DISCUSSION

GENERAL DISCUSSION:

Traditional medicine as it exist among the ethnic groups of Darrang district in Assam today is the result of a long historical and cultural development, and although the present study is basically a synchronic one it is indispensable to trace the most important historical lines and cultural influences that have moulded this tradition into what it is today. This historical background will — at least partly explain the considerable variations that exist within the traditional medicinal practice in the area of work, and especially the development of the urban and rural variants.

Darrang district is with a socio-cultural mosaic of the people of diverse ethnic identity, both indigenous as well as migrated to the district. This has resulted in continued and reciprocal cultural exchanges among different ethnic groups and also received impacts from mainland India and neighbouring countries. Traditional medicine as a part of the cultures of the ethnic groups also received impacts from this exchanges.

The use of herbs in curing ailments is a living tradition in the district with a history that disappears in the mists of the past. It is nonscholarly without any kind of institutional didactic instruction and has been transmitted individually from teacher to pupil — partly orally and partly by means of handwritten manuscripts. The materia medica is taken mainly from the botanical kingdom, but with ingredients also coming from animal and mineral kingdoms. The prescriptions often contain many ingredients, and the principles of preparing and administering the medicines are common to the tradition. Magical practices and incantations are an integral part of traditional medicine. Traditional herbalists do not perform any kind of surgery on or dissection of the human body, and their views of anatomy and the functioning of the body are thus quite different from those of the West. Traditional medicine is the ancient art of healing in the area, but it has over centuries, received influences with various degrees of impact from surrounding medical traditions and the traditions of the ethnic groups so that today it does not appear as one unified tradition. In addition to the outside influences, the aura of secrecy that surrounds the tradition has hindered
Fig. 6.1: Number of species, genera and families of different plant groups used in Ethnomedicine in Darrang district.
Fig. 6.2: Analysis of Prescriptions.

1 - Total Prescriptions.
2 - Less known Prescriptions.
3 - Prescriptions with single plant species.
4 - Prescriptions with two plant species.
5 - Prescriptions with three plant species.
6 - Prescriptions with four plant species.
7 - Prescriptions with more than four plant species.
Fig. 6.3: Diseasewise total number of prescriptions along with the number of less known prescriptions.

1 - Animal bites. 8 - GIT disorder.
2 - Antifertility. 9 - Pain & Fever.
3 - Anthelmintic. 10 - Respiratory.
4 - Bone fracture. 11 - UGT disorder.
5 - CNS disorder. 12 - Skin disorder.
6 - Cuts, Wounds & Swelling. 13 - Miscellaneous.
7 - ENT disorder.
Fig. 6.4: Methodwise no. and percentage of application of ethnomedicinal prescriptions.

- Orally administered (528).
- Topical and local (215).
- Smoking and inhaling (17).
- Bath (3).
- Massage and fomentation (28).
- Other (31).
1 - Whole plant.
2 - Root and tuber.
3 - Stem.
4 - Bark.
5 - Leaf and shoot.
6 - Flower.
7 - Fruit.
8 - Seed.
9 - Latex and juice.

Fig. 6.5: Frequency of plant parts used in the Prescriptions of Ethnomedicine.
communication among the practicing herbalists, a fact that has further enhanced localised and individual diversity.

Although from a historical point of view there exist two types of traditional cures: those practicing inside the courts ('Royal doctors') and those outside ('Common doctors'), the adjective referring to the social status of their patients, yet from a contemporary point of view one can reckon with basically two types of traditional medicine in Darrang district. The urban variant, which is the direct heir of the royal tradition, and in which also brought many of the Ayurvedic prescriptions into its folds. It is to some extent standardised in the form of handwritten manuscripts and even printed books. The rural or village variant is the traditional medicine as it is practised in the countryside. This later variant, which has hardly been studied up to now, consists of several local variants.

The rural or village variant is not only during its long existence has acquired experience in the treatment of diseases which may be valuable to science, but also it is an integral part of culture and social history of the ethnic groups. Furthermore, it has still survive as a dependable health care system among the ethnic groups in the face of advent of western medicine and thus worthy of study in itself.

**Traditional curers:**

The herbalist is but one of several types of traditional curers among the ethnic groups in their traditional medical practices in the area of present study. The types of curers found practicing in the area are:

(a) The general term 'Kabiraj' or 'Bez' or 'Ojha' (local doctor) refers to three types of curers — the herbalist, the blower, and the sender — who all have in common that they may be of either sex. In principle, one and the same person may be herbalist, blower and sender, although normally these functions are divided among different persons.

