CONCLUSION

Health is a man’s natural condition and it is the result of living in accordance with the natural laws pertaining to the body, mind and environment. These laws relate to fresh air, sunlight, diet and relaxation, sleep, cleanliness, elimination, right attitudes of mind, good habits and above all lifestyle. Modern medical science is often accused for its preoccupation with the study of disease, and neglect of the study of health. It has encouraged people to rely on drugs and tonics for the maintenance of health than teach them the rational way to health. Our hospitals are flooded with the sick, both physical and mental but there are no institutions to show people the road to good health. Our ignorance about health continues to be profound, as the determinants of health are not yet clear, the definition of health is elusive and there is no one single yard stick for measuring health.

Health continues to be a neglected entity despite lip service. At the individual level, it is usually subjugated to other needs like wealth, power, prestige, knowledge and security. Health is often taken for granted and its value is not fully realized. Health was “forgotten” when the covenant of the League of Nations was drafted after the First World War. Only at the last moment, world health was brought in. Health was again “forgotten” when the charter of the United Nations was drafted at the end of the Second World War. The matter of health had to be introduced adhoc at the United Nations Conference at San Francisco in 1945.

However, during the past few decades there has been a reawakening that health is a basic human right and a world-wide social goal: that it is essential to the satisfaction of basic human needs and the quality of life: and, that it is
to be attained by all people. In 1977, the 30th World Health Assembly decided that the main social target of Government and WHO in the coming decades should be “the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a social and economically productive life. With the adoption of health as an integral part of socio-economic development by the United Nations in 1979, health while being an end of itself has also become a major instrument of overall socio-economic development and the creation of a new social order.

India has one of the most ancient civilizations in recorded history. Thousands of years before the Christian era, there existed a civilization in the Indus Valley, known as the Indus Valley Civilization. Excavations in the Indus valley (e.g., Mohenjodara and Harappa), showed relics of planned cities with drainage, houses and public baths built of baked bricks suggesting the practices of environmental sanitation, by an ancient people as far back as 3,000 B.C. India was invaded by the Aryans around 1,400 B.C. It was probably during this period, the Ayurveda and the Siddha systems of medicine came into existence. Ayurveda or the Science of Life developed a comprehensive concept of health. The manu samhita prescribed rules and regulations for personal health, dietetics and hygienic ritual at the time of birth and death, and also emphasized the unity of the physical, mental and spiritual aspects of life. Sarva Jano Sukhino Bhavatu (may all men be free from diseases and may all be healthy) was an ancient saying of the Indian sages. This concept of happiness has its roots in the ancient Indian philosophy of life. Which conceived the oneness and unity of all people, wherever they lived.
The Post-Vedic period (600 B.C – 600 A.D.) was dominated by the religious teaching of Buddhism and Jainism. Medical education was introduced in the ancient universities of Taxila and Nalanda, leading to the titles of Pranacharya and Pranavishara (34). A hospital system was developed during the reign of Rahula Sankirtyana (son of Buddha) for men, women and animals and the system was continued and expanded by King Asoka.

The next phase in Indian History (650-1850 A.D.) witnessed the rise and fall of the Moghul empire. The Muslim rulers introduced into India around 1000 A.D. the Arabic system of medicine, popularly known as the Unani System, the origin of which is traced to Greek medicine. The Unani system since then became part of Indian medicine. With changes in the political conditions in India, the torch which was lighted thousands of years ago by the ancient sages grew dim, medical education and medical services became static, and the ancient universities and hospitals disappeared.

Health has been declared a fundamental human right. This implies that the State has a responsibility for the health of its people. National governments all over the world are striving to expand and improve their health care services. The current criticism against health care services is that they are (a) predominantly urban oriented (b) mostly curative in nature, and (c) accessible mainly to a small part of the population. The present concern in both developed and developing countries is not only to reach the whole population with adequate health care services, but also to secure an acceptable level of health for all through the application of primary health care programmes.
The coming of the British with their Renaissance ‘science and culture’ to India is an epoch-making event in Indian history. It initiated the process of subjugation and captivation of India’s traditional scientific systems by the fast-developing modern scientific systems of the West. India did not lose politically alone. It became a prized colony for the Western sciences, too. With the colonial power at the apex, the Western sciences, without facing any recognizable resistance, gradually dethroned and outdistanced the indigenous scientific systems and stamped the seal of their superiority. The British made full use of their sciences both in the creation as well as in the maintenance of the Empire.

