (ii) accessible to only a small part of the population. On this background the nearest health care provider in the remote corners of the country are local physicians. These group of medical men do not have any systematized and formal training and on the basis of some preliminary knowledge, which could be no more than some incomplete and erroneous knowledge of some medicines, they treat a vast population of the country. These so called medical men treat all kind of ailments and hence skin diseases are no exception.

Quackery in dermatological practice seems to be more rampant than any other branches of medicine. The reasons behind this could be: (i) most of the skin diseases do not have
any immediate threat to life, hence chance of death of the patients and its legal and social consequences upon the treating physicians are rare;(ii) apparently common skin diseases do not require much investigations, hence treatment can be started immediately;(iii) some readymade remedies in the form creams/lotions containing multiple ingredients in a single tube/bottle are available in the market which encourage quacks to prescribe them with a belief that any one or more of the ingredients might hit the target;(iv) almost all drugs including many with immediate healing action at the cost of dangerous side effects are available in the market without prescription. Quacks are not aware of these side effects but are using to treat their patients, as they have a fear of losing patients if the patient does not get relief at the earliest. Misuse of systemic corticosteroids is one well known example of this phenomenon. (v) Many of the skin diseases like eczema, psoriasis etc are not curable in currently available recognized systems of medicines. Patients become frustrated with the failure and expense and ultimately fall in the trap of quackery where at least the apparent cost of therapy is much lesser.(vi) Most of the quacks belong the same community and social environment as the patient, therefore patients are closer to them to confide diseases like leprosy, vitiligo etc. As these quacks are well versed with the customs and rituals of the society, their methods are suited accordingly and thus are more acceptable to the common people.

Thus whatever be the reason the role of quacks in the history of dermatology can not be denied. The modern science of dermatology is very badly affected by quackery and wrong methods of treatment that invites catastrophe. Though treated by quacks, the blame of these disasters fall upon the allopathic system of medicine and this leads the common people away from scientific medical management and they also form misconceptions about the subject as a whole. Deformity occurring in leprosy due to delayed and wrong diagnosis as well as treatment is a common example of this fact. Unless adequate medical facility and strict laws are provided, the menace cannot be eradicated.