(a-1) The herbalist covers almost the whole disease panorama, using his arsenal of herbs and other natural substances as the basis for his therapeutics. Incantations form an integral part of the tradition.

(a-2) The blower specializes in curing ailments by blowing incantations either directly on the affected part / organ of the body or through one or the other media.

(a-3) The sender performs a series of ceremonies aimed at reintegrating people, including sick ones, into the community, through ceremonies calling on the spirit-essence of a person or by sending away bad luck.
(b) Aching muscles or pains in any part of the body are often treated with massage, which is normally accomplished with oracles by persons specialised on it. Inspite of the fact that massage is very common treatment, there is no signs that this art is passed on through a tradition, nor did anyone making a living from it. However, there are several manuscripts dealing with the art of massage.

(c) The traditional midwives are predominantly female, specialising in pre-natal, peri-natal and post-natal care of both mother and the baby. Although most of the women now-a-days prefer to give birth with the aid of Western-trained midwives, or in hospitals, yet most women prefer to receive the care of traditional midwives during post-natal periods.

(d) The swinger is a female practitioner who finds the cause of minor children’s ailments through deviation.

(e) The medium who through possession of omniscient spirits, find the cause of diseases and may even attempt curing certain diseases with one or other kind of ceremonies.

Aquision of Knowledge:

As stated above medical tradition in the area of present study without any kind of institutional didactic instruction. The medical knowledge is passed on partly by word of mouth and partly in handwritten manuscripts. The herbal doctors aquire their basic medical knowledge heriditarily by a son from his practitioner father, or by establishing a teacher-pupil relationship with someone who is already within the tradition. A student of traditional medicine will normally establish many of the later relationship, and thus aquire knowledge from many different teachers, while the teacher most commonly just pass on certain part of their knowledge to each student.

Obviously nobody covers the total knowledge of the whole tradition. Very often the medical interest of a future herbalist will start because he or she himself of herself with one particular disease and is cured by a practicing herbalist. He or she will afterwards ask the herbalist for the prescription that cured him ; that is, become his disciple and then slowly begin practicing on patients with this particular disease. By and by he or she will collect more prescriptions against the disease and, if his or her interest, experience, and reputation allow it, expand his or her range of cure, acquiring new knowledge and other prescriptions by becoming a disciple of other herbalists. Practitioners thus start out as specialists but will, as time goes by, widen their range of curing activities and thereby become more and more generalists.
The medical manuscripts:

In an attempt to check and compare the oral information with the information in the medical manuals, more than 20 handwritten manuscripts were scrutinised. The contents of the manuscripts almost invariably turned out to contain simple sequences of independent prescriptions, written in no apparent order. In some cases, however, more detailed prescriptions of main disease groups are there. These manuscripts show that there have been attempts made to systematise small sections of disease panorama, even if inconsistently and incompletely. Furthermore, astrological data are also incorporated in some medical manuscripts and thus, use of astrology in determining the origin and development of disease are also evidence in some cases.

Prescriptions:

Each prescription is a separate entity. On the whole, there exist literally hundreds of different prescriptions in medical tradition of the district. An herbalist often possess large number of prescriptions, although only a small fraction of them - the ones that are considered particularly effective - are in daily use. There also exist many different prescriptions against the same disease. Also due to interaction of cultures of neighbouring areas or even countries like Bhutan for centuries, it is certain that a lot of prescriptions have found their way into the tradition.

The information on the prescriptions is always with three parts: first a brief heading with the name of the disease(s) and the symptom(s), followed by enumeration of the materia medica in the prescription (and sometimes relative weights), and finally an explanation of how the components should be treated and administered to the patient.

Prescriptions and materia medica:

All prescriptions are either mixed drugs composed of two, or more different ingredients or of single ingredient. Plant materials makes up the heavy part of the drugs, although some animal and minerals are commonly used. The composition of the prescription obviously has an economic value to the owner, and is thus guarded with great care. While the healer talk freely about the diseases and the curing properties of single plants, there is an aura of secrecy surrounding the way these components are form prescriptions.

The prescriptions - together with the incantations - make up the core and the most stable part of the medical tradition. The content of these have been fixed once and for all, and must not be tampered with. The omission of even a small part renders
them useless. Additions of new ingredients are, however, seldom.