Concern for health has been an important feature of all historical processes, and more so in a process like colonization which involved aggression, intrusion and imposition of one’s will upon another. Every naval dispatch from Europe had a surgeon on it, and he not only looked after the sick on board and land, but was the first to report on the flora, fauna and resources of the new territory. He was a surgeon-naturalist, an adventure-scientist in the true sense. The medical training that he had (especially from Edinburgh) was different and made him feel superior while encountering other medical practices. Epistemologically, the system that he represented was not very dissimilar to that of the East, and some of them did show respect to the latter. But this was gradually lost in the victorious march of the colonizers’ army. Gradual assimilation or synthesis was not on their agenda. Absolute supremacy of the one and total subjugation of the other characterized the Victorian imperialism for which the colonial medical men worked, and that is the reason their work, however noble and pioneering, can best be understood in terms of ‘colonial medicine’.
Preservation of European health in new and ‘hostile’ lands was colonial medicine’s first responsibility. Gradually the colonial doctors developed into a cultural force. They began defining or redefining what they saw in the colonies in terms of their own training and perceptions. Their work encompassed not only the understanding and possible of new diseases, but also the extension of Western cultural values to the non-Western world. Imperialism, both as an impulse and an attitude, required the operation of a set of skills and rules. European medicines undoubtedly complemented these. As Franz Fanon put it, in the colonial context going to see the doctor, the doctor, the administrator, the constable or the mayor became identical moves.

During the eighteenth century colonial medicine was wrapped in legendary adventures and medical geography in some scientific senses but in the Victorian era it graduated into an organized colonial effort, though the name given to it was tropical medicine, there was hardly anything tropical about it apart from the fact that it operated in a tropical environment. Most of the so-called tropical diseases (except scala ring-worn which thrived only in the tropical climes) which the tropical doctors dealt with were to be found in Europe as well. Europe had known cholera, plague and smallpox for centuries. What distinguished them in a tropical climate was their intensity and ferocity. Very organized efforts were needed to combat it. In the ‘settler’ colonies where the Europeans had found a permanent home, medical discourse took the language of practical public health and also professional advancement. But this was not to be so in classic colonies like India, Nigeria or Congo where it worked as an appendage of the army and spoke the idiom of political and cultural superiority. Settler colonies were the extension of
the European culture itself. In other areas both physical and cultural encounters took place in which the prevailing episteme and system has to be defeated and subordinated. The prevalent India medical practices therefore received more opprobrium than it deserved. Condemnation was easier but finding the cause of and a solution to the prevalent diseases was something different and difficult. Hence the blame was put on the climate; heat and humidity became the major obsessions of the tropical ‘miasmatic’ medicine and miasma held its sway till Pasteur arrived.

The last quarter of nineteenth century saw new breakthroughs. This was the era of bacteriology and parasitology. Search had begun for the microbes and the medium (the vector), and the tropical soil was found to be rich in both. What had begun as medical geography now became tropical medicine. A new discipline was ushered in with new specializations like helminthology, protozoology and medical entomology. Parasitology gave many colonizers a sense of purpose and practical programme. The microscope supplanted the sword, and the martial spirit gave place to research habit in some limited sense.

Yet the fact remains that whether it were the early miasmatic theories of the eighteenth century or the tropical medicine of the late nineteenth century, both were determined and influenced by the colonial conditions and imperatives; hence the use and relevance of the term ‘colonial medicine’ But it must be conceded and emphasized that ‘colonial medicine’ even if dependant, and public health policy, even if of a colonial character, were great improvements upon the pre-colonial medicine and health policies.
The present work is an exercise in exploring how the new medical system made its way through new educational policies and institutions; how it gradually professionalized itself through dispensaries and service cadres like the Indian Medical Service (IMS); and how and to what extent medical researchers were carried out. This work began on a wider canvas but as it progressed, the limitations came to the fore. The present work is to be seen basically from the perspective of social and institutional history.

The impact in greater detail. Was done by David Arnold and L. Catanach through their case studies on smallpox and plague, respectively. Arnold later edited an interdisciplinary volume devoted to imperial medicine. Locating science and technology component in the colonial expansion is the aim of this work. During the 1980s several works appeared in this context. One of the earliest was D.R. Headrick’s The Tools of Empire which showed how penetration into Africa was not possible without conquering the several diseases, especially that caused by the tsetse flies. Mastery in the local topography and the local environment was a sine qua non for any imperial expansion.