**Incantations**

The incantations are an integral part of the tradition as a whole. They are sometimes ‘blown’ on the drug while it is being prepared to enhance its effect, sometimes recited while the herbalist is administering the drug or performing other curing practices — especially the ‘rubbing way’ rituals or they are simply blown on to the patient without being accompanied by drugs at all. In most cases the language used in the oracles are not easily understandable and in most cases the individual words bear no apparent meanings. It is however ascertain that most of the words used in the incantations are form Buddhist tantric scriptures, Sanskrit scriptures, vernacular languages and form the dialects of the ethnic groups.

**DISEASE CONCEPTS AND DIAGNOSIS**

A disease concept may include both symptomatic, pathogenic, and etiologic characteristics. In cosmopolitan medicine most diseases are described and circumscribed with reference to all these criteria. The growing experiences and knowledge as to pathogenesis and etiology of illness have brought forward a classificatory system that puts the main emphasis on these criteria in disease circumscription rather than on the symptomology.

In a local medical tradition as it is practised in Darrang district, the situation is different. The medical knowledge is empirical, growing out of practical experiences, and diseases are only conceptualized in symptomatic terms. Etiological and pathogenic data are either not known or if known, it is of a very general nature and indeed of little or no importance in disease circumscriptions. Consequently, compared with cosmopolitan medicine the disease concepts in traditional medicine in Darrang district turn out to be “Collective diseases” or syndromes.

In a medical system it is important to distinguish between the verbally communicable disease concept on one hand, and the diagnosis of a disease in the medical practice on the other. A diagnosis is a label on a disease, and is the result of a diagnosis procedure during which all available information from the diseased is appraised with reference to the knowledge of the practitioner. In some cases however, it has been told by the practitioners that some identical symptoms may need quite different therapies, a fact that the practitioners recognise different disease having exactly the same symptoms. In those cases an on-the-spot diagnosis is impossible. The diagnosis has to be proved by the therapeutic response to the actual prescriptions and therefore, the diagnosis is established ex post facto.
DRUGS AND DISEASES:
The curing range of prescriptions:

The curing ranges vary considerably. They may be limited to one disease only — sometimes enlarged with a few symptoms — or they may contain several, or large variety of, diseases and symptoms. In other words, the curing ranges of the prescriptions are more or less extensive and they more or less overlap one another. This immensely complicates not only a comparison of the prescriptions but also a comparison of the medical applications of the plants within the prescriptions.

The ingredients:

An important question is which of the ingredients in a prescription are essential, that is, which of them contain bio-active principle that may cure the disease?

On a purely logical level it is assumed that ingredients with a high recurrency rate in prescription against one specific disease are promising in terms of possible therapeutic effects. However, the ingredients with a high frequency score in prescriptions against many other and quite different diseases as well are not likely to be the most essential parts of prescription. The promising ingredients are specially those with a high frequency score in prescriptions against one disease and no other, or those which are restricted to prescriptions against diseases with a common or similar symptoms.

At first glance it also look reasonable to assume that the shorter the prescriptions, the more likely they are to contain the most effective ingredients. The logic behind this assumption is plain enough: centuries of trial and error should have resulted in the effective ingredients being retained in the prescriptions and the ineffective ones being gradually dropped out.

At this point this exposition naturally raised a fundamental question: To what degree do the ingredients actually recur in prescription against the same diseases?

In spite of bits-and-pieces transfer of knowledge, one would expect the prescription to be a stable part of the tradition. This assumption is strengthened when we take into account the fundamental rule regarding transfer i.e. prescriptions have been passed on from time immemorial and should not be tampered with. With this rule in mind it becomes a paradox to discover the diversity and heterogeneity of the prescriptions.

Before this paradox is explained, it is imperative to ponder the ideology behind this rule: today's variety and fragmentation goes back to an original unity. In the
beginning everything was one: there was one original teacher who had the answer. Apparently he had found the cure (prescription) for each disease. The idea is that the past was glorious (and, implicitly, the present less so) and one should respect and cling to it. Therefore: do not omit particularly for the superstructure — the practitioner's own understanding of the tradition.

This is obviously an idealised version of history and the ultimate consequence of such a view is stagnation. In spite of this reverent and conservative attitude, the medical tradition has not been stagnating, but has on the contrary been continually changing. So much so that heterogeneity has become a fundamental characteristic of the practice of the tradition today. The reason is that besides the above mention rule, which aim at stability and homogeneity, there also exist three other implicit rule for transmission, which secure change and development of the practice of the tradition; namely addition, replacement and creation of new prescriptions.

**Addition:**

The rule of adding allows for new experiences (i.e. curative properties of plants) to be added to existing prescriptions. One might suspect that, in case of diseases that have turned out difficult to cure, the rule "if a prescription does not work, experiment by adding" has been applied, causing a continual increase in the number of ingredients in certain prescriptions. Another reason for the multi-ingredient prescriptions could be a general tendency in the tradition to incorporate rather than to exclude. Regarding drugs, practitioners of cosmopolitan medicine are prone to adopt the attitude: The less the better — in other words, isolate the active components and purify them, according to the rule. In medical tradition of Darrang district practitioners seem to take the opposite position: The more the better.

**Replacement:**

A practical reason for allowing the substitution of one ingredient for another is the situation herbalists commonly find themselves in when they can not get hold of one or more ingredients they need right away. But replacements must have been restricted in one way or another for one can not, of course, replace an ingredient with any other random ingredient. Obviously, the exchangeable ingredients must have same quantities in common.

Generally speaking, it can be assumed that experimenting with additions and substitutions have taken place. These experiences, however, have not normally been passed on to other curers. The same experiences may thus have taken place over and over again, resulting in an ineffective and slow accumulation of knowledge.
Creating new prescriptions:

One can come across examples of new prescriptions against any disease and one can not confirm beyond that new prescriptions are being created. It is not acceptable, however, that the rules of additions and replacement are sufficiently explain the heterogeneity of the prescriptions. The only way to explain this is to postulate that creation of new prescriptions (including loans from neighbouring medical traditions) simply must have taken place and still takes place, on a considerable scale.

It can be concluded that the transition from adding and replacing ingredients and merging of already existing prescriptions one hand, and creating new ones on the other, is a relative and gradual one.

DISCUSSION ON MEDICO-ETHNOBOTANICAL ASPECTS:

The core of the medical tradition of Darrang district is the curative aspect, and above all the utilisation, of plants as medicinal drugs or the Medico-botanical aspects. In fact, the tradition as a whole is built on around the practitioner’s knowledge of plants and their experiences with them or it can be put “The important thing is not what one call a disease, or from where it comes, but rather to know which preparation must be used to get rid of it”. In the minds of the user of traditional medicine a good doctor is one who has effective medicine at his disposal.

The medico-ethnobotanical investigation has resulted in recording the use of a total of 338 species under 271 genera belonging to 102 families in therapeutic practice of Darrang district. A breakdown of the number of species, genera and families of different plant groups involved is given in Fig. 6.1. Of the total 338 species, 25 (7.4%) species seems to be either little known or unknown for their medicinal use on comparison with common literature on medicinal plants, while the rest 313 (92.6%) species, though not all widely known, are found mention in literature.

Considering the number of species the families viz., Fabaceae, Euphorbiaceae, Asteraceae, Zingiberaceae and Solanaceae predominate in their use in ethnomedicine in Darrang district (Table- 6.1). The size of families naturally has a relationship with these figure.
Table 6.1: Dominant families used in Ethnomedicine in Darrang district.

<table>
<thead>
<tr>
<th>Families</th>
<th>No. of genera</th>
<th>No. of species</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fabaceae</td>
<td>18</td>
<td>20</td>
</tr>
<tr>
<td>Euphorbiaceae</td>
<td>11</td>
<td>15</td>
</tr>
<tr>
<td>Asteraceae</td>
<td>13</td>
<td>14</td>
</tr>
<tr>
<td>Zingiberaceae</td>
<td>7</td>
<td>14</td>
</tr>
<tr>
<td>Solanaceae</td>
<td>6</td>
<td>13</td>
</tr>
</tbody>
</table>

It is seen that out of 338 species, plants of herbaceous habit are the commonest to be used (134 species; 39.7%), followed by trees (86 species; 25.5%) and shrubs (81 species; 24.0%), the last being the climbers (36 species; 10.7%).