The works of P.D. Curtin are of special interest in this context. Michael Worboys has discussed the medical efforts in relation to Africa and other colonies. He has studied the emergence of tropical medicine as a new discipline and has made a valuable contribution to an understanding of its nature and context. In India, Radhika Ramasubban produced an analytical piece on the origins of public health and medical research. But hers is a slim volume and she has not been able to study its and its impact on the indigenous societies. Yet the confrontation between indigenous and Western medical systems is an area which calls for more attention. Around the same
time Roy Macleod and Lewis Milton edited a volume which makes a comparative study of European medicine and colonial practices spread over the continents of Africa, Asia and Australia. Both these volumes show how medicine served as instruments of the Empire; ‘touching the body’ as Arnold puts it, became the object and tool of control. Different colonial societies reacted in different ways.

More recent works of Mark Harrison and Warwick Anderson show the explicit and subtle differences in the approaches of different colonial powers. Taken together they all tend to explain the phenomenon from a metropolitan perspective. More perceptive analysis would require an understanding of local responses as evidenced in local sources and this is yet to be done. A recent work by Poonam Bala Imperialism and Medicine in Bengal is welcome attempt in this regard, and she is at her best in describing the professionalization of imperial medicine. There are useful charts on the ethnic profile of the medical students in Calcutta but the questions relating to cultural interaction are ignored.

The state of knowledge about the latter aspect hovers around those contained in Charles Leslie’s comparative volume on Asian medical systems. Leslie’s pioneering study supplemented by that of David Arnold provides valuable insights into the whole gamut of the relationship between modern and traditional medicine. Yet there remains a need to shift the focus from a metropolis-oriented discourse to that of the receiver’s perspective. To some extent this has been done by Deepak Kumar in his Science and the Raj. The inherent structural limitations of the recipient society, the cast structure so unique to India and its own strong traditions, with similar presumptions of them/us, inferior/superior, lower/upper, which predicated nineteenth
century European thought, need greater attention and the present work is an attempt towards

The British medical policy originated from and remained subservient to the needs and expediencies of the Empire. The rulers primarily concentrated on how to provide the best of hygienic, sanitary and medical facilities to the military and civil population of their own race. Together with the geological, botanical, zoological, and meteorological surveys of India. The medical men aimed to understand the Indian environment and render it habitable and bountiful for the Europeans. Despite the much condemned tropical heat and miasmas, the British led a healthier and richer life with increased vitality and life expectancy even when compared to the European standards. Many contemporary reports and critiques testified to his fact.

Europeans who enjoyed historic immunity against smallpox and plague and with the help of quinine they managed malaria quite well, and with excellent sanitary measures in and around the cantonments and civil lines they warded off cholera to a great extent. The real victims were the indigenous peoples who fell in droves at the outbreak of every epidemic.

Colonial medicine did not mean altruism; it meant uncanny imperialism par excellence. In a brilliant piece of study in imperial perceptions, the Raj Syndrome, Subash Chakravarty confirms that although imperialism and humanism were historical realities, that were not parallel phenomena. He rightly remarks that while imperialism had been a continuous process in British India, humanism was just an occasional and sporadic intruder. Colonial medicine proved, in fact, to be a twin-edged weapon which cut the colonized both physically and morally. Not only the
body but the mind as well was conquered. The conquest was so thorough that the Indian mind remained content in captivity for over a century. It could assert the need and importance of a national science only towards the end of the nineteenth century and that too in association with the emergence of the freedom movement in the country.

Another distressing but an outstanding outcome of the colonial medicine was that it added competition and complexities to the already hetero-geneous medical culture of the country. The common people became the worst victims of this diametrically opposed, mutually contentious and thoroughly unaccountable medical culture. The reason for this in Jeffery’s views was the inability of the imperial government to choose one and only one out of the two options available: to outlaw all but the Western doctors, or to integrate all medical teaching into a ‘national’ system. The first was essentially the pattern followed in Britain; the second was experimented upon by china with excellent results. The Indian solution combined the worst of both options: a multitude of practitioners, with no guarantee that any of them was trustworthy, and continual bickering between the existing groups only helped to frustrate the attempts to deal systematically with Indian health problems.

It was fairly clear since the beginning of the British rule that the colonial medicine derived its authority from the state and not from the consent of the people. Though chiefly dependent upon the coercive agencies of the army and police, the British desperately needed the people’s consent for the legitimating of its power and prestige and concomitant awe and wonder among the masses, they needed a class of collaborators and the Brahmins came handy to fill the vacant space. That was not without reason.
They had already demonstrated their testimonials of credence right from the Plassey days.