A total of 822 prescriptions based on 338 species have been recorded. Out of the total 822 prescriptions, 492 (59.8%) involve single plant, while 164 (20.0%) prescriptions involve two plant ingredients, 64 (7.8%) prescriptions three, 42 (5.1%) prescriptions four and rest 60 (7.3%) prescriptions involve the use of more than four plant ingredients (Fig. 6.2). As far as the use in a particular ailment is concerned, 145 (17.6%) of the total 822 prescriptions seem to be either little known or unknown on comparison with common literature on medicinal/ethnomedicinal plants, while the rest 677 (82.4%) prescriptions, though not all widely known, are found mention in literature. The less known prescriptions are marked with asterisk (*) sign in the text.

On the basis of curative properties with which they are associated, the prescriptions can be categorised: (1) Animal bites (snake-bite, insect-sting, dog-bite, scorpion-sting, etc.), (2) Antifertility, (3) Anthelmintic, (4) Bone fracture and dislocation of bones, (5) CNS disorders, (insanity, epilepsy, delirium, paralysis, etc.), (6) Cuts, wounds and swellings, (7) ENT disorders, (8) Gastrointestinal (GIT) disorders, (9) Pain, (10) Respiratory disorders, (11) Urinogenital (UGT) disorders, (12) Skin disorders, and (13) Miscellaneous. The miscellaneous category includes jaundice, dropsy, piles, spleen enlargement, diabetes, caries, anaemia, toothache, goitre and lactagogue.

The total number of prescriptions along with the number of less known ones used for these 13 ailment/symptom categories are shown in Fig. 6.3.

The maximum number of prescriptions used for a particular ailment can possibly show the prevalence of the ailment in the area of present study. Analysis of data
reveals that the maximum number of prescriptions have been reported for gastrointestinal disorders, followed by urinogenital disorders and skin diseases. For other ailments, relatively lesser number of prescriptions have been reported.

The study also revealed that at least six methods of application of medicine or usage are included in the prescriptions. The maximum number of prescriptions are orally administered (64.2%), which are followed by topical or local application (26.2%), massage and fomentation (3.4%), smoking and inhaling (2.0%), bath (0.4%), and others (3.8%) (Fig. 6.4).

Table 6.2: Method of application of ethnomedicinal prescriptions.

<table>
<thead>
<tr>
<th>Method</th>
<th>No. of prescriptions</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orally administered</td>
<td>528</td>
<td>64.2</td>
</tr>
<tr>
<td>Topical or local application</td>
<td>215</td>
<td>26.2</td>
</tr>
<tr>
<td>Massage &amp; fomentation</td>
<td>28</td>
<td>3.4</td>
</tr>
<tr>
<td>Smoking &amp; inhaling</td>
<td>17</td>
<td>2.0</td>
</tr>
<tr>
<td>Bath</td>
<td>3</td>
<td>0.4</td>
</tr>
<tr>
<td>Others</td>
<td>31</td>
<td>3.8</td>
</tr>
</tbody>
</table>

Medicines that were indicated to be administered orally included those claimed to be used mainly for treating intestinal parasites, diarrhoea, dysentery, other gastrointestinal diseases, bronchial troubles, urinary troubles, epilepsy, etc. Orally prescribed medicines includes liquid preparations, non-formulated medicines, pills and medicines mixed with foodstuffs.

Medicines recommended to be applied topically were included mainly for skin diseases, wounds, eye diseases, problems of ear, nose and throat, sprains, protruded rectum, swellings, eczema, external bleedings, bites, etc. These medicines were liquid preparations, pastes, ointments and powders.

Smoking was suggested to be employed for ailments of respiratory tract, throat infection, etc. In this case, non-formulated or powdered medicines were used to produce smoke.

An interesting method was steaming/inhaling of vapours in which packets of medicinal plant/plant parts are boiled in water while the patient is allowed to sit
under a blanket with pot containing the boiled plant/plant parts and inhaling vapours cures the patient.

The various methods employed in the preparation of prescriptions were:

i) Plant parts boiled or soaked in water to make an infusion or decoction.

ii) Plant parts bruised and applied externally.

iii) Plant parts chewed and sucked.

iv) Plant parts pounded and the juice extracted.

v) Plant parts dried and powdered.

vi) Plants parts pounded and made into a paste.

vii) Plant parts pounded and made into pills.

viii) Plant parts rubbed or inhaled.