Allopathy, a medical science of intrinsic merit in matters of diagnosis and effective treatment, would have settled itself on firm and popular footing even without the state support and monitored machinations. The clandestine arrival and all-India spread of homeopathy is a glowing reminder of this fact. Allopathy would have, in all probability, naturally outdistanced the traditional medicines and that too without much heartburning, breast-beating and counter-political resistance. Since it was routed via colonial medicine, it had to get identified with the imperial coercion and exploitation. The British never allowed it to sail freely in the Indian society. They controlled the oars and always predetermined its direction. Ultimately, thus they failed ‘to make sure that a true art of curing does exist’, and that ‘investment in health care is an obligation, and not just an option, of any civilized society’.

*The Medical School in Bangalore, A Government Institution* was started in January 1881 at Bangalore Peta Hospital by Dr. D.A. Choksi of the Grant Medical College, Bombay. It provided a three year course to qualify for the lower grades of medical subordinates. The minimum qualification for the admission was Metric pass or the Metric course. It was under the control of a Surgeon to the Commissioner who made periodic inspections, directed examinations, exercised control over teachers and students. The age limit for administration was between 17 and 18 years and every year 20 to 24 students were admitted. During 1881, there were 14 students on rolls. The school had a short span of life and was abolished in 1836 after which, there was no provision in the State for Medical Education.
till 1917, when students were sent to Madras and Bombay for Medical Education, at college and schools levels respectively. For higher studies in medicine, students were deputed to foreign countries.

Another medical School was started in Bangalore on the 1st July 1917 for training Sub-Assistant Surgeons and Private Medical Practitioners. It provided a course of four years and the first batch had 16 students. The Medical Officer of the Victoria Hospital was its principal. In addition to subjects of medicine, Physics, Chemistry and Biology were taught. When the Medical College was started (1924) at Bangalore, the School went under the control of Mysore University. Most of the teachers were from the State medical Department. It offered the L.M.P. Diploma of four years recognized all over India. When the Medical College was transferred to Mysore in July 1930, this School became an independent Unit to be continued under the University. The strength of the school was 16 in 1917 and 214 in 1941. As a policy decision to have only degree courses in Medical Education, this School was closed in 1856, when it had strength of 612 students.

Medical facilities has developed through the time and Bangalore houses a number of modern and super specialty health care facilities like the Mallya Hospital, St.Johns hospital, M S Ramaiah Hospital, Jayadeva Hospital (Govt.), Narayana,(i) Hrudayalaya (ii) Nthralaya, are some of the few specialty hospitals.

Modern trends in Indian medicine are Globalization and the trend towards ‘Herbalisation’. The demand for herbal products worldwide increased gradually. The international potential for Ayurvedic products. It
seems from this as if Ayurveda is facing resurgence and revival ‘in the world’, as it is ‘at home’. In keeping with the statement so far it is important to recognize the frame of knowledge and industry in which it is going to be cast and what implications it has for the medical system.

Further, that the assiduously cultivated frame of ethical promotion (including clinical trials and its legitimizing principles), the larger network of doctors, hospitals and medical education built up along with the pharma companies, is going to remain the frame in which these systems will have to find a defining position, if at all. Thus the forces of globalization, even as they appear to find a place for Ayurveda in the sun at last, continue the encounter between Ayurveda and modern medicine that goes back to the nineteenth century.

Going by sheer presence and a distinct identity, Ayurveda has existed in many parts of the world for a very long now. Its presence was initially part of the twentieth-century interest in things Indian-Philosophy, yoga, food- that were projected to receptive audiences in the ‘the West’. Thus, along with a number of people that taught different paths to spirituality, or the practice of yoga, ideas of Ayurveda as a system of holistic health gained ground. In the initial part of the twentieth century this remained confined to a limited audience, but since the 1970s, with the environmental and other movements seeking alternatives gained ground, it found a much larger audience. It is since the early 1980s then that two trends can be discerned in the practice and presence of Ayurveda.
The trend involves those practitioners that actually practice the medical system, in terms of diagnosis and treatment. Technically, there is no provision in any country outside of South Asia for Ayurvedic practitioners to have a license to practice the System of Ayurvedic medicine. Yet, it is well-known that not only is this being done, but also a number of practitioners and teachers regularly carry medicines from India, prescribe and dispense them. Many of these practitioners are well-known in conclaves of communities that rely on their knowledge and access to Ayurveda and probably are even more popular today.

Today, Bangalore is an international destination for health care, complicated surgeries related to neuro and nephrological department and cardiology department. Many patients from various countries with support of the government and various agencies are treated in these super specialty hospitals and genesis which started about century and half years ago continues to progress on and expands specialized services in all aspects of medical care.