The methods one and six are the commonest ones. As far as the techniques of preparation of medicine are concerned, these do not appear to resemble those specified in present day organised pharmaceutical practices. In some preparations, household utensils (e.g. cup, bowl, pot, knife, etc.) and naturally available materials (e.g. sticks, pieces of stones, etc.) were used. In all cases, medicines are prepared manually, while most preparations do not specify the quantities of ingredients to be included; those that indicate are only the use of rough measurements. In some cases, physical observations and use of cups and spoons are also indicated.

The study also revealed the frequency of different plant parts used in the prescriptions. It is seen that leaf and shoots (30.2%) are the commonest plant parts used, which are followed by roots and tuber (22.4%), bark (9.6%), stem (9.4%), fruit (8.7%), seed (8.6%), whole plant (6.2%), juice or latex (3.4%), and flower (1.5%) (Fig. 6.5).

The study also provides the following information with particular reference to plants:

(a) Same plant is often used for treating a number of different ailments.

(b) Same part of the plant is used for treating different, even unrelated, ailments.

(c) Different parts of a plant are used for treating different ailments, and

(d) Different parts of a plant are used for treating the same ailment.

Use of different parts of a plant for treating the same ailment indicates the possibility of having some active principle useful for the ailments.

Many of the medicinal plants used in the ethnomedicine of Darrang district
are well known for their medicinal value. Of the 338 plants recorded in the present study, 46 (13.6\%) plants are known in British and/or Indian Pharmacopoeia. There are also 86 (25.4\%) species known for their use in Ayurvedic, Unani and Siddha systems of medicine.

It is interesting to note here that ethnomedicinal practice prevalent in Darrang district has incorporated a number of medicinal plants which are not occurring in the area. These species viz., Coptis teeta, Croats sativus, Pistacia chinensis, Sausurea lappa, Swertia chirayita, Syzygium aromaticum and Tribulus terrestris have been procured either from crude drug dealers or in exchange from practitioners of neighbouring areas. In most cases these plant ingredients have been procured from crude drug dealers from Bhutan.

A pertaining question of traditional medicine in general through the globe is that how long it will survive in the face of cosmopolitan medical systems. The negative — or at best indifferent — official policy towards traditional medicine is to some extent counteracted by certain tendencies on both a national and international level.

In Assam a growing nationalism among the cultural group has made traditional medicine *en vogue* in certain quarters. Some regard traditional medicine as a national heritage which is their duty to preserve, others want to use the traditional doctors to ensure better health services for the majority of the people, while majority see the possibility of using the experiences of traditional medicine to find new drugs and to start producing them to reduce the new enormous imports of Western drugs. Unfortunately these people do not seem to be interested in the tradition as a whole, but only in the pharmaceutical side of it.

These tendencies are strengthened by a worldwide trend that springs from the realisation that, in the last two decades, development projects do not seem to have had the desired impact in the rural areas of the third world. This fact, coupled with the developed nation's fears regarding the population explosion and economic instability, has led to an increasing interest being taken in the peasants and people of these areas. In the health sector, the WHO is focusing its attention on the already existing cures in rural areas, having realised that Western medical treatment, as it organised in most developing countries, does not reach the majority of the population. WHO and other development agencies thus favour some kind of integration of the traditional and modern health-care system, along the Chinese model.

To bring better health-care to more people this trend is ideal, but a good deal of hypocrisy involved in this effort. What basically is happening is that traditional curers are being used to serve the spread of the Western medical tradition, and that this
exploitation will hasten the disintegration and destruction of the traditional medical systems throughout the world.

There are two prerequisites for any real integration in the true sense of the word. First the parties to be integrated must be somehow equally strong, and, secondly, there must exist a mutual respect. None of these conditions is present. Western medicine is young, strong, and self-confident (to the point of being arrogant), endowed with official backing and the advantages derived from being part of an economically and culturally expanding force, while traditional medicines throughout the world are old, weak and internally rather disorganised, having no backing. And despite all lip service to, and verbalized claptrap about the tradition, Western medicine does not have any real respect for traditional medicine.

The “integration” taking place under these circumstances is bound to be on the conditions of the stronger. What is actually happening is that traditional medicine is being swallowed by the modern — the unpalatable parts being spit out or remaining undigested. Traditional medicine is not just an overripe grape to be sucked for valuable pharmaceutical components for the immediate benefit of the Western pharmaceutical industry. It is a system belonging to a cultural tradition, and should be studied, appreciated, and used as such.